NEW MEXICANS WITH DISABILITIES:
COVID-19 AND ACCESS TO HEALTHCARE, EDUCATION AND EMPLOYMENT

2023

NM Governor's
Commission on Disability

PRESBYTERIAN
phs.org

CONTENTS

BACKGROUND

In 2020, the New Mexico Governor's Commission on Disability (GCD) conducted a series of **seven** focus groups with New Mexicans with disabilities (cognitive, physical and mental health disabilities; blind/visually impaired, deaf, hard of hearing and deaf-blind) to understand some of the barriers they experienced related to their disabilities and pandemic restrictions that had been enacted because of the COVID-19 pandemic.

Some key understandings and barriers people with disabilities face arose from those conversations discussing the nine themes – technology, healthcare, transportation, employment, education, social experiences, access to food/supplies, housing and voting – and the Governor's Commission on Disability realized it needed to expand the reach of this input to estimate the impacts of these issues on a larger scale.

The purpose of the preliminary report completed in early 2021 was to provide a snapshot of the effects the COVID-19 pandemic, shutdown of programs and services, and social distancing and masking mandate had on people with disabilities. This will in turn provide an opportunity to correct the deficiencies and provide information to the wider public about recommendations for further support to this marginalized community.

The preliminary report's findings were limited in scope because only 51 members of the disabled community participated in this project. GCD realized we needed a more complete, statewide study that reached communities not included in the preliminary research. We wanted to reach out to underserved communities of individuals with disabilities of all types, all ages, all race/ethnicities and all regions to be included in the study that were affected by the pandemic, plus their family and caregivers who may provide daily support.

In 2021, the Disability, Access and Functional Needs (DAFN) Coalition and the New Mexico Disability Emergency Planning Advisory Council (NMDEPAC) members gave support to a GCD staff member to further this study. The DAFN Coalition and NMDEPAC were an asset to creating an accessible survey in different formats, including suggestions and assistance in marketing the survey to the disability community across New Mexico.

GCD approached Presbyterian Healthcare Services (PHS) Community Health Department in the fall of 2021 as a referral from UNM Prevention Research Center to begin the study. After months of working with the PHS Institutional Review Board (IRB), the study was approved conditionally. Further development of the study led to adjustments in the survey tool, including the expansion of survey tools to increase accessibility. The survey officially went live on August 15, 2022.

This project was approved by the Presbyterian Healthcare Services IRB.

Methods

In conjunction with the Governor's Commission on Disability, we developed a survey to efficiently gather input from the disability community about their experiences with healthcare, education and employment. The survey was an iterative process and started from the key learnings from the After-Action focus groups. Review of the survey narrowed the scope of the questions to make the survey as short as possible.

The survey was developed in Qualtrics, using the embedded recommendations on accessibility.

The survey was open for seven months, from August 15, 2022 to March 23, 2023. Analysis consisted of collecting frequencies of pre-determined responses from multiple choice questions to identify common needs and experiences among survey-takers. These pre-determined responses, which were accompanied by opportunities for additional text entry elaboration, were developed based on the findings of the initial After-Action focus groups. For most questions, survey participants were able to select multiple options depending on what applied to their situation.

An Emphasis on Access and Equity

Ensuring the survey was accessible to as many people with disabilities as possible, we went through an extensive process to offer the survey in multiple formats. The landing page of the survey presented participants with the option to select which format they wanted to use to participate.

American Sign Language

We worked closely with the New Mexico Commission for the Deaf and Hard of Hearing, which developed a series of videos in American Sign Language (ASL) to accompany the written questions so deaf people who use ASL could have a mode of questioning that may resonate more with them.

Screen Reader Compatibility

We worked with the New Mexico Commission for the Blind to test the accessibility of the survey and how it interacts with screen readers. They also provided vital input into the survey design and advised on how to address the use of Braille for the survey. We used Qualtrics for the survey, which is considered an accessible surveying platform complete with accessibility recommendations.

Plain Language

To ensure people with cognitive disabilities had access to the survey, we worked with the New Mexico Developmental Disabilities Council (DDC) to develop a plain language survey. The survey was reviewed, and complex concepts were reworded to be more accessible.

Spanish

Through the PHS Translation Services department, we had the survey translated into Spanish to ensure people who primarily speak Spanish would be able to participate in the survey.

Base Survey

The base survey was written at a fifth grade reading level to ensure comprehension.

All partners provided valuable input into the language, structure and methods we used for the language. The base survey was reviewed by multiple parties at the Governor's Commission on Disability, Presbyterian Healthcare Services, and the Presbyterian Institutional Review Board.

Limitations

This study had several limitations. First, survey distribution was based on convenience sampling, which is less than ideal. Survey announcements were made online through listservs and social media posts, with a few flyers distributed in the community. Eighty-three people accessed the survey by scanning the QR code on the flyer.

The second significant limitation was the access of the survey. The survey was available online and, while any individual had the option to receive a paper survey, participating in the survey relied on internet access.

Finally, the survey was long. While we made every attempt to shorten it, with a total of 37 questions, the length may have contributed to the high number of incomplete surveys we received.

Table 1: Survey Completion

	Number	Percent
Incomplete Surveys	118	35.1%
Complete Surveys	219	64.9%
Total	337	100%

Participation

We collected 337 complete and incomplete surveys. Of those, five individuals did not consent to taking the survey and one did not answer the consent question. As a result, 331 surveys were included in the analysis. Additional survey characteristics can be found in Appendix B.

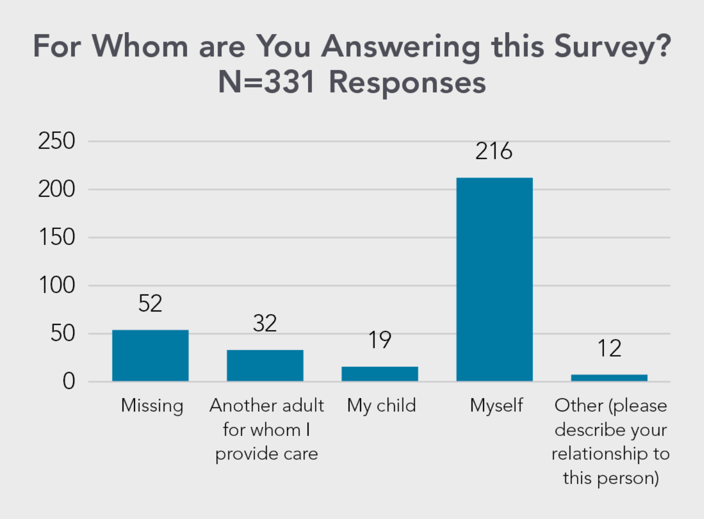
We counted a complete survey as one where the metadata recorded the participant clicking the submit button at the end of the survey. Partial (incomplete) surveys were included in the analysis if the consent field was completed and indicated the participant consented to the survey.

Because we did not require responses to all questions, most responses have missing values. Those values are referenced in the charts and are labeled as "missing n" along with a total survey sample n. We use the notation "n" to indicate a total number of people.

Table 2: Survey Consent

Consent	Number	Percent
I agree	331	98.2%
I don't agree	5	1.5%
Missing	1	0.3%
Total	337	100%

Most people who took the survey (n=216) completed the survey on behalf of themselves (65.2%) and 3.6% (n=12) said they were answering for someone else. Nearly 10% said they were answering the survey on behalf of an adult for whom they provide care. Other responses included service coordinators, agency providers, consultants (we assumed the question was interpreted as "please define your relationship to the person for whom you are answering"), family members and friends.



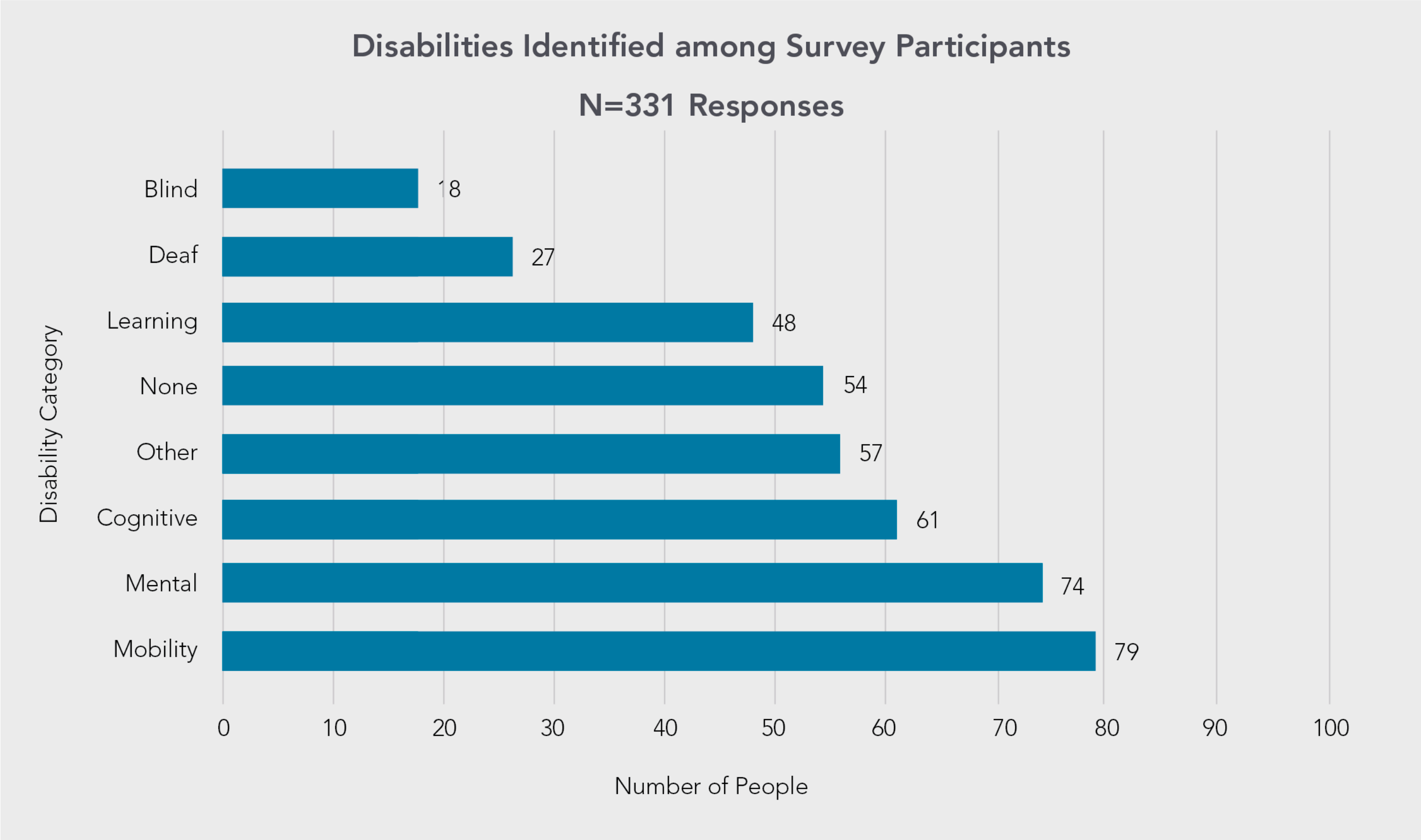
Seven surveys were completed in ASL with the same number completed in plain language. The remainder of the surveys (317) were completed in the base English version. Five Spanish surveys were collected, but all five responses were excluded because the survey-takers did not consent to take the survey.

Participants were asked to self-identify whether they had a disability and to indicate what their disability or disabilities was/were. Participants could select more than one disability and had the option to select "other" and self-identify. We categorized the responses into larger disability categories to protect anonymity and to simplify visualization of the data, but it should be noted that most participants (68.6%) selected multiple disability categories. This is important in understanding the cross-sectionalism of the disability community surveyed in this project. Disability does not always show up as one condition, and that intersectionality should be considered when designing and developing accessibility solutions for the disability community.

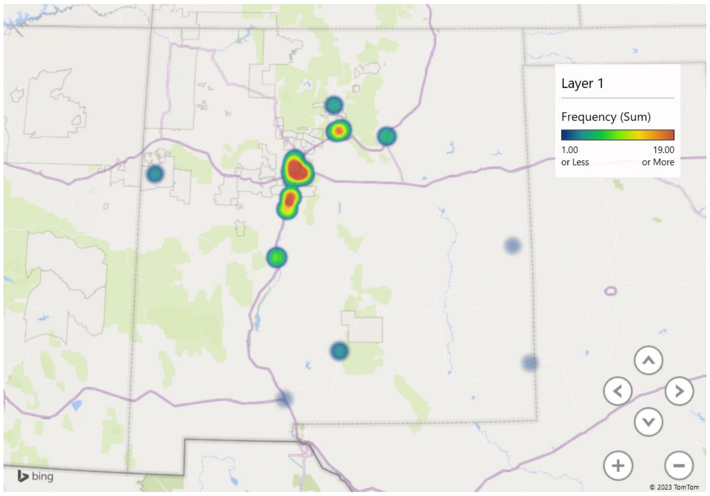
The chart below illustrates the prevalence of each disability category. Each bar of the chart represents the number of people who selected that disability category, regardless of whether they selected additional categories. The totals in the bars should not be added but interpreted as individual data points.

The most common disability identified among our survey population was mobility/motor disability (n=79) followed by mental health-related disabilities (n=74).

- 18 respondents indicated they were blind/ visually impaired.
- 27 respondents identified as deaf/hard of hearing.
- 48 respondents indicated they had a learning disability.
- 57 respondents indicated they had some other disability, which included a variety of self-identified conditions including autism, autoimmune illnesses, chronic fatigue and pain, diabetes, epilepsy, traumatic brain injuries, long COVID, cerebral palsy, heart failure and other specific conditions and syndromes.
- Only 63% of respondents who selected "other" offered additional information on their disabilities.
- Only 24% (n=104) of participants indicated they had only one disability, which left most participants indicating they had at least two disabilities.
- 54 respondents indicated they did not have a disability, which is our gating criterion. These 54 were excluded from additional analyses, leaving a total of 277 surveys for analysis.



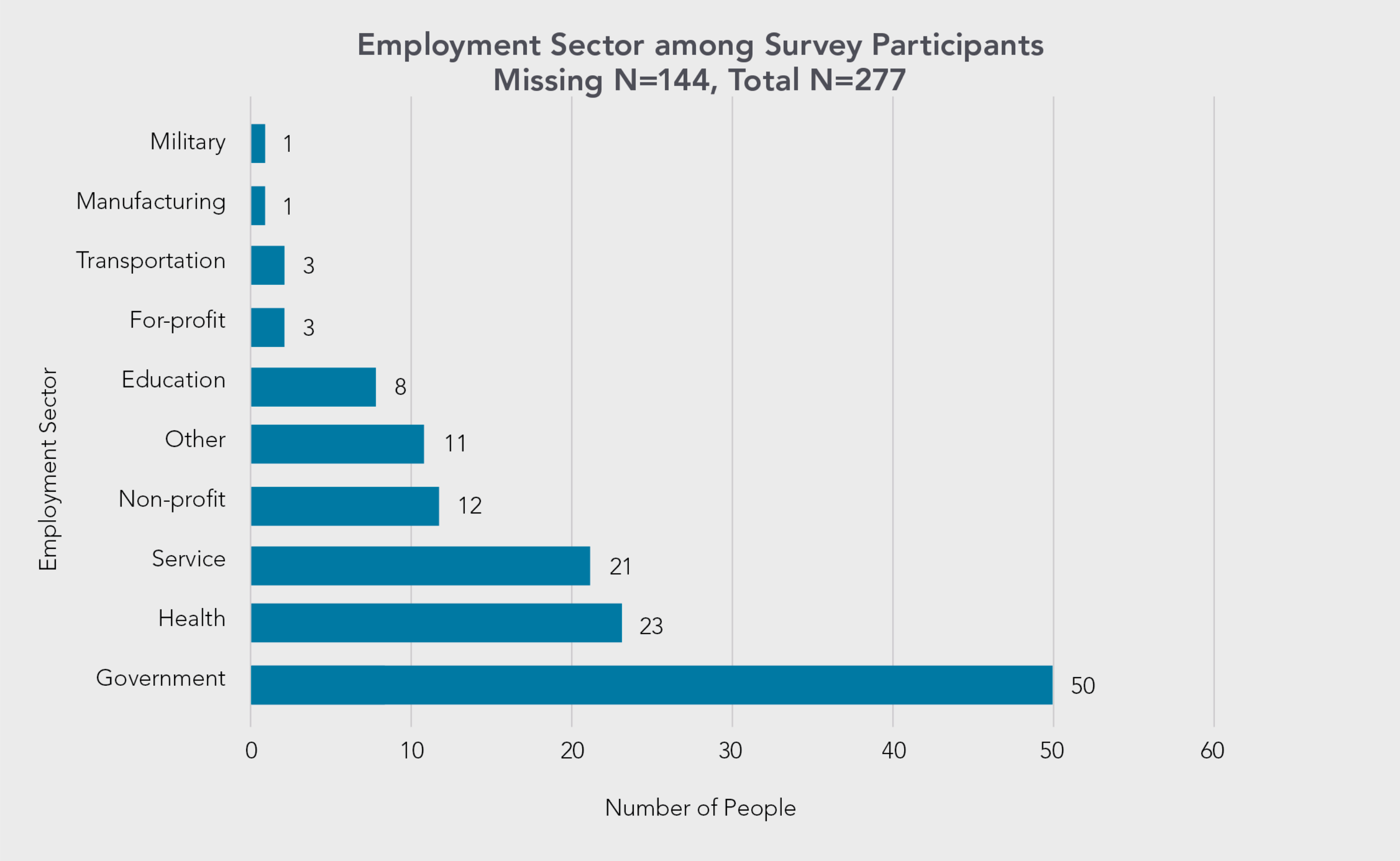
Demographic information can be found in Table 1 in Appendix A. Most respondents who identified their educational level had a graduate degree (n=53), followed by a high school diploma (n=46). Most (n=50) participants work in government and 23 work in health. Other professions identified include academic, food service, administration, law enforcement, engineering and restaurant employees. Most survey-takers were from the Albuquerque metropolitan area.



Employment

The first domain within the survey assessed employment experiences among people with disabilities during the pandemic restrictions. Of the 277 survey responses, 134 (48%) indicated the employment section pertained to them while 26% (n=73) said the employment section did not apply to them.

The chart below illustrates the sectors in which respondents work. Most people who answered the current employment question (in the demographics section of the survey) work for government of some type (local, state, or federal).



Of those who answered the employment section (n=112), most (n=67) said they shifted to working remotely when pandemic restrictions took place. Some had their hours cut, even fewer (16) were laid off and 11 were furloughed. It is important to understand how participants' employment sector relates to their job status during COVID-19 pandemic restrictions.

Job Status During the Pandemic	**Number of Responses**
Furloughed	11
Laid off	16
Had hours cut	18
Shifted to remote work	67
Total	**112**

Remote Work: Barriers

Participants were asked about barriers they experienced in working remotely if they shifted to remote work. The most common challenge identified was issues in communicating with their teams (n=36) followed by technology issues (n=34). Twenty-five people said they had to self-fund their at-home setup, which may have placed a financial burden on people who had to work remotely because of restrictions.

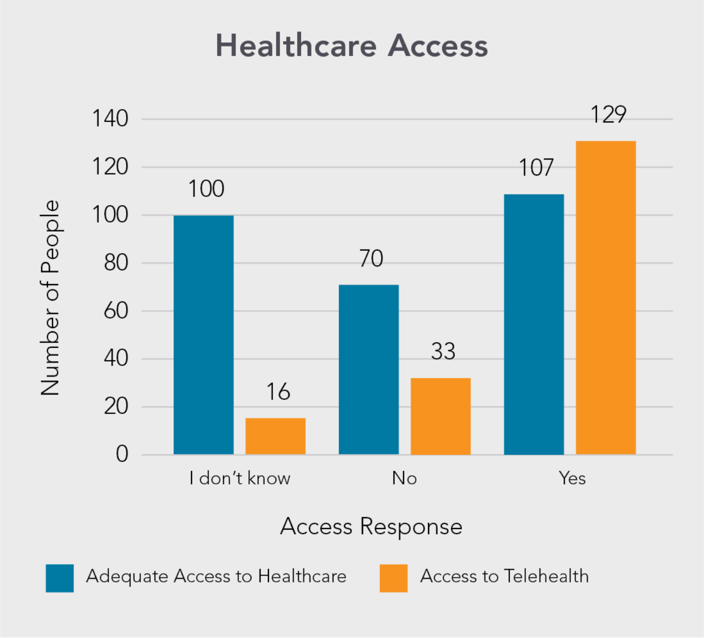
Forty survey respondents indicated that remote work was not offered for them. Eight indicated they did not know if remote work was offered. For those who identified that remote work was offered (n=84), they had the option to provide information on what may have prevented them from working remotely. Responses ranged from issues with access to online databases, still having clients that needed to be seen, the job not being conducive to remote work, and that they were simply required to work on-site. Several participants said they couldn't work remotely because they did not have the ability to have the setup needed to do so. There is indication that remote work was required, but the individual had to retire because their workplace would not accommodate their disability.

To wrap up the employment section, participants were asked what their current work situation was. Most (n=89) said they were back to working in person and 13 said they were unemployed. Eleven indicated they were working remotely and 10 said they were underemployed. Only one was furloughed at the time of taking the survey.

Access to Healthcare

This section sought to understand key barriers to accessing regular care as well as accessing the COVID-19 vaccine. Most participants who answered this question said they had adequate access to healthcare during the pandemic (38.6%) and about a quarter of the survey population said they did not have adequate access to healthcare. About 36% did not answer the question. More people said they had access to telehealth compared to the number of people who said they had adequate access to healthcare.

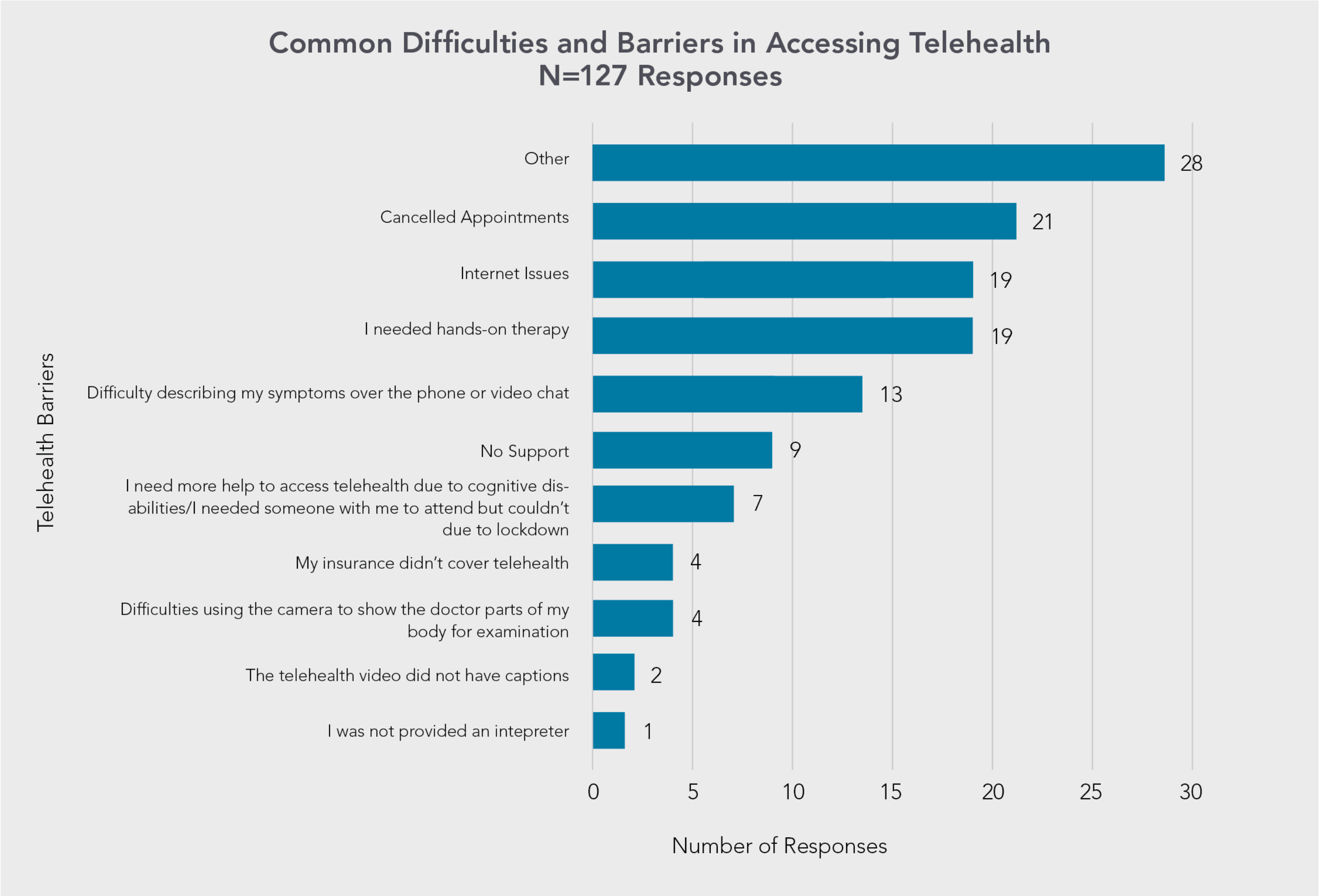
The large number of people who reported they didn't know could be due to confusion around the term "adequate access." We think of adequate access as the ability to get healthcare when needed, but others may have a different definition.



Common Difficulties and Barriers in Accessing Healthcare

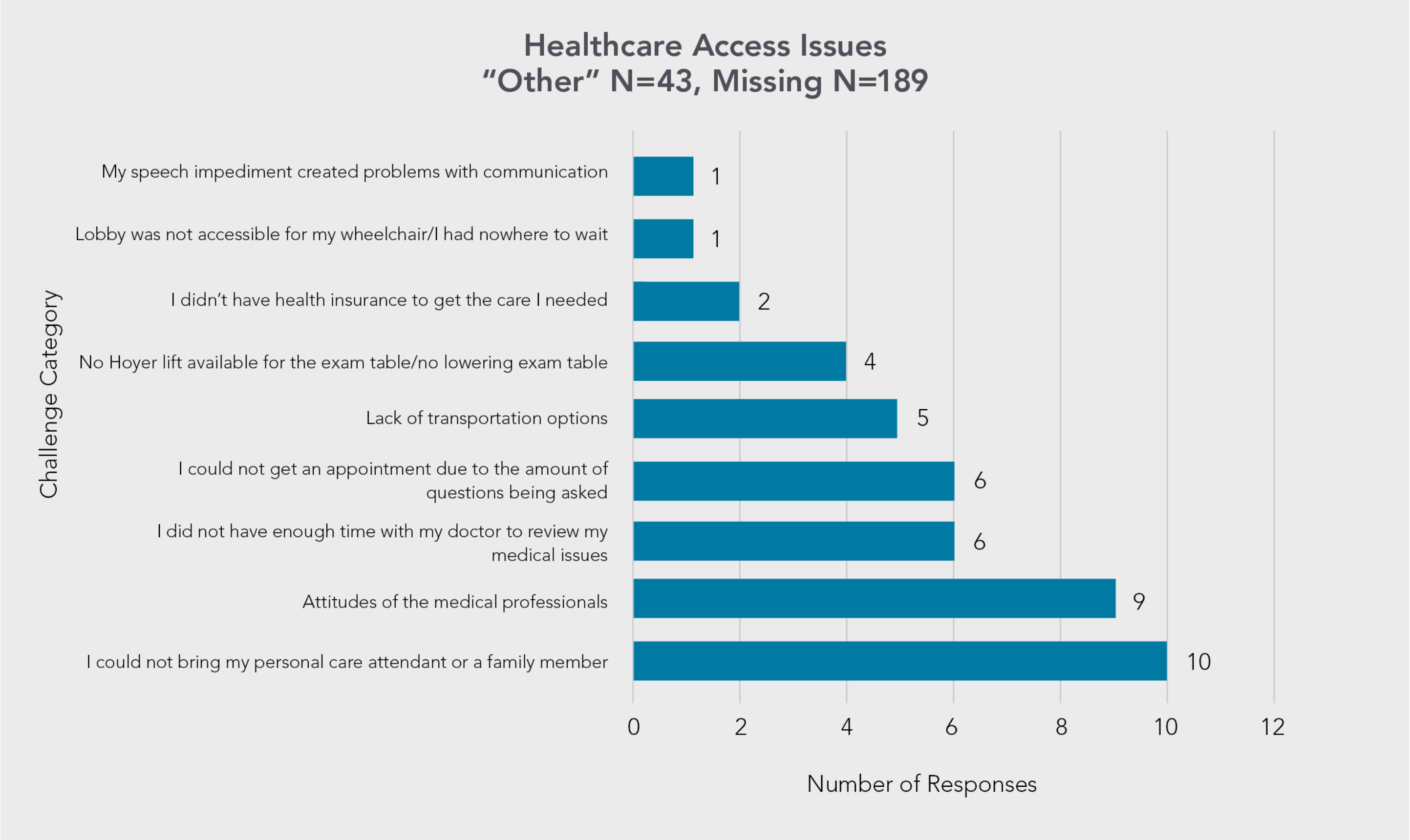
The most common healthcare access issue identified by survey participants was the limit on the number of people who could attend their medical appointments with them – a common COVID-19 restriction to help reduce the risk of transmission. Ten people said they could not bring their personal care attendant or a family member to help them with their appointment.

The second most common issue in accessing healthcare was the attitude of medical professionals. While we did not extrapolate what that meant, we did gain additional insight into some other issues that prevented or hindered access to healthcare. These problems, which participants classified as "other" in the chart below, include limitations on appointments – including long wait times due to provider shortages – no access to telehealth, not wanting to be around others who are sick due to the risk of catching COVID-19, and lack of COVID-19 prevention measures. In fact, 16 people indicated their challenge was lack of appointment availability.



Apart from "other," most participants said cancelled appointments, internet connectivity and needing hands-on therapy were common barriers to accessing telehealth. Technology issues seemed pervasive, including phone line issues leading to misunderstanding, problems hearing and lack of cameras or computers. Others indicated they experienced lower quality of care in their experiences, citing lack of listening to the patient and providers either canceling appointments or delaying appointments while they finish with other patients.

When asked what services were needed to make telehealth more accessible, most (n=49) people indicated the need for utilization of a platform the disability community is more familiar with, namely Zoom. Others indicated they would have benefited from being able to test the telehealth system before the appointment (n=37), having hybrid options for people who need hands-on therapy (n=34), and providing training to personnel on how to interact with people with disabilities (n=29). Other responses focused on the need for better training and expanded access to technology, including more reliable internet.



The COVID-19 pandemic is cited as being fraught with declining mental health among communities. Among our survey population, we found that nearly 30% (n=50) participants who answered the mental health screening question that is used in the Behavioral Risk Factors Surveillance System (BRFSS) said they experienced 14 or more poor mental health days in the 30 days prior to taking the survey. Almost 40% said they experienced frequent mental distress for less than five days in the last 30 days. Most people who experienced frequent mental distress were between the ages of 45 and 54, identified as white (60%), and self-identified as having a mental health disability (12%).

Vaccine Hesitancy and Barriers

To assess the prevalence of vaccine hesitancy among the disabled community with regards to the COVID-19 vaccine, we found that 92.6% of people who answered the vaccine question (n=163) reported they were fully vaccinated, defined as having both Pfizer or Moderna doses of the primary series or the one-shot Johnson & Johnson series. The survey was developed before additional boosters were available and we only assessed completion of the initial shot schedule developed prior to booster development. Almost 5% of respondents who answered the vaccine hesitancy question indicated they would not get vaccinated. Participants were prompted to identify which barriers they experienced when attempting to get a vaccine. The results are summarized in the table below. Participants were able to select multiple answers if it applied to them.

Vaccine-Related Barriers	Number of Responses
The website to reserve a vaccine appointment was not accessible to the blind or visually impaired.	1
Lack of accessible transportation to get to the vaccine site.	3
There were no trained staff to provide the blind and visually impaired to be guided to the vaccine table inside the facility.	3
No interpreters available either in person or through VRI (Video Remote Interpreting).	5
The facility was not accessible, such as no available accessible parking, ramps to enter the facility, wide doors, easy to use doors (i.e., the weight of the door, doorknob easy to use or lack of automatic doors to help) and no accessible restrooms were provided (but they were open to the public).	7
The vaccine site did not allow for a personal care attendant to be with me or did not have one available trained to assist as needed.	11
Other	27
There were no barriers experienced.	111

Other responses included lack of availability and appointment slots, access issues including location, transportation, accessibility of the facilities, vaccine staff lack of training on how to interact with people with disabilities, and in some cases an inability to maintain social distancing. Participants cited issues with the website, getting assigned vaccination appointments that were too far from their house (sometimes in different counties), and the overall rollout of vaccine events and appointments that seemed to be designed without consideration for people with disabilities, including standing in lines outside in the cold, transportation, long distances to walk from parking and long wait times. Finally, religious restrictions and lack of testing of the vaccine on people with autoimmune conditions contributed to people not getting the vaccine.

Education: Self

The education section did not apply to 122 individuals who took the survey. Forty-five people provided information on what type of adjustment they had to make because of pandemic restrictions. Most shifted to remote learning while some continued in-person learning. Six permanently dropped out of school and two dropped out but re-enrolled.

Change in Education Because of Pandemic Restrictions	Number of Responses
Temporarily dropped out but am now enrolled again	2
Permanently dropped out of school	6
Continued in-person learning during pandemic restrictions	8
Shifted to remote learning	29

At the time of answering the survey, seven people indicated they had completed their education; eight people said they were enrolled in remote learning; and another eight said they did not return to their education. Eighteen returned to in-person learning and three were in a hybrid model.

Current Education Situation	Number of Responses
Hybrid learning model	3
Completed education	7
Did not return to education	8
Remote learning	8
Returned to in-person learning	18

Twenty-one people indicated they experienced barriers in remote learning while 23 said they did not. Of the barriers identified, several people cited internet accessibility and other technological issues as barriers to learning remotely. Additionally, several participants said they didn't have support from the educational facility/faculty, including not having any support for tech issues, lack of help from educators in getting work done, some accessibility services being taken away, teachers not being able to spend time to answer questions, no captions on recorded videos, and a perceived reduction in the quality of the education.

Remote Learning – Accommodations – Self

Participants were asked to identify any accommodations they experienced that were meant to assist with at-home learning. Most (n=23) said that none were, while a smaller amount identified a reduction in workload, completing assignments independently outside of class, low student-to-teacher ratio, and extra processing time as accommodations meant to help with at-home learning.

Solutions to Augment Self-Learning when No Accommodations Were Provided	Number of Responses
If the parent is visually impaired or blind and unable to assist their sighted child in doing their work with equipment that is not accessible, use the Be My Eyes app that can see for you to tell you what is there.	1
Have a rotation of family members provide online educational support to student who does not have educational assistance.	2
If there is high-speed internet at home with limited bandwidth, have a rotation schedule to allow for only one person in the household to use the computer at any one time.	9
Other	9
Have two screens to augment learning: one for online class participation and the other for visual information as to what is being taught.	13

Education: Children

Sixteen participants indicated they had a child in education during the peak of pandemic restrictions while 29 said they didn't. The most common accessibility issue or barrier identified was the interference of their ability to give their full attention because in addition to assisting their child with education, they had a full-time job (n=8). Additionally, participants identified they had to provide educational or therapy services themselves that the child would have received in school and that they were not trained or qualified to provide. Six people indicated that regular therapy (e.g., occupational, physical, speech) was hands-on and was moved to an online setting, which was less than ideal. Additionally, educational assistants couldn't be sent to the home to assist the children in remote learning, which forced the parent to step into that role, and classroom-based adaptive tools that the children used in the classroom were not available in a virtual classroom experience, which led to a reduction in the child's educational experience (examples of tools include text-to-speech assistive tools, talking spell checker, etc.). Four people indicated extra textbook materials were provided as well as special scissors or pencils to assist with mobility issues. See the table below for more accommodations provided to children for remote learning.

Accommodations Provided to Assist Child	Number of Responses
Assistive technology that was used in my child's classroom was allowed to be brought home for virtual learning, such as frequency modulation systems, speech-to-text software for deaf, hard-of-hearing, blind or visually impaired students, Braille books, standing desks, wobble stools, touch screen monitors, etc.	1
Occupational therapy materials and supplies to complete therapy virtually.	1
Special scissors or pencils to help with mobility issues.	2
Extra textbook materials to work from and books to practice reading.	4
Other	4
None	27

Social Needs: Transportation

To further identify the impact COVID-19 pandemic restrictions may have had on New Mexicans with disabilities, we screened survey participants for food insecurity and transportation instability. We asked participants if at any point during the pandemic lack of transportation kept them from attending medical appointments, meetings or work, or from obtaining things needed for daily living. Only 12.4% said this was the case (n=41) while 38% said they did not have a lack of transportation that kept them from engaging in the above-mentioned activities (n=126). Nearly half of participants did not answer the question (n=110, 49.6%). While only 12.4% said they had transportation instability, it's important to note that, according to the American Community Survey (2016-2020 five-year estimates), approximately 5.7% of households in New Mexico do not have access to a vehicle.

Social Needs: Food Insecurity

We used the validated two-part food insecurity questionnaire asking if, within the past 12 months, the participants worried whether their food would run out before they got money to buy more or if the food they bought didn't last and they didn't have money to get more. We asked this question because it aligns with best practices for assessing food insecurity. Food insecurity is defined as answering "yes" to at least one of either of those questions. We found that 71% of respondents have food insecurity (n=235) while 96 (29%) do not experience food insecurity. This is an extremely high percentage of food-insecure New Mexicans with disabilities. For context, 13.5% of the population in New Mexico experiences food insecurity (Feeding America, 2021).

Other Barriers Faced

Survey respondents identified additional barriers they wanted to point out or discuss that were not addressed in the rest of the survey or provide more context to some of the barriers or challenges they faced during COVID-19 pandemic restrictions. These responses can be organized into six broad categories: isolation and mental health, healthcare, economy and employment, food, school and miscellaneous. Many of these additional challenges identified overlap categories, which suggests a deeper complexity to the issues. For example, some participants cited isolation in the form of not being able to leave the house because of COVID-19, and therefore were not able to use their EBT cards.

Several participants talked about isolation in two forms: not being able to socialize with their friends, families or loved ones, and not being able to go places and socialize with others for fear of catching COVID-19. One participant discussed the toxic environment that exists between people of differing views on vaccines as a contributor to isolation. Lack of mental healthcare, which spans two categories, was also an identified barrier and challenge during the pandemic.

While participants provided input into many of the common and anticipated barriers in accessing healthcare, they also provided additional barriers and challenges that we didn't cover. These include specific instances of experiencing discrimination, lack of appointments and cancellations, and experiences of medical providers being rude, mean and dismissive toward the needs of people with disabilities. In fact, this was the one topic that was repeated among participants; seven participants cited specific examples of how they were discriminated against, dismissed by providers or felt their providers didn't care about them or lacked empathy.

Four people discussed the need for additional provider training for caring for people with disabilities.

Specific needs identified include the need for more specialists for specific conditions, larger chairs in all rooms, insurance not covering preventive healthcare, issues with pharmacy benefits, and not being able to receive an interpreter at the last minute.

We knew that employment and the economy were important factors to address and assess in our study, and survey participants provided more information about the barriers and challenges they experienced in this area. The most common comment was lack of money: low wages (two participants); challenges accessing childcare; high costs associated with housing, maintenance and heating; and a difficult unemployment claims process that resulted in no response. Other challenges included employers allowing for accommodations for people with disabilities (three participants) and workplaces denying telework. On the other hand, one participant stated they had increased flexibility and productivity during the pandemic that fit their and their employer's needs, but the challenge came with the return-to-office mandate.

As mentioned above, low wages and high cost of goods and services economically exacerbated people with disabilities during the pandemic. Grocery delivery services were cited as being difficult to navigate without assistance. Food price increases and the lack of options for food stamps for drive-up or grocery delivery options made it difficult to get food. This is reflected in the staggeringly high percentage of people who report being food insecure.

Discussion and Recommendations

While most survey respondents said they shifted to remote work during the COVID-19 pandemic restrictions, many were either laid off, furloughed or had their hours cut. This survey revealed the two main effects and considerations from that:

1. Loss of work, including reduction in hours, combined with low wages and rising costs of goods and services, resulted in people not having the ability to obtain what they needed.
2. Those who were able to keep their jobs and work remotely experienced other challenges related to their disabilities, including employers not making accommodations, having to self-fund their accommodations, and overall experiencing added difficulties in carrying out their job duties related to technology issues.

We learned that low wages resulted in difficulties accessing food, transportation and medical care. This employment section taught us the importance of ensuring people with disabilities have the accommodations they need to succeed in work-from-home situations that do not place an undue burden on them if such a mandate is to be implemented. While there are deep-seated systemic issues behind wage gaps and access to unemployment resources in times of disaster, employers, state government and employment agencies can play an important role in easing the way to connect New Mexicans with disabilities with needed resources.

In the area of healthcare, we learned that a significant number of participants said they didn't have access to healthcare or telehealth. Significant access issues included accessibility needs (location, facility interpretation and equipment availability), lack of appointments and providers, and provider attitudes. In fact, when given the opportunity to elaborate, most survey participants commented on this topic, speaking of discrimination, lack of education among providers and inappropriate use of power differentials. Similar issues were prevalent in accessing healthcare via telehealth, but most were related to internet issues, technology issues, canceled appointments and the unique needs of people who need in-person care to receive needed services or to better communicate.

Additional concerns over lack of enforcement of COVID-19 precautions (masking, social distancing) for in-clinic visits and lack of ability to bring a personal care attendant, translator, interpreter or family member created barriers in receiving quality care. Isolation, declining mental health and lack of support from medical systems and providers impacted the disabled community negatively.

Healthcare facilities, including vaccination sites, should consider accessibility when developing procedures and protocols for complying with mandates like those in the COVID-19 pandemic. Many people with disabilities also have co-occurring morbidities that put them at greater risk of complications from COVID-19 and therefore should be considered in conjunction with their unique healthcare needs.

As with employment, people with disabilities in New Mexico saw similar issues related to technology and institutional support when learning was moved to at-home learning environments. Just as some people experienced layoffs and other loss of employment, some people experienced loss of educational opportunities due to the shift in the educational environment. Just as people experienced issues with technology and needing accommodations at home for work-from-home situations, those in school also needed additional support with technology and equipment to be successful at school. Youth in school had additional barriers as their parents became primary caregivers and teachers during lockdowns, often providing therapy and educational tutoring they were not trained or qualified to do. These difficulties led to a decrease in the quality of the education people received.

Schools, school systems and the New Mexico Public Education Department should consider the unique needs of people with disabilities when adjusting the learning environment. The support systems that exist in the school to assist learners in succeeding should be translated to the new learning environment with adequate resources (technology, training, personnel support and therapy services).

A prevailing theme among all three sections (healthcare, education and employment) was technology, specifically the internet. There seems to be assumptions that everyone has fast, reliable internet and technology to engage in remote learning, employment and healthcare visits. These challenges are pervasive enough throughout New Mexico, where about 16% of the population does not have broadband internet access (BRFSS), but many people with disabilities have access issues specific to their disabilities: platforms that support applications like screen readers and interpretation services interfaces. New technologies can be difficult to adjust to, and more support is needed, especially for people with cognitive disabilities.

While the peak of pandemic restrictions has long ended, people with disabilities in New Mexico are still experiencing some of the residual effects. One person commented on the long-term impact of COVID-19 infection on their ability to work. Another talked about their declining mental and physical health reminiscent from three years ago. Still another said they now forgo seeking medical care because of discrimination against people with disabilities and people with mental health disorders. Some of the survey participants indicated that they were still unemployed, underemployed, furloughed, or had not returned to school.

As workplaces begin to shift toward a return-to-office mandate, unique needs of individuals with disabilities need to be taken into consideration. The flexibility that was cited by participants with remote work allowed, in some cases, for a better work-life balance that aligned with the needs of their disabilities. It appears there are concerns that the return-to-work mandate will be executed in similar ways that lockdown was – rushed and without consideration for the needs of people with disabilities.

CONCLUSION

New Mexicans with disabilities experienced inequities in access to healthcare, education and employment because of pandemic restrictions during the lockdowns of the COVID-19 pandemic. Additionally, surveyed New Mexicans with disabilities have higher rates of food insecurity, transportation instability and prevalence of poor mental health. When planning for emergency response management, agencies with decision-making power should consider the needs of people with disabilities. These needs include logistic considerations like locations of services and accessibility of those services, accommodations to ensure success in alternate settings for activities like employment and school, and training for people who interact with people with disabilities.

Acknowledgements:

Sharz Weeks, Community Health Epidemiologist of Presbyterian Healthcare Services; Community Health

Lisa McNiven, MPA, Deputy Director of the NM Governor's Commission on Disability

Disability Access Functional Needs (DAFN) Coalition members and New Mexico Disability Emergency Planning Advisory Council (NMDEPAC):

Nathan Gomme, Director of the Commission for the Deaf and Hard of Hearing

Roger Robb, Community Education Specialist of the New Mexico Commission for the Deaf and Hard of Hearing

Greg Trapp, Director of the Commission for the Blind and Visually Impaired

Kelly Burma, Skills Center Coordinator of the Commission for the Blind and Visually Impaired

Alice Lui McCoy, Director of the Developmental Disabilities Council

Daniel Ekman, Program Manager of the Center for Self-Advocacy Program under the Developmental Disabilities Council

Eli Fresquez, Civil Rights Attorney with the New Mexico State Attorney General office

APPENDIX A – SURVEY RESPONDENTS

Table 1: Survey Respondents

Disability (self-identified)*	Number	Percent
Blind	18	5.4%
Deaf	27	8.2%
Cognitive	61	18.4%
Mental	74	22.4%
Mobility	79	23.9%
Learning	48	14.5%
Other	57	17.2%
None	54	16.3%
Only one	104	31.4%
Total survey participants	**331**	

* Individuals were able to select all that apply. These numbers represent the number of people who identified with each disability type and do not sum to the total participants. Percentages read as X% of all survey participants have Y disability.

* People who identified as having no disability were excluded from analysis moving forward.

Age*	Number	Percent
Missing	58	20.9%
18-24	23	8.3%
25-34	28	10.1%
35-44	41	14.8%
45-54	58	20.9%
55-64	36	13.0%
65-74	19	6.9%
75-84	6	2.2%
85 or older	1	0.4%
Under 18	7	2.5%
Total	**277**	

* People under 18 were excluded from analysis moving forward.

Race	Number	Percent
Missing	62	22.4%
Asian	5	1.8%
Black/African American	14	5.1%
Native American	20	7.2%
Native Hawaiian/ Pacific Islander	1	0.4%
White	149	53.8%
More than one race	18	6.5%
Some other race	6	2.2%
Decline	17	6.1%
Unknown	1	0.4%
Total participants	**277**	

Ethnicity	Number	Percent
Hispanic/Latinx	86	31.0%
Not Hispanic/Latinx	86	31.0%
Other	13	4.7%
Decline	15	5.4%
Unknown	7	2.5%
Missing	72	26.0%
Total participants	**277**	

APPENDIX B – SURVEY DETAILS

Table 2: Survey Details

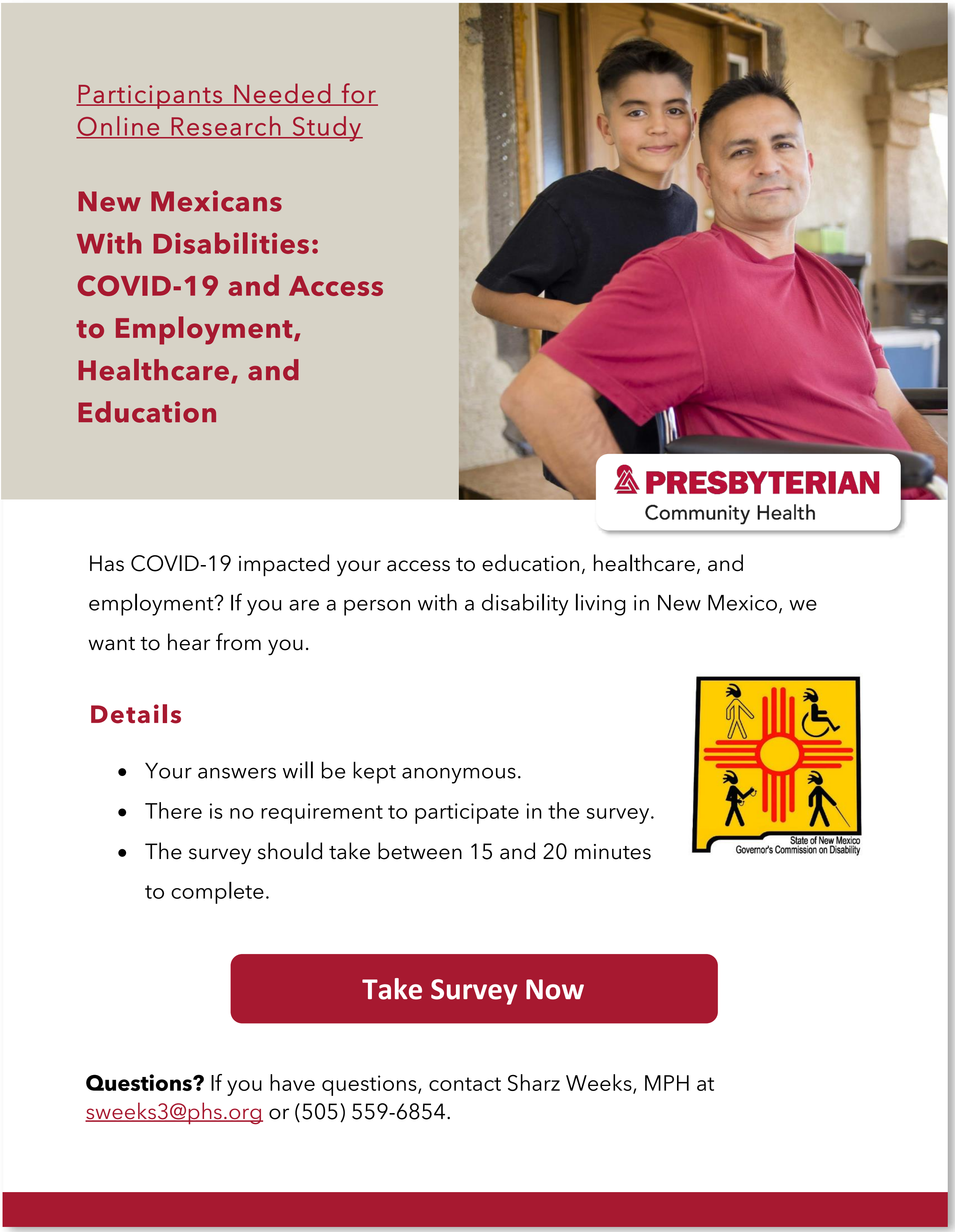
Number of People Who Finished the Survey	Number	Percent
Did not finish	118	35.01%
Finished	219	64.99%
Total	**337**	

Survey Consent	Number	Percent
Missing	1	0.3%
I agree	331	98.2%
I don't agree	5	1.5%
Total	**337**	

Distribution Channel	Number	Percent
Anonymous Link	254	75.37%
QR Code	83	24.63%
Total	**337**	

Survey Type	Number	Percent
ASL	7	2.11%
EN	317	95.77%
Plain Language	7	2.11%
Total	**331**	

APPENDIX C – FLYERS AND ADVERTISEMENTS FOR THE SURVEY



Participants Needed for Online Research Study

New Mexicans With Disabilities: COVID-19 and Access to Employment, Healthcare, and Education

PRESBYTERIAN
Community Health

Has COVID-19 impacted your access to education, healthcare, and employment? If you are a person with a disability living in New Mexico, we want to hear from you.

Details

- Your answers will be kept anonymous.
- There is no requirement to participate in the survey.
- The survey should take between 15 and 20 minutes to complete.

State of New Mexico
Governor's Commission on Disability

Take Survey Now

Questions? If you have questions, contact Sharz Weeks, MPH at sweeks3@phs.org or (505) 559-6854.

Se necesitan participantes para un estudio de investigación en línea

Nuevomexicanos con discapacidades: Acceso a empleo, atención médica y educación durante la pandemia de COVID-19

PRESBYTERIAN
Community Health

¿Le ha afectado la COVID-19 el acceso a educación, atención médica y empleo? Si usted es una persona con discapacidad que vive en Nuevo México, deseamos escucharle.

Detalles

State of New Mexico
Governor's Commission on Disability

- Sus respuestas se mantendrán anónimas.
- No hay ningún requisito para participar en la encuesta.
- La encuesta toma de15 a 20 minutos para completarse.

Haga la encuesta ahora

¿Preguntas? Si tiene preguntas, comuníquese con Sharz Weeks, MPH al sweeks3@phs.org o al (505) 559-6854.