

AUCD Association of University Centers on Disabilities Communication: Promising Practices for Reducing COVID-19 Vaccine Hesitancy and Disseminating Accessible Messages

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> Hello. Welcome to our webinar, Communication: Promising Practices for Reducing COVID-19 Vaccine Hesitancy and Disseminating Accessible Messages brought to you by AUCD, ASTHO, and NACCHO. We would like to thank all of you for joining us today. My name is Sara Lyons and I am the senior program analyst overseeing the health and disability portfolio at the national association of city and county health officials or NACCHO for short. Because of the number of participants your audio will be muted throughout the call. You can also submit questions at any point during the presentations via the Q&A box on your webinar console.

> We have CART captioning available and if you would like to access it please click CC title to view subtitles. There is also an American sign language interpreter in this session. You can click view on the top right corner to adjust your viewing preference.

> To set the stage for understanding the origin of these webinars, our colleagues at CDC held listening sessions with a variety of jurisdictions across the US to find out what some of the challenges and successful solutions were in reaching people with disabilities for the COVID-19 vaccine. We at NACCHO have partnered with AUCD and ASTHO to amplify what they learned from those sessions and have some of the jurisdictions talk with you about what their promising practices have been so you might be able to apply some of the ideas to your state, local, and community efforts. With that I'd like to introduce our speakers for this session so we can start hearing about successes. Our first speaker will be Mya Lewis who is the I/DD and TBI section chief for the division of mental health, developmental disabilities, substance abuse in the North Carolina Department of Health and Human Services. Next we will have Julie Foster Hagan who is the assistant secretary for the office for citizens with developmental disabilities through the Louisiana Department of Health. Next we will hear from two speakers within the division of, Valerie00 who is the developmental director and carry T self. RO who is the assistant director. Next week will hear from Becky Reitzeses, co-lead and program manager for King County's COVID-19 speakers' bureau at public health, Seattle and King County. We'll then hear from Alice Frame, program coordinator for the disability health program at the Michigan Department of Health and Human Services.

> Finally we'll hear from Jolene Sharp, the chief public information officer from the Tennessee council on developmental disabilities.

> First we have Mya. You may begin.

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> MS. LEWIS: Good afternoon. My name is Mya Lewis and I am with the North Carolina division of mental health, developmental disabilities, and substance abuse services. I just want to take this opportunity to share with you guys some of the ways North Carolina has worked to address vaccinen hippest among North Carolina. From the beginning when the vaccine discussion started North Carolina took some time to conduct some research to get an understanding of the vaccine attitudes for individuals in North Carolina. Based on that information, the team developed communication tool kits to help with the community to get important information out about the vaccine. So this included getting information tool kits out to healthcare professionals, leaders within the community, community

businesses as well as nonprofit organizations throughout the state that just spoke to the safety of the vaccine and the effectiveness of the vaccine and just all things vaccine-related. We also included the development of fliers, different postcards that could be sent out, graphics for those who may not be able to read some of the material we had info graphics and graphics that described this information, along with fact sheets. We also took the opportunity to develop personal video messages, messages and also what we have is a department-wide vaccine 101 presentation. With that presentation, it's one that is posted on our website and it speaks to a lot of different things around vaccines including the conversation around equity, equity distribution and access to the vaccine. Speaks openly about the importance of the state developing and gang trust where North Carolina related to the vaccine and its development and the privacy of individuals who sought to be vaccinated.

>> It also included information about our vaccine groups and how those were around and who would be eligible and when.

>> Also in that presentation it's one that we update as information shifts and information changes, it includes information and actual pictures of events that were held where individuals received vaccines. So it receives a quote and a picture of our own secretary of health and human services, Dr. Mandy COHEN, a very prominent civil rights leader here in North Carolina, reverend Barbara, Richard petty, but in those addition to those prominent names it also included every day people who were in the system so a dental hygienist, her name is TATE, a member of the community from Charlotte North Carolina, her name is Gladys.

>> So it reflects a wide span of individuals who look like the people in the community and who are part of the community in that presentation. In addition to that I think it's very important to know that through the research that we did and gathering understanding about hens, we knew we were going to have a high vaccine hens among those individuals from populations WEECHLT addressed that from the beginning. We spoke to and recognized whole heartedly the acknowledgement of the past wrongs that have happened to our historically marginalized populations that have been perpetuated by the government, by, you know, healthcare institutions among those historically marginalized populations. Like I like to say, we called a spade a spade. We addressed it and put it up front and have actively communicated and worked on building that foundation of trust so that the population, the historically marginalized populations and other people in North Carolina would be comfortable to trust the information that the department posted and distributed out from not only the health and human services but our health departments as well. And they be understood, had enough information to make informed decisions and that when we were able to shift from that hens to that contemplation to that decision to receive the vaccine that they have information to know how and where to get that information to get that vaccine. So I think it's important to note that we had to engage our community, our partners, our trusted community leaders, and I think one of the things that we said is sometimes the messenger is just as important as the message so we had to work with our strong community lead tors support with getting that information out so that decisions could be made with trusted information, accurate information, and to this day we continue to listen to our community, we continue to gather data to see with all the education that we're doing, are we seeing those numbers shift and are we seeing those numbers change with individuals getting vaccinated and identifying any additional gaps we see in the system so we can go back recess and educate and shift that information make sure we are addressing and reaching those people who may still have some vaccine hesitancy to this day. It's an ongoing opportunity and ongoing engagement with our community and our stake holders to make sure that we can get as many people vaccinated and those who want to be vaccinated when they

reach out to do so. That's all I have to share at this time. Thank you so much for the opportunity.

>> MS. LYONS: Thank you so much, Mya. Really appreciate your hard work in North Carolina and participating in you more than one webinar during this year. So thank you so much. Next I am happy to welcome Julie Foster Hagan from Louisiana Department of Health.

>> MS. HAGAN: Hello, everybody. Today I'm going to really hone in on a more focused or targeted group that we work to address in Louisiana, and that is our direct support professionals that provide services to persons with disabilities here in Louisiana. Okay? We really value in Louisiana stakeholder feedback and we look for any opportunity that we can for our citizens to give us feedback on what's working and not working on a regular basis. This includes persons with disabilities and the provider agencies and staff who support them. Very early on in our Louisiana vaccination planning, stake holders made it clear they wanted persons with disabilities and their staff to be in the first tears forrings vaccination. We were fortunate to have the intermediate care facilities that support people with developmental and intellectual disabilities as well people who receive our in home and community based services in those early stages of the vaccination efforts.

>> Here in Louisiana to give you an example of the number of folks we're talking about, we have approximately 26,071 participants receiving home and community based services. That includes people who are aging, who have adult onset disabilities, as well as those with intellectual and developmental disabilities. Supporting those 26,000 participants we have around 18,838 direct support workers who go into their homes and provide folks those services. Okay? So we wanted to start out by really gathering data. As soon as we knew that the direct support workers for in home services were going to be able to be included in those early tears. So we began our communication and our data collection strategies very early on. Here in Louisiana we have three provider association groups that represent the majority of all direct support provider agencies of home and community based services.

>> So we began communicating with them to really start to take a look at what the barriers to vaccination might be for their staff. We held regular meetings with those provider association groups. It actually started out weekly and they have shifted now to having monthly meetings so we can continue to consider the ongoing challenges.

>> One of our initial challenges was actually just being able to identify those in home providers as being in our eligible group.

>> We did a lot of outreach not only to our provider associations but to our vaccination providers to make sure folks were aware that they were in those eligible I believe groups.

>> As soon as we were able to clear that up the next large barrier that we identified with our providers was the vaccine hens. There was a very small number of individuals who provide those direct support services who were willing to be vaccinated and they expressed a lot of concern there.

>> So we developed multiple communication venues. These have been adjusted throughout our COVID event. The way that we typically communicate with our -- that we found works best to communicate with our provider networks here in Louisiana of those in home services is that we do send memos or letters or information to them but we always then follow that up with a webinar so that providers can ask us questions and answers. We have found that that's been a very efficient way of us being able to give information as well as us being able to get information. So similar to what Mya was telling you guys, we also did some surveys to be able to make sure that we were honing in on the right information so initially our surveys asked the provider agencies if they had arrangements to get vaccination. We were trying to find out where those difficulties might be if they were not able to make arrangements.

>> We also wanted to know if provider agencies and participants were getting vaccinated together and then just gather information on the number of workers, the number who had been vaccinated and the numbers who really wanted to be vaccinated but were not able to find a place to be able to get the vaccination.

>> Based on this data we identified that there was a very large number of direct support workers who still remained hesitant to get the vaccine.

>> Then we began strategizing about some successful -- looking for successful strategies or looking for ways we could address that vaccine hesitancy.

>> We did additional outreach to the providers and the provider association agencies. We were able to drill down in our data and find out which agencies actually had higher number of employees who were VAKTed so we did some targeted outreach to those agencies as well as the Solexs that support them. And we looked internally then at what the state may be able to do. So what are some practices that the provider agencies themselves did and what are some things that our state may engage into directly to help them.

>> Some of the things that our Department of Health and Office For Citizens With Developmental Disabilities did directly were we held some town hall meetings. Those were really to address the vaccine facts and vaccine myths and just to provide data. We did these virtually by webinar but we had the ability to do phone calls and to be able to phone into be able to participate. We always ensure that we have ASL interpreters and closed captioning to ensure that those folks that need that communication method have that. We had high amounts of participation in our town halls but we found even more success with hosting speakers and panels. With the speakers and panels, we geared these toward specific targeted populations. Early on in the effort we had a targeted discussion and panel for the African American community where we had many panelists who were well-known in the African American community. We agreed that if people see other people who look like them, who are a part of their community, who they can relate to to provide the information. We made sure that we promoted that panel discussion to all of our providers because we know that here in Louisiana a lot of our direct support professionals are in the African American community. We've also had targeted efforts to a faith-based panel and really excited that later in April we are actually going to have one that is targeted to persons with disabilities where we will have people with disabilities as well as their family members, their care givers, and some provider agencies share their stories in a panel presentation similar to this so that we can help get the word out that way.

>> Then finally our provider agencies told us some successful strategies that they used. Some of the inventive things folks came up with is we had some provider agencies who offered staff incentives, any of their staff who was willing to get vaccinated got their name in a Raffle and they got a paid day off or something of value out of that Raffle.

>> We also had the directors and supervisors in the provider agencies, they wrote personal letters to their staff really encouraging them to get VAKTed and to share information with them about how they will be helping to promote health and safety in our state for the participants they support and their own families. Finally we had directors and supervisors who actually took videos of them getting their vaccine so they could use that to share with their staff that they could practice what they preach. They were getting the vaccination too. Our initial data earlier was a very low rate of direct support professionals. We are happy to say that we now have 27.25 percent of our direct support professionals as of the end of March who have been VAKTed and many more who are now scheduled. We still have a lot of work to do but we do believe that these strategies that we're utilizing here in Louisiana are

really going to help make a differential in vaccine acceptance here. I will end there and turn it back over.

>> MS. LYONS: Thank you so much, Jew limit really exciting to hear all the great work you're exploring with the disability service providers in Louisiana. We're going to shift it over to the Missouri Department of Mental Health, division of developmental disabilities, and Valerie HUN and carry speak.

>> Thank you very much. I'm the director of the division of developmental disability here in Missouri. We've been fortunate. We brought into the Crystal group early on and we're part of a fusion cell that includes our division of developmental disabilities with all the state agencies so we were really able to be a part of a lot of conversations around vaccines very early which very similar to Louisiana, we had anybody getting services through the division including our state operated facilities were in the 1A category. Everybody else and their staff and everybody else was I/DD in 1 or 2 category. Our entire universe of staff and individuals supported were all eligible by January for vaccine access. I'm going to turn it over now to carry to talk through our vaccine numbers and what we've seen in terms of hesitance.

>> Thank you. My name is carry. I am the assistant director of department of mental health and I've been working on our response to our agency for all things COVID. I'm going to talk a little bit about what we did internally at our department as well as what we did for our community providers. The slides haven't advanced yet. Initially for our DMH facilities we have 12 facilities with 15 locations throughout the state. Eight of those are for individuals with developmental disabilities and seven of them are behavioral health hospitals. We didn't feel quite fit the mold. I think many of you felt the same I was at vaccines were rolled out because we weren't clearly a nursing home in many people's eyes but we weren't a hospital. We missed out on a lot of that initial information. For developmental disabilities facilities we thought the fastest way for them would be to join that federal partnership program and on the other side our behavioral health hospitals attempted the process to become vaccinators.

>> What we found out quite by accident was it was faster to become your own vaccinator than it was to get set up with that federal partner program and we got vaccine faster that way. By happy accident we were able to utilize both of those avenues for vaccine. So when we did get those federal vaccine partners on site for our developmental disabilities programs, we offered our behavioral health folks to come over and get vaccinated if they had not yet done so. We also had our behavioral health vaccine waiters go to developmental disabilities facilities and hold vaccination clinics there as well and having that ongoing multiple access for vaccine helped us get our numbers up. Next slide, please.

>> So internally for our facilities, for all of our residents both on our developmental disabilities side and our behavioral health side we're sitting at approximately 84 percent of those residents being fully VAKTed and approximately 51 percent of our staff, that includes our facility staff as well as our office staff throughout the department. Some of the things that we did in particular that had the most effectiveness in reaching people was a myth bus enter's presentation. We were fortunately enough to have Dr. Thomas from Washington University who is an immunologist put together a presentation for the fusion cell that walked through step by step myth by myth and provided the facts and information that was recorded. It is available even today on the state's COVID vaccine web page so anyone can watch it. We were able to take those slides and have live WebEx virtual town halls with people in our facility and present that information to them virtually in person. It wasn't a recording so it was interactive. They could ask questions. We found that to be really, really huge. They don't like to be

talked at but they liked to be talked to particularly with this information. So having the ability for them to ask questions and to put out what their concerns were so we could address them was really beneficial. We did that multiple times over with the multiple town halls. We were intentional with some of our initial scheduling of those town halls inviting influencers from our facility, direct care providers, our front line workers in those facilities to attend so we could get their questions answered.

>> As I mentioned earlier, we became our own vaccinator in some areas, we brought our clinics on site. We utilized ambassadors so whether it was having those influencers come to those town halls initially. We did a t-shirt campaign. We designed a t-shirt that said I've been VAKTed, ask me about it. We gave those out to people. It served as a tangible incentive to encourage people and it did encourage some people that decided to get a vaccine because we were giving them a shirt. Before they were a the no and became a yes. It rose awareness because we have people walking around our facility wearing those shirts and it did drive discussion. They saw someone they were comfortable talking to wearing that shirt they could ask questions about it. It's been helpful from that perspective. Really the big important things, we did all of your traditional avenues, we sent e-mails, we made fliers, we reached out and made some partnerships with Dr. Turner to help put messaging out and reach populations that may have been hard to reach. We set up QR codes so people could scan it with their phones and take them straight to that COVID-19 website that would give them information but also allow them to register and see where the vaccines are if they wanted to actually sign up. Offering all of that over and over again that messaging combatting the misinformation was really important. We did the same with our guardians to get their permission to vaccinate our residents.

>> As far as what we did in our community we were able to get some information just recently that indicates we have almost 37 percent of our developmental disabilities clients within the community have initiated vaccine. As you can see on the screen, we have some things to target with the 16 and 17 year olds who are eligible for Pfizer. They're at about 7.9 percent right now. We're going to be doing some effort to targeting those groups and regional groups and drill down on some of that data so we can improve these numbers and get more folks getting signed up for vaccines. Some of the things that we did for the community providers started before the vaccine. We started an ongoing rhythm of messaging WEECHLT did share specific information with them on how to sign up with that federal vaccine program. We had initially before vaccines set up an ongoing e-mail communication so they knew when to expect it, they could opt into receive those messages or not and we tried to send it out every day by 4:00 with all the day's news. As we ran through the pandemic we slowed that down to two or three times a week to once a week, et cetera. They're a little more sporadic. We did town hall meetings with them. Ongoing provider calls we started every week, every Friday same time same place where they could get all things COVID. The vaccine information was rolled straight into that. We're still doing those every two weeks. We repeated shared with them the priority phases and where mass VAKSZ events were occurring and where they could register that. Was put out through e-mail distributions and the website set up for providers as well as shared in those weekly and biweekly phone calls. We got a link to that myth bus enter presentation. We shared it with them. Now that it's a up on the website for all to see everyone can access it that way. We made sure they knew they could sign up through their local public health agencies or the mass vaccination events or we distributed quite a few vaccines through healthcare systems, making sure our providers knew that was available to them and how they could sign up.

>> Finally we worked with the Missouri pharmacy association to actually match providers with approved vaccinators in the state. When all of these other efforts weren't working and we were having

folks reach out saying they're unable to access vaccine or had not yet gotten to it we would take that information and send it to our pharmacy association contact and she would work with her pharmacy members to actually connect that pharmacy with that provider and get them set up for vaccine. So like I said we're still working to now drill down on these numbers and improve those vaccination rates but those are the things that work best for us. The last slide was if there were any questions and we'll turn it over to the next group.

>> MS. LYONS: Great. Thank you so much. We will be doing questions at the end. Feel free to continue to put questions in the Q&A. I'm now going to turn it over to Becky Reitzeses who co-leads -- is co-lead and program manager for King County's COVID-19 speaker's bureau at public health Seattle and King County.

>> MS. REITZES: Hi, everybody. I hope all are having a great day. I'm going to speak a little bit differently. I think I took a little bit of a different take on the question. I do want to say that our sites shh been doing amazing work around accessibility for both testing and vaccine. I'm going to focus a little bit more on the work that I've been directly involved in. I'm going to focus on three issues. One, I'm the lead and manager for our speaker's bureau. Last year we did over 150 speaking engagements virtually for the community so I'm going to talk a little bit about how we addressed vaccine hesitancy and how we train our trainers to address this and how we breakdown barriers regarding ADA disability.

>> I'm going to talk about relationships and partners that we've built in the disability communities and then our prioritization around accessibility of information specifically to disability communities.

>> So as part of the speakers' bureau, in the very beginning we were talking a lot about vaccine hesitancy, and the shift that I wanted -- that I -- the direction that I took it in for our speakers' bureau and our presentation and our speaking 18 gaugements, I want to be clear, we don't do Power Point presentations, Q&As and discussing miscon acceptses and conversations and ASL interpreters and live captioners, also do them interpreted from other languages as well.

>> The focus that we -- that I took in that we -- I train our speakers on is instead of thinking about vaccine hesitancy let's think about what is the distrust. As a trainer and educator and especially as someone who is a white trainer and someone who does not have disabilities, I think the's important, and someone who works for the government and public health, I think it's really important for me as the educator showing up for these conversations to acknowledge the deep distrust am communities have. This includes am communities including black, color communities, folks living in poverty, disability communities, refugee communities. When we think about the deep distrust of government and medical institutions it really comes a lot around historical and current traumas. When thinking about this for disability communities, I think it's really important for us to acknowledge the history and current medical trauma asthat folks with disabilities have faced at the hands of -- have experienced at the hands of government and medical communities. I think we talk about this a lot more am communities. I think unfortunately the disability communities often get left out. I think it's important when we're working with disability communities to being a knowledge -- and especially somebody that's coming from outside. I think it's one thing when there's sometimes an understanding, a united understanding, but somebody coming from outside of the community, I think it's real important to recognize not just hesitancy but deep distrust that is valid and real and important to acknowledge and also to have some ownership around in terms of, you know, again working for a government institution and that we have -- I don't like to talk about building trust with communities. We have a lot of trust worthiness to build. Why is our agency trust worthy? Why is the vaccine trust worthy? Why are our

medical clinics trust worthy? That's the place that we need to build from so trying to build trust with community we need to build our own trust worthiness as an institution that has historically done harm. Thinking about the disability community I think it's important for us to remember and acknowledge this deep history of eugenics in the United States and at the hands of government and to give refugee and communities, not just at the hands of the US government but also the government where folks are coming from. Part of this history includes forced sterilization, sexual abuse, institutionalizing of folks with disabilities, and recognizing that the distrust that people have for medical communities and for the vaccine comes from all of this historical and current injustice and it's in people's cells, in people's memories.

>> Many folks have experienced or own medical trauma and injustice and especially folks in the disability communities today.

>> When addressing vaccine distrust, I think it's not only important to acknowledge it but also to validate. So I'm not going to validate the -- if somebody says to me isn't there micro drug in this drug, I'm going to say no, it's not a micro chip and I want to acknowledge the fear behind it and validate where that misconception is coming from because that's real. People have received things into their bodies they have not wanted. People have been forcibly sterilized. People have been sexually assaulted and raped and this is at the hands of government. I want to validate the deep fear and distrust while being able to breakdown the misconceptions and also correct misinformation. So this is part of for all the speakers I had to work with and who I trained to present in community, this is part of the training they received. This is also true, you know, I want to acknowledge that we often do this training around folks, you know, not just for disability communities but also around folks who are living in poverty and thinking about genocide and, you know, and medical experimentation but since I'm talking today about disability communities I wanted to focus there.

>> That's one of the things that we do in terms of our speaking engagements.

>> Another I thing I want to talk about is we have created partner chanced and relationships in community with leaders from disability communities, with stakeholder groups. You know, early on I really want to say this isn't just like we're coming hear to talk to you. We have created relationships that folks can bring us concerns and feedback and the root of the mistrust that they're having and we've really had to listen. You know, I was doing a training at one point and I came into a breakout room and someone was complaining about the training and based around accessibility. I'm like we need to talk about this. I need to listen. We sat for an hour and a half after training, we had great conversation. We utilized the feedback in the conversation. Part of the -- part of it was the frustration with our system and so I was able to elevate these concerns and really create some better plans for accessibility disability community. One example of partnership that I was able to create was two disability community organizations, one with folks who are deaf and blind and one with folks who are deaf and hard of hearing and what we did was create materials -- I'm at seven minutes. I need top wrap it up. We create add training of trainers for community. We had their impact of the training, we created the material that they wanted. You know, we had their input, not just input but we worked together to create materials. We created everything in low vision, plain language, everything was interpreted. We hired interpreters. More than that we partnered to create the training and train staff so they could bring the information their clients, their communities and each other. I'm going to put some links in the chat for also our web page that has really wonderful videos and accessible information. I'm going to stop talking.

>> MS. LYONS: Thank you so much, Becky. Really appreciate all the amazing work that you're doing

in Seattle king county. Next I'm going to pass it off to Alice Frame at the Michigan Department of Health and Human Services, coordinating disability health program.

>> MS. FRAME: Hi there, this is Alice. I am focusing on the accessible communication piece more so than the vaccine hesitancy and the things we are doing in Michigan to make sure all messaging around COVID is accessible.

>> One of the biggest thing we've been focused on is making sure that all of our electronic and web documents and research is accessible. This is something we've been working for several years on but a lot of times the resources that were being shared with us, whether from the federal level, whether from community partners were not accessible, they were not able to be processed by people using screen readers or magnifying software.

>> We set up a system so that all documents that are being created and shared as COVID resources go through a round of ADA checking.

>> We also wanted to design our materials in a way that was more universally designed, so making sure when we were putting together packets on the vaccine or on COVID information or isolation and quarantine that we were making version that is use plain language that, they had pictures on them to help -- for individuals with I/DD or individuals where English may not be their primary language. We did a lot of work on making sure we had fonts and contrast and all of those things that go into accessible documents. Right now everything that is on the COVID resource page has been checked and run through with screen read tors make sure they are accessible.

>> Next slide.

>> Michigan has also done a lot of work in creating COVID-19ASL videos. Within our department of civil rights we have the division for deaf, deaf blind, and hard of hearing, and they have a team that has worked endlessly over the last year to make sure that any communication that's going out, any information about COVID, about the vaccine, that there is an ASL video version of that information somewhere. They also do this with all of the state's chief medical executives, all video abbreviation.

>> They then have an interpreter who krauts the ASL version as well and hosted side by side. These are all posted in a YouTube channel and they are there and readily available for folks to look back at any time. They are disseminated through partner networks to make sure we're reaching individuals that will benefit from that. In addition all of the governor's press conferences have an ASL interpreter and they are recorded as well and they put captioning in on all of the videos, but they've done a fantastic job and there's dozens of these videos now where they go through all of that COVID information. Next slide.

>> Just a couple of other things. One of the things we did is we put together a vaccination site tool kit on ways to promote accessibility and inclusion in the test site -- or I'm sorry, in the vaccination sites that are being set up. A large part of this is about accessible communications so kits for accessible communication from registration process all the way through the on site vaccination piece. We have ASL interpretation and translations services that are available at the mass vaccination site and available at all smaller local sites as well. We've done a lot of work making sure that anybody who is administering vaccines or signing people into a location have been trained and given information on how to continue to communicate accessibly.

>> That is the con thinned I have so I'm happy to take questions about any of it once it opens up at the end.

>> MS. LYONS: Great. Thank you very much, Alice. Finally we have Jolene Sharp, chief public information officer at the Tennessee council on developmental disabilities.

>> MS. SHARP: Hi, everyone. I'm so happy to be here this afternoon. I'm going to be talking about this from a little bit different perspective abuse the council role is a little different from an agency that's actually providing direct services to people with disabilities. I'm going to talk a little bit about what that role looked like and how we were able to help facilitate clear communication and making sure that our community was getting information that they could access.

>> Tennessee was actually the first state to prioritize people with intellectual and developmental disabilities in phase 1 A-1 which was great. We were really excited about that. A lot of that happened because our developmental disabilities agency actually is a cabinet level agency and had a seat at the table for those discussions early on.

>> That change happened on December 27. So right in the middle of the holidays it was on Page 15 of a 52-page distribution plan that was publicly available. The information just was not in plain language. It used math involved to communicate about the age of people who are eligible that caused some confusion. So within a few days the council was starting to hear a lot of confusion from our communities so we started to think about what is our role to make sure people have clear information and understand the steps they need to take.

>> So the council is really positioned to be a key connection between the field of people living this experience and the large agencies who were really trying to implement the vaccine, to get that out into the community. We had great perspective through our council members, through graduates of our partners and policy making program, people who were really dealing with this in their communities and were often a connection point for that community and it allowed us to start to identify some of the issues as this was going to be rolled out and help the state fix those issues and fill the gaps that we were seeing.

>> So in response to feedback that the council was able to help communication to the Department of Health and our DD agency, Tennessee's distribution plan for the vaccine was updated again three more times between January and March. The first time was to add direct support professionals. Obviously a key group. You all have talked about some of our states that was one of the first groups to be prioritized. The next update was care gives of children who are medically fragile, and that was defined in the plan, it had some pretty narrow parameters around it. Then the third update was a change made directly to -- because of feedback that we had gotten from folks in the field which was sign language interpreters really need to be prioritized.

>> Those changes happened but again the challenge was always how do we make sure that people understand these changes that they have clear information with it, they know they're eligible, they know what to do.

>> So the large agencies were so busy managing all of this distribution process that we were able to kind of step in and say let us help make sure that we get really clear plain language information out to the statewide community.

>> What that looked like was actually pulling out the update. So each time a new group was added, we would pull that update out and put it in really plain language on a one-page memo that has the logos of our Department of Health and our DD agency on the document and then those agencies would help us distribute it. It wasn't just a matter of getting that information to the disability community. It was also a matter of making sure that information got to local health departments.

>> As these updates to the distribution plan were being made, local health departments were sometimes not getting that information right away so a person who was eligible might show up at their local health department and then be turned away. We worked with the Department of Health and the

DD agency to make sure that this really clear plain language information about changes as they were rolled out were getting not just to the community but also to the local health department, the actual sites where those vaccination were happening so people would be Granted access when they showed up.

>> So part of the value leaning around prioritizing the developmental disabilities community for vaccination was how do you define that. And there was some confusion around that. One person told us they were turned away at their Local because the health department said that was for people who can't live independently and do anything for themselves. We found that part of the role in getting good clear information to our community was making sure that people understood what the definition of developmental disabilities actually was for that eligibility.

>> There was debate about how to best community that. We ended up using the legal language so that health departments understood very clearly that this was kind of the legal definition so that people were not going to be turned away based on misperceptions about who was eligible.

>> That was an important step to kind of defining who was eligible when.

>> The other people of this was because we're the council and not an agency serving -- delivering services, we really wanted to bring the lens of making sure we weren't just talking to people who are getting services. How are we talking to the whole state-wide disability community and getting this to people who may not be very well connected to state services. That was a lens that as the council we can bring to re that some of these agencies may not be thinking about as often. So that meant we were really using our social media platforms, our e-mail newsletters to break up information about the vaccine and about COVID into small easily digest I believe bite sized pieces of information.

>> On social media that looked like posting short Q&As with graphics so they were really visually appealing. It made it easy to share. On social media, making that information bite size, easily sharply helped us reach a much broader audience because people would share that with their met works and it helped us get information out to a community that may already be connected to a provider agency or through services, you know, probably aware that only 20 percent of people with disabilities are really getting services that leaves a large majority of people outside the system still needing access to this information.

>> So making sure that information is really plain language, visual, bite sized pieces and sharing that broadly through all of our platforms really was helpful. We also asked the state agency and our partner organizations to really help us with that. They helped us as I mentioned distribute the memos as updates were made to who was eligible and they often are also sharing some of our other plain language content. We developed a Coy individual one page front and back plain language Q&A document. We found another piece of our role that was really important as this -- as the vaccine was rolled out was making sure we were talking to people with disabilities and not just about them. We found that the tenancy during a crisis is to start talking about our community and we wanted to make sure that we were taking the time to make this information really plane language, cognitively accessible, and that we talked directly to people with disabilities instead of just about them. Our COVID plain language guide that went on our website that was shared broadly talked directly to people with disabilities in very clean language, explaining COVID, explaining the vaccine, and explaining what they needed to know to kind of take that next step. That was distributed very early on as the vaccine was first becoming available. That kind of gives a snapshot of our role in the vaccine roll out. We will continue to work really hard as the vaccine is more and more broadly available to use plain language tools and best practices to make sure that people with disabilities have access to

information but to make sure they can understand it, that it's clear, that it's talking directly to them and not about them. That continues to be a central part of our role as this unfolds. I think that's it for me. I'll hand it back over. I think we're going to open it up for questions.

>> MS. LYONS: Wonderful. Thank you so much, Jolene. We have about seven minutes to answer some questions. There's already been some in the Q&A. Feel free to keep putting in your questions over the next couple minutes. There was a question, I believe this was for Julie Foster Haig want, about what are the staff members like for implementing the program. I think it was your connection to the disability service providers so kind of what the range of how many people you were working with to get those VAKTed.

>> MS. HAGAN: In Louisiana we had vaccine partners which were pharmacies, they were home health agencies, they were hospitals. At this point we have, I believe, over 5,000 vaccination providers. We started slow when the supply was slower. Now that that's opened up. We continue to add more suppliers. We initially had about 2000 enrolled but only about 100 at a time that started to get vaccines again because of the supply. We made it a statewide effort. We worked with our regional office of public health folks who each have their own -- I'm not sure of the numbers there, but it was really a large state effort.

>> MS. LYONS: Great. Thank you. I know there was a lot of questions for Miss Foster's presentation so I hope everyone has that in the chat. If you have the recording we'll be sending that, will be available on AUCD's website. The chat feature was in the recording so you would be able to pull out any questions if you aren't able to get that information right now. Our next question is for Becky. Has your county department addressed or worked with healthcare organizations? If so, how have they responded to the focus on historical and current traumas? I'm trying to work with a number of health systems in our rural and urban counties because they're hosting the bulk of the facts events but it's been difficult to have conversations. So any tips or resources would be helpful. This is more for working with direct healthcare.

>> MS. REITZES: We've addressed this a few ways WHCHLT we provide training for community providers in our community partners around, you know, all the topics I mentioned, then we also actually have -- I'm going to put it in the chat. I'm trying to find the actual agreement we have. We have principles for equitable vaccine delivery document that we -- then we have a set of guidelines that any of the healthcare providers who we are partnering with to distribute vaccine have to actually agree to. And there's a few pieces to that. Some of it is around equity, making sure that we are focusing our vaccine distribution strategies to focus on specifically historically marginalized communities, disability communities, queer and trans communities. We also are partnering with community agencies to do pop up clinics and community clinics and all of the agencies have to be accessible, ADA accessible, have to be accessible on a bus line, have to be able to meet -- they're in community so instead of the community coming to us we're going to them. There's a number of different strategies we utilize, one is working with our community healthcare partners to ensure equitable distribution and that they're -- -- aligning with our equitable principles and we are training them and working with them on what that means and working in community, you know, with community partners to provide vaccine in the community. The other thing I would say is we also work with community health providers as well as fire departments to actually go and provide vaccine to people in their homes or in their living facilities as well. We have a lot of different modes that we're able to distribute and depending on the communities we're working with we make sure we use the correct mode. We put our equity principles in the chat to folks who look work with them as well. I hope that answers your question.

>> MS. LYONS: Wonderful. Thank you. Next question is really open to all so if we had one or two responses. How did you reach those who don't have access to the internet?

>> MS. LEWIS:

>> MS. REITZES: One we are going into faith based organizations, we're working with community based organizations and working directly in community based organizations and then again having folks go out into homes to distribute the vaccine but obviously we have to be able to connect with folks as well.

>> We have a phone line available as well that includes video so folks can have ASL interpretation. We also -- that phone line is -- we have other translation available. There's a state line where you get recording, but we have a phone line where you actually get a human and that human can connect you to interpreters as well.

>> MS. LYONS:

>> MS. LEWIS:

>> MS. HAGAN: We're about to do roll out Louisiana. We're going to be going door to door like you do to get out the vote but this is to get out the vaccine so we make sure we reach people and give them information about where to go, where to get it, and what the factual information is in a campaign like that. E!

>> MS. LYONS: Great. Okay. So we're almost at the top of the hour. Apologies if we weren't able to answer everything today. I just want to thank all of our speakers for doing such an amazing job presenting the great work you're doing in your communities. Just to close we're excited to report that the White House and the Department of Health and Human Services announced last week that CDC and ACL, which ACL will be partnering together to issue 98 million dollars of grants to the aging and disability networks in every state and territory to provide critical services to overcome barriers that are preventing people with disabilities and older adults from receiving the vaccine. Part of these funds will support national hotlines to support people with disabilities and OERLTD adults in registering and to connect them with agencies to provide services and support necessary to access them. For more information before CDC's COVID-19 a work related to people with disabilities please visit their disability tool kit that includes vaccination considerations for people with disabilities, guidance for how to equitably provide vaccine, and how vaccine sites can focus on accessibility solutions.

>> We encourage you to seek out those resources for yourself and share them with your networks. Thank you gain again for attending today.