

Presentation Transcript

Webinar #2: **Consideration: Promising practices for vaccinating family members of PWD and those who are homebound**

Dr. Adriane Griffen: Hello and welcome to today's webinar. Consideration. Promising practices for vaccinating family members of people with disabilities and those who are homebound. Today is the second part of a four-part lunch and learn webinar series brought to you by AUCD and our partners as well as ASTHO and NACCHO. Thank you for joining us today. My name is Adriane Griffin, senior Director of public health and leadership at AUCD and disability and public health. Today's webinar is about resource sharing, emerging best practices, I would also invite you to share resources around this issue that you may have found helpful. Through our public health for everyone online toolkit. That url is www.phetoolkit.org.

I also want to just say because of the number of participants, your audio is on mute. You can ask questions at any time through the Q and A box on your webinar console. So just to set the stage for today's webinar, our colleagues at CDC had listening sessions across the country to find out what were some of the challenges and successful solutions to reaching people with disabilities for vaccinations. And so we have partnered with NACCHO and ASTHO to amplify promising practices and to share more about what's working. So with that said, really I just want you to encourage you to listen to today and think about what are some of the Pearls of wisdom and lessons learned that you can apply in your own state, local, community efforts. I would like to introduce today's lineup of speakers. We are very excited to have a really robust set of panelists with us today. First, we will travel virtually to Indiana to hear from Michael cough Kauffman, then we will hear in Bonnie Silva, the office of the Director of community living in Colorado, Department of Health care policy and financing, then we will travel virtually to Amy Moore who is the Executive Director of Hope Haven in northeast Georgia. Then we will hear from Mya Lewis who is the intellectual disability and traumatic brain injury section chief for the division of mental health and developmental disabilities and substance abuse services. Then we will wrap up with a prospective from the Seattle, Washington area from a local county health department perspective rounding us out will be Erin Murphy, a communication specialist at King county health department.

With that said, I will turn the virtual stage over to you, Michael, to share your remarks on promising practices.

Dr. Kaufmann: Great. Can everyone hear me ok?

Dr. Adriane Griffen: Yes.; Dr. Kaufmann: Thanks for the opportunity to speak to all of you today. I can't think of a better background which is the Indianapolis motor speed way. We hosted a mass vaccination clinic for hoosiers. What better place to have a drive-through clinic than the world capital of motorists. I am Dr. Mike Kaufmann, an emergency physician by training for 23 years and have served as state's medical director for our emergency medical services division. Those are the paramedics and EMTs that operate ambulances across the state more than a million times per year making contact with patients. We have been working very closely with our Indiana Department of Health as they have been leading up the vaccination effort here in the state of Indiana. And, you know, this whole COVID-19 has truly been a blended public health, Human Services, and public safety endeavor. In Indy, in Indiana, we have used a dedicated special populations and equity lens in order to provide vaccine to those at highest risk of morbidity and mortality. One of the efforts we have been able to put in place through strong multi-

agency collaborations has been what you may have heard referred to as a hoosier initiative. Again, this is a multi agency and even community partnership to provide vaccine to individuals who are confined to their homes and would otherwise be eligible for vaccination based on the state's eligibility criteria which, as of this morning, has opened up to anyone over the age of 16. The program begins with a dedicated effort of family social services administration's local area agencies on aging. Outbound calls are made from those entities to all registered recipients who have received some in-home service at some point in time throughout their lifetime. Also calls can be made on an inbound basis by family members who are asking questions as to whether or not their loved one might qualify for a homebound vaccine. Individuals who are screened positive are then entered into a cloud-based data base that we set up specifically for this purpose. Local health departments, hospitals, FQHCs all have access through the course of their daily operations. The program was originally designed for vaccines. What would typically come from a no-show or canceled appointment, allocated to the homebound portal. Since the reception to the program, the response has been so overwhelmingly positive that we have started to dedicate vaccine specifically to our hoosier homebound program. Once a vaccine is identified, the vaccine-provided entity will use the FSHA agency to then identify the eligible candidate in their area. And that might be based on a ZIP Code or a county. Confirmation is made with that individual and then the available EMS -- and that's where my role comes in as the state's EMS medical director, the EMS provider agency available in that area is then contacted to execute the delivery and administration including the observation period, and recordkeeping of that administered vaccine. And I really want to emphasize that I think emergency medical services just really makes a great partnership for these community-based programs. EMS provider agencies really are ubiquitous in almost every community across the state, long thought of as a pillar of public safety. But I think there is so much opportunity to engage them in healthcare as well as public health functions as we have seen, their scope and ability to give I.M. injections and specifically vaccinations as part of their scope of practice. One of the things that was emphasized early on under the Biden-Harris administration was utilizing a public safety personnel such as EMTs and paramedics in this capacity and we have even seen that more recently since the launch of the PREP plan. So this multi partner agency really utilizes all of those assets in each community to get vaccine delivered to those who are homebound due to chronic disease or disability. The program has been incredibly successful as of to date with more than 750 hoosiers having received homebound vaccine in 90 of our 92 counties across the state of Indiana and again, these are considered high-risk individuals who otherwise might not have been vaccinated. We are thrilled at other states having already reached out to us. I am really just honored to be here on the call today. To give you an overview of this program. You can download and view what we have put together in a kind of a how-to manual for our EMS pro vader agencies and that's from the Indiana Department of homeland security website. I would be more than happy to provide you with a link to that here in the chat as soon as I am done speaking. And again, I just want to emphasize how much of a partner our EMS provider agencies can be at not only vaccine administration, but COVID testing and numerous other public health functions. Even just yesterday, we saw Dr. John Kromer, the head of the highway safety transportation's office of EMS, that's where EMS is housed at a federal level, published a letter signifying from a national scope or practice level that it, at the EMT level, it's been expanded so that our EMTs across the country can get even more involved in the vaccination effort. So, I know that was a very brief overview. I really want to make an effort to stay within our time constraints today but I am happy to answer any questions at the end in our Q and A session and certainly am happy to provide you with more of a detailed written

overview of our program and if you -- please reach out to me directly for that in the days to come. So with that, I think I'll stop. Thank you.

Dr. Adriane Griffen: Thank you very much, that was wonderful. We look forward to seeing links so, with the resources that you mentioned, that would be terrific. Thanks so much. && Dr. Kaufmann: You are welcome. && Dr. Adriane Griffen: Next up, we will travel to Colorado to hear from Bonnie Silva. I'll turn the virtual stage over to you, Bonnie. && Bonnie Silva: Thank you so much. Good morning or afternoon depending what part of the country you are in. Thank you so much for pulling this together. I am excited to share the framework that Colorado has put together and certainly excited to learn about what other states are doing, as well.

So, in my day job, -- community living at our state Medicaid agency. Every state is set up a little bit differently but in Colorado, the office that I oversee encompasses all long-term care supports for people with all types of disabilities from birth to death. So, they are really looking at, you know, potentially vulnerable population that may be homebound within the Medicaid component, which is why I think my partners at the health department reached out initially to say -- can you help us create a framework for this project? And I would say as a guidepost, one of the things we have learned throughout this pandemic is that when we collaborate across state agencies and work with local partners, we get better outcomes for the people we serve in our communities and I think that we took that approach with, you know, developing this framework, as well. At the end of the day, the deployment of homebound vaccinations certainly won't land with the state Medicaid agency, but we are thankful to have been part and parcel of the development. So just in terms of background, really our goal was -- is -- to be part of the process to ensure that we have the rapid deployment of the COVID vaccination for Coloradans for those at serious risk of the virus. We encompass how do we identify these folks? How do we outreach to them and then how do we deploy? So you know, our plan in terms of -- really our -- also leveraged our local partners in the work that they have put in place. So we defined, I think there was how do you define who actually is homebound? So we defined homebound people as those who have never or who have rarely left the home in the past month. And then, you know, got a little bit broader in terms of, you know, making sure that, you know, the reason that the person's homebound really doesn't matter to us. It could be because they have a physical disability, cognitive related disability, but make insuring that, you know, for somebody who needed that support that we were providing it to them. And so, we looked at, you know, what are the predictors of people who might be homebound. The prevailing prevail research showed that serious, older adults, chronic conditions, taking more prescription medications and having multiple hospitalizations. From the state Medicaid agency, we have an extraordinary amount of claim data.

Members who were eligible for the vaccine, but then plug in those additional factors to get even more granular to say ok, based off of these factors, this person may be homebound. And we very intentionally cast a wide net. So initially, our list was 70,000 potentially homebound Medicaid individuals. We then bumped up that data against the Sys data and found that 10,000 had already been vaccinated. So from a Medicaid universe perspective, our number was 60,000 people that we wanted to pro actively outreach to. And so, we also wanted to, in terms of Northstar is leverage our existing healthcare infrastructure which I think Dr. Kaufmann talked about. In Colorado, we have care management and case management agencies that are already connected to the people that have identified. They have known relationships. So we work to get federal dollars to support their outreach to the 60,000 members. The goal was, because we had cast -- to provide information about the vaccine for people who may be hesitant.

Maybe they have some questions that they need to have answered. Maybe it's not that they are homebound, but they need support with getting on a list or arranging transportation. We asked per that outreach that those agencies actually do that formation. And certainly to identify those who are homebound so that we could deploy vaccine to them. Outside of the Medicaid population, we wanted to make sure that we had a structure, you know. Prevailing research in that area says that up to 5.5% of older adults may be partially or completely homebound and our line of sight on that population is certainly a little bit more opaque, if you will. So we are mirroring the Medicaid process, but with the use of state contractors. So doing pro active outreach to those who we know based off age are eligible for the vaccine, and to again reach out and provide that support. Provide information about the vaccination to provide coordination to get to the vaccination and then to identify people. In addition to the proactive outreach, we are also using the state contractors to serve as a secondary lens so that whether it's a community physician or a triple A who identifies somebody who might be homebound, they can report up to make sure they are identified. We have what I am referring to as a private public and local plan. We are leveraging a private contract with a mobile primary care provider who, because they were a mobile primary care provider prior to the pandemic, they have some logistical infrastructure that most providers simply don't. And they are leveraging healthcare agencies and contracting directly with providers to manage all of the logistics. The assisted entry, the coordination, for about 85% of our population. And for everyone else then, we are inserting that public option so as a state, we have much like Indiana, contracted with our EMS providers, and additional other local entities, fire stations, that could deploy vaccines especially in hard-to-reach or rural communities. And then we have local. So local public health, while they don't have, in Colorado at least, statewide options, there are many communities that have really effective strategies for getting to their homebound population. So we are using all three to make sure that we have, you know, vaccination deployment across the board. So that is at a high level our framework infrastructure. Also want to make sure I stay within my time frame and leave time for questions. So I will stop there.

Dr. Adriane Griffen: This is Adrian. Thank you, Bonnie. Appreciate your remarks. So next we will travel virtually to Georgia and I'll turn the virtual stage over to you, Amy.

Amy Moore: Hello. It is afternoon here, so good to be invited into join you all. I guess I have a little bit of different perspective from Bonnie. I am coming to you from an actual pro vader in Georgia. The we support adults with developmental disabilities in all areas of their life. Day services, employment, residential, and in their private homes. So we cover almost all the Medicaid services for our population. We serve around I think we have about 88 enrolled in our program right now. We had our clinic on March 23. We partnered with Department of Public Health in Georgia. Walgreens who were the actual pharmacists who came out with the vaccine. It was a very fast turn around. I got a call said hey, you need to be on a conference call tomorrow, on March 9. We scheduled a date for our clinic. So it was a really fast turnaround. We have since said we wish we would have had more time to let more people know about it. But we were able to see 150 in the Athens and surrounding area. We had some folks, I am hearing you guys talking about the homebound and I am trying to like connect that to my population that we took care of here. We don't have that many, per say, that I would have called for COVID, but there were so many of our folks who haven't left home since last March. Gracious enough to help us to figure out a way for like maybe about 10 of these folks to come through in a drive-through setting instead of walking through the doors because we thought that would be -- and overwhelming for them to come into a building with a lot of people. And that was very -- to do that. But really our folks had no

issues. With getting this vaccine. No side effects, no behaviors during the clinic. It was from 10 to 3. It was super efficient. The Department of Health was great as well in helping to collaborate together with us. I think three other clinics that have clinics in place this week, just from this small collaboration. I don't have that overview of what all is happening in Georgia, but just from the local perspective, it has been amazing and hopefully these people are going to be able now to come back into services. We have gone from about 55 people in our day program down to 15. March through July of last year, nobody. And then since July, we have been able to support about face-to-face being able to practice with safety guidelines and that kind of thing. Seeing our light at the end of the tunnel, bringing folks back into services and providing supports that they need. Trying to think if I forgot anything I was going to share with you guys, but I probably don't have as much to say as the other folks on this panel. But we did have a great collaboration with Walgreen's and we were able to -- I advocated for the Johnson & Johnson vaccine so that our people would not have to come back for a second time and that was very successful. And Walgreen's was able to pull that off for us for all 152 people. Very glad to have been a part of that. We have a big facility where we were able to bring them in. And still space everybody out very safely. I'm happy to answer any questions. I don't come with a whole lot of knowledge on like I said for our whole state and how they are rolling things out. But just from our small town.

Dr. Adriane Griffen: This is Adriane. Thank you so much, Amy, for your perspective from your town level is valuable. It was nice to hear about how you worked collaborative low alley with the Walgreen's to serve your population. Great example. For those of you in the audience, please just a reminder to ask your questions through either the Q and A portal or the chat feature. We will get to those at the end. So next, we will travel virtually to North Carolina and hear from Mya Lewis. So I will turn the virtual stage over to you.

Mya Lewis: All right. Excuse me. Very good. Thank you. So again my name is Mya Lewis and I am with the North Carolina division of mental health developmental disabilities and substance abuse services. So I just wanted to start out by saying, like many states, you know, during the pandemic with the introduction of stay at home, increased positive case rates and things like that, we had many vulnerable individuals with disabilities who did not have access to their usual services and supports that they have. So as we prepared to roll out our vaccination plan, we wanted to make sure that those staff, those individuals, those direct support professionals who supported those individuals, were part of our group 1 for our vaccine rollout. That also included family members. So those family members who, because of stay-at-home orders and just individuals getting sick and certain programs, became those unpaid support. So not just the family members within the homes, but also those family members, those grandmothers, those aunts, siblings, that began to come together and support individuals who may have had medical care or have been vulnerable. So we actually did a good job of defining our definition, included not just those behavioral health supports and direct support professionals, but also those family members so that they, too, would be able to have access to the vaccine as part of our group one. We partnered with our, like many others, many of our local health departments, healthcare employers and hospitals, long term care pharmacists that some of our providers worked with to help make sure those individuals were able to access the vaccine. Eventually, any of the vaccine providers that were enrolled to support in what we have as our vaccine management system, were able to administer vaccines to those individuals in those groups and still are able to administer vaccines as we have progressed through the different group areas. Specific to homebound individuals, so North Carolina, we did do some work in the background to try to do a good job of identifying how many homebound

individuals is it that we have? And so we identified that we had approximately 97,000. Homebound individuals within our state. And so we worked with those provider agencies who we know are the ones that usually are the touchpoints for those individuals who are home bound. So we worked with approximately 220-plus agencies to help identify those individuals who are homebound. For vaccinations. So that included home health agencies, veteran associations for vets, our aging organizations and our community based organizations. Those agencies were the ones that supported us with identifying those individuals and then being able to access them to support with getting those individuals vaccinated. Our goal of course was to transport the vaccination to the homebound individuals. That was our preferred method of course is to reach them and work with those organizations that were able to provide vaccines to go to the homes. But we also thought beyond that for those who, maybe it was transportation that was truly an issue that made that individual homebound. But we also worked with our local communitys to support with transportation. For many of the local vaccine events that we did have where we partnered with church, worship centers. Other community centers. So we worked with our local transits, as well as those churches who may have been able to have transportation to support with those events. We also partnered with I think Indiana mentioned, we also may have some part in the local partnerships with our EMS that could also support with transport. When needed for medically fragile individuals to ensure that he this access to the vaccine in support with those vaccinations.

So I don't think that was seven minutes and I think I am definitely within my time but that does include some of the efforts that North Carolina has made to again ensuring those care-givers who are supporting individuals with disabilities were vaccinated or had access to be vaccinated if they chose to and also our efforts with supporting those individuals who may be homebound. And that's all I have. So thank you. >> Dr. Adriane Griffen: Thank you so much, Mya. That waser itivic. I appreciate your remarks, talking about the fullness of who provides care. Really thinking about that. In a whole community way, that is definitely a group of care providers that often aren't recognized and what you also brought that hadn't been mentioned yet by other panelists was the involvement of faith community and faith community leaders to get messages out to the community. So thank you. Thank you for being here and sharing that with us today. All right. Next we will virtually travel to the west coast to get a local county health department perspective from Seattle, Washington regional area. So, I'll turn it over to you, Erin.

>> [Erin] hi, thank you so much. I am Erin and I am a public health communicator with public health here in Seattle in King County. My world is about creating messaging and distributing those messages. Right now, emphasizing safety and access to COVID-19 vaccine. I am here today because I have been the communications point person for our accessible COVID-19 communications to disability communities since the early pandemic days. So I am going to speak to three things that we have done and learned from when communicating with disability communities both before we had a vaccine and now that we do have vaccines. Those three things are starting with acknowledging historical trauma and harm and ways in which we have messaged that. I will also touch on ways that we have used video and then, be honest about some of our challenges in this part. Because there are learnings there. So we acknowledge historical trauma and harm because that's often a baseline for trust building. People live in community and family units and so the trust building really needs to happen with a lot of people. Not only the individuals who may be homebound but also their care-givers, family members and so on. For trust building, we often need to be really honest and name the reason and the root causes for that

mistrust. So, how have we done this? King County has done this in a couple of ways. The bureau with trained staff that will present to any community that asks for information around the vaccine or COVID-19. And one of our go-to presentations is around historical trauma and harm. Because we know that there are historical and ongoing injustices for a number of communities including Black, Indigenous, Latinx, Jewish communities and more and results in understandable mistrust of both government and medical systems and we, at public health, represent both. So we are very up front with the fact history of genocide, including harmed folks with disabilities. There is a history of forced sterilization of people including people with disabilities. Really open about that is often a good way to just even start conversations and start that trust building. Another way that we have messaged this trust building is very relationally. So we have in a number of ways, we were very intentional in the early pandemic days to create a community branch of our response and so, we formed multiple task forces. We have representatives and community leaders from the disability community in this task force that has provided a feedback loop for us. They are speaking with and on behalf of the community and the coalitions they are a part of, very direct at telling us what it is folks are concerned about. The ways in which they want those messages shared. And when there are concerns, and reasons why folks are not trusting the messaging or feeling upset, being able to tell us that so we can really then try to speak to the heart of things in a relational way. We also have relational access points so we have a call center where there are real human beings that answer the phone and so, if somebody who is home bound calls and says I don't know how to get a vaccine, they can get a real-live person that can tell them here's how we can connect you to our mobile vaccination team. What do we need to know. And so these feedback loops have been really, really important for addressing both vaccine hesitancy and how to access the vaccine. Another important way we have embedded this messaging is in videos. So we were very intentional at creating I believe we have done three different videos where we speak directly to the historical harm and trauma in a number of communities. So while we focused largely on BIPOC communities and the speakers in these videos, were BIPOC community leaders. We made sure it was accessible, had ASL, transcripts, live captioning, recognizing that it's multiple communities and intersectionalities that experience this trauma. Diving a little bit deeper into how we have used video work, our county has been really, really committed to prioritizing racial equity. And so we have heard from a lot of BIPOC communities that they prefer video over written messaging. And the way in which we produce these videos lends itself really, really well to also ensuring that we are making those videos accessible. If we have to have a written script that needs to be translated into another language, then we already have that scripted and put a looped transcript, a screen reader, make sure it's translated into captions in the video itself and do our best to be intentional about having ASL in all of that video as well. It's largely about modeling the way about making sure you do accessibility as much as possible. And it's not only for the disability community specific messages, but making our broader messaging and messaging to communities of color and in other languages accessible, as well. And the more that we model that, the more we hope it will be done more and more. And then, before I wrap up, just want to be really honest about some of our challenges. So, even in our relationship building and the community leaders that have been our incredible resource both for giving us information about -- delivering those messages back out to communities, including homebound individuals, would he no that the disability community is diverse. And so we don't have representation for all of the different groups within that larger community. And so we know that we do have some gaps and even the representatives that we use for everyone or have expertise in everybody's lived experiences so that is something that we need to continue to be intentional about strengthening. And then the last challenge that I will share before

wrapping it up is while it is very, very important and we still need to improve how the county prioritizes racial equity, we often lose intersectionality and we know that there are folks of color who also have disabilities. And so one way in which, where it has been a challenge where yes, we know we need it prioritize racial equity, while not losing support and prioritization for disability communities is how we have created a community navigator program where we contact 30 different community leaders from a wide variety of both cultural and racial communities who serve as Ambassadors and I have not had -- being a disability representative in this group and so that's something that I need to continue to advocate for. Because it is important. I would be happy to answer any more questions, especially if it's specific to messaging around vaccine hesitancy or how to message how to access the vaccination. Thank you so much.

>> Dr. Adriane Griffen: That is Adriane. Thank you so much. We do have quite a few questions that rolled in. So I will hit the ground running with those. First question we got was around -- for the whole panel -- has anyone looked at the census, America community survey question 20 independent living difficulty because of physical, mental or emotional problem, do you have difficulty running errands alone, such as visiting a doctor's office or shopping. To get some kind of -- to the number of people in a county who might have difficulty going outside the home. So, just curious if anybody had used this census in that way. >> Mya Lewis: This is Mya. I cannot speak specifically if the state used that. We have a group of experts and data folks that, who are a lot smarter than me. So I am not exactly sure how we got to those numbers. And if that -- well I shouldn't say -- if that data was actually used, I'm not sure.

>> Dr. Adriane Griffen: Fair enough. So follow-up question to this is actually directed to you Bonnie. This person asked if you could provide the link to the data that allowed you to identify the predictors to use a lens on that Medicaid data you referenced? >> Bonnie Silva: Well that data contains a whole bunch of personal health information though it's not publicly available. >> Dr. Adriane Griffen: Fair enough. >> Bonnie Silva: And I think by partnering with your local Medicaid agency, my guess is as you're crafting plans in your respective state, that's data being a healthcare provider that we have access to and the census data, that's a fantastic idea for those outside of Medicaid, something I'll take back. But we have for people who receive long-term care, assessments that speak to those very issues. Like do you have mobility issues? Do you get data as well to really cast a net in such a way that we were targeting people who we believed may be most likely to be homebound and/or need additional support getting to a vaccination clinic.

Dr. Adriane Griffen: Great. Thank you. So this next question is specifically for you, Amy. If you could speak to whether your clinic was able to vaccinate care-givers as well as people with disabilities, was the sign-up site for the clinic open to both? Or did care-givers just attend too? >> Amy Moore: In Georgia as of March 8, people with I.D.D. were able to receive the vaccine and care-givers, as well. So on our vaccine clinic, we were able to allow people with disabilities as well as their care-givers, their paid staff and unpaid staff were all eligible at that time. So they were all able to receive the vaccine and we actually, because we had I think they had allotted like 230 vaccinations and we only had a little under 200 to sign up, they actually asked us to open it to the general public as far as anyone who was eligible in Georgia to receive the vaccine. So, actually some extra folks ended up coming through as well. That weren't really connected to our population.

Dr. Adriane Griffen: Thanks for that. So this is a general question for the panel. What are your state efforts to vaccinate unpaid care-givers of people with disabilities? I know a few of you mentioned that. I might ask -- I might ask you, my Mya, to start with that. You gave a shout out to this in your remarks.

Mya Lewis: Yeah, sure. So, um -- our direct support professionals and behavior health professionals, when we mentioned care-givers, we were talking about those who are unpaid, as well as some who may have been paid. We included those in our first group of folks for the vaccine. When that happened, they were able to, again, go to the vaccine clinics that were held and all the many partnerships that we had, we also had partnerships with Walgreen's and CVS and things like that. So they were part of our Group 1.

Dr. Adriane Griffen: Great. I don't know if anyone else wants to weigh in on reaching unpaid caregivers?

Bonnie Silva: In Colorado we took a holistic approach to, A, making sure that care-givers funded through home and community based programs were called out and prioritized as part of our vaccine phasing and we did not differentiate between paid and unpaid care-givers. Like if you were a care-giver, that places you at higher risk and therefore, you are eligible for the -- that was the approach. And they were in our top tier prioritization.

Dr. Adriane Griffen: Great. Thanks. So this person is writing in reaction to your remarks, Erin, this person wrote I love that your college is acknowledging historical trauma that has caused mistrust in various communities and -- other resources, perhaps slides or videos, are they accessible to other health professionals that work in the community at this level? And this person was offering their work on minority health in Nevada and they would like to, more of a comment than a question.

Amy Moore: Oh, my gosh, I am so happy to share, most of my -- [Erin] I will drop my e-mail in the chat so anybody who wants to follow up, amany happy to share what -- I am happy to share what I do and others, too. >> Dr. Adriane Griffen: Great. Thank you. We have a good amount of time left. So just keep the questions coming. I think you already replied in the chat area, some folks were looking for the video links. So that's terrific. Thanks for adding that there. There was another question about how any of you on the panel might operationally define what you mean by homebound and what definition did you use? >> Dr. Kaufmann: One of the things I'm looking through my files and am happy to add that to the chat is a list of our screening criteria that our local area agencies on aging are using when they make outbound calls and get folks registered into our portal. I'll post that for the group.

Dr. Adriane Griffen: Great. Thank you. That's terrific. Anyone else want to weigh in on that?

In Colorado we defined it as a person who has rarely left home in the past month and again, worked hard not to put any qualifiers as to why. So, if leaving a home is a barrier for whatever reason, we wanted to make sure that they get the vaccine.

Dr. Adriane Griffen: Got it. So, pretty broad approach. That's helpful. So, next --

Bonnie Silva: I would add that just for those trying to build programs, I think it's important for people to understand that this isn't necessarily a way to fast track getting your vaccine. It's logistically quite complicated so, you know, to the extent that we can help people get to a vaccine clinic, that is at the forefront of the strategy and certainly where people need it in home to make that available.

Dr. Adriane Griffen: Thank you. All right. So, the next question was around care givers, did they have to submit some kind of documentation that they are a care-giver? That has come off other forms I fit in. Your thoughts. Any of you on that?

With our particular clinic that we held, I found that it was very easy, I guess, to -- we didn't ask for much from the people coming through. They checked boxes on a questionnaire, provided an I.D., if possible, insurance if possible. But people didn't -- it wasn't, you know, a real strict try criteria type thing. It wasn't scary for them. You walk through, give your I.D. and get your vaccination. I don't know how it was handled everywhere but with our clinic, it was a simple process. We just took people's honesty on the questionnaire.

Dr. Adriane Griffen: This is Adriane, a bit of the honor system. Yeah. Ok. I'm seeing other panelists nod in agreement. Ok.

So, um, other questions are coming in. This is great. I encourage all of you to keep chiming in. Use the chat feature or Q and A feature. This is a general question for the entire panel. What are the next steps for vaccinations and what is the most common reason for refusing the vaccination?

Dr. Kaufmann: I think one of the challenges that we faced and I can speak directly to, some of the vaccine hesitancy that we realized within the public safety ranks, so within our police, fire, and EMS agencies, a lot of it simply has to do with misinformation, with not understanding the science. And what I really think is unfortunate, but the propagation of misinformation through social media. We have launched several community-wide and focused efforts, educational efforts on providing the strong and hard science behind the vaccines. Clearly emphasizing how safe and efficacious that they are. That's

Mya Lewis: I agree with that. In North Carolina, we are continuing to do education, to do that outreach, whether it be through our what is now our monthly calls that we do as a Department of Health and Human Services with provider agencies with our -- we have a call for individuals and families that speak to just things, updates, and then addressing questions. While all the questions are not vaccine related and just could be very in general about what's going on with the pandemic, that is an avenue we have. E-mail outreach. And then when we think about the hesitancy especially around people of color, Black and brown individuals and that historical perspective that Erin spoke to, we have outreach in those areas, as well. Again, providing accurate information about the vaccine and I said this before, on other calls. Acknowledging why there is the hesitancy, calling the spade the spade and saying this is the history we understand, here's some additional information. So that ongoing education outreach. And then Justin to acknowledge why some of that hesitancy is there. Not make it go away, but acknowledge and work through it with that education and outreach.

I cannot be nodding any more, Mya.

As part of our homebound outreach, [Bonnie] we document if they say no not ever, no matter how much information you give me. But then we have people who say not yet. Not now. So we are documenting sort of those calls in such a way that we can then provide targeted follow-up outreach. What we are seeing, you know, obviously most states, you know, prioritize congregate long term care facilities as their first priority. There was some shock for the direct care workers initially because there had been so many deaths that those workers witnessed first hand. This is a brand-new vaccine. It's under EUA and these workers are often parts of traditionally, you know, marginalized communities.

They are often, you know, new Americans, people of color. And so really, we had to pivot our approach to really, you know, provide that information around that confidence from trusted sources. The most trusted sources aren't often folks in government. In Colorado we are working hard to identify who is the trusted voice and how do we then partner with them for some more targeted outreach in a way that people feel safe in getting the questions that you have answered that might improve that vaccine confidence. So I am hopeful. I know in the long-term care settings in Colorado, we saw that vaccine confidence uptick has time has gone on. There have not been massive, you know, outburst, outcomes from vaccinations. That has certainly helped to improve the confidence and we will continue to do that for folks in the community, as well. And to provide those targeted approaches but then working directly with those trusted communities, the disability community in particular. How do we find positions that they themselves have disabilities that are, you know, known sort of entities within that community to help deliver the message. As a for example. It does require us at least in state government, to find new and different ways to get outcomes we want which is for the pandemic to be over. I think it's in progress is really, that was a very long way of saying in progress.

Dr. Adriane Griffen: Thank you for that. So, another question just came in. This person writes I am wondering could you all please elaborate on how you were able to reach out to and inform people who face barriers accessing technology. I think you all touched in that in some way. Any fresh takers on that?

>> Dr. Kaufmann: I'm happy to add a few comments to get things rolling here. So we knew when we started rolling out vaccine to those most vulnerable populations, that they were going to have significant challenges using technology to register. We are fortunate enough in Indiana to have a single and solitary point of registration for vaccination. So in an effort to do that, the two on one system is overseen and operated by our state family social services administration. So they utilize the two on one system to act as an in-bound call receiving center not only for information, but to assist. That's when they also engaged the local area agencies on aging as an outbound call center to reach out to those individuals who received some other type of service from their organization. That seems to be working very well at this point in time. Hope that helps a little bit.

Dr. Adriane Griffen: Thank you. Yes. Anyone else want to weigh in on that?

Mya Lewis: In addition to, you know, again, all those technology efforts, the webinars, the access, North Carolina also has a toll-free contact number folks can call to have their COVID vaccination questions addressed to get information about where they fall within the eligibility group, you know, is it their turn yet, to get access to the vaccine. Because we are a behavior health system, we are under managed care. Our, what we call our local management entities, they, too, had plans of outreaching to the individuals who were, you know, who were within their what we call their catchment area. We had people making phone calls checking on, you know, making contact with individuals and things like that. So that's just another way outside of having -- access, you know, there was a phone number that they could call and individuals who were actually making phone calls to individuals checking in. And providing information.

Dr. Adriane Griffen: That's great. Thank you. And another question just rolled in around asking about alternative forms of communication to reach individuals who aren't linked or connected over technology or other social media means or other typical -- I think you were addressing that in your remarks, too. But I did also have a follow up question. Should anyone --

I can weigh in on that since it's definitely about communicating out. [Erin] so for those individuals, we relied on relationships yet again for partners, service providers and others to tell us who those folks are.

And so primarily, it's been more of an old-school handout in those cases. Which isn't where we might be defaulting right now but they are recognizing that there are a number of folks where that is still the most effective means of communication. And we react accordingly.

Dr. Adriane Griffen: Thank you for that.

All right. And I see in the chat, Bonnie, you got a shout out and a question -- what was the title that you gave for state contractors that you were using to do the outreach. I don't know if that's something you -- if you worked with that group to develop a bit of a training program?

Bonnie Silva: So, to do the outreach, yeah. So I'm not at a point where I can share it just yet. But, you know, look at, you know, what are your state contracting options and yes, we have crafted a script, we have done the training, we have developed the process to mirror the Medicaid process to the extent possible for the non-Medicaid outreach and for the sort of inbound call spoken. So, you know, look to the organizations in your state that you might typically leverage and you know, Americorps for example. Are there other industry leaders that are stepping up to say they want to help. This is really information management and with the script we can get people to the right place. Dr. Adriane Griffen: Great. Thanks, Bonnie.

All right. Well I think that is going to be about it for the questions today. I did also just want to wrap us up to share some exciting news that some of you may have seen earlier this week. The white house and health and Human Services announced that CDC and the ACL will be partnering together to issue nearly \$98 million in grants to networks in every state and territory to provide these critical services to overcome barriers to make sure that those barriers are overcome to connect people with disabilities and older adults to receive vaccines and part of these funds are going to support national hotlines to help with this connecting in terms of registration, local disability and local aging agencies, necessary in connecting. So that's a bit of exciting news. The other thing is I encourage all of you to check out CDC's COVID-19 work related to people with disabilities and visit their disability toolkit. Anna will pop the link into the chat here. That toolkit includes just different considerations for vaccines for people with disabilities and guidance, as well as how to equitably provide the vaccine and just things that the sites can think about as you are working toward solutions there. So, again, with all of these resources today, wear down age you to review -- we encourage you to take them and what serves you best in your local communities. With that said, I do also want to remind folks that today's webinar will be archived in the archive. Please come back and check that out. We appreciate and want to thank all of the panelists for joining and for all of you for attending. We appreciate you sharing your emerging best practices. Thank you all so much. Have a good rest of your day. Dr. Kaufmann: Thank you. take care.