Presentation Transcript

Webinar #1 - Navigation: Promising practices for scheduling and transporting PWD to COVID-19 vaccination appointments

We would like to thank all of you for joining us today. Public health and leadership for AUCD and I also oversee our National Center on Disability and public health. Today's webinar is all about sharing strategies and resources to support vaccineation for people with disabilities. I encourage you to -- apply them in your local states and communities. I also encourage you to share resources that you may have developed over the last few months and share them through AUCD's public health is for everyone online toolkit at www.PHETOOLKIT.org. Because of the number of participants, your audio will be muted throughout the call but we do encourage you to submit questions at any point through the Q&A box on your webinar console. Understanding the origin of our webinar series, our colleagues at CDC help listening -- throughout the country and shared and found out what some of the challenges and successful solutions were in reaching people with disabilities for getting their vaccinations. Today AUCD is partnering with ASTO and NAC ho to amplify what they learned through the sessions and share some of the promising practices with you so you may be able to apply them in your efforts. With that said, I would like to introduce our speaker so we can start hearing about the successes. First we are going to hear from Minnesota Kody Olson, advisor for the Minnesota council on disability. And Tom Gottfried is -- transportation access. Next we'll hear from Louisiana Julie Foster Hagan -- developmental disabilities. And next we'll travel to Colorado where we will hear from Jarret Hughes, senior policy advisor on aging, Office of the Governor Jarret -- State of col Colorado. Then we'll hear from Hawaii, we have Mary Brogan -- Hawaii State Department of Health. And then wrapping up today's panel is Andrew Reece. Join me in welcoming the speakers and I will turn it over to you, Kody. Take it away.

Good afternoon, everybody, thank you so much for joining today and for the opportunity to present. I will be joined by my transportation partner in crime Tom Gottfried. And we'll both be discussing Minnesota aches approaches, some of our best practices and what we've learned over the past year rather transportation not just vaccinations but some of the lessons learned from the testing and some of the different COVID services. As Adrian mentioned, my name is Kody Olson, disability policy advisor, I work for the Minnesota council on disability but I'm the -- state emergency operations center and I've worked with the Minnesota Department of Health and our partner agencies to ensure that the state's COVID-19 response is inclusive to the Minnesota disability community. And as many folks know on this call, transportation barriers are among our highest concerns in ensuring that Minnesota Minnesotaance with disabilities and other high risk populations have access both to the vaccine and related services and they can reliabley and independently get to and from their appointments. Early on the Minnesota Department of Transportation leveraged CARES Act funding to expand our non-emergency medical transportation program to create a highly flexible program that reduced transportation barriers in getting folks with disabilities tested. And I'm going to ask Tom to talk about that after I talk about some of the other practices. We'll come back to that. Diagnosedy the Minnesota Department of Health contracted with various community-based disability organizations such as our centers for independent living and Blind incorporated, as well as conducting accessibility assessments of various service delivery sites. These community contractors have also assisted many folks with disabilities in finding transportation resources and assisting them in coordinating transportation logistics. A number of related to the contractors, a number of those we call them the CCCs, the

COVID-19 community contractors, not just for the disability populations but for communities of color, LGBTQ + communities, we have a variety of contractors that the Department of Health utilizes to reach out to the different populations. What's exciting is that in the very near future these coordinators, these contractors will be hosting their own vaccination sites from the -- allow them to reach to the populations that they serve. And several of these sites will be specific to the Minnesota disability community. Additionally the Minnesota Department of Health is currently converting six of our metropolitan buses into mobile vaccination clinics clinics. We're also considering the use of home nurses to conduct home visits for those who cannot leave their homes. We have successfully launched one pilot program here in the metro area in a suburb of St. Paul. One pilot program -- finally, one other thing I want to touch on is the Minnesota council on disability also serves as policy advisor to the state legislature legislature and the Governor's office and we're advocateing for a state legislative bill which would expand -- activities of daily living in our PCA program to also include transportation which would enable personal care assistants to drive their clients using their own or their client's vehicle. This policy change would hopefully give max -- utilizing our PCA program and to get tested and vaccinated. With that I'll turn it over to Tom to talk about some of the successes with the Minnesota council on transportation Council on Transportation Access.

Helps to hit the mute buttoned. Thank you very much for inviting me here to be part of this discussion. I'm Tom Gottfried with the Minnesota Council on Transportation Access and I'm the executive director. Minnesota Council on Transportation Access is actually a 13 state agency membership that's representative from the Commissioner level or designee and generally we have assistant Commissioner level participation in the council. We're very much at a policy level discussion point but at the same time we get into the elements of the nitty and gritty and of course COVID-19 created the opportunity for us to get involved in a variety of different needs that are associated with COVID-19 and the creation of that. And one of the things that Kody made reference to is they will never have me name a program again, but it was called the greater Minnesota COVID positive clientele transportation. It wasn't slick and it doesn't have a good acronym but fundamentally it was a program that was asked to stand up because there was a very serious concern about needs for people with disabilities very specifically but people just did not have traditional access to getting to doctor appointments who have already tested for COVID-19, not all patients actually ended up in the hospital or if they did end up in the hospital, they still needed to finish out their quarantine and needed to be transported in a non-emergency situation. Taking an ambulance service which is the only other service available to transport individuals this way would have cut their system by 50% or 25% because of the emergency response because the services we were rendering were not emergency, they were people being discharged and healthy enough but still very positive for COVID-19. So there was also medical needs for people to be transported to methadone treatments, various different cancer treatments. Actually the largest one was dialysis treatments. In a grand total of 78 days that we stood this service up, we provided just under a thousand, a little less than 900 individual trips. And because we were meeting all the CDC requirements for COVID-19 positive clientele transportation, it required a rather unique set of skills and talents that were very near to essentially as much as an ambulance service would be rendered. A good portion of the population, as a matter of fact, I would say about 80% of the population being transported were people in wheelchairs and having that need for additional access. So we utilized the system that we stood up very quickly exactly from soup to nuts, we set it up in six weeks and were under contract and operating in the first part of October through the December 30th. And it hit exactly at the perfect time for when we were peaking at our highest. There was higher peaks of COVID clientele, about four and a half fold in

March. We were able to stand that service up and it was really highly valued because of just the whole host of the access that was necessary for these people. It was looked at being extended beyond that. The good news and bad news is it was not viewed as something we would continue forward past December 30 but it did end and at the same time the peak had hit at that point. By January the levels where they were in December were less than half in the first part of December and November and scaled back. Also at that time a lot of our public transit systems started standing up their own programs that were very similar to what we stood up. We already created the model to follow so they were able to do in a patch work across the state. We managed to take care of a fairly significant portion of the population at that point. That was one of the programs that Kody was making reference to that we did stand up and we used COVID-19 funding that we got through FTA and associated with that as well as some special funding that was given to local units of government to the state to help facilitate because again, some of the service was so patch work across the state that they wanted us to have this 1800 number we'll take care of you and it didn't cost anything to the client. We have to admit that this price tag was expensive, probably average $860 a trip one way. Which some people would say wow, might as well got an ambulance service, but that's 1200 to $1,500 one way. In real dollars we saved money. The other aspect was the issue taking an emergency response vehicle out of service to do a non-emergency transportation and that was the bigger period of, especially during the peak time when people were wanting emergency vehicles to transport them to the hospital because that's the only way they could safely get there. Not in their own car car, not in their neighbor's car, in an emergency response vehicle. That was probably the biggest value that created at that point in time. We're also continuing to work in a partnership relationship because that's what NCODA is about. We'll be including them

as we get into the vaccine. Minnesota is working with the metropolitan council in the Twin Cities will be standing up a service for mobile vaccination services on buses and will be deployed in the greater Minnesota -- to that end those are the services that we're looking at and still continue to work with and work with all our unique partners in this discussion, all the way from public health to including the veterans services, the whole gamut. That's the reason why NCODA exists. I will answer any questions post that and I'm sure Kody will too.

Thank you both. This is Adrian. Thank you both for sharing the MCODA story with the group here. We will save space at the end for questions and answers so we'll keep on rolling with Louisiana. Turn it over to you, Julie.

Hello everybody. I'm Julie Foster Hagan and I'm the assistant secretary or director for developmental disability services here in Louisiana. You can go ahead and advance to the next slide. I'm here today to talk to you guys about some of the challenges we faced and some of the strategies we used related to the challenges we found here in Louisiana. So in Louisiana we really value our stakeholder feedback and we have many opportunities for our citizens to give us feedback on what's working and what's not working for them. Disability advocates made it clear to us early on that persons with disabilities to be prioritized in our vaccination efforts. Our residents in our large and small intermediate care facilities were in our initial 1A tier here in Louisiana. And persons who receive in-home home and community-based services and their staff were included in our Tier 1B Phase 1. We also heard from family members who provide unpaid services or natural supports to folks with disabilities that they wanted to be included and they were as part of our expanded phase. So next slide, please, we did a lot of outreach because while we had those folks in the tiers, we knew there were some barriers to folks being able to get the vaccination, even the folks with disabilities who receive services. So we did a survey through our

support coordination agencies here in Louisiana and we found some interesting information about what the barriers were to folks being able to get the vaccine. 49% weren't sure where to go. 19% were concerned about the risk to exposure if they had to go into a public facility and be around others to receive the vaccine. 16% identified transportation as a barrier to get the vaccine. 12% were concerned because they were concerned they wouldn't be able to wear a mask or understand social distancing protocols to be able to keep them safe to get the vaccine. And then we had 5% that were concerned about the long waiting times. So we were able to identify transportation and not only transportation but just more location issues to being able to get the vaccine. Next slide. Specific to our transportation service that we have here in Louisiana, our non-emergency medical transportation, some of the challenges that our stakeholders helped us identify with the NEMT or non-emergency medical transportation are that trips to pharmacies or locations other than the physician's office for vaccine were not a covered Medicaid service. And then they were only available as what we call a value-added service through the Medicaid managed care organization prior to COVID. So that made it especially a challenge for folks to be able to receive use that Medicaid service of NEMT to help them get to the vaccination site. Okay. So we used that data and we used the feedback from stakeholders to really begin diving into addressing those challenges. Here in Louisiana we do feel like we are fortunate in that our Louisiana Department of Health encompasses our Office of Public health, Medicaid, our Office of Aging and adult services, Office of Citizens with developmental disabilities and our Office of Behavioral health. Because we're all under one on that roof roof, we feel like that helps us form a team to be able to really address these challenges. And just for framework purposes here in Louisiana, we do have a managed care model for acute care services. Our individuals who receive home and community-based waiver services are also able to choose to get their acute care services through a Medicaid fee for service model. They're able to choose the fee for service or managed care. And our non-emergency medical transportation is a service that's available in both managed care and in our fee for service model. Again, just for framework purposes as we talk through some of the things that we did to address. In Louisiana, we're uniquely positioned to have to deal with emergencies on a regular basis, even outside of COVID. I know we all have our own challenges. But we engage in emergency preparedness protocols for hurricane response regularly. So we really used that emergency preparedness protocols are what we use really to attack a lot of our challenges that we have in our state. And so one of the models that we use is a task force model. So with our task force model we believe that it's important that we have cross-section participation across our department as well as feedback from our external stakeholders on those task forces. And of course as the previous speaker alluded to, COVID response has really given us a lot of opportunities to look for how we might pull folks together and attack an issue. And we thought that was especially important as as the development of the task forces as we looked at addressing our issues. One such task force that we developed was using the data that I presented to you earlier as well as feedback from other citizens that we really wanted to focus in on transportation as an issue. We knew that a primary barrier for folks to receive their vaccination was transportation to get the vaccination at a variety of settings. And some of those settings included pharmacies but also closed vaccination pods that we set up, drive through vaccination settings or any place where vaccinations vaccination efforts were being held. Next slide. So as a result we made some specific changes to our non-emergency medical transportation to be able to help folks specifically be able to get where they needed to to be able to get their vaccines. We advised our managed care organization that trips for COVID vaccine administration were not required to be flagged as a value-added service. This was done in order to ensure the service would be covered for anyone needing transportation to receive the vaccination. We

did put some things in place to make sure that we were able to do a verification to ensure that there were no fraudulent trips so there's a verification to do a match that the pharmacy trip -- trip -- the NEMT service and the vaccination were done on the same day so we could make sure that we had checks and balances in place for that. We also updated our language so our non-emergency medical transportation vendors knew that enrollees were to be transported to COVID-19 vaccine appointments regardless of the setting where that was to occur. We also did some other changes prior to the vaccination to NEMT to allow folks to be able to have access. And that was we allowed vehicles to be leased and use magnetic signage. We allowed virtual vehicle inspections and we reduced the minimum age of the drivers from 25 to 21 to increase the number of folks who could be drivers.

Okay. We communicated this in a variety of ways. In Louisiana we have health plan advisories so once we received approval from our secretary, we sent notification to all providers, we posted on our website pages that we have for providers here in Louisiana, and then we worked with our case management agencies and our advocacy organizations to make sure that those changes to NEMT, that all participants who might be able to access that information were aware of those changes. Okay. The next slide just provides you guys with some links where we posted the health plan advisory and where we advised the non-emergency medical transportation folks as well as our families of what those changes were. And the last link just provides some contact information for me should there be questions after the presentation. And I'll wrap it up there.

Adrian: Thank you so much, Julie. Appreciate those remarks. Next we will travel virtually to Colorado. I'll pass the virtual stage over to you, Jarret.

Thanks, Adrian. Jarret Hughes here in Colorado. I'm a policy advisor focusing on aging and older adult issues within our Governor's office. Initial vaccine role out was really dominated by an economies of scale approach with the most rational efficient means of administration and distribution being prioritized. We know hard to reach populations are often not the focal point of these large scale efforts and we kept that in the back of our minds during the initial roll out and we knew we did not want to leave any folks behind as we advanced through phases. As first our policy planning and attentions was really focused on our primary targeted accessing and administering 70% of vaccines to adults -- we met this goal and as I said we were also aware that there would be a percentage of this age cohort that would have significant issues with accessing either community clinics or vaccine appointments. We also knew as phases expanded we would grow into another age cohort and different subsets of our state demographics that would require some additional supports to access these appointments. So at the beginning we spent a great deal of our time kind of focusing on ensuring that our local public health agencies, retail pharmacies, community health clinics, federally qualified health centers, were aware of the existing services we had within the state. That involved a lot of trips through our area agency on aging network which has seen significant financial support through COVID stimulus funding and that the mile high United Way 211 number could be a valuable source for tracking down community-based services. Additionally, throughout this entire time we were working with our metropolitan planning organizations. More specifically their mobility managers and transportation planners. We have six NPOs in Colorado Colorado. We have a north front range, Denver metro, Pikes peak, Colorado Springs, grand Valley. We have a really strong NPO network in Colorado and they really took the lead on coordinating local transit and paratransit providers and not only in their specific regions but also in neighboring rural communities. Acting as a conveneer, we had our NPOs and Colorado transit agencies which is the lead stakeholder organization that brings together our rural and urban providers to collaborate and

brainstorm and bounce ideas off one another. Additionally in that fold we have our Department of Transportation and specifically the folks who oversee our FTA5310 grants for people with disabilities and older adults, they are excellent in actively engaging and working with our local providers and coordinating and collaborating. Many of the folks that are in our division of transit and rail actually come from mobility management backgrounds and have social work backgrounds and do a great job of integrating human service -- coordination efforts. Throughout this process we were also receiving anecdotal input from our providers indicating that they were adequately meeting demand and that concerns over wait times for drive through clinics were not as significant as we had initially expected. And in early February when it became increasingly clear that vaccine quantity was increasing across the country, we really came to the conclusion that we needed additional infrastructure to administer these doses. At the state level we spent a great deal of time coordinating and standing up six large points of distribution or PODs is the acronym. These were accompanied by smaller community clinics around the state but each one of these large PODs was located in an N NPO region, that's about where 85% of our state population lives. We had smaller community clinics that serve our rural and frontier parts of the state. These large PODs are capable of administration -- as phases expanded our area agency on aging network and those trips would become less and less applicable because the requirements attached to the funding would be changing and would not be applicable to Colorado under the age of 70. We knew we had to -- we essentially knew we had to develop and bolster our existing transportation infrastructure to meet air transit trips for additional phases. It sounds like many of us have leaned on our NEMT programs through Medicaid. So we in Colorado actually have one single broker for all of our non-emergency medical transportation trips. That company is Intel ride is our statewide broker. They contract with 120 transportation providers around the state and they can deploy accessible vehicles to those who need them to access these community clinics. We are actually kind of in the final stages of truly operationalizeing that and getting that rolled out. Our large PODs in the state opened last week so we're relatively young throughout this process and it's a a cross each and every bridge when we get there and there are lots of bridges along the way as you all know. Our demand right now is still pretty unclear for what these trips will be, so we are focusing first on these large six PODs that we have stood up and every two weeks we'll be evaluating capacity and expanding accordingly to smaller clinics around the state. I am really spending a lot of my time currently a lot of organize organizing with the ground level logistics and scheduling teams, making sure that all these community clinics are aware of the variety of transportation solutions that we have, both regular, transit and paratransit solutions. And to kind of wrap up, I would say that I'm kind of at a high-level, the key thing for me has been to try and identify touch points for coordination and information sharing where the state and the regional local planners and local providers can all come together in the same forum and same virtual meeting room if you will. And this has really been supported effectively by our metropolitan planning organizations, our Colorado Association of State transit agencies and our Department of

Transportation. I would say at times I think historically it is difficult for the state level to connect at the local provider level and overcoming that barrier is critical to human service transportation coordination. And I think this is especially true when we live in a world where transportation network companies like #UK#er -- Uber and Lyft are often proposed as quick physics. But we know that quick fixes rarely equate to good policy solutions. The only thing I would add is we have been doing a great deal of work around our homebound population as well. And we are close to identifying and operational Z operationalizing a solution for that. And I believe one of my colleagues will be presenting on that in tomorrow's webinar. I appreciate the opportunity. Thanks.

Adrian: Thank you, Jarret. Appreciate your remarks. Next we are going to travel virtually to Hawaii and I will pass the virtual stage over to you, Mary.

Mary: Thank you so much and thank you everybody. I'm realizing how much we have in common. I'm pretty sure that Colorado for some reason is a lot like Hawaii except we have ocean between our rural areas so I really am struck by that. I'm Mary Brogan, administer for the developmental disabilities division in Hawaii. I'm going to be presenting on different aspect of [Away from mic]. Next slide, please. So just a little bit about our back story and somebody mentioned no one gets left behind which is really the spirit that we entered into this work with. I have a picture of lele oh and Stitch, which O Hahna means no one gets left behind or forgotten. We really took this to heart. In Hawaii we were driven by early on by the need to create partnerships. One of the issues here and I think maybe in other state vacuation vaccination plans is that there was not an explicit codified defining of people who live in the community who meet a long-term care definition. So people who live in long-term care facilities were defined in that 1A group, but it was silent on people at HCBS who meet that level of care but live at home often with their families or other congregate care settings, including very small adult foster homes, et cetera. So we had to educate and make people aware that we were a priority. I think we were never really codified, which has become part of the problem. In fairly short order we were given the nod with the caveat that we were to put things together ourselves. Thus Sprang the particular partnership we had, particularly with the state Medicaid medical director, with our emergency management group that worked with aging and people who live in congregate care in the aging community. So those were our primary partners. And the partnership was tight. Communication was often, many times a day, while we stood these things up. And we started with looking across the state. In my slide you see population by island. We started to look at triageing lists by population, who are the people that live in different settings, who are the people that -- and I learned all these languages and adopted them -- are more ambulatory in nature and then homebound. And started with those lists and those lists continue to be refined over time time. We did a lot of outreach. The outreach happened because we stood up a unique partnership. That was with our independent pharmacies. So it wasn't the big pharmacies that have contracts with CDC and so forth or agreements, I wouldn't say they were contracts, but there are about 12 to 13 independent pharmacies that came to the table and really it was the human centered approach of they just realized that this was their calling and this was the time that they were going to, no matter what, provide vaccines for people. So on different islands there were different methods for doing that. Some of the the multiple delivery options, some of the pharmacies made house calls to the congregate settings. The other thing that we did was to stand up drive throughs with the pharmacies and then the state stood up some of the point of delivery sites or PODs and we were able to support those with our staff, our own nurses, our own physicians and so forth. We also, the pharmacies, went out and did PODs at the intermediate care facilities so that was another method. But what we started to find out early on is that there were people that continued to have access issues. That is they couldn't figure out how to register online because it was complex. And I'm going to talk about that in a minute in more depth, but as we entered into this work work, we started to realize that we needed to have other solutions. In the next phase we're still working on the data analysis and outreach, constantly working with our lists, looking at who's left and looking at who else we need to outreach to because there's a lot of people that still have not made up their minds about things.

I'm going to go on to the next slide. Thank you. So as we entered into this work, we realized that we had to send out very detailed, often visual instructions, that includes screenshots about how to register.

Asking people to help, find someone to help you register. If you don't have access to a computer, how can we help you?

So we did a dedicated email in our letters and also outreach with our case managers and found out that there was a group of people that could easily register and could come to the sites but even when they came to the PODs they needed help because they were entering into an environment with also elderly people, people in other groups, other essential workers, and for our population there was a big freak out factor. So we created a response where our staff would go out to the cars, our staff would help people by bringing people to quiet places to take them for a walk for a little while. So there was a lot of response that we had to do in that kind of way. But one thing that we did in our letters and through calls that we just got in our various offices was we provided a number to call the dedicated email and we got lots of emails and calls and realized that people, for various reasons, could not register online. They couldn't navigate it. It was complex to register online. You had to enter information that talked about your organization or what your position was, they didn't know what to enter into those things. As well, we had many people who do not speak English or have English as a second language or, again, don't have access to the technology to register. We quickly started to set up a call center where we referred all the people who were having difficulty to a small group of people who were trained in our case management branch, realized that we needed to have a pretty elite trained group to do this work with families because we were walking people through the online access. So ban vans or whatever it was that had been stood up because people could not navigate it but needed to get an email back in order to get their registration -- [Away from mic] mic] -- that it sometimes was taking half an hour, 45 minutes to walk people through that process. So that's what we did. We hung in there with them, however long it took. For some people we began to hear that we had to triage to other vaccine delivery methods, put them on the home visit list. So we were able to do that so it was constantly triageing and list management. So some lessons learned is that stay on the phone, have a human centered approach approach, do whatever's needed to get people an appointment or a home visit. We still continue to have a group that have not gotten home visits, but it's down to about 150 homes. So when we do these sweeps through the communities with our pharmacies, it's our participant in the HCBS program as well as anybody who lives in the home. Sometimes it's up to 10 people getting vaccinations and for this home visit visit, this last group, is primarily the caregivers' parents or maybe two or three people in the home. So I think there's a continued digital divide. I don't think we're finished with this yet. As you all know, I think we are going to have to circle back because there was that population of people that were unsure or that we somehow missed so we are going to continue to circle back. And recently the city in partnership with aging has set up a 211 system where people can just dial 211 and get that help in registration and again, leverageing all these partnerships and making sure no one's left behind continues to be what we believe in. Thank you very much.

Adrian: Thank you, Mary. Appreciate you very much. Next we are going to virtually travel to the DC department on disability services and I will turn the virtual stage over to you, Andrew.

Great. Thank you. Good afternoon, everyone. I'm Andy Reece with the DC department on disability services. Our scope is a bit smaller than the other agencies I have been hearing from in that we provide supports and services to people with intellectual disabilities. So what I'll be talking about is the efforts we had for scheduling and getting vaccine for the people supported by our agency, which you know, there were a number of factors that were challenges in the beginning. One of those being the plan in the district was something of -- the plan for vaccine roll out managed by our Health Department was

something of an evolving document because it would have to change based on the availability of vaccine in the city as well as the numbers and the data that we were providing about people affected, the risk of people regarding infection and of serious outcomes so that they could make their determination about where people were in that process. We initially had expected all of the people supported and the staff to be in group 1A, but ultimately our people -- the people supporting our folks were in group 1A. The people in our congregate settings, intermediate care facilities and residential habilitation, our group homes and waiver were in 1B. And all other people with disabilities in the district were in group 1C. So they roll out about a month apart, starting at the end of December, end of January, and then end of February. One of our big challenges, the other long-term care facilities that were getting vaccined tended to be large facilities whereas our largest intermediate care facility has six people, so figuring out the logistics of how to get all the people vaccines was our challenge. What we came up with was establishing first for our intermediate care facilities and residential habilitation a vaccine clinic directed just for them. It was a coordination between our Health Department, a pharmacy in the city, one of our medical schools, and our agency so it was a day for just our folks and Parks and Rec who had an available recreation center in the community that was large enough to accommodate people. One of the biggest challenges for the folks we support is many of them who have more complex needs were people who couldn't wear masks. So that complicated a little bit the transportation and being there to get the vaccine. So we had to be able to strictly enforce distance with people. It was in a very large setting so that we could ensure people's safety while getting the vaccine which I'm glad to report we were able to do. The other challenge is as a small jurisdiction some of our people are placed outside the state. So in the district almost half of our vaccine initially, because healthcare providers were the first priority, almost half the vaccine allocated to DC was going to people who lived in Virginia and Maryland and came in as healthcare workers. DC ensured that DC Health Department made sure that all of our folks, regardless of whether they worked in Maryland or DC were eligible for vaccine in DC because they were supporting people who were from the district. Transportation, not really an issue for us, fortunately. As part of our Medicaid services provided in our intermediate care facilities and as part of our waiver services we include transportation. And for folks who are able to access our metro paratransit services in DC, we have a cab service that's available to people, five dollars a ride, it doesn't matter what the reason for the ride is. Medical, non-medical, it didn't matter. That's a pretty accessible way for people to be able to get to vaccine appointments. The interesting issue as we were setting up our clinic, we were doing it along with, we were making the plans with DC health as well as our behavioral health agency and that agency identified an issue not just of transportation but of needing to have staff sometimes who could be available to go with the person to help them through the process because it could be a stressful process. Fortunately, in some instances we needed to remind providers but we advised people of the importance of sending staff to help support people through the process and coordinate the whole process. The scheduling then was done -- done -- we've essentially established enough clinics through our agency and our coordination, to provide vaccination for about half the people we support. The other half, the provider agency are able to work with them to schedule through the various mechanisms in the community. The benefit is some of our folks do live in Maryland so they can either register here or there or both and what we advise people is try every avenue available to you so you can get your vaccine as early as possible and we have staff who help people navigate that. For scheduling, for our clinics we take responsibility for it. And we have nurse consultants on our staff who worked with the director of nursing from each of the different provider agencies to sort of identify a priority of bringing people in for the clinics and then we then would do the schedule, the pharmacy would tell us you can schedule I think it

was 8 people every 15 minutes. So we would then turn the schedule over to the Health Department and the pharmacy once it was complete. It worked much better this way because we had coordinated with everyone, the provider agencies had their schedule when they arrived and they could bring a whole group of people at once. I'm just looking through all my notes. The biggest challenge that we have had has simply been the access, having enough vaccine, I think it's the issue across the country. The benefit that we have had in the district, I heard Jarret mention I think from Colorado the challenges of sometimes state local coordination. The benefit in DC is each agency is the state and the local agency. And we have done, I think think, a really good job of coordinating across agencies so that DC health has a person on their vaccine roll out committee who represents the interests of people with disabilities who meets with us every week so that we're making sure that our concerns as they're scheduling vaccine roll out for people, our concerns are being taken into account and we provide our data updated to them every week so they understand the urgency of vaccinating the various people supported by our agency. Overall, it's a process that I'm sure for a lot of people has moved too slowly. We are still as many people challenged with the issue of some resistance, what we see as the biggest reluctance of people to get vaccinated has been family members who have to provide consent. We're working with a local medical school and advocacy group to provide materials for education for that community. The only issue we've had about transportation is for people who really can't get transported to a vaccine so we have been developing the mechanism to bring the vaccine to them, and that includes the nurse consultants in our agency who will be bringing vaccine to the homes of people who can't safely travel and they will be able to then vaccinate those people along with the other folks in their home. That's it in a nutshell for DC. I would like to thank you for this opportunity and for all these sessions you're putting on. I hope to be listening in on the future ones.

Adrian: Thank you, Andy. I appreciate you and your remarks and all the panelists today. We do have a few minutes left for questions and answers and some discussion. I am looking at a few that have already come in but please feel free to use the chat function on your webinar console and we'll go from there. We'll get to as many we can today. I did want to let everyone know that we are going to archive today's webinar along with the slides on AUCD's webinar library. So rest assured it will be available to you that way. The first question was: I'm interested in how states are navigating non-emergency medical transportation with large scale clinics. We're finding scheduling these rides difficult or that we have to schedule very quick turn around to a transport for clinics that are moving people through quickly which can present issues. I know that came up for a few of you. Any of the presenters want to jump on that, feel free.

You know, I can kind of jump in real quick with some comments. I think unfortunately I don't think they are going to be particularly useful comments because we haven't really experienced that same issue here in Colorado. I don't know if it's scaling the community clinics appropriately to making sure they are not depending on how many vaccines you're looking to administer to each one. One thing that we have made clear to PODs is we have designated transportation lanes. That I think has also alleviated some of the stress and wait time and speeding up those trips because I know, for example, we were looking at the need to possibly expand waivers for $10 or $15 for wait times. But we just haven't really felt that that much in Colorado. I don't know what kind of other state experiences have been along those lines but I know it's a mixed bag.

Julie: In Louisiana. We experienced not only for vaccination but for testing even before then, we started seeing there was difficulty and I did mention this in the presentation, but we did find that when we did

make some changes to relax some of the requirements for our NEMT providers, some of the things I talked about were age limits in allowing the virtual inspections, we did find we were able to get more online to help be able to address the concern of having enough providers and enough available transportation through the NEMT program.

Adrian: Thank you both. We'll move on. Questions are coming on. This is great. Next question was: Do you have information on the date vaccine eligibility opened up specifically for people with disabilities in your region and how many people with disabilities actually have received their first dose or have been fully vaccinated?

I was typing in a response, but I can answer probably more quickly than I can type, I guess.

Go for it, Andy.

It was end of December, without specific dates dates, were staff for all of our people. End of January was people in congregate settings. And then all other people we support with any intellectual or developmental disability end of February. We're now getting together the data so we'll be publishing data on the actual outcomes but I don't have in front of me the percentages who have gotten vaccinated to date. But we have provider agencies that have 90 to 100% and we have some that are not doing as well and we're providing support to them.

Thanks.

I have data just on our people who live in residential settings. And that is about 70% of people in those settings, but that runs across our disability as well as other congregate care of people in the aging community. So about 70% of our people who live in our settings.

That's helpful. Thank you. This is Adrian. I also posted in the chat a resource that some of you might find helpful. It's a dashboard that tracks the eligibility groups across states for people with disabilities. I would invite those attending today to check that out as well. Moving on. Thank you for the robust set of questions. We do have another minute left for questions. The next one is: How are states working with family caregivers in terms of transportation to and from the vaccine sites?

For example, allowing the caregiver to accompany the person to the vaccine or paying caregivers to accompany?

Thoughts on that?

I know that came up today too.

We expanded in our waiver the ability of people to use family members as caregivers during the public health emergency. So providing a ride to a vaccination would be included as that kind of support.

Great. Thank you. Then I think this will need to be our last one because we're almost at time here. Are states running into challenges with transportation companies not being willing to provide transportation to vaccine appointments, especially those that need you to wait in your car and drive through?

Any quick thoughts on that?

We have not run is into that barrier in Colorado. But I also think we've also been specifically focusing on utilizing our transportation providers that already provide trips to our NEMT benefit through Medicaid. So I think we may have kind of pre-selected and filtered out through some of those providers that wouldn't be willing or as cooperative throughout that process.

Thank you all so much. That hour went by quickly. I have a couple of closing remarks to share on behalf of CDC. I thank you all very much for your time today for participating on this panel. This is the first of a four-part lunch and learn webinar series. So we look forward to seeing you tomorrow. We're excited -- just announced yesterday that CDC and ACL will be partnering together to issue nearly $98,000,000 in grants to the aging and disability networks in every state and territory to help provide critical services to overcome barriers such as the ones we talked about today to prevent people and -- part of these funds will also support national hotlines to assist people with disabilities and older adults in registering for vaccination appointment and to help connect them with local disability and aging agencies that can help support them in that access. For more information from CDC's perspective on the COVID-19 work, please is visit their disability toolkit. That includes information on vaccine considerations, guidance for how to quibble equitabley provide the vaccine and really accessibility solutions that vaccine sites can use. We encourage you to use these resources for yourself and highlight those that especially resonate for you for your networks. Thank you all so much for attending. We really appreciate your time and we look forward to seeing you throughout the rest of the lunch and learn webinar series. Take care.