Transcript Contents

Welcome/introductions

>> ADAM: GOOD MORNING, EVERYBODY. THANKS FOR BEING HERE ON TIME. THERE'S A NUMBER OF ACCIDENTS IN BOTH DIRECTIONS, 40 AND 85. IT TOOK ME AN HOUR TO GET HERE FROM CHAPEL HILL. I THINK WE'RE GOING TO SHOOT FOR 9: 15, BUT WE WILL GIVE PEOPLE EXTRA TIME TO GET HERE. WE'LL UPDATE YOU AS WE HAVE A BETTER ASSESSMENT OF THE SITUATION. HOPEFULLY, 9: 15, WE'LL GET STARTED. THANK YOU.

>> GOOD MORNING, EVERYONE, WHO IS NOT ONLY HERE IN THE ROOM BUT ALSO MAYBE PARTICIPATING BY PHONE. I WANTED TO SAY, BEGIN, GOOD MORNING, AND WELCOME TO THIS MORNING'S MEETING OF THIS TASK FORCE. I'M MARK BENTON ON BEHALF OF ADAM AND DAVID AND WE WANT TO THANK YOU FOR YOUR ONGOING PARTICIPATION AND AS PRACTICE IN PREVIOUS MEETINGS, WE'RE GOING TO QUICKLY GO AROUND THE ROOM AND IDENTIFY-- IF YOU WILL, IDENTIFY WHO YOU ARE AND WHO YOU REPRESENT. AND THEN WE'LL SWITCH OVER TO OUR COLLEAGUES ON THE PHONE AND THEN WE'LL GET INTO TODAY'S BUSINESS. THANK YOU.

>> HI.
THIS IS DAVID ROSENTHAL. I AM THE CO-CHAIR WITH MARK BENTON.

>> I'M KATHY AND I'M THE EXECUTIVE DIRECTOR OF THE AUDIOLOGY PROJECT. WE'RE WORKING WITH CDC TO HAVE AUDIOLOGY MANAGEMENT OF DIABETES IN THE DIABETES OF (INAUDIBLE).

>> HI. JAN WITHERS. I'M THE DIRECTOR OF THE DIVISION OF SERVICES FOR DEAF AND HARD OF HEARING.

>> GOOD MORNING. I'M TOVAH WAX, AND I'M HERE AS THE CHAIR OF THE COUNCIL THAT (INAUDIBLE) WORKS WITH THE SERVICES FOR DEAF AND HARD OF HEARING AND IN FULL DISCLOSURE AND WORKING WITH (INAUDIBLE) THE RESEARCH. I'M HERE TO REPRESENT CHILDREN OF DEAF ADULTS AND OUR EXPERIENCES WITH INTERPRETERS IN MY MEDICAL EXPERIENCE WITH MY PARENTS. I'M ALSO A

SIGN LANGUAGE INTERPRETER. CERTIFIED BY REGISTRY FOR INTERPRETERS OF THE DEAF AND ALSO LICENSED IN NORTH CAROLINA AS A SIGN LANGUAGE INTERPRETER. I WORK FOR SORENSEN COMMUNICATIONS VIDEO RELAY SERVICE. I'M THE DIRECTOR OF INTERPRETING FOR THAT COMPANY. AS I SAID, I'M HERE TO REPRESENT CODAsAND INTERPRETERS.

>> GOOD MORNING. I'M EILEEN CARTER. I REPRESENT THE NORTH CAROLINA PHYSICAL THERAPY ASSOCIATION. PLEASURE, AGAIN, TO BE HERE AGAIN TODAY.

>> GOOD MORNING. MY NAME IS BETH HATHAWAY. I'M PRESIDENT OF THE NORTH CAROLINA OCCUPATIONAL THERAPY ASSOCIATION AND I ALSO OWN A PEDIATRIC PRIVATE PRACTICE IN RALEIGH.

>> HELLO. I'M BERKELEY WITH THE NORTH CAROLINA INSTITUTE OF MEDICINE.

>> GOOD MORNING. I'M COREY DUNN WITH DISABILITY RIGHTS NORTH CAROLINA.

>> HELLO. I AM LEE WILLIAMSON, COMMUNICATION ACCESS MANAGER WITH DIVISION OF SERVICES FOR THE DEAF AND THE HARD OF HEARING.

>> HI. I'M CRYSTAL BOWE, I'M A FAMILY PHYSICIAN IN GASTON COUNTY, NORTH CAROLINA.

>> GOOD MORNING. I'M EILEEN RAYNOR. PEDIATRIC OTOLARYNGOLOGIOLOGIST AT DUKE AND THE NORTH CAROLINA MEDICAL SOCIETY.

>> GOOD MORNING. JEFF MOBLEY, SERVICES FOR DEAF AND HARD OF HEARING.

>> GOOD MORNING. KELLY OWENS, COMMUNICATION SERVICES FOR THE DEAF AND HARD OF HEARING, GREENSBORO, NORTH CAROLINA.

>> I'M JOHNNY SEXTON, EXECUTIVE DIRECTOR OF THE CARE PROJECT WHICH IS A NONPROFIT DEDICATED TO PROVIDING EMOTIONAL SUPPORT OPPORTUNITIES FOR FAMILIES WITH CHILDREN WHO ARE DEAF AND HARD OF HEARING.

>> GOOD MORNING. I'M BETH HORNER. I'M THE DIRECTOR OF CUSTOMER EXPERIENCE AND COMMUNICATIONS FOR THE NORTH CAROLINA STATE HEALTH PLAN.

>> GOOD MORNING. I'M JAMES COLEMAN. I'M WITH THE NORTH CAROLINA INSTITUTE OF MEDICINE.

>> GOOD MORNING. I'M RON TODAY OWEN AND I'M WITH THE DIVISION OF HEALTH BENEFITS, NORTH CAROLINA MEDICAID.

>> I'M TONY DAVIS. I AM THE HARD OF HEARING SERVICES COORDINATOR FOR THE DIVISION FOR SERVICES FOR DEAF AND HARD OF HEARING.

>> HI. GOOD MORNING. I AM ASHLEY BENTON. I AM THE DEAF, DEAF/BLIND SERVICES COORDINATOR

FOR THE DIVISION FOR SERVICES FOR DEAF AND HARD OF HEARING AND I'M HERE REPRESENTING THE DEAF-BLIND COMMUNITY AND I HAVE HERE WITH ME MY COMMUNICATION SUPPORT TEAM.

>> GOOD MORNING. ANDREW (INAUDIBLE) ASSOCIATE (INAUDIBLE) FOR ACROSS NORTH CAROLINA.

>> GOOD MORNING. I'M GREG GRIGGS, EXECUTIVE VICE PRESIDENT AND CEO OF NORTH CAROLINA ACADEMY OF FAMILY PHYSICIANS.

>> GOOD MORNING. I'M JULIE BISHOP. I'M PRESIDENT OF THE HEARING LOSS ASSOCIATION OF NORTH CAROLINA.

>> GOOD MORNING. I'M STEVE BARBER FROM HEARING LOSS ASSOCIATION OF NORTH CAROLINA AS WELL.

>> GOOD MORNING. MY NAME IS SHACORIL STUART AND I'M HERE JUST OBSERVING THE ASL INTERPRETERS.

>> GOOD MORNING. I'M LAWRENCE SHOCKEY. I AM THE RETIRED FROM THE NORTH CAROLINA DIVISION OF SERVICES FOR THE DEAF AND HARD OF HEARING, LICENSED INTERPRETER BUT I'M HERE AS A REPRESENTATIVE AS A PARENT WITH A DEAF CHILD.

>> HELLO. MY NAME IS DAVID HENDERSON. I'M THE CEO OF THE NORTH CAROLINA MEDICAL BOARD. THE MEDICAL BOARD IS THE STATE AGENCY THAT'S RESPONSIBLE FOR THE LICENSING AND REGULATION OF PHYSICIANS, PHYSICIAN ASSISTANTS AND A FEW OTHER HEALTHCARE. PROVIDERS.

>> I'M LAURA THORPE. I'M AN AUDIOLOGIST. I'M HERE REPRESENTING THE NORTH CAROLINA SPEECH LANGUAGE ASSOCIATION.

>> HI. I'M BRAD TROTTER. I'M HERE REPRESENTING THE DIVISION OF MENTAL HEALTH, DMH.

>> GOOD MORNING. I'M JENNIFER GILL. I'M REPRESENTING LEADING AGE NORTH CAROLINA WHICH IS AN ASSOCIATION OF NONPROFIT RETIREMENT COMMUNITIES.

>> GOOD MORNING. I'M ROB AND I'M THE PROJECT DIRECTOR FOR THIS TASK FORCE AND WORK HERE AT THE NORTH CAROLINA INSTITUTE OF MEDICINE. I WANTED TO PROVIDE A COUPLE OF UPDATES BEFORE WE GET STARTED.
>> ARE THERE PEOPLE ON THE PHONE?
>> ARE THERE PEOPLE ON THE PHONE? THAT WOULD LIKE TO INTRODUCE THEMSELVES?

>> YES. THIS IS DONNA NICHOLSON WITH MEDICAL MUTUAL COMPANY. WE'RE HERE TO SUPPORT OUR PHYSICIANS AND THE MISSION OF THE TASK FORCE.

>> GOOD MORNING. I'M MARTY WILSON. SORRY. HI, MARTY WILSON, PROGRAM DIRECTOR OF COMMUNITY HEALTH ASSOCIATION.

>> THIS IS SUZANNE BLACK, COMMUNITY OUTREACH FOR AARP FOR CAROLINA.

>> GOOD MORNING (INAUDIBLE) I'M THE CHIEF OF COMMUNITY INTEGRATION AND SERVICE SUPPORT FOR NORTH CAROLINA DIVISION OF VOCATIONAL REHABILITATION.

>> GOOD MORNING. I'M THE HEALTH POLICY DIRECTOR AT BLUE CROSS/BLUE SHIELD NORTH CAROLINA.

>> GOOD MORNING. THIS IS (INAUDIBLE) I'M THE MANAGER OF INTERPRETER SERVICES AT PARK CLINIC HOSPITAL IN MINNESOTA.

>> GOOD MORNING. THIS IS MAGGIE SAUER FROM THE OFFICE OF RURAL HEALTH AT DHHS.

>> GOOD MORNING. THIS IS HANK BAUERS, ASSISTANT DIRECTOR OF DIVISION OF AGING AND ADULT SERVICES.

>> GOOD MORNING. THIS IS (INAUDIBLE) I'M A DEVELOPMENT OF DSSH IN CHARLOTTE AND I WILL FOLLOWING (INAUDIBLE)

>> DID WE CATCH EVERYBODY'S NAME? I COULDN'T TELL WHO WAS CALLING IN FROM BLUE CROSS/BLUE SHIELD? WAS IT MELISSA?

>> HI, ADAM. IT'S MELISSA.

>> HI, MELISSA. ALL RIGHT. ANYBODY ELSE ON THE PHONE? DON'T WORRY. I WAS COMING BACK AROUND. WE HAVE A COUPLE MORE PEOPLE.

>> I'M SAM CLARK WITH THE NORTH CAROLINA HEALTHCARE FACILITY ASSOCIATION WHICH REPRESENTS NURSING FACILITIES IN THE STATE.

>> HI. I'M DR. CANDICE TATE , AND THE PROGRAM DIRECTOR FOR BROUTON HOSPITAL.

Laura Hanson’s Minnesota Hospital Consortium Presentation

>> I'M ADAM ZOLOTOR WITH THE NORTH CAROLINA INSTITUTE OF MEDICINE. I WANT TO ECHO MARK'S WELCOME. THANK YOU FOR BEING HERE TODAY AND JOINING US BY PHONE AND DID WE GET EVERYBODY IN THE ROOM ? I WANT TO MAKE SURE THAT I DEPART MISS ANYBODY I DIDN'T MISS ANYBODY. I WILL HAND IT OVER TO ROB.

>> OKAY. SO I JUST WANTED TO PROVIDE A FEW UPDATES BECAUSE OF THE LATER START. WE ARE GOING TO SWITCH, IF YOU LOOK AT THE AGENDA, LEE'S PRESENTATION AND LARISSA HANSON'S PRESENTATION ON MINNESOTA CONSORTIUM AND IF NEEDED, WE WILL TAKE A LITTLE BIT OF TIME

OFF THE DISCUSSION TO GET BACK ON TRACK WITH EVERYTHING THAT WE HAVE PLANNED FOR TODAY. LARISSA, ARE YOU ON THE PHONE?

>> YES, I AM.

>> ARE YOU LOGGED INTO THE ZOOM PRESENTATION?

>> I AM NOT. I WILL WORK YOUR SLIDES FROM HERE IF THAT'S OKAY. YOU CAN TELL ME NEXT SLIDE.

>> YES, ABSOLUTELY.

>> OKAY. CAN YOU GUYS HEAR ME OKAY IN THE ROOM?

>> YES.

>> OKAY.

>> SO GOOD MORNING. MY NAME IS LARISSA HANSON AND I WAS CONNECTED TO THIS GROUP THROUGH A CONTACT HERE IN MINNESOTA THROUGH ONE OF OUR SIGN INTERPRETING VENDORS.

>> CAN I INTERRUPT YOU FOR ONE SECOND? I JUST WANT TO CHECK IN WITH EVERYBODY IN THE ROOM TO MAKE SURE EVERYBODY THAT NEEDS TO WHY ACCESS TO OUR SIGN LANGUAGE INTERPRETERS AND EVERYBODY CAN HEAR OKAY? ANYBODY NEED TO MOVE? ANYBODY NEED TO MAKE ANY ADJUSTMENTS? OKAY. THANKS SO MUCH, LARISSA. SORRY ABOUT THAT.

>> NOT A PROBLEM AT ALL. SO THEY HAD ASKED ME TO GIVE A LITTLE PRESENTATION ON A MODEL THAT WE HAVE SET UP IN MINNESOTA THAT I THINK IS RELATIVELY UNIQUE. SO IF YOU WANT TO MOVE TO THE NEXT SLIDE. SO THIS SORT OF HOSPITAL CONSORTIUM CAME ABOUT STARTING IN 2005 AND THIS WAS SET UP INITIALLY BY THE VENDOR CSD, WHICH WAS A NATIONAL VENDOR FOR PEOPLE IN THE ROOM WHO MAY BE AWARE OF THIS AND WHAT THIS CAME PARTIALLY AS A RESULT OF IS THAT THERE WERE A NUMBER OF LAWSUITS FROM DEAF PATIENTS AGAINST HOSPITALS FOR PROVIDING WHAT THEY DEEMED TO BE INADEQUATE SIGN LANGUAGE INTERPRETING SERVICES. AND SO AS PART OF THESE LAWSUITS AND JUST GENERALLY A LACK OF ACCESS TO SERVICES AND WHENEVER A DEAF PATIENT WOULD WALK INTO OUR EMERGENCY ROOM BECAUSE WE DIDN'T HAVE-- WE KNEW THAT FINDING A SIGN LANGUAGE INTERPRETER FOR AN UNPLANNED NEED WAS HE TWENTYING TO BE QUITE DIFFICULT. AND SO THIS WAS STARTED IN 2005. THERE ARE EIGHT HOSPITALS IN THE TWIN CITIES AREA THAT ARE A PART OF THIS. THERE IS ONE HOSPITAL SYSTEM WHO HAS CHOSEN TO NOT PARTICIPATE, BUT IT'S BEEN IN EXISTENCE FOR 14 YEARS. AND WHAT'S NEAT ABOUT THIS MODEL IS THAT IT GIVES US GUARANTEED ACCESS, IN-PERSON INTERPRETERS, CONTRACTUALLY, IT SAYS WITHIN ONE HOUR 80% OF THE TIME AND WITHIN TWO HOURS 100% OF THE TIME FOR EMERGENCY ROOM CARE IN THE FIRST 24 HOURS OF THE HOSPITAL STAY.
THIS IS HOW IT WAS INITIALLY SET UP AND THAT DEFINITION OF EMERGENCY WAS (INAUDIBLE) AND ALSO WE FELT-- THIS WAS PRIOR TO VIDEO REMOTE INTERPRETING BEING WIDELY AVAILABLE AND SET UP. WHAT'S NICE IS THESE ARE REALLY HIGH QUALITY INTERPRETERS SO ABLE TO DO THE WORK OF

MENTAL HEALTH INTERPRETING OR DEAF-BLIND INTERPRETING, IN AN EMERGENCY SETTING. SO NEXT SLIDE. IN 2005, THERE WAS CHANGE HOW THIS PROGRAM WAS STRUCTURED AND THIS WAS DRIVEN BY CSD LEADING THE REFERRAL BUSINESS, SO THEY WERE NO LONGER ABLE TO RUN THIS PROGRAM AND SO WHAT WE DID WAS WE HAD-- WE'VE HAD PUT OUT AN RFP, A REQUEST FOR PROPOSAL, AND HAD A NUMBER OF VENDORS REPLY TO IT. WE INEVITABLY-- AT THE END OF IT, WE WENT TO WITH A VENDOR, ALAS. SO THE COST STRUCTURE DURING THIS, DURING THE INITIAL PHASE WAS THAT IT WAS A LITTLE COMPLICATED. SO TO HAVE INTERPRETERS AVAILABLE ON LAST-MINUTE NOTICE TO RUN INTO THE HOSPITAL SYSTEM, THEY NEEDED TO HAVE INTERPRETERS AVAILABLE ON CALL AND THAT WAS THE BULK OF THE COSTS ARE THESE STIPENDS ARE PAID TO HIGHLY SKILLED INTERPRETERS TO BE AVAILABLE. AND THE COST OF THIS IS APPROXIMATELY $30,000 PER MONTH AND SO HOW THIS INITIALLY SET UP FOR A COST PERSPECTIVE WAS THAT EACH HOSPITAL SYSTEM PAID A $500 PER MONTH SUBSCRIPTION FEE TO THE LINES OF THE CONSORTIUM AND THEN AN HOURLY RATE THAT WAS SIMILAR TO WHAT WE WOULD PAY FOR A NORMAL SIGN LANGUAGE ENCOUNTER WITH A TWO-HOUR MINIMUM. WAS DIFFERENT IS THAT WE PAID PORTAL TO PORTAL. AND WE PAID THAT TIME, FROM THE TIME THE INTERPRETER LEFT THEIR HOUSE AND RETURNED HOME OR WHEREVER THEY WERE LEAVING FROM. AND THEN THIS VARIABLE RATE WAS ALSO INCLUDED. SO EACH ENCOUNTER WOULD HAVE TWO CHARGES AND SO WE WOULD PAY A PERCENTAGE OF-- SO IF THERE WERE TEN APPOINTMENTS WE WOULD PAY-- ONE APPOINTMENT, WE WOULD PAY 10% OF THE $30,000 STIPEND FEE. SO THIS GOT TO BE COMPLICATED TO BUILD, BUT DID PROVIDE OUTSTANDING SERVICE. A LOT OF THE HOSPITALS VIEWED THIS AND CONTINUE TO VIEW THIS AS AN INSURANCE POLICY TO HELP US RECOVER THESE NEEDS. NEXT SLIDE, AS I MENTIONED IN 2015 WE WENT-- THIS PROGRAM SWITCHED TO THE VENDOR ASLAS WHICH IS ANOTHER SIGN LANGUAGE INTERPRETING VENDOR AND WE ATTEMPTED TO SIMPLIFY COST STRUCTURE WHEN WE WENT THROUGH THIS VENDOR AND WHAT WE DID WAS WE HAVE A $500 PER MONTH SUBSCRIPTION FEE AND THEN A HIGHER HOURLY RATE THAT COVERS BOTH THE STIPEND AND INTERPRETER HOURLY RATE AND ANY TRAVEL. WE DO NOT PAY PORTAL TO PARTIAL TIME ANY LONGER. WE JUST PAY FOR THE HOURS THAT ARE THERE. SO ONE OF THE INADVERTENT CONSEQUENCES OF THIS IS THAT THE RISK SHIFTED TO THE VENDOR. IF THERE WASN'T ENOUGH NEED, THEY WOULD BE STUCK PAYING THE HIGH STIPEND COSTS. NATURALLY, THEY WANTED MORE OF THE BUSINESS TO BE GOING TO CONSORTIUM SO THAT THEY COULD MAKE SURE THAT THEY WERE GENERATING ENOUGH REVENUE TO COVER THOSE COSTS. HONESTLY, IT REALLY HASN'T BEEN AN ISSUE. WE HAVE SO MANY NEEDS IN THE TWIN CITIES THAT THE NEEDS JUST CONTINUE TO INCREASE, BUT AS A RESULT OF THAT AND FRANKLY, A CHANGE IN HOW WE DO BUSINESS IN MINNESOTA, HEALTHCARE HAS MOVED TO MORE OF A SAME-DAY ACCESS MODEL HERE IN MINNESOTA, AND I ANTICIPATE SIMILARLY IN NORTH CAROLINA, BUT THE EMERGENCY DEFINITION HAS BEEN RELAXED SO WHEN THIS WAS INITIALLY PUT INTO PLACE, EMERGENCY WAS DEFINED AS EMERGENCY ROOM, E.R. VISITS IN THE FIRST 24 HOURS OF A HOSPITAL STAY. NOW WE CAN DETERMINE THAT SOMETHING IS EMERGENT, EVEN IF IT'S IN A FAMILY PRACTICE SETTING AND THAT WOULD BE CONSIDERED -- THAT WOULD BE CONSIDERED EMERGENT AND IF WE WANT TO USE CONSORTIUM, WE CAN. SO IF WE CAN MOVE TO THE NEXT SLIDE. THE PROs OF THIS ARE THAT WE HAVE REALLY HIGH QUALITY, DWAWRNTIED COVERAGE OF-- GUARANTEED COVERAGE OF EMERGENCY SERVICES. THIS IS GREAT. OUR SIGN LANGUAGE PATIENTS CAN COME INTO ANY OF OUR FACILITIES AND HONESTLY, OUR CONTRACT LANGUAGE SAYS ONE HOUR, 80% OF THE TIME. WE'RE GETTING AN INTERPRETER IN REALITY, IN AN HOUR 95% OF THE TIME. SO PATIENTS CAN WALK INTO AN EMERGENCY ROOM AND GET SERVICES QUICKLY. IT LOWERS THE RISK TO THE HOSPITAL SYSTEM AND IS REALLY EASY TO USE. IT'S NOT-- IT'S

NOT SOMETHING-- IT'S JUST KIND OF SEAMLESS AND ON AUTOPILOT WHICH IS WHAT A LOT OF COMPETING PRIORITIES FOR TIME AND SO THIS IS A GREAT SYSTEM. THE CONS OF THIS IS THAT IT'S QUITE COSTLY. BUT I THINK IT'S A USEFUL SERVICE FOR SURE. NEXT SLIDE, PLEASE. SO -- SO (INAUDIBLE) INTERPRETING WAS NOT EXISTENT WHEN THIS WENT INTO PLACE AND WE HAVE SUBSEQUENTLY ADOPTED VIDEO REMOTE INTERPRETING, HOW WE TEND TO USE VIDEO REMOTE INTERPRETING-- AND I GUESS I WAS GOING TO SPEAK MOSTLY FROM MY HOSPITAL SYSTEM BUT I THINK OTHER HOSPITAL SYSTEMS ARE SIMILAR HERE IN THE TWIN CITIES. WE USE VIDEO REMOTE INTERPRETING AS A BRIDGE TO GET UNTIL AN IN-PERSON INTERPRETER CAN COME. THIS IS IN A SETTING WHERE PATIENTS MAY NOT NEED EMERGENCY SERVICES BUT MAYBE CAME INTO URGENT CARE AND THEY HAD A SIGH US IN INFECTION AND NEEDED AN ANTIBIOTIC AND THEY WANT TO GET ON WITH THEIR DAY AS WELL AND THEY'RE MORE OPEN TO USING VIDEO REMOTE INTERPRETING IN THOSE SETTINGS. WE HAVE DEAF PATIENT POPULATION THAT HAS BEEN VOCAL AGAINST VIDEO REMOTE INTERPRETING IN MINNESOTA. AND SOMEBODY SHARED TO ME THAT WE HAVE TO UNDERSTAND WHAT WE UNDERSTAND AS HEARING PEOPLE COMMUNICATION BECAUSE WE LIVE IN A WORLD WHERE WE COMMUNICATE IN AN AUDIO SETTING AND SO-- WHEN YOUR COMMUNICATION IS VISUAL AND YOU'RE TRYING TO FOCUS ON A SCREEN THAT IS NOT LARGE AND YOU ARE NOT FEELING WELL AND THE INTERPRETER MAY BE FROM ANOTHER PART OF THE COUNTRY AND DOES NOT HAVE LOCALIZED SIGNS AND THIS BECOMES REALLY CHALLENGING. THAT'S BEEN THE PERSPECTIVE I HAD SHARED WITH ME BY THE DEAF PATIENTS THAT WE SERVE. SO THAT IS KIND OF MY CONTENT. IF WE CAN GO TO THE NEXT SLIDE. I WANTED TO OPEN IT UP TO QUESTIONS. OH, DID I MENTION THE RATES THAT WE WERE PAYING? I DIDN'T SHARE THE RATES. ARE PEOPLE INTERESTED TO HEAR WHAT WE ARE CURRENTLY PAYING PER HOUR?

>> YES.

>> YOU'RE GETTING A LOT OF YESES IN HERE.

>> YEAH.
>> YEAH.

>> SO, I TOLD THE VENDOR I WOULD BE SHARING THIS AND THEY WERE FINE WITH THAT. WE PAY $138 PER HOUR WITH A TWO-HOUR MINIMUM FOR CONSORTIUM INTERPRETERS. DO PEOPLE HAVE QUESTIONS?

>> THIS IS DAVID ROSENTHAL HERE. HI. GOOD TO HEAR FROM YOU.

>> HI.

>> MY QUESTION IS RELATED TO -- LET'S SAY A DEAF PERSON THAT COMES INTO THE EMERGENCY ROOM AND THEY'RE USING VRI TO BRIDGE THAT TIME UNTIL A LIVE INTERPRETER ARRIVES ON SITE. I DO UNDERSTAND ALSO SOMETIMES VRI CAN BE A GOOD SOLUTION FOR THAT INTERIM COMMUNICATION.

>> YES.

>> AND THEN WHAT IN THOSE SITUATIONS IF THE ISSUE IS COMPLETELY RESOLVES AND THE PATIENT IS DISCHARGED BEFORE THE INTERPRETER ARRIVES, HOW IS THAT HANDLED?

>> SO WE BRING THE PATIENT INTO THE DISCUSSION TO SAY, YOU KNOW, WE'LL BE ORDERING AN IN-PERSON INTERPRETER FOR YOU. IF THEY THINK THEY ARE GOING TO NOT BE THERE VERY LONG AND THEY MIGHT VOCALIZE THAT. IF THE PATIENT WERE TO JUST DECIDE I DON'T WANT TO BE HERE AND GET UP AND LEAVE AND WE'VE ALREADY DISPATCHED AN INTERPRETER, WE WOULD PAY THE TWO-HOUR MINIMUM AND JUST EITHER CALL TO LET THEM KNOW IT HAS BEEN -- THE PATIENT'S NO LONGER THERE OR ONCE THE PATIENT-- THE INTERPRETER ARRIVE, JUST LET THEM RELEASE THEM RIGHT AWAY, BUT IT'S-- I HAVEN'T HEARD OF THAT HAPPENING TOO MUCH. WE'RE NOT USING THIS USUALLY FOR QUICK ENCOUNTERS. WE'RE USING THIS WHEN SOMEBODY IS COMING IN ON AN IN-PATIENT BASIS WHEN THEY KNOW THEY HAVE A PROCEDURE COMING UP AND WE HAVEN'T BEEN ABLE TO COVER IT WITH THE POOL OF INTERPRETERS THAT WE WOULD NORMALLY USE.

>> THIS IS DAVID, THANK YOU.

>> JAN AND BERKELEY.

>> HI.
THIS IS JAN WITHERS. YES, I'M THE DIRECTOR OF THE NORTH CAROLINA DIVISION OF SERVICES FOR THE DEAF AND HARD OF HEARING AND I HAD A QUESTION FOR YOU ABOUT TRAINING. SO PARTICULARLY TRAINING FOR THE HEALTHCARE PROVIDERS, THE PEOPLE IN ADMINISTRATION AND ALSO IN THE DEAF COMMUNITY. SO HOW HAVE YOU TRAINED PEOPLE IN BOTH OF THOSE COMMUNITIES? WHAT TYPES OF TRAINING ARE YOU PROVIDING? HOW FREQUENTLY IS THAT TRAINING PROVIDED?

>> SO I'M SORRY. FOR OUR HEALTHCARE STAFF, WE HAVE TRAININGS THAT WE DO THROUGH OUR INTERNAL SERVICES, OUR WEB SERVICES. WE HAVE A TRAINING ABOUT HOW TO ACCESS THESE SERVICES AND WHEN TO USE THEM AND HOW TO DOCUMENT ALL OF THOSE AND THOSE ARE DONE ANNUALLY. TO THE DEAF COMMUNITY, WE ARE NOT-- WE ARE NOT TRAINING THE DEAF COMMUNITY. AND THEN THE SIGN LANGUAGE INTERPRETERS THAT IS ALL HANDLED BY THE INTERPRETING AGENCY, AND WE HAVE REQUIREMENTS ABOUT APPROPRIATE TRAINING LEVELS AND THE INTERPRETERS MUST MEET THAT TO BE COMING IN. DOES THAT ANSWER YOUR QUESTION?

>> THIS IS JAN. PARTIALLY YES. I DO VAGUELY REMEMBER HEARING SOMETHING ABOUT THAT VENDOR PROVIDING TRAINING TO THE DEAF COMMUNITY AND I WAS WONDERING SPECIFICALLY ABOUT , I GUESS-- THE TRAINING RELATED TO THEIR ABILITY TO ADVOCATE FOR THEMSELVES IN HOSPITAL SETTINGS.

>> YEAH. I WASN'T THAT INVOLVED WITH THAT. I'M NOT ABLE TO SPEAK TO THAT PIECE OF IT.

>> OKAY.
>> THAT CAN BE A QUESTION THAT YOU CAN DIRECT TO PAM AT ALSLAS, AND I THINK THERE ARE FOLKS IN THE ROOM WHO ARE IN CONTACT WITH HER. I'M SORRY, I'M NOT ABLE TO ANSWER THAT PART OF IT.

>> THIS IS JAN. THANK YOU.

>> THIS IS BERKELEY. I'M JUST WONDERING NOT BEING FAMILIAR ENOUGH WITH THE AREA, HOW BIG IS THE GEOGRAPHIC AREA THAT CONSORTIUM COVERS VAGUELY?

>> IT'S THE SEVEN-COUNTY METRO AREA. IT'S PROBABLY--

>> HOW LONG DOES IT TAKE TO DRIVE FROM THE TWO FURTHEST HOSPITALS, THE BETWEEN THE TWO?

>> PROBABLY WITHIN AN HOUR AND 15 MINUTES.

>> OKAY.

>> ON A GOOD DAY. YEAH.
[LAUGHTER]

>> SO YOU HAVE SEVEN MAJOR HOSPITAL SYSTEMS WITHIN A LITTLE MORE OF AN HOUR OF EACH OTHER?

>> EIGHT AND YEAH, THERE ARE MULTIPLE HOSPITAL SYSTEMS. YES. NO, EIGHT ARE INCLUDED AND THERE'S ONE THAT IS NOT INCLUDED AND SOME OF THESE HAVE MULTIPLE SYSTEMS IN THEM, TOO. SO WE'RE PRETTY DENSELY POPULATED.

>> BRAD WAS NEXT AND ASHLEY AND DAVID.

>> THIS IS BRAD TROTTER SPEAKING. I WANTED TO ASK, AS WELL, IF YOU WOULDN'T MIND ELABORATING ON REQUIREMENTS FOR MENTAL HEALTH INTERPRETING AND ALSO ANY-- ARE THERE ANY STATE PSYCHIATRIC HOSPITALS INCLUDED IN THE CONSORTIUM?

>> SO I WOULD HAVE TO PULL-- I WOULD HAVE TO PULL OUR REQUIREMENTS. I AM NOT COMPLETELY SURE ON WHAT THE REQUIREMENTS ARE FOR THE MENTAL HEALTH INTERPRETING PIECE. WE, AGAIN, CONNECT WITH PAM TO SEE WHAT THAT TRAINING REQUIREMENT IS AND YES, THERE IS IN-PATIENT MENTAL HEALTH AND IN SOME OF THE HOSPITALS THAT ARE PARTS OF THE HOSPITAL CONSORTIUM.

>> THIS IS BRAD. THANK YOU.

>> YEP.

>> HI. THIS IS ASHLEY BENTON. AGAIN, I'M REPRESENTING THE DEAF-BLIND COMMUNITY. I WANT TO SAY THANK YOU FOR THIS PRESENTATION, BUT YOU SAID THAT THERE ARE EIGHT HOSPITAL SYSTEMS AND THEN THERE'S ONE THAT'S NOT A PART OF THAT SYSTEM. SO HOW DOES THE ONE THAT'S NOT IN THE CONSORTIUM ADDRESS SIGN LANGUAGE INTERPRETING NEEDS?

>> THEY HAVE A STAFF MODEL THAT THEY'RE USING AND THEY HAVE STAFF INTERPRETERS THAT COVER THOSE HOURS. IF THERE ARE NOT NEEDS, THEY WILL PUT AN INTERPRETER THROUGH AN AGENCY ON CALL TO BE ABLE TO BE AVAILABLE. I THINK IT'S NOT EASILY REPLICATABLE BECAUSE THEY HAVE LIKE A LONG-TERM STAFF THAT'S WILLING TO DO THIS AND IF YOU ARE TRYING TO BUILD UP, IT WOULD BE CHALLENGING TO DO THAT. I KNOW THE COSTS THAT THEY PAID TO CARRY THE PAGER IS NOT VERY HIGH AND SO THE-- IT'S BEEN A CHALLENGE FOR THEM. THEY CONSIDERED DOING CONSORTIUM BUT HAVE NOT DONE SO. THEY'RE STILL MAKING IT WORK.

>> THANK YOU.

>> HELLO. THIS IS DAVID HENDERSON WITH NC MEDICAL BOARD. THANK YOU FOR YOUR PRESENTATION. I HAD A COUPLE OF QUESTIONS. FOR EXAMPLE IN 2018, DO YOU KNOW HOW MANY TIMES YOU HAD DEAF OR HARD OF HEARING PATIENTS USE EITHER LIVE INTERPRETERS OR VRI?

>> ARE YOU TALKING WITHIN MY SYSTEM?

>> YES.

>> WE HAD A LARGE DEAF PATIENT POPULATION AND FOR EMERGENCY SERVICES, WE USUALLY AVERAGE BETWEEN 5 TO 20 TIMES PER MONTH AND THEN WE HAVE A NUMBER OF DIFFERENT-- YOU KNOW, FOR PLANNED ENCOUNTERS, WE HAVE 10 TO 15 A DAY AND WE'RE ONE OF SMALLEST SYSTEMS IN THE TWIN CITIES. THERE ARE SYSTEMS THAT ARE LARGER AND HAVE A LOT MORE NEEDS.

>> AND DO YOU KNOW WHAT PERCENTAGE OF THOSE USE VRI VERSUS A LIVE INTERPRETER?

>> A VERY SMALL PERCENTAGE WE USE VIDEO REMOTE INTERPRETING FOR. IT'S REALLY JUST AS A BACKUP.

>> OKAY. DO YOU SEND SURVEYS OUT TO THOSE PATIENTS TO LEARN ABOUT THEIR EXPERIENCE WITH EITHER VRI OR LIVE INTERPRETERS?

>> WE DO-- WE SEND OUT GENERAL PATIENT SATISFACTION SURVEYS. WE HAVE NOT BEEN ABLE TO CAPTURE SATISFACTION ANECDOTALLY. I HAVE HAD PATIENTS SHARE THAT GENERALLY THEY HAVE NOT PREFERRED VIDEO REMOTE INTERPRETING BUT THERE ARE PATIENTS WHO DO LIKE IT. SO--
>> AND MY LAST QUESTION IS, DOES YOUR VRI PROGRAM, DOES IT MEET THE DOJ AND NAD RECOMMENDATIONS?

>> YES.

>> THANK YOU.

>> HI. THIS IS KELLY. I WORK WITH THE NONPROFIT ADVOCACY AGENCY PROVIDING SERVICES FOR THE DEAF AND HARD OF HEARING. YOU MENTIONED BEFORE AN EMERGENCY WAS ALSO CONSIDERED THE FIRST 24 HOURS OF A PATIENT STAY IN THE HOSPITAL.

>> YES.

>> WHAT DOES THAT LOOK LIKE? DOES THAT LOOK LIKE HAVING THE SAME INTERPRETERS AVAILABLE SHOULD A PROCEDURE OR A MEDICAL STAFF MEMBER NEED TO CONSULT WITH THE PATIENT, OR DOES THAT MEAN ON-SITE INTERPRETING AVAILABLE FOR THE FIRST 24 HOURS?

>> THAT WAS THE INITIAL DEFINITION AND WHAT WE TYPICALLY IS BASED ON THE ASSESSMENT OF THE PATIENT NEEDS FROM A MEDICAL STANDPOINT. WE DO NOT OFTEN HAVE INTERPRETERS AVAILABLE AROUND THE CLOCK FOR IN-PATIENT NEEDS UNLESS IT IS MEDICALLY NECESSARY. AND SO WE'VE ALSO EXPANDED WHAT WILL BE COVERED BY EMERGENCY SERVICES TO BEYOND THE FIRST 24 HOURS OF AN IN-PATIENT STAY BECAUSE A PATIENT'S HEALTHCARE CAN CHANGE AND AT THAT POINT IN TIME, WE MIGHT NEED TO-- A PROCEDURE MIGHT COME UP OR SOMETHING MIGHT BE THAT WE WEREN'T ABLE TO FORESEE AND WE WOULD BE ABLE TO USE CONSORTIUM FOR THAT. IT IS-- I KNOW IN MY HOSPITAL SYSTEM, WE TEND TO PROVIDE LARGE BLOCKS OF TIMES FOR IN-PATIENT NEEDS. MAYBE THREE, FOUR HOURS IN THE MORNING AND THEN TWO OR THREE HOURS IN THE LATE AFTERNOON, EARLY EVENING. I WOULD SAY WHAT WE MUST COMMONLY PROVIDE, BUT AGAIN THIS IS BASED ON THE PATIENT NEED. DOES THAT ANSWER YOUR QUESTION?

>> YEAH.

>> OKAY.

>> THIS IS BERKELEY. YOU MENTIONED PLANNED ENCOUNTERS. HOW DO YOU PAY FOR PLANNED ENCOUNTERS OR HOSPITAL STAYS LONGER THAN 24 HOURS? WHAT'S THE MODEL THERE? IS IT EACH INDEPENDENT HOSPITAL SYSTEM?

>> YES. SO EACH INDEPENDENT HOSPITAL SYSTEM THEN HAS EITHER A STAFF MODEL, OR THEY HAVE STAFF INTERPRETERS THAT ARE COVERING THE PLANNED ENCOUNTERS, AND THEN AN AGENCY THAT THEY WOULD USE AS BACKUP AT A MUCH LOWER COST TO COVER PLANNED ENCOUNTERS. AGAIN, HAVING A TWO-HOUR MINIMUM AT A MUCH LOWER HOURLY RATE.

>> THIS IS ASHLEY BENTON AGAIN, REPRESENTING THE DEAF-BLIND COMMUNITY. SO WHAT SORT OF SUPPORT DOES YOUR CONSORTIUM PROVIDE SPECIFIC TO DEAF-BLIND PATIENTS?
IS THERE ANYTHING IN ADDITION TO INTERPRETING SERVICES THAT'S PROVIDED THROUGH THE CONSORTIUM?

>> SO THEY PROVIDE-- DEAF BLIND INTERPRETING AND TACTILE INTERPRETING, I THINK, AS NEEDED. I THINK THAT'S A LITTLE NEWER, THE TACTILE PIECE AND THAT MAY NOT BE AS WIDELY AVAILABLE, AND THEN-- OUTSIDE OF THAT, WE DON'T REALLY PROVIDE. NOT THAT I'M AWARE OF. BUT THAT'S THE ADDITIONAL SERVICES.

>> OKAY. THANK YOU.

>> YEP.

>> THIS IS COREY DUNN WITH DISABILITY RIGHTS NORTH CAROLINA. CAN YOU TELL ME IF YOU TREAT FAMILY MEMBERS WHO ARE MEDICAL DECISION MAKERS WHO NEED INTERPRETING SERVICES THE SAME AS PATIENTS WHO NEED INTERPRETING SERVICES, OR IF YOUR MODEL MAKES A DISTINCTION BETWEEN HOW YOU ALLOCATE SERVICES FOR THE TWO?
>> NO. WE SPECIFICALLY CALL OUT FAMILY MEMBERS AND PATIENTS AS RECIPIENT OF SERVICES. SO WE WOULD PROVIDE INTERPRETERS FOR FAMILY MEMBERS AS WELL. AGAIN, ASSESSING THE NEED IN THAT INDIVIDUAL CIRCUMSTANCE WHAT WE WOULD NEED.

>> HI. THIS IS MARK. LARISSA, I'VE GOT A QUESTION . IT'S MORE SPECIFIC TO THE EIGHT HOSPITAL MEMBERS OF YOUR CONSORTIUM AND IT'S REALLY MORE OF A CURIOSITY QUESTION , IF YOU KNOW-- IF THERE'S A PARTICULAR CONTACT IN EACH HOSPITAL THAT SORT OF OVERSEES THEIR WORK AND THEIR INTERACTION WITH A CONSORTIUM AND WHAT I'M TRYING TO GET AT IS HAVE YOU FOUND THAT THE CONTACTS LARGELY FALL IN THE ADMISSIONS DEPARTMENT OR IN PATIENT REPHRASES OR DO YOU SEE THAT PRIMARY CONTACT IN THE DIRECTOR OF NURSING OR PERHAPS THE PATIENT SAFETY, QUALITY IMPROVEMENT SHOPS AT THE HOSPITAL?

>> THE CONTACT FOR THE CONSORTIUM ALL RESIDE WITHIN THE INTERPRETER SERVICES DEPARTMENT IN THESE HOSPITAL SYSTEMS, AND THOSE-- THOSE-- THE INTERPRETER SERVICES DEPARTMENTS REPORT VERY DIFFERENTLY FROM ORGANIZATION TO ORGANIZATION, OUR REPORTING STRUCTURE IS REALLY DIFFERENT. SO THE PRIMARY CONTACT FOR THE CONSORTIUM ARE ALL FROM THE SERVICES DEPARTMENT.

>> THIS IS MARK AGAIN. JUST A FOLLOW-UP. AND APPRECIATE THAT EIGHT HOSPITALS DO IT DIFFERENTLY, BUT SORT OF JUST BETWEEN US, IS THERE A PARTICULAR HOSPITAL THAT HAS A PARTICULAR STRUCTURE IN WHERE THAT INTERPRETER SERVICES DEPARTMENT REPORTS THAT YOU THINK DOES IT REALLY WELL? PART OF THE REASON FOR THE QUESTION IS, IF WE IN NORTH CAROLINA DO THIS, IT WOULD BE REALLY GREAT TO HEAR SORT OF A LESSONS LEARNED, WITH WORKED REALLY WELL VERSUS SORT OF THE REPORTING STRUCTURE THAT WORKED PERHAPS LESS WELL JUST FOR US TO BE ABLE TO THINK ABOUT THAT IF WE IMPLEMENT SOMETHING SIMILAR HERE.

>> YOU KNOW SO I CAN SPEAK-- I PERSONALLY REPORT TO UP THROUGH PRIMARY CARE WHICH DOESN'T MAKE A LOT OF SENSE, BUT THEY'RE VERY WELCOMING AND VERY SUPPORTIVE AND I QUITE ENJOY WHERE I REPORT THROUGH. I THINK THE PEOPLE WHO HAVE IT ALIGNED WITH SOCIAL WORK IT MAKES THE MOST SENSE. SO IN MY HOSPITAL SYSTEM, WE HAVE-- WE HAVE 30 SOME CLINICS ASSOCIATED WITH IT AND MOST OF OUR WORK IS OUT IN THE CLINICS AND SO THAT'S WHY I REPORT UP THROUGH PRIMARY CARE. IT'S CHANGED OVER THE YEARS, BUT SOME OF OUR HOSPITAL SYSTEMS HAVE-- I DON'T HAVE A TON OF INPATIENT NEEDS IN MY HOSPITAL SYSTEM. OTHER HOSPITAL SYSTEMS IN THE SYSTEM HAVE QUITE A BIT AND THEY REPORT UP THROUGH THEIR SOCIAL WORK OR A NUMBER OF DIFFERENT AREAS WITHIN THE HOSPITAL AND THAT MAKES SENSE FOR THEIR ORGANIZATIONS. I THINK IT KIND OF DEPENDS ON WHERE THE BULK OF YOUR WORK IS WITHIN YOUR SYSTEM.

>> GREAT. LARISSA, THIS IS ADAM. I HAVE A FEW NUTS AND BOLTS QUESTIONS. I DON'T KNOW HOW

MANY OF THEM YOU CAN OFFER OFF THE TOP OF YOUR HEAD. HOW MANY FREE-STANDING HOSPITALS ARE WITHIN THE SEVEN-HOSPITAL SYSTEMS THAT ARE PARTICIPATING? ROUGHLY.

>> I TWO--I COULD FIND THAT OUT. I'D HAVE TO THINK. HERE, I TWO--I KNOW THERE ARE SOME OF THE, LIKE, THE ALINAS HAVE-- IT'S A BIG HOSPITAL SYSTEM HERE. THEY HAVE MANY HOSPITALS IN THE SYSTEM.

>> SO MORE THAN SEVEN?

>> I WOULD GUESS-- YEAH. MORE THAN THE EIGHT MEMBERS. THERE'S MORE HOSPITALS THAN THAT, YES.

>> DO FREE-STANDING CLINICS THAT ARE NOT A
THATTED TO THE HOSPITAL, CAN THEY ACCESS SERVICES FOR EMERGENCIES? IF THEY'RE AFFILIATED WITH THE HEALTH SYSTEM?

>> YEP.

>> OKAY.

>> THE WHOLE SYSTEM.

>> GOT IT. AND HOW MUCH IS THE INTERPRETER PAID FOR CARRYING THE PAGER? YOU TOLD US THE HOURLY RATE BUT I DON'T THINK I HEARD HOW MUCH THEY GET PAID TO CARRY THE PAGER.

>> SO THROUGH THE CONSORTIUM , WE HAVE-- IT'S ABOUT 28, $27,000 PER MONTH THAT IS PAID TO INTERPRETERS TO HAVE A STIPEND. SO THAT'S 24 HOURS A DAY, AT LEAST THREE INTERPRETERS, SOMETIMES FOUR OR MORE, DEPENDING ON VOLUME AT A CERTAIN TIME. THEY'RE PAID WELL. THEY'RE PAID WELL TO JUST SIMPLY BE AVAILABLE.

>> THAT MAKES SENSE THINKING ABOUT HAVING THREE, FOUR DEEP, THE $27,000 A MONTH. AND MY LAST QUESTION, DAVID HENDERSON FROM THE MEDICAL BOARD ASKED YOU ABOUT VOLUME IN YOUR HEALTH SYSTEM. DO YOU HAVE ANY IDEA WHAT THE VOLUME OF FOR THE CONSORTIUM IS? OF THE SEVEN HOSPITAL MEMBERS HOW MANY TIMES PER MONTH IS THE CONSORTIUM CALLED ON TO PROVIDE EMERGENCY INTERPRETER SERVICES?

>> YEAH. SO IT IS-- I MEAN, I'M JUST PULLING UP. SO I HAVE-- USUALLY, WE HAVE AROUND-- BETWEEN 165 AND 250 REQUESTS PER MONTH AND THAT RESULTS IN BETWEEN LIKE 650 TO 900 HOURS OF INTERPRETING.

>> GOT IT.

>> OF BILLABLE HOURS.

>> THAT'S REALLY HELPFUL. IT GIVES ME A RELATIVE SENSE. I THINK DAVID ROSENTHAL HAD A QUESTION AND THEN WE SHOULD PROBABLY WRAP UP.

>> SURE.

>> YES, THANK YOU, LARISSA.

>> YEAH.

>> MY QUESTION HAS TO DO WITH THE RURAL AREAS OF MINNESOTA.

>> YES.
>> AS I UNDERSTAND, YOU'RE NOT PROVIDING THE SERVICES OUTSIDE OF THE METRO AREA SO WHAT HAS BEEN DONE TO ADDRESS THE ISSUE OF ACCESS TO EMERGENCY INTERPRETING SERVICES IN THOSE RURAL AREAS?

>> SO THERE ARE THE SIGN LANGUAGE INTERPRETING VENDORS THAT PROVIDE INTERPRETERS TO THOSE AREAS. MY SPECIFIC SYSTEM DOESN'T HAVE RURAL CLINICS AND HOSPITALS. SO WE'RE NOT-- I DON'T PERSONALLY HAVE TO DEAL WITH THIS. THEY MIGHT HAVE TO PAY FOR TRAVEL TIME. THEY LIKELY DO HAVE TO PAY FOR TRAVEL TIME, BUT I THINK THEY'RE RELYING ON VIDEO REMOTE INTERPRETING MORE. JUST OUT OF NECESSITY.

>> I THINK WE'RE GOING TO GIVE GREG. GREG'S THE LAST QUESTION. LET ME RUN AROUND, GREG.
>> GREG GRIGGS WITH THE NORTH CAROLINA ACADEMY OF FAMILY PHYSICIANS. JUST TRYING TO GET AN IDEA OF THAT LEVEL OF SERVICE. MENT WHAT'S THE POPULATION OF THAT METRO AREA THAT IS SERVED BY THOSE HOSPITAL SYSTEMS, HOW DOES THAT COMPARE TO THE OVERALL POPULATION OF MINNESOTA?

>> SO WE HAVE-- GOSH, I THINK THERE ARE 4 MILLION PEOPLE LIVING IN THE TWIN CITIES AND I -- GOSH, I'D HAVE TO LOOK UP WHAT THE TOTAL POPULATION OF MINNESOTA IS. WE'RE PRETTY CONCENTRATED IN THE TWIN CITIES. OBVIOUSLY, THERE'S A LOT OF RURAL PEOPLE AS WELL, RURAL PATIENTS. BUT-- 5.6 MILLION.

>> I'M NOT ABLE TO ANSWER THAT.

>> GOOGLE VERY QUICKLY GIVES US 3.6 MILLION FOR THE TWIN CITY METRO AREA AND 5.6 MILLION FOR THE STATE.

>> OKAY. THANK YOU.

>> GOOGLE IS THE SOURCE OF ALL KNOWLEDGE, RIGHT?
[LAUGHTER]
POSSIBLY ACCURATE, POSSIBLY NOT.
>> AS I WAS TALKING, I'M LIKE I WONDER IF I CAN GET THIS QUICKLY.

>> GOOD.
>> WELL, LARISSA, THANK YOU FOR JOINING US THIS MORNING AND THANK YOU FOR YOUR TIME AND YOUR EXPERTISE AND I THINK WE'RE GOING TO MOVE ON TO THE NEXT ITEM OF OUR AGENDA. THANK YOU.
[APPLAUSE]

Lee Williamson VRI Demonstration

>> THANK YOU. SO NOW WE'RE GOING TO MOVE ON TO A COUPLE OF VIDEOS THAT LEE HAS AND HE WILL EXPLAIN THEM AND WE'LL PLAY THEM FOR YOU.

>> HELLO. THIS IS LEE. AND JUST AS YOU PONDER AND THINK ABOUT WHAT YOU JUST HEARD FROM LARISSA, I'VE BEEN TALKING TO HER OFF-LINE AND SHE'S MORE THAN WILLING TO PROVIDE MORE INFORMATION. WE ALSO HAVE CONTACT WITH PAMELA WILLISON WHO RUNS THE AGENCY THAT PROVIDES THE SERVICE TO THE CONSORTIUM. A LITTLE SIDE NOTE, PAM WITH ASALS IS TRYING TO AI PLY THIS MODEL TO THE RURAL AREAS OF MINNESOTA. OF COURSE, IT WON'T BE AS LARGE AS HAVING THREE-DEEP ONCALL INTERPRETERS. HER RECOMMENDATION AND WHAT SHE'S PROPOSING TO THE MORE RURAL HOSPITAL IS ONE TO TWO INTERPRETERS ON CALL DURING THE OVERNIGHT HOURS SO MAYBE A 10 TO 12-HOUR SHIFT, RUNNING 7: 00 P.M. TO 7: 00 A.M. OR SO, AND SO I DON'T-- NOT QUITE SURE HOW FAR SHE'S GOTTEN TO THAT AND THAT'S SOMETHING SHE APPLIED TO THE RURAL AREAS OF MINNESOTA. SO PAM WOULD BE MORE THAN WILLING TO SHARE INFORMATION ABOUT WHAT HER AGENCY'S DOING AND HOW THINGS ARE WORKING IN MINNESOTA. IT IS INTERESTING TO CONSIDER THE POPULATION DIFFERENCES. NORTH CAROLINA IS TWICE AS LARGE POPULATION-WISE. TRIANGLE IS NOT LIKE THE TWIN CITIES WITH THREE MILLION PEOPLE. OH, I'M SORRY.

>> HAND IN THE BACK HIDING BEHIND THE CORNER FOR YOU, LEE.

>> HI. WHEN YOU MENTIONED THAT THEY'RE TRYING TO GET IT INTO THE RURAL AREAS OF THE STATE, IT BROUGHT UP A QUESTION FOR ME. DOES MINNESOTA HAVE A HIGHER POPULATION OF INTERPRETERS? DO THEY HAVE A BETTER SOURCE OF INTERPRETERS? BECAUSE WE STRUGGLE WITH THAT IN VERY RURAL PARTS OF THE STATE. HOW DO THEY HAVE SO MANY THAT THEY CAN EXPAND IT OUT INTO THOSE RURAL REGIONS?

>> THIS IS LEE. YES. YOU'RE ASKING EXACTLY WHAT I WAS ABOUT TO SAY.

>> I'M SORRY.
[LAUGHTER]

>> I WAS GOING TO SAY, WE'RE TWICE AS LARGE POPULATION-WISE. NORTH CAROLINA HAS JUST OVER 300 FULLY CERTIFIED OR NATIONALLY CERTIFIED INTERPRETERS, 3 TO 350, I'M NOT SURE EXACTLY OF THE NUMBER. MINNESOTA HAS OVER 600. HALF THE POPULATION BUT TWICE AS MANY CERTIFIED INTERPRETERS. IT COULD BE BECAUSE OF THE INTERPRETER TRAINING PROGRAMS THEY HAVE IN THAT STATE ARE VERY STRONG AND THEY'RE PRODUCING REALLY GOOD QUALITY INTERPRETERS. THEY HAVE A VERY GOOD PIPE LINE. I TALKED TO PAMELA AT ASALS AND ASKED WHERE ARE YOU GETTING THE

INTERPRETERS TO DO THIS? SHE SAID HER PIPE LINE IS THE HIGH SCHOOLS. IN MINNESOTA, ASL IS TAUGHT FAIRLY REGULARLY THROUGHOUT MANY OF THE HIGH SCHOOLS IN THE STATE BY ASLTA, WHICH IS AMERICAN SIGN LANGUAGE TEACHER ASSOCIATION, CERTIFIED TEACHERS. MOST OF THE TEACHERS ESPECIALLY IN THE TWIN CITIES AREA, THERE ARE TEN HIGH SCHOOLS IN THE TWIN CITIES AREA. ALL TEACHERS IN HIGH SCHOOLS TEACH LEVELS ONE THROUGH FOUR AND ALL THE TEACHERS ARE DEAF AND THEY'RE NATIVE USERS OF THE LANGUAGE. I GREW UP IN RURAL NORTH CAROLINA AND I TOOK SPANISH. MY SPANISH TEACHER FROM WILSON COUNTY AND I LEARNED COMO
[SPEAKING SPANISH WITH SOUTHERN ACCENT]
THAT'S WHAT WE'RE SEEING IN NORTH CAROLINA IN SOME OF THE HIGH SCHOOLS THAT TEACH ASL AND THAT MAY BE ONLY I'D SAY LESS THAN FIVE HIGHLE SCOOS IN THE ENTIRE STATE HAVE ASL CLASSES RIGHT NOW AND THEY'RE NOT ASLTA CERTIFIED TEACHERS THAT I KNOW OF. THAT'S SOMETHING TO CONSIDER AS YOU THINK ABOUT INTERPRETER REQUIREMENTS AND QUALIFICATIONS IN A PIPE LINE, BUT BUT THAT'S WHAT MINNESOTA HAS. I FOUND OUT THEY HAVE A REALLY GOOD PIPE LINE OF SECOND LANGUAGE LEARNERS COMING OUT OF HIGH SCHOOL. OKAY. WHAT I'M GOING TO BASICALLY DO IS GIVE YOU A BRIEF DEMO OF VIDEO REMOTE INTERPRETERS. IT'S NOT IDEAL. WE KIND OF CREATED A HOMEMADE VIDEO TO KIND OF SHOW-- WE GOT A VIDEO OF A GENTLEMAN IN AN EMERGENCY ROOM AND WE WERE BASICALLY USING AN iPAD WHICH YOU'LL SEE AT THE BOTTOM OF THE SCREEN WHICH NORMALLY A VIDEO REMOTE INTERPRETING, I HAVE ANOTHER VIDEO, IF YOU WANT TO SHOW THAT ONE FIRST. THAT MAY BE EASIER TO SHOW. WE WILL SHOW WHAT AN IDEAL VIDEO REMOTE INTERPRETING ENCOUNTER LOOKS LIKE.
THIS IS PRODUCED BY A HOSPITAL SYSTEM
IF YOU CAN START AT 1: 41 MINUTE AND WE WON'T HAVE TO SEE THE INTRO, BUT THE VIDEO WILL SHOW A PATIENT AND A PROVIDER BASICALLY HAVING A DISCUSSION WITH THE VIDEO REMOTE INTERPRETING CART, WHICH IS AN iPAD ON A CART . WE'LL SHOW THAT NOW.

(VIDEO)
>> HI. WHAT BRINGS YOU IN TODAY?
>> SHE'S SIGNING I'M DEAF. I NEED AN INTERPRETER.
>> I WILL GET YOU AN INTERPRETER. ONE SECOND.
>> HI. THIS IS-- SO WHAT BRINGS YOU IN TODAY?
>> WOW. MY SHOULDER HAS REALLY BEEN HURTING ME QUITE A BIT AND I'M IN A LOT OF PAIN.
>> I'M SORRY TO HEAR THAT. WELL, WE'LL JUST TAKE A FEW IMAGES AND WE'LL LET YOU KNOW THE RESULTS.
>> OH, THANK YOU SO MUCH.
>> ALL RIGHT. THAT WILL BE ALL FOR TODAY.
>> OH, REALLY? THAT'S FAST.
>> THAT IS ALL.
>> THANK YOU VERY MUCH.
>> ALL RIGHT. THANK YOU.
>> WOULD YOU LIKE THE INTERPRETER TO DISCONNECT AT THIS TIME?
>> YES.
>> OKAY. HAVE A GOOD DAY.
>> THANK YOU.
>> BYE-BYE.

>> INTERPRETING SERVICES ARE AVAILABLE FOR--
>> SO THAT'S YOUR BASIC, TO BE HONESTLY, I DON'T THINK IT'S IDEAL BUT I'M BIASED BECAUSE NOW THE INTERPRETER IS GONE AND THERE'S TWO PEOPLE IN THE ROOM. THAT'S MY THOUGHT ON THAT IF I WAS A PATIENT. OKAY. LET'S GO TO THE DEMONSTRATION. KELLY AND HER STAFF DID THIS IN HER OFFICES.

>> CRYSTAL HAS A COMMENT FOR YOU. SORRY.

>> NO PROBLEM.

>> I CAN'T LET IT SLIDE. I'M SORRY. SHE'S GOING TO JUMP OUT OF HER SEAT. I DON'T WANT THAT TO HAPPEN.

>> I UNDERSTAND YOUR CONCERN . THAT'S NOT HOW IT WORKS WHEN WE USE INTERPRETERS AND WHEN YOU ARE TRAINED TO USE INTERPRETERS AS I WAS AT EAST CAROLINA UNIVERSITY SCHOOL OF MEDICINE.

>> ROCK IT!

>> YOU KEEP THE INTERPRETER THROUGH THE PHYSICAL EXAM SO THAT YOU CAN ASK QUESTIONS ABOUT DOES THIS HURT, DOES THAT HURT, THAT IS THE BRIEFEST HPI I'VE EVER SEEN. THAT DOESN'T HAPPEN. I SEE YOUR CONCERN AND GENERALLY WE DON'T DO THAT AS PHYSICIANS. I WANT TO ALLAY THAT FOR YOU. SORRY.
[LAUGHTER]
>> YOUR SHOULDER HURTS. WE'RE TAKING PICTURES. GOOD-BYE.
>> NO PHYSICAL EXAM?
[LAUGHTER]

>> THIS IS LIE. I DON'T MEAN TO GET INTO THE CLINICAL DISCUSSION. YOU'RE CLINICIANS AND YOU KNOW THAT
[LAUGHTER]
I AM AN INTERPRETER AND I AM A CHILD OF DEAF ADULT WHO HAS BEEN IN SITUATIONS LIKE THIS AND I'M NOT SAYING IT'S THAT SHORT AND SWEET. BUT WHEN THE ENCOUNTER IS OVER, THE DEAF PERSON IS-- FEELS LIKE THEY ARE AT TOTAL CONTROL OF THE PROVIDER WHO CAN PUSH THAT BUTTON ON AND OFF AND WHEN IT'S TURNED OFF AND THEY MAY BE THINKING ABOUT THINGS A FEW MINUTES LATER, THEY DON'T HAVE ACCESS TO THE INTERPRETER RIGHT THERE. THERE'S A LOT OF DIFFERENCE. IF YOU PUT YOURSELF IN ANOTHER COUNTRY AND YOU WANT TO SPEAK WITH YOUR PROVIDER AND YOU DON'T HAVE THE INTERPRETER BUT FOR A FEW MOMENTS AND THERE ARE MORE QUESTIONS THAT POP UP A FEW MINUTES LATER, JUST THE WHOLE SITUATION.
IT'S NOT EQUAL ACCESS TO CARE. THAT'S-- THAT WAS MY PERSPECTIVE ON THAT I GUESS, THAT'S MY BIAS. DEFINITELY. WE'RE GOING TO HAVE DISCUSSION ABOUT THIS. I WANT TO GIVE YOU A QUICK EXAMPLE OF VRI. OKAY. ALSO THE THE CHALLENGES THAT THE DEAF COMMUNITY MEMBERS OR THE FRUSTRATIONS THEY HAVE IS THAT THE PICTURE IS NOT LIKE THAT ALL THE TIME. WE SET UP THIS HOMEMADE VIDEO AND IF YOU WATCH THE iPAD, THERE WILL BE A LIVE INTERPRETER OR ON-SITE

INTERPRETER RIGHT HERE. AND THEN THEY'RE LOOKING AT A SCENARIO THAT'S ON THE SCREEN. BUT IF YOU CAN SEE THE iPAD WHICH WILL BE SMALL AND THERE WILL BE CAPTIONS EXPLAINING WHAT'S HAPPENING ON THE iPAD. THIS WAS DONE THROUGH FACETIME. SO BASICALLY THE iPAD IS HERE. THE INTERPRETER IS IN THE ROOM NEXT DOOR USING FACETIME AND YOU'LL NOTICE THE TECHNOLOGY ISSUES.
LET'S RUN THAT FOR A MOMENT.

>> WE DON'T NEED YOUTUBE'S CAPTIONING ON THIS?

>> NO. I DON'T THINK SO.

[PLAYING VIDEO]
TONIGHTS V-I-C-H.
>> IS THE RIGHT HAND THAT YOU SIGN THE MOST WITH?
>> YES.
>> WE'LL PUT THIS ON THE LEFT. OKAY. MR. KURTAVICH, YOU ARE HERE WITH CHEST PAIN, TELL US ABOUT THE COMPLICATION. WHEN DOES IT START?
>> A FEW DAYS AGO. I NOTICE WHEN I WAS DOING SOME DIGGING AND WORK THAT THERE WAS SOME PAIN THAT STARTED. AND IT JUST STOPPED AND IT RUNS DOWN MY LEFT ARM AND MY LEFT LEG.
>> YOU CAN STOP IT.

>> THAT'S JUST A BASIC VIEW AND IT'S NOT WHAT IT WOULD REALLY LOOK LIKE. THE PICTURE OF CART, AGAIN, YOU KNOW, IF YOU ALL HAVE BEEN IN THE EMERGENCY ROOM THIS IS A SMALL AREA. YOU SEE TWO NURSES, TWO PROVIDERS, THERE'S PROBABLY IN A REAL LIFE SITUATION, WIFE, PARTNER, OR COMPANION THAT IS THERE IN THE ROOM AND MOST LIKELY DEAF AND I DON'T KNOW WHERE THEY SHOULD BE. WHEN I'M IN THE EMERGENCY ROOM AND CHILD AND MY WIFE AND I'M THERE AND COMMUNICATING AND ACCESSING INFORMATION, SO THE THE COMPANION PROBABLY HAS TROUBLE SEEING IT. THIS FROZE QUITE A BIT. IF YOU SEE THE POSITIONING OF HIM, HE'S SIGNING LIKE THIS AND HAD A VERY DIFFICULT LAST NAME TO CATCH. SO THERE WERE QUITE A FEW THINGS. FOR THE INTERPRETERS, I KNOW YOU WERE IS WILLENNING TO THE INTERPRETER. THIS IS A PROVISIONALLY LICENSED INTERPRETER, RECENT GRADUATE. I THINK SHE HAS EXCELLENT SIGNING SKILLS, A LOT OF POTENTIAL HERE. THERE MAY BE SOME CONCERNS ABOUT CERTAIN HEALTHCARE ASSIGNMENTS THAT YOU MAY WANT HER TO INTERPRET FOR. JUST SAYING FROM WHAT I'M SEEING AND WHAT YOU ARE HEARING FROM SOMEONE WHO DOESN'T KNOW INTERPRETING. GRADUATE FROM A GREAT PROGRAM, I SEE ONCE WE GET OUR MENTORING PROGRAM GOING AND SHE BECOMES ONE OF OUR METNEEs AT DHDSS, SHE'LL BE GREAT. I THINK THE REST OF THE MORNING IS ARE TO YOU GUYS TO DISCUSS HAVE DISCUSSION ON ALL OF THIS. I KNOW WE WANT TO GET TO THAT.

>> WE HAD MAYBE TWO HANDS UP. LET FOLKS HAVE COMMENTS, TOVAH AND DAVID AND WE'RE GOING TO MOVE ON.

>> THANK YOU. TOVAH HERE. I JUST HAD A RELATIVELY MINOR OBSERVATION ABOUT THE FIRST VIDEO WITH THE DOCTOR AND PATIENT IN THE CLINICAL SETTING. THE VIDEO THING WENT WAY OFF TO THE SIDE SO BOTH OF THEM COULDN'T SEE EACH OTHER. IT WOULD SEEM TO ME WE MIGHT HAVE TO LOOK

AT WAYS OF PRESENTING IT LIKE INTERPRETERS WHERE THEY'RE NEXT TO THE PERSON OR NEAR THE PERSON'S FACE AND POSSIBLY IN THOSE SITUATIONS ARE THE DISIKS THAT CAN BE RAISED AND LOWERED IN FRONT OF THE PATIENT SO THERE MAY BE LOGISTICAL THINGS AROUND THAT THAT COULD IMPROVE VRI SERVICES.

>> YOU'RE GETTING YOUR STEPS IN.

>> THAT'S MY GOAL.

>> THIS IS DAVID HENDERSON AGAIN. I WAS GOING TO ASK LEE, YOU TALKED ABOUT HOW THEY TURNED OFF THE, YOU KNOW, THE INTERPRETER AND THERE WAS-- CRYSTAL NOTED, THERE'S LOTS LEFT TO HAPPEN WITH THAT ENCOUNTER, WOULD THEY NOT ROLL THAT INTERPRETER AROUND THROUGHOUT THE ENTIRE PATIENT ENCOUNTER, LIKE A LIVE INTERPRETER WOULD FOLLOW THE PERSON AROUND UNTIL EVERYTHING WAS DONE?

>> GREAT QUESTION.

>> WHAT DO YOU THINK, CRYSTAL?

>> CAN I ANSWER QUICKLY? WHAT TYPICALLY HAPPENS WITH VIDEO REMOTE INTERPRETING AND IT VARIES FROM PROVIDER TO PROVIDER, IT VARIES WHAT TYPE OF TRAINING THEY HAVE AND WHAT THEY WANT TO DO. SAY YOU HAD THAT INITIAL ENCOUNTER, THE INITIAL VISIT, VRI IS TURNED OFF. SHE WILL SIT AND WAIT UNTIL SHE GOES TO THE NEXT PLACE WHERE THERE'S A TEST. THE CART WOULD GO WITH HER. THE CART WOULD BE OFF TYPICALLY. SHE GETS TO THE ROOM. CART'S TURNED BACK ON. IT'S A DIFFERENT INTERPRETER. SO THINK ABOUT THE CONTINUING DIALOGUE THAT HAPPENS BETWEEN A PATIENT AND HEALTHCARE PROVIDER THROUGHOUT THE ENTIRE VISIT OR PROCESS. NORMALLY THE INTERPRETER HAS ALL OF THIS INFORMATION THAT REALLY HELPS WITH THE INTERPRETATION AND AS AN INTERPRETER, IT'S DIFFICULT TO COME IN COLD IN THE MIDDLE OF SOMETHING THAT HAPPENED BEFOREHAND AND DOING CONTINUING INTERPRETING. THAT'S FROM A AN INTERPRETER'S PERSPECTIVE AND LIZ IS HERE FROM VIDEO RELAY SERVICES.
THAT'S ONE PROBLEM WE HAVE WITH VIDEO RELAY SERVICES WHICH IS INTERPRETING PHONE CALLS WHICH IS DIFFERENT. WE COME INTO AN INTIMATE CONVERSATION AND THE TWO CALLERS HAVE NO IDEA AND WE TALK LIKE BILLY IS A LITTLE BOY. WE FIND OUT THAT BILLY IS A DOG AND THAT MESSES MY ENTIRE INTERPRETATION UP. THAT HAS HAPPENED. IT IS EFFECTIVE AND IF THEY CAN KEEP THE CART ON AND HAVE THE INTERPRETER THERE THE WHOLE TIME. I DON'T THINK THAT HAPPENS ON A REGULAR BASIS
THAT HAS A LOT TO DO WITH TRAINING. THERE'S NO CONSISTENT TRAINING. THERE'S A LOT OF TURNOVER WITH STAFF. ONE THING WITH THE CONSORTIUM AND ASALS, THEY CREATED A VIDEO WHEN A DEAF INDIVIDUAL SHOWS UP FOR CARE IN ONE OF THESE PLACES THEY SHOW A SHORT VIDEO PRESENTED TO THEM IN SIGN LANGUAGE AND THEY'RE SHOWN THE OPTIONS THAT THEY'RE GIVEN. OPTIONS THAT THEY CAN HAVE WHERE IF THEY WANT AN ON-SITE INTERPRETER OR IF THEY WANT VRI AND THAT THEY HAVE A RIGHT TO CHOOSE AND TELL THE PROVIDER WHAT SERVICE THEY WOULD WANT AND I THOUGHT THAT WAS SOMETHING NEAT THAT THEY DO UP IN MINNESOTA AS WELL. THE DEAF PERSON, THOSE ARE OPTIONS AND IF THEY WANT VRI, THAT'S FINE. IT'S NOT SOMETHING THAT

WE'RE SAYING IS BAD. I THINK VRI IS VERY BENEFICIAL AND CAN HELP IN A LOT OF WAY. I THINK TECHNOLOGY AND TRAINING ARE HINDERING IT AS BECOMING AS EFFECTIVE AS IT COULD BE.

>> ONE QUICK FOLLOW-UP. DOES THIS WORK?

>> NO. IT ONLY PARTIALLY WORKS.

>> SO WHAT HAPPENED WITH THE LIVE INTERPRETER? DO THEY LEAVE WHILE THE PATIENT IS WAITING FOR IMAGES, OR DO THEY STAY WITH THE PATIENT? AND IF THEY STAY WITH THE PATIENT, WHY WOULD NOT THE PERSON ON THE MONITOR STAY WITH THE PATIENT?

>> THIS IS LEE AGAIN. TYPICALLY, THE ON-SITE INTERPRETER, WE WILL BE WITH THE PATIENT THE ENTIRE TIME. IT MAY DEPEND. SOMETIMES THERE ARE CERTAIN POLICIES FOR PRIVACY. IF THE PATIENT IS IN A ROOM, IN AN INPATIENT ROOM, THE HEALTHCARE PROVIDER WALKS OUT, THE INTERPRETER WILL WALK OUT OF THE ROOM AS WELL . THERE'S NO ONE THERE. WE'LL STAND IN THE HALLWAY OR AT THE NURSE'S STATION FOR IN-PATIENT SETTINGS AND EVEN IN A DOCTOR'S OFFICE OR A NURSE OR THE ASSISTANT OR THE DOCTOR COMES INTO THE ROOM, THE INTERPRETER COMES INTO THE ROOM AND LEAVES WITH THE PROVIDER. SOMETIMES THAT EVEN VARIES. BUT THAT'S TYPICALLY WHAT YOU WOULD SEE. SO THE INTERPRETER WOULD STILL BE THERE THROUGHOUT THE WHOLE TIME SOMEHOW.

>> HERE'S A QUESTION. IT'S CRYSTAL.

>> LET'S MAKE THIS THE LAST COMMENT.

>> SO I HEAR THE CONCERNS WITH VRI. WE KNOW ABOUT THE CONCERNS IN ACCESSING INTERPRETERS. FROM A PHYSICIAN'S STANDPOINT AT DIFFERENT POINTS IN THE STATE, WHAT ARE YOU GUYS OFFERING AS A SOLUTION FOR THOSE OF US IN PARTS OF THE STATE WHERE THERE AREN'T INTERPRETERS AVAILABLE AND WE KNOW VRI DOESN'T WORK WELL, HOW ARE WE EVEN GOING TO BEGIN TO ADDRESS THAT? WHICH IS COMMON IN EAST CAROLINA AND COMMON IN THE MOUNTAINS AS WELL. WE'RE POINTING OUT SOME OF THESE BUT WHAT ARE THE SOLUTIONS WE'RE PROPOSING TO THAT?

Discussion of Potential Recommendations

>> I THINK WE'RE GOING TO TALK ABOUT RECOMMENDATIONS AND MAYBE WE SHOULD MOVE INTO THE NEXT SECTION. I THINK YOU'RE RIGHT, CRYSTAL. I THINK WE WOULD ALL AGREE WITH THAT. AND I THINK WE DO HAVE SOME DISCUSSION ABOUT BUILDING THE PIPE LINE , ABOUT INCREASING ACCESS TO QUALIFIED SIGN LANGUAGE INTERPRETERS, SO WE DON'T HAVE THE SOLUTION. WE HAVE SOME IDEAS FOR HOW TO MOVE AN INTERACTION. I THINK YOU'RE RIGHT ON. I THINK BERKELEY IS HE DOING TO LEAD US IN A DISCUSSION OF SOME DRAFT RECOMMENDATIONS AND I THINK THE IDEA HERE IS TO START GETTING DOWN SOME THINGS ON PAPER, PROVERBIAL PAPER, SO THAT WE CAN TALK ABOUT WHERE YOU ALL ARE AT AS A TASK FORCE, DID WE GET THIS RIGHT? DID WE GET THESE WRONG? HOW

MUCH CONSENSUS IS THERE IN THE ROOM? WHERE DO WE NEED TO ALTER THE DETAILS? FOR EXAMPLE, WE WILL TALK ABOUT COMMUNICATION ACCESS FUND, AND THERE ARE A LOT OF VARIABLES. IF THERE'S CONSENSUS AROUND THE COMMUNICATION ACCESS FUND, WHICH KINDS OF PROVIDERS PAY AND WHICH KINDS OF PAYERS HAVE ACCESS TO THE FUND AND THERE ARE A LOT OF VARIABLES AND WE WANT TO SEE IF WE'RE MOVING IN THE RIGHT DIRECTION AND START TO MOVE TOWARD CONSENSUS AND LET'S GET COMMENTS ON SOME OF THOSE DETAILS.

>> ARE YOU GOING TO CARRY THAT AROUND? I DON'T KNOW HOW TO DO THIS EFFECTIVELY.

>> I THINK WE'RE GOING TO HAVE TO DO THAT.

>> I CAN HELP.

>> I THINK IT LOOKS LIKE WE HAVE QUESTIONS.

>> HI. THIS IS LIZ. AS WE GET STARTED, WHO ARE THESE PEOPLE THAT ARE INVOLVED IN THIS RECOMMENDATION? WHO ARE HELPING? I MEAN, I'M NOT AS FAR AS THESE RECOMMENDATIONS THAT ARE WRITTEN. WHO ARE THESE PEOPLE?

>> I'LL WAIT UNTIL I HAVE THAT.
[LAUGHTER]

>> OR, I CAN ANSWER ON THE WAY.

>> SO THE DRAFT RECOMMENDATION, EVERYBODY SHOULD HAVE A COPY OF THESE IN FRONT OF YOU OR IF YOU'RE ON A PHONE, THEY'VE BEEN EMAILED OUT. IT IS PROBABLY EASIER TO FOLLOW THAT WAY THAN THE SCREEN BECAUSE THERE'S A LOT GOING ON AND WE CAN'T INCREASE THE FONT SIZE BUT SO MUCH. THE DRAFT RECOMMENDATIONS ARE BASED ON WHAT THE DISCUSSION HAS HAPPENED IN THE TASK FORCE SO FAR IN MEETINGS WITH THE STEERING COMMITTEE. WE HAVE TRIED TO CAPTURE THE IDEAS WE HAVE HEARD. THAT DOESN'T NECESSARILY MEAN WE HAVE CONSENSUS AROUND THEM YET. SO WE'RE TALKING ABOUT THAT SOME THIS MORNING BUT THIS IS SO THE DRAFT RECOMMENDATIONS HERE, THE STEERING COMMITTEE HAS SEEN THEM, AND WEIGHED IN ON THEM, AND THEY REFLECT THE CONVERSATIONS THAT WE HAVE HEARD.

>> SO THAT STEERING COMMITTEE IS WHO?

>> IF YOU'RE ON THE STEERING COMMITTEE, WOULD YOU LIKE TO RAISE YOUR HAND? JAN'S ALSO ON THE STEERING COMMITTEE. THERE ARE A COUPLE OF PEOPLE WHO MIGHT NOT BE IN THE ROOM. BUT THEY HELP TO PLAN THE MEETINGS.
>> THANK YOU.

>> SO THE FIRST RECOMMENDATION IS ONE WE'VE TALKED A LOT ABOUT A, A COMMUNICATION ACCESS FUND. DO NOT KNOW THAT WE HAVE REACHED CONSENSUS ON THIS AND SO THE VERY FIRST ONE, THE DRAFT RECOMMENDATION IS THAT THE NORTH CAROLINA GENERAL ASSEMBLY SHOULD

AMEND THE LICENSING FEES PERTAINING TO CERTAIN MEDICAL LICENSING BOARDS AND ADD A FEE TO IT THAT WOULD BE USED TO FUND A COMMUNICATION ACCESS FUND. I'M SEEING A COUPLE OF HANDS . BIGGER!

>> I CAN INCREASE THE FONT SIZE AND SEE WHAT HAPPENS HERE.

>>> IF I MOVE THIS OUT OF THE WAY? IN WOULDN'T IT?

>> GOOD TO VIEW.

>> BOTTOM, RIGHT.
[LAUGHTER]
>> BOTTOM RIGHT WHERE IT SAYS 100%.
>> TRY 150.
>> OH, YEAH.
>> CANCEL THAT. SORRY. I WAS LOOKING AT THE FULL SCREEN. NOW LET'S SEE IF I CAN GET IT ON THE SCREEN AT ONCE. WE MAY HAVE MADE IT A LITTLE TOO BIG.

>> DO CONTROL A AND INCREASE THE FONT.

>> THAT'S GOOD.

>> IS THAT A LITTLE BIT BETTER? I THINK IF I GET IT ANY BIGGER, WE'LL HAVE TO SCROLL FROM SIDE TO SIDE, WHICH MIGHT MAKE PEOPLE A LITTLE ILL.

>> CONTROL A AND INCREASE THE FONT SIZE, YOU'LL GET THERE. BUT YOU'RE NOT GOING TO BE ABLE TO SEE. LY HAVE TO SCROLL SIDE TO SIDE.

>> IT'S JUST UP AND DOWN.

>> TRY SOMETHING IN BETWEEN, THOUGH.

>> WE'RE JUST GOING TO NOT BE ABLE TO SEE MUCH AT ONCE. OKAY. THAT'S UP. SO THE FIRST PART OF THE DISCUSSION IS THERE CONSENSUS AROUND THE COMMUNICATION ACCESS FUND? AS A REMINDER, COMMUNICATION ACCESS FUND WOULD BE A POOL OF MONEY. IN THIS CASE, THE RECOMMENDATIONS FOR THE GENERAL ASSEMBLY TO ADD LICENSING FEES TO AN AMOUNT FOR SOME MEDICAL PROFESSIONALS THAT WOULD BE USED TO PROVIDE MONEY INTO THE FUND. THE FUND WOULD THEN BE USED BY HEALTH PROFESSIONALS OUTSIDE OF HEALTH SYSTEMS, WHICH IS ANOTHER PIECE WE'LL GET TO IN A MINUTE BUT THE GENERAL IDEA IS WHERE ARE WE IN A COMMUNICATION ACCESS FUND? WE TALKED ABOUT IT A LOT. THERE SEEMS TO HAVE BEEN SUPPORT. WE'RE NOT SURE HOW MUCH SUPPORT THERE IS, IF THAT'S A UNIVERSAL OR CONSENSUS AROUND THAT THIS WOULD BE HELPFUL IN THE STATE OR NOT. SO WE CAN START TALKING.
>> I'LL RUN AROUND. I THINK IT WAS GREG AND JAN OR NO.

>> THE FIRST CONCERN I HAVE THE PRACTICALITY OF GETTING THIS DONE WITH IN THE GENERAL ASSEMBLY. THIS YEAR, THE MEDICAL BOARD AND I MAY LET DAVE JUMP IN HERE, TOO, IF YOU DON'T MIND, JAN, TRIED TO RAISE A FEE SMALLY THROUGH THE MEDICAL BOARD. HAD SUPPORT OF THE MEDICAL SOCIETY, SUPPORT OF THE PA ASSOCIATION, SUPPORT OF THE ACADEMY, HAD DONE ALL THEIR DUE DILIGENCE. IT GOT TO THE GENERAL ASSEMBLY AND GOT PULLED OUT AND THE GENERAL ASSEMBLY SAID NO. AND THAT'S JUST ONE BOARD AND THIS IS LOOKING AT IT VERY MUCH ACROSS A LOT OF BOARDS, WHICH I THINK GETS EXTRAORDINARILY COMPLICATED AND SO I THINK JUST THE PRACTICALITY OF GETTING THIS SET UP, YOU KNOW, I HAVE LOTS OF QUESTIONS ABOUT IT. YOU KNOW, LIKE HOW MUCH IS ENOUGH, WHO DOES IT APPLY FOR, HOW DO YOU APPLY IT FAIR AND EQUITABLY, SO THERE ARE MANY PHYSICIANS WORK FOR HEALTH SYSTEMS SO THEY'RE PAYING INTO IT AND IF THEY WORK FOR A HEALTH SYSTEM, THEY DON'T BENEFIT FROM IT, SO YOU KNOW, HOW DOES THAT WORK AND ARE THERE SOME OTHER OPTIONS LIKE TRYING TO LOOK AT IT THROUGH AN INSURANCE FEE OR SOMETHING LIKE THAT, WHERE IT CAN BE MORE FAIR AND EQUITABLE ACROSS STANDARDS? I DON'T DENY A NEED FOR SOMETHING LIKE THIS. I'M NOT SURE HOW PRACTICAL THIS IS AND THEN YOU LOOK AT, OKAY, YOU CAN DO IT IN A HOSPITAL EMERGENCY ROOM, BUT IS THAT A HOSPITAL EMERGENCY ROOM NOT AFFILIATED WITH THE HEALTH SYSTEM, WELL, WHAT HOSPITAL EMERGENCY ROOM IS THAT? THE SOUTHEASTERN HEALTH SYSTEM IN LUMBERTON, IS THAT A SYSTEM, OR IS IT NOT A SYSTEM? CAROMONT IN GASTONIA, IS THAT A SYSTEM OR NOT A SYSTEM? I THINK THERE ARE SO MANY QUESTIONS ON THIS THAT I THINK IT WOULD GET SO COMPLICATED THAT IT GETS BOGGED DOWN PRETTY EASILY AND I'M NOT SURE HOW FAR WE GET. IT ALSO DOESN'T ADDRESS WORKFORCE AT ALL. AND IF WE DON'T HAVE THE WORKFORCE, HOW DO WE EVEN IMPLEMENT THIS? I DON'T KNOW, DAVID--

>> I WILL TAKE MY TURN.

>> THEN DAVID, TOVAH AND COREY. JAN CONCEDED THE MICROPHONE.

>> ALL RIGHT. THIS IS DAVID WITH THE MEDICAL BOARD. SO MY EXPERIENCE HAS BEEN WHEN YOU'RE WANTING TO RAISE MONEY THROUGH A TAX, WHICH IS BASICALLY WHAT THIS IS, IT'S HELPFUL IF BEFORE YOU DO THAT, YOU DO A COUPLE OF THINGS. ONE IS, COLLECT DATA, AND THAT'S ONE OF THE REASONS I ASKED LARISSA ABOUT, HAD THEY COLLECTED DATA ON HOW MANY ENCOUNTERS THEY HAD WITH DEAF AND HARD OF HEARING PATIENTS AND WHAT WAS THEIR EXPERIENCE WITH THAT. I MISSED ONE OF THE SESSIONS, SO THAT MAY HAVE BEEN WHEN IT WAS DISCUSSED. I DON'T KNOW THAT WE HAVE A WHOLE LOT OF DATA AT THIS POINT ON THE EXTENT OF THE ISSUE. NOW, WE HEARD SOME REALLY, REALLY COMPELLING STORIES. I REMEMBER THOSE VIVIDLY ABOUT PEOPLE WHO HAD TERRIBLE EXPERIENCES WITH THE HEALTHCARE PROVIDER. AGAIN, MY EXPERIENCE HAS BEEN THAT IS NOT GOING TO WIN THE DAY AS FAR AS THE POLICYMAKERS AND STAKEHOLDERS AS FAR AS PUSHING YOU ACROSS THE LINE TO PREVAIL WITH A TAX, YOU KNOW, ON A CERTAIN GROUP OF PEOPLE. SO THAT'S ONE THING I THINK THAT WE REALLY NEED TO FOCUS ON BEFORE WE START TALKING ABOUT TAXING HEALTHCARE PROVIDERS TO RAISE MONEY FOR THIS FUND. THE OTHER THING I THINK THAT I FOUND IS VERY HELPFUL IS TO TRY TO EVERYTHING YOU CAN TO ADDRESS THE ISSUE BEFORE. AND SORT OF LIKE A LAST RESORT. HEY, WE'VE FL TRIED EVERYTHING WE CAN AND THIS IS NOT WORKING WE NEED TO RAISE MONEY FOR A CF. WHAT I'M TALKING ABOUT HERE IS EDUCATION AND REGULATION. SO WE-- THERE'S A LOT OF OPPORTUNITIES. I WILL SPEAK FOR THE MEDICAL BOARD. TO

MY KNOWLEDGE, WE HAVE NEVER DONE ANYTHING WITH OUR LICENSEES TO INFORM THEM ABOUT THE REQUIREMENTS OF THE ADA. WE TELL 'EM, YOU MUST FOLLOW ALL STATE AND FEDERAL LAWS. BUT THERE'S A LOT OF STATE AND FEDERAL LAWS OUT THERE, RIGHT. SO WE NEVER REALLY FOCUSED IN ON-- WE FOCUSED IN ON SOME KINDS OF STATE AND FEDERAL LAWS, THE OPIOID CRISIS AS A RECENT EXAMPLE. WE REALLY HAVE BEEN AFTER LICENSEES TO MAKE SURE THEY'RE PRESCRIBING APPROPRIATELY WITH OPIOIDS, BUT WE'VE NEVER-- I WASN'T AWARE OF THIS UNTIL JAN-- UNTIL THIS ISSUE. I SHOULD HAVE BEEN, BUT I WASN'T AIRWHAT OF THIS UNTIL JAN CALLED SEVERAL MONTHS AGO TO TALK ABOUT IT. WE HAVE A CAPTIVE AUDIENCE OF AROUND 40,000 LICENSEES. MOST OF THOSE ARE IN STATE. SOME OF ARE OUT OF STATE. WE'VE NOT DONE ANYTHING WITH OUR FOLKS AS FAR AS EDUCATING THEM ABOUT THEIR RESPONSIBILITIES , YOU KNOW, UNDER THE ADA TO ADDRESS THIS ISSUE. SO WE WOULD BE HAPPY TO DO THAT. WE WOULD ALSO REMIND THEM, YOU KNOW, THAT THE MEDICAL BOARD EXISTS, THAT IF PATIENTS, YOU KNOW, DO HAVE AN ENCOUNTER OR THEY FEEL LIKE THEY HAVE EFFECTIVE COMMUNICATION THAT WE WOULD LOOK INTO IT AND INVESTIGATE THAT. I KNOW THAT'S USUALLY PERSUASIVE OF PEOPLE. I KNOW THAT OTHER PEOPLE WANT TO SPEAK. I WILL STOP THERE. MY POINT HERE IS I THINK THAT IT'S NOT YET TIME FOR THE CAF, IN MY OPINION. I THINK WE'D BE WASTING A LOT OF TIME AND EFFORT ON SOMETHING THAT WILL NOT WORK AT THIS POINT. THERE'S OTHER THINGS WE CAN DO TO MOVE THE NEEDLE BEFORE WE GET TO THAT POINT.

>> GREAT.

>> TOVAH HERE. WHEN I TALKED BRIEFLY WITH HOWARD ROSIN BLIEWM WHO WAS THE GUY WHO RAISED THE CAF IDEA, IF YOU RECALL, ONE OF THE THINGS WE CHATTED ABOUT WAS ANOTHER POSSIBILITY IS TO HAVE PROVIDERS AGREE TO PAY A CERTAIN AMOUNT PER YEAR OR PER MONTH OR SOMETHING, EITHER IN ADDITION TO THEIR LICENSING VOLUNTARILY, NOT AS PART OF THE REQUIRED LICENSING FEE, AND THOSE WHO DID PARTICIPATE BY PAYING IN THIS WAY WOULD BE THE ONE TO HAVE ACCESS TO ESSENTIAL COMMUNICATION FUND THAT RAISES THE QUESTION OF HOW MANY PEOPLE EACH YEAR WOULD AGREE TO THIS AND KEEP IT UP AND OF COURSE, THE ADMINISTRATION OF THOSE FUNDS. I DO ALSO THINK THAT THE TAX REVENUE IDEA IS POSSIBLY ANOTHER WAY. WE ALREADY HAVE TAXES ON EVERYBODY FOR THE VIDEO RELAY SYSTEMS THAT WE HAVE IN THIS COUNTRY SO IT IS POSSIBLE TO CONSIDER TAXING BUSINESSES OR ENTITIES THAT PROVIDE SERVICES TO BE PART OF THE CONSORTIUM FUND ALSO.

>> THINKING ABOUT ALTERNATE SOURCES OF REVENUE FOR THE CAP.

>> ADAM, HI, THIS IS MELISSA . THIS IS FOOD FOR THOUGHT AS WE THINK ABOUT THE ALTERNATIVES. KEEP IN MIND THAT THERE ARE OTHER ENTITIES THAT ALSO HAVE (INAUDIBLE) OR OBLIGATIONS.

>> DID WE CATCH ALL OF THAT, MELISSA? I HEARD SAME OR SIMILAR OBLIGATIONS. I WASN'T SURE IF YOU GOT CUT OFF.

>> YEP. AS WE'RE LOOKING AT IT, YOU KNOW, HOSPITALS HAVE TO COMPLY, INSURERS HAVE TO COMPLY, PROVIDERS HAVE TO COMPLY, THERE'S A NUANCE WITH OBVIOUSLY HEALTHCARE VERSUS THE ADA WHEN YOU THINK ABOUT IT FROM A RETAIL OR BUSINESS PERSPECTIVE.

>> GOT IT. THANK YOU, MELISSA.

>> THIS IS COREY DUNN WITH DISABILITY RIGHTS NORTH CAROLINA. SO I THINK IT IS -- I THINK COMMUNICATION ACCESS FUND IS REALLY A TOOL FOR PROVIDERS TO COMPLY WITH EXISTING LAW AND SO FROM THAT PERSPECTIVE, WE HAVE ALWAYS AS ADVOCATES FOR PEOPLE WITH DISABILITY, SUPPORTED ANY TOOLS THAT PROVIDERS NEED TO COMPLY, BUT WE ARE-- WE RECOGNIZE THE DIFFICULTY ASSOCIATED WITH MATCHING THE FUNDING SOURCES, AS FOLKS HAVE MENTIONED, WHETHER THAT'S LICENSING FEES AND WHAT ENTITIES THAT MIGHT, MORE GENERALIZED TAXES SO TARGETED FEES VERSUS MORE BROADLY BORNE TAXES, OR VOLUNTARY COMMUNICATION ACCESS FUND MEMBERSHIP. WE THINK THAT ALL OF THOSE COULD WORK. RECOGNIZING THE CONCERNS ABOUT LEGISLATIVE ACTION. IT IS-- I THINK ALL OF THOSE ARE QUESTIONS ABOUT FEASIBILITY, THOUGH, BECAUSE THIS HAS BEEN LAW FOR 30 YEAR. THIS IS NOT NEW. IT IS NOT SURPRISING. AND TO THE EXTENT THAT PROFESSIONAL ASSOCIATIONS, PROFESSIONAL LIABILITY INSURERS AND OTHERS HAVE NOT ALREADY TAKEN IT ON, IT'S TIME FOR THOSE FOLKS TO CATCH UP BECAUSE THE ADVOCATES HAVE BEEN WORKING ON THIS FOR A VERY LONG TIME. SO I THINK THAT IF WE'RE-- IF THOSE SECTORS NEED SUPPORT FROM THE REST OF US TO MAKE THAT HAPPEN, THEN I THINK I WANT TO VOLUNTEER AND SAY WE WILL HELP IN WHATEVER WAY WE CAN. BUT I THINK THE COMMUNICATION ACCESS FUND, FRANKLY, HAS COME FROM THE ADVOCACY SECTOR AS A RECOMMENDATION TO HELP FILL A GAP THAT WE'VE SEEN THE PROFESSIONAL ASSOCIATIONS AND THE LIABILITY INSURERS AND OTHERS INVOLVED IN COMPLIANCE FAIL TO STEP UP TO.

>> SO CLEARLY I HAD SOME CONCERNS ABOUT THIS AS A PRACTICING PHYSICIANS WHO WORKS WITH PATIENTS WITH DIFFERENT DEVELOPMENTAL DISABILITIES. THE FIRST QUESTION WAS THE LACK OF SPECIFICITY IN THE WORDING. WHEN WE SAY MEDICAL BOARD THAT MEANS YOU'RE TARGETING PHYSICIANS ONLY. AMONGST PHYSICIANS THERE IS THE FEELING OF SOMEWHAT BEING PERSECUTED, FOR LACK OF A BETTER TERM. AS A PHYSICIAN WHO PROVIDES VRI AND IN-PERSON INTERPRETING SERVICES TO ALL PATIENTS WHO REQUEST IT, IT'S FRUSTRATING TO READ THE WORDING HERE BECAUSE I'M A PHYSICIAN WHO DOES HAVE TO PAY FOR IT BECAUSE OF THE MODEL OF COMPENSATION THAT I'M IN, BUT I WOULD BE EXCLUDED FROM HAVING ACCESS TO THIS FUND. WHEN WE TALK ABOUT A VOLUNTARY FUND, I HAPPILY PROVIDE THIS AND I PAY FOR IT NOW AND I WOULD CONTINUE TO PAY FOR IT, BUT THIS WOULD NOT HELP ME AND WOULD ACTUALLY ADD AN ADDITIONAL BURDEN. FOR PHYSICIANS I SPEAK IN EASTERN NORTH CAROLINA, THEY WOULD PAY A FEE AND STILL NOT HAVE ACCESS TO INTERPRETERS OR VRI. IT DOESN'T ADDRESS THE ISSUES THAT THOSE OF US WHO ARE VERY COMMITTED TO PROVIDING ACCESS TO COMMUNICATION HAVE IN DIFFERENT PARTS OF THE STATE . IT ALSO FOR PHYSICIANS-- FOR US TO BE AT THE TABLE TO BE PAYING A TAX WITHOUT THE INSURERS BEING INVOLVED IN THIS IS A SOURCE OF WOE. IF WE HAVE A BILLING CODE FOR TOBACCO CESSATION, A BILLING CODE FOR AUTISM SCREENING, BUT THERE'S NO BILLING CODE FOR INTERPRETER SERVICES, THAT IS A POINT OF CONTENTION FOR PHYSICIANS ACROSS THE COUNTRY. NOT JUST IN NORTH CAROLINA. I LOVE THE FACT THAT THIS WAS TALKING ABOUT MEDICAID CREATING A FUND, BUT PRIVATE INSURERS ALSO SHOULD COME TO THE TABLE AND WORK WITH US ON THIS. HOSPITAL SYSTEMS, WHICH DO WORK ON THIS, SHOULD ALSO HAVE A PART IN THIS. SO I THOUGHT IT WAS GOING TO BE MORE OF A TEAM-BASED APPROACH THAN JUST PHYSICIANS OR JUST PROVIDERS

BECAUSE ALL OF US HAVE A ROLE IN THIS.

>> THANK YOU. I JUST WANT TO MAKE A COUPLE OF COMMENTS. I OBVIOUSLY, THERE'S A LOT PACKED INTO THAT. KEEP IN MIND, THIS IS A TEST AND THIS IS TO GIVE YOU SOMETHING TO REACT TO, BY MEDICAL, WE MEAN HEALTHCARE, BUT WE DON'T KNOW WHERE THAT BEGINS AND ENDS. SO THIS IS A DISCUSSION POINT TODAY. AND THEN THE OTHER POINT YOU RAISED WAS ABOUT YOUR CLINIC AND THE COMPENSATION AND FINANCING MODEL IN YOUR CLINIC, AND WE MET WITH THE HEALTHCARE ASSOCIATION LAST WEEK AND ONE OF THE QUESTIONS WE HAD FOR THEM IS , HOW SHOULD WE THINK ABOUT CLINICS THAT ARE AFFILIATED WITH THE HEALTH SYSTEM THAT MIGHT NOT BE ON THE MAIN CAMPUS OF THE HEALTH SYSTEM, AND WE ARE TOLD THAT THERE ARE ABOUT SEVEN DIFFERENT FINANCING MODELS, I THINK WHAT WE KIND OF WALK ADD WAY FROM THAT WITH ALTHOUGH WE HAVEN'T HAD A CHANCE TO DISCUSS IT, IS IT MAY BE-- IT'S AT THE VERY LEAST UNCLEAR TO THINK ABOUT WHO IS IN AND WHO IS OUT. I THINK THAT WE WOULD WANT TO ERR MORE ON THE SIDE OF INCLUDING, AGAIN, I THINK PRACTICES THAT ARE NOT LOCATED ON THE CAMPUS OF THE MAIN HEALTH SYSTEM, BUT HOW WE OPERATIONALLIZE THAT AND I THINK THE DEVIL IS IN THE DETAILS. EILEEN HAD A QUESTION.

>> EILEEN CARTER WITH NCDA WE HAVE A TASK FORCE CALLED DIVERSITY TASK FORCE. THIS IS PART OF OUR RECOMMENDATION OF WHAT COMES OUT OF THIS GROUP TODAY. WE WILL BE REPORTING IN AUGUST. I'M THE CO-CHAIR, ONE OF THE CO-CHAIRS. SO I DID LIKE A LITTLE SURVEY OF THE HOUSE OF DELEGATES WHICH WE ACTUALLY PRESENT AND REPRESENT IN THE NATIONAL LEVEL, 11 OF US REPRESENT NORTH CAROLINA AT THE NCPA LEVEL AND WHEN I TOOK A SURVEY, WOULD YOU GUYS BE WILLING TO TAKE PART OF OUR LICENSURE MONEY OR INCREASE OUR LICENSURE MONEYS AND CONTRIBUTE TO THIS FUND. THEY SAID YES. IT'S THE RESOURCES. ARE WE GOING TO HAVE THOSE RESOURCES ONCE WE DEDICATE IT. IT PROBLEM WE HAVE IS IT TOOK US SIX YEARS. IT'S NOW IN THE GOVERNOR'S HAND TO SIGN THIS, IT TOOK US SIX YEARS TO GET PART OF OUR DIRECT ACCESS BILL TO BE CHANGED. NOW THAT WAS A LOT OF WORK FROM A LOT OF PEOPLE IN THE STATE OF NORTH CAROLINA. SO WE'RE THERE TO ADVOCATE FOR OUR PATIENTS, BUT WE WANT TO HAVE THE RESOURCES AND THE AVAILABILITY, AND I'M IN RURAL NORTH CAROLINA. AND EVEN THOUGH THERE'S A SCHOOL FORTH DEAF RIGHT THERE IN WILSON NORTH CAROLINA WHERE I HAVE A PRIVATE PRACTICE, IT DOESN'T MEAN THAT IT'S READILY ACCESSIBLE. IT DOESN'T MEAN IT'S READILY FINANCIALLY ACCESSIBLE. THANK YOU.

>> THIS IS SORT OF A SMALLER SCALE OF WHAT CRYSTAL'S TALKING ABOUT. THIS IS SHELLEY CRISTOBAL. I'M AN AUDIOLOGIST AND I OWN MY PRACTICE. SO IF I'M PAYING ON MY LICENSURE FEE AN EXTRA $5 INTO THIS FUND, IT'S SOMETHING IF I BROUGHT INTO AN INTERPRETER I WOULD HAVE PAID FOR, EITHER AS THE BUSINESS OR AS THE PROVIDER BUT IN THE END, MY BUSINESS WOULD HAVE PAID FOR IT. SO WHEN I HAVE AN EMPLOYEE AUDIOLOGIST, THEIR RESPONSIBILITY AND THEIR LICENSURE FUNDS WOULD BE ULTIMATELY THEIRS TO BE PAYING FOR THEIR LICENSE. BUT IF THEY WERE SEEING A PATIENT WHO HAD COME IN AND NEEDED AN INTERPRETER, I WOULD HAVE BEEN THE ONE AS A BUSINESS PAYING FOR THAT INTERPRETER. SO THAT'S WHERE I THINK THIS DISTINCTION GETS REALLY TRICKY. ESPECIALLY WHEN WE TALK ABOUT LARGE SYSTEMS WHERE THAT'S THE BUSINESS AND THE PROVIDER ARE MUCH MORE SEPARATE. SO THAT'S A BIG PIECE OF WHAT WE'RE TALKING ABOUT HERE. I WANT TO TALK MORE ABOUT THE EDUCATION PIECE, TOO. IT'S BETTER TO KEEP THIS ON THIS

CONVERSATION.

>> TOVAH IS NEXT

>> TOVAH HERE. I'M WONDERING IF WE ARE LOOKING AT THIS FROM A DIFFERENT ANGLE THAN MAYBE THE ONE WE SHOULD BE LOOKING AT. I GOT STUCK ON THE NOTION OF ADA, BEING AROUND FOR AS LONG AS IT'S BEEN AROUND, AND YET WE STILL HAVE SO MUCH EITHER IGNORANCE, RESISTANCE, OR DIFFICULTY COMPLYING WITH IT . I WONDER IF WHAT WE NEED TO DO IS TO FIND A WAY TO PUT SOME SERIOUS TEETH INTO THE LAW AND ITS APPLICATION, AND-- AND/OR INCENTIVIZING PEOPLE TO OBEY THE LAW. I WONDER IF MAYBE THAT'S AN AVENUE WE SHOULD GIVE MORE AGGRESSIVE PURSUIT TO THAT. BECAUSE THE LAW IS THERE. IT'S JUST NOT BEING USED VERY WELL EVERYWHERE.

>> THIS IS COREY DUNN, DISABILITY RIGHTS NORTH CAROLINA. ONE OPTION FOR CREATING MORE INCENTIVE WITHOUT CREATING NEW LEGAL STRUCTURES WOULD BE FOR PAYERS TO MONITOR COMPLIANCE WITH THE ADA, SO THAT COULD INCLUDE INSURANCE COMPANIES, INCLUDING PUBLIC INSURANCE COMPANIES LIKE MEDICAID AND ALSO-- SHOOT. I JUST WENT COMPLETELY BLANK.

>> PRIVATE INSURERS

>> BUT THE PAYERS CAN CREATE CONSEQUENCES OUTSIDE OF THE LEGAL STRUCTURE, AND THAT COULD HAPPEN LIKE AT THE NEXT CONTRACT RENEWAL. THAT DOESN'T HAVE TO BE A TEN-YEAR PROCESS.

>> THIS IS SHELLEY CRISTOBAL BALL AGAIN. THAT DOES CYCLE BACK TO THAT EDUCATIONAL COMPONENT. I DO THINK EVERY PROVIDER I HAVE TALKED TO AND I'VE TALKED EMERGENCY ROOM PHYSICIANS IN RURAL NORTH CAROLINA. I'VE TALKED TO CASE WORKERS AND SOCIAL WORKERS AND SORT OF THE WIDE RANGE OF PEOPLE WHO WOULD BE INVOLVED IN THIS AND BENEFIT FROM THESE RESOURCES. AND THEY'RE JUST UNAWARE. THEY DON'T KNOW THAT THEY NEED TO BE PROVIDING THIS AND IF THEY DO, THEY HAVE NO IDEA WHERE TO START. WE KNOW THESE RESOURCES EXIST, BUT HOW DO WE MAKE THESE CONNECTIONS? I THINK KATHY HAS SOME FANTASTIC WORK SHE'S DONE IN EDUCATING PROVIDERS ON HEARING CARE AND SOME OF THOSE SORT OF MEANS MIGHT BE REALLY HELPFUL IN CREATING WEBINARS OR VIDEOS THAT BOTH EDUCATE THE PATIENTS ABOUT WHAT RESOURCES ARE OUT THERE SO THAT THEY CAN SELF-ADVOCATE BECAUSE I THINK THAT'S REALLY IMPORTANT, TOO. BUT MAYBE INCORPORATING THIS COMMUNICATION DIVERSITY AWARENESS INTO OUR ETHICS REQUIREMENTS FOR PROVIDERS ACROSS THE BOARD, WOULD HELP DRIVE THE MOTIVATION FOR THIS FUNDING IF THAT'S WHAT NEEDS TO HAPPEN, BUT WOULD REALLY PUSH ALL OF THIS ALONG.

>> I'M TRYING TO BE REALLY CREATIVE AND THINK ABOUT HOW TO MOVE THE ROOM TO CONSENSUS BECAUSE I'M NOT HEARING ONE YET EMERGE. AND A COUPLE OF THOUGHTS. I WANT TO GO BACK TO DAVID'S COMMENT ABOUT DATA, BECAUSE I THINK THAT'S REALLY WISE. WE HAVE TALKED A LITTLE BIT ABOUT THE EXPERIENCE IN USING INTERPRETER SERVICES BASICALLY IN THE PIEDMONT AREA AND WHAT THE LARGEST VENDOR FOR INTERPRETER SERVICES BASICALLY, WHAT THEIR DEMAND IS FOR

SERVICES, AND WE TRIED TO EXTRAPOLATE THAT FOR WHAT IT MIGHT MEAN FOR THE STATE. THERE'S NOT REALLY A BETTER WAY OF COLLECTING DATA FOR NORTH CAROLINA, SO THERE IS A DATA GAP THAT WE ACKNOWLEDGE. WE CAN ALSO THINK ABOUTEN IN MINUTE'S EXPERIENCE AND TRY TO SEE HOW THAT COMPARES TO THE PIEDMONT TO GET OUR BEST IDEA OF WHAT THE NEED MIGHT BE. THE REALLY SPECIFIC ISSUE AND I THINK SHELLEY KIND OF GOT TO THIS. I BELIEVE AND I HAVE SAID THIS OUTLOUD. I BELIEVE THAT MOST PROVIDER WANT TO DO THE RIGHT THING MOST OF THE TIME. I THINK THAT'S FUNDAMENTALLY TRUE, BUT WHAT THAT MEANS IF YOU'RE A PHYSICAL THERAPIST IN PRIVATE PRACTICE WITH ONE PROVIDER AND HOW MUCH THE COST BURDEN OF PROVIDING INTERPRETER SERVICES MIGHT LOOK LIKE IN YOUR OFFICE VERSUS WORKING IN A RURAL EMERGENCY ROOM WHERE YOU WANT TO DO THE RIGHT THING AND YOU ARE NOT ACTUALLY GOING TO PAY FOR IT, BUT YOU REQUIRE THE SUPPORT OF YOUR HOSPITAL TO BE ABLE TO DO THE RIGHT THING BECAUSE IF THE HOSPITAL SAYS, NO WE'RE JUST USING VRI, YOU'RE GOING TO USE VRI. IF THE HOSPITAL WANTS TO MAKE IN-PERSON INTERPRETERS AVAILABLE, YOU WILL MAKE IN-PERSON INTERPRETERS AVAILABLE. I THINK THE ONE STORY THAT WE HAD AND I'M NOT GOING TO REMEMBER THE DETAILS OF THIS. WE HAD A CONSUMER, I THINK, REMOTELY TALK ABOUT THEIR EXPERIENCE WITH A GASTROENT ROLLINGS-- GASTRO ENTEROLOGIST AND EVENTUALLY THEY WERE ABLE TO GET IN-PERSON INTERPRETING SERVICES AND THEY WENT BACK AND ALL THE DEAF PATIENTS WERE SCHEDULED THE SAME DAY WHICH WAS INTERESTING AND THE GASTROENTEROLOGIST WAS TRYING TO MAKE THE CHANGE. THAT REQUIRES A LOT OF WORK. HOW MUCH CAN WE DO THIS THROUGH EDUCATION ADVOCACY, ENFORCEMENT OF CURRENT LAWS AND I LIKE THE IDEA THAT DAVID OFFERED TO INVESTIGATE, LIKE HOW MANY DEAF PEOPLE ARE ISSUING REPORTS FOR INADEQUATE, EXACTLY, THAT'S SOMETHING THAT WE CAN EDUCATE ADVOCATES AND THE DEAF COMMUNITY ABOUT. I THINK THAT THERE ARE THINGS THAT WE CAN DO AND MAYBE THAT MEANS THAT WE ARE NOT READY FOR COMMUNICATION ACCESS FUND BUT I ALSO WANT TO LIKE HAVE A WAY OF THINKING ABOUT GETTING THERE, IF THAT'S WHAT WE IDENTIFY THAT WE NEED AND SO IT MIGHT BE THAT THERE'S A HEALTHCARE COMMUNICATION ADVISORY COMMITTEE TO THE DIVISION THAT HELPS US THINK ABOUT THE NECESSARY EDUCATIONAL OPPORTUNITY, THE ENFORCEMENT OF CURRENT LAW, WORKING WITH INSURERS, AND IDENTIFYING WHEN WE'RE STILL NOT MEETING THE NEED AND IF THE REASON THAT WE'RE NOT MEETING THE NEED IS BECAUSE INDIVIDUAL PRACTICES IDENTIFY A FINANCIAL BARRIER TO MEETING NEED, IF THAT-- BECAUSE IT'S NOT CLEAR TO ME HOW OFTEN THE BARRIER IS A FINANCIAL BARRIER, AND I THINK THE ANSWER IS SOMETIMES BUT MAYBE NOT ALWAYS. TOVAH AND CRYSTAL.

>> TOVAH HERE.

>> LET'S SEE IF I CAN MOVE ANYBODY IN ANY DIRECTION.

>> TOVAH HERE. MY HEART RATE GOES UP A LITTLE BIT WHEN YOU SAY PROVIDERS WANT TO DO THE BEST THEY WANT TO DO. I CAN BELIEVE THAT. AT THE SAME TIME, IT'S A POWERFUL INCENTIVE OR DISINCENTIVE IN THAT PROVIDERS ARE ALREADY OVERWHELMED WITH ALL KINDS OF NEEDS. I MEAN, THE OPIOID CRISIS, THE ABORTION CRISIS. I MEAN THERE'S LOTS OF THINGS PROVIDERS ARE FACED WITH AND NOW YOU WANT TO TELL THEM TO DO THE RIGHT THING WITH DEAF AND HARD OF HEARING. THE OTHER THING TO REMEMBER, COLLECTING DATA IS IMPORTANT, YES, BUT IT CAN ALSO BE A DELAYING TACTIC WHICH WE HAVE ENOUGH STORIES AND ENOUGH DATA TO SHOW THAT WE REALLY DO HAVE TO ADDRESS THIS PROBLEM, PERIOD. AND THE OTHER THING I WANT REMIND YOU IS

A PATIENT COMES IN AND THE ISSUE OF ADVOCACY IS IMPORTANT, BUT MOST PEOPLE COMING IN ARE ILL OR NOT IN THEIR FULLY RIGHT MIND TO ADVOCATE FOR THEMSELVES AT THE MOMENT EVEN THOUGH THEY MIGHT HAVE BEEN EDUCATED BEFOREHAND. I MEAN, I'M A VERY STRONG ADVOCATE FOR MYSELF BUT IF I'VE BEEN IN A CAR ACCIDENT, GOD FORBID, AND I'M SHOT UP WITH MORPHINE, HOW WELL AM I GOING TO ADVOCATE FOR MYSELF ON THE WAY TO THE HOSPITAL? I THINK THERE ARE ISSUES LIKE THAT THAT INTERFERE WITH SOME OF THE THINGS THAT WE'RE SAYING HERE. I DO THINK IT'S PROBABLY ALMOST MORE IMPORTANT TO FIND WAYS TO ADDRESS THE ISSUE REGARDLESS OF HOW MUCH DATA. EVERY DEAF PERSON COUNTS. EVERY PERSON COUNTS.

>> I THINK CRYSTAL AND THEN BRAD.

>> I DEFINITELY THINK WHAT WAS MENTIONED ABOUT EDUCATION FOR PHYSICIANS, FULL DISCLOSURE, CLEARLY I WORK WITH FOLKS WITH DISABILITIES ALL THE TIME AND I SERVE ON THE BOARD OF DISABILITY RIGHTS OF NORTH CAROLINA, SO I KNOW THAT I MAY BE THE EXCEPTION IN SOME AREAS BUT I DO BELIEVE THAT MOST PHYSICIANS I WORK WITH AND SPEAK WITH ACROSS THE STATE DO WANT TO DO THE RIGHT THING AND ARE ACTIVELY TRYING, THE ONES I INTERACT WITH ANYWAY BECAUSE I'M ALWAYS PROMOTING THAT. THE EDUCATION PROBLEM WITH OPIOID CRISIS, WE REQUIRED TO HAVE IT THREE-HOUR TO OUR LICENSE AND ADDING A THREE-HOUR REQUIREMENT CAN EASILY BE DONE AND I'M SURE THAT NORTH CAROLINA WOULD BE HAPPY TO PROVIDE THE EDUCATION TO MAKE SURE WHAT PROVIDERS ARE GETTING ACROSS THE DATE COMPLIES WITH ADA, INVOLVES THE ADVOCACY COMPONENT AND PUSHES PROVIDERS WHO MAY BE ANTIQUATED IF THEIR THINKING AND UNDERSTANDING WHY THEY NEED TO DO IT AND WHY IT'S IN THEIR BENEFIT AND PUT THINGS IN THE OFFICE FOR PATIENTS AS WELL. EDUCATION MAY BE THE FIRST STEP AND WE HAVE AN COMPELLATION ORGANIZATION THAT CAN DO THAT.

>> LET'S LET BRAD SPEAK AND I WANT DAVID TO TELL US HOW EASY IT IS. CRYSTAL SAID IT WAS EASY. YOU WILL HAVE TO ANSWER THAT QUESTION NEXT.

>> YES, THIS IS BRAD. I WOULD LIKE TO TALK FOR A MOMENT ABOUT MY PERCEPTION FROM THE MENTAL HEALTH STANDPOINT. I THINK EDUCATION HAS A ROLE IN THIS PROCESS WHEN WE DETERMINE WHO SHOULD BE RESPONSIBLE-- OR, WE NEED TO DEVELOP OR WHETHER OR NOT WE NEED TO DEVELOP A CAF, BUT FROM MY PERCEPTION IN WORKING WITH MENTAL HEALTH, WE SEE MEDICAL PROFESSIONALS AND PEOPLE THAT WORK IN THE COMMUNITY PROVIDING MENTAL HEALTH SERVICES, THE PSYCHOLOGISTS, THE SOACIALG WORKERS, AND VARIOUS AGENCIES THAT DENY INTERPRETING SERVICES EVERY DAY. AND IT'S BECAUSE OF THAT, WE HAVE MOVED FORWARD WITH PROPOSING THIS IDEA OF A COMMUNICATION ACCESS FUND. BUT PART OF THE PROBLEM, I THINK, IS ALSO AT THE STATE LEVEL. I'LL BE VERY FRANK WITH YOU. WE'VE IGNORED THIS PROBLEM FOR A VERY LONG TIME. SUPPOSE A PROVIDER WAS DISCRIMINATING AGAINST A DIFFERENT RACE OR RELIGION OR ANY OTHER PROTECTED POPULATION, WE WOULD STOP THAT AT THE STATE LEVEL. WE WOULD NOT TOLERATE THAT. BUT AT THE SAME TIME, RIGHT NOW, WE SEE DEAF PEOPLE EXPERIENCING LANGUAGE DISCRIMINATION EVERY DAY, AND WE'RE NOT PAYING ATTENTION TO THAT. WE HAVE NOT SET UP ANY REGULATIONS OR OVERSIGHT TO STOP THAT FROM HAPPENING. SO I WOULD ALSO LIKE TO SEE SOME BETTER ENFORCEMENT AT THE STATE LEVEL AND MORE MONITORING OF INTERPRETING SERVICES THAT ARE PROVIDED. AND I THINK THAT'S PART OF THE SOLUTION ALSO.

>> DAVID, HOW EASY IS IT TO ADD A CMU REQUIREMENT? EASY, HARD?

>> IT'S HARD. NOT QUITE AS EASY CRYSTAL DESCRIBED IT. BUT THERE'S LOTS OF OTHER THINGS THAT COULD BE DONE. I MEAN, BRAD WAS JUST TALKING ABOUT ENFORCEMENT. I MEAN, THIS IS A FEDERAL LAW AND SO AND IT'S ENFORCED, I THINK, BY THE-- COREY WOULD KNOW.
>> WHO DOES THE ENFORCE--
>> THIS IS NOT--
>> CAN WE PAUSE AND ASK THAT REAL QUICK? WHO IS RESPONSIBLE FOR ENFORCEMENT OF THE ADA?
>> I CAN SAY IT AND YOU CAN REPEAT IT.

>> SO THE U.S. DOJ HAS AN OFFICE OF CIVIL RIGHTS AND THERE ARE CIVIL RIGHTS ENFORCEMENT DIVISIONS IN SEVERAL OTHER AGENCIES INCLUDING CENTERS FOR MEDICAID SERVICE.

>> HANG ON.

>> I DON'T FEEL THAT'S FAIR. I SEE PEOPLE LOOKING AROUND AND THEY'RE LOST.

>> THANK YOU.
>> DON'T WANT TO BE CONFUSING. I WANT TO RESTATE THAT. ENFORCEMENT OF THE ADA IS DIFFUSE. THERE IS AN OFFICE OF CIVIL RIGHTS DIVISION OF DISABILITY OR OLMSTEAD AND OTHER ADA DISABILITY AT THE U.S. DEPARTMENT OF JUSTICE BUT THERE ARE DIVISIONS OF THE OTHER NON-LITIGATING AGENCIES INCLUDING THE CENTER FOR MEDICARE AND MEDICAID SERVICES AND MORE GENERALLY THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR FEDERAL ENFORCEMENT, BUT THERE'S ALSO-- THERE'S ALSO RESPONSIBILITY FOR ENFORCEMENT THAT IS PASSED ALONG THROUGH MANY FEDERAL FUNDING SOURCES TO STATE AGENCIES SO FOR EXAMPLE, MEDICAID IS RESPONSIBLE FOR ENFORCING ADA COMPLIANCE WITHIN ITS OWN-- WITHIN ITS OWN PROVIDER THAT IT PAYS AT THE STATE LEVEL, AND THEN OF COURSE, PRIVATE PARTIES CAN SUE FOR COMPLIANCE UNDER THE ADA, BUT THERE IS NO-- THERE IS NO FINANCIAL INCENTIVE TO DO THAT. THERE IS NO MONETARY AWARD. YOU ONLY GET COMPLIANCE AS A SPECIFIC PERFORMANCE AS A REMEDY.

>> BACK TO DAVID AND STEVE YOU'RE NEXT.

>> THE PRESENTATION CAME BACK TO ME RIGHT NOW. I REMEMBER EVERYTHING NOW. BUT I THINK MY POINT IS THAT THIS IS-- WITH ALL THESE THINGS OUT THERE, YOU KNOW, THE DEPARTMENT OF JUSTICE, YOU GUYS ARE OVERWHELMED AT DISABILITY RIGHTS, I MEAN, THERE'S CURRENTLY-- TO BRAD'S POINT, I DON'T THINK THERE'S A REAL ENFORCEMENT PRIORITY HERE WITH-- AT THE FEDERAL OR STATE LEVEL. THIS IS I THINK WHERE THE MEDICAL BOARD CAN COME IN. WE WORK IN BOTH THE EDUCATION WORLD AND THE ENFORCEMENT WORLD. YOU KNOW, WE WANT OUR NUMBER ONE PRIORITY, WE DON'T LIE IN WAIT, CONTRARY TO POPULAR BELIEF, WE DON'T LIE IN WAIT TRYING TO GRAB SOMEBODY AND TRY TO DISCIPLINE THEM. OUR NUMBER ONE PRIORITY IS TO KEEP PEOPLE OUT OF TROUBLE BY EDUCATING THEM AS TO WHAT THE BOARD'S EXPECTATIONS ARE , AND AS I SAID, WE HAVE A CAPTIVE AUDIENCE, YOU KNOW, WITH OUR LICENSEES. WE HAVE LOTS OF WAYS TO COMMUNICATE WITH THEM AND THEY GENERALLY PAY ATTENTION TO WHAT WE SAY AND IT'S

SOMETHING THAT HAS TO DO WITH THE MEDICAL BOARD, MOST LICENSEES ARE GOING TO PAY ATTENTION TO THAT. THERE'S LOTS OF WAYS WE CAN GO AT IT. COREY WAS TALKING ABOUT THE LAWS HAVE BEEN HERE FOR A WHILE AND NOBODY'S DONE ANYTHING. WELL, I MEAN, SPEAKING FOR ME ME AND THE MEDICAL BOARD, WE HAVEN'T KNOWN A LOT ABOUT THIS RECENTLY AND I THINK THAT'S THE SAME FOR THE ACADEMY OF FAMILY PHYSICIANS AND THE NORTH CAROLINA MEDICAL SOCIETY, A LOT OF GROUPS THAT CAN GET THE WORD OUT TO MEMBERS AND LICENSEES HAVE NOT BEEN AWARE OF IT.
THAT'S THE OPPORTUNITY THAT I THINK THAT SHOULD BE TRIED FIRST BEFORE WE GO TO THE OTHER OPTIONS.

>> WE HAVE STEVE AND BRAD AND THEN LAWRENCE AND THEN BACK TO BERKELEY.

>> STEVE BARBER FROM HLAA. I DON'T SIGN. I DON'T NEED THESE SERVICES BUT IT'S OBVIOUSLY A BIG PROBLEM. I WANTED TO MAKE A COUPLE OF POINTS THAT I THOUGHT ABOUT AS I LISTENED TO EVERYONE MAKE THEIR POINT. FIRST OF ALL, COMMUNICATIONS ACCESS, WHETHER IT'S FOR HARD OF HEARING OR FOR DEAF, IS A UNIVERSAL PROBLEM. IT'S NOT JUST MEDICAL SITUATION. I KNOW THIS IS A MEDICAL TASK FORCE AND THAT'S BEEN OUR FOCUS, BUT IT'S A BIGGER PROBLEM THAN JUST MEDICAL. THERE ARE LAWYERS AND CPIs AND FUNERAL DIRECTORS AND STATE AGENCIES LIKE WHEN YOU TRIED TO GO GET A DRIVER'S LICENSE, ALL THOSE PLACES NEED TO PROVIDE ACCESS, COMMUNICATIONS ACCESS FOR, IN OUR CASE, DEAF. WE'VE BEEN TALKING MOSTLY ABOUT HOW TO FUND THAT THROUGH A COMMUNICATIONS ACCESS FUND, BUT WHAT WE NEED TO CONSIDER , I THINK,HOW TO PROVIDE A COMMUNICATIONS ACCESS SERVICE THAT WOULD BE -- WOULD BE ABLE TO PROVIDE THE QUALITY SERVICES STATEWIDE IN ALL OF THESE KINDS OF SITUATIONS. HOW TO PAY FOR IT DOESN'T NECESSARILY HAVE TO BE A LICENSING FEE ADD-ON. IT COULD BE AN INSURANCE PREMIUM THAT ALL OF THESE SERVICES WOULD BE INCLINED TO PAY IF THEY WHY UNDERSTAND STOOD THEIR RESPONSIBILITY TO PROVIDE COMMUNICATIONS ACCESS. IT COULD BE A SERVICE FEE ADD-ON LIKE WE DO FOR TELECOMMUNICATIONS ACCESS, A FEW PENNIES ON A PHONE BILL PAYS FOR RELAY SERVICES. NOW WHAT KIND OF SERVICE COULD WE PROVIDE A FEE, AN ADDITIONAL FEE FOR? NOT A TAX, BUT AN ADDITIONAL FEE FOR SOME SERVICE LIKE WE DO WITH COMMUNICATIONS ACCESS. THAT WOULD FUND A COMMUNICATIONS ACCESS SERVICE ACROSS THE STATE. WHATEVER THE SOLUTION WE DO, WE HAVE TO MAKE SURE IT'S FAIR TO THE PROVIDERS. SOME PROVIDERS, LIKE THIS PHYSICIAN OVER HERE-- I'M SORRY, CRYSTAL, IS THAT YOUR FAME?
[CRYSTAL NODS HEAD]

>> YOU HAVE BEEN ACTIVE IN PROVIDING SERVICES AND PAYING FOR IT YOURSELF. YOU WOULD BE AN ACTIVE PROVIDER AND WOULD HAVE TO BE REIMBURSED FOR SOME OF THOSE SERVICES. MY CPA PROBABLY DOESN'T GET ONE DEAF PERSON IN TEN YEARS TO COME IN TO WORK WITH HIM. SO YOU HAVE TO HAVE SOME WAY TO MAKE SURE THAT MY CPA DOESN'T PAY A HUGE INSURANCE PREMIUM OR HUGE SERVICE FEE OR HUGE LICENSE FEE FOR THE ONE PERSON THAT COMES IN WHILE YOU WOULD HAVE 20 PEOPLE COME IN A MONTH AND YOU WOULD BE REQUIRED TO PAY A LOT MORE. IF WE MAKE AN INSURANCE AND INSURANCE SERVICE TO PAY FOR THIS, WE COULD SET IT UP SO THAT THE BENEFITS WOULD BE-- THE PREMIUMS, I'M SORRY, THE PREMIUMS WOULD BE REFLECTED IN HOW MANY PEOPLE ARE BEING SERVED BY THE PARTICULAR PROVIDER. ONE LAST POINT I WANTED TO MAKE BECAUSE WE MENTIONED VRI, EVEN IN MINNESOTA, THEY ADMITTED THAT VRI IS STILL USED

EXTENSIVELY ESPECIALLY IN RURAL AREAS WHERE THERE'S-- THEIR COMMUNICATION ACCESS SERVICE IS NOT ABLE TO SUPPORT. WE HAVE TO SUPPORT COMMUNICATION ACCESS WITH VRI IN MANY SITUATIONS IN THE FUTURE. SO WHAT I WONDERED IS SURELY, THERE WILL ARE A LOT OF PROBLEMS WITH VRI. I UNDERSTAND THE PLOB PROBLEM OF SWITCHING INTERPRETERS IN THE MIDDLE OF A SESSION. THAT'S A PROBLEM. I UNDERSTAND THE PROBLEM WITH-- AN iPAD BEING 20 FEET AWAY AND ONLY THIS BIG. WHAT ARE THE TECHNICAL SOLUTIONS THAT COULD IMPROVE VRI SO IT CAN BE MORE EFFECTIVE WHEN AN ON-SITE INTERPRETER IS NOT POSSIBLE? WHAT ABOUT THE RESOLUTION OF THE SCREEN, THE SIZE OF THE SCREEN, THE BANDWIDTH THAT GETS YOU A SUITABLE ANSWER? WHAT ABOUT SOLVING THE PROBLEM OF SWITCHING INTERPRETERS IN MID-STREAM? CAN THOSE BE SOLVED TO MAKE THE COMMUNICATIONS ACCESS TO CHEAPER WHERE IT'S NOT POSSIBLE AND MORE EFFECTIVE WHERE IT'S NOT POSSIBLE TO HAVE ON-SITE. THERE ARE ALL MY THOUGHTS

>> WE DO HAVE A RECOMMENDATION ABOUT VRI COMING UP. SO THAT MIGHT ANSWER THAT. ALTHOUGH I'M NOT SURE WE'RE GOING TO GET TO IT TODAY. WE HAVE A FEW MORE PEOPLE. BRAD, I THINK YOU WERE NEXT.

>> YES. THIS IS BRAD TROTTER. I JUST WANTED TO ADD BRIEFLY THAT A LOT OF THE POWER WITH ENFORCEMENT COMES FROM THE PAYER. DEPENDING ON WHO IS PAYING FOR A SPECIFIC SERVICE. IF THE PAYER IS CLEAR ABOUT THEIR EXPECTATIONS AND THEIR OUTCOMES OR THE CONSEQUENCES FOR DISCRIMINATING AGAINST A PATIENT AND IF THEY'RE VERY CLEAR ABOUT THOSE CONSEQUENCES, THEN WE'LL SEE AN IMPROVEMENT.

>> WE WILL KEEP GOING IN ORDER.

>> HEY, ADAM, CAN I JUST-- CAN I CLARIFY? THIS IS MELISSA. THE SPEAKER THAT WAS JUST TALKING IN TERMS OF THE PAYER, ARE YOU TALKING MORE ON THE FEDERAL SIDE, THE MEDICAID AND MEDICARE, OR ARE YOU INCLUDING PRIVATE COVERAGE IN THAT?

>> BOTH. BOTH.

>> YEAH.

>> COREY MADE THAT POINT EARLIER AS WELL.

>> YES, IF MEDICAID-- I'M SORRY. CAN I GO AHEAD? YEAH. THIS IS BRAD TROTTER AGAIN. FOR EXAMPLE, IF MEDICAID IS INVOLVED IN PAYING FOR A SPECIFIC SERVICE, IF THE PROVIDER IS BILLING MEDICAID THEN BY LAW THEY ARE REQUIRED TO COMPLY WITH THE ADA AND I THINK FROM THE STATE LEVEL, I THINK THE STATE NEEDS TO BE VERY CLEAR ABOUT TELLING PEOPLE THAT IF THEY ARE BILLING MEDICAID, THEN WE AS A STATE ARE REQUIREDDED SUCH-AND-SUCH, AND IF YOU DO NOT COMPLY WITH THE ADA, THE FEDERAL REGULATION, THEN THERE'S A POSSIBILITY OF A PAYBACK BEING OWED FROM THAT PROVIDER, AND I THINK THAT'S A VERY REASONABLE CONSEQUENCE.
>> THAT'S WHY I WAS ASKING FOR CLARIFICATION. FROM A PRIVATE PAYER, PRIVATE INSURANCE COVERAGE VANTAGE POINT, WE HAVE THE SAME THING CONTRACTUALLY WHERE WE REQUIRE AS

PART OF THE CONTRACT, ET CETERA, THAT YOU COMPLY WITH ALL FEDERAL AND STATE REGULATIONS BUT FROM A COMPLIANCE OVERSIGHT PERSPECTIVE, YOU CAN IMAGINE WITH THE NUMBER OF PHYSICIANS AND I'M SURE THE GENTLEMAN FROM THE MEDICAL BOARD COULD ADDRESS IT, TOO, IN TERMS OF THAT COMPLIANCE OVERSIGHT, AND WHAT THAT WOULD LOOK LIKE.

>> THANKS, MELISSA.

>> THIS IS LAWRENCE. JUST A COUPLE OF QUICK POINTS AND I HEARD SOMEONE MENTION ABOUT ED EDUCATING THE CONSUMER TO ADVOCATE WHICH IS GOOD EXCEPT IF YOU ARE IN YOUR SECOND LANGUAGE, HOW DO YOU TALK TO YOUR DOCTOR ABOUT YOUR NEEDS. WHEN YOU NEED AN INTERPRETER TO DO THAT. THAT IS AND SOME CAN DO THAT AND MANY CANNOT. SO WHAT BRAD WAS SAYING WHEN I WORK FOR THE DIVISION ON ONE OCCASION, DSS REQUIRED A DEAF CONSUMER TO GET PSYCHOLOGICAL EVALUATION TO GET THEIR CHILDREN BACK. THE PSYCHOLOGIST REFUSED. AM I GOING TO CHALLENGE HIM BECAUSE I DEPEND ON HIS EVALUATION OR I DON'T GET MY CHILDREN BACK? HOW AM I GOING TO ADVOCATE THAT AND STAY ON THE GOOD SIDE? THAT PUTS IT ON THEM. I HAD AN EXCELLENT DOCTOR, IT SOUNDS LIKE, BUT I REMEMBER A DOCTOR CLEARLY SAYING I DON'T CARE WHAT THE LAW SAYS I'M NOT PROVIDING AN INTERPRETER AND I CAN TELL I DID THIS JOB FOR 19 YEARS AND THAT WAS VERY COMMON. AS FAR AS FINANCIAL, THE ADA HAS BEEN IN SINCE 1990 AND THERE IS AN UNDUE BURDEN CLAUSE. SO IF SOMEBODY IS HAVING DIFFICULTY, THEY CAN CLAIM AN UNDUE BURDEN. I THINK THAT NEEDS TO BE LOOKED AT, TOO. WHAT IS AN UNDUE BURDEN? I THINK THE MEDICAL BOARD IS AN EXCELLENT PLACE TO START SO THERE'S SOME AUTHORITY. THERE'S NO TEETH IN THE LAW. THE DEAF PERSON HAS TO EITHER SUE OR COMPLAIN OR DO-- THERE IS NO TEETH UNLESS THE DEAF PERSON AND EVEN THEN IT'S IN THE THAT WELL.

>> I THINK GREG WAS NEXT AND THEN TOVAH.

>> I'M GOING TO TRY TO HIT THREE OR FOUR THINGS REAL QUICKLY.
THIS IS GREG WITH THE ACADEMY OF FAMILY PHYSICIANS. FIRST OF ALL, IST REALLY THINK WE'VE GOT TO MAKE SOME WORKFORCE RECOMMENDATIONS AND MAYBE THEY'RE COMING LATER BECAUSE IF WE DON'T INCREASE SUPPLY, THEN I DON'T THINK WE'RE GOING TO SOLVE THIS PROBLEM. SO I THINK WE'VE GOT A SUPPLY AND DEMAND PROBLEM AND IT CAN'T JUST BE INCREASING NUMBERS. WE'VE GOT TO GET DISTRIBUTED CORRECTLY. WE ALREADY HAVE MALDISTRIBUTION OF HEALTHCARE PROVIDERS ACROSS THE STATE. SO WE'VE GOT-- WE'VE GOT TO WORK ON THAT. SECONDLY, I THINK WHERE YOU DO GET THE UNDUE BURDEN THAT WAS MENTIONED A FEW MOMENTS AGO IS WHEN YOU HAVE WILLING PHYSICIANS WHO ARE VERY OPEN TO THE DEAF AND HARD OF HEARING COMMUNITY. WE HAD ONE PERSON IN GREENSBORO WHO IS NOW RETIRED FROM PRACTICE WHERE WHEN HE WAS TAKING A FEW DEAF AND HARD OF HEARING PATIENTS, HE COULD DEAL WITH IT. BUT WHAT HAPPENED IS HE BECAME KNOWN TO BE VERY COMMITTED AND VERY COMFORTING AND ALL OF A SUDDEN, HE IS OVERWHELMED. AND HE WAS IN SOLO PRIVATE PRACTICE. AND WHAT BLUE CROSS PAID HIM IF IT WAS A BLUE CROSS PATIENT OR WHAT MEDICAID PAID HIM DOES NOT CHANGE WHETHER THAT PATIENT IS HEARING OR DEAF. WHAT YOU GET PAID FOR IN PRIMARY CARE, IT'S BASED ON WHAT'S CALLED A VALUATION OF MANAGEMENT CODES AND THAT CAN BE AS LOW AS $50 FOR

$15-MINUTE VISIT OR $150 FOR $15-MINUTE VISIT AND IF YOU ARE IN SOLO PRACTICE AND BRINGING IN INTERPRETER SERVICES THAT CHANGES GREATLY. IF IT'S ONE OR TWO PATIENTS, THAT'S ONE THING. IF YOU HAVE 40 OR 50 PATIENTS, IT'S VERY DIFFERENT. SO THERE ARE SOME FINANCIAL ISSUES THAT DO NEED TO BE ADDRESSED, BUT I DON'T KNOW THAT THE COMMUNICATION ACCESS FUND TRULY ADDRESSES THAT. I THINK IF THERE WAS A CODE FOR INSURANCE, FOR MEDICAID, MEDICARE, AND PRIVATE INSURANCE TO DO THAT, YOU ALMOST ADDRESS IT BETTER. GETTING A LITTLE BIT INTO VRI, I THINK WE'VE GOT TO LOOK AT VRI PARTICULARLY IN OUR RURAL AND UNDERSERVED AREAS, BUT I THINK WE'RE LOOKING AT THAT TYPE OF TECHNOLOGY FOR TELEMEDICINE, TOO. WE'RE LOOKING AT HOW DO YOU ACCESS DERMATOLOGY OR PSYCHIATRY REMOTELY WHEN THERE'S NOT PSYCHIATRISTS OR DERMATOLOGISTS IN THE COMMUNITY BUT YOU DO IN YOUR FAMILY PHYSICIAN'S OFFICE AND YOU HAVE THE SAME ISSUE WITH BROADBAND. IF YOU ARE HAVING A DERMATOLOGIST LOOK AT A SKIN ISSUE, FOR EXAMPLE , THAT MAY OR MAY NOT BE CANCEROUS TO GIVE ADVICE, OR YOU HAVE A PSYCHIATRIST DOING TELEPSYCHIATRY IN A PRIMARY CARE OFFICE, WE HAVE THE SAME ISSUES, BUT WE'RE WORKING ON TRYING TO ADDRESS THAT. THERE'S RURAL BROADBAND, THERE'S TELEMEDICINE AND THIS ALL CAN BE POTENTIALLY ADDRESSED IF WE ADDRESS ONE OF THOSE, WE'RE ADDRESSING ALL OF THEM. SO HOW DO WE LOOK AT THIS AS BROADER SOLUTIONS? AND FINALLY GOING BACK TO--

>> WHAT'S BEING DONE AROUND RURAL BROADBAND? THERE'S A LOT BEING DONE AROUND RURAL BROADBAND. RIGHT NOW, THERE'S PROPOSED LEGISLATION ON RURAL BROADBAND. THE NORTH CAROLINA RURAL CENTER IS VERY ACTIVELY ENGAGED IN RURAL BROADBAND. THERE ARE MANY HEALTHCARE ORGANIZATIONS, SUCH AS OURSELF, WHO ARE ACTIVELY INVOLVED IN RURAL BROADBAND. WE DON'T THINK TELEMEDICINE IS THE SOLUTION TO EVERYTHING.
IT'S NOT THE SOLUTION TO COMPLETE ACCESS, BUT IT IS PART OF A SOLUTION. AND I THINK VRI CAN BE SEEN AS THE SAME WAY. I DON'T THINK VRI IS THE SOLUTION TO EVERYTHING BUT IT MAY BE PART OF THE SOLUTION AND SINCE THERE ARE MOVEMENT AROUND TELEMEDICINE AND THESE OTHERS, HOW CAN WE SORT OF LINK IT TO MAKE IT WHERE IT'S NOT JUST SOLVING ONE PROBLEM AND MAYBE WE'RE SOLVING-- WE'RE NOT HELPING SOLVE ONE PROBLEM AND WE'RE HELPING TO SOLVE THREE, FOUR PROBLEMS AND IT'S NOT THE TOTAL SOLUTION. THEN THERE IS A LOT NEEDED ON EDUCATION AND BROADBAND AND MAYBE, YOU KNOW, I'LL TAKE SOME RESPONSIBILITY FOR IT. WE'VE DONE A LITTLE BIT OF EDUCATION THROUGH THE ACADEMY WITH OUR MEMBERS FOR CARING FOR THE DEAF AND HARD OF HEARING, BUT PROBABLY NOT WHAT WE NEED TO DO. AND I DON'T THINK IT IS OUT OF-- I THINK IT'S OUT OF SOMETIMES LACK OF KNOWLEDGE AND MAYBE WE SHOULD BE MORE KNOWLEDGEABLE. YOU KNOW, DAVID'S RIGHT. WE HAVEN'T ALWAYS HAD THE RESOURCES FOR THE KNOWLEDGE OURSELVES TO PROVIDE THAT EDUCATION, AND I THINK WHEN YOU'RE LOOKING AT IT ESPECIALLY FOR FAMILY MEDICINE, IF WE LOOK AT IT ON BROADER ADA BECAUSE BROADER ADA HITS SUCH A LARGE PORTION OF THE POPULATION, IF WE REALLY START DOING EDUCATION ON BROAD ADA AND MAKING SURE HEARING ADA IS A PART OF THAT AND ALSO WHEN WE'RE TALKING ABOUT LANGUAGE SERVICES, IF WE EDUCATE LIKE IF A HISPANIC SPEAKING PERSON WALKS INTO THE OFFICE, THEY HAVE THE SAME REQUIREMENTS TO MEET THAT AS A DEAF PERSON. NOW IT'S A LITTLE BIT EASIER BUT THE SAME REQUIREMENTS ARE THERE SO HOW DO WE LOOK AT EDUCATION THAT'S MAYBE BROADER EDUCATION THAT WE MAKE SURE WE INCLUDE THIS IN THERE WHICH I DON'T THINK WE'VE DONE A VERY GOOD JOB AT IN THE PAST. WE'VE HIT SOME OF THE OTHER AREAS BUT NOT THE DEAF SIDE.

>> THANKS, GREG. I THINK TOVAH AND JAN. WE'RE SUPPOSED TO BE DONE AT 11: 15. BERKELEY IS GOING TO TELL US WHAT SHE HEARD.

>> TOVAH HERE. FIRST, A QUICK QUESTION. I'M ASSUMING THAT ALL OF THE LICENSING BOARD-- I'M ASSUMING THAT ALL OF THE LICENSING BOARD, NOT JUST MEDICAL, I MEAN, PSYCHOLOGY, NURSING WORK, ARE ET CETERA, ARE ALL EDUCATION AND ENFORCEMENT BODIES, DO YOU ALL-- THE LEADERS OF ALL THESE ORGANIZATIONS DO THEY EVER MEET FOR ANY REASON? IF SO, IS IT POSSIBLE THAT ONE OR MORE OF THESE MEETINGS OF ALL OF THE LICENSINGS BOARDS, ESPECIALLY THE PERTINENT ONES FOR HEALTHCARE AND MENTAL HEALTH CARE, IS IT POSSIBLE TO DEVOTE ONE OR MORE OF THESE MEETINGS TO EDUCATING ABOUT AND LOOKING AT COMPLIANCE WITH COMMUNICATION ACCESS, FOR EXAMPLE?

>> I'M SUPPOSED TO RAISE MY HAND, FIRST.

>> YOU COULD SHAKE YOUR HEAD.

>> IT'S HARD FOR OTHER PEOPLE.

>> SORRY ABOUT THAT. THIS IS DAVID. THE ANSWER IS YES, WE DO MEET PRETTY MUCH ALL LICENSING AND REGULATORY BOARDS MEET ONCE A YEAR IN MAY AND WE HAVE A FULL DAY OF TRAINING ABOUT ALL SORTS OF DIFFERENT THINGS. I THINK GREG'S RIGHT. I THINK THIS DISCUSSION WILL BE PART OF A BROADER ADA DISCUSSION, BUT I'VE BEEN TO A LOT OF ADA DISCUSSIONS AND I NEVER HEARD ANYTHING ABOUT DEAF AND HARD OF HEARING CUSTOMERS OR PATIENTS OR WHATEVER. SO THEN ALSO FIVE OR SIX OF US WHO LEAD THE HEALTHCARE LICENSING BOARDS, WE MEET QUARTERLY AND WE DISCUSS ISSUES AS WELL.

>> CAN WE DO ONE AND TWO AND LIZ AND THEN WE'RE DONE.

>> THIS IS JAN, BUT I DON'T NEED THAT.

>> SORRY.

>> THIS IS JAN SPEAKING. REGARDING THE SUBJECT OF EDUCATION, WE AT THE DIVISION ARE IN THE BUSINESS OF EDUCATION. THAT IS OUR STATUTORY CHARGE AND WE ARE VERY HAPPY TO WORK WITH YOU ALL. THE ISSUE FOR US IS HOW CAN WE BEST REACH OUT TO AS MANY AS HEALTHCARE PROVIDERS IN AN EFFICIENT WAY CONSIDERING THE LIMITED SIZE OF OUR STAFF. SO WE NEED TO WORK WITH YOU ALL AND MAYBE AN IDEA WOULD BE FOR TO US JOIN THOSE MEETINGS THAT YOU HAVE. THAT'S VERY INTRIGUING AND I THINK THAT WOULD BE A GOOD POSSIBILITY. SO MY HOPE IS THAT AFTER THIS TASK FORCE WE CAN BEGIN THE PROCESS OF GETTING TOGETHER AND TALKING AND FIGURING OUT HOW WE CAN MAKE THIS WORK. I CAN ALSO SAY FROM MY EXPERIENCE AND I ECHO WHAT LAWRENCE SAID, WE HAVE SEEN TOO MANY SITUATIONS WHERE THERE IS TRUE RESISTANCE AND THAT'S WHERE WE NEED HELP WITH ENFORCEMENT. BUT YOU MAY KNOW BETTER THAN I DO HOW WE CAN MAKE THAT WORK AND HOW WE CAN PUT THE TEETH IN THE LAW. WILL THAT REQUIRE LEGISLATION? I'M NOT SURE AT THIS POINT, BUT I DO KNOW THAT THERE ARE TIMES AND SITUATIONS

WHERE STATE LAW IS DEVELOPED TO LEVERAGE EXISTING FEDERAL LAWS. SO MAYBE WE COULD LOOK AT THAT POTENTIALLY. AND FINALLY I JUST WANT TO MENTION VERY QUICKLY THE PIPE LINE. THE NORTH CAROLINA COUNCIL FOR THE DEAF AND HARD OF HEARING AND I'M LOOKING AT TOVAH, WHO IS THE CHAIR, I THINK THAT WE COULD DEVELOP A FORMAL PROPOSAL TO DPI ASKING THEM TO WORK WITH US AND HAVE THEM WORK WITH US TO LOOK AT THIS AS A WORKFORCE ISSUE.

>> THIS IS KELLY. JUST A QUICK COMMENT. ON THE BOTTOM OF THE RECOMMENDATION FOR THE COMMUNICATION ACCESS FUND, IT MENTIONS SOMETHING ABOUT DEFINING WHAT COMMUNICATION ACCESS WOULD LOOK LIKE. I THINK IT'S VERY IMPORTANT THAT WE REMEMBER ALL OF THIS TALK AND DISCUSSION THAT WE'VE BEEN HAVING FOR HOWEVER, PO MINUTES OR WHATEVER, IS ABOUT PAYING FOR SIGN LANGUAGE INTERPRETERS. THERE'S A VERY LARGE POPULATION OF PEOPLE WHO DO NOT USE SIGN LANGUAGE. AS STEVE STARTED TO MENTION, WHEN HE GAVE A FEW COMMENTS, SO COMMUNICATION ACCESS FOR THOSE INDIVIDUALS IS JUST AS IMPORTANT AS IT IS FOR PEOPLE WHO USE SIGN LANGUAGE, AND JUST REMEMBERING THAT LANGUAGE AND THAT EMPHASIS GOING FORWARD WITH THE RECOMMENDATIONS.

>> AND BECAUSE I CAN'T SEE THE WHOLE RECOMMENDATION, I DON'T REMEMBER THE WORDS I THINK THAT THE STEERING COMMITTEE HAS BEEN THINKING ABOUT USE OF TECHNOLOGY AS PART OF WHAT WOULD BE COVERED IN THE COMMUNICATION ACCESS FUND. GOOD POINT. I SAID THAT WE'RE GOING TO END THIS CONVERSATION WITH LIZ BUT THERE ARE PEOPLE ON THE PHONE AND WEBINAR THAT HAVEN'T HAD A CHANCE TO COMMENT. WE WILL LET THEM COMMENT AND LET BERKELEY FINISH IT UP.

>> I'M NOT IN A GOOD PLACE WITH THIS RIGHT NOW.

>> THIS IS MAGGIE FROM THE OFFICE OF MENTAL HEALTH.

>> MAGGIE, ONE MOMENT.

>> HANG ON ONE SECOND.

>> WE HAVE SOMEONE IF THE ROOM SPEAKING.

>> THIS IS LIZ

>> I'M SORRY.

>> NO, YOU'RE FINE. I'M NOT IN A GOOD PLACE BECAUSE I THINK OF A FRIEND OF MINE WHO IS ALSO A COLLEAGUE. HER DAD'S DOCTOR, THIS-- ALL RIGHT. HER DAD'S DOCTOR, THIS IS 2019, RIGHT? OKAY. HER DAD'S DOCTOR JUST RETIRED AND THAT FACILITY TOLD HER THEY'RE NOT GOING TO PROVIDE ANY MORE INTERPRETERS, OKAY. HAVE YOU GONE TO THE DOCTOR AND DEALT WITH MIGRAINES OR HAVE YOU TOLD ANYBODY THAT YOU HAVE MIGRAINES? I WAS BLESSED TO HAVE DEAF PARENTS , SO I WAS ABLE TO DEAL WITH THIS DEAF ISSUE ALL MY FREAKIN' LIFE WITH COMMUNICATION AND LACK OF OR RESISTANCE. I HAVE A DAUGHTER WHO HAS SEVERE MIGRAINES. EVERYBODY TELLS HER TO TAKE

EXCEDRIN FOR HEADACHES, OKAY. IF YOU HAVE HEADACHES, YOU KNOW THAT THEY VARY FROM JUST A HEADACHE TO DOWN RIGHT YOU'RE IN THE CLOSET TRYING TO HIDE FROM THE WORLD AND YOU CAN'T STAND IT WHEN THE CAT WALKS ACROSS THE CARPET BECAUSE YOU CAN HEAR THE TOENAILS. I MENTION THAT BECAUSE COMMUNICATION IS SO DIFFERENT FOR DEAF PEOPLE AND THE NEEDS OF DEAF PEOPLE IS SO DIFFERENT. AS WAS MENTIONED A PERSON MAY BE ABLE TO DEAL WITH IT JUST ONE ON ONE AND LET THEM MAKE THAT DECISION IF THEY WANT TO WRITE BACK AND FORTH. NOT THE DOCTOR. NOT THE PROVIDER. THEY'LL TALK LOUDER TO THE DEAF PATIENT BECAUSE THEY CAN'T HEAR, BUT THEY'RE DEAF. THEY'LL TALK LOUDER TO THEM. I TALK TO LOUDER WHO HAVE A FOREIGN ACCENT. DON'T ASK ME WHY. IT DOESN'T MAKE THEM HEAR ANY BETTER. BUT THAT'S WHAT I'VE DONE. I'VE HAD SO MANY EDUCATION-- EDUCATION IS IMPORTANT. EDUCATION IS VERY IMPORTANT. AS I MENTIONED, MY VERY FIRST MEETING WHEN MY MAMA DIED, HER PRIMARY REASON OF DEATH CONGESTIVE HEART FAILURE. THE SECOND REASON WAS BECAUSE SHE WAS DEAF. THAT'S-- WHO WROTE THAT DEATH CERTIFICATE? SHE DIED IN 1998. YEAH, THAT WAS IN THE 1900s.
[LAUGHTER]
I HAD A STUDENT WHEN I WORKED AT EAST CAROLINA UNIVERSITY THAT WENT INTO MED SCHOOL. DEAF GUY. AWESOME. TRIPLE MAJOR, BIOLOGY, CHEMISTRY, BIOCHEMISTRY. WHEN HE WENT INTO MED SCHOOL BECAUSE ECU WAS THE ONLY SCHOOL AROUND AND GRANTED THIS WAS IN THE 1900s, TOO, AND ECU WAS THE ONLY ONE TO ACCEPT HIM BECAUSE HE WAS THEIR ALUMNI. I REMEMBER ONE OF THE PROFESSORS TELLING ME HE WILL NEVER MAKE IT BECAUSE HE'S DEAF AND DUMB. HE GRADUATED IN THE TIME NECESSARY, SIX YEARS WITH HIS RESIDENCY, AND WE HAD HIS INTERPRETERS THERE WITH HIM ALL THE TIME. I'VE GOT A DOCTOR, A PRIMARY DOCTOR NOW WHO WAS A STUDENT WITH HIM WHO SAID HE DIDN'T THINK HE'D EVER FINISH. HE WAS SURPRISED THAT THIS DEAF GUY COULD FINISH MEDICAL SCHOOL. YEAH, EDUCATION NEEDS TO HAPPEN. EDUCATION NEEDS HAPPEN AND HOW CAN A DEAF PERSON ADVOCATE FOR THEMSELVES WHEN THEY'RE SICK ? HOW CAN THE FAMILY MEMBERS EDUCATE THEM? JAN EVEN, I REMEMBER WHEN JAN'S PARENTS WERE IN THE HOSPITAL. SHE HAD TO ADVOCATE FOR A FREAKIN' INTERPRETER FOR HERSELF. HER PARENTS WERE HEARING BUT JAN NEEDED TO KNOW WHAT WAS GOING ON WITH HER MOM, HER DAD, WHOEVER IT WAS. THAT HAPPENS ALL THE TIME. I'VE GOT INTERPRETERS THAT ARE CODAs WHO HAVE TO GO TO THE HOSPITAL WHO HAVE TO GO TO MAKE SURE THE INTERPRETERS ARE THERE. MONICA HAD A BABY SHE HAD TO FIGHT THE WHOLE TIME WHEN SHE HAD A BABY TO GET AN INTERPRETER. THAT WAS 2019 NOT THE 1900s. MY STOMACH IS UPSET. IT FEELS LIKE NOTHING HAS CHANGED, PERIOD. GO AHEAD. SK, SK. AND I'M NOT GOING TO EXPLAIN THAT. I'M SORRY. NO, I'M NOT.

>> I KNOW MAGGIE YOU WERE WANTING TO ADD SOMETHING. I DON'T KNOW IF THERE ARE OTHER FOLKS ON THE PHONE THAT HAD COMMENTS.

>> HEY, ADAM, THIS IS MAGGIE. I ACTUALLY WROTE YOU GUYS AN EMAIL, YOU JAN, AND MARK, ABOUT POSSIBLE OPPORTUNITIES FOR AHEC TO PROVIDE TRAINING AND SUPPORT SO I'LL JUST DEFER TO THAT RATHER THAN GOING ON.

>> THANKS, MAGGIE. OTHER FOLKS ON THE PHONE, I WANT TO MAKE SURE YOU ALL HAVE AN OPPORTUNITY TO CONTRIBUTE.

>> YOU HAVE A MESSAGE FROM SOMEBODY. I HAVE A COMMENT FROM DOCTOR--

>> ROB IS GOING TO TELL US SOMETHING THAT IS IN THE COMMENT BOX.

>> DR. NUTT WAS ACTUALLY ON THE WEBINAR BUT HE HAD TO LEAVE FOR ANOTHER MEETING SO HE ASKED ME TO READ THIS TO THE TASK FORCE SO IT WAS IN THE TRANSCRIPT AS WELL. HE WANTED TO COMMENT ON THE RESPONSIBLE ENTITIES AND COMMENTS OF PHYSICIAN RESPONSIBILITY FROM THE NORTH CAROLINA MEDICAL BOARD AND TOVAH, I THINK YOU WERE TALKING ABOUT THIS. HE WOULD LIKE TO PROPOSE AN EDUCATIONAL CONFERENCE FOR ALL INSURANCE AND HEALTHCARE SYSTEMS IN THE STATE. THIS WOULD INCLUDE INTERPRETING SERVICES, ADA COMPLIANCE OFFICERS, COOs, ET CETERA. AND PROVIDE EDUCATION ABOUT THE ADA AND TOPIC WE'RE ADDRESSING IN THIS TASK FORCE. I THINK THAT WITH REGARD TO INCREASING AWARENESS AND COMPLIANCE THAT THIS WOULD BE AN EFFECTIVE OUTCOME OF THE RECOMMENDATION FROM THIS TASK FORCE. I WOULD ALSO LIKE TO HIGHLIGHT THE ISSUE OF RURAL AREAS AND UNDERSERVED AREAS. THERE ARE POCKETS OF DEAF COMMUNITY IN NORTH CAROLINA, BUT WITH THE INTEGRATION MAINSTREAM MODELS INLE SCOOS, THERE ARE MANY FAMILIES THAT ARE ISOLATED. THIS IS WHY HAVING LISTENED TO LARISSA'S PRESENTATION THAT NORTH CAROLINA CAN IMPROVE ON THE MODEL AND BETTER SERVE OUR CITIZENS BY DOING THIS ON THE STATE LEVEL, NOT JUST IN THE TRIANGLE, PIEDMONT, AND WILSON. NOW I'LL HAND IT OVER TO BERKELEY TO TRY TO RECAP ALL OF THIS.

>> I'M NOT EVEN GOING TO TRY TO RECAP IT ALL. WHAT I AM GOING TO SAY IS THAT WE STARTED WITH ONE RECOMMENDATION. I THINK WE GOT A SENTENCE OF THAT AND THEN HAD A WONDERFUL DISCUSSION THAT ACTUALLY TOUCHED ALL OF THE DRAFT RECOMMENDATIONS THAT ARE HERE. I'M NOT SURE WE HAVE ANY CONSENSUS AROUND THE COMMUNICATION ACCESS FUND, BUT WE HAVE A LOT MORE DETAIL ABOUT WHAT PEOPLE THINK WE NEED IN TERMS OF EDUCATION, IN TERMS OF HOW WE MAYBE WE DO ENFORCEMENT AND COMPLIANCE. THERE WAS A FAIR AMOUNT TALKED ABOUT VRI AS WELL. SO WE'RE DEFINITELY GOING TO BE COMING BACK TO COMMUNICATION ACCESS FUND OR ANYTHING THAT MIGHT LOOK LIKE THAT. WE WILL ALSO BE LOOKING AT ALL OF THE OTHER DRAFT RECOMMENDATIONS, REVISING THEM AND END ISING THEM BACK OUT---AND SENDING THEM BACK OUT AS WELL AS FURTHER TALK WITH THE STEERING COMMITTEE. DO YOU HAVE ANY FURTHER COMMENT ON THAT?

>> JUST TO ECHO, WE SENT THESE DRAFT RECOMMENDATIONS OUT TO YOU, I THINK, LATE LAST WEEK BECAUSE WE HAVEN'T HAD A CHANCE TO TALK ABOUT ALL OF THEM TODAY. I THINK IT WOULD BE REALLY HELPFUL TO FUNNEL FEEDBACK TO YOU'LL AFTER THE DRAFT RECOMMENDATIONS TO ROB, SO WE CAN START TO GET COMMENTS AS WE REVISE THESE TO BE ABLE TO BRING THEM BACK TO YOU IN THE NEXT ONE OR TWO MEETINGS.

>> SO WE WILL-- WE'VE GOT THIS WONDERFUL TRANSCRIPT, SO WE DO HAVE EVERYBODY'S COMMENTS CAPTURED FULLY, AS WELL AS THE NOTES WE TOOK. WE WILL WORK ON REVISING THEM AND GIVEN EVERYBODY'S COMMENTS AND THERE WAS ALSO A COMMENT TOWARD THE END OF OUR DISCUSSION AROUND-- WE HAVE POPULATIONS WITH OTHER NEEDS, NOT JUST SIGN LANGUAGE INTERPRETING AND I THINK THAT'S ACTUALLY A GREAT KICKOFF BECAUSE WE'RE STARTING TO LOOK MORE AND MORE AT BOTH AT THE HARD OF HEARING POPULATION, I THINK BEGINNING WITH OUR DISCUSSION NOW. WE ARE-- NEXT UP, WE HAVE A PANEL DISCUSSION ON HEARING LOSS AND LONG-

TERM CARE FACILITIES AND SO WE DO WANT TO MAKE SURE—

Terms and Definitions Relating to Long-Term Care Facilities and Hearing Loss

>> FIRST, JAN HAS 10 MINUTES.

>> FIRST, JAN HAS 10 MINUTES. YOU ARE IN THERE.
[LAUGHTER]
I MISSED THAT PART OF IT. SO JAN IS GOING TO TALK ABOUT TERMS AND DEFINITIONS RELATING TO LONG-TERM CARE FACILITIES AND HEARING LOSS AND THEN WE'LL GO INTO THAT. SO I DO WANT TO MAKE SURE FOR THOSE OF YOU WHO FEEL LIKE WE HAVEN'T TOUCHED ON SOME OF THOSE ISSUES YET, WE ARE DEFINITELY MOVING MORE INTO THAT DISCUSSION STARTING TODAY. NOT THAT WE'RE GOING TO LOSE THE OTHER, BUT WE WILL BE DOING MORE OF BOTH AS WE MOVE FORWARD AND THERE WILL BE RECOMMENDATIONS COMING OUT OF ALL OF THAT AS WELL.

>> GOOD MORNING. THIS IS JAN WITHERS. SPEAKING AND I'M GOING TO COMMENT BRIEFLY ABOUT ABOUT ALL OF THE DIFFERENT TYPES AND DIFFERENT ARRANGEMENTS AND DIFFERENT FACILITIES THAT OLDER ADULTS MAY FIND THEMSELVES IN TO BE SURE WE HAVE A BASIC UNDERSTANDING BEFORE WE MOVE FORWARD INTO THIS TOPIC IT'S NOT WORKING.

>> CAN YOU SWITCH MICS WITH ME, PLEASE?
OKAY. SO I'LL BACK UP JUST BRIEFLY. ALL RIGHT. GOOD MORNING, AGAIN.
[LAUGHTER]
THIS IS JAN WITHERS SPEAKING. I THINK IT'S IMPORTANT THAT WE TAKE JUST A BIT OF TIME TO MAKE SURE THAT WE KNOW WHAT WE'RE TALKING ABOUT WHEN WE START TO DELVE INTO ALL OF THE DIFFERENT TYPES OF ARRANGEMENTS AND FACILITIES FOR OLDER ADULTS. ESPECIALLY FOR THOSE WITH HEARING LOSS. AND I CAN SPEAK FROM MY OWN EXPERIENCE, AND I KNOW THAT THERE ARE A NUMBER OF PEOPLE HERE WHO PROBABLY CONFUSED AND MAYBE CURIOUS AS TO WHAT DIFFERENT TERMS MEAN AND I KIND OF FACE THE SAME THING WHEN I STARTED DELVING INTO THIS TOPIC, BUT I DO WANT TO TALK TO YOU ABOUT WHAT'S MOST KNOWN FOR THOSE IN THE 55 AND UP COMMUNITY. THERE ARE PRIVATE HOMES. THERE ARE DIFFERENT PLACES THAT YOU CAN GO INTO INDEPENDENTLY AND YOU BUY A SPACE. THERE ARE ALSO CCRCs, WHICH ARE CONTINUING CARE RETIREMENT COMMUNITIES, WHICH ARE COMMUNITIES THAT ARE CENTRALLY OPERATED THAT INCLUDE, LET'S SAY, A STAND-ALONE HOME POSSIBLY, APARTMENTS, ALL THE WAY UP TO ASSISTED LIVING SERVICES AND THEN WHERE YOU CAN TRANSITION INTO SKILLED NURSING CARE AND SO THE WHOLE GAMUT IS INCLUDED WITHIN ONE COMMUNITY AND MY MOTHER WAS A PART OF THAT TYPE OF SYSTEM. SO I DID HAVE EXPERIENCE WITH HER TRANSITIONING FROM AN APARTMENT TO ASSISTED LIVING AND SO FORTH. THEN YOU HAVE A STAND-ALONE NURSING, SKILLED NURSING FACILITIES. AND SO STAND-ALONE ASSISTED LIVING FACILITIES. AND ADULT CARE HOMES. DR. WAX HAS AN EXCELLENT DESCRIPTION IN HER PRESENTATION. SHE'S GOING TO TALK TO YOU IN MORE DETAIL AS PART OF HER POWERPOINT. YOU'LL GET SOME MORE INFORMATION A LITTLE BIT LATER BUT I THOUGHT I WANTED TO SHARE WITH YOU JUST A TIDBIT OF WHAT WE'RE TALKING ABOUT BEFORE WE MOVE INTO THIS ISSUE. I ALSO WANTED TO TAKE THIS OPPORTUNITY TO LET YOU KNOW THAT BECAUSE OF THE COMPLEXITY OF WHAT WE WILL BE DISCUSSING AND AS WE'RE TRYING TO FIGURE OUT HOW TO BEST

SUPPORT OLDER ADULTS WITH HEARING LOSS AND VARIOUS TYPES OF FACILITIES, WE HAVE DECIDED TO GO AHEAD AND ESTABLISH AND WE, MEANING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, WE HAVE DECIDED TO GO AHEAD AND ESTABLISH AN INTERNAL WORK GROUP TO DO A DEEP DIVE INTO THESE ISSUES. SO THAT WE CAN TRY TO DETERMINE HOW WE CAN BEST WORK WITHIN THE PARAMETERS OF THE EXISTING FEDERAL AND STATE REQUIREMENTS. AND HERE, THE TASK FORCE CAN USE THIS AS AN OPPORTUNITY TO LOOK AT THINGS LIKE UNIVERSAL DESIGN, BEST PRACTICES, CULTURAL CHANGE WITHIN THE FACILITIES, AND I SEE THE TWO GROUPS INFORMING EACH OTHER AND HAVING AN INFLUENCE OVER EACH OTHER, BUT LET ME SHARE AN EXAPLE OF MY EXPERIENCE--SHARE AN EXAMPLE OF MY EXPERIENCE AND WHY WE NEED TO LOOK AT THOSE REGULATIONS AND WHY WE NEED TO WORK WITH THE INTERNAL DHHS GROUP. A WHILE BACK, SOMETIME LAST YEAR, WHEN THE DIVISION OF HEALTH BENEFITS WAS IN THE PROCESS OF DEVELOPING AN RFP, WHICH IS A REQUEST FOR PROPOSAL, THEY WERE DEVELOPING AN RFP FOR ENROLLMENT BROKER SERVICES. THEY ASKED TO SEE THE REQUIREMENTS FROM CMS FOR ACCESSIBILITY FOR DEAF AND HARD OF HEARING FOLKS. I FOUND OUT THAT THEY ONLY HAD ONE REQUIREMENT LISTED, WHICH WAS THE USE OF TTYs. NOW, IF YOU KNOW WHAT I'M TALKING ABOUT, YOU REALIZE THAT IS A VERY OUT-OF-DATE REQUIREMENT. I, MYSELF, HAVE NOT USED A TTY IN WELL OVER FIVE YEARS. NO ONE I PERSONALLY KNOW EVEN HAS A TTY ANYMORE. THIS IS VERY OUTDATED TECHNOLOGY. OUR DIVISION WORKED WITH DHB TO DEVELOP REQUIREMENTS THAT THEY COULD INCLUDE IN THEIR RFP FOR THEIR ENROLLMENT BROKERS. SO THAT'S ONE, JUST VERY SIMPLE EXAMPLE, AND I HAVE ALREADY ENGAGED DR. SEXTON WHO IS HERE IN THE ROOM WITH US TO LOOK AT THOSE CMS REQUIREMENTS FOR HEARING EVALUATIONS IN NURSING HOMES. AND I'M LOOKING TO DR. TOVAH WAX AND I'M HOPING SHE WILL ALSO BE ABLE TO GET INVOLVED WITH US AND DR. DOWD IN LOOKING AT ALL OF THESE DIFFERENT ISSUES SO THAT WE CAN FIGURE OUT WHAT WE NEED TO DO TO PROCEED WITH IMPROVING SUPPORT FOR THOSE WITH HEARING LOSS IN VARIOUS TYPES OF FACILITIES. DID YOU WANT TO ADD TO THAT, MARK?

>> THIS IS MARK AND JUST TO ADD PERHAPS JUST A LITTLE COLOR, A LITTLE DETAIL TO JAN'S VERY CORRECT DESCRIPTION THAT WE HAVE A VARIETY OF SETTINGS ACROSS THE CONTINUUM OF CARE FROM INDEPENDENT LIVING ALL THE WAY UP TO SKILLED NURSING, AS WELL AS HOSPITAL-BASED CARE, AND THE REASON WHY THIS IS REALLY IMPORTANT IT'S ALSO BECAUSE IT'S REALLY COMPLICATED THAT CERTAIN SETTINGS ARE DRIVEN MORE BY FEDERAL LAW AND FEDERAL REGULATIONSES. CERTAIN SETTINGS, JAN JUST MENTIONED, ASSISTED LIVING ADULT CARE HOMES, ARE MORE LARGELY DRIVEN BY STATE LAW AND STATE REGULATION SO AS WE SORT OF WORKED THROUGH THESE RECOMMENDATIONS AND AS DR. SEXTON AND OTHERS SORT OF LOOK AT THE FEDERAL REGULATIONS, THAT WILL HELP US PINPOINT WHERE THE SORT OF THE LEAD AS FAR AS REGULATION OR LAW IS BASED UPON SETTING.

>> THIS IS JAN SPEAKING. YES, THANK YOU, MARK. WE, AS A STEERING COMMITTEE, HAVE ALREADY ADDED A SEVENTH TASK FORCE MEETING AND I THINK WHEN WE STARTED THIS TASK FORCE, WE DID NOT REALIZE HOW COMPLEX AND HOW SIGNIFICANT ALL OF THE ISSUES THAT WE ARE DEALING WITH ARE. SO HOPEFULLY, THIS IS INTERNAL WORK GROUP WILL BE ABLE TO SUPPLEMENT THE WORK OF THIS TASK FORCE THAT WE ARE DOING HERE. SO THANK YOU.

>> WHO IS ON THE PANEL? SO TOVAH IS STILL IN THE ROOM. AND THEN DAVID IS ONLINE AND TONY IS MODERATING. DO WE WANT CHAIRS UP HERE?

>> WE'RE VERY GRATEFUL TO BE HERE TODAY AND WE'RE GOING TO TALK FOR A FEW MINUTES ABOUT COMMUNICATION BARRIERS IN LONG-TERM CARE SETTINGS. WE'VE COMPRISED THIS PANEL OF BILL LAMB AND DR. WAX AND ALSO DAVID KUHLMAN, WHO I INTERVIEWED LAST WEEK VIA VIDEO, IN MORGANTON. HE DROVE DOWN FROM BREVARD. WHAT YOU'LL NOTICE IS ALL THREE OF OUR PANEL SPEAKERS TODAY ARE ADULT CHILDREN THAT HAD PARENTS THAT WERE IN LONG-TERM CARE SETTINGS WHO HAD HEARING LOSS. EITHER THEY WERE HARD OF HEARING OR THEY HAD BOTH DUAL VISUAL AND HEARING LOSS COMBINED AND SO YOU'LL START TO HEAR FROM THEM SOME SIMILARITIES IN THEIR STORIES ABOUT HOW THEIR PARENTS STRUGGLED IN THESE CARE SETTINGS. ONE THING I WOULD LIKE TO SHARE IS THAT WHEN WE WERE TRYING TO RECRUIT PANEL MEMBERS WHEN WE WERE TALKING TO PEOPLE ABOUT WHO COULD COME OUT AND SHARE THEIR EXPERIENCES, IT WAS REALLY DIFFICULT, NEAR IMPOSSIBLE, TO FIND ANYONE WHO WAS CURRENTLY IN A LONG-TERM CARE SETTING THAT COULD SHARE THEIR EXPERIENCES. NOW THIS ALSO IS THE CASE FOR HOW PEOPLE SEEK HELP. SO FOR EXAMPLE, MANY PEOPLE THAT REACH OUT A OUR REGIONAL CENTERS AND REACH OUT TO GET HELP WITH THEIR HEARING LOSS AND LONG-TERM CARE SETTINGS, IT'S NOT THE PERSON THEMSELVES GETTING THROUGH THE EXPERIENCE. IT'S ACTUALLY THE ADULT CHILDREN WHO ARE REACHING OUT FOR THEM ON BEHALF OF THEM. SOMETIMES IT'S A SOCIAL WORKER. SOMETIMES IT'S A PERSON WHO WORKS WITH THEM DIRECTLY. AND WE THINK THAT ONE OF THE REASONS THIS IS IS BECAUSE SOME PEOPLE DON'T ACCEPT THEIR HEARING LOSS YET WHEN THEY'RE HARD OF HEARING. IT TAKES THEM A LONG TIME TO ACCEPT IT. SOMETIMES SEVEN YEARS. ON TOP OF THAT, IT'S ONLY 16% OF THE PEOPLE WHO BENEFIT FROM A HEARING AID ACTUALLY WEAR ONE. 16 TO 19%. SOME PEOPLE ARE AFRAID TO ASK FOR PEOPLE. THEY'RE JUST AFRAID IF THEY DO ASK FOR HELP, THERE WILL BE RETRIBUTIONS FOR THAT. THEY'RE AFRAID TO ASK FOR TOO MUCH. AND THEN SOME PEOPLE WHO ARE IN THESE LONG-TERM CARE SETTINGS DON'T HAVE ENOUGH ENERGY TO ASK FOR HELP. THEY MIGHT NOT BE AWARE OF THEIR HEARING LOSS. THEY MIGHT NOT HAVE BEEN SCREENED. WE'LL ACTUALLY SEE THAT QUITE OFTEN. THEY MAY NOT EVEN BE AWARE THERE'S ACCOMMODATIONS AND ADAPTATIONS THAT CAN BE MADE TO HELP THEM TO HEAR BETTER IN THESE LONG-TERM CARE SETTINGS. SO WHAT I'M GOING TO DO IS TO LET THESE PANEL MEMBERS SHARE FOR THEMSELVES THEIR EXPERIENCES THAT THEIR PARENTS HAD AND WHEN THEY'RE ALL DONE, I DO HAVE SOME EXPERIENCES MYSELF. I WORKED WITH ABOUT OVER 200 PEOPLE IN LONG-TERM CARE SETTINGS A YEAR BEFORE I CAME HERE TO NORTH CAROLINA. I CAME FROM MINNESOTA, JUST SIX MONTHS AGO, AND A YEAR AGO, I WAS WORKING WITH PEOPLE IN LONG-TERM CARE SETS EVERY WEEK. SO I HAVE SOME EXPERIENCES MYSELF THAT I MIGHT BE ABLE TO SHARE OR TOUCH ON OR MAYBE PERHAPS NOT. WE CAN DO THAT LATER. LET'S START WITH DAVE KUHLMAN AND HE WILL SHARE HIS EXPERIENCE ABOUT HIS MOTHER WHO WAS IN AN INDEPENDENT LIVING CENTER-- ASSISTED LIVING CENTER AND THEN IN A NURSING HOME LATER . LET'S HEAR WHAT HE HAS TO SAY. ASSISTED LIVING FACILITY IN THE NURSING HOME, IN BOTH CASES, THE STAFF WAS NICE PEOPLE, BUT UNTRAINED ON HOW TO DEAL WITH THE HEARING LOSS SITUATION. MY MOM HAD HEARING AIDS AND ALTHOUGH I DON'T KNOW WHAT SHE WOULD HAVE BEEN TESTED, I THINK IT WOULD HAVE BEEN LISTED AS A SEVERE HEARING LOSS. WITH HEARING AIDS, IF YOU SPOKE AT HER FACE TO FACE, SHE COULD UNDERSTAND. THE STAFF GENERALLY DID IN THE KNOW HOW TO

DO THAT. THEY HADN'T BEEN TRAINED ON FACE-TO-FACE COMMUNICATION BEING IMPORTANT. AT BOTH PLACES THEY WOULD COME IN AND TALK TO HER, WALK THROUGH THE ROOM, CHECK OUT THE BATHROOM, LOOK AROUND FOR ANY KIND OF A PROBLEM, ANYTHING SPILLED, BROKEN, AND TALK WHILE THEY'RE DOING THAT, BUT NEVER ACTUALLY FACING HER. A SIGN ON THE DOOR, A SIGN IN THE ROOM. I'M HARD OF HEARING, FACE ME WHEN YOU TALK, THAT JUST WOULD HAVE MADE A WONDERFUL DIFFERENCE. SHE THEN, AFTER A FALL, MOVED INTO A NURSING HOME. THAT WAS THE SAME FROM THE STAFF RESPONSE. ONE OF THE ADDITIONAL DIFFICULTIES IS THAT SHE INITIALLY HAD A ROOMMATE WHO WAS PRETTY MUCH COMATOSE AND IT WAS OUR IMPRESSION, MY WIFE AND MY IMPRESSION, THAT THE STAFF WOULD COME IN. THEY'D DEAL WITH THE COMATOSE PATIENT ON THE THINGS THEY HAD TO DO FOR HER BUT TREAT MY MOM IN THE SAME WAY. WITHOUT KNOWING WHETHER SHE HAD HER HEARING AIDS IN OR NOT, THEY PRETTY MUCH, AS NEAR AS WE COULD TELL, TREATED HER LIKE SHE HAD ALZHEIMER'S OR WAS DEMENTIA. I DON'T KNOW THAT THE STAFF AT EITHER PLACE HAD EVER CHANGED A BATTERY IN A HEARING AID OR EVER EVEN KNEW TO LOOK FOR THEM. MY WIFE AND I WOULD GO VISIT AND WE LOOK AROUND FOR THE HEARING AIDS AND QUITE OFTEN FIND THEM ON THE TABLE BESIDE HER CHAIR. SO PUT ON YOUR HEARING AIDS. DO THE BATTERIES WORK? DO ALL OF THAT AND THEN WE CAN COMMUNICATE. STAFF NEVER DID THAT. SHE WAS INVOLVED IN SOME OF THE ACTIVITIES AT THE NURSING HOME OR THE ASSISTED LIVING FOR A SHORT TIME, BUT SHE WOULDN'T PARTICIPATE MUCH BECAUSE SHE COULDN'T HEAR. ONE OF THE THINGS THAT WOULD HAVE MADE LIFE BETTER FOR HER WOULD HAVE BEEN A CAPTIONED PHONE OR SOME KIND OF AN AMPLIFIER. WITH A CAPTIONED PHONE, SHE COULD HAVE TALKED TO OUR YOUNGEST DAUGHTER WHO WAS IN COLLEGE. AND SHE WOULD HAVE JUST LOVED THAT. NEVER ONCE DID I RECALL DID SHE EVER GET INVOLVED IN A MEETING WITH THE STAFF OR THE MANAGER AT THE ASSISTED LIVING OR THE NURSING HOME FOR WHAT WAS GOING TO HAPPEN NEXT OR HOW IT WAS GOING TO HAPPEN. THERE WAS NEVER A SCREENING-- A HEARING SCREENING AT EITHER FACILITY . MY RECOMMENDATIONS ARE TRAINING FOR THE STAFF AND IT DOESN'T HAVE TO BE LENGTHY. A SHORT TRAINING SESSION MONTHLY ON REMINDING PEOPLE FACE YOUR PATIENT, TALK PLAINLY, DON'T SLUR YOUR WORDS, DON'T GO IN THERE WITH A MOUTHFUL OF CHEWING GUM AND TRY TO TALK. ASK ABOUT HEARING AIDS. ASK ABOUT BATTERIES. ASK FOR SOME KIND OF A RESPONSE THAT INDICATES THE HEARING IS WORKING.

>> OKAY. SO REAL QUICK. THIS IS ROB, BEFORE I HAND IT BACK OVER TO TONY, SOMEONE ON THE PHONE PUT US ON HOLD WITH THEIR ELEVATOR MUSIC AND WE HAD TO MUTE YOU IN THE ROOM. WE WANT TO BE ABLE TO KEEP THE MIC OPENED FOR THOSE OF YOU ON THE PHONE. SO IF YOU CAN HEAR ME ACTUALLY SAYING THIS, WE WILL PUT THE MIC BACK UP IF YOU ARE ABLE TO TURN OFF THE HOLD MUSIC. THANK YOU.

>> I JUST WANT TO POINT OUT AND REMIND YOU A COUPLE OF THINGS THAT DAVE SAID, JUST TO CLARIFY WHAT HE SAID AS WELL. WHEN HE TALKED ABOUT AN AMPLIFIER, HE WAS TALKING ABOUT A PERSONAL AMPLIFIER LIKE THIS, AND I BROUGHT THIS JUST TO SHOW YOU. I'LL TALK MORE ABOUT THIS AT THE NEXT MEETING. BUT IN MY EXPERIENCE, IT PROBABLY HELPED 200 PEOPLE A YEAR TO BE ABLE TO HEAR BETTER. I'M A BIG PROPONENT FOR HEARING AIDS AND HEARING AIDS DO A WONDERFUL JOB BUT NOT EVERYBODY WILL WEAR 'EM, AND SO THIS IS WHAT HE'S TALKING ABOUT. USING SOMETHING LIKE THIS IN THAT SETTING. SO BILL, I'M WONDERING IF I CAN TURN THE MIC OVER TO YOU AND YOU CAN SHARE IF YOU HAVE ANY SIMILAR EXPERIENCES WITH YOUR MOTHER AND I'LL SHARE SOME

>> SURE. THERE'S A LOT IN THAT LAST PRESENTATION THAT RESONATED WITH ME. I'M LITTLE LANE. I'M THE ECT TIFF DIRECTOR OF FRIENDS AND RESIDENTS IN LONG-TERM CARE. WE'RE A CITIZENS ADVOCACY GROUP DEDICATED TO IMPROVING THE CONDITIONS OF CARE IN LONG-TERM CARE, THE ASSISTED LIVING AND NURSING HOME FACILITIES IN NORTH CAROLINA. I'M TALKING TODAY FROM A PERSONAL EXPERIENCE I HAD WITH MY MOTHER. MY MOTHER SPENT FOUR AND A HALF YEARS IN A NURSING HOME. THIS NURSING HOME WAS A PART OF THE CCRC. THIS WAS TEN YEARS AGO. SHE DIED WHEN SHE WAS 88 AND THAT WAS 2009. SHE WAS PROFOUNDLY HARD OF HEARING. THAT RUNS ON HER SIDE OF THE FAMILY. SHE STARTED EXPERIENCING RELATIVE HEARING LOSS IN HER 50s AND SHE AS SHE AGED, HER HEARING DECLINED SO I'M 71. IT HADN'T HIT ME YET BUT YOU JUST NEVER KNOW. WHEN SHE WAS IN HER 50s, SHE RECOGNIZED SHE HAD A HEARING LOSS. SHE ENDED UP BUYING CHEAP HEARING AIDS. SHE WOULD USE THEM AT WORK. FRANKLY, WHAT SHE WAS INTERESTED IN IS SOMETHING THAT WAS COSMETICALLY INVISIBLE, AND IT WASN'T SO MUCH ABOUT THE HEARING, IT WAS ABOUT STAYING ATTRACTIVE . SHE RETIRED WHEN SHE WAS 65 AND THEN MOVED TO RALEIGH WHEN SHE WAS 70 AND ABOUT THAT TIME, HER HEARING LOSS WAS AT A POINT WHERE IT REALLY DID AFFECT HER ABILITY TO LIVE. WHEN SHOW WAS IN IN HER MID-70s, WE TOOK HER TO CHAPEL HILL FOR AN AUDIOLOGICAL WORK-UP THERE AND SHE MOVED FROM CHEAP HEARING AIDS TO DIGITAL HEARING AIDS AND IT MADE A HUGE DIFFERENCE. AT THAT TIME, THOUGH, THE FELLOW WAS TALKING ABOUT THIS, AS LONG AS YOU WERE STANDING IN FRONT OF MY MOTHER AND SPEAKING TO HER AND SHE HAD HER HEARING AIDS IN, SHE WAS FINE. IF YOU PUT HER IN A A SITUATION WHERE THERE WERE A LOT OF PEOPLE IN THE ROOM AND THERE WAS A LOT OF EXTRANEOUS NOISE AROUND, SHE WAS ABLE AND THAT LIMITED HER IN A NUMBER OF WAYS. AND ONE OF THE MOST IMPORTANT WAYS, FRANKLY, IS SHE DID PARTICIPATE IN CHURCH ACTIVITIES. DURING THE SERMON, SHE WAS FINE. AFTER CHURCH, SHE WAS MISERABLE. THE NOISE THAT WAS CORRECTED IN THE COFFEE HOURS AND THINGS LIKE THAT WERE A PROBLEM. SO THAT AFFECTED HER LIFE BEFORE SHE WENT INTO A NURSING HOME AND IT CERTAINLY AFFECTED HER LIFE AFTERWARD. SHE WOULD AVOID SITUATIONS WHERE SHE HAD SOCIAL EXPERIENCES LIKE THAT. MY MOTHER COULD HEAR ON AN AMPLIFIED PHONE. SHE BOUGHT INTO GETTING AMPLIFIERS FOR HER PHONES AND IF YOU TALK TO HER ON THE PHONE, SHE WAS FINE. SO WHAT WE JUST TALKED ABOUT ALSO WAS SOMETHING THAT WE DISCOVERED, AND WE HAD TO FIGURE THIS OUT OURSELVES. THIS WAS NOT SOMETHING THAT, YOU KNOW, CAME TO US. WE HAD TO GET IT-- I HAD TO GET OUT OF THE INTERNET, AND I HAD TO ASK QUESTIONS AND THAT KIND OF STUFF. THE DEVICE YOU'RE TALKING ABOUT, WE BOUGHT WHAT WAS CALL A POCKET TALKER FROM RADIO SHACK FOR IT WAS A LITTLE OVER 30 BUCKS AND FRANKLY THAT WORKED IN CONVERSATION BETTER THAN THE $6,000 HEARING AIDS. MY MOTHER DID HAVE CONGESTIVE HEART FAILURE. SHE FELL, BROKE HER HIP. THERE WERE A COUPLE OF THINGS THAT HAPPENED HE RELATED TO THAT. BUT ANYWAY, SHE ENDED UP IN A LONG-TERM CARE FACILITY IN THE NURSING HOME. THEY KNEW SHE WAS DEAF WHEN SHE WENT IN. WE HAD SOME TALK ABOUT IT. IT WAS NOT-- I DON'T THINK IT WAS REALLY ON HER CHART THAT MUCH. THE FOLKS IN THE NURSING HOME TRIED TO ACCOMMODATE WHEN THEY COULD, BUT THERE WAS NOTHING I WAS AWARE OF THAT WAS BUILT IN OR PLANNED CARE THAT RELATED TO HAVING A HEARING PROBLEM. MY MOTHER TRIED TO PARTICIPATE IN THE ACTIVITIES THAT WENT ON IN THE NURSING HOME. AND THAT DIDN'T LAST VERY LONG. ACTIVITIES ARE USUALLY LARGE GROUP ACTIVITIES. AND JUST LIKE THE AFTER-CHURCH KIND OF EXPERIENCE I WAS TALKING ABOUT. WITH HER HEARING AIDS IN, THAT WAS A MISERABLE EXPERIENCE. SO SHE ENDED UP WITHDRAWING MORE TO

HER ROOM. THE SAME WAS TRUE ABOUT THE DINING EXPERIENCE. THE DINING HALL AT THIS NURSING HOME WAS A LARGE ROOM, FULL OF PEOPLE, A LOT OF EXTRANEOUS NOISE. SO TWO THINGS HAPPENED. MY MOTHER ENDED UP GOING INTO HER ROOM, AID VOG ACTIVITIES. SHE-- AVOID ACTIVITIES AND TOOK ALL OF HER MEALS IN THE ROOM. SHE CAMPED OUT AFTER THAT IN HER ROOM. SHE WATCHED TELEVISION AND LIKE A LOT OF FOLKS HER AGE, SHE LISTENED TO THE RADIO A LOT. AND SHE WOULD CRANK THE TELEVISION UP AND THE RADIO UP ABOUT AS LOUD AS YOU COULD STAND IT AND IT WAS A CONSTANT BACK AND FORTH IN TERMS OF PEOPLE COMPLAINING THAT THE TV WAS TOO LOUD. THEY'D GO IN AND TURN IT OFF OR TURN IT DOWN. SHE COULDN'T HEAR IT. SHE'D TURN IT BACK UP. THEY'D COME BACK IN AND THEY WENT BACK AND FORTH AND BACK AND FORTH AND WHAT END UP HAPPENING IS WE FIGURED OUT A WAY TO GET THE EARPHONES SO THAT YOU COULD HEAR THE TELEVISION AND THE RADIO. THE RADIO WAS ACTUALLY CONNECTED TO THE EARPHONES BUT YOU COULD HEAR THE TELEVISION. SO NOW WHAT'S GOING ON IS MY MOTHER IS IN HER ROOM, COMPLETELY ISOLATED WITH THESE BIG EARPHONES AROUND HER HEAD AND SHE'S ON ANOTHER PLANET. SO SHE'S NOT AWARE OF ANYTHING GOING ON. WHEN THEY HAVE THESE ANNOUNCEMENTS THAT ARE INFORMING PATIENTS OR RESIDENTS THERE ABOUT STUFF GOING ON, SHE CAN'T HEAR ANY OF THAT AND SO SHE MISSES OUT ON THINGS. WHEN PEOPLE COME INTO PROVIDE CARE, THE PERSONAL CARE WORKERS, WHEN SHE DIDN'T HAVE ALL THAT STUFF ON, THEY WOULD TRY TO TALK WITH HER. THEY NEVER USED THAT POCKET TALKER. IT'S NOT THAT IT WAS A HUGE PRODUCTION, BUT YOU DID HAVE TO SIT DOWN AND SIT BESIDE HER BED AND YOU WOULD WERE KIND OF CHAINED TO HER AND I VISIT HER EVERY DAY. I WOULD USE IT. THE STAFF WOULD NOT. ANYWAY, SHE WAS COMPLETELY ISOLATED. I THOUGHT-- I'LL BE QUICK. I THOUGHT THE NOTION OF PUTTING SOME KIND OF INDICATION ON THE ROOM IS PROBABLY A GOOD IDEA. MY MOTHER IN THE LAST TWO YEARS WAS A FALL RISK. THEY HAD THIS BIG STAR OUTSIDE OF HER ROOM AND ALL THAT MEANS IS TO CATCH A FALLING STAR. THAT MEANS SHE'S A FALL RISK. AND THE FOLKS WHO GO IN THERE KNOW THAT'S A POTENTIAL PROBLEM. IT DOES STRIKE ME THAT THERE OUGHT TO BE AN INDICATOR THERE THAT YOU ARE DEALING WITH A RESIDENT WHO MAY HAVE A HEARING LOSS. AND I THINK I'LL GET INTO SOME OF THE OTHER DISCUSSIONS ABOUT RECOMMENDATIONS WHEN WE GET INTO MORE QUESTION-AND-ANSWER.

>> WHAT KINDS OF BARRIERS DID YOU SEE IN THE NURSING HOME OR LONG-TERM CARE SETTINGS WITH YOUR MOTHER AND WHAT WERE HER EXPERIENCES?

>> ALL OF THE ABOVE.
[LAUGHTER]
THIS IS TOVAH TALKING. CAN YOU HEAR ME OKAY. ALL OF THE ABOVE AND WITH THE CASE OF MY MOTHER WHO DIED IN 2015, WE LIVED IN TROY, NEW YORK, UPSTATE NEW YORK, AND IN ABOUT 2010, MY PARENTS MOVED TO NORTH CAROLINA, FIRST, TO AN INDEPENDENT LIVING SITUATION. MY FATHER DIED PRETTY QUICKLY AFTER THAT FROM LUNG CANCER AND MY MOTHER DIED IN 2015 FROM, I GUESS, WHAT YOU WOULD CALL NATURAL AGING. BECAUSE SHE WAS VERY HEALTHY AND THERE WAS NO SPECIFIC CAUSE OF DEATH. ANYWAY, SHE WAS BORN WITH SEVERE VISUAL IMPAIRMENT. SO THAT WAS ONE OF THE MAJOR ISSUES OF HER LIFE AND THEN, OF COURSE, WHEN SHE GOT OLDER, SHE LOST A FAIR AMOUNT OF HEARING SO SHE WAS BOTH VISUALLY IMPAIRED AND HEARING IMPAIRED AND WAS NOT HAPPY ABOUT ANY OF IT. SHE WAS ALSO VERY PRE-OCCUPIED WITH IMAGE AND VANITY. SHE HAD TREMENDOUS RESISTANCE BOTH TO WEARING GLASSES, WHICH, OF COURSE, WITHOUT THEM

SHE WAS BLIND AS A BAT AND ANYTIME WE HAD PHOTOGRAPHS TAKEN, SHE WOULD RIP THEM OFF AND STARE BLANKLEY TO WHERE THE CAMERA WAS. SO SHE DID NOT LIKE TO BE SEEN WITH ANY OF THIS. SO ANY MENTION OF HEARING AIDS OR OTHER DEVICES WAS MET WITH GREAT RESISTANCE AND BY GREAT RESISTANCE, I MEAN HOSTILITY, ANGER. AS AN EXAMPLE, ONE TIME WE BROUGHT A REMOTE CONTROL FOR THE TV THAT WAS LARGE. SHE THREW IT AT MY HEAD.
[LAUGHTER]
SO YOU KNOW, IT WAS NOT WELL RECEIVED. SO WHEN SHE MOVED TO, FIRST, ASSISTED LIVING AND THEN NURSING HOME CARE, IN CONTINUING CARE, RETIREMENT COMMUNITY, THEY WERE AWARE PARTLY BECAUSE OF MY OWN ADVOCACY BECAUSE MOM WASN'T GOING TO TALK VERY MUCH ABOUT IT, I WAS A STRONG ADVOCATE FOR UNDERSTANDING THAT SHE HAD HEARING IMPAIRMENT AND VISUAL IMPAIRMENT. THE ADDED PROBLEM IN OUR CASE, IN ADDITION TO ALL THE THINGS THAT WERE MENTIONED ALREADY ABOUT THE VARYING LEVELS OF STAFF AWARENESS, EDUCATION, AND HELP. MY MOTHER, I THINK, ALSO HAD MENTAL HEALTH ISSUES OR PERSONALITY ISSUES BECAUSE SHE WAS VERY ANGRY ALL THE TIME. SHE WAS HOSTILE AND I THINK SHE WAS DEPRESSED AND ANY ATTEMPT TO ADDRESS ANY OF THAT WAS MET WITH GREAT RESISTANCE. SO TRYING TO HELP HER WITH ANY OF IT WAS ALMOST IMPOSSIBLE. IT WAS VERY DIFFICULT. SHE DID THE SAME THING WITH CRANKING UP THE TV AND PEOPLE HAVING TO COME IN AND SAY, LOOK, IT'S TOO LOUD. SHE TRIED TO GIVE HER HEADPHONES OR EARBUDS TO WEAR WITH THE TV, SHE WOULDN'T HAVE ANY OF THAT. IN PART, I THINK IT WAS HER WAY OF GETTING ATTENTION BECAUSE SHE WAS ALSO LONELY AND ISOLATED. IT WAS HARDER AND HARDER FOR HER TO COMMUNICATE WITH PEOPLE. LIKE IN THE DINING ROOM OR, YOU KNOW, IN THE HALLWAYS OR IN THE LIVING ROOM, AND EVEN THE GROUP ACTIVITIES, IT WAS VERY, VERY DIFFICULT BOTH BECAUSE SHE COULDN'T HEAR AND SHE COULDN'T SEE. EVERY TIME THEY HAD AN ACTIVITY THAT REQUIRED USING PAPER, YOU KNOW, PUZZLES OR QUIZES TO FILL OUT OR GAMES ON PAPER, I WOULD ALWAYS HAVE TO ASK FOR THE LARGE PRINT AND MOM DIDN'T LIKE IT WHEN I DID THAT PUBLICLY, SO I WOULD HAVE TO GO LIKE BEHIND THE SCENES SO TO SPEAK WITH THE ACTIVITY DIRECTOR AND GET LARGE PRINT COPIES MADE AHEAD OF TIME BECAUSE SHE WAS VERY BENT ON IMAGE ISSUES. SHE ALSO STARTED ACTING DRAINED AT TIMES AND IT WAS FOR TWO REASONS APPARENTLY. ONE, WAS URINARY TRACT INFECTION WHICH SHE HAD REPEATEDLY AND THAT, BELIEVE IT OR NOT, IS ASSOCIATED WITH FORMS OF COGNITIVE CONFUSION OR EVEN DEMENTIA-LIKE BEHAVIOR AND THE SECOND OBVIOUSLY AND NOT OBVIOUSLY, BUT I BELIEVE ALSO HAD TO DO WITH NOT BEING ABLE TO HEAR AND GETTING MESSAGES MIXED OR CONFUSING INFORMATION. SO UNFORTUNATELY, I THINK THERE WERE MENTAL HEALTH ISSUES MIXED IN THERE SO WE WERE KIND OF HELPING IN MANY WAYS WITH HOW TO DEAL WITH THAT AND THE MOST IMPORTANT THING AT THE END WAS THAT SHE WAS ISOLATED TO THE POINT OF EXTREME ANXIETY AND SHE WAS CONSTANTLY PUSHING THE CALL BUTTON AND THE STAFF WOULD WAS CONSTANTLY HAVING TO RUN IN AND DEAL WITH HER AND SHE AT ONE POINT WANTED ALL HER MEALS SERVED IN THE ROOM, TOO, BECAUSE SHE DIDN'T WANT TO DEAL WITH THE DINING ROOM SITUATION OF BEING EMBARRASSED BY NOT BEING ABLE TO PARTICIPATE IN CONVERSATION. SO AT THE END, THEY WANTED TO KICK HER OUT OF THE PLACE AND FIRST, SHE DID END UP HAVING TO GO TO GERRY AT TRICK PSYCHIATRIC---- GERIATRIC PSYCHIATRIC UNIT AT A NEARBY HOSPITAL AND I HAVE TO SAY THAT UNIT IS FULL ALL THE TIME. IT WAS BECAUSE I HAPPENED TO KNOW SOMEBODY THAT I WAS ABLE TO GET HER IN THERE AND IN TERMS OF ACCESSIBILITY TO THESE OTHER RESOURCES IT WAS VERY DIFFICULT AND WE GOT HER IN. AND BEFORE THE NURSING HOME WOULD TAKE HER BACK, THEY SAID THAT WE WOULD HAVE TO HIRE ADDITIONAL-- IS THERE A COMMUNICATION ISSUE? I JUST WANT TO MAKE SURE.

>> WE HAVE A MINUTE BECAUSE WE NEED TO ASK QUESTIONS.

>> I'M GOING TO WRAP UP PRETTY QUICKLY. WE WERE TOLD THAT WE HAD TO HIRE BASICALLY A SITTER TO STAY WITH HER THE WHOLE TIME UP UNTIL THE END. ON MY SIDE OF IT, BEING DEAF, THE STAFF DIDN'T ALWAYS COMMUNICATE WITH ME RELIABLY. FOR EXAMPLE, I HAD GIVEN THEM ALL THE INFORMATION ON HOW TO CONTACT ME AND I ASKED THEM TO PROMISE TO CONTACT ME WHEN SHE WAS DYING SO I COULD BE THERE. UNFORTUNATELY, SHE DIED ON THE SECOND SHIFT AND APPARENTLY THEY NEVER GOT ALL THAT INFORMATION SO I MISSED MY MOTHER'S DEATH, WHICH LEFT ME FEELING QUITE ANGRY AND THAT WAS ANOTHER ISSUE. IN TERMS OF ONE SOLUTION THAT I THOUGHT OF THAT WOULD HELP IN MY MOTHER'S CASE BECAUSE OF HER IMAGE CONSCIOUSNESS AND I THINK, FOR EXAMPLE, POCKET TALKERS OR AMPLIFIERS WERE AVAILABLE AT THE DOOR OF EVERY ACTIVITY, AVAILABLE TO EVERYBODY, NOT JUST MY MOTHER, SHE WOULD FEEL LIKE ANYBODY HAD ACCESS TO THIS AND MORE PEOPLE WOULD USE IT AND IT WOULD FEEL LESS STIGMATIZING AND THAT'S ONE EXAMPLE, I THOUGHT OF IN TERMS OF HOW TO DEAL WITH THAT SITUATION.

>> I DO REALLY APPRECIATE YOU BRINGING THAT UP, IDEA OF HAVING PERSONAL AMPLIFIERS AVAILABLE FOR EVERYBODY IN ANY ACTIVITY AND EVEN OFFERING THEM AT DIFFERENT TABLES OF THE THAT'S A REALLY GOOD IDEA, AND THAT MAKES FACILITIES LIKE THIS MORE ACCESSIBLE AND I HAVE SEEN MANY FACILITIES WHO DO PROVIDE THIS TYPE OF ACCESS TO ACCOMMODATIONS AND PEOPLE SEEM TO BE ABLE TO PARTICIPATE MORE OFTEN IN THOSE TYPES OF SETTINGS. WE WANT TO OPEN IT UP FOR HOW LONG? FIVE OR TEN MINUTES FOR QUESTIONS FOR ANYBODY TO ASK THE PANEL MEMBERS. OBVIOUSLY, WE DON'T HAVE DAVE HERE, BUT I'M SURE BOTH BILL AND TOVAH, DR. WAX, COULD ANSWER SOME OF YOUR QUESTION QUESTIONS. ANYBODY HAVE ANY QUESTIONS RELATED TO COMMUNICATION IN LONG-TERM CARE SETTINGS. ASHLEY?
>> YES, THIS IS ASHLEY BENTON SIGNING. SO I THINK UNIVERSAL DESIGN IS SOMETHING WE CAN THINK ABOUT AND THAT'S WHERE YOU ARE TALKING ABOUT RECOMMENDING THINGS FOR THEM TO HEAR THE TV OR THE RADIO, ANYTHING THEY CAN LET THEM KNOW THAT THERE'S SOME SORT OF ANNOUNCEMENT COMING THROUGH, THAT THEY CAN INTERRUPT WHAT THEY'RE DOING SO THEY KNOW WHERE TO BRING THEIR ATTENTION, SO THOSE THINGS CAN BE THOUGHT ABOUT IN HOW SOMETHING IS DESIGNED IN THE FACILITY, AND I THINK EVERYONE IN THE FACILITY WOULD BENEFIT FROM THINKING IN THAT WAY.

>> I APPRECIATE YOU BRINGING THAT UP AND ACTUALLY I THINK, BILL, WE TALKED WITH THIS THE OTHER DAY SOME. BILL PROBABLY HAS SONG TO ADD TO THAT.

>> EXACTLY. SOMETHING SIMPLE LIKE, YOU KNOW, JUST FLASHING KINDS OF THINGS WHEN THE ANNOUNCEMENTS ARE COMING ON. MY MOTHER WOULD HAVE BEEN ABLE TO ASK, WHAT'S THAT ABOUT. THE OTHER THING AND THIS IS PRETTY SIMPLE. THE ACTIVITY ROOM THAT'S IN THE FACILITY THAT MY MOTHER WAS IN WAS ABOUT AS BIG AS THIS ROOM. SO WAS THE DINING ROOM. EXCUSE ME. THE FACILITIES ARE NOW MOVING TOWARD DESIGN WHERE THERE'S SMALLER GROUPINGS OF PEOPLE AND WITH THE POPULATION THAT WE'RE TALKING ABOUT. YOU GOT A LOT OF PEOPLE WHO HAVE SOME HEARING LIMITATIONS. SMALLER GROUPS ARE LOTS EASIER TO DEAL WITH. THEY'RE A LOT MORE COMFORTABLE AND FRANKLY, IT'S A LOT MORE HOME-LIKE. SO WHEN I TALK ABOUT CULTURE

CHANGE IN FACILITIES, I'M ALSO TALKING ABOUT TRYING TO GET AWAY FROM KIND OF THE INSTITUTIONAL LOOK AND FEEL OF A FACILITY AND JUST THE ARCHITECTURE OF THE BUILDING CAN MAKE A LOT OF DIFFERENCE NOT JUST FOR THE PEOPLE WITH HEARING IMPAIRMENTS OR FOR THE REST OF THE PEOPLE AS WELL, WHICH IS WHAT UNIVERSAL DESIGN IS ABOUT. IF WE'RE MAKING IT EASY FOR PEOPLE WHO HAVE TO BE ACCOMMODATED, YOU'RE MAKING IT EASY FOR EVERYBODY ELSE WHO HAS TO LIVE THERE.

>> NOISE DAMPENING SYSTEMS COULD BE INCORPORATED INTO THAT, SIMPLY RUGS ON THE WALLS OR QUILTS ON THE WALLS OR NOISE DAMPENING ACOUSTIC BOARDS THAT YOU PUT UP ON THE WALLS THAT WOULD REDUCE REVERBTATION AND ALSO BACKGROUND NOISE AND PEOPLE WITH AND WITHOUT HEARING LOSS TO HEAR BETTER. OTHER QUESTIONS?

>> YES. THIS IS JAN. I HAVE A QUESTION FOR BOTH OF YOU. SPEAKING FROM MY OWN EXPERIENCE, SOMETIMES, YOU CAN EDUCATE A PERSON AND THAT MAY LEAD TO BETTER COMMUNICATION BETWEEN YOU AND THAT INDIANA VIEWLG THAT YOU'VE EDUCATED. SOMETIMES YOU TRY TO EDUCATE A DIFFERENT PERSON AND DESPITE PROVIDING EDUCATION, COMMUNICATION NEVER REALLY IMPROVES. A LOT OF IT DEPENDS ON THE ATTITUDE OF THE PERSON YOU'RE INTERACTING WITH. SO FROM YOUR EXPERIENCE, HAVE EITHER OF YOU SEEN ANYTHING THAT LEADS TO AN ATTITUDINAL CHANGE IN THE PEOPLE YOU'RE WORKING WITH? I GUESS MY POINT BEING EVEN WITH THE KNOWLEDGE OF WHAT SOMEONE SHOULD DO AND HOW TO APPROPRIATELY TO INTERACT WITH THE PERSON WHO HAS HEARING LOSS, IT REQUIRES AN ATTITUDE CHANGE FOR PEOPLE TO BE WILLING TO TAKE THOSE STEPS. SO WHAT IS YOUR EXPERIENCE DEALING WITH THAT?

>> JAN IS CORRECT IN IMPLYING AND I WILL STATE THAT SOME STAFF, IN FACT, ARE EITHER RESISTANT OR EVEN HOSTILE TO MAKING THE APPROPRIATE CHANGES OR ADAPTATIONS. BECAUSE I HAPPEN TO ALSO BE IN THE MENTAL HEALTH FIELD, IT OCCURRED TO ME TO THINK THAT SOME STAFF HAVE ISSUES OF THEIR OWN. THEY HAVE PROBLEMS AT HOME. THEY DON'T GET PAID ENOUGH OR THEY'RE WORRIED ABOUT, YOU KNOW, THEIR OWN EXPENSES OR WHATEVER. AND MAYBE THEY ARE RESENTFUL TO THEIR BOSS, WHATEVER, THERE MAY BE THINGS GOING ON WITH THE STAFF. ONCE IN A WHILE, I WAS ABLE TOINTUIT WITH THE STAFF AND EMPATHIZE WITH THEM AND THAT IMPROVED THE ATTITUDE. THAT'S NOT MY JOB TO DO THAT. I'M DEALING WITH MY MOTHER, MY OWN PARENTAL SITUATION. SO I THINK ONE OF THE THINGS THAT MAY HAVE TO HAPPEN AT THE ADMINISTRATIVE LEVEL IN SOME PLACES IS TO CARE FOR THEIR STAFF A LITTLE BETTER AND PERHAPS FROM THE TOP DOWN THIS IS GOING TO BE MAJOR ARGUMENT THAT THINGS HAVE TO HAPPEN FROM THE TOP DOWN TO HAVE THE STAFF COMPLY OR GET COMFORTABLE MAKING SOME OF THE CHANGES THEY NEED TO MAKE.

>> THAT IS ALMOST EXACTLY WHAT I WAS GOING TO SAY. CULTURE CHANGE IS A-- IS A TERM THAT YOU HEAR A LOT NOW IN LONG-TERM CARE NURSING HOMES AND ASSISTED LIVING, BUT WHEN YOU GET UNDERNEATH, IT, IN REALITY, I DON'T SEE A LOT OF IT GOING ON. IT'S A LOT OF HAPPY TALK, FRANKLY. BUT WHEN IT IS SUCCESSFUL PEOPLE AT THE TOP OF THE ORGANIZATION BUY INTO IT AND THE DIRECTOR OF NURSING BUYS INTO IT AND THE LINE SUPERVISORS BUY INTO IT, AND YOU CAN CREATE A SYSTEM WHERE BEHAVIORS ARE REINFORCED. TRAINING IS NOT WORTH ANYTHING IF YOU GO BACK INTO A SETTING AND YOUR OLD BEHAVIORS ARE REINFORCED AND REWARDED. IT HAS IMPLICATIONS

FOR YOUR STAFFING, THE AMOUNT OF TIME YOU GOT AVAILABLE IN TERMS OF BEING ABLE TO CARRY OUT WHATEVER NEW BEHAVIOR IS SUPPOSED TO BE CARRYING OUT, AND YOU'VE GOT TO GET REINFORCED. IT'S NOT LIKE YOU CAN TAKE PEOPLE ASIDE, TRAIN THEM, AND EXPECT THEM TO RETAIN THAT KNOWLEDGE FOR VERY LONG. I MEAN, IT'S JUST THE WAY IT IS. SO YOU'RE GOING TO HAVE TO TRY TO FIGURE OUT THROUGH JUST THE ORGANIZATIONAL CLIMATE, ITSELF, HOW DO YOU REINFORCE THAT THIS IS THE WAY WE OPERATE? THIS IS AN IMPORTANT THING TO DO.

>> HOLLY HAD A QUESTION OR COMMENT. WHILE I'M WALKING TO THE BACK. I'M WONDERING IF JENNIFER OR SAM WOULD LIKE TO MAKE ANY COMMENTS ABOUT WHAT THE MEMBERS IN YOUR YOUR ORGANIZATIONS IN TERMS OF ADDRESSING THE UNIVERSAL DESIGN OR STAFF EDUCATION ISSUES.

>> HI, HOLLY RIDDLE, DHHS, OLMSTEAD COORDINATOR IN THE 2CLI PROGRAM. I REALLY APPRECIATE DR. WAX'S COMMENT ABOUT THE NEED TO HAVE A FRONTLINE STAFF IN ALL OF OUR FACILITIES THAT IS ADEQUATELY PAID. I JUST RECEIVED AN E-MAIL FROM A COLLEAGUE OF MINE AND SHE WRITES LAST YEAR, CEO PAY AT AN S&P 500 INDEX FIRM SOARED TO AN AVERAGE OF 361 TIMES MORE THAN THE AVERAGE RANK-AND-FILE WORKER OR PAY OF 13,940 MILLION DOLLARS A YEAR ACCORDING TO EXECUTIVE CEO PAY WATCH NEWS RELEASE AND SHE SENDS A LINK TO ME. I JUST BELIEVE ACROSS THE BOARD IN ALL OF OUR WORK THAT WE CANNOT FORGET THAT FRONTLINE WORK FORCE. THANK YOU, DR. WAX.

>> SAM OR JENNIFER, ANYTHING TO ADD TO HOW YOUR MEMBERS ARE THINKING ABOUT THIS? STEVE CAN BE NEXT.

>> THIS IS SAM CLARK WITH THE NORTH CAROLINA HEALTHCARE FACILITIES ASSOCIATION. I WOULD LIKE TO THINK THE VAST MAJORITY OF LONG-TERM CARE FACILITIES WANT TO DO THE RIGHT THING. THEY'RE HIGHLY RESTRICTED BY THE REGULATORY ENVIRONMENT THAT'S OUT THERE. IT CAN CONTROL THE KINDS OF DECORATIONS YOU CAN PUT UP, WHAT YOU CAN HANG ON THE WALL, THINGS LIKE THAT. THERE IS A CULTURE CHANGE MOVEMENT TAKING PLACE. IF YOU HAVE NOT BEEN TO A NURSING FACILITY THAT'S BEEN BUILT IN THE LAST TEN YEARS, YOU PROBABLY SHOULD BECAUSE IT'S NOT GOING TO BE LIKE THE NURSING HOME YOU'RE PICTURING IN YOUR MIND. TRAINING, THERE'S CONSTANT TRAINING GOING ON BECAUSE UNFORTUNATELY, THERE'S TURNOVER GOING ON CONSTANTLY . NURSE AIDES WHO ARE TYPICALLY THE BACK BONE OF THE INDUSTRY WHO DO MOST OF THE HANDS-ON CARE, THAT THE ACTIVITIES AND THE DAILY LIVING ASSISTANCE, TYPICALLY HAS OVER 100% TURNOVER PER YEAR WE ALL LOVE IT WHEN THE ECONOMY DOES GREAT BUT UNFORTUNATELY, UNEMPLOYMENT IS REALLY LOW. YOU HAVE TARGET WHO IS PAYING $15 AN HOUR. TYPICAL NURSE AIDE GETS $12 PER HOUR. IT'S HARD TO FIND PEOPLE IN THE RURAL AREAS TO WORK THERE BECAUSE THAT MEANS THEY HAVE TO STAY IN THE RURAL AREA. IT'S HARD TO GET WORKERS IN THE URBAN AREAS BECAUSE THERE'S SO MANY JOB OPPORTUNITIES OUT THERE. IT'S VERY COMPETITIVE. BUT WE'RE TRYING.

>> YEAH. I THINK WORKFORCE ISSUES ARE A BIG DEAL, I AGREE WITH SAM. I'M JENNIFER GILL. I REPRESENT LEADING AGE NORTH CAROLINA. SO IT'S A SMALLER SECTOR OF THE-- IT'S THE NONPROFIT RETIREMENT COMMUNITIES IN NORTH CAROLINA THAT ARE OUR MEMBERS. WORKFORCE IS A BIG DEAL IN TERMS OF IMMIGRATION POLICY AS WELL. SO THERE ARE A LOT OF INTERSECTING ISSUES THAT WE DEAL WITH, ATTRACTING PEOPLE TO THE WORKFORCE IN THE FIRST PLACE , WORKING WITH LD 0ER

ADULTS IS REALLY-- WITH OLDER ADULTS IS REALLY, REALLY CHALLENGING AND THEN KEEPING THEM THERE IS ALSO REALLY, REALLY CHALLENGING. WE'VE GOT A LOT OF WORK TO DO ON THE TOPIC OF MAKING RETIREMENT COMMUNITIES MORE ACCESSIBLE TO FOLKS WITH HEARING LOSS. I HAVE PARENTS IN COMMUNITY, ONE OF OUR MEMBER COMMUNITIES AND I HAVE SEEN EXACTLY WHAT BILL AND TOVAH DESCRIBED. IT IS VERY FRUSTRATING AS SOMEONE WHO ADVOCATES FOR MY PARENTS AND ALSO ADVOCATES FOR THE FIELD TO SEE THOSE TWO THINGS INTERSECT, AND CAUSE PERSONAL CONFLICT FOR ME AND MY PARENTS. IT WAS A REAL EYE-OPENING AND PAINFUL EXPERIENCE. I DO THINK THERE ARE OPPORTUNITIES AROUND EDUCATION. I AGREE WITH SAM. WE JUST NEED TO BRING THIS ISSUE FORWARD. I MEAN, I LOOK AT IT AS A RESPECT ISSUE AND I REALLY DO. FOR ME, THAT'S A FOUNDATIONAL VALUE. I'M A SOCIAL WORKER BY TRAINING. MY JOB AT LEADING AGE IS COMMUNICATION SO IT'S VERY RELEVANT THAT I WOULD BE HERE AND FOR ME, IT IS AN ISSUE OF RESPECT. AND I THINK THAT THE COMMUNITIES THAT WE REPRESENT ARE-- THEY CARE BUT THEY'RE DEALING WITH THINGS LIKE REGULATORY ISSUES. I THINK THEY'RE DEALING WITH THINGS LIKE HOW TO COMMUNICATE WITH FOLKS WHO ARE LIVING WITH DEMENTIA . THAT WE DO A LOT OF TRAINING AROUND DEMENTIA, AND IT'S INTERESTING, I DON'T KNOW THAT WE DO ANY AT ALL AROUND DEAF AND HARD OF HEARING. I THINK IT'S A REAL OPPORTUNITY FOR GROWTH. I SIT HERE AND I'M SAD AND I'M US FROM STRAIGHTED BY THE STORIES THAT I'M HEARING AND WHAT I'VE EXPERIENCED PERSONALLY. I AM ALSO VERY MOTIVATED AND I'M ALSO SITTING HERE TAKING NOTES ON OPPORTUNITIES TO IMPROVE BECAUSE WE REALLY NEED TO.

>> I'M SORRY.

>> STEVE.

>> WE WANT TO GET YOU TO LUNCH IN A COUPLE MINUTES.

>> I HAVE A COUPLE OF AS A VOLUNTEER FOR HLA, I HAVE GIVEN PRESENTATIONS TO A COUPLE OF ASSISTED LIVING PLACES. UNFORTUNATELY, THESE ARE THE CREAM OF THE CROP. IT'S ASSISTIVE LIVING LIKE SPRINGBOARD OR THE ONE IN CARY THAT'S VERY NICE. THEY HAVE A LOOPED TV ROOM BUT I DON'T KNOW HOW WELL THEY'RE GOING TO HANDLE THE DAY-TO-DAY COMMUNICATION WITH INDIVIDUALS AND I KNOW THAT THERE ARE A LOT OF OTHER ASSISTED LIVING FACILITIES THAT ARE NOT PRIME, EXPENSIVE PLACES THAT ARE GONNA EVEN HAVE A LOOPED TV ROOM OR AUDITORIUM AND SO FORTH. SO ONE POINT THAT I WANTED TO MAKE WAS THAT YOU HAVE TO REALIZE THAT THERE ARE PRIMO PLACES AND NOT SO PRIMO PLACES AND I EXPECT THAT THE DIFFICULTIES IN SKILLED NURSING FACILITIES ARE EVEN MORE CHALLENGING FOR PEOPLE WITH HEARING LOSS . SO I WANTED TO-- I LISTENED TO THE COMMENTS FROM THE PEOPLE TALKING ABOUT THEIR MOTHERS AND I AS AN HLAA PERSON, I'VE GOT A LOT OF SOLUTIONS, TECHNOLOGICALLY BUT MOST OF THEM ARE REQUIRE A LOT OF TRAINING AND ENFORCEMENT OF THE TRAINING BECAUSE OF THE TURNOVER AND BECAUSE OF THE LOW PAY, THE TURNOVER IS BAD AND THEY'RE NOT GOING TO HAVE THE TIME TO UNDERSTAND THE DETAILS IT TAKES PEOPLE A LONG TIME TO UNDERSTAND THE DETAILS OF HEARING AIDS, ASSISTIVE LISTENING DEVICES, NECK LOOPS, EARBUDS, HEADPHONES, BLUETOOTH, FM, INFRARED, THE TECHNOLOGY GETS VERY COMPLICATED. IT'S GOING TO BE VERY DIFFICULT CHALLENGE TO TRAIN SOMEBODY THAT MAKES $12 AN HOUR IS NOT GOING TO WORK THERE MORE THAN A YEAR ANYWAY TO KEEP THEM CURRENT. BUT WE HAVE TO DO THAT. HIS POINT-- TONY'S POINT ABOUT

PERSONAL AMPLIFIERS THAT IS A BASIC MINIMUM FOR ONE-ON-ONE COMMUNICATION. BUT IT INVOLVES HEADPHONES FOR SOME PEOPLE AND NECK LOOPS FOR OTHERS. IT'S COMPLICATED, AS I SAID. HEARING AIDS AND COCHLEAR IMPLANTS, COCHLEAR IMPLANTS ARE GOING TO BECOME MORE AND MORE COMMON. THE STAFF NEEDS TO BE ABLE TO UNDERSTAND HOW TO CHECK BATTERIES, PROVIDE BATTERIES , CHANGE BATTERIES, CONTROL THE DEVICES AND THE PROGRAMS, INSERT THEM PROPERLY INTO THE EAR OR USE THE MAGNET IN THIS CASE, AND VERIFY THAT THEY'RE WORKING ON THE PATIENTS THAT HAVE DIFFICULTY DOING THAT THEMSELVES. ASSISTIVE LISTENING SYSTEMS LIKE AMPLIFIERS OR TVs AND ROOM LOOPS AND THE STAFF KNOW HOW TO USE THOSE AND KEEP THEM OPERATIONAL, THAT'S ESSENTIAL. SIGNAGE, LIKE THE SIMPLE SIGN ON A DOOR THAT SAYS FACE ME, I'M HARD OF HEARING. EXTREMELY IMPORTANT TO REMIND THE STAFF TO DO THAT. CAPTIONS ON TVs, THAT SHOULD BE AUTOMATIC ON EVERY TV. THE STAFF UNDERSTANDS FACE ME. THE STAFF UNDERSTANDS NOISE AND WHAT THAT DOES TO YOUR ABILITY TO HEAR IF YOU DON'T HEAR WELL. THE STAFF SHOULD ALSO BE TRAINING FAMILIES. BACK TO THE STAFF. NOT BEING PERMANENT, NOT BEING PROFESSIONAL, NOT BEING PAID LIKE PROFESSIONALS, THAT REQUIRES SOME TRAINING OF MANAGEMENT.

>> THANK YOU.

>> ALL RIGHT.
THIS IS MY PASSION AND I COULD TALK ABOUT LOTS AND LOTS OF THINGS. I'M GOING TO STICK TO CONCRETELY WHAT'S SORT OF EXECUTION AND FEASIBILITY. YOU MENTIONED DEMENTIA AND DEMENTIA IS A HUGE, HUGE LINK WITH HEARING LOSS. WE HAVE LOTS OF RESEARCH THAT SUPPORTS A CONNECTION BETWEEN HEARING LOSS, LEADING TO DEMENTIA IN VARIOUS WAYS OR BEING ASSOCIATED WITH COMORBIDITIES, BUT WE HAVE SOME SOLID STUDIES THAT SHOW MILD COGNITIVE IMPAIRMENT OR PRE-DEMENTIA, MEASURES MUCH HIGHER IN FOLKS WITH UNTREATED HEARING LOSS AND WHEN WE TREAT THAT HEARING LOSS AND USE SOME OF THESE STRATEGIES, WE REALIZE IT'S NOT ACTUALLY THE DEMENTIA COMPONENT IS NOT THERE. SO WHEN WE LOOK AT THAT IN TERMS OF FUNDING AND MOTIVATING PROVIDERS, THAT'S GOING TO BE HUGE. THOSE ARE THE PIECES THAT ARE REALLY GOING TO-- FOLKS DON'T-- HEARING LOSS ISN'T IN THE CONVERSATION, AND THAT'S WHAT WE'RE TRYING TO DO HERE BUT TYING IT INTO THESE OTHER THINGS THAT PEOPLE ARE REALLY EXCITED ABOUT AND WORKING ON WILL HELP.

>> LAST WORD. I DON'T KNOW IF THERE'S ANYBODY ELSE AND WE'LL GIVE IT WHACK TO TONY TO WRAP UP.

>> YOU ALL THOUGHT YOU WERE DONE WITH ME BECAUSE MY PARENTS ARE GONE. I GOT A MOTHER-IN-LAW WHO IS IN ASSISTED LIVING FACILITY RIGHT NOW WITH SIGNIFICANT HEARING LOSS. I'M BACK IN THE GAME. DEMENTIA, THEY THOUGHT SHE HAD DEMENTIA UNTIL I WAS ABLE TO RECOMMEND LET'S SEE IF WE CAN GET HER HEARING AIDS WHEN I FIRST MET THIS FAMILY. SHE'S 96 AND SHE'S COGNITIVELY FIND AND SHE'S IN ASSISTED LIVING FACILITY BUT BECAUSE SHE CAN'T HEAR VERY WELL AND THE STAFF ISN'T TRAINED TO INTERACT WITH THE PERSON WITH THE HEARING LOSS, THERE'S MISUNDERSTANDING AND THEREFORE, I THEY THINK SHE HAS DEMENTIA AND THEN SHE'LL LET THEM

KNOW SHE UNDERSTANDS THEM AND THERE'S NOTHING WRONG WITH MY MIND. SHE WAS TOLD THE OTHER DAY, HER CARE ASSISTANTS, I DON'T KNOW WHO THE AIDES ARE ARE ONLY PAID DONALD CRAIG 8 AND THAT'S WHY THERE'S A HIGH TURNOVER. THEY MAY HAVE MISHEARD HER. I'M JUST SAYING. I'M TRYING TO BE POSITIVE. I'M TRYING TO DO THE API THING AS MUCH AS I CAN, ASSUME POSITIVE INTENT. MY HUSBAND'S FAMILY IS-- WE'VE BEEN MARRIED TWO AND A HALF YEARS AND I HAVE BEEN WITH THIS FAMILY FOR A WHILE. I HAD TO TEACH THEM ABOUT HEARING LOSS. THEY WEREN'T AROUND WHEN I WAS DEALING WITH MY MOM. THEY THINK THE NURSES SHOULD-- OH, THEY KNOW HOW TO DEAL WITH PEOPLE WHO ARE HARD OF HEARING. THEY KNOW HOW TO TALK DIRECTLY TO HER. NO, THEY DON'T. SO THERE IS THAT RESPECT THAT HAS TO COME THAT YOU MENTIONED OVER THERE. RESPECT FOR THE INDIVIDUALS, RESPECT THAT SHE'S HARD OF HEARING NOT THAT SHE HAS DEMENTIA. RESPECT THE TIME THAT YOU LOOK INTO INTO HER FACE AND TALK TO HER AND TAKE HER OUT OF THAT ENVIRONMENT AND GIVE HER ONE-ON-ONE ATTENTION AND SHE WON'T ACCEPT THAT SHE IS HARD OF HEARING AND NEEDS CLOSED CAPTIONING. I TURN ON THE CLOSED CAPSULING. I DON'T NEED THAT. SHE'S STRONG WILLED AND I HAVE TO BOW DOWN TO THAT WHICH IS FINE. YEAH, SHE'S VERY RESISTANT TO HER HARD OF HEARING LOSS. SHE'S GOT THE TWO HEARING AIDS. THANKFULLY, WITH THE SUPPORT OF THE DIVISION OF SERVICES FOR THE DEAF AND HARD OF HEARING, I GOT HER TO GO THERE AND TALK TO KAY, THE HARD OF HEARING SPECIALIST WITH THE RALEIGH CENTER AND SHE WAS ABLE TO GET HEARING AIDS. BUT YEAH, THE RESPECT AND JUST THE ADMIRATION OF THE PERSON WHO HAS LIVED SO MANY YEARS AND KNOWS WHAT'S GOING ON IN THE WORLD AS OPPOSED TO THE OTHER PEOPLE THAT MIGHT BE IN THAT FACILITY. I'M DEEING WITH THAT NOW. AND THAT'S BEEN HARD, BEING A PERSON THAT KNOWS A LOT ABOUT DEAFNESS AND GETTING PEOPLE TO BELIEVE ME. EVEN MY OWN IN-LAWS. EVEN MY MOTHER-IN-LAW. I THINK YOU GUYS ARE LUCKY TO HAVE ME ON THIS ONE, TOO.
[LAUGHTER]

>> VERY GRATEFUL FOR THE PANELISTS AND THEIR IDEAS, THE THOUGHTS, AND THEIR RECOMMENDATIONS.

>> I GOT ONE THING I WANT TO MAKE SURE THAT I LEAVE WITH. SO SAM AND JAN, THIS IS THIS FOR YOU. IT'S ALSO FOR THE REST OF THE AUDIENCE. THIS APPLIES JUST TO NURSING HOMES, BUT I WANT TO GET THIS ON THE RECORD FOR THIS COMMITTEE TO CONSIDER. THERE IS A PROGRAM THAT IS SUPPORTED THROUGH WHAT ARE CALLED CIVIL MONETARY PENALTIES. THESE ARE FINES THAT ARE LEVIED AGAINST NURSING HOMES. THAT MONEY IS SET ASIDE BY THE FEDERAL GOVERNMENT AND KEPT WITH NORTH CAROLINA'S NAME ON IT. AND THOSE MONEYS CAN BE USED BY FACILITIES AND BY THE STATE TO DO IMPROVEMENTS IN CARE ONLY IN NURSING FACILITIES. BUT IT DOES STRIKE ME THAT INDIVIDUAL NURSING HOMES WOULD BE ELIGIBLE TO RECEIVE CMP FUNDS TO TO PAY FOR EQUIPMENT AND EQUIPMENT UPGRADES AND ALL KINDS OF TECHNOLOGY AS A POTENTIAL CMP PROJECT AND PARALLEL TO THAT, A TRAINING PROGRAM THAT COULD BRING UP AWARENESS AND KNOWLEDGE ABOUT DEALING WITH DEAF AND HARD OF HEARING ISSUES. SEEMS TO ME WOULD BE RIPE. WE'RE SITTING ON $28 MILLION THAT IS GOING UNSPENT RIGHT NOW. AND IT SEEMS TO ME THAT THIS IS A RIPE RESOURCE FOR THIS PARTICULAR ISSUE.

>> LET'S TRY AND OPEN UP THE PHONE LINE. WE'RE GOING TO TRY TO OPEN UP THE PHONE LINES FOR A MINUTE. I'M NOT SURE IF WE'RE GOING TO BE ABLE TOKER WHAT. IF WE CAN, WE WANT TO INVITE

PEOPLE ON THE PHONE TO COMMENT.
>> WE'VE UNFORTUNATELY HAD YOU MUTED BECAUSE OF BACKGROUND NOISE. BUT WE HAVE THE PHONE LINES OPEN. ANYBODY WITH A QUESTION OR COMMENT?

>> I DO HAVE A COMMENT. GO AHEAD.

>> I'VE BEEN FOLLOWING THE PEDIATRICIAN AND I DON'T HAVE MUCH TO OFFER BUT AS A DEAF INDIVIDUAL, I THINK I HAVE A THOUGHT ABOUT THE EDUCATOR IN THE MEDICAL SETTING, AND I JUST WANT TO ADD SOME COMMENTS ABOUT
[CALL GOING IN AND OUT]
AND THIS IS DAILY LIFE BUT A DECAY WITH THAT AND WHAT I MEAN BY THAT IS YOU EDUCATE AND YOU CAN SUGGEST THAT HOW TO ADDRESS AGE-RELATED ISSUES IN THE NURSING HOME WITH TRAINING AND GET ASSISTANCE, THAT'S ONE PLACE THIS CAN HAVE MOVEMENT, THE PROBLEM IS THERE'S ONLY ONE INDIVIDUAL WHO IS TRULY DEAF AND SAYING THAT THE TRAINING PROGRAM BETWEEN THAT TIME AND THE TIME THAT INDIVIDUAL COMES ACROSS THAT WOMAN OR MAN IN THAT CHAIR IS GREAT AND THEY NEED MORE-- THEY NEED SOMETHING TO REFRESH THEIR KNOWLEDGE AND THINK ABOUT MY WORK WITH SPECIAL EDUCATION WITH CHILDREN, AND WHAT WE HAVE THERE IS WE HAVE ADVOCATES. WE HAVE EDUCATORS AND CONSULTANTS AND IN THE CASE OF CLINICAL CARE, WE HAVE FOLKS THAT HAVE PROTOCOLS AND THERE'S A WORKFORCE THAT MAY HAVE DIFFERENT SHEETS IN IT FOR SPECIFIC NEEDS FOR INDIVIDUALS AND ON TOP OF THAT AND I HOPE THAT NURSING HOMES HAVE THAT THE POWWOW OR HUDDLE TO GO OVER ALL OF THE PATIENT NEEDS AND THAT MAY NOT BE EVERY DAY, BUT THAT WOULD BE AN OPPORTUNITY FOR THE TEAM TO COME TOGETHER, AND TALK OVER INDIVIDUAL'S NEEDS WITH REGARD TO COMMUNICATION. SO I THINK THOSE ARE THE PLACES WHERE WE CAN INCREASE THE KNOWLEDGE, INCREASE THE (INAUDIBLE) AND INCREASE THE (INAUDIBLE) AND THE ISSUES WHEN IT COMES TO THE AGING POPULATION.

>> ROBERT, SOMEBODY HAS GIVEN US A LOT OF BACKGROUND NOISE. I THINK WE HEARD EVERYTHING YOU HAD TO SAY. ANYBODY ELSE ON THE PHONE THAT HAS A PRESSING COMMENT? I DON'T WANT TO NOT GIVE FOLKS AN OPPORTUNITY ESPECIALLY IF YOU HAVE BEEN HANGING IN THERE ALL DAY WITH US. I THINK THEN WE'RE GOING TO GO AHEAD AND HAVE LUNCH HERE. MAYBE WE'LL TRY AND BE BACK BY 10 TO 1:00. WE'LL HAVE AN EXTRA FIVE MINUTES FOR LUNCH. WE'LL HAVE BOXED LUNCHES AND GO THROUGH THE KITCHEN AND GRAB YOUR LUNCH AND WE'LL START BACK UP AT 12: 50 AND THERE ARE A COUPLE OF SEATS AVAILABLE AT THE TABLE. IF ANYBODY IS SITTING IN THE BACK WANTS TO MOVE.

>> SOMEBODY THIS MORNING USED THEIR OFFICE PHONE SYSTEM TO PUT US ON MUTE AND EVERYBODY WAS LISTENING TO BACKGROUND MICIC AND SO THAT'S REALLY DIFFICULT FOR THE OTHER PEOPLE ON THE CALL . SO IF YOU CAN PUT US ON MUTE THAT WAY, WE'LL BE ABLE TO REEVE THE LINES OPEN. IF WE ARE HEARING A LOT OF BACKGROUND NOISE AND WHAT WE WANT TO DO IS PUT EVERYBODY ON MUTE AND THEN WE'LL TRY TO UNMUTE YOU DURING QUESTION-AND-ANSWER SO WE CAN INVITE YOUR PARTICIPATION, BUT WE'D RATHER LEAVE THE LINES OPEN IF WE CAN. SO I THINK OUR NEXT SPEAKER IS ALREADY HERE. AND SO WE'RE GOING TO HAVE DR. TOVAH WAX TALKING TO US ABOUT OLDER ADULTS WITH HEARING LOSS AND LONG-TERM CARE FACILITIES.

>> OKAY. HELLO. AS I SAID, I AM TOVAH WAX AND I'M HERE AS A DEAF REPRESENTATIVE WHILE WE'RE WAITING FOR A LITTLE BIT OF TECHNOLOGY HERE. I WOULD GO AHEAD AND THOUGHT LET ME FIRST SAY THAT I'M HERE AS A DEAF REPRESENTATIVE ON THE ADVICE OF THE COUNCIL THAT WORKED WITH THE DIVISION OF SERVICES FOR DEAF AND HARD OF HEARING. I AM DEAF AND I'M ALSO HARD OF HEARING. I WAS BORN AND RAISED HARD OF HEARING LOST MY HEARING OVER TIME AND I HAVE COCHLEAR IMPLANTS. AMERICAN SIGN LANGUAGE IS MY SECOND LANGUAGE WHICH IS-- I THINK BETTER AND TALK BETTER IN ENGLISH, SO THAT'S WHY I'M NOT SIGNING UP HERE. WHICH I WOULD LIKE TO BE ABLE TO DO BUT NOT AT THE MOMENT.

>> TESTING. YEP. IT'S NOT THE BEST MICROPHONE SO CLOSE TO YOUR MOUTH IS BETTER.
>> HOW IS THIS? ARE PEOPLE TO HEAR ME?
>> NO.
>> IT WORKS BETTER IF YOU HOLD IT.
>> CAN YOU HEAR ME? NO. NO GOOD.
>> A LITTLE BIT.
>> GOOD!
>> NOW BETTER. OKAY. I'LL TRY TO ENKITE OVER HERE. BUT I'M GOING TO PRONE TO-- YOU NEED TO USE THE A-- SHE NEEDS THE OTHER TWO MICROPHONE.
>> THIS IS NOT WORKING VERY WELL. SO TRY TO PROJECT. YO IT DOOR VOICE.
>> OKAY. I HAVE A HAND UP THERE.

>> SO I AM A PERSON WHO IS HARD OF HEARING AND DON'T HAVE HEARING AIDS. EXPWRI UNDERSTAND THAT. BUT I CAN'T HELP THAT. I CAN NOW.

>> I'M GOING TO GO EVE HERE. --

>> SO. SHI I START AGAIN? AGAIN, I'M TOVAH WAX. I'M DEAF AND HARD OF HEARING. I KNOW SIGN LANGUAGE BUT IT'S EASIER FOR ME BECAUSE ENGLISH IS MY FIRST LANGUAGE TO SPEAK RATHER THAN SIGN FOR THIS PRESENTATION. THE FOCUS OF MY PRESENTATION IS GOING TO BE ABOUT HEARING LOSS ISSUES IN LONG-TERM CARE FACILITIES. THE FIRST PART OF MY SLIDE WILL BE A QUICK REVIEW OF SOME OF THE DEFINITIONS AND DEMOGRAPHICS BECAUSE I WOULD LIKE TO MOVE FAIRLY QUICKLY TO LOOKING AT THE THINGS THAT NEED TO BE ADDRESSED, BARRIERS THAT WE FACE AND POSSIBLY SOME IDEAS FOR SOLUTIONS. SO I'M GOING TO MOVE AHEAD WITH THAT. AGAIN, QUICK DEFINITION FOR DEAF, HARD OF HEARING, DEAF-BLIND, AND LATE DEAFENED. THESE ARE ALSO IN YOUR SLIDE PACKAGES SO YOU CAN REVIEW THEM AT LEISURE YOURSELF. ARE WE OKAY WITH COMMUNICATION SO FAR? I DON'T SEE OBJECTIONS, SO OKAY. FOR DEAF PEOPLE, THEY'RE THOSE WHO TEND TO USE VISUAL KINESTHETIC AND SOMETIMES TACTILE COMMUNICATION AS PRIMARY FORM OF COMMUNICATION BECAUSE HEARING AIDS AREN'T ALWAYS EFFECTIVE AND NEITHER COCHLEAR IMPLANTS FOR SOME DEAF PEOPLE AND MANY DON'T WANT THEM. THEY PREFER TO THINK OF THEMSELVES AS PART OF A CULTURAL COMMUNITY WHICH HAS ITS OWN FOLKLORE AND RULES AND PERSPECTIVE ON THINGS. HARD OF HEARING PEOPLE, MOST OF THE HARD-- THAT HAPPENS TO BE THE LARGEST GROUP OF PEOPLE WHO HAVER WHATTING LOSS AND A MAJORITY OF THOSE HAPPENED TO

BE PEOPLE WHO HAVE LOST THEIR HEARING WITH AGE, WHICH IS WHY WE ARE FOCUSED ON THIS POPULATION LIKE NOW. MANY WOULD BENEFIT FROM TECHNOLOGY, HEARING AIDS, AMPLIFIERS AND SO ON. THE PROBLEM IS THAT SO FEW PEOPLE ARE ACTUALLY ABLE TO HAVE THEM. IN FACT, WE HAVE SOME STUDIES THAT SHOW ONLY ABOUT 16% OF PEOPLE WHO NEED HEARING AIDS OR COULD USE THEM ACTUALLY HAVE THEM. 16%, THAT LEAVES OVER 80% OUT THERE WITHOUT RESOURCES. DEAF-BLIND PEOPLE ARE INDIVIDUALS WHO HAVE BOTH VISUAL AND HEARING LOSSES. AND IT VARIES GREATLY IN TERMS OF WHEN EITHER OR BOTH OF THESE LOSSES START, PRE-SPEECH, POST-SPEECH, SEVERITY CAN BE VERY DIFFERENT FOR DIFFERENT PEOPLE, AND MODES OF COMMUNICATION, AFFILIATION WITH THE DEAF COMMUNITY AND/OR THE BLIND COMMUNITY AND THE DEAF-BLIND COMMUNITY CAN VARY. SO THERE'S A LOT OF VARIANCE IN THIS POPULATION. THERE IS, FOR THIS GROUP, A FAIRLY HEAVY RELIANCE ON THE USE OF TECHNOLOGY AND SUPPORT SERVICES. ASHLEY BENTON HERE, MY FRIEND AND COLLEAGUE, IS AN EXAMPLE. LATE-DEAFENED PEOPLE ARE ALSO ANOTHER GROUP. THESE ARE PEOPLE WHO MAY LOSE THEIR HEARING, THEY MAY HAVE BEEN HEARING AT ONE POINT AND LOSE THEIR HEARING BECAUSE OF ACCIDENT OR ILLNESS. AND IN MANY CASES, THAT CAN BE VERY SEVERE AND IN SOME CASES, IN MANY CASES, NOT HELPED BY HEARING AID TECHNOLOGY. SO THERE'S A HEAVIER RELIANCE ON VISUAL INFORMATION, TEXT, NOTE, AND SOMETIMES SPEECH READING, BUT LET ME BE SURE YOU KNOW THAT SPEECH READING IS NOT A PARTICULARLY EFFECTIVE WAY OF COMMUNICATING. THINK ABOUT THIS. THE ENGLISH LANGUAGE IS ONLY-- IT'S 70% IN VISUAL ON THE LIPS. SO PEOPLE WHO USE SPEECH READING SPEND A HUGE AMOUNT OF THEIR COGNITIVE ENERGY JUST ON FILLING IN GAPS AND TRYING TO MAKE A CASTALT OUT OF WHAT IS BEING SAID. AND IN FACT, I TELL PEOPLE, I HAVE NO AUDITORY MEMORY BECAUSE I CAN'T REMEMBER A THING THAT I HEAR THROUGH MY EARS. I SPEND SO MUCH TIME TRYING TO FIGURE IT OUT IN THE FIRST PLACE THAT BY THE TIME IT'S FIGURED OUT, THEY'VE MOVED ON TO SOMETHING ELSE AND I HAVE NO CHANCE TO COGNITIVELY PROCESS IT. SOME LATE-DEAFENED PEOPLE DO BENEFIT FROM COCHLEAR IMPLANTS. BUT THAT'S ASSUMING THEY EVEN LEARN ABOUT THIS BECAUSE IF YOU HAVE BEEN HEARING MOST OF YOUR LIFE AND THEN BECOME DEAF, WHERE YOU KNOW ABOUT ANY OF THESE RESOURCES, GOOD QUESTION. SO THE FOCUS OF THIS PRESENTATION IS GOING TO BE ABOUT PEOPLE WHO ARE OVER 65 AND WHO ARE HARD OF HEARING AND LATE DEAFENED BECAUSE THAT IS THE MAJORITY GROUP. OUR STATISTICS SAY THAT THERE ARE ABOUT-- OVER 500,000 NORTH CAROLINA RESIDENTS OVER 65 WHO HAVE IDENTIFIED HEARING LOSS. BUT I WILL SAY A FEW WORDS ABOUT DEAF, DEAF-BLIND ELDERLY PEOPLE AND LONG-TERM CARE RESOURCES. THE OVERARCHING ISSUES, NO MATTER WHAT ELSE, IS GOING TO BE COMMUNICATION ACCESS. SO IN MY PERSONAL OPINION, YOU ESTABLISH GREAT COMMUNICATION ACCESS EVERYTHING ELSE WILL WORK OUT PRETTY MUCH. OF COURSE, LACK OF COMMUNICATION ACCESS FOR A LOT OF DEAF PEOPLE, ESPECIALLY THOSE WHO END UP IN NURSING HOMES OR OTHER FACILITIES BECAUSE THERE ARE A FEW DEAF PEOPLE COMPARED TO THE LARGER POPULATION, THERE'S ONE HERE, TWO THERE, ONE HERE, AND THEY'RE ISOLATED SO SOCIAL ISOLATION IS A BIG ISSUE. LACK OF EDUCATION ABOUT RESOURCES AND SERVICES. BECAUSE A LOT OF DEAF PEOPLE DON'T REALLY KNOW WHAT'S OUT THERE. MANY WITHIN THE DEAF COMMUNITY AND THEN THEY END UP HAVING TO GO SOMEWHERE ELSE AND THEY'RE AWAY FROM THEIR FAMILIES, AWAY FROM THEIR FRIENDS AND MAY NOT REALIZE THAT THERE ARE OTHER RESOURCES THEY COULD USE. MANY DEAF, UP UNTIL RECENTLY ANYWAY, MANY DEAF DO HAVE LOWER SOCIOECONOMIC STATUS. MANY STILL DON'T HAVE THE OPPORTUNITY TO, SAY, GO TO COLLEGE OR GET TRAINING IN HIGHER LEVEL PROFESSIONS, IF YOU WILL. MANY OF HAVE FEWER ASSETS TO WORK WITH. AND EVEN THOSE OF US WHO HAVE LIFELONG EXPERIENCE WITH HEARING

LOSS, THERE MAY BE ADDITIONAL ISSUES THAT ARISE AS WE AGE, ILLNESS, OTHER DISABILITIES, COGNITIVE DECLINE THAT ADD TO THE DIFFICULTIES OR THE CHALLENGES THAT WE FACE. LET ME REVIEW QUICKLY THE TYPES OF RESIDENTIAL FACILITIES. JAN ALREADY MENTIONED SOME EARLIER THIS MORNING, BUT THE MOST FAVORITE OF PEOPLE WHO ARE OLDER IS AGING IN PLACE. MOST PEOPLE PREFER, IF THEY COULD, TO STAY HOME WHERE THEY LIVE OR STAY WITH THEIR FAMILIES. SO AGING IN PLACE IS INCREASINGLY BECOMING A RESOURCE OF CHOICE. THE IDEA BEING IF THERE WERE ADEQUATE RESOURCES OUT THERE TO HELP THE FAMILY OR TO HELP THE INDIVIDUAL, MOST PEOPLE WOULD RATHER DO THAT THAN ANYTHING ELSE. UNFORTUNATELY, INSURANCE AND OTHER ASSETS DON'T ALWAYS COVER THE COSTS OF THESE THINGS. THE VILLAGE CONCEPT IS KIND OF AN INTERESTING IDEA THAT I FIRST HEARD ABOUT VILLAGE, LIKE A LITTLE COMMUNITY, IS AN INTERESTING IDEA I FIRST HEARD ABOUT OUT OF CALIFORNIA. WHERE ELSE?
[LAUGHTER]
THE LAND OF COMMUNES, RIGHT? AND THE VILLAGE CONCEPT IS NOT LIKE A HIPPY COMMUNE TYPE OF THING. IT'S A LITTLE BIT MORE BUSINESS LIKE IN THAT SOMETIMES THE GROUP OF PEOPLE WILL PURCHASE SOME LAND AND BUILD HOMES LIKE A NEIGHBORHOOD OR SUBDIVISION TYPE OF THING OR COMMUNE EVEN WHERE PEOPLE LIVE AND SHARE RESOURCES. THEY MAY TRADE WITH EACH OTHER LIKE BARTER FOR SERVICES. YOU DO THE PLUMBING. I'LL HELP YOU WITH YOUR ELECTRICITY OR YOU HELP ME WITH MY GARDEN AND I WILL GIVE YOU SOME VEGETABLES, THAT KIND OF EXCHANGE AND ALSO SOMETIMES CONTRACTING WITH BUSINESSES IN THE AREA TO COME IN AND SAY, DO MAINTENANCE OF THE WHOLE NEIGHBORHOOD, SO TO SPEAK. ALMOST LIKE A HOMEOWNERS ASSOCIATION AND IN SOME CASES, PEOPLE WILL PAY MONTHLY FEES TO MAINTAIN THAT KIND OF RESOURCE. INDEPENDENT LIVING ARE EITHER THE OVER 55 COMMUNITIES THAT WE SEE LIKE DALE WEBB, SOME OF YOU MAY HAVE HEARD DELL W-E-B-B, A LARGE BUSINESS THAT SETS UP THESE COMMUNITIES ALL OVER THE COUNTRY. THERE'S A HUGE ONE IN ARIZONA THAT HAS SEVERAL DEAF PEOPLE LIVING THERE. SO THESE COMMUNITIES ARE ALMOST LIKE MINI COLLEGE CAMPUSES AND THEY HAVE THESE HOMES ALL AROUND, THEY HAVE AN ACTIVITY CENTER WHERE PEOPLE CAN GO FOR SOCIALIZING OR MAYBE RESTAURANTS ON THE PREMISES. MAYBE HAIR SO LONGS ON THE PREMISES SO PEOPLE HAVE ACCESS TO VARIOUS RESOURCES BUT LIVE INDEPENDENTLY AND PRIVATELY. CCRC, CONTINUING CARE RETIREMENT COMMUNITIES, AS JAN MENTIONED, ARE LIFETIME TYPES OF COMMUNITIES THAT YOU BUY INTO A COMMUNITY, STARTING USUALLY CUSTOM AIRILY AT THE INDEPENDENT LEVEL AND YOU ARE GUARANTEED CARE ALL THE WAY TO HOSPICE, OKAY? IT HAPPENED TO BE THE MOST EXPENSIVE OPTION BECAUSE YOU HAVE TO BUY IN AND BUY IN, AVERAGE PRICE CAN BE ANYWHERE FROM $250,000 ON UP, UP FRONT TO MOVE INTO THESE PLACES. IN SOME CASES, YOU BUY THE PROPERTY AND SELL IT BACK TO THEM AND THE MONEY IS THEN TURNED OVER TO YOUR HIGHER LEVELS OF CARE, LIKE ASSISTED LIVING OR NURSING HOME CARE, ALL WITHIN THE SAME PREMISE. AND IN SOME CASES, YOU PAY FEE FOR SERVICE. YOU PAY MONTHLY RENT. THAT GOES UP WITH EVERY LEVEL OF CARE. YOU KNOW, DIFFERENT FINANCIAL ARRANGEMENTS BUT IT IS THE MOST EXPENSIVE OPTION. NOT A WHOLE LOT OF PEOPLE AND CERTAINLY NOT A WHOLE LOT OF DEAF PEOPLE CAN AFFORD THIS KIND OF THING. RESIDENTIAL CARE HOMES ARE SMALLER GROUP HOME TYPES OF SETTINGS IN WHICH YOU HAVE A COLLECTION OF PEOPLE ARE MAYBE UP TO 12 PEOPLE LIVING IN A HOUSE AND THEN IT'S USUALLY A FULL-TIME CARETAKER THERE WHO PROVIDE AND HELPS TO PREPARE MEALS AND HELP WITH SOME MEDICATION, AND MAYBE HELP WITH PROVIDING, YOU KNOW, PULLING TOGETHER RESOURCES THAT MIGHT BE NEEDED LIKE TRANSPORTATION OR MEDICAL VISITS AND SO ON. BUT IT REQUIRES SOME LEVEL OF INDEPENDENCE OR YOU KNOW, HIGHER THAN ASSISTED LIVING

TYPES OF NEEDS. ASSISTED LIVING THEN IS PEOPLE WHO ARE SOME DEGREE OF INDEPENDENCE, HAVE SOME DEGREE OF INDEPENDENCE, BUT NEED HELP WITH MEDICATION, NEED HELP WITH FOOD PREPARATION, NEED HELP WITH PERSONAL HYGIENE, MAYBE NEED HELP WITH MOBILITY SO THEY MAY NEED VARIOUS KINDS OF HELP ON A REGULAR BASIS. SO ASSISTED LIVING ALOUS FOR SOME INDEPENDENCE BUT BASICALLY IT'S FOR PEOPLE WHO NEED MORE DAILY HELP THAN THEY CAN DO ON THEIR OWN. FINALLY, OF COURSE, THE SKILLED NURSING FACILITY IS THE HIGHEST LEVEL OF CARE AND IT'S USUALLY FOR PEOPLE WHO ARE REALLY DEPENDENT ON 7/24 CARE. AND THESE PLACES USUALLY HAVE DOCTORS ON THE PREMISES, NURSES -- I MEAN, DOCTORS EITHER ON THE PREMISES OR THERE ON A REGULAR BASIS. THE NURSES ARE THERE 7/24 AND A WHOLE HOST OF OTHER SERVICES MAY BE THERE. OCCUPATIONAL THERAPY, PHYSICAL THERAPY, ACTIVITY THERAPY AND SO ON AND SO FORTH. SOME OF THESE PLACES ALSO HAVE MEMORY AND DEMENTIA UNITS OKAY. SO WHERE ARE ALL THESE DEAF AND HARD OF HEARING ELDERLY PEOPLE THAT WE'RE TALKING ABOUT? WELL, AS PART OF A CONTRACT I HAD WITH THE DIVISIONS OF SERVICES FOR DEAF AND HARD OF HEARING, I DID A NATIONAL SURVEY USING SEVERAL WEBSITES THAT HAD A LIST OF PLACES THAT INCLUDED DEAF AND HARD OF HEARING PEOPLE. AND I WAS ABLE TOED A PHI 44 FACILITIES RANGING FROM INDEPENDENT TO NURSING HOME THAT ACTUALLY WERE MOSTLY OR ALL DEAF AND HARD OF HEARING PEOPLE AND OF COURSE, THESE FACILITIES WERE GENERALLY FULLY EWHIPPED. I-- FULLY EQUIPPED. THEY WERE BUILT AND DESIGNED FOR DEAF AND HARD OF HEARING, VISUAL, KINESTHETIC, TACTILE, EVERYTHING WAS THERE. EXAMPLES WOULD BE THAT EACH APARTMENT HAD A VIDEO SCREEN SO IF SOMEBODY RAN THE FRONT DOOR, THERE WAS SOMEBODY TO LET-- RANG THE FRONT DOORBELL, THEY COULD SEE WHO WAS THERE AND THEY COULD LET THEM IN. THESE PLACES WERE SET UP PRETTY MUCH FOR THE PEOPLE WHO LIVED THERE. MOST WERE INDEPENDENT LIVING WHERE THEY HAD APARTMENTS AVAILABLE OR ALL OF THE APARTMENTS HAD THOSE KINDS OF DESIGNS. THEY WERE SKILLED NURSING FACILITIES. MOST WERE HARD OF HEARING AND THE FEWEST, OF COURSE, WERE DEAF-BLIND. I SHOULD MENTION WHEN I ASKED FOLKS WHO WERE IN THESE PLACES WHAT WERE YOUR GREATEST NEEDS OR WHAT WERE THE GREATEST PROBLEMS THAT YOU HAD, ONE ISSUE WAS CONTINUITY OF CARE. IN A GIVEN STATE, YOU MIGHT HAVE A WONDERFUL INDEPENDENT LIVING BUT IF THE PERSON NEEDS ASSISTED LIVING OR NURSING HOME, THAT WASN'T THERE. OR, MAYBE A STATE HAS A GREAT NURSING HOME BUT PEOPLE HAD TO EITHER GO FROM WHEREVER THEY WERE AT HOME DIRECTLY TO THE NURSING HOME . THERE WASN'T ANYTHING IN BETWEEN. CONTINUITY OF CARE WAS ONE ISSUE. THE OTHER ISSUE WAS IN TERMS OF THE FEW PEOPLE IN NURSING HOMES, MOST OF THE PEOPLE I TALKED WITH, ADMINISTRATORS OF THE FACILITIES THAT I INTERVIEWED, SAID THAT ASSISTED LIVING IS THE FASTEST-GROWING SEGMENT OF RESIDENTIAL CARE BECAUSE BECAUSE MOST PEOPLE ARIVE WILLING LONGER AND HEALTHIER , AND MOST WOULD REALLY RATHER STAY SOMEWHAT INDEPENDENT OR NEAR THEIR FAMILIES. SO ASSISTED LIVING SEEMED TO BE THE MOST POPULAR NEW, LET'S SAY NEW-AGE NURSING HOME, OKAY. SO NURSING HOMES SEEM TO BE DECLINING AS A PRIORITY AND ASSISTED LIVING SEEMS TO BE INCREASING AND NOW, OF COURSE, THIS RAISES ALL KINDS OF ISSUES ABOUT WHO IS PAYING FOR ALL OF THIS? INSURANCE COMPANIES DON'T REALLY PAY WELL FOR ASSISTED LIVING. THERE'S MUCH MORE RESOURCES FOR NURSING HOMES AND EVEN THERE, IT'S NOT ALWAYS ADEQUATE. ISSUES ARE GOING TO BE RAISED ABOUT WHAT ACCESS ARE WE GOING TO BE ABLE TO USE TO PAY FOR THOSE KINDS OF SERVICES, EVEN AS THEY INCREASE. IN NORTH CAROLINA, I SPOKE WITH REGIONAL COORDINATORS OUT OF THE DIVISION OF SERVICES FOR DEAF AND HARD OF HEARING. AND THEY ALL REPORTED FEW AND SCATTERED PEOPLE. ONE HERE, TWO THERE, ONE HERE, TWO THERE. AND I WAS KIND OF SURPRISED GIVEN THAT I HAVE ACTUALLY OTHER

DEMOGRAPHIC DATA THAT SUGGESTS THAT IN NORTH CAROLINA ALONE ARE AT LEAST 12,000 PEOPLE IN INSTITUTIONAL FACILITIES. I'M TALKING ABOUT PEOPLE OVER 65. WHERE ARE THOSE 12,000 -- I MEAN, WHO ARE DEAF OR HARD OF HEARING, WHO HAVE HEARING DIFFICULTY DEPENDINGEN ON THE SURVEY DEFINITION, AND IF THERE ARE AT LEAST 12,000, WHERE THE HECK ARE THEY? THE REGIONAL COORDINATORS AREN'T REPORTING THIS. SO WE DON'T KNOW IF IT'S UNIDENTIFIED OR IF PEOPLE AREN'T COMING FORWARD, THAT'S NOT CLEAR, BUT ANYWAY, THERE'S A DISCREPANCY THERE. AND THEY ALSO REPORT THAT THE PEOPLE WHO ARE IN THESE FACILITIES THAT THEY KNOW OF RARELY GET ADEQUATE ATTENTION OR RESOURCES. AND THEY DO A LOT OF WORK WITH THE EDUCATING AND THE ADVOCATING , BUT IT DOESN'T ALWAYS GET VERY FAR UNFORTUNATELY. I MET ALSO WITH THE CAPITAL DEAF SENIORS AND WE TALKED A LITTLE BIT ABOUT THEIR EXPERIENCES. THE GROUP THAT I WAS TALKING WITH WERE BASICALLY LIVING INDEPENDENTLY OR WITH THEIR FAMILIES AND BASICALLY HAD NO IDEA WHAT THEY WOULD DO IF THEY FEEDED TO MOVE TO ASSISTED LIVING OR NURSING HOME CARE. SO THAT WAS KIND OF A REVELATION TO ME BECAUSE IT'S LIKE, WELL, SUPPOSE YOU FALL AND YOU HAVE TO GO TO ASSISTED LIVING, SOME SAY, WELL, I DON'T KNOW WHERE THEY ARE. SOME SAID, I CAN'T AFFORD IT . SO IT WAS CLEAR THERE'S A HUGE GAP IN INFORMATION HERE. YOU HAVE YOUR HAND UP . I SEE A HAND UP OVER THERE.

>> SO VICKIE SMITH WITH ALLIANCE OF DISABILITY ADVOCATES, AND I THINK I KNOW WHERE YOU'RE-- YOUR MISSING PEOPLE ARE. THEY'RE IN ADULT CARE HOME, WHICH ARE NOT NURSING HOMES NOR ASSISTED LIVING HOMES AND I KNOW THAT COREY DUNN, BEFORE SHE LEFT, ASKED ME TO MAKE SURE THAT I REMINDED FOLKS ABOUT WHAT MAY OR MAY NOT BE HAPPENING IN ADULT CARE HOMES WHICH ARE-- THEY DON'T PROMOTE INDEPENDENT LIVING. THEY DON'T DO ANYTHING EXCEPT PROVIDE PEOPLE FOOD AND MEDICATION MANAGEMENT AND WE HAVE PROBABLY THE NUMBER OF PEOPLE THAT YOU CAN'T FIND, I WOULD GUESS, LIVING IF THOSE FACILITIES. AND IT'S IMPORTANT FOR PEOPLE IN THIS ROOM TO UNDERSTAND THAT THESE ARE, BY IN LARGE, UNDERRESOURCED FACILITIES THAT ARE DEPENDENT UPON MEDICAID FOR REIMBURSEMENT AND NOT MUCH ELSE. I SHOULD PROBABLY DISCLOSE. I HAVE A BIASED TOTALLY AGAINST ADULT CARE HOMES AND WHEN I WAS AT DISABILITY RIGHTS NORTH CAROLINA, STAFF THERE SPENT AN AWFUL LOT OF TIME INVESTIGATING THE POOR QUALITY OF SERVICES HERE. SO TO ME, THE ELEPHANT IN THE ROOM.

>> YES, AND I DO HAVE TO SAY THAT THE SURVEY-- THE PARTICULAR CENSUS REPORT THAT I LOOK AT, WHICH WE CANNOT GUARANTEE FOR ACCURACY OR WELL-DEFINED TERMS, SAID INSTITUTIONAL. SO WE DON'T KNOW. THAT COULD MEAN ANYTHING, INCLUDING THOSE PARTICULAR TYPES OF RESIDENCIES, YEAH. OKAY. WHAT I'D LIKE TO DO IS MOVE ON NOW TO LOOKING AT THE THE IMPACT OF UNTREATED HEARING LOSS. IT'S VERY IMPORTANT THAT WE UNDERSTAND HOW SERIOUS AN ISSUE THIS IS . HEARING LOSS TENDS TO BE AMONG THE MOST UNDERIDENTIFIED AND UNADDRESSED MEDICAL CONDITIONS OF-- MEDICAL CONDITIONS IN GENERAL. UNTREATED HEARING LOSS, WE'VE ALL HEARD ALREADY IS HIGHLY ASSOCIATED WITH MULTIPLE MEDICAL CONDITIONS. DIABETES, DEMENTIA, COGNITIVE MEMORY DEFICIT, CARDIOVASCULAR DISEASE, MENTAL HEALTH ISSUES AND OF COURSE, YOU HAVE GENETICS AND OTOTOXIC ISSUES AS WELL. FOR EXAMPLE, IT WASN'T VERY LONG AGO THAT WE LEARNED THAT THE MICEN FAMILY OF ANTIBIOTICS ARE HIGHLY OTOTOXICS AND MANY PEOPLE FROM TAKING THEM HAVE BECOME DEAF. MANY WITH HEARING LOSS HAVE DIFFICULTY MAINTAINING TREATMENT. THEY GET HEARING AIDS, THEY DON'T KNOW HOW TO USE THEM. THEY LOSE THEM. THEY BREAK THEM. THEY DON'T KNOW HOW TO DEAL WITH THAT. THEY HAVE TROUBLE MAINTAINING

AUDITORY REHABILITATION STUDIES NECESSARY TO BECOME EFFECTIVE AT USING HEARING AIDS AND USING HEARING THAT'S LEFT. UNTREATED HEARING LOSS HAD BEEN ASSOCIATED WITH MORE FREQUENT HOSPITALIZATION AND INSTITUTIONALIZATION. PROPER TREATMENT OF HEARING LOSS HAS BEEN ASSOCIATED WITH REDUCTION IN MOST OF THESE CONDITIONS. HIGHER HEALTH COSTS HAVE BEEN ASSOCIATED WITH UNTREATED HEARING LOSS. OVERALL, MANY STUDIES, A VARIETY OF STUDIES SHOW THAT GENERALLY SPEAKING, PEOPLE WITH UNTREATED HEARING LOSS ARE SPENDING ABOUT 30% MORE IN OUT-OF-POCKET EXPENSES. I KNOW ALSO SPENDING MORE IN TERMS OF MEDICAL CARE WHETHER IT'S COVERED BY MEDICARE OR MEDICAID OR OUT-OF-POCKET. SO IF YOU THINK ABOUT 500,000 RESIDENTS IN NORTH CAROLINA WHO ARE 65 AND OLDER WHO HAVE UNRECOGNIZED OR-- IF THEY HAVE HEARING LOSS, IF THEY'RE NOT TREATED, WE ARE LOOKING AT ANYWHERE BETWEEN 200 MILLION TO $1 BILLION IN EXTRA EXPENSES RELATED TO NOT IDENTIFYING HEARING LOSS. OF COURSE, THE SOCIAL EFFECTS PEOPLE WITH UNTREATED HEARING LOSS EXPERIENCE, DIFFICULTIES WITH COMMUNICATION, WITH RELATIONSHIPS, WITH DECLINE IN PHYSICAL FUNCTIONING, POSSIBLY LOSS OF INDEPENDENCE, INCREASING SOCIAL ISOLATION AND MENTAL HEALTH ISSUES. A LOT OF PEOPLE HAVE DIFFICULTY RECOGNIZING OR DEALING WITH HEARING LOSS. WE GAVE EXAMPLES OF MY MOTHER, FOR EXAMPLE, OR PEOPLE WHO HAVE DIFFICULTY WITH IMAGE OR BEING AFRAID OF TECHNOLOGY, OR JUST NOT WANTING TO FACE THE FACT THAT THEY'RE GETTING OLDER AND HAVE TO DEAL WITH INCREASING CHANGES IN HEALTH. THE IRONY, TO ME, IS THAT WE NOW KNOW THAT PROBABLY ABOUT 80% OF NURSING HOME RESIDENTS HAVE HEARING LOSS AND YET THESE ENVIRONMENTS ACT LIKE THAT'S NOT EVEN AN ISSUE. I MEAN, THE DINING ROOMS ARE NOISY. ACTIVITY ROOMS ARE NOISY. AND PEOPLE FORGET TO FACE PEOPLE WHO HAVE HEARING IMPAIRMENTS OR DON'T EVEN KNOW THAT PEOPLE HAVE HEARING IMPAIRMENT ATTRIBUTED TO OTHER THING, LAZINESS, STUBBORNNESS, NON-COMPLIANCE, AND OTHER THINGS, ATTRIBUTES RATHER THAN THE FACT THAT THEY MAY NOT BE HEARING WHAT'S GOING ON.

>> STUPIDITY.

>> STUPIDITY WOULD COULD BE ANOTHER ONE.
[LAUGHTER]
FROM THE ENVIRONMENTAL POINT OF VIEW, LIVING SPACES ARE GENERALLY NOT DESIGNED FOR PEOPLE WITH HEARING LOSS. IN MANY CASES, ALSO PEOPLE WITH VISUAL LOSSES. THE FIRST ACCESSIBILITY THING THAT MOST OF THESE PLACES THINK OF IS MOBILITY ASSESSMENT, MOBILITY ACCESSIBILITY, MEANING ACCESSIBILITY MEANS RAMPS FOR WHEELCHAIRS BUT LITTLE OR NO THOUGHT IS GIVING TO LIGHTING, NOISE LEVELS, CARPETING, THE SIZE OF HALLWAYS AND SO ON AND SO FORTH THAT WOULD MAKE LIFE EASIER FOR PEOPLE WITH OTHER DISABILITIES. FOR EXAMPLE, IN EVERY NURSING HOME I'VE BEEN TO AND I HAVE BEEN TO A LOT, I HAVE NOT SEEN ANY VISUAL ANNOUNCEMENTS OR SIGNAGES THAT WOULD HELP PEOPLE WITH WHAT'S GOING ON AND NOT ONLY THAT, BUT THE SCHEDULE THAT I HAVE SEEN FOR ACTIVITIES ARE IN SUCH TINY PRINT I NEED A MAGNIFYING GLASS TO LOOK AT, SO IMAGINE PEOPLE WITH VISUAL IMPAIRMENT TRYING TO READ THE SCHEDULE ON THE CENTRAL BOARD FOR WHAT'S GOING ON ON A PARTICULAR DAY OR WEEK. OF COURSE, THERE ARE A NUMBER OF PEOPLE WHO HAVE AUDITORY DEVICES AND HEARING AIDS, BUT I CAN TELL YOU STORIES OF PEOPLE WHO ARE WEARING THEIR HEARING AIDS BUT THEY'RE NOT WORKING. I SEE THE LIGHT FLASHING SHOWING THAT THE BATTERY IS DEAD. OR, THAT THEY LOST THEM. OR, THEY DON'T KNOW HOW TO OPERATE THEM. SO I MEAN, LACK OF CONSISTENCY IN TAIN

MAINTAINING-- WE HEARD THIS ALREADY THIS MORNING. THE LACK OF CONSISTENCY IN MAINTAINING DEVICES AND ASSISTIVE PRODUCTS. WHAT ARE SOME THE BEAR CAREERS THAT WE FACE IN TRYING TO DEAL WITH ANY OF THIS? THERE ARE MANY, UNFORTUNATELY. THE MOST IMPORTANT BARRIER IS HEARING LOSS IS JUST NOT IDENTIFIED AS OFTEN AS IT SHOULD BE. I MEAN, IF THE MAJORITY OF PEOPLE LOSE THEIR HEARING WITH AGE, WHY ISN'T THIS A SYSTEMATIC PART OF EXAMINATION FOR ANY PERSON OVER 65 WHO COMES TO THE DOCTOR'S OFFICE OR MENTAL HEALTH OFFICE. A LOT OF TIMES PEOPLE THEMSELVES DON'T RECOGNIZE THEY HAVE HEARING IMPAIRMENT. THE MIND HAS AN INCREDIBLE WAY OF ADAPTING TO CHANGES IN HEARING TO THE POINT WHERE YOU DON'T NOTICE. I HAVE CAN GIVE YOU AN EXAM OF MY HUSBAND WHO HAS SIGNIFICANT HEARING LOSS WHO DENIES IT'S A PROBLEM.
IT'S MY SPEECH WHO IS DETERIORATING.
[LAUGHTER]
THIS IS, YOU KNOW, A CHALLENGE FOR ME. HOW DO I GET-- HERE I AM. I'M A FUNCTIONING HARD OF HEARING PERSON. HOW DO I GET HIM TO A HEARING EVALUATION, RIGHT, TO BEGIN WITH. SO VANITY, IMAGE, THESE ARE IMPORTANT PSYCHO-SOCIAL FACTORS. PEOPLE DON'T WANT TO BE STIGMATIZED OR BE SINGLED OUT. THEY DON'T WANT TO LOOK (INAUDIBLE) AND ESPECIALLY IF THEY ARE HAVE BEEN ACTING ALL THEIR LIFE AND FEELING IN CERTAIN WAYS ALREADY. A LOT OF PEOPLE HAVE DIFFICULTY ACCESSING HEARING HEALTHCARE, TRANSPORTATION, KNOWING THAT THEY'RE THERE OR BEING WILLING TO DO IT AND USE IT, LIKE IN THE CASE OF MY HUSBAND. THANKFULLY, HE CAN AFFORD IT BUT HE WON'T GO. OF COURSE, IN TERMS OF DEAF CULTURE, SO MANY PEOPLE ARE NOT FAMILIAR WITH OR NOT COMPETENT DEALING WITH CULTURALLY DEAF PEOPLE. ECONOMIC THE BARRIERS, OF COURSE, INCLUDE PROCEED TO ACTUAL DIFFICULTY IN AFFORDING TO PAY FOR HEARING HEALTHCARE AND ALL THE THINGS THAT GO WITH THAT. HEALTH INSURANCE COVERAGE IS VERY LIMITED IF IT EXISTS AT ALL. THEN, OF COURSE, BECAUSE OF MISDIAGNOSIS OR MISCONSTRUING WHAT'S GOING ON, YOU MAY HAVE MEDICAL TREATMENT THAT WOULD EITHER UNNECESSARY OR ADDITIONAL BECAUSE OF PEOPLE EXPERIENCE HEALTH PROBLEMS RELATED TO NOT HAVING THEIR HEARING LOSS TREATED OR RECOGNIZED. FROM A MEDICAL AND HEALTH PERSPECTIVE, HEARING LOSS IS OFTEN CONSIDERED A PART OF AGING, OH, IT'S NORMAL TO LOSE YOUR HEARING. IT'S NORMAL TO LOSE YOUR VISION. IT'S NORMAL TO ARTHRITIS. IT'S NORMAL THIS AND THAT. NONE OF IT IS NORMAL. HEALTHY OLDER PEOPLE ARE HEALTHY. YOU KNOW, ALL THESE OTHER THINGS ARE HEALTH ISSUES. THERE'S NOTHING NORMAL ABOUT IT. SURE, THERE ARE CHANGES WITH AGE. THERE ARE SOME CHANGES COGNITIVELY WITH AGE. THERE'S SOME CHANGES WITH MOBILITY AND EXFLIBILITY AND ALL THESE THINGS. BASICALLY IF A PERSON IS HEALTHY, THERE'S NO REASON WHY HE OR SHE CANNOT CONTINUE TO FUNCTION INDEPENDENTLY SO WE CANNOT ASSUME THAT THESE ARE JUST NORMAL CHANGES. A LOT OF PROVIDERS ARE RELUCTANT AS WE HAVE HEARD ALL MORNING AND FOR THE PAST SEVERAL MEETINGS, ALL THE COMPLICATED THINGS ABOUT HEARING LOSS THAT MAKE IT INTIMIDATING TO DEAL WITH AND THERE ARE LOTS OF PROVIDERS OUT THERE WHO MIGHT BE INTERESTED OR ARE WILLING BUT WHO ARE INTIMIDATED BY THE POTENTIAL COSTS AND IMPLICATIONS FOR THEIR REIMBURSEMENT OR LACK OF REIMBURSEMENT AND THE TIME THAT THEY HAVE TO PUT IN. WHEN MANY SAID YOU CAN DO THINGS IN 15-MINUTE INCREMENTS AND YOU KNOW IT'S GOING TO TAKE AN HOUR AND A HALF TO TALK TO THIS PERSON, YOU KNOW IT'S GOING TO BE VERY DIFFICULT TO ACCOMMODATE. OF COURSE, IT'S ALSO DIFFICULTY IN MAINTAINING STAFF. EVEN IF WE DO EDUCATION AND TRAINING AS WE KNOW, A LOT OF PLACES HAVE HIGH STAFF TURNOVER, ESPECIALLY IF THEY'RE NOT PAID WELL OR NOT SUPPORTED WELL IN THE WORK THAT THEY DO. THAT'S ANOTHER

MAJOR ISSUE THAT WE HAVE TO FACE. TECHNOLOGY, WE'VE ALREADY TALKED ABOUT THE IMAGE AND VANITY ISSUE AND WE HAVE TO ADDRESS THE FACT THAT MANY OF THE DEVICES ESPECIALLY FOR OLDER PEOPLE, EVERYBODY'S UK TAKING ABOUT HOW HEARING AIDS ARE GETTING SMALLER AND MORE INVISUAL AND THE SMALLER AND MORE INVISUAL THEY GET, THE HARDER THEY ARE TO DEAL WITH. IF YOU HAVE ART ARTHRITIS OR NO FEELING IN YOUR FINGERTIP, HOW WILL YOU CHANGE A BATTERY THAT YOU NEED A MAGNIFYING GLASS TO SEE TO REPLACE THE BATTERY IN HEARING AID? MANY IS THE EXECUTIVENESS AND MANY DON'T WORK AS WELL AS WE HAVE SEEN SEVERAL TIMES HERE. WE COULDN'T GET THE MICROPHONE TO WORK ON THAT OTHER DEVICE AND THE STATIC AND SO ON AND SO FORTH. SO THERE'S A LOT OF THINGS ABOUT TECHNOLOGY THAT MAKE IT HARD. AND THE OTHER IMPORTANT THING IS GOODNESS OF FIT. A LOT OF PLACES THAT THINK ONE SIZE FITS ALL APPROACH IS EFFECTIVE. THAT IS NOT TRUE. AS WE KNOW WITH VRI, ONE SIZE DOES NOT FIT ALL. HEARING AIDS DON'T WORK FOR EVERYBODY. SOME PEOPLE FIND THEM PAINFUL AND UNCOMFORTABLE. SOME PEOPLE DON'T WANT TO CARRY THE PARAPHERNALIA. I HAVE A FRIEND WHO TRAVELS A LOT AND SHE TELLS ME HOW MUCH STUFF SHE HAS TO TAKE WITH HER TO ACCOMMODATE NOT ONLY HER OTHER MEDICAL ISSUES BUT ALSO HEARING ISSUES, BATTERIES AND CHARGER CASES AND SPARE PARTS AND SO ON AND SO FORTH. I BETTER ASK THAT YOU HOLD QUESTIONS TO THE END BECAUSE I'M TRYING TO GET THROUGH THIS IN THE ALLOTTED TIME THAT I HAVE. SO THOSE ARE SOME OF THE TECHNOLOGICAL ISSUES. OVERCOMING BARRIERS. WELL, RECOGNIZING THE CENTRALITY OF HEARING LOSS WILL BE IMPORTANT. IF WE KNOW THAT PEOPLE OVER 65, MOST OF THEM ARE GOING TO BE DEAF, HARD OF HEARING, LATE-DEAFENED, JUST ASSUME THAT YOU HAVE TO CHECK FOR IT. JUST MAKE THAT ASSUMPTION AS PART OF EVERY EVALUATION, EVERY MEDICAL ADMISSION, EVERY DOCTOR'S VISIT, THAT SHOULD BE ONE OF THE ASSUMPTIONS YOU MAKE IS TO LOOK OUT FOR HEARING AND COMMUNICATION ISSUES. OF COURSE, HAVING ADEQUATE AUDIOLOGICAL SERVICES AND ORAL REHABILITATION SERVICES ARE IMPORTANT. ENCOURAGING FAMILY AND FRIENDS TO KNOW MORE ABOUT THESE THINGS AND TO BE SUPPORTIVE AS WELL. BECAUSE I HAVE TO TELL YOU IRONICALLY IN MY FAMILY, I WAS THE DEAF-- I WAS THE ONLY DEAF PERSON IN MY FAMILY, AND YET ALTHOUGH MY PARENTS DID A LOT OF THINGS RIGHT, ONE OF THE THINGS THEY DID WRONG WAS JUST ASSUME THAT JUST BECAUSE I HAD LEARNED HOW TO SPEECH READ AND SPEAK THAT THAT'S ALL I NEEDED. OTHERWISE, I SHOULD BE ON MY OWN, YOU KNOW, THEY SHOULDN'T HAVE TO DO MUCH ELSE. SO WHEN I ASKED THEM TO PROVIDE AN INTERPRETER FOR A RELIGIOUS SERVICE THAT I WAS ATTENDING, THERE WAS A LOT OF RESISTANCE. SO I HAD TO REALLY WORK HARD ON MY OWN FAMILY TO GET THEM TO BE MORE ACCEPTING. WHEN I STARTED LEARNING SIGN LANGUAGE, I WAS 2 YEARS OLD AND MY PARENTS FREAKED OUT. YOU'RE GOING TO LOSE EVERYTHING WE EVER TAUGHT YOU. YOU'RE GOING TO LOSE YOUR ENGLISH. YOU'RE GOING TO BECOME STUPID. I'M LIKE, NO, THE OPPOSITE IS TRUE. MY WORLD WILL EXPAND AND IT DID, AND THEY WERE ABLE TO SEE THAT EVENTUALLY, BUT I GOT A LOT OF RESISTANCE FROM THEM. SO THAT'S IMPORTANT. OF COURSE, ONGOING-- ONGOING EDUCATION AND TRAINING OF STAFF AND EVERYONE INVOLVED WITH RESIDENTS THAT THEY SERVE. ENVIRONMENTAL AND PSYCHOSOCIAL ADAPTATION. I'M GOING TO JUMP AHEAD A LITTLE BIT TO SHOW YOU SOME OF WORK THAT'S BEEN DONE WITH WHAT'S CALLED DEAF SPACE. IT'S A PROJECT BETWEEN GALLAUDET UNIVERSITY AND AN ARCHITECTURAL FIRM IN WASHINGTON, D.C. THAT GIVES YOU EXAMPLES IN OF THE WAYS IN WHICH SPACE CAN BE BETTER DESIGNED FOR PEOPLE WITH HEARING LOSS. YOU MAY FIND IT HARD TO SEE THESE PICTURES BUT SOME EXAMPLES OF DESIGN THAT WOULD MAKE THINGS MORE EFFECTIVE WOULD INCLUDE SEATING ARRANGEMENTS . FOR EXAMPLE, IN CONFERENCE ROOMS TO ALWAYS HAVE SEATING ARRANGEMENTS

THAT ARE EITHER HORSESHOE SHAPED OR SMALL GROUPS OR CIRCULAR FORMATION . I CAN TELL YOU ONE TIME I WENT TO A LECTURE WITH MY-- WHEN I WAS VISITING MY MOTHER AND THE SEATS WERE ALL IN ROWS, OKAY, AND THE SLIDE SHOW AND THE LECTURER WERE AGAINST A BANK OF WINDOWS WITH LIGHTS COMING IF SO THEY WERE SILHOUETTED IN EFFECT. HE'S HOLDING THE MIC UP HERE LIKE THIS. COULDN'T SEE HIS FACE. IN THE MIDDLE OF THE LECTURE, I RAISED MYER HAND AND I SAID EXCUSE ME. I'M VISITING WITH MY MOTHER HERE AND I HAPPEN TO BE DEAF, I WONDER HOW MANY OF YOU ARE HAVING DIFFICULTY WITH THIS ARRANGEMENT? THE MAJORITY OF THE ROOM RAISED THEIR HANDS AND I SAID, WELL, HELLO. WHY HASN'T SAID ANYBODY OR DONE ANYTHING ABOUT THIS. SO FROM MY POINT OF VIEW, IT WAS BOTH THE FACT THAT PEOPLE IN THE AUDIENCE WERE PEOPLE WHO HAD HEARING LOSS LATER IN LIFE ARE NOT USED TO OR NOT KNOWLEDGEABLE ABOUT HOW TO ADVOCATE FOR THEMSELVES IN THIS RESPECT OR DON'T WANT TO STICK OUT TO DO IT. AND THE OTHER, OF COURSE, IS THAT THEY THE FACILITY CULTURE, ITSELF, DIDN'T LEND ITSELF TO THINKING ABOUT THESE ENVIRONMENTAL CONSIDERATIONS. OTHER THINGS INCLUDE, FOR EXAMPLE, THE COLOR OF THE PAINT USED IN THE HALLS AND WALLS, THAT FOR VISUALLY IMPAIRED PEOPLE AND FOR PEOPLE WITH HEARING LOSS, IT'S EASIER IF IT'S A LITTLE BIT DARKER SO WE CAN SEE BY CONTRAST, SEE EACH OTHER, OKAY. AND SEATING ARRANGEMENTS SO THAT WHEN I GO INTO A DOCTOR'S OFFICE, FOR EXAMPLE, I FIND THE SEAT WHERE I CAN SEE EVERYTHING THAT IS GOING ON, ALMOST 360-DEGREE CIRCLE. WHEN I GO TO A RESTAURANT, I GRABBED THE SEAT WITH MY BACK TO THE WINDOW AND CAN SEE OUT. SO SETTING UP ROOMS WITH CHAIRS AND ARRANGEMENTS FOR CONVERSATION IN A WAY THAT EVERYBODY CAN SEE EACH OTHER AND DOORWAYS BEING OPENED OR WINDOWS IN THE HALLS SO PEOPLE CAN SEE INTO ROOMS DOWN THE HALL. I'M TALKING ABOUT PUBLIC SPACES NOT NECESSARILY PRIVATE ROOMS BUT FOR EXAMPLE, YOU ARE GOING DOWN THE HALL TO THE ACTIVITY ROOM OVER HERE, COMMUNITY ROOM OVER THERE, NURSING STATION OVER THERE. ALL OF THESE SHOULD HAVE WINDOWS SO THE PEOPLE CAN SEE AND ALSO THE PEOPLE IN THE ROOM CAN COMMUNICATE WITH THE PEOPLE IN THE HALLS. HALLWAYS NEED TO BE WIDER BECAUSE THE SIGNING SPACE BETWEEN PEOPLE IS LARGER THAN NORMAL CONVERSATION SPACE. MAYBE TOVAH CAN FINISH UP AND TAKE QUESTIONS.

>> THAT'S WHY I JUMPED A HEAD A LITTLE BIT TO SHOW YOU EXAMPLES OF HOW THE ENVIRONMENTAL SPACE CAN BE CHANGED. SOME CAN BE DONE RELATIVELY INEXPENSIVELY. MOVE SOME CHAIRS AROUND. GET SOME ABSORBENT TILES OR CARPETS FOR FLOORS AND I WOULD RECOMMEND, FOR EXAMPLE, ANY CURRENT FACILITIES THAT ARE PLANNING TO DO RENOVATION SHOULD INCLUDE ELEMENTS OF UNIVERSAL DESIGN IN THE RENOVATION. ANY NEW FACILITIES THAT ARE BEING BUILT SHOULD INCORPORATE UNIVERSAL DESIGN OF THIS SORT. AND THAT'S ONE EXAMPLE OF HOW YOU CAN CHANGE THE ENVIRONMENT. OVERALL FOR THE OTHER TYPES OF CHANGE PSYCHO, SOCIAL, MEDICAL, AND SO ON. , IT HAS TO BE DONE FROM THE TOP DOWN. IT'S WELL AND GOOD AND I'M NOT MINIMIZING THE IMPORTANCE OF INDIVIDUAL GRASS ROOTS ORGANIZATION IS A-BY-AGENCY ADVOCACY IN EDUCATION, BUT YOU WOULD FIND YOURSELF CONTINUING TO REPEAT, REPEAT AND REPEAT IF THE CULTURE THE FACILITIES, THEMSELVES, AREN'T CHANGED FROM THE TOP DOWN. I THINK IT'S IMPORTANT TO HIT THE CEOs, THE COOs, THE DIRECTORS, THE SUPERVISORS, THEY ALL HAVE TO BE TRAINED. AND FULLY UNDERSTAND THE IMPLICATION OF HEARING LOSS AND ECONOMIC TERMS AND PSYCHO-SOCIAL TERMS AND IN HEALTH AND MEDICAL TERMS SO I THINK I'LL STOP HERE. I COULD GO ON FOREVER, OF COURSE, BUT I KNOW I HAVE TO TURN IT OVER TO OTHER PEOPLE.

>> WE'RE GOING TO HAVE YOU TAKE QUESTIONS.

>> JUST FOR FOLKS ON THE PHONE BECAUSE WE'RE GETTING A NOTE THAT OUR COMPUTER IS ABOUT TO SHUT DOWN, ROB IS HE GOING TO RESTART THE COMPUTER AND RESTART THE ZOOM, OR ARE YOU-- YOU'LL STILL BE SIGNED INTO ZOOM ON JAMES' COMPUTER?

>> ROB, BEFORE YOU SIGN OUT, TRY TO MAKE ME A HOST AND I WILL SEE IF THAT WILL KEEP US IF--

>> WE WILL TRY TO KEEP THE ZOOM MEETING OPEN AND I WANT TO OPEN IT UP FOR FIVE MINUTES FOR QUESTIONS FOR TOVAH. THIS IS A GROUP THAT IS NEVER WITHOUT QUESTIONS.

>> SO IT'S TRUE THAT ONE OF THE BIG PROBLEMS I'VE SEEN WITH VRI IS THAT WHEN I, AS A DEAF PERSON, GO INTO THE HOSPITAL AND I AM ILL, I'VE HAD SITUATIONS WHERE I HAVE GONE IN, I'VE BEEN VERY, VERY SICK AND VERY STRESSED OUT ABOUT TRYING TO DEAL WITH VRI, ON TOP OF WHICH I'M BEING GIVEN MEDICATION THAT'S MAKING IT DIFFICULT FOR ME TO SEE AND THAT MAKES VRI MUCH MORE DIFFICULT FOR ME. I WANTED TO SAY IT MAKES A MUCH BIGGER DIFFERENCE FOR ME TO HAVE IN-PERSON INTERPRETER THAN TRY TO DEAL WITH VRI WHEN I CAN'T SEE ANYTHING, MY EYES ARE CROSSING BECAUSE I'M SICK OR ON MEDICATION AND HAVING THAT IN-PERSON INTERPRETER. IF I WASN'T MEDICAIDED AT THAT POINT, IF I WAS GOING TO GET A SHOT OR TAKING A PILL, SURE, VRI MAY BE SOMETHING THAT WOULD WORK. BUT THAT'S JUST SOMETHING I WANTED TO MENTION THAT WHEN I AM VERY SICK, IT'S NOT SOMETHING THAT'S EFFECTIVE.

>> THANK YOU.

>> I HAD A QUESTION REGARDING YOUR PRESENTATION, TOVAH, HOW WOULD YOU SUGGEST NURSING HOMES AND OTHER KINDS OF FACILITIES THINK ABOUT FINANCING SOME OF THE RENOVATIONS YOU WERE TALKING ABOUT? ANY THOUGHTS ABOUT THAT?

>> I DON'T HAVE GOOD ANSWERS FOR THAT BECAUSE I'M NOT AN ECONOMIST OR FINANCIAL ANALYST, BUT I MEAN, THAT'S THE KIND-- MONEY TALKS. I MEAN, THAT'S WHAT IT COMES DOWN TO. MONEY TALKS, AND TOP-DOWN TALKS, AND YOU KNOW, I THINK THAT ONE OF THE CONVINCING WAYS TO GET MONEY EITHER FROM LEGISLATURE OR FROM OTHER PLACES TO FINANCE NURSING HOMES IS TO DEMONSTRATE THE EXTRA COSTS INVOLVED IN HEARING LOSS WHEN HEARING LOSS IS NOT TREATED. I MEAN, WE'RE TALKING BILLIONS ANDLE ABOUTS OF DOLLARS FOR NORTH CAROLINA ALONE NEVER MIND THE REST OF THE COUNTRY. I THINK THAT'S GOING TO BE ONE CONVINCING ARGUMENT. THE OTHER CONVINCING ARGUMENT WILL BE THAT IN TERMS OF ACCESSIBILITY, EVEN IN PLACES THAT ARE NOT GOING TO BE RENOVATED THERE ARE MANY WHO CAN'T AFFORD TO JUST FLIP, TEAR DOWN AND FLIP, IT'S TO IMPROVE THE CULTURE AND DO MORE OF THE MINOR THINGS. I MEAN, MOST NURSING HOMES EVENTUALLY HAVE TO REPAINT OR GET NEW FURNITURE SO IN THE DOING OF THOSE THINGS WHEN THEY DO THAT, GRADUALLY AT LEAST GRADUALLY MAKE THOSE CHANGES , I THINK, ALL ALONG. . ?
SO I JUST WANTED TO INVITE FOLKS IN THE ROOM WHO MAY KNOW ABOUT RESOURCES, SEEM RESPONSIBLE FOR ALL THE NEWSLETTERS THAT GO OUT TO ALMOST 70 DIFFERENT COMMUNITIES IN NORTH CAROLINA FROM OUR ASSOCIATION AND ONE OF THE NEWSLETTERS THAT I PRODUCE IS

CALLED INCLUSION INSIGHTS AND IT'S INCLUSIVETY PRACTICES, TRENDS AROUND EVERYTHING FROM SEXUAL ORIENTATION AND RACE TO GENDER AND ABILITY TO AND DISABILITY. SO FOR ANYONE WHO IS IN THIS ROOM WHO HAS GOOD NEWS SOURCES, I REALLY WANT TO KNOW ABOUT THEM BECAUSE I WANT TO BE ABLE TO INCLUDE THEM IN THIS NEWSLETTER. FOR EXAMPLE, LIKE THERE ARE DIVERSITY AND INCLUSION ASSOCIATIONS THAT I'VE SIGNED UP FOR THEIR NEWSLETTER, ANYTHING LIKE THAT WOULD HELP US REACH OUR MEMBERS ON THIS PARTICULAR TOPIC. OF COURSE, I'LL LOOK AT THE SOURCES THAT HAVE BEEN, YOU KNOW, NAMED IN SOME OF THESE PRESENTATIONS, BUT IF THERE ARE OTHER REALLY CURRENT THINGS THAT ARE COMING OUT, I REALLY WOULD LIKE 0 KNOW ABOUT. I'M JENNIFER GILL IF YOU ARE LOOKING ON THE LIST OF MEMBERS MY EMAIL ADDRESS IS THERE I WOULD REALLY LIKE TO KNOW ABOUT IT. AS WE SIT AND TALK ABOUT ALL THE BARRIERS, I FIND MYSELF REALLY WANTING TO FIND OPPORTUNITIES AS WELL.

>> GREAT.

>> HELLO THIS IS ALICIA ON THE PHONE. CAN YOU HEAR ME?

>> WE CAN. GO AHEAD

>> I'M SORRY. I'M DRIVING AND I HAVE ANOTHER MEETING AT 2:00, ANOTHER TELECONFERENCE BUT REAL QUICK, I WANTED TO SAY THAT I HAVE BEEN ENJOYING THE MEETING. AND I KNOW I WAS TALKING TO JANE VIA CHAT MAINLY ON THE ELDERLY OR OLDER DEAF INDIVIDUALS OR INDIVIDUALS WHO ARE DEAF BECAUSE I'VE HAD QUITE A FEW PARENTS AS THE VOICE (INAUDIBLE) AND THEY THEIR CHILD AGE OUT THEY WANT TO FOE WHERE THEY CAN GO TO BE A LITTLE BIT INDEPENDENT AND THEY'RE LOOKING TO ARE A GROUP HOME THERE
[PHONE CALL DROPPED]
THEY HAVE IT SET UP WHERE THE STAFF IS GETTING TRAINING AND IN ASL BUT THEY HIRED DEAF STAFF MEMBERS TO COME IN AND DO CERTAIN TASKS WITH THE DEAF INDIVIDUALS SO THAT THEY'RE NOT THERE ALONE AND IF THERE'S SOMETHING PRESSING TO LET THE STAFF KNOW, THEY HAVE SOMEONE THERE TO COMMUNICATE THAT TO THE STAFF. SO THEY WERE ACTUALLY TRYING TO FIGURE OUT IF THERE WAS A WAY FOR THE OWNER AND I CAN'T REMEMBER THE NAME AND I CAN GET HIM AND TRY TO GET ONE LATER AND I DON'T KNOW THE REGULATIONS FOR THAT ESPECIALLY WITH HAVING INDIVIDUALS ON STAFF THAT CAN SIGN, BUT I THOUGHT THAT WAS A REALLY GOOD IDEA FOR THE YOUNG ADULTS THAT ARE COMING OUT THAT ARE HAVE NOWHERE TO GO AND THEY WANT TO BE OUT ON THEIR OWN BUT CAN'T FULLY LIVE IN THEIR OWN APARTMENT.

>> GREAT. THANK YOU, ALYCIA.

>> I WANT TO GO BACK TO THIS GENTLEMAN. I HELD ONTO THIS NUGGET THAT YOU DROPPED EARLIER BEFORE LUNCH ABOUT A $28 MILLION POT OF MONEY. I WOULD LOVE TO SEE HOW THAT COULD BE ACCESSED TO AT LEAST ADDRESS A LOT OF THESE ISSUES WHEN IT COMES TO THE PHYSICAL PLAN FOR THE FACILITIES.

>> SO LET ME GIVE YOU A PARALLEL. THE CMP FUNDS HAVE BEEN USED IN GREAT MEASURE TO FUND A PROGRAM CALLED MUSIC AND MEMORY. THESE ARE NOTHING BUT LITTLE HAND-HELD DEVICES THAT

HAVE A PLAYLIST THAT IS DEVELOPED FOR RESIDENTS THAT IS CONSISTENT WITH THEIR COMING OF AGE MUSIC.
IT'S HAD A HUGE IMPACT. MANY FACILITIES APPLIED FOR AND RECEIVE MONEY TO PURCHASE THOSE DEVICES AS WELL AS THE SITE LICENSE FOR OPERATING THIS PARTICULAR PROGRAM. IT STRIKES ME THAT THE KIND OF TECHNOLOGY WE'RE TALKING ABOUT IS NOT A HEAVY LIFT. BUT COULD BE USED IN A SIMILAR FASHION TO HAVE FACILITIES PAY FOR THOSE KINDS OF ENHANCEMENTS THAT THEY COULD USE IN THEIR FACILITIES TO MAKE THE LIVES OF THEIR RESIDENTS BETTER. I ALSO WANTED TO MAKE A COMMENT. I WANTED TO REINFORCE SOMETHING THAT VICKIE AND COREY WERE TALKING ABOUT AND THE LONG-TERM CARE LANDSCAPE IN NORTH CAROLINA ONE OF THE THINGS THAT IT IS WHAT NORTH CAROLINA IS KNOWN FOR IS A HUGE COMMITMENT TO ADULT CARE HOMES OR ASSISTED LIVING. AS THE COMPONENT IN OUR CONTINUUM OF CARE. WE HAVE FOR YEARS, THROUGH CERTIFICATE OF NEED AND ACTUALLY BOTH ARE CONTROLLED BY CERTIFICATE OF NEED, WE'VE CONTROLLED NURSING HOME BED SUPPLY, SO WHEN YOU LOOK AT OUR BEDS-TO-POPULATION RATIO, WE'RE CONSIDERED TYPE BEDDED. GUESS WHAT. LONG-TERM CARE DEMAND GOES SOMEWHERE AND IF YOU DON'T BUILD A NURSING HOME BED, IT'S GOING INTO ASSISTED LIVING. SO THE CONVERSATION WE ALSO NEED TO BE HAVING IS WITH OUR FOLKS IN MEDICAID AND WITH OUR DIVISION OF AGING AND ADULT SERVICES IN TERMS OF THE PUBLIC DOLLARS THAT ARE DOING INTO SUPPORT THOSE PARTICULAR FACILITIES. THE FUNDING SOURCES FOR ASSISTED LIVING, PARTICULARLY IS TRUE, NURSING HOMES TOO, BUT IT'S REALLY TRUE OF ASSISTED LIVING, IS EITHER PUBLIC FUNDS, MEDICAID AND SPECIAL ASSISTANCE OR PRIVATE PAY. THERE'S A LITTLE BIT OF PRIVATE LONG-TERM CARE INSURANCE IN THE MIX, BUT YOU CAN HARDLY MEASURE IT. SO WITH ASSISTED LIVING, YOU'VE GOT A RANGE OF FACILITIES FROM HIGH END FACILITIES THAT ARE ALL PRIVATE PAY, THAT HAVE WONDERFUL ACCOMMODATIONS, DOWN TO MEDICAID ONLY FA IT ISES AND WHEN YOU LOOK AT WHAT WE PROVIDE THOSE FACILITIES TO PROVIDE CARE, IT'S SURPRISING ANYTHING GOOD IS HAPPENING IN THOSE FACILITIES AT ALL. I'D STOP SHORT A LITTLE BIT IN THE SENSE THAT I DO THINK THERE ARE SOME PLACES THAT TRY TO DO THE RIGHT THING, BUT IT'S LIKE TRYING TO SHOOT PEOPLE WITH NO BULLETS. WE DON'T GIVE THEM A SUFFICIENT RESOURCES TO GET THE JOB DONE, LET ALONE TRY TO ADDRESS THE NEEDS OF POPULATIONS THAT WE'RE TALKING ABOUT. AND THAT IS A PART OF WHAT THIS COMMITTEE IS GOING TO NEED TO ADDRESS IF ANY IMPACT IS GOING TO BE MADE ON THAT POPULATION.

>> ANYBODY ELSE? DO YOU WANT TO SAY SOMETHING, SAM, AND THEN WE'RE GOING TO MOVE ON OUR TO OUR NEXT SPEAKER

>> THIS IS SAM CLARK. THE REASON THE STATE ACCUMULATED 28 MILLION IN CIVIL MONETARY PENALTY, IT'S EASY FOR THEM TO GET BUT THERE'S SO MANY RESTRICTIONS ON WHAT IT CAN BE USED FOR. THAT'S WHY IT'S ACCUMULATED. IT CAN'T BE USED FOR CAPITAL EXPENDITURES.
IT CAN BE USED FOR ANYTHING THE FACILITY IS REQUIRED TO PROVIDE. EXAMPLE I LIKE TO USE IS IT CAN'T BE USED FOR STAFF TRAINING BUT YOU CAN BUY AN ICE CREAM MACHINE WITH IT. BECAUSE THEY'RE REQUIRED TO TRAIN THE STAFF BUT THEY'RE NOT REQUIRED TO HAVE ICE CREAM.

>> SO CAN THEY BUY ASSISTED DEVICES?

>> AS LONG AS IT'S NOT REQUIRED THAT THEY HAVE THEM. WE ENCOURAGE OUR MEMBER FACILITIES

TO GO THROUGH, THERE'S A GATEKEEPER AT THE STATE BEFORE IT GOES OFF TO FEDERAL GOVERNMENT FOR THEIR APPROVAL, BUT WE HEAR A LOT OF NOs FOR EVERY WHY HE THAT WE GET.

Audiology Services in Long-Term Care Facilities

>> IT SOUNDS LIKE SOMETHING WE CAN LOOK INTO. TOVAH, THANK YOU. C.A.T. I HAD IS PULLING UP HER PRESENTATION -- KATHY IS PULLING UP HER PRESENTATION AND SHE WILL TALK TO ABOUT AUDIOLOGY SERVICES IN LONG-TERM CARE FACILITIES.

>> OKAY. CAN YOU ALL HEAR ME? GOOD. MY NAME IS DR. KATHY DOWD. I'VE BEEN AN AUDIOLOGIST FOR 41 YEARS AND IN 1993, I STARTED WORKING IN NURSING HOMES. WHAT I FOUND WHEN I STARTED GOING INTO THE NURSING HOMES IS THE SPEECH THERAPIST WERE DOING OCIAL REHABILITATION, SO THEY WERE CATCHING PEOPLE THAT THEY THOUGHT HAD A HEARING PROBLEM. THEY WERE PUTTING AN ASSISTED LISTENING DEVICE ON THEM TO DO AN EVALUATION. THEN THEY WERE DOING 20 VISITS OF ORAL REHAB. THEN THEY WERE TAKING THE ASSISTED LISTENING DEVICE, PUTTING IT ON THE NEXT PATIENT, AND STARTING THE SAME PROCESS OVER. SOME OF MY FACILITIES, WHICH FIT SOMEONE WITH HEARING AIDS, A FAMILY WROTE ME A NOTE AND SAID, THIS IS EXTRAORDINARY. THESE SERVICES ARE COSTING ME $7,000, AND I'M THINKING, I CALLED THEM AND I SAID, NO. THE HEARING AIDS WERE $2,000. I DON'T KNOW WHAT YOU'RE TALKING ABOUT THE. THE $5,000 WAS THE ORAL REHAB WAS BEING BILLED TO MEDICARE AND THEY WERE LEFT WITH NOTHING AS FAR AS PERMANENT CORRECTION FOR THEIR HEARING. SOME OF THE FACILITIES ALLOWED ME TO COME IN TEST HEARING AND FIT HEARING AIDS AND THEN DO ORAL REHAB, WHICH IS THE MOST APREP YAT WAY TO DO ORAL REHAB. PUT THE HEARING AIDS ON AND SHOW THE PERSON HOW TO ADJUST TO THE NEW SOUNDS. BUT SOME DID NOT. THEY WOULD BLOCK ME AND SAID, NO, WE DON'T HAVE ANY HEARING IMPAIRED PEOPLE HERE , WHICH IS A LITTLE BIT UNUSUAL BECAUSE THE INCIDENCE IS 80% IN SKILLED NURSING FACILITIES. I WANTED TO SHOW YOU THIS. UP ON THE SCREEN YOU SEE ON OUR WEBSITE, WHICH IS A-- WE'RE A NONPROFIT ENTITY BECAUSE WE'RE WORKING WITH CDC TO HELP DEFINE AUDIOLOGY MANAGEMENT IN DIABETES CARE. SO THIS IS AN AUTOMATIC HEARING SCREENING APP. IT'S BEEN VALIDATED BY THE UNIVERSITY OF CINCINNATI SPEECH AND HEARING. SO IT GIVES YOU A GOOD PASS-FAIL. IT TAKES THREE MINUTES. YOU HAVE TO PUT-- YOU HAVE TO INSERT EARPHONES. YOU HAVE TO BE IN A QUIET PLACE, BUT YOU WILL GET A CORRECT PASS OR FAIL, AND IT TAKES THREE MINUTES. THERE'S ALSO ONE I LEARNED ON THURSDAY FROM THE SPEECH THEN PISS, THE WORLD HEALTH ORGANIZATION HAS THIS SAME APP. NOW THE APP ONLY WORKS IF YOU USE IT. IF YOU DON'T USE IT, YOU HAVE NO IDEA. IT'S IMPOSSIBLE TO KNOW IF SOMEBODY HAS A HEARING LOSS BY LOOKING AT THEM OR TALKING TO THEM. IT'S IMPOSSIBLE TO KNOW. I HAVE BEEN FOOLED MANY TIMES BY PEOPLE COMING INTO MY OFFICE AND HE SAY I THINK MY HEARING IS FINE. I'M HERE BECAUSE OF MY WIFE. I PUT THEM IN THE BOOTHS, AND I'M SURPRISED BECAUSE I THOUGHT ONE-ON-ONE, FACE-TO-FACE IN A QUIET EXAM ROOM, THEY DID PRETTY WELL. AND THEY HAVE A MODERATE TO SEVERE HEARING LOSS. HOW DID THAT HAPPEN? SO IT'S IMPOSSIBLE TO KNOW UNTIL YOU START WITH AUDIOLOGICAL EVALUATION TO KNOW WHAT IT IS AND TO KNOW WHAT THE HISTORY IS THAT CAUSED IT TO BE LIKE THAT. AND THEN TO BE MONITORING IT AND MANAGING IT OVER TIME. SO I JUST WANTED TO SHOW YOU THAT. YOU CAN LEAVE THAT UP AND GO TO THE PRESENTATION? SO AS I SAID, I'VE BEEN AN AUDIOLOGIST FOR 41 YEARS. I SPENT FIVE YEARS AT

WAKE COUNTY SCHOOLS DOING EDUCATIONAL AUDIOLOGIST AND I ALSO WORKED IN LOUISIANA AS SUPERVISOR OF THE HEARING IMPAIRED PROGRAM. I WORKED AT ENT OFFICES AND ALSO IN PRIVATE PRACTICE. I NO LONGER AM DOING DIRECT SERVICES, EXCEPT IN A NURSING HOME PILOT THAT WE'RE PRESENTLY DOING IN ORDER TO SUBMIT A CMP GRANT TO GET HEARING AIDS FOR PART A PEOPLE. AS SOON AS THEY COME IN, THEY NEED TO BE TESTED AND THEY NEED TO HAVE THEIR HEARING FIXED. BEFORE YOU GO INTO MENTAL HEALTH ISSUES, COGNITIVE ISSUES, YOU NEED TO KNOW WHAT THE HEARING LEVELS ARE. SO THE ROLE OF THE AUDIOLOGIST IN SKILLED NURSING, OBVIOUSLY, CHRONIC DISEASES CAUSE HEARING PROBLEMS. YES, AS YOU GET OLDER, AGING MAKES YOU MORE SUSCEPTIBLE TO CHRONIC DISEASES. MY MOTHER-IN-LAW WAS DIAGNOSED AT AGE 88 WITH DIABETES. SHE ALREADY HAD CONGESTIVE HEART FAILURE AND HYPOTHYROIDISM AND SHE HAD A MODERATE HEARING LOSS AND SUDDENLY SHE GETS A NEW DIAGNOSIS OF DIABETES. MY BROTHER AND I WERE BOTH AT HER ASSISTING LIVING. HE WAS RUNNING AROUND TRYING TO GET HER FOOD, CHANGED, CHECKED HER BLOOD SUKHI COAS AND I MENTIONED TO RICHARD, WE HAVE TO KEEP A CLOSER CHECK ON HER HEARING. RICHARD SAID, WHERE DID THAT COME FROM? I SAID, WELL, DIABETES CAUSES HEARING LOSS . RICHARD SAID, I'VE NEVER HEARD OF THAT. RICHARD IS THE HEAD OF DIABETES EDUCATION FOR THE STATE OF MICHIGAN.

[LAUGHTER]

I SAID, OKAY. WHERE DO YOU GET YOUR INFORMATION? HE SAID, THE CDC AND THE AMERICAN DIABETES ASSOCIATION. I SAID, OKAY, WHEN I GET HOME, I'LL GET YOU THE RESEARCH. BUT I GOT HOME AND INSTEAD OF JUST SENDING HIM THE RESEARCH, I EMAILED CDC AND AFTER ABOUT A MONTH AND A HALF OF BUGGING THEM, I GOT AN EMAIL THAT SAID, CAN WE TALK? I SAID, SURE. I SPOKE WITH DR. PAMELA ALWEISS, IN ATLANTA, THE DIRECTOR OF TRANSLATIONAL SERVICES FOR DIE BEAT TEAS, AND SHE SAID, ALL OF MY COLLEAGUES ELECTED ME TO CALL YOU BECAUSE NONE OF US HAVE EVER HEARD OF THIS BEFORE. SO I STARTED SENDING-- THIS WAS 2011. I STARTED SENDING HER THE RESEARCH. AFTER ABOUT THREE MONTHS, SHE SAID, OH, LOOK WHAT I DUG UP. SHE FOUND RESEARCH THAT CDC DID TWO YEARS EARLIER. SO NOW WE ARE WORKING ON TRYING TO GET AUDIOLOGY IN DIABETES CARE IN THE DIABETES SELF-MANAGEMENT EDUCATION BOOK. SHE SAYS IT'S GOING TO TAKE 20 YEARS.

[LAUGHTER]

IT'S BEEN NINE. I'LL BE 80 YEARS OLD BY THE TIME IT COMES AROUND.

[LAUGHTER]

IT'S NOT AGING. IT IS THE CHRONIC DISEASES AND THE MEDICATIONS THAT ARE CAUSING THIS PROBLEM. AND ALSO TRAINING THE STAFF. I MEAN, SLP, SPEECH LANGUAGE PATHOLOGISTS, HAVE GUIDELINES. ASHA PUTS IN GUIDELINES FOR THEM WHEN THEY'RE SUPPOSED TO SCREEN. IT SAYS WHEN THERE IS A CHRONIC DISEASE, OR WHEN THERE IS OTOTOXIC MEDICATION. IT'S IN THEIR GUIDELINES AND THEY'RE NOT DOING IT. AND THEY'RE DOING-- NOW THEY'RE DOING COGNITIVE EVALUATIONS. WITHOUT EVER CHECKING HEARING FIRST. IT'S A LAW WITH OBRA THAT YOU NEED TO CHECK HEARING AND IT'S ALSO IN THE NORTH CAROLINA LAW THAT YOU NEED TO CHECK VISION AND HEARING WITHIN THE FIRST 14 DAYS. NOW WHAT MANY FACILITIES POINT TO IS THAT THEY USE THE CMS/MDS ASSESSMENT, WHICH INVOLVES GOING UP TO THE RESIDENT AND SAYING, DO YOU HAVE A HEARING PROBLEM? WELL, THEY'VE NEVER BEEN TESTED BEFORE. OR, THEN THEY LOOK AND SAY, OH, YOU'VE GOT A HEARING AID. SO THEY CHECK OFF THAT YOU'RE OKAY. THEY JUST GOT OUT OF THE HOSPITAL WITH A MAJOR INFECTION OR A MAJOR DIABETES OUT OF CONTROL THAT AFFECTS YOUR HEARING AND YOUR VISION, AND SO THEIR HEARING NEEDS TO BE CHECKED AGAIN, AND IT SHOULD BE

DONE BY THE SLP, BUT THE CMS, THE MEDICARE GUIDELINES FOR MDS ARE NOT VALIDATED. THEY'VE BEEN USING THEM SINCE 1987. THEY'RE INVALID. THAT TEST THAT I PULLED UP BEFORE IS A VALIDATED SCREENING. IF YOU WANT TO USE SOMETHING, USE THAT. IT GIVES YOU A CORRECT PASS-FAIL, AND THEN YOU DO AN AUDIOLOGICAL IF THEY FAIL.

>> WHAT'S THE SLP?

>> SPEECH LANGUAGE PATHOLOGIST.

>> THANK YOU.

>> SORRY. JUST RAISE YOUR HAND IF I START DOING THAT. OBVIOUSLY, BEING ABLE TO HEAR IS GOING TO IMPROVE YOUR QUALITY OF LIFE, YOUR COGNITION, YOUR DEPRESSION, WHICH ARE THE MAIN THINGS THAT ARE GOING TO CHANGE IN OCTOBER WITH THE REIMBURSEMENT IN THE NURSING HOMES. THEY'RE FOCUSING ON COGNITION AND DEPRESSION. SO THIS COULD BE A HAY DAY FOR THE SLPs BECAUSE THEY HAVE MOVED FROM DOING ORAL REHAB IN 1993 TO DOING COGNITION EVALUATIONS.

>> I'M ALSO NOT SURE THE ROOM KNOWS ABOUT THE CHANGE IN PAYMENT STARTING IN OCTOBER. SO YOU MIGHT WANT TO PROVIDE A LITTLE SOMETHING BAP GROUND THERE.

>> I DON'T KNOW WHAT PDPM. PATIENT-DRIVEN PAYMENT MODEL. THANK YOU VERY MUCH. THEY'RE FOCUSED ON COGNITION AND DEPRESSION. BOTH ARE HIGH RED FLAGS FOR HEARING LOSS. SO HEARING LOSS SMU BE SCREENED AND SHOULD BE ASSESSED AS SOON AS THEY COME IN. IF YOU USE THE CMS AND I HAVE WRITTEN TO CMS AND TOLD THEM I WANTED TO MEET WITH THEM BECAUSE IT IS AN INVALID SCREENING TOOL. BUT IT IS WHAT THEY PROMOTE AT THIS POINT. MY HUSBAND WENT INTO THE NURSING HOME TWO YEARS AGO. HE HAD SEPSIS, WHICH WAS A VERY STRONG INFECTION. HE HAD ACUTE RENAL FAILURE, AND HE HAD METABOLIC ENSELF ENCEPHALOPATHY AND IT TOOK HIM THREE WEEKS TO GET OUT OF THE HOSPITAL. I KNEW THEY WERE GOING TO DO COGNITIVE. ON THE SECOND DAY IN THE NURSING HOME, THE SPEECH THERAPIST CAME IN AND SAID, I'M GOING TO DO A COGNITIVE EVAL. I SAID I WANT HIS HEARING CHECK. HE HAD BEEN ON VANCAMYACINE. THAT IS AN ANTIBIOTIC THAT CAUSES HEARING LOSS. SHE SAID I DON'T HAVE EQUIPMENT. I SAID THAT'S FINE. I WANT HIS HEARING CHECKED BEFORE YOU DO A COGNITIVE. MY HUSBAND, IN HIS STUPER AND WORRIED ABOUT RAMIFICATIONS, SAID, OH, LET HER GO AHEAD. AND SO SHE DID. AND I WAS FURIOUS. AND THEN ABOUT A WEEK AND A HALF LATER, HE GOT A UTA, URINARY TRACT INFECTION, AND HE STARTED GETTING MORE CONFUSED AND I WENT TO THE NURSE PRACTITIONER AND THE SLP AND SAID, I THINK WE SHOULD HOLD OFF ON THE COGNITIVE TRAINING WHICH I THOUGHT WAS A JOKE TO BEGIN WITH, AND THEY SAID, OH, NO, NO
HE'LL DIGRESS. HE'LL GET WORSE WITH HIS COGNITION. HE WAS WORSE BECAUSE OF THE UTI. AFTER TWO DAYS, I WENT TO THE NURSE AND I SAID, I JUST DON'T FEEL COMFORTABLE. DON'T YOU THINK HE SHOULD GO TO THE HOSPITAL. HE WAS NOT GETTING ANY BETTER. SHE SAID, WELL, I CAN'T CALL AN AMBULANCE BUT IF YOU TELL ME THAT'S WHAT YOU WANT, I'LL DO IT. I SAID, WELL, I DON'T KNOW. HE'S GETTING WORSE. SHE SAID, IF YOU TELL ME THAT'S WHAT YOU WANT, THAT'S WHAT I'LL DO. I SAID CALL AND GET AN AMBULANCE. THIS SHOULD NOT HAPPEN. THOUSANDS OF DOLLARS ARE BEING

PAID FOR THIS BOGUS REHAB OF COGNITIVE TREATMENT WHEN YOU HAVE NOT CHECKED HEARING FIRST. AND-- WELL, I FILED A COMPLAINT WITH OUR LICENSING BOARD, BUT THEN I LOOK UP METABOLIC ENCEPHALOPATHY, IT REQUIRES COGNITIVE REST. NOT COGNITIVE TREATMENT. SO THEY WERE WAY OFFBASE ALL THE WAY AROUND. SO I HAVE A LITTLE BIT OF AN INTEREST IN THIS. BUT AUDIOLOGIST SHOULD BE PART OF THE ASSESSMENT TEAM. WHY THEY WERE NOT ON THE REHAB TEAMS WHEN THEY WERE DEVELOPED, I HAVE NO IDEA. HEARING ALWAYS COMES BEFORE SPEECH, LANGUAGE, ANYTHING LIKE THAT YOU ALWAYS HAVE TO KNOW WHAT THE HEARING LEVELS ARE. SO IN A SKILLED NURSING FACILITY, THE INCIDENCE OF HEARING LOSS IS OVER 80%. WE TEST EVERY SINGLE BABY AT BIRTH IN NORTH CAROLINA AND THE INCIDENCE IS 1 TO 2%, AND THAT IS A VERY IMPORTANT STEP THAT WE TOOK IN 1990. ONE TO TWO PERCENT. NOW THESE KIDS WILL SHOW UP IN KINDERGARTEN AND THEY'RE ALREADY ASSESSED. THEY ALREADY EITHER HAVE COCHLEAR IMPLANTS. THEY HAVE HEARING AIDS.

THEY'RE USING OTHER SYSTEMS OF COMMUNICATION. RIGHT OFF THE BAT. 80% INCIDENCE AND WE'RE NOT DOING ANYTHING. ALL HEALTHCARE FACILITIES ARE 92%. I DON'T KNOW HOW I DID THAT. BUT THE HEARING LOSS IS DUE TO DISEASE. AND PRESCRIPTIONS AND AGE BECAUSE YOU'RE LOSING YOUR SUSCEPTIBLITY TO THESE DISEASES AS YOU GET OLDER. SO YOU'RE GOING TO GET MORE CHRONIC DISEASES. SO THIS IS WHAT'S WRITTEN. A PERSON'S HEARING LOSS MAY INTERFERE WITH OBTAINING OR MAINTAINING THE HIGHEST PRACTICALLABLE PHYSICAL AND MEANT PSYCHOSOCIAL WELL BEING, ADVERSE CHANGES IN COGNITION AND QUALITY OF LIFE, SUCH AS POOR HEALTH, DEPRESSION, AND REDUCED INDEPENDENCE HAVE ALSO BEEN ASSOCIATED WITH HEARING LOSS UNTILLED 0ER ADULTS. IT WILL HAVE A POSITIVE EFFECT ON A PERSON'S WELL BEING TO BE ABLE TO IDENTIFY AND CORRECT THE HEARING PROBLEM AND YOU START WITH THAT. THEN IF YOU FIND THAT THERE IS STILL A COGNITIVE PROBLEM, AFTER THEY'VE GONE THROUGH THE E ECLIMATIZATION PERIOD OF SIX TO TWELVE WEEKS, THEN YOU LOOK AT COGNITION. SO THESE ARE OVERREQUIREMENTS FOR AUDIOLOGY. ALL PERSONS LIVING IN NURSING HOMES SHOULD RECEIVE OR HAVE ACCESS TO COMPREHENSIVE AND CONTINUING INTEGRATED AUDIOLOGY SERVICES FOR THE PURPOSE OF MAINTAINING AND OBTAINING THE HIGHEST PRACTICAL LEVEL OF PHYSICAL, MENTAL, AND PSYCHO-SOCIAL WELL BEING. BACK IN 1987, THE OMNIBUS BUDGET AND RECONCILIATION ACT KNEW THIS WAS IMPORTANT AND THEY INSERTED IT. SOMEHOW, IT GOT OVERLOOKED. IN THE STATE LAW AND JAN WITHERS WAS SO NICE TO SEND ME THIS, HOWEVER, IT WAS TOO LATE. YOU HAVE TO FILE A COMPLAINT WITH THE STATE WITHIN 12 MONTHS AND I DIDN'T REALIZE THAT. SO WHEN I CALLED THEM AND TOLD THEM ABOUT MY HUSBAND'S EXPERIENCE, THEY SAID, I'M SORRY. IT'S BEEN AFTER 12 MONTHS SO HE STILL HAS PROBLEMS WITH HIS HEALTH, SO WE MAY BE BACK ONBOARD. SO YOU HAVE TO CHECK FOR THE PRESENCE OF VISUAL, HEARING AND OTHER SENSORY DEFICITS. I AM NOW A VOLUNTEER UMBUDSMAN IN MECKLENBURG COUNTY. AND WHAT I SEE GOING INTO NURSING HOMES IS THEY DO HAVE VISION PEOPLE ONBOARD. THEY DO HAVE THEIR REHAB ONBOARD. THEY DO NOT LIST ANYTHING ABOUT HEARING LOSS. I WENT INTO A FACILITY SATURDAY. THE FIRST ROOM I WENT INTO NOW I'M STILL IN TRAINING SO I WAS WITH ANOTHER LADY. AND SHE WENT OVER TO THE LADY AND STARTED TALKING TO HER AND THE LADY JUST KEPT SHAKING HER HEAD. AND SHE SAID, WELL, I DON'T THINK SHE'S DOING OKAY. I WENT OVER TO HER AND STARTED YELLING IN HER EAR, HOW ARE YOU DOING TODAY, MISS SMITH? SHE LOOKED AT ME AND SAID, I HAVE A HEARING LOSS. I SAID, HAVE YOU HAD IT CHECKED? SHE SAID, NO. BUT I CAN'T HEAR. AND THIS IS WHAT I'M FINDING AND NOW EVERYBODY ON MY TEAM IS LOOKING OUT FOR HEARING LOSS WHICH IS A GREAT THING BECAUSE WE'RE ALL COMING BACK AFTER GOING INTO ALL THESE ROOMS AND WE'RE TELLING PEOPLE, WHICH

ROOMS WE-- BY THE TIME YOU NOTICE THERE'S A HEARING PROBLEM, IT'S A SEVERE HEARING LOSS. THAT'S NOT EVEN ADDRESSING THE MILD TO MODERATE HEARING LOSSES. AND I'M YELLING SO MUCH, I MAY ROZ MY VOICE HERE. BUT THERE ARE GUIDELINES FOR AUDIOLOGY ON THE WEB WHICH UNFORTUNATELY IF YOU GO TO MY WEBSITE AND SEND ME AN EMAIL, I WILL BE GLAD TO SEND YOU THE AUDIOLOGY REQUIREMENTS FOR SKILLED NURSING FACILITIES. THEY WERE WRITTEN IN 1996 AND THEY'RE VERY, VERY COMPREHENSIVE. SO THESE ARE WHAT THE OBRA GOALS THAT YOU ARE LOOKING FOR FOR HEARING PROBLEMS, TO RESTORE AND MAINTAIN THE HIGHEST POSSIBLE LEVEL OF FUNCTIONAL INDEPENDENCE. TO PRESERVE INDIVIDUAL AUTONOMY, TO MAXIMIZE QUALITY OF LIFE, PERCEIVED WELL BEING AND LIFE SATISFACTION AND TO STABILIZE CHRONIC MEDICAL CONDITIONS. WHO CAN SIGN ORDERS FOR AUDIOLOGY? WE HAVE TO HAVE AN ORDER IN ORDER TO BILL MEDICARE FOR OUR SERVICES. CLINICAL NURSE SPECIALISTS, TOVAH, IF YOU'RE A CLINICAL SOCIAL WORKER, ARE YOU A CLINICAL SOCIAL WORKER? OKAY. YOU CAN SIGN AN ORDER FOR A HEARING EVALUATION BY AN AUDIOLOGIST. SO THESE ARE ALL THE PEOPLE WHO CAN SIGN THE ORDERS FOR THE HEARING PROBLEM. TO GET IT ASSESSED . SO A HEARING PROBLEM IS AN INVISIBLE HANDICAP. YOU CANNOT TELL BY LOOKING AT ANYBODY YOU HAVE A HEARING PROBLEM. I CAN TELL. YOU HAVE THAT LOOK ON YOUR FACE. THERE'S NO WAY TO KNOW UNTIL I PUT YOU IN THE BOOTH, RUN THE WHOLE TEST, AND THEN IT'S A PICTURE OF WHAT YOU CAN HEAR AND WHAT YOU CAN'T. AND IT TELLS ME FOR SURE WHAT WE NEED TO DO ABOUT IT. BUT THERE IS MEDICAL NEED BECAUSE IT'S DUE TO THE CHRONIC DISEASES, DUE TO THE MEDICATIONS, AND WHEN THEY COME OUT OF THE HOSPITAL, THEY'VE BEEN IN A TRAUMATIC HEALTH PROBLEM. SO THAT'S ENOUGH OF A NEED. I DON'T KNOW WHY THE HOSPITALLISTS DON'T SCREEN HEARING WHEN THEY'RE IN THE HOSPITAL, BUT A LADY WHO JUST MOVED IN DOWN THE STREET FROM ME IS A HOSPITALLIST, AND SHE AND I WERE TALKING AND I SAID, DO YOU HAVE PEOPLE WITH DIABETES IN THE HOSPITAL? SHE SAID, ALL THE TIME. I SAID, DO THEY HAVE TROUBLE HEARING? SHE SAID, YES, A LOT OF THEM DO. I SAID, WELL, WHAT DO YOU DO ABOUT IT? WELL, I HAVE TO WAIT FOR THEIR FAMILIES TO COME IN. I SAID, WHY DON'T YOU GET THEIR HEARING CHECKED? WHY DON'T YOU GET THEM SOMETHING SO THEY CAN HEAR? SHE SAID, WE DON'T HAVE RESOURCES. THIS IS ATRIUM HEALTHCARE, ONE OF THE LARGEST IN THE SOUTHEAST, AND SO THEY'RE JUST KIND OF STEPPING OVER THIS ELEPHANT IN THE ROOM. BUT WE ALSO HAVE TO INVOLVE THE STAFF BECAUSE IF THERE'S EQUIPMENT THAT COMES IN, WE HAVE TO MAKE SURE BATTERIES ARE CHANGED. THEY'RE PUT ON CORRECTLY. . AND THEY KNOW HOW TO USE THEM AND EVERYONE ON THE STAFF DOES. IT HAS A BIG IMPACT ON QUALITY OF LIFE. THE TIMES THAT IT DOES NOT HAVE AN IMPACT IS IF SOMEBODY IS IN END-STAGE ALZHEIMER'S, AND I HAVE TESTED PEOPLE WHERE THEY'RE NO LONGER IN THIS WORLD. EVEN IF I CAN MAKE THE SOUND WHERE THEY CAN HEAR IT, MENTALLY, THEY ARE NO LONGER HERE. THAT'S NOT-- I'M NOT GOING TO BE DOING ANYTHING TO IMPROVE THEIR QUALITY OF LIFE TO CORRECT THEIR HEARING PROBLEM. IT SEEMS SAD, BUT I KNOW AND I'VE CONVERTED WITH THE STAFF ABOUT THIS, AND THERE REALLY IS NOTHING YOU CAN DO AT THIS POINT. WHEN MENTALLY YOU KNOW YOU'VE GOT THEIR HEARING TO WHERE THEY CAN HEAR AND THEY'RE STILL, THEY'RE END STAGE, IT'S ONLY GOING TO GET WORSE. SO THESE ARE THE DISEASES THAT AFFECT HEARING, DIABETES, CHRONIC RENAL DISEASE, CARDIOVASCULAR, HYPOTHYROIDISM, ALZHEIMER'S DISEASE, INFECTIOUS DISEASES , AND IN THE NURSING HOMES, ABOUT 50% OF THE RESIDENTS HAVE IMPACTED WAX. SO BEFORE YOU CAN EVEN ASSESS HEARING, YOU HAVE TO GET THE WAX OUT. I DON'T KNOW IF IT'S BECAUSE THEY'RE LAYING DOWN SO MUCH IN THE HOSPITAL AND WHEN THEY GET INTO THE SKILLED NURSING. ANOTHER AUDIOLOGIST WHO WORKED IN NURSING HOMES SAID SHE THOUGHT IT WAS BECAUSE THEY WERE NO PG LOOR ON SOLID FOOD AND THEY

WERE NO LONGER MOVING THEIR JAW AND GETTING THE WAX TO MOVE. I DON'T KNOW WHAT THE REASON IS, BUT ABOUT 50% OF THE PEOPLE HAVE IMPACTED WAX SO BEFORE WE DO THE TESTING WE HAVE TO GET THE WAX OUT. AND THAT IS USUALLY DONE BY THE AUDIOLOGIST. INFECTIOUS DISEASES, MY MOTHER-IN-LAW ABOUT TWO YEARS AFTER SHE GOT THE DIAGNOSIS OF DIABETES, SHE HAD A DIAGNOSIS OF CDIF, CLAUSTRODIUM DIDN'T DISTTROPHEAL. SHE WAS IN KENTUCKY. I KEPT HEARING THEY GOT HER ON NEW MEDICINE. IT'S NOT WORKING. I WENT OUT TO VISIT AGAIN AND I THOUGHT SHE IS NOT HEARING ME. I CHECKED HER HEARING AIDS, THEY WERE FINE. I WENT AND LOOKED AT HER CHART. THEY WERE GIVING HER GENTAMYACIN, AND I SAID, HETTY, CAN I GO WITH YOU TO YOUR NEXT VISIT TO THE GASTROENTEROLOGIST. SHE SAID SURE. I SAT DOWN WITH THE DOCTOR AND I SAID, YOU KNOW, THERE'S ANOTHER PROCEDURE CALLED FECAL TRANSPLANT. IT WAS A BIG ARTICLE IN THE CHARLOTTE PAPER ABOUT IT, AND IT WORKS . NO MEDICATION. HE SAID, WE DON'T DO THAT HERE IN LOUISVILLE. I SAID, WELL, THE PROBLEM IS GENTAMYACIN IS KILLING HER HEARING. HE SAID, DON'T WORRY. WHEN SHE GOES OFF THE GENTAMYACIN, HER HEARING IS GO TO COME BACK. WHEN SHE GOES OFF THE GENTAMYACIN, IN REALITY, HER HEARING CONTINUES TO DECLINE THREE TO SIX MONTHS MORE AND IT SHOULD BE MONITORED AND WHAT HAPPENED WITH HER HEARING BECAUSE SHE HAD HER CHECKED, HER THRESHOLDS, HER LEVEL OF HEARING ONLY WENT DOWN 10 DECIBELS SO NOT EXTREMELY BAD BUT HER DISCRIMINATION WENT FROM 0% TO ZERO. THAT WAS IT. TURN OUT THE LIGHTS. SHE DIDN'T WANT TO WEAR HEARING AIDS ANYMORE. SHE DIDN'T WANT TO WATCH TV ANYMORE. AND THAT WAS REALLY THE BEGINNING OF THE END, HER ANXIETY GOT REALLY BAD. IT WAS UNFORTUNATE. BUT THERE'S A LOT OF EDUCATION THAT WE AS AUDIOLOGISTS NEED TO DO BECAUSE PHYSICIANS DON'T KNOW THIS. I'M NOT SURE. THEY DON'T SEEM TO WANT TO KNOW THIS. BUT IT IS STILL IMPORTANT. IS SO DIABETES, WHAT HAPPENS WITH DIABETES, YOU HAVE A RUPTURE IN THE SMALL BLOOD CECILS AND THE BLOOD GETS INTO THE INNER EAR AND IT DISRUPTS THE SIGNAL AND THERE'S NEURAL DEGENERATION ALONG THE EIGHTH NERVE SO THE SIGNAL IS NOT GOING UP TO THE AUDITORY CORTEX THE WAY IT SHOULD. SO YOU'VE GOT TWO THINGS IN PLAY. IT ALL DEPENDS ON WHETHER THE PERSON CAN KEEP THEIR BLOOD GLUCOSE LEVELS IN CHECK. IF THEY DO WELL WITH THAT, THEY MAY NOT HAVE ANY VISUAL OR HEARING PROBLEMS. BUT IF IT'S OUT OF CHECK, IF IT'S A PROBLEM, THEN THEY'RE GOING TO START WITH DECLINING HEARING. IT ALSO AFFECTS YOUR BALANCE

YOU'RE MORE AT RISK FOR FALLS BECAUSE YOU LOSE YOUR VISION AND YOU LOSE THE FEELING IN YOUR FEET, IN ADDITION TO THE VESTIBULAR EFFECTS AND THE EIGHTH NERVE FROM THE EAR ALSO COMES OFF THE VESTIBULAR TODAYLE THATS AND SO FOR BOTH OF THEM, IT'S DEGENERATING AND IN ADDITION, YOU HAVE THE OTOTOXICITY FROM THE DIABETES MEDICATION WHICH WE JUST HAD DR. ROBERT DESOBER DO AN ANALYSIS OF INSULIN MEDICATION AND IT'S ON OUR WEBSITE.

YOU CAN LOOK AT THE MEDICATION AND SEE WHAT THE EFFECTS ARE ON HEARING, RISK OF FALLS, AND COGNITION. NOW, I'M NOT GOING TO TELL ANYBODY DON'T TAKE THAT MEDICINE, BUT YOU DO HAVE TO UNDERSTAND WHAT THE CONSEQUENCES ARE AND GET YOUR HEARING CHECKED MORE FREQUENTLY. CARDIOVASCULAR DISEASE, OBVIOUSLY, IF YOU HAVE A STROKE, THERE'S A GREAT POSSIBILITY. YOU LOSE THE HEARING IN ONE EAR. SO YOU MAY NOT DETECT WHEN YOU GO OVER AND ASK SOMEBODY, DO YOU HAVE A HEARING PROBLEM WHILE THE GOOD EAR IS LISTENING. WHERE IT'S GOING TO BE A PROBLEM WITH JUST ONE EAR IS WHEN THERE IS A BACKGROUND NOISE SO WHEN YOU GO INTO THE DINING ROOM, SO THEY'RE SCRATCHING THEIR HEAD SAYING, THE-- THE STAFF IS SAYING YOU MUST HAVE A COGNITIVE PROBLEM BECAUSE YOU SEEM TO HEAR OKAY, BUT THEN YOU SEEM REALLY CONFUSED IN SOME SITUATIONS. UNLESS YOU HAVE IT TESTED, YOU DO NOT KNOW.

AMINOGLYCOCIDE ANTIBIOTICS, AND THESE ALL AFFECT HEARING, DARVOCET, CANCER, CHEMO THERAPEUTIC MEDICINE, HORMONE REPLACEMENT TREATMENT. I SHOWED THIS LIST TO AN ENT DOCTOR AND HE SAID, YOU FORGOT ED MEDICATION. I SAID, YES, I DID. SO--
[LAUGHTER]
AND THEN QUANINE. QUNINE DOWN IN THE MIDDLE OF NORTH CAROLINA I HAD A DOCTOR SAY, DO YOU HAVE ANY RESEARCH ABOUT QUANINE AND HEARING LOSS. NO, BUT WHY? WELL, WE HAVE AN OLD DOCTOR WHO'S HELPING BIRTH ALL THE BABIES AND HE USES THAT AS AN OLD WIVE'S TALE TO GIVE THEM ALL QUNINE AT THEY'RE BORN AND WE'RE HAVING ALL THESE KIDS WITH A MILD HEARING LOSS AND SURE ENOUGH, QUANINE, EVEN TONIC WATER, IF YOU'RE SUSCEPTIBLE TO IT CAN CAUSE A HEARING LOSS. SO BE CAREFUL IF YOU LIKE VODKA TONICS. BE CAREFUL. IT'S QUANINE TONIC WATER. I MOW SOME OF YOU HAVE ALREADY SEEN THIS. THIS IS THE VIDEO THAT WILL SHOW YOU-- OKAY. LET ME START BACK OVER. YOU SEE THIS AS A NORMAL HEARING LOSS. NOW IT'S GOING TO FILTER AS BARNEY AND WHAT'S HIS NAME-- FRED. AS THEY TALK. SO WATCH THE GRAPHS. OH!
OH. I

>> I THINK IT PLAYED YOUR SLIDES RATHER THAN THE VIDEO.

>> ALL RIGHT. LET ME TRY ONE MORE TIME.

>> AH!
YOU'RE ON MY APARTMENT BUILDING. ON GRANITE AVENUE. YOU OWE ME 300 BUCKS. GIVE IT UP.

>> FRED, TAKE IT EASY. IT'S ONLY A GAME.

>> WILMA, JUST LIKE THEM BIG TYCOONS, I PLAY TO WIN. NOW BARNEY, PAY UP OR GET OUT OF THE GAME.

>>
[SOUND FADES]
[VOICES ARE MUFFLED]
SO IF YOU LOOKED AT THE LOW PITCHES, THOUGH, WHAT HAPPENED IS THEY WERE A MILD HEARING LOSS EVEN THOUGH IT SAID SEVERE. SO THE PERSON IS ABLE TO HEAR THE VOWEL SOUNDS WHICH ARE LOUDER AND LOW PITCHES.

>> ONE, TWO, THREE, FOUR. BARNEY, THAT'S ENOUGH.
[LAUGHTER]

SO THEY MAY STILL BE ABLE TO HEAR BUT THEY WILL NOT UNDERSTAND. AND ONE OF THE STARK THINGS THAT HAPPENED WHEN I WAS AT WAKE COUNTY SCHOOLS IS THEY REFERRED A LITTLE BOY THAT WAS FOUR YEARS OLD. THEY WERE GETTING READY TO PLACE HIM AS MENTALLY RETARDED AND THEY HAD DONE A PSYCHOLOGICAL. THEY SCREENED HIS HEARING AND SOMEBODY ELSE SAID, YOU KNOW, WE HAVE AN AUDIOLOGIST. WHY DON'T WE GET HIM TESTED. THEY SENT HIM OVER TO ME. I PUT HIM IN THE BOOTH. HE WAS AGE FOUR, SOW CAN-- THEY'RE PRETTY GOOD ABOUT RESPONDING . I GOT A PRECIPITOUS LOSS, BOTH EARS. IT WENT FROM MILD IN THE LOW PITCHES TO MODERATE IN

THE MIDS, AND SEVERE IN THE HIGHS. SO WHEN THE TEACHER WAS TALKING TO HIM AND CALLED HIS NAME, HE WOULD TURN AROUND AND THEN WHEN SHE SAID GO GET YOUR BOOK BAG AND STAND BY THE DOOR WITH THE OTHER KIDS, HE STOOD THERE. HE LOOKED DUMB. SO I TOLD THE PSYCHOLOGIST, GO BACK AND RETEST HIM USING THE LITER, L-I-T-E-R, WHICH IS FOR HEARING IMPAIRED. HE HAD NORMAL INTELLIGENCE. THEY WERE GETTING READY TO PUT HIM IN TRAINABLY MENTALLY RETARDED. HE PASSED THE HEARING SCREENING. I DON'T KNOW HOW MANY OTHERS WE DIDN'T CATCH, BUT THAT WAS ONE WE DID. SO WHAT HAPPENS IS SIMILARITIES BETWEEN THE COGNITION AND ALZHEIMER'S, YOU HAVE DEPRESSION, ANXIETY, AND DISORIENTATION, HEARING LOSS IS DEPRESSION, ANXIETY, AND FEELING OF ISOLATION. ALZHEIMER'S, REDUCED LANGUAGE COMPREHENSION. HEARING LOSS, REDUCED COMMUNICATION ABILITY. ALZHEIMER'S, IMPAIRED MEMORY, ESPECIALLY SHORT TERM, REDUCED FOR HEARING LOSS, REDUCED COGNITIVE INPUT. INAPPROPRIATE PSYCHO-SOCIAL RESPONSES, FOR BOTH OF THEM. IT'S THE SAME. NOW MY HUSBAND, LIKE YOURS, TOVAH, IS STARTING TO SAY WHEN I TALK TO HIM, HE'LL DO THIS.
[MUMBLES]
HE SAID, YOU'RE NOT TALKING LOUD ENOUGH. I'M TALKING THE WAY I'VE BEEN TALKING FOR 45 YEARS. I SAID, YOU HAVE A HEARING PROBLEM. NO, I DON'T. BUT HE'S DOING THAT MORE AND MORE. SO I KNOW WHATEVER-- AND HE'S GOT A LOT OF HEALTH PROBLEMS. HE'S ON LOTS OF MEDICATION. SO I ANY I'VE GOT TO GET HIM BACK INTO THE AUDIOLOGIST, BUT THAT'S WHAT IT LOOKS LIKE. THE EFFECTS OF UNTREATED HEARING LOSS, EMBARRASSMENT, FATIGUE, IRRITABILITY, TENSION, STRESS, AVOIDANCE OF SOCIAL ACTIVITIES, DEPRESSION, NEGATIVISM, BRINGS TO MIND ONE PERSON THAT WE SAW ON FRIDAY IN A SKILLED NURSING FACILITY. I'M SITTING IN THE ADMINISTRATION OFFICE AND SHE ROLLS IN WITH HER WHEELCHAIR AND SHE SAID, WHERE IS THE NURSE? I SAID, THE NURSE JUST LEFT A FEW MINUTES AGO. SHE SAID, WHAT DID YOU SAY? AND SO I GOT REAL CLOSE TO HER AND I RAISED MY VOICE AND SAID I THINK SHE'S COMING BACK. DO YOU HAVE A HEARING PROBLEM? SHE SAID, YES! I TALKED TO THE DOCTOR YESTERDAY. I WAS ASKING HIM QUESTIONS ABOUT MY HEALTH. I COULDN'T UNDERSTAND ANYTHING HE SAID. . SO WE GOT HER TESTED. SHE HAD A 70 DB HEARING LOSS. I GRABBED HER CHART. AND THE NOTE ON HEARING SAID, HEARING GROSSLY INTACT. THEY SHOULD HAVE LEFT OFF THE INTACT. HER HEARING WAS GROSS, UNCORRECTED. SHE HAD BEEN THERE OVER SIX MONTHS. THAT IS INCONCEIVABLE, BUT IF YOU ASK HER AND MAYBE IT'S GOTTEN WORSE OVER THE LAST SIX MONTHS, I DON'T KNOW. BUT IT'S INCONCEIVABLE TO ME AS AN AUDIOLOGIST THAT THIS IS STILL HAPPENING FROM 1993 WHEN HE STARTED, IT IS STILL HAPPENING WITH TERRIBLE EFFECTS. OH THIS IS WHAT I ALREADY READ YOU. THE MAIN THING IS JUST REFER. AN AUDIOLOGIST HAS A DOCTORAL-- CLINICAL DOCTORAL DEGREE IN HEARING HEALTH MANAGEMENT. A HEARING AID DEALER HAS A HIGH SCHOOL EDUCATION IN NORTH CAROLINA AND DOES A ONE-YEAR APPRENTICESHIP TO DISPENSE HEARING AIDS. AN ENT DOCTOR IS OUR GO-TO PERSON WHEN 10 TO 15% OF THE TIME WE FIND A MEDICAL NEED. THERE NEEDS BE SOME SURGERY OR THERE'S AN INFECTION THAT NEEDS TO BE TREATED. SO THOSE ARE YOUR THREE PROFESSIONALS. EVEN THE ENT STARTS WITH THE AUDIOLOGIST. GO DOWN THE HALL. GET YOUR HEARING TESTED, AND THEN I'LL TALK TO YOU ABOUT WHAT WE NEED BECAUSE WE FIND THE MEDICAL NEED ON THE HEARING TEST. IT'S A MATTER OF GETTING THEM TESTED. IF THEY GO BACK INTO THE HOSPITAL, THEY HAD PNEUMONIA. WE HAD TO SEND THEM BACK TO THE HOSPITAL. THEY COME BACK. OH, THEY'RE JUST A LITTLE BIT MORE CONFUSED SINCE THEY CAME BACK. WELL, THEY WERE ON ARITHOMYACINE FOR PNEUMONIA. DO YOU THINK THAT NEEDS TO BE TESTED? EVERY TIME YOU COME INTO THE FACILITY, THAT SHOULD BE TESTED. I KNOW CMS HAS THEIR REGULATION OF THE MINIMUM DATA SET OF ASKING SOMEBODY, DO YOU HAVE A HEARING

PROBLEM, OR YOU'RE WEARING A HEARING AID, SO YOUR HEARING MUST BE OKAY. IT'S ALREADY TAKEN CARE OF. NO, IT'S NOT. YOU JUST CAME OUT OF THE HOSPITAL. AND THERE'S A VERY STRONG POSSIBILITY SOMETHING HAPPENED. SO I WILL-- WELL, THERE'S MY WEBSITE RIGHT THERE. SO IF YOU WANT TO LOOK AT THE HEARING SCREEN, YOU CAN USE THAT IN YOUR OFFICES. YOU CAN PUT HEADPHONES INTO THE COMPUTER . YOU CAN HIT THE START BUTTON. IT WILL RUN THREE MINUTES. IT'S A DIGITS IN NOISE TEST. I TOOK IT MYSELF. IT NEEDS TO BE IN A QUIET PLACE. IF YOU FAIL, THERE ARE TWO PLACES WHERE YOU CAN FIND AN AUDIOLOGIST OR YOU CAN GO TO YELLOW PAGES OR ONLINE TO FIND ONE. BUT IT'S IMPORTANT TO KEEP A CHECK ON YOUR HEARING. YOU GO TO THE EYE DOCTOR. YOU GO TO THE DENTIST. YOU NEED TO KEEP A CHECK ON YOUR HEARING. IT IS AN INVISIBLE HANDICAP. DOES ANYBODY HAVE ANY QUESTIONS?

>> YES.

>> THANK YOU. THAT WAS A GREAT PRESENTATION. YOU MENTIONED THE 14-DAY REQUIREMENT IN THE SKILLED NURSING HOMES.

>> THE TESTING HAS TO STANDARDS OF GEAR WITH REGARD TO THE TYPE AND YOU MENTIONED THE HEAR SCREEN APP AND WHAT ARE PEOPLE DOING OUT THERE?, WELL

>> WELL, IN MY HUSBAND'S CASE IN MY HUSBAND'S CASE WHEN I ASKED, ANY DIDN'T HAVE AND THEY DIDN'T COME IN AND ASK HIM IF HE HAD A HEARING PROBLEM WHICH I THIS IS A JOKE TO TO EVEN DO THAT, THIS IS A VALIDATED TOOL, IT'S ON THE WORLD HEALTH ORGANIZATION SITE. YOU CAN PULL IT UP ON THE APP ON YOUR PHONE, HEAR SCREEN AND ARE THERE ANY REQUIREMENTS TO THE QUALITY OF THE TEST. CMS HAS NO--

>> CMS REQUIREMENTS FOR SOMEBODY COMING INTO THE NURSING HOME ARE TO ASK THE PERSON IF THEY HAVE A HEARING PROBLEM OR TO SEE IF THEY HAVE A HEARING AID, AND --

>> THAT'S IT.

>> USUALLY THEY'RE NOT EVEN DOING THAT, BUT THAT'S THE CMS REQUIREMENT IN THE MINIMUM DATA SET. YES, JOHNNY.

>> THANK YOU. JOHNNY SEXTON HERE. KATHY, EXCELLENT PRESENTATION. THERE IS NO SPECIFICITY IN THE REGULATION. HOWEVER, THERE IS A NORTH CAROLINA LICENSURE LAW AUDIOLOGY THAT DOES SPELL OUT WHO CAN DO WHAT WHEN IT COMES TO HEARING ASESMENT. IF YOU'RE SCREENING HEARING, WE'VE GOT TO GET THEM TO DO THAT FIRST, RIGHT? IF YOU'RE REQUIRING A HEARING SCREENING, THEN ANY INDIVIDUAL CAN DO THAT IF THEY'RE TRAINED AND SUPERVISED BY A NORTH CAROLINA LICENSED AUDIOLOGIST AND THE ONLY INDIVIDUAL WHO IS QUALIFIED UNDER STATE LAW TO PERFORM A HEARING EVALUATION IS THE NORTH CAROLINA LICENSED AUDIOLOGIST. THERE ARE OTHER WAYS TO KIND OF COME AT THAT, IF WE CAN IMPACT THOSE REGULATIONS FOR THE NURSING HOME TO DO MORE THAN ASK A PERSON IF YOU HAVE A HEARING LOSS OR JUST CHECK THE BOX IF THEY HAVE A HEARING AID.

>> VERY GOOD PRESENTATION. DEFINITELY. I DO HAVE A CONCERN WITH PEOPLE WHO ARE DEAF THAT ARE ASKED, DO YOU HAVE A HEARING PROBLEM. MY EXPERIENCE HAS BEEN, WHEN I WAS HIRED TO INTERPRET FOR A PERSON WHO WAS DEAF, THE HEALTHCARE DEPARTMENT DID NOT WANT TO PAY FOR INTERPRETERS. THEY WANTED TO BE ABLE TO EITHER WRITE BACK AND FORTH FOR THE NEXT SEVEN MONTHS BECAUSE SHE WAS PREGNANT OR AS-- THEY WOULDN'T LET ME INTERPRET ALL THAT. THEY WROTE BACK AND FORTH TO THE PERSON, AND SHE WAS ABLE TO UNDERSTAND THE WRITING BACK AND FORTH, AND THEY ASKED HER, DOES YOUR HUSBAND HAVE A HEARING PROBLEM, AND SHE SAID, NO. AND THEY SAID, WELL, GOOD. HE CAN COME INTERPRET FOR YOU. HE SAID, NO, HE'S DEAF. HE DOESN'T HAVE A PROBLEM HEARING.
[LAUGHTER]
FOR PEOPLE WHO ARE HEARING, THOUGH, AND HAVE LOST THEIR HEARING LATER ON IN LIFE, THEY WOULD UNDERSTAND THAT HEARING PROBLEM. FOR SOMEBODY WHO IS ALREADY DEAF OR HAS MAYBE SOME RESIDUAL HEARING, THEY MAY NOT CONSIDER IT A PROBLEM AND THEREFORE, IF THEY RESPOND AS MY MOM HAD GOOD SPEECH, OH, YOU DON'T HAVE A PROBLEM. SHE CAN LIP READ. SO WHEN I HEAR HEARING PROBLEM, IT TAKES ME BACK TO THE 1900s. I'M SORRY.
[LAUGHTER]

>> SO ONE THING THAT JAN WANTED ME TO SAY, THOUGH, WAS THAT WE ARE FILING A CMP GRANT TO FILL IN THE GAPS TO GET EQUIPMENT IN EVERY SINGLE FACILITY. BOTH FOR IMMEDIATELY BEING ABLE TO CHECK HEARING AND FOR BEING ABLE TO CORRECT THE HEARING RIGHT OFF THE BAT. SO AND WE'VE HAD SOME VERY POSITIVE RESPONSES ALL THE WAY AROUND ABOUT DOING THIS. I'M WORKING WITH JAN'S GROUP BECAUSE THEY'RE GOING TO TRAINING VIDEOS ALSO AND WORK WITH US ON THAT.

>> SO I'D LIKE TO ASK A QUESTION. THERE'S ONE CONCERN ABOUT HEARING AIDS AND I UNDERSTAND THAT'S OKAY FOR SOMEONE WHO MAY BE HARD OF HEARING, BUT WHEN YOU TALK ABOUT THE DIFFERENCE BETWEEN A HEARING AID AND COCHLEAR IMPLANT--

>> THE DIFFERENCE BETWEEN A HEARING AID.

>> I WANT TO ASK HER A QUICK CLARIFYING QUESTION.

>> SO ALSO UNDERSTAND BECAUSE THE IMPLANT IS IMPLANTED INSIDE THE BODY. IT CAN BECOME INFECTED AND I'VE HEARD STORIES ABOUT THAT, THAT ARE REALLY SHOCKING. SO I KNOW THAT'S SOMETHING THAT PEOPLE HAVE TO BE AWARE IS THE COCHLEAR IMPLANT BEING INSIDE THE BODY AND HIGH RISK OF GETTING INFECTION. THAT'S A CONCERN THAT I HAVE.

>> ESPECIALLY IF YOU HAVE DIABETES, YOU'RE MORE PRONE TO INFECTION AND IT'S MORE DIFFICULT TO GET RID OF THE INFECTIONS. SO FOR THOSE PEOPLE PEOPLE WHO HAVE DIABETES AND A COCHLEAR IMPLANT, YOU KNOW, YES, EVERYBODY'S RADAR SHOULD BE UP ABOUT THAT.
>> AND THAT'S ONE THING-- I KNOW PEOPLE WANT A COCHLEAR IMPLANT BECAUSE THEY FEEL LIKE IT

WILL HELP THEM TO HEAR BETTER. I KNOW ONE PERSON IN MY CHURCH THAT GOT A COCHLEAR IMPLANT. WAS VERY EXCITED BIT. VERY HAPPY THAT THEY FELT LIKE THEY COULD SOCIALIZE, INTERACT, AND CONVERTS WITH PEOPLE INITIALLY AND BECAME SICK BECAUSE OF THE IMPLANT AND ENDED UP IN THE HOSPITAL . AND THE DOCTORS FOUND THAT THEY HAD AN INFECTION AND HAD TO HAVE SURGERY TO CORRECT THAT, AND ENDED UP WITH REPEATED SURGERIES, TRYING TO ADDRESS IT.

>> I THINK SHELLEY--

>> I'M OKAY.

>> CAN YOU TALK A LITTLE BIT MORE-- LET ME. CAN YOU TALK A LITTLE BIT MORE OR MAYBE JAN ABOUT THE CMP GRANT TO GET EQUIPMENT. WHAT IS CMP? HOW MANY FACILITIES ARE WE TALKING ABOUT, SKILLED NURSING FACILITIES? IS THAT A POTENTIAL OPPORTUNITY IN EVERY SKILLED NURSING FACILITY IN NORTH CAROLINA?

>> THERE ARE 420 PLUS THAT ARE ELIGIBLE AND SO WE'RE LOOKING AT A GRANT THAT COULD SUPPLY FOR ALL OF THEM , OR AS MANY AS WANT TO PARTICIPATE. WE DO FEEL LIKE WE HAVE THE WHERE WITHAL TO DO THAT. SO THAT WOULD GET EQUIPMENT INTO THE 420 NURSING HOMES, BUT WOULD IT GET TRAINED, LICENSED AUDIOLOGISTS TO DO THE SCREENING OR EVALUATION?

>> YEAH. SO WE'RE LOOKING AT ALL OF THAT IN THE PERSONNEL AND ALSO COMING BACK TO FIT THOSE PEOPLE WITH HEARING AIDS THAT THE FACILITY WILL OWN. SO THERE'S NO REASON IN PART A TO SAY, OH, WE DON'T HAVE THE MONEY. THEY WILL BE FACILITY-OWNED HEARING AIDS AND THEY CAN BE USED RIGHT OFF THE BAT FOR SOMEBODY WHEN THEY COME IN THAT HAS A PROBLEM.

>> THIS IS JAN, THANK YOU. I WANTED TO ADD TO SOME OF THAT AS WELL. SO WE ALREADY HAVE A CURRICULUM DESIGNED TO PROVIDE TRAINING FOR STAFF IN SKILLED CARE FACILITIES AND NURSING FACILITIES, AND WE JUST FINISHED UPDATING THAT TRAINING LAST MONTH AND TONY DAVIS IS OUR HARD OF HEARING SERVICES COORDINATOR, HE AND HAS BEEN TAKING THE LEAD ON THAT TRAINING UPDATE. SO THAT'S SOMETHING WE'RE GOING TO BE WORKING WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THEIR CONTRACTING PROCESS TO GET THE SERVICES OF A VIDEO PRODUCTION COMPANY THAT WILL HELP US IN DEVELOPING A VIDEO VERSION OF THAT TRAINING AND ALSO WE ARE ABLE TO PROVIDE THE TRAINING -- WELL, LET ME BACK UP A LITTLE BIT. THE STAFF WHO TAKE THAT TRAINING WILL BE ABLE TO GET CEUs AND THAT'S SOMETHING THAT WILL WORK VERY WELL WITH THE DIVISION OF HEALTH SERVICES REGULATION. SO I THINK WE HAVE A GOOD START WITH DR. DOWD'S PARTNERSHIP.

>> ONE MORE ANNOUNCEMENT IS NEXT TUESDAY, JUNE 25th, DR. PAMELA ALWEISS IS GIVING A WEBINAR AND THE REGISTRATION LINK IS ON OUR WEBSITE. SHE ASKED SPECIFICALLY FOR US TO INVITE FAMILY PHYSICIANS, AND SO WE WENT TO A LOT OF LENGTHS TO FREE CONTINUING EDUCATION FOR ALL SIX OF OUR WEBINARS FOR PHYSICIANS, NURSES, DIETITIANS, PHARMACISTS, PODIATRISTS, OPTOMETRISTS, DENTISTS AND AUDIOLOGISTS, AND I WOULD INVITE ALL OF YOU TO WATCH THE VIDEO. DR. ALWEISS IS VERY COMMITTED TO HELPING AUDIOLOGY GET INTO DIABETES SELF-CARE MANAGEMENT. YES.

>> THIS IS TOVAH. ARE ANY OF THOSE WORKSHOPS OR WEBINARS CAPTIONED?

>> NO. WE TRIED IN 2018 AND WE HAD SOMEBODY CAPTION FOR TWO WEBINARS AND THEN WE COULDN'T GET THEM BACK ON. I DON'T KNOW IF WE WERE GOING TOO FAST. AND THEN ONE OF THE PEOPLE-- MAYBE JAN KNOWS MORE.

>> I'M NOT SURE ABOUT THAT, BUT WHOEVER IS PROVIDING THE TRAINING, IF THEY AREN'T PROVIDING CAPTIONS, YOU COULD REQUEST THE SERVICE OF RELAY CONFERENCE CAPTIONING AND THAT'S SOMETHING THAT'S AVAILABLE THROUGH RELAY NORTH CAROLINA AT NO LARGE-- AT NO CHARGE TO THE PERSON PRODUCING IT. IT REQUIRES TWO-DAY PRIOR NOTICE. CAN TONY CONFIRM THAT? IT'S SIMILAR TO THE SERVICE THAT WE'RE USING CART ON-SITE HERE BUT IT'S THROUGH THE PHONE AND IT CAN CONNECT TO THE WEBINAR TO PROVIDE CAPTIONING IN REALTIME.

>> OKAY. WELL, I THINK WE HAVE OF YOU IN TIME TO DO THAT BECAUSE WE'RE ABOUT A WEEK AWAY AND THEY SAID IF WE SAVE IT TO YOUTUBE THAT YOU CAN PULL UP CLOSED CAPTIONING ON UNIVERSITY. I DON'T KNOW IF THAT'S TRUE OR NOT.

>> YES.

>> EH, I WOULDN'T RECOMMEND IT AND TOVAH IS SAYING NO, NOT ALWAYS.

>> THE QUALITY OF THOSE AUTOMATIC CAPTIONS IS VERY POOR.
[LAUGHTER]

>> THANK YOU.
[APPLAUSE]
PZ

Discussion/Closing thoughts

>> WE HAVE A LITTLE BIT OF TIME FOR DISCUSSION. SO FROM WHAT FOLKS HAVE HEARD THIS AFTERNOON, DO WE HAVE PRELIMINARY IDEAS FOR RECOMMENDATIONS IN REGARD TO UNIVERSAL DESIGN OR THE APPROACHES TO RESIDENTS IN DIFFERENT KINDS OF INSTITUTIONAL SETTINGS. I'M SORRY, I KEEP DOING THAT. I'M GOING TO TRY OVER HERE. YEAH. TOVAH.

>> I'M SORRY. I KNOW I CONFUSE THE INTERPRETERS BY SWITCHING BACK AND FORTH BETWEEN SIGNING AND VOICES, I SHOULD STAY CONSISTENT. FROM MY POINT OF VIEW, I CAN'T ALWAYS KEEP THINGS TO THE MOST (INAUDIBLE) THOUGHT AND I THINK THERE ARE TWO GROUPS OF SUMMARY THAT YOU CAN THINK ABOUT FOR RECOMMENDATION. ONE IS EDUCATION AND TRAINING OUTREACH. THAT'S A WHOLE AREA RIGHT THERE. THE OTHER IS THE COMPLIANCE, YOU KNOW, COMPLYING WITH MAKING-- COMPLIANCE WITH THE CENTRALITY OF HEARING LOSS, WHICH INCLUDES EVERYTHING FROM TRAINING STAFF TO UNIVERSAL DESIGN TO ENSURING ACCESSIBILITY AND COMMUNICATION

ACCESS IN ALL PLACES THAT DEAL WITH PEOPLE WHO HAVE HEARING LOSS. I MEAN, WE'RE TALKING HERE ABOUT OLDER PEOPLE, PEOPLE OVER 65, I THINK THOSE ARE THE TWO MAJOR AREAS TO LOOK AT. I DO THINK THAT FUNDING AND FINANCING IS CRITICAL ISSUE. BUT THAT COMES UNDER COMPLIANCE, TOO, I THINK.

>> THIS IS VICKIE FROM ALLIANCE OF DISABILITY ADVOCATES AND THIS MIGHT MAKE ME UNPOPULAR WITH SOME IN THE ROOM, BUT COMPLIANCE -- IF COMPLIANCE IN AND OF ITSELF WAS THE PROPER WORD, THEN THAT HASN'T BEEN WORKING. AND SO WHAT WE HAVE, REALLY, IN NORTH CAROLINA IS VOLUNTARY COMPLIANCE. PEOPLE DO IT IF THEY HAVE SOME PERSONAL MOTIVATION FOR DOING SO OR IF THEY UNDERSTAND THE REPERCUSSIONS OF NOT DOING IT. AND I THINK THAT WE SHOULD CONSIDER RECOMMENDING FINES FOR PEOPLE. THAT COULD BE A NORTH CAROLINA STATUTE CHANGE THAT ANY LICENSED PRACTITIONER WHO FAILED TO PROVIDE REASONABLE ACCOMMODATIONS TO PEOPLE WHO ARE DEAF OR HARD OF HEARING THAT SHOULD-- AND IT'S INVESTIGATED THAT THERE BE SOME TYPE OF FINE LEVEVIED WHICH CREATES AN ACCESS POOL OF MONEY TO HIRE. NOW, THAT'S A SHORT-TERM FIX BECAUSE PERHAPS IF THERE ARE FINES THEN PEOPLE WILL START COMPLYING AND THEN THERE WON'T BE ENOUGH MONEY TO DO IT, BUT WITH ALL DUE RESPECT IN THE ROOM, THIS SHOULD COME AT NO SURPRISE TO ANY-- TO THE MEDICAL BOARD OR ANY OTHER LICENSED-- LICENSING ORGANIZATION IN THIS STATE. ADA HAS BEEN AROUND FOR A LONG TIME AND THERE IS NO EXCUSE FOR ANYONE WHO IS-GIVING PEOPLE A LICENSE TO SERVE OTHER PEOPLE FOR FAILING TO HOLD THEM ACCOUNTABLE TO MEET THE MINIMUM REQUIREMENTS OF THE LAW.

>> SO CERTAINLY FOLKS WANT TO RESPOND TO THAT. WE CAN, AND I'M KIND OF CURIOUS, HOW THAT APPLIES TO LONG-TERM CARE FACILITIES AND I THINK IT MIGHT, BUT I'M NOT SURE.

>> SO IT ALL GOES WITH THE PEOPLE WHO LEVY THE FINES AND WHETHER OR NOT THEY ACTUALLY DO IT AND COLLECT IT, BUT AT LEAST ADULT CARE HOMES DO GET FINED AND I THINK ASSISTED LIVING, I'M NOT TERRIBLY SURE OF NURSING HOMES, I DO BELIEVE THAT'S THE CASE, TOO. SO THERE IS A FINING SYSTEM, BUT I'M NOT SURE THAT IT'S CLEARLY ARTICULATED WHAT TO DO WITH THOSE FINES.

>> AND I THINK THAT ONE OF THE THINGS THAT I DON'T KNOW ENOUGH ABOUT WHAT ARE THE REQUIREMENTS UNDER ADA FOR SOMEBODY WHO IS HARD OF HEARING? SO THAT'S WHERE I'M A LITTLE--
>> ALL THEY HAVE TO DO IS HAVE A DISABILITY, HARD OF HEARING IS A DISABILITY. THEY GO IN. THEY SAY I HAVE A DISABILITY. I THINK THAT IN SOME CASES YOU MIGHT-- YOU MIGHT BE CHALLENGED TO PROVIDE DOCUMENTATION THAT YOU HAVE A HEARING LOSS OF SOME SORT. SINCE WE USUALLY LOOK AT PEOPLE WHO HAVE HEARING AIDS, THAT SEEMS TO BE DOCUMENTATION ENOUGH. AND THEN THEY SHOULD BE-- THAT SHOULD BE IT. THEY SHOULD GET THE ACCOMMODATIONS THEY NEED, PURE AND SIMPLE. IT'S NOT VOLUNTARY. IT'S THE LAW AND THE LAW IS BEING VIOLATED IN NORTH CAROLINA.

>> ANYBODY WANT TO RESPOND TO VICKIE'S RECOMMENDATION AROUND FINE FOR NORTH CAROLINA FACILITIES AND PRACTITIONERS?

>> I'LL RESPOND TO THAT. SO, WE DO HAVE THE AUTHORITY TO IMPOSE FINES. IT GOES TO THE

SCHOOL SYSTEM. SO THAT'S BY THE NORTH CAROLINA CONSTITUTION, BUT IT IS IN CERTAIN SITUATIONS BEEN VERY EFFECTIVE TO GET PEOPLE'S ATTENTION. WE ALSO, IF WE TAKE PUBLIC ACTION AGAINST SOMEBODY, THAT HAS A GENERAL SORT OF EDUCATIONAL IMPACT ON THE ENTIRE POPULATION, NOT JUST THE INDIVIDUAL PHYSICIAN. SO AGAIN, WE'RE NOT OMINICIENT. PEOPLE HAVE TO LET US KNOW IF THERE IS A CONCERN, BUT ONCE WE ARE INFORMED OF THAT, WE WILL INVESTIGATE IT. WE WILL OPEN AN INVESTIGATION. WE WILL ASK FOR A RESPONSE FROM A LICENSEE. OFTENTIMES, I WILL SAY THE PHYSICIAN ACKNOWLEDGES THAT HE OR SHE COULD HAVE DONE SOMETHING BETTER AND INDICATES A WILLINGNESS TO COMPLY GOING FORWARD, WE OFTEN WILL CLOSE THAT WITH WHAT WE CALL A PRIVATE LETTER OF CONCERN. IF WE GET REPEAT COMPLAINTS, YOU KNOW, OR IF IT'S SOMEONE WHO IS HAVING DIFFICULTY UNDERSTANDING, YOU KNOW, THEIR RESPONSIBILITY UNDER THE LAW, WE'LL RAMP UP OUR REGULATORY EFFORTS UNTIL, YOU KNOW, THEY EITHER DON'T HAVE A LICENSE, YOU KNOW, OR THEY COMPLY. SO-- BUT BACK TO THE LONG-TERM CARE ISSUE, I MEAN, I THINK THE-- WHAT I WAS REALLY SURPRISED BY IS THAT EITHER AT CMS OR WITH THE STATE REGULATIONS THERE'S NOT MORE SPECIFICITY OF WHAT IS EXPECTED AS FAR AS A SCREENING, ADEQUATE SCREENING BECAUSE IF YOU DON'T DO ADEQUATE SCREENING, YOU CAN NOT REFER THAT PERSON TO AN AUDIOLOGIST. TO ME, WHETHER IT'S GETTING EQUIPMENT, WHETHER IT'S THE TRAINING, JAN WAS TALKING ABOUT, HOWEVER WE DO IT, THAT SEEMS TO BE THE PLACE TO START. IT REMINDS ME OF THE STORY OF THE ELDERLY FELLA THAT WENT TO SEE HIS DOCTOR FOR HIS ANNUAL EXAM, AND WHEN THEY WERE DONE, THEY SAID ANY OTHER CONCERNS YOU HAVE, AND HE SAID, YEAH, MY WIFE. I THINK SHE'S SUFFERING FROM HEARING LOSS BECAUSE SHE CANNOT HEAR ANYTHING I'M SAYING. AND THE DOCTOR SAID, WELL, WHEN YOU GO HOME, STOP JUST INSIDE THE DOOR AND SAY, HONEY, I'M HOME. WHAT'S FOR DINNER? AND IF SHE RESPONDS, YOU KNOW HER HEARING IS FINE. IF SHE DOESN'T, YOU NEED TO STEP ON IN A LITTLE BIT FURTHER AND SAY, HONEY, I'M HOME, WHAT'S FOR DINNER? AND IF SHE DOESN'T RESPOND THEN, YOU NEED TO GO INTO THE KITCHEN AND SAY IT AND THAT WILL HELP YOU DETERMINE THE EXTENT, IF ANY, OF HER HEARING LOSS. HE DOES THAT. HE GOES HOME. HE STEPS IN THE FRONT DOOR. HE SAYS, HONEY, I'M HOME. WHAT'S FOR DINNER? NOTHING. HE HEARS NOTHING. OH, THIS IS NOT GOOD. HE WALKS IN A LITTLE BIT FURTHER. HONEY, I'M HOME. WHAT'S FOR DINNER? AGAIN, NOTHING. HE STEPS INTO THE KITCHEN, HONEY, I'M HOME. WHAT'S FOR DINNER? SHE SAID, FOR THE THIRD TIME, WE'RE HAVING STEAK AND POTATOES. .
[LAUGHTER]

>> I WOULD JUST LIKE TO SAY THAT THEY WILL-- THE MEDICAL BOARD WILL BE VERY RESPONSIVE BUT IT IS PRIMARILY COMPLAINT-DRIVEN, AND SO THEY REGULATE 40,000 PHYSICIANS AND PAs, BOTH IN NORTH CAROLINA AND WHO HAVE A NORTH CAROLINA LICENSE BUT ARE OUT OF STATE AND SO THERE'S A PORTAL ON THEIR WEBSITE. YOU CAN-- SOMEONE CAN CALL AND MAKE A COMPLAINT. THERE ARE MULTIPLE WAYS TO MAKE A COMPLAINT. THEY ARE REQUIRED TO INVESTIGATE EVERY COMPLAINT THEY RECEIVE AND IT CAN EVEN BE ANONYMOUS. IT DOESN'T HAVE TO BE, YOU KNOW, I ALWAYS HAVE A LITTLE BIT OF TROUBLE WITH INVESTIGATING AN ANONYMOUS COMPLAINT BECAUSE, YOU KNOW, HOW CAN'T DOCTOR EVEN KNOW WHICH PATIENT, ET CETERA, ON THAT, BUT IT CAN ABSOLUTELY BE ANONYMOUS COMPLAINT. SECOND THING, I'D LIKE TO SAY IS THE MEDICAL BOARD AND THE ACADEMY OF FAMILY PHYSICIANS, WE'RE IN THE ROOM. WE DON'T HAVE TO BE IN THE ROOM. WE'RE IN THE ROOM BECAUSE WE CARE ABOUT THE ISSUE. LONG-TERM CARE FACILITIES IN THE ROOM BECAUSE WE CARE ABOUT THE ISSUE. WIRE WILLING TO TRY TO DO SOMETHING ABOUT THE

ISSUE. YOU KNOW, MY STAFF IS FIVE PEOPLE INCLUDING ME. I HAVE MAYBE TWO-THIRDS OF AN FTE INCLUDING PART OF MY TIME THAT IS FLEXIBLE, AND I'M CHOOSING TO BE HERE AS LONG AS I'M IN TOWN. SO WE HAVE A COMMITMENT TO BE HERE AND WE HAVE A COMMITMENT TO DO SOMETHING ELSE. TO YOU ON YOUR FAMILY PHYSICIAN CME, IF YOU WANT TO REACH OUT TO FAMILY PHYSICIANS, PLEASE CALL ME. HOWEVER, I WILL TELL YOU OUR BOARD POLICY-- AND THIS IS SOMEWHAT TRUE NATIONALLY, TOO, IS IF WE'RE NOT INVOLVED IN DEVELOPING THE CME WE DON'T PROMOTE IT. SO IF YOU WANT TO DO SOMETHING FOR FAMILY PHYSICIANS, CALL US UP AND INVOLVE IT US IN IT, INVOLVE A FAMILY PHYSICIAN AND THE ACADEMY IN DEVELOPING IT AND IT MEETS OUR CRITERIA, AND JAN, TO ONE OF THE QUESTIONS YOU HAD THIS MORNING, I'LL TAKE AN EMAIL OF ANY RESOURCES THAT YOU ALL HAVE, WE DO AN EVERY OTHER WEEK ENEWSLETTER. IT'S USUALLY TWO TO THREE-SENTENCE ARTICLES WITH LINKS TO MATERIALS. SO IF I GET LINKS TO PARTICULARLY STATE-BASED MATERIALS, I CAN SEND THAT OUT. I'M ALSO WILLING TO PUT ARTICLES IN OUR MAGAZINE, USUALLY 400 TO 500-WORD ARTICLES THAT COMES OUT FOUR TIMES A YEAR AND I THINK MOST HEALTHCARE ORGANIZATIONS WOULD BE WILLING TO DO THAT. BUT THERE ARE A LOT OF PHYSICIAN GROUPS. THE MEDICAL BOARD AND THE ACADEMY OF FAMILY PHYSICIANS ARE SITTING HERE IN THE ROOM WITH YOU.

>> JAN AND THEN TOVAH AND MAYBE WE'LL GIVE IT TO ROB TO WRAP UP.

>> YOU CAN HOLD ONTO THAT, TOVAH.

>> THANK YOU.

>> THIS IS JAN SPEAKING. I WANTED TO RESPOND TO VICKIE'S IDEA. I THINK THAT'S MAYBE A GREAT FOR INDIVIDUAL HEALTHCARE PROVIDERS, BUT WHAT ABOUT HEALTHCARE SYSTEMS, LIKE LARGE HOSPITALS, AND HOW DO WE HOLD THE HOSPITALS ACCOUNTABLE AND SOMETHING LIKE THAT? THAT'S SOMETHING ELSE TO CONSIDER, INDIVIDUAL PROVIDERS VERSUS THE SYSTEMS. SOMETHING THAT WE ALWAYS SAY IS THAT THE GOAL OF COMMUNICATION ACCESS IS SIMPLE. THAT TWO PEOPLE UNDERSTAND EACH OTHER CLEARLY. COMMUNICATION MOVES BOTH WAYS. HOW YOU ACHIEVE THAT IS PRETTY COMPLICATED. SO WHATEVER ENFORCEMENT METHODS THAT WE ARE ABLE TO COME UP WITH, WE NEED TO MAKE SURE WE INCLUDE REQUIREMENTS FOR TRAINING AS A PART OF THOSE. I MEAN, IT'S SOME SORT OF RAMP THAT LEADS PEOPLE TO UNDERSTANDING. AND UNDERSTANDING THE DIFFERENT OPTION OF COMMUNICATION ACCOMMODATIONS. AND UNDERSTANDING HOW TO FIND THE BEST FIT FOR AN INDIVIDUAL NEED. AND IF THAT PERSON ISN'T GOOD AT SELF-ADVOCATING, AND YOU'VE ALREADY HEARD THAT MANY PEOPLE THAT HAVE HEARING LOSS ARE NOT GOOD AT ADVOCATING FOR THEIR OWN NEEDS. SO HOW CAN WE KNOW WHAT THOSE OPTIONS ARE TO HELP THEM DO THAT? ALSO, WHEN WE'RE CONSIDERING FUNDING, WE NEED TO THINK ABOUT WORKAROUNDS. EVERYTHING COMES BACK TO SERVING THE GOAL OF EFFECTIVE COMMUNICATION. HOWEVER WE DO THAT, WHICH INCLUDES TRAINING AS WELL AS PAYING FOR THOSE ACCOMMODATIONS ULTIMATELY. REGARDING INVESTIGATIONS, IF YOU ARE DEALING WITH A, SAY, CULTURALLY DEAF PERSON, IT HELPS TO UNDERSTAND THERE ARE SOME CULTURAL ISSUES INVOLVED AS WELL. IF YOU ATTEMPT TO INVESTIGATE A SITUATION WITH THE UNDERSTANDING ONLY OF YOUR OWN CULTURE, YOU MAY MISS IMPORTANT INFORMATION FROM A CULTURALLY DEAF PERSON'S PERSPECTIVE. SO THAT'S ALSO SOMETHING TO THINK ABOUT WITH INVESTIGATIONS AND OUR

DIVISION IS HAPPY TO WORK WITH ANYONE ON ADDRESSING ANY OF THOSE ISSUES, HOWEVER WE CAN.

>> TOVAH HERE. BUT I DO THINK THAT AT SOME POINT, WE WILL HAVE TO FACE THE ISSUE OF FINANCING ALL OF THESE THINGS. IT'S WELL AND GOOD TO HAVE CMPs. IT'S WELL AND GOOD TO HAVE BIG POTS OF MONEY AROUND THE STATE FOR DOING DIFFERENT THINGS LIKE BUILDING OR REFURBISHING NURSING HOMES AND HOSPITALS AND STUFF LIKE THAT. I DO THINK AT SOME POINT WE WILL HAVE TO FACE THE ISSUE OF INSURANCE COVERAGE FOR A VARIETY OF THINGS BETTER OR MORE INSURANCE COVERAGE FOR HEARING LOSS, FOR LONG-TERM CARE, FOR PERSONAL AND IN-HOME HEALTHCARE. I THINK WE'RE GOING TO HAVE TO FACE THAT ISSUE AT SOME POINT, AND YOU KNOW, ADDRESS BETTER INSURANCE POLICIES OR BETTER INSURANCE COVERAGE OR FUNDING. MEDICARE HAS VERY LIMITED INSURANCE FOR HEARING AIDS. MEDICAID IS MUCH MORE SUPPORTIVE IN TERMS OF FUNDING AND EVEN THERE, IT'S NOT QUITE ADEQUATE BUT IT'S EASIER TO GET IT THROUGH MEDICAID THAN THROUGH MEDICARE. I DO THINK THAT WE WILL HAVE TO FACE THAT MUSIC SOME DAY AND AT THE STATE AND/OR FEDERAL LEVEL.

>> SURE. AS LONG AS IT'S QUICK. LET ME BRING YOU THE MICROPHONE.

>> SO RON TODAY OWEN WITH DIVISION OF HEALTH BENEFITS AND I SO APPRECIATE WHAT DAVID WAS SAYING ABOUT THE LEGISLATURE AND ABOUT DATA, BUT I ALSO APPRECIATE WHAT MANY PEOPLE HAVE SAID THAT THIS HAS BEEN GOING ON FOR 30 YEARS SO AS WE MOVE FORWARD, I'M JUST THINKING ABOUT CONSIDERING MAYBE BOTH SCHOOLS OF THOUGHT. WE COULD WAIT UNTIL WE HAD ADDITIONAL DATA AND THEN GO FORWARD TO THE LEGISLATURE, OR WE COULD GO WITH SOUNDS LIKE GOOD, SOLID DATA THAT WE HAVE NOW ABOUT SOME DIFFERENT SCENARIOS AND APPROACH THEM ABOUT WHATEVER PLAN WE COME UP WITH, IF IT'S AN ABILITY TO FINE GROUPS TO PUT THAT IN THE POT OF MONEY THAT MIGHT COME FROM LICENSURE INCREASES. IF WE GO WITH THE DIRECTION OF LICENSURE INCREASES, I WOULD LIKE TO SEE THAT BE EVERY MEDICAL PROFESSIONAL THAT MAY ENCOUNTER A DEAF OR HARD OF HEARING OR DEAF-BLIND PATIENT. NOT JUST A PARTICULAR GROUP. WITH THE INSURANCE COMPANIES THAT SOMEHOW FEELS LIKE WAY OVER MY HEAD, SO I DON'T KNOW WHAT TO SAY ABOUT THAT WITH ALL OF THE LAWS AND REQUIREMENTS THAT MIGHT BE INVOLVED. BUT AS MEDICAL PROFESSIONALS, THERE BEING MAYBE AN ACROSS-THE-BOARD INCREASE OR TAX OR LEVY OR SOMETHING THAT WOULD CREATE THAT INITIAL POT OF MONEY TO WORK FROM THAT WOULD BE MANAGED BY DIVISION OF DEAF AND HARD OF HEARING SERVICES FOR DEAF AND HARD OF HEARING AND THEN IF WE CONSIDERED SOME TYPE OF FINE AND THAT MONEY WOULD GO INTO THAT POT AS WELL. BUT I'M A LITTLE HESITANT TO WAIT BECAUSE IF WE GO TO THE REGULATURE AND THEY SAY, OH, WE NEED MORE DATA, AT LEAST WE STARTED A PROCESS. THEY MAY ASK FOR A LEGISLATIVE STUDY THAT GIVES A GREATER PLATFORM, OR MAYBE THERE MIGHT BE PEOPLE AT THE TABLE WHO WOULD JUST GO, YOU KNOW, THIS HAS BEEN NEEDED FOR A LONG TIME AND LET'S MOVE THIS FORWARD. I DON'T KNOW THAT WE HAVE ANYTHING TO LOSE BY MOVING SOMETHING FORWARD AND STARTING THE PROCESS WITH CHANGE.

>> THANK YOU FOR EVERYBODY'S PARTICIPATION TODAY. YOUR WISDOM AND I THINK YOU'VE GIVEN US A LOT TO THINK ABOUT. CLEARLY, WE'RE NOT ALL IN AGREEMENT ABOUT EVERYTHING THAT WE TALKED ABOUT TODAY. THAT'S OKAY. WE HAVE A COUPLE OF MORE MEETINGS TO MOVE IN THAT

DIRECTION AND SEE WHAT THE STEERING COMMITTEE CAN COME UP WITH TO BRING BACK TO THE TASK FORCE. ROB WILL REMIND US OF NEXT STEPS

>

> ON THAT NOTE, I WANT TO ENCOURAGE EVERYONE IF YOU DO HAVE COMMENTS OR RECOMMENDATIONS THAT YOU WANT TO SHARE, IF YOU WANT TO MAKE THEM ANONYMOUS, I ENCOURAGE THE FEEDBACK TO ME BECAUSE WE FORM THESE AND MAKE THESE FROM WHAT WE HEAR IN THE ROOM AND WE GO OVER THE TRANSCRIPTS AND EVERYTHING WE'VE HEARD. SO I THINK THAT THE MORE EMAILS WE GET AND THE MORE WE CAN SIFT THROUGH, THAT'S HOW WE CAN GET TO WHERE I THINK WE ALL WANT TO BE. AND JAN MENTIONED THIS, BUT WE DID ADD A SEVENTH MEETING AND WE CAN CONFIRM ON SEPTEMBER 24th. THAT'S GOING TO BE A TUESDAY. JAMES IS GOING TO SEND OUT THOSE CALENDAR INVITES EITHER TODAY OR TOMORROW, BUT YOU GUYS WILL GET THOSE CALENDAR INVITES AS WELL, AND THEN THE FINAL THING IS IF EVERYONE CAN PLEASE LEAVE YOUR NAME TAGS, WE'LL COLLECT THOSE FOR YOU AND THANK YOU EVERYONE FOR TODAY AND YOUR PARTICIPATION.