Resources for Integrated Care

Addressing Menopause and Health Across the Life Course for Dually Eligible Women with Disability

October 16, 2023

Nikki Racelis (Moderator)

Hello everyone. My name is Nikki Racelis with the Lewin Group, and I am honored to serve as your event facilitator today. Before we begin, we would like to orient you to the platform.

Audio should automatically stream through your computer's speakers. Please make sure that your computer is connected to reliable internet and that the speakers are turned up. If you are experiencing any difficulties with your connection, please turn off your network VPN.

There is no phone dial in option and the recording will be available after the event. In the center of your screen, you will see the slides for today's presentation. Directly below are resources to download, including the PDF of today's slides.

Closed captions are also available if you select the resources icon. A questions window should be open by default. Here you can enter questions for our presenters or chat with the webinar team if you need support.

Our team will also send helpful messages via the questions window. If you minimize a box and would like to bring it back, you can click on the associated icon at the bottom of your screen. Also, feel free to move the windows to fit your screen.

Welcome to the webinar Addressing Menopause and Health Across the Life Course for Dually Eligible Women with Disability. Thank you for taking the time to join us today. We're looking forward to sharing innovative solutions and best practices for disability competent care for dually eligible women at midlife and beyond, including addressing menopause and associated conditions.

Today's session will include presentations from our esteemed presenters, a panel discussion, and we will close with time for questions and answers. The recording and a copy of today's slides will be available at https://www.resourcesforintegratedcare.com/.

Continuing education credits are available at no cost to participants. We strongly encourage you to check with your specific regulatory boards or other agencies to confirm that the courses taken from this accrediting body will be accepted by that entity. Social workers may obtain one continuing education unit through the National Association of Social Workers. For those interested in continuing education, you must complete the pre-test at the beginning of the webinar, as well as complete the post-test with a passing score by 11:59 p.m. tomorrow, October 17.

This webinar is supported through the Medicare Medicaid Coordination Office (MMCO) at the Centers for Medicare and Medicaid Services. MMCO is helping beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality healthcare that includes the full range of covered services in both programs.

To support providers in their efforts to deliver more integrated, coordinated care to dually eligible beneficiaries, MMCO is developing technical assistance and actionable tools based on successful innovations and care models, such as this webinar. To learn more about current efforts and resources, please visit our website or follow us on Twitter. Recently rebranded as X, our handle is @Integrated_Care. You will also find us on LinkedIn.

The roadmap for our time together today is as follows, we will start by introducing our speakers and reviewing the learning objectives. Next, we will collect some information from the audience via two polls.

We will then provide some background information before turning it over to our presenters, who will share the following presentations: Dr. Beth Marks will present about Health Equity for Women with Disability: Future Connections, Practices, and Action. Dr. John Harris will then present on Supporting Women with Disability During Menopause: Considerations for Providers. Next, Claire Abenante will present about enhancing disability competent care for dually eligible women with disability across the continuum of care. After these presentations, our speakers will offer their perspectives in a guided panel discussion before we engage in some audience Q&A. If you have questions, please type them into the questions window as we go, and we will answer as many questions as we can.

We will close by sharing additional resources and requesting your feedback on the information shared today. At this time, I'd like to introduce our presenters and panelists. Dr. Beth Marks is a research associate professor in the Department of Disability and Human Development at the University of Illinois, Chicago, and former president of the National Organization of Nurses with Disabilities. Dr. John Harris is the Director of the University of Pittsburgh Medical Center, McGee Women's Hospital Center for Women with Disabilities and Assistant Professor with the McGee Women's Research Institute at the University of Pittsburgh.

Claire Abenante is the Director of Primary Care and Women's Health Access Program at Independence Care System, or ICS, and Evelyn Castillo is an ICS member, disability activist, facilitator, and crisis responder. She is also a dually eligible woman living with disability and will serve as a panelist during today's event. Thank you to our presenters for sharing their time with us today.

This event will accomplish the following learning objectives: identify the unique challenges experienced by dually eligible women living with disability with a particular focus on preventive health and health equity. Describe actionable strategies that providers or health plans can use to enhance disability competent care for women living with disability pre-menopause and post-

menopause and discuss approaches that support health promotion for women with disability during and after the menopausal transition. Next, we have a couple of polls.

The goal of these questions is to get a better sense of our audience members today. To ensure all participants are able to participate in this poll, I will read each response option aloud. To participate, you can chat in your response or click the button corresponding with your response.

You should see a pop up on your screen asking, in what care setting do you work? The options you may select from are health plan, ambulatory care setting, long term care facility, home care agency, community-based organization, consumer organization, academic or research, or other. And I will give everyone another 20 seconds or so to respond and thank you in advance for your participation in these polls. All right, so it looks like our top responses to this poll include health plan and ambulatory care setting.

So thank you, everyone who responded to that poll. Our second poll asks which of the following best describes your professional area? Response options for this question include health plan case manager or care coordinator, health plan customer service, health plan administration or management, medicine, nursing, physician assistant or provider, pharmacy, social work advocacy, or other. And again, feel free to chat in your response, or you can select the response that corresponds to your response option, and we'll give everyone another few seconds to respond.

And it looks like our top responses to this poll question include health plan case manager or care coordinator, and health plan administration or management. Thank you again, everyone, for participating, and welcome. So next, I'd like to set the stage by reviewing some background information on this important topic.

In 2020, 12.2 million individuals were dually eligible for Medicare and Medicaid. 51% of those dually eligible individuals qualified for Medicare based on disability status, and 59% of dually eligible individuals were female.

In the US, approximately 1.3 million women transition into menopause each year, which typically begins between the ages of 45 and 55.

For every year older a woman is when reaching menopause, her breast cancer risk increases by 3%. Postmenopausal women are at a higher risk of osteopenia and osteoporotic fracture and may experience changes in cardiovascular health. Women with disabilities or impairments that affect their mobility are at an increased risk for conditions associated with menopause, including heart disease and osteoporosis.

Women living with disability are less likely than women without disability to receive preventive health care. These include pelvic exams, mammograms, and bone density screenings. Reason for this include lack of accessible facilities and equipment, healthcare provider awareness, and transportation.

In 2021, Resources for Integrated Care, or RIC, produced a webinar titled *Supporting the Preventive Healthcare Needs of Dually Eligible Women with Disability*. The webinar addressed barriers and solutions to support dually eligible women with disability in accessing person-centered preventive health care. More specifically, the webinar highlighted key issues relevant to the role of provider training, communication, and stigma, as well as accessibility to appropriate equipment and facilities.

Today's webinar will build off the past webinar and explore innovative solutions and best practices for disability competent care for dually eligible women at midlife and beyond, including addressing menopause and associated conditions. The information shared today will focus on accessibility, provider awareness and education, health promotion, and strategies for consumers and providers in coordinating healthcare services and supports for dually eligible women across the life course. The 2021 webinar is included on the resources slide at the end of this presentation.

For those of you looking for more information on this topic. As I'm sure you all are, I'm looking forward to some engaging presentations from our speakers. So, without further ado, I'll turn things over to Dr. Beth Marks, research associate professor at the Department of Disability and Human Development at the University of Illinois, Chicago, and former president of the National Organization of Nurses with Disabilities.

Dr. Marks, the floor is yours.

Dr. Beth Marks

Great, thank you.

And thank you all for joining us today. So, for today's presentation, I would like to acknowledge and thank my colleague, Dr. Yasminga Sisdek for her thought, leadership and advocacy in our work to identify structural and social determinants of health including ableism cultural humility that can impact healthcare interactions and universal access to settings-based health care and the full continuum of health services for women with disability.

This full continuum includes essential health services and can range from health promotion, disease prevention, treatment for health-related conditions, rehabilitation, and palliative care. And next slide, please.

For people with disability, attitudes and words matter. So the picture on the right depicts how some wheelchair users feel when they hear the term wheelchair bound. For many wheelchair users, their wheelchair is the mode of transportation and provides a sense of freedom. So language has really been evolving, particularly in the past several years.

And it's not a one size fits all. Most people have been taught to use person-first language, and that is where you describe someone as a person first, then specify a disability, such as a person

with epilepsy or person with diabetes. Person-first language is meant to remove stigma, emphasize personhood, and remind us that a posting is more than a disability.

And today it's still considered standard etiquette and a safe guess. But increasingly, disabled people don't want to use this type of language. And some people feel that the emphasis of personhood despite a disability contribute to the stigma.

So imagine how it would sound to refer to someone as a person with blindness or a person with tallness. So while person-first is a neutral way to discuss people, it might not be the best choice. So identity-first language puts the descriptor first and is more common among specific disability communities, such as the deaf community.

So they might prefer deaf person rather than person with deafness. Identity-first language is born from the disability pride movement, asserting that disability is nothing to be ashamed of. And for many people, it feels like person-first language is a sidestep, that the fact that someone has a disability. For that reason, it really wonders or begs the question if you can truly be seen if you don't acknowledge their disability. So whenever possible, ask a person how they choose to identify rather than assume. And next slide, please.

As we think about health care advocacy among women with disabilities, the Americans with Disabilities Act, or the ADA of 1990 and the Amendment Act of 2008 defines who is covered under the ADA and what we can do to advocate to improve healthcare access for equitable care. And both the ADA and the Amendment Act use a three-pronged definition, an individual with a disability is someone who one has a physical or mental impairment that substantially limits one or more major activities, has a history or record of such impairment or perceived by others as having such an impairment. And the next slide, what's great about the ADA is that it shifts our view of disability from a medical model to a social model.

With the medical model, healthcare providers often assume that an individual's economy is limited because of their disability or impairment and may have limited ability to participate in society. And as we shift to a social model and understanding of the ADA, [a] healthcare provider can think about the impact of the external environment on the problems experienced by women with disability and appreciate how disability is socially constructed oftentimes. With the social model, we can advocate for the removal of social barriers to promote inclusion and social change leading to improved health care.

And then the next slide. With the ADA, we can also identify and dismantle the external and structural and systemic barriers for people rather than solely focusing on curing people's impairment. With external, structural and systemic inequity, they may contribute to disparities in accessing health care for people living with disabilities.

A 2023 survey by Lisa Ayazoni and her colleagues reported on responses of 714 US physicians regarding their knowledge about the Americans with Disabilities Act and accommodation for patients with disabilities. Bear in mind, the ADA is 33 years of age, so over 70% did not know

who determines accommodation, about 68% felt at risk for ADA lawsuit, and more than 35% report little or no knowledge about their legal responsibility, and about 20% could not identify who pays for needed accommodation.

And next slide, please. In addition to the for healthcare providers to understand civil rights, for people with disabilities to have reasonable accommodation or changes to policies, practices, procedures to provide equitable or equal access to healthcare facilities and services, we also need to appreciate that people with disability are our family, friends and neighbors, not just people that we think of as other. The Centers for Disease Control and Prevention (CDC) has some excellent infographics, such as the picture in this slide, noting that one in four adults in the US have some type of disability.

Worldwide, according to the World Health Organization, approximately 16% of the global population lives with the disability today. Medical advances continue to support more people to live long, productive lives with disability.

And additionally, most people with disabilities have non-apparent disabilities that do not have the visual indicators that we often associate with having a disability. And with the next slide. Additionally, the CDC also reports the following population estimates for people with disabilities so again, thinking about people with disabilities as our friends, family, neighbors and patients.

People with disabilities consist of people who have difficulty walking, climbing stairs, about 12% of people [have] serious difficulty concentrating, remembering, or making decisions. Difficulty doing errands alone [affects about] 7%, deafness or serious hearing affects about 6%, blindness or serious difficulty seeing about 5%, and difficulty dressing or bathing about 4%. So a disability really impacts all of us. And next slide, please.

So as we think about people with disabilities, one thing as our family, friends and patients and neighbors, we can incorporate legal and social changes. And this slide is really meant to just be kind of an overview or a snapshot of the various laws and policy changes that have provided significant changes. And it's a good one to refer back to in thinking about how dramatic the lives of people with disabilities have, the changes in terms of being able to live, learn, work, play and love in their own communities. Starting with Title Five in 1935, which gave access to medical care. Several decades later, we had the first civil rights protection from the Section 504, the Rehabilitation Act of 73 and the right to education for all, renamed Idea Individual with Disability Education Act in 2004. And then moving forward to 1990 with the ADA and then the 2008 Amendment Act. Both of those sought to broaden the agencies and businesses to include compliance among both public and private entities for nondiscrimination and accessibility provisions. So you can kind of see from the landscape change, we really have moved from helping people to live, learn, work, play and love.

So we moved forward to 2014, and this was kind of a big one that went by fairly unnoticed, but it was a 7% rule with the Office of Federal Contract and Compliance in section 503 of the Rehab Act of [19]73. And that was meant to ensure that 7% of any employer who had federal contract

that they had to have 7% of their workforce. This isn't aspirational, so there's a lot of debate as to whether it really meant anything.

I think it did mean something, but that's debatable. In 2021. Biden aimed to ensure that diversity, equity, inclusion initiatives extended to accessibility to increase employment for people with disabilities through both executive order in early 2021.

And then the most exciting one came on September 26, which was about the 50-year anniversary of the Rehab Act. And this was a designation by the National Institute of Minority Health and Health Disparities to include people with disabilities as a population with health disparities. This was a major step toward any effort to improve access to healthcare and health outcomes for all people with disability and really fits in with today's theme.

So, as you can see with the images, people with disabilities have really been at the forefront of all social and legal landscape changes around the world. Joe Shapiro 93 Book of No Pity really provides a rich history of how people with disabilities forged new civil rights. Worth a read.

And then additionally, the first US based Disability Pride Parade was held in Chicago in 2004, led by an amazing colleague and disability rights advocate Sarah Triano, who noted that disability is a natural and beautiful part of human diversity. Which sums up the impact of all the legal and social changes and I hope sets the precedent for today's talk about why we need to do a better job in healthcare. So the next slide one of the things that happened during COVID was that many people, early on, within weeks with disability, saw how quickly healthcare policies were made to deny care for them.

This served to push the disability community for more public action to unmask healthcare ableism and to convey how ableism in healthcare impacts their care. Ableism starts with an attitude that people with disabilities are intrinsically less than, rude in the assumption that people with disability require fixing and defines people by their disability. Like racism, sexism, ageism, ableism classifies entire groups of people as less than and includes harmful stereotype misconceptions and generalization discrimination experienced by people with disabilities is often seen as a social etiquette or common sense versus a social justice or equity issue.

Providers consciously have good intention, positive attitude, but research more recent research indicate pervasive implicitly negative attitude by providers. And the next slide. This has shown, the need to improve cultural humility and equitable health outcome is really demonstrated by a survey that was done in 2020 reporting that almost 84% of healthcare professionals implicitly preferred people without disability.

The study supports other work documenting views among healthcare professionals that individuals with disabilities may have lower quality of life or just might be unwell as a result of their disability. The impact of these attitudes depicts, another nice infographic from the CDC, about one in four adults with disabilities don't have a usual healthcare provider, one in five have unmet health care need because of the cost of healthcare in the past year, and then one in four

did not have routine checkups in the past year. These stats highlight the importance of today's webinar and the next slide, please.

So, if we can support healthcare providers to dismantle structural and social barriers in health care, women can more readily access equitable health care, which often present as repeated lifelong challenges for many women. Unfortunately, women are often on their own in obtaining health care and may be denied care due to outdated attitude. People who are born with a disability or acquire a disability often don't share their disability identity with family and support, which add to the challenges.

There's no roadmap as to how you gain and access your civil rights. We also need more role models, including disabled healthcare professionals, to model advocacy skills, teach strategy to navigate access to disability legal and civil rights, and demonstrate the value of having a disability and how disability history can be a source of pride. And then the next slide.

Along with disparate health outcomes, women with disabilities may also experience a concept called weathering. More studies are talking about weathering, but we often don't include people with disabilities. So weathering for women with disabilities can be experienced as a chronic stress related biological process, increasing their vulnerability with earlier onset and more chronic diseases, which is magnified among women with multiple underserved identity and disabilities, especially people with intellectual and developmental disabilities.

And women with disabilities are more likely than their peers [without disabilities] to have chronic conditions, and next slide please. Additionally, compared to women without disabilities, women with disabilities experience less health care access, more intimate partner violence, sexual violence, physical violence, stalking, psychological aggression, control of reproductive or sexual health, access to women's shelter. Many of the screeners out there will not pick up the unique features that women with disabilities experience in relation to violence. Low rates of breast and cervical cancer screening, higher rates of breast cancer mortality, especially among women with circulatory or respiratory condition.

Mental distress is more common in disabled women, especially people who are experiencing poverty, unemployment and unmet health care needs due to cost and an unfortunately earlier death as well. And the next slide please.

So, as we think about so what, what can we do to improve health outcome for women with disability? Plans and providers can support dually eligible women in living longer with new health conditions and health care need in the context with significant disparities in health care and health outcome due to structural social determinants of health by working to change attitudes and expectations about living meaningful lives with disability, supporting women's access to shared experiences with other women or role models with disability, and understand that multiple chronic conditions is an under addressed issue for people with different types of disability. As seen in another CDC infographic, people with disabilities experience higher rates of obesity, more likely to smoke, have heart disease, have diabetes when compared to their non-

disabled peers and the next slide treating comorbidity so healthcare plans and providers can address complex health condition by focusing on disability related care. Two things that we really have to think about is avoid diagnostic overshadowing, which is the assumption that an individual's symptoms are due to their disability.

Diagnostic overshadowing may be more of a concern with poorly managed multiple chronic conditions like high cholesterol, hypertension or high blood pressure, cardiovascular disease, obesity and mental health concern. And then the second thing is completing screening tests regularly or on the usual time schedule. Undetected health issues can be due to lack of screening and prevention for vision, oral health, hearing, mental health, fitness and cancer.

And all of those are woefully underfunded, but really would have a big impact on health outcomes. And then the next slide please. Thinking about improving healthcare access.

So, what can we do with our plans and providers? Well, a couple of things ensure accessible healthcare spaces considering buildings, practices, equipment, communication, make sure people can get in move about structural barriers through a lens of accessibility. One of the big things is exam tables. We've had some awesome accessible exam tables since the 80s.

I'm not sure why these still are not the default, but it really would increase access for everyone, not just people who are wheelchair users. So that would be a huge change. Educate clinicians about the care of people with disabilities and person-first and identity-first language.

Also think about strategies to improve health literacy. We often think about what can providers do, what can healthcare systems do? But we really need to think about how do we engage people in their care appropriate care dependent upon people being able to communicate signs and symptoms of emerging health care concern.

Many people might benefit from learning strategies to effectively communicate this information with the provider and especially people who have disabilities. And the next slide please. Improving access and uptake of preventive services so women with disabilities exist across many communities experiencing inequities related to race, gender, ethnicity, sexual orientation and age.

Healthcare plans can ensure screening tools such as the American Academy of Family Practitioners. I really like the Everyone project that includes the Neighborhood Navigator which can assess and discuss and include strategy to address structural social determinants of health. I'll talk about that in a minute.

And then the second thing is universal design an accessible communication strategy to enable health system to welcome women across all communities. Universal design refers to the practice of intentionally designing spaces and material to best support accessibility needs of many people with diverse needs. And I always say one of the best, easiest things you can do is say hello, how are you? How can we best support you today? And do you need any

accommodation so that can open up lots of doors? And then the next slide please. A policy to improve health equity.

So what can health plans do? They can ensure compliant with the ADA and the Amendment Act of 2008, provide equitable reimbursement to providers and help providers really understand what their responsibilities are and how they can pay for it and other avenues that they can get more reimbursement for people with disabilities avoid inequitable discharge of people with disabilities from their practices. Provide interprofessional education to eliminate bias and reluctant to care for people with disabilities.

Some awesome pilots going on. We have one at University of Illinois, Chicago. I'm happy to talk about it offline that include dentistry, nursing, pharmacy and people with disabilities. Expand and also addresses social determinants of health and moving toward a social model approach.

Expand beyond a medical view of disability as an inherently negative trait to view disability as a marker of diversity and then provide information on respectful interactions for everyone. Advocate, as I mentioned a lot of disabilities are non-apparent, so you really just want to have accessible communication that works for all and then advocate for disability friendly expressions as well. And then next slide.

Health plans can take the following step to address structural and social determinants of health. Looking at attitudinal, physical, communication, social, financial, transportation and policy based barriers. Ensure compliance and make sure that people participate in disability education and training programs to understand legal and civil rights for women with disability, improve clinical knowledge to care for women, including assessment skills that to properly examine including sexual history, violence, reproductive preferences, pregnancy, intention and preventive health and then practicing person centered care across all healthcare encounters. And then reduced structural barriers.

And then getting close to my last slide. Moving upstream to address social structural determinants of health. So this is becoming more common with larger health systems to look at those determinants of health to make sure that people can adequately access treatment for their downstream health care or whatever their immediate health care needs are. So as you move upstream, you're looking at where people live, where they work, and how those can interfere or support their ability to access care to the upstream and look at the structural factors to support health equity.

And as I mentioned before, the American Academy, they have this nice questionnaire short that looks at assessing housing, food, utilities, all the things that can interfere with treatment. Love the questionnaire, better to have people answer it for themselves, they're more likely to be honest. And also, they have this awesome online interactive neighborhood navigator. You plug in a zip code and it pulls up all the things I just mentioned in terms of housing, food, resources. So it allows for very quick teachable moment to make sure that people have their midstream, upstream social determinants of health addressed so that they can do their treatment

downstream. And then the last thing has to do for the last slide, Nikki, is provider-patient concordance and back to the cultural humility.

Unfortunately, we've looked at racial ethnic minorities for that provider-patient concordance, we've not done a good job, or really much of a job of making sure that we recruit and employ healthcare professionals with disabilities. In nursing, which is my profession, we really have no idea. How many students have disabilities in medical school? It's less than 5%.

When you look at the labor statistics, overall, people with disabilities account for 38% in the workforce, compared to 77%. So it's still pretty dismal employment statistic. But for sure as healthcare professionals and with plans, we need to really start pushing for healthcare providers to help create a new vision in future to learn about disability, advocacy, identity and pride.

Encourage healthcare providers with disability to offer their unique perspective and skills and in this way we will enhance appropriate culture and language in providing healthcare, improve individual involvement and satisfaction which has been shown in other communities that have disparate health outcomes and then finally achieve equitable health care and health outcome. And one last comment, with all of these we can really do a better job with that user manual to help people navigate a really complex system and thank you. I'm going to pass it back to you Nikki. And that's it.

Nikki Racelis (Moderator)

Dr. Marks, thank you so much for sharing your valuable insights. Next, I would like to introduce Dr. John Harris, Director of University of Pittsburgh Medical Center, McGee Women's Hospital Center for Women with Disabilities, and assistant professor with the McGee Women's Research Institute at the University of Pittsburgh. Dr. Harris, the floor is yours.

Dr. John Harris

Thank you, Nikki.

Thank you, Dr. Marks, for your wonderful presentation.

Next slide. So, first I'd like to tell you a little bit about the center where I work. The center for Women with Disabilities in Pittsburgh is an amazing center that's been around since 2001.

Yearly, we care for in-person about 420 individuals, as well as even more nurse and virtual visits, and about 61% of those are dually eligible individuals. We do provide a wide range of services, including well-woman care, gynecologic consultations, pregnancy consultations, and surgical consultations. Our patients range from 15 to 95, with many patients in the age range that's most appropriate for menopausal issues that we will discuss today.

The clinic would not be present without the amazing work of Dr. Sandra Wellner, who was a woman who developed a mobility disability as an adult and dedicated the rest of her life to improving care for women in health care. She was quite a dynamic individual.

And besides starting multiple clinics, including the one in Pittsburgh, she also started a company that developed more accessible exam tables, she wrote a textbook, and she was inducted into the Hall of Fame for persons with disabilities before her untimely death in 2001. I'm joined by some amazing providers, including Julie McKechnie, who is a nurse midwife Peter Bulova, who's an internal medicine physician to help with complex medical issues with our patients while they're receiving their women's health care. And then Jennifer Stephens is the nurse coordinator of the clinic, and the clinic would not run without her amazing oversight.

Next slide, please. So, to zoom in on the discussion that Dr. Marks so aptly kind of cohesively described in the broad terms, I'm going to talk about how we can improve access for individuals by providing disability competent care and addressing these menopause and health issues across the life course for these dually eligible women with disabilities.

So first, as Dr. Marks has already described, there are facility accessibility issues, so ensuring availability of facilities, equipment, and appropriate appointment times for these individuals.

Next, there are communication accessibility issues. So communicating with people with disability takes humility openness and requires a curiosity about an individual's abilities and preferences. And we'll talk a little bit more about that relating to menopause care. And then finally tailoring decision-making support.

So for everyone, they should have personalized decision making. But individuals with disabilities do face unique risks and benefits to traditional treatment pathways, and physicians must communicate these parameters in a way that empowers individuals to make an informed decision that's best for them and is not kind of a blanket decision based on someone's disability status. Next slide, please.

So providers can help provide this kind of care by, in general, getting to know the specific needs and past experiences of each individual who needs this sort of care. It may take some extra time to understand exactly what that looks like, but once you have understood that basic fact, the next thing is to acknowledge that you may have ascertained that a person has a certain disability or certain mobility, sensory or intellectual disability. But you have to remember that even though someone may have what looks like the same diagnosis, that everyone is different, and their capabilities relating to performing tasks, providing history, and making a personalized decision about treatment may vary and should be individualized. So it's a good thing to spend more time and to understand each person as an individual. Next slide, please.

So now I'm going to focus on facility accessibility, and the first thing is preparation. So before an individual even interacts with a healthcare facility, it's best to be prepared as best as possible for that individual. So when possible, I'm going to ask some questions that we would like each facility to have thought about.

Does the team know what each individual needs before they come? Types of transfer or equipment that's needed in a plan for space utilization and scheduling? Does the team have

staffing to be able to provide this necessary care? So sometimes it's not only equipment, but it may require extra staff to assist with transfers or exams. Are the staff well trained to do this sort of care, including providing care for people with autism spectrum disorder or intellectual disability? And do they have adequate training with the equipment to keep the patient and the staff safe? Next, can the facility provide access to other services, ideally on the same day? So, for instance, in a well woman visit, it's really wonderful if we can also do a mammography visit at the same visit if those services are co-located, as well as access to subspecialty care such as oncology in my case, euro gynecology or even dentistry care. And then finally, do staff understand the historic challenges of people with disabilities as well as the need to avoid stigma or bias when providing this care? This sort of historical knowledge helps us be more humble and helps us understand the limitations that we have because of our background and historical inequities.

Next slide, please. So, next thinking about this facility. We should think about accessibility as these individuals are starting to interact with the physical space.

So how accessible is this location? Are there enough handicapped parking spaces? How wheelchair accessible are the van drop off areas where many individuals may come by an access van or other disability accessible transportation? How much does parking cost? We provide vouchers at our facility because our valet services typically have a monetary charge with them, but the hospital has thankfully provided free services for individuals with disabilities. And in large buildings and hospitals, does the front desk know where the clinic is? Many times, if someone is new to the clinic or doesn't know where they're going, it's helpful to provide good access for individuals and their caregivers. Next, how accessible is the specific clinic space that starts with check-in, where we want to make sure that the clinic check-in desk is low enough for people who utilize wheelchairs for mobility to be able to communicate clearly with staff. And is the waiting area accessible for people with wheelchairs? Next. Is the waiting area accommodating for people with intellectual disabilities? Some caregivers for intellectual disability prefer slightly larger waiting areas where there's a little bit more space for people so that people can feel comfortable. Next slide, please.

Finally, when we think about the specific clinic space and exam space, is there things like a wheelchair accessible scale? Is there enough space for a wheelchair or stretcher for transfer in the exam room? Is the exam table low enough to allow for transfers for people that need a mechanical lift or hoyer lift, is that available? Where is it, and are people trained to use it? For gynecologic exams are there full support leg rests available? Traditional exam tables have small footrests that only support people's heels and are not appropriate for people that may need additional assistance controlling or positioning legs. And are there tools available for people with intellectual disability or autism to feel comfortable? Next slide, please.

Next we're going to go to menopause related topics. So first it's important to screen all individuals who could be at risk for menopause. So for instance, screening tools like the Menopause Quick Six Questionnaire is a great way to screen for a variety of different symptoms

people may have. We need to remember that these symptoms can vary depending on people's sensory, intellectual or mobility disability. And for instance, in an intellectual disability, behavior changes and agitation may be associated with menopausal changes, and we need to remember that these symptoms can be relieved with a variety of treatments, including hormone replacement therapy.

Next slide, please. So again, we need to think as individually about each person who comes to our settings. And so for people with intellectual or cognitive impairment, some conditions associated with these conditions will be associated with early initiation of menopause.

For instance, individuals with down syndrome will often go into menopause in their late 30s or early 40s, about ten years before individuals without down syndrome. And it may in some cases be difficult to obtain a normal symptom history from the individual, but you can obtain one from caregivers or family members. And then for individuals with mobility disability, it's important to remember that menopausal symptoms may present differently, with increases in some symptoms and less apparent other symptoms.

And additionally, for people with mobility disability, there may be higher risks of bone loss, bone density loss, cardiovascular disease, weight gain, or impaired balance. Next slide, please. For people with a sensory disability that would be hard of hearing or deafness or vision impairment, or blindness, there's certainly a need for more accessible menopause education materials if this hasn't been well provided in the past.

For instance, in the UK study in 2018 and 19 deaf and hard of hearing individuals noted that only 7% of these women were able to access menopause health information in British Sign Language, while 83 [%] indicated that they would like access to this information in sign language. Physicians often rely on written materials for individuals that may be hard of hearing in a time constrained office visit. Other medical conditions may take precedence, and people may not get around to their menopausal concerns.

And providers must conduct expanded screening for atypical menopausal symptoms such as bladder infection screening, which may be more difficult if it's harder to obtain that urine culture. Next slide, please. Again, the consequences of menopause include a variety of issues related to estrogen deficiency that include bone density loss.

It's important to screen for this and also to manage it aggressively. There are a variety of medications that would be appropriate for osteoporosis in a general population, as well as appropriate for people with disabilities. We want to remember that with age as well as menopause, that cardiovascular health can be compromised.

So it's important to remember that estrogen in hormone replacement therapy may increase thromboembolism risk, and we need to balance that with an increased risk of thromboembolism that's usually associated with using wheelchairs for mobility. Estimating this risk can be difficult because of just the individualism of each person, and that traditional risk

calculators may not be appropriate for every individual. Weight gain can be associated with loss of independence, and so we want to watch out for that.

Impaired balance is associated with menopause, and this can be especially concerning for fall risk for individuals that are at a higher fall risk already. And just remembering the consequences of estrogen deficiency are important to consider for people with mobility disability, the negative and positive effects of estrogen. Next slide, please.

So, in considering hormone replacement therapy in this population, providers must thoughtfully assess risks and benefits associated with using HRT to treat and relieve some menopausal symptoms. Women and their caregivers should be seen as shared decision makers in this decision. And risk calculation varies according to several factors, including the current quality of life compared to the quality of life before menopause, the personal risk of cardiovascular disease, blood clots, osteoporosis, cancer and the relative degree of mobility and independence, as well as a concern for decreasing mobility and decreasing independence.

Next slide, please. So, how can health plans with providers take steps to improve care and outcomes for women with disabilities? I think there's a multitude of ways to add on to what Dr. Marks already mentioned, but health plans can encourage, support and potentially incentivize providers through improved accessibility initiatives to update facilities to be more accessible, for instance, helping purchase new exam tables or renovate restrooms, things like that.

Health plans can provide education to providers on bias, disability, stigma and accessible care and providers can support and improve data collection efforts by ensuring early bone mineral density measurement among people with individuals. And finally, health plans and providers can support research on menopause and dually eligible women with disabilities. Thank you for this opportunity and I look forward to the panel discussion and question answer back to Nikki.

Nikki Racelis (Moderator)

Dr. Harris, thank you so much for your presentation and thank you for sharing your knowledge and expertise with us. Next. I would like to introduce Claire Abenante, Director of Primary Care and Women's Health Access Program with Independence Care System. Claire, the floor is yours.

Claire Abenante

Thank you so much, Nikki.

Thank you to Resources for Integrated Care, for having me, [and] to Dr. Harris and Dr. Marks for their robust presentation filled with important and valuable information.

And thank you all for attending. My name is Claire Avenante, and I'm the director of women's health and primary care at Independence Care System. Next slide, Nikki.

A little background. ICS, Independence Care System, was created to fill the gap in manage long term care for people with physical disabilities, particularly those with mobility impairments. ICS

consistently lived its mission to support the health, mobility and independence of adults living with physical disabilities so they can live full, productive lives in their community.

Common conditions among our ICS members include stroke, muscular dystrophy, cerebral palsy, spina bifida, rheumatoid arthritis, Parkinson's disease, spinal cord injury, multiple sclerosis, and amputation of extremities. Next slide, please.

The ICS demographics. We have a health home with a total of 1805 members. 39% of those members are dually eligible. 61% are women. 25% of our members are dually eligible women, 39% of our women are women of color, and ICS serves all five boroughs of New York City. Next slide, please.

ICS became a health home for people with physical disabilities in 2019. A Health Home is a Medicaid funded program consisting of a group of healthcare professionals who ensure members get the care and services they need to stay healthy in the community. The focus on serving vulnerable population, including individuals with chronic health conditions, mental illness, substance abuse disorder, and HIV/AIDS. ICS is the first health home for people with physical disabilities.

Next slide, please, Nikki. As I mentioned, we're the first and only health home in New York State specializing in working with adults with physical disabilities. In addition to general health home services, the ICS Health Home Program provides disability-competent care management, which includes access to specialized programs such as care transitions for people who have been hospitalized, wheelchair services, repairs and seating evaluations. Wound care and prevention, primary care and women's health independent living, durable medical equipment and supplies, support benefit resources for social determinants of health for example, assisting people with their Snap benefits or housing application especially for people who need accessible housing. We have member programming and a strong advocacy. Next slide, please.

The World Health Organization estimates that 60% of people living with disability are women. Women with disabilities are more likely to have unmet health care needs than women without a disability, such as lower prevalence of up-to-date breast cancer and cervical cancer screenings. Women living with a disability that affects their mobility are at an increased risk of developing conditions such as heart disease and osteoporosis, both of which are associated with menopause.

Next slide, please, Nikki. Some barriers that women with disabilities face receiving care, I think thank you to both Dr. Marks and Dr. Harris who have gone over this as well. But women with physical disabilities face a myriad of barriers to receiving quality care, including physical barriers, attitudinal barriers, lack of disability-competent care, lack of oversight, or enforcement of the ADA or state and local disability laws. Next slide, please.

The physical barriers. I know everybody has touched on it before, but lack of automatic entry doors or narrow doorways, lack of or flimsy wheelchair ramps, inaccessible bathrooms, narrow

dressing rooms, small examination table with no turn radius for a wheelchair, and lack of accessible medical equipment, including a height adjustable exam table, wheelchair scale and transfer lift. You'd be surprised to know how many women with disability don't know their exact weight because they have not had the ability to be weighed at their doctor's appointment.

Next slide, please. In addition to the physical barriers, there are a lot of attitudinal barriers. Holding a deficit-based view of individuals can impact physicians understanding of or approach to providing appropriate care for women with disabilities.

Providers and plans may benefit from seeking resources to help them better understand and address the human potential for bias and systematic factors that can include implicit stereotyping or stigma in care delivery. I have a quote from the founder of the ICS women's health program, Marilyn Saviola. “It is presumed that women with disabilities don't need gynecological care and that there is an assumption that they are not sexually active.”

Next slide, please, Nikki. The lack of ADA enforcement in healthcare facilities is also a large challenge. There are several structural factors that can lead to inadequate enforcement of the ADA.

Professional accrediting bodies do not provide oversight or incentives to maintain ADA compliance. For example, the Joint Commission accreditation does not include ADA compliance in their accreditation standards. The onus is on the individual to report violations.

New York State and New York City. Human rights commissions enforces human rights laws. However, it's the responsibility of the individual to file a complaint.

Next slide, please. Lack of disability competent care. Dr. Marks mentioned Dr. Lisa Ayazoni's survey. 714 US Physicians and their perception of people with disabilities and health care, and only 40% were confident about their ability to provide quality care to patients with disabilities. And this is related to medical and nursing student education is often inadequate and does not mirror real world conditions for treating people with a disability. Most medical and nursing students learn about disabling conditions in their respective schools.

However, many medical students reported no simulation training with a person with a disability and reported not learning how to make accommodations to complete a physical exam. Next slide, please. Lived experience with barriers in an accessible exam space can lead to women with disability delay or forego necessary gynecological care.

Women with disabilities often need frequent gynecological care to address incontinence issues, skin breakdowns, and rash. Another quote from the founder of our program there are very few places for women who are wheelchair users to get comprehensive gynecology services. Next slide, please.

The Women's Health Program at ICS started in 2008, the ICS Women's Health Program has provided women with physical disability appropriate preventative and gender specific services.

Primary care services, including preventative health screenings and gynecological exams, were added to services and offered in 2012 for women's health and then 2020 for primary care. Funding from the Greater New York City affiliated Susan G. Coleman foundation, as well as public funds received in partnership with New York City Health and Hospitals, has helped ICS partner with New York City Health and Hospitals to support women with physical disabilities in accessing care. Some of the support that we received was installing adjustable height exam tables, providing lifts for more usefully transfers for women with disabilities from their wheelchairs to the exam table, and renovating a mammography suite to increase space and improve wheelchair maneuverability and accessibility.

Next slide, please. Moving to some clinical considerations for women with gynecological exams. Some actionable recommendations are to request a private interview without aides or family members to identify any potential signs of abuse.

Signs of abuse can be a little tricky. It could be dehydration or lack of adequate nutrition. It checks skin integrity to make sure that a woman with a disability is not able to position herself, is being turned, and positioned appropriately. Defer to the individual about transferring and positioning. Consider using knee crutch, stirrups, and a safety belt. If unavailable, involve extra staff to help hold the individual's legs.

Ask individuals with a neurogenic bladder to void prior to their appointment and have some straight catheters on hand if needed. Consider that individuals with a spinal cord injury T6 or higher at most, at risk for developing autonomic dysreflexia. Autonomic dysreflexia is a sudden exaggerated reflex, which can increase the blood pressure and cause a patient's heart rate to drop.

Usually, a pounding headache comes on with it as well, and this would be in response to bladder or bowel distension. Ask individuals who experience muscle spasms to pre-medicate prior to their appointment. Next slide, please.

This picture is of Marilyn Saviola, who was the founder of the ICS women's health program. The impetus for the program Marilyn Saviola was ICS's Senior Vice President for Advocacy and Women's Health, and she lost a dear friend to breast cancer. It was then that she learned the staggering statistic that women with disabilities didn't have a higher incident of breast cancer, but a higher mortality rate due to late diagnosis and less aggressive treatment.

The death of her friend was the impetus to start the Women's Health program. In her meetings, in trying to find a spot that we could partner with a hospital, Mammography supervisor told her, people like you can't come here. And when she asked, where should I go? They responded, where people like you go.

Next slide, please. ICS's approach to addressing some of these barriers are developing relationships with healthcare facilities that serve dually eligible individuals. Increased leadership

buy-in, and provider willingness and engagement are foundational to the success of the partnership.

ICS conducted environmental assessments of physical sites and made recommendations and common-sense solutions to increase accessibility, including moving furniture, removing clutter in exams room to allow for a wheelchair to easily maneuver. Purchasing a barrier free equipment, including height adjustable exam tables, wheelchair scales, transfer lifts, sliding boards, and knee crutch stirrups. As Dr. Marks mentioned earlier in her presentation, the barrier free height exam table will not only help people with mobility disabilities, but the elderly, pregnant women, anybody. It's a universal exam table will really help more people in addition to people with physical disabilities. Next slide, please.

The other ways that ICS has approached women with disabilities is we provided disability sensitivity and awareness and clinical competency trainings to ICS partners and clinicians and health centers within New York City health and hospitals.

We provided disability relevant health navigation and coordination to dual eligible members, completing functional assessments sent over in advance so the facilities could know if a member needed help transferring or wheelchair scale or a transfer lift, and offered an ICS nurse educator to accompany women to their exams, providing support and recording information on barriers and solutions. Thank you very much for having me. And it's back to you, Nikki.

Nikki Racelis (Moderator)

All right, thanks, everyone. Thank you so much, Claire, for your presentation and sharing about how Independence Care supports women with disability. We will be moving into some information about lived experience.

So next I'd like to introduce Evelyn Castillo, independence Care System member, disability activist, facilitator, and crisis responder. Evelyn is also a dually eligible woman living with disability and will serve as a panelist during the panel discussion. Her first-person perspective will provide valuable insight into the impact of provider and facility accessibility, as well as recommendations for how providers and health plans can better support women with disability.

Before we dive into the panel discussion, I would like to give Evelyn the opportunity to share a little more about herself by way of responding to a couple questions. Evelyn, can you briefly describe your experience as an activist for social justice?

Evelyn Castillo

Hi. My name is Evelyn Castillo.

I facilitate a support group for the LGBTQ community for people with disabilities. They are called the Rainbow Connections, and we have monthly meetings. I also do advocacy work within the community, for example, advocating for accessibility and emergency preparedness so that

wheelchair users can bring their wheelchairs into the ambulances with them. Also, I'm advocating to protect transportation benefits for people with disabilities in New York City.

Nikki Racelis (Moderator)

Thank you, Evelyn. The work that you're doing within your community sounds both impactful and rewarding. My second question for you is, what advice do you have for women with disability?

Evelyn Castillo

Advocate for yourself. You know, network with other people. Learn about accessible facilities. Sometimes word of mouth is the best way to learn and the easiest way to learn.

Also, use Street View on Google Maps to verify information regarding facility accessibility. And don't neglect your health because you can't find a clinic. There's always something out there.

Nikki Racelis (Moderator)

Thanks so much, Evelyn. It's a pleasure to have you join us today. All right, wonderful.

We will now move into our panel discussion, and I'll pause briefly. So our first question in the panel discussion is for Evelyn and Claire. How would you recommend providers and health plans better support women with disability? And Evelyn, I'm wondering if you could please start us off.

Evelyn Castillo

Sure. Make sure the facility is accessible for people with disabilities having the proper equipment in place to be able to conduct proper examinations. For example, examination tables to adjust for safer transfer from the wheelchair to the examination table.

Also, ask patients if they need any accommodations when they're scheduling an appointment. Provide an accurate description of your facility's accessibility online. Don't indicate that the facility is accessible if you don't have accessible exam rooms, waiting tables, bathrooms, et cetera.

And also, ensure staff have sensitivity training when they're dealing with a person with a disability. Emphasize the need for empathy and the ability to imagine oneself in the shoes of a person with a disability. Example of a lived experience is when I went for an MRI, the technician was very accommodating.

He allowed my personal aid to accompany and help me onto the table. And to also accommodate my claustrophobia he gently covered my ears and eyes during the procedure.

Nikki Racelis (Moderator)

Thank you, Evelyn, so much for sharing your experience and insights. Claire, would you mind sharing your thoughts and recommendations for providers and health plans next?

Claire Abenante

Sure. Thank you, Nikki. In addition to providers making their exam rooms barrier free, both health plans and providers can support women with disabilities by being more proactive around their genital urinary care.

Women with disabilities have a higher incidence of UTIs and skin breakdowns to begin with. Add vaginal changes that come with menopause in those UTI, risks are increased. Providing access to enough incontinence supplies or catheters would be a great support for women with disabilities.

In addition, easy access to UTI testing. What we've seen at ICS is the majority of our members receive their healthcare at clinics and do not have access to same day appointments. Or they can't come into a clinic for a walk in or experience very long wait times.

There's no on-site lab. Finally, they avoid standalone urgent care centers because many urgent care centers don't accept Medicaid. All of this means that women with disabilities end up going to the ER with UTI symptoms just so they can be tested on site and get a prescription, which increases ER utilization.

Nikki Racelis (Moderator)

Excellent. Thank you both so much for your responses. Our next question is for Evelyn, Dr. Marks and Claire. What's an example of an attitudinal barrier that limits access to health care for women with disability? And how can this barrier be overcome? Claire, will you please start us off?

Claire Abenante

Sure. Thank you.

Nikki, an example of an attitudinal barrier is not seeing women with disabilities as sexual beings. As we heard today, menopause comes with sexual health changes, and many of those changes can be addressed like topical vulval, vaginal estrogen for painful sex. But many providers tend to overlook options for sexual satisfaction when they're talking to women with disabilities.

Nikki Racelis (Moderator)

Thank you, Claire. Evelyn, would you mind sharing your thoughts next?

Evelyn Castillo

Sure. Well, living with a disability, I experienced a lot of impatience from medical staff.

I think people don't understand that anyone can become disabled. They may not be disabled now, but there's no difference between them and me. I think if people understood this, they would be more sensitive and empathetic.

Knowing I may experience this attitude of impatience or insensitivity makes the process of going to the doctor even less appealing. So, I can see how it would discourage some women with disability from seeking care. I don't know if this is an attitudinal barrier behind this, but after my hysterectomy, I was not offered hormone replacement therapy.

I was really struggling with the symptoms of immediate onset menopause, and I wish I had been allowed to consider that option.

Nikki Racelis (Moderator)

Evelyn, thank you so very much for sharing your lived experience. Dr. Marks, I'll turn it over to you for your response to this question.

Dr. Beth Marks

Okay, so, women with disabilities face multiple access barriers for health care related to attitudinal issue. And some of these attitudinal issues include erroneous assumption, negative attitude, being ignored or judged, violence, abuse, insults, impoliteness, and not being deemed capable of understanding information.

And one of the things related to the violence and abuse and some of those attitudinal issues is that I mentioned earlier, we don't have good assessment tool, and many women with disabilities don't necessarily understand the features of abuse that impact them. So, for example, women who have intimate partners or are living with someone, they may not have bruises on them because if they use mobility devices, it's easy enough to put women in a bathroom and take away their mobility devices so they can't get out. Or people that are blind or unable to see it's easy enough to remove their food.

I think there's some attitudinal pieces that we still assume that women with disabilities have everything, all the health care they need. So, I think that's probably the biggest one. And then the other piece is still finding healthcare providers who share their identity and can really one appreciate what they're going through and provide information that's really helpful for women to live and thrive in their communities.

Nikki Racelis (Moderator)

Excellent. Thank you, Dr. Marks.

Our next question is for Dr. Marks, Dr. Harris and Claire, what are long term risks of under screening for menopause symptoms in populations of dually eligible women with disability? Dr. Marks, will you please start us off?

Dr. Beth Marks

Thank you Nikki. Similar to women without disability, disabled women can experience an increased risk of some health condition post-menopausal, including heart disease, osteoporosis or weak bone, potential fractures, urinary tract infections, weight gains, changes in sexual function. Disabled women need to also receive education and support and access to healthy diets and lifestyle options, along with regular cancer screenings such as cervical and breast screenings. Thank you.

Nikki Racelis (Moderator)

Thank you, Dr. Marks. Claire, I'll turn it over for your response next.

Claire Abenante

Thanks Nikki. People with disability are at higher risk of osteoporosis and falls.

The risk of osteoporosis can be attributed to people with disabilities are less likely to build and maintain bone mass through muscle strength and weight bearing activities like their able body counterparts. In addition, some medications that are necessary for some women with disabilities may contribute to bone loss. As we've learned, women can begin to lose bone density in the first few years following menopause, under screening for menopause symptoms in women with disabilities can result in a lack of timely bone density screenings.

Menopause symptoms also mimic other illnesses and providers shouldn't be so quick to make assumptions that health changes like an increased A1C are disability related. As we know, the incidence of certain conditions increase after menopause coronary artery disease, diabetes, breast cancer, colon cancer. So, understanding a woman's symptoms and their menopause status can really help guide providers in providing preventative screenings promptly.

Nikki Racelis (Moderator)

Thank you, Claire and Dr. Harris, would you mind sharing your thoughts?

Dr. John Harris

Sure. In addition to what's already been said, when menopause symptoms aren't screened for, women are going to suffer from treatable symptoms for perhaps many years when effective evidence-based solutions exist.

Unfortunately, menopause symptoms can last up to two decades in some cases. These symptoms can be personally difficult and even overwhelming for individuals with disabilities and can even affect caregivers, such as when an individual may have changes in behavior or increased agitation for women with intellectual disabilities.

Nikki Racelis (Moderator)

Great, thanks so much.

And our final question is for Dr. Marks, Dr. Harris and Claire.

What steps should be taken to improve disability competent care education in the healthcare profession's education system? Dr. Harris, will you please start us off?

Dr. John Harris

Thanks. There are many important topics to address in the healthcare profession continuing education system.

When balancing these many topics, of course, there's important to remember that disability is common, one in ten adults under the age of 65 and one in three adults 65 and older. And so common issues should be addressed regularly in our educational curriculums, including disability health. Another effective solution is identifying disability competent care champions in your healthcare system to lead educational initiatives. The passion and dedication of these individuals can improve professional education and care across the healthcare system.

Nikki Racelis (Moderator)

Thank you, Dr. Harris.

Dr. Marks, would you mind sharing your insights?

Dr. Beth Marks

Sure. So, healthcare professional education programs need to embrace the intersectionality of disability across all diversity, equity and inclusion and accessibility initiative, DEIA. Also need to identify and report disparities to recruit, retain and promote the unique talents and skills that disabled students and healthcare professionals bring to both the classroom and clinical settings to impact equitable care for people with disabilities and understand the rich history of disability rights. Activists and scholars can also improve knowledge of disability civil rights laws to promote the provision of culturally and linguistically competent care development of culturally competent disease management program that include people women with disabilities and then have strategy to increase diversity and minority healthcare workforce pipeline to improve disability, cultural competence, disability cultural humility and ultimately health outcomes for people across all communities. Thank you.

Nikki Racelis (Moderator)

Thank you, Dr. Marks, and Claire, I will turn it over to you next for your response.

Claire Abenante

Thanks Nikki.

It's a great question. Healthcare professional education does a great job of teaching disabling conditions but not clinical considerations or modifications for people with disabilities. And as we have learned today, people with disabilities are a marginalized group, but often overlooked in their DEI efforts.

People with disabilities intersect all races, sexual orientations, religions, and identified genders. Medical and nursing schools should teach both sensitivity and awareness, including patients with disabilities in their simulation labs. Thank you.

Nikki Racelis (Moderator)

Thank you all. So, we have just a couple minutes for questions and answers. So, one question that we have received is what are some considerations for women with disability facing menopause? Are there starting points for women who have not yet reached menopause but who want to be prepared to use in conversations with health plans or providers? Dr. Harris, I'm wondering if you might be able to respond to this question first.

Dr. John Harris

Sure. So, menopause is defined by the lack of a period for one year.

So as a part of that process, there's the perimenopausal process where there may be early hot flash symptoms, irregular periods, urinary symptoms. These are all things that individuals can ask their providers about these symptoms and get early help even before menopause is formally diagnosed.

Nikki Racelis (Moderator)

Excellent. Thank you, Dr. Harris. Dr. Marks, do you have a response to this question?

Dr. Beth Marks

I think Dr. Harris's response was terrific. I don't have anything to add.

Nikki Racelis (Moderator)

That sounds good. Claire, do you have anything to add?

Claire Abenante

I agree. I think Dr. Harris did a great job. The only thing I think that we can do is try to improve health literacy for people with disabilities. I do feel like even for able bodied women, menopause is not something that is talked about often, and I think a lot of the signs and symptoms of menopause can be overlooked.

And I think it's important to when women are starting to present with those irregular periods and at that age, that it's really important to have the conversations of what women with disabilities are experiencing.

Nikki Racelis (Moderator)

Wonderful. Thank you all so much.

I know we didn't have much time for audience Q A, but please feel free to continue to chat in your questions as they can help inform future RIC events. So, at this time, if you have additional questions or comments, you can also email us at RIC@lewin.com. The slides for today's presentation, a recording and a transcript will be available on the Ric website shortly.

Additional resources referenced during today's presentation are included at the end of this presentation. These resources will be available to you upon downloading the slides. As a reminder, please take the post-test. If you are interested in earning NASW CE, you must take the post-test by 11:59 p.m. Tomorrow, Tuesday, October 17. With a passing score, you can retake the post-test multiple times to earn this score.

Please complete our brief evaluation of our webinar so we can continue to deliver high quality presentations. We would also like to invite you to provide feedback on other RIC products, as well as suggestions to inform the development of potential new resources using the link included on this slide. On the next two slides are RIC resources that will support efforts to improve care for people with disability, and then the last slides contain references from this presentation in case they are helpful.

A huge thank you again to our speakers, Dr. Beth Marks, Dr. John Harris, Claire Abenante, and our guest panelist, Evelyn Castillo for sharing your insights, expertise and experiences.

And thank you to our audience members for your participation. Have a wonderful rest of your day. And this concludes today's event.