



A Virtual Symposium: Legal Considerations of Disability Healthcare

Evaluation Report

Prepared: June 30, 2026
Wyoming Institute for Disabilities (WIND)

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Executive Summary

The virtual symposium had 132 attendees from 222 registrants (59.5%). The response rate was strong among attendees of which 73 attendees completed or partially completed the evaluation (55.3% of attendees). Session 1 had the largest attendance ($n = 117$), followed by Session 3 ($n = 109$), Session 2 ($n = 105$), and Session 4 ($n = 95$). Overall ratings were highly favorable. Nearly all respondents reported being satisfied (98.6%) or very satisfied with the symposium and rated the overall quality as 4 or 5. Respondents also rated all five symposium objectives positively (ranging from $M = 4.51$ to $M = 4.79$), with especially strong results for ADA requirements and accessibility barriers. Implementation confidence was favorable but comparatively lower than satisfaction and quality ratings, suggesting that participants valued the symposium while still needing practical supports to apply the content in real settings. The most frequently selected barriers were organizational and systems barriers ($n = 53$, 72.6%) and lack of time, staff, or resources ($n = 48$, 65.8%). Geographically, the event primarily served Wyoming while also reaching participants from other U.S. states and a small number of international attendees. Among attendees, 92 were from Wyoming, with Albany and Laramie counties accounting for the highest numbers of Wyoming attendees.

Methods

Survey Instrument and Layout

The WIND Health and Disability Survey instrument comprised of Demographic Information, Overall Symposium, Session 1, Session 2, Session 3, Session 4, and Additional Feedback. The survey asked respondents about their administrative attendance. The survey also had categorical items, Likert-type rating items, multiple-response questions, and open-ended prompts.

Data Source and Analytic Sample

The analytic file included 222 individual records after excluding one aggregate totals row (see Table 25 Appendix A for detailed Variable-by-Variable Descriptive Inventory). Attendance fields identified 132 individuals who attended at least one session. All 73 evaluation respondents were attendees. One evaluation record was incomplete but contained valid responses; therefore, item-level analyses used all valid responses available for each item (see Table 27 in Appendix C for detailed breakdown of the core evaluation denominators).

Analytic Approach

Descriptive statistics were calculated for all available variables. Binary attendance and multi-selected items were summarized as counts and percentages. Ordinal rating items were converted to numeric values using the response label or the leading numeric value in the response option. For 1-5 objective and quality ratings, favorable responses were defined as 4 or 5. For session-level agreement items, positive agreement was defined as agree or strongly agree. Open-ended responses were summarized thematically and de-identified; names, phone numbers, and email addresses were not printed in the report.

Evaluation Findings

Demographic Information

Job Title

As shown in Table 1, among the 72 respondents with job title, the largest category was other roles ($n = 23$, 31.9%), indicating that many participants held positions that did not fit neatly into the main role groups. The next largest group was case manager/care coordination ($n = 19$, 26.4%), followed by administration/program leadership ($n = 16$, 22.2%). Case management/care coordination and administration/program leadership accounted for nearly half of respondents ($n = 35$, 48.6%), suggesting strong participation from professionals involved in service coordination, program operations, and systems-level support. Clinical roles were also represented, although to a lesser extent. Nursing accounted for 12.5% of respondents ($n = 9$), while social work/clinical social work represented 5.6% ($n = 4$). Physical therapy/rehabilitation was minimally represented ($n = 1$, 1.4%). Overall, the results suggest that the symposium reached an interdisciplinary audience, with particularly strong representation from care coordination, administrative leadership, and other community-based or service-oriented roles.

Table 1

Open-Text Role Group Summary

<i>Role group</i>	<i>n</i>	<i>% of respondents with job title</i>
Other roles	23	31.9%
Case manager/care coordination	19	26.4%
Administration/program leadership	16	22.2%
Nursing	9	12.5%
Social work/clinical social work	4	5.6%
Physical therapy/rehabilitation	1	1.4%

Note. Role groups were created from open-text job titles for interpretive reporting. Percentages are based on the 72 evaluation respondents with job title data.

Organization

The most frequently represented organizations were the University of Wyoming and Memorial Hospital of Sweetwater County (see Table 2 below). The Wyoming Department of Health and LIV Health each had four respondents, while several organizations, including Jordan School District, Wyoming Institute for Disabilities, and Volunteers of America, each had three respondents. This distribution suggests that the symposium reached participants across academic, healthcare, public health, school-based, disability service, and community service settings. This breadth is important because the symposium focused on topics that require collaboration across clinical, educational, public health, and community-based systems.

Table 2

Top Organizations Represented

Organization	<i>n</i>	% of known organizations
University of Wyoming	5	2.3%
Memorial Hospital of Sweetwater County	5	2.3%
Wyoming Department of Health	4	1.8%
LIV Health	4	1.8%
Jordan School District	3	1.4%
Wyoming Institute for Disabilities	3	1.4%
Volunteers of America	3	1.4%
Wyoming Independent Living	2	0.9%
Align Services of Wyoming	2	0.9%
Quality Case Management	2	0.9%

Note. Organization names are reported only in aggregate counts.

Sessions

The findings show that 132 of 222 registrants (59.5%) attended at least one session. Attendance was highest for Session 1 ($n = 117$, 52.7% of registrants) and remained substantial across Sessions 2-4 (see Table 3 below).

Table 3

Attendance by Session

Attendance variable	<i>n</i>	% of registrants	% of attendees
Session 1: ADA Overview	117	52.7%	88.6%
Session 2: Guardianship	105	47.3%	79.5%
Session 3: Practical Accessibility	109	49.1%	82.6%
Session 4: Lived Experience Panel	95	42.8%	72.0%
Attended at least one session	132	59.5%	100.0%

Note. The Total variable indicates attendance in at least one session.

Location

Country

As shown in Figure 1 below, country was available for 219 of 222 records (98.6%). Among known country records, most participants were from the United States ($n = 214$, 97.7%), with additional participation from India, Morocco, and Indonesia.

Figure 1

Countries Represented^{1,2}

Countries Represented



Note. Countries with participant records are shaded; the legend uses a log scale because the United States had substantially more participants than other countries.

¹ Natural Earth. (n.d.). Admin 0 - Countries. <https://www.naturalearthdata.com/downloads/110m-cultural-vectors/110m-admin-0-countries/>

² U.S. Census Bureau. (2024). Cartographic boundary files - shapefile. <https://www.census.gov/geographies/mapping-files/time-series/geo/cartographic-boundary-file.html>

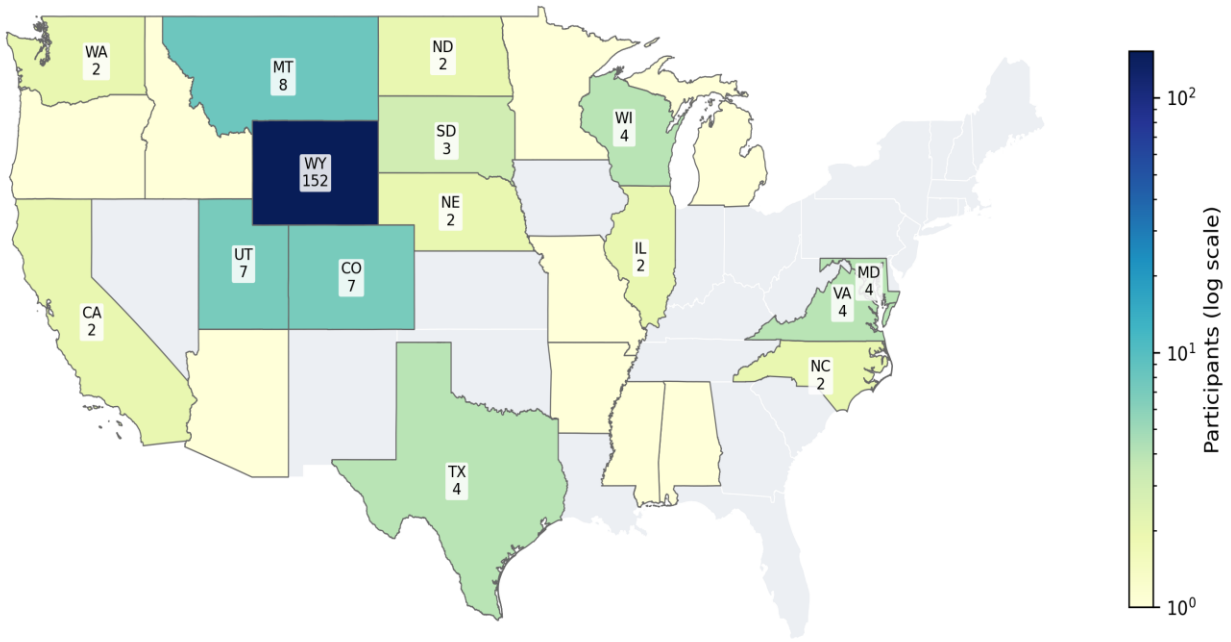
Participants Across the United States

As shown in Table 4 below, twenty-four states participated in the symposium. Wyoming was the largest state group ($n = 152$, 71.0%).

Table 4*State Representation*

<i>State</i>	<i>n</i>	<i>%</i>
Wyoming	152	71.0%
Montana	8	3.7%
Missing	8	3.6%
Utah	7	3.3%
Colorado	7	3.3%
Wisconsin	4	1.9%
Virginia	4	1.9%
Maryland	4	1.9%
Texas	4	1.9%
South Dakota	3	1.4%
North Dakota	2	0.9%
North Carolina	2	0.9%
Illinois	2	0.9%
California	2	0.9%
Washington	2	0.9%
Nebraska	2	0.9%
Alabama	1	0.5%
Michigan	1	0.5%
Minnesota	1	0.5%
Arizona	1	0.5%
Idaho	1	0.5%
Arkansas	1	0.5%
Missouri	1	0.5%
Mississippi	1	0.5%
Oregon	1	0.5%

Note. Percentages for listed states use the number of nonmissing state records as the denominator; the missing category uses total registrants.

Figure 2*U.S. States Attendees by State*^{3,4}**U.S. States Represented**

Note. States with participant records are shaded. The legend uses a log scale to show smaller state counts while preserving the dominant Wyoming count.

³ Natural Earth. (n.d.). Admin 0 - Countries. <https://www.naturalearthdata.com/downloads/110m-cultural-vectors/110m-admin-0-countries/>

⁴ U.S. Census Bureau. (2024). Cartographic boundary files - shapefile. <https://www.census.gov/geographies/mapping-files/time-series/geo/cartographic-boundary-file.html>

Wyoming State

Wyoming had the largest participants ($n = 152$) where Laramie County ($n = 37$) and Albany County ($n = 29$) had the most represented counties (see Table 5 and Figure 3 below).

Table 5
Wyoming County Representation

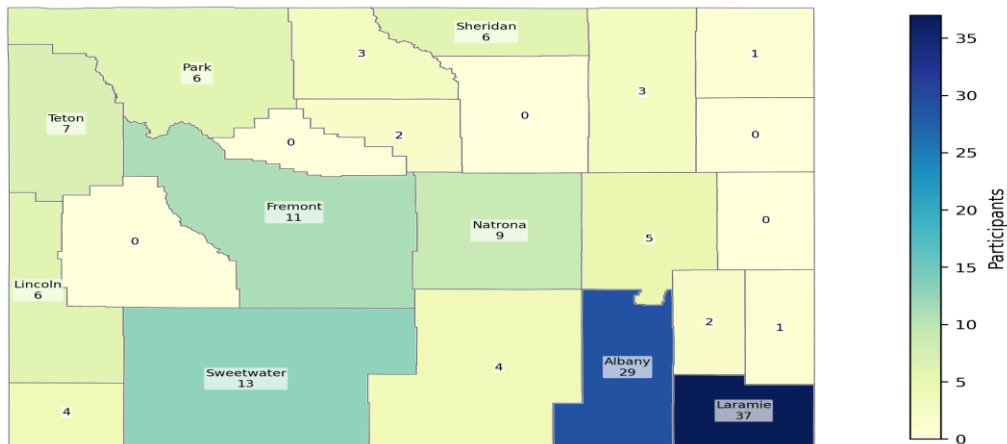
Wyoming county	<i>n</i>	%
Not Specified	70	31.5%
Laramie County	37	24.3%
Albany County	29	19.1%
Sweetwater County	13	8.6%
Fremont County	11	7.2%
Natrona County	9	5.9%
Teton County	7	4.6%
Lincoln County	6	3.9%
Sheridan County	6	3.9%
Park County	6	3.9%
Converse County	5	3.3%
Carbon County	4	2.6%
Uinta County	4	2.6%
Campbell County	3	2.0%
Big Horn County	3	2.0%
Not Applicable	3	2.0%
Washakie County	2	1.3%
Platte County	2	1.3%
Goshen County	1	0.7%
Crook County	1	0.7%

Note. The denominator is the number of records with a nonmissing Wyoming county field. Not Specified is retained in the table but is excluded from the county map.

Figure 3

Wyoming Attendees by County

Wyoming Counties Represented



Note. County boundaries are shown for Wyoming. Not Applicable responses are excluded from the map.

Profession Profile of Participants

Are you a licensed healthcare professional?

Among respondents, 46.6% reported being licensed healthcare professionals and 39 (53.4%) reported that they were not (see Table 6 below).

Table 6

Licensed Healthcare Professional Status

<i>Response</i>	<i>n</i>	<i>% of respondents</i>
Yes	34	46.6%
No	39	53.4%

Note. Denominator is evaluation respondents ($N = 73$).

What are your credentials?

Registered nurse was the most selected credential, followed by other credentials and licensed clinical social worker (see Tables 7 and 8 and Figure 4 below).

Table 7

Credentials Reported

<i>Credential</i>	<i>n</i>	<i>% of respondents</i>
RN	16	21.9%
Other	9	12.3%
LCSW	4	5.5%
NP	3	4.1%
MD	2	2.7%
PT	1	1.4%
SLP	1	1.4%
RD	1	1.4%

Note. Credential percentages use evaluation respondents as the denominator. Because this was a multi-selected question, percentages may sum to more than 100%. Zero-count credential choices are reported in Appendix A.

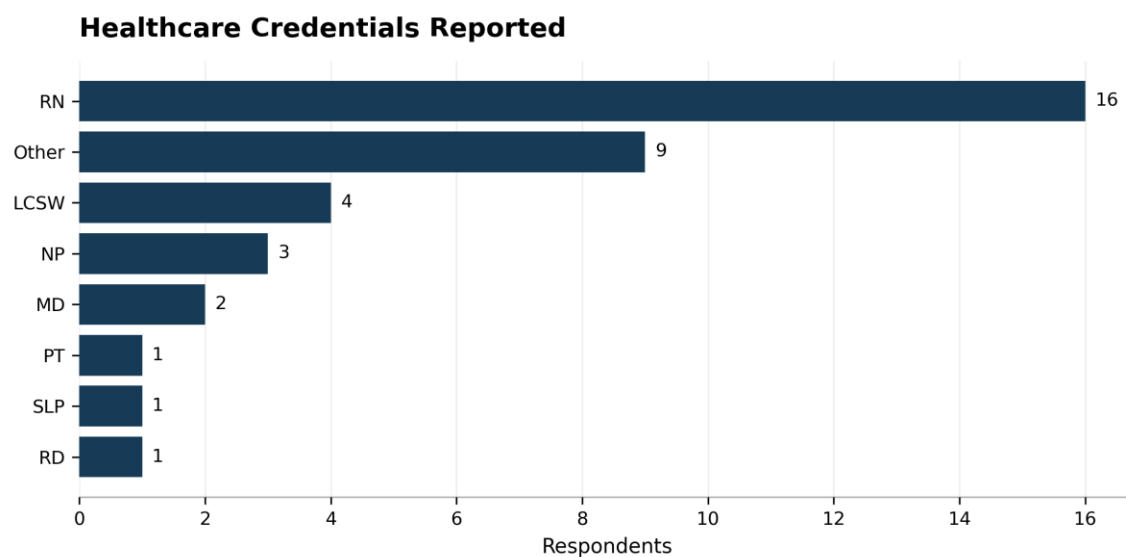
Table 8

Open-Text Role Group Summary

<i>Role group</i>	<i>n</i>	<i>% of respondents with job title</i>
Other roles	23	31.9%
Case manager/care coordination	19	26.4%
Administration/program leadership	16	22.2%
Nursing	9	12.5%
Social work/clinical social work	4	5.6%
Physical therapy/rehabilitation	1	1.4%

Note. Role groups were created from open-text job titles for interpretive reporting. Percentages are based on the 72 evaluation respondents with job title data.

Figure 4
Healthcare Credentials Reported



Note. Only nonzero credential selections are shown in the figure.

If other, what is your credential?

Nine respondents provided other credentials which included the following. The responses included CSW, PCSW, medical laboratory technician (MLT), DNP, EMT, SANE-A, LPN, and NHA (see Table 9 below).

Table 9
Other Credential Responses

<i>Other credential</i>	<i>n</i>	<i>% of other credential responses</i>
MLT	2	22.2%
CSW	1	11.1%
PCSW	1	11.1%
DNP	1	11.1%
EMT	1	11.1%
SANE-A	1	11.1%
LPN	1	11.1%
NHA	1	11.1%

Note. Text responses were summarized as written, with no names or contact details.

Quality of the Symposium

Participants were asked to rate their overall satisfaction with the symposium. Overall satisfaction was very high. Nearly all respondents (98.6%) were satisfied or very satisfied, including 72.6% who were very satisfied (see Tables 10 and 11 and Figure 5 below).

Table 10

Overall Satisfaction

<i>Satisfaction response</i>	<i>n</i>	<i>% of respondents</i>
Very Satisfied	53	72.6%
Satisfied	19	26.0%
Very Dissatisfied	1	1.4%

Note. Denominator is evaluation respondents ($N = 73$).

Table 11

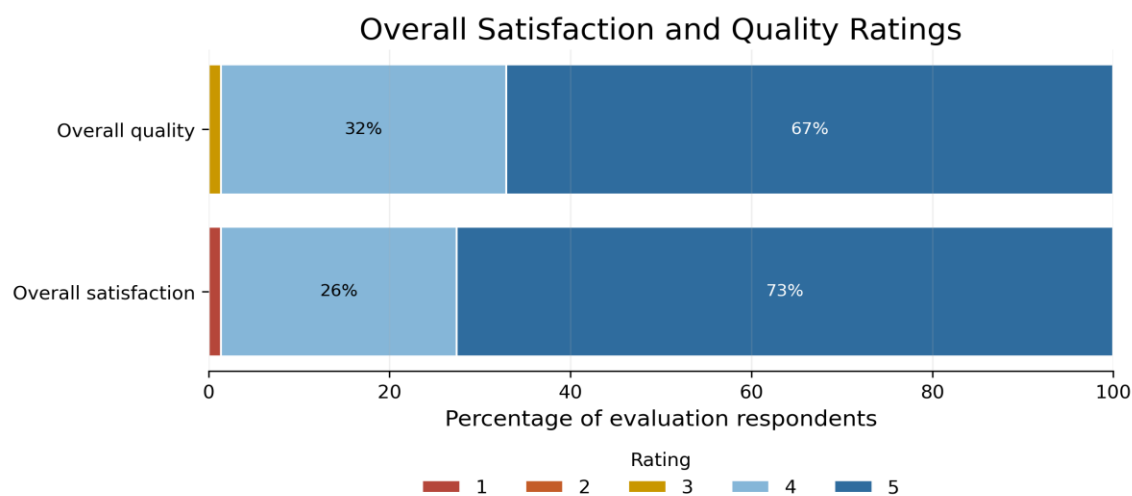
Overall Quality Rating

<i>Measure</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>Mdn</i>	<i>Range</i>
Rate the overall quality of the symposium.	73	4.66	0.51	5	3–5

Note. Quality was scored on a 1-5 scale, with higher scores indicating higher perceived quality.

Figure 5

Overall Satisfaction and Quality Ratings



Note. Ratings were coded from 1 to 5, with higher values indicating more favorable responses. Percentages are based on 73 evaluation respondents.

Objectives of Symposium

Please rate how well the objectives of this symposium were achieved

As shown in Table 12, respondents rated the symposium objectives highly overall, indicating strong perceived achievement of the training goals. The overall capacity-building objective, focused on strengthening healthcare professionals' ability to provide accessible, high-quality, and culturally humble healthcare for people with disabilities, received a strong mean rating ($M = 4.63$, $SD = 0.54$). Most respondents rated this objective as good or excellent ($n = 71$, 97.3%), suggesting that participants perceived the symposium as effective in advancing its broader professional development purpose.

The objective focused on identifying key requirements of the Americans with Disabilities Act (ADA) in healthcare settings and applying at least two ADA-related best practices was among the strongest-rated items ($M = 4.79$, $SD = 0.41$). All respondents who answered this item rated it as good or excellent, indicating that the ADA-focused content was especially well aligned with participants' learning needs and expectations. Similarly, the objective related to recognizing common accessibility barriers in healthcare environments and identifying strategies to improve accessibility across physical spaces, virtual platforms, and care processes was rated very highly ($M = 4.78$, $SD = 0.42$). All respondents rated this objective as good or excellent, suggesting that participants found the accessibility content clear, relevant, and applicable to healthcare practice.

Respondents also rated the lived-experience objective strongly ($M = 4.74$, $SD = 0.50$). This objective focused on incorporating insights from individuals with disabilities and caregivers into strategies for improving healthcare provision. The high rating suggests that participants viewed lived-experienced perspectives as valuable for informing more inclusive, responsive, and person-centered healthcare practices.

The objective focused on differentiating between guardianship and shared decision-making options was rated positively but had the lowest mean among the objective items ($M = 4.51$, $SD = 0.63$). Although this rating still reflects a strong level of perceived achievement, the comparatively lower mean suggests that future training may benefit from additional depth, applied examples, or case-based discussion related to guardianship, shared decision-making, and their implications for healthcare decision-making and patient care.

Table 12*Goal and Objective Ratings*

<i>Goal/objective</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>Mdn</i>	<i>Range</i>	<i>Good/excellent, n (%)</i>
Build capacity of healthcare professionals to provide accessible, high-quality, and culturally humble healthcare for people with disabilities.	73	4.63	0.54	5	3–5	71 (97.3%)
Identify key requirements of the ADA and apply best practices.	73	4.79	0.41	5	4–5	73 (100.0%)
Recognize accessibility barriers and identify strategies to improve accessibility.	73	4.78	0.42	5	4–5	73 (100.0%)
Incorporate lived-experience and caregiver insights into healthcare improvement.	73	4.74	0.50	5	3–5	71 (97.3%)
Differentiate guardianship and shared decision-making options and impacts.	73	4.51	0.63	5	2–5	70 (95.9%)

Note. Ratings were scored from 1 to 5. Good/excellent refers to ratings of 4 or 5.

Does the education content of the symposium address an educational need or a professional practice gap?

Nearly all respondents indicated that the symposium addressed an educational need or professional practice gap ($n = 72$, 98.6%, see Table 13 below).

Table 13*Educational Need or Professional Practice Gap*

<i>Response</i>	<i>n</i>	<i>% of respondents</i>
Yes	72	98.6%
No	1	1.4%

Note. Denominator is evaluation respondents ($N = 73$).

How confident are you that you will be able to implement the information from this symposium?

Implementation confidence was strong. A total of 57 respondents (78.1%) were very or extremely confident that they could implement the information from the symposium (see Table 14 below).

Table 14*Confidence to Implement Symposium Information*

<i>Confidence response</i>	<i>n</i>	<i>% of respondents</i>
Extremely Confident	15	20.5%
Very Confident	42	57.5%
Moderately Confident	15	20.5%
Slightly Confident	1	1.4%

Note. Denominator is evaluation respondents ($N = 73$).

Do you plan to share information from this symposium?

Most respondents planned to share information from the symposium ($n = 70$, 95.9%), indicating potential reach beyond direct attendees (see Table 15 below).

Table 15

Intent to Share Symposium Information

<i>Response</i>	<i>n</i>	<i>% of respondents</i>
Yes	70	95.9%
No	3	4.1%

Note. Denominator is evaluation respondents ($N = 73$).

What barriers exist to implementing practice changes/actions related to providing accessible, high quality, and culturally humble healthcare for people with disabilities?

Implementation barriers were primarily structural. Organizational and systems barriers and lack of time, staff, or resources were selected most often, indicating that future follow-up should include applied implementation supports and system-level tools (see Table 16 and Figure 6 below).

Table 16

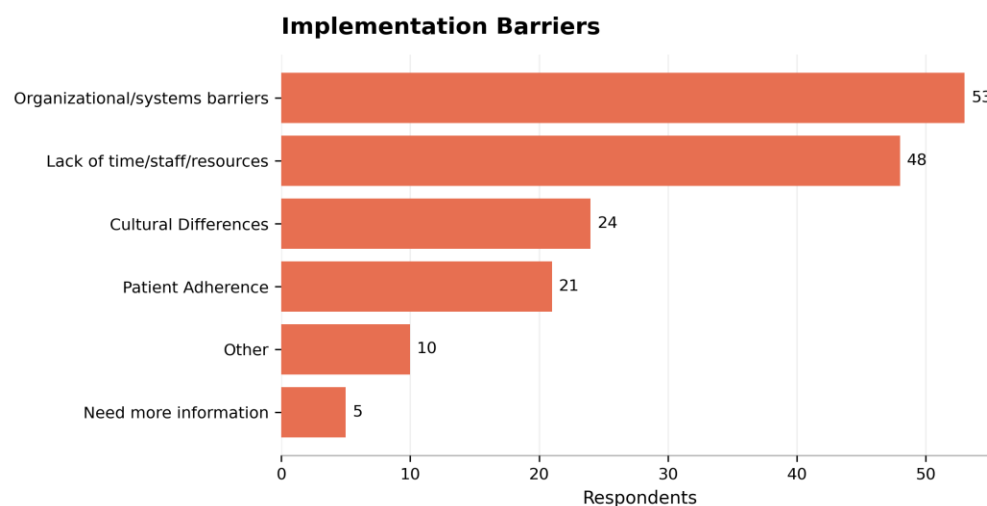
Implementation Barriers

<i>Barrier</i>	<i>n</i>	<i>% of respondents</i>
Organizational/systems barriers	53	72.6%
Lack of time/staff/resources	48	65.8%
Cultural Differences	24	32.9%
Patient Adherence	21	28.8%
Other	10	13.7%
Need more information	5	6.8%

Note. Respondents could select more than one barrier. Percentages use evaluation respondents ($N = 73$) as the denominator.

Figure 6

Implementation Barriers



Note. Bars display the number of respondents who selected each barrier.

If other, please specify.

Eleven respondents provided text for other barriers. Responses clustered around financial or cost barriers, lack of training or awareness, institutional willingness or adherence to existing regulations, and role-specific limits on ability to make direct practice changes. Some entries indicated no additional barrier or that barriers depend on client needs.

Training***I am interested in training opportunities related to***

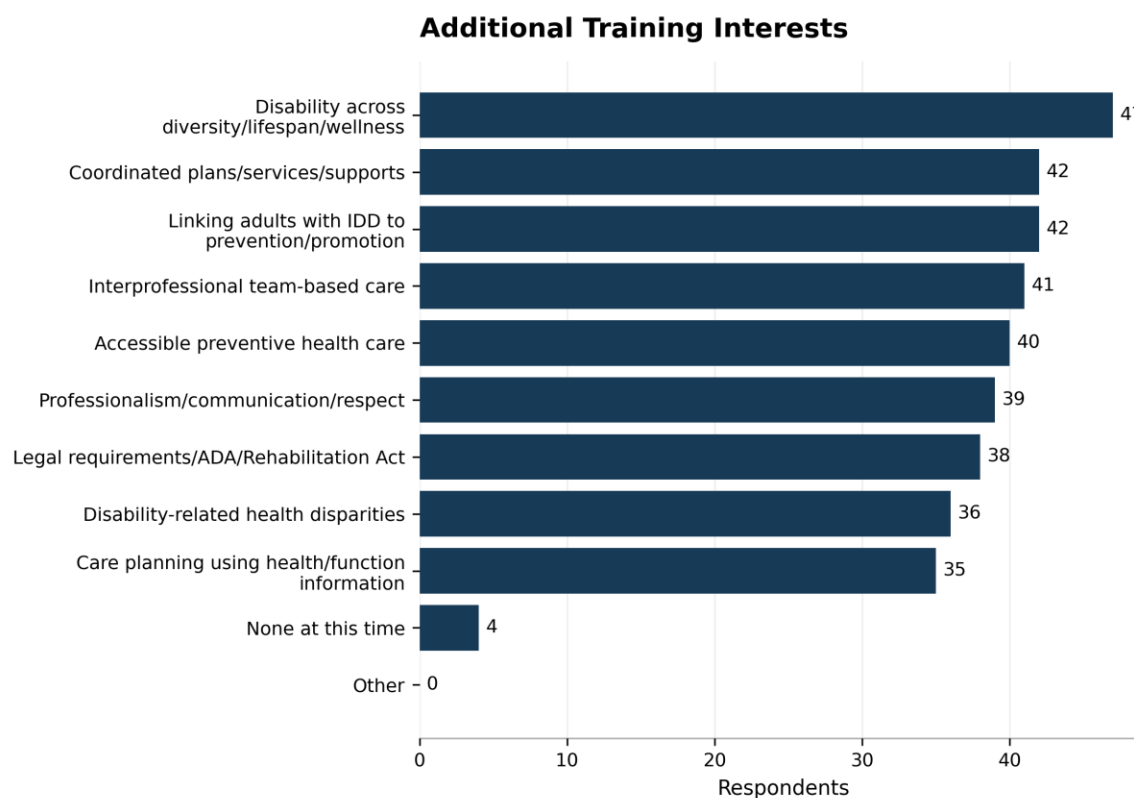
As shown in Table 17 and Figure 7 below, interest in additional training was broad. The most selected topic was disability in the context of diversity, lifespan, wellness, injury, and social/cultural environments, followed by coordinated plans, services, and supports; linking adults with intellectual and developmental disabilities to prevention/promotion; and interprofessional team-based care.

Table 17***Additional Training Interests***

<i>Training topic</i>	<i>n</i>	<i>% of respondents</i>
Disability in the context of human diversity, the (check all that apply) lifespan, wellness, injury, and social and cultural environments.	47	64.4%
Effective strategies to engage patients with disabilities in creating a coordinated plan of care with needed services and supports.	42	57.5%
Linking adults with intellectual and developmental disabilities to preventive health care and health promotion programs in their community.	42	57.5%
Engagement and collaboration with team members within and outside their own discipline to provide high-quality, interprofessional team-based health care to people with disabilities.	41	56.2%
Best practices in providing accessible preventive health care to adults with disabilities.	40	54.8%
Professionalism, communication, respect for patients, and recognizing optimal health and quality of life from the patient's perspective.	39	53.4%
Legal requirements for providing health care in a manner that is, at minimum, consistent with federal laws such as the Americans with Disabilities Act (ADA), Rehabilitation Act, and Social Security Act to meet the individual needs of people with disabilities.	38	52.1%
Health disparities that disproportionately impact individuals with disabilities.	36	49.3%
Relevant information about the health and function of patients with disabilities to engage patients in creating a plan of care that includes essential and optimal services and supports.	35	47.9%
None at this time	4	5.5%
Other	0	0.0%

Note. Respondents could select more than one topic. Percentages use evaluation respondents ($N = 73$) as the denominator.

Figure 7
Additional Training Interests



Note. Bars display the number of respondents who selected each training topic.

If other, please describe

No respondents provided other training-interest text.

Session-Level Results

Session-level results were generally positive. Session 1 had the highest average positive agreement, and Session 2 showed the clearest opportunity for refinement, especially on identifying actions to apply the information (see Table 18 and Figure 8 below).

Table 18

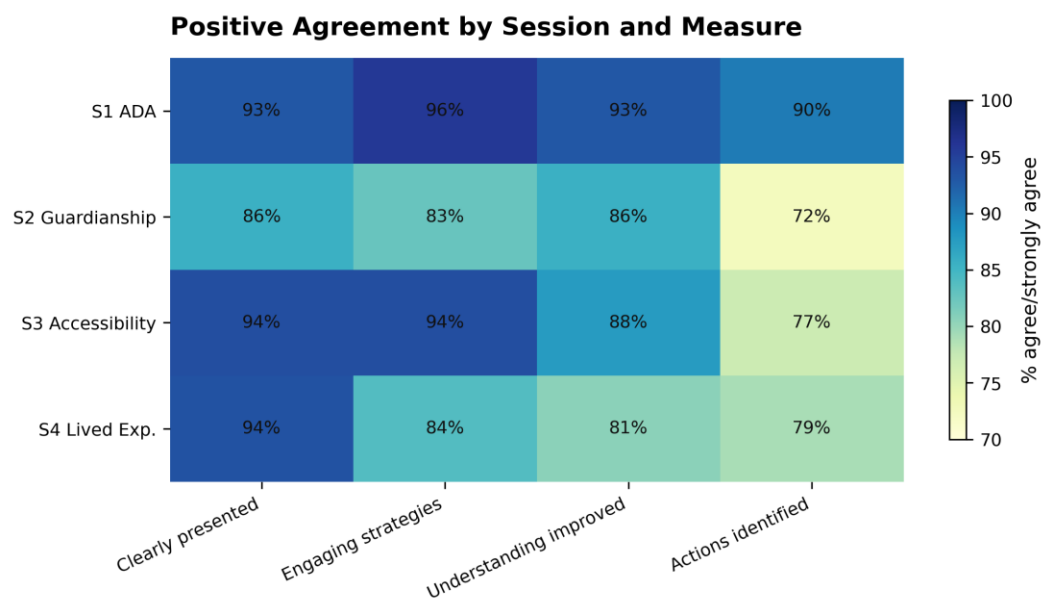
Session-Level Summary

<i>Session</i>	<i>Attended, n</i>	<i>% of respondents</i>	<i>Average M</i>	<i>Average positive agreement</i>
Session 1: ADA Overview	72	98.6%	4.44	93.1%
Session 2: Guardianship	69	94.5%	4.19	81.5%
Session 3: Practical Accessibility in Rural Healthcare Settings	65	89.0%	4.33	88.1%
Session 4: Lived Experience Panel	62	84.9%	4.28	84.3%

Note. Average M and positive agreement are calculated across the four session-specific evaluation items for each session.

Figure 8

Positive Agreement by Session and Measure



Note. Positive agreement is the percentage of valid responses rated agree or strongly agree.

Session 1: ADA Overview for Healthcare Professionals

Did you attend ADA Overview for Healthcare Professionals with Emily Shuman from 9:30-11:00 am MT?

72 evaluation respondents reported attending Session 1: ADA Overview (98.6% of evaluation respondents, see Table 19 below).

Table 19

Session 1: ADA Overview: Session-Specific Evaluation Items

<i>Item/question</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>Mdn</i>	<i>Range</i>	<i>Agree/strongly agree, n (%)</i>
The information was clearly presented.	72	4.54	1.05	5	1–5	67 (93.1%)
The speaker used teaching strategies that engaged and enhanced my learning.	72	4.49	0.87	5	1–5	69 (95.8%)
My understanding of key requirements of the Americans with Disabilities Act (ADA) in healthcare settings to reduce barriers and improve accessibility for patients with disabilities has improved as a result of this session.	72	4.44	0.82	5	1–5	67 (93.1%)
I have identified actions I will take to apply the information I learned from this session.	72	4.28	0.83	4	1–5	65 (90.3%)

Note. Agreement items were scored from 1 = strongly disagree to 5 = strongly agree.

Session 2: Guardianship: Necessity, Legal Meaning & Alternatives

Did you attend Guardianship with Donna Sheen from 11:00-12:00 pm MT?

69 evaluation respondents reported attending Session 2: Guardianship (94.5% of evaluation respondents, see Table 20 below).

Table 20

Session 2: Guardianship: Session-Specific Evaluation Items

<i>Item/question</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>Mdn</i>	<i>Range</i>	<i>Agree/strongly agree, n (%)</i>
The information was clearly presented.	69	4.28	0.89	4	1–5	59 (85.5%)
The speaker used teaching strategies that engaged and enhanced my learning.	69	4.22	0.86	4	1–5	57 (82.6%)
My understanding of common guardianship and shared decision-making options, their impact in healthcare decision-making and patient care in clinical practice, has improved as a result of this session.	69	4.25	0.83	4	1–5	59 (85.5%)
I have identified actions I will take to apply the information I learned from this session.	69	4.03	0.89	4	1–5	50 (72.5%)

Note. Agreement items were scored from 1 = strongly disagree to 5 = strongly agree.

Session 3: Practical Accessibility in Rural Healthcare Settings

Did you attend Practical Accessibility in Rural Healthcare Settings with Dr. Melinda Poyer & Nena James from 1:00 - 2:00 pm MT?

65 evaluation respondents reported attending Session 3: Practical Accessibility in Rural Healthcare Settings (89.0% of evaluation respondents, see Table 21 below).

Table 21

Session 3: Practical Accessibility in Rural Healthcare Settings: Session-Specific Evaluation Items

<i>Item/question</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>Mdn</i>	<i>Range</i>	<i>Agree/strongly agree, n (%)</i>
The information was clearly presented.	65	4.45	0.92	5	1–5	61 (93.8%)
The speakers used teaching strategies that engaged and enhanced my learning.	65	4.40	0.83	5	1–5	61 (93.8%)
My understanding of common accessibility barriers in healthcare environments and strategies to improve accessibility has improved as a result of this session.	65	4.35	0.96	5	1–5	57 (87.7%)
I have identified actions I will take to apply the information I learned from this session.	65	4.12	0.98	4	1–5	50 (76.9%)

Note. Agreement items were scored from 1 = strongly disagree to 5 = strongly agree.

Session 4: Lived Experience Panel

Did you attend the Lived Experience Panel from 2:00-3:00 pm MT?

62 evaluation respondents reported attending Session 4: Lived Experience Panel (84.9% of evaluation respondents, see Table 22 below).

Table 22

Session 4: Lived Experience Panel: Session-Specific Evaluation Items

<i>Item/question</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>Mdn</i>	<i>Range</i>	<i>Agree/strongly agree, n (%)</i>
The information was clearly presented.	62	4.39	0.93	5	1–5	58 (93.5%)
The facilitator and speakers used teaching strategies that engaged and enhanced my learning.	62	4.26	0.92	4	1–5	52 (83.9%)
My understanding of healthcare experiences of individuals with disabilities and their caregivers has improved as a result of this session.	62	4.27	0.99	5	1–5	50 (80.6%)
I have identified actions I will take to apply the information I learned from this session.	62	4.19	0.99	4	1–5	49 (79.0%)

Note. Agreement items were scored from 1 = strongly disagree to 5 = strongly agree.

Additional Feedback

Please provide any additional feedback you may have for the WIND team including your satisfaction with the ½ day live virtual training

Open-ended feedback was broadly positive and emphasized the value of the content, the virtual format, and lived-experience perspectives (see Table 26 below).

Table 23

Qualitative Feedback Themes

<i>Theme</i>	<i>Mentions</i>	<i>% of substantive comments</i>
Positive, informative, or valuable overall experience	29	72.5%
Virtual format, accessibility, or schedule worked well	18	45.0%
Lived experience, patient perspective, or panel was valued	9	22.5%
Need for more time, questions, or split sessions	5	12.5%
Interest in recordings or access to missed segments	3	7.5%
Guardianship topic needs more depth or refinement	3	7.5%

Note. Themes were coded at the aggregate level and are not mutually exclusive; percentages use 40 substantive comments as the denominator.

Who are leaders (including yourself) in our state around inclusive health and disability?

As shown in Table 24, twenty-five respondents provided leader or contact suggestions. Because these responses included personally identifiable contact information, names, phone numbers, and email addresses are intentionally excluded from this public-facing report. De-identified responses clustered around state agencies, disability advocacy and independent-living organizations, guardianship resources, community health organizations, behavioral health providers, and rehabilitation professionals.

Table 24

Leader and Partner Nomination Themes

<i>Nomination theme</i>	<i>Summary</i>
Wyoming Department of Health, Medicaid/long-term care, and public health agencies	Multiple responses identified state public health, Medicaid/CHIP, long-term care, or related staff as potential partners.
Disability advocacy and independent living organizations	Responses named organizations such as independent living, guardianship, NAMI, and disability-focused coalitions.
Tribal, rural, and community health partners	Several nominations emphasized Wind River, tribal health, rural clinics, behavioral health, and community-based providers.
Clinical and rehabilitation professionals	Respondents identified physicians, nurses, physical therapists, occupational therapists, and behavioral health professionals.

Note. Contact-level details were intentionally not reproduced because the responses contained personally identifying information.

Discussion

Findings indicate that the virtual symposium was well received by attendees and addressed a recognized educational need. The strongest results centered on satisfaction, quality, ADA requirements, accessibility barriers, and the practical value of lived-experience content. Respondents also demonstrated strong intent to share information, suggesting that the symposium may have influence beyond direct attendance. The implementation findings add nuance. Although confidence was favorable, it was lower than satisfaction and objective ratings. The most common barriers were organizational or systems barriers and lack of time, staff, or resources. These findings suggest that future training may benefit from tools that help participants translate knowledge into concrete organizational practices, workflows, checklists, and policy-level changes.

Recommendations

The findings support continuation of the symposium model with refinements focused on implementation, depth, and accessibility of follow-up resources.

- Maintain the virtual training format and continue to protect time for live discussion, because respondents valued the accessibility and organization of the format.
- Offer session recordings or an on-demand version for participants who miss content or want to revisit complex legal and implementation topics.
- Develop a deeper guardianship and shared decision-making module with more applied examples, concrete tools, and time for questions.
- Pair legal and accessibility content with implementation supports such as ADA checklists, accessibility audit templates, workflow examples, and communication prompts.
- Address structural implementation barriers directly through follow-up technical assistance focused on organizational systems, staffing/time constraints, and resource limitations.
- Use training-interest data to design a follow-up series on disability across the lifespan, coordinated plans/services/supports, accessible preventive care, interprofessional care, and disability-related health disparities.
- Add a 60- to 90-day follow-up survey to assess whether respondents shared resources, applied content, changed workflows, or still need implementation support.

Limitations

The analysis is entirely descriptive and based on attendance and survey data from a single symposium. Evaluation responses may overrepresent participants who were more engaged or satisfied. Some fields were open-text and required grouping for summary reporting. Several geography fields were missing or not applicable. Finally, ratings represent self-reported perceptions immediately after the event and should not be interpreted as direct evidence of longer-term practice change.

Conclusion

The symposium achieved meaningful reach, strong satisfaction, and consistently positive learning ratings. The strongest quantitative and qualitative pattern is that the symposium filled an educational need while also revealing that practice change depends on organizational capacity, staffing, workflows, and continued support. Future symposium should, therefore, move from training satisfaction to implementation outcomes by offering tools, recordings, follow-up technical assistance, and topic-specific modules.

Appendices

Appendix A: Variable-by-Variable Descriptive Inventory

The table below reports every variable in the dataset. For privacy, participant names and identifiable leader/contact details are summarized rather than reported. For multi-select items, the summary shows the number and percentage of evaluation respondents who selected each item. Missing *n* is calculated against the full registration sample ($N = 222$). Evaluation items are expected to have more missingness because they apply only to evaluation respondents.

Table 25
Variable-by-Variable Descriptive Inventory

No.	Variable/question	Valid <i>n</i>	Missing <i>n</i>	Summary
1	ID	222	0	222 unique identifiers; no analysis beyond record tracking.
2	Name	222	0	222 unique names; values not reported to preserve privacy.
3	Organization	217	5	180 unique organizations. Most common: University of Wyoming ($n = 5$); Memorial Hospital of Sweetwater County ($n = 5$); Wyoming Department of Health ($n = 4$).
4	Job Title	72	150	59 unique titles. Most common normalized titles: Case Manager ($n = 14$); Rn ($n = 2$); Licensed Clinical Social Worker ($n = 2$).
5	State	214	8	Most common: Wyoming ($n = 152$); Montana ($n = 8$); Colorado ($n = 7$).
6	Country	219	3	Most common: United States ($n = 214$); India ($n = 3$); Morocco ($n = 1$).
7	Wyoming County	152	70	Most common: Laramie County ($n = 37$); Albany County ($n = 29$); Sweetwater County ($n = 13$).
8	Session 1 9:30-11:00	222	0	Attended: $n = 117$ (52.7% of registrants; 88.6% of attendees).
9	Session 2 11:00-12:00	222	0	Attended: $n = 105$ (47.3% of registrants; 79.5% of attendees).
10	Session 3 1:00-2:00	222	0	Attended: $n = 109$ (49.1% of registrants; 82.6% of attendees).
11	Session 4 2:00-3:00	222	0	Attended: $n = 95$ (42.8% of registrants; 72.0% of attendees).
12	Total	222	0	Attended at least one session: $n = 132$ (59.5%).
13	Are you a licensed healthcare professional?	73	149	No: $n = 39$ (53.4%); Yes: $n = 34$ (46.6%).
14	What are your credentials? (choice=DO)	73	149	Selected: $n = 0$ (0.0% of evaluation respondents).
15	What are your credentials? (choice=LCSW)	73	149	Selected: $n = 4$ (5.5% of evaluation respondents).
16	What are your credentials? (choice=LMFT)	73	149	Selected: $n = 0$ (0.0% of evaluation respondents).
17	What are your credentials? (choice=LPC)	73	149	Selected: $n = 0$ (0.0% of evaluation respondents).
18	What are your credentials? (choice=MD)	73	149	Selected: $n = 2$ (2.7% of evaluation respondents).
19	What are your credentials? (choice=NP)	73	149	Selected: $n = 3$ (4.1% of evaluation respondents).
20	What are your credentials? (choice=OD)	73	149	Selected: $n = 0$ (0.0% of evaluation respondents).
21	What are your credentials? (choice=OT)	73	149	Selected: $n = 0$ (0.0% of evaluation respondents).
22	What are your credentials? (choice=PA-C)	73	149	Selected: $n = 0$ (0.0% of evaluation respondents).
23	What are your credentials? (choice=PharmD)	73	149	Selected: $n = 0$ (0.0% of evaluation respondents).
24	What are your credentials? (choice=PhD)	73	149	Selected: $n = 0$ (0.0% of evaluation respondents).
25	What are your credentials? (choice=PT)	73	149	Selected: $n = 1$ (1.4% of evaluation respondents).
26	What are your credentials? (choice=SLP)	73	149	Selected: $n = 1$ (1.4% of evaluation respondents).
27	What are your credentials? (choice=RD)	73	149	Selected: $n = 1$ (1.4% of evaluation respondents).
28	What are your credentials? (choice=RDN)	73	149	Selected: $n = 0$ (0.0% of evaluation respondents).
29	What are your credentials? (choice=RN)	73	149	Selected: $n = 16$ (21.9% of evaluation respondents).
30	What are your credentials? (choice=Not Applicable)	73	149	Selected: $n = 0$ (0.0% of evaluation respondents).
31	What are your credentials? (choice=Other)	73	149	Selected: $n = 9$ (12.3% of evaluation respondents).
32	If other, what is your credential?	9	213	9 text responses; 8 unique entries.
33	Rate your overall satisfaction with the symposium.	73	149	Very Satisfied: $n = 53$ (72.6%); Satisfied: $n = 19$ (26.0%); Very Dissatisfied: $n = 1$ (1.4%).
34	Rate the overall quality of the symposium.	73	149	$M = 4.66$, $SD = 0.51$, $Mdn = 5$, range = 3–5; favorable = 72 (98.6%).
35	Build capacity of healthcare professionals to provide accessible, high-quality, and culturally humble healthcare for people with disabilities.	73	149	$M = 4.63$, $SD = 0.54$, $Mdn = 5$, range = 3–5; favorable = 71 (97.3%).
36	Identify key requirements of the Americans with Disabilities Act (ADA) in healthcare settings and identify ways to apply at least two best practices to comply with ADA requirements	73	149	$M = 4.79$, $SD = 0.41$, $Mdn = 5$, range = 4–5; favorable = 73 (100.0%).
37	Recognize common accessibility barriers in healthcare environments and identify at least two strategies to improve accessibility across physical spaces, virtual platforms, and care processes.	73	149	$M = 4.78$, $SD = 0.42$, $Mdn = 5$, range = 4–5; favorable = 73 (100.0%).
38	Incorporate insights from experiences shared by individuals with disabilities and caregivers into a	73	149	$M = 4.74$, $SD = 0.50$, $Mdn = 5$, range = 3–5; favorable = 71 (97.3%).

No.	Variable/question	Valid n	Missing n	Summary
	strategy to improve healthcare provision for people with disabilities.			
39	Differentiate between common guardianship and shared decision-making options that families might have and identify how each option may impact healthcare decision-making and patient care in clinical practice.	73	149	M = 4.51, SD = 0.63, Mdn = 5, range = 2–5; favorable = 70 (95.9%).
40	Does the education content of the symposium address an educational need or a professional practice gap?	73	149	Yes: n = 72 (98.6%); No: n = 1 (1.4%).
41	How confident are you that you will be able to implement the information from this symposium?	73	149	Very Confident: n = 42 (57.5%); Extremely Confident: n = 15 (20.5%); Moderately Confident: n = 15 (20.5%); Slightly Confident: n = 1 (1.4%).
42	Do you plan to share information from this symposium?	73	149	Yes: n = 70 (95.9%); No: n = 3 (4.1%).
43	What barriers exist to implementing practice changes/actions related to providing accessible, high quality, and culturally humble healthcare for people with disabilities (select all that apply) (choice=Patient Adherence)	73	149	Selected: n = 21 (28.8% of evaluation respondents).
44	What barriers exist to implementing practice changes/actions related to providing accessible, high quality, and culturally humble healthcare for people with disabilities (select all that apply) (choice=Cultural Differences)	73	149	Selected: n = 24 (32.9% of evaluation respondents).
45	What barriers exist to implementing practice changes/actions related to providing accessible, high quality, and culturally humble healthcare for people with disabilities (select all that apply) (choice=Lack of Time/Staff/Resources)	73	149	Selected: n = 48 (65.8% of evaluation respondents).
46	What barriers exist to implementing practice changes/actions related to providing accessible, high quality, and culturally humble healthcare for people with disabilities (select all that apply) (choice=Organizational and Systems Barriers)	73	149	Selected: n = 53 (72.6% of evaluation respondents).
47	What barriers exist to implementing practice changes/actions related to providing accessible, high quality, and culturally humble healthcare for people with disabilities (select all that apply) (choice=I Need More Information)	73	149	Selected: n = 5 (6.8% of evaluation respondents).
48	What barriers exist to implementing practice changes/actions related to providing accessible, high quality, and culturally humble healthcare for people with disabilities (select all that apply) (choice=Other)	73	149	Selected: n = 10 (13.7% of evaluation respondents).
49	If other, please specify.	11	211	11 text responses; 11 unique entries.
50	I am interested in training opportunities related to (check all that apply) (choice=Disability in the context of human diversity, the lifespan, wellness, injury, and social and cultural environments.)	73	149	Selected: n = 47 (64.4% of evaluation respondents).
51	I am interested in training opportunities related to (check all that apply) (choice=Professionalism, communication, respect for patients, and recognizing optimal health and quality of life from the patients perspective.)	73	149	Selected: n = 39 (53.4% of evaluation respondents).
52	I am interested in training opportunities related to (check all that apply) (choice=Legal requirements for providing health care in a manner that is, at minimum, consistent with federal laws such as the Americans with Disabilities Act (ADA), Rehabilitation	73	149	Selected: n = 38 (52.1% of evaluation respondents).
53	I am interested in training opportunities related to (check all that apply) (choice=Engagement and collaboration with team members within and outside their own discipline to provide high-quality, interprofessional team-based health care to people with dis	73	149	Selected: n = 41 (56.2% of evaluation respondents).
54	I am interested in training opportunities related to (check all that apply) (choice=Relevant information about the health and function of patients with disabilities to engage patients in creating a plan of care that includes essential and optimal services	73	149	Selected: n = 35 (47.9% of evaluation respondents).
55	I am interested in training opportunities related to (check all that apply) (choice=Effective strategies to engage patients with disabilities in creating a coordinated plan of care with needed services and supports.)	73	149	Selected: n = 42 (57.5% of evaluation respondents).
56	I am interested in training opportunities related to (check all that apply) (choice=Best practices in providing accessible preventive health care to adults with disabilities.)	73	149	Selected: n = 40 (54.8% of evaluation respondents).
57	I am interested in training opportunities related to (check all that apply) (choice=Linking adults with	73	149	Selected: n = 42 (57.5% of evaluation respondents).

No.	Variable/question	Valid n	Missing n	Summary
	intellectual and developmental disabilities to preventive health care and health promotion programs in their community.)			
58	I am interested in training opportunities related to (check all that apply) (choice=Health disparities that disproportionately impact individuals with disabilities.)	73	149	Selected: n = 36 (49.3% of evaluation respondents).
59	I am interested in training opportunities related to (check all that apply) (choice=None at this time.)	73	149	Selected: n = 4 (5.5% of evaluation respondents).
60	I am interested in training opportunities related to (check all that apply) (choice=Other)	73	149	Selected: n = 0 (0.0% of evaluation respondents).
61	If other, please describe	0	222	0 text responses; 0 unique entries.
62	Did you attend ADA Overview for Healthcare Professionals with Emily Shuman from 9:30-11:00 am MT?	73	149	Yes: n = 72 (98.6%); No: n = 1 (1.4%).
63	The information was clearly presented.	72	150	M = 4.54, SD = 1.05, Mdn = 5, range = 1–5; agree/strongly agree = 67 (93.1%).
64	The speaker used teaching strategies that engaged and enhanced my learning.	72	150	M = 4.49, SD = 0.87, Mdn = 5, range = 1–5; agree/strongly agree = 69 (95.8%).
65	My understanding of key requirements of the Americans with Disabilities Act (ADA) in healthcare settings to reduce barriers and improve accessibility for patients with disabilities has improved as a result of this session.	72	150	M = 4.44, SD = 0.82, Mdn = 5, range = 1–5; agree/strongly agree = 67 (93.1%).
66	I have identified actions I will take to apply the information I learned from this session.	72	150	M = 4.28, SD = 0.83, Mdn = 4, range = 1–5; agree/strongly agree = 65 (90.3%).
67	Did you attend Guardianship with Donna Sheen from 11:00-12:00 pm MT?	73	149	Yes: n = 69 (94.5%); No: n = 4 (5.5%).
68	The information was clearly presented..1	69	153	M = 4.28, SD = 0.89, Mdn = 4, range = 1–5; agree/strongly agree = 59 (85.5%).
69	The speaker used teaching strategies that engaged and enhanced my learning..1	69	153	M = 4.22, SD = 0.86, Mdn = 4, range = 1–5; agree/strongly agree = 57 (82.6%).
70	My understanding of common guardianship and shared decision-making options, their impact in healthcare decision-making and patient care in clinical practice, has improved as a result of this session.	69	153	M = 4.25, SD = 0.83, Mdn = 4, range = 1–5; agree/strongly agree = 59 (85.5%).
71	I have identified actions I will take to apply the information I learned from this session..1	69	153	M = 4.03, SD = 0.89, Mdn = 4, range = 1–5; agree/strongly agree = 50 (72.5%).
72	Did you attend Practical Accessibility in Rural Healthcare Settings with Dr. Melinda Poyer & Nena James from 1:00 - 2:00 pm MT?	73	149	Yes: n = 65 (89.0%); No: n = 8 (11.0%).
73	The information was clearly presented..2	65	157	M = 4.45, SD = 0.92, Mdn = 5, range = 1–5; agree/strongly agree = 61 (93.8%).
74	The speakers used teaching strategies that engaged and enhanced my learning.	65	157	M = 4.40, SD = 0.83, Mdn = 5, range = 1–5; agree/strongly agree = 61 (93.8%).
75	My understanding of common accessibility barriers in healthcare environments and strategies to improve accessibility has improved as a result of this session.	65	157	M = 4.35, SD = 0.96, Mdn = 5, range = 1–5; agree/strongly agree = 57 (87.7%).
76	I have identified actions I will take to apply the information I learned from this session..2	65	157	M = 4.12, SD = 0.98, Mdn = 4, range = 1–5; agree/strongly agree = 50 (76.9%).
77	Did you attend the Lived Experience Panel from 2:00-3:00 pm MT?	73	149	Yes: n = 62 (84.9%); No: n = 11 (15.1%).
78	The information was clearly presented..3	62	160	M = 4.39, SD = 0.93, Mdn = 5, range = 1–5; agree/strongly agree = 58 (93.5%).
79	The facilitator and speakers used teaching strategies that engaged and enhanced my learning.	62	160	M = 4.26, SD = 0.92, Mdn = 4, range = 1–5; agree/strongly agree = 52 (83.9%).
80	My understanding of healthcare experiences of individuals with disabilities and their caregivers has improved as a result of this session.	62	160	M = 4.27, SD = 0.99, Mdn = 5, range = 1–5; agree/strongly agree = 50 (80.6%).
81	I have identified actions I will take to apply the information I learned from this session..3	62	160	M = 4.19, SD = 0.99, Mdn = 4, range = 1–5; agree/strongly agree = 49 (79.0%).
82	Please provide any additional feedback you may have for the WIND team including your satisfaction with the ½ day live virtual training (feedback about format of the training, content, accessibility, etc.)	44	178	44 text responses; 44 unique entries.
83	Who are leaders (including yourself) in our state around inclusive health and disability? Please provide the contact information (name, organization, and email or phone) of Wyoming healthcare professionals who could contribute to the future learning opportunities	25	197	25 text responses. Identifiable names/contact details summarized but not printed.
84	Complete?	73	149	Complete: n = 72; Incomplete: n = 1.

Appendix B: Attendance Log Summary

Table 26

Attendance Log by Session

<i>Session</i>	<i>Attendance field</i>	<i>n</i>	<i>% of registrants</i>	<i>% of attendees</i>
Session 1	Session 1: 9:30 am - 11:00 am	117	52.7%	88.6%
Session 2	Session 2: 11:00 am - 12:00 pm	105	47.3%	79.5%
Session 3	Session 3: 1:00 pm - 2:00 pm	109	49.1%	82.6%
Session 4	Session 4: 2:00 pm - 3:00 pm	95	42.8%	72.0%

Note. Attendance log percentages are shown relative to all registrants ($n = 222$) and all attendees who attended at least one session ($n = 132$).

Appendix C: Core Evaluation Denominators

Table 27

Core Evaluation Denominators

<i>Measure</i>	<i>n</i>	<i>% / Description</i>
Total registration records	222	100.0%
Attended at least one session	132	59.5%
Did not attend a session	90	40.5%
Evaluation respondents	73	32.9% of registrants; 55.3% of attendees
Completed evaluation form	72	98.6% of evaluation respondents
Incomplete evaluation form	1	1.4% of evaluation respondents

Note. Attendance percentages use total registrants as the denominator unless otherwise noted. Evaluation response rate among attendees was calculated using attendees who participated in at least one session.