



“A Deeper Dive”
Examining the impact of COVID-19 on adults with physical disabilities from marginalized communities

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CART Transcript

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RRTC

APRIL 22, 2021

>> ALISON SWEET: Hello and welcome, everybody. Looks like we've got some people coming in. We'll just take a moment so that more people have a chance to arrive before we begin our presentation. Thank you for joining us.

Okay, I think we can go ahead and get started. Welcome, everybody. We are so delighted to have you join us. This webinar will be recorded. And the recording and slides will be sent to you via e-mail. During the live presentation, please excuse your colleagues for any unexpected moments. We hope this doesn't happen, but if the webinar were to close unexpectedly, please reopen it from the link you used to attend this presentation.

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Lisa, the floor is yours.

>> LISA REBER: Greetings. My name is Lisa Reber and members of the research team and I will be presenting ourselves during the presentation in time. So, I'm just going to jump right in and get going at this point. And today we're going to talk about some research -- a study we conducted. It addresses the COVID-19 pandemic and how it impacted adults with physical disabilities.

So, this is a qualitative study, and it draws from a larger project. And this larger project looks at the factors that allow adults with physical disabilities who are living in low-income, racially-marginalized communities to live full and meaningful lives. Today's study focuses on part of the larger study. It looks at the impact of the pandemic, in its early days, so about one year ago in April and May 2020. This COVID study, as I'll refer to it, explores the day-to-day experiences and perceptions.

So, from the start of the study, I and Dr. Meade, who is the lead researcher, wanted to be sure that we were well-informed and that we accurately understood the information we learned from participants. We're both white women without physical disabilities. We do not reflect the target population. As a result, it was extremely important that we have others on our research team who do. Thus, as part of the larger study, we hired two community liaisons, Gina DeShong and Jaime Junior. Gina?

>> GINA DESHONG: Good afternoon. I'm program Director at the Disability Network and a lifetime resident of the Flint community. I began this project as a community liaison for Flint. My position was as information referral specialist. My job was to answer phone calls and provide information about available resources and programs in the Flint community. I have worked with people with disabilities in various capacities for over 20 years. I'm very familiar with the challenges that they face on a daily basis. Here in Flint we have a saying -- when everyone else gets a cold, Flint gets the flu. So just imagine what that means for people with disabilities who struggle on a daily basis just to find the resources to survive and thrive.

>> LISA REBER: And Jaime?

>> JAIME JUNIOR: Good afternoon, everyone. I am a woman with developmental disability. I have cerebral palsy. I use a wheelchair mobility device to get around. I am the mother of one child. At the beginning of this study I was working with an organization called Warriors on Wheels in Metropolitan Detroit. It is an advocacy organization for people with disabilities, by people with disabilities. Currently I serve as the community coordinator for the City of Detroit's newly started Office of Disability Affairs. I wanted to work with this study because, as a lifelong Detroitter, and a member of the target population in the study, I have a lot of insight into different things, and wanted to learn more. And as COVID developed, there were a lot of different aspects that seemed interesting. And --

>> LISA REBER: I met with Gina and Jaime weekly. They expanded my awareness of issues related to disability, and to race, and to the specific communities we were targeting. More recently we added Jodi Kreschmer, a research associate. Jodi?

>> JODI KRESCHMER: Hi, I work for the University of Michigan Department of physical medicine and have for about five and a half years now. I am also a woman with cerebral palsy. With this project, what I've found most interesting is the creativity of people with disabilities as to how they lived their lives during the pandemic. And now I want to go back to Lisa so she can tell us more about this.

>> LISA REBER: Thank you, Jodi. And I'm Lisa. I have a PhD in social justice and I'm a qualitative researcher. I've been working with the RRTC for about a year and a half now and on this larger project. So the initial analysis of interview material for the COVID study was conducted by myself and Dr. Meade. Following this, Gina and Jodi provided feedback and critique. Together the four of us re-examined the data and developed stronger ways of thinking about it. Today we want to share with you some of the things we learned from the people who were in the study. But first I'll tell you a little about who was in it and where we conducted it. In the early days of the pandemic Wayne County, which is in the Southeast of Michigan, soon followed New York City as an epicenter of the pandemic in the US.

Several weeks ago, at the end of March, Michigan was reported as having the fastest-growing COVID-19 case rate in the country. Key reasons for why Southeast Michigan was an epicenter are the same reasons we chose this region as the sites for our study. Both Detroit and Flint of high percentages of African-Americans, low-income households, and people living in poverty. To participate, individuals had to have a moderate to severe physical disability for at least five years and they had to live in Flint or Metro Detroit.

We attempted to include only or mainly those of low-income households, which we identified through the ZIP codes. The study also included key informants. And these were people who had important insights about the experiences of the target audience. For our larger study, our goal was to have a racial demographic of participants reflecting that of each city.

However, the individuals we interviewed for the COVID study were recruited prior to the pandemic. As a result, we simply interviewed those who we already had. The number of participants in the COVID study as a result did not evenly divide between the two cities. Most of them ended up being in Detroit. But interestingly enough, for Detroit the numbers were spot on. Detroit is 79% African-American and for the COVID study, 80% of the participants were African-American.

So this table shows the 16 participants I interviewed, one on one, about the pandemic. The green and blue colors reflect the racial-ethnic groups, blue for African-American and other people of color. The lighter color are the participants. There were 12. And the more intense blue and green at the bottom of the table are the key informants. The key informants themselves were not necessarily from low-income communities. However, they were able to speak to the experience of those who did live in such communities because of their work with them. Three of the four informants also had physical disabilities. And inevitably their interviews also included their own experiences. Only one didn't have a disability that would have qualified her for the study. The interviews lasted about an hour and a half.

On the right you'll see duration, which refers to the amount of their interview that addressed issues relevant to the pandemic. It averaged about 15% of the entire interview. For three of the participants it was 25% or more of the entire interview. During interviews we talked about many different topics, including social support, the built environment and healthcare access. I asked specifically about the pandemic but usually it came up many times throughout the entire interview.

(Speaking at the same time).

>> JODI KRESCHMER: When we were analyzing the data we talked about what people with disabilities were currently dealing with, with the COVID-19 pandemic. First, people with disabilities thought that they weren't represented in how the COVID-19 pandemic may impact them. And second, this was a major theme with another population for people with disabilities because they relied on social supports more than others. Another theme we saw was unable to access healthcare. And for people with disabilities, this is very important because they need more in-person healthcare. People with disabilities utilize personal care to help them with their daily activities. And it was also hard for people with disabilities to find resources in their communities to use such as transportation that didn't surround them by lots of people.

We found some overarching factors. Basically, there was a continuum which we'll discuss in more detail with the risk on one side and community need on the other. And a lot of people with disabilities needed to balance whether they wanted to take the risk to get their needs met or not take risks and not have their needs met. So, to balance that out, people with disabilities used accommodations like food delivery services; having personal care assistants stay at home with them. We'll be talking more about that later in the presentation.

>> LISA REBER: The individuals in the study were typically in a difficult position with difficult choices to make.

As Erica said...

>> JAIME JUNIOR: If you have to stay in the house because you're susceptible to what's going on out in the public, then what do you do?

>> LISA REBER: So, how do they get their needs met?

>> GINA DESHONG: When participants were forced to choose between not having needs met and having them met, they typically chose the latter.

>> LISA REBER: As Shawnta said...

>> JAIME JUNIOR: They go out maybe once a week and do their grocery shopping. And so it stresses them out that they have to get on public transportation.

>> LISA REBER: And Carnise added...

>> JAIME JUNIOR: Because you know you have the President talking about he wants to reopen, like yesterday. So that causes some anxiety, and especially for people like me that are more at risk.

>> LISA REBER: Not all participants said they felt at risk. Some didn't think their circumstances were much different from those without disabilities. But many did.

>> JODI KRESCHMER: Normally the minimization of risk had to do with whether or not they wanted to have healthcare providers and personal assistants assist them throughout the pandemic. Many people using personal care assistants and healthcare providers as support throughout their lives, were now without support and this was not good for them, both physically and mentally. Many people with disabilities had no choice but to have their healthcare providers or personal care assistants come into their home following quarantine protocol, because they needed the help.

Once people with disabilities had personal care providers in their home, they did not want to "rock the boat" if their personal care assistant did not wear the correct PPE or abide by COVID-19 guidelines. Because the person with disabilities needed the care and they couldn't get it from anywhere else. So, if they "upset or angered" their personal care assistant, they would not be able to find somebody else to help them. But people with disabilities, to avoid losing their personal care assistants, also tried to normalize the situation, saying it's okay if they don't wear masks or things like that, because they're only with me for a couple seconds, or, I need this help, and you know what, it's okay if you're not doing this, because as long as you wash your hands, we should be okay.

>> LISA REBER: Or, as one key informant put it...

>> JAIME JUNIOR: They're just saying, I value what this person can give me, more than I value the consequences.

>> GINA DESHONG: The issue most frequently talked about was isolation, fear of it, and the need for connection. It was discussed by nine of the participants. I think for people without disabilities it can be difficult to understand why the pandemic is any worse for those with disabilities. Feelings of isolation and access of healthcare and resources were fairly common. They were experienced by many in society. But it is different.

As Laura, a key informant, also said...

>> JAIME JUNIOR: The pandemic is further isolating people. So, if people felt isolated before, this is like taking a deeper dive into isolation.

>> LISA REBER: Sources of connection and community can be different for people with long-term disabilities and chronic diseases. One important comment revealed the important role of those in healthcare, important because of the human connection that they can provide. Medical practitioners, rehab services, physical therapy. The people who do these jobs play an important role in providing social interaction. When these forms of interconnect and interactions are put on hold, a small circle that the participants engaged with, shrank, and in many cases, became non-existent.

Ramon said...

>> JAIME JUNIOR: I used to go to therapy four times a week. But of course I can't do that. I don't really -- really talk to anybody.

>> LISA REBER: When isolation is already an enduring, unending part of one's life, the isolation that the pandemic brought can result in that isolation being more intensely experienced than it already is. During the pandemic, participants had to continually weigh two options, not having their needs met or engaging in risks to have them met. In many cases the need to choose between these two options could have been avoided had accommodations been provided.

This was the second overarching factor. By accommodations we're talking about the presence of services, environments, policies and how these can help make access to resources not a privilege but a right. The participants' narratives, they reflected the inability to access accommodations as well as the negative impact on their physical and mental health. During the pandemic, participants had received almost no accommodations. Not for their healthcare needs, not for the resources they required, or for the assistance they required in their home.

>> JAIME JUNIOR: And for people with natural supports, oftentimes it was even more traumatic. People like myself, for example, who receive all of their support from their family, don't have much connection to community organizations. Or receive the necessary information about how to acquire free or low-cost PPE and other things to help them feel safe. They also found it difficult, in some cases, to find connection or to get needed stimulation.

>> LISA REBER: There's also other factors that can provide some individuals with greater access, and hence, the ICF model raises awareness of the specific factors that can privilege, and as a result, give access and accommodations to some people, and not others. Personal factors include such things as race and socioeconomic status. And environmental factors include the built environment, the people around us, as well as the attitudes that those people hold. Personal and environmental factors interact and influence the relationship between impairment and functioning.

So the ICF's personal and environmental factors can be looked at in relationship to our participants' experiences. Their experiences reflect where identity and personal circumstances interacted with systems and structures and attitudes. And in process, they reveal the intentional importance of such factors as racial identity, networks and connections, and the power and privilege they grant.

As an example, Steve and Grady, two young men in our study, both required 24-hour home care assistance and were in COVID at-risk groups. Steve, like Grady, had multiple caregivers entering his home during the pandemic. Steve saw this as high-risk. However, unlike most folks, Steve was able to change his situation and live with only one caregiver. Both Steve and Grady have limited education beyond high school and live in low-income neighborhoods. But that's about where the similarities come to an end. Steve is white. Immediately following his injury, he received support from a local nonprofit organization whose Director groomed him to be a disability rights advocate. Combined with the knowledge and skills acquired, and his extensive social networks and connections he'd developed, Steve could conceive of different possibilities, and he could change his circumstances. Grady in contrast is an African-American man. He was not connected to any disability groups, and he was socially isolated and lacked social

networks and resources and connections. Unlike Steve, Grady described an upbringing lacking warmth and support. All of this of course occurs within a society that puts a greater degree of value on whiteness. Steve and Grady's experiences help make visible the potential impact of environmental factors on personal factors and vice versa.

The model of healthcare disparities in disability builds on the ICF. This is a framework for helping us think about the personal and environmental factors and their impact on one's experience with health care. The model focuses our attention on the factors that can lead to disparities, including things like accommodations that may or may not be provided. This particular factor, provider attitude, received quite a bit of attention in the early stages of the pandemic. In the media, and in commentaries, and in op-ed. In relationship to issues of rationed care. If healthcare resources are being limited, who gets priority? Or more importantly, who will be de-prioritized?

Interestingly, though, when asked about this, none of our participants expressed explicit concern about receiving care if they needed to be hospitalized. Though some did hint at it.

As Tavell said...

>> JAIME JUNIOR: I would hope that I would be -- would get the fair treatment, but I wouldn't. I don't know if I would or not, you know?

So with the underlying issues that I have already, I believe I would be prioritized because I have one, those underlying conditions.

>> JODI KRESCHMER: Another aspect in relation to access to care in rationing of care was access to one's personal assistant. In the beginning of the pandemic, people were not allowed to have family members or friends in the hospital with them. And for people with disabilities, this is more of a burden because your personal care assistants know more about you than your healthcare providers sometimes because they are with you day-to-day and help you with your physical needs. If you don't have that person there, how do you know that your needs are going to get met. During the pandemic people were worried that they wouldn't be able to get all the healthcare that they needed in the hospital.

As Steve states...

>> LISA REBER: The man above, Steve, who had the ability to alter his living arrangement, felt far less confident about what would happen if he had to go to the hospital.

As Steve said...

>> JAIME JUNIOR: When a person, if they're paralyzed and they're recovering, there's not time to have people sitting in a room, you know, waiting on you. A person like me, I need 24-hour care. It's about survival, really.

>> LISA REBER: In the early stages of the pandemic -- go ahead, Jaime.

>> JAIME JUNIOR: In the early stages of the pandemic there was talk of rationing care. Going back to several World War II instances where doctors made the decision based on what they perceived the quality of life of a person to be as to whether or not they would receive care. Several advocates rallied and this resulted in Governor Whitmer signing Executive Order 2020-64, affirming anti-discrimination policies and requiring certain health care providers to develop equitable access to care protocols.

>> LISA REBER: Participant testimony provided us with examples of the challenges they encountered during the pandemic as a result of a lack of accommodations, accommodations that can bridge need and risk. Looking closely at the personal and environmental factors helped reveal distinctions in their experiences, and how this can be the result of their particular identities. Identities that impact access to accommodation, access to resources, to health care, the human connection, and to less isolation. This study helps make the invisible visible. It helps make more visible, certain members of society, their care, their unique health concerns, and the resources they require. It also makes visible the need for greater inclusion of people with disabilities in disaster planning at all levels. And in the emergency response policies that would accompany it.

Gina, Jodi, Jaime and I thank you for attending and we're happy to answer any questions you might have. Thank you.

>> GINA DESHONG: Lisa, there is a question in the comment field. Can I read it to you?

>> LISA REBER: Yes, I need to stop sharing my screen, just a moment.

>> GINA DESHONG: Okay. This is from --

>> LISA REBER: Alison, did you want to speak first? Wait a minute, Gina. Alison, do you want to re-discuss the protocol here?

>> ALISON SWEET: Yes, thank you. I was going to confirm with you. There was one question that popped up there early during the webinar. It's from Kathryn Wilson. She is asking why it's just low-income, since diversity is treated the same whether low-income or not, it would have been important to see if income made a difference for those with disabilities.

>> LISA REBER: Sure, I can address that. The study in general, the broader study, was looking at more marginalized populations. The majority of research being conducted is on more convenient populations, meaning middle class and white. And so Dr. Meade, who designed the project, specifically wanted to target those populations that were more often being neglected, low-income and regionally marginalized. And those are what we had available for our COVID study, too, those that we were targeting.

>> ALISON SWEET: And then we had the next question -- how do we move forward?

>> LISA REBER: Okay, ah. How do we move forward? I would just say, as I included there, in terms of involving people with disabilities more in the planning stages and preparing.

Can anybody else add to that?

>> JAIME JUNIOR: Sure. I agree with you, Lisa, having individuals with disabilities at the table when planning things like interventions, resources and the like will help us move the needle. Because who knows better what we need than us? Would anybody else like to say anything?

>> GINA DESHONG: You could contact your local CILs to see how you can support people with disabilities in your local area. Centers for Independent Living. They're in every community. Disability Network here in Flint. You can contact your CILs to see what kind of things you could help with, volunteer for. So, that would be a good way to start.

>> JAIME JUNIOR: Yeah. I'm reading in the chat and one person talked about being a caregiver and an advocate for someone with complex invisible chronic illness and profound medical trauma related to PTSD. And she says...

I am currently not allowed into the ER, despite the fact that their medical PTSD is why I am there.

Stories like that, they hit me really, really hard. Um... I work with a lot of individuals that have developmental disabilities or cognitive disabilities. As a matter of fact, my nephews -- I have two nephews that are autistic, and they lack the ability to communicate sometimes effectively what they need or want because of their social anxieties. So it's always troubling to me, that no one is allowed.

I also had a personal experience. My mother was 82 years old. She contracted COVID. And while she was in a rehab care facility, not only could we not visit her at the rehab care facility because of the protocols, but when she was at the hospital, we couldn't visit her. And the hospital staff barely took our calls. So... I can definitely relate to how anxiety-producing it is.

Looks like we have a hand up.

>> ALISON SWEET: Yes, I was going to remind everybody that if anybody needs to speak, to ask their question, please click on the raised-hand icon at the bottom of your Zoom window. I'm sorry I did not remember to do the reminder instructions. But someone did raise their hand so I'm going to allow this person to talk. And they should receive a prompt to unmute themselves.

>> LISA REBER: What's the person's name, Alison? Maybe that would help.

>> ALISON SWEET: I think she can speak now. Can you speak?

>> Hi, this is Carolyn Grawi. I'm associated with both University of Michigan and down here in the South with the University of West Florida. And I'm just curious, with the research that was done, if there's any thought or inclination to look at more in-depth regionally or a broader study, to look at the pieces. Because as both of your guest speakers also shared, there are CILs, across the country and across the world, that vary heavily across the United States, and there are centers in many well-income areas throughout the country, as well as the pieces to look at how are people treated day-to-day when we have individuals with disabilities that are being seen in medical care and other places as compared to our counter parts. And also looking at what the next outcomes will be, since we know that there's lots of long-term cases that are impacted with disability and COVID, as well as what will be the vaccination protocols going forward past this first round. So I'm just curious what the next steps to the research may look like, as far as a broader community.

>> LISA REBER: Specifically related to COVID, there's no clear next-steps. We have the broader, larger project that we are still continuing with on adults with physical disabilities from marginalized communities. But inevitably as we --

We've interviewed most of the people we have. But when we interview more people, we will continue to ask about the pandemic. But unfortunately, the majority of our participants were all interviewed prior to that. So, we can't go back at this point and get more information on that. It will need to go into a new project.

>> JAIME JUNIOR: Lisa, there's a --

>> LISA REBER: Somebody also asked about -- are you addressing another question that's up here in writing?

>> JAIME JUNIOR: Yeah, I was looking at that.

>> LISA REBER: There's a question here about the collection of data.

Right. And so collecting data, so we know who's getting the vaccine and who's not among individuals with disabilities. And it may be that you might know something about that, Jaime, from your position?

>> JAIME JUNIOR: Yeah, actually, there is the Protect Michigan Workgroup Commission that exists in Michigan under the Michigan Health and Human Services division of the government. And there is a disability workgroup that I sit on. And we've been working on trying to convince health care providers that collecting the data is necessary. So we can develop equity plans, but you would be happy to know that the disability workgroup has put together a manual for best practices. So, things like providing interpreters without reservation, things like providing more individuals with mobility disabilities, people with service dogs... Actual protocol on how to welcome and make people with disabilities feel comfortable in mass vaccination sites. You can find more information on that at michigan.gov/protectmichigancommission or PMC. I hope that was helpful.

>> ALISON SWEET: Someone else also raised their hand. His name is Thomas. And I just asked him to unmute himself. Try again, Tom, I'm sorry.

>> How about now?

>> ALISON SWEET: Yes.

>> Hi, everybody. I sent my question in the chat but then I rose my hand because I wasn't sure which you preferred. But I don't remember seeing numbers coming up in a slide on whether anyone talked about being admitted to the hospital during the pandemic because, you know, they made a choice and a compromise, and as a result, symptoms worsened and they had to be readmitted. Because I work with the spinal cord injury population and I found that among some of my peers. That's it.

>> LISA REBER: I only interviewed one person who had been hospitalized. And he was hospitalized before it even became an issue -- or, I mean, before it erupted. And he was in an intensive care unit and everything. But he went in, in like February I think, and he was in for maybe four or six weeks. And he didn't -- he was in by himself. But he was able to, um... no, he would have been fine in the hospital on his own. He did not require 24-hour caregiving so it wasn't an issue for him while he was there. But otherwise, no one else had been in the hospital.

Does that answer your question?

>> Tom: It does. Can you hear me? It does answer it. I just, um... I know of an individual that really called it -- or, um, it was a close call. Because they were afraid to go to the hospital due to, obviously, contracting COVID. So it was just a really difficult choice, and wondered if you found that. So, thanks for sharing that.

>> LISA REBER: No, like I said, it wasn't -- one, he didn't know about the thing of COVID at that point. And two, I think he collapsed actually and the ambulance came and had to take him away. So, it hit him quite hard.

>> Tom: Okay, thank you.

>> ALISON SWEET: Okay, I'm going to mute Tom right now, and the next question is from Els...

Her question is what about looking at the environmental factors more in depths, e.g., lack of policies, lack of support, access to vaccines et cetera, by identifying the environmental barriers one should or could develop strategies to eliminator minimize the environmental barriers.

>> LISA REBER: That would be very good. That would be great to look into. I also see that Els asks for our definition of disability. Jodi, how would you like to answer that one?

>> JODI KRESCHMER: (Mute).

>> LISA REBER: Oh, we can't hear you, volume!

>> ALISON SWEET: Yes, I'm asking you to unmute.

>> JODI KRESCHMER: Got it! Sorry. We mainly focused on people with physical disabilities.

They could have a variety of disabilities from arthritis, cerebral palsy, spinal cord injury, different things like that. So, we have a wide range of people. It has to affect their mobility to some point. And we also have some people who also have mental disabilities as well.

>> ALISON SWEET: Okay, great. I see Michelle Meade also raised her hand so I'm going to allow her to talk and ask her to unmute herself. Michelle Meade?

>> MICHELLE MEADE: Okay, thank you. First of all, thank you for putting together this presentation and bringing us this information. Hopefully I am not showing you all of my house, but you can see me instead... No, you can't? Okay, sorry, let me see if I can turn it on. Okay, then you'll just hear, I guess.

There are so many great points that people have brought up. The importance of using this information to change policy, to be proactive. The importance of recognizing that this is only a slice of the picture of what's going on, and recognizing that there is other research out there, and I think this supplements and complements it. Once again, recognizing that this is part of the larger RRTC project, and so this provided some -- this study really sets the stage to provide some of the qualitative understanding. It's also being complemented by a quantitative study in this area, and surveys being conducted. And then it's being followed up by community surveys, in which we are going to be reaching out to CILs and other organizations across the country to have them identify what best practices are.

Here at the University of Michigan, I think we have heard the concern from individuals with disabilities, particularly about hospitalization. I guess my sense is that everyone needs an advocate when in the hospital. And so it is problematic not having visitors, not having people who can be there to help vocalize that, and have worked with the health system to develop guideline for visitation, for care partners, as well as just best practices with treatment at vaccination sites.

Once again, having people with disabilities at the table, and pro-actively making sure that any guidelines that are developed, we're recognizing the unique challenges that are posed. So there's a lot

that I know we are talking about and discussing, but I think it all fits within a broader content. We all use the pieces from this study and others to continue to advance the policy and to recognize the impact of systemic racism and ableism. And help to move the dial to improve outcomes and lives.

>> JAIME JUNIOR: --

>> LISA REBER: Michelle, if I could ask, just a minute, Jaime, somebody asked what would be government agencies with whom this information would be useful to share? Might you have any direction there? And Michelle's gone... is she?

Okay. I'm not sure about the answer to that. Jaime, you might actually have some ideas in terms of agencies which would be interested in this information, governmental agencies.

>> JAIME JUNIOR: I'm sure MDHHS would be interested in this information. As I said, the Protect Michigan Commission and its workgroups, as well as even the Detroit Health Department would probably be interested in this information, to help further work on enhancing their programs.

One thing that I neglected to mention during the presentation that I want to make sure that I say right now is, that Executive Order 2020-64 did provide for sign language interpreters to be present for individuals who were Deaf or hard-of-hearing. But it did not alleviate the anxiety of not being able to have a loved one visit you or be in the room with you. So, I just wanted to put that out there and I apologize I neglected to mention that during the presentation.

I saw that Jerry in the chat invited us to join him for the FEMA Region 5 Workgroup? For a presentation on May 11th. Thank you, Jerry. I just wanted to say that I saw that, and I'll make sure that information gets to the other presenters.

>> ALISON SWEET: Thank you. I want to note that Carolyn says please reach out if we can be helpful.

From Michelle, we have conducted check-ins and have also helped a vaccination clinic in our CILs. And she also commented later, disability rights which I'm assuming she is referring to what government agencies (may be interested in this information). Are there any other questions? We have been receiving some really excellent questions, thank you so much. I don't see anybody --

>> LISA REBER: Alison, if I could point out -- me.

I just want to let people know that there will be an evaluation afterwards, and there's a part specifically for if you have a physical disability and questions about your experience and how it compares to the findings from our study. We're really curious to know. It was a very small population, right, that we included, the sample. And how does your personal experience align with it, or is it completely different?

>> ALISON SWEET: Thank you so much. I think, unless anyone else in the panel has anything to add, I think we are done with our presentation. Does anyone else from the panelist group have anything to add here? No?

All right. I want to say thank you to everybody who presented and attended. I hope you learned a lot from each other. And I hope you all have a great day. Take care.

>> GINA DESHONG: Thank you, bye!

>> LISA REBER: Thank you.

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