



Hello, we are going to get started in just a moment. Just making sure everyone gets in.

All right, hi, everybody. My name is Aryana. Thank you for joining us. I'm the communications assistant here at AUCD. I will be leading us through the accessibility and the COVID-19 vaccine experience for people with disabilities. For the sake of time, I will introduce each presenter as we go. Following the presentation.

We will have a brief panel discussion and open the floor to audience and questions and you can use the chat box at any point with any questions or you just need help or clarification. I will turn this over to our first speaker who is Robin Shaffert. She is with Georgetown center for people with disabilities.

>> Robin: Good afternoon, everyone. I have been asked to talk about the devastating impact of COVID-19 and exploring on the disability community and exploring race and difficult. I could talk about any subtopic on this for an hour, so I'm going to go through this quickly. Next slide, please.

No, one more slide, please. So, what we know about the impact of the COVID-19 pandemic on people with disabilities? We don't know enough. The data are still emerging, but we know from the recently published literature that COVID-19 has had a disproportionate impact on people with disabilities due to underlying health conditions and that is both in term of morbidity, people testing positive for the Coronavirus and mortality, people dying from the virus.

During the pandemic, people with disabilities have experienced delayed and poor quality of health care, discrimination and biases by health care professionals institutions and there are extensive deficits, including the failure to examine COVID-19 data by race, ethnicity, languages spoken and in the tribal nations. We're going to go back one slide for a minute.

We know the COVID-19 pandemic has had a devastating impact on people with intellectual disabilities. People with intellectual disability that are more likely to contract COVID, more likely to require hospitalization and more likely to die from COVID-19. We're going to look at what is going on here in D.C. where I live and work. The population of the district is just under 700,000 people right now, and about 8% of those people have tested positive over the course of the pandemic, up until this month. Of those people, 2%, 1,059 people have died. That is 45% black or African American. The people supported by our developmental disability administration of our department on disability services are adults with intellectual disabilities. It is approximately 2,400 and of that smaller group, we have had 332 people test positive, almost 18% of the people served by DDA. 61 of those people have died.

We know that 37 of those people that the cause of death or contributing factor to the cause of their death has been COVID and that's almost 9%, 8.5% of the positive, so over four times as many people who have COVID have died of COVID in this population, of the people who tested

positive and it is over twice as many testing positive. Next slide.

A variety of factors contribute to this. Many people with disabilities live in congregate settings and they have staff coming in supporting them on rotating shifts, so isolation, so people coming in and out of the homes when many people in the general population were able to lockdown more than that. There are high rates of health conditions, there is poor access to competent health care and there was a lack of guidance tailored for this population. Next slide, please.

That is a look at people with intellectual disabilities, but the disability population is diverse, so I would like to talk about other impacts we saw in the community. The first one I want to talk about and this list is by no means exhaustive. One of the things you heard a lot in the beginning of the pandemic, don't worry so much, only people who are old or have preexisting conditions are dying from COVID. This was said to make people feel more comfortable, but it devalues disabled lives. People with preexisting conditions are just as important. The other thing that happened that we saw early in the pandemic and there was some action by the office of Civil Rights at HHS around there was health care rationing plans that would give less health care to people with disabilities that would rate them lower, because they had disabilities.

Hospitals put in place no visitor policies, well, that has a different impact on people with cognitive disabilities, having someone advocate for them or help them communicate are not visitors, those are support people. Masks and a number of different ways had a disproportionate impact for people who are deaf and read lips, masks block that and now there are masks that you can see people's lips, most people are not using those. People with disabilities can't take their own mask off and it is not safe to wear a mask if you can't take it without assistance, and there are people with disabilities for whom the masks are harder to wear.

The mental health needs are exacerbated because of the social isolation and because of the anxiety of the pandemic. Outdoor restaurants created issues for people with wheelchairs. We know that remote learning was hard for all students, but people getting special education services, including for those with IEP had difficulty in remote learning.

Let's talk about the intersectionality of race during the pandemic. The term, intersectionality we take from a lawyer and Civil Rights activists who wrote about, because of their membership in multiple social groups may experience oppression and marginalization. Kimberly Crenshaw focused on black women, but since she wrote this work in 1991, intersectionality has been used by many people, including disability advocates. It is important to remember when we use the term intersectionality, it is not confused with multicultural and the discrimination and marginalization and oppression.

Let's use -- next slide -- let's use the words of our colleague Andy who expressed it this way. From childhood through adult life I experienced stereotyping, marginalization and discrimination because of my LGBTQ-ness, Hispanic-ness, and my disability, so each of those things leads to

discrimination and marginalization. Next slide.

When we look at the intersectionality of race and disability, one of the things we have to recognize is disability prevalence varies by race and what you can't see on this chart, the last piece is covered over by the speakers and the interpreter is in the Asian community, one in 10 people have a disability. All the way across Hispanic, native Hawaiian, Pacific, white, black, and American Indian who have three in 10. That leads to a lot of different outcomes around COVID. Next slide.

We're talking today about a lot of -- about the accessible communication, we're going to need accessible messaging for the COVID-19 vaccine, and one of the things that we see here and I apologize that this chart may be hard to read. When you get it, you can full screen the whole chart and you can see it better, but what we see here is in every racial and ethnic group, adults with disabilities have higher vaccination rates than adults with disabilities. With the highest vaccination rate of 95.9 for nonhispanic, Asians without a disability down to 77.4% for Hispanics or Latinos with disabilities, so you really see in these two charts the intersectionality -- the intersectional impact of race and disability. Next slide, please.

So, because of these impacts, accessible and culturally and linguistic and competent messages will be essential to meet people and their families with disabilities where they live. We have an at-risk population, communication challenges, including lack of access to technology, including challenges with accessing the vaccine, lack of transportation and vaccine sites themselves being inaccessible to people with disabilities. There is historical stress of the health care and linguistically incompetent messaging.

When we look at culturally and linguistically competent messaging, it is important that the message is essential, but who delivers the message is equally as important as who delivers the message themselves. Next slide. What are our challenges to creating and disseminating accessible culturally and linguistically competent through messengers who are appropriate for it? We have the historical and present-day experiences of discriminate authentication, ableism and racism. Lack of trust of the health care system and lack of trust for providers, and then we have the challenge of the literacy. For many people, a lack of knowledge of how to use technology and the lack of access to the technology, and then inconsistent to their providers adhering to accessible mandates and providers.

Next slide. The other speakers going to talk about this in more detail, we need to engage people with disabilities to identify the hesitations and concerns to build messaging to impact people. We need to partner with persons with intersectionality identities, race, LGBTQ status to create appropriate health messaging. We need to find the credible voices to deliver the messages and identify people's preferred modes of receiving messages. Do people use social media, face-to-face communication, individual phone calls, video, print, ethnic media advocacy, faith-based communications, community-based organizations and these answers will differ for different groups of people. I don't want to leave without saying, we need to collect data and assess the

effectiveness of messages and messengers so we can learn and continue to work out way out of the pandemic. I will turn it over to Aryana.

>> Aryana: Thank you, Robin. Did you have any final thoughts you wanted to add?

>> Robin: Those were my final thoughts.

>> Aryana: Our next presenters will be Max Barrows and Hasan.

>> Max: My name is Max Barrows. We want to emphasize how important it is to effectively involve people with disabilities in your project. The two territories for producing plain-language information are knowing what to say and how to say it. The details of how to write in plain language is essential, but you need to pay as much attention to the content of your information. Always begin by looking at your information and deciding what is need to know versus nice to know. Then focus on using words that are easy to understand for most people and when you think you have a great document in plain language, always have it reviewed by a focus group of people with disabilities, to make sure it is clear.

As a self-advocate organization, we are constantly reminded how people have their own way of doing things even though our staff are people with disabilities, we are constantly surprised by some of the barriers people have encountered during the pandemic. It is key to connect with your audience in real ways. The most effective way to know what people are facing is to ask them.

Next slide. Speaking of the barriers that people with disabilities have been facing, I want to make a few suggestions. As you know, the Delta variant is a whole new ballgame. Our messages must clearly point out how much more dangerous COVID is today. Find ways with graphics or stories to get across the numbers. For example, an unvaccinated person is 11 times more likely to die from Delta. People with disabilities who have been more afraid of the vaccine than they are of COVID, they need to understand how dangerous COVID has become.

Hassan: People are having a hard time with COVID sites to sign in. They don't understand, and they need someone to support them on how to sign in and call with the phone and they need help with those kinds of areas. When people realize what they are supposed to do, for them it is a hard time for people to speak for them, it is very hard for them. >> Max: All right, thank you, Hassan. All right, so, as a self-advocate and as a self-advocacy organization, we know people who want a vaccine, but their guardian says no. It is important to share information about how to get a free lawyer from protection and advocacy to help the person make their case and be able to get a vaccine.

Number five, I would say -- we would say this, there is so much false information on social media like Facebook. Unfortunately, the bad messages are pretty basic and easy to understand, whereas often the medical messages are more complicated. This needs to change. We need to flip the switch and thanks for all you are doing to make your vaccine information catchy, attention getting, easily remembered, as well as valuable and reliable.

Next slide. That is you, Hassan.

>> Hassan: For me, how I got a vaccine, I had to ask my family and my sister how to get it and they helped me to get it and helped me to sign in to the website. We went to sign in and get a vaccine, and for me very hard time for signing in for that and for many if they can ask a family or friend or if there is a way to ask somebody to help you with that. Also, I had a hard time with the how be independent and my sister helps me with that and that is how people can get COVID vaccine. Go ahead, Max.

>> Max: In January and February of 2021, well, this year, the Vermont health department provided vaccination clinics geared for new American households. At the time, in Vermont, vaccines were being given out according to age. At the time, we were giving out vaccines for people 75 or older. It was decided that for new Americans, if a family member was 75 or older, the whole household was able to get vaccinated. The goal was to make sure translators were able -- were available at the vaccine sites to give information and the goal was to meet the needs of the community. New Americans were experiencing a three to four times higher rate of getting COVID vaccine this was a benefit to new Americans with disabilities. All righty, on that note, that is all from Hassan and I.

>> Aryana: Thank you so much for sharing. And next, we have Shirley from NCRN.

>> Shirley: Hello, my name is Shirley.

>> Aryana: Take it over.

>> Shirley: My name is Shirley and I'm going to be speaking about creating accessible materials for blind and visually impaired. I'm partially scythed and when it comes to COVID-19 materials, you want to make sure everyone is able to engage in the message that you're disseminating. For example,, a lot of blind or visually impaired people use screen readers. Next slide, please.

So, the first element that I want to emphasize is alternative text. It is a short description of tell what is an image is and it describes any image or post. Specifically -- yeah, OK. Alternative text should be used when any information is provided. Thankfully, alternative text is being incorporated more and more in social media platforms and if it is not included, it is advised to provide a visual description at the end of the post. It is important to describe why the image is important and being able to describe it and quote it word for word and also being able to summarize graphs and charts. And checking for readability. We want to make sure what is being described is understood by everyone and it is clear. Next slide.

The next element I want to emphasize is color contrast, it is colors that are high contrasts like a black background and this works well with colors, blue on green, yellow, I did provide samples. Using color contrast can be an effective way to emphasize important information related to COVID-19 that is easy to read. I studied advertising that I understand that in every organization there is a designed color palette, so being able to expand your knowledge to make it easier for people with blindness or low visual makes it easier to read. Audio descriptions is an additional audio track that describes and gives context of essential visual information in media for people who are blind or visually impaired. Typically, audio descriptions occur in small existing pauses within a video to describe gestures or quick little images that are happening in a video. It helps people with disabilities to know what is going on in the video, are you showing a person getting

a vaccine in the video? Are you showing someone assisting a person with a disability filling out their information to get their vaccine, just little details like that make a big difference. This is quickly becoming a feature that is known to be needed for accessibility.

Of course, there are so many more details I could describe about audio description, the types of software available to do this, how to describe the videos, but for the lack of time, I won't do that. Next slide, please.

Now, I do want to discuss alternative formats, I mentioned elements for digital accessibility, but I want to talk about Braille or large print. These individuals may use what is known as a Braille display that is an assistive technology device that displays Braille, which is cool, because you can have documents converted to e-Braille that is ready to use and read the information on the document. For example, a COVID-19 sign-up or filling out your medical information and having the files ready, so that people who are blind or visually impaired have the independence to fill it out on their own because it is accessible. Also, having embossed Braille or raised Braille. Typically, this is provided upon request, but it is important to have an extra sheet available, because you never know when a person who is blind or low visioned attends a vaccination site.

Large print is in 16-font and having accessible fonts that are open that don't have the little -- I would say the little tabs at the end of each character and those types of fonts are Sans Serif, Tahoma and that makes the information easier to clearly reads, you're not using italicized fonts. You should use bold or semi-bold. This is important. When I attended the vaccination site, they give me the forms to fill out my medical information and the document was cluttered with all of this information I need to see and it was small print. They did not ask. I needed assistance and I had to let them know this document is small. I cannot read it. Can someone read it to me?

When I got the vaccine, they provided a pamphlet with all you needed to know about the vaccine, it would have been great if they had an accessible pamphlet of this, but they didn't. It is nice to have accessible information and digital information that you disseminated is as really important.

>> Aryana: All right, thank you so much, Shirley. And finally, we have Meg and Nick from the University of Montana, a rural institute of University of Montana. Nick is from the Mazoola county of office management. >> Meg: We're going to talk from the perspectives of Mazoola and Nick is presenting as a peer advocacy coordinator. Joel is the Executive Director of the centers for independent living and Ann is our state DDPH and surge coordinator. Next slide.

I want to acknowledge Chris who passed away and was with summit independent living for many years working with us until the time of his death in April. The foundation of this work is built through partnerships that we formalized overtime and continues to work on and specifying



roles within emergency management, emergency operation center, disability organizations, such as our centers for independent living. We are lucky to have very strong centers without covering all counties in the state. Our university center for excellence here and with our state, local and tribal public health departments. Next slide.

We have been taking a whole-community approach in strengthening these partnerships for about 10 years. We have been working with Missoula. It is a work group and subcommittee of the local emergency planning committee. We will be sharing two articles. Today's webinar showing work and the approach from Missoula county. In Lewis and Clark, it is a cross-cutting work and pulls in from the health center. It is called an inclusiveness work group, so it informs activities from the public health department and its partnership with the community health center. I included a link in our slides to a video developed with the national association of chronic disease Directors on this committee and its work. We will share the policy that guides the work of that work group. I'm going to turn it over to Nick to say how these work groups and disability partners support the work of the incident command.

>> Nick: We activated our all hazards incident management team and this is the basic organizational structure of incident command teams all over country. I'm a public information officer on the team. These teams expand and contract as needed.

As an all-hazards team, we are generalists with an expertise in organized disaster response, so we rely on cooperators who have specific information or statutory responsibilities in those aspects of the response. Next slide, please. So, as I mentioned, we do rely heavily on the cooperatedders. We're generalists and people like Meg come in and help us, guide us through all of this and allow us to have sort of a high level look down and they help us with the tactics on the ground to make sure we're as accessible and inclusive as we can during the response effort. Next slide, please.

So, all disasters have a disaster cycle that includes normal operations and the disaster response recovery, mitigation and resilience. This is what it looks like for your everyday disaster like wildfire, flooding or hurricanes. For a pandemic, all of the lines are blurred on top of each other, because the response is still happening, the recovery is still happening and everything else is still happening and we're trying to get back to normal operations at the same time.

Even though these lines may not be exact and they may overlap for a pandemic, these different phases of the disaster are part of the pandemic response. Next slide, please. So, again, we rely on our cooperators and this is born out of the relationships that we developed early on, way before the pandemic ever occurred, years before the pandemic occurred. I think Meg and I have been collaborating for quite a few years now, and we rely on others' expertise to guide us through what the A.D.A. says we need to do and what we are actually doing. Next slide, please.

Now, this is really the engine that drives our response activities. This is called the planning-P and the lower part of the P. happens one and then we get into the O-part where we go through the cycle every day and this informs what our operations is going to look like for any operational

period. We start off every day with an operations briefing, shoeshine what is going to happen and the general staff, the folks that showed on the previous slide get together and check in with each other and let everybody know who is doing what and how it is going. After that, we break up into our various groups and have tactic meetings. This is where a lot of the cooperators come in, for example, Meg and Travis and Chris and I would get together at 1:00 a few days of the week to make sure we are moving forward with accessibility and inclusivity for folks with accessible needs and doing everything that we can.

The relationships that I just discussed are the most important thing. Nobody can be fully prepared for all disasters, especially not a huge, all-encompassing one like the pandemic, but if you have the relationships in place, you're in a better spot than if you're starting from the bottom without that. Next slide.

I think that is probably where I pass it to Travis.

>> Meg: I want to underscore what some of the presenters before us said. There needs to be access for people with disabilities and their support workers and we will share a letter from the Montana association for independent living put forth to all tribal officials and officials and that should be 2020 that was very specific about how support workers needed to be covered, not just in institutional settings, but also in community settings as well. We really worked hard locally with Nick and other partners to understand how they were doing outreach to health care, ors, to schools and said, oh, we can do similar outreach to disability providers and people with disabilities and advocacy organizations. Travis worked closely with Nick to extend the communications in targeted ways and expanded a group of partners, cooperators.

Just the ongoing objectives to increase vaccinations among residents and workers in the highly dangerous long-term care facilities and congregate facilities. We're happy to share some of the extended strategies that we put in place quickly following the federal pharmacy partnership efforts. And then Travis is going to talk about how we, as Nick showed, as we talked at a tactic levels building inclusive, accessible services. Next slide.

These next 10 slides we're going to go through quickly. Travis is going to take that on, but we try to take everything we're learning in our tactics group and put it into a training for staff, so anybody who came into the incident command or working in the operations had this three-page document to review. They could see all of the accessibility supports being built across the operations, and be aware of those, and therapy prompted to get certain trainings like certifications and how to use relay, a telephone call that involved relay.

>> Travis: I'm the advocacy coordinator at the independent living in Montana. When a pandemic strikes or a wildfire and whatnot and people have to leave their homes, it is straightforward. There are shelters all over the place, but when it comes to a pandemic, it is at different animal. Normal matter how good the guidance is, it is coming from the Federal Government, throughout the state, especially Montana the state is so fragmented. We have 56 health entities responding at the local level, so their ability or knowledge of taking a guidance that says these must be accessible to people with disabilities, but what does that mean and what does it mean for people with different disabilities and different populations and Nick pointed it out that is the value



of partnerships with organizations that are focused to providing services to different at-risk or marginalized populations. It is taking that information that is high level and boiling it down and putting it in a format where individuals who are on the public health response team can really get through the weeds and implement in a meaningful and timely fashion. I think that's one of the beneficial things of developing checklists. Make sure you are reaching all populations, so we have good guidance at the beginning of the pandemic on how vaccination was going to reach those who lived in congregate facilities, such as nursing homes and assist ant living facilities. Unless the public health agency serving their region knew about how community-based services work and people who might oftentimes be receiving services in nursing homes, they are getting services in their homes. How do we reach those people? How do we accommodate that population? Those who have communication needs for ASL, Braille, audio descriptions, how do we make sure the information that we're putting out is accessible to those populations? I think that is where the importance of the partnerships, especially with centers for independent living and others who do this on a routine basis is very valuable. These checklists can be very valuable for emergency response teams.

>> Meg: We just have a minute left. Lauren, if you can advance to the slide, after action reporting. This is our training for staff that came out of the guidance and used as action in our agenda and we're thinking about our reviews and this webinar is providing an opportunity on what the options have been. If you can advance, Lauren to the next figure, we just provided these here because this is what we're thinking about. We are starting to formalize into activities into action. I want to give the last comments to my colleague at the state Ian Thigpen.

>> Ian: You will see in the graphic in the bottom right-hand corner. This is talking about the whole response cycle, because there are things that input into the planning P. and the planning P. has outputs in operations and in the entire process. I'm not going to get into all of the nuts and bolt, but for access needs and inclusion there is in the response machine for communication management, understanding who that population is. How we're integrating expertise into the planning process and assisting all of our strategies and tactics for inclusion. Resource management, what resources are we bringing in to achieve inclusion outcomes and operations, what are we doing on the ground, what are we doing with public information and warning? How do we integrate all of these things into the incident management process, the operational cycle, so to speak. We have some ideas.

>> Meg: Thanks, Ian.

>> Aryana: I'm so sorry. We're moving into our Q&A panel, so -- thank you again to the Montana team for that great presentation. All right, to start off, I would like to ask the panel if we can get everybody in.

I will present the questions to the panel as we get everybody on, but how can we use the strategies talked about today to better engage people with disabilities as we all work to end COVID-19? Robin, I believe we will start with Robin.

>> Robin: Thank you, Aryana. You heard a lot of important information today and I want to emphasize what Meg said about partnerships and Max and I said about talking to people with disabilities in each of these communities. I hate the phrase "low-hanging fruit," but to the extent there was low-hanging fruit around the vaccine, it is gone. We have to work hard to -- on a very granular basis, on an individual basis to talk to people, get the right messengers with the right messages for people to access to persuade people who are hesitant to get the vaccine to help them make appointments and help them get to the vaccine, to have the place where is they get the vaccine accessible. Getting the right group of people together, finding out people with

disabilities and different communities what the barriers are and working in small and big ways to breakdown the barriers and get people vaccinated. And make sure people are getting the health care they need and the mental health care they need and the other supports and services.

>> Aryana: Thank you, Robin. Meg, would you like to jump in?

>> Meg: There is nothing about us without us and having leadership in the disability community, opportunities to engage in the state level and the ACL dollars, C.D.C. dollars that have come to different entities in the state to work in a new way, so that we're ready to support as cooperators at the local and tribal levels, local operations and vaccinations. I think we have a lot to learn about how these strategies work in rural. Lewis Clark and public health, our coordinator there. there is talking with rural counties and some don't have the staff, in some of the ways that Nick described. Thinking with the underrepresented group, how are the strategies going to work, and how are we going to achieve outcomes that are equitable across communities?

I think we need to invest in those partnerships, and not just individual organizations, but in the opportunities for those organizations to collaborate.

>> Aryana: Thank you, Meg. Anybody else from the panel? You can un-mute yourself. I would like to ask the audience if they would like to ask any questions, now would be the time.

>> I would add that investing in the partners help drive what the tactics are to get the strategies out there. You need to engage the folks within the different communities with different disabilities, so you know what tactics can best be used to communicate directly with them. >> I would add, too, not only get involved in your work, but have some leadership role and have their, you know, have our voices, you know, and input involved and taken seriously in the work that you do.

>> Shirley: I just wanted to mention, in regards to the communication and implementation, I think it is important in messaging related to COVID-19 by, you know, once you begin developing the material, accessibility can be a check box that you go through, so it is not missed and kit can the b -- it can be done. It is important to accommodate everyone with their needed formats.

>> I also want to add, too, sorry, I would say also just find ways to reach out to local peer groups and connect with self-advocacy groups on a local level that way you can model how to address concerns when a person is afraid or does not know how to get a vaccine.

>> Aryana: Thank you, Max and Shirley. I have a question from Susan Millner the chat. She asked the question earlier and I'm going to pose that question and her current question. Earlier she asked if anybody had the current -- the current -- does anyone know the rate of infection for new Americans now? And her new question is, what were the other community partners which were found to be helpful centers for independent living? Was one example mentioned? How does one change a culture from top down to nothing about us without us? Thank you, Susan.

>> Travis: Some of the other entities that I mentioned that my good partners or whatever, protection and advocacy organizations, so often it is difficult rights Montana or disability rights in Texas or whatever state you live in, service providers, I agree with what Max said before. Local peer groups a great resource as well.

>> Robin: I would add to the list that Travis gave, which agree with. In every state there is a

developmental disability council and there are statewide committees on independent living and committees for people with intellectual and developmental disability. We also partner with the organization of service providers in the district and with some other local disability organizations, so you know, I think following up on what Meg said in response to the last question. I think some of the collaboration that we have done during COVID will strengthen our ongoing collaboration across all of our issues. It has been a time when we have needed to collaborate and we stepped up.

In terms of the infection rate, I can't answer that and it is interesting that Max had that data in Vermont. That is going to be data that is available to the extent it is broken down in that way on the state's Coronavirus website. I would also say there has been a lot of effort in term of people who are coming into the country to get people vaccinated that has been true for people who have come here from Afghanistan recently. So, there is a focus on that and I'm going to stop talking, because I don't remember the rest of the questions.

>> Travis: I was going to address the top-down-change culture from top down. I think it is important to remember that as a public health entity, you are ultimately responsible that to make sure your services, programs are accessible, especially as a title II entity under the A.D.A. and receiving funds and how do you best do that? If you have somebody onboard that is an expert in inclusion and accessibility, great, but oftentimes that is not the case. So, I think that advocacy organizations like the ones we're mentioned getting involved is not to say, hey, you're doing it wrong. You need to change. Those organizations, they want to partner with public entities to ensure things are accessible and it does not have to be confrontational. It can be a great partnership.

>> Robin: Also, we should remember that we want to be reaching people with disabilities and the other people in the disability community, family members, friends, other supporters. We're at the point where the age for vaccination will hopefully go down rapidly, so we want to be involving the family groups, which is everything from large organizations like chapters of the arc and other local disability, family disability organizations, as well as the parent training and information centers. Really getting parents to vaccinate their kids, especially in light of the Delta variant is going to be important in getting us out of this.

>> Aryana: Thank you, guys. We are going to pose the last question we got from the chat and what data sources did you access to find the group you were working to reach or what other ways you found people?

>> Meg: I will say we use public health systems to educate our public health colleagues about the number of people with disabilities and where they live. Often time there is a misperception that people with disabilities, either they believe that everybody lives in congregate care settings or they believe there are few people and they don't understand congregate. We have to show them the data available for from the census and other sources to say most people with disability live in the community and there are a lot of them. One in four by some estimates. And congregate care settings and do not miss that nursing homes are almost 100% of people with disabilities. We start there and we use our administrative data lists. You have to be, you know, Medicaid approved to be a provider of home-based services or community choice services and those are lists of businesses, organizations. Our centers for independent living, our organizations are partnered through a variety of federal grants with other partners who may not

be on the lists and we compare those and create lists to create our outreach lists and allow people to opt in for regular e-mails where we were forwarding our situational report on COVID or health advisory announcements, and where vaccination clinics are going to be happening. All of those are going out with these lists. I hope that is helpful.

>> Robin: If I can follow on to what Meg was saying. I said a couple of times in my presentation that there is a lack of really good data around a lot of disability issues and that is true, but it is better than it used to be. I used some data from our local department on Disability Services and some data from the census bureau and some data from the C.D.C. There is as disability data that you can use from the Department of Education from the bureau of labor statistics at the Department of Labor. There is more and more data and people with disabilities a part of every community, and are impacted by every service that the government provides, so you know, we're at a point where we have to use the data that we have and continue to advocate to make it better.

>> Aryana: Thank you so much. We are out of time. We thank you all for joining us today and being a part of this conversation as it continues to evolve. You may e-mail any of our speakers. They are up on the slides and will be shared as well after. To learn more visit the national center on disability public health website linked in the chat for more information. Thank you so much and feel free to follow up with anybody as needed.