INDEPENDENT LIVING RESEARCH UTILIZATION

DISABILITY‑BASED DISPARITIES IN SOCIAL DETERMINANTS OF HEALTH AMONG WORKING‑AGE ADULTS:

EVIDENCE FROM THE 2018 NATIONAL HEALTH INTERVIEW SURVEYS

SEPTEMBER 30, 2020

Presented by Jae Kennedy

 >> MEGAN GILLESPIE: Good afternoon, and welcome, everybody. My name is Megan Gillespie with ILRU. This webinar is being recorded and will be available on demand within a few days. Today you'll have the opportunity to ask questions during the webinar, and we do have the number to your events. First of all, in the Zoom platform, one of the options is Q & A. You do an option there to ask questions during the presentation. If you have a clarifying question, please feel free to ask it during the presentation. Otherwise, we will wait for the question and answer after the presentation.

 Closed captioning is available. You can view the captioning by selecting the CC tab on the Zoom platform. You can make the box larger by clicking the box and pop out corner. If you would still prefer a larger font, I recommend you check out the full screen CART attachment. You can find the URL in the chat on the main webinar screen.

 Also, if you're on the full-screen CART captioning today, there is a chat option there. We will be logged into that chat and you can ask questions your there as well. We will be sure to monitor them during our Q&A break.

 Finally, when we finish up the day, an evaluation form will open up on your screen, and we hope you'll give us your thoughts, and thank you in advance.

 Now, I'd like to introduce our presenters. Dr. Jae Kennedy, chairs the Department of Health Policy and Administration at Washington State University. He began studying disability policy at the World Institute on Disability in 1989, and completed his doctorate in Health Services and Policy Analysis at UC Berkeley in 1996. His research focuses on understanding the health and employment disparities experienced by people with chronic illness and disability, and on developing effective programs and policies to lessen those disparities. He has published over 50 peer-reviewed journal articles, and received the Switzer Distinguished Research Fellowship from the National Institute on Disability and Rehabilitation Research in 2000.

 Our other presenter, Liz Wood, (indistinguishable), is an Assistant Professor and a research scientist for the Collaborative on Health Reform and Independent Living on the Washington State University research team. Prior to her graduate work, she served as the administrative coordinator for the Washington Rural Health Association, a nonprofit advocacy group.

 With that, I will turn it over to Jae and Liz.

 >> JAE KENNEDY: Thank you. I really appreciate you all joining us today. I will apologize in advance. Obviously, we're doing this from our home computers here, and you may hear dogs barking or the screen cuts out on us, something like that. I'm quite confident that whatever happens, this will go more smoothly than the presidential debate did yesterday.

 I can't see myself anymore, but do you see this big, red rock behind me. Megan, do they see pictures of me now?

 >> MEGAN GILLESPIE: I see it, yes.

 >> JAE KENNEDY: This is a picture I shot on Saturday. My son and I final broke quarantine and went to my parents' in southern Utah. That's why my nose is sunburned. But I'm pointing this up for a PSA here.

 As you know, Utah has one of the highest per capita rates of new infections in the country right now, and I was nervous, particularly visiting my elderly parents. We had a great time. We hung out at my family ranch which is where this picture was taken.

 When we left to fly back to Spokane on Sunday, I'd been coughing and sneezing at the ranch and I assumed it was the dust and the elevation and the dry air, but we were stuck in the airport for five years, wearing my little mask, and was pretty miserable, and I was coughing in bed, woke up kind of cruddy, so I bit the bullet and got a COVID test on Monday afternoon and I got a call back, a negative, but -- the point here is we really need to take this seriously. This is my second COVID test, and it's getting a little better now. They only went halfway up rather than into the bottom of my brain. But just to make sure I hadn't exposed my parents, wasn't exposing my colleagues when I got back here, I thought it was important to self-quarantine and get tested. It's a pain, but you don't want to be infected with COVID.

 My wife was one of the earliest cases in the county and was miserable and still dealing with some symptoms. So please, protect yourself and encourage your colleagues to do the same. Now, that's my little PSA and we can go into the presentation itself.

 Next slide, please. So I'm afraid this is actually the last day of Collaborative on Health Reform and Independent Living. It ends at the end of September. This was a five-year project I've been working on with groups like ILRU, the University of Kansas and George Mason and the National Institute on Disability and with NCIL and April, and the National Institute on Disability, Independent Living and Rehabilitation Research. Still struggling with the latest acronym. This was done during the grant and need to seek out additional support in this area.

 Next slide, please. So the report we're going to be talking about today is based on analyses of the 2018 National Health Interview Survey, and we used this survey to look at rates of work limitation, activity limitation, functional limitation, and disability program participation among working aged adults.

 And then we look at rates of disability in specific subpopulations of the adult population. And kind of the bulk of the presentation, we're going to discuss how Social Determinants of Health differ among working-aged adults with disabilities as opposed to without disabilities, and spent most of the time looking the healthcare demands social determinants, that we cover all of them. And end with a recap and calls to action for researchers and groups.

 We meant to have the full report up, but as I said, I've been self-quarantining so I haven't been in the office to put it online. The whole report should be available for you to download in rich text, PDF, and Word formats. If Liz has had right, at least one set of the figures is optimized for people with color-blindness.

 Next slide. We're going to start by just defining our terms here. Talking about health disparities and Social Determinants of Health through this facility's perspective.

 Next slide, please. So what are health disparities? Health disparities are a kind of difference between populations, the difference in health between populations that closely linked with social or economic disadvantage. So health disparities adversely affect groups of people that experience greater social or economic obstacles to health and more broadly, community participation and employment. These are typically minority groups that experience disadvantage on the basis of race and ethnicity, religion, socioeconomic status or gender, sexual orientation, geographic location, rural or urban or a portion of the country, and finally, disability.

 So this is kind of the Healthy People 2000 definition, also being carried forward to the Healthy People 2030 initiative, that disparities of certain classes held differences. They're important to understand the health of the nation and we need to focus carefully on disparities between different populations in the US.

 Next slide. So unfortunately, in this relatively narrow area of public health research, people with disabilities aren't a priority. At least in the US. The United Nations describes people with disabilities as the world's largest minority, but the US research agencies don't spend much time addressing health disparities in the population. The National Institutes of Health designates a number of different populations as health disparities populations -- racial and ethnic minorities, socioeconomically disadvantaged populations, sexual and gender minorities, and rural populations. But people with disabilities are not on the list, and we would argue that's a mistake.

 Next slide, please. So we're going to do our best, kind of complicated and higher-level, but I would say in most public health research, disability is read the as a health outcome, like infection rates, or injury rates, or self-assessed health. But disability is a minority group status. It's disparate. It's conceptually distinct from that. We argue that the focus on disability is kind of a health-outcome measure a variability, problematic, and we should be looking at disparities and it's closely linked with social or economic disadvantage. Now, people with disabilities might have conditions as a result of their health or condition or injury. But the action as the minority group status of external factors that are referred to as Social Determinants of Health, and we'll be addressing those in a moment.

 Next slide. Making sure there's no question about this terminology here. So to start with the findings, we identify a subpopulation of adults, the National Health Interview Survey, and we know here that disability is common in the adult working population but even more among certain minority groups.

 Next slide, please. So we reclassified working-age adults as disabled if they or their proxy report any of the following. Limited or unable to work due to a physical, mental, or emotional condition, need the help of another person with self-care or routine chores, having difficulty walking without special equipment. If they have difficulties remembering or periods of confusion or if they're enrolled in a federal disability program, specifically, SSI or SSDI.

 Next slide, please. So based on our analyses of the second most recent National Health Interview Survey, we estimate that approximately 13% of this broad disability category, 25 million working-age adults, the remainder, 87% of working-age adults, do not classify as having a disability under this.

 And we tested the weighted estimates of the group of people with disabilities, working-age people with disabilities to the group of people without disabilities. And we tested those statistically using the Rao-Scott chi-square tests, really a technical thing, but what it's doing is correcting for weighting strategy within the survey.

 Next slide, please. So one of the things we did in the survey is look at a variation of race and disability within other minority populations. And this is part of the -- kind of the broader concept of intersectionality, which is that people are often a member of more than one group, and the sources of those -- that consequences of those group memberships may interact in ways that affect their health and health outcome.

 I assume most of you are familiar with the term, but if you want discussion of that, we can address it in the Q&A.

 So we find that this is consistently higher in certainly racial and ethnic minorities, highest observed disability rates were American Indians and Alaska natives, 21%, also high in people who reported multiracial affiliations and those would were Black or African-American. Those among non-Hispanic whites were close to the national average and disability rates were lower with Hawaiian/Pacific Islanders Latinx and a lot of other things under disability.

 Next slide, please. So disability is also more common among people who identify as gay or bisexual. Disability is more common among folks living in the Southern US than among other reasons of the Midwest, Northeast, or West. And disability and race are actually lower for noncitizens and immigrants. So there's a possibility that that's due to -- I don't know. Older Americans' health behaviors that people pick up the longer they remain in the US. It might be something about the younger average ages. But it's potentially important because one of the concerns about, you know, letting immigrants into the big stressor or social welfare, but this suggests we could increase immigration and these folks would be relatively less likely to tax our disability programs, I guess, as far as DI.

 Next slide, please. We didn't find any difference in rates by gender in this working-age population. We know that women live longer than men, and consequently, they could have higher rates of disability, but there's no statistically different differences between men and women. But we did look at intersecting disability groups, like women of color with disabilities. So there may be some gender interaction that we're not picking up in this presentation.

 So for researchers and policymakers to truly understand the needs of these populations, disability must be a component, for them to understand the need of the disability community, intersection identities must also be a component.

 You need to look at disability in relation to other group memberships to really start to understand how social determinants play out in public health.

 Next slide. So really, the consistent theme in this report is that people with disabilities are consistently disadvantaged really across all domains across Social Determinants of Health. Next slide. And I think this is from Healthy People 2020 again. Yeah. Social determinants in that initiative are described as conditions in the environment in which people are born, live, learn, work, play, worship, and age, that affect a wide range of health, functioning, and quality of life outcomes and risks. in other words, social determinants are outside of the environment, in the home, the neighborhood, the community, or their region or the country.

 And Healthy People 2020 classifies social determinants in five major domains -- economic stability, education, neighborhood and built environment, social and community context, and healthcare.

 This is an important set of distinctions here. A lot of people think just about healthcare -- the drugs and treatments and services that we provide to help manage a population. But one of the insights in epidemiology, there's class and socioeconomic status and those habits much or more to do with the population of an individual attribute.

 Next slide, please. Can I get the next slide? There you are. So first, in the economic stability domain, people with disabilities working with people with disabilities are a lot more likely to be poor than those without disabilities. So it's a pretty stark difference here if you look at annual household income. Over a quarter of working-aged adults with disabilities have incomes below the federal poverty line compared to about 8% of people without disabilities.

 In a related point, people with disabilities are significantly less likely to be working in paid work, compared to people without disabilities. 38% versus 85% for those without disabilities. Adults with disabilities are more likely to report being food insecure.

 Next slide. We've got some pretty standard measures of education here. Just educational obtainment, but the statistics are clear with other work, people with disabilities are more likely to report never having completed high school, 18% versus 10%. Slightly more likely to report attending some college, but are half as likely to report graduating from college. People with disabilities are also less likely to have a graduate degree.

 There are a lot of reasons for that -- access to accessible, high-quality education is a challenge, 504 and the IDEA. So major educational disparities.

 Next slide. This is really interesting, particularly for folks that are trying to improve accessibility of the built environment. Healthy People 2020 categories break out neighborhood and built environment. Unfortunately, they don't get into the health environment at all, but how people perceive their neighborhood.

 And people with disabilities are over twice as likely to disagree with statements like people in this neighborhood help each other out. People in this neighborhood can be trusted. This is a close-knit neighborhood. So it appears that these people with disabilities perceive that their neighborhoods are less supportive to their health and independent living.

 Next slide, please. Social and community context domain is really -- can be defined broadly in terms of, you know, community resources, infrastructure and stuff like that. Again, the HIS is a person survey, so the only information we really have is about household composition of variable status. But we do note that the households of working-age people with disabilities can be quite different from those without disabilities.

 People with disabilities are less likely to live in households with children. Less likely to live with a spouse or partner, and more likely to live alone. They're more likely to never marry, and those who do are more likely to become divorced, separated, or widowed. So they don't have the same level of support as people without disabilities.

 Next slide. So this is the last kind of domain, health and healthcare. So we found, broadly, the people with disabilities experience healthcare disparities, not just because they're sick or they have a chronic disease or an injury that needs to be taken care of. It's also essentially attributable to their minority group status from the institutional discrimination, disadvantage that they experience.

 Next slide. I'm sorry, next slide, please. So it's important to tease out disability-based healthcare disparities from kind of more predictable disability differences in health. But the same main conditions will cause folks with disabilities to interact more with the healthcare system and the same conditions are going to decrease their level of health. But there's observable disparities in coverage, access, and satisfaction that aren't necessarily, solely or primarily the result of the healthcare condition itself. So we're going to compare here in the next series of slides rates of use of health services, problems with access, and satisfaction with the services they receive.

 Next slide, please. So people with chronic conditions use more healthcare. That's expected and that's what we found. People with disabilities go to healthcare providers much more frequently. When you think of the number of doctors, for example, nearly half of people with disabilities reported going to the doctor at least five times the previous year compared to 16% of those without disabilities.

 People are disabilities are more likely to go to the ER, and more likely to go to the ER multiple times. When you look at utilization of specialists, people with disabilities with a lot more specialist care with one potential notable and troubling exceptions. Women with disabilities are less likely than women without disabilities to see a gynecologist or obstetrician. If you want to discuss that, we can do it in the Q&A.

 Next slide. So one of the big differences in people with and without disabilities in the working age population is their source of health insurance coverage. Working-age adults with disabilities are less likely to receive private, employer-based health insurance. Because of their low workforce participation, they are much more likely to be category eligible for public health insurance programs like Medicaid and Medicare. And because they're more likely to use the health programs, they're less likely to be uninsured. And we have dozens of these bar graphs in the report, but we tried to keep these out of the presentation.

 But next, there's a bar graph with insurance coverage.

 Sharon, can you switch to the next slide? Thank you.

 You can see over 70% of working-age adults without disabilities are getting private insurance, primarily through their employer. And in contrast, the most common source of health insurance coverage for adults with disabilities is public insurance, mean Medicare and Medicaid. You can also see the uninsured.

 Next slide, please. Sorry, I'm trying to keep up with the chat. It's distracting.

 People with disabilities are more likely to report difficulty finding a doctor. 6%, report difficulty finding a doctor, compared to 3% without disabilities. But people without disabilities are likely to seek out and identify medical care for preventative services and usual healthcare. So in other words, because of their chronic health conditions, it's important for them to have a primary care provider, and they go through the effort of making sure that they have one. But that search is often difficult.

 And people with disabilities, presumably, because of their low incomes and the types of insurance that they have, report that they have disability paying for some of the services and they're much more likely to keep needed medical care, definitely care, not fill or refill prescription medications, not get prescription eyeglasses or to get needed mental health services because of the cost of those services. if you look at the percentages here, it's 2 to 3 times more likely that you're not going to get a needed health service because you can't afford it.

 People with disabilities are much more likely to delay the care they need because of cost as well as long wait times, and particularly here, lack of transportation. So in other words, access is a real problem for the working-age population.

 Next slide, please. So lower rates of uninsuranced among people with disabilities does not translate to fewer concerns about healthcare costs, which suggests that people feel underinsured. Even though they have insurance, they can't pay for things they need. And people with disabilities are significantly more likely to report problems paying medical bills or having to pay these bills off over time.

 Also, when you ask about their concerns, they're nearly twice as likely to say that they're very worried about not having the resources to pay for a serious illness or injury. And more than twice as likely to say that they're very worried about not being able to pay for regular medical costs.

 Next slide, please. If you look at satisfaction rates, people with disabilities are more likely to say that they're very dissatisfied with their healthcare over the past year, or somewhat dissatisfied. This last bullet point, we hypothesize that one of the reasons that people are less satisfied with the healthcare they receive is because they -- every time you go to the doctor you have the opportunity to be annoyed by the wait times or the paperwork or something else. So given that people use more healthcare if they have a disability or chronic condition, it's probably not surprising that they are more likely to be frustrated with that system.

 Next slide. So the implications of the study, and next steps for research and action are as follows.

 Next slide. Again, over 25 million people age 18 to 64 in the US have disabilities, and they're a diverse and complex population. In particular, disability prevalence is high in certain working-age populations, including immigrants -- okay. Sorry. That's a typo there. Disabilities is actually more common among nonimmigrants, black and indigenous people of color, and people who identify as gay, lesbian, or bisexual.

 They are disadvantaged across multiple domains of Social Determinants of Health, poorer, less food-secure, less educated, less likely to be complied, more likely to live alone and have frequent healthcare problems.

 People with disabilities constitute a minority group that is disadvantaged in every domain of Social Determinants of Health. It's clear that disability overlaps significantly with other minority groups who experience health inequity, and experience worse access to healthcare, a higher burden of care and costs.

 Next slide. So the research implications is that I think are fairly clear, but important. Researchers in public health and in the field of health and healthcare disparities really need to engage with disability as more of an outcome measure. It's not a health status outcome. It's a group membership category. So it's really important to include disability in research as a potential risk factor. The minor group membership and not just an outcome measure use. More technical, research methodology terms, disability needs to be treated as an independent variable of analysis rather than as a dependent variable.

 This is more broad meta commentary, but with the CHRIL and other projects, it's important to engage whenever possible with members of the disability community and not just researchers with disabilities, like the folks in the CHRIL, but also with advocates and consumers and regular folks that are living with health system and society trying to understand what they're going through, you need to ask them and you need to engage them, early and consistently, and we need to conduct research that ensures that disability is always understood in terms of its intersections with other factors that predict health, including membership in other disadvantaged populations.

 Next slide, please. From a policy perspective, we need our research institutions to support disparities research on people with disabilities. And it's not just the NIH formally recognizing people with disabilities as a category. That seems like more of a political point. But what really matters in the public health research domain, we need to make this a priority for funding and encourage disability-focused research and disability research by people with disabilities looking at health and health disparities, healthcare and healthcare disparities. I'm sorry.

 Now, I would point out that this is -- there are all kinds of -- most of the federal government already does this. We have strong civil rights laws protecting people with disabilities just like we have strong civil rights laws for other minority populations. So another of those,

 the Americans with Disabilities Act, recognizes, explicitly recognizes people with disabilities as a minority group that requires special civil rights protection because they're subject to systematic bias and description, in housing and hiring and transportation and a lot of other -- education, and we need to look at that in terms of health and healthcare too. It's not like this is anything radical. The federal government already does this, but we don't see groups like the National Science Foundation or really the National Institutes of Health looking at disability this way, and that needs to change. There are also foundations who are not doing a particularly good job on that.

 So other minority groups are the focus of the research, population-specific disparities research and looking at the differences between gender and race or socioeconomic status and orientation and need to add disability into this mix if we're really going to get a clear picture of what's happening in the subset of populations, most importantly including people with disabilities.

 I don't know if that's my last slide or not, Sharon. Okay. Conclusions here. Kind of a final takeaway point, the 21st century has brought renewed research and policy attention to the health implications of social disadvantage more minority populations, and that's a significant change in public health, and that's a good thing. We created the National Institute on Minority Health and Health Disparities, specifically looking at this issue, and certainly, our work around Healthy People 2020 and Healthy People 2030 helped solidify this thing.

 But between membership categories, it's not well understood and needs to be investigated. So one of the largest and most disadvantaged groups, i.e., people with disabilities, is still missing from a lot of this research. So we believe that it's important that research institutions and universities and government agencies and foundations invest in a program of disability-based research as a step toward creating a more equitable and efficient healthcare system.

 Next slide, please, Sharon. Or is that my last slide? Q&A. Okay. Kind of rushed through that. I apologize if I frustrated the captioner there. It's hard to talk to people with no feedback. But please, if you've got any questions or comments, I'd be delighted to entertain them at this time.

 I guess first I would just ask Liz, you don't need to unmute or talk necessarily but did I miss anything, mischaracterize anything in these slides?

 >> LIZ WOOD: I did this to Jae by changing up a lot of slides at the last minute. I did want to clarify one thing on immigration. While there does seem to be on effect of moving to the US, being separated from your social circle, being thrown into a different set of health behaviors and all the stressors associated with that, there's also just the simple fact that we consider health and disability when we are considering who to approve for the immigration process.

 So there are both kind of Social Determinants of Health that contribute to what we're seeing in terms of lower rates of disability among people who were not born in the US, but there's also very deliberate policy choices that go in there. I just wanted to clarify that.

 >> JAE KENNEDY: Okay. Thank you. Well, I can see the Q&A here as well as anybody else here. Uninsured -- happened -- Trump is trying to remove the ACA -- if I'm understanding this question correctly, we've seen an increase in working-age adults who are uninsured over the past several years, and that's accelerated, obviously, during the pandemic recession, and I think it's safe to say that if the Affordable Care Act were repealed by the Supreme Court which is going to be deliberating in mid-November, that would have consequences for the entire working-age population, but particularly, people with disabilities because they really need that health insurance to get the services that help them manage their chronic condition.

 >> LIZ WOOD: Yes, specifically, the things we are presenting today are from 2018 data, right?

 >> JAE KENNEDY: Yes.

 >> LIZ WOOD: So this is during the time when repeal and replace was campaigned on, the -- I can't remember the name of the bill that they did. It was terrible. But it was legislative priority. It didn't happen. There were a lot of policy changes happening in general. In general, what we've seen through the window of 2014 when the first Medicaid expansion and change was rolled out through today is people with disabilities are seeing lower rates of un-insurance. They're not seeing the same gains of people without disabilities are because of the different factors of employer-sponsored cover versus Medicaid versus Medicare, and essentially, those gains are starting to level off out of the past few years and part of that has to do with the eroding aspects of the ACA that have been invalidated or defunded.

 >> JAE KENNEDY: I would add to that, that certainly since the beginning of the year with the catastrophic economic condition that we're in right now, there's been a big decline in insurance coverage and a shifting of people from private insurance to public insurance. We really don't know yet how that plays out for people with disabilities. At least using this survey, we're going to have to wait another year or two to get that information. We have information on employment, and disability disparities in employment since the beginning of the pandemic. We would have to infer the implications for health insurance coverage.

 Any other questions, folks?

 >> LIZ WOOD: From Jean, thanks for the softball pitch, Jean. Do you think the disparities in the Social Determinants of Health account for the high rates of COVID-19 infection and death rates among people with disabilities, particularly in nursing homes and other congregate living facilities? What do you think, Jae?

 >> JAE KENNEDY: Yes, I think the disparities in the Social Determinants of Health are a significant factor here. I think most vividly with the extraordinarily high rates of infection and death in nursing homes, you can see that the population is marginalized, institutionalized, placed them in potentially dangerous environments. And we don't have as much information with people living in the community yet, but you would think these would lead to higher rates of exposure to COVID infection with disabilities, you know, reported access problems of all kinds of healthcare, one would suspect that they're also experiencing access problems with PPE, with access to testing, and with access to nondiscriminatory treatment. I mean, our colleague has done some work on editorials, but we have troubling reports that people with COVID in the hospital might be experiencing different and less rigorous or less effective treatment protocols for healthcare disability. It's clearly something to monitor, and it makes the otherwise, you know, intellectual argument, much more urgent and people are dying as a result of these disparities in this population.

 >> LIZ WOOD: Yeah, this question brings up as well that any one piece of this that we want to get at is affected by so many factors. We know that one contributing factor to the high rates of institutionalization is government either at the state, local, federal level not adhering to statute about people being able to live and being supported in the least restrictive environment. But we also know, if you think back to some of the social support stuff we talked about, people with disabilities are less likely to have kids. When you're less likely to have a kid under 18 with you at the time the survey captured it, that kid is not growing up to an adult, which would stay in the home with you. If you're married, to have a spouse who stays with you, and those are also more contributing factors to while you'll see people in institutions, and you can pick any piece out and get into it. What kind of insurance to have and did it come through your job. Do you have good long-term insurance or not? It depends a lot on how much you work, who you worked for, what kind of field it was. Every piece of this is driven by factors that are hard to unpack. But that doesn't mean that it's not worth trying to tease out teach piece so we can address these because they clearly have serious implications.

 Do you have to take the question about the built environment?

 >> JAE KENNEDY: We have some other questions. Helped with that lull, there, Jean. Thanks.

 Does the report capture information on the impact of built environment and its potential impact on health and well-being of people with disabilities. Unfortunately, no. A popular Social Determinants of Health, for the population in general and folks with disabilities as well -- things like sidewalks, parks, public transportation, really include people's ability to exercise, to socialize and to work and it's heartening that this is listed in the Healthy People 2020 and the Healthy People 2030, for Social Determinants of Health, but we didn't look at that and I would encourage the colleagues in the public health more generally to look at that. I'm afraid that's all we can...

 >> LIZ WOOD: So Marilyn had a question about, does your research survey include any of the large homeless population with multiple health needs and/or disabilities in the numbers report with disparities, which is an outstanding question. So we are using the National Health Institutes Survey study which is conducted by the federal government, that did not have as much input as I would like in what they cover. They do reach out to people who live in homeless shelters, but they do not survey with no fixed address. So the answer is, there are some people in these numbers who are considered homeless under the definition of they are qualified to be contacted through this homeless shelter. But if they do not have that resource, they're not reflected here in this survey, and it's definitely a limitation.

 >> JAE KENNEDY: It would be great to break out population of people, you know, but that's – that is not positive with this household survey. That's a significant limitation of the survey.

 Any other questions or comments?

 >> LIZ WOOD: Just tidying.

 >> JAE KENNEDY: Well, I'll sweat for another minutes here. If there are no other questions, I would wrap it up. Back to Jean's question about the impact of COVID on people with disabilities, ILRU worked with us on a survey for the Centers for Independent Living that we administered in I guess April and May, soon after the pandemic really kicked in, asking the Centers for Independent Living how the pandemic had affected service delivery and health, CIL staff and CIL consumers were affected by the pandemic, and we're working now to pull together a follow-up on that number. We're asking them things and the reactions from CIL directors were most by just coping with the immediate challenges of converting to a mostly remote work environment and dealing with just the survival needs of their consumers as far as PPE and medications and groceries and eating and you've like that. We're going to be going back and doing the research on that, on research delivery, and hope to do a second round of our consumer survey, following up with folks we interviewed in 2019 about a whole bunch of healthcare and healthcare variables as well as employment and participation level and other stuff like that and asking them directly, what happened after the pandemic hit, to your life and your work and your living situation and your income. All that kind of stuff.

 So stay tuned for more specific research in that area.

 >> MEGAN GILLESPIE: Okay. Well, if nobody else has any questions, if you do have questions, please put them in the Q&A box now. I think we can probably wrap this up. So directly follow the webinar, you will see an evaluation survey on your screen, and we do take your feedback seriously. I think that's it, guys. Thank you so much for joining us today, and we will see you again in our next event. Thank you, everyone.

 >> JAE KENNEDY: Thank you.

 >> LIZ WOOD: Thank you, everyone.

 (End of session at 3:54 p.m.)