

PACIFIC ADA CENTER
EMERGENCY MANAGEMENT AND PREPAREDNESS:
INCLUSION OF PERSONS WITH DISABILITIES
6/10/21
2:10-4:00 P.M. ET

>> LEWIS KRAUS: Welcome to the Emergency Management and Preparedness: Including People with Disabilities Webinar Series. I am Lewis Kraus from the Pacific ADA Center, your moderator for this series. This series of webinars is brought to you by the Pacific ADA Center on behalf of the ADA National Network. The ADA National Network is made up of 10 regional centers that will be federally funded to provide training, technical assistance and other information as needed on the Americans with Disabilities Act. You can reach your regional ADA Center by dialing 1-800-949-4232. Realtime captioning is provided for this webinar. The caption screen can be accessed by choosing the CC icon in the meeting control toolbar. You can turn that meeting control toolbar permanently on by pressing the alt key and press it again a second time to make it stay on. As always in our sessions, only the speakers will have audio. If you do not have sound capabilities on your computer or prefer to listen by phone, you can dial 1-669-900-9128 or 1-646-558-8656 and use the webinar ID of 8720730-7836. And as a reminder this webinar is being recorded and can be accessed on the ADApresentations.org website in the archives section next week. This is the seventh year of this Webinar Series which shares issues and promising practices in emergency management, inclusive of people with disabilities and others with access and functional needs. The series topics cover emergency preparedness and disaster response, recovery, and mitigation, as well as accessibility and reasonable accommodation issues under the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, the ADA, and other relevant laws. Upcoming sessions are available at ADApresentations.org under the schedule tab in the emergency management section. These monthly webinars occur on the second Thursday of the month at 2:30 Eastern, 1:30 Central, 12:30 Mountain and 11:30 a.m. Pacific time. By being here you are on the list to receive future notices in this series. Those notices go out two weeks before the next webinar and open that webinar to registration. You can follow along the webinar platform with the slides. If you are not using the webinar platform you can download a copy of today's PowerPoint presentation at ADApresentations.org in the schedule section of emergency management. At the conclusion of today's presentation, there will be an opportunity for everyone to ask questions. You may submit the questions using the chat area within the webinar platform. The speakers and I will address them at the end of the session, so feel free to submit them as they come to your mind during the presentation. To submit your questions, you can type them in the chat area text box or press alt H if you are using keystrokes and enter text in that chat area. If you are listening by phone and not logged into the webinar, you can ask the questions by emailing them to us at adatech@adapacific.org. If you have any technical difficulties during the webinar, you can send a private chat message to us by typing in the chat window and you can type your comment in text box and hit enter and, again, if you're

using keyboard, you can use alt H to access the chat box. You can also tell us about any technical difficulties at adatech@adapacific.org or you can call us at 510-285-5600. Today's ADA National Network Learning Session is entitled "Disability Inclusion and Considerations in Vaccination Centers and Operations." This session will discuss accessibility considerations for vaccination centers centered primarily around physical accessibility, communication access, and programmatic access, including staff training and information sharing. Vaccination sites come in all sizes and this discussion will highlight the mega sites and will focus around the sites in Los Angeles, California. Mobile vaccination to large cities and remote groups and fixed facilities in Nevada and Washington. Today's speakers are Linda Mastandrea. She's the director of the Office of Disability Integration and Coordination or the ODIC or FEMA. Roxann Crawford, she's the region IX Disability Integration Specialist for FEMA. Danielle Bailey is the Region X Disability Integration Specialist for FEMA. And Vance Taylor is the chief of Office of Access and Functional Needs at Cal OES. Vance is responsible for insuring the needs of individuals with disabilities and persons with access functional needs are identified before, during and after disasters and integrating those needs in emergency management systems in California. I will now turn it over to you, Linda, Roxann, Danielle and Vance.

>> LINDA MASTANDREA: Thank you, Lewis. And thanks for having us here this afternoon. So good morning, good afternoon, wherever you're calling in from. My name is Linda Mastandrea, I'm the director of FEMA's Office of Disability Integration and Coordination and very pleased to kick off this important session today. I would like to thank the Pacific ADA Center for the opportunity to join this ADA National Network Learning Session and what is really a very important topic. I'm looking forward to sharing some information with you today. So for those of you who don't know, FEMA's mission is helping people before, during and after disasters. And the Office of Disability Integration and Coordination or ODIC is a really important part of that mission. We help people with disabilities before, during and after disasters. And we do that by working across FEMA to proactively design programs, policies and procedures to integrate the needs of people with disabilities in all phases of emergency preparedness, response and recovery. We deploy disability integration advisers to active disasters across the nation to ensure that the needs of people with disabilities who have been impacted by disasters are met. We engage with disability stakeholders around the nation, and we take part in several White House led and federal interagency workgroups and committees aimed at improving access to resources and services for people with disabilities. So our Regional Disability Integration Specialists, including Roxann, Danielle, who you will hear from momentarily today, implement the mission of ODIC across the regions. They serve as liaisons between the regions and headquarters during disasters, to make sure that people with disabilities impacted by disasters have accessed programs and services they need to successfully recover. They're also responsible for integrating the needs of people with disabilities into the FEMA programs and services in their regions, and working with emergency managers, disability stakeholders, and other partners at the state, local, territorial and tribal levels. So over the last year and some months during the FEMA COVID response and vaccination

center implementation efforts, ODIC coordinated across all of these lanes to respond to the first disaster in our agency's history that literally affected every state, territory and tribe. In early 2021, President Biden issued a mandate for FEMA to help vaccinate 100 million people in the first 100 days of his administration. And when that initial goal was met ahead of schedule, he revised the goal, aiming for 200 million vaccinations within the first 100 days, and on April 21st, that goal was achieved. To make it happen, FEMA worked with our state, local, tribal and territorial partners to bring the COVID-19 vaccine to communities around the nation, establishing vaccination centers, accelerating statewide efforts, and collaborating on communications campaigns aimed at getting people to get the vaccine. And through it all, ODIC and our federal interagency partners focused on making sure that people with disabilities had access to the vaccine in a safe and accessible way. For example, as part of the White House disability policy workgroup, we developed common language defining disability for data collection across federal agencies. FEMA, CDC and ACL partnered on stakeholder outreach through the ODIC disability stakeholder engagement calls and presentations to groups like the North American spinal cord consortium and others. CDC and FEMA collaborated on a whole suite of American Sign Language interpreted videos. NACDD and the UCEDs partnered on vaccination awareness. So all along the way, FEMA and our federal partners were and are committed to the equitable vaccines. Toward that end, FEMA convened a civil rights advisory group and developed a civil rights checklist to further those efforts.

Our disability integration advisers and our Regional Disability Integration Specialists worked to ensure not only that the centers were accessible but that every person with a disability who wanted a vaccine could get one. Some examples, making sure accessible technology was available to provide video remote interpreting. Our disability integration advisers trained field staff on communicating and interacting with people with disabilities.

In the next months, in continued partnership with state governments, FEMA will continue to provide federal support to the community vaccination centers, including supplemental vaccine allocation to nine pilot sites. And now, you know, as of June 1st, hurricane season has begun, and so FEMA is shifting its focus to readying the nation for the upcoming storm season. So our state and local partners will continue to oversee the COVID vaccination effort. And here is where we are across the country with that effort at the present time. As of June 8th there are nine active or temporarily closed federal community vaccination center pilot sites, and 90 mobile pop-up sites that are receiving supplemental vaccine allocations and other federal support. There's three federal community vaccination center pilot sites that are receiving federal personnel support but are no longer receiving supplemental vaccine allocation. 27 federal community vaccination center pilot sites and 130 mobile pop-up sites have completed the pilot program. The federal community vaccination center pilot sites have administered more than 5.6 million vaccinations. And as of June 4th, 18 mobile vaccination units were deployed across Arizona, Connecticut, Idaho, Maine, Maryland, Nevada, New Mexico, New York, and Oregon. These mobile units have delivered more than 56,000 vaccinations. We encourage you to visit [vaccines.gov](https://www.vaccines.gov) if you or someone you know has not yet received the vaccine. And if you want to learn more and help

spread the word, please visit the official public education campaign website at wecandothis.hhs.gov.

And now Vance, Roxann and Danielle are going to talk more about promising practices and lessons learned during the community vaccination center operation in Regions IX and X. Thanks for being with us today again, and over to you, Roxann.

>> ROXANN CRAWFORD: Hey, everybody, this is Roxann, Region IX integration specialist. I'm going to throw it to Vance and have him kick us off with the California operations. Vance.

>> VANCE TAYLOR: Thanks Roxann and Linda. I'm glad to be on the great panel here with our partners from FEMA.

It says I'm unable to start video. So I will not do that. But I will make sure that the slides come up. Perfect. Here we go...

So you heard in the intro, but I'll go ahead and restate, I'm Vance Taylor, and I serve as the chief of the Office of Access and Functional Needs at the California Governor's Office of Emergency Services. I always joke, it's a very long title. I think it's a state government thing. And the reality is I think it's an unspoken rule that the longer the title the better, and if that's the case, I'm definitely winning. As we jump into this conversation, I really want to make sure we're all on the same page just in terms of definitions. So let's go ahead and go to the next slide. When we're talking about access and functional needs, we're talking about individuals -- and I list it all out here, but mental, intellectual or physical disabilities, chronic conditions or injuries, limited English proficiency, or we're talking about individuals who are older adults or children or pregnant, people in institutionalized settings. And those who are low income, homeless or transportation disadvantaged.

So it really is a broad swath of individuals, all of whom fall under this umbrella that we refer to as access and functional needs. And the reason why this matters, of course is because what we have found historically is that any time there's any type of disaster, whether a fire or a flood or a pandemic, it's people with access in functional needs always hit the hardest. So always this disproportional impact. And we've seen that -- I think Hurricane Katrina put a very bright light on that. But it was during Katrina we saw out of everyone who perished, 70% of the people who died had access or functional needs

So we begin to look at, why is this happening? Why is it that over and over and over again people with access and functional needs are hit the hardest, especially when you look at plans and what was put in place to help people before, during and after disasters. What we started to find is there was a common link, that so much of the planning was happening in a vacuum. What I mean by that is to say emergency managers are good, wonderful people, striving to do good things for folks and to serve their communities, but oftentimes we're talking about former first responder types, right? Law enforcement, you know, EMTs or former military salt of the earth but oftentimes not people who have a lived experience with disability or functional and access needs. So the way they prepare and respond and recover was really from a limited perspective. But when they thought about things like communication, they weren't considering or appreciating the fact that not everybody can hear the messages that are being said at a

press conference, so we need interpreters, or not everybody speaks English, so we needed that translated into different languages. Or that not everybody can see the visuals that are put up, so we need alternative formats. And so the messages that went out didn't reach everybody. When talking about transportation and evacuation, they weren't appreciating the fact that a lot of people rely on accessible transportation resources. And so it's that idea that is in the school bus to evacuate folks, which worked for a great majority of people, but then somebody in a wheelchair would come and ask the question, where is the lift? Where is the ramp? And it forced people to make these terrible decisions between do I get picked up out of my chair and put on this bus and leave behind in my independence and safety and security? Sometimes dignity. Or do I stay in my chair and remain in the impact area and just hope and pray that I'll be okay? So it was this terrible situation, and at shelters where people would go and realize -- they would put their shelters in an inaccessible building, or they don't have dietary considerations considered. There's nobody to assist with feeding or toileting or transferring. The cots aren't ADA compatible to easier transfer from a chair on to a cot. And so these gaps while never intended to be there were built into the system. So recognizing that, we decided to move ahead, and for California let me tell you what that looked like. Next slide. For California it resulted in us establishing the Office of Access and Functional Needs and if we can get the next slide going we talk a little bit about that. So my bad. And so we established in 2008 this Office of Access and Functional Needs, and the governor placed a chief. And two-fold mission. One is to identify what are the needs that people have before, during and after a disaster. And then two, once the needs are identified, how do we integrate those needs throughout the entire emergency management process? In partnership and coordination and in conjunction with our community-based organizations and our community partners, so that we could have a broader perspective and more inclusive path forward to emergency management that not only reduced the loss of human life on the part of people with access and functional needs, but also reduced human suffering. So let's fast forward and talk about what does that mean for what we've seen during COVID? Let's go to the next slide. So you heard Linda say that President Biden said, look, we're going to do this race to 100 million vaccinations. And it's bold goal. Right? But it's a goal that some people looked at and said is too bold, but we can't reach that number. But nonetheless, the president set that bar and challenged us to meet it. Recognizing California is the biggest state in the union. The president said, we need to have some pilots, right? So California, we want you to work with our partners at FEMA and to set up two mega sites or vaccinations. I love that they use the word "mega." I think that gives you the idea of the scope and scale they were looking at. The first site was the Oakland Coliseum, and the second was at CSULA. And the idea was to run an eight-week pilot that would create a lot of lessons learned, a lot of best practices. That we can develop into essentially a blueprint that could be used by all the other states as they stood up their mega vaccination sites as a part of meeting this goal to get 100 million people vaccinated.

And for us in California, we knew that we needed to set something up that was equitable that would address social vulnerability and something that provided access in a way that wasn't just physically accessible, but that was programmatically accessible as well. So that's something we started out to do, if we go to the next slide, with

language services, right? We recognize that when people are going to come and get vaccinated, they're going to need to be able to communicate. And that communication needs to be effective. And so we made sure that we had onsite in-person ASL interpreters. Now, what we did is brought in a number of them, and they were there every day. All hours of our operation. But we thought, look, if ever there is a time when these interpreters are all being utilized at the same time, we need to make sure there's a backup. And we also need to make sure that any member of our staff that is working these sites is going to have the capability to communicate effectively. And so we work with our logistics team, and they were wonderful. We actually downloaded through the remote interpreting app on to every single iPad that staff members used. Before those iPads were distributed, the app was open, username and password were put in, and it was tested to make sure it's working, and then we set up WiFi high speed at each site. And the idea there is that if needed, any person on staff could tap a button and provide instant video remote interpreting to answer questions via concerns or provide directions. So we had in person, but we also had the backup of video remote interpreting.

California, we have a very diverse population that speak a lot of different languages. So we made sure that we had the most commonly spoken languages in Oakland and LA covered. And so that included Spanish and Vietnamese, Mandarin and Cantonese. And we had in person translators. But recognizing that a few things were possible. One, that we have more people sure enough than we had people to translate for. We knew that was possible. But somebody would show up that needed language support put in a different language. So what we did is we contracted with a translation service. They provide actual assistance for 9-1-1 centers, and so they provide quick, immediate access to more languages than you can count, more languages than you've heard of. But any time somebody came and needed translation services, all they would need to do is specify the language, and if we didn't have somebody there in person to assist them, every single iPad came pre-loaded with a number to call you say what language you need, and the translator comes right on the line. So communication was key, and it was effective. And, of course, that helped people not just to feel comfortable but to navigate the site where they came. Let's go to the next slide.

We wanted for people to have a physically accessible experience, right? We wanted to make sure that all the bathrooms were ADA compliant. We wanted to make sure all the portable accessible bathrooms were placed in locations that were easy to get. We wanted to ensure that people had privacy rooms

So even at these large facilities we set up spaces, that even though it was primarily a drive-thru, we could have walk-up services, well, we set up privacy rooms because some people had sensory issues and just needed a moment. And we had some individuals that because of things like sensory issues couldn't wear face masks. So we wanted them to be able to come in, and they could still receive their vaccine even though they couldn't wear face masks. Which we were told by a lot of folks was a real blessing for them, because they had gone to doctor's offices and couldn't receive vaccinations because they couldn't wear masks. Climate controlled tents, recognizing that, look, not everybody can tolerate heat or cold. And California, so sometimes you just wait 10 minutes and the weather changes. And so we created tents that were accessible that people could be in and wait in that were kind of controlled and comfortable. And we placed "just ask" signs throughout each of the sites. And that was

our way of making sure that people knew that if they needed some form of accommodation, all they had to do is ask. And it wasn't anything to feel bad about. It was something that increased their independence and it was something that we provided and we were proud to provide.

And like I said, we had designated isolation areas for anybody that needed it.

Now, language services are fantastic, and physical access is important, and essential. But what about getting there? Let's go to the next slide. We knew transportation access was going to be an issue for some people. While a lot of people were able to either get transported there because they have a vehicle and they can drive, or they've got somebody that can drive them, and others would take the bus or the train, we knew that that wasn't going to work for everybody.

And so we worked with paratransit providers and were able to provide free paratransit service to and from people's homes. And then we worked with those same paratransit and transportation providers as well as our local friends to provide free shuttles, and these shuttles, what they would do is go to all the surrounding bus stops and all the surrounding train stops, and these accessible shuttles would pick up anybody for free and bring them to the site for the destination and then take them back to the bus stop or train stop of their choice. At the site we had dedicated paratransit lanes. And so it's fantastic. Because what it allowed for -- we ran it two different ways. In Oakland people that were using paratransit would have this dedicated lane. They would disembark the vehicle and get their shot, and then we had standby vehicles right there to pick them up and take them home. So that they didn't have to wait for a ride back. Because we all have experienced that terrible paratransit situation where you get dropped off and then there's a problem with the ride back home. Well, this didn't happen because we had standby vehicles on site. In LA, we did it a little bit differently. In LA we worked with a paratransit provider and they would come through the dedicated lane and we would have somebody actually come on to the vehicle and they would provide the vaccine right there on the vehicle. They would wait with the individual in the vehicle. After the observation time passed, they would hop off and the person would go home and never ever have to even disembark from the vehicle. Which was comfortable and appreciated. And I will say that someone wanted to disembark, of course they had that option. We also put signage of other transportation hubs, because we wanted to note the accessible routes, right? And, again, it's all just about that empowerment and letting people know what is what. The other thing that is really exciting, if we go to the next slide, we also had mobile vaccination clinics. The great thing you know, recognizing that not everybody is going to be able to, even with all the resources we put out there make it to these sites. So we were able to provide mobile vaccination clinics, and we had two per site, and what we would do is we would send these clinics, each who could do 250 shots a day, and we would send them out to community open based organizations, and they would be there Monday to Friday at one spot, and then they change location for Saturday and Sunday. And we would work with our partners to identify those locations. And so sometimes they would go to service centers that provided resources for people who were deaf and hard of hearing. Sometimes they would go to Independent Living Centers. Sometimes they would go to other places, but always community members and always with the goal of trying to reach what people often categorize as hard to reach communities. And so it was great, because they

could constantly move around and then they would come back three weeks later, and then those same people were able to receive their second doses. Now, I want to go on to the next slide, and I want to just really highlight that none of this would have been possible without full community partnership. We received direct input from like the Pacific ADA Center, for example. They put together a wonderful guide and toolkit on what accessibility looks like at a vaccination site. Our partners at Disability Rights California, they were able to help us develop language that outlined things like reasonable accommodations, that put together sort of a menu of things that people could ask for and then of course provided opportunities for people to specify things that were not on the list. The California Foundation for Independent Living Centers set this up with Independent Living Centers, another community-based organizations were phenomenal just in helping us know where to go with mobile vaccination clinics, but also in just trying to think through the best way to serve the community. Our whole community partners were involved in planning and implementation. They were trusted sources. So public messaging, because we recognized that for a lot of people, there's hesitancy, right? You can tell somebody, they come to the site and it's going to be accessible, but if that person has had a negative experience in the past, they might not trust that, right? They might not believe that. And so that person, because there's going to be doubts or concerns or lack of trust, may not get the life-saving shot that they need. And so to address that head-on we work with the whole community partners. And what we found was -- I could say, hey, this is Vance Taylor and Cal OES promises that things are going to be accessible for you, and that was okay. But when our partners were the ones to say... hey, we've been involved in this and you can go and we assure you it's going to be fine, that's when people got over it and came. And so that credibility and that trust was essential. And we see that with all the planning that we do. That there's just nothing that can beat having that type of assurance. We also provided access and help for people to register for vaccine appointments. And that was a big lift as well. Our community open based organizations would actually help people register through the registration system. In a way that provided them with priority access to registration appointments but also in a way that provided more equity in terms of how those appointments were scheduled. So let's go to the next slide. So in summary and in closing, I will simply say that together we achieve great things. As of April 12th is when we were finishing the pilot. More than 720,000 vaccines have been administered. Over 103,000 of those were done through mobile clinics, and almost 70% of the doses were administered and targeted underserved communities and people of color. And so we really were able to meet that mission and that challenge of providing mega vaccination services and an equitable and efficient and fair manner. For what people consider to be the most socially vulnerable or hardest to reach communities. And I'll say that the mission had to be collaborative in order to be successful. The mission is bigger than any one entity. It was bigger than Cal OES. It was bigger than FEMA. It was bigger than any one person or organization. But when we came together as a community with the commitment, trying to meet this bold goal, we found that collaboratively we were able to do more. We did 6,000 shots a day, we found that we did upwards of 300 on average shots day. I think that just goes to tell you that, yep, when you lift and our partners lift, all Californias in this case at these sites were able to ascend. I think this should be a

springboard for not just how we do these type of vaccination or testing sites in the future, but for the way that we tackle all of our emergency management related issues, planning in silos or vacuums, they're for not including our community partners. We're not going to end up with the same success. Our products won't be as good. There will be gaps that get built inherently within the products that get put together. It's got to be collaborative and together. We have to adopt a one team one fight mentality. One of the things that we've done, the process that we're doing right now, is providing a very detailed overview of the things I just outlined in a blueprint. That outlines best practices and lessons learned for standing up accessible testing and vaccination sites. It's applicable not just to what we did and what other states and jurisdictions will do to stand up their sites for COVID, but also any communicable disease, including things like flu. So that's what we did we're proud of it and thank you for your partnership and happy to answer questions at the end. With that I'll turn it over to Roxann.

>> ROXANN CRAWFORD: Hey, thanks so much, Vance. Always awesome to hear about all of the hard work that Cal OES is doing and moving that needle forward. So thank you, thank you, thank you! I'm going to jump right in, because I know that we are kind of pressed for time. So we'll just go straight to the next slide. I wanted to start by something Vance touched on a little bit. And that was having the subject matter experts at the table. Because it's a real game changer. We definitely found in the vaccination missions in Region 9 and Region 10 all the regions really nationally, that it's immeasurably important to have people whose job it is to focus on access and integration. Emergency management wide, we find when we have people whose sole job is to work with individuals on access concerns, it makes a big difference in how the mission is carried out. Just some examples there, and Vance touched on it, so we'll move pretty quickly through. An example would be the federal structure that we had at the FEMA state joint sites and mobile routes in Region IX. At the California mega sites in Oakland and Los Angeles, we had two to three disability integration advisers assigned to each location. And those advisers were closely coordinating with Vance's team at the California Office of Emergency Services, and also with local community partners and organizations. The two mobile routes in Nevada, one in the north of the state and one in the south of the state, each of those had a Disability Integration Specialist assigned to them, and the mobile routes in Arizona were staffed with disability integration advisers from FEMA as well. And they focused on everything related to access a few sites, physical, communication, and programmatic. You can go to the next slide.

Training and support was hugely important to carrying out an effectively accessible mission. You know, that programmatic access piece is directly tied to the training of staff. These trainings and briefings really ensured that the people who are making decisions about the sites, the people who are providing services, and even the people who impact services such as guards and traffic enforcement, these trainings allowed them to be empowered to make accommodations to assist people in receiving services in a way that best suits their needs, the individual who is receiving services. The training is great and definitely goes a long way. But also making sure that people had some takeaways, the simple one-page guides provided. They talked about things like etiquette, language and communication access procedures, how to contact the front for

in-person interpreters at the mega sites, how to utilize the VRI, how to utilize the language lines. It was a big best practice and it really insured that staff had references to look back at. And they also had the contact information for disability integration team on site, and in some cases offsite virtually supporting, just let them confidently know that they would get the support that they needed. It goes back to that having a subject matter expert available who gave people the comfort and saying if I'm really in a place where even though I received training and even though I have these guides, I'm still not exactly sure what to do, they knew they had someone to come back to and feel supported. So it really made a difference, that training. Whole community engagement. An example of some of the training. I put this slide in here because it really did make a huge difference. It's the information that we received the most feedback about from the briefings and training that we gave to staff. They really encouraged employees to focus on needs rather than conditions. It was an impactful message and shaped the way people engaged and provided accommodations at the site. So just explaining to them to focus on the need rather than conditions, diagnosis, burdens or labels, and to minimize labeling people to not use terms like special needs, vulnerable, at risk, some examples, not helpful, someone is here with multiple sclerosis who is easily fatigued and has numbness in his legs. It's not necessary to tell everyone all of that information. What is more helpful is to just communicate what the need is. Needs a wheelchair while waiting in line for vaccination. So really educating people on the fact that they weren't there to make decisions for people to expose conditions or diagnoses, but just to ask how can we provide a service to you, how can we accommodate you, and to let people know that they had the right and the ability to ask for an accommodation, and we would find a way to provide a service for them in the way that best suits their needs.

Partnerships. Vance touched on this a lot. So, again, I'll breeze through it. We partnered a lot with local disability-focused organizations, and that's really across the board. In California we work a lot with Vance's team and they have great connections with the community and we did work some with the community as well. But we found the impact of working with disability organizations and local groups in our Nevada mobile routes and our Arizona mobile routes, which were very rural routes. It was key to being able to reach those community partners and have input and communication about accessibility at the sites as they came through. Those key disability community partners, we worked with them throughout and continue to work on after action reports and checklists for potential future operations. While we hope we don't have to do a pandemic again, a pandemic operation or vaccinations, you know, we do -- we have noticed some trends and things that could impact future operations and disaster response and outreach, so we're really looking through those two ensure that inclusion is part of the first steps and not afterthoughts. We work with Vance and his team, who in California specifically coordinated language and interpreter support services, the iPads, VRI partnerships, and mobile route partnerships. So in California, the mega sites has those mobile operations that Vance spoke about and then were more urban focused than our mobile routes in Nevada and Arizona, but they were able to kind of reach out through Vance's office to find organizations that were interested in hosting the mobile units at their facilities, and if they weren't able to accommodate that mobile unit, we were able to incorporate them into other mobile locations providing passes and

opportunities for their clientele to also receive services. Paratransit providers was a huge partnership, and Vance really talked in depth about that. It made a really big difference having those designated lanes and designated opportunities so that individuals could receive the services on the vehicles. We can move forward. It's an intro slide. Mobile vaccination clinics and rural routes. So here we'll talk about site selection considerations in these rural routes. You can go two slides forward, actually Indoor versus outdoor. Obviously we try to choose indoor over outdoor to the extent possible, with the emphasis on climate conditions, people with disabilities and access and functional needs. I know that this was kind of a back-and-forth during COVID, because indoor created potential increased exposure versus outdoor operations, but in these states, Region IX has the mobile units in Nevada and Arizona, we are facing some very serious temperature and sun, and the outdoor facilities and safety wise indoor was superior whenever possible for those climate controls.

Providing accommodations for people with at-risk health conditions. Again, you know, we were facing temperatures and direct sunlight pretty extreme, especially in our Southern Arizona routes. So we had to really take into consideration how to be able to provide those accommodations. MVUs operating as healthcare facilities need to comply with the ADA and regulation when providing services, and sometimes this was challenging in that people really want to get the vaccine out, they want to get it to people, and in the rush to bring services they can miss the importance of not only the obligation to maintain accessibility compliance but to see how it's absolutely the right thing to do. That's again going back to the very first thing we talked about. Having someone whose sole focus is accessibility and makes a big difference and educate and encourage and help come up with creative solutions to providing services in an effective and accessible manner. It can be confusing who the law applies to, and we do lean back to the team at the Pacific ADA Center as a referral to individuals who have more detailed questions about their legal responsibilities. You can go forward, and then again. So mobile site set-up. The location and signage of accessible parking specifically is closest to the entrance and exit with clear signage. So an example would be in Arizona, parking, greeting staff was trained to systematically ask guests who had accessible parking placards or who had the parking plates or indicated that they had a disability, they were trained to ask if they preferred to receive service or the vaccination in their vehicle. And it was important because it allowed guests to self-determine how they wanted to receive services and to identify if they felt safe and comfortable accessing the services, waiting in lines, going into the facility, etc.

A typical problem identified -- and it's just something to be aware of. Not just in a vaccination site, but in all of the facilities that we set up after emergencies or disasters. It was that the exit did not have a clear path of travel back to the parking. Operations preferred set-ups where guests exited a different way than they entered, but it made it challenging to identify the best parking locations. It's really something to consider in this post-COVID environment as routing has become a big focus in a lot of environments. You go to the grocery stores and they have arrows directing you which way to go through and do the shopping. They have this similar things at airports and other facilities. So if we're going to be using directional travel with separate entrances and exits, we need to be focused on that accessibility, both the way in and the way out.

Bathrooms. Locating bathrooms near the entrances, we found allowed the guests to utilize it while waiting and as they exited the site, rather than putting them indoors or in the center of the site, it just made them kind of easier to be accessed throughout the entire operation.

Signage is a super important part of the accessibility features, adequate and appropriate signage helps the mission and helps people to quickly identify and understand what services, accommodations and access is available. If we have appropriate signage, we can kind of address some issues that came up, like people would roll up in, say, Arizona and they would see a long line, and immediately think, I just can't wait in this line, but if we had appropriate signage at the front that said, you know, we'll provide accommodations, all you need to do is ask or let us know how we can better assist you, they were more likely to engage with the staff than if we had no signage available. Staff briefings, we did daily staff briefings to emphasize the independence model to review communication equipment, the language line and other resources regularly, staff switches out on these events. Another challenge is educating staff on the importance of setting up sites that can be used by people independently to the maximum extent possible. And with the sites changing, especially on a mobile route like this, they were changing sometimes daily. And it may seem like overkill to do a daily briefing, but briefings at every site allowed for new features or issues or accommodations specific to that site to be discussed. Then also reviewing the site setup daily and throughout the day. Things get moved around really easily at mobile sites, and reviewing the site regularly throughout the day to make sure that the site pathways are clear, that wheelchairs are not out in the sun getting really too hot to touch, hand wipes may need to be refilled. We noticed regularly people come up with brilliant plans to reroute parking or traffic without really thinking about how those actions would impact the accessibility of the facilities. It happens way more than you think. And so that kind of regular access and regular reviews really, you know, stops that from having too much of an impact. You can go forward. And then again. And one more. Sorry about that. We put some lead slides in, but given the current time constraints, we're going to keep moving through the information.

Just to cover some of the best practices, things that we found really had a big impact, in Arizona and Nevada, we effectively used remote ASL interpreter services via FEMA VRI and limited English proficiency lines to assist with individuals speaking other languages. No, it's not perfect, but on some of the rural routes, it's really challenging, regardless of what groups we engage with or how hard we tried to find in-person support. Some of these locations for the staff in particular were more than 180 miles from their lodging, from the closest any type of hotel or motel. So they're really far out there. But the ability to utilize that VRI service and to have the services available on the mobile units made it so that there was at least an opportunity to communicate with individuals in a way that works best for them. In California, thanks to the diligent work from the Cal OES team, there were onsite interpreters at every mobile site based on the needs of that specific community, and in addition to having those onsite interpreters, there was access to VRI and language line at all times for use when the best-laid plans didn't go perfectly. There were communication accessibility kits in Arizona and Nevada. There was at least one communication accessibility kit per mobile site, and staff were trained on how to use its contents to improve accessibility at the site.

It seems silly but sturdy chairs that can accommodate all guests. At first the mobile routes had some kind of fold-out chairs, and the maximum that they were able to support was 200 pounds. It doesn't always -- it doesn't accommodate everyone for sure. So we made recommendations to source sturdier chairs with a weight limit of 350 pounds. And sturdier chairs were placed in waiting areas, as well as vaccination tables. It's also important to note that chairs with arm rests became a part of standard practice on the mobile routes. So at least a percentage of the chairs had arm rests to allow guests to be able to push up to a stand. Having multiple options for people allows them to determine what type of seating serves their needs best. At least three wheelchairs available per site with one being extra large. It's important to have those multiple sizes so that people are able to safely use the equipment. Tents were adjusted throughout the day to maintain shade. Shade was provided and adjusted throughout the operational hours using tarps and in coordination with logistics partners. Conditions change throughout the day. And making changes and modification regularly makes a difference in how services are received. It goes back to that reviewing the set-up and services regularly. Signage identified services available. So having that signage there, directional signs and signs showing available services were placed in waiting areas, accessible parking signs and van accessible parking signs were provided, allowing people to know upfront what services were available and that they were able to add a request for accommodations. Cooling fans and cold water provided at all mobile sites, especially when the sites had to be outdoors. And privacy tents. Privacy tents were a big success. They provided reasonable accommodation tents for shops based on religious preference, privacy concerns, individuals who maybe aren't able to receive a shot in an arm and may need more privacy to receive a shot in an alternate location, or just even a less stimulating environment. Accommodation by patients also getting vaccinated in cars. You know, as previously mentioned, that was always an option presented to individuals on the mobile routes and it did get used pretty regularly. Outreach and coordination. So just identifying disability organizations and non-profit agencies in the area coordinating with the county to ensure vaccinations reach whole community partners, including organizations that serve individuals with disabilities and organizations that serve communities that are traditionally underserved. FEMA teams worked closely with the civil rights adviser to share information and coordinate on outreach strategies. And we found that partnering with the civil rights adviser gave us an opportunity to reach even more people. We were to identify disability organizations and nonprofit agencies in the area to engage on timing, location, accessibility at certain locations and to engage with their clients as a trusted source. We compiled data and shared with FEMA Voluntary Agency Liaisons, just sharing the list of disability organizations that would benefit from vaccination campaigns, especially in Southern Arizona. And we conducted outreach canvassing organizations in and around the site, just ensuring that we had engaged with as many different groups as possible to let them know that we were there and to help them better understand the accessibility features and accommodations that can be made at the sites, so we can work directly with their clients. Next slide.

So there were some success stories. I'm going to breeze through them because I think I'm kind of running short on time. In Arizona, the team identified and used a resource called Go Go Grandparent that helped secure free rides for individuals in need of

vaccination, especially being a rural area, some of that public transportation was a real challenge. The privacy tent was utilized so many times, but specifically a young adult with autism was able to have a quiet setting for a successful experience and walked away, you know, feeling good about their experience there. The privacy tent was utilized, again, as a religious accommodation. Language line and VRI services were utilized regularly. And pocket talkers, the amplified listening devices were used to amplify sound, even while using the phone spoken language interpreter, which was impactful. Next slide.

Some considerations for improving sites. When setting up a site from scratch, a lot of signage is needed, and additional personnel is needed to guide and orient people to the site. I think Danielle is going to talk a little more about signage, so I'll kind of stop there. But I can't stress enough how important that signage is. In close coordination with the state and County early on to make recommendations about what should be included in contracts. For example, the chairs provided by special event contractor, again, could only accommodate up to 200-pound capacity or capability. And so if those requirements and expectations are known, they're more likely to be achieved.

Next slide. So mobile healthcare facility. It's set in place reasonable accommodation standards for mobile medical staging and the procurement request process. Contractors should be made aware of accessibility compliance requirements or be provided with a checklist, so that they better understand what the needs are going to be for the location that goes back to that setting expectations piece. Interpreters with a medical background or medical interpreters with emphasis on the demographics being served, since it kind of raises the issues of proper informed consent. In the picture you can see an accommodation for people who use a wheelchair or who have limited use of their lower extremities. The hand wash station in appearance is reachable, but it can't be operated unless a foot pedal is pressed. So they decided to keep hand washing sanitizing towel packs to the sink base to allow people to be sanitary, but it still doesn't help with stigma or with the task of providing equal access. So pre-identifying those resources and how to obtain them, things like fully accessible ADA compliant hand washing stations, it's critical in getting it right. Were they able to provide a safe and sanitary environment? Yes, but it doesn't really meet the mark. So I'm going to hand it to Danielle now to talk to you more about mobile vaccination outreach and challenges. Danielle.

>> DANIELLE BAILEY: Hello. Next slide, please.

Hi, this is Danielle Bailey, as said before I'm the Region X disability integration add adviser. And our mission here in Region X, and particularly with disability integration was to support. And that support is to local states to create accessible and culturally specific vaccine sites that reached the identified communities that we previously identified as being disproportionately affected by COVID. And our areas, and I'm predominantly going to be talking about Washington and also highlight work in Jackson County, Oregon. These populations included migrant and seasonal workers, the Latinx population and then specifically in Jackson County those individuals who were impacted by the recent wildfires. So this is the population that we specifically concentrated on. I want to acknowledge both the Yakima County Health District in Washington and Oregon Health Authority. Anything we were able to implement in these areas was made

possible by their full support and leadership. And I do want to say that it was really kind of refreshing, I think -- I don't know a better word -- but refreshing to work with our public health partners, and I believe -- and I think Vance mentioned this before, I think as emergency managers, we can really benefit a lot from their expertise, methods, and considerations around the entire community. In every case, our public health partners throughout the COVID operation, they always have come from a place of yes. So nothing was off the table. So I really want to highlight that. And I think Vance and Roxann discussed accessibility features and processes of sites. But when working in rural communities both with Yakima and Jackson County are fairly rural, we're not as resource rich. They come with their own set of challenges but also I think the possibilities around partnership were amazing. So that's what I want to highlight and kind of this discussion is around the mobile vaccination team outreach and the importance of those partnerships. Next slide.

So first of all, the picture that you're looking at here is a group of individuals that are kind of celebrating the 10,000 mark of vaccines distributed at the mobile site in Yakima County. And so what you see here are people pictured from Yakima Health District, Yakima Emergency Management, Yakima Fire and Police Department, contractors, the Western Washington Incident Management team, Washington State Emergency Management, Department of Health, Department of Defense, and some community stakeholders. I think what we can agree on, you know, there was a lot of discussion, I think through all of this, you know, from our end and the FEMA perspective around the mega sites, and these big drive-thru operations. And I think everyone on this call can probably agree upon that sometimes those operations were very successful in reaching large numbers of individuals, but as we know and as these operations changed and morphed, they definitely don't reach everyone. And so transportation obviously you can't go to a drive-thru site without transportation. I think if you just look at this picture with the tents and the lanes and the cones, it's overwhelming. It can be complicated. People have different work schedules, hours of operations, childcare, and just convenience factor. Some folks are kind of turned off right away, if there's any idea of long lines or wait times, and then also in the communities that we work with, particularly migrants, seasonal farmworkers, Latinx population, the comfort level with staff better uniformed. And so we worked a lot with our Department of Defense partners who were exceptional, but there were concerns with comfort level with uniforms. So that can go on and on. And so as in Region IX and a lot of the other regions and states and locals, Yakima implemented a number of teams to go out in the communities and provide vaccines. So this was in partnership with various community partners, the Health District assigned a team of individuals who -- it was a really big feat. They researched, they called, they documented, and they coordinated mobile delivery. And so there were around 3 to 7 teams each day, depending, who would go out into the community. These teams identified all of those community-based organizations and included entities such as housing authorities, homeless shelters, camps, a variety of community-based organizations, private sector from, you know, grocery stores to places of business, libraries, schools, faith-based, and even places of employment specifically for the migrant seasonal workers. So these teams identified these agencies, organizations, entities, contacted them, coordinated these events, oftentimes vaccines were done in two to three-hour window periods, and then you had to coordinate the first dose and

then also the second dose. So you can see how that can be quite a scheduling fete. I think Vance mentioned as well, this was always, always planned with community partnership and support. So I think one of the most promising aspect of this operation was that no matter which idea organization agency event, anything that came across the table, it was a go. Like I said before, the partners were really receptive. It was always from a place of "yes," and they really wanted to do that outreach to the larger community and provide those outlets for folks to access the vaccine easily. Next slide. So I just want to quickly go through some of the best practices that we experienced in the Yakima area. In the state of Washington, a lot of folks may be aware of, we have a pretty robust disability advisory group at the state level, which is the Coalition on Inclusive Emergency Planning. This is where I start any conversation that I'm having in regards to inclusive emergency planning, COVID, whatever it may be. Right away there is a member of that group from the Central Washington Center for Independent Living. We were connected with Josh Hackney. Josh is a great partner and has been a part of the CF group, that coalition, for quite some time. Through that partnership with Josh and the Center for Independent Living, they're located in Ellensburg, which is about 30, 40 minutes outside Yakima, but Josh was pretty instrumental in this initial meeting. He put us in contact with a lot of the agencies and organizations in Yakima, and one of those prominent agencies that we were able to connect with and really develop a relationship is entity called People for People, a robust agency in the area which really embodied the mission of equity and service in the area. They provided senior nutrition programs. They had their own independent paratransit. They even held the contracts, the Greater Columbia area, the 211 contract. I'll go into that later, but that is pretty instrumental in getting all sorts of insights and information about what is working and what is not working and what information people are seeking. They also had Work First programs, advocacy for minority-owned businesses. So this really expanded our connection with not only disability partners but it really -- the intersects of disability, the needs of the Latinx, migrant and seasonal worker worker population. This group with a number of different partners we continue to meet throughout this operation or as long as FEMA disability integration was on the ground. We continued to meet just to talk about potential issues, potential partners, and that kind of coordination. And so they were pretty instrumental in coordinating a lot of the events or helping to coordinate or identified events. Just to name a few, there were many events, but we did an event for the Sunnyside Housing Authority. And so that really brought vaccines to individuals who could not easily leave their home. They coordinated an event with KDNA Radio, a Spanish language public radio station in the Yakima Valley that really focuses on that health education civic partnership type. And then People for People, they did host their own vaccination site through a nutrition program recipient and sponsored their own event. But through this coordination People for People brought I think that wider lens beyond just disability and that intersect and they really kind of helped us kind of provide that outreach, identify folks who needed extra support and so forth, and they also filled in those gaps, whether it was transportation for some of the other events and so forth. In addition I think integrating key partners into operational planning meetings. Like I said before, People for People, they represent -- they have a contract for 211. So this was pretty critical in the public information. COVID is definitely a public information overload. And so through 211, everybody knows what that system is and where people

call, they ask questions, they get redirected or resources, and so 211 was fielding thousands of calls in regards to where can I get a vaccine, how can I register a vaccine, registering folks for vaccines. So they were really able to add to the operation around public information around the barriers that people were experiencing, around getting the vaccine, messaging, how to schedule transportation. And then also able to communicate to people the most accurate information. So I do believe that partnership and integrating them into the operations was pretty key.

Another best practice is conducting site reviews and a questionnaire of mobile site locations. You know, we talked a lot about the accessibility, and so this is kind of your tip call travel parking lots, that type of thing. A lot of our events were hosted in parking lots indoors. They could have been drive-up. So there was a variety of options that people could host a mobile event so to speak. But we started the conversation with a basic questionnaire, which did address kind of those basic accessibility features like the path of travel, is it a paved surface, are there wheelchair accessible bathrooms, what does accessible parking look like? Is there a need for interpreters, translators, transportation you know, WiFi connections, all of that good stuff. But it also looked at their plan to message. So, again, these are partnerships. So it looked at the plan to message the events. How was that partnership or how were they going to be actively involved with messaging. And also was there an interest in collaboration with other partner agencies and organizations. So how can we amplify this event? How can we partner? How can we get more folks involved? And ultimately it was up to that entity to register folks. We could always provide -- they could always provide vaccines for folks who just kind of offhand walked up, but, you know, again, to plan accurately for number of vaccines and so forth, they wanted folks to pre-register. So with the mobile vaccine operation, they gave those community-based organizations who are hosting kind of a private registration code. So that really kind of helped with those efforts. And I think as Roxann talked about, continuous staff training, transportation planning in the field, just in time. This continuous site staff training and transition planning, so this was just -- it wasn't just kind of a one-and-done. I think throughout the operation, what we saw is just a tremendous turnover and changing of staff, sometimes daily. So that would either be through DoD staff, Department of Defense staff, contractors, that type of thing. So the idea of disability integration to provide ongoing just in time in the field training on auxiliary aids, disability awareness, those type of things were critical. And kind of one thing we did as a best practice was to identify a super user among those groups. So specifically Department of Defense with kind of that chain of command, it all has to be approved top down. And so how do we identify those super users to, again, carry in that message if by chance that one day when there is a staff change that Disability Integration Adviser is not there, there is a staff that can carry on that message and especially as we transition through. Next slide.

So just to communicate to force multiple site event information. Asking partners interested in hosting mobile events about their plan to outreach to individuals was key. It's beyond just kind of sending an email or a text. Oftentimes these folks were calling folks by the phone, putting it in their newsletter, social media, flyers. So that was a really promising practice, the message coming from those entities and not from government entities, and building that local capacity around disability access and leveraging federal funds. This was key for us in these county areas, some of the

Region X states are not as robust with accessibility planning or proactively thinking about accessibility planning, especially when we get to the local level. So I think this was a big opportunity to get to work at the local level specifically in Yakima and provide the insight on how do we build auxiliary kits, can we purchase those, about signage, about interpreters? So that was really a promising practice to kind of build that capacity around disability access, and that was made possible through the federal funds. Vaccine events, so another best practice, it wasn't just come get your shot and go home, where we saw more success with mobile events is if they were paired with another overarching event. So whether it was a health fair, we saw a lot of this with our Latinx migrant seasonal workers. There may have been folks advocating from labor and industry, providing health information for those communities. So food boxes, whatever that is, if they could incentivize or make it more of an event, it was always more successful. And then the overall increased collaboration among public health and emergency management. This was key. So I think we have a lot to learn from our public health partners and it was interesting to kind of see that collaboration I think in emergency management. We typically try to get things done quickly and efficiently and then in public health I think there's more of a methodical and thoughtful approach. So it was nice to kind of see those two worlds collide.

Next slide.

So lessons learned, working smarter to develop partnerships in rural communities. We need to break down those silos, I think as Vance had said. So finding those communities that match, that have a larger equity mission. They approach across -- they have that silo breaking view, and their approach across programs in areas of outreach is broader. They coordinate with small, large, nonprofit organizations, and they have that ability to widen their circles of awareness and influence. That was key for People for People. We need to understand how communities consume and get information. I think the COVID information overload has been huge. Use of language that is inclusive, easy to understand. We need to communicate how we're adapting our approach and the priorities. We need to prioritize translations for communities whose first language is not English. And as always and super critical and sometimes we often forget it is we want to highlight the accessibility features on the flyer, the signage, the radio spots. We really need to break down that cycle of exclusion. I think understanding how communities consume and get that information is key. And then collaborative cross-partner and cross planning is key. I think that intersect with the Latinx migrant seasonal worker, advocacy agencies, organizations and disability, disabilities overarching, doesn't matter race, ethnicity, that was really key for us, so beyond just working with our Centers for Independent Living, aging entities, it really kind of opened our eyes and presented a lot more opportunity, and then really thinking outside the typical partnerships, looking at the private sector, Rotatory Club, these can enhance operations. And then lastly lessons learned challenges with signage. Signage was a big heavy lift. I don't know if it was just a region 10 issue or not, but we went into local communities, not a lot of resources, a lot of these concepts and information was new. I think we can all benefit from having some type of signage bank. These are not new signs we have at FEMA. They do need to be enhanced. They need to be at a standard size, font, and we need to standardize these a little bit and then make them more generic where they can be used across all sectors and folks can put their logos

and so forth. In both Jackson and Yakima there's limited in person sign language interpreting resources. This was a huge challenge for us. And I'm not quite sure how to remedy. We did have access to video remote interpreting, but sometimes connectivity can be an issue or maybe spotty. When we did have interpreters, we often had to compete be our urban counterparts in Seattle and Portland and often pay for travel and hotel and so forth to get those interpreters to the site. Another big lesson learned challenge is federal versus state assets. So, again, these were not federally operated sites. They were federally supported. So -- and a lot of our sites maybe across the nation we could support with our disaster recovery center auxiliary aid kits, effective communication kits. We did deploy those to Region X but due to the fact we did not have FEMA federal staff work at all the sites, you know, we needed to build that capacity with the state. So one promising thing is that the -- in each of the counties or jurisdictions, they did adopt these kits. So whether it was the Oregon Convention Center, the hospital system purchase add number of kits, the Oregon Health Authority put together over 100 kits to serve all of their disaster -- all of their COVID operations and enhance future disaster operation, and Yakima County and local health jurisdiction purchased their own kits as well. And then transportation. I think we talked about this quite a bit. Transportation in rural areas can sometimes be challenging. Routes are not as robust. People have to make a number of transfers. So it is trying to find those community-based organizations who have that built into their system and how can we incorporate them into the overall operation. So, again, that People for People, they provided paratransit services and were very instrumental in helping to augment the mobile vaccine areas.

>> LEWIS KRAUS: Danielle, this is Lewis, I'm going to have to stop you here. We've crossed over the 1:00 o'clock ending point here and I want to respect people's time. Can we move to the last slide? Did you leave contact information for everyone? For the speakers, I mean? You can go to the last slide.

>> This is the last slide.

>> LEWIS KRAUS: All right. Very good. Well, thank you. Sorry that we didn't really have much chance for questions, although there weren't very many questions anyway. If you didn't get a chance to ask your question, you can contact -- if it's an ADA question you can contact the regional ADA Center. And Vance and Roxann and Danielle, if you want to put your contact information in the chat window, if people had specific questions, they can follow up with you on that. And for everyone, you will receive an email with a link to an online session evaluation. Please complete that evaluation for today's program. We value your input and want to demonstrate the value of this to our funder. And we want to thank all of our speakers today for sharing their time and knowledge with us. It was obviously very interesting and involved as we ran out of time. And a reminder that today's session was recorded and will be available for viewing next week at ADApresentations.org in the archives section. Our next webinar will be on July 8th, and for that we will be joined again by Linda and the FEMA Office of Disability Integration and Coordination as well as the individual assistance team for presentation on personal assistance services guidance in disasters. We hope you can join us. Watch your email two weeks ahead of time for the announcement of the opening of that

registration. Thank you so much, everyone, once again for staying with us here. And thank you all, all the speakers, thank you very much for your time, and the great information that you imparted today. It was really good, the vaccination system worked very well as we can tell. All right, everyone, have a good rest of your day! Bye-bye!