NCIOM Task Force on Health Services for Individuals who are Deaf and Hard of Hearing

7/19/2019 – Task Force Meeting 5

Meeting agenda can be found HERE

A summary of the meeting can be found HERE

Meeting Five Transcript

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Introductions

[GAVEL BANGING]
>> GOOD MORNING, EVERYONE. WE'RE GOING TO GO AHEAD AND GET STARTED. SO ON BEHALF OF DAVID AND ADAM, I WANT TO WELCOME YOU ALL TO OUR AUGUST MEETING. HEY, FOLKS.
>> WE'RE STARTING THE MEETING. GOOD MORNING.
>> I WANTED TO THANK YOU FOR BEING HERE TODAY AND CERTAINLY WHEN YOU LOOK AT WHAT IS FORECASTED TEMPERATURE-WISE, I THINK WE PROBABLY ARE ALL FAIRLY GRATEFUL TO BE INSIDE. WE'VE GOT A GREAT AGENDA TODAY WITH A LOT OF REALLY IMPORTANT TOPICS, BUT BEFORE WE SORT OF OFFICIALLY KICK THINGS OFF, IT'S PROBABLY GOOD TO REMIND FOLKS OF SOME OF OUR SORT OF COMMUNICATION RULES THAT, FIRST IS IF WE WANT TO BE RECOGNIZED, PLEASE RAISE YOUR HAND. WAIT FOR THE FACILITATOR TO RECOGNIZE YOU AND MOST IMPORTANTLY, AS YOU BEGIN SORT OF YOUR COMMENTS OR QUESTIONS, MAKE SURE THAT YOU IDENTIFY YOURSELF AS FOR THE BENEFIT OF THE FOLKS WHO ARE NOT ONLY HERE BUT ESPECIALLY FOR FOLKS THAT ARE ON THE PHONE. LOOKING FORWARD TO A GREAT MEETING AND AGAIN THANK YOU FOR BEING HERE.
>> WE'LL GO THIS WAY. GOOD MORNING. WELCOME. ADAM ZOLOTOR. THIS DEVICE, WE USUALLY USE ONE WITH A LANIARD THAT YOU ARE SPEAKING IN THE BOTTOM OF, BUT YOU WANT TO HOLD THIS UPSIDE DOWN TO BE MOST EFFECTIVE AND WE WILL PASS THIS AROUND TO EVERYBODY IS ABLE TO HEAR. I WAS GOING TO GO THIS WAY AND END WITH DAVID WHO IS GOING TO KICK US OFF. HOW ABOUT THAT? DOES THAT WORK FOR YOU?
>> YEAH. GOOD MORNING, EVERYONE. ROB KURZYDLOWSKI, I'M THE PRODUCT DIRECTOR HERE AT THE

INSTITUTE OF MEDICINE.
>> HEY, GOOD MORNING. I'M KATHY SMITH. I'M WITH THE ASSOCIATION FOR HOME AND HOSPICE CARE OF NORTH CAROLINA.
>> GOOD MORNING, EVERYBODY. I'M JAN WITHERS. I'M THE DIRECTOR OF THE DIVISION OF SERVICE FOR THE DEAF AND HARD OF HEARING.
>> GOOD MORNING. I'M EILEEN CARTER AND I REPRESENT THE NORTH CAROLINA PT ASSOCIATION.
>> I'M A PETE YAT TRICK OTOLARYNGOLOGIES AT DUKE.
>> GOOD MORNING. I'M SHELLEY CRISTOBAL BALL. I'M AN AUDIOLOGIST WORKING PRIMARILY WITH ADULTS WHO LOST HEARING OVER TIME.
>> HELLO. I'M LEE WILLIAMSON, COMMUNICATION ACCESS MANAGER WITH THE DIVISION OF SERVICE FOR THE DEAF AND THE HARD OF HEARING.
>> HI. GOOD MORNING. THIS IS ASHLEY BENTON. I'M THE DEAF AND DEAF/BLIND SERVICE COORDINATOR WITH THE DIVISION OF SERVICES FOR THE DEAF AND HARD OF HEARING. I WORK WITH THE DEAF/BLIND COMMUNITY.
>> GOOD MORNING. I'M DONNA NICHOLSON AND I'M THE VICE PRESIDENT OF RISK MANAGE WITH CURY, A MEDICAL MUTUAL COMPANY.
>> GOOD MORNING. I'M RONDA OWEN AND I WORK WITH NORTH CAROLINA DIVISION OF HEALTH BENEFITS, NORTH CAROLINA MEDICAID.
>> GOOD MORNING. MY NAME IS TONY DAVIS, AND HARD OF HEARING SERVICES COORDINATOR WITH THE DIVISION OF SERVICES FOR THE DEAF AND HARD OF HEARING.
>> GOOD MORNING. I'M JULIE BISHOP. I'M WITH HEARING LOSS ASSOCIATION OF AMERICA, NORTH CAROLINA SECTION.
>> GOOD MORNING. STEVE BARBER FROM HEARING LOSS ASSOCIATION AMERICA, WAKE CHAPTER.
>> AND I'M LISE HAMLIN. I DON'T KNOW WHICH WAY TO FACE HERE. I'M THE DIRECTOR OF PUBLIC POLICY AT HEARING LOSS ASSOCIATION OF AMERICA AND IN BETHESDA, MARYLAND.
>> GOOD MORNING. MY NAME IS BETH HATHAWAY AND I'M THE PRESIDENT OF THE NORTH CAROLINA OCCUPATIONAL THERAPY ASSOCIATION.
>> HELLO, EVERYONE. THIS IS BRAD TROTTER. I'M WITH THE DIVISION OF MENTAL HEALTH.
>> GOOD MORNING. I'M JOHNNY SEXTON, THE EXECUTIVE DIRECTOR OF THE CARE PROJECT.
>> GOOD MORNING. I'M JAMES COLEMAN. I'M A RESEARCH ASSISTANT AT THE NORTH CAROLINA INSTITUTE OF MEDICINE.
>> GOOD MORNING, EVERYONE. MY NAME IS ANDREW AND I WORK IN THE HEALTH POLICY OFFICE AT BLUE CROSS NORTH CAROLINA.
>> I'M BERKELEY AND I'M THE ASSOCIATE DIRECTOR OF THE NORTH CAROLINA INSTITUTE OF MEDICINE.
>> I'M JENNIFER GILL, DIRECTOR OF COMMUNICATIONS FOR LEADING AGE NORTH CAROLINA.
>> I'M VICKIE SMITH, EXECUTIVE DIRECTOR OF ALLIANCE OF DISABILITY ADVOCATES.
>> HI, I'M CAL CUNNINGHAM. I'M AN OTOLARYNGOLOGIES AT DUKE UNIVERSITY.
>> HI. THIS IS TOVAH WAX. I'M THE CHAIR OF THE COUNCIL ON SERVICES FOR THE DEAF AND HARD OF HEARING AND WORKING WITH THE DIVISION OF SERVICES FOR THE DEAF AND HARD OF HEARING. ALSO I'M A CONTRACT WORKER ALSO WITH THE DIVISION OF SERVICES FOR DEAF AND HARD OF HEARING AND I WORK ON HEALTH ACCESS FOR THE ELDERLY. BUT FROM HERE ON IN I'LL BE USING MY VOICE.
>> HI. I'M HANK BOWERS, ASSISTANT DIRECTOR WITH THE DIVISION OF AGING AND ADULT SERVICES.
>> ASK FOR PEOPLE ON THE PHONE AND INTRODUCE YOURSELF .
>> HI, GOOD MORNING. THIS IS DAVID ROSENTHAL HERE AND I'M THE CO-CHAIR WITH MARK BENTON

WITH THIS TASK FORCE. WELCOME, EVERYONE. GOOD MORNING. AND I THINK WE'RE GOING TO TURN IT OVER TO THE PEOPLE ON THE PHONE BEFORE WE ACTUALLY BEGIN.
>> GOOD MORNING, MELISSA, HEALTH POLICY OFFICE FOR BLUE CROSS.
>> GOOD MORNING. PAMELA LLOYD OGOKE IS HERE. SHE'S THE CHIEF OF THE COMMUNITY INTEGRATED SERVICES SUPPORT FOR THE DIVISION OF THE OFFICE.
>> HELLO.
THIS IS ALICIA SPENCER, DIRECTOR OF HANDS AND VOICES AND MOM OF TWO DEAF BOYS.
>> HI.
THIS IS CORYE DUNN WITH DISABILITY RIGHTS NORTH CAROLINA, PROTECTION AND ADVOCACY AGENCY.
>> THIS IS SAM CLARK WITH THE NORTH CAROLINA HEALTHCARE FACILITIES ASSOCIATION.
>> THIS IS CANDY DOUGLAS WITH COMMUNICATION SERVICES FOR DEAF AND HARD OF HEARING IN GREENSBORO.
>> DO WE HAVE ANYBODY ELSE ON THE PHONE? GREAT. WELL, THANK YOU ALL FOR JOINING US BY PHONE AND IN PERSON. AND I WILL LET DAVID GET US STARTED.

Task Force Meeting Four Debrief

>> GOOD MORNING, EVERYONE. THIS IS DAVID SPEAKING. BEFORE I START, WE WANT TO EXPRESS OUR GRATITUDE FOR YOUR PARTICIPATION IN THIS TASK FORCE AND WHAT YOU'VE DONE ALL ALONG IN THIS EFFORT. FOR SOME OF US, THIS HAS BEEN A VERY LONG, HARD ROAD, TO BE ABLE TO GET TO THIS POINT WHERE WE CAN ALL COME TOGETHER AND EVEN COME TOGETHER AROUND THE TABLE TO DISCUSS THE ISSUES THAT WE'RE DISCUSSING AND THE DISCUSSIONS CAN BE EMOTIONAL AT TIMES. CHANGE TAKES TIME AND ENERGY. SOMETIMES GETTING TO THE SOLUTIONS REQUIRES GOING THROUGH TRYING TIMES, LET'S SAY. BASICALLY, ANYTIME YOU'RE WORKING TOWARD A SOLUTION, IT TAKES A LOT OF EFFORT TO BE ABLE TO TALK WITH EACH OTHER, TO MAKE SURE THAT WE ALL UNDERSTAND WHERE EVERYONE IS COMING FROM. SOMETIMES THOSE DISCUSSIONS HAVE TO BE VERY FRANK AND HONEST, BUT IT'S A HEALTHY PROCESS TO GO THROUGH. SOLUTIONS MAY NOT BE WHAT WE WANT EXACTLY. SOMETIMES THE TIMING IS NOT THE RIGHT TIME. TIMING IS NOT PERFECT. WE DO HAVE TO REMEMBER THAT THIS IS A VERY LONG PROCESS AND AS JAN LIKES TO SAY, THIS IS THE LONG GAME. THE PROCESS, ITSELF, MAY NOT ALWAYS BE SMOOTH, AND THERE'S A SAYING THAT I'VE HEARD SINCE I WAS IN COLLEGE AND THAT IS, NOTHING GOOD HAPPENS FAST. RIGHT? SO IT'S GOOD TO REMEMBER THAT. WE'VE COME A LONG WAY ALREADY IN THE TIME THAT WE'VE SPENT TOGETHER. WE ARE MORE ADVANCED THAN OTHER STATES, THAN ANY OTHER STATE IN THIS EFFORT WITH ALL OF THE DISCUSSIONS THAT WE'VE HAD SO FAR AND TO HAVE GOTTEN AS FAR AS WE'VE GOTTEN WITH ALL OF THE DIFFERENT IDEAS AND ALL OF THE DIFFERENT RECOMMENDATIONS AND ALL THE DIFFERENT POSSIBLE SOLUTIONS FOR ALL OF THE ISSUES THAT WE'RE DISCUSSING. SO WE ALL HAVE A RIGHT TO BE PROUD OF THAT. AS WE NEAR THE END OF THIS TASK FORCE PROCESS AND THE WORK THAT WE ARE DOING, THE WORK WILL CONTINUE. WHAT WE START HERE TOGETHER AS A TASK FORCE WITH ALL OF THE DISCUSSIONS AND THE IDEAS AND THE RECOMMENDATIONS, THIS WORK WILL BE CARRIED FORWARD AFTER WE CONCLUDE OUR BUSINESS HERE AND WE WILL CONTINUE TO WORK ON THESE ISSUES. EVERY ONE OF YOU IS VALUED. YOUR PERSPECTIVES, YOUR OPINIONS ARE ALL VALUED . YOUR OPINIONS, YOUR IDEAS AND RECOMMENDATIONS ARE VALUED, THEY'RE VALID, AND WE APPRECIATE THEM. AND YOUR PARTICIPATION, FROM EACH AND EVERY ONE OF YOU, VERY IMPORTANT IN THIS

PROCESS. WE CAN DO A LOT MORE TOGETHER THAN WE COULD HAVE EVER DONE INDIVIDUALLY. INDIVIDUALLY, WE CANNOT TACKLE THIS ISSUE. WITH ALL OF US COMING TOGETHER, THIS MAKES US STRONGER. IT HELPS US ALL UNDERSTAND EACH OTHER'S PERSPECTIVE, AND SO THAT CAN HELP US GET TO A POINT WHERE WE CAN ALL WORK TOGETHER TOWARD SOLUTIONS. AND WE ARE SO THANKFUL FOR ALL OF YOU BEING HERE. WE WOULD NOT BE HERE WITHOUT YOU. SO THANK YOU.
>> THANK YOU, DAVID. I'LL JUST ECHO EVERYTHING THAT DAVID SAID. I THINK IT'S REALLY WISE AND JUST ADD TWO THOUGHTS.
>> ADAM, USE THE MIC.
>> OH, THANK YOU. JUST TO ECHO WHAT DAVID SAID AND ADD A FEW THOUGHTS. I REALLY APPRECIATE THE TIME AND ENERGY AND WISDOM THAT EVERYBODY'S CONTRIBUTED. I CAN'T SAY OVER AND OVER AGAIN HOW MUCH I'VE LEARNED THROUGH THIS PROCESS AND HOW MUCH WE'VE MOVE FORWARD THROUGH LISTENING TO ONE ANOTHER, WHICH I THINK ONE OF THE MOST IMPORTANT PARTS OF THIS PROCESS. I THINK THAT ONE OF THE THINGS IN TERMS OF PERSPECTIVE AS WE START TO MOVE TOWARD THE CONCLUSION OF OUR TASK FORCE IS THAT OFTEN THE BEST RECOMMENDATIONS THAT COME OUT OF OUR WORK AND THE THINGS THAT WE CAN ACTUALLY ADVANCE AFTER OUR TASK FORCE HAS CONCLUDED ARE THINGS THAT REPRESENT COMPROMISE, THINGS WHERE EVERYBODY GETS SOMETHING BUT EVERYBODY GIVES UP MAYBE SOME OF WHAT THEY WANTED. SO I THINK IT'S IMPORTANT TO OWN THAT SOME OF US HAVE REALLY GOOD IDEAS BUT THEY MAY NOT BE READY AND THEY MAY NOT BE THINGS THAT WE ALL AGREE ON, BUT WE'RE GOING TO LOOK FOR THE PLACES THAT WE CAN FIND AGREEMENT TO MOVE SOME OF THE CHALLENGES FOR HEALTHCARE ACCESS FOR THE DEAF AND HARD OF HEARING POPULATION FORWARD. I LOOK FORWARD TO CONTINUING THIS PROCESS WITH YOU ALL. AGAIN, I THINK THAT LISTENING TO ONE ANOTHER IS ONE OF THE MOST IMPORTANT THINGS THAT WE CAN DO AND THE OTHER THING THAT I WANTED TO FRAME FOR YOU ALL IS WE'RE MOVING TOWARD WRAPPING UP OUR TASK FORCES, THAT WE'RE TRYING TO MOVE TOWARD DIGGING INTO SOME TOPICS THAT WE'VE DISCUSSED AND TRYING TO AVOID INTRODUCING NEW AREAS BECAUSE WE DO KNOW THAT WE HAVE LIMITED TIME TOGETHER AND YOU HAVEN'T PROMISED US TO SPEND TWO YEARS ON THIS TASK FORCE. YOU KNOW, THE STEERING COMMITTEE AND STAFF WANT TO CONTINUE TO LISTEN TO YOUR IDEAS, BUT WE MAY BE LIMITING THE AMOUNT OF TIME THAT WE HAVE TO INTRODUCE NEW TOPICS AT THIS POINT. AGAIN, THANK YOU FOR YOUR TIME AND YOUR ENERGY AND YOUR WISDOM.
>> I WANT TO SAY TWO THINGS. BEFORE WE GET STARTED WITH THE PRESENTATION TODAY. I WANT TO SAY TWO THINGS. FOR THE DISCUSSION QUESTIONS YOU HAVE TODAY, THESE ARE REALLY TO GET TO A POINT TO WHERE WE CAN WRITE THE DRAFT RECOMMENDATIONS THAT YOU SAW FOR THE OTHER TOPICS FOR THESE LONG-TERM CARE TOPICS AND OTHER TOPICS AND OUR NEXT MEETING WILL REALLY FOCUS A LOT ON GOING THROUGH ALL OF OUR RECOMMENDATIONS. WE'RE GOING TO GO BACK TO THE OTHER RECOMMENDATIONS BUT THEN WE'RE GOING TO HAVE ONES FORMULATED FROM THESE TOPICS AND WE'RE GOING TO GO THROUGH ALL OF THAT AND THIS NEXT MEETING WILL BE A VERY IMPORTANT ONE TO ATTEND AND FINALLY, I WANT TO SAY OUR CART DISPLAY, WE INCLUDED A LINK UP HERE BUT THERE'S A HANDOUT AS WELL AROUND THE ROOM THAT IF YOU WOULD LIKE IT ON YOUR DEVICE YOU'RE USING TODAY, AND EVEN YOUR SMART PHONE, YOU CAN TYPE IN THAT LINK AND THE CART WRITING WILL COME UP ON YOUR DEVICE. OKAY. SO TODAY, WE CAN GET THE MEETING STARTED. TONY, I BELIEVE, IS OUR FIRST PRESENTER TODAY AND HE IS GOING TO COME UP AND SPEAK WITH US ABOUT ACCOMMODATIONS FOR HARD OF HEARING RESIDENTS IN LONG-TERM CARE. AND ALSO I JUST WANTED TO MAKE SURE IS EVERYONE COMFORTABLE IN THEIR

SEAT AND CAN SEE THE CART AND INTERPRETER? ANY CHANGES THAT NEED TO BE MADE ? IT LOOKS LIKE WE HAVE A LOWER ATTENDANCE SPACE AND IF YOU SEE SEATS THAT ARE OPEN, FEEL FREE TO MOVE. TONY, DO YOU WANT TO GET STARTED?

Accommodations for Hard of Hearing Residents in Long Term Care

>> GOOD MORNING, EVERYONE. I'M REALLY HAPPY AND EXCITED TO BE HERE TO TALK TO YOU-- SORRY. I'M GOING TO MOVE OVER. WHERE WOULD BE THE BEST PLACE.
>> STAND HERE AND I'LL MOVE OUT OF YOUR WAY.
>> OKAY. SO GOOD MORNING, EVERYONE. I'M REALLY EXCITED AND HAPPY TO BE HERE TO TALK TO YOU ABOUT SOME ACCOMMODATIONS IN LONG-TERM CARE SETTINGS. I'M REALLY GOING TO JUST TALK ABOUT THREE SPECIFIC TYPES OF ACCOMMODATIONS IN LONG-TERM CARE SETTINGS. THE FUNDING FOR EACH, HOW THEY'RE PRESENTLY FUNTED AND I'M GOING TO GIVE YOU SOME DIFFERENT RECOMMENDATIONS ON WHAT WE COULD DO TO IMPROVE ACCOMMODATIONS IN LONG-TERM CARE SETTINGS. FIRST OF ALL, WE'RE GOING TO TALK ABOUT HEARING AIDS JUST A BIT. I DO RECOGNIZE THAT--WELL, MANY PEOPLE IN THIS ROOM ARE SPECIALISTS. WE HAVE DOCTORS, SURGEONS, WE HAVE AUDIOLOGISTS. THEY KNOW MORE ABOUT HEARING AIDS THAN I DO. I PROMISE YOU, AND SO MY GOAL IS NOT TO TRY TO TEACH THEM MORE BUT MY GOAL IS JUST HELP EVERYONE TO UNDERSTAND HOW VALUABLE HEARING AIDS, PERSONAL AMPLIFIERS AND LARGE AREA SYSTEMS ARE IN THESE LONG-TERM CARE SETTINGS AND I WILL TALK ABOUT MEDICAL SETTINGS AS WELL BUT MORE FOCUSED ON LONG-TERM CARE SETTINGS. AND THEN WE'RE GOING TO TALK FIRST ABOUT HEARING AIDS. SO, HEARING AIDS ARE NOT THE SAME NOW AS THEY WERE 20 YEARS AGO, 15 YEARS AGO, 10 YEARS AGO, 5 YEARS AGO, EVEN A FEW MONTHS AGO. HEARING AIDS-- THE TECHNOLOGY IN HEARING AIDS ARE GROWING LEAPS AND BOUNDS, AND THEY CAN DO SO MANY DIFFERENT THINGS. JUST THIS LAST YEAR, WE HAD THE VERY FIRST HEARING AID THAT CAME OUT THAT COULD ACTUALLY START TO UNDERSTAND OR DETECT FALLS AND THAT'S SIGNIFICANT. SO HEARING AIDS ARE BECOMING WEARABLES. YOU CAN ACTUALLY WALK INTO CERTAIN SETTINGS LIKE A CONFERENCE ROOM OR A CERTAIN ROOM AND HAVE A LITTLE PIECE OF TECHNOLOGY UP ON THE WALL AND THAT CAN LET YOUR HEARING AID TO KNOW TO CHANGE ITS PROGRAM SO YOU KNOW BETTER IN THAT SITUATION. HEARING AIDS CAN DO A LOT FOR PEOPLE BUT WE KNOW THAT ONLY 16 TO 20% OF PEOPLE WHO WOULD BENEFIT FROM A HEARING AID ACTUALLY DO WEAR A HEARING AID OR HAVE A HEARING AID, FOR THAT MATTER. MANY PEOPLE IN THE LONG-TERM CARE SETTINGS ARE RESISTANT TO HEARING AIDS. AND THERE'S SEVERAL REASONS. IT MAY BE THAT THEY HAD HEARING AIDS A WHILE BACK AND THEIR EXPERIENCE WAS NOT GOOD AND IT MAY BE THAT WHOEVER WAS HELP THEM TO ADJUST TO THAT HEARING AID DIDN'T DO SO WELL. IT MAY BE THAT THEY DIDN'T GO BACK AND HAVE IT ADJUSTED WHEN THEY NEEDED TO AND THEIR HEARING GOT WORSE AND IT WASN'T HELPING AS MUCH. IT MAY BE THAT THE BATTERIES WERE NOT CHANGED OFTEN ENOUGH AND SO IT WASN'T ALWAYS WORKING. BUT FOR MANY PEOPLE WHAT HAPPENS IS THEY ENDED UP THROWING THEIR HEARING AIDS IN THEIR DRESSER DRAWERS OR PUTTING IT ON THE NIGHTSTAND AND SO FORTH AND NOT USING IT. WHAT THEY DON'T KNOW IS THAT HEARING AIDS ARE SO AMAZING NOW AND THEY COULD REALLY HELP THEM, AND SO I'LL TALK A LITTLE BIT MORE ABOUT PERSONAL AMPLIFIERS LATER BECAUSE SOME PEOPLE JUST WON'T ACCEPT USING HEARING AIDS, AND WE KNOW FOR A FACT THAT THEY'RE NOT WILLING TO USE HEARING AIDS. BUT WE WOULD REALLY LIKE TO SEE MORE PEOPLE IN THESE SETTINGS

GET HEARING AIDS. IT HELPS WITH PARTICIPATION IN ACTIVITIES. THE ONE THING WE DON'T WANT TO SEE IS HAVING PEOPLE GO TO THEIR ROOM AND STAYING IN THEIR ROOMS, AID VOING THE ACTIVITIES, JUST WATCHING TV, NOT EVEN BEING ABLE TO UNDERSTAND THE TV, JUST ISOLATING THEMSELVES AND UNFORTUNATELY, FOR PEOPLE WITH HEARING LOSS, ESPECIALLY OUR OLDER PERSONS WITH HEARING LOSS, THIS OFTEN HAPPENS IN THESE LONG-TERM CARE SETTINGS. WHAT HAPPENS IS PEOPLE SELF-ISOLATE. THEY DON'T PARTICIPATE IN ACTIVITIES. THEY DON'T PARTICIPATE IN MEALTIMES WITH OTHER PEOPLE. THEY DON'T PARTICIPATE IN THEIR OWN CARE PLANNING AND WHAT I MEAN BY THAT IS OFTENTIMES THE FAMILIES AND THE NURSING DIRECTORS AND THE SOCIAL WORKERS AND THE ADMINISTRATORS ARE MAKING DECISIONS FOR THESE PEOPLE IN THESE LONG-TERM CARE SETTINGS, THESE RESIDENTS BECAUSE THE RESIDENTS CAN'T HEAR ENOUGH TO PARTICIPATE. SO THAT'S AN ISSUE. WE ALSO SEE THAT PEOPLE AREN'T ABLE TO COMMUNICATE WITH THEIR PHYSICIANS AS WELL OR EVEN THE NURSES WHO ARE DOING ASSESSMENTS OR WORKING WITH THEM ON A DAILY BASIS. SO HEARING AIDS WOULD HELP THAT . WE KNOW THAT THERE'S A CORRELATION BETWEEN UNTREATED HEARING LOSS AND TO ME THAT MEANS HEARING AIDS ARE NOT DOING SOMETHING ABOUT THE HEARING LOSS, AND FALLS, DEMENTIA AND A LOT OF OTHER HEALTH IMPLICATIONS AS WELL. . SO, FIRST OF ALL, FUNDING FOR HEARING AIDS. THIS IS AN ISSUE FOR PEOPLE IN LONG-TERM CARE SETTINGS AND OTHERS AS WELL. MEDICARE DOES NOT COVER HEARING AIDS. IT DOESN'T. AND THERE'S A LOT OF REASONS BEHIND THAT AND WE COULD ACTUALLY-- WE HAVE THE DIRECTOR OF POLICY FROM HLAA HERE AND SHE CAN PROBABLY GIVE A WHOLE-DAY PRESENTATION JUST ON THAT REASON ALONE. SO WE WON'T DIVE INTO IT, BUT MEDICARE DOES NOT COVER HEARING AIDS. THERE ARE SOME MEDICARE SUPPLEMENTAL PLANS. I KNOW THAT UNITED HEALTHCARE PLAN, FOR EXAMPLE HERE, WILL COVER ONE HEARING AID. NOW THERE'S A CAP LIMIT ON THAT, AND WHAT I'VE HEARD ALSO IS THAT EVEN WITH THESE SUPPLEMENTAL OR ADVANTAGE PLANS WE VERY TO BE REALLY CAREFUL BECAUSE PERHAPS A HEARING AID PROVIDER WILL SAY, IF YOU SWITCH TO THIS PLAN, WE'LL BE ABLE-- WE'LL BE ABLE TO GET YOU ONE HEARING AID, BUT WHEN THEY SWITCH TO THE PLAN, MAYBE THE PLAN DOESN'T COVER OTHER ESSENTIAL THINGS THAT THEY NEED, LIKE DIABETES CARE AND SO FORTH. SO PEOPLE NEED TO BE REALLY CAREFUL HAD THEY SWITCH TO THESE ADVANTAGE PLANS. MEDICAID IN NORTH CAROLINA, HEARING AIDS ARE NOT COVERED FOR ADULTS. THEY ARE COVERED FOR CHILDREN. I WAS JUST TOLD LAST WEEK THAT LAST YEAR ALONE, 900,000 WAS SPENT ON CHILDREN, 5 TO 600 DIFFERENT BENEFICIARIES. SO THAT'S WONDERFUL BUT WE ALSO NEED OUR ADULTS COVERED. TWENTY-FIVE STATES COVER HEARING AIDS UNDER MEDICAID IN ONE WAY OR ANOTHER. SOMETIMES IT'S ONLY ONE HEARING AID. SOMETIMES IT'S TWO HEARING AIDS. THERE'S LIMITATIONS ON WHEN SOMEBODY CAN GET IN ONE STATE AND IT'S IN MISSOURI, YOU CAN GET HEARING AIDS IF YOU LIVE IN LONG-TERM CARE PROGRAM OR ARE PREGNANT OR BLIND AND OTHER STATES HAVE OTHER TYPES OF LIMITATIONS AND IT'S IMPORTANT TO UNDERSTAND THAT 25 STATES HAVE COVERAGE , MEDICAID COVERAGE THAT DOES COVER HEARING AIDS IN ONE WAY OR ANOTHER. PRIVATE INSURANCE COMPANIES, WE'RE SEEING THIS GETTING A LITTLE BIT BETTER FOR INSURANCE COMPANIES ASSISTING THOSE WITH HEARING AIDS. SOME WILL CONTRIBUTE 500 TO $1,000 TOWARD HEARING AIDS, WHICH IS REALLY GREAT. OTHERS WILL GIVE PEOPLE AN ALLOWANCE OR REIMBURSE PEOPLE. WHAT WAS REALLY INTERESTING IS I WAS AT A CONFERENCE RECENTLY AND AT THAT CONFERENCE, WE HAD AN INSURANCE BROKER THERE FROM ONE OF THE MAJOR COMPANIES AND SHE SAID, EVEN THOUGH WE MIGHT TELL PEOPLE THAT THEY CAN GO OUT AND GET HEARING AIDS UNDER THEIR PLAN, THEY NEED TO BE REALLY CAREFUL TO MAKE SURE THAT THEY MATCH THE QUALIFICATIONS. THEY COULD GO OUT-- THEY CAN GET HEARING AIDS, AND THEN SUBMIT FOR REIMBURSEMENT BUT THEY DON'T MEET THE

CRITERIA EVEN THOUGH THEY WERE TOLD THEY COULD GET THEM. PEOPLE NEED TO BE CAREFUL ABOUT PRIVATE INSURANCE COVERAGE. THEY NEED TO MAKE SURE THAT IT'S THEY LOOK AT ALL OF THE TECHNICAL WORDS, THE LEGAL WORDS THAT ARE IN THAT COVERAGE. ALSO SOME INSURANCE COMPANIES WILL ALLOW PEOPLE TO BUY HEARING AIDS FROM SPECIFIC PROVIDERS. YOU MAY HAVE ONE TYPE OF PROVIDER WHO HAS ONE TYPE OF HEARING AND AID AND THAT INSURANCE COMPANY WILL ALLOW THAT PERSON TO BUY HEARING AIDS AT 30%. VETERANS ADMINISTRATION, GREAT PLACE TO GET HEARING AIDS. WHAT'S AMAZING IS THE VETERANS ADMINISTRATION IS ABLE TO BUY BULK HEARING AIDS FOR PEOPLE FOR ABOUT $300 APIECE, WHICH IS SO INTERESTING TO ME. THEY'RE VERY GOOD AT COVERING PEOPLE. A LOT OF VETERANS THAT I WORKED WITH AND WHEN I WAS IN MINNESOTA FOR A NUMBER OF YEARS DIDN'T BELIEVE THEY COULD GET COVERED. THEY HAD ALWAYS BEEN TOLD ULT NEVER GET COVERED FOR HEARING AIDS BECAUSE IT JUST HASN'T HAPPENED. OAF THE LAST FEW YEARS, THEY'VE BEEN DOING A BETTER JOB AT THIS, COVERING PEOPLE WITH HEARING AIDS. WE HAVE TWO DIFFERENT TYPES OF BENEFITS. ONE IS BASED ON PERCENTAGE OF DISABILITY AND THE OTHER IS BASED ON JUST THE GENERAL HEALTHCARE PLAN. IT'S IMPORTANT THAT VETERANS UNDERSTAND THAT IF THEY HAVE THE DISABILITY BASE COVERAGE AND THEY GO INTO MEET WITH THE DOCTOR ABOUT DISABILITY-- THEIR DISABILITY-RELATED HEARING LOSS, THEY'RE NOT GOING TO GET HEARING AIDS RIGHT AWAY. IF THEY GO IN FOR THE HEALTHCARE PART, THEY'LL GET HEARING AIDS RIGHT AWAY, IF THEY QUALIFY. WHAT I HEARD AT A RECENT CONFERENCE WAS THAT IF SOMEBODY HAD FOUR YEARS OF SERVICE, THEN THEY WOULD BE ABLE TO QUALIFY FOR THE HEALTHCARE PORTION OF VETERANS ADMINISTRATION SERVICES. FOR HEARING AIDS. DO YOU WANT TO GO TO THE NEXT ONE. THERE'S SOME DIFFERENT NORTH CAROLINA FUNDING CHOICES. WE HAVE OUR EQUIPMENT DISTRIBUTION PROGRAM THROUGH THE DIVISIONS FOR SERVICES FOR DEAF AND HARD OF HEARING. IT'S A GREAT PROGRAM. IT HELPS PEOPLE WHO ARE 250% OR BELOW THE LINE TO GET ONE HEARING AID TO HELP THEM ON THE TELEPHONE. A GREAT PROGRAM. MANY PEOPLE HAVE BEEN HELPED, BUT THAT'S ONE HEARING AID. SO WE ARE STILL LOOKING FOR COVERAGE FOR THE OTHER. BECAUSE OFTENTIMES, PEOPLE NEED TWO. ALSO, WE HAVE THIS OTHER LIST OF DIFFERENT RESOURCES. I'M NOT GOING TO GO THROUGH EACH ONE BUT I WANTED TO PUT UP THERE THAT WE DO HAVE PLACES IN NORTH CAROLINA THAT CAN HELP, BUT SOMETIMES IT'S DIFFICULT TO ACCESS THIS. ONE PROGRAM SPECIFICALLY, NORTH CAROLINA INDEPENDENT LIVING PROGRAM, GREAT PROGRAM. HELPS PEOPLE WITH HEARING AIDS BUT THEY DON'T HELP PEOPLE WITH HEARING AIDS IN LONG-TERM CARE SETTINGS. THE PERSON HAS TO BE GOING BACK TO A MORE INDEPENDENT STATE, LIKE HOME OR AN ASSISTED LIVING FACILITY, GOING BACK TOWARD INDEPENDENCE TO GET HELP WITH HEARING AIDS. I WAS THINKING ABOUT SELF-HELP CREDIT UNION. THEY HAVE A GREAT PROGRAM AS WELL. 4% LOAN TO HELP PEOPLE GET HEARING AIDS, BUT HOW MANY OF THE PEOPLE IN LONG-TERM CARE SETTINGS CAN ACTUALLY AFFORD A 4% LOAN? NOT MANY. SO POTENTIAL BARRIERS, FIRST OF ALL, A PERSON MAY NOT FINANCIALLY QUALIFY AND THEN SECOND OF ALL, DO PEOPLE KNOW ABOUT THESE RESOURCES? WE DON'T HAVE A LOT OF PEOPLE CONTACT US ABOUT THESE RESOURCES. SO THAT MEANS A LOT OF PEOPLE DON'T KNOW. ESPECIALLY IN LONG-TERM CARE SETTINGS WHERE WE'RE LOOKING AT OVER 70% OF THE PEOPLE IN THESE SETTINGS THAT HAVE HEARING LOSS. THESE PEOPLE THAT DO NOT KNOW ABOUT THESE RESOURCES. OKAY. NEXT. SOME DIFFERENT NATIONAL RESOURCES. THEY'RE ALL RIGHT HERE, AND I'M NOT GOING TO GO INTO EACH ONE, BUT I'D LIKE TO POINT OUT THAT THESE CAN BE INTIMIDATING FOR PEOPLE TO APPLY FOR. I'LL GIVE YOU AN EXAMPLE. NOW THE STARKEY HEAR NOW FOUNDATION, GREAT PROGRAM AND GREAT HEARING AIDS. PEOPLE WOULD REALLY BENEFIT FROM THEM. IN ORDER FOR PEOPLE TO APPLY FOR THAT PROGRAM, THEY HAVE TO

PAY $150 PER HEARING AID UP FRONT. AND IT'S GREAT. THEY'LL EVEN PAY FOR THE SETUP OF THE HEARING AIDS AND EVERYTHING. BUT PEOPLE GET REALLY SCARED ABOUT PUTTING UP $150 UP FRONT ESPECIALLY WHEN THEY DON'T HAVE A LOT OF MONEY THAT THEY'RE LIVING ON IN THESE SETTINGS. SO THAT'S A BARRIER. AND AGAIN, PEOPLE JUST DON'T KNOW WHERE THE RESOURCES ARE, AND PEOPLE MAY NOT HAVE THE ENERGY TO APPLY FOR THESE PROGRAMS. THEY MAY NOT HAVE THE HELP. THEY MAY NOT HAVE THE FAMILY TO HELP THEM APPLY FOR THESE PROGRAMS. SO RECOMMENDATIONS THAT I'D LIKE TO MAKE TO CONSIDER RELATED TO HEARING AIDS IN LONG-TERM CARE SETTING. SO WHEN PEOPLE CANNOT AFFORD HEARING AIDS IN THESE SETTINGS, LET'S LOOK TO MEDICAID. IT WOULD BE GREAT IF MEDICAID BOTH ARE, BOTH MANAGED CARE AND DIRECT MEDICAID, COULD PROVIDE HEARING AIDS FOR BOTH EARS EVERY FOUR YEARS. SO WE HAVE HUMAN CONDITIONS HERE IN NORTH CAROLINA. PEOPLE NEED HEARING AIDS A LITTLE BIT MORE OFTEN BECAUSE OF THE BREAKDOWN OF THE HEARING AIDS. I PROPOSE WE FIND A WAY THAT MEDICAID DOES THIS. THIS IS ALL OF YOU THAT ARE MAKING THESE RECOMMENDATIONS. YOU CAN DECIDE IF YOU FEEL LIKE THAT THIS MATCHES YOUR VISION OF WHAT WE NEED. I WOULD ALSO LIKE TO PROPOSE THAT MEDICAID PROVIDE DRYING OR STORAGE FOR HEARING AIDS. NOW THIS IS A REALLY UNIQUE DRIER RIGHT HERE. YOU PLUG IT IN. SOME DRIERS ARE DRY BRICK STORAGE AND SOME PEOPLE WOULD JUST NOT BE ABLE TO AFFORD THE DRY BRICKS THAT COME WITH THE DRYING SYSTEMS, AND SO THAT WOULD BE A COST ASSOCIATED THAT TWO--THEY WOULD HAVE TO PAY FOR ON A REGULAR BASIS. THIS IS JUST PLUG-IN. IT'S CONVECTION. AND THIS IS ABOUT $20, IF IT'S BOUGHT IN BULK AND IT HAS A LITTLE LABEL PRINTED ON THE FRONT. I HAD THEM PUT THE LABEL ON. IT'S CALLED-- IT SAYS HEARING AIDS IN BIG, PINK LATERS. I ASKED FOR BRIGHT PINK LETTERS. THE REASON WHY IS THIS IS A GREAT WAY TO HELP PEOPLE NOT LOSE THEIR HEARING AIDS IN LONG-TERM CARE SETTINGS. WE NEED STORAGE TO BE ABLE TO PROTECT OUR HEARING AIDS, AND SO THIS IS A GREAT STORAGE BOX AND DRIER SYSTEM. I RECOMMEND THAT MEDICAID COVERS THIS. I ALSO RECOMMEND THAT NAVIGATORS-- WE HAVE NAVIGATORS TO HELP PEOPLE TO BE ABLE TO UNDERSTAND WHERE THEIR RESOURCES ARE, WHERE THEY CAN GET HEARING AIDS. EVEN PERSONAL AMPLIFIERS. AND THESE NAVIGATORS HELP THEM APPLY FOR THESE HEARING AIDS. WHO IS THERE TO HELP THESE PEOPLE IN LONG-TERM CARE SETTINGS TO BE ABLE TO APPLY AND GET THE RESOURCES THAT THEY NEED. I ALSO RECOMMEND THAT SOCIAL WORKERS IN BOTH LONG-TERM CARE SETTINGS AND HOSPITALS ARE MANDATED TO HEM PEOPLE TO KNOW WHERE RESOURCES ARE INCLUDING OUR DIVISION AND IT WOULD HELP PEOPLE TO ACCESS HEARING AIDS. PERSONAL AMPLIFIERS. I LOVE PERSONAL AMPLIFIERS. I WORKED WITH PEOPLE IN LONG-TERM CARE SETTINGS FOR A VERY LONG IMTOO, AND IN MINNESOTA, I WORKED FOR ALMOST EIGHT YEARS ALMOST EVERY DAY WITH PEOPLE WITH HEARING LOSS IN LONG-TERM CARE SETTINGS. NOW PERSONAL AMPLIFIERS-- HEARING AIDS ARE WONDERFUL, BUT AGAIN, MANY PEOPLE WON'T WEAR THEM. MANY PEOPLE CAN'T BE HELPED BECAUSE THE HEARING LOSS IS SO SEVERE, THEY NEED SOMETHING ELSE. I'M NOT RECOMMENDING THAT PERSONAL AMPLIFIERS BE USED ALL DAY LONG. THAT'S OVERWHELMING FOR PEOPLE SOMETIMES. IT CAN ALSO DISRUPT BALANCE AND DIFFERENT THING LIKE THAT WHEN YOU HAVE TOO MUCH AMPLIFICATION FOR TOO LONG. BUT PERSONAL AMPLIFIERS CAN REALLY HELP PEOPLE TO PARTICIPATE IN ACTIVITIES, HEAR THEIR VISITING FAMILY MEMBERS, TALK ON THE PHONE, MANY OF THOSE DIFFERENT SITUATIONS PARTICIPATE IN CARE PLANNING MEETINGS AND SO FORTH. AUDITORIUMS LISTENING TO WATCHING MOVIES AND SO FORTH. I'M GOING TO GIVE YOU A COUPLE OF EXAMPLES REALLY QUICK. FIRST OF ALL THIS IS A POCKET TALKER 2.0. I USED IT ALL THE TIME IN MINNESOTA . I WILL GIVE YOU A COUPLE OF STORIES. FIRST OF ALL, I WENT TO SOMEBODY'S LONG-TERM CARE SETTING AND VISITED THEM AND THEIR AUDIOLOGIST

HAD JUST TOLD THEM WITHIN THE LAST WEEK, I'M SORRY. HEARING AIDS WON'T HELP YOU. YOUR HEARING IS TOO SEVERE TO BE HELPED AND SHE WENT BACK HOME CRYING, VERY UPSET. HER DAUGHTER WAS CRYING. SHE'S NOT BEEN ABLE TO HEAR A CONVERSATION FOR A LONG TIME. NOT BEEN ABLE TO COMMUNICATE WITH FAMILY, NOT BE ABLE TO HEAR ON THE PHONE, ANY OF THAT. I THOUGHT TO MYSELF, OKAY, WHAT CAN WE DO HERE? LET'S TRY THIS. I DIDN'T THINK IT WAS GOING TO WORK BECAUSE I THOUGHT IF HEARING AIDS WON'T WORK, THIS IS NOT GOING TO WORK, BUT WE TRIED IT. SO WE PUT HEADPHONES ON WITH THIS POCKET TALKER RIGHT HERE AND TO MY AMAZEMENT SHE WAS ABLE TO CARRY ON CONVERSATIONS WITH US, GO TOPIC TO TOPIC. THEN SHE WAS ABLE TO HOLD THIS UP TO THE PHONE AND HEAR ON THE PHONE A LITTLE BIT AND COMMUNICATE ON THE PHONE WITH HER FAMILY FOR THE FIRST TIME TEN YEARS OR SO. THEN WE LOANED IT TO HER AND SHE WENT TO HER DOCTOR AND WAS ABLE TO COMMUNICATE WITH HER DOCTOR. SHE WAS ABLE TO DO ALL THESE ACTIVITIES. SHE WAS ABLE TO TALK TO HER SHUTTLE DRIVER. I MEAN, IMAGINE HOW THAT OPENED UP THE WORLD TO HER. A DIFFERENT PERSON, I WENT TO GO SEE THEM AND THEIR SON WAS OVER HERE AND SHE WAS IN FRONT OF ME, THERE'S NOTHING YOU CAN DO THAT'S GOING TO HELP ME. I SAID, CAN WE TRY THIS? BECAUSE I HAD SEEN THIS WORK FOR OTHER PEOPLE. OKAY. YOU KNOW, AFTER SOME STRUGGLE TO COMMUNICATE. AND THE SON'S LIKE THERE'S NOTHING YOU'RE GOING TO BE ABLE TO DO TO HELP HER. I PUT THIS ON WITH-- AGAIN, WITH HEADPHONES AND I STARTED TALKING TO HER AND SHE WAS SHOCKED. SHE SAID, WOW, WHAT'S THAT? THAT'S MY VOICE. SHE'S LIKE, NO WAY. HER SON WHO WAS SITTING OVER THERE JUST MAYBE TEN FEET AWAY FROM HER STARTED TALKING IN A DIALECT, IT WAS BOSNIAN. I CAN'T REMEMBER THE LANGUAGE EXACTLY. SHE STARTED TALKING BACK IN THAT DIALECT. SHE COULD HEAR FOR THE FIRST TIME AND WELL ENOUGH TO TALK IN HER NATIVE LANGUAGE TO HER SON, WHICH HAPPENED FOR A-- WHICH HADN'T HAPPENED FOR A VERY LONG TIME. WE'RE SEEING THAT PEOPLE CAN TALK ON THE PHONE. WE'RE SEEING THAT PEOPLE CAN TALK TO THEIR PROVIDERS, TO THEIR DOCTORS. WE'RE SEEING THAT PEOPLE ARE REALLY BENEFITING FROM PERSONAL AMPLIFIERS. IT'S SIGNIFICANT. WE CAN EVEN-- YES, JOHNNY, DR. SEXTON.

>> DO I NEED THE MIC?

>> THIS IS JOHNNY SEXTON. I WANTED TO MAKE A COMMENT. IT'S DISTURBING TO HEAR THAT AN AUDIOLOGIST TOLD SOMEONE THAT HEARING AIDS WOULD NOT HELP AND KNOW THAT THE PERSONAL AMPLIFIER DID. I DON'T WANT ANYONE IN HERE TO THINK THAT TECHNOLOGY WON'T HELP CERTAIN SEGMENTS OF THE POPULATION. WHAT I WOULD RECOMMEND IS THAT YOU SEEK A SECOND OPINION. THERE ARE WAYS TO HELP AND PERSONAL AMPLIFIERS ARE A GREAT SOLUTION, BUT TO HEAR A PATIENT WAS TOLD THAT IS DISTURBING TO ME.

>> THANK YOU. THAT WAS ACTUALLY SOMETHING I WANTED TO BRING UP. I WILL COME BACK OVER HERE.

[LAUGHTER]

THAT WAS SOMETHING I WANTED TO BRING UP. THESE DEVICES, HAVE ACTUALLY LED TO A PERSON FIGURING OUT THEY HAVE HEARING LOSS. IT'S NOT A SCREENING TOOL, BUT SOME PEOPLE SAY, OH, YOU KNOW, I DON'T HAVE HEARING LOSS. I DON'T NEED HELP. OH, DO YOU WANT TO TRY THIS AND JUST SEE? WOW!

THIS IS AMAZING. OKAY. MAYBE YOU SHOULD GO GET A HEARING TEST NOW. THESE ARE GREAT WORKS OF ART HERE. GREAT TECHNOLOGY THAT CAN HELP IN MANY DIFFERENT WAYS INCLUDING HELPING PEOPLE TO BE ABLE TO GET TO THEIR HEARING AID EXPERTS, THEIR AUDIOLOGIST OR HEARING DISPENSERS. THANK YOU FOR BRINGING THAT UP. SO THEY'RE NOT THAT EXPENSIVE. THEY

CAN BE PURCHASED AND USED IN LONG-TERM CARE SETTINGS AND THEY CAN BE PURCHASED AND USED BY THE ACTUAL LONG-TERM CARE SETTING THEMSELVES, PLACED IN A BASKET, PLACED AT THE FRONT OF A DINING ROOM, MAYBE SOMEBODY WALKS AROUND WITH A BASKET FULL OF AMPLIFIERS AND SAY, DO YOU WANT ONE FOR DINNER, DO YOU WANT ONE FOR DINNER, THOSE KINDS OF THINGS. SO FUNDING , BASICALLY, THERE'S NO FUNDING OPTIONS EXCEPT FOR PRIVATE PERSONAL FUNDING, PERSON BUYING ONE FOR THEMSELVES, AND IN SOME STATES LIKE MINNESOTA, WHERE I WAS, YOU COULD USE A WAIVER TO BUY A PERSONAL AMPLIFIER. AND THAT WAS SIGNIFICANT. WE USED THAT ALL THE TIME IN LONG-TERM CARE SETTINGS. SO WE WOULD USE AN ELDERLY WAIVER OR IF SOMEBODY WAS IN AN INDEPENDENT LIVING APARTMENT, WE'D USE A CATI WAIVER WHICH IS A CERTAIN KIND OF MEDICAID WAIVER USED TO PURCHASE THESE DEVICES. VETERANS ADMINISTRATION WILL COVER THESE DEVICES, BUT WE HAVE TO LET OUR VETERANS KNOW TO ASK FOR THEM AND KNOW THAT THE VA WILL COVER THEM. SOMETIMES THEY'LL GO AND THEY WON'T BE OFFERED. SO WE HAVE TO LET PEOPLE KNOW ABOUT THAT. SO RECOMMENDATIONS TO CONSIDER RELATED TO PERSONAL AMPLIFIERS, THAT LONG-TERM CARE SETTINGS, MEDICAL CENTERS, AND SMALL BUSINESS-- SMALL PRACTICES, PROVIDER PRACTICES CARRY AMPLIFIERS IN THEIR DIFFERENT SETTINGS AND THE NUMBER IS UNIQUE TO THEIR SETTINGS. FOR INSTANCE, IF I GO TO DUKE OR I GO TO UNC, PERHAPS IN THE WAITING ROOMS, THEY HAVE TWO PERSONAL AMPLIFIERS. SO A PERSON CAN START WITH THE FRONT DESK WHO CAN GIVE THEM THE PERSONAL AMPLIFIER AND THEY MIGHT BE ABLE TO HEAR THEIR NAME CALLED AND THEY GO INTO THE BACK TO MEET WITH THE DOCTOR AND THEY CAN HEAR THE DOCTOR BETTER. PERHAPS IN A LONG-TERM CARE SETTING, THEY HAVE FIVE PERSONAL AMPLIFIERS FOR EVERY TEN RESIDENTS BECAUSE SO MANY PEOPLE HAVE HEARING LOSS AND AGAIN, THESE CAN BE PASSED AROUND. THEY CAN BE PLACED IN A BASKET RIGHT IN THE FRONT OF THE ACTIVITY AREA. THEY CAN HAVE SIGNAGE THAT SAYS, PLEASE USE. WE'RE CHANGING THE CULTURE IN THESE LONG-TERM CARE SETTINGS IF WE PUT UP SIGNAGE AND WE MAKE IT ACCEPTABLE TO USE THESE TYPES OF DEVICES AND THE MORE PEOPLE THAT SEE PEOPLE WEARING HEARING AIDS, THE MORE PEOPLE THAT SEE PEOPLE WEARING POCKET TALKERS OR PERSONAL AMPLIFIERS, THE MORE LIKELY WE ARE TO SEE PEOPLE IN THESE SETTINGS USE THESE DEVICES. BECAUSE IT REDUCES THE STIGMA. I RECOMMEND THAT WE HAVE HEADPHONES OR EAR BUDS FOR EACH RESIDENT THAT WOULD USE IT. THAT WAY, THEY'RE NOT SHARING GERMS. WE CAN ALSO USE A NECK LOOP THAT GOES AROUND OUR NECK THAT COMMUNICATES WITH THE DEVICE AND SENDS A SIGNAL UP TO THE HEARING AID. IT ACTUALLY HELPS A PERSON WITH HEARING AIDS TO HEAR BETTER. AND I RECOMMEND THAT MEDICAID COVERS THESE DEVICES THROUGH WAIVERS. WAIVERS WITHIN THE STATE OF NORTH CAROLINA TO SOMEHOW IB INCORPORATE THE USE OF THESE DEVICES OR COVERING THAT. SO LIKE MINNESOTA, I RECOMMEND THAT WE LOOK AT CREATING A WAIVER PROGRAM JUST FOR PEOPLE WITH HEARING LOSS. SO THAT THEY CAN GET DEVICES PERHAPS EVEN HEARING AIDS. SO IF WE HAVE A WAIVER PROGRAM FOR PEOPLE WITH HEARING LOSS, THEN WE CAN GET PEOPLE MORE OF THE TECHNOLOGY THAT THEY NEED TO BE SUCCESSFUL. THE CIVIL MONEY PENALTY REINVESTMENT PROGRAM THROUGH CMS, THROUGH MEDICAID, CAN BE USED TO PURCHASE THESE DEVICES AND SET UP A PROGRAM JUST TO HELP PEOPLE BE ABLE TO HEAR IN LONG-TERM CARE SETTINGS. OKAY. SO THEN WE HAVE WIDE AREA LISTENING SYSTEMS AND WE'LL GO AHEAD AND GO TO THE NEXT ONE. ARE WE OKAY ON TIME? OKAY. AND A WIDE AREA LISTENING SYSTEM, WELL, THERE'S SEVERAL KINDS. YOU CAN HAVE INFRARED SYSTEMS WHICH YOU FIND IN MOVIE THEATERS OR CHURCHES OR DIFFERENT PLACES LIKE THAT. EACH SYSTEM TYPICALLY HAS A RECEIVER AND YOU HAVE FM SYSTEMS LIKE WHAT WE'RE USING TODAY AND IT HAS A RECEIVER AND THEN SOMETIMES INDUCTIVE LOOP SYSTEMS HAVE

A RECEIVER. YOU HAVE A TRANSMITTER AND A RECEIVER, AND THESE ARE GREAT. WHEN WE SAY WIDE AREA LISTENING SYSTEMS, WE LIKE TO THINK OF IT AS AUDITORIUM STYLE LISTENING SYSTEMS, AUDITORIUM STYLE. YOU COULD PUT A WIDE AREA LISTENING SYSTEM IN A THEATER AT A LONG-TERM CARE SETTING. YOU CAN PUT IT IN A CONFERENCE ROOM. YOU CAN PUT IT IN AN ACTIVITY ROOM. IT CAN BE SET UP IN MANY DIFFERENT PLACES. WHEN WE USE THESIS TESTIMONIES, WE CAN PASS OUT 10, 15, 20 DIFFERENT RECEIVERS AND SO THAT MANY PEOPLE WOULD HEAR A LOT BETTER. WHAT'S REALLY NEAT IS THAT THE MICROPHONE CONNECTS DIRECTLY TO THE SOUND SYSTEM, LIKE HOW WE HAVE IT TODAY OR SO RON HAS SET UP A TRANSMITTER. WE'RE USING THIS-- SORRY. WE'RE USING THIS RIGHT HERE AND THEN IT IS SENDING OUT THE SIGNAL TO THE FM RECEIVERS AND SO YOU'RE HEARING BETTER. WE CAN SET THESE UP IN ASSISTED LIVING FACILITIES OR LONG-TERM CARE FACILITIES. IT'S NOT DIFFICULT. IT IS ACTUALLY REGULATED BY ADA AND THEY-- DIFFERENT FACILITIES THAT RECEIVE GOVERNMENT FUNDING HAVE TO SET THESE UP, OR THEY'RE SUPPOSED TO BE SETTING THEM UP. MAYBE LISE HAMLIN OF HLAA WILL TALK ABOUT THAT LATER. INDUCTIVE LOOPS, WE HAVE LOOP SYSTEMS WHERE YOU CAN RUN A WIRE EITHER ALL THE WAY AROUND THE CEILING, LIKE IN THIS ROOM, OR UNDER THE FLOOR, OR EVEN GLUED DOWN TO THE FLOOR , AND THESE INDUCTIVE LOOPS WILL SEND AN ELECTRIC MAGNETIC SIGNAL UP TO PEOPLE'S HEARING AIDS AND THAT ALLOWS THEM TO HEAR THE SPEAKER BETTER. IT'S CONNECTED DIRECTLY TO THE SOUND SYSTEM. AND SO THESE WOULD BE GREAT IN LONG-TERM CARE SETTINGS BECAUSE SO MANY PEOPLE DO HAVE HEARING AIDS. WE'RE HOPING MORE PEOPLE GET HEARING AIDS, OF COURSE. WHAT'S NEAT ABOUT INDUCTIVE LOOPS IS THAT YOU CAN HAVE A PERSONAL AMPLIFIER, MANY PERSONAL AMPLIFIERS HAVE A T SWITCH ON IT. THERE'S A LITTLE SWITCH RIGHT HERE. YOU CAN LOOK AT IT LATER IF YOU WANT. I CAN USE A PERSONAL AMPLIFIER WITH HEADPHONES AND THIS WILL CONNECT DIRECTLY TO THE LOOP SYSTEM. WE COULD SET UP A LOOP IN A CONSULTATION ROOM IN A HOSPITAL. SO WHEN SOMEBODY-- WHEN A PATIENT WITH HEARING LOSS WENT INTO THE CONSULTATION ROOM, THEY COULD TALK TO THEIR CARE PROVIDER, USING A PERSONAL AMPLIFIER WITH HEADPHONES CONNECTED TO THE LOOP, OR THEY COULD USE THEIR HEARING AIDS CONNECTED TO THE LOOP, WHICH EVER WAY. YOU CAN SET THAT UP IN DOCTOR'S OFFICES, ASSISTED-- LONG-TERM CARE SETTINGS, ANYWHERE, ANY HEALTHCARE FACILITY COULD HAVE THAT. AGAIN, WE TALKED A LITTLE BIT ABOUT THE FUNDING. ADA REQUIRES IT. AND THEY ACTUALLY HAVE RATIOS, THEY HAVE RATIOS OF HOW MANY RECEIVERS YOU HAVE TO HAVE TO TRANSMITTERS. IT'S DEPTHS UPON THE POPULATION-- IT'S DEPENDENT UPON THE POPULATION. RECOMMENDATIONS RELATED TO ASSISTIVE LISTENING SYSTEMS. AGAIN, LET'S CHANGE THE CULTURE, SIGNS, MAKE IT EASILY ACCESSIBLE. SIGNS UP, BASKETS. WE HAVE AN AIST ISED-- WE HAVE AN ASSISTED LISTENING SYSTEM. WE HAVE A LOOP, YOU KNOW, DIFFERENT THINGS FOR THAT. HEARING AID PROVIDERS NEED TO BE NOTIFIED IF IF THERE ARE SYSTEMS IN PLACE BECAUSE WHAT THEY CAN DO IS ACTIVATE THE TELECOIL ON THE HEARING AID WHICH THEN WORKS WITH THESE LOOP SETTINGS. AND SO THE HEARING AID PROVIDER HAS TO KNOW, OF COURSE. CIVIL MONEY PENALTY REINVESTMENT PROGRAM COULD BE USED TO SET UP THESIS TESTIMONIES TO HELP FACILITIES SET THIS UP. WE NEED TO SEE MORE OF THAT. AGAIN, THIS MONEY IS TO AID NURSING HOME TEAMS IN REDUCING ADVERSE EVENTS, IMPROVING STAFFING QUALITY AND IMPROVING DEMENTIA CARE AND THERE'S A CORRELATION BETWEEN HEARING LOSS AND DEMENTIA. WE KNOW THAT. THERE'S A CORRELATION. THERE'S A LOT MORE BEHIND THAT, BUT THERE'S A CORRELATION. SO HERE WE HAVE LARGE AREA LISTENING SYSTEMS, PERFECT ACCOMMODATION TO MATCH THAT CIVIL MONEY PENALTY REINVESTMENT PROGRAM FUNDING . AND THEN LONG-TERM CARE SETTINGS, THEY COULD CONTACT THE DIVISION OF SERVICES FOR DEAF AND HARD OF HEARING TO GET EXPERT OPINIONS ON HOW TO

SET UP SYSTEMS ON WHAT'S OUT THERE TO BE EDUCATED AND WE HAVE PEOPLE THAT CAN GO OUT, A STAFF THAT CAN GO OUT AND EDUCATE THESE FACILITIES AND WHAT TO GET. QUESTIONS AT ALL?
>> TONY, LET ME PASS THAT AROUND AND WE CAN PASS IT BACK AND FORTH?
>> OKAY.
>> THERE WAS A HAND UP HERE. WAS IT MAGGIE?
>> MAGGIE: THANK YOU FOR THAT PRESENTATION. THAT WAS AWESOME. I'M HARKINING BACK TO JOHN-- JOHNNY AND I USED TO WORK TOGETHER ON A TEAM AT UNC. AND SO I JUST WANTED TO MAKE A POINT, TOO, I THINK ABOUT THE AUDIOLOGISTS AND THIS HAS TO DO WITH A PERSONAL STORY WITH MY DAD WHO WAS A FARMER AND A RANCHER AND ALSO A VETERAN, HAD HEARING IMPAIRMENT. SO ONE DAY-- WE LIVED 15 MILES OUTSIDE OF TOWN, AND A MIRACLE EAR GUY SHOWS UP AT THE DOOR WITH THE SAME KIND OF LITTLE MACHINE THAT WE ALL HAD IN SCHOOL. SO MY DAD MAKES A PURCHASE OF HIS HEARING AIDS AND GUESS WHAT. HE PAID A LOT OF MONEY FOR HEARING AIDS THAT DID NOT FIT. SO I THINK, YOU KNOW, THE IMPORTANCE, TO JOHNNY'S POINT, ABOUT GETTING A SECOND OPINION AND TO THE EXTENT THAT WE'RE ALWAYS MAKING SURE THAT PEOPLE HAVE GOOD HEALTH AND THEY'RE GOING BACK TO THEIR AUDIOLOGISTS TO MAKE SURE THAT THAT TECHNOLOGY MATCHES THEIR BENEFIT. SO I JUST-- I'LL TELL YOU WHAT. I CALLED THE MIRACLE EAR REPRESENTATIVE AND WE HAD WORDS. I'LL JUST SAY THAT. I WAS LIKE DON'T YOU EVER COME NEAR MY DAD AGAIN OR I WILL TAKE A GUN AND RUN YOU OFF THE PLACE.
[LAUGHTER]
SORRY, THAT'S WHAT YOU SAY ON A RANCH, RIGHT?
[LAUGHTER]
SO THEN THE OTHER PART OF THAT IS I JUST WONDER WITH LONG-TERM CARE SETTINGS AND WITH THE PENALTY DOLLARS THAT ARE AVAILABLE, ARE THERE TIEWPTDS NOW-- I DON'T KNOW HOW THESE FACILITIES ARE GOVERNED IN TERMS OF WHEN THEY'RE BUILT. SO CAN THEY BUILT WITH THE INFRASTRUCTURE REQUIRING THEM TO HAVE SOME OF THIS INFRASTRUCTURE BUILT INTO-- SO WE KNOW EVERYBODY'S AGING , RIGHT? WE'RE GOING TO HAVE MORE FACILITIES, NOT LESS. WE HOPE PEOPLE ARE AGING AT HOME, BUT IS THERE SOMETHING THAT COULD BE DONE TO THE FACILITY REQUIREMENTS WHEN THINGS ARE CONSTRUCTED THAT JUST BUILDS THIS INTO THE INFRASTRUCTURE OF THE BUILDING? SO YOU'RE NOT TALKING ABOUT ADDING THAT ON LATER. IT JUST BECOMES PART OF THE ADA REQUIREMENTS FOR HOW A BUILDING IS CONSTRUCTED SO THAT PEOPLE ARE THEN JUST USING SOMETHING WHEN THEY WALK INTO THE DOOR. IT'S NOT ABOUT AN ADD-ON TO A BUILDING. THAT'S MY QUESTION.
>>
>> ADAM: DO YOU WANT TO ANSWER THAT, TONE MI?
>> TONY: FIRST OF ALL, I'M SORRY ABOUT YOUR FATHER'S EXPERIENCE.
>> MAGGIE: OH, WE GOT IT FIXED.
[LAUGHTER]
WITHOUT A GUN.
[LAUGHTER]
>> TONY: WHAT I WOULD LIKE TO DO FOR YOUR SECOND STATEMENT IS DEFER THAT TO OUR NEXT PRESENTATION BECAUSE LISE HAMLIN, FROM HLAA, THE POLICY DIRECTOR, SHE PLANS TO DISCUSS THAT SPECIFICALLY A LITTLE BIT AND SHE'S-- SHE'LL HAVE A BETTER ANSWER ON THAT AS WELL.
>> ADAM: TONY'S TIME IS UP AT 10: 55 AND I SAW THREE MORE HANDS UP. WE'LL TRY TO GET TO THOSE THREE.

>> TOVAH: BEFORE I COMMENT AND ASK THE QUESTION, I WOULD LAKE TO GO BACK TO WHAT DAVID SAID EARLIER THIS MORNING ABOUT NOTHING GOOD HAPPENS FAST, THAT THAT IMPLIES THAT BAD THINGS HAPPEN FASTER. WHAT I REALLY WANT TO SAY IN CONNECTION WITH THAT IS THAT-- AND I THINK THE NEXT PRESENTER CAN ADDRESS THIS, TOO, A LITTLE BIT. IT'S THAT ALL OF THESE WONDERFUL-- AND YOUR PRESENTATION WAS WONDERFUL, BY THE WAY. I THOUGHT THIS WAS A LOT OF GOOD INFORMATION, BUT I THINK ALL OF THIS WON'T WORK SO WELL IF THERE ISN'T TOP-DOWN CAUTIOUS SETTING FOR FOCUSING ON THIS AND IMPLEMENTING THIS BECAUSE IT'S ONE THING TO TRAIN STAFF ON HOW TO USE THIS STUFF BUT IF THE ADMINISTRATION DOESN'T SEE TO IT THAT ALL THE STAFF ARE DOING WHAT THEY'RE TRAINED TO DO IT AIN'T GOING TO WORK . SO I THINK THE TOP-DOWN ADMINISTRATIVE ISSUES HAVE TO BE ADDRESSED, NO MATTER WHERE AND WHAT WE DO. AND I DO HAVE A QUESTION ABOUT OVER-THE-COUNTER HEARING AIDS. YOU HAVEN'T MENTIONED THAT IN YOUR TALK, BUT I THINK THAT'S ANOTHER AVENUE WHERE PEOPLE MAY BE BUYING HEARING AIDS CHEAPER AND NOT ONLY THAT BUT I THINK THERE WILL BE A SECONDARY MARKET OF PREVIOUSLY OWNED HEARING AIDS THAT WILL BE EVEN CHEAPER, YOU KNOW, BOUGHT ON CONSIGNMENT OR THRIFT STORES OR WHATEVER. I THINK THAT NEEDS TO BE ADDRESSED IN TERMS OF THE FACT THAT PEOPLE NEED TO KNOW THAT JUST BUYING THESE HEARING AIDS WON'T BE ENOUGH. THEY HAVE TO ALSO GET THE TRAINING AND ALL THESE OTHER THINGS.
>> TONY: SO, I KNOW THAT THE OVER-THE-COUNTER HEARING AID DISCUSSION WILL BE BRIEFLY COVERED, AGAIN, BY LISE HAMLIN AND ALSO DR. ANDREW REED LATER TODAY AND THEY'LL COVER THAT MORE. THERE ARE ALL KINDS OF MAKE AND USE PROGRAMS FROM DIFFERENT PLACES THAT ARE REFURBISHED AND THAT'S A ANOTHER AFFORDABLE SOURCE AND THAT WILL BE AVAILABLE TO CONSUMERS. DEFINITELY, PEOPLE CAN GET HEARING AIDS FOR UNDER $200.
>> ADAM: THERE'S A COUPLE OVER HERE.
>> EILEEN: HI. I HAVE A QUESTION AND RECOMMENDATION. MY QUESTION IS, IN LONG-TERM CARE FACILITIES, FREQUENTLY THE RESIDENTS HAVE DIFFICULTY KEEPING UP WITH THEIR STUFF. SO FOR EXAMPLE, MY FATHER-IN-LAW IS IN A FACILITY IN RALEIGH AND HAS GONE THROUGH FOUR PAIRS OF EYEGLASSES. THEY JUST DISAPPEAR. SHOES DISAPPEAR. I LIKE THE SUGGESTION OF THE FACILITY ACTUALLY KEEPING THE POCKET AMPLIFIERS AS OPPOSED TO THE RESIDENTS. ONE OPTION WOULD BE TO USE REUSABLE OR DISPOSABLE EARBUD COVERS SO THAT IT'S MORE SANITARY BECAUSE IF A RESIDENT HAS THEIR OWN HEADSET, THE LIKELIHOOD IS VERY HIGH THAT THING WILL DISAPPEAR AND THEY WON'T HAVE THE ACCESS, AND THEN MY RECOMMENDATION IS THAT WHEN PATIENTS ARE ADMITTED TO THESE FACILITIES, USUALLY THEY'RE ACCOMPANIED BY FAMILY MEMBERS AND SOME EDUCATION OF THE FAMILY ABOUT THESE AMPLIFIERS WILL BE REALLY HELPFUL BECAUSE FAMILIES COULD ACTUALLY BRING THEM THEM WITH THEM FOR THEIR VISITS AND MAKE THEIR LONG-TERM CARE FAMILY MEMBER PART OF THAT CONVERSATION. SO IF THEIR FAMILY MEMBERS ARE RESPONSIBLE FOR BRINGING IT BACK AND FORTH, THE LIKELIHOOD OF IT DISAPPEARING IS A LOT LESS.
>> ADAM: MAYBE PEOPLE CAN PASS IT ALONG AND YOU CAN ADDRESS BOTH COMMENTS AT THE SAME TIME. I WANT TO KEEP US MOVING ALONG.
>> SHELLEY: THIS IS SHELLEY CRISTOBAL BALL. I'M AN AUDIOLOGIST AND I'M IN A COUPLE OF LONG-TERM CARE FACILITIES AND DEAL WITH A LOT OF THIS, BOTH EDUCATION, ASSISTIVE DEVICES, TRAINING OF NURSING AND CARE STAFF, AND WORKING WITH RESIDENTS DIRECTLY. SO I WANTED TO ADD A COUPLE OF ADDITIONAL RECOMMENDATIONS THAT I FOUND TO BE EXTREMELY HELPFUL. SOME ARE MORE REALISTIC THAN OTHERS. BUT I-- FOR ANYONE WITH DEMENTIA OR WHO IS HAVING TROUBLE WITH DEXTERITY OR RECEIVING A LOT OF SUPPORT WITH THEIR DEVICES, I SUGGEST A

RETENTION SYSTEM, LIKE OTOCLIPS. IT'S LIKE THE LANIARD THAT YOU PUT BEHIND YOUR GLASSES SO YOU CAN TAKE THEM OFF AND PUT THEM AROUND YOUR NECK. WE'VE GOT THEM TO ATTACH TOKER HAG AIDS, WHETHER THEY'RE IN THE EAR OR OVER-THE-EAR DEVICES AND I PUT ONE OF THOSE WITH A TILE ON IT MY RESIDENTS WHO HAVE DEMENTIA SO WHEN, INEVITABLY, THE HEARING AIDS END UP UNDER THE DISCUSSIONS OF THE COUCH, THEIR ADULT CHILD OR A STAFF MEMBER CAN TAKE THEIR iPHONE OR IPAD OR ANDROID OR WHATEVER AND FIND THE HEARING AIDS UNDER THE COUCH. THAT HAS BEEN A LIFESAVER FOR A LOT OF FACILITIES. I ALSO RECOMMEND ANYONE WITH DEMENTIA, DEXTERITY ISSUES OR GOING TO BE RECEIVING SIGNIFICANT SUPPORT WITH THEIR DEVICES HAS SIZE 13 BATTERIES ARE LARGER SO THE BATTERIES LAST AT LEAST SEVEN DAYS. TYPICALLY, THOSE DEVICES BATTERIES ARE GOING TO LAST BETWEEN 8 AND 12 DAYS DEPENDING ON THE DEGREE OF HEARING LOSS. WHEN BATTERIES LAST MORE THAN SEVEN DAYS, THEN THE CAREGIVER WHO IS LAYING OUT MEDICATION FOR A WEEK CHANGES THE BATTERIES AT THAT POINT IN TIME, OR IF THEIR DAUGHTER COMES OVER TO TAKE THEM TO CHURCH, THEY CHANGE THEM EVERY SUNDAY MORNING OR WHATEVER THE CASE MAY BE THAT MAKES SENSE FOR THAT INDIVIDUAL BUT IT'S A SEVEN-DAY EVENT BEFORE BATTERIES ARE OUT AND THERE'S A PERSON WEARING HEARING AIDS AS EAR PLUGS FOR THREE DAYS BEFORE ANYONE REALIZES THAT THE BATTERIES WENT OUT. TELECOILS, I'M A BIG FAN OF TELECOILS, ANYWHERE WE CAN GET THESE ESPECIALLY IN THESE COMMUNITIES AND THERE'S SYSTEMS LIKE TV STREAMERS THAT RUN OFF INFRARED AND TYPICALLY A BLUETOOTH PLATFORM THAT A LOT OF MODERN HEARING AIDS CAN PAIR TO THESE WIRELESSLY. SO RESIDENTS WHO SIT IN THE COMMON ROOM AND WATCH THE NEWS WITH A GROUP OF OTHER RESIDENTS CAN LISTEN TO THE TELEVISION AT THEIR OWN VOLUME, FILTERED THROUGH THEIR PRESCRIPTION AND THEIR HEARING AIDS AND GET MUCH BETTER SPEECH UNDERSTANDING. SO THAT'S REALLY HELPFUL AS WELL AND OFTEN, WHEN WE'RE-- IF WE'RE PUTTING HEARING AIDS ON SEVERAL PEOPLE IN A COMMUNITY, BUYING ONE DEVICE THAT MAKES THAT TV COMPATIBLE WITH SEVERAL RESIDENTS IS MUCH MORE COST EFFECTIVE AS WELL. I TYPICALLY TRY AND SET IT UP SO THE FACILITY KEEPS THE HEARING AIDS. WHEN THEY'RE ASSISTING A RESIDENT GETTING INTO BED, THEY COLLECT THE HEARING AIDS AND THE STAFF MEMBER KEEPS THEM IN THE MEDICATION CART AND IN THE MORNING HAD THEY HELP GET OUT OF BED OR HELP THEM WITH MORNING ROUTINE, THEY BRING IN THE HEARING AIDS. MAKE SURE THEY SQUEAL WHEN THEY SQUEEZE THEM. IN THE A FULL LISTENING CHECK, MAKE SURE THEY'RE DOING SOMETHING AND HELP THEM PUT THEM IN THEIR EARS PROPERLY. SO OFTEN REDUCED HEARING WITH THE OLDER POPULATION IS JUST BECAUSE IT'S HARD TO GET THEM IN RIGHT. IT'S AWKWARD TO PUT THINGS IN YOUR EARS WHEN YOUR DEXTERITY IS GOOD. WHEN YOUR DEXTERITY HAS CHANGED ESPECIALLY IF IT CHANGED SUDDENLY, IT'S MUCH HARDER SO THAT'S MY SORT OF LIST OF TO-DOs IN MY FACILITIES. SOME OF THOSE ARE MORE REALISTIC THAN OTHERS, AND I DID WANT TO RESPOND TO THE COMMENT ABOUT RECONDITIONED DEVICES. THAT IS CERTAINLY SOMETHING THAT EXISTS AND IS A VERY COST EFFECTIVE OPTION. YOU DO WANT TO MAKE SURE THAT ANYONE LOOKING AT RECONDITIONED HEARING AIDS IS GOING THROUGH PROPER CLANLES BECAUSE SOMETIMES YOU LOSE WARRANTY RESOURCES, IF YOU JUST PUT ON YOUR HEARING AIDS YOU FOUND IN A AN ESTATE SALE, WHICH I HAD PATIENTS COME TO ME WHO STARTED WEARING HEARING AIDS THEY PICKED UP IN AN ESTATE SALE.
[LAUGHTER]
YEAH. YOU CAN DAMAGE YOUR EARS FURTHER. PRETTY SIGNIFICANTLY. THEY DO REQUIRE PROFESSIONAL CARE TO MAKE SURE THEY'RE SET APPROPRIATELY FOR THAT PERSON'S EARS BUT PHYSICALLY AND ACOUSTICALLY. THAT'S A LOT.
>> ADAM: IT'S 10:00. WE'RE RUNNING A LITTLE LATE. UNFORTUNATELY, WE NEED TO LIMIT QUESTIONS

AND COMMENTS SO WE CAN STAY ON SCHEDULE. I WANT TO LET TONY RESPOND TO THOSE COMMENTS AND THEN I THINK WE NEED TO MOVE ALONG.
>> TONY: I THINK ALL OF WHAT YOU BOTH HAD TO SAY WAS GREAT AND YOU KNOW. YOU WORK IN THESE FACILITIES AS WELL. YOU GO OUT AND MEET PEOPLE. YOU KNOW THE NEEDS. AND SO AND YOU'RE A MEMBER OF THE TASK FORCE, SO ALL OF THESE SUGGESTIONS ARE THINGS THAT PEOPLE HERE CAN CONSIDER AS FAR AS MAKING RECOMMENDATIONS FOR CHANGES. I APPRECIATE THE WORK YOU DO OUT THERE. AND I APPRECIATED YOUR COMMENTS AS WELL. THANK YOU. AND WE TALKED ABOUT STORAGE. I THINK THIS IS REALLY IMPORTANT. EVEN IF NURSES OR THE FACILITY, THEM OF ISES, KEPT HEARING AIDS THEY COULD HAVE DRY EAR SYSTEMS IN STORAGE SYSTEMS. YOU COULD PUT PATIENTS' NAMES ON THEM AND THIS WOULD BE A GREAT THING TO HAVE. SO I APPRECIATE EVERYONE'S COMMENTS SO FAR. I'LL BE AROUND TO DISCUSS THINGS IF YOU NEED TO. ONE MORE THING IS IN YOUR PACKETS TODAY, YOU'LL SEE AN OVERVIEW OF HEARING LOSS AND TREATMENT ASSISTANCE IN NORTH CAROLINA. THIS HAS A LOT OF COVERAGE INFORMATION ON COCHLEAR IMPLANTS, BONE CONDUCTIVITY HEARING AIDS, BONE-ANCHORED HEARING AIDS AND IT HAS A LOT OF INFORMATION ON WHETHER PRIVATE ENTRANCE OPTIONS ARE AVAILABLE OR PUBLIC ENTRANCE OPTIONS ARE AVAILABLE FOR THESE DEVICES.
>> ADAM: LET ME BORROW THIS MICROPHONE AND SAY BECAUSE I KNOW THERE ARE MORE COMMENTS IN THE ROOM WHICH IS GREAT BUT WE'RE GOING TO TRY TO KEEP ON SCHEDULE AFTER&AFTER SPEAKERS GO, LET'S TRY TO LIMIT TO QUESTIONS FOR THE SPEAKER AND LONGER PERIODS OF DISCUSSION WHERE WE CAN PUT MORE IDEAS ON THE TABLE WHICH I THIS IS SUPERIMPORTANT AND THAT WILL HELP US CONSOLIDATE IN RECOMMENDATION THINKING. THE OTHER--THE ONLY SUGGESTION I HAD ABOUT SOME THE RECOMMENDATIONS FROM TONY AND OTHERS, WHICH WERE REALLY GREAT AND REALLY PRACTICAL IS THAT AS WE THINK ABOUT RECOMMENDATIONS, I FIND THAT THERE ARE TWO TYPES OF RECOMMENDATIONS. LIKE, GETTING PEOPLE TO DO THE RIGHT THINGS FOR THE RIGHT REASONS, WHICH IS SUPERIMPORTANT AND I THINK WE SHOULD MAKE SOME OF THOSE RECOMMENDATIONS BECAUSE IT'S THE RIGHT THING TO DO AND THERE ARE OTHER RECOMMENDATIONS WHERE WE CAN BUILD A STRONG RETURN ON INVESTMENT RATIONALE AND I WANT THE WISDOM AND EXPERTISE IN THE ROOM TO HELP US DO THAT. LIKE I'M I HAD THINKING TO ME, IF YOU TELL MEDICAID COVERING A $20 STORAGE DEVICE IS GOING TO INCREASE THE LIFE EXPECTANCY BY 50%, I DON'T KNOW WHAT THE NUMBERS ARE BUT WE NEED TO THINK ABOUT OR COVERING HEARING AIDS IS GOING TO HELP PREVENT FALLS, THOSE ARE THE SORTS OF THINGS THAT I THINK WE REALLY NEED TO FOCUS ON TO BE ABLE TO BUILD OUR CASE. I THINK DOING THE RIGHT THING FOR THE RIGHT REASON IS GOOD BUT LET'S MAKE IT OVERWHELMINGLY COMPELLING THAT WE SHOULD DO THE RIGHT THING FOR RETURN ON INVESTMENT, TOO. SO THANK YOU SO MUCH, TONY. THAT WAS GREAT AND I THINK OUR NEXT SPEAKER IS LISE HAMLIN FROM HLAA, THE POLICY DIRECTOR. WHY DON'T YOU MAKE YOUR WAY UP, LISE. ROB IS PULLING UP YOUR PRESENTATION. THAT'S THE WAY WE'RE TALKING.

Communication Access for People Who Have a Hearing Loss in Health Care and Long-Term Care

>> LISE HAMLIN: GREAT. THANK YOU SO MUCH. DO YOU NEED ME TO MOVE A LITTLE BIT ? CAN YOU

SEE? I CAN MOVE THIS, TOO. IS THAT OKAY? YOU CAN SEE NOW? THANK YOU SO MUCH FOR INVITING ME. I AM LISE HAMLIN, DIRECTOR OF PUBLIC POLICY AT HEARING LOSS ASSOCIATION OF AMERICA. YOU CAN MOVE TO THE NEXT SLIDE, THANK YOU. HEARING LOSS ASSOCIATION OF AMERICA FOR PEOPLE WHO ARE UNFAMILIAR WAS FOUNDED-- AND I HAVE TO LOOK-- 197, AND WE HAVE BEEN AROUND FOR A LONG TIME BECAUSE THERE ARE PEOPLE WHO ARE NOT DEAF SIGN LANGUAGE USERS WHO NEEDED TO FIND A PLACE OF SUPPORT AND UNDERSTANDING AND INFORMATION LIKE ALL THE INFORMATION THAT TONY JUST GAVE YOU. I MEAN, IT'S FABULOUS STUFF, BUT PEOPLE WITHER WHATTING LOSS DON'T KNOW ABOUT IT. PROVIDERS OF CARE, AND I WAS SO HAPPY TO HEAR WHAT YOU JUST SAID ABOUT YOUR LONG-TERM CARE FACILITY. MY HUSBAND IS IN A SKILLED NURSING FACILITY. THEY DON'T EVEN HAVE A CONTRACT WITH AN AUDIOLOGIST. I CAN'T BRING IN MY OWN. THEY DON'T HAVE A CONTRACT. I'VE SUGGESTED IT. THREE YEARS LATER, NOTHING. IT'S HUGELY IMPORTANT. I'M GLAD TO SEE THAT NORTH CAROLINA IS DOING BETTER AT LEAST AT ONE PLACE BUT THAT, IN AND OF ITSELF, IS A MESSAGE THAT YOU CAN SEND TO YOUR PEOPLE, LET'S AT LEAST HAVE CONTRACTS. LET PEOPLE KNOW THIS IS AN ISSUE THAT'S IMPORTANT. SO BACK TO HLAA, WE DO ADVOCATE. I'M AN ADVOCATE. I'M NOT AN ATTORNEY. I'M NOT A TECH PERSON. I'M A PERSON WHO HAS BEEN LIVING WITH HEARING LOSS FOR ALMOST 40 YEARS NOW. BUT I'VE HAD TO BECOME A TECH PERSON AND AS AN ADVOCATE, I KNOW ABOUT THE LAW, BUT I HEARD THAT SOMEBODY IS ON THE PHONE WHO IS ACTUALLY DISABILITY RIGHTS PERSON. SO PLEASE FEEL FREE TO CORRECT ME IF I MISSPEAK ON EITHER TECH ISSUES OR ON THE LAW. I DON'T WANT TO BE-- I DON'T WANT TO SEND ANY INCORRECT MESSAGES, BUT I'VE BEEN IN THIS BUSINESS NOW FOR ALMOST 30 YEARS AS WELL. I BECAME AN ADVOCATE ALMOST AS SOON AS I LOST MY HEARING AID AND HEARING LITERALLY OVERNIGHT, WHICH IS KIND OF THE THING THAT PUSHES YOU INTO IT. I WAS AROUND 30 YEARS OLE OLD. I COULDN'T HEAR ANYMORE THE NEXT DAY, AND THAT BECAME, WELL, WHERE IS MY INFORMATION? THAT'S, AGAIN, WHAT YOU'RE LOOKING AT. PEOPLE WHO ARE HARD OF HEARING LIVE IN A HEARING WORLD THEIR WHOLE LIVES AND THEN THEY AGE INTO IT, AND I'M HERE TO TELL YOU IT'S AMAZING. PEOPLE SAY, OH, THEY'RE IN DENIAL. THEY DON'T DEAL WITH THEIR HEARING LOSS. I'M HERE TO TELL YOU THAT THE BRAIN DOES AMAZING THINGS. THEY ADJUST . THEY SAY, OH, I CAN ADJUST TO WHAT I'M HEARING. IT'S NOT LIKE IT WAS BEFORE BUT IT'S HAPPENING GRADUALLY AND I CAN ADJUST UNTIL IT GETS TO A POINT WHERE YOU CAN NO LONGER ADJUST. SO I'M HAPPY TO SEE OTHER PEOPLE IN THE ROOM HERE WHO ARE LOOKING TO WORK TO MAKE THAT ADJUSTMENT MORE PROFITABLE, MORE USEFUL TO PEOPLE WITH HEARING LOSS. LET'S GO TO THE NEXT SLIDE. SO MANY OF YOU ARE PROBABLY FAMILIAR WITH THE REPORT FROM THE NATIONAL ACADAMIES OF SCIENCES AND ENGINEERING AND MEDICINE THAT HAPPENED SEVERAL YEARS AGO, 2016, AND THAT HAPPENED ACTUALLY AFTER A LOT OF PEOPLE WERE PUSHING FOR THAT TO HAPPEN ON A NATIONAL LEVEL FROM THE NATIONAL INSTITUTES OF HEALTH, THE CENTER FOR HEARING AND COMMUNICATIONS DISORDERS BEGAN TO PUSH AND SAY, LOOK, WE REALLY NEED SOME WORK ON THIS AND I'M SURE MANY OF YOU HAVE SEEN THE REPORT THAT THEY PUT OUT . BUT THESE ARE THE TWO THINGS THEY WERE SAYING. LOOK, HEARING LOSS IS A SIGNIFICANT PUBLIC HEALTH PROBLEM. PEOPLE ARE NOT RECOGNIZING IT AS A HEALTH PROBLEM. THEY JUST SEE-- THEY'RE JUST MOVING AHEAD. AND THE BARRIERS TO COMMUNICATION ACCESS THAT HAVE BEEN REPORTED INCLUDE HIGH COSTS, LACK OF INSURANCE COVERAGE, THE STIGMA ASSOCIATED WITH HEARING DIFFICULTIES AND WEARING HEARING AIDS, AND THE LIMITED AWARENESS OF AVAILABLE OPTIONS. YOU CAN MOVE ALONG HERE. SO WHO ARE THESE PEOPLE WITH HEARING LOSS? WELL, THE THING IS THEY'RE EVERYWHERE AND NOWHERE. SO YOU CAN'T SEE THEM. YOU DON'T KNOW WALKING DOWN THE STREET USUALLY UNLESS THEY HAVE A BIG COCHLEAR

IMPLANT ON OR A REAL HEARING AID YOU CAN ACTUALLY SEE BUT THEY'RE OUT THERE AND THERE'S A LOT OF US THAT WE ESTIMATE THAT THERE ARE APPROXIMATELY 48 MILLION PEOPLE WITH HEARING LOSS. THAT STATISTIC COMES FROM DR. FRANKLIN AT JOHN HOPKINS AND HE WAS LOOKING AT THE WORLD HEALTH ORGANIZATION DEFINITION OF HEARING LOSS WHO PUTS IT AT 25 DECIBELS DOWN FOR ONE EAR. YOU KNOW, WE'RE COVERING ALMOST EVERYBODY WHO HAS ANY KIND OF A LOSS. PEOPLE DON'T RESPOND TO THEIR LOSS UNTIL THEY'RE A LITTLE BIT FARTHER ALONG THAN 25 DB IN ONE EAR. LET'S GO TO THE NEXT SLIDE. HARD OF HEARING. I'M GOING TO FOCUS BECAUSE THAT'S MY AREA OF EXPERT TESS. I WORK WITH PEOPLE AT THE NATIONAL ASSOCIATION OF THE DEAF AND I WAS HAPPY TO HEAR THAT HOWARD ROSENBAUM WAS HERE TO TALK TO YOU BEFORE AND I WORK WITH TDI, TELECOMMUNICATIONS FOR DEAF AND HARD OF HEARING, BUT I FOCUS ON PEOPLE-- I REPRESENT THE PEOPLE I REPRESENT AND WORK WITH PEOPLE WHO ARE HARD OF HEARING AND THAT'S ANY DEGREE OF HEARING, ANY DEGREE OF HEARING LOSS ARE PEOPLE WHO COME TO US AND LOOK FOR HELP. WE'RE ALSO WORKING WITH PEOPLE WHO ARE LATE DEAFENED. AND WE REFER TO THE WHOLE GROUP INSTEAD OF HARD OF HEARING, WE REFER TO THE GROUP AS PEOPLE WITH HEARING LOSS. GO AHEAD. SORRY TO MAKE YOU WORK FORWARDING ALL THESE SLIDES HERE. OKAY. SOME OF YOU, OBVIOUSLY, THE AUDIOLOGISTS AND THE DOCTORS IN THE ROOM ALREADY UNDERSTAND THIS, BUT ONE OF THE THINGS THAT WE ALSO LOOK AT IS THAT SEVEN TO TEN YEARS BEFORE SOMEBODY ACTUALLY SEEK SOME KIND OF TREATMENT AND AGAIN, I REALLY BELIEVE THIS IS BECAUSE PEOPLE ADAPT AND ADJUST UNTIL THEY CAN NO LONGER DO IT. OUR FOLKS USE TECHNOLOGY. THEY LIKE TECHNOLOGY. THEY SAY, WOW, THIS STUFF REALLY WORKS. IT'S LIKE THE EXAMPLES THAT TONY WAS GIVING YOU OR PEOPLE USING A POCKET TALKER FOR THE FIRST TIME AND BEING AMAZED. I'VE SEEN THE SAME THING. NOW, SOMEBODY WHO IS LATE DEAFENED, WE'RE TALKING ABOUT PEOPLE IN MY COMMUNITY AGAIN TEND TO BE PEOPLE WHO ARE ALREADY ADOPTED LANGUAGE BEFORE THEY LOST THEIR HEARING. NOW IT DOESN'T HAVE TO BE THAT LATE IN LIFE. IT COULD BE JUST SOMETIME WHEN THEY'RE STILL VERY COMFORTABLE USING THEIR LANGUAGE OF ORIGIN, SPANISH, ENGLISH, WHATEVER VERBAL LANGUAGE THEY HAD A HOLD ON, THAT'S WHAT THEY DO, AND I'VE HAD PEOPLE COME TO TELL ME AND SAY, YOU KNOW, THE FIRST THING PEOPLE DO WHEN THEY SAY AND WALK UP TO THEM AND I SAY I HAVE A HEARING LOSS. THE DO YOU KNOW SIGN LANGUAGE? MOST PEOPLE WHO AGE INTO HEARING LOSS OR ARE LATE DEAFENED DO NOT KNOW SIGN LANGUAGE. THEY JUST DON'T. THEY NEVER PICK IT UP AND PART OF THE REASON FOR THAT IS, FIRST OF ALL, SIGN LANGUAGE, ASL, IS A DIFFICULT LANGUAGE TO LEARN. I DON'T KNOW HOW MANY PEOPLE HAVE TRIED. I HAVE HAD ACCESS. IT'S ONE OF THE FIRST THINGS I DID WHEN I LOST MY HEARING OVERNIGHT, AND IT'S JUST-- I'M NOT A LANGUAGE PERSON. IT'S VERY DIFFICULT FOR ME. SO I KNOW A FEW SIGNS. I KNOW A LITTLE BIT. I CAN PICK UP STUFF AND I HAVE BEEN IN THE FIELD FOR A WHILE, SO I KNOW IT, BUT MANY PEOPLE ARE NOT AROUND PEOPLE WITH HEARING LOSS. THEY'RE WITH THEIR FAMILIES, THEY'RE WITH PEOPLE WHO SPEAK WHATEVER LANGUAGE THEY GREW UP WITH. THAT'S HOW THEY WANT TO COMMUNICATE. THAT'S THEIR FRIENDS AND IF THE OTHER PERSON DOESN'T KNOW SIGN LANGUAGE OR IF I KNOW IT, IF MY BROTHER DOESN'T KNOW IT, WHAT WILL I DO? SO THIS SEGMENT JUST DOESN'T HAVE THAT MODE OF COMMUNICATION WHICH WOULD MAKE LIFE EASIER IN A LOT OF WAYS BUT THEY HAVE TO DEPEND ON TECHNOLOGY BECAUSE THEY DON'T HAVE THAT OPTION. NOW HEARING LOSS IS ALSO NOT INTUITIVE, WHICH IS, AGAIN, THE PEOPLE IN THIS ROOM MAY UNDERSTAND THESE ISSUES BUT THE PEOPLE OUTSIDE THIS ROOM, IN LONG-TERM CARE FACILITIES AND MORE LIKELY IN THE DOCTORS' OFFICES, PLACES WHERE THEY'LL SEE ONLY OCCASIONALLY SOMEBODY COME IN WITH A HEARING LOSS, THEY DON'T GET IT. THEY DON'T UNDERSTAND IT. SO IN ONE SITUATION, I'M PERFECTLY FINE

HEARING YOU. I'LL BE SITTING IN A DOCTOR'S OFFICE AND ALL OF A SUDDEN, SOMEBODY WILL ROLL DOWN THE HALL WITH SOME CART WITH ALL KINDS OF NOISY THINGS ON IT. I NO LONGER CAN HEAR AND THE GUY DOESN'T GET IT. WHAT'S GOING ON HERE? PART OF THAT , I BELIEVE, IS THAT MOST PRIMARY CARE PHYSICIANS ARE NOT TAUGHT IN SCHOOL. THEY DON'T SPEND ANYTIME ON IT. NURSES DON'T SPEND A WHOLE LOT OF TIME ON IT. IT'S JUST-- YOU KNOW, SOMETIMES I SAY THE HEAD IS SORT OF IGNORED IN MEDICAL FACILITY AND I THE EYES AND EARS, FORGET IT AND MENTAL HEALTH STUFF, WELL, THAT'S A WHOLE OTHER ISSUE. WE DON'T SPEND ENOUGH TIME ON IT AND WE NEED, AS A SOCIETY TO REALLY FOCUS ON THIS AND SEEING YOU FOCUS ON HEARING IS REALLY IMPORTANT. OKAY. SO NOW I'LL TALK A LITTLE BIT ABOUT THE AMERICANS WITH DISABILITIES ACT. YOU BROUGHT UP THE IDEA OF, WHY ISN'T THIS IN THE BUILT-IN ENVIRONMENT? SO, IT SHOULD BE IN THE BUILT-IN ENVIRONMENT. IT SHOULD BE-- ADA HAS BEEN AROUND FOR ALMOST 30 YEARS NOW AND IT'S A CRIME WE'RE STILL TALKING ABOUT THIS. IT SHOULD BE IN EVERY BUILDING, EVERY NEW BUILDING AFTER 20-- ADA OF 2010. IT WAS BEFORE THEN. THAT WAS WHEN THE NEW RULES WERE MADE, BUT FOR 30 YEARS, IT SHOULD BE IN PLACE. IT'S ALSO FOR REN MOTIVATIONS CAN GOING FORWARD. SO PART OF THE REASON THAT IT DOESN'T HAPPEN IS I WAS JUST IN MARYLAND WHERE WE CREATED A NEW LAW THAT SAID IN MARYLAND STATE, ANY FUNDING THAT IS PROVIDED FOR ANY BUILDING THAT USES STATE FUNDING, THAT BUILDING MUST PUT IN A LOOP SYSTEM OR SOMETHING SIMILAR. THAT'S JUST MIRRORING THE ADA. IT'S NO BIG DEAL. WE GOT THE LAW PASSED IN ONE SESSION. IT WAS REALLY EASY. WE SAT DOWN WITH THE PEOPLE WHO HAVE OVERSIGHT OF THAT BILL AND THE GUY WHO DOES INSPECTIONS FOR EVERY STATE BUILDING SAID TO ME, YOU KNOW, I INSPECT FOR HOW HIGH THE WATER FOUNTAIN IS AND HOW WIDE THE DOORS ARE SO THAT PEOPLE CAN USE A WHEELCHAIR AND WHETHER THERE'S BRAILLE SIGNAGE WHERE IT NEEDS TO BE BUT I NEVER INSPECTED FOR ANY KIND OF LISTENING SYSTEM. WHILE I DIDN'T PUT THIS AS A RECOMMENDATION, IT'S SOMETHING YOU MIGHT THINK ABOUT. I DON'T KNOW HOW MUCH YOU CAN DO ABOUT THAT BUT SOME OF YOU CAN DO IN OTHER WAYS BUT THERE SHOULD BE INSPECTION FOR ADA REQUIRED-- FOR ADA REQUIREMENTS. IF THERE'S A LISTENING SYSTEM AND IF THE FACILITY HAS COMMON AREAS AND ADA REQUIRES AND SCOPES FOR IS THE NUMBER-- THE RATIO OF SEATS IN THE ROOM, HOW MUCH YOU CAN ACCOMMODATE. THE ADA 2010 DEAL, DEPARTMENT OF JUSTICE PUT STANDARDS IN FOR HOW MANY RECEIVES YOU NEED. IF YOU PUT A LOOP IN THE ROOM, CLEARLY SOMEONE USES THEIR HEARING AID AND YOU DON'T NEED QUITE AS MANY. YOU NEED RECEIVES FOR PEOPLE LIKE THE POCKET TALKER THAT HAD RECEIVE ARE TO THE LOOP OR LIKE FOR FM LIKE I'M WEARING TODAY AND MY NECK LOOP THAT I'M WEARING BECAUSE I HAVE A TELECOIL BUT OTHER PEOPLE MIGHT NEED A HEADSET. ALL OF THAT IS ALREADY AVAILABLE AND REQUIRED UNDER THE ADA

THE KEY TO THE ADA FOR PEOPLE WITH HEARING LOSS IS EFFECTIVE COMMUNICATION. THAT IS IN THE LAW. YOU MUST PROVIDE EFFECTIVE COMMUNICATION TO ANYONE COMING IN. SO EVEN IF IT'S ONE PERSON, IT DOESN'T HAVE TO BE A MASS OF PEOPLE. IF ONE PERSON COMES IN, THEY NEED TO BE PROVIDED EFFECTIVE COMMUNICATION AT ANY PUBLIC ACCOMMODATION, ANY STATE OR GOVERNMENT SERVICES OR FACILITIES. YOU MUST PROVIDE THAT. NOW THAT'S WHATEVER SOMEBODY NEEDS F THEY NEED SIGN LANGUAGE INTERPRETING, THAT'S WHAT THEY GET. IF THEY NEED AN ASSISTIVE DEVICE, THAT'S WHAT THEY SHOULD GET AND OF COURSE, OFTEN DON'T, BUT THAT'S WHAT'S UNDER THE REQUIREMENTS. NOW THE ATTORNEY GENERAL OF VIRGINIA HAS BEEN PUSHING FOR THE VIRGINIA REGION AND OF COURSE, THIS HAPPENED NATIONALLY AS WELL THAT THEY HAVE BEEN INSTITUTING LAWSUITS OR IN MOST CASES, THEY CAN SETTLE OUT. AND WHEN THEY DO SETTLE OUT, THEY MAKE SURE THAT WHAT HAPPENS IS THAT THERE ARE SPECIFIC RULES IN PLACE

FOR THE REQUIREMENTS MADE FOR THAT FACILITY, FOR THAT HOSPITAL THAT THEY-- THEY'VE BEEN TAKING PRIVATE OFFICES TO TASK FOR NOT COMING UP WITH THE COMMUNICATION ACCESS NEEDS. AND IN ADDITION, WHAT THEY WILL DO IS MAKE SURE THAT THEY KNOW-- THAT THE RULES ARE KNOWN NOT JUST BY ADMINISTRATION AND IT'S A VERY GOOD TO HAVE TOP DOWN, IT'S HUGELY IMPORTANT BUT IT'S ALSO KNOWN BY EVERYBODY ON STAFF. SO WHEN I WAS DOING-- WHEN I WHATS IN NEW YORK MANY YEARS AGO PROVIDING HEALTHCARE ACCESS, I FOUND IT VERY DIFFICULT TO GET IN THE DOOR OF A FACILITY JUST SAYING, YOU KNOW, YOU NEED TO HEAR ABOUT, I KNOW YOU NEED EDUCATION FOR YOUR STAFF AND I CAN PROVIDE IT TALKING ABOUT HEARING LOSS, EH, IT SOUNDS NICE BUT I'LL TALK TO YOU LATER. AS SOON AS THAT FACILITY WAS SUED, BOOM, I GOT EVERYBODY IN THE ROOM INCLUDING DOCTORS, WHICH IS NEVER EASY, BUT EVERYBODY SHOWED UP BECAUSE THE COURT SAID, YOU KNOW, YOU BETTER HAVE THIS SESSION. YOU BETTER KNOW WHAT IT TAKES TO HAVE COMMUNICATION ACCESS IN YOUR FACILITY. HEARING LOSS ASSOCIATION DOESN'T HAVE A TEAM OF ATTORNEYS. WE DON'T GO OUT AND SUE PEOPLE, BUT SOMETIMES LAWSUITS HELP. SOMETIMES LAWSUITS PUSH THINGS ALONG A LITTLE BIT. I WOULD LIKE TO SAY THAT ONCE THOSE LAWSUITS WERE INSTITUTED IN NEW YORK, EVERY FACILITY WAS THEN ADA -- LIVED UP TO ALL THEIR ADA REQUIREMENTS. I'M SORRY TO SAY THAT WE STILL HAVE PROBLEMS GETTING IN. SO WHAT DOES IT MEAN? WHAT DOES EFFECTIVE COMMUNICATION MEAN? I THINK YOU HAVE TO LOOK AT IT AGAIN, ON A CASE-BY-CASE BASIS. IT DOESN'T MEAN THAT YOU'LL BE ABLE TO PROVIDE-- I WOULD LOVE IT IF IT WAS ONE SIZE FITS ALL AND WE JUST DID ONE THING AND WE BROUGHT IN A SIGN LANGUAGE INTERPRETER AND BOOM, WE'RE DONE. WE CAN'T BECAUSE DIFFERENT PEOPLE HAVE DIFFERENT NEEDS. YOU NEED TO FIGURE OUT WHAT IS EFFECTIVE. SO THIS IS THE KIND OF THING THAT TONY WAS JUST TALKING ABOUT. THE RADIO FROAK IS A, THAT'S THIS, OR FM. IT CAN BE REFERRED TO EITHER WAY. IT'S A RADIO SIGNAL. THIS IS JUST FM SIGNAL THAT'S WORKING, INFRA RED HE TALKED ABOUT. YOU ARE SEEING LESS AND LESS INFRARED SIGNALS. YOU HAVE TO HAVE I ATRANSMITTER AND A RECEIVER AND IF YOU GET IN THE WAY OF THE SIGNAL, SOMETIMES IF THEY'RE NOT PROPERLY SET UP SO SOMEBODY TALL WALKS BY AND BOOM, I LOSE MY SIGNAL. SO YOU DON'T SEE AS MANY OF THOSE BUT YOU CAN USE THEM. THE HEARING LOOP IS WHAT WE RECOMMEND TO OFTEN AND HEARING LOSS ASSOCIATION HAS BEEN ADVOCATING FOR THAT BECAUSE THE SIGNAL IS STRONGER AND CLEANER FOR PEOPLE WITH MORE SIGNIFICANT HEARING LOSS. SO I BENEFIT WITH A LOOP AROUND MY NECK SO I CAN WEAR THIS RECEIVER AND I'M FINE. BUT SOME PEOPLE'S HEARING LOSS IS SO SIGNIFICANT THAT IT JUST DOESN'T GIVE THEM ENOUGH POWER BUT IF YOU HAVE-- WE CALL IT A LOOP BUT IT'S NO LONGER A LOOP.
IT'S MORE LIKE AN ARRAY OF A WIRES UNDERNEATH THE CARPET THAT I CAN THEN PICK UP THAT MAGNETIC SIGNAL WITH THE HEARING AID AS THE RECEIVER AND I DON'T HAVE TO PICK UP A RECEIVER ANYMORE AND WHILE IT'S NICE TO HAVE THE BASKET OF RECEIVERS SOMEWHERE, WHAT IF THE FACILITY DOESN'T HAVE THAT? I CAN WALK IN, TURN ON THE HEARING AID AND BE ACCOMMODATED. THAT'S WHY WE'RE PUSHING IT, CONSIDER WE THINK IT WORKS WELL AND WE'RE SEEING MORE AND MORE USE OF IT. BUT FRANKLY, IF IT'S-- IF SOMEBODY SAYS, WELL, I CAN'T DO THAT BUT I CAN PUT A PORTABLE FM SYSTEM IN, GOD BLESS YOU. DO IT. DO WHAT YOU NEED TO DO. NOW THE PERSONAL AMPLIFIERS ARE ALSO AVAILABLE. AND PERSONAL AIM FLYERS ARE LIKE WHAT TONY SAID.
THING ABOUT A PERSONAL AMPLIFIER IS ALSO GOOD. DR. LYNNE AT JOHN HOPKINS RAN A STUDY AT THIS GIVING A BASIC HEARING AID TO SOME PEOPLE OR PERSONAL AMPLIFIER AND HE FOUND THE ADOPTION RATES WERE REALLY GOOD. THAT PEOPLE SAID, YES, THIS IS REALLY HELPFUL AND IT'S ONLY $140 AND WHILE THAT'S STILL CASH TO SOMEBODY WHO IS REALLY LOW INCOME, IT MAKES A HUGE

DIFFERENCE. I DON'T HAVE TO SPEND $4,000 ON A HEARING AID. THAT MAKES A HUGE DIFFERENCE AND MAKES IT MUCH MORE AVAILABLE. OKAY. OTHER SERVICES. NOW CART IS BEING OFFERED IN THIS ROOM AND IT'S WONDERFUL. SO FOR PLACES LIKE IF THERE ARE PRESENTATIONS, PATIENT EDUCATION, EDUCATION OF STAFF, AND WE CAN'T FORGET THAT SOME OF THE PEOPLE ON STAFF ARE ALSO GOING TO HAVE A HEARING LOSS SO YOU HIRE SOMEBODY WHO IS DEAF OR SOMEBODY WHO IS HARD OF HEARING, THOSE PEOPLE NEED ACCOMMODATIONS AS WELL. AND SHOULD HAVE ANY KIND OF PRESENTATIONS, IF CART IS REQUESTED AS AN ACCOMMODATION, SHOULD BE PROVIDED. CAPTIONING IS-- SO THE CAPTIONING TODAY WE'RE GETTING-- I'M RECEIVING IT ON MY TABLET. YOU CAN RECEIVE CAPTIONING ON YOUR SMARTPHONE. YOU CAN , AGAIN, DO PATIENT VIDEOS. YOU HAVE PATIENT EDUCATION VIDEOS. INSTEAD OF HAVING IT ALL AUDIBLE AND I CAN'T ACCESS IT, SOMEBODY WHO IS DEAF CAN'T ACCESS, THINK ABOUT WAYS THAT THIS CAN BE DONE. IT'S ALSO REQUIRED-- IT'S AN AUXILLARY AID IN SERVICE UNDER THE ADA, AND IT SHOULD BE REQUIRED. IT GOES BACK TO WHAT TONY WAS SAYING. PEOPLE DON'T KNOW ABOUT IT. THEY DON'T KNOW THEIR RIGHTS OR THEIR RESPONSIBILITIES UNDER THE ADA AND IT MAY NEVER ASK FOR IT. IT HELPS TO BE PROACTIVE AND FOR ME, IT MAKES-- I DON'T UNDERSTAND WHY HEALTHCARE PROVIDERS WOULDN'T WANT TO BE SURE THAT EVERYTHING THEY SAY IS UNDERSTOOD BY THE PEOPLE THAT ARE LISTENING TO THEM OR TRYING TO LISTEN. THEY WANT TO COMMUNICATE IN EDUCATION AND WANT TO COMMUNICATE IN I WHATS THAT THEY'RE SUPPOSED TO GO FORWARD AND BE HEALTHY AND PREVENT FALLS. IT'S HUGE. YOU WANT TO BE MAKE SURE THAT THIS COMMUNITY GETS THE HEALTHCARE THEY NEED AND YOU SHOULD-- YOU SHOULD DO THE RIGHT THING BUT I GET WHAT YOU WERE SAYING ABOUT MAKING IT ALSO--MAKE SURE THERE'S A COST BENEFIT AND IT'S THERE.

IT'S OUT THERE AND WE'RE SEEING MORE AND MORE STUDIES THAT WILL SHOW THAT. OTHER KINDS OF AUXILLARY AIDS AND SERVICES THAT CAN BE PROVIDED IN HEALTHCARE, HEARING AID COMPATIBLE TELEPHONES. WE'RE SEEING-- I WAS JUST IN THE HOSPITAL RECENTLY AND THEY DON'T-- YOU DON'T EVEN SEE TELEPHONES ANYMORE BECAUSE MOST PEOPLE HAVE THEIR OWN SMARTPHONE.

THAT'S ONE THING YOU MIGHT SEE BUT IF A PHONE IS PROVIDED FOR OTHER PEOPLE, THEY SHOULD BE PROVIDED THAT ARE HEARING AID COMPATIBLE FOR PEOPLE WHO NEED THOSE. CAPTIONED PHONES ARE A POSSIBILITY, BUT IN IN LONG-TERM SETTINGS, IF THEY PROVIDE PHONES, YOU CAN GET A CAPTION PHONE BUT THE FCC STILL REQUIRES THAT PHONE IS ASSIGNED TO AN INDIVIDUAL NOT TO THE FACILITY. SO IT MAKES IT A LITTLE BIT HARDER BUT IT CAN BE DONE IF SOMEBODY NEEDS IT IN THE ROOM OR-- LESS LIKELY IN A HOSPITAL SETTING. PROBABLY NOT GOING TO HAPPEN THERE. BUT YOU CAN-- WE'RE WORKING ON IT SO MAYBE SOME DAY IT WILL HAPPEN AND WE'RE STILL PUSHING FOR THE FCC TO CHANGE THAT RULE BUT FOR THE MOMENT, YOU WOULD HAVE TO DO IN A SETTING WHERE THEY WERE ACTUALLY A RESIDENT AND COULD SAY, THIS IS MY PHONE. VISUAL ALERTS FOR MEDICAL TESTING. YOU KNOW, YOU GO INTO RADIOLOGY AND THEY SAY HOLD YOUR BREATH AND IF YOU CAN'T HEAR AND THEY GO OUT OF THE ROOM, RIGHT? AM I SUPPOSED TO HOLD MY BREATH FOREVER? ANY KIND OF INSTRUCTIONS THAT YOU CAN PUT. ALL YOU HAVE TO DO IS PUT A LIGHT ON, YES. LIGHT GOES ON, HOLD YOUR BREATH, LIGHT GOES OFF AND YOU CAN RELEASE NOW. IT'S OKAY. SO IT'S THINGS THAT PEOPLE DON'T EVEN THINK ABOUT THAT WOULD BE REALLY HELPFUL, MAKE IT VISUAL. THINK ABOUT HOW YOU CAN MAKE IT ACCESSIBLE AND VISUAL. NOW I WANTED TO ALSO TALK ABOUT SPEECH-TO-TEXT APPS AND WHEN A FEW PEOPLE SAW MY POWERPOINT AND SAID, I DON'T KNOW IF YOU WANT TO TALK ABOUT THEM BECAUSE THOSE ARE HORRIBLE AT THIS POINT. AUTOMATIC SPEECH RECOGNITION IS REALLY GETTING THERE BUT IN A SITUATION-- SO I WAS A PROTESTER FOR ONE OF THE APPS THAT DOES SPEECH RECOGNITION. I TOOK IT TO MY BROTHER'S

HOUSE AT CHRISTMAS AND THERE WAS A PARTY, LOTS OF CROSS-TALK AND MY BROTHER LOOKS OVER MY SHOULDER AND SAYS, THAT'S MAD LIBS FOR DEAF PEOPLE.

[LAUGHTER]

IT GOT SO MUCH WRONG THAT YOU HAD TO GUESS AT WHAT WAS HAPPENING JUST LIKE YOU USED TO WITH MAD LIBS. SO NOT EVERYBODY KNOWS. I CAN SEE ONLY A FEW PEOPLE ARE SMILING BECAUSE YOU DON'T KNOW MAD LIBS. YOU'RE FILLING IN THE GAPS OF WHAT GOES ON. YOU'RE MAKING IT UP. BUT THEN I SAID TO MY BROTHER, WELL, WELCOME TO MY WORLD. MY WORLD IS LISTENING AND THE AUDIOLOGISTS HERE KNOW, IT THINGS DROP OUT. IT'S NOT THAT I CAN'T HEAR EVERYTHING. I HEAR A LOT, BUT IT COMES IN AND I'M TRYING TO-- THE BRAIN IS CONSTANTLY WORKING TO SAY, THIS MEANS THIS WORD, THIS MEANS SOMETHING ELSE. I'M PULLING IT ALL TOGETHER AND SOMETIMES I GET IT WRONG, AND THAT'S THE PROBLEM. AND THE PROBLEM IS NOT ONLY THAT I GET THINGS WRONG. THE PROBLEM-- WHEN I KNOW I GET SOMETHING WRONG, I CAN SAY TO YOU, YOU KNOW, DOCTOR, WHAT DID YOU SAY? SAY THAT AGAIN. I DIDN'T CATCH THAT, BUT IF I THINK I HEARD YOU SAY YOU'RE NOT SUPPOSED TO TAKE THIS MEDICATION WITH FOOD BUT I HEARD YOU SAY YOU'RE SUPPOSED TO TAKE THIS MEDICATION WITH FOOD, THEN THAT ONE WORD, I'VE LOST. AND THAT'S WHY COMMUNICATION ACCESS IS SO IMPORTANT. THAT'S WHY YOU NEED TO BE SURE SOMEBODY WITH HEARING LOSS REALLY UNDERSTANDS WHAT YOU'RE SAYING. AND THE LAST ONE I SAID WAS THAT WRITTEN NOTES REALLY DON'T PROVIDE EFFECTIVE COMMUNICATIONS. SO SOME OF THESE SPEECH-TO-TEXT APPS ARE GETTING BETTER AND MAYBE USABLE AND WHAT THE BEAUTY OF A SPEECH-TO-TEXT APP IS THAT THE PERSON YOU ARE TALKING TO CAN SEE WHAT'S THERE, THEY SAY, OH, NO, NO. I DIDN'T SAY THAT. I SAID SOMETHING ELSE. NOW I GOT IT. IF YOU CAN, RECORD THAT BECAUSE THE OTHER THING ABOUT HAVING HEARING LOSS IS YOU ARE SPENDING A LOT OF TIME PROCESSING IN THE MOMENT. SO I'M SITTING HERE TALKING AND THINKING AND THEN SOME OF IT GETS FORGOTTEN BECAUSE I'M SO MUCH IN THE MOMENT, IF I CAN HAVE A WRITTEN RECORD OF WHAT WENT ON THAT WOULD MAKE MY LIFE A WHOLE LOT EASIER. AND MAYBE KEEPING ME FROM MAKING A MISTAKE THAT THE DOCTOR SAID SOMETHING TO ME THAT WAS WRONG AND NOW I HAVE IT IN WRITTEN FORM. I'M HERE TO TELL YOU THAT SPEECH TO TEXT IS GETTING THERE AND WE MAY SEE IT IN THE NEXT FEW YEARS. THE BIG GUYS ARE, WOULDING ON IT, MICROSOFT, YAHOO, GOOGLE, THEY'RE ALL WORKING ON IT AND I THINK THEY'RE REALLY CLOSE, BUT YOU HAVE TO WATCH BECAUSE IT MAY NOT ALWAYS BE ACCURATE. BUT DON'T USE-- WRITTEN NOTES ARE TERRIBLE FOR COMPLEX CONVERSATION BECAUSE WHAT HAPPENS IS THE DOCTOR WILL SHORTEN WHAT THEY'RE SAYING. YOU WON'T GET THE WHOLE PICTURE. IT WON'T WORK FOR SOMEBODY WHO IS HARD OF HEARING. IT WON'T WORK FOR SOMEBODY WHO IS DEAF. YOU'RE NOT GETTING THE WHOLE THING. THAT'S DIFFERENT IF SOMEBODY COMES IN A HOSPITAL ROOM AND I'M SAYING, I'M ABOUT TO GIVE YOU TEST YOUR BLOOD PRESSURE. OKAY. YOU CAN DO THAT ON A WRITTEN FORM. IT'S REAL QUICK AND EASY. HE COME. THEY GO. YOU DON'T HAVE TO DO REAL ACCOMMODATIONS EVERY SINGLE TIME YOU HAVE AN INTERACTION BUT YOU DO IF IT'S COMPLEX OR THE PERSON REALLY NEEDS TO KNOW. SO WHAT CAN YOU GUYS DO? SUPPORTING THE ADA, LIKE SAYING, OKAY, IN THE BUILT ENVIRONMENT, HOSPITALS, LONG-TERM FACILITIES, YOU SHOULD BE HAVING IN YOUR COMMON AREAS, YOU SHOULD BE MAKING THEM ACCESSIBLE AS THE RULES STATE UNDER THE ADA. THERE ARE PLACES WHERE AND AGAIN, THE FACILITY IN MARYLAND, THEY'RE RENOVATING THIS COMMON AREA AND I SAID WHAT ABOUT A LISTENING SYSTEM AND THE GUY SPEAKING TELLING THIS ROOMFUL OF PEOPLE WHO HAVE ALREADY BEEN SAYING TO THE GUY IN THE BACK, THE GUY IN THE BACK SAYS, I CAN'T HEAR YOU, HE SAID, WELL, NO, WE HADN'T THOUGHT ABOUT THAT . IT JUST ASTOUNDS ME. YOU HAVE TO PUSH FOR FACILITIES NOW UNDER THE LAW THAT

EXISTS NOW, THERE ARE THINGS THAT CAN BE DONE. BUT YOU CAN GO BEYOND THAT. YOU CAN SAY-- WHAT WE'RE SEEING, CONSUMERS ARE SEEING THAT. LIKE I TOLD YOU ABOUT MARYLAND STATE HAVING A LOOP LAW. THE ONLY REASON WE DO THAT WAS BECAUSE WE KNEW THAT PEOPLE WERE NOT FOLLOWING THE ADA. WE DIDN'T KNOW ABOUT THE INSPECTOR WHO TOLD US THAT, OH, NO, I DON'T INSPECT FOR THAT. WELL, NOW HE WILL. BUT WE DIDN'T KNOW THAT. ALL WE KNEW IS WHEN WE WENT IN A FACILITY, WE WERE GOING INTO THAT MEETING ROOM AND THERE WOULD BE NOTHING THERE IN THE BUILT ENVIRONMENT THAT SHOULD BE THERE. AND IT'S THERE, IT'S BETTER IN TWO WAYS. FIRST OF ALL, EVERY TIME YOU TAKE A PORTABLE DEVICE, YOU END UP MESSING IT UP A LITTLE BIT. ONCE IT MOVES, IT TAKES MORE STRESS. IF IT'S BUILT ENVIRONMENT, IT'S THERE. IT'S SET UP. YOU FLIP THE SWITCH. IT'S ON. IT'S DONE. THE OTHER THING IS THAT PEOPLE GET USED TO IT. SO THE STAFF HEED TO BE USED TO WHAT'S THE PROCEDURE, HOW DO I DO IT? AND IT'S THERE AND THEY DON'T HAVE TO GET USED TO EVERY SINGLE DIFFERENT PORTABLE DEVICE. THIS LOOKS DIFFERENT THAN ANY OF THAT I HAVE SEEN BEFORE. I HAD TO HAVE A COUPLE MINUTE OF INSTRUCTIONS AND THE GUYS BACK THERE ARE EXCELLENT AT KNOWING HOW TO DO THAT. IF YOU HAVE A NURSING STAFF THAT LOOKS AT SOMETHING BRAND NEW, CHANS ARE THEY MAY NOT KNOW HOW TO MAKE IT WORK. YOU HAVE TO HAVE SOMETHING THERE. SO WE WOULD SUGGEST THAT TO THE EXTENT THAT YOU NEED NEW LAW AND YOU MAY NOT NEED IT AS A LAW. YOU MAY JUST NEED IT TO PUSH THE REQUIREMENTS OR HAVE VOLUNTARY-- WE HAVE SEEN SOMETIMES THAT ONCE INSTITUTIONS UNDERSTAND VOLUNTARY COMPLIANCE, THEY'LL DO THAT, TOO. SOMETIMES THEY'RE VERY RESISTANT TO HAVING A BRAND NEW LAW AND WILL GO TO THE LEGISLATORS AND SAY, NO, NO, WE DON'T WANT THIS. YEAH, THE LAW WE PUSHED, WE HAD ZERO RESISTANCE. EVERY LEGISLATOR VOTED FOR IT ON BOTH THE HOUSE AND THE DELEGATE SIDE BECAUSE, AGAIN, WE WERE JUST SAYING IT'S A LAW THAT SHOULD BE ADHERED TO ANYWAY. IT'S ALREADY IN PLACE. JUST DO IT, GUYS. BUT WE'RE SAYING UNDER STATE LAW NOW THERE ARE REPERCUSSIONS IF YOU DON'T DO IT. SO SOME OF THE BARRIERS. NOW THIS-- SOMEBODY MENTIONED THIS EARLIER. TOP-DOWN PRIORITIZATION. IF THE GUYS WHO ARE RUNNING THE SHOW DON'T THINK IT'S FOR PEOPLE TO HAVE THIS AND AGAIN, THE NURSING HOME THAT I GO TO, I CAN'T BELIEVE NOBODY SET UP A CONTRACT WITH AN AUDIOLOGIST. WHY WOULDN'T THEY DO THAT? IT'S A FACILITY THAT DEALS WITH DEMENTIA CARE AND IT ALSO DEALS WITH PEOPLE WHO ARE IN REHAB OF ALL SORTS. IT'S JUST STUNNING TO ME THAT THEY WOULDN'T DO THAT. SO TOP DOWN, REALLY THE MESSAGE SHOULD BE AND THE FACT THAT YOU'RE WORKING ON THIS TASK FORCE IS GREAT BECAUSE THE MESSAGE COMES RIGHT FROM THE TOP TO THE PEOPLE WHO NEED IT. THE OTHER THING IS LACK OF STAFF TRAINING. WHEN I DID THESE TRAININGS IN NEW YORK, WHEN I GOT THROUGH THE FRONT DOOR, THE NURSES LOVED IT. LOVED IT. BECAUSE IT'S I WAS NOT JUST TALKING ABOUT TECHNOLOGY THAT THEY MAY OR MAY NOT HAVE HAD. I WAS TALKING ABOUT COMMUNICATION STRATEGIES, WHAT DO I DO? HOW DO I DO THIS? WHAT ARE THE TIPS? AND AGAIN, I LOVED YOUR CONCRETE TIPS ON WHAT CAN MAKE IT BETTER IN A NURSING SITUATION. THAT'S THE KIND OF THINGS THEY NEED . THEY WORK DAY TO DAY. THEY WORK REALLY HARD. ANYTHING THAT MAKES THEIR LIVES A LITTLE EASIER MAKES THEM-- BECAUSE IT'S A ROUTINE.
IT'S THERE. THEY KNOW WHAT TO DO. THEY KNOW HOW TO COMMUNICATE THAT THEY REALLY APPRECIATED IT. I THINK TRAINING NEEDS TO BE EMBEDDED IN THE TRAINING, HOW DO YOU COMMUNICATE WITH PEOPLE AND WHAT'S THERE. I THINK THE OTHER BARRIER IS THAT WE-- A LOT OF PEOPLE DON'T KNOW OF THIS ARRAY OF DIFFERENT OPTIONS THAT TONY BROUGHT THAT THE-- YOU KNOW, I TALKED TO MY SON WHO IS A NURSE IN NEW YORK CITY AT JACOBY HOSPITAL AND HE SAYS WHEN SOMEONE COMES IN AND REQUESTS A SIGN LANGUAGE INTERPRETER, THEY HAVE THAT. THEY

DON'T HAVE ANY OF THIS. BUT THEY HAVE AN INTERPRETER, BUT EVEN SO, IT'S LIKE A BIG SIGH, OH, OKAY, I GOT TO GET THE SIGN LANGUAGE INTERPRETER BECAUSE IT'S NOT A REGULAR PART OF WHAT THEY DO. IT'S NOT EASY. THEY HAVE TO FIND WAYS TO GET TO THAT SIGN LANGUAGE INTERPRETER. IT SHOULD BE EASY FOR STAFF. THEY SHOULD BE ABLE TO KNOW IMMEDIATELY HOW DO I COMMUNICATE, WHAT DO I DO? AND THEN I THINK PART OF THE BARRIERS IS THE PERCEIVED COSTS. YOU KNOW, WHEN I TELL PEOPLE THAT POCKET TALKER IS $140, THEY SAY, OH, I CAN DO THAT. THERE'S A FEELING THAT THE COST OF PROVIDING TECHNOLOGY WILL BE TOO GREAT AND SO THEY SAY, I DON'T EVEN WANT TO FIND OUT. YES WANT TO DEAL WITH IT. IT'S TOO MUCH. BUT IT'S PERCEPTION
THE REALITY OF IT IS IT'S CERTAINLY NOT AS EXPENSIVE AS PUTTING THE NEXT MRI EQUIPMENT THEY NEED IN THEIR HOSPITAL. IT'S NOT EXPENSIVE AS DEALING WITH THE FACT IF YOU'RE IN A NURSING HOME, SOMEBODY IS FALLING DOWN BECAUSE THEY HAVEN'T HAD AN AUDIOLOGIST LOOK AT THEM AND SAY, THIS PERSON HAS BALANCE ROBS. -- THIS PERSON HAS BALANCE PROBLEMS. IT HELPS THEM. THEY DON'T KNOW THAT, THE PERCEIVED COST IS MORE THAN THEY THINK IT'S WORTH DOING. AND THE TRUTH IS THE LACK OF AWARENESS OF HEARING AID AND IN LONG-TERM CARE FACILITIES IT'S A PROBLEM OF KEEPING THE HEARING AID ON. FOR PEOPLE WHO GO TO DOCTORS' OFFICES AND SETTINGS, PEOPLE KNOW ABOUT HEARING AIDS. THEY DON'T KNOW ABOUT THIS ASSISTIVE EQUIPMENT, BUT THEY KNOW ABOUT HEARING AIDS, SO THE COST OF HEARING AIDS FOR INDIVIDUALS IS STILL A HUGE BARRIER. IT IS THE NUMBER ONE CALL WE GET AT HEARING LOSS ASSOCIATION OF AMERICA. IN FACT, WE JUST GOT NEW STAFF WHO IS ANSWERING THE PHONE AND SHE WAS LIKE AMAZED, OH, MY GOD. I KEPT GETTING CALLS SAYING WHAT DO I DO? I CAN'T AFFORD A HEARING AID. NUMBER ONE CALL WE GET. WHATEVER WE CAN DO TO REDUCE THE COSTS OR MAKE PROGRAMS MORE AVAILABLE TO MORE PEOPLE TO HELP THEM SUBSIDIZE THAT COST THE BETTER. AND LACK OF AWARENESS BY PRIMARY CARE PHYSICIANS. AGAIN, I DON'T KNOW HOW MUCH TIME THEY SPEND ON IT BUT I HAVE BEEN TOLD THEY SPEND VERY LITTLE TIME ON HEARING LOSS. MOST-- THEY'LL SCREEN FOR VISION, AND THEY'LL, YOU KNOW, TAKE YOUR HEART RATE AND DO ALL OF THAT WHEN YOU'RE HAVING YOUR WELLNESS VISIT. THEY RARELY SCREEN FOR HEARING LOSS. MY BOSS FINALLY GOT HER PRIMARY CARE SET UP SCREENING IN HIS OFFICE. SHE WAS SO PROUD. I GOT MY HEARING SCREENED. SHE HAS FULL HEARING. SHE DOESN'T HAVE A PROBLEM BUT SHE WANTED TO MAKE SURE THAT PRIMARY-- IT WAS ON HIS MIND. YEAH. NOT JUST FOR HER BUT WHAT ABOUT THE PEOPLE THAT I'M SEEING WHO ARE COMING IN WHO ARE BEGINNING TO SAY, WHAT DO I DO? SO I THINK, AGAIN, GOING BACK, I'M GOING THROUGH THIS LIST. POLICY MUST BE REALLY CLEAR. THE POLICY IN THE HOSPITAL AND HOW THEY-- AND I THINK YOU MIGHT HAVE SOME IMPACT ON THAT. HOW THE FACILITY SEES HEARING LOSS, SEES COMMUNICATION ACCESS AS IMPORTANT. AND THEN NOT JUST SAYING, OKAY, WE SEE-- LET'S PUT IT ON A WALL. LET'S HAVE OUR PATIENT RIGHTS. WE SEE IT THERE AND THEN IGNORE IT BUT ACTUALLY UNDERSTAND WHAT IT MEANS, WHAT ARE THE COMMUNICATION OPTIONS? AND ACCOUNTABILITY . THAT'S THE OTHER KEY, AND I DON'T KNOW WHAT YOUR CHARGE IS FULLY AND WHETHER YOU CAN DO SOMETHING TO MAKE IT-- PEOPLE ACCOUNTABLE, BUT THERE NEEDS TO BE SOMETHING THAT SAYS THERE IS A RESULT FOR NOT DOING THIS. SOMETHING-- I DON'T KNOW IF THE FACILITY CAN, EVEN, AGAIN, IF YOU SAY WELL, THE RESULT SAYS THERE WILL BE MORE FALLS IN YOUR FACILITY AND WHEN PEOPLE RATE YOUR FACILITY, THEY'LL SEE THAT THIS FACILITY IS NOT TAKING CARE OF ITS PEOPLE BECAUSE THEY'RE FALLING ALL THE TIME AND THEY HAVE TO GO TO THE HOSPITAL, AND THIS CAN HAVE AN IMPACT ON HOW OTHERS RATE THEIR FACILITY. OKAY. SO STAFF TRAINING, THESE ARE THE KINDS OF THINGS I THINK SHOULD BE INCLUDED. JUST A BASIC, WHAT DOES IT MEAN TO HAVE HEARING LOSS. CULTURAL SENSITIVITY, SO THEY UNDERSTAND THE DIFFERENCE

BETWEEN SOMEBODY WHO IS DEAF, HARD OF HEARING AND LATE DEAFENED. THE OPTIONS AND AGAIN, ACCOUNTABILITY ON THE HIGH LEVEL BUT YOU ALSO NEED ACCOUNTABILITY ON STAFF LEVEL. WHAT DOES IT MEAN? WILL I KEEP MY JOB? WILL I HAVE A GOOD RATING AT THE END OF THE YEAR FOR MY BOSS IF I INCLUDE THINGS? OR NOT, OR WILL THEY JUST IGNORE THE FACT THAT I DIDN'T PAY ATTENTION TO THE FACT THAT I CAN'T COMMUNICATE WITH THESE FOLKS -- IGNORE THE FOLK THAT I CAN'T COMMUNICATE WITH THESE FOLKS. SO SOME THE THINGS AND NOT ONLY SHOULD WE HAVE CONTRACTS WITH AUDIOLOGISTS, WE SHOULD HAVE CONTRACTS WITH CART, SIGN LANGUAGE INTERPRETERS, WE SHOULD HAVE CONTRACT FOR SERVICES SO THAT WHEN WE NEED THEM, I DON'T HAVE TO THINK ABOUT IT. YOU KNOW, IT DOESN'T TAKE THREE YEARS TO FIND A CART PROVIDER OR AUDIOLOGIST OR INTERPRETER AND INSTALLED SYSTEMS AND WE CAN DO THIS NOT JUST IN LARGE AREAS AND HERE'S WHERE YOU CAN GO ABOVE AND BEYOND. THE ADA DOESN'T REQUIRE YOU TO-- YOU HAVE TO HAVE EFFECTIVE COMMUNICATION BUT YOU'RE NOT REQUIRED TO PUT IN A SYSTEM IN A HELP DESK OR IN A CONSULTATION ROOM. BUT THOSE ARE PROVIDING EFFECTIVE COMMUNICATION, SO TO THE EXTENT THAT YOU'RE PUTTING YOURSELF AT RISK BY NOT DOING IT, YES, BUT TO THE EXTENT THAT PEOPLE HAVE-- DON'T SPEND A LOT OF TIME. HARD OF HEARING PEOPLE, I'M HERE TO SAY, DON'T SUE A LOT. YOU'RE NOT GOING TO SAY, I DIDN'T GET MY ACCOMMODATION IN MY CONFERENCE ROOM, BUT YOU'RE GOING TO GET BETTER COMMUNICATION. SO THAT'S THE KIND OF THING THAT YOU CAN PAY. YOU CAN HAVE A PORTABLE LOOP SYSTEM RIGHT AT THE HELP DESK AND YOU DON'T HAVE TO HAVE THE MOST EXPENSIVE THING YOU ABOUT YOU CAN PUT A LOOP IN THE CONFERENCE ROOMS. YOU CAN PUT THEM IN NURSING STATIONS SO I DON'T HAVE TO STRUGGLE TO HEAR. THE ADA TALKS ABOUT, AND YOU'RE AWARE, IT'S NOT JUST THE INDIVIDUAL BUT THEIR COMPANION. MY HUSBAND'S IN THE HOSPITAL AND I'M TRIKING TO TALK TO THE NURSE AT THE HELP DESK AND I CAN'T HEAR HER, I SHOULD BE ACCOMMODATED AS WELL. AND THEN, AGAIN, THOSE VISUAL ALERTS THAT I WAS TALKING ABOUT. NOW, I PUT DOWN SOME OF THE COSTS AND SOME ARE CLEARLY MORE EXPENSIVE THAN OTHERS. YOU HAVE A POCKET TALKER THAT'S $150. BOOM, I CAN GET THAT DONE. BUT FOR THE INSTALLMENT, YOU NEED TO HAVE A PROCESS AND YOU NEED TO BE SURE THAT, THAT'S AGAIN, TOP DOWN WHEN THEY BUILD, WHEN THEY BUILD THAT OR IF YOU ARE GOING TO RETROFIT, THINGS ARE RETROFITTED AND THE SOUND SYSTEM IS UPGRADED AND WHEN THAT HAPPENS, IT SHOULD HAPPEN THEN. SO HERE ARE THE COSTS. THE CONSUMER REPORTS ARE VERY INTERESTED IN WHAT'S GOING ON. IT TOOK US YEARS TO PUSH THEM. THEY HAD DIFFICULTY COMPARING HEARING AID TO HEARING AID AND THEY STARTED DOING STUDIES LIKE THIS WHICH THEY SAID, WHAT DO HEARING AIDS COST IN DIFFERENT SITUATIONS. WE KNOW 16% OR 20% OF THE PEOPLE WHO COULD BENEFIT FROM HEARING AIDS GET THEM, AND WE THINK COST IS THE BIG PART OF THAT ISSUE. WHICH IS WHY HEARING LOSS ASSOCIATION CAME OUT IN FAVOR OF HAVING THOSE OVER-THE-COUNTER HEARING AIDS, GOING THROUGH AND HAVING THE OVER-THE-COUNTER LAW ENACTED. IT'S BECAUSE FOR TWO REASONS. ONE WAS, AGAIN, OUR NUMBER ONE CALL AND WE KNEW OUR PEOPLE WERE SUFFERING AND NOT ABLE TO GET ANY KIND OF HEARING AID. THE OTHER REASON IS THAT WE FELT THAT THE HEARING AID INDUSTRY NEEDED TO BE SHAKEN UP A LITTLE BIT. THEY REALLY WERE ENTRENCHED IN A MODE OF SALES THAT MADE IT SO THAT ALL HEARING AIDS WERE WELL ABOVE REACH FOR A LOT OF PEOPLE AND WE WERE STRUGGLING WITH WAYS TO TRY TO FIND LOWER COSTS. SO THE PROGRAMS TONY TALKED ABOUT, A, PEOPLE DON'T KNOW ABOUT THEM. B, THEY'RE HARD TO ACCESS, AND WHAT IF YOU'RE NOT 200% BELOW POVERTY LEVEL? WHAT IF YOU DON'T QUALIFY? THEN YOU'RE IN THAT RANGE OF PEOPLE THAT CAN'T QUITE GET THE HEARING AIDS AND, WELL, YOU KNOW, I'LL JUST DO WITHOUT. AND THOSE PEOPLE WHO COULD ACTUALLY AFFORD THEM. SO THAT'S WHY WE

WENT BEHIND IT. AND SO OVER-THE-COUNTER HEARING AIDS WAS ONE OF RECOMMENDATIONS. I'M SORRY.
>> JAN: I DO HAVE A QUICK QUESTION FOR YOU. IF YOU GO BACK UP TO THE PREVIOUS SLIDE. MY UNDERSTANDING IS THAT THE BIGGEST PART OF THE COST IS THE MARKUP AND I DO RECALL DOING SOME RESEARCH ON THAT. IT WAS SEVERAL YEARS AGO, AND I ACTUALLY LEARNED THAT THE MARKUP COULD BE AS MUCH AS 750% SO THAT'S ANOTHER ISSUE THERE AS WELL. I JUST WANTED TO ADD THAT IN.
>> LISE HAMLIN: SO THE MARKUP DEPENDS ON WHERE YOU ARE. I HEARD OF A HEARING AID SOLD FOR $5,000 PER HEARING AID, SOMEBODY PUTS IN $10,000 IN THEIR EARS. IT HAS HAPPENED AND I DON'T KNOW HOW MANY PEOPLE ARE AWARE THAT WHEN YOU BUY A HEARING AID CURRENTLY, WHAT YOU'RE BUYING IS USUALLY NOT JUST A HEARING AID, WHICH IS WHY THE VA AND VR SERVICES ALSO OFTEN GET IT FOR $300 FOR THE AID. IT'S BECAUSE YOU'RE ALSO BUYING THE SERVICES OF THE AUDIOLOGIST AND THAT'S BUNDLED TOGETHER. WE HAVE, FOR A LONG TIME AT HEARING LOSS ASSOCIATION, HAVE ADVOCATED FOR SEPARATING OUT. SO IF SOMEBODY SAYS, I KNOW I'M SPENDING 300, $400 FOR MY HEARING AID AND I NEED TO PURCHASE SERVICES BECAUSE THE SERVICES OF THE AUDIOLOGIST ARE VALUABLE, I NEED THOSE SERVICES. THEY'RE SEPARATED OUT. I UNDERSTAND WHAT EXACTLY I'M PURCHASING AND WHEN I SPEND WHATEVER IT IS I SPEND, WHATEVER THESE COSTS ARE. SO $1,900 FOR LIKE A COSTCO AND PEOPLE REALLY LIKE IT. THEY LIKE BEING ABLE TO GO TO COSTCO. IT'S RIGHT THERE. THAT WAS THE OTHER THING THE NAS REPORT SAID. SOMETIMES PEOPLE ARE INTIMIDATED BY THE PATHWAY TO GET TO THE AUDIOLOGIST. OH, MY GOD. WHERE DO I GO? WHO DO I SEE? DO I GO TO YELP AND DECIDE WHO IS THE AUDIOLOGIST I GO TO? HOW DO I FIND A DOCTOR? THEY'RE CONFUSED OR FIND IT A BARRIER. DID YOU WANT TO SAY SOMETHING? YOU NEED THIS.
>> Speaker: CURRENTLY, MEDICARE REQUIRES A PHYSICIAN REFERRAL. THERE IS NOT DIRECT ACCESS TO AUDIOLOGIST WHICH IS A WHOLE SEPARATE LINE OF ADVOCACY WE'RE WORKING ON. IT DRIVES UP THE COST.
>> LISE HAMLIN: ABSOLUTELY. HLAA SUPPORTED DIRECT ACCESS LAWS THAT HASN'T REALLY GONE ANYWHERE AND WE'RE SUPPORTING CHANGES IN MEDICARE. RIGHT NOW, WE'RE AT A POINT WHERE MEDICARE EXPANSION MIGHT JUST HAPPEN. WE DON'T KNOW FOR SURE, OBVIOUSLY, WITH CONGRESS, YOU NEVER KNOW. I DIDN'T REALLY SPEAK TO THAT HERE BECAUSE MY UNDERSTANDING WAS YOU GUYS DIDN'T HAVE A LOT OF PUSH. THAT WASN'T PART OF YOUR CHARGE TO GO FOR MEDICARE. I'M HAPPY TO TALK TO SOMEBODY THAT MEDICARE REALLY SHOULD COVER HEARING AIDS AND THE SERVICES OF AUDIOLOGISTS AND DIRECTLY AS WELL.
>> TOVAH: THIS IS TOVAH HERE. I WANT TO MENTION ALSO THAT THE OTHER THING THAT ISN'T REALLY TAKEN INTO ACCOUNT IS THE MAINTENANCE OF HEARING AIDS. IT'S ONE THING TO HAVE THE UPFRONT COSTS FOR HEARING AID AND AUDIOLOGIST REHAB SERVICES, BUT BASICALLY, LIFETIME MAINTENANCE OF HEARING AIDS, BATTERIES, REPAIRS, ALSO HAVE TO BE FACTORED IN.
>> LISE HAMLIN: THAT'S ABSOLUTELY TRUE. BATTERIES BECOME A BIG COST. I HAVE BEEN GETTING MY BATTERIES ONLINE AND FINDING OUT THAT DOESN'T WORK ALL THE TIME. IT'S REALLY-- IT'S AN ONGOING COSTS.
THAT'S TRUE-- I HAVEN'T SPOKEN A LOT ABOUT COCHLEAR IMPLANTS AND THAT'S TRUE WITH COCHLEAR IMPLANTS, TOO. YOU BUY IT AND YOU THINK, OH, THIS IS GREAT. I HAVE MY COCHLEAR IMPLANT AND THEN YOU HAVE TO GET NEW BATTERIES. OH, MY GOD AND THE OTHER PIECES. SO YES. IT'S AN ONGOING MAINTENANCE AND SOMEBODY HAS TO BE ABLE TO AFFORD THAT IF THEY'RE GOING TO DO THAT. THE NAS REPORT SUPPORTED OVER-THE-COUNTER HEARING AIDS, AND WE CAME ON

AND SUPPORTED IT AS WELL, AND SO WHEN I TALK ABOUT SHAKING UP THE MARKET, WHAT IT IS, THE FORMULA NOW IS THAT HEARING AIDS ARE SOLD BY MANUFACTURERS WHO SELL TO AUDIOLOGISTS AND THERE'S A POOL OF APPROXIMATELY-- AND THIS IS THE LAST TIME I LOOKED AT THE CENSUS, SO IT COULD BE A LITTLE BIT DIFFERENT NOW, BUT ABOUT 16,000 AUDIOLOGISTS FOR THE WHOLE COUNTRY AND ABOUT 5,000 HEARING AID INSTRUMENT SPECIALISTS. SO YOU HAVE 20,000 PEOPLE THAT THEY MARKET TO. THAT'S A WHOLE LOT LESS THAN MARKETING TO 48 PEOPLE IN THE COUNTRY AND YOU DON'T KNOW WHERE THEY ARE. BUT WHEN OVER-THE-COUNTER CAME IN, THE OTHER TECHNOLOGY PEOPLE STARTED SAYING, HEY, THERE'S THIS VACUUM OF PEOPLE. IF ONLY 16% OF THE PEOPLE, WHO COULD BENEFIT? NOT THE WHOLE 48 MILLION BUT THE PEOPLE WHO COULD BENEFIT WHICH IS ABOUT 28 MILLION, I CAN-- THEY'RE NOT SELLING IT TO EVERYBODY. I CAN SELL. SO BOSE SAID, WE SUPPORT THIS AND HEARING AID, I LIKE THE IDEA BECAUSE NOT ONLY DOES IT MEAN THAT THERE'S NO COMPETITION WHERE THERE WASN'T BEFORE BUT IT ALSO MEANS THAT THE HEARING AID MAY NOT LOOK LIKE A HEARING AID ANYMORE. THAT'S STIGMA STUFF THAT SOME PEOPLE GET CAUGHT UP IN. YOU MIGHT HAVE SOMETHING THAT GOES AROUND THE NECK AND WORKS WITH YOUR SMARTPHONE TO DO THAT. TO SHAKE UP THE MARKET, TO DO SOMETHING DIFFERENT WAS SOMETHING WE WANTED TO DO. AND I SEE I'VE GOT A QUESTION IN THE BACK THERE. WHAT DO WE NEED FOR YOU? OH, YOU'RE GOING TO DO IT. I DIDN'T HAVE TO GO.
>> ASHLEY: THIS IS ASHLEY SPEAK. IT'S INTERESTING TO LISTEN TO ALL THESE OPTIONS WITH HEARING DEVICES AND OVER-THE-COUNTER HEARING AIDS AND ALL THOSE KINDS OF THINGS BUT PARTICULARLY FOR LONG-TERM CARE STAFF AND ALL OF THE TRAINING THEY NEED, THEY'RE GOING TO NEED TRAINING ON ALL THESE DIFFERENT TYPES OF HEARING AIDS AND ALL OF THESE DIFFERENT DEVICES. I'M WONDERING IF THAT'S GOING TO BE DIFFICULT FOR THEM WITH EVERYBODY NOT USING THE SAME DEVICES. IT SEEMS IF EVERYONE WAS USING MORE STANDARD TYPE OF HEARING AID, EVERYBODY HAD A HEARING AID WITH A TELECOIL SWITCH AND BLUETOOTH COMPATIBLE AND EVERYBODY WAS USING THE SAME TYPE AMPLIFIED DEVICES, IT WOULD BE EASIER TO BE IN COMPLIANCE WITH PROVIDING THESE SERVICES?
>> LISE HAMLIN: AND THAT'S WHY THEY SHOULD HAVE AN AUDIOLOGIST ON CONTRACT OR ON STAFF. I THINK WHAT THE ISSUE IS NOT SO MUCH THAT NURSING STAFF NEEDS TO KNOW EVERY SINGLE KIND OF-- I MEAN, THAT'S THE JOB OF THE AUDIOLOGIST. THEY NEED TO KNOW EVERY KIND OF HEARING AID AND COCHLEAR IMPLANT. NURSING STAFF DOESN'T NEED TO KNOW ABOUT THAT. THEY NEED TO KNOW THAT A PERSON HAS A HEARING AID. THEY NEED ACCOMMODATIONS AND SOME OF THESE ACCOMMODATIONS HAD WORK WITH WHATEVER HEARING AID. WE NEED TO HAVE MORE, WHAT WE'D LIKE TO SEE IN THE FUTURE AND I DON'T KNOW IF THIS WILL HAPPEN IS MORE KIND OF UNIVERSAL SOLUTIONS, SO THAT AUDIOLOGIST DOESN'T HAVE TO PURCHASE THE SOFTWARE FOR PHONAK AND WIDAC AND OTOCON AND THEY BUY THREE. IF THEY WERE OPEN SOURCE HEARING AID, THEY WOULDN'T HAVE TO DO THAT. THEY COULD SAY, I CAN HANDLE ANY HEARING AID IN THIS ROOM. YOU'RE RIGHT, THERE'S TECHNICAL PROBLEMS TRYING TO SOLVE EVERYBODY'S HEARING LOSS WITH EVERY SINGLE HEARING AID. AGAIN, INSTEAD OF JUST HAVING AN APPLE-- AN iPHONE THAT, WOULDS WITH MADE-FOR-APPLE HEARING AIDS AND I CAN'T PLUG IN MY iPAD THE SAME WAY I PLAY IN MY ANDROID DEVICE. LET'S MAKE IT OPEN SOURCE. THAT MAY NOT HAPPEN. THAT'S PIE IN THE SKY. YOU CAN THE DO ANYTHING ABOUT THAT. WE CAN MAKE PEOPLE MORE AWARE ABOUT HEARING LOSS. WE CAN ENSURE-- ONE OF THE RECOMMENDATIONS WOULD BE TO HAVE AUDIOLOGISTS AVAILABLE AT EVERY FACILITY. EVEN ON CONTRACT SO THEY KNOW WHERE TO TURN IF THEY SAY, GEE, I DON'T KNOW WHAT TO DO NEXT. AND YOU KNOW, THEY COULD ALSO CONSULT WITH THE LOCAL HEARING

LOSS ASSOCIATION OF AMERICA, WHICH HAVE CONSUMERS THAT ARE HAPPY TO TALK ABOUT ALL OF THESE THINGS FROM THE CONSUMER PERSPECTIVE. I'M RUNNING OUT OF TIME HERE. SO STATE HEALTH DEPARTMENTS CAN HAVE A ROLE. I KEEP KICKING OFF MY OWN. SO I JUST KICKED OFF MY OWN ACCESS.

SO I'M CIRCLING AROUND MY PROGRAM TO THE ONE I CAN HEAR ON. SO IF I COME OFFMIC FOR ANYBODY ELSE, LET ME KNOW BECAUSE I'M OFF MY MICROPHONE HERE. YOU CAN PROMOTE IT AND WE HAVE POSITION PAPERS ATTAR WHATTING LOSS ASSOCIATION ON OUR WEBSITE, WHICH I'VE LISTED ON OUR RESOURCES AND YOU CAN HAVE ACCESS TO THAT IF YOU NEED SOMEBODY TO SAY, YES, THESE PEOPLE ALSO RECOMMEND THE SAME THING. THESE ARE BASIC RECOMMENDATIONS TO MEET OR EXCEED MINIMUM REQUIREMENTS AND REMEMBER THE ADA WAS A COMPROMISE BILL. IT'S THE FLOOR. IT'S WHERE WE SHOULD BE BASICALLY. YOU CAN GO BEYOND THAT. EVEN IN MARYLAND AGAIN, AND I TALK ABOUT MARYLAND BECAUSE THAT'S WHAT I KNOW. IN THE ADA RELIGIOUS ORGANIZATIONS ARE EXEMPT. NOT IN MARYLAND, YOU HAVE TO PROVIDE ACCOMMODATIONS TO PEOPLE IN RELIGIOUS SETTINGS , EVEN THERE. SO A STATE HAS THE FLEXIBILITY TO GO ABOVE THE ADA. ELIMINATE BARRIERS. OUR RECOMMENDATION SAYS ELIMINATE AS MANY BARRIERS AS YOU CAN TO ANY KIND OF COMMUNICATION ACCESS, ACROSS THE SPECTRUM, ALL THE WAY FROM PROFOUND AND USING SIGN LANGUAGE AND ALL THE WAY UP TO SOMEBODY WHO USES A POCKET TALKER. AND TRAINING AND EDUCATION FOR STAFF. GREATER ACCESS TO HEARING AIDS TO THE EXTENT THAT YOU GUYS CAN DO THAT TO PROMOTE IT, EVEN TO RECOMMEND IT, I THINK IS HUGELY HELPFUL. AND EVEN PROMOTING HEALTHCARE AND WELLNESS IN MEDICAL VISITS. AS I SAY, IT MAKES A DIFFERENCE BECAUSE THE TRUTH IS, MOST PEOPLE LEARN ABOUT HEARING LOSS BY THEIR SPOUSE. YOU CAN'T HEAR, HONEY. I DON'T WANT THE TV UP THAT LOUD, HONEY. BUT YOU KNOW WHAT, THEY DON'T LISTEN TO THEIR SPOUSE. YOU GO TO THE DOCTOR, OH, YOU'RE TELLING ME, OH, OKAY, I SHOULD DO SOMETHING. IT'S A MORE EFFECTIVE WAY OF LETTING SOMEBODY KNOW ABOUT THEIR HEARING LOSS AND ACTUALLY DOING SOMETHING ABOUT THEIR HEARING LOSS. SO HERE'S OUR RESOURCES AND AGAIN, I KNOW YOU HAVE ACCESS. I'M HAPPY TO GIVE OUT MY CARD SO THAT ANYBODY WANTS TO CONTACT ME LATER CAN. AND AGAIN, I WOULD BE HAPPY TO SHARE RESOURCES AS WE NEED IT. SO I'M SHORT ON TIME BUT IF YOU HAVE ANY QUESTIONS THAT YOU HAVEN'T ALREADY ASKED.

>> ADAM: WE'RE GOING LIMIT TO QUESTIONS RATHER THAN SUGGESTIONS FOR OTHER RECOMMENDATIONS AND MAYBE TAKE A COUPLE. WAS THAT YOUR HAND UP, JOHNNY.

>> JOHNNY: IT WAS. JOHNNY SEXTON. YOU CAN HELP ME UNDERSTAND OR RECONCILE THE DISCONNECT THAT I'M HEARING IN SUPPORT OF OVER-THE-COUNTER HEARING AIDS AND YOUR WONDERFUL SUPPORT FOR AUDIOLOGY SERVICES? TO ME, THERE'S A DISCONNECT THERE.

>> LISE HAMLIN: I DON'T SEE IT AS A DISCONNECT. I DON'T. WE STILL SAY TO PEOPLE ESPECIALLY TO SOMEBODY WHO IS A FIRST-TIME USER THAT THE GOLD STANDARD IS TO GO TO YOUR AUDIOLOGIST . IF YOU'VE NEVER HAD A HEARING AID, IF YOU NEVER HAD THAT BEFORE, GOLD STANDARD, GO TO THE AUDIOLOGIST, GET THE RECOMMENDATIONS FROM A PROFESSIONAL AND COUGH UP THE MONEY, IF YOU CAN, IF YOU HAVE THE ABILITY TO DO THAT. BECAUSE THE LONG TERM IT'S BETTER FOR YOU TO KNOW. I TALK TO PEOPLE ALL THE TIME WHO HAD A STABLE HEARING LOSS FOR MANY YEARS, WHO HAVE BEEN TO THEIR AUDIOLOGIST, KNOW WHAT IT IS AND WOULD LOVE TO BUY IT OVER THE COUNTER AND WOULD LOVE TO BE ABLE-- SEPARATELY, THERE'S ANOTHER GROUP OF PEOPLE WHO SAY, YOU KNOW, I'D LIKE TO BUY THE INSTRUMENT AT A LOWER COST AND THEN GO TO MY AUDIOLOGIST TO HAVE THEM HELP ME. RIGHT NOW WITH BUNDLED SERVICES THAT'S A PROBLEM, BUT WE'D LIKE TO SEE PEOPLE UNBUNDLE THAT AND SAY, YES, I CAN HELP YOU. I HAVE SPOKEN TO BOTH

CLINICS AND TO INDIVIDUAL-- MY OWN AUDIOLOGIST WHO SAYS, SURE, I WILL PROVIDE THE WHOLE RANGE. I'LL PROVIDE EVERYTHING FROM A REALLY INEXPENSIVE BASIC, OVER-THE-COUNTER HEARING AID ALL THE WAY UP TO SOMETHING THAT HAS ALL THE BELLS ANDIST WHENLES YOU COULD NEVER USE IN YOUR WHOLE LIFE. I WILL DO THAT BECAUSE THAT'S WHAT I WANT FOR MY PATIENTS.
I'M NOT GOING TO STAND IN THE WAY. SO FOR ME, THERE ISN'T A DISCONNECT. THERE'S FEAR OF CHANGE AND THERE'S REASON FEAR BECAUSE YOUR MIRACLE EAR EXPERIENCE. THERE WAS A TIME WHEN WE HAD PEOPLE KNOCKING ON DOORS, GOING DOOR TO DOOR AND JUST SELLING WHATEVER PIECE OF GARBAGE THEY HAD. WE UNDERSTAND THAT. WE FEEL IT'S HUGELY IMPORTANT. INCUMBENT UPON US TO EDUCATE OUR CONSUMERS TO SAY THE FIRST LINE IS GOING TO YOUR AUDIOLOGIST AND UNDERSTANDING YOUR OWN HEARING LOSS AND THEN AFTER THAT, IF YOU STILL FIND IT A BURDEN, THEN GO AHEAD, BUT I WILL FOREVER GO TO MY AUDIOLOGIST. I LOVE MY AUDIOLOGIST. I WILL NEVER GO ANYWHERE ELSE.
>> JULIE BISHOP: THIS IS JULIE BISHOP, HLAA NATIONAL GETS SUPPORT ORIGINALLY FROM THE ASSOCIATION OF AUDIOLOGISTS, I DON'T KNOW IF THAT'S CORRECT, IN SUPPORT OF THESE-- OF YOUR POSITION ON THE OVER-THE-COUNTER, YES.
>> LISE HAMLIN: WELL, ACTUALLY, NO. AUDIOLOGISTS REALLY ARE WORRIED AND WHEN WE'RE PROMOTING THE LAW, THEY WERE REALLY VERY WORRIED ABOUT THE REPERCUSSIONS, AND I GET IT. I DO. I UNDERSTAND THAT WE'RE WORRIED ABOUT WHAT COULD HAPPEN. MANUFACTURERS ACTUALLY CAME OUT EVEN STRONGER AGAINST THE LAW AND HAD LOBBYISTS IN CONGRESS EVERY DAY RIGHT UP TILL THE END. BUT WE FELT REALLY CONVINCED THAT THIS WAS A WAY TO, AGAIN, DO TWO THING. TO SHAKE UP THE MANUFACTURERS AND TO ALSO PROVIDE SOME KIND OF RELIEF FOR PEOPLE WHO CAN'T FIND ANY OTHER WAY TO GET A HEARING DEVICE. I KNOW YOUR HAND IS KIND OF--
>> SHELLEY CRISTOBAL BALL:: AAMERICAN ACADEMY OF AUDIOLOGY AND DOCTORS OF AUDIOLOGY BOTH ENDED UP IN SUPPORT OF THE BILL THAT WAS PASSED. IT TOOK A WHILE TO GET THERE. THERE WAS THE FEAR OF TRANSITION, OF CHANGE. I THINK THERE'S A GENERAL FEAR OF PUBLIC PERCEPTION, OF MAKING SURE THE CONSUMER IS GOING TO REALLY UNDERSTAND THAT THE SHARP CONTRAST BETWEEN AN OVER-THE-COUNTER HEARING AID THAT IS AN AMPLIFIER MAY BE AN AMPLIFIER WITH HIGH FREQUENCY DIFFERENCES IS DRAMATICALLY DIFFERENT THAN A TRUE HEARING AID SET UP WITH REAL MEASUREMENTS. A HEARING AID FROM PHONAK OUT OF THE BOX IS USELESS.
IT REALLY HAS TO BE SET UP PROPERLY. NOT JUST BASED ON THE HEARING LOSS BUT ALSO THE SHAPE OF THE EAR CANAL. I NEED THE PATIENT'S EAR AND THE HEARING AID IN FRONT OF ME WITH A MICROPHONE IN THE EAR TO GET BEST POSSIBLE BENEFIT, AND THERE'S LOTS OF RESEARCH THAT SUPPORTS THAT 'S THE WAY TO OPTIMIZE SPEECH UNDERSTANDING. AUDIOLOGISTS DO WANT TO MAKE SURE THAT IS THE GOLD STANDARD AND THAT THE PATIENTS KNOW HOW TO GET VERY BEST SPEECH UNDERSTANDING. BUT THIS OTHER 80% OF PEOPLE WHO ARE NOT GETTING ANY BENEFIT AND EXPERIENCING COGNITIVE DECLINE, FALL RISKS, OTHER CONCERNS, THE SOONER WE CAN GET THEM INTO SOME HELP, THE BETTER. WE WERE SORT OF CHATTERING A LITTLE BIT. WHEN COSTCO GOT INTO THE HEARING AID GAME, THE AVERAGE AGE OF-- STARTING TO USE A HEARING AID DROPPED BY FIVE YEARS,67 TO 52. TIMEFRAME OVERLAPSE. I DON'T KNOW IF IT'S BECAUSE OF COSTCO. TIMEFRAME OVERLAPSE AND THERE'S A CORRELATION. SO THERE IS A HOPE THAT THERE WILL BE AN INCREASE-- THAT CULTURE CHANGE, THAT ACCEPTANCE, BUT OF COURSE, THERE'S THAT CAUTION. THERE'S THAT CAUTION BECAUSE I HAVE HAD A PATIENT IN HEARING AIDS THEY BOUGHT OFF AMAZON COME IN, HAVING HAD DAMAGE TO HER HEARING BECAUSE SHE GOT THEM OFF AMAZON AND WORE THEM THE WAY THEY WERE SET WITHOUT SUPPORT. AND SO THE PROFESSIONAL COMPONENT IS REALLY

IMPORTANT TO MAKING SURE WE GET THE RIGHT FIT FOR A PERSON IN A WAY THAT'S SAFE.
>> LISE HAMLIN: SO I AGREE WITH YOU THAT THERE IS-- THERE ARE THINGS THAT CONSUMERS NEED TO KNOW. THERE ARE THINGS THAT WE HAVE TO PROTECT AGAINST AS WE'RE WAITING FOR THE FDA RULES-- I MEAN WE'RE WAITING. WE'RE WAITING. SOME DAY THEY'LL HAPPEN. AND WE ARE HOPING TO SEE THAT THE RULES ARE REASONABLE, BUT I'M ALSO HERE TO SAY THAT THERE ARE PEOPLE WHO CAN-- THERE ARE WAYS-- WELL, LET ME SAY THIS . NOT EVERY AUDIOLOGIST IS LIKE THE AUDIOLOGIST IN THIS ROOM.
I HAVE HEARD STORIES ABOUT AUDIOLOGISTS WHO REALLY DO NOT DO WELL BY THEIR PATIENTS. EVERY TIME I PRESENT SOMEBODY SAYS, I SPENT $4,000 EACH ON HEARING AIDS AND THEY'RE IN MY DRAWER. I SAY, GO BACK TO THE AUDIOLOGIST. WELL, I HAVE. THAT MEANS, TO ME, THEY HAVEN'T FOUND THE RIGHT PERSON TO WORK WITH. NOW, WHO KNOWS WHY. THERE NEEDS TO BE ANOTHER WAY AROUND. THERE NEEDS TO BE MORE FOCUS ON THE WHOLE THING. I AGREE. I THINK THE FACT THAT COSTCO HAS MADE IT FRIENDLIER AND EASIER AND OVERCOMES THOSE BARRIERS OF FINDING IT AND THE MORE PEOPLE WHO USE THE DEVICES, THE BETTER BECAUSE THEN THERE WILL BE MORE PEOPLE-- YOU'LL SEE MORE PEOPLE AS WELL AS COSTCO HE SOING MORE PEOPLE. I REALLY BELIEVE THAT TO BE TRUE. SO WE HAVE --
>> ADAM: WE'LL MAKE THIS THE LAST QUESTION.
>> ASHLEY: THIS IS ASHLEY SPEAKING AND MAYBE THIS MAY NOT BE AN APPROPRIATE COMPARISON. I'M THINKING IT COULD BE ANALOGOUS TO GLASSES. PEOPLE WANT CHEAPER FRAMES. THEY WANT TO GET A CHEAPER LENS AND THEY HAVE A PRESCRIPTION WITH ALL OF THE MEASUREMENTS AND ALL OF THAT. BUT THEN THEY CAN GO SOMEWHERE ELSE AND GET THE RIGHT GLASSES SO MAYBE THAT'S AN APPROPRIATE COMPARISON TO GETTING OVER-THE-COUNTER HEARING AIDS IS THAT THERE'S A DIFFERENCE BETWEEN HAVING TO GET IT FROM YOUR DOCTOR OR GETTING JUST-- JUST GETTING THE PRESCRIPTION FROM YOUR GLASSES FROM YOUR DOCTOR AND WHAT GOING SOMEWHERE ELSE TO BUY YOURS GLASSES. WOULD THAT BE AN APPROPRIATE ANALOGY?
>> LISE HAMLIN: SO IT'S AN IMPERFECT ANALOGY. WHEN YOU'RE YOUNGER AND YOU GET YOUR GLASSES AND THEY FULLY CORRECT YOUR GLASSES, IT'S VERY COOL AND THAT'S FINE. YOU PUT YOUR GLASSES ON AND YOU GO. YOU CAN'T DO THAT WITH HEARING AIDS. YOU REALLY NEED ADJUSTMENTS, AND AGAIN, A GOOD AUDIOLOGIST, MY AUDIOLOGIST IS FABULOUS AND SHE USES REAL EAR. IN MY 35 YEARS, 40 YEARS OF HAVING HEARING LOSS, SHE'S THE ONLY PERSON WHO EVER USED USED REAL EAR TESTING. COME ON, GUYS, IT WAS SO EASY. IN FIVE MINUTES SHE MADE A HEARING AID THAT WAS USELESS INTO SOMETHING I COULD WEAR. THERE'S LEFTS AND GRADES OF AUDIOLOGY, BUT THERE'S STILL MORE OF A PROFESSIONAL, EVEN A BAD AUDIOLOGIST WILL KNOW A WHOLE LOT MORE THAN A CONSUMER WILL KNOW, BUT WHAT WE'RE HOPING IS TO SEE THAT THE TECHNOLOGY THEY USE AND THIS, AGAIN, IS ONLY FOR THE MILD TO MODERATE RANGE. SO PEOPLE GETTING INTO THE RANGE AND THE FDA CREATING RULES TO MAKE SURE IT'S LIMIT AND WON'T DESTROY SOMEBODY'S HEARING AND GETTING IT AT AN ESTATE SALE OR AMAZON, THEY'LL HAVE WAYS AND I THINK THERE WILL ALWAYS BE PEOPLE WHO SAY I LIKE THIS OVER THE COUNTER BUT I REALLY NEED HELP. SO THE MORE AUDIOLOGISTS ARE WILLING TO DO THAT, IT WILL MAKE IT MORE AFFORDABLE AND PROVIDE THE CARE THAT PEOPLE NEED AND ALLOW THE PEOPLE WHO ARE LONG-TIME USERS AND VERY FAMILIAR WITH TAC AND THERE-- THERE ARE PLENTY OF PEOPLE COMFORTABLE WITH TECH AND CAN ADJUST THEIR OWN HEARING AIDS, AGAIN, IN A WAY THAT WON'T HURT THEM. I AM OVER. I WANT 0 STOP. THANK YOU SO MUCH.
[APPLAUSE]

Discussion: Draft Recommendations (1ST Session)

>> ROBERT: SO NOW WE'RE GOING TO MOVE ONTO THIS SHEET THAT WAS CREATED FOR ALL OF YOU. ON THE FRONT, WE HAVE A SUMMARY OF DR. WAX'S PRESENTATION AND DR. DOWD'S PRESENTATION FROM THE PREVIOUS MEETING. AND ON THE BACK, WE HAVE SOME DISCUSSION QUESTIONS THAT GO OVER THAT I PULLED OUT FROM THESE PRESENTATIONS BUT ALSO I REVIEWED THE PRESENTATION WE HAD TODAY AND PULLED SOME OF THAT OUT OF IT, TOO AND THE QUESTION PROMPTS ON THE BACK ARE FOR DISCUSSION BUT THE INPUT YOU GIVE TODAY WILL HELP US. THE STAFF IS GOING TO TAKE NOTES AND HELP US FORM DRAFT RECOMMENDATIONS THAT WE'RE GOING TO PRESENT TO YOU AT THE NEXT MEETING. SO I GUESS WE CAN JUST START WITH THE FIRST QUESTION AND I'M GOING TO GIVE-- I'M GOING TO EXPLAIN A COUPLE POINTS ON HERE BEFORE WE START DISCUSSING IT. BUT IS THERE AN OPPORTUNITY TO PUT ASSURANCES IN PLACE TO-- SO HEARING SCREENINGS ARE ACTUALLY DONE ON ADMISSION OR WITHIN THE STATED TIME PERIOD AT ALL LONG-TERM CARE FACILITIES? AND I THINK TO THIS RECOMMENDATION, WE COULD ALSO ADD THE BUILT ENVIRONMENT IDEAS BECAUSE IF YOU GO TO LETTER A, I LOOKED ON THE DIVISION'S WEBSITE OF HEALTH SERVICES REGULATION AND THEY DO SAY THAT THEY DO ROUTINE INSPECTIONS EVERY 9 TO 15 MONTHS ON THESE FACILITIES, ALL LONG-TERM CARE FACILITIES, THAT THEY HAVE SUPERVISION OVER. SO SOMETHING AS SIMPLE AS ADDING TO THIS CHECKLIST, LIKE WE'VE HEARD OF COMPLIANCE BY LOOKING AT PATIENT FILES TO SEE IF THEY'VE BEEN SCREENED FOR HEARING SCREENINGS OR TO DO THE ADDING THE-- WHAT WE HEARD TODAY, THE BUILT ENVIRONMENT THINGS. WE CAN ADD THIS OR PUT A RECOMMENDATION FORTH ADDING TO THESE CHECKLISTS OR KIND OF FIRST MAYBE GET A REVIEW OF WHAT'S ACTUALLY ON THESE CHECKLISTS AND THEN SEE IF WE NEED TO RECOMMEND SOMETHING LIKE THIS TO THEM. AND THEN JUST BEFORE I OPEN IT UP, PART D, I PUT THIS DOWN AS SCREENINGS ALREADY COVERED BY MEDICARE. I AM GOING TO REFER THIS BACK OUT TO YOU. IT'S MY UNDERSTANDING THAT THEY'RE COVERED IN LONG-TERM CARE FACILITIES BUT IF YOU GO TO A PROVIDER, THEY NEED TO REFER TO IT, SO DO YOU NEED A REFERRAL IN A LONG-TERM CARE FACILITY TO HAVE THIS TEST INITIALLY, OR IS IT SOMETHING YOU CAN GET WITHOUT A REFERRAL IF YOU'RE IN ONE OF THESE FACILITIES?

>> SORRY. I JUMPED RIGHT HERE. I'M SHELLEY CRISTOBAL BALL. YOU'RE SCREENING AND CHANGE INTERCHANGEABLY. IN HEALTHCARE, SCREENING IS THERE A DISORDER, A TESTING IS WHAT DEGREE, WHAT EXTENT OR THE ROOT OF THAT IS. A SCREENING IS, CAN YOU HEAR AT THE LIMITS OF WHAT'S NORMAL? ANYTHING BEYOND THAT, WHICH AN AUDIOLOGIST WOULD BE TESTING FOR THE SITE OF LESION, DEGREE ACROSS DIFFERENT PITCHES WHEN WE LOOKED AT VIDEOS OF DIFFERENT DEGREES OF PITCHES, ASSESSING THAT AS WELL AS SPEECH UNDERSTANDING, HOPEFULLY AS WELL AS SPEECH UNDERSTANDING AND NOISE WHICH A DIFFERENT FUNCTION ENTIRELY.

>> VICKIE SMITH: SO VICKIE SMITH. I HAVE A CLARIFICATION. IN ALL LONG-TERM CARE FACILITIES, WHAT DOES THAT MEAN, ALL? WHAT IS THE DEFINITION OF A LONG-TERM CARE FACILITY? ARE WE INCLUDING FAMILY CARE HOMES, ASSISTED LIVING FACILITIES, OR ARE WE JUST TALKING ABOUT NURSING HOMES?

>> ROBERT: I USE THIS TO MEAN IF YOU TURN OVER DR. WAX'S PRESENTATION, WE GAVE THE TYPES OF RESIDENTIAL FACILITIES AND THESE ARE THE ONES THAT ARE SUPERVISED BY THE DIVISION OF HEALTH SERVICES REGULATION, I BELIEVE SO. SO THESE ARE THE ONES THAT WE'RE REFERRING TO WHEN WE SAY ALL LONG-TERM CARE FACILITIES.

>> ADAM: CORRECT ME IF I'M WRONG, I THINK THAT MEANS SKILLED NURSING. I'M SORRY. THANK YOU. I THINK, VICKIE, WHAT WE'RE TALKING ABOUT IS SKILLED NURSING FACILITIES.

>> VICKIE: IF THAT'S THE CASE, THEN YOU'RE NOT TALKING ABOUT ADULT CARE HOMES BECAUSE THEY'RE NOT SKILLED NURSING.

>> ADAM: CORRECT.

>> VICKIE: SO THIS IS INCOMPLETE BECAUSE IF WE'RE JUST LOOKING AT SKILLED NURSING THEN WE'RE LEAVING OUT THOUSANDS OF PEOPLE LIVING IN ADULT CARE HOMES WHICH ARE ALSO LICENSED BY THE DIVISION OF HEALTHCARE. I MEAN, SERVICE REGULATIONS.

>> ADAM: SOMEBODY ON THE PHONE?

>> THANKS, VICKIE FOR BRINGING THAT UP. A NUMBER OF TIMES IT WAS MENTIONED THAT PEOPLE WITH DEMENTIA, PEOPLE WITH DEMENTIA TYPICALLY DON'T GO TO SKILLED NURSING UNLESS THEY HAVE (INAUDIBLE) IN NORTH CAROLINA, THEY ARE-- IF THEY'RE GOING TO BE IN A CONGRESS GRI GATT SETTING, THEY WILL NEED A UNIT OF AN ADULT CARE HOME WHICH IS LIKE THE NEW ISR BUT COMPLETELY SEPARATE FROM SKILLED NURSING FACILITIES AND IT'S NOT A LICENSURE CATEGORY THAT EXISTS IN MOST OTHER STATES. SO IT'S TOUGH TO COMPARE APPLES TO APPLES TO OTHER STATES. IN A LOT OF OTHER STATES, MORE PEOPLE ARE IN SKILLED NURSING BECAUSE THAT LOWER LEVEL STILL DOESN'T EXIST, SO WE WANT TO MAKE SURE THAT WE'RE BEING PRECISE ABOUT THE SCOPE OF WHAT WE WANT TO TALK ABOUT. BECAUSE IF YOU WANT TO TALK ABOUT SERVING FOLKS WITH DEMENTIA IN CONGRESS GRI GATT CARE SETTING-- CONGREGATE CARE SETTINGS, YOU HAVE TO INCLUDE ADULT CARE HOMES.

>> ADAM: THANK YOU, CORYE. MY CONFUSION AND I DON'T KNOW THE ANSWER TO THIS. I KNOW WHEN RESIDENTS ARE ADMITTED TO LONG-TERM CARE FACILITY, TO SKILLED NURSING HOMES, THEY'RE REWIRED TO GET A HEARING SCREENING, AND I DON'T KNOW IF THEY'RE REQUIRED TO GET A HEARING SCREENING ON ADMISSION TO ADULT CARE HOME. I DON'T KNOW THE ANSWER TO THAT.

>> I CAN GIVE YOU THE ANSWER TO THAT.

>> ADAM: GO FOR IT.

>> THEY ARE NOT. WHEN THEY'RE ADMIT TO THE SKILLED NURSING FACILITIES, THEY'RE REQUIRED TO DO THE PASS ON ONE AND TWO FORMS THAT DOES REQUIRE THE TRAINING AND THEY'RE ADMITTED (INAUDIBLE) AND THOSE ARE FSL AND THERE'S NO REQUIRED (INAUDIBLE).

>> JAN: THIS IS JAN. I WOULD LIKE TO MAKE ACTUALLY TWO COMMENTS AND THE FIRST OF WHICH I AM HEARING-- I DON'T REMEMBER WHERE I HEARD IT BUT THE GENERAL TREND SEEMS TO BE GOING TOWARD FEWER AND FEWER PEOPLE ARE GOING INTO SKILLED NURSING HOMES OR SKILLED CARE NURSING HOMES AND MORE AND MORE ARE ENTERING ADULT CARE FACILITIES OR AISTED IS LIVING FACILITIES. MY SECOND-- ASSISTED LIVING FACILITIES IS THE CORRECT TERM. SECONDLY, WE SHOULD BE CONCERNED WITH FACILITIES THAT CARE FOR PEOPLE WITH DEMENTIA BECAUSE OF THE CLEAR LINK AND CONNECTION BETWEEN HEARING LOSS AND DEMENTIA. THEY MAY BE CASES OF MISDIAGNOSIS. SO I REALLY THINK WE NEED TO BE LOOKING AT A BROADER SPECTRUM OF LONG-TERM CARE FACILITIES.

>> TOVAH: AT LEAST IN NORTH CAROLINA, WE KNOW THAT SKILLED NURSING FACILITIES-- FEDERALLY, FEDERALLY AND STATEWIDE, THEY, IN GENERAL, SKILLED NURSING FACILITIES, SNF, ARE REGULATED BY FEDERAL AND STATE LAWS. DIFFERENT STATES HAVE DIFFERENT REGULATIONS OR OVERSIGHT FOR OTHER FACILITIES, LIKE AIST ISED LIVING, ADULT CARE HOMES AND OUR DIVISION OF DHR, SOMETHING LIKE THAT, CERTIFIES OR OVERSEES THOSE OTHER FACILITIES. SO THE ISSUE FOR US IS GOING TO BE WHENEVER FACILITIES HAVE OVERSIGHT, STATE OR GOVERNMENT OVERSIGHT, THEY ARE GOING TO BE LIABLE FOR ADA COMPLIANCE OR OTHER TYPES OF COMPLIANCE, SO TO THE EXTENT THAT ANY OF THESE FACILITIES ARE OVERSEEN, WE CAN ENCOURAGE OR EVEN ADVOCATE OR FORCE.

>> ASHLEY: THIS IS ASHLEY SPEAKING. IF WE LOOK AT THE FIRST QUESTION TALKING ABOUT LICENSURE AND RENEWAL, YOU KNOW, WE KNOW LONG-TERM FACILITIES FOCUS ON PEOPLE WITH HEARING LOSS BUT I THINK WE'RE FORGETTING THE CULTURALLY DEAF SIGNING COMMUNITY AND WE NEED TO INCLUDE THAT IN OUR SCOPE WHEN WE'RE DOING THESE INVESTIGATIONS AND SCREENINGS. WE NEED TO HAVE DEAF SIGNERS THAT ARE INCLUDED IN COMMUNICATION ACCESS AS WELL. SO THERE ARE A MYRIAD OF KINDS OF SERVICES THAT ARE NEED, SIGN LANGUAGE INTERPRETERS IS JUST ONE EXAMPLE, SO I WANT TO MAKE SURE WE'RE INCLUDING THAT IN THE LONG-TERM CARE MAINTENANCE THAT WE DO FOR COMMUNICATION ACCESS AND OF THOSE CHECKLIST EXCEPTIONS.
>> ADAM: SO I WANT TO GO BACK TO THE ORIGINAL IDEA FOR A MINUTE AND I THINK THAT WE'RE ALL IN AGREEMENT THAT ASSISTIVE CARE FACILITIES, ADULT CARE HOMES SHOULD DO SCREENING FOR HEARING LOSS ON ADMISSION. I'M NOT SURE THAT I UNDERSTAND THE RIGHT MECHANISM FOR THAT, AND SO IT MAY BE THAT WE TO HAVE A FOLLOW-UP CONVERSATION WITH DSR TO UNDERSTAND WHAT OUR OPTIONS ARE. I THINK WITH SKILLED NURSING WHEN WE HAD CONVERSATIONS WITH DHSR TWO YEARS OR SO AGO NOW, WE WERE TOLD THAT THE FACILITIES THEY REGULATE ARE IN COMPLIANCE, AND I DON'T KNOW IF THAT'S TRUE, RIGHT, BUT THIS IS WHAT THEY TELL US BASED ON THEIR INSPECTION, AND SO THERE MAY BE DIFFERENT AVENUES. IT MAY BE THAT WE NEED TO ASSURE COMPLIANCE WITH FEDERAL LAW AMONG OUR SKILLED NURSING FACILITIES BUT I'M NOT YET SURE WHAT THE ADULT CARE HOME, WHAT THE CORRECT AVENUE IS TO GET THEM TO DO SCREENING. IS THAT WE NEED TO CHANGE STATE LAW OR IS THAT ABOUT FEDERAL LAW? AND VICKIE I THINK HAS SOMETHING TO SAY AND MAYBE THAT WAS CORYE ON THE PHONE. CORYE, WAS THAT YOU?
>> IT IS. THANK YOU SO SOMEONE ELSE MAY BE ABLE TO WEIGH IN ON THIS AND THE OVERSIGHT IS PERFORMED AND STILL THE FORCE AND IT'S A DIFFERENT SET OF LEGAL STANDARDS AND IN THE CASE OF NURSING HOMES, THE OVERSIGHT IS DONE EFFECTIVELY ON BEHALF OF THE CENTERS (INAUDIBLE) AND COMPLETELY DIFFERENT. SO-- CORYE
>> ADAM: YOU'RE BREAKING UP A LITTLE BIT. I DON'T KNOW IF YOU HAVE A SPEAKER PHONE OR IF YOU NEED TO SLOW DOWN A LITTLE BIT. WE WANT TO CATCH WHAT YOU SAY.
>> CORYE: SORRY ABOUT THAT. I WAS JUST DESCRIBING THE DIFFERENCES BETWEEN THE REGULATION OF ADULT CARE HOMES AND THE REGULATION OF SKILLED NURSING FACILITIES AND THOSE ARE THE TWO LEGAL DESIGNATIONS. ADULT CARE HOMES, WHICH IN NORTH CAROLINA INCLUDES EVERYTHING WE CALL ASSISTED LIVING, PRETTY MUCH EVERYTHING WE CALL A MEMORY CARE UNIT OR SPECIAL CARE UNIT, AND EVERYTHING WE CALL A FAMILY CARE HOME. THOSE ARE LICENSED UNDER ONE PARTICULAR STATUTE OF STATE LAW. THE OTHER TYPES ARE SKILLED NURSING FACILITIES, WHICH ARE,- WHOSE LICENSURE IS GOVERNED BY FEDERAL LAW, PRIMARILY, BUT THE DIVISION OF HEALTH SERVICES REGULATIONS OVERSEES BOTH TYPES OF FACILITIES. IN THE CASE OF SKILLED NURSING, THEY DO SO ON BEHALF OF CMS, THE CENTERS FOR MEDICARE AND MEDICAID SERVICES. BUT FOR ADULT CARE HOMES, IT IS SIMPLY ON BEHALF OF THE STATE. SO IT'S THE SAME DIVISION BUT DIFFERENT PEOPLE IN DIFFERENT STANDARDS. I AGREE THAT CHANGING STANDARDS FOR ADULT CARE HOMES IS DIFFERENT. I WOULDN'T SAY IT IS HARDER, THOUGH, BECAUSE SKILLED NURSING FACILITIES YOU HAVE TO DEAL WITH FEDERAL GOVERNMENT AND REALLY THIS IS AN INTERNAL STATE DECISION WHEN WE'RE TALKING ABOUT STATUTES AND REGULATIONS THAT APPLY TO ADULT CARE HOMES, INCLUDING ALL OF THE (INAUDIBLE).
>> MARK BENTON: THIS IS MARK.
>> ADAM: GO AHEAD, CRYSTAL.
>> CRYSTAL: A QUICK POINT. THIS MAY BE OVERLY SIMPLISTIC, WHEN I DEAL WITH PATIENTS WHO ARE

GOING INTO ADULT CARE HOMES, ASSISTED LIVING OR NON-SKILLED, WE ARE REQUIRED TO FILL OUT THE SL2 FORM. IF WE WE'RE REWIRED TO HAVE A HEARING SCREEN AS PART OF THAT FORM AND PROCESS, THAT MIGHT BE A WAY TO ENSURE THIS IS DONE. I'M NOT SURE WHO REGULATES THAT OR REQUIRES THAT FORM BE COMPLETED, BUT THAT MAY BE A WAY IN WHICH TO ADD TO THE PROCESS THAT WE'VE ALREADY GOT IN PLACE IN NORTH CAROLINA THAT MAY GO TOWARD WHAT YOU GUYS WANT TO SEE DONE.
>> MARK BENTON: THIS IS MARK BENTON. JUST TO ADD ON TO WHAT CORYE AND CRYSTAL JUST SAID, FOR OUR ADULT CARE HOME, OUR ASSISTED LIVING FACILITIES AND EVEN OUR BEHAVIORAL HEALTH FACILITIES GOVERNED BY STATE LAW AND WE HAVE ALL ACKNOWLEDGED THAT OUR SKILLED NURSING FACILITIES ARE DRIVEN AND GOVERNED BY FEDERAL LAW BUT THOSE WHO ARE GOVERNED BY STATE LAW, WE DON'T NECESSARILY HAVE TO HAVE NEW LEGISLATION. WE CAN ACTUALLY ADOPT ADMINISTRATIVE RULES THAT MAKE CERTAIN REQUIREMENTS ONIT OUR PROVIDERS AND ON TOP OF THE ADMISSIONS PROCESS. SO THAT IS ABSOLUTELY AN AVENUE OR RECOMMENDATION THAT THIS GROUP COULD MAKE THAT THE DIVISION OF HEALTH SERVICES REGULATION MOVE FORWARD AND DO THAT. THE ONLY THING THAT WOULD LIKELY REQUIRE LEGISLATION JUST IN THE CONVERSATION WE'VE BEEN HAVING OVER THE LAST HOUR OR SO, WHEN IT COMES TO THE BUILT ENVIRONMENT, LIKE IF WE WANT TO PUT IN A LOOP OR REQUIRE A LISTENING DEVICE SYSTEM, THAT WOULD HAVE TO BE SORT OF BAKED INTO THE STATE BUILDING CODE STANDARDS, WHICH WOULD VERY MUCH REQUIRE LEGISLATION. I'M NOT SAYING THAT'S NOT DOABLE BUT THAT WOULD BE THE MOST APPROPRIATE PLACE TO PUT THAT.
>> ADAM: MARK AND VICKIE AND OTHERS, WHAT WOULD LIKELY BE THE RESPONSE FROM THE ADULT CARE HOME INDUSTRY , AND HOW CAN WE FACILITATE THIS IN A WAY THAT HELPS THEM TAKE BETTER CARE OF THEIR CLIENTS, RIGHT?
>> MARK BENTON: THIS IS MARK AGAIN. I ANTICIPATE THIS AN ADULT CARE TODAY HOME PROVIDER, ASSISTANT PROVIDER, GROUP HOME PROVIDER, ONE OF THE FIRST THINGS THEY WOULD ASK THEMSELVES IS, IS THIS NEW REQUIREMENT GOING TO REQUIRE ADDITIONAL STAFF OR ADDITIONAL COSTS AND IF THE ANSWER TO EITHER OF THOSE IS YES, THEY WILL THEN LOOK TO WHOEVER PAYS FOR THE CARE ASSOCIATED WITH THAT NEW COST, WHETHER IT BE MEDICAID, OR IN HANK HANK SHOP, OUR ASSISTED PROGRAM, AND THEY WILL LOOK AT RATES AND SEE IF THOSE RATES ARE EFFICIENT FOR ME TO HIRE THE STAFF TO DO THE SCREENING OR HIRE ADDITIONAL STAFF OR PERFORM AN ADDITIONAL SERVICE. THAT WILL BE SOMETHING THEY WILL ASK FOR AND IF IT'S NOT SUFFICIENT, THEN THEY WILL LOOK TO THE DEPARTMENT, LOOK TO THE LEGISLATURE TO INCREASE THE FUNDING RATES FOR ONE OR BOTH.
>> MAGGIE: MARK, AS A FOLLOW-UP TO THAT QUESTION, CAN THOSE PENALTY DOLLARS BE USED AS A PLACE TO SUBSIDIZE THAT KIND OF SUPPORT? SO IT WOULDN'T NECESSARILY HAVE TO INCLUDE AN ADDITIONAL BUDGET ITEM BUT YOU CAN ACTUALLY GO BACK AND USE SOME OF THOSE PENALTY DOLLARS TO HELP UPFIT?
>> MARK BENTON: GREAT QUESTION ABOUT THE CIVIL MONETARY PENALTY DOLLARS THAT WE'VE TALKED ABOUT, NOT ONLY TODAY BUT I THINK EARLIER. WHAT'S IMPORTANT TO REMEMBER ABOUT THOSE DOLLARS IS THAT THEY ARE IMPOSED ON SKILLED NURSING FACILITIES WHO HAVE FALLEN SHORT, HAVE HAD A FINE IMPOSED BY CMS. THEY'RE ON DEPOSIT. WE ACTUALLY HOLD THEM IN A BANK ACCOUNT HERE IN NORTH CAROLINA, BUT THEY CAN ONLY BE SPENT BACK INTO SKILLED NURSING FACILITY. I THINK TONY ACKNOWLEDGED THAT IN HIS PRESENTATION, THEY HAVE TO GO BACK TO WAYS TO IMPROVE THE QUALITY OF CARE IN A SKILLED NURSING FACILITY.

IT WOULD BE GREAT IF WE COULD USE THOSE IN ANY OTHER SETTING THAT THE DIVISION LICENSED BUT THE FEDERAL GOVERNMENT IS VERY SPECIFIC. THEY ARE IMPOSED ON SKILLED NURSING FACILITIES AND THEY CAN ONLY BE USED BACK INTO SKILLED NURSING FACILITY. BUT ONE THING THAT MAY BE HELPFUL TO NOTE, I THINK NEXT MONDAY'S AGENDA, DHSR IS COMING IN AND ONE THING THEY WANTED TO PROVIDE THE GROUP AND I KNOW IT'S LATE IN THE PROCESS IS GIVING YOU THE SENSE OF THE ROUGHLY TWO DOZEN HEALTHCARE FACILITIES THAT THEY LICENSE. THE KINDS OF THINGS THEY LICENSE FOR, WHETHER THOSE THINGS THEY LOOK FOR AND REGULATE ARE DRIVEN BY FEDERAL LAW VERSUS STATE LAW AND THEY CAN ALSO PROVIDE YOU GREAT INPUT ON IF THERE ARE CHANGES THAT NEED TO BE MADE EITHER IN THE REQUIREMENTS OR THE OVERSIGHT, WHETHER THAT WOULD BE A CHANGE IN FEDERAL LAW, WHICH IS A LITTLE HARDER FOR OUR GROUP TO DEAL WITH, OR IF IT'S SOMETHING THAT CAN BE DONE AT THE STATE, WHETHER IT BE LAW, RULE, OR POLICY.
>> BERKELEY: THIS IS BERKELEY. I WANT TO FOLLOW UP. THE HEARING SCREENING ISSUE WITH NON-SKILLED NURSING FACILITIES, IF HEARING SCREENING IS ALREADY REQUIRED FOR SKILLED NURSING FACILITIES, IF WE'RE TALKING ABOUT WHAT IN NORTH CAROLINA ARE ADULT CARE HOMES, I MEAN, WE COULD REQUIRE FACILITIES DO IT UPON ENTRY. WE COULD ALSO, I THINK CRYSTAL PROPOSED SAYING THAT IF IT'S ADDED TO THE FORM THAT IS USED UPON ADMITTANCE, IT WOULD PUT IT BACK ON WHOEVER IS-- THE PHYSICIAN THAT IS REFERRING SOMEBODY TO AN ADULT CARE HOME. THAT'S ONE OPTION. EITHER WAY, WHAT DO WE WANT TO HAVE HAPPEN AFTER A HEARING SCREENING? BECAUSE YOU CAN DO A HEARING SCREENING AND NOTE IT ON A PIECE OF PAPER DO KNOT. I THINK WE HAVE TO FIGURE OUT WHERE THE HEARING SCREENING HAPPENS AND ALSO WHAT DO WE EXPECT TO HAPPEN OVER THAT.
>> CRYSTAL: THIS IS CRYSTAL. I WANT TO ADD TO THAT. ONE OF THE BIG ISSUES WE HAVE IN PRIMARY CARE WITH HEARING SCREENINGS IS THAT THEY'RE NOT COVERED. EVEN WHEN WE DO THE HEARING SCREENINGS, THE PATIENT WILL END UP WITH AN OUT-OF-POCKET COST FOR THAT WE CAN DO THEM IN PRIMARY CARE AND REFER THEM TO THE AUDIOLOGIST BUT SOME THINGS IF YOU DON'T FIND A PROBLEM, THE PATIENT WILL TAKE IT AND GETTING THE SCREENING IS EVER COD IS ONE THING AND THE SECOND PART TO YOUR ISSUE IS GETTING HEARING AIDS TO BE MORE AFFORDABLE IS THE SECOND PART. SO WHEN WE FIND THE SCREENINGS NOR THE PATIENT, NOR THE FAMILY NOR THE FACILITY CAN AFFORD THE TREATMENT OR AFFORD THE HEARING AID, THAT'S THE SECOND. YOU'RE RIGHT. IF WE CAN SCREEN AND SCREENING CAN BE COVERED AND PATIENTS ARE WILLING TO GET SCREENS BUT CAN'T AFFORD THE HEARING AIDS ARE POINTLESS. I HAVE PATIENTS WHO REFUSE TO GET SCREENED BECAUSE AND THEY KNOW THEY HAVE HEARING LOSS BUT CAN'T AFFORD IT.
>> ADAM: THERE'S ONE PART IN BETWEEN AFTER YOU MOVE FROM SCREENING, YOU GO TO DIAGNOSIS, RIGHT. SO MEDICARE AND MEDICAID DO COVER AUDIOLOGICAL EVALUATIONS, EVEN THOUGH LARGELY NOT HEARING AIDS.
>> SHELLEY: I WASN'T GOING TO START THERE BUT I'M GOING TO START THERE. BECAUSE IT WOULD BE HELPFUL TO LAY THAT OUT. A SCREENING IS WHERE YOU START. A SCREENING SHOULD HAPPEN FOR-- I THINK ANYONE SHOULD BE SCREENED BEFORE YOU DO ANY ASSESSMENT FOR DEMENTIA OR MILD COGNITIVE IMPAIRMENT. THERE'S SOLID EVIDENCE THAT WE OVERESTIMATE RATES OF DEMENTIA AND MILD COGNITIVE IMPAIRMENT WHERE IT'S ACTUALLY HEARING LOSS AND CORRECTING HEARING LOSS ELIMINATES WHAT SHOWS UP AS DEMENTIA ON TESTING. FROM THE COST PERSPECTIVE, IF YOU KEEP SOMEONE OUT OF LONG-TERM MEMORY CARE FOR SIX WEEKS, THAT'S THE COST OF A PAIR OF HEARING AIDS. WHEN WE TALK ABOUT THE BIG PICTURE OF COST HERE. THERE'S A TREMENDOUS AMOUNT OF BALANCE THAT WE'RE LOOKING AT. FROM SCREENING, WHICH IS WHAT EVERYBODY'S

CIRCLING AROUND, THEN YOU NEED A TEST. YOU NEED TO BE ACES ISED BY AN AUDIOLOGIST, WHICH INVOLVES HOW LOUD DOES SOUND NEED TO BE FOR YOU TO HAVE ACCESS AND HOW DO YOU UNDERSTAND SPEECH WHEN IT'S EARS ONLY, NO VISUAL CUES OR CONTEXT. THAT IS COVERED BY MEDICARE WHEN IT'S MEDICALLY APPROPRIATE. THAT MEANS REFERRED BY A PRIMARY PHYSICIAN. WE'RE WORKING TO ELIMINATE THAT BECAUSE THE NUMBERS SHOWS IT DRIVES UP THE COST TO THE OVERALL PROCESS BUT THAT'S WHERE IT IS RIGHT NOW. AND THEN COMMUNICATION BACK TO THE PRIMARY CARE, AND THEN RECOMMENDATIONS ARE MADE AND THOSE RECOMMENDATIONS FOR SOMEONE WITH REALLY FAR ALONG DEMENTIA MIGHT BE A POCKET TALKER OR MIGHT BE HEARING AIDS. I KNOW YOU GUYS HAVE HEAR A LOT FROM ME. I APOLOGIZE. YOU CAN IMAGINE I HAVE GOT A COUPLE OF BULLET POINTS HERE. THE COST OF HEARING AIDS IS SOMETHING THAT PEOPLE CITE AS A MAJOR CONCERN AND CERTAINLY, THAT'S THERE, BUT WHEN WE LOOK AT ENGLISH-SPEAKING COUNTRIES WHERE HEARING AIDS ARE PAID FOR BY A PUBLIC SYSTEM, ACCEPTANCE RATES ARE THE SAME AS HERE. WHERE PEOPLE PAY NOTHING OUT-OF-POCKET, ACCEPTANCE RATES ARE 3% HIGHER THAN HERE. SO THERE'S MORE TO IT. NOT THAT THE COST BARRIER ISN'T SOMETHING WE NEED TO ADDRESS , BUT WE ALSO NEED TO BE WORKING ON THIS CULTURAL CHANGE BECAUSE THE STIGMA ASSOCIATED WITH USE OF HEARING AIDS IS PROBABLY A MORE ACCURATE PRIMARY BARRIER. WE STILL THINK OF HEARING AIDS AS BIG BROWN BANANAS THAT SQUEAL ALL THE TIME WHEN YOU GIVE SOMEBODY A HUG OR SIT NEXT TO SOMEBODY IN CHURCH.

THAT'S SO FAR THAN MOST PEOPLE'S EXPERIENCES WITH PROFESSIONALLY SET UP DEVICES WITH SOME EXCEPTIONS BECAUSE AS YOU KNOW, THERE ARE BAD APPLES ANYWHERE. YOU MENTIONED MARKUP, I WANTED TO QUICKLY ADDRESS MARKUP ON HEARING AIDS BECAUSE THAT GETS THROWN AROUND A LOT. WHEN I'M PRICING A HEARING AID IN MY PRACTICE, THIS IS SOME PERSONAL INFORMATION HERE, PERSONAL BUSINESS INFORMATION, I TAKE THE COST OF THE DEVICE AND LOOK AT HOW MUCH TIME I AM GOING TO SPEND WITH THAT PATIENT FOR A PERIOD OF TIME. A MINIMUM OF 45 DAYS FOR FOLKS WHO DON'T NEED A WHOLE LOT OF HELP BECAUSE IN GETTING THINGS UP AND RUNNING TAKES A LOT OF WORK. USUALLY, A PATIENT WHO IS NEW TO HEARING AIDS IS END SPING THREE TO FOUR HOURS OF FACE TIME WITH A DOCTOR IN THE FIRST YEAR. THAT'S EXPENSIVE, TOO, AND THAT IS, IN MY PRACTICE, BUILT INTO 75% OF THE HEARING AIDS. I HAVE UNBUNDLED OPTIONS AS WELL. BUT UNBUNDLING OR SEPARATING OUT THE COST MAKES IT MORE TRANSPARENT AND THERE'S A LOT OF VALUE TO THAT BUT DOESN'T TAKE AWAY THE NEED FOR THAT CARE. ESPECIALLY AND MY 50 SOMETHINGs WITH A MILD TO MODERATE HEARING LOSS, THEY CAN BUY A HAND VAC ON AMAZON AND KEEP IT WORKING WITHOUT MY HELP. MY 80-SOMETHINGS NEED ME TO PUT MY HANDS ON HEARING AIDS EVERY THREE TO FOUR MONTHS IF THEY WANT TO HEAR AS WELL AS POSSIBLE. I USE ASSISTANTS TO CUT THE COST THERE.

THERE'S SOME COSTS BUILT IN THERE. THAT WAS ANOTHER BULLET POINT, I THINK WE NEED TO ENHANCE THE AUDIOLOGY ASSISTANTS IN NORTH CAROLINA. RIGHT NOW, THERE'S ONE LITTLE LINE THAT YOU CAN CALL SOMEBODY AN AUDIOLOGY ASSISTANT BUT THERE'S REALLY NO REGULATION AND THAT'S A WAY THAT EVERY OTHER HEALTHCARE PROVIDER CUT COSTS OF CARE THAT WE NEED TO WORK ON OUR LAWS HERE TO MAKE THAT CATEGORY, ALLOW US TO PROVIDE MORE EFFECTIVE CARE ESPECIALLY I CAN SEE IN THESE LONG-TERM CARE FACILITIES, THESE ASSISTANTS DOING THE SCREENINGS, THESE ASSISTANTS DOING THE MAINTENANCE. YOU DON'T NEED AN AUDIOLOGIST TO GET EAR WAX OUT OF A HEARING AID BUT THE SUPPORT NEEDS TO BE THERE FOR THE NURSING STAFF TO NOT HAVE TO DO THE TROUBLE SHOOTING WHERE IT'S A LITTLE BEYOND. THEY DO ENOUGH ALREADY. THEY DO A TREMENDOUS AMOUNT. THAT WAS ANSWERING THAT QUESTION. I DID WANT

TO JUMP BACK TO YOUR POINT FROM THE VERY BEGINNING OF THE DAY IS, HOW DO WE MAKE THIS BENEFIT EVERYBODY'S BOTTOM LINE? AND THERE'S A COUPLE OF THINGS I WANTED TO MAKE SURE WERE BROUGHT UP TODAY. ONE IS MEDICARE REIMBURSEMENT IN LONG-TERM CARE FACILITIES IS CHANGING REIMBURSEMENT MODELS EVER SO SLIGHTLY STARTING IN OCTOBER. QUALITY OF LIFE AND MENTAL HEALTH ARE GOING TO BE SOMETHING THAT'S MEASURED AS OUTCOMES IN-- WHAT'S THE RIGHT WORD. IN FACILITIES WHERE THOSE OUTCOMES ARE HIGHER, THEY GET HIGHER REIMBURSEMENT.
THERE'S A REAL PUSH AMONG LCSWs AND COUNSELORS TO GET INTO THESE PLACES TO BOOST MENTAL HEALTH AND WE KNOW TREATING HEARING LOSS IS GOING TO HELP MENTAL HEALTH AND DEMENTIA MANAGEMENT AND QUALITY OF LIFE AS WELL. SO THERE'S A REAL SORT OF COST BENEFIT FOR THESE FACILITIES, COMING VERY SOON. IT'S REALLY NOT ON EVERYBODY'S RADAR YET BECAUSE IT DOESN'T START UNTIL OCTOBER. IT'S ABOUT TO BE A FINANCIAL INCENTIVE ON THE TABLE. THE OTHER PIECES, AND HAD IS A ROOM WHERE I CAN REALLY GEEK OUT OVER THIS STUDY. A STUDY WAS PUBLISHED ON MONDAY. THE FIRST STUDY FROM AN ENGLISH-SPEAKING POPULATION, WITH 25,000 PEOPLE TRACKED OVER-- OH, GOSH, 15 YEARS THAT SHOWED HIGHER LEVEL OF COGNITIVE FUNCTION FOR INDIVIDUALS WHO WORE HEARING AIDS COMPARED TO FOLKS WHO HAD HEARING LOSS WHO DIDN'T WEAR HEARING AIDS. THAT'S BEEN SHOWN IN FRENCH. IT'S BEEN SHOWN IN OTHER POPULATIONS, BUT IT'S A GREAT STUDY. THE EVIDENCE IS THERE NOW IN A REALLY SOLID WAY THAT THE QUALITY OF LIFE BENEFITS THAT WE'VE ALL KNOWN ARE THERE ARE REALLY THERE. ALL RIGHT. THANK YOU FOR LETTING ME RAMBLE.
[LAUGHTER]
>> ADAM: I HAVE A QUICK CLARIFYING POINT. GO AHEAD.
>> Speaker: THANK YOU SO MUCH. I AM A PART OF A COMMITTEE FOR AUDIOLOGY IN A HEARING ASSOCIATION AND WE WOULD LIKE TO MAKE A STATEMENT. I HAVE EMAILED THIS TO SEVERAL PEOPLE THERE ALREADY. I JUST WANTED TO READ THIS STATEMENT. TO THE AUDIOLOGY COMMITTEE MET ON WEDNESDAY TO DISCUSS RAISING AWARENESS OF HEARING LOSS TO THE STATE. SINCE THE INSTITUTE OF MEDICINE AND DIVISION OF DEAF AND HARD OF HEARING AGENCY ARE MEETING ON THE SUBJECT, THE COMMITTEE IS REQUESTING SUPPORT FROM THIS TASK FORCE FOR OUR EFFORTS TO IMPROVE ACCESS TO HEARING HEALTHCARE AND AUDIOLOGY FOR NORTH CAROLINA RESIDENTS. THE NATIONAL ACADAMIES OF SCIENCE, ENGINEERING AND MEDICINE, A REPORT OF 26 TEAMS FOCUSED ON THE ISSUE IN IMPROVING ACCESS TO HEARING HEALTHCARE FOR ADULTS IN THE UNITED STATES. THE REPORT IS TITLED HEARING HEALTHCARE FOR ADULTS, PRIORITIES FOR IMPROVING ACCESS AND AFFORDABILITY, FOCUSED ON AGING IN AMERICA AND THE INVISIBLE HANDICAP OF HEARING LOSS. THE SUMMARY OF THE REPORT IS AS FOLLOWS. HEARING LOSS CAN TAKE MANY FORMS. IT CAN BE MILD OR SEVERE AND BEGIN AT BIRTH OR LATER IN LIFE, OCCUR GRADUALLY OR SUDDENLY, RESULTS FROM A HEALTH CONDITION OR ACCOMPANY AGING. IT'SEST MADED THAT 30 MILLION PEOPLE IN THE U.S. HAVE HEARING LOSS AND HEARING LOSS HAS BEEN IDENTIFIED AS THE FIFTH LEADING CAUSE GLOBALLY AS THOSE WHO LIVE WITH DISABILITIES. FURTHER ISP MORE, AS OLDER ADULTS INCREASE, HEARING LOSS WILL BECOME AN AREA OF GREATER CONCERN. HEARING IS A VITAL SENSE THAT CAN BE IMPORTANT TO HEALTH AND CAN AFFECT QUALITY OF LIFE. FOR A VARIETY OF REASONS, MANY PEOPLE DO NOT SEEK OUT OR RECEIVE HEARING HEALTHCARE. ESTIMATES OF HEARING AIDS ARE 67% OF ADULTS 50 YEARS AND OLDER WHO MAY BENEFIT FROMMER WHATTING AIDS, DO NOT USE THEM AND MANY HEARING ASSISTIVE TECHNOLOGIES AS WELL AS AUDITORY REHAB SERVICES ARE NOT FULLY UTILIZED. LONG SEEN AS AN ISSUE FOR INDIVIDUALS AND TO SOME EXTENT THEIR FAMILIES AND

FRIENDS, THERE IS A GROWING RECOGNITION THAT HEARING LOSS IS A SIGNIFICANT PUBLIC HEALTH CONCERN THAT CAN BE ADDRESSED BY ACTIONS AT MULTIPLE LEVELS. SINCE THIS REPORT, RESEARCH POINTS TO THE NEED FOR SCREENING HEARING IN THE ADULT POPULATION DUE TO THE IMPACT OF CHRONIC DECEASES AND OTOTOXIC MEDICATIONS IN THIS POPULATION. A REVIEW OF ADULT AUDIOLOGICAL EVALUATIONS IS A MEDICARE DATABASE SHOWS THEFULLOWING COMORBIDITIES AMONG ADULTS TESTED BY AUDIOLOGISTS IN 2017. HYPERTENSION IS SEEN IN 65, AND OF PATIENTS TESTED. HYPER(INAUDIBLE) 55%. DIABETES, 29%. CHRONIC KIDNEY DISEASE, 25%. THE CENTERS FOR DISEASE CONTROL IS ADDING AUDIOLOGY TO DIABETES CARE. THE AUDIOLOGY COMMITTEE WANTS TO RAISE AWARENESS OF THIS EPIDEMIC WITH FAMILY PHYSICIANS, INTERNAL PHYSICIANS AND OTHER MEDICAL SPECIALTIES. WE KNOW (INAUDIBLE) GOES UNNOTICED. WE WOULD LIKE TO SEE NORTH CAROLINA LEAD THE NATION IN CREATING A THREE-MINUTE HEARING SCREENING PROGRAM AND USE FOR PATIENTS WHO HAVE CHRONIC DISEASES AND WHO ARE TAKING OTOTOXIC MEDICATIONS FOR PAIN, INFECTION, AND WITH (INAUDIBLE) INHIBITING DIE RHETTICS. WE ARE REQUESTING THAT THIS TASK FORCE CREATE A SPECIAL FORUM TO DISCUSS AND OUTLINE A PROGRAM TO EDUCATE AND COLLABORATE AMONG AUDIOLOGISTS AND MEDICAL COMMUNITIES. USING THE NASEM REPORT AND HEARING RESEARCH, AUDIOLOGISTS IN NORTH CAROLINA FEEL THAT PROGRAMS CAN BE DEVELOP IN OUR STATE TO ENSURE BETTER PATIENT UNDERSTANDING, BETTER PATIENT COMPLIANCE, AND BETTER PATIENT OUTCOMES AND MEDICAL TREATMENT BY ADDRESSING THE INVISIBLE HANDICAP IN HEARING AND IN PHYSICIANS' OFFICES. THANK YOU FOR YOUR TIME.
>> ADAM: THANK YOU SO MUCH FOR THAT STATEMENT AND THE SUGGESTIONS. I KNOW, JAN, YOU WANTED TO MAKE A COMMENT NEXT.
>> JAN: THIS IS NOT A COMMENT OF WHAT SHE JUST REPORTED ON BUT I ACTUALLY HAD A COUPLE OF THINGS. AND ACTUALLY SHE JUST MENTIONED A THREE-MINUTE HEARING SCREENING AND I BELIEVE SHE WAS TALKING ABOUT A FREE APP THAT WAS DEVELOPED IN SOUTH AFRICA JUST RECENTLY AND IT HAS BEEN ENDORSED BY PROFESSIONAL ASSOCIATIONS OF AUDIOLOGISTS AND I CAN'T REMEMBER EXACTLY THE NAME OF THAT ASSOCIATION BUT MY UNDERSTAND IS THAT THIS APP IS SOMETHING THAT WE SHOULD INVESTIGATE AS A HEARING SCREENING TOOL. AND THAT REMOVES THE COST AS A BARRIER. AND THE SECOND THING I WANTED TO MENTION RELATED TO THAT IS COULD THE TASK FORCE LOOK AT FINDING A WAY OR POSSIBLY DEVELOPING A RECOMMENDATION THAT WOULD REQUIRE FACILITIES TO CONTRACT OR HAVE IN PLACE A WAY OF OBTAINING AUDIOLOGICAL SERVICES, SO I JUST WANTED TO MENTION THAT. I ALSO WANTED TO MENTION-- TO MAKE A COMMENT RELATIVE TO THE CIVIL MONETARY PENALTY FUND. MY UNDERSTANDING IS THAT FUND CAN BE ALSO SPENT VIDEO PRODUCTION. FOR EXAMPLE, VIDEOS THAT WOULD BE USED FOR TRAINING TO THE STAFF. SO WE COULD ALSO MAKE THAT, IF WE MADE IT SPECIFICALLY FOR THE SKILLED CARE NURSING FACILITIES, IT COULD ALSO BE MADE AVAILABLE TO THE OTHER ASSISTED LIVING FACILITIES AS WELL.
>> TOVAH: JUST A MOMENT. I'M TRYING TO FIGURE OUT HOW TO HOLD THE MIC HERE. I CAN'T HELP BUT COME BACK TO TWO OR THREE ESSENTIAL THINGS. ONE IS WE DO ALREADY HAVE MANY LAWS AND MANY REGULATIONS IN PLACE. THE ISSUE TO ME SEEMS TO BE MORE ABOUT PUTTING TEETH INTO COMPLIANCE OR MOTIVATING COMPLIANCE. THE MOTIVATION FOR COMPLIANCE WILL DEPEND, IN LARGE PART, ON THE ECONOMICS AND THERE ARE TWO ECONOMIC ISSUES. ONE IS WE HAVE ENOUGH DATA TO PROVIDE COMPELLING EVIDENCE THAT IT COSTS MORE NOT TO TREAT HEARING IMPAIRMENT THAN TO TREAT IT. SO THAT'S ONE CLEAR THING WE NOW HAVE. THE OTHER ISSUE IS, HOW TO FUND AND PAY FOR ANY OF THE THINGS THAT WE DO . EVEN IF WE PROVIDE FREE SCREENING, FOR EXAMPLE, AND FIND OUT PEOPLE WHO HAVE HEARING LOSSES, WHO WILL PAY FOR THE

TREATMENTS AFTER THAT. ECONOMICS IS GOING TO BE A MAJOR ISSUE. I THINK THE ONE ISSUE HAD TO DO WITH COMPLIANCE. HOW DO WE GET COMPLIANCE FROM THE TOP DOWN ? AND THE OTHER, HOW ARE WE GOING TO FUND THIS IN TERMS OF INSURANCE COVERAGE OR STATE OR FEDERAL FUNDING TO DO THE THINGS THAT WE WANT TO GET COMPLIANCE FOR. THE THOSE SEEM TO BE THE TWO MAJOR AVENUES THIS WE HAVE TO ADDRESS.
>> BIRKELEY: SO, WE HAVE A REGULATION CURRENTLY THAT SKILLED NURSING FACILITIES SCREEN FOR HEARING LOSS-- SCREEN NOT TEST, OKAY. WHY DO WE THINK THEY'RE NOT COMPLYING? I THINK FROM HEARING FROM THE DIVISION OF SERVICES-- NO, HEALTH SERVICES REGULATION NEXT MONTH, WE ARE GOING TO-- I THINK WHAT SOMEBODY PUT UP EARLIER WAS THAT THEY SAY THAT SKILLED NURSING FACILITIES ARE IN COMPLIANCE WITH CURRENT REGULATIONS. SO WHERE IS OUR EVIDENCE THAT THEY'RE NOT IN COMPLIANCE, AND THEN-- BECAUSE IF THEY'RE NOT IN COMPLIANCE WITH THE DHSR REGULATIONS, THEY SHOULD BE PAYING INTO THE SKILLED NURSING FACILITIES' PENALTY FUND FOR NOT BEING IN COMPLIANCE. SO ARE WE TELLING THEM THEY'RE NOT IN COMPLIANCE AND WE HAVE THE DATA TO BACK IT UP, OR ARE WE ASKING THE DIVISION, ARE PEOPLE IN COMPLIANCE WITH THIS PIECE OF THE REGULATION?
>> THIS IS LAURA ON THE PHONE AGAIN. I AM IN THE SKILLED NURSING HOME FACILITY. I GO TO 50 LONG-TERM SKILLED NURSING HOME FACILITIES AND I CAN TELL YOU AS A FACT THEY ARE NOT BEING SCREENED. THE WAY THAT I GET REFERRALS IS THE SOCIAL WORKER IDENTIFIES THE PATIENT AS HAVING A HEARING LOSS, OR THE FAMILY SAYS THEY CAN'T HEAR AND I GET A REFERRAL. ALSO, BEFORE THE SPEECH PATHOLOGIST SEES THE PATIENT FOR TREATMENT, THEY SHOULD BE DOING HEARING SCREENINGS, SO THAT'S ANOTHER AREA WE NEED TO LOOK AT. THE SPEECH PATHOLOGIST CAN USE THIS ONLINE APP TO DO THE SCREENINGS PRIOR TO THEIR TREATMENT. AS FAR AS EVIDENCE, I CAN TELL YOU FIRSTHAND EXPERIENCE IN THE 120 SKILLED NURSING FACILITIES THAT HEARING LIFE IS IN, THEY ARE NOT BEING SCREENED.
>> ADAM: WE WILL HAVE TO ASK THAT QUESTION OF DHSR. LE
>> BIRKELEY: SON PART OF THAT THEN IS WE NOT ONLY NEED TO ASK DHSR BUT WE WANT TO ASK THEM IF FACILITIES ARE CURRENTLY PASSING THEIR COMPLIANCE REGULATIONS BUT THIS IS A REGULATION, THE QUESTION IS, HOW DO WE-- WHAT IS NEEDED TO BETTER ENFORCE OR WHAT IS THE-- WHAT SORT OF OVERSIGHT IS THERE, AND HOW IS THIS BEING MISSED, AND THEN HOW DO WE-- WHAT NEEDS TO BE DONE WITHIN THE REGULATIONS TO MAKE SURE THAT THIS IS NOT BEING OVERLOOKED IN THE OVERSIGHT OF SKILLED NURSING FACILITIES?
>> JOHNNY: I AGREE. IT IS MY RECOLLECTION THAT THE STATEMENT IN THE REGULATION THAT REQUIRES HEARING SCREENING IS VAGUELY WRITTEN. SO WHAT IF THEY'RE STILL USING THE WHISPER VOICE TEST. CAN YOU HEAR ME?
[JOHNNY WHISPERS]
IS IT WRITTEN SO SPECIFIC THAT IT REALLY DOES ADDRESS HEARING, OR IS IT VAGUE AND THERE'S AN OPPORTUNITY TO HAVE A LITTLE CONVERSATION AND THEY PASS? THAT'S A BIGGER CONCERN. IF IT'S IN PLACE AND THEY SAY THEY'RE IN COMPLIANCE-- SORRY, AND I'M HOPEFULLY BIG.
[LAUGHTER]
IF THEY'RE IN COMPLIANCE, YOU KNOW, WHAT ARE THEY DOING TO STAY IN COMPLIANCE? HOW DO THEY MEET THAT REQUIREMENT? WHAT METHODOLOGY IS BEING USED? I THINK IT'S VAGUE AND I THINK IT'S NOT WHAT WE THINK IT IS.
>> JAN: YES THIS IS JAN SPEAKING. SORRY. WE'LL WAIT JUST ONE SECOND. WANT TO MAKE SURE EVERYBODY CAN SEE ME. AND YOU ACTUALLY ALREADY SAID WHAT I WAS PLANNING TO SAY. I THINK

WE DO HAVE TWO DIFFERENT ISSUES HERE.
FIRST OF ALL, THE CMS REQUIREMENTS AND WHETHER THEY'RE SUFFICIENT AND THEN SECONDLY, COMPLIANCE, SO THERE ARE TWO DIFFERENT ISSUES.
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>> TOVAH: I'M NOT A LAWYER BUT IN TERMS OF TRYING TO UNDERSTAND THESE REGULATION, THE CMS DOES HAVE GUIDELINES FOR HOW TO DO HEARING SCREENING. THEY'RE NOT THAT WELL DEFINED, BUT DO INCLUDE THINGS LIKE, FOR EXAMPLE, INQUIRING ABOUT COMMUNICATION ISSUES AND SEVEN DAYS OF OBSERVATION OF A PERSON IN DIFFERENT HEARING SITUATION, HOW MUCH OF THAT DO YOU THINK IS ACTUALLY DONE? WHO HAS THE TIME FOR THAT AND WHO PAYS FOR THAT? THAT'S NUMBER ONE . NUMBER TWO, YOU CAN DO ALL THE SCREENING YOU WANT AND DO IT FOR FREE. IT'S A SIMPLE APPLICATION, BUT MANY PLACES DON'T WANT TO OR AFRAID TO BECAUSE YOU FIND OUT, LET'S SAY, THAT HALF YOUR POPULATION HAS HEARING IMPAIRMENT, WHAT DO THEY DO NEXT? HOW IS THAT GOING TO BE COVERED? SO I THINK YOU HAVE-- YOU HAVE THE REGULATION BET, SOME ARE BETTER DEFINED THAN OTHERS BUT THE ISSUE IS, HOW DO WE OBEY THESE REGULATIONS IN A WAY THAT WE CAN AFFORD?
>> ROBERT: ONE THING AND OF -- BEFORE WE GO FORWARD. THIS IS KATHY DOWD, WHAT SHE WAS TALKING ABOUT LAST MEETING. IT COVERS AND IT SAYS NURSING FACILITIES OR COMBINATION HOMES, WHICH COVERS ADULT CARE HOMES, TOO. I'M NOT SURE. I WOULD ASK FOR SOME INPUT. IF THIS IS A PLACE BEFORE-- WHERE A CHANGE IS NEEDED, THIS IS THE DEFINITIONS THAT IT COVERS, NURSING HOME AND COMBINATION FACILITY. IF A CHANGE IS NEEDED WHERE IT WOULD COVER BOTH SKILLED NURSING FACILITIES AND ADULT CARE HOMES. IS THAT BETTER? NO.
>> ADAM: STATE GENERAL STATUTE?
>> ROBERT: STATE LAW, YES.
>> MAGGIE: SO, SINCE WE'VE BEEN TALKING ABOUT COMPLIANCE AND THE ABILITY TO BE IN COMPLIANCE, AND I APOLOGIZE, I MAY NOT REALIZE WHETHER OR NOT SOME OF THIS HAS TO DO WITH WORKFORCE ISSUES IN TERMS OF REGULATION BECAUSE I THINK WE TALKED ABOUT AUDIOLOGY AIDE AND WHAT AN AUDIOLOGY AIDE CAN DO AND I AM THINKING ABOUT RURAL FACILITIES, WHERE THIS CAN BE A REAL CHALLENGE FOR THEM AS WELL. I'M WONDERING ARE THERE MODELS THAT WE COULD CONSIDER THAT WOULD ALLOW SOME ASSISTANCE TO NURSING FACILITIES THAT MAY ACTUALLY BE VIRTUALLY CONNECTED TO AN AUDIOLOGIST. I'M NOT SAYING DOING THE TESTING. OBVIOUSLY CAN'T DO THAT. JUST IN TERMS OF TRAINING, CONSULTING, AND ANY OTHER KIND OF TECHNICAL ASSISTANCE THAT COULD BE DONE. I'M JUST TRYING TO THINK ABOUT WORKFORCE ISSUES.
>> JOHNNY: IN NORTH CAROLINA STATUTE RELATED TO AUDIOLOGY ASSISTANT, THERE'S VIRTUALLY ONE LINE. IT'S NOT DEFINED. THE STATE HAS NEVER PURSUED THAT. AS COMPARED TO SPEECH LANGUAGE PATHOLOGY ASSISTANTS, IT'S HEAVILY DEFINED AND REGULATED. THERE ARE NATIONAL PRACTICE STANDARDS FOR ASSISTANTS AND TRAINING. SO IT REALLY WOULD BE PERHAPS A RECOMMENDATION. JAMES AND I HAVE BEEN TALKING ABOUT THIS TODAY-- TO THE NORTH CAROLINA LICENSURE BOARD TO CLEARLY DEFINE SPECIFICS ON TRAINING AND SUPERVISION, AS WELL AS RESPONSIBILITIES AND IT THEN BECOME A PART OF THE STATUTE SO THERE THERE IS A CLEARLY DEFINED PROGRAM THAT WOULD BE ABLE TO BE UTILIZED.
>> SHELLEY: SO A LOT OF WHAT I'M THINKING OF USING ASSISTANTS FOR IN A LONG-TERM CARE FACILITY WOULD BE FAIRLY HANDS ON. MAINTAINING DEVICES, REPLACING WAX FILTERS, CHECKING-- THERE'S A LOT OF PHYSICAL BLOCKAGE THAT GETS IN THE WAY OF ACOUSTICS, PARTICULARLY WHEN MOBILITY IS REDUCED, EAR WAX PRODUCTION INCREASES DRAMATICALLY. THERE'S ESTIMATES THAT

MORE THAN HALF OF PEOPLE IN LONG-TERM CARE FACILITIES LIKELY HAVE FULL INCLUSIONS OF EAR WAX IN THEIR EARS. MANAGEMENT OF JUST THE HEARING AIDS, THEMSELVES, DOES REQUIRE HANDS ON. TELEHELP OPTIONS, THE MORE WE CAN DO REMOTE, THE MORE WE CAN HELP ESPECIALLY IN THE RURAL COMMUNITIES AROUND. I HAVE DONE YOUTUBE VIDEOS OF TROUBLE SHOOTING THAT I WILL EMAIL TO A CAREGIVER SO I CAN TALK THEM THROUGH IT WHEN I'M NOT ABLE TO BE THERE WITH THEM. SO THERE'S SOME OTHER ROUTES THAT WE CAN UTILIZE TECHNOLOGY, BUT I DON'T KNOW THAT SORT OF DIRECT TELEHEALTH IS QUITE AS PRACTICAL HERE. REALLY FOR TESTING OR FOR MANAGEMENT, WE NEED OUR HANDS ON THEM.
>> SO I AM ON THE STATE BOARD OF EXAMINERS FOR SPEECH AND AUDIOLOGY. ADAM, WHO IS THE CHAIRMAN, AND CARRIE PAYHILL, WHO WASSAN THE BOARD, AND I HAVE BEEN WORKING ON REVISING THE AUDIOLOGY LAWS AND INCLUDING INFORMATION ABOUT AUDIOLOGY ASSISTANTS AND SPECIFICS RELATED TO THAT AS WELL AS TELEHEALTH AND TELEPRACTICE. ONE OF THE BARRIERS TO TELEHEALTH AND TELEPRACTICE IS THAT MOST INSURANCES DON'T REIMBURSE FOR THEIR TIME AND SERVICES, SO PEOPLE ARE A LITTLE RESISTANT TO USING IT. THE OTHER BARRIER-- IT'S NOT REALLY A BARRIER, BUT IT'S SOMETHING THAT SIDE RAILED A LITTLE BIT THE CHANGE IN THE LAW IS THAT THERE'S A LOT OF DISCUSSION ABOUT AN INTRASTATE LICENSURE COMPACT AMONGST-- INTERSTATE LOCAL COMPACT AMONG VARIOUS STATES SO PEOPLE CAN APPLY FOR LICENSURE IN ONE STATE AND ARE ABLE TO PRACTICE ACROSS THE LINES. IT DOESN'T CHANGE THEIR SCOPE OF PRACTICE WITHIN THAT PARTICULAR STATE. BECAUSE THAT COMPACT IS IN THE DRAFTING STAGES, WE DON'T WANT TO MUDDY THE WATERS BY OPENING UP ARTICLE 22 FOR REVISIONS WITH THE AUDIOLOGY SCOPE UNTIL WE HAVE ALL OF THIS INFORMATION REGARDING THE INTERSTATE COMPACT. THAT IS MAKING A LOT OF PROGRESS BUT ISN'T QUITE FINISHED.
>> ADAM: ONE OTHER QUESTION ON WORKFORCE. SOMEBODY SAID WE HAVE 16,000 LICENSED AUDIOLOGIST IN THE COUNTRY AND BY MY MATH MEANS WE HAVE LESS THAN 500 IN NORTH CAROLINA. WHAT IS OUR RURAL ACCESS TO LICENSED AUDIOLOGISTS LOOK LIKE? WE CAN FIND THIS OUT IF WE DON'T KNOW. RURAL ACCESS TO LICENSED AUDIOLOGISTS. IF WE HAVE TO GUESS ABOUT 500 IN THE STATE?
>> JOHNNY: THERE ARE 700 IN THE STATE.
>> ADAM: I WAS CLOSE. THERE ARE ABOUT 700 IN THE STATE, SAYS JOHNNY SEXTON.
>> SHELLEY: KNOCK OUT SCHOOL SYSTEM. BUT FROM THIS PICTURE OF TALKING ABOUT LONG-TERM CARE FACILITIES, WE'D KNOCK OUT THE SCHOOL SYSTEM AUDIOLOGISTS AND THE HEALTHCARE SYSTEM, HOSPITAL-BASED AUDIOLOGISTS. I DON'T KNOW WHAT PERCENTAGE THAT MAKES UP BUT IT'S A SUBSTANTIAL PORTION.
>> ADAM: WHAT WE CAN DO AS A STARTING POINT IS GET A MAP OF THE PRIMARY PRACTICE LOCATIONS OF AUDIOLOGISTS AND SEE WHAT THAT LOOKS LIKE.
>> I HAVE A QUESTION THAT IS GOING TO TOUCH BACK ON SOMETHING ASHLEY RAISED EARLIER AND I'M WONDERING, SO IF THERE'S A HEARING SCREENING GOING INTO A FACILITY AND SOMEBODY IS IDENTIFIED-- WELL, YOU MAY NOT NEED THE HEARING SCREENING AND ANYWAY, SOMEBODY COMING INTO THE FACILITY IS DEAF, WHAT SORTS OF SERVICES IS THE FACILITY REQUIRED TO PROVIDE, AND HOW DOES THAT DIFFER FOR SOMEBODY WITH HEARING LOSS? I MEAN, UNDER THE ADA, THEY SHOULD BE HAVING TO PROVIDE SOME SUPPORT SERVICES AND I JUST DON'T KNOW WHAT THAT LOOKS LIKE FOR ONE POPULATION VERSUS THE OTHER? I'M WONDERING IF WE HAVE PROBLEMS WITH BOTH--
>> JAN: TOVAH, YOU MAY BE A BETTER PERSON TO ANSWER THAT QUESTION AND LET ME PASS THIS

ON.
>> TOVAH: AS ASHLEY ALREADY POINTED OUT EARLIER, WE BASICALLY HAVE TWO DIFFERENT POPULATIONS. WE HAVE DEAF PEOPLE AND BY DEAF PEOPLE, I MEAN THOSE WHO ARE PART OF THE KOHL TOORLLY DEAF, OR DEAF COMMUNITY, WHO PRIMARILY USE SIGN LANGUAGE WHO PROBABLY HAVE BEEN DEAF MOST OR ALL OF THE THEIR LIFE VERSUS THE LARGER, MORE PERVASIVE POPULATION OF PEOPLE WHO ARE HEARING AND, QUOTE, NON-DISABLED, MOST OF THEIR LIFE WHO OVER TIME ACQUIRE DIFFERENT DISABILITIES, ILLNESSES AND AILMENT THAT ACTUALLY AFFECT HEARING. THIS IS A HUGE-- THIS IS THE MAJORITY OF THE POPULATION, AND THAT IS PROBABLY WHY WE'RE SO FOCUSED ON THIS GROUP BECAUSE THE PERVASIVENESS OF HEARING LOSS. THE PERVASIVENESS OF MEDICAL CONDITIONS THAT ARE RELATED TO HEARING LOSS IS MUCH LARGER FOR THAT GROUP. PEOPLE WHO ARE DEAF PROBABLY -- FOR THE MOST PART HAD THE SKILL OF COMMUNICATION ISSUES AND BARRIERS AND OBSTACLES AND CHALLENGES THAT THEY FACE. SO COMING IN, THEY ALREADY HAVE THAT INFORMATION AT HAND AND PEOPLE ARE FACED WITH DIFFERENT RESOURCES THAT ARE NEEDED, SUCH AS SIGN LANGUAGE INTERPRETERS, OR CART SERVICES, AND THINGS LIKE THAT SO THE ACCESSIBILITY ISSUES FOR DEAF PEOPLE IT REALLY KIND OF ON A DIFFERENT TRACK THAN THE ACCESSIBILITY ISSUES OF HARD OF HEARING OR PEOPLE WITH HEARING LOSS THAT ARE NOT PART OF THE CULTURALLY DEAF POPULATION AND JAN, YOU MAY WANT TO ANSWER THAT.
>> JAN: YES, ACTUALLY, THE QUESTION POSED IS, WHAT DOES THE NURSING HOME STAFF DO TO SUPPORT OR TO ENSURE COMMUNICATION ACCESS FOR DEAF RESIDENTS? WHAT'S ACTUALLY GOING ON? SO MAYBE YOU CAN SHARE WITH THE FOLKS HERE WHAT YOUR RESEARCH FINDINGS WERE IN OTHER STATES WHEN THEY ATTEMPTED TO BUILD CENTERS THAT WERE DEAF FRIENDLY, WHERE THEY HAD SIGNING STAFF, AND THE CONCEPT OF LIKE, FOR EXAMPLE, HAVE A WING WHERE YOU COULD HIRE SIGNING STAFF AND HAVE A WING OF DEAF RESIDENTS, SO WHAT'S GOING ON THERE? WHAT'S THE SITUATION LIKE THAT?
>> TOVAH: I THINK I MENTIONED IN MY PRESENTATION AND I PROBABLY THREW SOME STATISTICS OUT IN MY PRESENTATION FROM LAST TIME FROM THE FACT THAT IN MY RESEARCH, I DISCOVERED ABOUT 44 FACILITIES THAT WERE DEAF FRIENDLY OR ESSENTIALLY DEAF PEOPLE RUN WITH DEAF STAFF. IN SOME STATES THAT WORKS BECAUSE GEOGRAPHICALLY, IT'S POSSIBLE, FOR EXAMPLE, IN A STATE LIKE ARIZONA, WHICH IS KIND OF SQUARE AND THE FARTHEST POINT HAD ANY STATE IS NOT THAT FAR AWAY BUT NORTH CAROLINA IS LONG AND EIGHT HOURS LONG IN DRIVING DISTANCE SO HAVING A CENTRAL FACILITY THAT IS DEAF FRIENDLY OR DEAF ONLY MAY NOT WORK AS WELL FOR NORTH CAROLINA AS IT MIGHT FOR ARIZONA. IN SOME CASES, IT MAY BE ADVISABLE TO HAVE A WING OF PARTICULAR FACILITIES LIKE ASSISTED LIVING FACILITIES OR SYLVAIN NURSING FACILITIES, THAT IS DEDICATED TO DEAF PEOPLE AND POSSIBLY DEAF BLIND PEOPLE, WHICH STAFF WHO ARE DEAF OR WHO KNOW SIGN LANGUAGE OR KNOW DEAF CULTURE AND DEAF COMMUNITY, THOSE SEEM TO BE THE WAYS IN WHICH THAT CAN BE HANDLED, THAT IS A SMALLER POPULATION THAN THE LARGER ONE THAT WE ARE FACED WITH AT THE MOMENT. SO IT IS TWO AVENUES OF ACTION THAT WE HAVE TO TAKE.
>> JAN: THIS IS JAN, IF I CAN TO CURRENTLY ANSWER THE QUESTION SPECIFICALLY HERE. RIGHT NOW, THEY ARE NOT GETTING THE ACCOMMODATIONS THEY NEED HERE IN NORTH CAROLINA. FOR EXAMPLE, IF YOU THINK ABOUT CARE BEING PROVIDED IN THE MORNING, AT NOON, NIGHT, ALL THROUGHOUT THE DAY, THERE SHOULD BE OPPORTUNITIES FOR RESIDENTS TO HAVE COMMUNICATION WITH THE STAFF ALL THROUGHOUT THE DAY. THEY ARE NOT GETTING THAT COMMUNICATION ACCESS. THE STAFF ARE NOT PROVIDING THAT. THEY MIGHT BRING IN AN

INTERPRETER FOR INITIAL EVALUATION, FOR ADMISSIONS, AND THAT'S IT. I DON'T EVEN KNOW IF THEY'RE DOING THAT EVERY TIME. PROBABLY NOT, OKAY, BUT DEFINITELY NOT ON THE DAY-TO-DAY CONVERSATIONS. DOES THAT ANSWER YOUR QUESTION?
>> BERKELEY: IT SEEMS LIKE WE HAVE ADA COMPLIANCE ISSUES IN LONG-TERM FACILITIES AND I'M NOT SURE HOW TO HANDLE SORT OF THE DEAF POPULATION NEEDS. THE OTHER THING I WANT TO KNOW IS IN ADDITION TO THE SCREENING, DO WE WANT TO TALK ABOUT FACILITY REQUIREMENTS THAT SHOULD BE IN PLACE GIVEN THE HIGH RATE OF HEARING LOSS FOR BEING IN COMPLIANCE WITH THE ADA? LIKE HEARING LOOPS IN FA ITS IS, DO WE NEED TO MAKE A RECOMMENDATION THAT ALL SKILLED NURSING FACILITIES HAVE SOME SORT OF ACCOMMODATION FOR INDIVIDUALS WITH HEARING LOSS. ? IT JUST SEEMS TO MAKE SENSE. I DON'T KNOW IF IT'S CURRENTLY IN THE REGULAR LACES. MY GUESS IS NO. IT DOESN'T SOLVE ALL ISSUES BECAUSE IT ONLY HAS TO BE IN CERTAIN PLACES, IS MY UNDERSTANDING, WHERE PEOPLE GATHER. BUT I MEAN, WE CAN GO AFTER SCREENING AND WE CAN GO AFTER TRYING TO MAKE FACILITIES EQUIPPED TO HANDLE THE POPULATION THAT IS LIVING IN THEM. SO I DON'T WANT TO LEAVE OUT THE UPFITTING FACILITIES TO MEET THE NEED WHILE WE QUIBBLE OVER WHETHER PEOPLE ARE DOING SCREENINGS OR NOT. I FEEL LIKE THERE ARE TWO DIFFERENT WAYS TO GO AFTER THIS.
>> BRAD: THIS IS BRAD SPEAKING. TOVAH THIS EVALUATION OR SCREENING OF PEOPLE WHEN THEY ENTER IN A LONG-TERM CARE FACILITY, WHO MONITORS THAT TO MAKE SURE IT'S-- LIKE, FOR EXAMPLE, IF SOMEBODY RECOGNIZES THAT THE PERSON DOES HAVE A HEARING LOSS AND THEY NEED ASSISTANCE OR THEY NOTICE THAT DURING THE ASSESSMENT, IS THERE ANY MONITORING OF THAT, OR ANY OVERSIGHT, OR ANY FINDINGS THAT WE COULD TRACK TO MAKE SURE THAT THERE'S ACTUALLY FOLLOW-UP PROVIDED?
>> TOVAH: YOU CAN PROBABLY ANSWER BETTER THAN I CAN. TO MY KNOWLEDGE, IN SKILLED NURSING FACILITY, THERE IS CMS OVERSIGHT, YOU KNOW, MEDICARE PEOPLE WHO ARE SUPPOSED TO BE RESPONSIBLE FOR ENSURING MEDICARE COMPLIANCE. I DON'T KNOW IF THEY CALL THOSE MEDICARE OFFICERS OR WHAT. SMS IS REWIRED TO SUBMIT REPORTS, EITHER ANNUALLY OR QUARTERLY, THAT DEMONSTRATE THEIR, YOU KNOW, WHAT THEIR COMPLIANCE WITH THE REGULATION THAT THEY'RE EXPECTED TO COMPLY WITH AND THAT INCLUDES THE HEARING SCREENING SO THEY'RE SUPPOSED TO DOCUMENT IN SOME WAY THAT THEY'VE DONE THESE THINGS THAT'S MY UNDERSTANDING.
>> BERKELEY: I THINK WE'RE HEARD FROM MARK THAT IN THIS STATE OR MAYBE FROM THE PERSON ON THE PHONE, CORYE, THAT THE DIVISION-- DIVISION OF HEALTH SERVICES REGULATION, IS WHO ACTS AS THE CMS REGULATOR IN THE STATE. THIS IS ANOTHER SET OF QUESTIONS TO THEM NEXT MONTH IS, WHEN HAPPENS AFTER SCREENING, IF IT'S SHOWN, THAT SOMEBODY HAS NEED? I DON'T THINK WE HAVE AN ANSWER FOR THAT UNLESS SOMEBODY KNOWS WHAT HAPPENS. I THINK ASHLEY HAD A QUESTION.
>> ASHLEY: THIS IS ASHLEY. I WANTED YOU TO-- I WANTED TO THANK YOU FOR RECOGNIZING THIS. I BROUGHT THIS UP FOR A REASON AND I WANT TO MAKE SURE THAT WE LOOK AT EVERYTHING AT THE SAME TIME. WHEN WE LOOK AT SCREENING, WE WANT TO SEE IF SOMEBODY IS DEAF, THEN WE NEED TO KNOW WHAT TO DO AND A TREE OF WHERE TO GO AND IF THEY'RE DEAF, THEY'RE GOING TO DO THIS AND THIS AND THEN THIS. WE NEED TO MAKE SURE THAT EVERYTHING IS ADDRESSED AT THE SAME TIME, HARD OF HEARING, ET CETERA. WE KEEP SAYING WE'RE FOCUSING ON HEARING LOSS AND THE HEARING LOSS COMMUNITY IS A VERY LARGE NUMBER OF THE PEOPLE THAT ARE GOING TO BE SERVED BUT DEAF AND DEAF-BLIND PEOPLE, EVEN THOUGH IT'S A SMALLER POPULATION, THEY'RE AT

MUCH HIGHER RISK OF MISSING OUT ON INFORMATION. SO PLEASE REMEMBER TO CONSIDER THEM, EVEN THOUGH THEY'RE SMALL IN NUMBERS, THE RISK IS HIGH AND WE NEED TO CONSIDER ALL POPULATIONS AT THE SAME TIME.

>> VICKIE: THIS IS VICKIE, AND I'M NOT AN ATTORNEY AND I DON'T WORK FOR AN ORGANIZATION THAT HAS ATTORNEYS ANYMORE, BUT I WOULD CAUTION YOU OF RYING TO COMBINE THESE TWO ISSUES BECAUSE THEY HAVE PROBABLY DISTINCTLY DIFFERENT RESPONSES. SO AN AGENCY OR AN EMPLOYER OR A FACILITY OR ANYTHING HAS TO PROVIDE REASONABLE ACCOMMODATIONS FOR PEOPLE WITH DISABILITIES . THAT CERTAINLY INCLUDES PEOPLE WHO ARE HARD OF HEARING, PEOPLE WHO ARE DEAF, BUT YOU HAVE TO ASK FOR IT. YOU HAVE TO REQUEST IT AND SO IF A DEAF PERSON IS IN A NURSING HOME, THEN THEY SHOULD BE REQUESTING ACCESSIBLE COMMUNICATION. WE WOULDN'T BE HERE IF WE KNEW THAT HAPPENED AUTOMATICALLY. WHEN YOU GO TO THE DOCTOR, IT DOESN'T. BUT SEPARATE OUT THE SCREENING AND THE TESTING OF PEOPLE WHO ARE HARD OF HEARING OR NEWLY DEAF AND THEN TALK ABOUT WHAT YOU WANT TO DO AS A COMMUNITY, AS A-- YOU SAID NON--- PEOPLE WHO ARE DEAF OR NON-DISABLED AND YET IN ORDER TO GET PROTECTS UNDER THE AMERICANS WITH DISABILITIES ACT, YOU HAVE TO DISCLOSE A DISABILITY. SO I THINK FOR THE PURPOSE OF THIS TASK FORCE AND LOSING OUR FOCUS, THAT WE REALLY HAVE TO KIND OF PARSE THIS OUT AND TAKE BITES OF, YOU KNOW, NOW I'M CONFUSING ALL MY ANALOGIES. OF DIFFERENT-- DIFFERENT PROBLEMS THAT HAVE DIFFERENT SOLUTIONS. SO FIRST, FOR PEOPLE WHO ARE HARD OF HEARING, WE HAVE TO SCREEN, AND THEN TEST AND EVALUATE, MEET THAT NEED, AND THEN PROVIDE ACCOMMODATIONS FOR THAT POPULATION, WHO ARE MOST LIKELY GOING TO BE DIFFUSED ACROSS ALL OF THESE FACILITIES ACROSS THE STATE, AND THEN SEPARATE AND APART FROM THAT, THINK ABOUT THE CULTURAL NEEDS OF PEOPLE WHO ARE DEAF AND WHERE DO THEY WANT TO LIVE? DO THEY WANT TO BE CONFUSED-- FIF FUSED ACROSS ALL THE NURSING HOMES, OR DO YOU WANT A PLACE WHERE YOU CAN COMMUNICATE WITH THE PEOPLE WHO LIVE IN THOSE FACILITIES ? SO JUST KEEP YOUR FOCUS HERE.

>> BERKELEY: YOU RAISED AN INTERESTING POINT THAT I'M WONDERING. IF A SCREENING IS DONE AND THERE'S HEARING LOSS AND IT'S A HEALTHCARE ISSUE AND THE PERSON DOESN'T ADVOCATE FOR THEMSELVES AS A DISABILITY, ARE THERE DIFFERENT REQUIREMENTS FOR THE FACILITY? OR, DOES THE FACILITY HAVE TO RECOGNIZE THAT HEARING LOSS IS A DISABILITY AND THEY HAVE-- I JUST SORT OF WONDER. YOU BROUGHT UP WHEN DOES HEARING LOSS FALL UNDER. ADA VERSUS NOT.

>> VICKIE: I WOULD ASK FOR A MORE THOUGHTFUL LEGAL OPINION ON THAT BECAUSE THAT'S A GOOD QUESTION. ALSO ANY FACILITY SHOULD HAVE NOTICE OF AND PROBABLY ARE REQUIRED TO GIVE NOTICE AND YOU HAVE A DISABILITY, HERE'S HOW YOU REQUEST A REASONABLE ACCOMMODATION. IT'S PRETTY STANDARD.

>> SHELLEY: HI, CORYE. THAT'S LEGAL ADVICE. I'LL BE QUIET.

>> CORYE: I DO THINK THIS IS AN IMPORTANT DISTINCTION, BUT I AM NOT SURE HOW YOU WOULD TWO--HOW YOU COULD REASONABLY ARGUE-- SO YOU CAN ARGUE THAT IF YOU WALKED INTO A SPORTING GOODS STORE, YOU HAVE TO DISCLOSE YOUR DISABILITY IN ORDER TO GET APPROPRIATE ACCOMMODATIONS, BUT IF YOU ARE RECEIVING HEALTHCARE SERVICES IN A FACILITY, IT WOULD BE HARD FOR ME TO UNDERSTAND HOW THEY WOULDN'T KNOW THAT YOU HAVE A DISABILITY. YOU DON'T HAVE TO CALL IT HEARING LOSS FOR YOUR-- THERE ARE NO MAGIC WORDS. YOUR HEALTHCARE PROVIDER WHO IS SPEAKING TO YOU IN A RAISED VOICE OR SAYS THAT YOU CAN'T UNDERSTAND, THERE MAY NOT BE AN AUDIOLOGIST TEST INVOLVED BUT I THINK IT'S OFTEN THE CASE AND CERTAINLY NOT ALWAYS BUT OFTEN THE CASE THAT HEALTHCARE PROVIDERS ARE PRESUMED TO BE

ON NOTICE OF YOUR DISABILITY AND THEIR NEED TO ACCOMMODATE IT WITHOUT ANY SPECIAL MECHANISM.

>> SHELLEY: THIS IS SHELLEY CRISTOBAL BALL TALKING FROM EXPERIENCE IN SKILLED NURSING CENTERS IS THAT A CAREGIVER COMES INTO THE ROOM, WHATTING THEIR HANDS AND THEY ARE NOT FACING THE INDIVIDUAL WHO HAS A HEARING LOSS AND THE CAREGIVER IS TALKING ABOUT PLANS FOR THE DAY AND CHITCHATTING AND TRYING TO ALLOW FOR SOME BONDING, RAPPORT BUILDING, BUT THEN MAYBE TALKING ABOUT MEDICATION OR DIET DECISIONS THAT ARE MORE CONCRETELY RELATED TO THEIR WELLNESS. SO THERE'S A MEASURE OF THE SCREENING IS REALLY IMPORTANT FOR INDIVIDUALS WITH ACQUIRED HEARING LOSSES THAT IS GRADUAL BECAUSE OFTEN THEY DON'T RECOGNIZE IN THEMSELVES A DEGREE OF HEARING LOSS THAT IMPACTS THEIR FUNCTIONING IN THAT LONG-TERM CARE WITH THOSE CAREGIVERS. I LOVED ASHLEY'S IDEA ABOUT THE DECISION TREE. THAT JUMPED OUT AT ME. I THINK THAT WAS A REALLY HELPFUL THOUGHT PROCESS WITH SCREENING MAKING A PERSON WHO HEARS FAIRLY WELL TO FUNCTION IN THIS ENVIRONMENT, A PERSON WHO NEEDS SOME SORT OF FOLLOW-UP ON HEARING, OR A PERSON WHO DOESN'T USE HEARING AND NEEDS TO GO DOWN A DIFFERENT PATHWAY AND MAYBE THAT AWARENESS IS PART OF THE EDUCATION WE NEED TO BE TALKING ABOUT. SO THAT IS SOMETHING WE CAN CATCH AND BE SOMETHING DIFFERENT. SO I DO WANT TO MAKE SURE THIS WE'RE TAKING CARE OF THOSE TWO DIFFERENT COMMUNICATION NEEDS INDIVIDUALLY.

>> WE HAVE A LOT OF HANDS GOING UP AND WE'RE GOING TO KEEP MOVING. JOHNNY, JAN, TOVAH, ASHLEY, AND THEN LUNCH.

[LAUGHTER]

>> SHELLEY: I WANT TO MAKE A PLAN FOR THE FOLLOW-UP, THE NEXT STEP. SCREENING IS ONE THING, BUT IF THERE ISN'T SOME SORT OF TEETH IN WHAT HAPPENS NEXT AND THAT'S PROBABLY WHAT JOHNNY IS GOING TO SAY. I'LL STOP. THANK YOU.

>> JOHNNY: THERE IS A MODEL STATEWIDE IN THE PUBLIC SCHOOLS. THAT'S MY WORLD. THE QUALIFIED PROVIDER, THE QUALIFIED MANAGER OF ALL OF THESE COMPONENTS THAT WE'RE TALKING ABOUT IS A LICENSED AUDIOLOGIST IN THE STATE OF NORTH CAROLINA. THAT'S REITERATED ON THE FEDERAL LEVEL WITH IDEA, WHICH IS THE FEDERAL SPECIAL EDUCATION LAW, AND WE TALKED A LITTLE BIT OVER SEVERAL MEETINGS ABOUT AUDIOLOGY SERVICES BEING A MANDATED PART OF WHAT HAPPENS TO OVERSEE THESE ENVIRONMENTS. AS WE TRY TO GET TO RECOMMENDATIONS, THAT'S SOMETHING I WOULD ASK THAT YOU CONSIDER. A SINGLE POINT OF ENTRY, WHO IS GOING TO ENSURE THAT, YOU KNOW, THEY'RE IN COMPLIANCE, THE SCREENING IS APPROPRIATE. THAT SAME AUDIOLOGIST INVOLVED WITH FACILITIES COULD ADDRESS RURAL HEALTH ISSUES IN EMPLOYING ASSISTANTS IN OVERSEEING WHAT THEY DO. IT'S ALREADY IN NORTH CAROLINA STATE LICENSURE LAW THAT ANY INDIVIDUAL IN THIS STATE WHO CONDUCTS A HEARING SCREENING MUST BE TRAINED AND SUPERVISED BY LICENSED AUDIOLOGIST OR PHYSICIAN. THERE ARE A FEW BITS AND PIECES OUT THERE, BUT IF YOU'RE TRYING TO COORDINATE AND LOOK AT A RECOMMENDATION TO MOVE FORWARD, THAT IS SOMETHING I WOULD ASK YOU TO CONSIDER. SINGLE POINT OF ENTRY, WHO IS HE DIDDING TO BE RESPONSIBLE FOR OVERSEEING ALL OF THIS AND IT CAN BE A LICENSED AUDIOLOGIST.

>> ADAM: JAN WAS NEXT, TOVAH AND THEN ASHLEY.

>> JAN: OKAY. I AND I MY STAFF WORK WITH A WIDE VARIETY OF DIFFERENT KINDS OF ORGANIZATIONS AND AGENCIES THAT SERVE OR ARE FOCUSED ON SERVING OLDER ADULTS. AND I CANNOT TELL YOU HOW OFTEN EVEN THOUGH THEY KNOW THAT OLDER ADULTS HAVE A HIGHER CHANCE OF HAVING A HEARING LOSS, HIGHER THAN ANY OTHER GROUP, WHEN THEY START TALKING ABOUT POLICIES AND

PROCEDURES AND SERVICES OR WHATEVER, THEY TOTALLY FORGET ABOUT PEOPLE WITH HEARING LOSS. AGAIN, WE'RE TALKING ABOUT 30%. WHEN YOU TALK ABOUT PEOPLE AGED 60 TO 74, IT'S 30% AND THEN 50% OVER THE 8-K OF 75. OKAY. AND THERE'S A HUGE IMPACT ON EVERYTHING IN A PERSON'S LIFE HAD THEY HAVE A HEARING LOSS AT THAT AGE. LOTS OF HEALTHCARE CONDITIONS, BUT FOR SOME REASON, THESE AGENCY AGENCY PERSONNEL CONTINUE TO FORGET ABOUT PEOPLE WITH HEARING LOSS AND WE, OUR STAFF, HAVE TO CONSTANTLY REMIND THEM TO ENSURE THAT THEY REMEMBER US . SO THERE'S THAT. ALSO MY STAFF SO MANY TIMES HAVE HAD THE EXPERIENCE WHERE THEY HAVE A HARD TIME GETTING PEOPLE TO UNDERSTAND HEARING LOSS AND WHY SOME BEHAVIORS ARE INAPPROPRIATE. LIKE YELLING AT SOMEBODY. OFTENTIMES DOES NOT HELP. WE CANNOT SAY THAT OFTEN ENOUGH THAT SCREAMING AT SOMEBODY IS NOT GOING TO HELP THEM HEAR YOU BETTER. SO THE IDEA OF--OH, ACTUALLY LOSING MY POINT. HOLD ON JUST A SECOND. I THINK WHAT I WANT TO SAY IS-- OH, YES. GOING BACK TO YOUR QUESTION, BERKELEY, AND YOUR COMMENTS, VICKIE, THE CONSUMER HAS TO ASK FOR THE ACCOMMODATION, BUT THERE IS A HUGE DEGREE OF PASSIVITY OR OF OPPRESSION, FEELING DISENFRANCHISED, IT'S A COMBINATION OF FIRST OF ALL, PEOPLE WHO HAVE NO CLUE ABOUT THEIR HEARING LOSS TO BEGIN, AND THEY SHOULD KNOW BUT THEY DON'T KNOW AND THE PASSIVITY AND THAT PASSIVITY AND IGNORANCE OF THEIR OWN CONDITION CAN BE LETHAL. NOW I DID CONTACT THE NATIONAL ASSOCIATION OF THE DEAF DIRECTOR AND ASKED HIS OPINION ABOUT HOW WE CAN MAKE SURE THAT WE ARE LOOKING AT THIS APPROPRIATELY AND HOW WE SHOULD BE EXPECTING A CERTAIN LEVEL OF RESPONSIBILITY ON THE PART OF THE FACILITY, WHEN THEY ARE TEAL DEALING WITH RESIDENTS WHO MAY NOT HAVE THE WHERE WITHAL WHO TO REQUEST THE ACCOMMODATIONS THEY NEED.
>> TOVAH: I WANT TO FOLLOW UP ON THE ISSUE OF REASONABLE ACCOMMODATION AND ASKING FOR IT. IT IS TRUE THAT THE-- WELL, LET'S THROW OUT STATS FIRST. TAKE SKILLED NURSING FA IT ISES, WE KNOW AS MANY AS 80% OF RESIDENTS IN SKILLED NURSING FACILITIES HAVE SIGNIFICANT HEARING LOSS. AND YET THERE IS THIS GREAT DISCONNECT BETWEEN THE POLICIES AND PROCEDURES THAT ARE SET UP IN THESE PLACES AND NOT ACKNOWLEDGING OR EVEN INCORPORATING HEARING LOSS AS PART OF THAT. IN THE SAME FACILITY, LESS THAN 1% ARE DEAF, IF THEY SHOW UP THERE AT ALL. MOST OF THEM PREFER NOT TO BE THERE AT ALL BECAUSE OF THE ISOLATION AND LOSS THAT THEY HAVE THERE. SO IN TERMS OF REASONABLE ACCOMMODATIONS, A DEAF PERSON YOU SEE IN ONE OF OUT THREE NURSING HOMES MAY ASK FOR ACCOMMODATION AND MAYBE THEY'LL GET IT WITHOUT A LOT OF TROUBLE AND FUSS. BUT THE MAJORITY OF PEOPLE THERE ACTUALLY WHO NEED IT WOULDN'T KNOW TO ASK BECAUSE THEY'VE NOT HAD TO DO SO MOST OF THEIR LIVES UNTIL THEY GET THERE SO ASKING FOR REASONABLE ACCOMMODATION MAKES NO SENSE. IN THOSE SITUATIONS, YOU HAVE THE NORM OF HEARING IMPAIRMENT AND THEREFORE, THESE PLACES SHOULD BE BUILT AROUND DIFFERENT NORMS THAN THE REST OF SOCIETY, FOR EXAMPLE.
>> BERKELEY: THAT'S A GREAT POINT AND NOW ASHLEY.
>> ASHLEY: IN ' YES. THIS IS ASHLEY SIGNING AND JAN ACTUALLY TOUCHED ON WHAT I WAS PLANNING TO SAY AND THAT WAS THAT. WE AS DEAF PEOPLE MUST ASK FOR ACCOMMODATION BUT SOMETIMES WE'RE ALREADY OPPRESSED. WE ALREADY SUFFERED WITH THE LACK OF RESOURCES, THE LACK OF OPPORTUNITIES, THE LACK OF CHOICES AND SO WE'RE CONSTANTLY HAVING TO ASK FOR ACCOMMODATIONS AND WE'RE USED TO THE FACT THAT THERE'S NOTHING OUT THERE EVEN WHEN WE DO ASK AND SO I'M JUST SPEAKING TO ME AS REPRESENTING DEAF, DEAF-BLIND PERSONS, WHEN YOU ARE WORKING WITH THE COMMUNITY, SOMETIMES IT'S EASIER FOR THE HARD OF HEARING COMMUNITY BECAUSE WE SAY, OKAY, WE'RE GOING TO SCREEN YOU AND HOOK YOU UP WITH WHAT

YOU NEED AND WE JUST WANT TO MAKE SURE THAT THINGS ARE SET UP THE SAME WAY FOR THE DEAF AND DEAF-BLIND POPULATIONS AS THEY ARE FOR THE HARD OF HEARING COMMUNITY OF THE THAT'S ALL I'M SAYING.
>> ADAM: I'M INTRIGUED ABOUT THE DISCUSSION WE'RE HAVING ABOUT HEALTHCARE PROVIDERS ARE, IN SOME WAYS, ON NOTICE. HEALTHCARE PROVIDER NOSE WHEN THEIR PATIENTS ARE HARD OF HEARING. I THINK THAT THE SITUATION IN THE SKILLED NURSING HOME IS REALLY DIFFERENT BECAUSE OF THE VERY HIGH PREVALENCE AND SO I FEEL LIKE THOSE FACILITIES SHOULD BE THINKING ABOUT UNIVERSAL DESIGN BUT THEN I THINK ABOUT HOSPITAL OR CLINIC OR ANOTHER KIND OF SETTING WHERE, SURE, THERE ARE A LOT OF HARD OF HEARING CONSUMERS. THE PERCENT THAT , AGAIN, ON NOTICE THAT ARE IMPAIRED MIGHT BE A LOT LOWER BUT IT CERTAINLY IS. I KNOW AMONG MY PATIENTS THAT I KNOW WHICH ONES ARE-- I KNOW WHICH ONES I KNOW ARE HARD OF HEARING BUT I DON'T KNOW WHICH ONES I DON'T KNOW ARE HARD OF HEARING. RIGHT? AND THE ONES I THOUGH THAT ARE HARD OF HEARING, IT'S NOT THAT MANY, AND SO THE PROBLEM THAT I'M HAVING IS I DON'T KNOW WHAT REASONABLE ACCOMMODATIONS ARE UNTIL SOMEBODY ASKS BECAUSE I'VE NEVER BEEN TAUGHT. I KNOW MORE NOW THAN I DID SIX MONTHS AGO AND I HAVE BEEN PRACTICING MEDICINE FOR 20 YEARS. SO FIGURING OUT HOW TO LIKE CLOSE THAT LOOP BECAUSE I DO THINK IF SOMEBODY TOLD ME TEN YEARS AGO I NEEDED TO BUY A POCKET TALKER TO HELP ONE PATIENT, I WOULD HAVE JUST ORDERED ONE, RIGHT? LIKE THAT'S EASY BUT I DIDN'T KNOW WHAT A POCKET TALKER WAS UNTIL TONY TAUGHT ME A COUPLE MONTHS AGO. I DO THINK IT'S AN EDUCATIONAL GAP. THAT'S DIFFERENT THAN-- YOU WANT CONSUMER TOES ASK FOR ACCOMMODATIONS AND YOU WANT PROVIDERS TO OFFER ACCOMMODATIONS WITHOUT BEING ASKED, BUT THOSE PROVIDERS NEED TO KNOW WHAT THOSE ACCOMMODATIONS ARE AND WHAT PEOPLE NEED. I DON'T THINK THAT EVERYBODY IS THERE. YOU GET THE LAST WORD AND THEN WE'RE GOING TO HAVE LUNCH.
>> VICKIE: SO ONE OF THE THINGS ABOUT AND IF YOU JUST TALK AND DON'T THINK ABOUT WHAT YOU ARE SAYING, I THINK THE CRUX OF THE MATTER HERE IS THAT SOMEONE WHO KNOWS-- SOMEONE WHO KNOWS THIS THEY ARE DIFFERENT AND COMMUNICATE DIFFERENTLY FROM THE REST OF THE POPULATION CAN GET PROTECTIONS UNDER THE ADA BY SAYING I HAVE A DISABILITY. AND THEN THIS ARE THE REST OF US WHO DON'T KNOW THAT WE HAVE A DISABILITY BECAUSE WE HAVEN'T RECOGNIZED, ACCEPTED OR WANTED TO DEAL WITH THE HEARING LOSS, AND I THINK WHAT I WAS TRYING TO SAY THAT FROM MY UNDERSTANDING OF THIS IS THAT IF WE TRY TO MERGE THESE TWO CHALLENGES, WE WILL FAIL AND WHEN JAN AND I STARTED TALKING ABOUT THIS SIX YEARS AGO OR SEVEN, IT WAS REALLY HOW TO FOR DEAF PEOPLE TO ACCESS HEALTHCARE AND THEN AS WE OPENED UP THE CONVERSATION, WE STARTED LEARNING ABOUT ALL OF THE PEOPLE WHO ARE HARD OF HEARING AND THAT'S A DIFFERENT CHALLENGE. WE HAVE TO SCREEN AND TEST AND IDENTIFY AND THEN HELP PEOPLE UNDERSTAND THAT THEY NEED AN ACCOMMODATION RATHER THAN-- AND THEY MIGHT HAVE TO ASK FOR IT BECAUSE IT'S NOT GOING TO BE GIVEN AUTOMATICALLY TO ANYONE. WELL, DEPENDING ON WHERE YOUR PROVIDER IS. THAT'S WHAT I THINK-- I DON'T THINK WE CAN HAVE ONE SOLUTION THAT WE MIGHT HAVE TO HAVE SEVERAL SOLUTIONS FOR THIS.
>> ATAM: BERKELEY, REMIND PEOPLE THEY NEED TO BE IN THEIR SEATS TWO MINUTE BEFORE 1:00.
>> BERKELEY: HE SAID WE HAVE 30 MINUTES FOR LUNCH. IT'S CATERED BY ALPACA, IT'S GREEN BEANS AND FRENCH FRIES AND IT WILL TAKE LONGER TO GET THROUGH THE LINE. IF PEOPLE CAN CYCLE THROUGH THE LINE FOR LUNCH AND FOR THOSE WHO HAVEN'T COME, WE GO OUT THIS DOOR. THERE'S A BUFFET AND CIRCLE AROUND AND COME THROUGH THIS DOOR.

[LUNCH BREAK HELD]
[LUNCH BREAK IS HELD]
PLEASE STAND BY FOR THE EVENT TO RESUME. OTOLARYNGOLOGY
>> WE WILL GET STARTED IN A MINUTE AND IF YOU LOOK AROUND IN THE ROOM AND SEE A MICROPHONE IN FRONT OF YOU AND MAKE SURE YOU WILL TURN THEM ON AND CONSERVE SOME BATTERY DURING LUN. .
>> DR. REED, ARE YOU ON THE LINE? DR. REED, ARE YOU STILL ON THE LINE WITH US?
>> DR. REED: I AM.
>> WE WILL GET STARTED IN 30 SECONDS.

Promoting Hearing Health in Older Adults

>> ADAM: WE'RE GOING TO GET STARTED. WE HAVE A REMOTE PRESENTER AND HE'S ON A TIGHT TIME SCHEDULE.
>> DR. REED, WE HAVE EVERYONE IN THE ROOM AND WE'RE READY FOR YOU TO PRESENT. I'M NOT SURE IF YOU GOT JAMES' EMAIL AND THE WAY WE HAVE THE SCREEN SET UP, I WILL WORK THE SLIDES FOR YOU
LET ME KNOW WHEN TO CHANGE SLIDES AND I WILL DO THAT FOR YOU. YOU CAN GET RT STAKED WHENEVER YOU'RE READY.
>> THERE'S QUITE A FEW TRANSITION SLIDES, LIKE SLIDES LIKE ANIMATIONS, I GUESS. I'LL DO MY BEST TO GO QUICK THROUGH THOSE. I'M NICK REED, I'M A PROFESSOR AT JOHN HOPKINS UNIVERSITY, OTOLARYNGOLOGIST IN CLINICAL TRAINING AND MY Ph.D. WORK IS IN CLINICAL TRIALS ACTUALLY. IT'S A LITTLE BIT UNIQUE AND I WAS (INAUDIBLE) AND EVEN MORE STRANGE, ALL OF MY CLINICAL PRACTICE WAS IN PEDIATRICS AND THEN IT SOLVED THIS PROBLEM, THOUGH, WITH OUR GERRY AT TRICK GERIATRIC PATIENTS AND WE HAD FAIL SAFE BUILT IN BUT WE HAD LITTLE TO HELP OUR GERIATRICS TO BE LESS TO THE WAYSIDE. I ENDED UP DEDICATING MY CAREER TOGERIATRICS. CHANGE THE SLIDE. JUST CONFLICT OF INTERESTS. I'M FUNDED (INAUDIBLE) AND THEY STILL. ELEANOR SCHWARTZ FOUNDATION. I'M A NON-FINANCIAL MEMBER OF THE SCIENTIFIC ADVISORY FOR SHOEBOX AND I'M A CONSULTANT TO HELEN AND TROY. THIS WORK COMES FROM MANY DIFFERENT PEOPLE. GO AHEAD AND SWITCH SLIDES. SO THIS IS AN AUDIOGRAM AND I'M SURE YOU'RE FAMILIAR WITH IT BUT TO GIVE THE BASICS BECAUSE IT'S A GOOD PRIMER. MANY PEOPLE THINK THAT HEARING LOSS IS A VOLUME ISSUE AND HEARING LOSS GENERALLY ISN'T A VOLUME ISSUE WHEN IT COMES TO AGE-RELATED HEARING LOSS. WE LOSE OUR HEARING BY FREQUENCY. CLICK ONE MORE TIME. YOU'LL SEE WHAT A STANDARD AUDIOGRAM LOOK LIKE. WHAT WE HAVE IS RELATIVELY MILD, NORMAL HEARING IN THE LOW FREQUENCIES AND THEN IT SLOPES DOWN TO A PROFOUND. IT'S CUTTING FREQUENCIES IN HALF SO IF YOU CLICK ONE MORE TIME. YOU'LL SEE THAT THIS IS THE SECTION HERE. SO HEARING LOSS IS NOT A VOLUME ISSUE. FOR ME IN THE HEALTHCARE SETTING, IF I SEE THE PHRASE, YOU SHOULD GO TO THE PHARMACY BEFORE YOU GET TO YOUR HOUSE AND THIS IS WHAT THE SPECTRAGRAPH WOULD LOOK LIKE. CLICK ONCE FOR ME. ONE HEARS THAT WITH HEARING LOSS AND CLICK AGAIN . ONE MORE TIME. THEY HAVE TO PROCESS THIS SOUND WITH THE POOR SIGNAL. IT'S LIKE LISTENING ON A BAD SELL PHONE SIGNAL. IT'S NOT THAT VOLUME WOULD HELP. IT'S CLARITY. CLICK ONE MORE TIME. AND WITH A PERSON WITH HEARING LOSS, IT LOOKS LIKE THIS. IT'S A GARBLED YOU OULD GO TO ARM, AND WE LOSE THE HIGH FREQUENCY COMPETENCE. THAT'S AN IMPORTANT CONSIDERATION AS WE TALK THROUGH. CLICK AGAIN. ONE MORE TIME. IF WE LOOK AT JUST HEARING

LOSS AND WHO HAS HEARING LOSS, IF WE USE THE WORLD HEALTH ORGANIZATION DEFINITION AND USE A BETTER EAR AVERAGE AND THIS IS BASED ON DATA AS REPRESENTING THE ENTIRE UNITED STATES. HEARING LOSS INCREASES WITH AGE SUCH THAT TWO-THIRDS OF ADULTS OVER THE 8-K OF 70 HAVE A HEARING LOSS. THAT'S 38 MILLION ADULTS IN THE U.S
IF YOU USE UNILATERAL AND LOOK AT THE POORER EAR, IT'S 38 MILLION ADULTS. FOR COST PERSPECTIVE AND THE IMPORTANT THING IS THAT WE THIS HIGH INCIDENCE OF HEARING LOSS BUT IF WE LOOK AT THE SAME PEOPLE WHO HAVE HEARING LOSS AND NOW WHAT YOU'RE SEEING IS THOSE WITH HEARING AIDS, THE UPTAKE OF HEARING AIDS IS INCREDIBLY LOW. YOU HEAR NUMBERS SOMETIMES AS HIGH AS 30% BUT THIS IS ACTUALLY USING AOBJECTIVE DATA. THIS IS USING NATIONALLY REPRESENTED DATA AND IT'S AS LOW AS 16.4%. THE NUMBER IS SOMEWHERE IN THE MIDDLE BUT THE TRUTH IS, AS A SCIENTIST, I WOULD LEAN TOWARD THIS NATIONALLY REPRESENTED SYSTEMATICALLY COLLECTED DATA BY THE CDC. CLICK AGAIN. AND I THINK THE REASON FOR THIS IS BECAUSE THERE'S THIS BASIC QUESTIONS AROUND AGE-RELATED HEARING LOSS THAT REALLY HAVEN'T BEEN ANSWERED FOR ADULTS. CONSEQUENCES, WHAT'S THE IMPACT, HOW DO WE EFFECTIVELY ADDRESS THIS? THE CRUX OF QUESTION IS THIS . CLICK THE SLIDE. IF WE HAVE A YOUNG CHILD WHO IS 12 YEARS OLD AND HE HAS THIS HEARING LOSS THIS IS A MILD HEARING LOSS. MOST CLINICIANS IN THE UNITED STATES, MOST POLICYMAKERS, MOST EDUCATIONAL PROFESSIONALS WILL ALL SAY WE HAVE TO DO SOMETHING ABOUT THIS CHILD. WE HAVE TO HELP HIM. BECAUSE WE SORT OF ADDRESS THESE QUESTIONS. WE KNOW THE IMPACT OF HEARING LOSS IN CHILDREN. WE KNOW WHAT EFFECTS EDUCATIONAL OUTCOMES. WE KNOW IF WE TREAT IT, WHETHER THAT MEANS WE USE SIGN LANGUAGE TRAINING, ASL, OR IF WE USE COCHLEAR IMPLANTS OR HEARING AIDS, DEPENDING ON THE FAMILY'S PREFERENCE, WE TOW THAT WE CAN HAVE NORMAL LANGUAGE BRAIN DEVELOPMENT AND HAVE NORMAL EDUCATION OUTCOMES. WE ALSO KNOW HOW TO SORT OF DO THIS IN THE COMMUNITY. WE THINK ABOUT THESE THINGS IN TERMS OF NEWBORN HEARING SCREENINGS, IN TERMS OF SCHOOL SCREENINGS, IN TERMS OF NETWORK SUPPORT SYSTEMS FROM THE GOVERNMENT, BUT IF YOU GO AHEAD AND CLICK AGAIN. YEAH. YOU SAW IF WE TAKE THIS SAME GENTLEMAN AND NOW HE'S A 72-YEAR-OLD, ALMOST ALL CLINICIANS AND ALL POLICYMAKERS SAY SOMETHING ALONG THE LINE, YOU HAVE HEARING LOSS AS EVERYONE ELSE YOUR AGE. DO WHAT YOU WANT. THAT'S A PROBLEM THAT WE TREAT IT THIS WAY. IT'S THE SAME FUNDAMENTAL WORLD AND THAT HEARING IS THE SAME . IT'S JUST THAT FOR SOME REASON, WE HAVE A DIFFERENT STANDARD FOR THIS ADULT BECAUSE THEY LIVED IN THAT WORLD FOR A LONG TIME. GO AHEAD AND CLICK FORWARD. BECAUSE WE DON'T KNOW THESE QUESTIONS WHEREAS WE KNOW THEM FOR CHILDREN, I THINK. THE QUESTION BECOMES, IF YOU CLICK FORWARD, WHERE DOES HEARING REALLY FIT INTO THIS HEALTHY AGING ASPECT? I THINK WE HAVE ALL THESE DIFFERENT AREAS. IT'S VERY HARD TO DEFINE HEALTHY AGING. IT COULD BE COGNITION. IT COULD BE HEALTH RESOURCE UTILIZATION, ABILITY, SOCIAL ENGAGEMENT. IT'S SORT OF ALL INCUMBENT AND DECIDE WHERE HEARING LOSS COMES IN, WE NEED A FRAMEWORK APPROACH. IF WE TAKE-- CLICK FORWARD IN THE SLIDE. IF WE TAKE COGNITION AND PHYSICAL AND WE THINK ABOUT WHERE HEARING LOSS FITS IN, IT COULD BE IT'S JUST A COMMON PATHOLOGICAL PROCESS. WE AGE AND WE DEVELOP HEARING LOSS. WE AGE AND WE DEVELOP COGNITIVE DECLINE. OR, WE AGE AND WE DEVELOP HIGH BLOOD PRESSURE AND THAT CONTRIBUTES TO HEARING LOSS AND AT THE SAME TIME, THOSE ISSUES CAN CONTRIBUTE TO COGNITIVE DECLINE AND THERE'S NO CAUSATION IN THAT CASE. WE THINK THERE IS CAUSATION BETWEEN THESE OUTCOMES. IF YOU CLICK FORWARD. THE FIRST ONE WE THINK IS COGNITIVE LOAD AND THEN BRAIN STRUCTURE AND SOCIAL ISOLATION AND WHAT THESE ARE , COGNITIVE LOAD IS THE CONCEPT THAT AT

ANY GIVEN TIME YOUR BRAIN CAN ONLY DO SO MUCH. IT'S ALWAYS WORKING ON 100% CAPACITY AND IF YOU GIVE YOUR BRAIN A BAD SIGNAL LIKE WE SHOWED BEFORE WHERE YOU LEFT OUT THE CONFIDENCE, THE BRAIN CAN PROCESS THE SIGNAL FILL BUT IT COMES AT THE EXPENSE OF SOMETHING ELSE. WORKING MEMORY MIGHT BE-- MAY BE DIMINISHED BECAUSE YOU'RE TRY OG SO HARD TO PROCESS THE BAD SIGNAL. I THINK EVERYONE CAN RELATE TO THIS. EVEN PEOPLE WITH NORMAL HEARING. IF YOU THINK ABOUT LISTENING ON A BAD CELL PHONE SIGNAL, WHEN YOU'RE TRYING TO LISTEN TO THAT PERSON, YOU START TO CONCENTRATE SO MUCH ON JUST LISTENING, UNDERSTANDING WHAT THEY SAY, YOU ACTUALLY LOSE YOUR CAPABILITY TO ENCODE THAT INFORMATION INTO YOUR SHORT-TERM MEMORY SO YOU TEND TO FORGET WHAT THEY SAY BECAUSE YOU WERE SO FOCUSED ON JUST TRYING TO UNDERSTAND THE WORDS AND THIS HAPPENS QUITE REGULARLY TO PEOPLE AND THIS IS WHAT YOU CONSIDER AGE-RELATED HEARING LOSS. BRAIN STRUCTURE CHANGES, WE HAVE EVIDENCE FROM OUR LABS THAT OVER TIME, AGE-RELATED HEARING LOSS THIS IS NOT-- I JUST WANT TO REMIND YOU ALL THAT I'M NOT ACTUALLY TALKING ABOUT CONGENITAL HEARING LOSS OR DEVELOPING HEARING LOSS EARLY IN LIFE.
THIS IS VERY MUCH WHEN YOU DEVELOP YOUR HEARING LOSS LATER IN LIFE AND RELATED TO THE BRAIN STRUCTURE CHANGES YOU CLING DEMYLENATION, REDUCED VOLUME OF THE WHITE MATTER, AND LASTLY, I THINK BOTH INTUITIVELY, WE THINK HEARING LOSS BEING RELATED TO SOCIAL ISOLATION AND HEARING LOSS IS RELATED TO COGNITIVE AND PHYSICAL (INAUDIBLE) AND WE KNOW WHEN PEOPLE SORT OF ISOLATE THEMSELVES AND STOP REALLY COMMUNICATING WITH THE OUTSIDE WORLD AS MUCH, THEY TEND TO GO DOWN A FAST, RAPID DECLINE OF COGNITIVE AND PHYSICAL AND IT'S NOT JUST PHYSICAL BECAUSE YOU'RE NOT GETTING OUT AND MOVING AROUND. THERE'S ACTUAL PROOF THAT EVEN WHEN YOU CONTROL FOR HOW MUCH EXERCISE SOMEONE DOES, NOT BEING SOCIAL AS A HUMAN TRULY DOES CHANGE YOUR ALMOST DNA-LEVEL STRUCTURE SUCH THAT IT CHANGES THE REGULATION OF PRO-INFLAMMATORY GENES WITHIN YOUR BODY. THAT'S JOHN CAPIOCCHO'S WORK OUT OF UNIVERSITY OF CALIFORNIA. IF YOU CLICK FORWARD, IF WE BELIEVE THIS INFORMATION THAT I THINK IS WORTH INVESTIGATING AND SO IN OUR LAB, WE HAVE SORT OF INVESTIGATED THIS AREA AND FRANKLIN IS THE HEAD OF OUR LAB. HE STARTED SEVERAL STUDIES ON COGNITION AND HEARING LOSS. WHAT YOU ARE LOOKING AT ON THIS SCREEN IS DATA FROM 2,000 ADULTS WHO ARE OLDER THAN 70 YEARS OLD, AND DARK DOT IS THE HEARING GROUP AND THE CIRCLE DOT WITH WHITE IN IT IS THE HEARING LOSS GROUP AND YOU ARE LOOKING AT OVER AN 11-YEAR PERIOD, THEIR SCORES ON A COGNITIVE TEST. SPECIFICALLY, THIS TEST IS A MINI MENTAL STATUS EXAM. WHAT I WANT YOU TO PAY ATTENTION TO IS NOT JUST THAT THEY'RE DIFFERENT. IT'S NOT THAT THEY'RE DIFFERENT, IT'S AT THE SLOPE OF THE LINES IN DIFFERENCE, REPRESENTING A FASTER RATE IN COGNITIVE DECLINE. 41% FASTER IN COGNITIVE DECLINE. IF YOU SEE THE DIGIT SYMBOL OF SUBSTITUTION. YOU WILL SEE WITH DIGIT SYMBOL SUBSTITUTIONS, A 3 IT 2% RATE OF FASTER DECLINE. THESE ARE DIFFERENT. THE DIGIT SYMBOL SUBSTITUTION TEST DOES NOT REQUIRE ANY AUDITORY CAPABILITY OR ORAL COMMUNICATION TO TAKE THE TEST. HOWEVER, THE MINI MENTAL STATUS DOES REQUIRE THAT, AND I THINK IT'S IMPORTANT THAT WE CONSIDER THAT IN THE SCIENCE THAT WE LOOK AT. IF THE COGNITIVE TEST TASK REQUIRED SOMEBODY TO HEAR THE WHOLE TIME, YOU'RE NOT TESTING THEIR COGNITION ANYMORE. YOU'RE TESTING WHETHER OR NOT THEY CAN HEAR. THE DFS IS TRULY SORT OF NON-VERBAL, AND THAT WOULD SUGGEST THAT THERE'S STILL A RELATIONSHIP HERE. IT'S JUST TEMPERED AND IT'S NOT AS LARGE AS SOME MIGHT THINK. GO AHEAD AND CLICK ONE MORE TIME. AND SO YOU CAN GO AHEAD AND CLICK. SO WHAT YOU ARE LOOKING AT NOW IS THE LAST ONE WITH A COGNITIVE DECLINE TEST THIS IS THE INCIDENCE OF DEMENTIA. SO DEVELOPING NEW

DEMENTIA. THE CHART IS CALLED A KAPLIN MYER CHART AND YOU ARE LOOKING AT TIME. ZERO REPRESENTING ZERO YEARS, 16 REPRESENTING 16 YEARS. AND THEN WHAT YOU JUST SORT OF PAY ATTENTION TO HERE, EVERY TIME YOU SEE THE LINE GO DOWN, SOMEBODY IN THAT GROUP DEVELOPED DEMENTIA AND SO WE HAVE SPLIT INTO THOSE WITH NORMAL HEARING, MILD HEARING LOSS, MODERATE HEARING LOSS AND SEVERE HEARING LOSS AND YOU SEE THAT OVER TIME THOSE WITH SEVERE HEARING LOSS ARE MORE LIKELY TO DEVELOP DEMENTIA. WE CAN LOOK AT THIS AS A HAZARD RATIO WHICH CAN BE INTERPRETED SIMILAR TO AN ODDS RATIO, SUCH THAT OVER THIS 10-YEAR PERIOD, AMONG 640 ADULTS, THOSE WITH MILD LOSS HAVE TWO TIMES THE ODDS OF DEVELOPING DEMENTIA. THOSE WITH MODERATE LOSS HAVE THREE TIMES THE ODDS AND THOSE WITH SEVERE LOSS HAD ALMOST FIVE TIMES THE ODDS OF DEVELOPING DEMENTIA AND THIS IS BASED ON THE LONGITUDE STUDY OF AGING WHICH MEANS THE DEMENTIA IS NOT JUST A CLINICAL DIAGNOSIS, NOT JUST A PHYSICIAN SAYING THEY HAVE DEMENTIA. IT'S BASED ON A SERIES OF TEST WITHIN THE STUDY, ITSELF. THIS IS CULMINATED IN VERY KEY STUDIES HERE. WHAT YOU'RE LOOKING AT NOW IS THE ATLANTA COMMISSION STUDY WHICH YOU ARE FAMILIAR OF TO SOME DEGREE. THE REAL TASK OF THIS STUDY WAS TO LOOK AT WHAT CAUSES DEMENTIA AND WHAT WE CAN DO TO TREAT DEMENTIA. WHAT WE FOUND, AND WE WERE SURPRISED, THEY FOUND SEVERAL STUDIES, THREE TO BE EXACT. I GUESS NOT SEVERAL BUT MAYBE A FEW. THEY WERE WELL DOCUMENTED. RELATIONSHIP BETWEEN HEARING LOSS AND DEMENTIA AND WE PUT ALL OF THESE STUDIES INTO A LARGE RISK-ADJUSTED MODEL AND WHAT THEY CAME OUT WITH WAS, IN GENERAL, WE LOOK AT DEMENTIA, 65% OF DEMENTIA IS TOTALLY NON-MODIFIABLE. IT'S GENETIC. 35% MODIFIABLE, IS THAT THERE ARE THINGS IN YOUR LIFE THAT WILL AFFECT DEMENTIA, BEING OBESE, LESS EDUCATION AND SMOKING. AMONG THOSE FACTORS THAT ARE MODIFIABLE, CLICK ONE MORE TIME. ONE MORE. HEARING LOSS ACCOUNTS FOR THE LARGEST POTENTIALLY MODIFIABLE FACTOR FOR RISK IN DEMENTIA. 995% OF DEMENTIA IS LINKED TO DEMENTIA.
THAT'S THE LARGEST CONTRIBUTABLE FACTOR. I SPOKE DIRECTLY WITH THE AUTHORS OF THIS STUDY AND EVERY TIME THEY SPEAK ABOUT IT, THEY SEEM VERY-- THEY SEEM ALMOST LIKE THEY WERE SURPRISED. LIKE THEY DID A LOT OF EFFORT TO MAKE SURE THAT THEY TRUSTED THIS FINDING. SO MOVING FORWARD, YOU CAN ALSO THINK ABOUT HEARING LOSS IN TERMS OF HEALTHCARE UTILIZATION. ONE ASPECT OF HEALTHY AGING BEING DEMENTIA AND BEING PHYSICAL FUNCTION AND ALSO HOW YOU INTERACT WITH THE HEALTHCARE SYSTEM IS A HEALTH AGE MARKER AND SO WHAT WE BUILT HERE IS A MORE COMPLICATED MODEL AND FRAMEWORK. AND YOU CAN IMAGINE, THOSE WITH SOMEONE WITH HEARING LOSS MAY GO TO THE HOSPITAL AND THAT HEARING LOSS MAY CAUSE POOR TREATMENT UNDERSTANDING, IT MAY CAUSE COMMUNICATION BREAKDOWN AND IT MIGHT RESULT IN ISOLATION. THE COMMUNICATION BREAKDOWN COULD RESULT IN CONFUTION OR AGITATION AND THEN THESE ARE GOING TO CHANGE FUNDAMENTALLY THE INTERACTIONS WITH THE HEALTHCARE SYSTEM, SUCH THAT THEY MAY REDUCE SATISFACTION. YOU MAY END UP IN THE HOSPITAL LONGER BECAUSE YOU HAVE DIFFICULTY GOING BACK AND FORTH WITH YOUR DOCTOR. YOU MIGHT END UP-- THERE'S EVIDENCE THAT DELIRIUM IS RELATED TO HEARING LOSS SUCH THAT PEOPLE DON'T HAVE SENSORY DEPRIVATION AND THEY ARE ISOLATED AND BECOME WITHDRAWN
MOST DELERIUM AND WE THINK OF PEOPLE WHO ARE HYPERACTIVE AND SHOUTING AND SAYING GIBBERISH BUT IN REELT, MOST DELERIUM IS A WITHDRAWAL, SUCH THAT THEY HAVE HYPODELERIUM AND YOU'RE NOT ACTIVE AT ALL. YOU ARE WITHDRAWN FROM SOCIETY. AND THINK ABOUT THE LONG-TERM CHANGES, AND READMISSIONS AND IF YOU CLICK FORWARD A SLIDE. WE LOOKED AT THIS LARGE-SCALE DATA SETS AND SO ONE SUCH STUDY IF WE BELIEVE THAT THESE ASPECTS ARE PRESENT,

WE LOOKED AT HEALTHCARE COSTS OVER A TEN-YEAR PERIOD AND FOR THIS STUDY WHAT WE DID WAS TAKE A LARGE CLAIMS DATA SET AND PROPENSITY MATCHED ON 24 INDICES PEOPLE WITH AND WITHOUT HEARING LOSS. SUCH THAT AT TWO YEARS WE HAVE 150,000 PEOPLE AND IT'S DIVIDED EVENLY AND THEY'RE MATCHED ON AGE, RACE, SEX, WHERE THEY LIVE IN LIFE, AND EVEN BASELINE, THEY'RE MATCHED ON HOW MUCH HEALTHCARE THEY USE, HOW MANY COMORBIDITIES THEY HAVE, WHETHER OR NOT THEY HAVE DEMENTIA, CANCER. SO WE FOUND PEOPLE WHO BASICALLY REPRESENT THIS EXACT SAME PERSON JUST WITHOUT HEARING LOSS AND WE LOOK AT THEM OVER A TEN-YEAR PERIOD AND IN TEN YEARS, JUST BY NATURE OF REDUCTION, WE'RE DOWN TO ONLY ABOUT 5,000 PEOPLE IN OUR SAMPLE, STILL QUITE LARGE FOR A MATCH AND THEN OVER THAT TEN-YEAR PERIOD, PEOPLE WITH HEARING LOSS INCURRED $2,000 MORE IN HEALTHCARE EXPENDITURES. WE CHECKED TO SEE IF THIS WAS RELATED DIRECTLY TO HEARING LOSS, LIKE HEARING (INAUDIBLE) AND IT DOESN'T HAVE ANYTHING TO DO WITH THAT AND WE EXCLUDED HEARING NEEDS BECAUSE WE DIDN'T WANT HEARING AIDS TO AFFECT THIS RELATIONSHIP OF COST. WE CAN LOOK AT UTILIZATION METRICS AND IF YOU CLICK FORWARD ON THE SLIDE. LOOKING AT THE SAME STUDY OVER THE TEN YEARS, WE SEE THAT PEOPLE WITH HEARING LOSS HAD A 47% HIGHER RATE OF HOSPITALIZATION. THEY SPENT 2.5 DAYS LONGER DURING HOSPITAL STAYS SO THEY'RE MUCH MORE LIKELY SIGNIFICANTLY MORE LIKELY TO SPEND MORE TIME IN THE HOSPITAL. THE MOST IMPORTANT FACTOR OF THE STUDY TO ME IS THE NEXT ONE. PEOPLE WITH HEARING LOSS WITH UNCORRECTED HEARING LOSS, NO HEARING AID, UNTREATED HEARING LOSS, I SUPPOSE, 44% HIGHER RISK OF 30-DAY READMISSION. THAT'S REALLY TELLING BECAUSE 30-DAY READMISSION MEANS THAT PEOPLE AREN'T RECEIVING GOOD HEALTHCARE GENERALLY. IT'S NOT-- 30-DAY READMISSION HAS LESS TO DO WITH THE SEVERITY OF SOMEONE 'S HEALTH THAN IT DOES WITH THE TREATMENT RECEIVE. SOME INSURERS DON'T REIMBURSE ON 30-DAY READMISSION. THEY SAY THAT'S THE HOSPITAL'S FAULT. THE HOSPITAL SHOULD HAVE DONE BETTER AND THE HOSPITAL SHOULD HAVE KEPT THAT PERSON LONGER IF THEY THINK THEY NEEDED TO STAY OR NEEDED BETTER TREATMENT. 30-DAY READMISSION IS A HUGE, HUGE DEAL ACTUALLY. AND TO ME, IT'S AN INDICATOR THAT PEOPLE WITH HEARING LOSS ARE RECEIVING SORT OF POOR CARE. THEY ALSO HAVE A HIGHER RISK OF EMERGENCY DEPARTMENT VISITS AND INTERESTINGLY, THAT EMERGENCY DEPARTMENT RISK STAYS THE SAME BASICALLY AND TWO, FIVE AND TEN YEARS. IT DOESN'T REALLY CHANGE AND THE OTHER ONES ARE LARGER. GO AHEAD AND CLICK FORWARD. REAL LIRR INTERESTING TO ME IS IF WE TAKE OBJECTIVE MEASURES OF HEARING LOSS AND WE LOOK AT SATISFACTION WITH CARE AND IF THIS STUDY WE HAVE 256 PEOPLE, AGED 67 TO 89, WESTERN MARYLAND, AND WE HAVE THEIR PURE TONE AUDIOGRAM AND A LOT OF INFORMATION ON THE REST OF THEIR LIFESTYLES, INCLUDING WHERE THEY LIVE, IF THEY HAVE A SPOUSE, IF THEY LOST A SPOUSE RECENTLY, THEIR DEPRESSION MEASURES, WE HAVE THEIR COGNITIVE MEASURES AND BLOODWORK AND COMORBIDITIES AND WHETHER OR NOT THEY DRIVE. IT'S A VERY LONGITUDINAL COHORT STUDY THAT WE HAVE A LOT OF INFORMATION ON THESE PEOPLE AND WE LOOKED AT WHETHER OR NOT THEY REPORT SATISFACTION WITH QUALITY OF MEDICAL CARE OVER THE PAST CAREER AND WHAT WE'RE REALLY LOOKING AT HERE IS THE ODDS OF BEING DISSATISFIED WITH MEDICAL CARE. AND THIS IMAGE THAT YOU'RE LOOKING AT IS THERE'S AN INTERACTION THAT WAS REALLY INTERESTING TO US AND SO IF YOU CLICK ONE MORE TIME, THIS IS A MUCH EASIER WAY TO SORT OF UNDERSTAND THE INTERACTION. SO IN A 75-YEAR-OLD IN OUR STUDY, EVERY 10 DB IN HEARING LOSS, THAT MEANS 10 DB IN THE HEAR TONE AVERAGE, THE ODDS DIDN'T CHANGE. FOR A 75-YEAR-OLD, HEARING LOSS DIDN'T HAVE AN AFFECT ON THEIR SATISFACTION WITH CARE BUT FOR AN 85-YEAR-OLD, FOR EVERY TEN DB IN HEARING LOSS, THE ODDS OF BEING LESS SATISFIED AND BEING DISSATISFIED INCREASED BY 30% EVERY

TEN DB. THIS IS ADJUSTED FOR COGNITION BUT WHAT WE THINK IS GOING ON IS WHEN YOU'RE HOLDER, OLDEST TO OLD, THE SAME DEGREE OF HEARING LOSS, IN YOUNGER ADULT REALLY PLAYS A DIFFERENT ROLE. YOU HAVE LESS COGNITIVE RESERVE TO SORT OF OVERCOME THE HEARING LOSS. SO IF YOU'RE YOUNGER, YOU HAVE A LITTLE BIT MORE COGNITIVE RESERVE AND YOU CAN SORT OF PUT CONTEXTUAL CUES INTO THE SITUATION AND OVERCOME THE HEARING LOSS. WHEN YOU'RE OLDER, WE SORT OF LOSE THAT COGNITIVE RESERVE AND UNFORTUNATELY, THAT'S NOTHING SPECIAL. EVERYBODY LOSES THEIR COGNITIVE RESERVE. UNFORTUNATELY, FOR ALL OF US, AS SOON AS WE HIT AROUND 25, WE'RE ALREADY PEAKED AS FAR AS OUR COGNITIVE ABILITY.
[LAUGHTER]
WE START DECLINING NATURALLY AND FULLY. SO IF YOU CLICK FORWARD ONE MORE TIME. YOU CAN BRING UP THIS WHOLE SLIDE. WHAT WE SEE, THOUGH, IS REAL CHANGES IN INTERACTIONS WITH THE HEALTHCARE SYSTEM, AND I THINK, AS I MENTIONED ALREADY AND ALLUDED TO, IT'S REALLY PATIENT-PROVIDER COMMUNICATION. INSTITUTES OF (INAUDIBLE) RELEASED A 400-PAGE REPORT WHERE THEY TALKED ABOUT PATIENT PROVIDER CARE AND THE RELATIONSHIP IN THE CORNERP IS STONE OF PATIENT-CENTERED CARE AND THAT WAS CARE THAT WAS RESPECTFUL OF AND RESPONSIVE TO PATIENT PREFERENCES, NEEDS, AND VALUES. THE AMAZING THING ABOUT THIS REPORT IS THEY TALK ABOUT COMMUNICATION AND THEY NEVER ONCE MENTIONED HEARING LOSS AND HEARING WOULD BE FUNDAMENTAL TO THE NEEDS OF AN OLDER ADULT. SO IF AN OLDER ADULT HAS HEARING LOSS, COMMUNICATION IS FUNDAMENTAL TO THEIR NEED. WE NEED TO OVERCOME THAT HEARING LOSS. THERE'S A STUDY DONE OUT OF NYU WHERE THEY LOOKED AT PATIENT PROVIDER COMMUNICATION PAPERS AND THEY FOUND ONLY 23% OF PAPERS IN THEIR STUDY EVEN MENTIONED HEARING LOSS AND OF THOSE, ONLY FOUR PAPERS OUT OF THEIR ENTIRE 67 SETS THAT THEY FOUND INCLUDING HEARING LOSS IN THE ANALYSIS. WE DID OUR OWN SYSTEMATIC REVIEW, AND WE MADE IT QUITE LARGER. WE LOOKED IN FIVE DATABASES ACROSS THE WORLD. WE WERE LOOKING AT ALL OF THE LARGEST LITERATURE DATABASES AVAILABLE. WE PULLED THOUSANDS AND THOUSANDS OF ARTICLES, AND WE ACTUALLY ONLY FOUND 13 STUDIES THAT INCLUDED HEARING LOSS IN THEIR PATIENT PROVIDER COMMUNICATION STUDY AND IN THOSE STUDIES, EVERY SINGLE STUDY, HEARING LOSS, WAS NOT JUST ASSOCIATED WITH POOR PATIENT-PROVIDER COMMUNICATION, IT WAS GENERALLY THE LARGEST ASSOCIATION. MEANING THAT THIS ENTIRE BODY OF LITERATURE FOR DECADES HAS FOCUSED ON THINGS LIKE THAT LITERACY RATES, EDUCATION LEVELS FOR PATIENT-PROVIDER EDUCATION BUT FUNDAMENTALLY IGNORED HEARING LOSS AND HEARING IS BASIC TO COMMUNICATION. SO WE THINK IT'S A BIG AREA AND I THINK THE QUESTION THAT SHOULD BE EMERGING IN OUR MINDS NOW, IF WE CLICK FORWARD A SLIDE, IS, OKAY, WE'RE PROPOSING THESE FRAMEWORKS AND WE'RE PROPOSING THESE MODIFIABLE MECHANISTIC PATHWAYS CAN WE REDUCE THE COGNITIVE LOAD, CAN WE INCREASED BRAIN STIMULATION TO PREVENT ATROPHY? COULD WE IMPROVE SOCIAL ENGAGEMENT TO PREVENT COGNITIVE DECLINE? I THINK IT'S A FANTASTIC QUESTION AND I THINK IT'S A QUESTION HIGHLY WORTH EXPLORING AND SO SOME PEOPLE HAVE TRIED. IF YOU CLICK FORWARD A SLIDE , THE FUNDAMENTAL ISSUE, THOUGH, IS BACK TO THIS SLIDE. IT WE HAVE THIS INCREDIBLY LOW UPTAKE OF HEARING AIDS AND WE KNOW FROM CARRIE NEIMAN'S WORK THAT HEARING AID USE IS UNFORTUNATELY ASSOCIATED WITH HIGHER SOCIOECONOMIC STATUS. IT'S ASSOCIATED WITH BEING MORE AFFLUENT, BEING CAUCASIAN, HIGHER EDUCATION LEVELS, HIGHER INCOME, IF HEARING AID USE IS ASSOCIATED WITH ALL THESE FACTORS, IT'S VERY HARD IN SECONDARY DATA ANALYSIS TO ACTUALLY UNDERSTAND WHAT YOU'RE LOOKING AT BECAUSE MOST LIKELY WHAT YOU'RE REALLY ANALYZING ARE (INAUDIBLE) MORE THE WEALTHY. IF YOU CLICK THAT SLIDE ONE MORE

TIME. THE CURRENT SECONDARY DATA IS COMPLETELY LIMITED BECAUSE ALL OF THESE OTHER FACTORS WERE ALSO PROTECTED. SO IF PEOPLE WITH HEARING AIDS ARE ALSO HIGHER EDUCATED THAN THOSE WITHOUT, THAT'S AN ISSUE BECAUSE EDUCATION IS PROTECTIVE OF COGNITIVE DECLINE. SO THE REAL FUNDAMENTAL CASE HERE IS THAT WE NEED RANDOMIZED TRIALS. I MEAN, FORTUNATELY, I CAN REPORT THAT THOSE TRIALS ARE GOING ON. OUR CENTER IS ACTUALLY THE LEAD CENTER FOR $20 MILLION TRIAL LOOKING AT HEARING AID USE AND COGNITIVE DECLINE AND WHETHER IT CAN CHANGE THE EFFECT. BUT WE'RE NOT GOING TO HAVE THAT ANSWER FOR ANOTHER FIVE YEARS, UNFORTUNATELY. WE DON'T STOP THERE. I THINK THAT THERE'S STILL ROOM, AT LEAST OUR CENTER BELIEVES TO MAKE SORT OF PUBLIC HEALTH POLICY INITIATIVE CHANGES. SO IF YOU CLICK FORWARD A SLIDE. PERFECT. WE LOOK AT THIS. WE SEE THAT THERE'S LOW HEARING AID UPTAKE AND WE THINK ABOUT WHAT IT'S RELATED TO AND WE LOOK AT THE LITERATURE AND THERE'S COST AND AFFORDABILITY AND THAT'S NOT EVERYTHING. COST AND AFFORDABILITY CAN IN THE BE THE ONLY THING DRIVING THIS AND COUNTRIES WHO PROVIDED HEARING AIDS FOR FREE WILL NOT HAVE HIGHER UPTAKE AND THEY DO BUT IT'S NOT THAT MUCH HIGHER. FOR EXAMPLE, THE UK WHERE HEARING AIDS ARE COVERED UNDER THE NATIONAL HEALTH SERVICES SYSTEM, THEIR UPTAKE IS ONLY USING THE SAME OBJECTIVE TYPE MEASURE AND THEIR UPTAKE IS ONLY 20% AND OURS WAS LIKE 16 AND IF YOU USE SELF-REPORT MEASURES THAT ARE A LITTLE BIT DIFFERENT THAN SURVEY MEASURES, IT'S STILL ONLY A DIFFERENCE OF LIKE 20% IN THE U.S. AND 40% IN THE UK. SO IT'S NOT PERFECT. WE THINK THERE'S OTHER FACTORS. SO FOR THE NEXT ONE, IF YOU CLICK ONCE MORE, A LOT OF IT MIGHT HAVE TO DO WITH THE ACCESS TO SERVICES AND TECHNOLOGY. WE'RE LIVING IN A WORLD ARE WITH TO GET A HEARING AID AS AN OLDER ADULT, IT LOOKS LIKE THIS. YOU MIGHT GO TO YOUR PRIMARY PROVIDER AND TELL THEM YOU HAVE HEARING LOSS. IN WHICH CASE THEY WILL SEND YOU TO AN AUDIOLOGIST TO TEST IT. THE AUDIOLOGIST WILL TEST YOU AND SAY, YEAH, I THINK YOU HAVE HEARING LOSS AND NOW YOU SHOULD SEE AN OTOLARYNGOLOGIST AND THEY WILL SEND YOU BACK TO THE AUDIOLOGIST TO FIT THE HEARING AID AND THERE'S MULTIPLE STEPS AND A LONG PROCESS AND IT COSTS A LOT OF MONEY, SO IT'S TIME AND MONEY. WHEN I THINK ABOUT THIS PROCESS, I THINK ABOUT WHERE I LIVE IN EAST BALTIMORE WHERE JOHN HOPKINS IS AND YOU KNOW, TO BE HONEST, I'M FROM HERE AS WELL AND I KNOW THIS NEIGHBORHOOD REALLY, REALLY WELL. IT'S A VERY POOR NEIGHBORHOOD. VERY POOR SECTION OF THE CITY IN GENERAL. WE HAVE RATE OF CAR OWNERSHIP IS LESS THAN 40%.

LESS THAN 40% OF WHERE I LIVE ACTUALLY OWN A CAR AND OUR PUBLIC TRANSPORTATION IS NOT THAT GREAT. WE HAVE LOW INCOME AND LOW CAR OWNERSHIP. IF YOU CAN IMAGINE SOMEONE IN MY NEIGHBORHOOD TRYING TO NAVIGATE THIS SYSTEM, THIS IS DARN NEAR IMPOSSIBLE FOR THEM. IT'S MULTIPLE PROVIDERS AND MULTIPLE DAYS OF VISITS AND IT'S A DIFFICULT SYSTEM TO OVERCOME. I THINK THERE'S A FUNDAMENTAL ISSUE WITH THE ACCESS TO SERVICES AND TECHNOLOGY. WE THINK THERE'S OTHER PIECES SO IF YOU CLICK FORWARD. THERE'S A LACK OF AWARENESS AND UNDERSTANDING. AND THE THINGS WE'RE DISCUSSING RIGHT NOW ARE NOT TRULY CLEAR TO THE PUBLIC AND ALSO IF YOU CLICK ONCE MORE, THERE'S A LACK-- ISSUES IN TECHNOLOGICAL DESIGN. THE TECHNOLOGICAL DESIGN OF HEARING AIDS IS BASED ON THE MODEL OF DELIVERY, THEY'RE DESIGNED FOR THE AUDIOLOGIST OR THE HEARING AID DISPENSER TO MAKE A DIFFERENCE WITH. THEY'RE NOT DESIGNED WITH OLDER ADULTS TRULY IN MIND BECAUSE WE DON'T HAVE A DIRECT-TO-CONSUMER BUSINESS MODEL. SO THERE'S NO REAL INCENTIVE FOR THE COMPANY IS TO REALLY CHANGE THE WAY THEY DO THINGS. I'M NOT SAYING THAT'S GOOD OR BAD. I'M SAYING IT'S THE CURRENT STATUS QUO. SO WHAT THIS DID RESULT IN, THOUGH, IS THE POLICY. IF YOU CLICK FORWARD AND YOU CAN JUST

CLICK OUT THE WHOLE SLIDE AND I'LL TALK THROUGH IT. THANK YOU. IN 2013, THE INSTITUTE OF MEDICINE STARTED SEEING THE DATA ON HEARING LOSS AND COGNITIVE DECLINE AND THEY HELD A WORKSHOP MEETING. OUT OF THAT WORKSHOP THERE'S A REPORT THAT WE NEED TO DO SOMETHING ABOUT THIS. NOT ONLY IS HEARING LOSS RELATED TO HEALTHY AGING FACTORS, THERE'S A REALLY LOW UPTAKE OF HEARING AIDS THAT WE HAVE TO BE ABLE TO DO SOMETHING. AT THE SAME TIME, THE WHITE HOUSE HAD THEIR CONFERENCE ON HEALTHY AGING-- CONFERENCE ON AGING, I SHOULD SAY NOT HEALTHY AGING WHICH HAPPENS GENERALLY OVER TWO YEARS AND I DON'T THINK THE CURRENT ADMINISTRATION HAD ONE YET. I'M NOT SURE THEY WILL HAVE ONE BECAUSE I BELIEVE THE CURRENT ADMINISTRATION DIDN'T ACTUALLY FILL OUT THE PRESIDENT'S COUNCIL ON ADVISORS ON SCIENCE AND TECHNOLOGY. THE CURRENT ADMINISTRATION GOT RID OF THAT WHICH WOULD HAVE BEEN THE GROUP TO SUPPORT THIS CONFERENCE. EITHER WAY. THIS IS THE LAST REAL CONFERENCE ON AGING WE HAD. THEY ADDED HEARING LOSS AS A TIER 1 FACTOR AND THEY ACTUALLY DISCUSSED HEARING LOSS.
THE PRESIDENT'S COUNCIL OF ADVISOR ON SCIENCE AND TECHNOLOGY ARE GENERALLY SOME OF THE TOP SCIENTISTS IN THE U.S
THEY'RE NOT OTOLARYNGOLOGIST OR AUDIOLOGISTS BUT THEY'RE VERY GOOD SCIENTISTS. SO THEY TRIED TO COME TO A RECOMMENDATION AND THEY CAME TO THE RECOMMENDATION THAT WE NEEDED SORT OF AN OVER-THE-COUNTER HEARING AID MODEL. THE NATIONAL ACADAMIES AND SCIENCE AND MEDICINE WHICH USED TO BE THE INSTITUTE OF MEDICINE, THEY HELD SEVERAL WORKSHOPS AND THEY ENDED UP WRITING A CONSENSUS REPORT ON HEARING CARE. CHAPTER FOUR OF THAT REPORT WAS ALL ABOUT THE IDEA THAT WE NEEDED OVER-THE-COUNTER MODELS OF HEARING CARE. WE NEEDED DIRECT-TO-CONSUMER MODEL FOR ALL OF THESE ADULTS WITH MILD TO MODERATE HEARING LOSS TO TRY TO HELP THEM IN THEIR LIFE SO THEY COULD HAVE MORE AFFORDABLE AND MORE ACCESSIBLE DEVICES. THIS TRIGGERED THE FDA TO HOLD A MEETING WHERE ESSENTIALLY, I MEAN, TO BE TOTALLY HONEST WITH YOU THAT MEETING WAS MANUFACTURERS, SORT OF BICKERING WITH VARIOUS PUBLIC HEALTH PEOPLE AND SERVICE PROVIDERS AND JUST KIND OF A BACK AND FORTH OVER WHETHER OR NOT OVER-THE-COUNTER DEVICES ARE SAFE, I SUPPOSE. IN THE END, THEY WERE DEEMED PHASED TO THE FACT THAT HEARING LOSS WAS DEEMED INCONSEQUENTIAL THAT THE FDA DECIDED AT THAT MEETING A FEW MONTHS LATER THAT THEY WERE GOING TO STOP ENFORCING THE MEDICAL CLEARANCE RULE FOR HEARING AIDS AND SO TECHNICALLY DO YOU NEED MEDICAL CLEARANCE WHERE YOU USED TO NEED THEM UNDER MEDICARE. THE OVER-THE-COUNTER HEARING AID ACT CAME IN 2017. SO CO-SPONSORED BY A DEMOCRAT AND A REPUBLICAN. WHICH IS RARE BUT BECAUSE OF THAT, I THINK IT WAS SORT OF WELL RECEIVED AND IT WAS TACKED ONTO THE FDA REAUTHORIZATION ACT AND PASSED QUITE READILY. IT WAS PASSED QUITE EASILY. WE'RE IN A PERIOD WHERE WE'RE WAITING. THAT ACT SAID THAT THE FDA HAS UNTIL 2020, AUGUST 2020 TO GIVE US THE REGULATIONS FOR WHAT OVER-THE-COUNTER HEARING SHOULD LOOK LIKE, AND THEY'RE WORKING ON THAT RIGHT NOW AND THEY'VE SORT OF HINTED THAT PROBABLY IN THE NEXT, YOU KNOW, SIX MONTHS, EIGHT MONTHS WE'RE PROBABLY GOING TO GET A HINT OF WHAT THEY REALLY ARE THINKING. . THAT BRINGS TO US SORT OF WHERE WE ARE NOW AND SORT OF WAITING WITH THAT. YOU CAN CLICK THROUGH THE FIRST PARTS OF THIS, YEAH, GOOD. WHAT WE END UP WITH WAS A REAL OVER-THE-COUNTER HEARING AID AND COST AND AFFORDABILITY MAY BE REDUCED BECAUSE CONSUMER ELECTRONIC MANUFACTURERS WILL INCREASE COMPETITION LEADING TO REDUCTION IN COST OF DEVICES TO CONSUMERS. ACCESS WILL BE CHAINED BECAUSE THERE'S A DIRECT ACCESS TO HEARING AIDS THAT WILL MEET STRICT CRITERIA IN SAFETY AND EFFECTIVENESS. WHAT'S IMPORTANT

HERE IS THAT THE ACT REQUIRES THE FDA TO SET THE CRITERIA FOR THIS. SO IT'S NOT A FREE FOR ALL. IT'S NOT THAT ANYBODY CAN SELL YOU A HEARING AID THAT DOESN'T MEET ANY CRITERIA. IT'S ACTUALLY MORE REGULATION THAN THERE WAS BEFORE FOR CERTAIN OVER-THE-COUNTER MODELS. BUT THE ENTRANCE OF CONSUMER ELECTRONIC MANUFACTURERS, THERE MAY BE BROADER ADOPTION OF TECHNOLOGIES, EVEN AMONG THE NON-HEARING IMPAIRED SO YOU MAY SEE THE INCREASE OF HEARABLES BEING USED AND IN GENERAL, WHEN PEOPLE LIKE BOSE AND PHILIPS AND SONY AND SAMSUNG AND POTENTIALLY EVEN APPLE AND GOOGLE ARE GETTING INVOLVED IN HEARING CARE, WHAT YOU'RE GOING TO SEE IS A CHANGE IN THE MARKETING TO RAISE AWARENESS OF HEARING DEVICES. RIGHT NOW, THE MARKET FOR HEARING DEVICES IS REALLY SORT OF TO GET THE AUDIOLOGIST TO SELL YOUR DEVICE. THE END USER DOESN'T REALLY HAVE MUCH OF A SAY IN WHICH BRAND THEY'RE USING SO THIS IS A FUNDAMENTAL CHANGE IN THE WAY MARKETING WILL OCCUR AND THE WAY CONSUMERS MAY START UNDERSTANDING MORE ABOUT HEARING LOSS. THE OTHER THING AT THE END IS THAT THE DEVICES ARE CREATED WITH THE END USER IN MIND. SO THAT THE INTEGRATION OF CONSUMER ELECTRONICS AND THE ADOPTION OF WIRELESS STANDARDS FOR FAR FIELD TRANSMISSIONS ARE FAR MORE LIKELY BECAUSE THE END USER WILL BE DRINKING THAT INNOVATION AREA. USERS WILL HAVE INCREASED DEMAND FOR THE WAY THINGS WORK. THE ONLY ISSUE, THOUGH, I THINK IS THAT IF YOU CLICK ONCE MORE. IT WILL POP UP. WITH THE OTC ACT, WE'RE SEEING THE SORT OF SEPARATION OF DEVICE AND SERVICES BECAUSE UNDER THE MODEL RIGHT NOW, DEVICE COMES WITH SERVICES. AND I REALLY BELIEVE THAT THERE'S A WHOLE DEBATE THAT COULD GO ABOUT THIS. I BELIEVE THAT THE SERVICES SIDE MATTER A LOT. AND BY SEPARATING THEM, WE MAY BE DOING A DISSERVICE TO SOME ADULTS. SO I THINK THERE'S ANOTHER BATTLE SORT OF ON THE HORIZON, SUCH THAT ADULTS WITH HEARING LOSS WHO BUY OTC PRODUCTS DESERVE ACCESS TO SERVICES AND SO OUR TEAMS, TO BE HONEST WITH YOU, IS PUSHING MEDICARE TO ACTUALLY PUT THROUGH A BILL WHERE HEARING SERVICES, SO THE COUNSELING THAT COMES WITH THIS, HELPS WITH FITTING HEARING AIDS, ALL THOSE SORT OF EXTRA PIECES THAT HELP MAXIMIZE THE BENEFIT WOULD BE AVAILABLE TO OLDER ADULTS UNDER MEDICARE. WE ALSO THINK THAT WE'VE GOT ANOTHER PIECE THAT IT'S NOT PUBLISHED YET BUT IT'S IN PRESS WHERE THE OVER-THE-COUNTER HEARING AID ACT IS ONLY TARGETING ADULTS WITH MILD TO MODERATE HEARING LOSS AND MARGINALIZING ADULTS WITH PROFOUND HEARING LOSS AND WHAT KIND OF CHANGES CAN WE MAKE FOR THEM TO START BEING CONSIDERED. THIS HAS OPENED UP A WHOLE CAN OF WORNLS, THOUGH. OTC HEARING CARE IS QUITE QUESTIONABLE TO SOME PEOPLE BECAUSE WE DON'T KNOW THE OUTCOME. WE HAVEN'T STUDIED IT. IF WE BACK UP AND THINK ABOUT WHAT A HEARING AID IS VERSUS THE CURRENT PRODUCT WHICH IS REFERRED TO AS A PERSONAL SOUND AMPLIFICATION PRODUCT GENERALLY, HEARING AIDS ARE REGULATED BY THE FDA. THEY COST 800 TO $3,000 PER DEVICE AND THEY'RE THE GOLD STANDARD OF CARE AND THEY TREAT HEARING LOSS. THE FEDERAL TRADE COMMISSION SAID YOU CAN ADVERTISE HEARING AIDS BECAUSE THEY'RE FDA APPROVED. AT THE SAME TIME, WE HAD FOR A LONG TIME THIS CLASS OF DEVICES CALLED PIECE APPS, PERSONAL AMPLIFICATION PRODUCTS. THEY'RE NOT REGULATED. THEY COST A LOT LESS. THEY ARE SOLD ONLINE BUT YOU CAN FIND THEM IN SOME STORES

THERE'S BEEN TREMENDOUS RECENT ADVANCES. BECAUSE THEY'RE NOT APPROVED BY THE FDA, THE FEDERAL TRADE COMMISSION SAYS THEY CAN'T ADVERTISE FOR HEARING LOSS. THEY CAN ONLY ADVERTISE FOR ACTUALLY LISTENING FOR NORMAL PEOPLE, WHICH THEY GET AROUND THIS BY CREATING ADS THAT LOOK LIKE, YOU KNOW, AN OLDER ADULT RYING TO LISTEN AND SEND THE INNUENDO OUT THAT THEY'RE FOR HEARING LOSS. THAT'S ANOTHER STORY. THE MOST TREMENDOUS

RECENT ADVANCES IS BECAUSE ENGINEERS ARE GETTING INVOLVED IN SELLING PIECE APPS AND YOU ARE SEEING SOME DECENT PIECES IN THE MARKET. OUR LAB WANTED TO INVESTIGATE THAT. IF YOU CLICK FORWARD AND YOU CAN CLICK OUT THE WHOLE SLIDE AGAIN. WE DID A SINGLE BLIND CROSSOVER WITHIN A STUDY WHERE WE SCREENED PEOPLE AT BASELINE. SO THIS STUDY, MIND YOU THIS IS WHAT WE REFER TO AS EFFICACY RESEARCH. WE'RE TRYING TO ISOLATE THE DEVICES BECAUSE THE QUESTION OUT THERE WAS, ARE THESE PIECE APPS INFERIOR TO HEARING AIDS BECAUSE THERE'S NO REGULATORY BODY ON EITHER SIDE OTHER THAN THE FDA SAYING THIS WORKS LIKE A HEARING AID, YOU END UP WITH THE SAME EXACT DEVICE THAT IS A HEARING AID AND PSAP AND THERE WAS A COMPANY NOT THAT LONG AGO THAT WAS SELLING A PSAP AND HEARING AID AND THEY WERE THE SAME DEVICES AND LITERALLY, THE EXACT SAME DEVICE. ONE THEY LABELED AS A PSAP AND ONE THEY LABELED AS A HEARING AID. SO THERE WAS NO REGULATION. WE DID IT ON THE EVALUATION AND WE FIT THE DEVICES. WE USE ONE TRADITIONAL HEARING AID AND USED FIVE PSAPS AND WE ALSO DID A CONDITION AND WE DID THEM IN SPEECH AND NOISE TESTING SO LITERALLY BEING ABLE TO RECOGNIZE SPEECH IN THE PRESENCE OF BACKGROUND NOISE IN A RESTAURANT MAYBE. IF YOU CLICK FORWARD ONE MORE SLIDE. WHAT WE SAW WAS UNAIDED, PEOPLE WERE ABLE TO GET 77% OF THE WORDS CORRECT. THESE PEOPLE WITH MILD TO MODERATE HEARING LOSS (INAUDIBLE). WITH THE HEARING AID, THEY IMPROVED BY 12% BASICALLY. WITH THE PSAPs, THEY IMPROVED BY ALMOST AS MUCH OF, 11%, 10%, 7.7, 5% AND WITH ONE PSAP, THEY DID A LOT WORSE. THIS IS REALLY IMPORTANT. THE PSAPS WERE THEY DID BETTER AND RELATIVELY COMPARABLE TO A HEAR AID, THESE ARE HIGH-END PSAPs THAT WE HAVE SEEN GOOD RESULTS WITH AND WE KNOW THE TECHNOLOGY WAS FOUND BUT THE ONE PS SAP THEY DID WORSE ON WE BOUGHT AT CVS AND THEY WERE SUED BY THE FCC BECAUSE THEY HAD FALSE ADVERTISING CLAIMS BUT THE DEVICE WAS REALLY BAD FORTUNATELY AND PEOPLE DID WORSE WITH IT BECAUSE THE DEVICE HAD SO MUCH DISTORTION. SO WHAT I THINK THE CONCLUSION OF THE STUDY IS NOT ONLY ARE THERE SOME DEVICES COMPARABLE TO HEARING AIDS IN A CONTROLLED SETTING FOR IMPROVING SPEECH THAT A BAD DEVICE ACTUALLY ON THE OTHER SIDE OF THE SPECTRUM COULD MAKE THINGS WORSE FOR YOU AND IN A WAY, THE PUBLIC NEEDED THE OTC HEARING AID ACT BECAUSE IT WILL GET RID OF THE POOR DEVICES BECAUSE IT'S A REGULATION ACT. NOW THESE OTC DEVICES SITTING ON THE MARKET, THEY HAVE TO MEET SOME STANDARDS. SO IT'S QUITE A GOOD THING FROM THAT PERSPECTIVE. OTHER STUDIES ARE DONE-- GO FORWARD. STUDIES DONE IN OUR LAB ARE THINKING ABOUT COMMUNITY APPROACHES TO HEARING CARE. I SHOWED YOU THIS EARLIER. WE HAVE THIS LARGE MODEL. WHAT HAPPENS IF WE USE COMMUNITY HEALTHCARE WORKERS TO SORT OF ADOPT SOMETHING? IF YOU CLICK FORWARD, WE HAVE A STUDY CALLED THE BALTIMORE HEARS STUDY, TBLAWB AND THIS IS RUN BY CARRIE NEIMAN, ONE OF MY COLLEAGUES AND WHAT SHE HAS DONE IS OVER TIME BASICALLY USING THE COMMUNITY HEALTHCARE WORKER TO USE A REALLY SIMPLE APPROACH TO HEARING CARE, WHERE THE COMMUNITY HEALTHCARE WORKER GOES INTO RETIREMENT COMMUNITIES OR IS AT THE LIVING FA IT IS EVEN AND FOR BASICALLY JUST THE PRICE OF THE HEARING AID AND THE PRICE OF THE WORKERS' TIME WHICH ENDS UP BEING $200 BECAUSE WE USE OVER-THE-COUNTER HEARING AID-- OVER-THE-COUNTER PSAP, SORRY THE USER GOES THROUGH THIS PROGRAM WHERE THEY SET A GOAL, THEY DEMONSTRATE AND PRACTICE ON EACH OTHER AND THE ACTUAL USERS OF THE HEARING TEACH THEIR CO-RESIDENTS THE SAME THING THEY JUST LEARNED.

IT'S A FULL PROCESS. ALL DELIVERED IN THE COMMUNITY AND IN STUDIES THAT'S SHE'S DONE AND WHAT YOU ARE LOOKING AT ON THE RIGHT SIDE OF THE SCREEN, OVER TIME WITH A LOT OF HANDICAPPED AT BASELINE REALLY SEE HEAVY REDUCTIONS IN HANDICAPS THROUGH A STUDY LIKE

THIS BECAUSE INSTEAD OF JUST FOCUSING ON HANDING SOMEONE A DEVICE AND SAYING, SEE YOU LATER, THEY FOCUS ON COMMUNICATION TECHNIQUES. SO IF YOU CLICK FORWARD ONE, WE THOUGHT A LOT ABOUT HOW WE APPLY THOSE COMMUNICATION TECHNIQUES IN A HOSPITAL SETTING. RIGHT NOW, THERE'S NO UNIVERSAL PROGRAM TO IDENTIFY NON-HEARING LOSS IN ADULTS AND THERE'S BEEN CALLS FOR THIS BUT MOST IGNORE BASIC PRINCIPLES. THEY'RE NOT SUSTAINABLE. A LOT OF THE TRAINING PROGRAMS THAT YOU SEE FOR ADULTS IS TO SELL THEM A HEARING AID AND IN REALITY, WE COULD GO BACK TO THE PRINCIPLES I INTRODUCED EARL CAREER THAT MAYBE WE SHOULD BE SCREENING FOR HEARING LOSS TO OVERCOME PATIENT-PROVIDER EDUCATION ISSUES AND WE HAVE A PROGRAM CALLED ENHANCE. CLICK FORWARD. THEY TEACH-- YOU CAN LEAVE IT THERE, IT'S FINE. THEY TEACH PEOPLE ABOUT HEARING CARE SO WE TEACH OUR NURSES AND OUR PROVIDERS ABOUT HEARING LOSS . WE SCREEN FOR HEARING LOSS WHEN THEY COME INTO THE HOSPITAL AND THEN WE FOCUS ON THESE COMMUNICATION CONSIDERATIONS, LIKE ENSURING ATTENTION, FACE-TO-FACE COMMUNICATION, SPEAKING SLOW, NOT SHOUTING AT PEOPLE AND GETTING CONTEXT FOR THE CONVERSATION. WE DO GIVE OUT A DEVICE. ONE MORE CLICK. YEAH.
THAT'S THE DEVICE AND WE ALSO USE POSTERS. THE POSTERS DON'T LABEL THE PATIENTS WITH HEARING LOT. SOMETHING THAT BOTHERS ME IS IN HOSPITALS YOU WILL SEE A LABEL SAYING THIS PERSON HAS HEARING LOSS, THAT'S NOT REALLY FAIR TO THAT PERSON BECAUSE IT PUTS THE ONUS ON THEM TO EXPLAIN THEIR HEARING LOSS AND TRY TO WORK THROUGH IT. IN REALITY, ANYBODY WHO WE IDENTIFY WITH A HEARING LOSS IN OUR HOSPITAL, WE PUT UP THESE POSTERS AND THE POSTERS ARE ABOUT FOR THE PROVIDERS, SAYING HERE'S TIPS ON HOW TO BEST COMMUNICATE. WE DON'T MENTION HEARING LOSS BECAUSE WE THINK COMMUNICATION IS FUNDAMENTAL FOR EVERYONE. GOOD COMMUNICATION DOESN'T BENEFIT THOSE WITH HEARING LOSS. IT BENEFITS EVERYONE. WE ALSO HAND OUT DEVICES WHEN PEOPLE NEED THEM. UNLIKE OTHER HOSPITALS, WE JUST DON'T KEEP ONE DEVICE ON THE FLOOR BECAUSE THAT USUALLY TENDS TO RESULT IN ONE DEVICE BEING USED AND NOT AVAILABLE. SOMETIMES IT BREAKS AND SOMETIMES IT GOES WALKING AND WE BUY THE DEVICES IN BULK AND WE GIVE THEM TO TAKE HOME. WE DO THIS BASED ON THE FACT THAT HIDDEN BULK-- BUYING IN BULK THESE ARE $40, HALF THE COST OF AN I.V. FLUID BAG IF IT STAYS IN THE HOSPITAL AND PREVENTS THEM FROM COMING BACK BECAUSE THEY DON'T UNDERSTAND THEIR TREATMENT, WE'RE SAVING THE HOSPITAL MONEY IN THE LONG RUN. IN GENERAL, SORT OF CONCLUDING MY BIG TALK HERE IS THAT WE HAVE THESE ISSUES WITH HEARING CARE. WE'VE RECOGNIZED THAT THERE'S ASSOCIATIONS BETWEEN HEARING LOSS AND HEALTHY AGING. IF YOU CLICK FORWARD ONE MORE SLIDE. RIGHT NOW, WE HAVE GOLD STANDARD OF HEARING CARE.
IT'S ACCEPTED AND IT TAKES A LONG TIME. THERE'S NO REASON WHY WE CAN'T INTEGRATE ALL OF THESE OTHER MODELS INTO ONE LARGE PYRAMID OF HEARING CARE WHERE PEOPLE CAN KIND OF GO AT THEIR OWN PACE AND GET INVOLVED WITH HEARING CARE, WHERE THEY NEED TO GET INVOLVED SO MAYBE THEY JUST NEED A PSAP OR OTC PRODUCT BECAUSE THEY WANT TO HEAR BETTER IN ONE SITUATION AND THEY ARE NOT WILLING TO COMMIT THE GOLD STANDARD. MAYBE THEY WANT TO WORK WITH COMMUNITY HEALTHCARE WORKER BECAUSE THEY DON'T HAVE THE FEASIBILITY TO GET TO THE AUDIOLOGIST OR THEY DON'T THINK THE PROBLEM IS STRONG ENOUGH YET. THAT'S FINE. I THINK WHAT'S LACKING, THOUGH,THIS PYRAMID OF CARE. THE TAKE-HOME MESSAGES OF THIS ARE HEARING LOSS HAS AN ASSOCIATION WITH MARKERS OF HEALTHY AGING. PERSONS WITH HEARING LOSS INTERACT WITH THE HEALTHCARE SYSTEM DIFFERENTLY. WE HAVE POOR UPTAKE OF HEARING CARE IN THE U.S

THERE'S PENTDING POLICY EFFECTS, WITH OVER-THE-COUNTER DEVICES AND MAY IMPROVE. ACCESS AFFORDABILITY, THERE'S NOVEL DELIVERY MODELS BEING TESTED RIGHT NOW, BUT IN ENJ, I THINK ALL OF THIS, THE BIG PICK FOR ME IS THAT THERE'S LOTS OF RESEARCH NEEDED. EVERYTHING I TOLD YOU NEEDS MORE RESEARCH TO KEEP PUSHING TOP OF THE LINE CARE FOR THE PUBLIC. WITH THAT, I'VE GOT TEN MINUTES FOR QUESTIONS.
>> YES. WE HAVE HANDS UP IN THE ROOM. I WILL HAND OUT THE DEVICE SO QUESTIONS CAN BE ASKED.
>> THIS IS BERKELEY. I'M INTERESTED IN HOW YOUR HOSPITAL GOT TO THE PART TO BUY DEVICES IN BULK AND HAND THEM OUT.
>> WE APPROVED THAT WITH-- SO THAT SATISFACTION STUDY, WE DID THAT STUDY AND BROUGHT IT TO THE HOSPITAL. FOR ANY OF YOU WHO ARE HOSPITAL ADMINISTRATORS, YOU ARE PROBABLY FAMILIAR WITH THE HPAPs, AND THAT'S A SATISFACTION MEASURE IN MEDICARE. HAD WE SAW IT WAS RELATED TO SATISFACTION AND, USING STUDIES TO OVERCOME THE HEARING LOSS AND IF WE IMPROVE SATISFACTION, WE IMPROVE OUR HPAP SCORES AND THOSE SCORES ARE REIMBURSEMENT AND SCHEMES IN THE HEALTH SYSTEM, MEANING THAT IF YOU HAVE POOR SATISFACTION SCORES AS A HOSPITAL, YOU GET LESS REIMBURSEMENT FROM MEDICARE. SO WHEN WE SHOWED OUR HOSPITAL THAT IF WE IMPROVE OUR SATISFACTION SCORES BY ADDRESSING HEARING LOSS WE IMPROVE OUR REIMBURSEMENT LEVELS, AND THAT ACTUALLY WOULD MAKE A HOSPITAL LIKE JOHN HOPKINS, WHICH IS QUITE LARGE AND WE HAVE 24 HOSPITALS IN OUR SYSTEM, IF WE IMPROVE OUR SATISFACTION SCORES, WE WOULD MAKE MILLIONS AND I SHOWED THAT IMPROVING CARE RESULTS IN PROFITABLE MEASURES AND THEY WERE WILLING TO LET US BUY THESE DEVICES AND TEST THESE PROGRAMS OUT. IF IN TWO YEARS, OUR PROGRAMS FAIL THAT'S DIFFERENT. THEN WE NEED IT GO BACK TO THE DRAWING BOARD BUT SO FAR, KNOCK ON WOOD, BUT WE HAVE SOME TRIALS THAT WILL BE IMPRESSED IN THE NEXT YEAR OR SO. THEY'RE WRAPPING UP RIGHT NOW AND I WILL HAVE REALLY GOOD INFORMATION FOR EARN THAT I THINK IS POSITIVE. -I WILL HAVE REALLY GOOD INFORMATION FOR EVERYONE.
>> BERKELEY: DO PATIENTS BRING THEM BACK WITH THEM WHEN THEY COME BACK TO CARE.
>> YES. I COULD HAVE DONE A WHOLE TALK ON JUST OUR PROJECT. THE FIRST TIME WE RAN THE PROJECT AS A FEASIBILITY STUDY THIS AMAZING THING HAPPENED. WE SCREENED 502 PEOPLE AND IDENTIFIED 81 PEOPLE WITH MORE MODERATE LOSS AND GAVE THEM A DEVICE. ONLY 75 TOOK THE DEVICE. SIX REFUSED IT, WHICH IS FINE. IN THAT THREE-MONTH PERIOD WHERE WE RAN THE STUDY, EIGHT PEOPLE WHO HAD A DEVICE CAME BACK INTO THE HOSPITAL. THOSE EIGHT PEOPLE READMITTED BROUGHT THEIR DEVICE BACK AND WE ASKED THEM WHY. IT BROKE DOWN LIKE THIS. THREE OF THEM TOLD US THAT THIS DEVICE WAS EXTREMELY HELPFUL TO THEM HAD THEY WERE IN THE HOSPITAL AND THEY REALLY APPRECIATED IT AND THEY BROUGHT IT BACK. THEY SAID THEY DIDN'T USE IT ANY OTHER TIME. THEY LIKED IT IN THE HOSPITAL AND HE KEPT IT. THE OTHER FOUR ACTUALLY TOLD US THAT ESSENTIALLY THEY SAID NO ONE HAD EVER ASKED ME ABOUT MY HEARING LOSS BEFORE. NO ONE HAD EVER GIVEN ME ANYTHING AND THEY WERE USING THE DEVICE IN THEIR EVERYDAY LIFE. YOU HAVE TO REMEMBER WHERE WE ARE IN JOHN HOPKINS, WE'RE ONE OF THE POOREST COUNTRIES IN THE COUNTRY AND MANY OF OUR CONSTITUENTS, MANY OF OUR PATIENTS DON'T HAVE PEOPLE SORT OF HELPING THEM WITH PREVENTATIVE MEASURES. SO PART OF OUR STUDY NOW HAVE ALSO BECOME-- AFTER WE LEVERAGE HOSPITAL (INAUDIBLE) HEARING LOSS IN THE HOSPITAL LIKE THE ENHANCE PROGRAM THAT SORT OF PROMOTE STREAMED CARE IN GENERAL AND WE HAVE NEXT LEVEL, MULTILEVEL STUDIES GOING ON NOW.

>> THANK YOU. ARE THERE ANY MORE QUESTIONS IN THE ROOM?
>> STEVE: THIS IS ACHIEVE BARBER FROM HLAA. YOU HAVE EXCELLENT INFORMATION AND CORRELATION BETWEEN HEARING LOSS AND DEMENTIA. BUT EXACTLY HOW DO YOU SEPARATE WHICH ONE IS THE CAUSE AND WHICH ONE IS THE EFFECT?
>> THE TRUTH IS I WOULDN'T ACTUALLY CALL IT A CORRELATION. CORRELATION GENERALLY REFERS TO A MODEL WHICH IS CROSS-SECTIONAL OVER TIME AND CAUSAL MEANS WE USE THINGS LIKE LONGITUDINAL DATA AND WE HAVE LOOKED LIKE HEAL CRITERIA AND THAT'S INFERENCE AND EPIDEMIOLOGICAL STUDY, AND WITHIN THAT, WE HAVE THE BIOLOGICAL PLAUSIBILITY, WE HAVE A GRADIENT RESPONSE MEANING THAT THE MORE HEARING LOSS, THE HIGHER THE RESPONSE, THE STRONGER THE ASSOCIATION. WE HAVETEMPORAALITY AND STUDIES OF PEOPLE WITH THE SAME HEARING LOSS THAT SHOW THE SAME RELATIONSHIP AND THE MODELS TO SUPPORT IT. I ACTUALLY, DID-I ACTUALLY DON'T THINK-- IT'S NOT JUST CORRELATION. CORRELATION WOULD REFER TO THOSE TWO THINGS HAPPENING AT THE SAME TIME WITH NO ADJUSTED FACTORS AND INSTEAD IN OUR STUDIES, WE STRATIFIED AND ADJUSTED FOR MANY OF THE OTHER FACTORS ASSOCIATED WITH DEMENTIA. SO THE POINT WHERE-- I DON'T THINK THAT A SCIENTIST WOULD READ OUR PAPERS AND SAY-- I'M NOT EVEN TALKING ABOUT AUDIOLOGIST OR OTOLARYNGOLOGIST. I MEAN LIKE GENERAL SCIENTISTS WOULD READ THESE PAPER AND SAY IT'S CORRELATION AND NOT CAUSATION. WHEN YOU SEE THE TEMPORALTY MEASURES OVER A LONG PERIOD OF TIME, THAT'S ABOUT AS STRONG AS EVIDENCE AS YOU ARE REALLY GOING TO GET. I REALLY THINK IT FALLS BACK TO HILL'S CRITERIA AND I THINK THAT'S WHY YOU SEE THESE PAPERS BEING PUBLISHED IN A VERY HIGH LENS JOURNALS WHERE THE PEER REVIEWERS ARE, AGAIN, THEY'RE NOT HEARING LOSS EXPERTS AT ALL. THEY'RE JUST SCIENCE EXPERTS.
>> STEVE: YES, WE KNOW THAT BEING ABLE TO PROCESS AUDIO SOUNDS INTO HEARING AND UNDERSTANDING WORDS TAKES A LOT OF BRAIN POWER. SO IT'S NATURAL TO EXPECT THAT IF YOUR BRAIN POWER'S BEING DIMINISHED, THEN YOU WOULD HAVE DIFFICULTY UNDERSTANDING SPEECH. THAT WOULD INDICATE THAT IT'S POSSIBLE THAT LOSS OF BRAIN POWER COULD BE A CAUSE OF HEARING LOSS BUT OF COURSE, IT'S ALSO POSSIBLE THAT ISOLATION AND WITHDRAWING COULD ALSO CAUSE DEMENTIA. SO I CAN SEE AN ARGUMENT FOR BOTH SIDES ABOUT WHICH ONE IS THE CAUSE AND WHICH ONE IS THE EFFECT.
>> I AGREE WITH YOU. I THINK THAT'S A GREAT POINT. THE THING IS, THOUGH, WE ONLY EVER USED PERIPHERAL MEASURES OF HEARING. WHEN WE USE SPEECH MEASURES, WHICH ARE A COGNITIVE PROCESS WHICH WOULD OFFER THE SORT OF REVERSE PATHWAY THAT YOU'RE TALKING ABOUT, THE CAUSAL AND EFFECT, THAT WOULD BE DIFFERENT, BUT WE'VE REVIEWED THAT THE PERIPHERAL MEASURE IS A FAR UPSTREAM PROCESS TO DOWNSTREAM COGNITIVE PROCESSING SUCH THAT THERE IS NO REVERSE PATHWAY THERE THAT'S BIOLOGICAL FEASIBILITY.
>> JULIE: THIS IS JULIE BISHOP. YOU MENTIONED EARLIER THAT HEARING LOSS IS THE LARGEST MODIFIABLE RISK FACTOR KNOWN FOR DEMENTIA AND I BELIEVE THAT NUMBER WAS 9%. IS THERE A SIMILAR NUMBER, LIKE, LET'S SAY 9% THAT COULD BE APPLIED TO COST SAVINGS, FOR EXAMPLE, MEDICARE COSTS, IF HEARING LOSS WAS TREATED, HAS ANYONE EVER LOOKED AT THOSE NUMBERS?
>> WELL, I CAN TELL YOU A LOT OF PEOPLE WANT TO LOOK AT THAT NUMBER. THAT'S LIKE SUCH A GOOD QUESTION. THE ISSUE IS, THOUGH, THAT YOU CAN ATTRIBUTE A CERTAIN AMOUNT OF RISK TO EXPOSURE IN THESE MODELS, BUT YOU CAN'T MAKE THE ASSUMPTION THAT IF YOU GET RID OF THE RISK, IT REDUCES ALL OF IT. BECAUSE WE DON'T KNOW HOW MUCH HEARING AID USE ACTUALLY REDUCES AND CHAINS THE ASSOCIATION BUT THE REAL-- THE GOOD PART OF THIS I CAN SAY IS THAT

THE BIG CLINICAL TRIAL GOING ON RIGHT NOW THAT OUR TEAM LEADS AND SEVERAL SITES AROUND THE COUNTRY AND A THOUSAND PEOPLE AND LOOKING AT HEARING CARE ON COGNITIVE DECLINE, THAT STUDY WILL TELL US WHETHER OR NOT HEARING CARE DELAYS COGNITIVE DECLINE AND WITH SUCH A STUDY, WE WOULD BE ABLE TO THEN DO A COST BENEFIT ANALYSIS FOR MEDICARE, AND I CAN TELL YOU, I CAN LITERALLY TELL YOU RIGHT NOW, WE'VE ACTUALLY STOOD BEFORE THE CONGRESSIONAL BUDGET OFFICE AND TRIED TO CONVINCE THEM TO WORK WITH US ON COVERING HEARING AIDS AND WHAT THEY SAY EVERY TIME IS THAT THERE IS NO EVIDENCE RIGHT NOW UNTIL THAT STUDY COMES OUT TO SAY THAT, OKAY, IF YOU HAVE HEARING AIDS THEN YOU REDUCE THE RATE OF DEMENTIA OR THE RISK OF DEMENTIA AND THAT WAS TAKING MONEY. RIGHT NOW BECAUSE WE DON'T HAVE THAT LINK, WHICH IS FUNDAMENTAL TO YOUR QUESTION , WE CAN'T MAKE THE ASSUMPTION, BUT IT WOULD BE GREAT IF WE COULD. I MEAN, YOU COULD DO SOME STUDY TO SAY IF YOU REDUCE% OF DEMENTIA, WHAT DOES IT DO TO COSTS AND SCIENTIFICALLY, IT'S NOT CORRECT.
>> JULIE: THANK YOU.
>> ASHLEY: YES. THIS IS ASHLEY SPEAKING. THANK YOU VERY MUCH, DR. REED, FOR YOUR PRESENTATION AND I REPRESENT THE DEAF-BLIND COMMUNITY ON THIS COUNCIL. I WAS CURIOUS. I'M AWARE OF THE CORRELATION BETWEEN HEARING LOSS AND DEMENTIA BUT ALSO BETWEEN VISION LOSS AND DEMENTIA. SO IF SOMEONE HAS A HEARING LOSS AND A VISION LOSS AND THEIR ACCESS TO COMMUNICATION IS LIMITED, THEIR ACCESS TO STIMULATION IS LIMITED AS WELL, JUST WONDERING WHAT YOU THINK ABOUT DEMENTIA AND THE RELATIONSHIP THERE WITH PEOPLE WHO HAVE BOTH THE HEARING AND A VISION LOSS?
>> MAN, ASHLEY, IT'S LIKE YOU'RE READING MY MIND. I HAVE A COLLEAGUE, BONNIE SWEANOR, HERE AT JOHN HOPKINS, SHE'S LEGALLY BLIND AND SHE STUDIES VISION LOSS AND SHE DID A LOT OF WORK ON COGNITIVE DECLINE AND VISION LOSS AND HER AND I WORK CLOSELY TOGETHER ON FULL SENSORY IMPAIRMENT AND WHAT THAT IS LIKE FOR PEOPLE AND WE DON'T HAVE A LOT OF GOOD DATA, BUT THERE DOES SEEM TO BE SOME SUGGESTIONS THAT PEOPLE WHO HAVE BOTH IMPAIRMENTS LATER IN LIFE HAVE A HIGHER RATE OF COGNITIVE DECLINE AND THE SAME IS NOT TRUE FOR HAVING HEARING LOSS AND BLINDNESS EARLIER IN LIFE. IT SEEMS THE ADAPTATION MECHANISMS THAT HAPPEN EARLIER IN LIFE ARE PROTECTIVE OF THESE FACTORS, BUT I THINK THE AREA YOU'RE OPENING UP IS SUPER INTERESTING AND I PERSONALLY HAVE A FEW PAPERS THAT I DIDN'T TALK ABOUT NOW THAT INSTEAD OF LOOKING AT INTERACTIONS WITH THE HEALTHCARE SYSTEM AND JUST HEARING LOSS, I LOOK AT THE AS THE PHYSICIAN AND HEARING WITH DUAL SENSORY IMPAIRMENT IS LIKE. I THINK IT'S A POPULATION THAT'S BEEN VERY MARGINALIZED IN THAT MANY OLDER ADULTS HAVE SORT OF BOTH AND IN MY OWN FAMILY, WE HAVE A HEREDITARY DEAFNESS GENE AND MANY FAMILY MEMBERS WHO ARE OLDER WHO ARE DEAF AND ALSO HAVE VISION LOSS. IT'S DIFFICULT TO OVERCOME BOTH. WE DON'T THINK ABOUT THE ACCOMMODATIONS WE MAY NEED FOR BOTH AND IN THE TREATMENT PATTERNS, WE'RE TREATING OUR SENSORY IMPAIRMENTS IN SILOS. PEOPLE IN THE AUDIOLOGY WORLD DON'T CONSIDER VISION AND PEOPLE IN THE VISION WORLD DON'T CONSIDER HEARING AND I THINK THEY'RE REAL FUNDAMENTAL TO EACH OTHER. I THINK WE DON'T SUDDENLY SORT OF WORK AS ONE AND NOT THE OTHER. EVERYTHING IS WORKING TOGETHER. SO I ACTUALLY REALLY APPRECIATE YOUR QUESTION AND I'M GLAD THAT YOU BROUGHT IT UP.
>> MAGGIE: THIS IS MAGGIE AND I WORK WITH DHHS AND MY QUESTION IS ADDITIONAL DATA YOU MAY GET FROM THIS. ONE OF THE THINGS YOU BROUGHT UP IS THE FOLKS FROM MARGINALIZED NEIGHBORHOODS WHO ACTUALLY HOSPITALIZED AND I ALWAYS THINK ABOUT-- I MEAN, ARE YOU THINKING ABOUT BEING ABLE TO FOLLOW SOME OF THOSE PATIENTS WHO HAVE THE DEVICES

THROUGH SOME SORT OF GEOMAPPING AND THEN I GUESS I THINK ABOUT WITH THAT GENOME MAPPING THE AMOUNT OF CHRONIC DISEASE THAT CAN ACCOMPANY SOME OF THAT AND COMPROMISE HEARING? SO ARE YOU THINKING OF ANY WAY OF SORT OF PULLING OUT THE DATA TO LOOK AT HOW THESE DEVICES MIGHT BE AFFECTED PARTICULARLY FOR THOSE GROUPS THAT YOU SAID HAVE TRANSPORTATION ISSUES, HAVE MAYBE LESS ACCESS TO HEALTHCARE IN A WAY OF TALKING ABOUT HOW THAT COULD THEIR OVERALL HEALTHCARE EVEN AFTER THEY LEAVE THE HOSPITAL?
>> I THINK MY ANSWER TO THE WE IS YES AND NO. WE ARE WORKING A LOT ON-- TO BE HONEST, WE'RE FOCUSING REALLY, REALLY ON DELERIUM IN HEARING LOSS AND WHETHER OR NOT WE GIVE PEOPLE DEVICES TO PREVENT DE LERIUM AND THAT'S HERE AT JOHNS HOPKINS AND IN AUSTRALIA, THERE'S A UNIVERSITY THAT APPLIED MY PROGRAM AND WE'RE FOLLOWING PEOPLE THERE AFTER THEY LEAVE THE HOSPITAL TO SEE HOW THEY HOW IT AFFECTS THEIR UPTAKE OF HEARING CARE. WE ARE FOLLOWING PEOPLE. WE DON'T HAVE THE RESOURCES AND THE TIME TO FOLLOW GROUPS FOR EVERYTHING AND INSTEAD, WE'RE FOLLOWING SPECIFIC CONDITIONS THAT WE CAN AFFORD TO DO THE STUDIES ON. YOU KNOW, JUST LIKE WITH ANY SCIENCE, WE HAVE TO SORT OF SACRIFICE SOMETHING JUST BECAUSE WE CAN'T AFFORD IT ALL.
>> THANK YOU. I THINK WE HAVE ONE MORE QUESTION. JAN.
>> JAN: YES THIS IS JAN SPEAKING. JUST VERY QUICKLY, HELLO, DR. REED. I'M JAN WITHERS, I'M THE DIRECTOR OF SERVICES FOR DEAF AND HARD OF HEARING IN NORTH CAROLINA. I DO HAVE A QUICK QUESTION. DO YOU HAPPEN TO KNOW THE STATISTICS REGARDING DUAL HEARING AND VISION LOSS? I HAVE HEARD IT'S ONE OF THE FASTEST GROWING DUAL DISABILITIES, ESPECIALLY AMONG OLDER ADULTS. COULD YOU EWILL BE RATE ON THAT?
>> YEAH. SO THE COLLEAGUE OF MINE, BONNIE, THAT I TOLD YOU ABOUT A MINUTE AGO, SHE DID A REALLY GREAT PAPER WHERE SHE TOOK OBJECTIVE MEASURES DONE THROUGHOUT THE UNITED STATES IN A NATIONALLY REPRESENTED POPULATION FROM CDC DATA, AND SHE LOOKED AT THE INCIDENCE OR SORRY, THE PREVALENCE OF DUAL SENSORY IMPAIRMENT, AND IT'S NOT AS HIGH AS VISION OR HEARING ALONE BUT IT IS RATHER HIGH SUCH THAT SOMETHING 1 IN 10 OLDER ADULTS HAVE A DUAL SENSES ISRY IMPAIRMENT. I DON'T REMEMBER THE EXACT NUMBERS BUT I CAN SEND-- I CAN ACTUALLY SEND THIS PAPER TO DAVID OR JAMES MY EMAIL AND THEY CAN DISTRIBUTE IT WITH YOU BUT AS FAR AS GROWING, I DON'T KNOW DATA ON THE ACTUAL CHANGE IN PERCENTAGE. I KNOW THE PREVALENCE IS HIGH BUT THE INCIDENCE, I'M NOT SURE OF, BUT WHAT I WOULD SAY IS EVEN WITHOUT HAVING NUMBERS, JUST KNOWING THAT THE PREVALENCE INCREASES WITH AGE AND WE'RE LIVING LONGER AS A SOCIETY, IT PROBABLY IS ONE OF THE FASTEST-GROWING SENSORY IMPAIRMENT AREAS BECAUSE WE'RE SEEING PEOPLE LIVE LONGER AND MOST LIKELY, THERE ARE MORE AND MORE PEOPLE DEVELOPING DUAL SENSORY IMPAIRMENT.
>> JAN: THANK YOU.
>> ROB: ONE MORE FROM JULIE.
>> JULIE: THIS IS JULIE BISHOP. A LITTLE WHILE AGO, A SMALL GROUP OF US WERE DISCUSSING SMALL PENETRATION OF COCHLEAR IMPLANTS, THAT IS ONLY 6 TO 8% OF PEOPLE WHO ARE CANDIDATES FOR COCHLEAR IMPLANTS ACTUALLY RECEIVE THEM. AND LOOKING AROUND THE ROOM, SIX OF US HAVE COCHLEAR IMPLANTS AND OUR FEELING IS THAT IT'S SUCH A ROBUST TECHNOLOGY AND I WAS WONDERING IF YOU KNEW-- IF YOU WERE STUDYING THE REASON FOR THE SLOW PENETRATION. ALSO, HAS THERE BEEN ANY STUDIES TO SHOW THAT PERHAPS PEOPLE THAT HAVE COCHLEAR IMPLANTS AS THEY AGE SEEM TO DO BETTER COGNITIVELY? I MEAN, IT'S KIND OF OUT THERE, BUT I WAS JUST CURIOUS.

>> I THINK THAT'S A GREAT QUESTION. THERE IS A TRIAL GOING ON RIGHT. THERE ARE-- ACTUALLY, THERE'S EVIDENCE FROM FRANCE ACTUALLY, ISABEL MONET HAS DONE SOME STUDIES IN FRANCE. SHE'S A AN OTOLARYNGOLOGIST. SHE DOES COCHLEAR IMPLANT SURGERY AND SHE HAS STUDY THAT SAYS COCHLEAR IMPLANT IMPROVES COGNITION AND THAT'S A FACTOR OF BEING ABLE TO ACCESS THE TEST BUT SHE SHOWS THAT OVER TIME THOSE FOLKS WHO HAVE A COCHLEAR IMPLANT HAVE A SLOWER RATE OF COGNITIVE DECLINE. SHE HAS GOOD DATA AND HER DATA HAS LED TO A STUDY HERE IN THE UNITED STATES. THERE'S, I THINK, TWELVE CENTERS THAT ARE COLLECTING DATA AND I ACTUALLY DON'T KNOW WHAT THE LONG-TERM FOLLOW-UP THERE. TO BE CLEARLY HONEST WITH YOU, BECAUSE COCHLEAR, THE COMPANY COCHLEAR THAT MAKES COCHLEAR IMPLANTS, GAVE A REALLY LARGE GIFT TO OUR CENTER, BECAUSE I DON'T WANT A CONFLICT OF INTEREST, I DON'T DO COCHLEAR IMPLANT RESEARCH. I WIPE MY HANDS OF THAT AND I DON'T TOUCH THAT AREA. AS FAR AS LOW INCIDENCE, AS FAR AS I UNDERSTAND IT, FROM THE COCHLEAR PEOPLE, WITH THEIR CEO AND HIGHER-UPS, THEY BELIEVE THAT THE INCIDENCE MOSTLY HAS TO DO WITH A LACK OF AWARENESS OF COCHLEAR IMPLANTS AND HOW THEY CAN BENEFIT PEOPLE. SO THEY ACTUALLY FIRMLY BELIEVE THAT IT TAKES PUBLIC HEALTH STRATEGIES TO IMPROVE AWARENESS WHICH WOULD EVENTUALLY RESULT IN MORE PEOPLE GOING FORWARD WITH COCHLEAR IMPLANTATION.
>> ROB: THANK YOU, DR. REED. WE APPRECIATE YOU BEING ON THE LINE WITH US TODAY.
[APPLAUSE]
>> THANK YOU FOR HAVING ME.

Discussion: Draft Recommendations (2nd Session)

>> SO WE HAVE 45 MINUTES TO GO BACK TO THIS QUESTION. WE DID A LOT AROUND QUESTION ONE, WHICH IS PROGRESS AND FOR QUESTION TWO, THIS-- QUESTION TWO IS, IS THERE AN OPPORTUNITY TO ENSURE AUDIOLOGISTS ARE ON LONG-TERM FACILITY AND INTAKE ASSESSMENT TEAMS? THIS IS A QUESTION NEXT MEETING IN ASKING DHSR UNLESS ANYONE IN THE ROOM HAS ANY INFORMATION ON THIS, BUT WHETHER THESE FACILITIES CONTRACT THE AUDIOLOGIST AND MAKE SURE I GET THIS RIGHT, ASSESSMENT VERSUS TESTS, RIGHT? SO IF THE ASSESSMENTS ARE BEING PERFORMED, HOW IS THAT HAPPENING? YEAH. SO I'M NOT SURE IF WE WANT TO DISCUSS MUCH ON THIS, OR WE WANT TO POSE THIS AS A QUESTION FOR NEXT MONTH WHEN WE HAVE MARK PAYNE HERE AS WELL. DOES ANYONE IN THE ROOM WANT TO COMMENT ON QUESTION TWO?
>> TOVAH: I DON'T HAVE AN IMMEDIATE ANSWER ABOUT WHETHER OR NOT SKILLED NURSING FACILITIES HAVE CONTRACTS WITH SERVICE CONTRACTORS BUT THERE IS A NEED OF CONTINUING CARE RETIREMENT FACILITIES THAT NORTH CAROLINA PUTS OUT EVERY CAREER AND I HAPPENED TO NOTICE THAT SOME OF THEM INDICATE THAT THEY HAVE AUDIOLOGISTS AVAILABLE ON THE PREMISES SO MAYBE ONE PLACE TO LOOK QUICKLY AT THAT IS HOW MANY OF THOSE PLACES HAVE AUDIOLOGISTS ON STAFF OR ON CONTRACT WITH THEM.
>> JENNIFER: JENNIFER FROM LEADING AGE NORTH CAROLINA. WE'RE A MEMBERSHIP ASSOCIATION OF MAINLY CONTINUING CARE RETIREMENT COMMUNITIES AND IF YOU DECIDE YOU WANT TO PURSUE THAT OR ANY OTHER QUESTION OF THAT PARTICULAR GROUP OF LONG-TERM CARE PROVIDERS, WE COULD EASILY, YOU KNOW, POST A QUESTION, MAKE PHONE CALLS AND WHATEVER AND FIND OUT OF THE 60 PLUS FOLKS THAT ARE CCRCs IN NORTH CAROLINA, HOW DO THEY HANDLE THESE ASSESSMENTS, WHO WAS ON CONTRACT, DO THEY HAVE ANYONE ON STAFF, WHAT KINDS OF QUESTIONS ARE THEY ASKING? HAVE THEY EVER BEEN CALLED OUT IN A REGULATORY SURVEY FOR NOT

HAVING-- I MEAN, WHATEVER THE QUESTION IS THAT'S MOST RELEVANT AND HELPFUL, THAT IS SOMETHING WE'D BE HAPPY TO DO. WE DO IT A LOT. WE GET GOOD RESPONSE RATE, TOO.
>> ADAM: LET ME ADD TO THAT TIM CLARK FROM THE HEALTHCARE FACILITIES ASSOCIATION HAD TO JUMP OFF BUT SENT ME AN EMAIL THEY HAVE A MEMBERSHIP MEETING NEXT MONTH AND HE WOULD BE HAPPY TO DISTRIBUTE A SURVEY TO GET SIMILAR DATA FROM THEIR MEMBERS SO THERE MAY BE A WAY TO GET AT SOME OF THOSE QUESTIONS.
>> CRYSTAL: THE ONE THING I WOULD LIKE TO HIGHLIGHT AND THIS TIES IN EARLIER ABOUT GETTING QUESTIONS ANSWERED AND THIS IS THE OUTPATIENT SETTING AS WELL AS THE LONG-TERM CARE FACILITY SETTING IS WHAT WE'RE CONSIDERING AS THE SCREENING ASSESSMENT. I THINK WE HAVE TO RECOGNIZE THAT ALL SCREENING ASSESSMENTS ARE NOT EQUAL. SOMEBODY MENTIONED THE WHISPER TEST WHICH IS ONE THAT IS FREQUENTLY USED, BUT IF WE'RE TALKING ABOUT WHY PEOPLE MAY NOT BE GETTING RECOGNIZED FOR NOT HAVING HEARING LOSS IT DEPENDS ON THE SCREENING ASSESSMENT, AND WE SHOULD CLARIFY DEPENDING ON THE SETTING HOW PEOPLE FIND THE LOSS SO WE CAN MAKE RECOMMENDATIONS AND THOSE RECOMMENDATIONS WILL BE TO THE HIGHER METRIC AND SHELLEY CAN TALK ABOUT THOSE BETTER WHAT IS THE BEST WAY WE WANT PEOPLE TO BE SCREENED ONCE WE FIND OUT THEY OUGHT TO BE SCREENED, IF THEY ARE BEING SCREENED.
>> THIS IS CAL CUNNINGHAM. I WANTED TO REITERATE WE NEED TO DEFINE WHAT KIND OF TOOL IS USED AND WHETHER IT'S A VALID METHOD OF ASSESSING FOR INITIAL HEARING LOSS.
>> ADAM: AGAIN, THAT'S SOMETHING WE COULD ASK. WE COULD SAY, ARE YOU SCREENING? WHAT METHODS ARE YOU USING FOR SCREENING? AND FOLLOW-UP, ALL OF THOSE THINGS, YEAH.
>> I JUST ACTUALLY EMAILED YOU A LINK TO TWO DIFFERENT SUGGESTIONS. ONE IS AN NIH VALIDATED QUESTIONNAIRE THAT IS SOME SPECIFIC QUESTIONS ABOUT DIFFERENT SITUATIONS, INCLUDING TENITIS. THAT'S ONE I USE TO DISTRIBUTE TO PCPs LOCALLY. THE GOLD STANDARD WOULDN'T BE AN ACOUSTIC SCREENER, THAT'S WHAT WE USE IN SCHOOL. CAN YOU HEAR A SOUND AT THE LOUDEST POINT THAT'S STILL CONSIDERED TO BE NORMAL HEARING ACROSS A COUPLE OF DIFFERENT PITCHES, AND THAT'S WHAT I REALLY WOULD LIKE TO SEE OUR PRIMARY CARE DOCS USING IS AN ACOUSTIC AWARENESS SCREENER ACROSS THE DIFFERENT-- A FEW DIFFERENT PITCHES THIS THEIR OFFICES. I JUST BOUGHT ONE FROM A MEDICAL WHOLESALE PLACE UNDER 20 BUCKS AND THAT'S GOING-- OTHER THAN BATTERIES SCREEN HUNDREDS OF PEOPLE PRETTY EASILY. IT DOESN'T HAVE TO BE AN A AUDIOMETER THAT COSTS A COUPLE THOUSANDS TO GET THE JOB DONE.
>> ADAM: LET ME ADD TO THAT. SHELLEY AND I WERE TALKING ABOUT THIS OVER LUNCH. IN MY OFFICE, THEY'RE USING AUDIOOM METER AND THEY'RE NOT SKILLED AT IT AND DO YOU THINK MAKING IT CHEAP AND MAKING IT SIMPLE, AND THIS IS THE WAY TO GET PEOPLE PROPERLY SCREENED?
>> SHELLEY: YEAH, IT'S SIMPLER. IT DOES NEED TO BE A QUIET ROOM AND WE OFTEN RUN INTO FALSE POSITIVES ESPECIALLY THIS TIME OF YEAR, THERE'S NEVER NOT AN AIR CONDITIONER RUNNING AND COVERING UP LOW FREQUENCY SOUNDS WHICH DOES MAKE IT TRICKY. SOMETIMES YOU NEED A SMALL SPACE WHERE YOU CAN TURN OFF THE AIR FOR A FEW MINUTES, OR I RUN INTO A LOT OF PEDIATRICIAN OFFICES GOING, YEAH, YOU FAILED BUT IT'S FINE AND WE WANT TO MAKE SURE THE FOLLOW-UP, IF PEOPLE AREN'T GETTING SOUND IS HAPPENING PROPERLY. YOU'VE GOT A BETTER SENSE OF SCREENING THAN I DO.
>> JOHNNY: WHAT I WOULD RECOMMEND THAT WE PUT FORTH IS A SET OF BEST PRACTICES. IT'S NOT THIS PIECE AND THAT PIECE AND EVEN WHAT YOU WERE SAYING, YOU ISSUE IS TRAINING OF YOUR STAFF. SO THERE IS AN ARRAY OF THINGS THAT NEED TO BE BROUGHT INTO A RECOMMENDATION AND BEST PRACTICES IS WHAT I WOULD SUPPORT AND NOT TALK ABOUT THIS, THAT, WHATEVER AND COST

IS A FACTOR, OF COURSE, BUT BEST PRACTICES AND THERE ARE CERTAINLY SOME REFERENCES OUT THERE FOR THEM.

>> CRYSTAL: I WOULD BE HAPPY TO HEAR ABOUT THE BEST PRACTICES AND THE COST BECAUSE LIKE SHELLEY WAS JUST TALKING ABOUT, WE ALL CAN USE THE AUDIOMETER AND WE HAVE THE ISSUES WITH AMBIENT SOUND AND IF THERE'S A CHEAPER WAY TO DO IT THAT IS AS GOOD OR BETTER THAN WHAT WE'RE DOING IN THE PRIMARY CARE OFFICE, WE WOULD BE HAPPY TO HEAR THAT AND ADJUST OUR PRACTICES TO BE EFFECTIVE AND NOT INCREASE THE COST TO THE CLINIC OR THE PATIENT.

>> SHELLEY: WE JUST WANT TO MAKE SURE IT CAN BE DONE RIGHT.

>> JOHNNY: AND YOU'RE NEVER GOING TO CHANGE THE BACKGROUND NOISE IN YOUR OFFICE.

>> ROB: I THINK WE HAVE SOMETHING TO WORK ON FOR THAT QUESTION. THIS NEXT ONE GETS TO-- WE TALKED ABOUT INCORPORATING THE UNIVERSAL DESIGNS AND SEEING IF THAT'S POSSIBLE IN RECONSTRUCTION AND NEW WINGS BUT THIS GETS THE PRESENTATIONS WE HAD LAST MONTH OF OF, IS THERE A WAY TO PUT IN PLACE UNIVERSAL DESIGN FUNCTIONS THIS ARE LOW COST OR HIGH COST BUT WE CAN SHOW THEIR LEVEL OF IMPACT? SO SOMETHING LIKE THIS I READ ON YOUR PRESENT THATION, TOVAH'S PRESENTATION THAT CHAIRS WITHOUT ARMS, SOMETHING AS SIMPLE AS THAT CAN IMPROVE CARE. LITTLE THINGS LIKE THAT, EDUCATING UNIVERSAL DESIGN FUNCTIONS THAT WE CAN PUT TOGETHER A BEST PRACTICES GUIDE, INFORMATIONAL GUIDE AND THEN AFTER HEARING SHELLEY TODAY, TOO, I THINK THIS ALSO CAN INCLUDE LIKE THE BATTERY THING YOU WERE TALKING ABOUT , SOMETHING AS SIMPLE AS MAKING SURE YOU HAVE THESE BATTERIES IN PLACE AND THE LESSONS LEARNED, I THINK, MAYBE SOMETHING LIKE THAT OF WHERE WE CAN HAVE THIS INFORMATION AND GIVE IT OUT TO THESE FACILITIES AND TO PROVIDE BETTER CARE. SO I WANT TO GET YOUR THOUGHTS ON THAT AND SEE IF THERE MAY BE A PARTNERSHIP, WHO BE A PART OF THAT PARTNERSHIP, AND THIS WOULD ALSO BE COUPLED WITH THE DESK SPACE -- THE DEAF SPACE ELEMENTS.

>> ADAM: THOSE ARE GREAT IDEAS AND I PROPOSE THAT WE COME UP WITH A LIST OF BEST PRACTICES THINK ABOUT THE MEMBERSHIP ASSOCIATIONS REPRESENTED IN THIS ROOM AND ON THE TASK FORCE, I THINK. THEY MIGHT NOT LISTEN TO US BUT THEY MIGHT LISTEN TO LEADING AGE, HEALTHCARE FACILITIES ASSOCIATION AND LISTEN TO THE HEALTHCARE ASSOCIATIONS AND I THINK WE HAVE THE RIGHT PARTNERS TO BE ABLE TO PROMOTE SOME OF THOSE BEST PRACTICES.

>> CRYSTAL: SORRY. WHEN YOU TALK ABOUT UNIVERSAL DESIGN, ONE OF THE THINGS I REALIZE NOW, WE'RE IN A PRETTY NEW PRACTICE. WE HAVE THE SOUND GOING INTO EACH PRACTICE THAT GIVES THE NOISE THAT YOU CAN'T HEAR WHAT'S GOING ON IN OTHER ROOMS AND ONE THING WE REALIZED TOO LATE IN THE PRACTICE IS WE NEEDED TO TURN IT OFF IN EACH PARTICULAR ROOM AND IF WE WANTED TO DO THE SCREENING, IT'S LITTLE THINGS LIKE THAT, IT WOULD REMIND PRACTICES AND ARCHITECTS TO DO IT IN A WAY YOU CAN DO IT WHERE IT'S UNIVERSAL DESIGN AND EVERYBODY WANTS IT.

>> ROB: YEAH. THANK YOU FOR THAT COMMENT. ASHLEY?

>> ASHLEY: YES THIS IS ASHLEY. UNIVERSAL DESIGN SOMETIMES CAUSES THINGS TO BECOME EVEN MORE FLAT THAN THEY NORMALLY ARE AND IN MY ENVIRONMENT, I NEED MORE OF A TOUCH ENVIRONMENT SO SOMETIMES TACTILE IS BETTER. SOMETIMES SIMPLE THINGS LIKE, FOR EXAMPLE, A KOHL BUTTON, I MIGHT HIT A CALL BUTTON AND I DON'T HEAR THE SOUND AND I DON'T HEAR ANYBODY RESPONDING TO THE CALL BUTTON SO I DON'T EVEN KNOW IF ANYBODY HAS HEARD MY CALL BUTTON, IF ANYBODY IS COMING. SO MAYBE THERE NEEDS TO BE A VIBRATION THAT LETS ME KNOW THAT SOMEBODY HEARD ME AND GOT ME AND THERE'S NEEDS TO BE A VISUAL SIGNAL THAT GOES ALONG WITH IT. JUST THINK ABOUT THOSE OTHER TYPES OF UNIVERSAL DESIGN ELEMENTS AND

INCLUDE TOUCH.
>> ROB: I'M NOT SURE IF THE BEST WAY GOING FORWARD IS FOR THE ASSOCIATION THAT WE HAVE IN THE ROOM KIND OF COME BACK WITH A LIST, OR DO YOU THINK THERE SHOULD BE CLOSER TO THE END AND ONGOING LIKE A WORKING GROUP, WE RECOMMEND A GROUP TO WORK ON THIS VERSUS HAVING THEM TO THE TASK FORCE BY THE NEXT MEETING?
>> ADAM: I GUESSED QUESTION IS, DO WE KNOW WHAT THE CORE UNIVERSAL DESIGN FEATURES ARE? IS IT JUST A QUESTION OF PUSHING THOSE OUT, OR DO WE NEED TO BETTER UNDERSTAND THEM? I'M NOT SURE THAT I KNOW THE ANSWER TO THAT.
>> TOVAH: TOVAH HERE. I BELIEVE I MENTIONED SOME REFERENCES FOR UNIVERSAL DESIGN PRINCIPLES AND IDEAS AND SUGGESTIONS SO PERHAPS IN TERMS OF BEST PRACTICES, WE KIND OF IDENTIFY PROBABLY LOW COST OR UNIVERSAL DESIGN CHANGES THAT CAN BE MADE TO EXISTING FACILITIES OR, YOU KNOW, FURNITURE OR WHATEVER VERSUS NEW BUILDINGS AND NEW CONSTRUCTION BECAUSE WITH NEW CONSTRUCTION, YOU DO HAVE SOME WEIGHT ACCESSIBILITY LAWS. NOT JUST RAMPS, BUT ALSO LIGHTING AND TEXTURE AND SOUNDPROOFING AND OTHER KINDS OF THINGS THAT WOULD BENEFIT EVERYONE NOT JUST DEAF OR HARD OF HEARING PEOPLE.
>> MARK: THIS IS MARK. JUST TO ADD ONTO TOVAH'S POINT AND TO MAYBE ADD ONTO A COMMENT THAT I MADE EARLIER IF WE'RE GOING TO ASK FOR NEW PUBLIC BUILDINGS TO HAVE LISTING DEVICES THAT ARE BAKED INTO THEIR INFRASTRUCTURE, THE STATE BUILDING CODE IS A GREAT PLACE TO PUT IT. THAT STILL REMAINS TRUE BUT ANOTHER ONE THAT I JUST THOUGHT OF THIS WE OUGHT NOT LOSE SIGHT IS THAT LOCAL MUNICIPALITIES CAN ALSO ADOPT THEIR OWN CODES AND SOMETIMES THEY CAN ACT A LOT FASTER THAN THE STATE AND CERTAINLY A LOT FASTER THAN FEDERAL GOVERNMENT AND THEY ALSO, YOU KNOW, ARE RESPONSIBLE FOR A NUMBER OF LOCAL BUILDING PROJECTS.
>> ROB: THANK YOU. ANY MORE COMMENTS ON THIS QUESTION?
>> ADAM: THIS IS PROBABLY A QUESTION FOR YOU, LISE. I APPRECIATED YOUR PRESENTATION AND REALIZED HOW CONFUSED I AM ABOUT THE WIDE AREA TRANSMITTER ISSUE AND THINKING ABOUT HOW THAT WORKS AND WHO IT'S FOR. SO IF I WAS HARD OF HEARING CONSUMER AND I HAD A HEARING AID AND I WALKED INTO A BUILDING, SOMEBODY WOULD NEED A TRANSMITTER FOR IT TO BE TRANSMITTED TO MY HEARING AID AND THEY WOULD HAVE TO KNOW TO GRAB THE TRANSMITTER AND MAYBE IF THERES WITH A PA BROADCAST THAT WOULD GO THROUGH MY HEARING AID. I DON'T KNOW UNDERSTAND THIS TECHNOLOGY VERY WELL.
>> LISE HAMLIN: WHAT HAPPENS IS I'M USING A MICROPHONE.
THIS IS A MICROPHONE AND A TRANSMITTER. SO THAT TRANSMITS INTO MY RECEIVER. THAT'S NOT MY RECEIVER.
[LAUGHTER]
THESE ARE MY CARDS IF ANYBODY WANTS CARDS. MY RECEIVER. SO THAT TYPE OF SYSTEM HAS TO HAPPEN-- I JUST LOST SOMETHING. I HAVE TO GO BACK. FOR THOSE OF YOU AUDIOLOGISTS, YOU KNOW I'M SWITCHING AROUND PROGRAMS SO I CAN HEAR AGAIN . TECHNOLOGY, LOVE IT AND HATE IT AT THE SAME TIME. SO WHEN I WALK IN, IF THEY'VE INSTALLED AN INFRARED SYSTEM OR FM SYSTEM, I NEED SOMEBODY TO USE THE MICROPHONE AND RECEIVER, TURN IT ON AND I NEED TO TURN ON MY-- EXCUSE ME, MY TRANSMITTER. THEY HAVE THE MICROPHONE TRANSMITTER. I HAVE THE RECEIVER, I NEED TO HAVE THAT. IF YOU WALK INTO A LOOPED ROOM, MY HEARING AID AND MY COCHLEAR IMPLANT BECOME THE RECEIVER. BUT YOUR SPEAKER STILL HAS TO USE A MICROPHONE. SO IT DOESN'T COME OUT OF NOWHERE. THEY HAVE TO TRANSMIT THAT SIGNAL TO ME. YES, ABSOLUTELY AND THAT'S WHERE ASKING FOR AN ACCOMMODATION MAKES THE DIFFERENCE AND IN THE

HEALTHCARE SETTING, YOU SHOULDN'T HAVE TO ASK OR IF YOU HAVE DEMENTIA, YOU'RE GOING TO WALK INTO A ROOM, YOU SHOULDN'T HAVE TO ASK FOR IT, BUT SOMEBODY NEEDS TO KNOW THAT THEY HAVE TO USE IT AND THAT THE PERSON, IF THEY HAVE DEMENTIA TO TURN ON OR GIVE THEM A RECEIVER THEY CAN USE OR IF THEY DON'T HAVE DEMENTIA, SOMEBODY SAYS, OKAY, YOU'RE -- I'M GOING TO A COMMON ROOM AND I NEED-- THEY'RE HAVING A BINGO GAME AND I NED TO HEAR, BUT BOTH PEOPLE HAVE TO USE IT. SO YES, THAT'S HOW IT WORKS. IT'S PRETTY SIMPLE, BUT YOU HAVE TO KNOW.

>> ROB: ANY OTHER COMMENTS ON THIS QUESTION? ON THIS ONE SPECIFICALLY, TOO, I WOULD APPRECIATE IF ANYONE HAS ANY BEST PRACTICES OR RESEARCH ON UNIVERSAL DESIGNS AND I'LL TRY TO COME UP WITH A RECOMMENDATION THAT WE CAN WORK ON NEXT MONTH THAT INCORPORATES THAT INFORMATION. SO WE'LL MOVE ONTO QUESTION FOUR. IS THERE ANY LINKAGE BETWEEN HEARING LOSS AND CHRONIC DISEASES IS WE RECENTLY MET WITH THE MEDICAL BOARD AND THAT WAS DAVID HENDERSON WHO WAS AT OUR LAST TASK FORCE MEETING INVITED US THERE AND THEY-- WE TOLD HIM ABOUT-- WELL, THE DIVISION'S ISSUE OF NOT GETTING HIGH ATTENDANCE AT CERTAIN TRAININGS, WHETHER IT BE AROUND THE ADA OR WHATEVER IT BE, SO THEY HAD A SUGGESTION OF OFFERING INFORMATION ABOUT THIS TASK FORCE IN SMALL BITS AND THEY THINK THAT MAY BE A BETTER WAY TO GET IT IN FRONT OF PROVIDERS, MORE PROVIDERS, AND IN A MORE EFFECTIVE WAY AND THIS WOULD BE SOMETHING LIKE THEIR OPIOID TRAINING, THEY WOULD ACCEPT ONE OR TWO SLIDES AT&PUT IT THE AT THE END OF THAT INTRAING AND DO A SIMPLE FYI AT THE END OF THEIR TRAININGS THAT ARE MORE WELL ATTENDED AND GIVE THIS INFORMATION TO A LARGER GROUP OF PROVIDERS AND I THOUGHT ALONG WITH THE ADA, THINGS LIKE THIS LINKAGE AND SIMILAR PRESENTATION CAN ALMOST BE ONE OF THOSE SLIDES THAT WE END UP GENERATING AND HAVE THE UNIFORM SLIDES THAT WE CAN SEND TO THEM ON A TIME PERIOD AND HAVE THEM USE THOSE SLIDES DURING THAT PRESENTATION FOR THAT TIME PERIOD. ANY COMMENTS ON THIS?

>> TOVAH: I NEVER THOUGHT THAT IN ANY CONFERENCE OF ANY GROUP OF PROFESSIONALS THAT JUST TALKING ABOUT ADA WAS ENOUGH. I THINK THAT, PERSONALLY I THINK THERE SHOULD BE A REQUIREMENT. LIKE THE ETHICS REQUIREMENT, YOU KNOW, EVERY LICENSED GROUP HAS TO HAVE AN ETHICS, NUMBER OF HOURS OF ETHICS IN ORDER TO GET LICENSED, RIGHT? SO WHY NOT MAKE IT 'REQUIREMENT THAT YOU HAVE TO TAKE SO MANY HOURS ACCESSIBILITY AND NOT JUST ADA, BUT ALSO MAYBE PRACTICAL ISSUES LIKE WHAT CAN A PRACTICE DO TO IMPROVE ACCESSIBILITY IN CERTAIN AREAS, NOT JUST FOR PEOPLE IN WHEELCHAIRS BUT VISUAL IMPAIRMENT, HEARING IMPAIRMENT, COGNITIVE IMPAIRMENT AND IT CAN BE NOT JUST DEAF ISSUES BUT ANY OF THE ISSUES BUT EVERY YEAR, I PERSONALLY THINK THEY SHOULD HAVE SOME REQUIREMENTS THAT EVERY YEAR SOME COURSE IN ACCESSIBILITY IS NEEDED FOR LICENSURE.

>> VICKIE: I'VE BEEN GOING TO A LOT OF MEETINGS WITH EMERGENCY MANAGEMENT BECAUSE IT'S HURRICANE SEASON, AND ONE OF THE THINGS THAT THEY TALK ABOUT ALL THE TIME IS SOMETHING CALLED JUST-IN-TIME TRAINING, AND IT'S SIMPLE THAT YOU CREATE A SERIES OF SHORT VIDEOS OR PIECES SO THAT-- AND YOU CREATE A LIBRARY THAT'S ACCESSIBLE TO FOLKS SO THAT WHEN SOMEONE WALKS IN THE DOOR, THEY CAN SAY, OH, I HAVE JUST-IN-TIME TRAINING FOR THIS TYPE OF INDIVIDUAL OR SITUATION AND THEN THEY LOOK IT UP AND IT'S LIKE TWO OR THREE, FOUR OR FIVE MINUTES OF REMINDERS, TIPS, TO DRAW ON PEOPLE'S MEMORY BECAUSE I'M SURE THAT MY FAMILY POSITION-- PHYSICIAN HAS A LOT ON HER MIND ALL THE TIME. SO MAYBE THINKING ABOUT A SERIES OF JUST-IN-TIME.

>> EILEEN: HI. THERE'S A COUPLE OF DIFFERENT VENUES THAT THIS COULD REALLY BE EXPANDED. SO

THE STATE HAS AREAS CALLED AHEC, AREA HEALTH EDUCATION CENTERS, THAT ARE ACROSS THE STATE. THEY PROVIDE CONTINUING MEDICAL EDUCATION, TO NOT JUST MEDICAL PRACTITIONERS BUT ALSO NURSES AND HOSPITALS, PRIMARY CARE PHYSICIANS, PRIVATE PRACTITIONERS, GO TO IT, AND THAT IS A GREAT VENUE TO PROVIDE EDUCATION AND INFORMATION NOT JUST ON ACCESSIBILITY OR ADA, BUT ALSO THE IMPLICATIONS ON OVERALL HEALTH. ESPECIALLY SINCE SOCIAL DETERMINANTS OF HEALTH IS A HUGE LINE ITEM NOW THAT PEOPLE ARE TALKING ABOUT AND LOOKING INTO IN ALL OF THESE DISABILITIES AND/OR COMORBIDITIES INTERPLAY INTO EACH OTHER ESPECIALLY AS THE POPULATION AGES. AGAIN, POPULATION HEALTH IS A BIG HOT TOPIC ITEM. SO THIS WHOLE DISCUSSION COULD BE EXPANDED ACROSS THE STATE AND THE OTHER PLACE THAT IT WOULD BE REALLY BENEFICIAL IS IN THE FIRST RESPONDERS SO PARAMEDICS, BECAUSE THOSE PEOPLE ARE OFTENTIMES FIRST ON THE SCENE AND IF THEY DON'T RECOGNIZE THAT PATIENT MAY BE HARD OF HEARING, DEAF, VISUALLY IMPAIRED AND ALL OF THE ABOVE, THAT COULD CERTAINLY IMPACT HOW THEY MANAGE THAT PATIENT AND THOSE CRITICAL FIRST MOMENTS. I THINK NOT JUST FOCUSING ON PRIMARY CARE PHYSICIANS BUT EXPANDING THAT TO ALL TYPES OF DIFFERENT HEALTHCARE PROVIDERS AND FIRST RESPONDERS WILL GET MUCH BETTER IMPACT.
>> JAN: IF I CAN FOLLOW UP ON HER COMMENT ABOUT THE AHEC. JUST VERY QUICKLY, I HAVE A QUICK COMMENT ABOUT AHEC. WE AT THE DIVISION OF SERVICES FOR THE DEAF AND HARD OF HEARING WERE ABLE TO ESTABLISH A TRAINING THROUGH AHEC, AND WE DID DO SEVERAL TRAININGS THROUGH SEVERAL DIFFERENT AHECs ACROSS THE STATE. IN SOME AREAS THEY WERE SUCCESSFUL. IN SOME AREAS, WE JUST DID NOT GET ENOUGH ATTENDANCE OR INTEREST. IT WAS KIND OF A MIXED BAG. WE'RE NOT SURE WHY. WE HAVEN'T YET REACHED A TIPPING POINT WHERE THERE'S ENOUGH UNDERSTANDING FROM PEOPLE THAT THEY NEED TO COME TO THE TRAINING. SO WE HAVE DECIDED TO RETHINK OUR APPROACH. SO I JUST WANTED TO LET YOU KNOW THAT IT HAS BEEN A CHALLENGE FOR US. WE ARE TRYING TO GO WHERE PEOPLE ARE ALREADY GOING TO TRAINING AND THEN TRYING TO TAG ON THIS ISSUE TO THAT TRAINING WHERE THEY ALREADY ARE.
>> HOLLY: HOLLY RIDDLE, DHHS. I THINK MOST OF YOU WHO KNOW ME HEARD ME SAY THIS SO MANY TIMES. I LOOK FORWARD TO THE STATE OF NORTH CAROLINA ADOPTING COMPETENCY-BASED TRAINING IN SOME OF THE SETTINGS THAT WE'VE BEEN TALKING ABOUT TODAY. PARTICULARLY OUR LONG-TERM CARE SETTINGS. WHEN WE HAVE COMPETENCY-BASED TRAINING AND WE DELIVER THAT ONLINE IN A CONSISTENT FASHION ACROSS THE STATE TO OUR FRONTLINE WORKFORCE IN HEALTHCARE, NOT ONLY CAN WE ENSURE THAT STAFF WHERE A GREAT DEAL OF TURNOVER GETS THE MESSAGE BUT ALSO, FOR EXAMPLE, IF SHELLEY AND I WERE TO GO HOME TONIGHT AND WRITE A CURRICULUM, WE CAN DROP THAT CURRICULUM ACROSS THE STATE AND REQUIRE STAFF TO TAKE THAT PARTICULAR CLASS LITERALLY IN 24 TO 48 HOURS. I SO LOOK FORWARD TO US FINDING A WAY TO DO THIS. MANY, MANY STATES HAVE ADOPTED CURRICULA AND YOU CAN TAKE EXISTING, EXISTING PLATFORMS AND WRITE COURSES. I CAN JUST SEE TOVAH WAX WRITING A COURSE. YOU GUYS, AND INSERT IT ONTO A PLATFORM THAT IS ALREADY EXISTING. THANK YOU.
>> ADAM: I'M GOING TO GIVE IT BACK TO YOU, HOLLY. WHAT'S THE BARRIER TO ADOPTING CURRICULUM-BASED COMPETENCY FOR STAFF? WHY HAVEN'T WE DONE IT?
>> HOLLY: MARK BENTON, I'D LIKE TO KEEP MY JOB.
[LAUGHTER]
ADAM, I THINK THE DIFFICULTY HAS BEEN TRYING TO FIND A PAYOR. IN SOME STATES, AN ENTITY LIKE DHHS HAS ELECTED TO PURCHASE A CURRICULA AND DROP IT DOWN. WE DO HAVE PROVIDERS IN THE STATE THAT USE CURRICULUM THAT ARE COMPETENCY-BASED. OTHER PROVIDERS DO NOT USE THOSE

CURRICULA. THE QUESTION BECOMES SHOULD THE STATE PAY, SHOULD THE LMCAOs PAID, SHOULD THE PROVIDER, THEMSELF, PAY? I THINK THAT'S THE ANSWER. THANK YOU, MARK, FOR LETTING ME KEEP MY JOB.
[LAUGHTER]
>> ADAM: DIPLOMATICALLY PUT.
>> ADAM: I WANT TO REFLECT BACK ON A COUPLE OF COMMENTS. I THINK IDENTIFYING THE BEST AND MOST EFFECTIVE ROUTE FOR PROFESSIONAL EDUCATION IS LIKE AN ONGOING THING THAT WE STRUGGLE WITH AND SORT OF EVERY TASK FORCE THAT WE HAVE. WE HAVE KIND OF A FORMULA. I DON'T THINK IT'S VERY SATISFYING TO ME OR TO MOST FOLKS IN THE ROOM. TOVAH, YOU MAKE A REALLY GOOD POINT. SOMEBODY WANTS TO LOBBY FOR, YOU KNOW, REQUIRED TRAINING IS A PART OF LICENSURE AND EVERY TASK FORCE. IF YOU ALL TELL US TO DO THAT, WE'LL MAKE THAT RECOMMENDATION. IT NEVER GOES ANYWHERE. THE ONLY REQUIRED TRAINING FOR ONGOING LICENSURE FOR PHYSICIANS IS THREE HOURS EVERY THREE YEARS ON OPIATES AND THAT TOOK A LONG TIME AND A LOT OF DEATHS TO GET TO THAT. WE HAVE NO ONGOING ETHICS REQUIREMENTS. WE HAVE 50 HOURS PER YEAR TOTAL BUT NO OTHER SPECIFIC REQUIREMENTS, AND WE'VE, YOU KNOW, I DON'T KNOW, WE'VE TALKED ABOUT SPECIFIC REQUIREMENTS AROUND INTERPERSONAL VIOLENCE, SUBSTANCE USE, ALCOHOLISM, CHILD ABUSE AND PROBABLY LOTS OF--
>> EVERY SINGLE TASK FORCE.
>> EVERYBODY WANTS THIS AND IT'S FINE. I AGREE AND THE ISSUE I'M WORKING ON THIS YEAR IS THE MOST IMPORTANT ISSUE. SO I THINK THAT WE CAN MAKE A CASE FOR IT, BUT I DON'T THINK IT'S LIKELY TO GO ANYWHERE. YOU NO, I'M A LITTLE BIT WORRIED LIKE IN A SCENARIO THAT YOU'VE PROPOSED, JAN, THIS WE DON'T GET ENOUGH PEOPLE TO SIGN UP. I'M A LITTLE BIT WORRIED THAT IN ADDING A SLIDE TO THE END OF THE OPIOID TRAINING, NOBODY IS REALLY PAYING ATTENTION. DOING THINGS THAT ARE OVERLY AUTOMATED. SO THIS IS SOMETHING THAT HAS COME UP IN THIS ROOM. WHAT ABOUT PART OF ORIENTATION FOR HOSPITAL STAFF? AND SO, YOU KNOW, USUALLY A NEW NURSE MIGHT HAVE SOME NUMBER OF HOURS OF NEW ORIENTATION AND YOU MIGHT MAKE IT PART OF, YOU KNOW, ANNUAL TRAINING, PHYSICIANS THAT OUR HOSPITAL STAFF DO IT TOO. THE PROBLEM IS PEOPLE DON'T PAY ATTENTION. IT'S NOT ACTIVE ADULT LEARNING.
IT'S SOMETHING PEOPLE DO PASSIVELY. I'M SORT OF WONDERING ABOUT,-THE PLACE THAT I THOUGHT YOU WERE GOING THROUGH BITE-SIZED, IS THERE A WAY TO PRESENT THIS IN SOCIAL MEDIA. SO THINK ABOUT ACADEMY OF FAMILY PHYSICIANS, THEY HAVE SOCIAL MEDIA. THE NORTH CAROLINA NURSE'S ASSOCIATION, THEY HAVE SOCIAL MEDIA SO ASK THEM TO DO TWEETS ABOUT THIS OCCASIONALLY. ASK THEM TO INCORPORATE BITS IN THEIR NEWSLETTER, ASK THEM TO HAVE TRAINING ON ADA, AS PART OF THEIR CONTINUING EDUCATION AND I WONDER IF THIS IS THE KIND OF THING WHERE WE NEED MULTIPLE AVENUES OR SORT OF MUTUALLY REINFORCING SOLUTIONS. I SAW VICKIE FIRST AND THEN EILEEN AND THEN TOVAH.
>> I GUESS THAT'S WHAT I WAS GETTING AT WITH THE JUST-IN-TIME TRAINING. YOU COULD DO SOMETHING LIKE-- THERE'S TWO PROGRAMS OUT ON THE MARKET, TOONLY AND DULY AND IF YOU WATCHED ROBERT REICH EXPLAIN SOMETHING, THAT'S EXACTLY WHAT HE'S USING. IT'S LIKE TWO TO THREE MINUTES EXPLANATION, VERY SIMPLE BREAKDOWN, AND THE IDEA THAT WE'RE TRYING TO USE ON THE DISASTER RESPONSE SIDE IS LET'S SAY WE'RE SENDING PEOPLE INTO A SHELTER WHEN THEY GET THERE, WE WANT TO ENCOURAGE THEM TO OPEN IT UP, JUST GET A QUICK REFRESHER, AND THEN GO IN. IT'S NOT GOING TO BE THE ONLY THING, BUT IT'S LIKE IN THE MOMENT WHEN YOU HAVE TO USE IT, YOU TAKE TWO OR THREE MINUTES AND GET PROMPTED.

>> ADAM: I TOTALLY AGREE AND THAT'S A GREAT IDEA. YOU NEED TO GET IT IN FRONT OF PEOPLE REGULARLY ENOUGH SO YOU REMEMBER IT EXISTS WHEN THEY NEED. TOTALLY GOOD IDEA. LOVE IT. EILEEN.

>> EILEEN: EILEEN CARTER WITH THE NORTH CAROLINA PHYSICAL THERAPY ASSOCIATION. I'M CO-CHAIR WITH A DIVERSITY TASK FORCE. WHAT I'M GATHERING FROM US, OUR EXPERTS TODAY IS ACTUALLY GOING TO BE PRESENTED TO OUR LICENSURE-- NOT OUR LICENSURE, BUT IT'S HE DIDDING TO BE PART OF THAT, TO OUR BOARD OF THE NORTH CAROLINA PT ASSOCIATION. SO I SEE THIS AS A GRASSROOT LEVEL BUT JUST-IN-TIME TRAINING, TAKE IT TO FOR PHYSICAL THERAPY IN THE STATE OF NORTH CAROLINA, WE HAVE DISTRICTS SO WE GO TO EACH DISTRICT. WE DO A JUST-IN-TIME VIDEO TRAINING. THEY GET CONTINUED COMPETENCY FOR OUR LICENSURE, FOR PTs AND PTAs, IT'S TIME DIFFERENCE.

IT'S NOT ABOUT CONTINUING ED, BUT IT'S ABOUT DOING THINGS IN THE COMMUNITY.

THIS IS LIKE COMMUNITY SERVICE WHERE WE DO THE DOG AND PONY TRAINING WITH THE JUST-IN-TIME TRAINING AND TAKE IT THERE AT GRASSROOTS AND I SAY GO STATEWIDE. I CAN'T SPEAK FOR OT AND SPEECH OR AUDIOLOGIST BUT AS A HEALTHCARE PROVIDER I SEE IT GOING STATE AND THEN OUR NATIONAL. WE ACTUALLY HAVE TWO SEPARATE MEETINGS THAT HAPPEN THROUGHOUT THE UNITED STATES TWO TIMES DURING THE YEAR AND IN OUR COMBINED SECTIONS MEETING, IT CAN BE A COLLABORATION OF OUR TEAM IN PRESENTING TO THOUSANDS. I'M TALKING 15 PLUS THOUSAND PTs AND PTAs ACROSS THE NATION. IT COULD BE THOUSANDS OF OTs. SO WE COULD ACTUALLY DO THIS AS A COLLABORATION, STARTING AT THE GRASSROOT, GOING TO THE STATE LEVEL AND THEN GOING NATIONAL. SO IT COULD BE A BLOSSOMING MUSHROOM EFFECT. THANK YOU.

>> TOVAH: I REALLY THINK THAT JUST HAVING AN HOUR ABOUT ADA IS NOT ENOUGH. IT'S NEVER ENOUGH. I THINK MUCH MORE TO THE POINT IS SOMETHING VERY PRACTICAL LIKE JUST-IN-TIME THING, OR YOU KNOW, SOME EASY WAY OF GETTING QUICK INFORMATION WHEN IT IS NEEDED. I THINK THE PRACTICAL ASPECT IS WHAT WE NEED TO BE LOOKING AT BECAUSE, YOU KNOW, LIKE WE WERE TALKING AT LUNCH, PEOPLE GET BUSY AND THEY GO TO A LECTURE AND GET ININTIERED TO COME HOME. THEY GET CAUGHT UP IN INSURANCE PROBLEMS OR THEY HAVE 50 PATIENTS THEY HAVE TO SEE IN 20 MINUTES. YOU KNOW, IT GETS LOST BY THE WAYSIDE. I THINK VERY PRACTICAL. ADA, YEAH, I KNOW, I KNOW, ADA, YEAH, YEAH, BUT IT'S MORE ABOUT I GOT A PERSON HERE WHO JUST WALKED IN WHO IS DEAF. WHAT DO I DO NOW? I THINK THAT IS THE ANSWER THAT PEOPLE NEED ALMOST IMMEDIATELY. I THINK THAT IS A VERY STRONG RECOMMENDATION, VERY PRACTICAL TO-DOs.

>> ASHLEY: YES. THIS IS ASHLEY. I HEARD ONE OF THE THINGS THAT JOHN-- JUST-IN-TIME TRAINING YOU WERE TALKING ABOUT AND THAT DEFINITELY MATCHES WITH IT SO TODAY. PEOPLE ARE USED TO QUICK BITES OF INFORMATION THROUGH SOCIAL MEDIA, THROUGH GOOGLE AND SOMETIMES THOSE THINGS STICK ESPECIALLY IF YOU LOOK UP SOMETHING PARTICULARLY THAT YOU'RE INTERESTED IN AND SOMETIMES THAT'S WHAT HAPPENS, BUT WHAT WE NEED TO THINK ABOUT IS IF THEY SAY IN THE MOMENT SOMEBODY SAYS, OH, I NEED AN INTERPRETER. IF THEY CAN LOOK UP SOMETHING VERY QUICKLY, IT'S GOING TO HELP IT STICK IN THEIR BRAIN. I THINK IT MIGHT HELP THE MEDICAL PROVIDERS GET MORE INVOLVED IF THEY HAVE THAT MOMENT WHERE THEY'RE ACTUALLY ENGAGED IN WHAT'S GOING ON. WE DO A TRAINING WITH OUR DIVISION THAT'S CALLED A DIFFERENT, DIFFERENT WORLD, THAT WE DID THE VERY FIRST TASK FORCE MEETING WHICH PUTS YOU IN THE SHOES OF WHAT IT'S LIKE TO HAVE THAT EXPERIENCE AND I THINK IF PEOPLE HAVE THAT EXPERIENCE, THEN THAT KIND OF MAKES THAT WAY FOR THEM OF KNOWING EXACTLY WHAT THEY'RE GOING TO HAVE TO ENCOUNTER AND SO THAT HELPS THEM BE A LITTLE BIT MORE PROACTIVE OF SETTING

THINGS IN PLACE.
>> JAN: THIS IS JAN. THIS HAS BEEN A FANTASTIC DISCUSSION. AND I WAS ALSO TALKING ABOUT THIS WITH MY STAFF, THIS TASK FORCE, AND HOW COULD WE REALLY DEVELOP THE KIND OF TRAINING THAT WOULD BENEFIT THE HEALTHCARE PROVIDERS? WE ALREADY PROVIDED SOME TRAINING LIKE I MENTIONED. BUT AS WE REALLY DELVE DEEPER INTO HEALTHCARE AND INFRASTRUCTURES, WE'VE REALIZED THAT WE NEED TO REALLY ENGAGE THE RIGHT PEOPLE FROM THE HEALTHCARE SYSTEM, TO LOOK AT THIS, LOOK AT WHAT WE DEVELOPED, THE CONTENT AND HOW IT MATCHES UP WITH WHAT THEY PROVIDE, AND THE FORMAT THAT WE USE, AND WHAT WOULD WORK WITH THEIR PEOPLE. THERE'S SO MANY QUESTIONS RELATED TO THAT. SO WHO WOULD BE THE BEST PEOPLE TO HELP US US ENGAGE WITH THE HEALTHCARE SYSTEM TO DEVELOP THIS TYPE OF TRAINING THAT WE CAN USE. I DO LIKE THE IDEA OF JUST-IN-TIME THAT YOU HAD MENTIONED. THAT'S GOOD. BUT WHAT ABOUT THE ATTITUDES AS WELL? YOU KNOW, LIKE, OH, GOSH, I HAVE TO TAKE ANOTHER TRAINING AND NOW I HAVE TO GET AN INTERPRETER FOR THIS, THAT'S NOT GOING TO ADDRESS THAT. SO THERE'S OTHER THINGS TO THINK ABOUT. THERE'S MORE LAYERS TO IT.
>> BERKELEY: I WAS GOING TO SAY MEETING THE MEDICAL BOARD AND HEARING FROM PEOPLE IN THE ROOM, I THINK THERE'S A LOT OF WILLINGNESS TO WORK WITH YOUR DIVISION, JAN. I THINK IT'S SOMETHING THAT A LOT OF OUR PROFESSIONAL ASSOCIATIONS AND PROFESSIONALS WE'RE JUST NOT AWARE OF. AND SO SITTING IN THE ROOM HAS MADE THEM MORE AWARE AND THEY THINK THEIR FELLOW ASSOCIATIONS WOULD BE PERFECTLY WILLING TO ENGAGE AND THINK ABOUT WHERE THE EDUCATION IS. IF IT'S NEWSLETTERS, IF IT'S INCORPORATING IT INTO OTHER PRESENTATIONS, IF IT'S FIGURING OUT LITTLE BITES OF INFORMATION. I THINK WHAT WE'VE HEARD IS A WILLINGNESS TO ENGAGE, BUT A LOT OF GUIDANCE NEEDED FROM THE DIVISION TO HELP THEM FIGURE OUT WHAT IS THE MOST IMPORTANT THING TO GET TO PEOPLE. IF WE CAN GET THEM SOMETHING IN 30 SECONDS, WHAT'S THE RESOURCE THAT HAS MORE IN-DEPTH INFORMATION ABOUT HOW TO GET INTERPRETERS AND DIFFERENT QUESTIONS THEY MIGHT HAVE. AS A RECOMMENDATION, WE CAN CERTAINLY ENGAGE BOTH THE HEALTHCARE ASSOCIATION AND THE PROFESSIONAL ASSOCIATIONS AROUND THIS ISSUE.
>> HILLY COUGHMAN WITH THE NORTH CAROLINA NURSES ASSOCIATION. IRHAVEN'T THOUGHT OF THIS IDEA BEFORE BUT LISTENING TO PEOPLE TALK ABOUT THE JUST-IN-TIME SOUNDS REALLY GOOD BECAUSE I WORKED WITH NURSING STUDENTS THIS YEAR, 20-YEAR-OLDS, 19 YRBLED-- 19-YEAR-OLDS AND BELIEVE ME, THAT'S WHERE THEY'RE GETTING THAT INFORMATION. THEY'RE GETTING ON THAT INTERNET, ON THEIR CELL PHONES OR ON THE COMPUTER PICKING UP TWO MINUTES OF INFORMATION. AND SO I THINK THAT THE NORTH CAROLINA INSTITUTE OF MEDICINE MIGHT BE THE PLACE TO COMPILE JUST IN TIME, A WHOLE SITE. NO, BECAUSE THEN-- BECAUSE THEN EVERYBODY-- YOU COULD DO IT ON DISABILITIES. YOU COULD DO IT ON-- I DON'T KNOW. A LOT OF DIFFERENT HEALTHCARE ISSUES SO THAT WHEN IT DOES COME UP, IT WOULD BE ONE WEBSITE AND EVERYBODY WOULD SAY, OH, I KNOW NORTH CAROLINA INSTITUTE OF MEDICINE, GO THERE AND THEY'VE GOT INFORMATION ON DEAFNESS OR BLINDNESS OR DIABETES OR, YOU KNOW, DIFFERENT KINDS OF THINGS, INSULIN PUMPS, THAT WE DON'T HAVE OTHERWISE BECAUSE IF WE HAVE TO GO AND JUST FISH ON THE INTERNET AND THE OTHER THING IS THAT YOU CAN BE THAT-- SOMEBODY SAID LIKE THAT FOCAL POINT BECAUSE YOU COULD UPDATE IT REGULARLY. THERE'S A LOT OF STUFF ON THE INTERNET THAT GETS-- LIKE EVEN WITH THE TECHNOLOGY'S CHANGING SO FAST FOR DEAF AND HARD OF HEARING THAT, YOU NO HE, WHATEVER'S ON THERE THIS MONTH IS GOING TO BE OUTDATED BY NEXT YEAR AND SO SOME KIND OF LOCAL, MAJOR OUTLET FOR THAT KIND OF INFORMATION, I THINK, WOULD BE GOOD.

>> STEVE: I CAN AGREE WITH THAT. I JUST RETIRED FROM SAS AND LIKE MOST LARGE CORPORATIONS THEY HAVE A COUPLE OF VERY HOT BUTTONS THAT THEY NEED TO HAVE ALL THEIR EMPLOYEES BE CERTIFIED IN AND TYPICALLY, IT'S SEXUAL HARASSMENT AND, SAY, ETHICS. SAS HAD SHORT VIDEOS AND IT WAS IN AN APP. IT WASN'T IN A WEB PAGE, BUT IT COULD BE IN EITHER ONE. SO A SPECIAL APPLICATION YOU RAN ON YOUR COMPUTER. THEY STREAMED IT DOWN TO YOUR COMPUTER AND SAID YOU HAVE TO WATCH THIS AND SOMETIME IN THE NEXT 30 DAYS AND NOW THESE WERE TYPICALLY 10 OR 15 MINUTES LONG, BUT THEY COULD BE TWO MINUTES LONG OR ONE MINUTE LONG ON JUST SHORTER TOPIC. IT'S POSSIBLE THAT THROUGH THE WEB OR THROUGH A PROGRAM OF SOME SORT, THOSE LITTLE TOPICS, THOSE LITTLE ONE, TWO, THREE-MINUTE LONG INTRODUCTION TO WHAT TO DO WHEN STORIES COULD BE NOT JUST AVAILABLE. THEY COULD BE REQUIRED TO SEE OCCASIONALLY AND THE SYSTEM WOULD KEEP RECORDS ON WHO HAS SEEN THEM AND REMIND YOU WHEN SOMEBODY HASN'T SEEN THEM. SO IT'S POSSIBLE THAT TECHNOLOGY CAN COME TO THE RESCUE HERE.
>> JOHNNY: I LOVE THE IDEAS YOU'RE DISCUSSING. SO I'M GOING TO THROW OUT A DIFFERENT ONE.
[LAUGHTER]
NOT INSTEAD OF. THE CARE PROJECT HAS PARTNERED WITH THE NORTH CAROLINA EDI PROGRAM TO DO A VARIETY OF THINGS THAT WOULD BETTER EDUCATE NOT ONLY PROFESSIONALS BUT CONSUMERS. WE JUST DID A CONFERENCE AND EVERYBODY ROLLS YOUR EYES, OH, BUT WE DID A REAL CULTURAL IMMERSION EXPERIENCE OVER A TWO-DAY PERIOD CALLED THE PARENT-PROFESSIONAL COLLABORATIVE. I WAS BANKING ON 100 PEOPLE COMING AND WE HAD 200 PEOPLE SHOW UP AND WE DID CONTINUING EDUCATION APPROVAL FOR EVERY PROFESSIONAL WHO ENTERED THE DOOR. SO WE MADE IT, HOPEFULLY, ATTRACTIVE TO ANYONE WHO WANTED TO COME BUT IT IT INVOLVED NOT ONLY PROFESSIONAL PRACTITIONERS WORKING WITH INDIVIDUALS WITH HEARING LOSS. IT ALSO INVOLVED INDIVIDUALS WHO ARE DEAF AND HARD OF HEARING. SO WE HAD EVERY REPRESENTATIVE THAT YOU COULD IMAGINE IN TERMS OF THE DEAF CULTURE AND THE HARD OF HEARING POPULATION TOGETHER FOR TWO DAYS TOGETHER, SEPARATED, WE DID MANY OF THE DIFFERENT KINDS OF THINGS, ALL TO SAY I THINK IF WE'RE LOOKING AT ALL KINDS OF OPTIONS THAT COULD BE SOMETHING THAT THE STATE OF NORTH CAROLINA COULD DO, COULD PUT TOGETHER AND INVOLVE, INVITE PROFESSIONALS FROM A BROAD SPECTRUM AS WELL AS INDIVIDUALS WHO ARE DEAF AND HARD OF HEARING FOR THAT EXPERIENCE.
>> ADAM: I LOVE THAT IDEA. I THINK ONE THING I WANTED TO PIGGYBACK ON THAT THAT I THINK HAS BEEN SO EFFECTIVE, NOT JUST FOR ME BUT FOR SOME OF THE PROFESSIONAL ASSOCIATIONS THAT HAVE BEEN INVOLVED IN THIS TASK FORCE IS HEARING SO MANY MEMBERS OF THE DEAF COMMUNITY. I THINK THAT THERE IS A HUMAN FACE AND I THAT I THAT HELPS PEOPLE UNDERSTAND THE BARRIERS TO GETTING CARE, LIKE, WHY CAN'T I JUST WRITE NOTES TO MY DEAF PATIENTS? I ACTUALLY UNDERSTOOD THAT TEN YEARS AGO AND I UNDERSTAND THAT SOME OF MY COLLEAGUES HAVEN'T FIGURED THAT OUT YET. I THINK HELPING WITH A HUMAN FACE AND HELPING PEOPLE UNDERSTAND SOME OF THE CHALLENGES. I WANT TO JUST TELL MILLY THAT WE'RE NOT GOING TO DO THAT.
[LAUGHTER]
SO THERE ARE SO MANY REASONS. PROVIDERS DON'T COME TO US FOR THAT KIND OF INFORMATION. WE DON'T HAVE THE EXPERTISE TO PRODUCE THAT INFORMATION. AND WE DON'T HAVE THE STAFF TO KEEP IT UP TO DATE. LIKE I THINK IT'S A REALLY GOOD IDEA. I WONDER IF IT'S THE JOB OF OUR PROFESSIONAL ASSOCIATIONS, OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND SO I WAS VOLUNTOLD, I WILL VOLUN IT'S TOLD THE PERSON NEXT TO ME. I DIDN'T WANT PEOPLE TO WALK OUT

THINKING THAT THE NORTH CAROLINA INSTITUTE OF MEDICINE AGREED TO THAT. HAND UP HERE.
>> BETH HATHAWAY WITH THE NORTH CAROLINA OT ASSOCIATION. SO I WANT TO PIGGYBACK WHAT YOU SAID ABOUT HOW MUCH I'VE LEARNED JUST FROM SITTING HERE AND ESPECIALLY LISTENING TO THE PERSONAL STORIES. EVEN IF YOU JUST WERE ABLE TO POST SOME OF THOSE PERSONAL STORIES ON DIFFERENT ASSOCIATION WEBSITES OR ON THEIR SOCIAL MEDIA PLATFORMS , WE HAVE A VERY LOW MEMBERSHIP RATIO. WE HAVE 6,500OTs LICENSED IN THE STATE AND MAYBE 350 MEMBERS OF THE ASSOCIATION, SO A VERY LOW PERCENTAGE. BUT ON OUR FACEBOOK PAGE, WE GET THOUSANDS OF FOLLOWS. SO IF WE CAN JUST POST LITTLE PUBLIC ANNOUNCEMENTS ON SOCIAL MEDIA, I THINK IT WOULD REACH A LOT.
>> ADAM: I THINK ONE OF THE THINGS THAT WE'VE TALKED ABOUT IS USING SOME OF THE STORIES THAT WE'VE HEARD WHEN WE HAVE PERMISSION TO ILLUSTRATE SOME OF THE POINTS THAT WE'RE MAKING THOSE MIGHT BE THINGS THAT CAN BE CARVED UP IN WAYS TO BE USED IN SOCIAL MEDIA FOR OUR VARIOUS PARTNERS, SO I THINK THAT'S A REALLY GOOD IDEA. I THINK ASHLEY HAD A HAND UP.
>> ASHLEY: THIS IS ASHLEY. I LIKE HOW THIS IS GOING AND I DO BELIEVE IN THE VALUE OF HEARING STORIES FROM THE COMMUNITY BUT THAT MAY MAKE IT UNCOMFORTABLE FOR SOME PROVIDERS SO I ALSO WANT TO THINK ABOUT HEARING FROM THE PROVIDERS AND IN TERMS OF WE CAN DO IN TERMS OF EDUCATION AND TEACHING THEM. I THINK THAT THERE HAS STILL BEEN SOME FRUSTRATION AND SOME RESISTANCE TO PROVIDING COMMUNICATION ACCESS, AND I DO REMEMBER FROM HOWARD ROSEBLUM'S PRESENTATION AND TALKING ABOUT HAVING TO SUE OVER AND OVER AGAIN AND SOMETIMES SUING ONE PLACE MULTIPLE TIMES, YOU KNOW, EVEN THOUGH THEY HAD LEARNED WHAT WOULD HAPPEN IF THEY DIDN'T PROVIDE COMMUNICATION ACCESS, THEY STILL DID NOT PROVIDE COMMUNICATION ACCESS AGAIN, AND SO MANY OF THE PEOPLE THAT WERE ALREADY AWARE OF THE ISSUES STILL WEREN'T PROVIDING THE COMMUNICATION ACCESS SO IS IT A RESOURCE ISSUE, IS IT A FUNDING ISSUE, WE NEED-- CITIZEN FORCEMENT ISSUE, SO WE NEED TO FIGURE OUT THAT WE CAN HAPPEN AND AS WE'RE INVESTIGATING SOLUTIONS, WE NEED TO THINK ABOUT THE DIFFERENT SOLUTIONS THAT WE CAN PURSUE, THAT COMMUNICATION ACCESS FUND WAS ONE THAT PEOPLE WERE PRETTY EXCITED ABOUT AND THEN ENFORCEMENT IS AN ISSUE, TOO. WE ALSO NEED TO -- I WOULD HOPE THAT WE COME UP WITH SOLUTIONS THAT ARE MORE PROACTIVE. SO THAT THEY WILL DEFINITELY ADDRESS THE NEEDS OF THE DEAF AND HARD OF HEARING AND DEAF- BLIEBD COMMUNITIES-- DEAF-BLIND COMMUNITIES.
>> BEFORE ROB WRAPS UP, I WANT SAY THAT WE TALKED ABOUT HAVING TWO-MINUTE VIDEOS BECAUSE WE HAVE A SHORT ATTENTION SPAN AND I WANT TO THANK YOU FOR HAVING A FIVE-HOUR ATTENTION SPAN IN BEING WITH US TODAY. YOU ALL ARE AMAZING.

Looking Forward to Meeting 6 and Next Steps

>> ROB: AT OUR NEXT MEETING, ASHLEY IS GOING TO GIVE US A PRESENTATION FROM DEAF-BLIND PERSPECTIVE AND SOME RECOMMENDATIONS THAT WE CAN HOPEFULLY IMPLEMENT FROM HER AND WE WILL HAVE MARK PAYNE HERE. IF YOU HAVE ANY ADDITIONAL QUESTIONS THAT YOU THINK OF FOR THE DIVISION OF HEALTH SERVICES REGULATION THAT YOU WANT ANSWERED, PLEASE FEEL FREE TO EMAIL THEM TO ME. YES, MARK
>> MARK: THIS IS MARK AND AS YOU THINK ABOUT THE QUESTION ABOUT WHAT YOU WOULD LIKE THE FOLKS AT DHSR TO TALK ABOUT NEXT MONTH, AGAIN, REMINDING YOU THAT THEY REGULATE

OVER TWO DOZEN TYPES OF HEALTHCARE FACILITIES. SO THEY CAN BE INCREDIBLY-- THEY CAN TALK BROADLY ABOUT ALL OF THEM BUT IT WILL BE A VERY SHALLOW AND THAT'S NOT JUDGMENTAL TERM, BUT IT WILL BE A LIGHT TOUCH ON TWO DOZEN FACILITIES, OR IF YOUR PREFERENCE IS TO NARROW IN ON HOSPITAL SETTINGS, SKILLED NURSING, AND PERHAPS ADULT CARE, ASSISTED LIVING, THEN YOU CAN PROBABLY HAVE A MORE ROBUST DISCUSSION AND EXPLORATION OF WHAT THE REQUIREMENTS ARE SO IT'S REALLY YOUR PREFERENCE. YOU DON'T HAVE TO DECIDE AT THIS VERY MOMENT. AS WE GET A LITTLE CLOSER INTO NEXT MONTH, THAT WILL BE REALLY HELPFUL TO THEM WHETHER YOU WANT BROAD LIGHT OR NARROW AND DEEP.

>> ROB: WE WERE GOING TO ADDRESS RECOMMENDATIONS AND HAVE THEM OVER TO HIM BEFORE THE MEETING SO HE HAS AN IDEA WHAT WE ARE I THISSING ABOUT EVEN IN THIS TASK FORCE TOO. YEAH. THAT'S OUR MEETING FOR TODAY. THANK YOU ALL FOR COMING. IF YOU CAN LEAVE YOUR NAME TAGS HERE WITH US AND THANK YOU.