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

8/23/2019 – Task Force Meeting 6

Meeting agenda can be found HERE

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Introductions + Task Force Meeting 6 Recap

[GAVEL BANGING]

>> GOOD MORNING, EVERYBODY. I HOPE EVERYONE IS READY TO GET STARTED TODAY. I KNOW WE HAVE A WHOLE LOT AHEAD OF US, AND WE ARE NEARING THE END OF THIS PROCESS, BUT I'M VERY EXCITED FOR THIS TIME THAT WE HAVE. I KNOW WE'VE GOT A LOT OF DISCUSSION AND A LOT OF THOUGHTS THAT WE'RE SORTING THROUGH. AND WE ARE CONSIDERING MANY DIFFERENT POINTS OF VIEW HERE. SO NOW AS WE'RE GETTING CLOSE TO KIND OF WRAPPING UP THIS PROCESS, I'M VERY EXCITED TO BE ABLE TO TALK ABOUT WHAT WE'VE ACCOMPLISHED THROUGH ALL OF THIS. I DO SEE A HAND IN THE BACK OF THE ROOM. SO I JUST WANT TO CHECK IN.

>> WHOEVER IS SPEAKING, COULD YOU SPEAK UP?

>> SURE. THANK YOU. SO WITH THAT, I-- WELL, BEFORE WE GET STARTED, I WANT TO DO INTRODUCTIONS I SUPPOSE. MY NAME IS DAVID ROSENTHAL. I AM THE CO-CHAIR FOR THIS TASK FORCE WITH MARK. SO MARK, IF YOU WANT TO INTRODUCE YOURSELF AND THEN MAYBE WE'LL GO AROUND THE ROOM AND THEN GET PEOPLE THAT ARE ON THE PHONE. AND WE'LL END WITH ROB.

>> GOOD MORNING, EVERYONE. AS DAVID SAID, EYE MAIM IS MARK-- MY NAME IS MARK BENTON WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES. I'M ONE OF THE CO-CHAIRS OF THE TASK FORCE.

>> GOOD MORNING. ADAM ZOLOTOR WITH THE NORTH CAROLINA INSTITUTE OF MEDICINE. THANK YOU FOR BEING HERE TODAY I WANT TO REFRESH EVERYBODY'S MEMORY ON THE TECHNOLOGY

BECAUSE WE OFTEN GET A LITTLE CONFUSED WITH WHAT WE'RE TALKING INTO. THIS IS NOT A MICROPHONE. WHAT WE HAVE HERE IS A-- WHAT'S THE CORRECT NAME FOR THIS DEVICE?
>> ALD.
>> ASSISTIVE LISTENING DEVICE.
>> ASSISTIVE LISTENING DEVICE. THIS HAS A TRANSMITTER FOR PEOPLE WITH CERTAIN KINDS OF HEARING DEVICES THAT NEED AMPLIFICATION. THAT'S THE BOX THAT YOU'RE SPEAKING INTO. THE LITTLE LIPSTICK-SHAPED THING IS A TELEPHONE RECEIVER. SO WE ARE NOT PASSING AROUND A MICROPHONE, WHICH MEANS THAT WE HAVE TO PROJECT OUR VOICES. WE DO HAVE A MICROPHONE, BUT I THINK THAT'S TOO MANY DEVICES AND THINGS START TO FALL APART PRETTY QUICKLY. THE ONLY OTHER THING I WANT TO REMIND FOLKS OF, WE WILL INTRODUCE FOLKS ON THE PHONE AFTER WE GO AROUND THE ROOM. IF YOU COULD MUTE YOURSELVES UNTIL THEN, IT WOULD BE HELPFUL IN CUTTING DOWN ON BACKGROUND NOISE, AND I'LL ASK YOU TO MUTE YOURSELVES DURING DISCUSSION UNLESS YOU HAVE A QUESTION OR COMMENT TO ADD SO WE CAN MINIMIZE SOME OF THE BACKGROUND NOISE IN THE ROOM.
>> MY NAME IS GREG GRIGGS.
I'M EXECUTIVE VICE PRESIDENT OF THE NORTH CAROLIN AACADEMY OF FAMILY PHYSICIANS.
>> GOOD MORNING. I'M EILEEN CARTER. I REPRESENT NORTH CAROLINA PHYSICAL THERAPY ASSOCIATION. I WANTED TO LET YOU KNOW THAT I'LL BE PRESENTING WHAT WE ARE SUMMARIZING TODAY WITH OUR BOARD OF DIRECTORS TOMORROW IN MONROE, NORTH CAROLINA. SO IT'S GOING TO BE PART OF OUR DIVERSITY TASK FORCE THAT WE'RE WORKING ON AND HOPEFULLY WILL BE A STANDING COMMITTEE, SO WE CAN PUSH FORWARD TO GET THINGS HAPPENING IN NORTH CAROLINA. THANK YOU VERY MUCH FOR LETTING US BE HERE.
>> HI. THANK YOU. THIS IS JAN WITHERS. I WANT TO STAND UP TO MAKE SURE EVERYONE CAN SEE ME IF THEY NEED TO. MAKE SURE PEOPLE CAN SEE MY SIGNING. THIS IS JAN WITHERS. I'M THE DIRECTOR OF DIVISION OF SERVICES FOR THE DEAF AND HARD OF HEARING.
>> HI. I'LL START SIGNING AND THEN I'LL PROBABLY BE VOICING FOR THE REST OF THE MEETING TODAY BUT MY NAME IS TOVAH WAX. I AM HERE AS A DEAF CONSUMER AND I'M ALSO FROM THE-- I'M A MEMBER OF THE COUNCIL OF DEAF AND HARD OF HEARING, AND I'M A REPRESENTATIVE AS A DEAF CONSUMER ON THAT COUNCIL. I ALSO HAVE A SECOND ROLE HERE IN THAT I AM CONTRACTED WITH THE DIVISION OF SERVICES WITH THE DEAF AND HARD OF HEARING AND I WORK ON DIFFERENT ISSUES RELATED TO HEALTH CARE AND ACCESS IN HEALTH CARE. SO FOR THE REST OF THE MEETING, I'LL PROBABLY BE VOICING FOR MYSELF. THANK YOU.
>> GOOD MORNING. I'M COREY DUNN. I'M THE DIRECTOR OF PUBLIC POLICY FOR DISABILITY RIGHTS, NORTH CAROLINA WHERE . WE'RE THE STATES PROTECTION ADVOCACY FOR PEOPLE WITH DISABILITIES.

>> I'M TONY DAVIS, HARD OF HEARING SERVICES COORDINATOR WITH THE DIVISION OF SERVICES FOR THE DEAF AND HARD OF HEARING.
>> I'M KATHY DOWD. I'M AN AUDIOLOGIST. I'M ON THE DEAF AND HARD OF HEARING COUNCIL AND A MEMBER OF THIS TASK FORCE. AND THE EXECUTIVE DIRECTOR OF THE AUDIOLOGY PROJECT RAISING AWARENESS OF CHRONIC DISEASE AND HEARING LOSS AND RISK OF FALLS AND A VOLUNTEER OMBUDSMAN FOR NURSING HOMES.
>> MY LIST ISN'T QUITE THAT LONG. MY NAME IS BETH HATHAWAY AND I'M PRESIDENT OF THE NORTH CAROLINA OCCUPATIONAL THERAPY ASSOCIATION.
>> GOOD MORNING. I'M EILEEN RAYNOR. I'M A PEDIATRIC OT OTOLARYNOLOGIST.
>> I'M LISA WAIN WRIGHT, EXECUTIVE OFFICER AT TRILIUM. WE'RE ONE OF THE MANAGED CARE ORGANIZATIONS THAT MANAGE BEHAVIORAL HEALTH, SUBSTANCE USE DISORDER SERVICES AND SERVICES FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES IN NORTH CAROLINA.
>> GOOD MORNING. I'M JAMES COLEMAN. I'M HERE WITH THE NORTH CAROLINA INSTITUTE OF MEDICINE.
>> GOOD MORNING. I'M JEFF MOBLEY, ACCESSIBILITY-- I'M SORRY. ANYWAY, I'M WITH THE SERVICES FOR THE DEAF AND HARD OF HEARING AT YOUR DISPOSAL.
>> I'M JOHNNY SEXTON. I'M THE EXECUTIVE DIRECTOR AND FOUNDER OF THE CARE PROJECT, WHICH IS A NONPROFIT PROVIDING EMOTIONAL SUPPORT OPPORTUNITIES FOR FAMILIES WITH CHILDREN WHO ARE BORN DEAF AND HARD OF HEARING. I'VE ALSO BEEN A PEDIATRIC AUDIOLOGIST FOR OVER 40 YEARS NOW.
>> I'M VICKIE SMITH, THE EXECUTIVE DIRECTOR OF ALLIANCE OF DISABILITY ADVOCATES, SO CENTER FOR INDEPENDENT LIVING SERVING THE RALEIGH-DURHAM AND SURROUNDING AREAS.
>> I'M LIZ STRACKTON, I'M WITH HLAA CHARLOTTE AND I'M ON THE NORTH CAROLINA COUNCIL FOR THE DEAF AND HARD OF HEARING
>> ANDREW, HEALTH POLICY AT BLUE CROSS NC.
>> GOOD MORNING. BETH HORNER. I'M WITH THE NORTH CAROLINA STATE HEALTH PLAN.
>> HELLO. I'M LEE WILLIAMSON, COMMUNICATION ACCESS MANAGER WITH THE DIVISION OF SERVICES FOR THE DEAF AND THE HARD OF HEARING.
>> HELLO. DAVID HENDERSON, CEO OF THE NORTH CAROLINA MEDICAL BOARD.
>> GOOD MORNING. I'M LIZ BELK ROBERTSON. I'M A CHILD OF DEAF ADULTS. I'M A SIGN LANGUAGE INTERPRETER. I'M ALSO THE DIRECTOR OF INTERPRETING SERVICES FOR SORENSON RELAY VIDEO SERVICE AND COMMUNITY INTERPRETING AS WELL.
>> I'M JULIE BISHOP, AND I REPRESENT THE HEARING LOSS ASSOCIATION, NORTH CAROLINA STATE

ASSOCIATION.
>> I'M STEVE BARBER REPRESENTING HEARING LOSS ASSOCIATION OF AMERICA, WAKE CHAPTER.
>> I'M SHELLEY CRISTOBAL BALL. I'M AN AUDIOLOGIST. I'M HERE WITH NORTH CAROLINA AUDIOLOGY ASSOCIATION. I ALSO WORK WITH THE PRIVATE SECTOR PRIMARILY WITH ADULTS.
>> DO THOSE ON THE PHONE WANT TO GO AHEAD AND INTRODUCE YOURSELVES?
>> HI. THIS IS MELISSA WITH BLUE CROSS/BLUE SHIELD NORTH CAROLINA.
>> THIS IS KIM OWENS.
>> GOOD MORNING.
>> GO AHEAD, KELLY.
>> THIS IS KELLEY OWENS WITH COMMUNICATION FOR DEAF AND HARD OF HEARING IN GREENSBORO, NORTH CAROLINA.
>> HI THERE. GOOD MORNING. THIS IS PAMELA LLOYD. I'M WITH DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR VR, VOCATIONAL REHABILITATION, AND FOR COMMUNITY INTEGRATION SUPPORT. I'M HAPPY TO BE HERE TODAY WITH ALL OF YOU.
>> GOOD MORNING. THIS IS RON TODAY OWENS, AND I AM THE PRESENT MANAGER FOR HEARING AID SERVICES AND AUDITORY (INAUDIBLE) MARK SERVICES FOR NORTH CAROLINA MEDICAID.
>> GOOD MORNING. THIS IS MARILYN TRADER, SOUTHEAST REGIONAL REPRESENTATIVE FOR THE HELEN KELLER NATIONAL CENTER.
>> ADAM: DO WE HAVE ANYBODY ELSE ON THE PHONE?
>> HI. MY NAME IS DR. CANDICE TATE AND I AM FROM BROWTON HOSPITAL. I'M DIRECTOR OF DEAF SERVICES UNIT THERE.
>> OKAY. WELCOME, EVERYONE. I'M ROB KURZYDLOWSKI AND I'M WITH INSTITUTE OF MEDICINE AND THE PROJECT DIRECTOR FOR THIS TASK FORCE. REAL QUICK, I WANT TO GO OVER OUR AGENDA FOR TODAY AND WE CAN GO AHEAD AND GET STARTED. WE'RE GOING TO START WITH A CONSUMER STORY ACTUALLY FROM LEE, AND THIS IS A STORY THAT RECENTLY-- HE'S GOING TO SHARE SOMETHING THAT HAPPENED WITH HIS MOTHER IN TRYING TO ACCESS CARE, BUT I THINK HOW IT WOULD BE PRODUCTIVE FOR THE TASK FORCE TO GO ABOUT IT IS TO TREAT IT AS A CASE STUDY. SO WE CAN HEAR HIS STORY, HEAR EVERYTHING THAT HAPPENED AND SEE IF THE RECOMMENDATIONS THAT WE HAVE UP TO THIS POINT WOULD HAVE ALLEVIATED THE SITUATION IN ANYWAY, WOULD HAVE HELPED OR EVEN PREVENTED THE SITUATION . WE'RE GOING TO THEN GO-- IT SAYS DRAFT RECOMMENDATIONS NEXT, BUT I THINK WE CAN ALSO-- I'M NOT SURE HOW LONG IT WILL TAKE TO DISCUSS WHAT WE WANT TO DISCUSS AFTER LEE'S STORY AND KIND OF CLARIFY A FEW THINGS. SO THAT MIGHT GET CHANGED AROUND A BIT, BUT THEN WE HAVE THREE PRESENTERS THAT ARE GOING TO BE HERE FROM THE DIVISION OF HEALTH SERVICES REGULATION. IT SAYS MARK PAYNE, BUT WE ACTUALLY HAVE THREE

OTHER PRESENTERS THAT ARE GOING TO BE HERE, AND THEY'RE GOING TO TALK ABOUT THE HOSPITAL SYSTEM, ACUTE CARE, AND ONE MORE, AND THEN WE'LL GO INTO DRAFT RECOMMENDATIONS INTO LUNCH, AND THEN WE HAVE A VIDEO PRESENTATION FROM ASHLEY BENTON, AND WE HAVE A POWERPOINT SLIDE, TOO, THAT I BELIEVE SOMEONE IS GOING TO NAVIGATE FOR HER IN SOME WAY. AND THEN WE'LL DO DRAFT RECOMMENDATIONS FOR THE REST OF THE DAY, AND THEN LOOKING FORWARD AND THAT'S SUPPOSED TO SAY MEETING SEVEN AS THIS IS MEETING SIX. SO YEAH. LEE WE'LL LET YOU GO AHEAD AND GET STARTED.

Consumer Story + TF Discussion

>> LEE WILLIAMSON: HELLO.
THIS IS LEE. I'LL TRY TO REPORT THIS AS A CASE STUDY, EVEN THOUGH IT IS PERSONAL. IT DID INVOLVE MY MOTHER. MY MOTHER'S OKAY. HER HEALTH IS FINE. BUT IT'S A PERFECT SCENARIO OF IF YOU RAN INTO ANY PERSON WHO USES ASL TO COMMUNICATE OR NEEDS A SIGN LANGUAGE INTERPRETER FOR HEALTH CARE ACCESS, YOU'LL PROBABLY GET A STORY VERY MUCH SIMILAR TO THIS ONE SOMEWHERE IN THEIR LIFETIME, AND YOU WOULD THINK THESE TYPES OF SITUATIONS WOULDN'T HAPPEN BUT THEY STILL DO, AND SO I'LL JUST START AND YOU GUYS CAN DISCUSS THIS AND SEE HOW RECOMMENDATIONS CAN APPLY AND HELP ALLEVIATE THE CHALLENGE. MY MOTHER LIVES IN WILSON, NORTH CAROLINA. SO IT'S A SMALL COMMUNITY, 45, 50,000 PEOPLE. THE SCHOOL FOR THE DEAF, ONE OF THE RESIDENTIAL SCHOOLS FOR THE DEAF IS IN WILSON. VERY LARGE COMMUNITY OF DEAF PROFESSIONALS, EDUCATED, TEACHERS, ADMINISTRATORS, ALUMNI OF THE SCHOOL. SO IT'S-- IN A LOT OF WAYS, IT'S A HUB WHERE THERE'S A LARGE DEAF COMMUNITY. MY MOTHER GOES FOR HER ANNUAL EYE EXAM. SHE GOES TO AN OPTOMETRIST FOR HER ANNUAL EYE EXAM LIKE WE ALL DO. AN INTERPRETER IS PROVIDED FOR THAT APPOINTMENT. THIS WAS BACK IN JUNE. DURING THAT APPOINTMENT, THE OPTOMETRIST DIAGNOSED OR SAW THAT SHE HAD AN EPI RETINAL MEMBRANE. SO I GUESS EPM, EPIRETINAL MEMBRANE, IF I'M CORRECT HERE. SHE WAS GIVEN A PAMPHLET AND THIS WAS ALL EXPLAINED TO HER THROUGH AN INTERPRETER. THE OPTOMETRIST REFERRED TO HER A RETINAL SPECIALIST. THERE ISN'T A RETINAL TYPE OFFICE AND THERE ARE OFFICES WHERE THERE ARE OPTHALMOLOGIST BUT THIS OTHER PRACTICE IN WILSON WHERE SHE WAS REFERRED TO HAS SOMEONE COME IN ON TUESDAY AND THURSDAYS FROM A LARGER PRACTICE IN THE TRIANGLE AREA. MY MOTHER WAITS FOR THE CALL FROM THE REFERRAL OFFICE, THE OPHTHALMOLOGY OFFICE FOR THE APPOINTMENT. SHE RECEIVES THE CALL THROUGH VIDEO RELAY SERVICE. MY MOTHER, THEY WORK ON A DATE, TIME, AUGUST 8th, 10:00 A.M., AND MY MOTHER THEN MAKES THE REQUEST FOR A SIGN LANGUAGE INTERPRETER. THE RESPONSE-- AND AT THIS TIME, SHE WAS DEALING WITH THE

RECEPTIONIST OR WHOEVER SCHEDULES APPOINTMENTS. THE RESPONSE WAS, WE DON'T PROVIDE INTERPRETERS FOR THE FIRST VISIT. AFTER THE FIRST VISIT, IF WE SEE THAT ONE IS NEEDED, WE MAY ARRANGE-- WE'LL ARRANGE FOR ONE AFTER THE FIRST VISIT. MY MOTHER WAS VERY TROUBLED BY THIS. SO SHE TRIED TO CLARIFY THAT THAT'S NOT APPROPRIATE AND HER WAY OF TRYING TO ADVOCATE AS AN INDIVIDUAL, SHE SAID THAT'S JUST NOT RIGHT. I REALLY NEED AN INTERPRETER FOR THE FIRST VISIT, SO I CAN MAKE SURE I UNDERSTAND. YOU'RE A NEW OFFICE. I DON'T KNOW ANYTHING ABOUT YOU. IT WOULD MAKE SENSE TO HAVE SOMETHING FOR THE FIRST VISIT, AND THE RECEPTIONIST WENT ON, SORRY, BUT THAT'S NOT OUR POLICY. THAT'S WHEN MY MOTHER REACHED OUT TO ME EXPLAINING THE SITUATION AND SEEING IF THERE WAS ANYTHING I CAN DO. I'M COMMUNICATION ACCESS MANAGER. I VERY MUCH KNOW WHAT I NEED TO DO.

[LAUGHTER]

SO YOU WOULD THINK THAT, YOU KNOW, THAT WOULD WORK. ANYWAY, AT THE SAME TIME, MY MOTHER ALSO KNOWS THAT WILSON HAS A REGIONAL CENTER FOR THE DEAF AND HARD OF HEARING FROM OUR DIVISION THAT ALSO DOES ADVOCACY. SO MY MOTHER REACHED OUT TO THE REGIONAL CENTER AND OUR POLICY IS OUR DEAF SERVICES SPECIALIST IN THE REGIONAL CENTER WITHIN-- WOULD THEN TALK TO THE DEAF CONSUMER, SEE WHAT THEY HAVE DONE AND TRY TO HELP THEM WITH SELF-ADVOCACY. THE REGIONAL CENTER REALIZED THAT MY MOTHER DID EVERYTHING SHE SHOULD HAVE DONE AND RAN INTO A DEAD END. SHE COULDN'T GET ANY FURTHER. THE REGIONAL CENTER CALLED THE OFFICE. SPOKE WITH PROBABLY THE OFFICE MANAGER. I STILL DON'T KNOW EXACTLY THE ROLE OF THE PERSON, BUT IT'S THE PERSON EVERYONE'S BEEN REFERRING EVERYONE TO TO DISCUSS THIS ISSUE. THE REGIONAL CENTER, EXPLAINED THE ADA, THE NEEDS OF A DEAF PATIENT, THE FACT THAT THEY WERE REQUESTING AN INTERPRETER. AGAIN, THEIR POLICY WAS, AGAIN, THE PERSON REPEATED THEIR POLICY. IN THE ON THE FIRST VISIT. WE DON'T DO IT. MAYBE AFTER THE FIRST VISIT, IF WE SEE THERE'S A NEED. SO THAT DIDN'T WORK WITH OUR DEAF SERVICES SPECIALIST. WE FOLLOWED OUR INTERNAL ESCALATION PROCESS FOR ADVOCACY. I WENT TO THE MANAGER. THE MANAGER THEN TRIED CALLING THE OFFICE. SHE WAS IMMEDIATELY REFERRED TO VOICEMAIL TWO OR THREE TIMES AND NEVER GOT A RESPONSE. IT WAS THEN ES TODAY IT LAKED TO OUR HOME OFFICE, TO OUR ACCESSIBILITY WHATEVER AT YOUR SERVICE PERSON.

[LAUGHTER]

JEFF MOBLEY. OUR ACCESSIBILITY RESOURCES COORDINATOR. SO IT WAS ESCALATED TO JEFF, WHO THEN WORKED WITHIN OUR DEPARTMENT'S LEGAL TO SEE WHAT STEPS WE COULD TAKE, AND WE'RE REALLY LIMITED AS A STATE AGENCY IN WHAT WE CAN DO. WE'RE STILL AT A PLACE WHERE WE DON'T KNOW. DURING THAT TIME, I WAS CONSULTED TO JUST REMAIN AS THE SON AND ADVOCATE AS A SON.

THAT'S WHAT I DID THROUGHOUT THAT TIME. SO I BEGAN CALLING THE OFFICE TO TRY TO SPEAK TO THIS PERSON AND WAS ALWAYS REFERRED TO VOICEMAIL. I DIDN'T TRY TO BE SNEAKY OR ANYTHING, SAYING, I WAS SOMEONE ELSE. I ALWAYS TOLD THEM MY NAME AND THEY KNEW MY BY LAST NAME WHY I WAS CALLING. I WAS REFERRED TO VOICEMAIL EVERY TIME AND USED UP THE WHOLE TWO MINUTES EACH TIME. SO I LEFT THREE, FOUR VOICEMAILS AND NEVER GOT A RESPONSE. RIGHT BEFORE THE APPOINTMENT NEAR THE END OF JULY, THE OFFICE DID CALL MY MOTHER, LEAVE A MESSAGE ON VIDEO RELAY SERVICE. SO IT WAS A VIDEO SIGN MAIL MESSAGE, WHICH THANKS TO TECHNOLOGY, MY MOTHER CAN SAVE THE AND EMAIL TO HE INTO. I SEE THE MESSAGE, I SEE THE INTERPRETER SIGNING THE MESSAGE, AND IT WAS BASICALLY, AGAIN, OUR POLICY IS NOT TO PROVIDE INTERPRETER FOR THE FIRST VISIT. IN FACT, I'VE ALREADY REACHED OUT TO THE MEDICAL BOARD AND TO THE ADA, WHICH I DON'T KNOW HOW YOU REACH OUT TO THE ADA YOU CAN REACH OUT TO THE DOJ. YOU CAN REACH OUT TO DSS, BUT THE ADA. ANYWAY, AND THEY CONFIRMED THAT OUR POLICY IS RIGHT, IS CORRECT, AND DAVID AND I ALREADY DISCUSSED THIS. SO WE'RE GOOD. THAT'S WHY WE'RE SITTING BESIDE EACH OTHER. SO THAT WAS THE RESPONSE. SO MY MOTHER SHARED THAT WITH ME AND I REACHED OUT TO DAVID AND DAVID WAS OUT OF THE OFFICE, ABOUT YOU WE HAVE DISCUSSED THIS. BASICALLY FROM MY FINDINGS, AND I THINK WHAT'S HAPPENING IS THE INFORMATION THAT THE MEDICAL BOARD, WHAT DAVID SHARED WITH ME AND WHAT WAS PROBABLY SHARED WITH THEM IS BASICALLY WHAT THE ADA STATES ABOUT ACCOMMODATIONS IN PROVIDING THEM. AND THAT'S BEEN THE CHALLENGE THE WHOLE TIME WITH TRYING TO ADVOCATE FOR ACCESSIBILITY IS THAT THE ADA IS WRITTEN IN A WAY WHERE THERE'S A LOT OF ROOM FOR INTERPRETATION. IF YOU REALLY SAT DOWN WITH SOMEONE AND TALKED ABOUT IT, I GUESS, IN DETAIL THAT ROOM FOR INTERPRETATION WOULD PROBABLY GO AWAY, BUT WHEN YOU LEAVE IT OPEN, WHEN IT SAYS THAT THE ADA SAYS THAT YOU NEED TO WORK WITH THE PATIENT TO DETERMINE WHAT IS THE BEST ACCOMMODATIONS, THE WAY THE OFFICE IS PROBABLY SEEING IT IS THAT'S WHAT WE'RE DOING DURING THE FIRST VISIT. WE'RE GOING TO DO THE EXAM AND SEE HOW IT WORKS AND IF IT WORKS, THEN, HEY, WE DIDN'T NEED AN INTERPRETER. IF IT DOESN'T WORK, THEN, YEAH, WE NEEDED AN INTERPRETER AND YOU CAN COME BACK FOR A SECOND VISIT. IN FACT, THE OFFICE SAID THIS IN THE MESSAGE, AND THE MESSAGE SAYS, IF THE FIRST VISIT WE DETERMINE WE NEED AN INTERPRETER, YOU CAN COME BACK FOR THE SECOND VISIT AND YOU WON'T HAVE TO PAY FOR IT. WHICH WAS VERY NICE TO OFFER, YOU DON'T HAVE TO PAY FOR YOUR SECOND VISIT IF YOU HAVE TO COME BACK. ANYWAY, SO MY MOTHER GO. WE GO BACK AND FORTH ABOUT WHETHER WE SHOULD GO TO THE APPOINTMENT. SHE COULD HAVE SCHEDULED AND WENT TO ANOTHER PROVIDER. MY MOTHER WAS VERY NERVOUS. ANYTHING RELATED TO YOUR EYES, I CAN UNDERSTAND AND IT'S VERY EMOTIONAL FOR A PERSON WHO CANNOT HEAR. THAT WAS THINGS I LEFT IN THE MESSAGE, THAT WHETHER I WOULD SAY THINGS IN THE MESSAGE, WHETHER

YOU ARE TRYING TO FOLLOW THE LAW OR NOT, THINK ABOUT PATIENT CARE AND THINK ABOUT CARE FOR AN INDIVIDUAL, AND I WOULD ASSUME THAT YOUR PROVIDERS, YOUR DOCTORS WOULD WANT TO PROVIDE THE BEST CARE, AND I'M SURE THE DOCTOR HAS NO IDEA. THE DOCTOR WORKS FROM ONE PRACTICE TO THE OTHER AND IS IN WILSON ON TUESDAY AND MAY NOT KNOW HE WILL SEE A DEAF PATIENT THAT DAY BEFORE HE GETS THE CHART ON THAT VISIT. THIS DECISION IS MADE IN THE PRACTICE. MY MOTHER DOES GO TO THE APPOINTMENT. SHE'S VERY NERVOUS.

SHE SAYS I WILL GO. SHE SAYS, QUOTE, LIKE I ALWAYS DO. I'LL MAKE DO. SO SHE SHOWS UP. THE STAFF WERE VERY NICE AND FRIENDLY. THE NURSE TRIED TO SHOW A FEW FINGERSPELLED LETTERS TO SHOW I KNOW FINGERSPELLING AND MY MOTHER SAYS FINE. WHEN MY MOTHER DOES THE EYE CHART, SHE GOES--

[INDICATING IN THE ROOM]

ASSUMING THAT THE NURSE-- I'M FINGERSPELLING LETTERS, A, C, AND MY MOTHER IS DOING IT IN SIGN LANGUAGE AND MY MOTHER USES HER VOICE AND SAYS, DO YOU UNDERSTAND ME? THE NURSE LOOKED VERY NERVOUS AND THEN WROTE DOWN HER NOTE MY MOTHER SAYING, I DO KNOW SOME FINGERSPELLING. SO MY MOTHER SAYS I HAVE NO IDEA. SHE GAVE ME A THUMB'S UP AFTER THE EYE EXAM. SHE'S ASSUMING EVERYTHING WORKED OUT, AND MY MOTHER SHARED WITH ME THE NOTES AND THEY WERE HANDWRITTEN NOTES. IT WAS BASIC INSTRUCTIONS. SO A LOT OF GESTURING. INSTRUCTIONS WERE LIKE HAVE A SEAT HERE. THE DOCTOR WILL BE WITH YOU IN A MOMENT . YOU KNOW, SO MY MOTHER SITS AND WAITS. THEY COME BACK IN A FEW MINUTES LATER, ANOTHER NOTE WAS WRITTEN. THERE ARE TWO PATIENTS AHEAD OF YOU. SO THINGS LIKE THAT AND NOT MUCH WAS WRITTEN BACK AND FORTH. THE DOCTOR COMES IN. BASICALLY DOES AN EYE EXAM AND MY MOM DOESN'T MENTION ANY COMMUNICATION HAPPENING DURING THE EYE EXAM. BASICALLY JUST KIND OF GESTURING AND TELLING HER WHERE TO PUT HER HEAD AND LOOK IN AND DO THIS AND THAT, AND WE SEE THAT, TOO. THE DOCTOR OFTEN WOULD TALK TO US AND SAY, OKAY, FOLLOW MY EYE. LOOK UP, LOOK DOWN, TO THE LEFT, TO THE RIGHT. WE KNOW ALL THAT STUFF AND THE DEAF PERSON KNOWS THE BASIC EYE EXAM AND MANY DEAF INDIVIDUALS MAY NOT REQUEST AN INTERPRETER FOR AN OPTOMETRY APPOINTMENT BECAUSE THEY'RE USED TO THE ROUTINE. SAME WITH DENTAL APPOINTMENTS AND YOU MAY SAY IF I AN INTERPRETER OR NOT, IT'S OKAY. THAT'S NOT THE POINT. IT IF THEY DO WANT ONE, I THINK THEY SHOULD HAVE ONE. WHAT MY MOTHER GOT BACK IS YOU HAVE EPIRETINAL EMBRAIN MILD. MY MOTHER SAW MILD AND THE REST OF WHAT HE WROTE SHE DIDN'T PAY ATTENTION AND HE STARTED USING WORDS AND SHE SHOWED ME THE NOTE. YOU HAVE EPI RETINAL MEMBRANE AND THE FIRST STEP IS SURVEILLANCE.

THAT'S A GREAT WORD TO WRITE. IF YOU ARE WRITING BACK AND FORTH WITH ANYONE, SURVEILLANCE. THAT PICTURE IS POLICE. YOU KNOW, WHAT DOES THAT MEAN?

[LAUGHTER]
I GET IT. DOCTORS ARE CLINICAL PEOPLE. SO THAT'S SOMETHING TO THINK ABOUT WHEN PEOPLE ASSUME WRITING BACK AND FORTH IS GOOD. WE KNOW HOW DOCTORS TALK AND AS A HEARING PERSON OR LAYPERSON, I MAY CLARIFY SURVEILLANCE, YOU MEAN, WE'RE GOING TO KEEP AN EYE ON IT, RIGHT? I WOULD DO THAT KIND OF INTERACTION WITH THE DOCTOR AND MY MOTHER IS NOT GIVEN THAT CHANCE. SHE BASICALLY READS SURVEILLANCE, IF IT'S BAD, TRY GLASSES. IF IT CONTINUES TO BE BAD, WE'LL LOOK AT CATARACT SURGERY, AND THEN THE NEXT WOULD BE,-HE GAVE HER A PAMPHLET ON SOMETHING PUCKER, SOMETHING PUCKER. I DON'T KNOW. ANYWAY, IT'S A PROCEDURE. BUT MY MOTHER, AFTER ALL THAT, SHE STILL DOESN'T QUITE KNOW WHAT HE'S SAYING. SHE SAW MILD AND THAT IT CAN HAPPEN BECAUSE YOU GET OLDER IS BASICALLY WHAT SHE GOT OUT OF THAT. WHAT SHE DID DO IS HAD ALL THE PAPERWORK FROM HER OPTOMETRIST, THAT THE OPTOMETRIST GAVE HER THAT SHE UNDERSTOOD. IF SHE HADN'T GOTTEN THAT, SHE WOULD HAVE NO IDEA WHAT EPIRETINAL MEMBRANE IS. SHE KNOWS WHAT THAT IS THANKS TO AN INTERPRETER AND GOOD OPTOMETRIST. SHE HAD THAT PAPERWORK AND SHOWED IT TO THE OPTHALMOLOGIST. SHE SHOW SHOWED IT AND SAID, THIS IS WHAT I HAVE, RIGHT? THE OPTHALMOLOGIST NODS YES, THAT'S WHAT YOU HAVE. COME BACK IF IN SIX MONTHS. SHE LEAVES. FROM THE DOCTOR'S APPOINTMENT OFFICE PERSPECTIVE THAT APPOINTMENT WENT GREAT. MAY MOM WILL MAKE JOKES HERE AND THERE. SHE WANTS TO MAKE PEOPLE COMFORTABLE. MY MOTHER IS 75 AND TELLS ME, WE ARE TRAINED TO PLEASE HEARING PEOPLE. WE ARE TRAINED NOT TO MAKE A FUSS. SO I'M GOING TO GO IN THERE AND NOT MAKE A FUSS. SHE SAYS I'M STARTING TO STOP BEING THAT WAY NOW. I'M OLD AND RETIRED, AND IT SHOULD BE THE OTHER WAY AROUND, BUT SHE DID TELL ME THAT. BUT ANYWAY, COMING HOME, I TALKED TO HER THAT EVENING AND SHE HAD BEEN ASLEEP ALL AFTERNOON. SHE SAYS I WAS EXHAUSTED. I WAS SO SCARED. I DIDN'T KNOW WHAT WAS GOING TO COME OUT OF IT. I DIDN'T KNOW WHAT TYPE OF ENVIRONMENT I WAS GOING INTO, WAS IT GOING TO BE HOSTILE? SO ALL OF THESE OTHER THINGS THAT WE JUST DON'T THINK ABOUT. THE LAW BASICALLY SAYS THAT-- AND WHAT WAS SHARED WITH THE DOCTOR'S OFFICE WAS-- THE POINT IS, WHATEVER ACCOMMODATION YOU PROVIDE NEEDS TO ENSURE THAT THE PERSON WITH DISABILITIES CAN, QUOTE, ENJOY ACCESS TO SERVICES OFFERED TO THE SAME EXTENT AS A PERSON WITHOUT DISABILITIES. SO THERE'S NO WAY ON EARTH YOU CAN CONVINCE ME-- AND YOU'RE AN ATTORNEY, I DON'T KNOW WHAT A COURT OF LAW WOULD USE TO DEFEND THIS, BUT MAYBE SOMEONE COULD APPROVE THAT WRITING BACK AND FORTH WOULD BE THE SAME EXTENT AS WE WOULD HAVE BEING ABLE TO COMMUNICATE WITH A PHYSICIAN , AS CLOSE AS POSSIBLE TO INTERACTING, TALKING BACK AND FORTH. WRITING DOES NOT WORK. SO IN MY MIND, INTERPRETER SHOULD BE FIRST AND THEN THE DEAF PERSON CAN DETERMINE IF NOT. OF COURSE, WITH ADA AND TITLE 1 OR TITLE II ENTITIES,

IT'S A GOVERNMENT ENTITY. THE GOVERNMENT SHOULD BE REWIRED TO GO WITH WHATEVER THE PERSON WITH THE DISABILITY WANTS. THERE IS TALK NOW WITH THE AFFORDABLE CARE ACT AND THE WHOLE CIVIL RIGHTS LAWS THAT IT ACTUALLY BUMPS DOCTORS' OFFICES TO TITLE II RESPONSIBILITY. THERE'S A LOT OF DEBATE GOING ON ABOUT THAT IN COURT. SAYING ALL OF THAT, JUST WANTED YOU TO CONSIDER THAT, THAT ARE THESE RECOMMENDATIONS GOING TO BE ENOUGH TO HELP WITH SITUATIONS? BECAUSE THE TWO BARRIERS FOR THIS SMALL PRACTICE, THIS WOULD NOT HAPPEN IN A LARGER PRACTICE, BUT THIS IS A SMALL PRACTICE, IN WILSON OF ALL PLACES, WHO KNOW BETTER. THIS PRACTICE SEES QUITE A FEW DEAF PEOPLE. I HAVE AN AUNT WHO IS DEAF. SHE ALSO GOES TO THIS PRACTICE. MY AUNT TALKED TO MY MOTHER ABOUT THIS AND MY AUNT TOLD HER THAT WHAT SHE DOES BEFORE SHE GOES IS SHE SITS DOWN AN HOUR OR TWO OR WHENEVER SHE CAN AND WRITES DOWN A PAGE FULL OF QUESTIONS BEFORE SHE GOES. BECAUSE SHE'S NOT GOING TO BE ABLE TO THINK AT THE APPOINTMENT, AND SHE'S GOING TO BE INTIMIDATED. SHE HAS SOMETHING FOR THE DOCTOR TO FILL OUT, WHICH I THINK IS RIDICULOUS THAT SHE HAS TO DO THAT, WHEN IT SIMPLY TAKES AN INTERPRETER THAT WILL COST MAYBE $150. THAT WOULD NOT HAVE PUT A PRACTICE OUT. THAT IS NOT ON UNDUE BURDEN. THAT IS NOWHERE NEAR ONE. THAT'S WHY THE PRACTICES ARE DOING IT BECAUSE OF MONEY. THE DOCTOR, I'M SURE, WOULD LOVE TO HAVE AN INTERPRETER. IT'S THE BUSINESS MANAGER PREVENTING IT, AND WE SEE THAT A LOT, MONEY. THE BOTTOM LINE IF THEY'RE WORRIED ABOUT MONEY, THEN A DOCTOR-- I'M GOING TO MAKE THIS A PLATFORM HERE, THEN A DOCTOR SHOULDN'T SPEND 15 MINUTES WITH A PATIENT. SEE MORE PATIENTS. IF MONEY IS NOT IMPORTANT, SEE MORE PATIENTS. THAT'S WHAT BUSINESS MANAGERS SHOULD TELL DOCTORS, STOP CHIT CHALKING WITH-- CHITCHATTING WITH YOUR PATIENTS. ANOTHER BARRIER FROM THESE STEHRI DON'T TYPES, ASSUMING THAT WRITING BACK AND FORTH WILL WORK AND I SEE THAT ALL THE TIME, ASSUMING THAT'S FINE AND IN SOME SITUATIONS, IT'S FINE BUT FOR HEALTH CARE, IT SHOULDN'T BE. THAT'S MY STORY. I DON'T KNOW IF THERE'S ANY DISCUSSION, BUT THAT'S BASICALLY THE SITUATION.

>> SO LEE, THANKS FOR SHARING THAT. I THINK THAT THE TWO THINGS THAT COME TO MIND AND YOU AND I FIGHT HAVE TALKED ABOUT SOME OF THIS. I THINK I'VE SAID IN THIS ROOM BEFORE THAT I THINK MOST HEALTH CARE PROVIDERS WANT TO DO THE RIGHT THING MOST OF THE TIME AND DON'T NECESSARILY KNOW HOW. WE DON'T HAVE NECESSARILY-- WE DON'T KNOW WHO TO CALL. WE DON'T KNOW WHERE TO GET PEOPLE. SOMETIMES THE BUSINESS MANAGER GETS IN THE WAY, BUT CLEARLY THAT'S NOT ALWAYS TRUE, RIGHT? THERE ARE SOME HEALTH CARE ENVIRONMENTS WHERE PEOPLE HAVE REALLY POOR EXPERIENCES BECAUSE OF EITHER THE BOTTOM LINE OR WHATEVER THE MOTIVATION IS. SO CLEARLY, IN SOME ENVIRONMENTS, AND I THINK IT'S IMPORTANT THAT WE REMIND OURSELVES THAT THIS HAPPENED. AND I THINK I WOULD JUST WANT TO SUPPORT YOU SAID

ABOUT THE WRITING BACK AND FORTH. I, OVER THE COURSE OF MY 15 YEARS IN CLINICAL PRACTICE, I'VE HAD TWO DEAF PATIENTS, AND I WORK IN A HEALTH SYSTEM THAT DOES A PRETTY GOOD JOB OF GETTING SIGN LANGUAGE INTERPRETER IN PERSON BUT THE SYSTEM IS BROKEN SOMETIMES AND YOU KNOW, THE RECEPTIONIST DIDN'T PUT THE RIGHT FLAG UP TO CALL THE INTERPRETER OR WHATEVER. SO WE'LL GIVE PATIENTS A CHOICE IT USED TO BE RESCHEDULE THE APPOINTMENT OR WRITE NOTES BACK AND FORTH. NOW WE HAVE VRI AS A THIRD OPTION, AND SO OCCASIONALLY I HAVE DONE VISITS WITH MY TWO DEAF PATIENTS WRITING NOTES BACK AND FORTH AND THEY SUCK. SO I WOULD GUESS THAT WE COMMUNICATE ABOUT A THIRD AS MUCH BECAUSE IT TAKES A LOT MORE EFFORT TO WRITE NOTES BACK AND FORTH. IT'S A LOT SLOWER TO WRITE NOTES BACK AND FORTH, AND WE HAVE THE SAME 15-MINUTE APPOINTMENT, RIGHT? I THINK WE'RE DOING A LOT LESS COMMUNICATION. I THINK WE'RE INVITING FEWER QUESTIONS AND OFFERING SHORTER RESPONSES, AND THE OTHER THING IS ONE OF MY DEAF CONSUMER WAS PROBABLY LIKE I'M GOING TO SAY A MEDIUM-LOW LITERACY DEAF CONSUMER, AND WE WOULD WRITE BACK AND FORTH AND I THINK SHE HAD TROUBLE UNDERSTANDING ME AND I SOMETIMES HAD TROUBLE UNDERSTANDING HER WHEN WE'RE USING WRITTEN NOTES. I THINK IN MANY SITUATIONS, THAT'S GOING TO BE WHOLLY INADEQUATE. IF ALL YOU'RE DOING IS CLEANING SOMEBODY'S TEETH AND YOUR HANDS ARE IN THEIR MOUTH ANYWAY, THAT'S FINE. CLEARLY, WHEN YOU'RE TALKING ABOUT SOMETHING THAT COULD COMPROMISE SOMEBODY'S VISION, THAT'S A BIG DEAL. THANKS FOR SHARING THAT STORY. I DON'T KNOW THAT I HAVE ANY ANSWERS, AND I THINK THAT WE HAVE SOME RECOMMENDATIONS THAT MIGHT HELP BUT OTHERS THAT ARE MAYBE NOT GOING FAR ENOUGH.

>> TOVAH WAX HERE. I CAN APPRECIATE WHAT YOU'RE TALKING ABOUT, AND I'D LIKE TO ACTUALLY GENERALIZE IT A LITTLE BIT BECAUSE MYSELF YESTERDAY, I MADE A CALL TO GET AN APPOINTMENT WITH THE DOCTOR OVER SOMETHING THAT CAME UP. NOW I WAS FEELING FINE, NO PAIN, NO WEAKNESS, NO TIREDNESS, BUT I SPENT 45 MINUTES ON THE PHONE JUST MAKING THAT APPOINTMENT BECAUSE THE FIRST TIME I CALLED THROUGH THE RELAY, THEY KEPT HANGING UP ON ME SO I CALLED AND GOT SOMEBODY ELSE IN THE OFFICE AND EXPLAINED THE SITUATION, WHICH MEANT THAT I ASKED TO TALK TO THE FIRST PERSON WHO HUNG UP SO I COULD EXPLAIN WHAT THEY WERE DOING INAPPROPRIATELY. SO IT TOOK ME 45 MINUTES TO MAKE A VERY SIMPLE APPOINTMENT, YOU KNOW. NOW MULTIPLY THAT BY EVERY TIME, AS A RETIRED PERSON, I WANT TO GO OUT AND DO SOMETHING, WHETHER IT'S A SERIES OF MEDICAL APPOINTMENTS, WHETHER IT'S GOING TO CLASSES, WHETHER IT'S GOING TO ACTIVITIES, LECTURES, TRAVELING, WHATEVER. EVERY SINGLE TIME, I HAVE TO THINK OF ACCESSIBILITY ISSUES AND EVERY SINGLE TIME, A GREAT VARIETY IN WHO DOES WHAT. YOU KNOW, THE ANSWERS MAY NOT BE EASY BUT THE FACT IS THAT THERE NEEDS TO BE A LOT MORE TEETH TO UNDERSTANDING AND INTERPRETING ACCESSIBILITY.

>> I WILL GET MY EXERCISE TODAY, RIGHT?

>> HI. I'M LIZ. I KNOW LEE'S MOM, SO IT REALLY HURTS MY HEART. I DROPPED THE BALL IN SOMETHING THAT I TOLD DAVID AND JAN THAT I WOULD DO BACK IN JUNE. I HAVE A COLLEAGUE THAT WORKS WITH ME. SHE'S A CODA SISTER, CHILD OF DEAF ADULT, SISTER. HER FATHER IS THE ONE THAT I MENTIONED BEFORE THAT HAD A DOCTOR'S PRACTICE AND HE WAS GOING TO. I MISSPOKE. I THOUGHT THE DOCTOR HAD RETIRED. THE AGENCY THAT THEY WERE USING TO PROVIDE SIGN LANGUAGE INTERPRETERS, THAT AGENCY RETIRED. SO THEREFORE, AND I'M GOING TO USE HER NAME, WHEN KAREN'S FATHER CALLED THE DOCTOR'S OFFICE TO MAKE A FOLLOW-UP APPOINTMENT FOR HIS STUFF OR WHATEVER HIS HEALTH STUFF IS, THE DOCTOR'S OFFICE SAID, WELL, WE NO LONGER PROVIDE INTERPRETING SERVICES BECAUSE THE AGENCY WE USED IS RETIRED. AND THEY HAVE A LOT OF DEAF PEOPLE. ALL RIGHT. SO OF COURSE, SHE PANICKED. SHE WANTED TO GO TO THE DIVISION OF SERVICES FOR THE DEAF AND HARD OF HEARING AND RAMP UP. WHO'S GOT THE TIME TO DO THAT? HER DAD NEEDED HEALTH CARE. THEY FOUND ANOTHER DOCTOR, AND I THINK IT'S THE JOHNSTON COUNTY HOSPITAL IN THAT AREA IN CLAYTON, AND THIS IS A GOOD STORY. AND WHERE I DROPPED THE BALL WAS BECAUSE I HEARD IT WAS A GREAT STORY. THEY WELCOMED THIS MAN IN TO THIS PRACTICE . THEY GIVE HIM ANOTHER APPOINTMENT. THEY PROVIDE AN INTERPRETER. FIRST, THEY SAID THEY WOULD DO VRI. KAREN IS LIKE, WHATEVER, WE'LL TRY IT. LET'S TRY VRI AND SEE IF IT WORKS. WHEN THEY GOT THERE, THEY HAD A LIVE INTERPRETER THERE WHICH WAS PHENOMENAL. THE LIVE INTERPRETER INTERPRETED EVERYTHING AND THEY DID A FOLLOW-UP AND WANTED HIM TO COME IN AND DO SOMETHING ELSE AT ANOTHER TIME TO GET SOME BLOODWORK. I'M NOT EVEN SURE WHAT THE WHOLE STORY IS. WHAT THEY DID DO IS TAKE THE TIME TO GUIDE HIM THROUGH THE FACILITY WITH THE INTERPRETER AND EXPLAIN WHAT HE NEEDED TO DO BECAUSE HE SAID, I WON'T NEED AN INTERPRETER BECAUSE HE NEED THE ROUTINE. YOU GO IN AND GET YOUR BLOOD DRAWN. NO, LET'S WAIT. LET'S GUIDE YOU THROUGH THIS. THEY GUIDE HIM THROUGH WITH THE INTERPRETER. KAREN SAT OUT FRONT. THE WHOLE FACILITY SHOWED HIM EXACTLY WHAT HE NEEDED TO DO, AND BLAH, BLAH, BLAH, AND IT WAS THE MOST AWESOME EXPERIENCE SHE'S EVER HAD. WHERE I DROPPED THE BALL IS I WANTED TO COME BACK AND TALK TO THE OFFICE MANAGER AND SAY, HOW DID THIS HAPPEN? WHAT DID YOU DO? I DID GET THE NAME OF THE DOCTOR'S OFFICE? THAT'S THE MOST WONDERFUL EXPERIENCE SHE'S EVER HAD WITH HER FATHER GOING TO A DOCTOR. THIS WAS AT THE CONFERENCE I SPOKE TO JAN AND DAVID AT THE INTERPRETING CONFERENCE THAT WE HAD IN CHARLOTTE. WHILE I WAS THERE, THE NORTH CAROLINA ASSOCIATION FOR THE DEAF ALSO HAD THEIR CONFERENCE, AND SO I ASKED A COUPLE OTHER DEAF PEOPLE, WHAT ARE YOUR EXPERIENCES? ANOTHER DEAF INDIVIDUAL IN THE COMMUNITY GOES TO A DOCTOR IN GARNER. WONDERFUL EXPERIENCE. SO IT HAPPENS. I MEAN, IT HAPPENS. BUT LIKE WE'RE SAYING, HOW CAN YOU GET TO

THAT MAIN PERSON TO MAKE IT OKAY, TO MAKE THAT PROCESS HAPPEN WHERE YOU'RE NOT SPENDING 45 MINUTES ON THE PHONE, WHERE YOU DON'T GO IN THERE PANICKED AND FREAKING OUT ABOUT WHAT WILL HAPPEN TO MY EYES BECAUSE I'M DEAF AND IF I LOSE MY EYES, I'M DONE FOR SOMEONE AT THAT AGE? IT'S UNFORTUNATE BUT IT'S ALL-- THE ONLY THING I'VE GOT TO SAY IS DEAF PEOPLE DON'T WANT TO HAVE AN INTERPRETER IF THEY DON'T HAVE TO HAVE ONE. A CODA DOESN'T WANT THEIR PARENTS TO HAVE AN INTERPRETER IF THEY DON'T HAVE TO HAVE ONE. IF THEY'RE REQUESTING ONE, IT SHOULDN'T BE ABOUT YOUR MONEY. IT SHOULD BE YOUR HEART, YOU KNOW. THERE IS A RETINAL SPECIALIST THIS MY MOM SAW AT WILSON A LONG TIME AGO. HE WAS IN RALEIGH. HE WOULD TAKE HIS 15 MINUTES WHEN HE KNEW A DEAF PERSON WAS COMING AND MAKE THAT APPOINTMENT 30 MINUTES WITH OR WITHOUT AN INTERPRETER SO HE DIDN'T PISS OFF EVERYBODY ELSE. THAT'S EXACTLY WHAT HE TOLD ME. I DIDN'T WANT TO TICK OFF THE REST OF MY PATIENTS. I WOULD DO 30 MINUTES WITH THAT DEAF PERSON SO I KNEW WE HAD ADEQUATE TIME. HE WAS WILLING TO GIVE UP 159-MINUTE, HOWEVER MUCH HE WAS GETTING. ALL DEAF PEOPLE WANT IS EQUAL ACCESS AND TO FEEL COMFORTABLE IN AN APPOINTMENT. THE MONEY, WHATEVER, YOU CAN RECOUP THAT, BUT IF YOU HAVE SOMEBODY WITH OTHER ISSUES, IS MALPRACTICE WORTH IT? IS THE DEATH OF SOMEBODY WORTH IT BECAUSE OF NEGLIGENCE WORTH IT? I'M SORRY YOUR MOM WENT THROUGH THAT. SHE'S NOT THE ONLY ONE AND SHE WON'T BE THE LAST ONE.

>> THANKS, LIZ. GREG, DID YOU WANT TO-- OKAY. HI, LAWRENCE. -DO YOU WANT TO ADD SOMETHING?

>> I WANT TO MAKE A COUPLE QUICK COMMENTS ON LEE AND WHAT LIZ SAID. AS THE INTERPRETING SERVICE SPECIALIST FOR 19 YEARS WITH THE DIVISION I JUST WANT TO REMIND PEOPLE I RETIRED IN OCTOBER AND I'M NOT THERE AS A REPRESENTATIVE. THE ONLY CORRECTION I WOULD MAKE WITH LEE IS IT'S NOT JUST SMALL MEDICAL. I WORKED WITH LARGE HOSPITALS IN THE AREA THAT DID NOT PROVIDE INTERPRETERS SO IT'S NOT JUST SMALL. ALTHOUGH, IT HAPPENS MORE FREQUENTLY THERE. SO JUST THAT CORRECTION. AND WHAT I FOUND IS WHEN I FIRST GOT HIRED I WAS TOLD TO GO OUT AND EXPLAIN TO MEDICAL PROVIDERS AND ALL THAT HOW TO GET AN INTERPRETER AND ALL THAT, BUT THEY WERE OBLIVIOUS TO THAT BECAUSE THEY DIDN'T THINK THEY NEEDED AN INTERPRETER. THEY'RE LIKE, OH, WE CAN WRITE BACK AND FORTH. THEY DON'T UNDERSTAND WHY WRITING BACK AND FORTH DOESN'T WORK. SO A LOT OF THE FOCUS NEEDS TO BE ON WHY THERE NEEDS TO BE AN INTERPRETER BECAUSE THEY NEED THAT. AS FAR AS WHAT LIZ, WE WERE TALKING ABOUT INTERPRETING AGENCIES, I ACTUALLY WORKED WITH PLACES THAT HAD CONTRACTS WITH INTERPRETING AGENCIES WHO MAY ONLY HAVE ONE OR TWO INTERPRETERS ON STAFF AND THEY REFUSED TO GO OUTSIDE THAT AGENCY OR ADD ADDITIONAL CONTRACTS AND SO THEREFORE, THE DEAF PERSON'S MEDICAL APPOINTMENT WOULD BE BASED ON WHEN THE NEXT AVAILABLE

INTERPRETER WAS NOT BECAUSE IT WASN'T AVAILABLE INTERPRETERS IN THE AREA BUT THERE WASN'T AVAILABLE INTERPRETERS THROUGH THE AGENCY THAT THEY CONTRACT WITH, AND THEY BASICALLY JUST CONTRACT WORKING WHERE THEY CAN SAVE THE MOST MONEY, AND THE LAST PART IS AS FAR AS TEETH, AS FAR AS WHAT TOVAH WAS SAYING, I'M STILL NOT UNDERSTANDING EVEN AFTER 19 YEARS, I UNDERSTAND THAT IF SOMEBODY IS A MEDICAL PROVIDER IN THE STATE CAN PULL THE MONEY IF THEY GO THAT ROUTE, BUT THERE'S ALSO UNDER THE REHAB ACT, THE STATE CAN'T DO BUSINESS WITH ANYONE WHO DISCRIMINATES, AND THE STATE CAN'T DO BUSINESS WITH ANYBODY WHO DOES BUSINESS WITH ANYONE WHO DISCRIMINATES. SO IF YOU FOLLOW THE MONEY, JUST ABOUT EVERY MEDICAL PROVIDER, EVEN IF THEY DON'T ACCEPT MEDICAID, MEDICARE OR ANY GOVERNMENT MONEY DIRECTLY DOES BUSINESS WITH SOMEONE WHO DOES RECEIVE IT. WHY DON'T GO WE DOWN THAT AVENUE AS FAR AS PUTTING TEETH IN? I WILL HAND IT BACK OVER.
>> THANKS, LAWRENCE. THIS IS GREG GRIGGS, AND CHANGING MY MIND BACK AND FORTH.
>> IT'S HARD TO DECIDE. I TOTALLY AGREE WITH WHAT HE WAS SAYING AND WHAT ADAM WAS SAYING. I THINK THERE IS A LACK OF UNDERSTANDING, A LACK OF EDUCATION. I THINK MOST HEALTH CARE PROVIDERS, NOT ALL, BUT MOST WANT TO DO THE RIGHT THING. I DON'T KNOW THAT THEY ALWAYS UNDERSTAND WHAT THE RIGHT THING IS. I THINK EDUCATION ABOUT WHY INTERPRETERS ARE IMPORTANT. I'VE LEARNED A LOT AT THESE MEETINGS ABOUT THE VRI VERSUS LIVE INTERPRETER, AND I THINK THAT THERE IS A REALLY LACK OF KNOWLEDGE OF WHAT IS NEEDED, AND I KNOW THAT'S NOT AN EXCUSE, BUT I THINK THAT'S SOMEWHERE WE CAN DEFINITELY START AND MAKE HEADWAY. AS HAVING GONE THROUGH A LOT OF HEALTH ISSUES WITH MY OWN MOTHER RECENTLY, WHO'S 83, I CANNOT IMAGINE ANOTHER BARRIER. SHE HAD ENOUGH BARRIERS THAT SHE WAS DEALING WITH TO THE POINT WHERE HER LAST HEALTH APPOINTMENT NOT ONLY DID MY SISTER AND I BOTH WENT WITH HER. SHE NOW IS LIVING WITH MY SISTER, BUT MY SISTER IS NOT ALWAYS REALLY HEALTH SAVVY HERSELF AS FAR AS-- AND JUST BECAUSE OF THE JOB I HAVE, NOT REALLY ANY EXTRA EDUCATION ON THE SIDE, BUT THE JOB I HAVE, I'VE LEARNED TO NAVIGATE THE HEALTH CARE SYSTEM BETTER THAN THE AVERAGE PERSON AND MY MOM ENDED UP HAVING A TOTALLY UNNECESSARY HEART C.A.T. ADVERTISE-- CATHERTIZATION WHICH HER DOCTOR QUESTIONED WHETHER IT WAS NEEDED OR NOT. I CAN'T IMAGINE GOING THROUGH THAT IF SHE CAN'T HEAR. SHE HAS EVERY OLOGIST IN THE WORLD BECAUSE OF CHRONIC DISEASES. SHE GETS SCARED VERY EASILY. SHE THOUGHT BECAUSE OF ONE NEPHROLOGIST SHE WENT TO SHE WOULD BE IN DIALYSIS IN A YEAR AND WE SWITCHED NEP HROLOGIST WHO HAD BETTER COMMUNICATION SKILLS WITH HER AS A HEARING PERSON AND THAT NEPHROLOGIST IS BARELY ROUTE SIDE OF NORMAL AND SHE'S A LONG WAY FROM DIALYSIS AND JUST MAKING THAT COMFORT LEVEL AND GOING THROUGH THAT AND LISTENING TO THESE CONVERSATIONS ABOUT ADDING THAT ONE MORE BARRIER ON TOP OF IT, IT'S PRETTY ALMOST

UNIMAGINABLE TO ME AS A HEARING PERSON. SO, BUT I THINK-- WE'VE GOT TO-- I THINK TELLING THOSE STORIES TO PHYSICIANS AND HEALTH CARE PROVIDERS, TELLING BOTH THE STORY OF THE POSITIVE AND HOW IT WORKED WELL AND TELLING THE STORY OF THE NEGATIVE AND JUXTAPOSING THOSE IS REALLY, REALLY IMPORTANT, AND I BET A LOT OF HEALTH CARE PROFESSIONALS HAVEN'T HEARD THOSE TYPES OF STORIES.

>> I AGREE. TOVAH AND THEN SHELLEY.

>> TOVAH HERE. JUST A QUICK REBUTTAL. WE'VE HAD THESE LITTLE TUSSLES BEFORE ABOUT EDUCATION VERSUS ADVOCACY ISSUES. IT'S TRUE THAT A LOT OF PEOPLE STILL NEED EDUCATION. I WON'T DIMINISH THAT, BUT THE FACT IS IN THAT PARTICULAR STORY, IT WAS A MATTER OF INTERPRETING AND INTERPRETING WAS IN FAVOR OF SAVING MONEY, THE MOTIVE, YOU KNOW, THE MOTIVE IS ALWAYS-- IT'S UNFORTUNATELY ALMOST ALWAYS ABOUT SAVING MONEY AND MAKING THINGS MORE COST EFFECTIVE. SO THE FACT IS THAT SOMETIMES THAT INTERPRETTATION, YOU KNOW, ASCERTAIN WHAT THE NEEDS ARE ACCORDING TO THE ADA AS OPPOSED TO JUST MEETING THE NEEDS, WHICH IS LATER IN ADA AND IT SAID PROVIDE WHAT IS APPROPRIATE, RIGHT. SO I THINK THE FACT IS IN THIS CASE, WHAT I HEARD WAS A MOTIVE OF TRYING TO SAVE MONEY, AND SO I THINK THERE WAS ENOUGH EDUCATION IN THAT OFFICE. THEY KNEW WHO TO CONTACT, WHO TO TALK TO AND WHO TO GET BACKING FROM, SO IT WASN'T AS EASY AS NOT BEING WELL EDUCATED ENOUGH.

>> I WILL SEE IF GREG SAYS WHAT I HAVE TO SAY AND IF HE DOESN'T, I'LL ADD.

>>

>> GREG: JUST REMEMBER THAT HASN'T THE HEALTH CARE PROFESSIONAL THAT WAS THE BARRIER UP FRONT, AND SECOND , AND I PROBABLY SHOULDN'T SAY THIS--

[LAUGHTER]

>> ADAM: NOBODY WILL CALL YOU OUT ON THAT.

>> GREG: I APPRECIATE THAT. THE OLD SAYING NO MARGIN, NO MISSION. I MEAN, WHEN A FAMILY PHYSICIAN COMES OUT WITH $250,000 WORTH OF DEBT TYPICALLY WHEN THEY'RE COMING OUT OF SCHOOL AND I'M GOING ABOUT THIS FROM FAMILY MEDICINE. FAMILY PHYSICIANS DON'T GO INTO FAMILY MEDICINE TO GET RICH. THEY ARE-- FAMILY MEDICINE AND PEDIATRICS ARE LOWEST PAID SPECIALIST. THE OPTHALMOLOGIST AND--

>> PSYCHIATRY.

>> GREG: PSYCHIATRY AS WELL. OPTHALMOLOGIST, THAT'S A LITTLE DIFFERENT. I DON'T HAVE A LOT OF SYMPATHY FOR THE OPTHALMOLOGIST. A 15-MINUTE VISIT IN A FAMILY OFFICE THAT OFFICE RECEIVES $84. AND SO THE FINANCES, YOU'VE GOT TO CONSIDER IT TO SOME EXTENT BECAUSE WHAT DID YOU ALL SAY INTERPRETERS WERE? 125 BUCKS AN HOUR AND THERE'S A MINIMUM OF TWO HOURS AND THERE'S $250 FOR ONE 15 OR 30-MINUTE VISIT, SO YOU'VE GOT TO-- ESPECIALLY IF YOU'RE AN

INDEPENDENT PRIMARY CARE PHYSICIAN. SO I KNOW PLENTY OF INDEPENDENT PRIMARY CARE PHYSICIANS THAT ARE DOING THE RIGHT THING AND DOING IT ANYWAY. I THINK THEY SHOULD BE DOING IT ANYWAY. I DON'T THINK WE CAN DISMISS FINANCES ALTOGETHER IN EVERY INSTANCE.
>> ADAM: I WANT TO ADD SOMETHING BECAUSE GREG DIDN'T SAY EVERYTHING I WANTED TO ADD. I THINK WE'RE ON THE SAME WAVE LENGTH. I THINK THAT THE ISSUE-- LIKE I WOULD JUST LIKE THE OPPORTUNITY, TOVAH, TO TALK TO THAT OPTHALMOLOGIST AND EXPLAIN TO THEM WHY WRITING NOTES IS CRAPPIE CARE. IT'S DIFFERENT THAN UNDERSTANDING THE ADA I THINK THERE'S AN A FUNDAMENTAL MISUNDERSTANDING. ME BEING IN THIS ROOM WITH YOU SIX MONTHS AND I THOUGHT I WAS DOING A GREAT JOB SIX MONTHS AGO BUT IT'S TRANSFORMED MY THINKING. PEOPLE NEED TO LEARN IT DOESN'T MEAN IT'S GOOD ENOUGH IN EVERY CIRCUMSTANCE. I THINK THERE'S MORE EDUCATION AND I THINK WE DO NEED TO THINK ABOUT WHERE THE TEETH ARE. I THINK THAT'S PART OF THE CONVERSATION. SO JAN AND THEN TOVAH AND I SWEAR, SHELLEY, YOU'RE ON MY LIST. [LAUGHTER]
>>
>> YES THIS IS JAN. I WANTED TO ADD TO GREG'S COMMENT AS WELL. THAT'S EXACTLY WHY WE NEED THE COMMUNICATION ACCESS FUND. THAT IS INTENDED TO SOLVE THAT EXACT PROBLEM. SO IF WE CAN FIND A WAY TO DEVELOP RECOMMENDATIONS THAT WILL SET THE FOUNDATION TO SUPPORT A COMMUNICATION ACCESS FUND SOONER RATHER THAN LATER, I THINK THAT WOULD BE FANTASTIC.
>> SHELTLY AND REMIND ME OF YOUR NAME. AND THEN CANDICE.
>> SHELLEY: I DO WANT TO TAG ON A THOUGHT THERE. THERE'S SUCH A CONVERSATION TO BE HAD. AS A HEALTH CARE PROVIDER WHO OWNS MY OWN PRACTICE, I DO HAVE AN ETHICAL RESPONSIBILITY TO BE PRESENT FOR MY PATIENTS IN FIVE YEARS OR TEN YEARS. THE AUDIOLOGISTS DON'T MAKE A WHOLE LOT OF MONEY EITHER. BUT THAT'S A SEPARATE CONVERSATION. THERE'S A LOT OF GIVE AND TAKE THERE DEPENDING ON AN INDIVIDUAL PROVIDER AND SPECIALTY. MY THOUGHT WAS FROM BOTH STORIES, FROM BOTH THE GOOD STORY AND THE BAD STORY, THE PART THAT WAS TROUBLESOME ABOUT THE BAD STORY CAME FROM ADMINISTRATORS MAKING THE DECISIONS FOR PROVIDERS. THE PROVIDER PROBABLY DIDN'T KNOW IT WAS GOING TO BE AN ISSUE UNTIL THEY WERE WALKING IN THE DOOR. AND WHEN THINGS WENT BEAUTIFULLY , THE PEOPLE WHO SET THAT UP WERE NOT THE PROVIDERS. IT WAS THE SUPPORT TEAM MAKING THAT HAPPEN. SO I WANT TO CYCLE BACK TO THESE RECOMMENDATIONS WE'RE TALKING ABOUT BECAUSE THAT'S WHAT WE'RE HERE FOR. THE RECOMMENDATIONS WE'RE TALKING ABOUT ARE ABOUT EDUCATING THE HEALTH CARE PROVIDERS, AND THEY ARE OFTEN, TO SOME EXTENT, RESPONSIBLE FOR THEIR SUPPORT STAFF BUT OFTEN THEY'RE NOT SO HOW DO WE GET THIS EDUCATION AND THIS AWARENESS, OR THE TEETH TO SUPPORT THE NEED FOR THE SUPPORT STAFF TO KNOW THIS? HOW DO WE GET THESE

RECOMMENDATIONS AND THIS EDUCATION AND THIS AWARENESS TO THE PEOPLE WHO AREN'T HEALTH CARE PROVIDERS, BUT ARE ACTUALLY MAKING THE PATIENT EXPERIENCE?
>> ROB: I'M GOING TO SAY ONE THING ON THAT WHILE IT'S RELEVANT. I REACHED OUT TO THE NCMGA, SO THE INCOME McMEDICAL GROUP MANAGERS ASSOCIATION. YES, YES, THANK YOU. AND THEY REPRESENT ABOUT 800 PRACTICE ADMINISTRATORS IN NORTH CAROLINA AND THEY WERE RESEPTEMBERRIVE TO THE IDEAS THAT WE HAVE IN THESE RECOMMENDATIONS AND BEING ADDED TO THIS LIST THAT WE WILL MAKE PARTNERSHIPS WITH.
>> SHELLEY: GREAT. THAT'S WHAT WE NEED.
>> THIS IS DAVID. YOU MAY ALREADY KNOW THIS, BUT THE NORTH CAROLINA ASSOCIATION OF MEDICAL STAFF SERVICES IS ANOTHER GROUP THAT WE SHOULD BE IN CONTACT WITH.
>> LAWRENCE I THINK WANTED TO SAY SOMETHING AND THEN CANDICE AND STEVE.
>> YES, THIS IS LAWRENCE. I WAS GOING TO SAY AS FAR AS THE BUSINESS ORGANIZATION IS A NOT HAVING FUNDS, THAT IS ALREADY IN THE ADA FOR THOSE WHO CAN PROVE FINANCIAL BURDEN THERE IS A PROCESS THEY CAN FOLLOW TO MAKE SURE THAT THEY'RE NOT IN THAT SITUATION IN THE FOLLOWING YEAR, I DON'T KNOW WHAT THE TIMEFRAME IS. THERE IS SOMETHING BUILT INTO THE ADA FOR THOSE WHO CAN PROVE THEY HAVE FINANCIAL BURDENS SO IT'S NOT LIKE WE'RE FORCING ANYBODY WHO REALLY CAN'T AFFORD IT. IN MY OPINION, A LOT OF IT COMES DOWN TO PRIORITIES, YOU KNOW, WHEN I USED TO GIVE PRESENTATIONS I USED TO TALK ABOUT, WELL, SOMEHOW YOU FOUND THE MONEY TO CUT THE GRASS AND THERE'S NO FEDERAL LAW REQUIRING THAT AND YET WHEN IT COMES TO AN INTERPRETER, YOU DON'T HAVE ENOUGH MONEY. A LOT OF IT COMES TO PRIORITIES. THERE ARE THOSE WHO CAN'T AFFORD IT. AS FAR AS THE FUND, I'VE ACTUALLY TALKED TO A COUPLE OF DEAF PEOPLE AND TALKED TO A COUPLE OF INTERPRETERS ABOUT THIS FUND AND I GUESS THE QUESTION COMES DOWN TO WHO WOULD CONTROL THAT FUND? FROM THE INTERPRETER PERSPECTIVE, THE INTERPRETERS I HAVE SPOKEN TO, THEY'RE NOT KEEN ON THE IDEA THAT THE STATE WOULD COORDINATE INTERPRETERS BECAUSE THEY WOULD BE PRICE FIXING OR WHO WOULD DECIDE WHAT THEY WOULD PAY THE INTERPRETERS BECAUSE DHHS HAS THE CONTRACT AND IF YOU WORK WITH DHHS, YOU HAVE TO FOLLOW THAT CONTRACT. WOULD IT BE THE SAME CONTRACT THAT LIMITS THEIR FUNDING? WHICH ISN'T SO MUCH OUR ISSUE, BUT WHEN I SPOKE TO SEVERAL DEAF PEOPLE, THEY DON'T WANT AN AGENCY WHO KNOWS MOST OF THE PEOPLE IN THE STATE OF NORTH CAROLINA, MOST OF THE DEAF PEOPLE IN THE STATE OF NORTH CAROLINA KNOWING EVERY TIME THEY HAVE IT GO TO A DOCTOR. SO THEY WANT THAT CONFIDENTIALITY, AND THEY'RE AFRAID THEY WOULD LOSE THAT IF IT WOULD GO TO (INAUDIBLE) STATE (INAUDIBLE).
>> CANDICE: YES. THIS IS DR. TATE. SO I'M JUST CURIOUS FOR THE PEOPLE WHO ARE HERE, WE HAVE REPRESENTATIVES-- YOU WHO ARE HERE HAVE MALPRACTICE INSURANCE, AND IS THERE ANYONE THAT

REPRESENTS A MALPRACTICE INSURANCE COMPANY HERE? BECAUSE IT WOULD SEEM THAT IF APPROPRIATE ACCESS IS NOT BEING PROVIDED FOR SOMEONE'S APPOINTMENT, THEN THAT REALLY ELEVATES THE RISK OF MALPRACTICE FOR THOSE PROVIDERS. SO WHY NOT CONSIDER THAT EVERY TIME A DOCTOR IS NOT PROVIDING APPROPRIATE COMMUNICATION ACCESS, ONE POTENTIAL CONSEQUENCE FROM A MALPRACTICE INSURANCE COMPANY PERSPECTIVE WOULD BE TO INCREASE THEIR RATES FOR INSURANCE BECAUSE THEY'RE INCREASING RISK, AND THAT WOULD BE A CONCRETE CONSEQUENCE, AND IT WOULD IMPACT THEIR BUDGET EITHER WAY. SO I DON'T KNOW. IT MIGHT BECOME CHEAPER TO PROVIDE INTERPRETERS RATHER THAN INCREASE THE COST OF THEIR MALPRACTICE INSURANCE.

>> STEVE BARBER: I WANTED TO MAKE A COUPLE QUICK POINTS ABOUT THE DISCUSSION WE'VE HAD ONE OF THEM IS IF YOU HAVE A SYSTEM THAT RELIES ON DOCTORS MAKING $84 FOR 15-MINUTE VISIT, HAVING TO PAY $250 FOR A TWO-HOUR INTERPRETER SESSION, YOU'RE GOING TO RUN INTO PROBLEMS. THAT'S FUNDAMENTALLY FLAWED WHEN IT'S JUST GOING TO WORK IN CASES WHERE YOU HAVE A DOCTOR WILLING TO COMMIT TO THAT RESPONSIBILITY, BUT YOU'RE GOING TO FIND DOCTORS AND STAFF THAT ARE NOT GOING TO WANT TO UNDERSTAND THE WAY THAT WORKS. IT JUST-- IT'S FINANCIALLY UNVIABLE. IT WOULD BE A LOT BETTER TO HAVE SOME FORM OF GENERAL INSURANCE COVERAGE FOR COMMUNICATION ACCESS, SOME FORM OF PAYING FOR THAT IN A GENERALIZED WAY THAT SPREADS THE COST AND PREVENTS SOME INDIVIDUAL DOCTORS FROM GETTING INUNDATED FROM LARGE NUMBERS OF DEAF PATIENTS. SO MY POINT ON THAT IS IT'S JUST FUNDAMENTALLY FLAWED WHEN THE COST OF DOING BUSINESS DRAMATICALLY EXCEEDS THE BENEFIT OF DOING BUSINESS. NOW, THE SECOND POINT I WANTED TO MAKE IS REGARDING LEE'S DISCUSSION, A LOT OF THAT PROBLEM WAS NOT JUST INTERPRETERS, BUT THE FRUSTRATION OF TRYING TO ARRANGE THEM AND ASK FOR THEM BECAUSE TOO MANY PROVIDERS DO NOT HAVE A REASONABLE WAY TO ACTUALLY CALL THEM AND RELAY STILL WORKS KIND OF BUT MOST PEOPLE WILL NOT NEED IT BECAUSE THEY HAVE A SMARTPHONE. WHY DON'T WE REALLY ENCOURAGE ELIMINATING THAT FRUSTRATION BY MAKING ALL SERVICE PROVIDERS MAKE SURE THEY HAVE A CHAT LINE THAT THEY CAN USE OR THEY CAN HAVE AN SMS SYSTEM THAT THEY CAN USE BECAUSE RELAY SYSTEM IS JUST-- IT'S NOT COMMONLY-- PEOPLE DON'T EVEN HAVE HOME PHONES ANYMORE. SO IT'S FRUSTRATION NOT JUST INTERPRETERS.

>> I'M BEING TIMEKEEPER TODAY. IS MARK COMING IN PERSON?

>> ROB: IT'S NOT MARK. THREE FOLKS IN THE BACK.

>> GREAT. I DO THINK WE HAVE TO CUT OFF CONVERSATION BECAUSE WE HAVE ALREADY MISSED A 35-MINUTE AGENDA ITEM THERE ARE TWO MORE HANDS UP.

>> I WANT TO HELP THEM OUT. JUST REAL QUICK. I PROMISE I WON'T GO ON. I PROMISE.

>> 30 SECONDS AND THEN I'M TALKING BACK

>> INTERPRETERS DON'T COST $250 FOR TWO HOURS.

>> OKAY. JUST USING THE WRONG DATA.

>> I TOLD I WAS GOING TO BE QUICK.

>> I DON'T KNOW IF WE HAVE TIME TO COME BACK TO THIS DISCUSSION WHEN WE REVIEW RECOMMENDATIONS LATER.

Division of Healthcare Services Regulation Informational Session + Question & Answer

>> ROB KURZYDLOWSKI: I WANT TO INVITE THE FOLKS FROM DEPARTMENT HEALTH REGULATION SERVICES. DO YOU KNOW THE ORDER YOU'RE PRESENTING IN? IF YOU WANT TO COME UP ONE AT A TIME AND DO IT THAT WAY , I'LL PULL IT UP FOR YOU.

>> YEAH. THAT WILL BE GREAT. I'M CINDY----

>> ROB KURZYDLOWSKI: SORRY, ONE SECOND.

>> I'M CINDY DEPORTER AND THIS IS LIZZEY KINLEY AND WE WILL HAVE A SEQUENCE AND WE'LL START WITH LIBBY AND EACH OF US WILL GO ALONG. HOW ABOUT THAT? I'M SORRY. IT'S AZZIE GOING FIRST. I APOLOGIZE.

>> IS IT FINE? GOOD MORNING. IF I JUST SIT IN THIS CHAIR RIGHT HERE AND THAT WAY, I CAN SEE THE SLIDES A LITTLE BETTER.

>> GOOD MORNING, AGAIN. I'M AZZIE CONNALLY. I'M A REGISTERED NURSE WITH THE DIVISION OF HEALTH SERVICE REGULATION, AND I'M EXCITED TO BE HERE TODAY. BEFORE WE MOVE TO THE NEXT SLIDE, I'LL SHARE WITH YOU THAT I'M GOING TO BE TALKING TO YOU ABOUT HOSPITAL REGULATIONS, PROVIDING REGULATORY OVERSIGHT IN HOSPITALS, WHAT SOME OF THE EXPECTATIONS ARE , AND A SUMMARY FORMAT, HOW WE GO ABOUT CONDUCTING OUR STATE LICENSURE AND/OR MEDICARE SURVEYS IN HOSPITALS. ONE OF THE THINGS I WANTED TO POINT OUT IS THAT THIS SUBJECT IS VERY DEAR TO ME. BACK DURING THE DAYS WHEN I WAS ATTENDING NURSING SCHOOL, I ACTUALLY HAD A DEAR FRIEND OF MINE THAT MADE THE DECISION TO GO TO NURSING SCHOOL SIMPLY BECAUSE SHE HAD A YOUNG SON THAT WAS DEAF, AND HE WAS HOSPITALIZED IN THE WESTERN PART OF THE STATE, AND THERE WERE NO STAFF THAT COULD PROVIDE CARE AND COMMUNICATE EFFECTIVELY WITH HER SON. SO I START THE PRESENTATION WITH THAT. I AM ALSO FROM BURKE COUNTY, AND MANY OF YOU ARE FAMILIAR WITH THE SCHOOL FOR THE DEAF THAT OPERATED FOR MANY, MANY YEARS IN THAT COMMUNITY. NEXT SLIDE, PLEASE. I SHARE WITH YOU FEDERAL REGULATIONS THAT TALK ABOUT THE SOCIAL SECURITY ACT JUST TO PROVIDE YOU INFORMATION THAT WE HAVE AN AGREEMENT WITH

CENTER FOR MEDICARE AND MEDICARE SERVICES, WHICH IS THE DRIVING FORCE OF A COMPONENT OF OUR WORK. CMS SETS THE REQUIREMENTS AND INTERPRETATIONS OF THESE REGULATIONS THAT WE AS STATE AGENCY REPRESENTATIVES MUST FOLLOW. NEXT SLIDE. THIS SLIDE RIGHT HERE IS JUST, AGAIN, TO HIGHLIGHT THAT ALL HOSPITALS IN NORTH CAROLINA, EXCEPT FOR THOSE THAT ARE STATE OPERATED, MUST HAVE STATE LICENSURE AND BE IN COMPLIANCE WITH REGULATIONS THAT ARE ADDRESSED UNDER CHAPTER 13.B. HOSPITALS VOLUNTARILY PARTICIPATE IN THE MEDICARE AND MEDICAID PROGRAM, AND AGAIN, HOSPITALS VOLUNTARILY PARTICIPATE IN ACCREDITATION WITH THE ACCREDITED ORGANIZATION SUCH AS JOINT COMMISSION WHICH IS KNOWN PRIMARILY THAT THE ONE THAT A MAJORITY OF OUR HOSPITALS ARE ACCREDITED BY. I SHARE WITH YOU THESE TWO REGULATIONS. I WON'T SPEND A LOT OF DETAIL TALKING ABOUT THEM, BUT JUST TO HIGHLIGHT THEM, THAT THERE IS THE EXPECTATION THAT INDIVIDUALS THAT ARE STATE LICENSED AND/OR RECEIVE MEDICARE FUNDING ARE IN COMPLIANCE WITH SECTION 504 OF THE REHABILITATION ACT AND ALSO AMERICANS WITH DISABILITIES ACT, TITLE III. SEVERAL OF THE REGULATIONS FROM OUR HOSPITAL REGULATORY OVERSIGHT THAT'S PROVIDED BY MEDICARE SERVICES, I'VE HIGHLIGHTED THE MAJOR ONES THAT WOULD IMPACT OR COULD LEAD TO AN AREA OF NON-COMPLIANCE IN OUR HOSPITAL SETTINGS. THIS FIRST REGULATION IS FOUND AT 482.11, COMPLIANCE WITH PED RAL, STATE-- WITH FEDERAL, STATE AND LOCAL LAWS. AGAIN, I REFERENCE THE FEDERAL ACTS PREVIOUSLY SECTION 504 AND THE AMERICANS WITH DISABILITY RIGHTS UNDER TITLE 3. THOSE ARE EXAMPLES OF ACTS OR FEDERAL REGULATIONS THAT HOSPITALS ARE TO BE IN COMPLIANCE WITH. THERE ARE TWO PARTICULAR TAGS THAT WE COULD CITE IN A HOSPITAL SETTING IF VIOLATIONS ARE FOUND DURING OUR SURVEYS. THE NEXT ITEM, 48 2.13, IT'S CATEGORIZED AS PATIENT RIGHTS AND WHAT THAT REGULATION BASICALLY SAYS IN SUMMARY IS THAT PATIENTS HAVE A RIGHT TO RECEIVE QUALITY CARE IN A SAFE ENVIRONMENT BY QUALIFIED STAFF. THE OTHER REFERENCE TO ONE OF THE TAGS THAT I HAVE REFERENCED UP THERE INCLUDES A REGULATION THAT TALKS ABOUT PATIENTS MUST HAVE THE RIGHT TO INFORMED CONSENT. I SHARE WITH YOU THAT SIMPLY BECAUSE WHEN SOMEONE COMES IN TO PROVIDE YOU, SAY, FOR EXAMPLE, INFORMED CONSENT PRIOR TO SIGNING DOCUMENTS FOR SURGICAL PROCEDURE, THE PRESENTATION OF THAT INFORMATION SHOULD BE PRESENTED IN A MANNER THAT MEETS THE NEEDS OF THE PATIENTS. IT MAY BE, FOR EXAMPLE, SOMEONE THAT SPEAKS IN SPANISH, THE LANGUAGE SHOULD BE APPROPRIATELY DEFINED IN A LANGUAGE THAT WOULD BE ACCEPTABLE TO MEET THE NEEDS OF THAT PATIENT. IF IT'S AN INDIVIDUAL THAT IS DEAF, THERE SHOULD BE AN INTERPRETER OR SOMEONE AVAILABLE OR SOME ASSISTIVE DEVICE AILL VAABLE SUCH THAT EFFECTIVE COMMUNICATION CAN BE PROVIDED TO THAT PATIENT AND THAT DOES NOT LIMIT ACCESS TO A PATIENT REPRESENTATIVE OR FAMILY MEMBER THAT WOULD BE AVAILABLE TO HAVE A CLEAR UNDERSTANDING BEFORE THOSE DOCUMENTS ARE ASSIGNED. THE NEXT REGULATORY BASE,

AGAIN, FROM CMS REGULATIONS, IS 482.23, NURSING SERVICES. THAT IS REAL CRITICAL. WE HAVE THE PHYSICIANS THAT MUST DO A HISTORY AND PHYSICAL OF ALL PATIENTS THAT ARE ADMITTED TO THE HOSPITAL, BUT THE ROLE OF THAT NURSE IS ACTUALLY VERY CRITICAL, VERY ESSENTIAL TO THE DELIVERY OF CARE FOR OUR PATIENTS. THAT NURSE IS ULTIMATELY RESPONSIBLE FOR CONDUCTING THE NURSING ADMISSION ASSESSMENT OF ALL PATIENTS THAT ARE ADMITTED TO THE HOSPITAL. INTERESTINGLY, THERE IS NOT A REGULATION THAT DEFINES OR DICTATES HOW COMPREHENSIVE THAT ASSESSMENT MUST BE OR THAT DEFINES THE TOOL. AND SO USUALLY WHEN THAT NURSE IS DOING A HEARING ASSESSMENT OF A PATIENT THAT ASSESSMENT MAY INCLUDE SUCH THINGS AS, ARE YOU HARD OF HEARING? IF I SAY YES, THAT IS GOING TO DRIVE IN THE MANNER MY CARE PLAN IS DEVELOPED. IF I SAY NO, USUALLY THAT HEARING ASSESSMENT COMPONENT IS GOING TO STOP AT THAT POINT IN TIME. THERE'S ANOTHER QUESTION THAT YOU'LL SEE A LOT OF TIMES WHEN WE'RE DOING THE NURSING ASSESSMENT, AND IT MAY BE, DO YOU USE HEARING AIDS? AND THEN YOU WOULD CHECK OFF YES FOR A RIGHT, YES FOR A LEFT, AND THOSE ARE THE TYPES OF ITEMS THAT WILL BE ON THAT NURSING ASSESSMENT. ANOTHER EXAMPLE, DO YOU HAVE DIFFICULTY HEARING BECAUSE OF NOISE? AND THAT MEANS SO DIFFERENT THINGS TO INDIVIDUALS BECAUSE IF YOU ASK ME, IF I'M IN THE CAR GOING TO VIRGINIA, DO I HAVE DIFFICULTY HEARING MY RADIO, THERE ARE AREAS THAT I'M IN THE CAR AND I CANNOT HEAR BECAUSE OF THE NOISE ON THE HIGHWAY. BUT THEN I COULD BE TRAVELING INTERSTATE 40 IN NORTH CAROLINA AND HAVE NO PROBLEMS WHATSOEVER AND BE ABLE TO MAINTAIN MY RADIO STATION AT A DIFFERENT VOLUME. IF YOU THINK IN TERMS OF IT, AND I'LL AGAIN, USE MYSELF AND OTHERS AS AN EXAMPLE, IF YOU NOTICE AND I HAVE DIFFICULTY WITH BACKGROUND NOISE IS TO GET INFORMATION AS TO EXACTLY WHAT THAT MEANS IN TERMS OF THE NURSING SERVICES AND THAT NURSING ASSESS. THAT NURSING ASSESSMENT, THIS ADMISSION ASSESSMENT IS WHAT'S GOING TO DRIVE THE CARE DELIVERY PROCESS FOR PATIENTS WHEN THEY'RE IN THE HOSPITAL, AND I REFER BACK TO-- WE'LL USE, FOR AN EXAMPLE, HEARING AIDS AND AN INDIVIDUAL SAYS, YES, I HAVE A RIGHT HEARING AID AND APLEASE STAND BY FOR YOUR OO HE VENT TO BEGIN.

PLEASE STAND BY FOR YOUR EVENT TO BEGIN.

PLEASE STAND BY GORE YOUR EVENT TO BEGIN.

PLEASE STAND BY FOR YOUR EVENT TO BEGIN. PLEASE STAND BY FOR YOUR EVENT TO BEGIN.

>> I DEEPLY APOLOGIZE FOR THE TECHNICAL CHALLENGE AND I HOPE YOU ENJOYED YOUR UNSCHEDULED BREAK. OZZIE, I AM SO SORRY THAT WE INTERRUPTED YOU THAT WAY. WE WILL GIVE THE FLOOR BACK TO YOU WHICH MEANS I NEED TO GET GREG GRIGGS TO STOP TALKING.

[LAUGHTER]

>>> I THINK WE ENDED THE CONVERSATION AND WE WERE TALKING ABOUT THE PATIENT

ASSESSMENTS, HOW THE PATIENT ASSESSMENT THAT THAT NURSE DOES-- THE PATIENT ASSESSMENT THAT THAT NURSE DOES DICTATES THE ITEMS THAT ARE DEVELOPED ON THE PATIENT CARE PLAN AND INITIAL ASSESSMENT OF A PATIENT MAY INDICATE, YES, I DO HAVE A HEARING AID OR NO, I DON'T HAVE A HEARING AID, OR I HAVE DIFFICULTY HEARING. THE EXPECTATION IS THAT AS EACH CARE NURSE GOES THAT ROOM THAT THE ASSESSMENT OF THAT PATIENT CONTINUES, AND AS YOU MAKE UP DATES IN THE ASSESSMENT OF THE PATIENT, THE PATIENT CARE PLAN OR TREATMENT PLAN SHOULD BE UPDATED AND MODIFIED TO ADDRESS THE NEEDS OF PATIENTS AS WELL. ONE OF THE THINGS THAT WE TEND TO SEE AND WE HIGHLY SUGGEST THAT HOSPITAL STAFF CONTINUE TO DO AND THAT IS AS YOU'RE DOING THE ASSESSMENTS AND DEVELOPING THE PLANS OF CARE THAT YOU ALSO ACKNOWLEDGE WHAT THE PATIENT'S PREFERENCES ARE. THERE ARE PATIENTS, IF MY PREFERENCE IS WHEN SOMEONE COMES INTO THE DOOR THAT I NEED YOU DIRECTLY IN FRONT OF ME WHEN WE'RE COMMUNICATING, THOSE ARE THE TYPES OF THINGS THAT WE WOULD EXPECT TO SEE DOCUMENTED ON THE CARE PLAN AND IT ALSO BE COMMUNICATED THROUGH A WHITE BOARD OR WHITE SHEET IN THE INDIVIDUAL'S ROOM. THERE ARE SO MANY DEVICES THAT INDIVIDUALS ARE USING NOW, TABLETS, SMARTPHONES, AMPLIFYING DEVICES, AND IT VARIES FROM HOSPITAL TO HOSPITAL WHICH TOOL THAT PARTICULAR HOSPITAL MAY HAVE IN STOCK, BUT AGAIN, MEETING THE NEEDS OF PATIENTS IS THE EXPECTATION OF BOTH THE STATE AND THE FEDERAL REGULATIONS AND SOME THE TIMES THAT MAY INCLUDE UPDATING EQUIPMENT OR DEVICES TO MEET THE PATIENT'S NEEDS. I MENTIONED EARLIER THAT FOR INDIVIDUALS THAT YOU IDENTIFY WITH HEARING AIDS, THE IMPORTANCE OF MAKING SURE THAT THERE IS A PLAN TO ADDRESS THE SECURITY OF THOSE HEARING AIDS, IF THEY ARE REMOVED AT NIGHT, MAKING SURE THAT THERE'S A STRATEGIC TIME THAT THE PATIENT SHOULD RECEIVE THEIR HEARING AIDS, SUCH THAT THEY'RE BACK IN THEIR EARS TO ASSIST WITH THE DELIVERY OF QUALITY CARE THE FOLLOWING MORNING. THAT PRETTY MUCH INCLUDES THE HIGHLIGHTS THAT I WANTED TO SHARE FROM A HOSPITAL STANDPOINT. WE DO CONDUCT COMPLAINT INVESTIGATIONS. WE CONDUCT SURVEY ACTIVITIES AND ONE OF OUR RESPONSIBILITIES, AS WE'RE DOING THIS SURVEY IS WE'VE GOT TO MAKE SURE THAT WE CAN COMMUNICATE WITH PATIENTS WHEN THEY'RE PULLED TO BE INCLUDED IN OUR SAMPLE. THE OTHER THING ALSO IS AS WE'RE DOING OUR INVESTIGATIONS OR SURVEY ACTIVITIES, WE'RE REVIEWING THE INFORMATION, NUMBER ONE, TO SEE IF THAT ASSESSMENT IS ACCURATE. IF THAT PATIENT CARE PLAN IS CURRENT AND IF IT MEETS THE NEEDS OF THE PATIENTS AND THAT THEIR DAILY DAY-TO-DAY ASSESSMENT IS WARRANTED AND THAT INFORMATION IS CARRIED OVER INTO THE DISCHARGE TO ENSURE THAT AN INDIVIDUAL THAT IS DISCHARGED HOME HAS THE ASSISTANCE THAT THEY WOULD NEED WHEN THEY RETURNED TO THEIR HOME SETTING. THANK YOU FOR THE OPPORTUNITY.

>> I THINK WE'LL OPEN IT UP TO HOSPITAL-SPECIFIC QUESTIONS AND WE'LL GO BY EACH SECTION.

CORYE, GO FIRST.
>> HI, I'M CORYE DUNN WITH DISABILITY RIGHTS NORTH CAROLINA. I'M WONDERING IF DHHS WERE TO GET COMPLAINTS ABOUT ADA VIOLATIONS OF PROVIDERS IN A HOSPITAL SETTING IF THAT WOULD-- BECAUSE WE HAVE AN ADA COMPLAINT PROCESS IN PLACE WOULD THAT THEN ALSO GET REPORTED TO YOUR SECTION SO THAT YOU COULD TREAT IT AS A COMPLAINT FOR SURVEY PURPOSES, OR DOES THAT NOT GET COMMUNICATED TO YOUR SECTION? HAVE YOU EVER GOTTEN THOSE?
>> FROM A COMPLAINT STANDPOINT, IT WOULD PROBABLY CONTINUE TO BE REPORTED TO THE ADA HOTLINE AND BASED ON THEIR REVIEW THERE ARE ITEMS IN THAT PARTICULAR COMPLAINT WHETHER IT BE THE INITIAL INFORMATION COMING IN AND/OR AFTER SOMEONE HAS DONE AN INITIAL INVESTIGATION BASED ON THE OUTCOME OF THAT INFORMATION, THERE ARE AREAS THAT COULD EASILY BE REPORTED TO OUR AGENCY. WE WOULD REVIEW THAT INFORMATION AND MAKE A DETERMINATION AS TO WHETHER OR NOT THERE ARE AREAS OF CONCERN THAT WOULD FALL WITHIN THE PARAMETERS OF THE REGULATIONS THAT WE PROVIDE OVERSIGHT. IN ADDITION TO THAT, WE ALWAYS HAVE AN AVENUE WHERE WE CAN MAKE REFERRALS TO THE OFFICE OF CIVIL RIGHTS IN ATLANTA WHICH IS THE REGION THAT WE FALL UP UNDER AND IF WE NEED TO REFER SOMETHING TO THAT PARTICULAR AGENCY, THEY WOULD REVIEW IT AND MAKE A DECISION AS TO HOW THEY WOULD POSSIBLY TREAT THOSE CONCERNS.
>> DAVID: YES. THANK YOU FOR YOUR PRESENTATION. I FOUND THIS VERY INTERESTING. TALKING ABOUT ALL THE DIFFERENT REGULATIONS THAT ARE INVOLVED. ONE OF THE THINGS THAT I'M WONDERING REGARDING THE HEARING AID AND THAT SURVEY THAT'S DONE, I DO APPRECIATE HEARING FROM YOU EVEN UNDERSTANDING THAT'S AN IMPORTANT ISSUE, BUT MY QUESTION IS COULD DO YOU, I GUESS, DOUBLE CHECK TO SEE IF THE STAFF STAFF ARE ENSURING THAT THE BATTERIES ARE WORKING, THAT THE BATTERIES ARE LIVE, THAT THEY HAVEN'T DIED? SO IS THAT PART OF THE PROCESS THAT YOU FOLLOW?
>> THAT WOULD BE PART OF THE PROCESS. NUMBER ONE, IF AN INDIVIDUAL IS IDENTIFIED THAT WEARS HEARING AIDS AND IF THEY'RE PRESENTLY IN THE HOSPITAL, IT'S A LOT EASIER IF WE MAKE THOSE DECISIONS AND CAN DETERMINE WHETHER OR NOT THE BATTERIES ARE OPERATING. EVEN FROM THE STANDPOINT OF STAFF THAT ARE ASSIGNED TO PROVIDE CARE TO THAT INDIVIDUAL PATIENT, YOU ALSO WOULD REVIEW A SAMPLE OF INDIVIDUALS PROVIDING THE CARE TO THE PATIENT TO SEE WHAT DEGREE OF TRAINING THEY'VE HAD IN REGARD TO MEETING THE NEEDS OF SOMEONE THAT'S HEARING IMPAIRED. THE OTHER THING ALSO WOULD BE ASSISTIVE DEVICES UTILIZED BY THAT PATIENT AND AT THE TIME THAT PATIENT IS ADMITTED, IT MIGHT MEAN THAT WE DO A HUDDLE AT THE BED WITH THE PATIENT, WITH THE PATIENT'S REPRESENTATIVE, WITH AN AUDIOLOGIST THAT MAY BE ON STAFF, WHATEVER IT IS THAT NEEDS TO BE DONE TO BE SURE THAT THE CARETAKER IS ABLE TO

EFFECTIVELY PROVIDE CARE TO THE REFERENCED PATIENT.

>> THIS IS DAVID, THANK YOU.

>> HI. I'M AN AUDIOLOGIST, AND I HAVE A PHYSICIAN THAT LIVES DOWN THE STREET FROM ME. SHE'S A HOSPITALLIST, AND SHE IS NEW TO THE NEIGHBORHOOD, SO I WAS TALKING TOKER HAD IF SHE HAD PATIENTS COMING IN THAT HAD DIABETES AND SHE SAID, OH, YES, YES. THERE THEIR DIABETES IS OUT OF CONTROL, AND I SAID, DO YOU HAVE ISHT PAS WITH HEARING PROBLEMS?

SHE SAID, ACTUALLY, YES. IT'S A LOT. I SAID, WHAT DO YOU DO ABOUT THOSE PATIENTS? SHE SAID IT'S VERY DIFFICULT BECAUSE I CAN'T COMMUNICATE WITH THE PATIENTS. I HAVE TO WAIT UNTIL THEIR FAMILY COMES IN. I ASKED HER IF SHE HAD A WAY TO ASSESS THEM, AND SHE SAID NO. WE DON'T HAVE ANY RESOURCES. I SAID, DO YOU HAVE ANYTHING YOU CAN GIVE THEM SO THEY CAN HEAR? SHE SAID, NO, WE DON'T HAVE ANY OF THOSE SYSTEMS AND SHE'S WITH ATRIUM HEALTH CARE AT A MAJOR HOSPITAL IN CHARLOTTE, AND SHE'S HAVING TO WAIT FOR THE FAMILY MEMBERS TO COME IN TO THE HOSPITAL SO SHE CAN TRY TO RELAY WHAT SHE'S-- ABOUT THEIR MEDICAL CONDITION TO SOMEBODY WHO CANNOT HEAR. I GUESS YOU UNDERSTAND THAT THE CMS GUIDELINES FOR THE NURSING ASSESSMENT ARE FLAWED. YOU CANNOT ASK SOMEBODY WITH A HEARING PROBLEM IF THEY HAVE A HEARING PROBLEM, THAT'S NOT BEEN DIAGNOSED. THEY WILL SAY, NO, I DON'T HAVE A HEARING PROBLEM.

[LAUGHTER]

NOW IF YOU ASK-- IF THERE'S A SPOUSE OR FAMILY MEMBER AND YOU ASK THEM, THEY'LL SAY, OH, MY GOD, YES. I CAN'T STAY IN THE SAME ROOM WITH THEM WHEN THEY'RE WATCHING TV. BUT THE PERSON, THEMSELVES, HAS AN INABILITY TO KNOW THAT THEY HAVE THIS SENSORY IMPAIRMENT . SO YOU HAVE TO HAVE AN OBJECTIVE SCREENING, LIKE A HEAR SCREEN APP, A THREE-MINUTE OBJECTIVE, DIGITS AND NOISE TEST THAT THE WORLD HEALTH ORGANIZATION USES TO SCREEN HEARING. IT'S BEEN VALIDATED IN THE U.S. BY THE UNIVERSITY OF CINCINNATI. IT TAKES THREE MINUTES IN A QUIET PLACE WITH HEADPHONES AND YOU CAN FIND IT ONLINE. SO I THINK-- I KNOW THE CMS GUIDELINES HAVE BEEN LIKE THAT FOR OVER 30 YEARS BUT THEY ARE NOT VALID. YOU CANNOT ASK SOMEBODY SUBJECTIVELY TO KNOW THAT THEY HAVE A HEARING PROBLEM. IT'S BASICALLY FLAWED AND YOU'RE MISSING LOTS OF PEOPLE.

>> I THINK IN REGARDS TO THE COMMENT, THE CMS REGULATIONS ARE CURRENTLY, YOU KNOW, THE ONES THAT ARE ACTIVELY IN PROCESS FOR COMPLIANCE WITH OUR MEDICARE CERTIFIED HOSPITALS. IN REGARD TO THE HOSPITALLIST, THAT'S AN ITEM THAT I BELIEVE REALLY NEEDS TO BE RESEARCHED BECAUSE ON THE ONE HAND THAT ALMOST SOUNDS LIKE HOSPITALLISTS OR POSSIBLY MEDICAL STAFF, AN AREA OF MEDICAL STAFF TRAINING OF OUR HOSPITALLISTS, THAT MAY BE AN AREA THAT NEEDS TO BE REVIEWED AND RECOMMENDATIONS POSSIBLY MADE WITHIN A HOSPITAL SETTING. BUT THAT'S

ALSO AN AREA THAT COULD POSSIBLY CAN TRIGGER A COMPLAINT INVESTIGATION. I'M NOT SAYING NECESSARILY CALL THAT IN, BUT I WOULD LIKE TO GET SOME ADDITIONAL INFORMATION FROM YOU. BECAUSE WHAT WE TEND TO SEE IS IN THE EMERGENCY DEPARTMENT, THERE MAY BE INDIVIDUALS THAT ARE HARD OF HEARING AND THERE ARE AT LEAST LARGE PRINT PRINTED DOCUMENTS THAT INDIVIDUALS CAN BE PRESENTED WITH TO ASSIST AS YOU'RE DOING THAT-- EXCUSE ME-- AS YOU'RE DOING THE INITIAL SCREENING IN THE EMERGENCY DEPARTMENT AS WELL AS THAT PATIENT IS MOVED UPSTAIRS TO A HOSPITAL BED. SO I SAY THAT TO SAY THERE ARE SEVERAL DIFFERENT DEVICES THAT A LOT OF THE HOSPITALS HAVE. NOT KNOWING THE PARTICULAR HOSPITAL IN THIS PARTICULAR CASE. IT'S DIFFICULT FOR ME TO SAY WHAT THIS PARTICULAR SETTING MAY BE. BUT I WOULD LOVE TO TALK WITH YOU A LITTLE BIT MORE ABOUT IT. ON THE OTHER HAND, WHEN THE PATIENT DOES GET TO THE NURSE, THE NURSES ARE IN A POSITION TO SCREEN THAT PATIENT BASED ON THE ADMINISTRATION ASSESSMENT AND AGAIN, I THINK I REITERATED THAT THE ASSESSMENTS ARE UPDATED AS ADDITIONAL CARE NURSES COMING INTO THE ROOM AND THE EXPECTATION IS THAT YOU CONTINUE TO EVALUATE THAT PATIENT, AND AT THAT POINT IN TIME, IF THAT MEANS YOU DO FURTHER ASSESSMENT OR COMMUNICATION WHEN THE FAMILY MEMBER COMES INTO THE ROOM, THOSE ARE THINGS THAT SHOULD BE TAKEN INTO CONSIDERATION AND ARE BEING TAKEN INTO CONSIDERATION WHEN PATIENTS ARE ADMITTED TO THE HOSPITAL, AND AGAIN, IT'S A DAILY, DAILY EVALUATION OF THE PATIENT TO MAKE SURE THAT YOU'RE ASSESSING THAT PATIENT, EVALUATING THE PATIENT'S NEEDS AND DEVELOPING AND DELIVERING THE PLAN OF CARE IS WARRANTED TO MEET THAT PATIENT'S NEEDS, BUT THANK YOU FOR YOUR COMMENT.

>> ROB KURZYDLOWSKI: WE'LL TAKE ONE MORE HOSPITAL-RELATED QUESTION AND AT THE END, WE WILL DO A GENERAL Q&A OF ALL THE SECTIONS WE WILL GO OVER.

>> THIS IS TOVAH HERE. I HAVE SEVERAL QUESTIONS BUT LET ME START WITH ONE OR TWO AT LEAST. IT'S MY UNDERSTANDING THAT HOSPITALS ARE ALSO LICENSED OR REGULATED BY THE STATE NOT JUST FEDERAL REGULATIONS, RIGHT? YES. OKAY. IS IT POSSIBLE THEN THAT IF THERE ARE LAPSES IN COMPLIANCE, LIKE FOR EXAMPLE, INTERPRETERS AREN'T PROVIDED OR THE CARE DOESN'T MATCH THE ASSESSMENT NEEDS OR WHATEVER THAT THERE COULD BE ENFORCEMENT OF COMPLIANCE IF-- I MEAN, ENFORCEMENT OF STATE LICENSING AND REGULATION IF THE HOSPITALS DON'T COMPLY APPROPRIATELY WITH THE CARE OF PEOPLE WHO ARE DEAF AND HARD OF HEARING, FOR EXAMPLE? WE TALKED A LOT ABOUT HEARING AIDS BUT FOR EXAMPLE, OUR INTERPRETERS RELINELY PROVIDED, IF THAT'S WHAT'S NEEDED AND IF THEY'RE NOT, IS THERE SOMETHING THAT COULD BE DONE TO REMIND THE HOSPITAL THAT THEIR LICENSURE DEPENDS UPON COMPLYING WITH THESE LAWS?

>> COULD YOU GO BACK TO SLIDE NUMBER-- LET'S GO BACK A COUPLE OF SLIDES. I'LL SHOW YOU. SLIDE FOUR.

>> ON THIS PARTICULAR SLIDE RIGHT THERE, SHOWS YOU THE DIFFERENT AREAS THAT COULD BE CITED IF AN AREA OF NON-COMPLIANCE IS IDENTIFIED AND JUST FOR CLARIFICATION'S SAKE, THE HOSPITALS THEY MUST BE IN COMPLIANCE WITH STATE LICENSURE REGULATIONS AS WELL AS THE MEDICARE CONDITIONS OF PARTICIPATION. SO AS YOU'RE DOING YOUR COMPLAINT INVESTIGATION OR YOUR SURVEY ACTIVITY, YOU CAN EASILY-- EXCUSE ME. YOU CAN EASILY HAVE AN AREA OF NON-COMPLIANCE IDENTIFIED IN A STATE AREA AND/OR A FEDERAL AREA AND AGAIN, THOSE ARE JUST EXAMPLES OF RIGHT THERE OF REGULATORY TAGS IS WHAT WE GENERALLY REFER TO, THAT WOULD BE CITED. NOW IN REGARDS TO OUR HOSPITALS, WE DO NOT HAVE A CIVIL MONETARY PENALTY THAT'S ENFORCED IN NURSING HOMES AND SOME OF OUR OTHER PROGRAMS. SO A DEFICIENCY CITATION WOULD BE THE COURSE OF MSH ADMINISTRATION ACTION OR THE CITE OF NON-COMPLIANCE THAT WE WOULD HAVE IN A HOSPITAL SETTING. IF I COULD JUST HIGHLIGHT, THERE ARE TWO LEVELS OF DEFICIENCIES. FOR EXAMPLE, UNDER PATIENT'S RIGHTS OR THE AREA OF COMPLIANCE WITH FEDERAL AND STATE LAWS, THE FIRST TAG GENERALLY REPRESENTS THAT HIGHEST LEVEL OF DEFICIENCY CITATION, WHICH WOULD BE AT THE CONDITION LEVEL, AND THEN THE SECOND LEVEL-- THE SECOND TAG REFERENCES THE NEXT LEVEL OF CITATION, WHICH IS REFERRED TO AS A STANDARD LEVEL OF DEFICIENCY . ONCE A DEFICIENCY IS CITED, THE HOSPITAL WOULD BE REQUIRED TO SUBMIT A CORRECTIVE ACTION PLAN AND WE WOULD HAVE THE AUTHORITY TO GO BACK AND CONDUCT AN ON-SITE SURVEY IF THAT'S WHAT IS NEEDED TO DETERMINE WHETHER OR NOT THE HOSPITAL IS IN COMPLIANCE WITH THE REGULATIONS.

>> THANK YOU SO MUCH. WE'RE GOING TO MOVE ON TO THE NEXT SECTION OF THIS PRESENTATION AND INVITE LIBBY UP.

>> HI. I'M LIBBY KINSEY. I'M A REGISTERED NURSE AND I'M THE ASSISTANT SECTION CHIEF OF THE ADULT CARE LICENSURE SECTION. ONE OF THE THINGS I WANTED TO DO FOR YOU BECAUSE I DO NOT KNOW EVERYONE IN THE AUDIENCE, BUT I DID WANT TO SHARE WITH YOU A LITTLE BIT ABOUT WHAT ARE ADULT CARE HOMES, BECAUSE IT IS VERY MUCH A DIFFERENT SETTING THAN WHEN YOU ARE TALKING ABOUT ACUTE CARE OR SKILLED NURSING SERVICES. ADULT CARE HOMES ARE VERY MUCH TO BE A HOME-LIKE ENVIRONMENT FOR RESIDENTS, SO AS I GO INTO MY PRESENTATION, I JUST WANT TO SHARE A LITTLE BIT ABOUT WHAT IS AN ADULT CARE HOME, WHO DO WE SERVE IN ADULT CARE HOMES, AND HOW DO WE CARRY OUT OUR REGULATORY RESPONSIBILITIES TOENSURE THAT RESIDENTS RECEIVE APPROPRIATE SERVICES. IN AN ADULT CARE HOME, AND MANY OF YOU HAVE HEARD DIFFERENT TERMS, THOSE ARE LICENSED ASSISTED LIVING FACILITIES AND WE ALSO HAVE FAMILY CARE HOMES. OUR LARGER FACILITIES ARE ADULT CARE HOMES AND WITHIN THOSE LICENSED FACILITIES, THE PRIMARY FOCUS IS ASSISTANCE WITH ACTIVITIES OF DAILY LIVING. SO IF YOU GO ON TO THE NEXT SLIDE, THE PRIMARY THINGS THAT ARE DONE WITHIN AN ASSISTED LIVING AND FAMILY CARE

ADULT CARE FACILITY IS ASSISTANCE WITH THOSE ACTIVITIES OF DAILY LIVING, BOTH ON A SCHEDULE BASIS AN UNSCHEDULED BASIS AND WHEN I TALK ABOUT ACTIVITIES OF DAILY LIVING, I'M TALKING ABOUT ASSISTANCE WITH EATING, IF SOMEONE NEEDS ASSISTANCE WITH EATING, ASSISTANCE WITH GOING TO THE BATHROOM, WITH TOILETING, WITH TRANSFERRING , WITH BATHING, DRESSING, THOSE ARE THE TYPES OF SERVICES THAT SHOULD BE PROVIDED IN AN ADULT CARE HOME. RESIDENTS ARE NOT THERE FOR NURSING SERVICES. I THINK THAT'S ONE OF THE THINGS THAT IS IMPORTANT TO KNOW ABOUT ADULT CARE HOMES. ADULT CARE HOMES DO NOT HAVE LICENSED HEALTH CARE PROFESSIONALS WORKING IN THEM. THERE ARE REQUIREMENTS FOR THE ADMINISTRATION, OF THE FACILITY, BUT THE STAFF-- MANY-- WHEN WE HAVE FOLKS WHO CALL, FAMILIES OR SOMEONE CALLS AND SAYS, YOU KNOW, WHY ISN'T THERE A NURSE IN THE FACILITY? WELL, IT'S NOT A HEALTH CARE, IT'S NOT A SKILLED SETTING, SO THAT IS WHY THEY ARE NOT THERE. THE EAR THING THAT MANY RESIDENTS-- MOST RESIDENTS RECEIVE IS ASSISTANCE WITH MEDICATION ADMINISTRATION, AND THEN WE TALK ABOUT OUR POPULATION, YOU'LL SEE BASED ON THE NUMBER OF FOLKS WITH DEMENTIA OR ALZHEIMER'S-RELATED DEKNEES, MANY PEOPLE COME TO ASSISTED LIVING-- SEIZE, MANY PEOPLE COME TO ASSISTED LIVING AND COME FOR HELP. THEY ARE NOT ABLE TO LIVE SAFELY IN THEIR HOME ANY LONGER BECAUSE THEY MAY NOT REMEMBER TO UNIT THE STOVE OFF. THEY MAY NOT REMEMBER TO TAKE THEIR MEDICATIONS. THEY MAY NOT JUST REMEMBER TO TAKE CARE OF THEIR SELF, THEIR PERSONAL NEEDS SO THEY COME INTO A FACILITY. ON THE FAR END OF THAT SPECTRUM IS WHEN SOMEONE HAS BEEN TAKEN CARE OF OR NO LONGER ABLE TO LIVE SAFELY BECAUSE THEY HAVE A-- DUE TO DEMENTIA, THEY MAY ELOPE. THEY MAY TRY TO GO SOMEWHERE THAT IS NOT SAFE. LIKE HOME, IF THEY HAVE DEMENTIA AND THEY THINK THEY'RE GOING BACK HOME BECAUSE THEY FEEL LIKE THEY'RE 16 YEARS OLD AND THEY ARIC SEEKING A FORMER TIME-- THEY ARE SEEKING A FORMER TIME. THE OTHER THING THAT THE FACILITIES ARE RESPONSIBLE FOR IS BECAUSE THEY ARE LICENSED-- NOT HEALTH CARE PROFESSIONALS AND WHAT WE SAY IS WE SAY THEY ARE NON-PROFESSIONAL STAFF. THEY HAVE TO MAKE REFERRALS, SO WHEN THEY IDENTIFY CERTAIN NEEDS OF RESIDENTS, THEY HAVE TO MAKE AN APPROPRIATE REFERRAL TO A -- USUALLY ALL THE RESIDENTS HAVE PRIMARY-- THEY HAVE PRIMARY CARE PHYSICIANS, SO THAT PRIMARY CARE PHYSICIAN, HE OR SHE HAS A LOT OF RESPONSIBILITY FOR THE CARE OF THAT RESIDENT AND ASSISTING IN WHAT SERVICES NEED TO BE PROVIDED THERE. AS I SAID EARLIER, IF YOU'RE NOT FAMILIAR WITH THE TERM, FAMILY CARE AND ADULT CARE, WE JUST HAVE TWO LICENSURE CLASSIFICATIONS. ONE IS A MORE RESIDENTIAL SETTING AND THAT IS ACTUALLY A FAMILY CARE HOME THAT CARES FOR TWO SIX PEOPLE, AND THEN OUR LARGER FACILITIES CARE FOR ANYONE FROM SEVEN OR MORE. WE HAVE SOME FACILITIES THAT OVER 90 RESIDENTS WITH IN THEM. SO WHO LIVES IN ADULT CARE HOMES?

SO SOME OF YOU, I DO KNOW IN THIS SETTING AND OVER THE YEARS, THERE ARE CHALLENGES WITHIN

ADULT CARE HOMES BECAUSE OF THE VARIED POPULATION WITHIN THOSE SETTINGS. I KIND OF SAY THAT IT IS VERY WIDE, VERY WIDE. WE HAVE YOUNG PEOPLE. YOU ONLY HAVE TO BE 18, AND THEN WE HAVE PEOPLE THAT ARE OVER 100. WE HAVE FACILITIES THAT CARE FOR A PRIMARILY POPULATION OF PEOPLE WITH THAT ARE WHAT I CONSIDER FRAIL AND ELDERLY. THEN WE HAVE POPULATIONS WHERE THE FACILITIES TAKE CARE OF PEOPLE WITH MENTAL ILLNESS, WHO CANNOT LIVE IN THE COMMUNITY AND THERE'S NOT OTHER PLACEMENT OPTIONS AND SOMETIMES YOU HAVE A MIXED COMMUNITY. SO AS IT SAYS HERE, WE HAVE OVER 28,000 RESIDENTS LIVE INNING OUR FACILITIES IN NORTH CAROLINA. WE HAVE FACILITIES IN, I BELIEVE, 98 COUNTIES OF THE 100. SO THEY ARE SPREAD EVERYWHERE. AS YOU CAN SEE, THE MAJORITY OF THE FOLKS IN THE FACILITY ARE 63% ARE 75 AND OLDER. BUT THERE IS THAT PERCENTAGE, 30%, WHERE I FALL, IN THAT 55 AND 74 AGE, SO I CALL THOSE THE YOUNG PEOPLE. I HOPE YOU ALL WOULD AGREE.

[LAUGHTER]

SO EVEN 75, YOU KNOW, NOT UNTIL YOU'RE ABOUT 90 DO I CONSIDER THAT REALLY A SENIOR CITIZEN AND I'M GOING TO BE MOVING THAT NUMBER FARTHER OUT THE OLDER I BECOME. SO AS I SAID BEFORE , AND IT'S INTERESTING, 41% OF OUR RESIDENTS-- AND THIS INFORMATION AND I WANT TO JUST SAY THAT THESE NUMBERS ARE SELF-REPORTED THROUGH OUR ANNUAL LICENSING PROCESS, SO WHEN OUR FACILITIES RENEW THEIR LICENSES ON AN ANNUAL BASIS, THESE NUMBERS COME FROM THOSE, SO THEY ARE SELF-REPORTED SO THEY ARE SUBJECT TO SOME VARIABILITY DEPENDING ON THE FACILITY. SO 41% HAVE A PRIMARY DIAGNOSIS OF ALZHEIMER'S OR DEMENTIA. SO THAT, IN ITSELF, WHEN YOU TALK ABOUT HEARING OR HEARING LOSS, THAT PRESENTS A CHALLENGE IN ITSELF, IF THAT IS THE POINT IN TIME WHERE THAT HEARING LOSS IS BEING IDENTIFIED WITH THAT INDIVIDUAL, AND THEN LIKE I SAID, SOME OF OUR FACILITIES DO CARE FOR PEOPLE WHO HAVE DIAGNOSES OF MENTAL ILLNESS AND OF COURSE, THAT CAN IMPACT SCHIZOPHRENIA, THOSE TYPES OF THINGS CAN ALSO IMPACT AN INDIVIDUAL'S SENSORY DEFICITS. WE ALSO HAVE VERY SPECIFIC FACILITIES THAT ARE-- WE HAVE A LICENSURE CATEGORY WHERE A FACILITY CAN IDENTIFY THAT THEY ONLY CARE FOR PEOPLE 55 AND OLDER AND THEN WE ALSO HAVE FACILITIES, WE HAVE 250 FACILITIES THAT ARE LICENSED TO CARE FOR RESIDENTS WITH ALZHEIMER'S AND RELATED DEMENTIA. THAT'S A SPECIFIC LICENSURE CATEGORY. WE ACTUALLY HAVE SOME FACILITIES THAT THEIR WHOLE POPULATION IS THAT LICENSURE CATEGORY AND THEN WE HAVE MANY, THE MAJORITY OF WHICH HAVE SMALLER UNITS OF 25 OR 30 RESIDENTS THAT ARE IN A SECURE PART OF THE FACILITY. SO REALLY, THE PART THAT I THINK MANY OF YOU ARE INTERESTED IN IS HOW DO WE LOOK AT RESIDENTS FROM A REGULATORY STANDPOINT, AND HOW IS THE FACILITY RESPONSIBLE TO MEET THE NEEDS OF RESIDENTS? ONE OF THE THINGS I WANT TO ALSO TELL YOU THAT MAKES THIS A LITTLE BIT DIFFERENT, WE ARE THE DIFFERENT AGENCY IN A DHSR, FOR SURE. OUR LOCAL COUNTY DEPARTMENTS OF SOCIAL SERVICES SHARE THROUGH A

STATUTORY REQUIREMENT MONITORING RESPONSIBILITIES WITHIN ADULT CARE HOMES AND THEY ALSO COMPLETE COMPLAINT INVESTIGATIONS. SO AT THE LOCAL COUNTY LEVEL, THERE ARE STAFF WITHIN THE ADULT SERVICES SECTION WHO HAVE-- WHO ARE TRAINED AND HAVE RESPONSIBILITIES IN ROUTINE, WHICH OUR DEFINITION OF ROUTINE IS AT LEAST QUARTERLY, GOING INTO A FACILITY AND MONITORING DIFFERENT RURAL AREAS AND ALSO THEY DO COMPLAINT INVESTIGATIONS. THAT CAN EITHER BE RECEIVED AT THE LOCAL LEVEL AT THE COUNTY DEPARTMENT OF SOCIAL SERVICES, OR THAT MAY COME IN THROUGH THE DHSR COMPLAINT INTAKE UNIT. AND THEN OUR AGENCY, WE HAVE STAFF ACROSS THE STATE THAT DO ANNUAL AND BIANNUAL INSPECTIONS OF FACILITIES. WHAT IS THE FACILITY'S RESPONSIBILITY IN CARE OF RESIDENTS? THE FIRST THING IS PRIMARILY IS RESIDENTS' RIGHTS, AND THE PRIMARY RIGHT IS THAT THE RESIDENT WILL RECEIVE CARE AND SERVICES THAT ARE APPROPRIATE AND IN COMPLIANCE WITH STATUTES AND RULES, AND ONE OF THE THINGS I WANT TO BACK UP ABOUT THIS, TOO. ADULT CARE HOMES ARE-- IT'S STRICTLY STATE LICENSURE. THERE ARE NOT FEDERAL. WE ARE NOT UNDER CMS. ALL OF THE LAWS AND THE RULES ARE NORTH CAROLINA LAW AND RULE. THERE IS NOT A ANY RAL LAWS AT THIS TIME BECAUSE ONE OF THE CHALLENGES ACROSS THE COUNTRY IS THAT ASSISTED LIVING IS VERY DIFFERENT FROM STATE TO STATE. SOMETIMES DEPENDING UPON PAYMENT SOURCES, THERE IS A PROVISION WITHIN NORTH CAROLINA THROUGH NORTH CAROLINA MEDICAID FOR PERSONAL CARE SERVICES, TO BE-- FOR PAYMENT FOR PERSONAL CARE SERVICES IN FACILITIES, AND THEN THERE IS PAYMENT THROUGH THE SPECIAL ASSISTANCE PROGRAM TO HELP WITH ROOM AND BOARD, FOR PEOPLE THAT ARE UNABLE TO PAY PRIVATELY. OF COURSE, THERE ARE PEOPLE WHO PAY PRIVATELY AND WHO MAY BE PAYING OUT-OF-POCKET OR THROUGH PRIVATE INSURANCE THROUGH LONG-TERM CARE INSURANCE. BUT ANYWAY, IT IS A STATE OVERSIGHT. SO WHEN THE PERSON COMES IN, THE FACILITY IS RESPONSIBLE FOR COMPLETING AN ASSESSMENT . NOW, OUR ASSESSMENT IS VERY DIFFERENT THAN WHAT YOU'VE HEARD FROM AZZIE AND WHAT YOU'RE GOING TO HEAR FROM CINDY. THESE ASSESSMENTS ARE FOR FUNCTION AND FOR ASSISTANCE WITH ACTIVITIES OF DAILY LIVING. THEY ALSO SHOULD INCLUDE, YOU KNOW, DOES AN INDIVIDUAL WEAR GLASSES? DOES AN INDIVIDUAL HAVE DENTURES? DOES THE INDIVIDUAL HAVE A HEARING AID? YOU KNOW, ARE THEY ABLE TO MAINTAIN THEIR HEARING AID THEMSELVES? BUT IN THAT PROCESS THAT ASSESSMENT IN CARE PLANNING ARE DONE PRIMARILY BY UNLICENSED STAFF. THEY ARE NOT DONE BY NURSES. NOW WITHIN THE MEDICAID PROGRAM FOR PEOPLE WHO RECEIVE PERSONAL CARE SERVICES, THOSE RESIDENTS ARE ASSESSED BY A LICENSED-- A REGISTERED NURSE THROUGH THE CONTRACTED THE AGENCY. LIBERTY HAS THE CONTRACT WITH NORTH CAROLINA AND THEY DO THOSE ASSESSMENTS SO THAT ASSESSMENT IS, BUT IT IS VERY FOCUSED UPON ACTIVITIES OF DAILY LIVING AND THAT ASSISTANCE. NOW DURING THE ASSESSMENT AND CARE PLANNING PROCESS, AND AS IT-- I MEAN, JUST TO BE COMPLETELY TRANSPARENT, OUR ASSESSMENT PROCESS IS NOT SOMETHING THAT

CONTINUES. THE WELL, WHAT OUR STAFF-- WHAT OUR FACILITIES ARE DIRECTED IS THAT IF SOMEONE COMES IN TODAY AND THIS IS THEIR BASELINE, AND THEN IN A MONTH, YOU SEE A DIFFERENCE IN THEM, LIKE THEY ARE NOW MORE CONFUSED, THEY ARE WITHDRAWN, THERE'S BEEN SOME KIND OF CHANGE WHETHER IT'S A PHYSICAL CHANGE, BUT THERE HAS BEEN A CHANGE IN THEIR CONDITION, THE FACILITY IS RESPONSIBLE FOR REPORTING TO THE PHYSICIAN. AS I SAID BEFORE, STAFFING FACILITIES, THEY DON'T DIAGNOSE, YOU KNOW, TO SAY THAT, WELL, I THINK SOMEONE HAD A STROKE, WELL, YOU'RE NOT ABLE TO MAKE THAT DETERMINATION. YOU TELL THE PHYSICIAN THE SYMPTOMS THAT THE PERSON IS HAVING AND THEN WE LOOK TO THE PHYSICIAN TO ORDER TREATMENTS, TESTS, WHATEVER KINDS OF THINGS NEED TO BE ORDERED TO TREAT OR IDENTIFY CHANGES THAT HAVE OCCURRED WITHIN THAT RESIDENT. THE FACILITY STAFF ARE PRIMARILY RESPONSIBLE IN PROVIDING THAT PERSONAL CARE, SO IF YOU DO HAVE SOMEONE WHO HAS HEARING AIDS AND THEY HAVE-- THEY NEED ASSISTANCE, THE STAFF SHOULD PROVIDE THAT. NOW, I WILL ALSO BE PERFECTLY, YOU KNOW, TRANSPARENT WITH YOU. I HAVE-- IN MY PREVIOUS LIFE ALMOST 20 YEARS AGO, I ACTUALLY WORKED IN A FACILITY, IN MANY FACILITIES. I WAS AN ADMINISTRATOR IN NURSING HOMES AND ASSISTED LIVING AND YOU KNOW, THINGS ARE VERY DIFFERENT. HEARING AIDS ARE MUCH MORE-- I SPEAK FROM PERSONAL EXPERIENCE THROUGH MY HUSBAND. HE HAS HEARING AIDS, AND I GET REALLY MERE VOWS IN TOUCHING THEM BECAUSE THEY, FOR ONE THING, ARE VERY EXPENSIVE, AND I DON'T WANT TO BREAK THEM, AND SO HE TAKES CARE OF HIS HEARING AIDS, BUT IT'S VERY HARD TO CHANGE THE BATTERIES IN HIS HEARING AIDS AND I THINK I HAVE PRETTY GOOD DEXTERITY. SO WHEN YOU THINK ABOUT-- AND I'M JUST MAKING THIS PERSONAL FOR ME. WHEN I THINK ABOUT THAT AND THINK ABOUT THE CAREGIVERS WITH IN A FACILITY, SOMETIMES THEY ARE AFRAID TO TOUCH PEOPLE'S HEARING AIDS, OR THEY DON'T KNOW LIKE THE GENTLEMAN SAID EARLIER, YOU KNOW, THAT THOSE BATTERIES SHOULD BE CHANGED EVERY WEEK AND I KNOW FOR MY HUSBAND'S, HIS EMITS AI LITTLE NOISE BUT HE'S ALSO IN A ROUTINE TO CHANGE IT, AND PEOPLE DON'T ALWAYS KNOW THAT BUT THOSE THINGS CAN BECOME PART OF A PLAN OF CARE FOR AN INDIVIDUAL BECAUSE ONE OF THE THINGS AS A NURSE AND AS AN ADVOCATE FOR RESIDENTS IN ADULT CARE HOMES IS IT'S VERY IMPORTANT THAT PLANS OF CARE ARE SPECIFIC TO THE INDIVIDUAL, THAT IT'S NOT JUST A COOKIE CUTTER PLAN OF CARE, BUT IT IS PERSON-CENTERED TO THEIR NEEDS TO, BASED UPON THEIR EXPERIENCES IN LIFE AND WHAT THEIR EXPECTATIONS ARE AND WHAT THEY WANT, WHAT THEIR RIGHTS, WHAT DOES THE PERSON WANT TO OCCUR WITHIN THE FACILITY? WHAT TO THEY WANT THE STAFF TO ASSIST THEM WITH? BECAUSE IT IS VERY MUCH A BALANCING ACT BETWEEN TRYING TO ENCOURAGE AND HELP SOMEONE REMAIN INDEPENDENT IN AS MUCH OF THEIR CARE AS POSSIBLE AND ALSO MAKING SURE THAT NEEDS AND THE ENVIRONMENT IS SAFE. SO THE FACILITIES HAVE TO BALANCE THAT BUT THEY SHOULD BE HELPING RESIDENTS WITH THEIR HEARING AIDS. IF A RESIDENT

HAS A CHANGE IN THEIR CONDITION AND LET'S SAY ORIGINALLY THEY SEEM TO BE ABLE TO RESPOND AND ALSO SIMILAR TO WHAT AZZIE SAID, YOU OFTEN LEARN WHETHER YOU NEED TO FACE SOMEONE WHEN YOU ARE SPEAKING TO THEM. YOU KNOW, IF YOU ARE TALKING BEHIND THEM AND THEY DON'T HEAR YOU OR THEY DON'T APPROPRIATELY RESPOND AND THE STAFF HAVE TO INVESTIGATE AND SEE WHAT NEEDS TO OCCUR. MANY TIMES, THE FAMILIES ARE VERY IMPORTANT PARTS OF WHAT THE NEEDS ARE OF THIS PERSON, WHAT HAS BEEN THEIR PERSONAL HABITS, HOW HAVE THINGS BEEN CARRIED OUT IN THE HOME, OR WHEREVER THEY LIVED, WHAT WERE THE CHALLENGES THERE? BECAUSE IF THERE WERE CHALLENGES IN THE HOME, THOSE CHALLENGES ARE NOT GOING TO GO AWAY WHEN THEY COME TO THE ASSISTED LIVING FACILITY. IF AN INDIVIDUAL CAN'T KEEP UP WITH THEIR DENTURES OR THEY COULDN'T KEEP UP WITH THEM AT HOME, THEY'RE PROBABLY GOING TO BE -- IT'S PROBABLY GOING TO BE DIFFICULT IN THE FACILITY TO DO THAT ALSO. BUT THE PRIMARY PART IS THAT FACILITIES ARE TO ASSESS, TO IDENTIFY CHANGES OR CHANGING CONDITION, EVEN THOUGH THEY MAY NOT NOT KNOW WHAT CREATED THAT CHANGE, COMMUNICATE THAT TO THE APPROPRIATE HEALTH CARE PROVIDER AND FOR THAT HEALTH CARE PROVIDER TO WORK WITH THE RESIDENT AND THE FAMILY IN MAKING APPROPRIATE DECISIONS. THERE ARE CHALLENGES WITH HEALTH CARE PROVIDERS THAT SEE RESIDENTS IN ASSISTED LIVING, SOMETIMES THE STAFF DON'T COMMUNICATE, YOU KNOW, THEY'LL SAY, WELL, THIS PERSON'S HAVING THIS PROBLEM BUT THEY DON'T CLEARLY IDENTIFY ALL THE PROBLEMS AND YOU KNOW, IF THAT HEALTH CARE PROVIDER'S ONLY IN THE FACILITY FOR A SHORT PERIOD OF TIME OR IF THE INDIVIDUAL IS LEAVING THE FACILITY AND GOING TO THEIR OFFICE TO MAKE SURE THAT ALL THE INFORMATION IS COMMUNICATED, THERE ARE TIMES WHEN IT IS NOT. AND THAT'S ONE OF THE THINGS THAT OFTENTIMES FROM A REGULATOR THAT WE SEE IS THAT A FACILITY DOCUMENT-- IF A FACILITY DOCUMENTS OR HAS KNOWLEDGE OF THIS, THEN WE, PECT THAT TO BE CARRIED OUT THROUGH THE COMMUNICATION WITH THE PROVIDER. IT'S IMPORTANT FOR FACILITIES TO KNOW WHAT ARE THE RESOURCES WITHIN THEIR COMMUNITIES. SO OFTEN FACILITIES ARE VERY MUCH, AS I SAID, PRIMARILY YOU GO TO YOUR -- THE PRIMARY HEALTH CARE PHYSICIAN. THE PERSON MAY HAVE CARDIOLOGIST OR ENDOCRINOLOGIES AND IF THEY HAVE AN AUDIOLOGIST SEEING THEM, THIS SHOULD BE WHATEVER FREQUENCY OF VISITS THIS OCCUR. WHAT WE LOOK AT IS TO MAKE SURE THAT THE PERSON IS TREATED WHOLLY AND THAT EVERYTHING OR ALL NEEDS ARE IDENTIFIED. ONE OF THE THINGS I WOULD JUST SPEAK TO YOU AND THIS IS AT A PERSONAL LEVEL IS THAT THERE ARE CHALLENGES WITHIN COMMUNITIES FOR PEOPLE TO KNOW WHAT RESOURCES BECAUSE IF THEY GO TO THE PRIMARY CARE DOCTOR AND HE'S NOT OR SHE'S NOT AS KNOWLEDGEABLE AS WHO'S AVAILABLE, THEN THERE MAY-- THINGS MAY NOT BE REALLY TREATED AS THEY COULD BE AND I'M NOT TRYING TO BASH PRIMARY CARE PHYSICIANS BUT SPEAKING FROM EXPERIENCE IN WHAT YOU SEE AND WHEN WE INTERVIEW DOCTORS, SOMETIMES THEY'RE LIKE, WELL,

NOBODY TOLD ME THAT AND THAT IS IMPORTANT. THE COMMUNICATION BETWEEN THE FACILITY AND THE PHYSICIAN, SO HE OR SHE DOES KNOW WHAT THE RESIDENT NEEDS . I JUST WANT TO TAKE A COUPLE MINUTES, IF YOU DON'T MIND, BECAUSE SENIORS ARE NEAR AND DEAR TO MY HEART AND ONE DAY I AM GOING TO BE ONE AND BECAUSE ALL OF US, ALL THREE OF US ARE VERY PASSIONATE ABOUT WHAT WE DO EVEN THOUGH AS REGULATORS, PEOPLE DON'T ALWAYS LIKE THE REGULATORS AND UNFORTUNATELY, WE DON'T ALWAYS MAKE EVERYONE HAPPY EITHER BECAUSE SOMETIMES FROM A FAMILY'S PERSPECTIVE OR RESIDENT OR SOMEONE ELSE, YOU KNOW, WE HAVE LIMITATIONS WITHIN OUR ROLE AND WITHIN WHAT THE LAWS SAY, BUT WE TRY TO FOCUS ON WHAT THE RESIDENTS' NEEDS ARE, WHAT THEIR RIGHTS ARE, ENSURING IF THEY HAVE CHANGES. I JUST THINK IT'S VERY IMPORTANT AT COMMUNITY LEVELS BECAUSE OFTEN, OUR RESIDENTS ARE ABLE TO GO TO COMMUNITY EVENTS LIKE TO THE SENIOR CENTER. THEY DON'T JUST STAY IN THE FACILITY. THEY'RE INVOLVED IN THEIR CHURCHES. THEY'RE INVOLVED IN, YOU KNOW, COMMUNITY EVENTS AND MAKING SURE THAT THERE ARE-- THERE'S A KNOWLEDGE OF WHAT KIND OF RESOURCES ARE AVAILABLE FOR THE DEAF AND HARD OF HEARING OR FOR PEOPLE THAT NOW HAVE A PROBLEM THAT THEY DIDN'T HAVE BEFORE. ONE OF THE THINGS IS THAT WE ARE ONLY SPEAKING FROM A REGULATORY STANDPOINT AND THE REGULATED FACILITIES BUT THERE ARE-- AND IN THIS AREA A LOT, FACILITIES THAT ARE SENIOR LIVING COMMUNITIES, THAT ARE HIGH RISES AND APARTMENT COMPLEXES, YOU KNOW, AND MAKING SURE THAT THOSE PEOPLE KNOW WHAT'S AVAILABLE TO THEM, HAVING, YOU KNOW, WHERE COMMUNITY FAIRS OR THINGS LIKE THAT. I HAVE, MY SON'S FIANCE IS CURRENTLY STUDYING TO BE AN AUDIOLOGIST.

SHE HAS ONE MORE YEAR OF SCHOOL AND SHE WILL DO HER EXTERNSHIP, BUT SHE AND I TALK ABOUT THIS OFTEN ABOUT THE OPPORTUNITY FOR STUDENTS WHO MAY BE IN SPEECH LANGUAGE PATHOLOGY AND UNIVERSITIES TO GO OUT AND DO HEARING SCREENINGS AT COMMUNITIES TO BUILD THOSE RELATIONSHIPS. SOMETIMES FACILITIES ARE SO BUSY CARING FOR THEIR RESIDENTS THAT THEY DON'T ACTUALLY GO OUT AND SEEK THOSE OPPORTUNITIES FOR PEOPLE TO COME IN AND PROVIDE INFORMATION AND RESOURCES FOR THEIR RESIDENTS, BUT WHEN PEOPLE DO COME IN, THEY'RE LIKE, OH, YEAH, THAT WOULD BE GREAT. WE CAN HAVE A HEALTH FAIR IN OUR FACILITY AND HAVE DIFFERENT PEOPLE WHO CAN PRESENT INFORMATION TO RESIDENTS. SO HAVING THAT INVOLVEMENT AT THE COMMUNITY LEVEL, HAVING RESOURCES FOR FACILITIES TO KNOW WHAT'S AVAILABLE AND ALSO HAVING TRAINING INFORMATION AVAILABLE FOR STAFF SO THEY CAN UNDERSTAND WHAT A HEARING AID IS, HOW HEARING AIDS WORK, YOU KNOW, WHETHER IT'S A PIECE OF PAPER THAT HAS INFORMATION ON IT, ABOUT CHANGING BATTERIES, VERY SIMPLE THINGS THAT, YOU KNOW, MAY BE GIVEN TO SOMEONE IN THEIR HOME BUT ALSO WILL BE VERY APPROPRIATE FOR SOMEONE WHO IS CARING FOR THEM IN AN ASSISTED LIVING COMMUNITY. THANK YOU SO MUCH FOR YOUR TIME. IF

YOU HAVE QUESTIONS, I'LL BE GLAD TO ANSWER THEM.
>> WE CAN DO ONE OR TWO QUESTIONS FOR THIS SECTION AND AGAIN, SAVE THE REST FOR AFTER.
>> HI. THIS IS TOVAH. THANK YOU SO MUCH FOR A VERY INFORMATIVE PRESENTATION HERE, BUT NOW I'M A LITTLE CONFUSED ABOUT THE DISTINCTION BETWEEN WHAT WE THINK OF AS ASSISTED LIVING FACILITIES VERSUS ADULT CARE HOME. THERE SEEMS TO BE A LOT OF OVERLAP THERE. SO COULD YOU HELP CLARIFY THAT, THAT'S THE FIRST PART OF MY QUESTION. THE SECOND PART HAS TO DO WITH HOW DO YOU-- HOW DO ACHs ENFORCE COMPLIANCE, SAY, FOR THE NEED FOR SIGN LANGUAGE INTERPRETERS FOR DEAF RESIDENTS AND THINGS LIKE THAT?
>> IT IS VERY CONFUSING THE DIFFERENT TYPES OF FACILITIES. SO JUST TO GIVE YOU, AGAIN, A GENERAL STATUTE QUICK AND DIRTY LESSON. IN NORTH CAROLINA GENERAL STATUTES, ASSISTED LIVING IS DESIGNED AS ADULT CARE HOMES AND IT'S ALSO DEFINED AS AN UNLICENSED CATEGORY CALLED MULTIUNIT ASSISTED HOUSING WITH SERVICES. FOR SHORT, IN OUR OFFICE, WE CALL THAT A MAHA. THEY HAVE INDIVIDUALS THAT LIVE THERE. THOSE SERVICES ARE PROVIDED BY LICENSED HOME CARE AGENCIES THAT ARE REGULATED BY AZZIE'S SECTION, AND PEOPLE WHO LIVE THERE ARE, ACCORDING TO THE LAW, NOT SUPPOSED TO HAVE UNSCHEDULED NEEDS OR NEEDS SUPERVISION, BUT THAT IS AN ASSISTED LIVING CATEGORY IN THE STATE AND THERE IS PART OF THE LAW SAYS THEY ARE TO REGISTER WITH OUR AGENCY. THOSE LAWS ARE VERY-- LET'S JUST LEAVE IT AT THEY ARE TO REGISTER, BUT WE HAVE NO ENFORCEMENT RESPONSIBILITY OVER THOSE AGENCIES. I MEAN, THOSE MULTIUNIT FACILITIES OR KNOW HOW MANY THERE ARE IN THE STATE. SO THAT IS AN ASSISTED LIVING CATEGORY. SO I AM SPECIFICALLY IN OUR AGENCY, IN OUR SECTION, ACTUALLY WE HAVE REGULATORY RESPONSIBILITY OVER WHAT WE CALL ADULT CARE HOMES, AND ADULT CARE HOMES ARE THOSE TWO LICENSED CATEGORIES OF FAMILY CARE AND THEN I KNOW IT'S WEIRD, THE LARGER HOMES ARE ADULT CARE. THEY DON'T HAVE THEIR OWN SPECIAL CATEGORY. SO IT IS VERY CONFUSING FOR CONSUMERS WITHIN THIS STATE, BUT PRIMARILY, WE ARE ADULT CARE HOMES WITH THOSE TWO CATEGORIES. THE ENFORCEMENT AND WHEN WE GO IN OR IF THE COUNTY GOES IN AND DOES AN INVESTIGATION OR MONITORING, WE HAVE THE ABILITY TO CITE A FACILITY FOR A STANDARD LEVEL VIOLATION OR A--- STANDARD LEVEL DEFICIENCY OR VIOLATION. WE HAVE GENERAL STATUTES THAT DEFINE WHAT THOSE VIOLATIONS ARE. THEY DO CARRY SOME-- SOME OF THEM DO CARRY PENALTIES. OUR CIVIL PENALTY MONEY GOES TO THE GENERAL EDUCATION FUND IN NORTH CAROLINA. SO WE DON'T GET TO USE ANY OF THAT MONEY OR APPLY FOR GRANTS OR ANYTHING TO ASSIST OUR COMMUNITIES AND ANYWAY, THAT'S JUST A WHOLE DIFFERENT THING. SO, WE AND THE COUNTIES ARE ABLE TO CITE FACILITIES FOR STANDARD LEVEL DEFICIENCIES, BUT WHEN THEY ARE-- THINGS THAT IMPACT OR ARE DETRIMENTAL TO THE HEALTH AND SAFETY OF AN INDIVIDUAL OR WHETHER SOMEONE HAS THE POTENTIAL TO BE HARMED OR WHETHER SOMEONE HAS BEEN HARMED, THEN THAT IS HOW WE WOULD CITE A FACILITY

FOR FAILURE TO PROVIDE APPROPRIATE CARE TO A RESIDENT OR A GROUP OF RESIDENTS. OUR SURVEYS ARE SAMPLES, SO WE GO IN. WE DO A SAMPLING OF RESIDENTS WITHIN THE FACILITY. THAT SAMPLE IS DETERMINED BY INTERVIEWS AND OBSERVATIONS. IT'S ALSO DETERMINE FUNDAMENTAL WE HAVE A COMPLAINT IN THE SYSTEM AND THOSE PEOPLE ARE INCORPORATED INTO THOSE INVESTIGATIONS, BUT WE PRIMARILY LOOK TO SEE CARE BEING PROVIDED AND LOOK FOR CONCERNS OR INCONSISTENCIES AND BY TALKING WITH THE RESIDENTS AND FOR THOSE THAT HAVE CONCERNS ABOUT THEIR CARE AND THEIR FAMILY.

>> TOVAH: (INAUDIBLE).

>> THAT WOULD BE LOOKED AT YOU WERE TALKING ABOUT AN INTERPRETER. THAT WOULD BE LOOKED AT THROUGH THE CARE PLANNING PROCESS TO ENSURE BECAUSE IF YOU WERE GOING-- OUR EXPECTATION IS THAT NO MATTER WHO THE RESIDENT IS, THEY ADMIT, THEY HAVE TO MAKE SURE THAT THE SUPPLEMENTAL SERVICES OR WHATEVER IS NEEDED FOR THAT INDIVIDUAL. ONE OF THE THINGS I'LL TELL YOU IS THAT ADULT CARE HOMES BECAUSE OF THE WIDE VARIETY OF RESIDENTS, SOME, YOU KNOW, SOME FACILITIES TAKE-- SOME FACILITIES TAKE PEOPLE WHO HAVE LESS FUNCTIONAL NEED, LIKE AS FAR AS ASSISTANTS OR THEY MAY NOT ADMIT SOMEONE WHO HAS WANDERING BEHAVIORS, BUT NO MATTER, IF THE INDIVIDUAL HAS A HEARING DEFICIT OR SOME TYPE OF RESPONSIBILITY, THE FACILITY, WHETHER THEY USE A BOARD OR SOME OTHER TYPE OF COMMUNICATION DEVICE, THEY SHOULD BE MAKING ARRANGEMENTS AND WORKING ON THAT. AT THE VERY BEGINNING. MANY OF OUR FACILITIES DO PRE-ADMISSION SCREENINGS AND THEY GO OUT TO THE HOME AND TALK TO PEOPLE. SO THEY SHOULD BE ADDRESSING THOSE TYPES OF THINGS AT THE BEGINNING THROUGH THAT PLANNING PROCESS WHEN SOMEONE COMES IN. BY HER FACIAL RESPONSE.

>> SHE'S NOT AGREEING WITH IT. THANK YOU SO MUCH. LET'S CALL UP OUR NEXT PRESENTER, CINDY TO TALK ABOUT NURSING HOMES.

>> MAY I STAND UP?

>> SURE. IN FACT, I CAN DO THIS, TOO. I CAN MULTITASK. THANK YOU. HI THERE. I'M CINDY DEPORTER, AND I I'M GOING TALK ABOUT NURSING HOMES AND IT'S VERY INTERESTING. AZZIE SHARED A PERSONAL EXPERIENCE. MY FATHER HAD POLIO WHEN HE WAS A CHILD AND SO HE ONLY HAD 20% HEARING AND SO I GREW UP IN A HOME THAT-- THAT WE HAD TO LEARN TO COMMUNICATE WITH MY DAD AND AS HE'S GOTTEN OLDER, HE HAS A VERY, VERY COOL HEARING AID THAT REALLY HELPS HIM, AND SO IT'S BEEN -- IT'S BEEN INTERESTING. I REMEMBER AS THE HEARING AIDS CONTINUE TO IMPROVE THROUGH THE YEARS, HE CALLED ME UP ONE TIME AND HE SAID, YOU'RE NOT GOING TO BELIEVE THIS. I CAN HEAR A BIRD SING. AND THAT'S A WAY COOL THING. I, TO THIS DAY, BECAUSE AS I WAS GROWING UP HE NEVER DID ANYTHING WITH HIS HEARING, WE HAD TO TALK VERY LOUD. SO TO

THIS DAY, I TALK VERY LOUD AND I HAVE TO BE VERY CAREFUL TO USE MY INSIDE VOICE. AND SOMETIMES MY STAFF REMIND ME, YOU'RE USING YOUR OUTDOOR VOICE.
[LAUGHTER]
I HAVE TO BE CAREFUL. OKAY? SO ANYWAY, I WANTED TO SHARE THAT BECAUSE THIS IS ALSO SOMETHING THAT'S NEAR AND DEAR TO MY HEART. AS THE PROCESS THAT WE UTILIZE ACROSS OUR HEALTH CARE, IS IT PERFECT? IT'S ABSOLUTELY NOT PERFECT. AND I DON'T THINK ANY OF US THAT WORK IN STATE BELIEVE THAT. WE DO THE BEST WE CAN. WE TRY TO SUPPORT OUR RESIDENTS AND OUR PATIENTS, OUR CLIENTS THAT ARE IN FACILITIES AND WE REALLY ATTEMPT TO MAKE SURE THAT PEOPLE GET WHAT THEY NEED. SO YOU KNOW, I WANTED TO SHARE THAT BECAUSE WE DO ATTEMPT TO DO THAT AND DO WE ALWAYS DO IT? NO, BUT WE DO ALWAYS ATTEMPT TO DO THAT. NURSING HOMES ARE THE MOST REGULATED HEALTH CARE ACROSS THE UNITED STATES. FOLKS PROBABLY MAY NOT KNOW THAT, BUT THEY TRULY ARE. THEY ALSO HAVE ENFORCEMENT, AND BECAUSE THEY HAVE ENFORCEMENT, THAT MEANS THEY CAN RECEIVE VERY HIGH FINES IF THEY DON'T COME INTO COMPLIANCE, OR IF THEY DON'T PROVIDE THE CARE OR THERE'S HARM. IT'S DIFFERENT LEVELS BASED ON THE TYPE OF SITUATIONS IT IS AND WHAT ACTUALLY OCCURS OR DOESN'T OCCUR WITH THE CARE THAT IS PROVIDED. SO I START THAT OUT BECAUSE THERE IS A MYRIAD OF POSSIBILITIES AND OPPORTUNITIES THAT WE HAVE WHEN WE WORK WITH THE NURSING HOMES AND MANAGE THE NURSING HOMES. SORRY ABOUT THAT. IN NORTH CAROLINA, WE HAVE 438 NURSING HOMES AND OUT OF 438 NURSING HOMES, ALL OF THOSE ARE CERTIFIED TO RECEIVE MEDICARE AND MEDICAID FUNDING EXCEPT NINE FACILITIES, AND THOSE NINE FACILITIES ONLY HAVE, THEY'RE STATE RULE SO THEY ONLY ACCEPT PRIVATE PAY OR MAY ACCEPT PRIVATE INSURANCE. SO THE MAJORITY OF WHAT WE'RE TALKING ABOUT IN NORTH CAROLINA ARE MEDICARE, IN ED CAID CERTIFIED AND AZZIE DID A GOOD JOB DESCRIBING THAT CMS OVERSIGHT. WE DO, FOR OUR CERTIFIED WORK AS REQUIRED BY OUR CONTRACT WITH CMS, IS WE ARE REWIRED TO GO INTO NURSING HOMES. WE HAVE TO MAINTAIN A TWELVE-MONTH AVERAGE. THAT IS REQUIRED BY FEDERAL LAW. WE ALSO DO COMPLAINT INVESTIGATIONS, AND FOR NURSING HOMES, WE TRIAGE ALL COMPLAINT INVESTIGATIONS TO A TWO-DAY, WHICH WOULD BE CONSIDERED A JEOPARDY SITUATION, OR POSSIBLY A TEN-DAY, WHICH WOULD MEAN THAT THE RESIDENT HAS BEEN HARMED. SO WE ALSO HAVE THAT COMPLAINT, AS ALL OF OUR PROGRAMS DO, IN TERMS OF DOING A COMPLAINT INVESTIGATION. SO THAT CAN BE AN ADDED TYPE OF THING. ALL OUR SURVEY TEAMS ARE COMPOSED. WE ARE REQUIRED BY FEDERAL LAW 0 HAVE A MINIMUM OF ONE NURSE, THAT IS ON THE SURVEY WITH A RECERTIFICATION SURVEY. WE ALSO HIRE SOCIAL WORKERS, DIETITIANS. WE ALSO HAVE CUE SPECIALIST, TOO, ON OUR TEAMS AND PHARMACISTS THAT HELP SUPPORT OUR ACTIVITIES WHEN WE GO INTO FACILITIES. OUR SURVEYS ARE EXTREMELY INTENSIVE. IT TAKES A MINIMUM OF FOUR DAYS TO DO A FEDERAL SURVEY AS WE LOOK AT

OVER 900-- EXCUSE ME, 500 REGULATORY REQUIREMENTS THAT WE HAVE TO TAKE A LOOK AT. WE ARE ASSISTED BY A SOFTWARE PROGRAM THAT IS UTILIZED BY EVERY STATE AGENCY SURVEYOR ACROSS THE UNITED STATES AND WHAT THAT PROGRAM DOES IS IT PULLS BECAUSE THERE IS A REQUIRED COMPREHENSIVE ASSESSMENT THAT I'M GOING TO TALK ABOUT IN JUST A MINUTE THAT IS REQUIRED BY EVERY NURSING HOME TO UTILIZE ON EVERY NURSING HOME THAT IS A CERTIFIED BED AND THAT EXRE HNSIVE ASSESSMENT IS ABOUT 20-PAGE AND IT LOOKS AT PSYCHO-SOCIAL, EMOTIONAL, PHYSICAL, HEALTH CARE, MEDICATIONS AND IT LOOKS AT A MYRIAD OF DIFFERENT TYPES OF THINGS THAT OCCUR TO RESIDENTS. WHAT HAPPENS IS THAT A FACILITY HAS TO TRANSMIT THOSE ASSESSMENTS TO US AND SO WHEN WE GO ON SITE INTO A NURSING HOME, WE PULL THE PAST SIX MONTHS' DATA OF EVERY NURSING HOME-- EVERY RESIDENT THAT HAS BEEN IN THAT PARTICULAR NURSING HOME TO DRIVE OUR NURSING HOME SURVEY. SO IT'S VERY SPECIFIC. IT WILL TARGET SPECIFIC OUTLIERS WITH IN A NURSING HOME AND IT ALSO TARGETS SPECIFIC RESIDENTS FOR US TO TAKE A LOOK AT IF THERE ARE IDENTIFIED ISSUES AND PROBLEMS. THE SURVEYS ARE VERY MUCH HANDS-ON TYPES OF SURVEYS.

WE SPEND QUITE A BIT OF TIME WHEN WE FIRST GO IN, WE'LL TOUR THE FACILITY AND WE ALSO, AS WE CONTINUE THROUGHOUT THE SURVEY PROCESS, WE TALK WITH STAFF. WE TALK WITH FAMILIES. WE TALK WITH RESIDENTS. WE TALK WITH PHYSICIANS. WE TALK WITH THERAPISTS. WE ALSO LOOK AT RECORDS AND WE DO A TREMENDOUS AMOUNT OF OBSERVATION ABOUT THE CARE THAT IS BEING PROVIDED TO RESIDENTS IN NURSING HOMES SO WE LOOK AT THOSE TYPES OF STAFF INTERACTIONS THAT ARE HAPPENING. HEARING IS REVIEWED ON EVERY SURVEY THAT WE GO IN FOR AN ANNUAL SURVEY AND IT'S PART AND PARCEL OF THE SURVEY PROCESS. THERE IS A,-AN ENTIRE ASSESSMENT PORTION OF THE COMPREHENSIVE ASSESSMENT THAT I HAVE TALKED TO YOU ALL ABOUT EARLIER THAT LOOKS AT-- IT LOOKS AT COMMUNICATION. IT LOOKS AT HEARING. IT LOOKS AT VISUAL . AND IT ASSESSES A MYRIAD OF EVERYTHING THAT IS HAPPENING WITHIN-- FOR THAT RESIDENT AND HOW THE FACILITY NEEDS TO PROVIDE CARE FOR THAT RESIDENT. THEY HAVE TO ENSURE THAT THE RESIDENT, IF THE RESIDENT HAS ANY TYPE OF HEARING DEVICE THEN THE FACILITY IS RESPONSIBLE FOR MAKING SURE THE CARE PLAN FOR THE UTILIZATION OF THAT DEVICE. THEY HAVE TO CARE PLAN FOR HOW THAT PERSON WANTS TO BE -- WANTS TO BE COMMUNICATED WITH. THEY HAVE TO ALSO MAKE SURE THAT THEY ARE CARE PLANNING HOW THAT CARE PLAN OR THAT DEVICE IS GOING TO BE MANAGED FOR THAT RESIDENT THROUGHOUT THE PERSON'S STAY IN THE NURSING HOME AND THEN THAT HAS TO ALSO BE COMMUNICATED DOWN THROUGH THE LAYERS TO MAKE SURE THAT ALL THE STAFF ARE AWARE OF THAT. SO THIS IS SOMETHING THAT WE WOULD EXPECT TO SEE ON THE CARE PLAN AND YOU'LL SEE SOME PRETTY EXTENSIVE CARE PLANS BECAUSE THEY HAVE TO ADDRESS-- THEY HAVE TO BE MEASURABLE. THEY HAVE TO HAVE TIMEFRAMES, AND THEY HAVE TO HAVE SPECIFIC INDIVIDUALIZED

APPROACHES. WE ALSO, AS I SAID, I DID WANT TO MENTION IF THERE ARE ANY PROBLEMS WITHIN HE TYPE OF CARE THAT THE PERSON RECEIVES, THEN WE DO HAVE-- WE HAVE A STATE COMPLAINT INTAKE UNIT THAT TAKES COMPLAINTS FOR ALL OF OUR HEALTH CARE ENTITIES AND FOR NURSING HOMES, WE ARE-- IT'S VERY, VERY TARGETED IN TERMS OF EVERY COMPLAINT THAT COMES IN AND JUST TO GIVE YOU SOME SORT OF SENSE, YOU KNOW, WE RUN ABOUT 4,000 COMPLAINTS PER YEAR JUST ON NURSING HOMES. OKAY. AND THAT IS TRIAGED, AS I SAID, IT'S VERY-- WE'RE VERY CONTROLLED AS FAR AS THE FEDERAL GOVERNMENT GOES ON SPECIFICALLY WHAT WE ARE REQUIRED TO TAKE A LOOK AT AND HOW WE HAVE TO MANAGE THAT. SO IF SOMETHING IS A HARM, THEN WE'RE GOING TO GO IN WITHIN TEN WORKING DAYS. IT'S F IT'S CONSIDERED A JEOPARDY TYPE SITUATION, WE'RE GOING TO BE WITHIN TWO WORKING DAYS. SURVEY, 24 HOURS A DAY, 7 DAYS A WEEK F WE HAVE COMPLAINTS THAT COME IN THAT THERE ARE PROBLEMS ON THE WEEKENDS, THEN WE WILL SEND A SURVEY TEAM IN ON THE WEEKENDS. I PERSONALLY HAVE BEEN IN AT 4:00 IN THE MORNING IN A FACILITY TO MAKE SURE THAT TYPE OF CARE, THAT CARE, IF THAT WAS THE PROBLEM, THAT'S WHEN WE WOULD BE IN. THAT'S ALSO PART OF THOSE REQUIREMENTS. I THINK THAT'S PRETTY MUCH IT. IF WE HAVE ANY QUESTIONS FOR ME .

>> ON THE BOTTOM OF-- WELL, IT'S OUR PAGE 16 AND NOW IT'S OUR PAGE 8. IT SAYS HEARING IS REVIEWED ON EACH ANNUAL RECERTIFICATION SURVEY. CAN YOU GIVE LITTLE DETAILS ABOUT HOW THEY PERFORM THAT REVIEW?

>> ABSOLUTELY. HAPPY TO DO THAT. THIS IS WHAT THE ASSESSMENT LOOKS LIKE IN PAPER THAT THEY'RE REQUIRED TO DO ON EVERY RESIDENT THAT COMES IN TO A NURSING HOME, TO THE CERTIFIED BED. ONE OF THE THINGS THAT IS DONE, AS I SAID, IS THE HEARING, SPEECH THERAPY. JUST TO GIVE YOU SOME IDEAS ON THIS, WHAT THIS DATA SET ADDRESSES AND LET ME TAKE MY GLASSES OFF BECAUSE THESE ARE MY DRIVING GLASSES. I APOLOGIZE. THEY ASK QUESTIONS, THE ABILITY TO HEAR. IT IS THEN BROKEN DOWN INTO ADEQUATE, MINIMUM, MODERATE DIFFICULTY, OR HIGHLY IMPAIRED. THERE'S QUESTIONS, DOES THE PERSON HAVE A HEARING AID? THEY ALSO THEN TRY TO LOOK AT SPEECH CLARITY TO SEE IF THE SPEECH IS CLEAR, UNCLEAR SPEECH, NO SPEECH AT ALL. ALSO, ABILITY TO EXPRESS IDEAS AND WANTS. IS A PERSON ABLE TO BE UNDERSTOOD, USUALLY UNDERSTOOD? SOMETIMES UNDERSTOOD? RARELY UNDERSTOOD? AND THEN THERE'S THE ABILITY TO UNDERSTAND OTHERS. SAME TYPE OF CRITERIA THERE AND WITH AND WITHIN THIS, WE LOOK AT VISION AND THERE IS COGNITIVE STATUS. PART OF WHAT THEY HAVE TO ASSESS IS THE COMMUNICATION NEEDS. WHEN THE PERSON FIRST COMES INTO THE NURSING HOME BECAUSE A COGNITIVE STATUS MOST CERTAINLY CAN ADVERSELY AFFECT THE WAY A PERSON'S GOING TO COMMUNICATE WITH. THE FEDERAL REGULATIONS GOT UPDATED IN 2016 AND THEY ADDED A THREE-PHASED PUSH-IN TO MAKE SURE THAT THINGS DEMENTIA TRAINING AND BEHAVIORAL TRAINING WAS

ADDED ON TOP OF THE TRAINING THAT WAS CURRENTLY REQUIRED AND THAT WAS A VERY BIG TYPE OF CHANGE THAT WAS MADE. WE HAVE BEEN-- WHEN THEY MAKE THAT TYPE OF ASSESSMENT AND IT IS SENT IN TO-- AGAIN, THE ANNUAL ASSESSMENTS OR EXCUSE ME, THE ASSESSMENTS ARE DONE ANNUALLY AND THEN THEY'RE DONE EVERY QUARTER. AND SO UNLIKE SOME OF THE OTHER PROGRAMS THAT WERE TALKED ABOUT, A RESIDENT THAT'S IN A NURSING HOME, ONCE THEY COME IN, THEY HAVE THIS COMPREHENSIVE ASSESSMENT, AND THEN FOR EVERY QUARTER AFTER THAT, THERE IS AN ASSESSMENT ON THESE AREAS AND SO THE CARE PLAN IS UPDATED EVERY TIME. IF THERE'S ANY KIND OF SIGNIFICANT CHANGE WITH THE PERSON, WHETHER IT'S MEDICAL, WHETHER IT WAS PSYCHOSOCIAL, WHETHER IT WAS EMOTIONAL, THEN THAT PERSON IS REWIRED TO BE IMMEDIATELY REASSESSED. WE DO THINGS, PART OF THE RESPONSIBILITY FOR THE FACILITY IS THE ASSESSING OF THE RESIDENTS IS THAT THEY HAVE TO MOST CERTAINLY DO OBSERVATIONS OF THAT RESIDENT WITHIN AND WHILE THEY'RE MAKING THIS ASSESSMENT, WHICH IS DUE WITHIN THE FIRST 14 DAYS OF THE PERSON BEING IN THE FACILITY. THEY HAVE TO DO OBSERVATIONS. THEY HAVE TO TALK TO THE RESIDENT. THEY HAVE TO TALK TO THE RESIDENT REPRESENTATIVE. THEY HAVE TO TAKE A LOOK AT THEIR MEDICAL RECORDS. THEY ALSO HAVE TO OVER A 24-HOUR PERIOD, THEY HAVE TO LOOK AT THE PERSON THROUGH THE ENTIRE DAY, THE SPECTRUM. DURING THE NIGHT, DURING THE EARLY IN THE MORNING, SO THEY'RE TRYING TO TAKE A LOOK AT THE PERSON AND HOW THEY'RE MANAGING IN THE ENVIRONMENT IN A 24-HOUR PERIOD. THERE ARE VERY SPECIFIC INFORMATION THAT THEY SHOULD BE INCLUDING FROM ANY KIND OF-- IN THEIR MEDICAL DOCUMENTATION AND THEY HAVE TO THINK ABOUT THINGS, SUCH AS WHAT AFFECTS THE COMMUNICATION, MEDICAL CONDITION, VCVA, PARKINSON'S, PSYCHIATRIC, DISORDERS, ALL DIFFERENT TYPES OF THINGS AND COMMUNICATION AIDES AND THOSE ARE THINGS THAT THE FACILITY HAS TO INCLUDE IN THAT ASSESSMENT AND MOST CERTAINLY THAT WE TAKE A LOOK AT. THEN WE HAVE MANY, MANY REGULATIONS WHERE WE-- OUR SITE FACILITIES IF THEY DO NOT MEET THESE REQUIREMENTS. I WON'T GO INTO ALL OF THOSE, BUT WE DO HAVE SEVERAL. I WILL TAKE A WALK BACK HERE. I'LL COME TO YOU. HOW ABOUT THAT?

>> I'M CURIOUS TO KNOW HOW IS HEARING ASSESSED? YOU TALK ABOUT HEARING AND OTHER ASPECTS OF THE PATIENT AS THEY'RE COMING INTO THE NURSING HOME FACILITY INITIALLY AND THEN OVER TIME, HOW IS THE HEARING ASSESSED? AND BY WHOM?

>> SO WITH HEARING AND HOW IT IS ASSESSED, ONE OF THE THINGS THAT I WAS JUST REFERRING TO WAS THE QUESTIONS THAT THE FACILITY HAS TO ASK RESIDENTS, OKAY. DURING THE FIRST 14 DAYS, DURING THE ASSESSMENT, THEY HAVE TO DETERMINE THE-- I WENT THROUGH THE ABILITY TO HEAR, HEARING AID, SPEECH CLARITY, MAKE SELF UNDERSTAND, ACT TO UNDERSTAND. WOULD DOES IT? IN THE REQUIREMENTS, THE FACILITY-- THE EXPECTATION IS THAT THE PERSON-- THE HEALTH PROFESSIONAL THAT CAN BEST ASSESS THAT-- IN THIS CASE, IT'S GOING TO BE THE NURSE, TO BE

PERFECTLY HONEST. BECAUSE FACILITIES HAVE TO HAVE-- THERE'S A DIFFERENT LEVEL OF WHAT KIND OF PROFESSIONAL YOU HAVE TO HAVE IN THE FACILITY. SO A NURSING HOME IS REQUIRED TO HAVE AN RN ON STAFF EIGHT HOURS A DAY, SEVEN DAYS A WEEK AND THEY ALSO HAVE TO HAVE LPNs, AND OF COURSE, THEY ALSO HAVE NURSE AIDES. SO THE ASSESSMENT IS REQUIRED TO BE SIGNED OFF OF, THIS BIG THING HERE, BY THE RN. SO THE RN IS RESPONSIBLE FOR MAKING SURE THAT THE ASSESSMENTS ARE DONE CORRECTLY. FACILITIES HAVE THERAPISTS. THEY HAVE SPEECH THERAPISTS. IF THERE'S A PROBLEM, THEN THEY WOULD SAY WE NEED TO HAVE THE SPEECH THERAPIST TAKE A LOOK AT THIS INDIVIDUAL. SO THERE'S DIFFERENT TYPES OF PROFESSIONALS THAT DO THE ASSESSMENT BASED ON THE INDIVIDUAL.

>> HI. I'M KATHY DOWD. I'M AN AUDIOLOGIST AND I WORKED FOR 25 YEARS IN SKILLED NURSING AND WHAT I UNDERSTAND THEY DO IS TO ASK THE PERSON IF THEY HAVE A HEARING PROBLEM, OR TO OBSERVE IF FACE-TO-FACE, ONE-ON-ONE, THEY SEEM TO BE UNDERSTANDING WHAT'S BEING SAID. THERE IS NO OBJECTIVE HEARING SCREENING WITH ANY EQUIPMENT OR ANY SCREENING TOOL THAT WOULD GIVE YOU A PASS-FAIL. SO THAT IS A PROBLEM. THE CMS REGULATIONS ARE NOT OBJECTIVE. ASKING A PERSON IF THEY HAVE A HEARING PROBLEM DOES NOT REALLY UNCOVER A PROBLEM. AGAIN, FACE TO FACE, THEY CAN LIP READ. IN A QUIET ROOM, THEY CAN PROBABLY GET BY WITH UNDERSTANDING SO I THINK A LOT IS MISSED. I KNOW FROM YOUR STANDPOINT, YOU'RE FOLLOWING CMS REGS. IT'S JUST THEY'RE NOT VALID. THE SPEECH THERAPISTS ARE SUPPOSED TO SCREEN HEARING EVERY TIME BEFORE THEY DO A SPEECH EVAL OR A COGNITIVE EVAL AND IN MY OWN PERSONAL EXPERIENCE WITH MY HUSBAND TWO YEARS AGO, I ASKED FOR A HEARING SCREENING AND I WAS TOLD, WE DON'T HAVE EQUIPMENT. I CAN'T DO THAT AND IT WOULD TAKE ME WEEKS TO REFER OUT. THAT WOULD BE VERY DIFFICULT. BUT I UNDERSTAND YOU'RE FOLLOWING THE CMS REGULATIONS AND THEY DON'T DICTATE AN OBJECTIVE SCREENING OF HEARING. IT'S A SUBJECTIVE SCREENING. DO YOU HAVE A HEARING PROBLEM? SO IT IS A PROBLEM.

>> IT'S NICE MEETING YOU IN PERSON, KATHY. WE TALKED ON THE PHONE.

>> WAS THAT YOU?

>> YES, I WAS ON THE PHONE WITH BECKY AND BEVERLY. IT'S NICE TO PUT A FACE WITH YOU.

>> YOU KNOW WHERE YOU'RE COMING FROM. ABSOLUTELY. WHEN I SAW YOUR NAME, I WAS LIKE, OH, IT'S ALWAYS GOOD. I ALWAYS WISH I COULD SKYPE BUSINESS SO I CAN SEE WHAT PEOPLE LOOK LIKE. NOT THAT PEOPLE WANT TO SEE WHAT I LOOK LIKE. IT'S GOOD TO PUT THAT FACE AND NAME TOGETHER. I WON'T DISAGREE WITH ANYTHING YOU SAID, BUT THE EXPECTATION AND WITH YOUR SITUATION WITH YOUR HUSBAND, IF HE NEEDED THAT AND HE DIDN'T GET IT, YOU MOST CERTAINLY HAVE A RIGHT TO CALL IN A COMPLAINT AND WE WILL INVESTIGATE IT, AND WE ARE PRETTY-- WE'RE PRETTY AGGRESSIVE, I'LL JUST TELL YOU. WE DO THE COMPLAINTS AND WE DO THEM. I THIS THINK

MOST PEOPLE WILL TELL YOU-- I THINK THAT MOST PEOPLE WILL TELL YOU THAT THAT KNOW US. I'M SORRY YOU DIDN'T COMPLAIN BECAUSE WE WOULD HAVE BEEN HAPPY TO GO IN AND TAKEN A LOOK AT YOUR HUSBAND.

>> WE'LL DO TWO MORE QUESTIONS AND THEN I THINK WE WANT TO GET BACK TO SOME RECOMMENDATIONS.

>> SO YOU'RE ENFORCING THE RULES BUT I THINK THERE'S A LOT OF FOLKS IN THIS ROOM THAT ARE CONCERNED ABOUT WHAT THE RULES SUGGEST. SO IF WE WANTED WITH THESE RECOMMENDATIONS OR WITH THIS PROCESS TO TRY TO START THE PROCESS OF CHANGING THE REGULATIONS, OKAY. HER FACE IS ANSWERING MY QUESTION FOR PEOPLE ON THE PHONE.

>> GET TO THE QUESTION.

IT'S IMPORTANT.

>> WHAT IS THE PROCESS? HOW DO WE INITIATE THE PROCESS, EITHER IN OUR STATE OR NATIONALLY, MANDATING OBJECTIVE MEASUREMENT OF HEARING AS PART OF THE SCREENING PROCESS? BECAUSE I THINK ALL OF US WOULD SEE THAT AND I THINK THE WORDING OF THIS ALSO EXCLUDES ALTERNATE COMMUNICATION MEANS IN A LOT OF WAYS, AS WELL. LIKE FOLKS WHO USE SIGN LANGUAGE OR NEED INTERPRETERS.

IT'S IN THERE.

>> YEAH.

>> HOW WOULD WE START THE PROCESS OF MAKING THOSE CHANGES?

>> SO ONE OF THE THINGS THAT I TALKED ABOUT AND I ATTEMPTED TO TALK ABOUT THAT SO YOU ALL WOULD UNDERSTAND HOW INTENSIVE OUR SURVEYS ARE WHEN WE GO IN. WE DON'T -- WE LOOK AT EVERYTHING AND SO AS FAR AS THE FEDERAL REGULATIONS GO, WOULD YOU, OF COURSE, MOST CERTAINLY I'M ASSUMING TALK TO YOUR CONGRESSMAN. THAT'S NOT--WE DON'T GET INTO THAT PART OF IT. AS FAR AS STATE RULES GO, MOST CERTAINLY THERE'S A STATE RULE-MAKING PROCESS THAT YOU CAN CERTAINLY ALSO GO WITH THAT. IT'S VERY IMPORTANT TO REALIZE THAT WE-- WE LOOK AT EVERYTHING AND WE DO IT BASED ON THIS ASSESSMENT. CAN WE LOOK AT EVERYTHING FOR-- FOR EVERY-- IT WOULD BE PHYSICALLY IMPOSSIBLE. WE WOULD END UP STAYING IN A TREMENDOUS AMOUNT OF TIME. I DON'T KNOW IF THAT WOULD SERVE THE NEEDS OF THE POPULATION CORRECTLY. THIS ACTUALLY DOES-- THE COMPREHENSIVE ASSESSMENT IS, IT'S FOR THE MOST PART, I AGREE IT'S NOT AN AUDIOLOGIST COMING IN AND DOING A SCREEN. BUT THAT'S NOT WHAT IS REQUIRED BY THE FEDERAL REGULATIONS. IT IS REQUIRED THAT THE FACILITY, IF THEY DON'T DO THAT. THEN THEY CAN BE OUT OF COMPLIANCE AND THAT'S WHY WE HAVE THE COMPLAINT INTAKE PROCESS. IF THE CONSUMER DOESN'T BELIEVE THAT THE FACILITY IS DOING THEIR JOB, THEN THEY CAN CALL US AND WE WILL GO IN AND IF LIKE WITH KATHY'S HUSBAND, WE MIGHT HAVE FOUND OUT, YEAH, THEY SAID

NO. WELL, WE WOULD HAVE CITED THAT FACILITY. THEN THAT HAPPEN AND AND MIGHT HAVE A PERSON WHO GOES TO THE HOSPITAL HOSPITAL. SORRY ABOUT THAT. AND SO THOSE ARE PART OF WHAT WE GO IN TO TARGET ISSUES SUCH AS LIKE SOMETHING WITH THE HEARING LOSS. IS THE PROCESS PERFECT? I DON'T-- I WOULD NEVER SAY THERE'S ANY PROCESS THAT'S PERFECT. DOES MORE REGULATIONS HELP IT? I CAN'T SAY THAT MORE REGULATIONS ARE THE ANSWER TO THAT. BECAUSE WITH THAT, THEN YOU START HAVING TO LOOK AT WHAT OUR TIME CONSTRAINTS ARE AND WHAT YOU'RE GIVING UP IF YOU ARE FOCUSING ON A SPECIFIC THING AND WE HAVE, YOU KNOW, WE LOOK AT ABUSE, WE LOOK AT NEGLECT, WE LOOK AT THEFT, WE LOOK AT THE WAY A PERSON'S MEDICATIONS ARE MANAGED, WE LOOK AT THE WAY THAT THE DOCTOR'S COMING IN AND PROVIDING THE CARE, IF SOMEBODY AND THE THING THAT'S VERY, VERY INTERESTING WITH NURSING HOMES AND I STARTED AND I AM OLDER THAN DIRT, BUT I STARTED IN THIS JOB BACK IN 1990 AND WHAT NURSING HOMES WERE THEN AND WHERE THEY ARE NOW AND THE LEVEL OF CARE THAT HAS TO BE PROVIDED IS VERY, VERY MUCH DIFFERENT

ALSO, THERE'S A VERY BIG DIFFERENCE, AND WE TALKED ABOUT THIS WITH KATHY, AND I THOUGHT IT WAS A VERY IMPORTANT POINT YESTERDAY, THAT PEOPLE THAT-- WHEN FOLKS ARE COMING INTO NURSING HOMES RIGHT NOW, A LOT OF TIMES, THEY'RE IN THERE FOR REHAB ND SO THEY'RE IN AND OUT WITHIN LESS THAN 20 DAYS AND YOU HAVE THAT PIECE OF IT THAT BECOMES VERY DIFFICULT IF THEIR PRIMARY REASON IS TO BE THERE FOR PHYSICAL THERAPY AND OCCUPATIONAL THERAPY TO MAKE SURE THAT THEY'RE GETTING THAT THERAPY BECAUSE THEY NEED TO GO HOME AND THEN THAT TIES IN ALSO TO MANAGED CARE AND HOW MUCH THAT MEDICARE WOULD PAY FOR THOSE INITIAL THERAPY SESSIONS, TO MAKE SURE THAT THE PERSON IS STABILIZED BEFORE-- EVERYBODY WANTS TO GO HOME AND SO IT'S A RUSH. THOSE FIRST 20 DAYS OR LESS AND A LOT OF TIMES IT'S LESS IS VERY, INTENSIVE GETTING THE RESIDENT UP AND GOING AND WHAT THEY WANT ALSO. I DON'T KNOW IF THAT ANSWERS YOUR QUESTIONS.

>> ONE MORE QUESTION FROM TOVAH AND THEN MOVE ON.

>> IT'S MORE OF A COMMENT THAN A QUESTION THAT I LISTENED TO TWO, THREE DIFFERENT PEOPLE FROM DSSR TALKING ABOUT THE DIFFERENT FACILITIES AND CARE. I HEARD AN AWFUL LOT ABOUT THE REGULATIONS AND CONSTRAINTS UNDER WHICH YOU HAVE TO WORK IN TERMS OF ASSESSING, EVALUATING, RESPONDING TO COMPLAINTS AND EVERYTHING. WHAT I HAVE NOT HEARD ABOUT, NOT AT ALL FROM THE ACH AND FROM VERY LITTLE FROM THE NURSING HOME AS SPECT IS ABOUT COMMUNICATION PREFERENCES IN THE ASSESSMENT FOR HEARING AND COMMUNICATION. I HEAR YOU TALK ABOUT LEVEL OF HEARING, SPEECH RECEPTIVITY AND STUFF, BUT MANY RESIDENTS HAVE PREFERENCES FOR SIGN LANGUAGE COMMUNICATION OR AUDIO LOOPS AND OTHER TYPES OF DEVICES. THAT DOES NOT SEEM TO BE CLEARLY LOOKED AT . MORE TO THE POINT, COMPLIANCE AFTER

YOU'VE DONE THE ASSESSMENT AND CONSISTENCY OF APPLICATION OF THE EXPECTATION OR NEEDS, IT'S NOT ALWAYS THERE. I AM A GERIENTOLOGIST AND I NEVER SEE THE ACCOMMODATION THAT NEEDS TO BE MADE. WHEN YOU CONSIDER THE PEOPLE WHO ARE OVER 55 THAT GO TO THESE FACILITIES, ALL OF THEM, THE MAJORITY OF THEM HAVE HEARING LOSS AT SOME TIME AND WE KNOW NOW THAT THE COST OF UNTREATED HEARING LOSS OR UNSUSTAINED MANAGEMENT OF HEARING LOSS IS MUCH HIGHER MEDICALLY THAN INVESTING IN ACCOMMODATING THOSE NEEDS. SO I THINK THE FOCUS IS TOO MUCH, I THINK, ON OBEYING THE REGULATIONS AND NOT ENOUGH ON SEEING HOW THESE REGULATIONS CAN ACTUALLY BE FEASIBLY MANAGED, YOU KNOW, PERFORMED ON A CONSISTENT BASIS PAST THE ASSESSMENT PHASE.

>> I'M GOING TO GIVE YOU A PASS CINDY, AND SAY YOU ARE REPRESENTING A REGULATORY AGENCY AND SO THAT'S YOUR JOB. I WANT TO-- I DO WANT TO COME BACK TO YOUR POINT BECAUSE I THINK IT'S REALLY IMPORTANT AND CINDY, I THINK THE ONE THING I WOULD ASK YOU TO ADDRESS, I DON'T THINK YOU ALL FOCUSED ON COMMUNE PREFERENCES BUT THAT MIGHT BE PART OF YOUR REGULATION. IF YOU WANT TO RESPOND TO THAT PARTICULAR PART.

>> YES. THANK YOU. I DIDN'T SAY IT ENOUGH BUT YES, PART OF THE ASSESSMENT, I THOUGHT I SAID IT BUT MAYBE I DIDN'T. USUALLYI'M PRETTY CLEAR. SOMETIMES I'M NOT. IT'S VERY CLEAR. IT TALKS ABOUT ARE THEY USING DEVICES? I THOUGHT I SAID, HOW DO THEY PREFER TO BE COMMUNICATED WITH? SO IT CAN BE A COMMUNICATION BOARD ? IT COULD BE-- THERE'S-- WE SEE TONS OF DIFFERENT THINGS OUT THERE, BUT THAT'S PART OF WHAT THEY HAVE TO ASSESS. I'M NOT GOING TO SAY EVERYBODY'S PERFECT THE WAY THEY ASSESS IT. BUT YES, THEY HAVE GOT TO ASSESS HOW THAT PERSON WANTS TO BE COMMUNICATED WITH. THAT WAS ONE OF THE QUESTIONS THAT I READ OUT THAT SAID, HOW DOES A PERSON WANT TO BE COMMUNICATED WITH ? IS IT SIGN LANGUAGE? IS IT A COMMUNICATION BOARD? IS IT-- DO THEY HAVE A HEARING AID? HOW IS THAT? SO YES, THAT HAS TO BE LOOK AT EVERY TIME. SORRY. I DIDN'T SAY THAT WELL ENOUGH FOR YOU. I APOLOGIZE.

>> I WANT TO UNDERSCORE, I THINK YOUR OTHER POINT IS REALLY IMPORTANT, TOVAH. I THINK THAT WE HAVE SOME CONCERN ABOUT THE WAY HEARING IS ASSESSED AND ACCOMMODATIONS ARE MADE IN ALL THE FACILITIES THAT WE'VE BEEN TALKING ABOUT TODAY BASED ON WHAT WE'VE HEARD FROM TASK FORCE MEMBERS, CONSUMERS, AND FAMILY MEMBERS, AND I THINK THERE ARE AT LEAST THREE DIFFERENT WAYS TO GO ABOUT THINKING ABOUT CHANGING THE ENVIRONMENT THAT PEOPLE ARE BEING CARED FOR. WE COULD EDUCATE THE PEOPLE WHO PROVIDE THAT CARE. I THINK EDUCATION SHOULD BE PART OF THE CONVERSATION. WE CAN ENCOURAGE CONSUMERS TO ADVOCATE AND REGISTER COMPLAINTS. THAT'S A PROCESS THAT'S AVAILABLE. THERE'S A WHOLE SET OF FEDERAL REGULATIONS IN PLACE. BUT IF PEOPLE DON'T MAKE REPORTS, THOSE FEDERAL REGULATIONS ARE NOT ENFORCED AND I THINK THE THIRD-- SOMEBODY MADE IT. I THINK IT WAS KATHY MADE THE POINT,

WHAT ABOUT STATE REGULATIONS? IS THERE SOMETHING OR WAS IT SHELLEY? IS THERE SOMETHING WE CAN DO BETTER? I DEFINITELY HEAR, CINDY, YOUR HESITATION. THERE ARE A LOT OF REGULATIONS. IS THEY TAKING-- IS THIS MAKING EVERYTHING A NAIL BECAUSE WE HAVE A HAMMER? WE HAVE TO THINK ABOUT THAT. WE ARE GOING TO GRAPPLE WITH SOME OF THOSE ISSUES. I WANT TO THANK THE FOLKS FROM DSR FOR COMING AND MOVE US BACK INTO DISCUSSING OUR RECOMMENDATIONS WHICH WE HAVE NOT DONE AT ALL YET TODAY.

>> RIGHT NOW, WE HAVE-- YOU KNOW, WE HAVE A CIVIL MONEY PENALTY FUND THAT IS UTILIZED THAT FOLKS CAN UTILIZE FOR PROJECTS, AND WE'RE ACTUALLY WORKING WITH SOMEONE ON WORKING TOWARD A PROJECT, SUCH AS YOU SAY AS FAR AS MAKING THIS A BETTER HEARING TEST AVAILABLE TO PEOPLE IN NURSING HOMES AND WE'RE IN THE PROCESS OF DOING THAT RIGHT NOW, AND THAT IS-- THAT FUND CAN BE UTILIZED FOR THAT BECAUSE THAT'S SPECIFICALLY BACK TO THE BENEFIT OF THE RESIDENT AND SO WE'RE IN THAT PROCESS OF DOING THAT, AND WE'RE VERY EXCITED THAT THIS INDIVIDUAL BROUGHT THIS PROCESS, BROUGHT THIS PROJECT TO US, WE'RE GOING TO-- WE'RE REALLY GOING TO GET THIS GOING BECAUSE WE THINK IT WILL BE SOMETHING THAT WILL BE VERY, VERY BENEFICIAL, AND THAT'S ONE OF THE WAYS THAT WE CAN TAKE IT TO ANOTHER STEP.

>> CAN YOU TELL US ABOUT THAT PROJECT? I WONDER IF THAT'S SOMETHING THAT WE CAN ENCOURAGE OTHER FACILITIES TO DO.

>> WE CAN'T AT THIS POINT

WE'RE NOT AT A POINT WHERE IT CAN BE RELEASED AT ALL. WE'RE IN THE BEGINNING OF STAGES OF THAT PROJECT AND SO IT'S BEING WRITTEN UP AND, WOULDED UP SO YOU'LL BE HEARING MORE ABOUT IT BECAUSE IT WILL BE OFFERED TO NURSING HOMES AND SO IT'S PRETTY EXCITING.

>> GREAT. WE GOT TO TALK ABOUT THE RECOMMENDATIONS. YOU GUYS WANT TO ASK QUESTIONS AND THEY'RE SUCH GOOD QUESTIONS. TOVAH, YOU NEED TO RESPOND TO SOMETHING AND JULIAN AND THEN WE'RE DONE.

[LAUGHTER]

>> I CAN'T SAY ANYTHING?

[LAUGHTER]

>> ABSOLUTELY NOT. ?

TOVAH HERE. CALL ME THE THORN IN YOUR SIDE FOR THE DAY BUT IN ANY EVENT, AGAIN, YOU KNOW, IT'S BEEN WONDERFUL TO HEAR ALL THESE THINGS AND LEARN A LOT MORE ABOUT HOW THIS STUFF WORKS BUT I WANT TO REMIND YOU THAT ON THE ADVOCACY NOTE, YOU KNOW, SELF-ADVOCACY AND STUFF, REMEMBER, A LOT OF DEAF AND HARD OF HEARING CULTURE DOES MAKE IT VERY DIFFICULT FOR US TO DO THAT AND ON TOP OF THAT, PEOPLE GOING INTO THESE FACILITIES ARE ALREADY ILL, FRAIL, COGNITIVELY DECLINED, OR A BUNCH OF OTHER THINGS. IT'S MUCH HARDER TO

DO THAT KIND OF ADVOCACY. IT CAN'T JUST BE ONLY-- IT IS IMPORTANT FOR US TO LEARN HOW TO DO THAT, BUT YOU GET TIRED OF DOING THAT AFTER A WHILE, YOU KNOW.

[LAUGHTER]

I THINK IT'S IMPORTANT TO REMEMBER THAT PART.

>> ONE OF MY CONCERNS-- I'M SORRY. I'M JULIE BISHOP. I'M WITH THE HEARING LOSS ASSOCIATION OF NORTH CAROLINA. ONE OF MY CONCERNS IS THAT AFTER THE SCREENING IS DONE ON ANY OF THESE FACILITIES THAT WE'VE TALKED ABOUT THIS MORNING, PRE-ADMISSION, AND SOMEONE IS IDENTIFIED AS HAVING A HEARING LOSS, WHAT HAPPENS NEXT? I MEAN ESPECIALLY IN NURSING HOMES, DO THEY TELL THE FAMILY THAT THERE'S A HEARING LOSS ISSUE? DO THEY CONSULT A DOCTOR TO GET REFERRAL FOR AN AUDIOLOGIST TO COME IN? I GUESS THAT'S MY CONCERN. WE DON'T WANT TO STOP WITH THE SCREENING. WE NEED TO KNOW WHAT'S BEING DONE AFTER THE SCREENING HAS IDENTIFIED A PERSON WITH HEARING LOSS. SO I DON'T KNOW IF YOU DO ANYTHING AFTERWARDS.

>> CINDY: THANK YOU ARE TO THE QUESTION. THE ANSWER TO THE QUESTION IS IT'S THE RESPONSIBILITY OF THE FACILITY IF THEY THINK THE PERSON NEEDS AN AUDIOLOGIST REPORT, IF THEY NEED TO HAVE THE HEARING LOOKED AT, WHATEVER, IT'S THE RESPONSIBILITY OF THE FACILITY TO FOLLOW THROUGH WITH THAT. NOW THE PROBLEM IS IS THAT SOMETIMES THAT'S NOTFULLOWED THROUGH WITH AND SO THAT'S WHERE THE COMPLAINTS COME IN THAT WE TALKED ABOUT. BECAUSE IF A PERSON-- IT WOULD BE JUST LIKE IF A PERSON HAD AN ISSUE-- THEY HAD A MEDICAL ISSUE, THEY WOULD HAVE TO FOLLOW THROUGH WITH THAT. THIS IS THE SAME THING. IT'S NO DIFFERENT. THEY HAVE TO FOLLOW THROUGH WITH PSYCHO-SOCIAL, PHYSICAL, WHATEVER, IF THE PERSON NEEDED TO HAVE A HEARING CHECK DONE, THAT WOULD BE THE EXPECTATION. THE FACILITY NEEDED TO MAKE SURE THAT OCCURRED. WE CITE FACILITIES FOR NOT DOING THINGS THAT THEY'RE SUPPOSED TO DO. CONSULTS, IF IT'S A MEDICAL DIRECTOR OR MEDICAL CONSULT, MAYBE WITH AN ONCOLOGIST, MAYBE IT'S A CONSULT WITH AN AUDIOLOGIST, THAT WOULD BE THE RESPONSIBILITY. THEY SHOULDN'T BE SAYING LIKE KATHY SHARED, WE CAN'T DO THAT. THAT'S NOT ACCEPTABLE . WE HAVE TO KNOW ABOUT IT, THOUGH. WILL WE PICK IT UP WHEN WE GO INTO A FACILITY? YES, SOMETIMES WE DO, BUT SOMETIMES WE DON'T. YOU KNOW, YOU'RE TALKING ABOUT A WHOLE LOT OF INFORMATION AND IT'S WHAT IT IS. WE DON'T LOOK AT-- WE DON'T HAVE TIME TO LOOK AT AND IF IT'S 100-BED FACILITY, WE DON'T LOOK AT ALL HUNDRED FOLKS. WE HAVE A SAMPLE THAT WE LOOK AT AND WE USE THE SOFTWARE THAT I TALKED ABOUT TO PULL THAT ASSESSMENT INFORMATION TO TARGET FOLKS. SO IF SOMEBODY HAD A HEARING PROBLEM AND IT CAME THROUGH, WE WOULD TARGET THAT RESIDENT AND WE WOULD TALK WITH THAT RESIDENT, AND SO YOU KNOW, IT'S WHAT IT IS. THERE'S NO WAY-- YOU CAN'T LOOK AT A HUNDRED PEOPLE IN FOUR DAYS AND THE REGULATIONS DON'T SAY THAT WE

HAVE TO DO THAT. AS I SAID, I STARTED THE CONVERSATION, IT'S AN IMPERFECT SYSTEM, BUT A COMPLAINT WILL GET US RIGHT IN AND WE TARGET IT.
>> THANK YOU SO MUCH TO ALL THREE OF YOU.
[APPLAUSE]

DRAFT Recommendations Review

>> WE WILL GET TO RECOMMENDATIONS NOW I HAVE FOUR CAVEATS TO GET THROUGH THESE AND WE WILL START AT THE BEGINNING. THE FIRST ONE IS THE FORMATTING ON YOUR PERSONAL RECOMMENDATIONS IN FRONT OF YOU MAY BE A LITTLE DIFFERENT THAN THE ONES ON THE SCREEN JUST BECAUSE WE WANTED TO MAKE THE FONT BIGGER FOR THE ONES IN FRONT OF YOU. SECONDLY, THIS ONE IS SPECIFICALLY FOR CORYE. I'M NOT SURE WHEN WE'RE GOING TO GET TO IT, BUT IF THERE'S A RECOMMENDATION TO DRNC, I WAS OPTIMISTIC AND IF YOU WANT TO PROVIDE YOUR FEEDBACK, ONCE WE GET TO THEM. WE WILL START FROM THE BEGINNING BUT IF YOU SEE THEM COME UP AND HAVE SOME INPUT. ALSO ON THE COMMENTS I DID RECEIVE, I GOT A LOT OF QUESTIONS ABOUT REASONING AND A LOT OF THINGS THAT ARE GOING TO GO INTO THE BACKGROUND OF THE REPORT. SO I KNOW IT'S HARD TO SEE NOW BUT THESE ARE RECOMMENDATIONS BUT BEFORE EACH OF THESE, THERE'S GOING TO BE A COUPLE PARAGRAPHS EXPLAINING WHY WE CAME TO THIS CONCLUSION AND WHY WE'RE RECOMMENDING IT. I THINK A LOT OF INFORMATION I DID RECEIVE WILL GO INTO THAT PART, BUT I AM GOING TO KEEP IT TO MAKE SURE IT GOES INTO THE REPORT. FINALLY, USED LONG-TERM CARE FA IT ISES, THE TERM, THROUGHOUT THIS REPORT AND I'M NOW REALIZING AFTER THE PRESENT PRESENTATIONS TODAY THAT IS NOT COMPLETE. I WILL BE ASKING FOR HELP ON HOW WE WANT TO PHRASE ALL OF THOSE FACILITIES THAT WE HEARD TODAY THROUGHOUT THE REPORT AND SPLITTING THOSE UP. SO WE'RE GOING TO BEGIN AT SECTION ONE AND EDUCATION AND--
>> WE CAN SOLVE THIS RIGHT NOW. JENNIFER, WHAT'S THE BEST CATEGORY, UMBRELLA TERM TO INCLUDE SKILLED NURSING AND ASSISTED LIVING?
>> WE DO USE LONG-TERM CARE, WAY TOO GENERAL WOULD BE AGING SERVICE PROVIDER AND THAT'S WAY TOO GENERAL BUT THOSE ARE THE TWO.
>> LONG-TERM CARE IS GOOD. WE CAN DEFINE IT AS INCLUDING.
>> DEFINE IT SOMEWHERE IN THERE.
>> SO I THINK THE BEST PROCESS TO GO THROUGH THIS. IS I'M GOING TO GO SCROLL THROUGH THIS AND GO THROUGH THE COMMENTS WE RECEIVED AND WE WILL DISCUSS THE RECOMMENDATIONS AS WE'RE GOING THROUGH IT. FOR FIRST ONE, IN EDUCATION, IS EVERYONE OKAY IF I TAKE THE INTERPRETER OFF THE SCREEN. PEOPLE AT HOME CAN STILL SEE IT, BUT JUST TO MAKE THIS BIGGER

FOR EVERYONE IN THE ROOM?

>> THIS IS JAN SPEAKING. I'M SORRY, CAN YOU CLARIFY? NCHCA? YOU'VE GOT AN ACRONYM UP HERE, NCHCA?

>> NORTH CAROLINA HEALTH CARE CARE ASSOCIATION.

>> JAN: I THOUGHT IT WAS NCHA.

>> YES.

>> FOR ALL THE ACRONYMS IN THIS REPORT, TOO, I HAVE NOT GONE THROUGH YET AND SPELLED THEM OUT LIKE I DID THE FIRST ONE, BUT THEY WILL BE. FOR THIS FIRST ONE, A COUPLE OF QUESTIONS THAT CAME UP WAS THE DIVISION OF SERVICES FOR DEAF AND HARD OF HEARING , WE'LL PROBABLY NEED ADDITIONAL STAFF TO DO THIS. THE FEEZIBILITY AROUND THEM DOING THIS AND THE FUNDING FOR THE TOOLKIT DEVELOPMENT AND PRODUCTION. SO LATER IN THE REPORT, WE HAVE A RECOMMENDATION FOR ONE ADDITIONAL STAFF AT THE DIVISION LEVEL. AND THAT'S WHERE WE'RE AT RIGHT NOW WITH THIS. I DON'T KNOW IF THERE'S ANY QUESTIONS OR COMMENTS ON MAYBE WHO THAT FUNDING WOULD BE TO, IF ONE ADDITIONAL PERSON IS OKAY. YEAH.

>> THIS IS LAWRENCE.

>> THIS IS JAN. I WAS GOING TO START BUT LET'S GO TO LAWRENCE.

>> THIS IS LAWRENCE. I'M RETIRED AND I'M NOT REPRESENTING HSDHH. BUT HAVING WORKED THERE FOR YEARS, ONE STAFF IS NOT GOING TO BE SUFFICIENT BUT NOT IN THE FIELD. IN THE SENSE OF CURRENTLY AND JAN OR SOMEONE AT DSDHH CORRECT ME IF I'M WRONG, CURRENTLY, THEY HAVE ALL THE STAFF IS RESPONSIBLE FOR EVERYTHING BUT WE HAVE A (INAUDIBLE), THEY HAVE ONE STAFF AND I WILL SPEAK TO THE RALEIGH OFFICE, 17 COUNTIES WHO'S RESPONSIBLE FOR TRAINING EVERY POLICE DEPARTMENT, EVERY SHERIFF'S DEPARTMENT, EVERY 911 CENTER, EVERY HOSPITAL IN THAT 17-COUNTY AREA, ONE PERSON. SO JUST ONE PERSON CAN'T DO THE MEDICAL ALONE IF YOU TOOK THE OTHERS AWAY. ONE PERSON-- IT'S GOING TO TAKE A LOT MORE THAN ONE PERSON IN THE FIELD IF YOU WANT TO GET OUT AND EDUCATE. I WILL RETURN THIS BACK TO THE FLOOR.

>> JAN?

>> YES, THIS IS JAN SPEAKING . WHAT I THINK WILL WORK IS FOR DSDHH TO WORK WITH KEY MEDICAL ORGANIZATIONS, SUCH AS THE NORTH CAROLINA MEDICAL BOARD TO DEVELOP TRAINING MATERIALS. WE BELIEVE THAT IT'S VERY IMPORTANT TO INCLUDE THE MEDICAL PROVIDER'S PERSPECTIVE SO WE CAN PROVIDE TRAININGS THAT ARE GOING TO WORK FROM THEIR PERSPECTIVE, AND SO THE KEY IS TO DEVELOP ONE SET OF MATERIALS, LIKE A TOOL KIT, IF YOU WILL, THAT ALL LICENSING BOARDS, MEDICAL ASSOCIATIONS AND SO FORTH WOULD BE ABLE TO USE. WITH OUR CONTACT INFORMATION INCLUDED, SO THAT YOU CAN REACH OUT TO US FOR CONSULTATION ON SPECIFIC CASES OR SPECIFIC TRAINING NEEDS FOR YOUR STAFF AND SO FORTH. I DO THINK THIS IS DOABLE. AS FOR CREATING NEW

POSITIONS, I HAVE TWO THINGS TO COMMENT ABOUT THAT AND LAWRENCE IS PROBABLY RIGHT. IT DEPENDS ON HOW YOU LOOK AT WHAT NEEDS TO BE DONE. IF YOU'RE TALKING ABOUT A HIGH LEVEL OVERSIGHT OF THE PROCESS OF THE DEVELOPMENT OF THE MATERIALS AND THE ASSURANCE THAT ALL THOSE MATERIALS ARE DISSEMINATED, THEN YES, WE CAN START WITH ONE POSITION. NOW AS FAR AS HOW MANY MORE WE MIGHT NEED, IT DEPENDS ON WHAT YOU'RE LOOKING TO DO. AND I'M NOT SURE YET HOW TO ACTUALLY TO PHRASE THE RECOMMENDATION. THE SECOND THING IS I DO REMEMBER SEEING SOMEWHERE ELSE IN THE DOCUMENT ABOUT MAKING A RECOMMENDATION THAT THE LEGISLATURE LOOK INTO CREATING A NEW POSITION, AND I DO HAVE TO TELL YOU THAT IS NOT HOW OUR BUDGET WORKS. WE ARE 100% RECEIPT SUPPORTED. ALL OF OUR FUNDS COME FROM THE SURCHARGE ON YOUR LAND LINE AND WIRELESS TELEPHONE BILLS. WE DO NOT RECEIVE ANY STATE APPROPRIATIONS, WHICH MEANS WE DO NOT HAVE TO GO TO THE LEGISLATURE TO REQUEST A NEW POSITION. SO THAT GIVES US A LITTLE BIT MORE FLEXIBILITY. SO THAT'S THE GOOD NEWS. BUT AGAIN, WE WILL NEED TO BE ABLE TO JUSTIFY THE CREATION OF A POSITION THROUGH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THE OFFICE OF STATE BUDGET MANAGEMENT.

>> THANK YOU. THAT'S HELPFUL. I THINK HOW THIS WAS WRITTEN IS THAT THE POSITION WOULD ALMOST BE LIKE A PROGRAM COORDINATOR BECAUSE WE WOULD EXPECT THE ORGANIZATIONS THAT WE PARTNER WITH, WHETHER IT BE THE MEDICAL BOARD OR WHOEVER THAT THEY WOULD DESIGNATE SOMEONE TO BE ON THAT TEAM AND THE STRATEGIC PARTNERSHIP THAT WE'RE TALKING ABOUT AND LIKE I THINK YOU REFERENCED IN THE FIRST PART OF YOUR COMMENT.

>> YES, YES, AND THIS IS JAN. IF I COULD ADD ONE MORE THING. I HAVE MADE IT CLEAR THAT I DO NOT WANT DSDHH TO BE RESPONSIBLE FOR EDUCATING ALL OF THE MEDICAL PROFESSIONALS. THAT IS THE RESPONSIBILITY OF LICENSING BOARDS AND MEDICAL ORGANIZATIONS AND MEDICAL ASSOCIATIONS. WE ARE RESPONSIBLE FOR HELPING TO DEVELOP MATERIALS AS THE SUBJECT MATTER EXPERTS AND WE ARE VERY HAPPY TO HELP WITH THE DESIGN OF THOSE MATERIALS AND WE WILL DEFINITELY RELY ON YOUR FEEDBACK TO ENSURE THAT WHATEVER WE DO DESIGN WILL WORK FROM THE MEDICAL PROFESSIONAL PERSPECTIVE.

>> THIS IS GREG GRIGGS WITH THE NORTH CAROLINA ACAD I IN OF FAMILY PHYSICIANS. I WAS ALMOST GOING TO SAY EXACTLY THAT, JAN. WE DON'T HAVE THE ABILITY TO DEVELOP A TOOLKIT BECAUSE WE DON'T HAVE THE EXPERTISE OR THE STAFF BUT ONCE THAT TOOLKIT IS DEVELOPED, THERE ARE A LOT OF PEOPLE OUT THERE WHO CAN HELP DISSEMINATE IT ONCE WE HAVE SOMETHING DONE, WHETHER IT'S THE MEDICAL BOARD, WHETHER IT'S SPECIALTIES, SOCIETIES, STATE AMEC PROGRAM. THE STATE AHEC PROGRAM HAS ALL KINDS OF ONLINE EDUCATION.

ONE TOOL KIT CAN BE UTILIZED TO BE DISTRIBUTED AND DISSEMINATED IN MANY DIFFERENT WAYS. WE HAVE OUR ANNUAL MEETING EACH YEAR THAT HAS 800 ATTENDEES AT IT . SO IF THERE'S A 45-

MINUTE PROGRAM DEVELOPED, BOOM, I CAN SLOT THAT INTO OUR ANNUAL MEETING OR ONE OF OUR SMALLER MEETINGS. WE CAN LINK THROUGH OUR COMMUNICATIONS OR ENEWSLETTER OR MAGAZINE TO MATERIALS TO ONLINE VIGNETTES, TO THOSE TYPES OF THINGS TO-- AND I WOULD SAY WHETHER IT'S THE PEDIATRIC SOCIETY, WILL IT'S THE HOSPITAL ASSOCIATION, HEALTH CARE ASSOCIATION, WHETHER IT'S THE MEDICAL BOARD, MEDICAL SOCIETY, AHECs, LICENSED PROFESSIONAL COUNSELORS, AUDIOLOGISTS, ET CETERA, THERE ARE A LOT OF DISVB USE POINTS. YOU KNOW, THAT'S WHY I'M AT THE TABLE. WE'RE SEEKING MATERIALS TO DISTRIBUTE AND TO BETTER EDUCATE AND HONESTLY HAVING -- HAVING IT CO-PRESENTED BY A HEALTH CARE PROVIDER AND A DEAF OR HARD OF HEARING PERSON AT OUR MEETING WOULD BE PRETTY COOL TO HAVE DONE ESPECIALLY SOME OF THE VIGNETTES.

>> I SEE EILEEN IN THE BACK. ONE THUG I WILL SAY WALKING BACK HERE IS I WANT PEOPLE WHO REPRESENT HEALTH CARE PROFESSIONS TO THINK ABOUT IS THE RESPONSIBILITY LIVE IN THE BOARD OR THE SPECIALTY ASSOCIATION, OR IS IT A JOINT RESPONSIBILITY?

>> BOTH.

>> THAT'S WHAT I THOUGHT.

>> THIS IS EILEEN RAYNOR. I WOULD SUBMIT THAT WE DEVELOP A SUBCOMMITTEE OF THIS TASK FORCE TO DEVELOP THE MATERIAL FOR TRAINING BECAUSE THIS IS GOING TO BE TARGETED NOT JUST AT HEALTH CARE PROVIDERS BUT AS WE'VE HEARD EARLIER AT HEALTH CARE MANAGEMENT ASSOCIATIONS, HEALTH CARE ADMINISTRATORS, AS WELL AS LONG-TERM CARE FA IT ISES AND OTHER INTERESTED PARTIES. SO THE INFORMATION NEEDS TO BE CONSISTENT. IT NEEDS TO BE COMPREHENSIVE AND THERE NEEDS TO BE AVOIDANCE OF CONFLICT BETWEEN THE MESSAGING. SO I THINK HAVING A SUBCOMMITTEE FROM THIS TASK FORCE WORK TOGETHER ON DEVELOPING THESE MATERIALS WILL HAVE THE PERSPECTIVE OF WHAT WE RECEIVED OVER THE LAST SIX MONTHS AND REALLY ENHANCE THE QUALITY OF THOSE MATERIALS AND THEN WE'LL BE ABLE TO FIGURE OUT THE DISTRIBUTION AS WELL.

>> I THINK WE JUST HEARD FROM OUR FIRST VOLUNTEER.

[LAUGHTER]

>> WHAT I'D LIKE TO SEE IS A HARD OF HEARING PERSON-- AS A HARD OF HEARING PERSON, WHAT I'D LIKE TO SEE IN THAT TOOLKIT IS SOME EDUCATION FOR THE CONSUMER. I WORK WITH THE HEARING LOSS ASSOCIATION FOR 35 YEARS AND JULIE AND STEVE CAN TELL YOU, WE CONTINUE TO DO THE SAME PROGRAMS, WE DID 35 YEARS AGO, PEOPLE STILL DON'T KNOW HOW TO READ THEIR AUDIOGRAMS AND USE ASSISTIVE LISTENING DEVICES. THEY DON'T KNOW ABOUT THE MICROSOFT TRANSLATOR OR THIS, THAT AND THE OTHER. PART OF YOUR ROLE, IT WOULD BE GREAT TO EDUCATE THE PEOPLE WHO WILL ACTUALLY USE YOUR SERVICES.

>> I JUST WANT TO RESPOND BEFORE YOU GO, VICKIE. I THINK THAT IS SECTION E IN THE RECOMMENDATION, THAT WE DO HAVE A SEPARATE SECTION JUST TO EDUCATE CONSUMERS BUT I WILL TAKE THAT BACK.
>> THIS IS VICKI. I WAS GOING TO SAY THAT I DON'T THINK IT'S THE SAME WORK GROUP. I THINK IT'S A DIFFERENT WORK GROUP. I THINK THERE ARE TWO WORK GROUPS BECAUSE I THINK FOR CONSUMERS YOU ALSO WANT TO DEVELOP SOME ADD VOTE IS CASEY SKILLS TRAINING THAT'S GENERIC-- ADVOCACY SKILLS TRAINING THAT'S GENERIC THAT WILL BENEFIT THEM WORKING ACROSS WHATEVER THEY WANT TO ACHIEVE WHICH IS DIFFERENT THAN TRYING TO CONVINCE PROVIDERS ABOUT HOW TO-- THEIR LEGAL OBLIGATIONS, IF NOT MORAL AND ETHICAL.
>> I WANT TO ENCOURAGE US NOT TO-- THIS IS A LOT OF GREAT FEEDBACK. SOME OF IT CAN BE DONE ELECTRONICALLY. THINK ABOUT THE THINGS WE NEED TO SAY THAT ARE GOING TO REALLY CHANGE THE TENOR OF THE RECOMMENDATION IN SUCH A WAY THAT EVERYBODY MIGHT NOT AGREE. THOSE ARE THE THINGS THAT WE HAVE DISCUSSION ABOUT. ALL OF THIS IS GREAT FEEDBACK. I THINK WE WOULD SAY UH-HUH AND ROB CAN WORDSMITH IT AND WE WILL GET TO LOOK AT FUTURE DRAFTS OF IT, BUT THAT MIGHT HELP US MOVE ALONG. I WANTED TO ASK A LITTLE BIT ABOUT THE RESOURCE ISSUE. SO IT SOUNDS LIKE THE GENERAL ASSEMBLY DOESN'T HAVE TO CREATE A POSITION AND YOU GET FUNDS FOR YOUR DIVISION FROM TAXES, BUT I IMAGINE THOSE ARE NOT UNLIMITED FUNDS. I WANT TO MAKE SURE THAT WE UNDERSTAND THAT THERE ARE RESOURCES TO DO THIS AND I DON'T THINK IT'S JUST THE STAFF POSITION. I THINK THAT THERE'S VIDEOGRAPHY EXPERTISE AND GRAPHIC DESIGN EXPERTISE. SO THERE'S MORE TO THIS THAN JUST PEOPLE MEETING DEVELOPING SOME GOOD IDEAS AND THAT'S WHAT I'M NOT SURE WE'VE CAPTURED YET. SO YOU'RE AGREEING WITH ME BUT YOU WILL HAVE TO HELP US FIGURE OUT HOW TO DO THAT.
>> YES. THIS IS JAN SPEAKING. YES, WE WOULD HAVE TO SUBMIT A BUDGET REVISION REQUEST TO THE OFFICE OF STATE BUDGET AND MANAGEMENT. BUT YOU'RE RIGHT ABOUT THE NEED TO HAVE OTHER RESOURCES OTHER THAN JUST THE STAFF POSITION AND I DO THINK THAT'S DOABLE. WE CAN WORK THROUGH TEMPORARY SOLUTIONS AND THAT IS AN AGENCY THAT WE CAN UTILIZE TO HIRE PEOPLE ON A TEMPORARY BASIS. WE CAN HIRE THE PERSONNEL THAT WE WOULD NEED TO DO THE DESIGN AND THE DEVELOPMENT AND SO FORTH. YEAH. SO YES.
>> I HAVE THREE POINTS AND I HAD TWO, BUT NOW I HAVE THREE. REGARDING POSITIONS WITHIN DSDHH, JAN AND I WERE JUST TALKING A LITTLE BIT ABOUT THE CONCERN I HAVE THAT ANY POSITION WE HAVE THAT AFFECTS STATEWIDE FUNCTIONING, IN TERMS OF ANY OF THESE NEW EXPECTATIONS OR PROPOSALS, I THINK THAT ULTIMATELY, DHHS NEEDS TO HAVE A FAIRLY EXPLICIT RESPONSIBILITY FOR MAKING SURE THAT THESE THINGS HAPPEN. EVEN IF THE POSITIONS ARE LOCATED IF DSDHH, WHICH IS THE LOGICAL PLACE TO PUT THESE POSITIONS BECAUSE OF THE EXPERTISE THERE. THAT'S

ONE CONCERN. THE SECOND ISSUE I HAVE IS IN TERMS OF THE TOOLKIT, I THINK WE NEED TO CONSIDER ALSO THAT THE TOOLKIT MAY NEED TO INCLUDE SUPPLEMENTAL INFORMATION FOR SPECIFIC PROFESSION. FOR EXAMPLE, WHILE PHYSICAL THERAPISTS MAY NEED TO KNOW, OR WHAT OCCUPATIONAL THERAPISTS NEED TO KNOW, MENTAL HEALTH THERAPY AND SUBSTANCE ABUSE THERAPY, WHAT THESE PEOPLE NEED TO KNOW MAY NEED ADDITIONAL TOOLKIT INFORMATION, AND THERE MAY NEED TO BE A SUPPLEMENTAL PROCESS FOR THAT. THE THIRD THING I WANT TO COMMENT ON FOR THE WHOLE DOCUMENT, NOT JUST FOR THE SECTION, I WOULD LIKE THE LANGUAGE TO BE ADJUSTED TO REFLECT THAT IT IS A TWO-WAY STREET BECAUSE, FOR EXAMPLE, IN THIS SECTION YOU DESCRIBED FOR THE EDUCATIONAL PIECE IS THAT THE PROVIDER NEEDS TO BE AWARE OF THE NEEDS OF THE DEAF AND HARD OF HEARING. THE FACT IS THE COMMUNICATION PROBLEM IS ALSO THE PROVIDERS, NOT THE CONSUMERS OR THE PATIENT. SO I WOULD LIKE TO SUGGEST THAT THE LANGUAGE REFLECT THAT THE COMMUNICATION ACCESS IS NOT THEY FACING IT BUT THE PROVIDER AND THE CONSUMER WILL FACE.

>> HELP US GET THAT LANGUAGE RIGHT.

>> SO HAVING GROWN UP A MONEY PERSON AND I THINK THIS WAS THE SECOND PART OF YOUR QUESTION, JAN, WHAT'S THE DELTA? I MEAN, WHAT'S THE ROOM TO GROW WITHIN THE TAXES THAT YOU HAVE AVAILABLE? SO UNDERSTAND THAT YOU'RE SUPPORTED AND YOU CAN GO TO STATE BUDGET AND GET ADDITIONAL POSITIONS AND TEMPORARY SOLUTIONS AND ALL THAT KIND OF STUFF. I'M ACUM SUING THERE'S NOT MILLIONS OF DOLLARS OF TAXES LAYING AROUND THAT ARE NOT ALREADY SPOKEN FOR.

[LAUGHTER]

SO HOW MUCH ROOM TO PLAY DO WE HAVE IN THERE?

>> WHILE SHE'S THINKING-- I'LL REMIND YOU-- I READ THAT WE HAVE $900 MILLION BUDGET SURPLUS. SO COME ON.

>> I DID AND YET $7.5 MILLION IN SINGLE STREAM FUNDING FOR MENTAL HEALTH. THAT'S MY SOAP BOX.

>> YOU DON'T HAVE TO ANSWER THAT QUESTION, JAN, BUT I THINK THAT THE POINT IS TO MAKE SURE THAT WE IDENTIFY THE SERVICES WE NEED TO ACCOMPLISH THIS AND FIGURE OUT WHO WE'RE ASKING AND OFTEN, OUR RECOMMENDATIONS MIGHT INCLUDE PHILANTHROPIC RESOURCES AND THIS IS KIND OF AN INTERESTING OPPORTUNITY TO ASK FOR PHILANTHROPIC RESOURCES BECAUSE SOME OF THESE EXPENSES ARE ONE-TIME INVESTMENTS WHICH ARE THINGS THAT PHILANTHROPY LIKES TO INVEST IN. SOME DIFFERENT WAYS THAT WE CAN DO THIS BUT I THINK WE NEED TO FIGURE OUT HOW MUCH WE NEED AND PUT TOGETHER A PORTFOLIO OF OPPORTUNITIES TO BE ABLE TO GET ACCESS TO THOSE RESOURCES.

>> DID I SEE YOUR HAND HALF GOING UP? YOU WERE THINKING ABOUT IT? I'M WALKING BY YOU. IT'S A GOOD TIME TO GRAB IT.

>> IS THIS IS DAVID. YEAH, I WAS THINKING ABOUT IT. YES, ONE OF THINGS THAT WE HAVE DONE-- WE DID BACK IN MINNESOTA WAS THAT WE CONTRACTED WITH AN AGENCY TO DEVELOP THE WHOLE PACKAGE OF TOOLKIT OR TRAINING MATERIALS, OR WHATEVER YOU WANT TO CALL IT. AND SO WE DID THAT ON A CONTRACT BASIS . SO YOU'RE FAMILIAR WITH WHAT I'M TALKING ABOUT. YEAH. SO WE DID THAT ON A CONTRACT BASIS, SO THAT WOULD BE A POSSIBILITY HERE. THAT COULD BE SOMETHING THAT THE DIVISION COULD DO WHICH WOULD MEAN WE WOULDN'T NECESSARILY HAVE TO HIRE A POSITION. WE COULD DO THAT ON A CONTRACT BASIS AND WHOEVER GOT THAT CONTRACT WOULD THEN HAVE TO WORK WITH EVERYONE THAT WAS IDENTIFIED IN THE HEALTH CARE PROFESSIONAL COMMUNITY TO MAKE SURE THAT WE GOT THAT PROFESSIONAL PERSPECTIVE AND GOT THE PRODUCT WE WERE LOOKING FOR.

>> GREAT. GOOD SUGGESTIONS. ARE WE READY TO MOVE ON FROM THIS RECOMMENDATION?

>> JUST ONE MORE THING. AND THEN I WILL LET EVERYONE GET TO LUNCH.

>> THE WORDS THAT ARE HIGHLIGHTED WE'LL IDENTIFY. FOR HEALTH PROFESSIONAL ASSOCIATIONS AND LICENSING BOARDS, DO WE WANT TO INCLUDE ALL OF THEM?

>> YEAH.

>> I SEE A LOT OF HEADS SHAKING YES. CORYE?

>> SORRY. DON'T WE WANT THE INSURANCE COMPANIES INVOLVED IN THAT AS WELL BECAUSE THEY'RE PART OF THE TRAINING CIRCLE?

>> YEAH. THEY'RE ALL UP THERE. I THINK MALPRACTICE INSURANCE IS UP THERE. I DON'T KNOW IF I HAVE PRIVATE INSURERS. BUT YEAH. I MEANT SPECIFICALLY IN THOSE TWO GROUPS ARE THE SUBSETS OF EACH.

>> AS YOU THINK ABOUT PHILANTHROPY, THEY'RE CERTAIN THAT THE BIG FUNDERS LIKE BLUE CROSS FOUNDATION AND DUKE ENDOWMENT, THOSE TYPES OF THINGS BUT WE HAVE PARTNERED WITH PUBLIC HEALTH IN THE PAST. NOT ON BIG FUNDING THINGS, BUT FOR INSTANCE, WHEN EACH SMART BORN NORTH CAROLINA WAS FIRST GETTING STARTED, THE ACADEMY BOUGHT THE DOMAIN NAME AND PAID ARE TO THE WEB HOSTING FOR THE FIRST YEAR. YOU KNOW, SO THERE ARE PARTNERS LIKE US AND OTHERS THAT, YOU KNOW, ARE COMMITTED TO TO THIS WHERE, NO, CAN I BRING THOUSANDS AND THOUSANDS OF DOLLARS? NO, I CAN'T. BUT THIS WAS A SITUATION WHERE GETTING THAT DOMAIN NAME DONE QUICKLY THROUGH THE STATE REGULATIONS WAS GOING TO BE A PROBLEM. SO THROUGH AN ASSOCIATION, I CAN DO THAT MUCH QUICKER AND GET IT DONE. SO AGAIN, I CAN'T BRING THOUSANDS TO THE TABLE BUT I CAN, YOU KNOW, FOLKS LIKE ME CAN HELP, TOO, NOT TO THE LEVEL LIKE A DUKE ENDOWMENT COULD BUT YOU NEED SMALL THINGS THAT NEED

TO BE DONE QUICKLY, THERE ARE PEOPLE OUT THERE WHO ARE WILLING TO HELP.

>> I THINK LUNCH?

>> RIGHT.

>> SO YOU ALL HAVE BEEN SO GREAT TO SIT IN YOUR SEATS FOR THREE HOURS AND 15 MINUTES AND WE'RE GOING TO LET YOU EAT NOW.

[LAUGHTER]

WHAT TIME DO WE NEED TO BE BACK?

>> 1:00.

>> 1:00. DO WE WANT TO TRY TO STEAL 15 EXTRA MINUTES BACK SINCE WE DIDN'T DO MUCH OF OUR RECOMMENDATIONS YET? DO CAN WE TRY FOR 12: 45 INSTEAD. THEY'RE BOXED LUNCHES AND THE LINE SHOULD BE QUICK. LET'S DO THAT. LET'S PLAN ON RECONVENING AT 12: 45 AND LUNCH IS THROUGH THE DOOR.

[LUNCH BREAK IS HELD]

Presentation Deaf-Blind Related Issues/Recommendations + Q&A

>> ALL RIGHT. SO GOOD JOB. WE'RE GOING TO GO AHEAD AND GET STARTED. AND WE'RE GOING TO SEE IF WE CAN MOVE OUR WHOLE AGENDA UP BY 15 MINUTES SO WHAT IS LISTED AT 1:00, WE'RE GOING TO ACTUALLY BE DOING NOW AND THAT INVOLVES A VIDEO AND THEN A REMOTE PRESENTATION SO WE'RE HOPING THE TIMING OF BOTH OF THESE THINGS WORKS OUT. I WILL LET ROB GET STARTED.

>> GREAT. SO WE RECEIVED A VIDEO FROM ASHLEY BENTON, AND WE'RE GOING TO PLAY THAT FIRST, AND THEN AFTER THE REMOTE PRESENTER, WE'LL BE BACK ON THE LINE TO GO THROUGH THE PRESENTATION THAT ASHLEY CREATED. I'LL PLAY THIS NOW.

>> THIS IS JAN. CAN I MAKE A SHORT STATEMENT FIRST. JUST VERY QUICKLY. . I DID WANT TO LET EVERYONE KNOW THAT WHEN YOU ARE LOOKING AT THESE RECOMMENDATIONS, THEY'RE TIED SPECIFICALLY FOR ASHLEY'S PRESENTATION, COMMUNICATION ACCESS FOR PEOPLE WHO ARE DEAF-BLIND AND EVEN WITHIN THAT COMMUNITY THERE ARE DIFFERENT TYPES OF COMMUNICATION ACCESS, BUT THEY ALL STILL FALL UNDER THE SAME UMBRELLA AS WHAT WE'VE BEEN DISCUSSING. HER PRESENTATION IS ABOUT A-- IS A LITTLE DIFFERENT ABOUT CRITICAL ACCESS TO HEALTH CARE, SO THERE IS A CONNECTION. IT'S REALLY A CONTINUUM OF DIFFERENT WAYS TO ACCESS HEALTH CARE. I WANTED TO MAKE YOU AWARE THAT WHAT SHE'S TALKING ABOUT STILL FALLS UNDER THE SCOPE OF THIS TASK FORCE.

>> I'D LIKE TO SHARE WITH YOU SOME OF ISSUES RELATED TO DEAF-BLIND PEOPLE AND THEIR ACCESS TO HEALTH CARE AND THEIR NEED FOR SUPPORT SERVICE PROVIDERS, OR SSPs. FIRST, LET ME START BY EXPLAINING A LITTLE BIT ABOUT THE NATIONAL STATISTICS. IN THE U.S., THERE ARE-- I'M GOING TO START THIS OVER.

>> I WOULD LIKE TO SHARE WITH YOU SOME OF THE ISSUES RELATED TO DEAF-BLIND PEOPLE AND THEIR ACCESS TO HEALTH CARE AND THEIR NEED FOR SUPPORT SERVICE PROVIDERS, OR SSPs. FIRST, LET ME EXPLAIN A LITTLE BIT ABOUT THE NATIONAL STATISTICS. IN THE U.S., THERE ARE APPROXIMATELY 2.4 MILLION PEOPLE THAT HAVE BEEN IDENTIFIED AS HAVING BOTH A HEARING AND VISION LOSS. THAT IS USING A VERY BROAD DEFINITION, SO IT CAN MEAN ANY DEGREE OF HEARING AND VISION LOSS. IT CAN BE SOMETHING VERY MILD TO VERY SEVERE. NOT EVERYONE WITHIN THIS POPULATION IDENTIFIES THEMSELVES AS BEING DEAFBLIND. IN THE STATE OF NORTH CAROLINA, THE STATISTICS SHOW THAT 83,648 PEOPLE HAVE BOTH A HEARING AND VISION LOSS AND THAT STATISTIC ALSO COMES FROM USING THE SAME BROAD DEFINITION FOR THE NATIONAL STATISTICS OF IDENTIFYING PERSONS HAVING BOTH A HEARING AND VISION LOSS. WHEN CONSIDERING THIS POPULATION, THERE ARE SOME CONCERNS. FOR THOSE WITH HEARING AND VISION LOSS, RESEARCH HAS FOUND THEM TO BE AT AN INCREASED RISK IN THREE OVERARCHING CATEGORIES. THEY ARE AT HIGHER RISK FOR LATE ONSET COGNITIVE IMPAIRMENT, WHICH IS LARGELY WITH OLDER ADULTS . SECOND, THEY ARE AT HIGHER RISK FOR DEPRESSION. DEPRESSION MOST LIKELY TRIGGERED TO FEELINGS OF ISOLATION AND THE FRUSTRATIONS FELT REGARDING COMMUNICATION BARRIERS. AND THIRD, SURPRISINGLY, IT IS NOW THAT FOUND THIS POPULATION, OLDER ADULTS WITH HEARING AND VISION LOSS ARE ALSO AT A HIGHER RISK FOR MORTALITY. THIS GROUP IS AT A HIGHER RISK OF EARLIER DEATH COMPARED WITH THEIR HEARING AND SIGHTED PEERS. WHEN CONSIDERING WHY THESE THINGS HAPPEN, THIS POPULATION FACES A LOT OF CHALLENGES. I'M GOING TO START ABOUT EXPLAINING COMMUNICATION DIFFERENCES FOR PEOPLE WITH VARYING DEGREE OF HEARING AND VISION LOSS. FOR INSTANCE, SOMEONE WHO WAS BORN DEAF AND LATER LOST THEIR VISION MAY RELY ON USING SIGN LANGUAGE. THEIR VISION LOSS CAN INTERFERE WITH THEIR ABILITY TO SEE VISUAL SIGN LANGUAGE COMMUNICATION. CONVERSELY, OTHERS THAT WERE BORN BLIND AND THEN LATER LOSE THEIR HEARING HAVE THE OPPOSITE EXPERIENCE. THEY DEPENDED ON WHAT THEY HEARD IN THEIR ENVIRONMENT AND USED IT TO COMMUNICATE THAT INFORMATION. FOR OTHER PEOPLE WHO ARE BORN DEAF-BLIND, YOU OBVIOUSLY NEED TO START EXPOSING THEM TO LANGUAGE AND INFORMATION AT AN EARLY AGE, BUT COMMUNICATION CAN BE ESPECIALLY TRICKY FOR PEOPLE WHO WERE BORN DEAF-BLIND. THE LAST GROUP IS PEOPLE WHO GREW UP HEARING AND SIGHTED AND THEN EXPERIENCED VISION AND HEARING LOSS LATER IN LIFE. THAT CAN BE A CHALLENGE SINCE THEY ARE USED TO GETTING INFORMATION VISUALLY AND THEY MAY FEEL DISORIENTED AS THEY LEARN

HOW TO COMMUNICATE. SO COMMUNICATION IS AN IMPORTANT FACTOR AND WE NEED TO ENSURE THAT PEOPLE HAVE APPROPRIATE ACCESS TO COMMUNICATION. FOR PEOPLE WHO SIGN, THEY NEED ACCESS TO A SIGN LANGUAGE INTERPRETER. BUT NOT JUST ANY SIGN LANGUAGE INTERPRETER. THE INTERPRETER NEEDS TO BE QUALIFIED TO WORK WITH PEOPLE WHO ARE DEAF-BLIND AND BEING QUALIFIED MEANS THE INTERPRETER NEEDS TO KNOW SPECIFIC COMMUNICATION STRATEGIES, SUCH AS TACTILE, TRACKING, AND OTHER METHODS OF COMMUNICATION.

IT'S IMPORTANT FOR THE HEALTH CARE PROVIDERS TO CONSIDER THE DIFFERENT COMMUNICATION NEEDS FOR THIS POPULATION AND ALSO FOR THOSE WHO RELY ON RESIDUAL HEARING, ASSISTIVE TECHNOLOGY CAN BE USED TO HELP AN INDIVIDUAL HEAR BETTER. NEXT, ORIENTATION AND MOBILITY IS THE ABILITY FOR SOMEONE TO MOVE AROUND THEIR ENVIRONMENT SAFELY, AS WELL AS GETTING FROM POINT A TO POINT B AND KNOWING HOW TO NAVIGATE A SPACE. THAT IS A CHALLENGE AND THERE ARE ADDITIONAL ISSUES. IF SOMEONE'S LIVING IN A NURSING HOME, YOU WOULD THINK IT WOULD BE VERY PREDICTABLE BUT IT'S NOT. IF IT'S FURNITURE, A RESIDENT CAN BUMP INTO IT OR THEY NEED TO FIGURE OUT HOW TO GET FROM THEIR BEDROOM TO THE CAFETERIA. THERE ARE DIFFERENT ISSUES TO CONSIDER. AND THERE'S THE CHALLENGE OF GETTING ENVIRONMENTAL INFORMATION, SUCH AS SIGNS THAT ARE BEING POSTED, CALENDAR OF EVENTS, SOCIAL EVENT INFORMATION. SOMETIMES THAT INFORMATION IS NOT READILY AVAILABLE TO THEM. MAYBE THEY DON'T HEAR THE ANNOUNCEMENTS OR SEE THE POSTINGS ON THE WALL. THEY'RE NOT GETTING THE INFORMATION THAT THE OTHER RESIDENTS ARE GETTING. THEREFORE, THEY ARE NOT ABLE TO MAKE INFORMED CHOICES. THEY DON'T KNOW WHAT'S ON THE MENU IN THE CAFETERIA. THESE ARE ISSUES TO KEEP IN MIND FOR CONSIDERATION. TRANSPORTATION IS ANOTHER CHALLENGE. WHILE THERE ARE A RANGE OF OPTIONS FOR PUBLIC TRANSPORTATION, LIKE PARATRANSIT, SERVICES LIKE THAT, THE PROBLEM IS THAT DEAF-BLIND PEOPLE MAY EXPERIENCE COMMUNICATION DIFFICULTIES. MAYBE THE DRIVER DOESN'T KNOW SIGN LANGUAGE OR THEY DON'T KNOW THE PERSON HAS A HEARING LOSS. THE COMMUNICATION BETWEEN THE DRIVE PERT DEAF-BLIND PERSON WHILE THEY WERE ON THEIR WAY TO THE APPOINTMENT, OR THEY GET THERE, THEY DON'T KNOW HOW TO GET TO THE MEDICAL OFFICE. THERE ARE A LOT OF ACCESS AND USING TRANSPORTATION IS NOT ENOUGH. THERE IS A NEED FOR COMMUNICATION AND CONSIDER THAT SOME INDIVIDUALS MIGHT NEED SIGHTED GUIDANCE. IN CONSIDERING HOW TO OVERCOME SOME OF THESE CHALLENGES, ONE GREAT SERVICE WE HAVE IS SUPPORT SERVICE PROVIDERS, SSPs. SSPs PROVIDE ENVIRONMENTAL AND VISUAL INFORMATION TO PERSONS WITH A HEARING AND VISION LOSS FOR A DEAF-BLIND PERSON. SSPs HAVE TRAINING AND KNOW HUMAN SIGHTED GUIDE TECHNIQUES. THEY PROVIDE TRANSPORTATION IN SOME CASES, WHICH PROVIDES CLEAR COMMUNICATION. THEY CAN SHARE ENVIRONMENTAL INFORMATION, WHICH INCLUDES POSTINGS AND MENU INFORMATION. THEY CAN HELP WITH FILLING OUT PAPERWORK AND

FORMS AND ASSIST WITH INFORMAL COMMUNICATIONS. THERE ARE A LOT OF THINGS THAT SSPs CAN DO TO ASSIST DEAF-BLIND PEOPLE. SSPs MUST FOLLOW THE CODE OF PROFESSIONAL CONDUCT ESTABLISHED BY THE REGISTRY OF INTERPRETERS FOR THE DEAF, R.I.D. THIS INCLUDES ALL THE INFORMATION THEY'RE PRIVY TOO AND RESPECTING THEIR CONSUMER'S PRIVACY, PROFESSIONALISM, KEEPING UP WITH TRAININGS AND SO FORTH. SSPs REALLY ASSIST A DEAF-BLIND PERSON TO BE MORE INDEPENDENT. THEY GIVE THE DEAF-BLIND PERSON INFORMATION, SO THEY CAN THEREFORE MAKE INFORMED DECISIONS. SSPs CAN HELP IN A VARIETY OF SETTINGS, LIKE WORK, RECREATION, SOCIAL EVENTS AND HEALTH CARE . THERE ARE SO MANY PLACES WHERE THEY CAN PROVIDE INFORMATION, HELP A DEAF-BLIND BE MORE SUCCESSFUL AND BE ON EQUAL FOOTING FOR THEIR HEARING AND SIGHTED PEERS. CONSIDERING WHEN. SSsAND ARE AVAILABLE, NATIONWIDE THERE ARE 35 STATES THAT HAVE ESTABLISHED SSP SERVICES FOR PERSONAL USE. THIS MEANS A CONSUMER CAN USE THIS TRANSPORTATION FOR DOCTOR'S APPOINTMENTS, GROCERY SHOPPING, GO TO EVENTS, SOCIALS, CHURCH, AND THING LIKE THAT. CERTAINLY 35 STATES HAVE ESTABLISHED PROGRAMS BUT THEY ARE SET UP DIFFERENTLY WITH HOW THEY ARE FUND, DESIGNED, AND OPERATED. FOR FUNDING, SOME STATES RELY ON APPROPRIATIONS. SOME ON GRANTS. SOME USE MEDICAID WAIVERS. THE OTHERS USE DONATIONS AND SOME USE A COMBINATION OF THESE. AS FOR DESIGN, SOME STATES SET UP WHERE CONSUMERS GET TEN HOURS A WEEK WHILE OTHER STATES GIVE CONSUMERS 20 HOURS A MONTH. IT VARIES. NORTH CAROLINA HAS NO SUCH SSP PROGRAM FOR PERSONAL USE . THE STATE DOES HAVE SSP SERVICES FOR DEPARTMENT, HEALTH AND HUMAN SERVICES EMPLOYEES THROUGH THE DRIVER SSP VENDOR LIST, DSSPVL. THIS MEANS WE CAN HIRE AN SSP VENDOR FOR WORK USE. WE CAN ALSO USE THE SAME LIST FOR DEAF-BLIND CONSUMER ACCESSING SERVICES FROM DHHS, UNFORTUNATELY HIRING AN ASSP TO GO TO THE GROCERY STORE OR DOCTOR'S APPOINTMENT IS NOT PART OF THE PROGRAM. THERE ARE 14 REGISTERED VENDORS ON THE VENDOR LIST.

THESE SSPs HAVE MET THE TRAINING AND EXPERIENCE REQUIREMENTS NEEDED AND HAVE PASSED SCREENINGS IN ORDER TO BE ABLE TO CONTRACT WITH DHHS. THESE VENDORS ARE ALSO REQUIRED TO HAVE SPECIFIC CAR INSURANCE FOR BUSINESS USE. ADDITIONALLY, WE ALSO HAVE A VOLUNTEER DATABASE MAINTAINED BY THE DEAF-BLIND ASSOCIATES ORGANIZATION. THERE ARE 375 NAMES ON THE LIST, AND THEY HAVE BEEN COLLECTING NAMES SINCE 2001 BUT MANY OF THOSE PEOPLE HAVE MOVED AWAY OR NO LONGER ARE AVAILABLE DUE TO FAMILY OR WORK CONSTRAINTS. BEING ON THE VOLUNTEER LIST MEANS THAT THEY HAVE HAD SOME TRAINING AND THAT THEY WANT TO HELP DEAF-BLIND FOLKS. IT'S NOT NECESSARILY FREE TO CONSUMERS. THEY MAY GIVE THEM A LITTLE MONEY FOR GAS OR FOOD, BUT WE ARE FINDING THAT SOME CONUM SOARS DON'T USE THEM BECAUSE THEY FEEL UNSURE ABOUT HOW TO COMPENSATE THEM OR UNSURE WHETHER THEY ARE GIVE THEM APPROPRIATE COMPENSATION FOR THEIR ASSISTANCE. A LOT OF DEAF-BLIND PEOPLE ARE NOT USING

THEM AND HONESTLY, SOME OF THOSE VOLUNTEERS ARE NOT AVAILABLE. NORTH CAROLINA REALLY WANTS TO ESTABLISH AN SSP SERVICE PROGRAM FOR PERSONAL USE, SO WE DECIDED WE NEEDED TO COLLECT SOME DATA. WE ESTABLISHED A WORK GROUP THAT WOULD EXPLORE THIS FURTHER AND COLLECT THE DATA. WE SENT OUT AN ACCESSIBILITY NEEDS IS YOUR TO THE COMMUNITY ASSESS WHAT THE NEEDS ARE. WE WANT TO KNOW HOW MANY CONYOU'LL SOARS, WHAT THE NEEDS ARE, AND WHAT THEY WOULD USE THE SSP FOR

WITH THE SURVEY, WE SENT THEM OUT TO THREE DIFFERENT GROUPS, CONSUMERS, FAMILY MEMBERS AND PROVIDERS. PROVIDERS INCLUDED THE SSPs, INTERPRETERS, AND SERVICE PROVIDERS. WE USE THE SAME QUESTIONS ACROSS THE THREE SURVEYS BUT WORKED TO GET RESPONSES FROM THE AUDIENCE PERSPECTIVE. THE RESPONSE WAS GOOD. WE HAD 258 RESPONDENTS AND 101 OF THOSE RESPONDENTS WERE DEAF-BLIND CONSUMERS. WE ASKED A VARIETY OF QUESTIONS. ONE BEING WHETHER SSPs WERE CONSIDERED HELPFUL. OBVIOUSLY, OVER 50% OF ALL GROUPS RESPONDED THAT SSPs ARE HELPFUL. FOR CONSUMERS, 77% REPORTED THEM TO BE HELPFUL. WE ASK THAT THEY FELT DEPENDENT ON FAMILY MEMBERS FOR ACCESS TO HEALTH CARE AND MEDICAL APPOINTMENTS. 71% OF THOSE DEAF-BLIND CONSUMERS RESPONDED THAT THEY ARE, IN FACT, HEAVILY DEPENDENT ON FAMILY MEMBERS TO GET ACCESS FOR HEALTH CARE. THIS A CONCERN. IT'S THE SAME THING AS HAVING AN INTERPRETER. WE'RE NOT ENCOURAGING THE FAMILY MEMBERS TO USE-- TO USE A FAMILY MEMBER AS INTERPRETER BECAUSE THEY HAVE NO LICENSING. THEY ARE NOT PROFESSIONALS. DO NOT FOLLOW THE RID CODE OF CONDUCT. IN ADDITION, SOME COMMENTS FROM CONUM SOAR SAID THINGS THEY HAD TO WORK AROUND FAMILY MEMBER SCHEDULES. SOME FELT IT WAS AN INVASION OF THEIR PRIVACY. FAMILY MEMBERS FELT IT WAS AN INVASION OF PRIVACY, SOME MEMBERS DIDN'T HAVE A GUIDE, DON'T HAVE TRAINING, THEY DON'T RESPECT ME, THEY AREN'T PROFESSIONAL, AND SO FORTH. THESE WERE CONCERNS GENERATED DURING THE COMMENTS. ONE OF THE OTHER QUESTIONS WE ASKED ON THE SURVEY WAS IF YOU HAVE REGULAR ACCESS TO SSPs, WHAT WOULD YOU REGULARLY ATTEND? THE TOP ANSWER WAS MEDICAL APPOINTMENTS, AND THE SECOND ANSWER WAS GROCERY SHOPPING. THIS CERTAINLY MAKES A POINT, OBVIOUSLY, THAT THESE ARE INTEGRAL PARTS OF A PERSON'S LIFE AND USING AN SSP FOR HEALTH CARE AND GOING TO THE GROCERY STORE IS RELATED TO OVERALL WELLNESS. OVERALL, YOU'RE GETTING SUPPORT, YOU ARE ABLE TO TAKE BETTER CARE OF YOURSELF AND MAKE BETTER CHOICE SO ALL OF THOSE THINGS ARE INTERCONNECTED. LASTLY, THE RECOMMENDATIONS I WOULD LIKE THE NCIOM TO CONSIDER BASED ON MY PRESENTATION ARE TWO-FOLD. NUMBER ONE, TO LOOK TO DHHS TO ESTABLISH AN SSP PROGRAM FOR NORTH CAROLINA SO THAT CONSUMERS CAN ACCESS HEALTH CARE AS WELL FOR OTHER PERSONAL NEEDS. THE SECOND RECOMMENDATION I'D LIKE YOU TO CONSIDER IS THE DEVELOPMENT OF POLICIES AND PROCEDURES TO ENCOURAGE FRONTLINE STAFF TO DO AN INITIAL

ASSESSMENT IN LONG-TERM CARE FACILITIES. TO ENSURE THAT THEY'VE BEEN IDENTIFIED AS HAVING A HEARING AND VISION LOSS. IF AN ASSESSMENT IS DONE AND THEY ARE IDENTIFIED, THEN THEY CAN MAKE APPROPRIATE REFERRALS FOR SERVICES AND THAT WOULD REALLY IMPROVE THEIR QUALITY OF LIFE AS WELL AS EXTEND THEIR LIFE. AND IT WOULD IMPROVE THEIR OVERALL WELL BEING.
>> OKAY. IT TURNS OUT THAT WE DO HAVE MARILYN STILL ON THE PHONE, BUT ASHLEY ACTUALLY DID DO THE PRESENTATION IN HER VIDEO, SO THOSE WERE THE SAME SLIDES AS THE PRESENTATION THAT ARE IN FRONT OF YOU. MARILYN IS AVAILABLE FOR QUESTIONS AND TO GIVE YOU A LITTLE BIT OF BACKGROUND, SHE IS FROM THE HELEN KELLER NATIONAL CENTER FOR DEAF BLIND YOUTHS AND ADULTS. MARILYN, ARE YOU ON THE LINE?
>> I SURE AM. HI, EVERYBODY. GOOD AFTERNOON. THANK YOU SO MUCH FOR LISTENING TO ASHLEY'S PRESENTATION I'M BEYOND EXCITED ON THE NATIONAL LEVEL FOR THIS EVEN HAPPENING. OUR NATIONAL DIRECTOR, HELEN KELLER NATIONAL CENTER, DEFINITELY WANTS US TO SEE WHAT COME OUT OF THIS GREAT TASK FORCE HERE BECAUSE THIS IS SOMETHING THAT CAN BE REPLICATED ACROSS THE UNITED STATES. PLEASE DO NOT HESITATE TO ASK ANY QUESTIONS WHATSOEVER. AS YOU KNOW, YOU HAVE DDHH STAFF IN THE ROOM. THIS IS THE START OF MANY MORE TASKS AHEAD OF US. THERE ARE CONSUMERS WHO DO IN THE GO TO MEDICAL APPOINTMENTS. THEY DON'T EVEN GET THE OPPORTUNITY TO GO GROCERY SHOPPING OR HAVE A SOCIAL LIFE, AND WHEN YOU HAVE THE TOP NEED OF BEING ABLE TO SCHEDULE MEDICAL APPOINTMENT AND CAN'T GET THERE AND YOU DO GET THERE AND THEY WANT YOUR FAMILY MEMBER TO INTERPRET, AS WE KNOW AND DISCUSSED ALL MORNING, IT'S COMPLETELY WRONG, SO I WAS ABLE TO LISTEN TO LEE'S PRESENTATION THIS MORNING BUT THEN I HAD ANOTHER MEETING AFTER THAT. PLEASE DON'T HESITATE TO ASK ANY QUESTIONS RELATED TO OUR DEAF BLIND POPULATION HERE IN NORTH CAROLINA OR ACROSS THE NATION. GLF ARE THERE ANY QUESTIONS IN THE ROOM?
>> EXCUSE ME.
THIS IS DR. TATE. I'M WONDERING, CONCERNING TRANSPORTATION SERVICES BEING PROVIDED, MUST THOSE BE RELATED-- ARE THESE SERVICES YOU'RE SUGGESTING ONLY FOR SOMEONE WHO IS DEAF BLIND? MEANING, FOR EXAMPLE, I WORK AT BRAUGHON HOSPITAL AND WE GET PATIENTS FROM ALL OVER THE STATE WHO COME TO THE HOSPITAL AND THE MEDICAL PORTION OF THE HOSPITAL WANTS TO REFER-- A MEDICAL HOSPITAL WILL REFER PATIENTS TO BRAUGHTON AND THEY WILL BE TRANSFERRED FOR MENTAL HEALTH SERVICES AND BECAUSE OF CONFIDENTIALITY, WE MAY NOT KNOW WHO THAT PERSON WAS BEFORE THEY'RE REFERRED. SO IS THERE A WAY TO REQUEST TRANSPORTATION SERVICES JUST FOR THE GENERAL DEAF-BLIND POPULATION AND THEN RELATING TO THAT, A RECENT EXPERIENCE WHERE WE HAD SOMEONE WHO NEEDED-- THAT USED A TRANSPORTATION COMPANY AND THEN WHEN THE DEAF BLIND PERSON CAME WITH THAT

TRANSPORTATION COMPANY, THEY ARRIVED RESTRAINED WITH THEIR HANDS BOUND, AND THAT WAS A FOUR-HOUR DRIVE THAT THEY HAD RESTRAINED WITH NO WAY TO COMMUNICATE BECAUSE OF THAT TRANSPORTATION COMPANY DRIVER. SO THAT'S OBVIOUSLY A HUGE CONCERN AND I WANT TO KNOW IF THERE'S ANY WAY WE CAN ADDRESS ACCESS FOR DEAF BLIND PEOPLE TO TRANSPORTATION SERVICES AND ADDRESSING THE CONFIDENTIALITY OF THOSE PATIENTS.

>> SO THIS IS MARILYN SPEAKING. THERE'S A FEW THINGS. ONE, AS FAR AS THE RELATION TO BOUNDING OUR CONSUMERS TO TRAVEL FOR MENTAL HEALTH SERVICES, SUCH AS-- I WAS A MENTAL HEALTH COUNSELOR/SOCIAL WORKER. ASHLEY AND I WORKED TOGETHER FOR TEN YEARS BEFORE THIS AND I WORKED TEN YEARS BEFORE THIS ROLE AND AS WE KNOW, THAT IS CERTAINLY SOMETHING THAT NEEDS TO BE BROUGHT UP TO BRAD TROTTER BECAUSE CONSUMERS ARE NOT SUPPOSED TO BE BOUND WHERE THEY CAN'T HAVE ACCESS TO COMMUNICATION ACCESS AND THERE ARE CERTAIN REGULATIONS WHEN IT COMES TO TRANSFERRING CONSUMERS POINT A TO THE HOSPITAL. (INAUDIBLE) WOULD NOT PROVIDE THAT SERVICE SPECIFICALLY. AS FAR AS IN THE COMMUNITY, SSP SERVICES WOULD BE PROVIDED AND WOULD BE CONFIDENTIAL AND THAT IS WHY THEY HAVE TO BE BOUND BY THE CODE OF ETHICS THAT WE DO SET FORTH. ANY PROGRAM SET UP ACROSS THE UNITED STATES FOR SUPPORT SERVICE PROVIDERS MUST HAVE POLICIES AND PROCEDURES THAT EVERY SSP FOLLOWS AND THAT IS WHY THE DRIVER SSPs HAVE TO GO THROUGH EXTENSIVE TRAINING TO ENSURE THEY KNOW WHAT THOSE RULES AND REGULATIONS ARE. TRANSPORTATION SERVICES IN THE COMMUNITY NOW ARE MORE IN THE SENSE OF MEDICAL, WHETHER YOU GO TO AN AUDIOLOGY APPOINTMENT, A DIABETES APPOINTMENT, WHATEVER THE APPOINTMENT MAY BE AND IN ADDITION TO THAT, IT'S NOT LIKE UBER WHERE THEY PICK THEM UP AND JUST BRING THEM. IT'S PRIMARILY PICKING THEM UP, GUIDING THEM, PROVIDING THAT HUMAN GUIDING, THE (INAUDIBLE) THAT ASHLEY WAS TALKING ABOUT, GIVING THEM THE VISUAL INFORMATION AS TO WHAT ARE THE DOCUMENTS THAT ARE THERE, ASSISTING WITH SIGNING THEM AND MAKING SURE THE INTERPRETER IS THERE AND OF COURSE, TRANSFERRING OVER THE SERVICES TO THE INTERPRETER WHO IS SKILLED AND QUALIFIED AND WORKING WITH DEAF-BLIND SPECIFICALLY WHICH WE ALSO ADDRESSED EARLIER AS WELL.

>> ADAM?

>> YEAH. MARILYN, THANKS FOR BEING AVAILABLE. THIS IS ADAM ZOLOTOR WITH THE NORTH CAROLINA INSTITUTE OF MEDICINE. I HAVE A COUPLE OF QUESTIONS. I'M CURIOUS. HOW MANY STATES HAVE A FUNDING MECHANISM FOR SSPs?

>> SURE. WHAT WE DO THE NATIONAL COLLECTION OF SSP DATA COMES FROM THE HELEN KELLER NATIONAL CENTER AND WE COLLECT A LISTING OF ALL THE SSP PROGRAMS ACROSS THE UNITED STATES, AND WE'RE ON A NATIONAL COMMITTEE TO ASSIST OTHER STATES THAT DO NOT HAVE THIS YET, AND SO CURRENTLY, THERE ARE 35 PROGRAMS ACROSS THE UNITED STATES, BUT THESE

PROGRAMS ARE PAID PROGRAMS AS WELL. THIS DOES NOT REALLY ACCOUNT FOR SEVERAL OF THE OTHER ONES THAT ARE VOLUNTEER PROGRAMS. SOME OF THEM THAT ARE THERE ARE ALSO RESTRICTED ON WHAT AREAS THEY COVER. FOR INSTANCE, TENNESSEE IS ONE OF THE STATES I COVER AND ONLY CONSUMERS IN KNOXVILLE ARE ABLE TO OBTAIN SERVICES THROUGH THAT PAID SSP PROGRAM, AND THAT'S ALSO ANOTHER FACTOR IN SOME STATES, SO IT DEPENDS ON HOW THEIR PROGRAM IS SET UP AND IN SOME OTHER STATES, IT'S ONLY FOR CONSUMERS WHO ARE 55 AND OVER AND SOME OTHER STATES, IT'S ONLY FOR CONSUMERS WHO ARE SIGNERS. SO IT EELLY DOES DEPEND ON THE PROGRAM AND WHAT THEY SET UP AND HOW THEIR POLICIES AND PROCEDURES GO.

>> DO YOU HAVE DATA ON EACH OF THOSE PROGRAMS THAT YOU CAN SHARE IN TERMS OF QUALIFICATIONS, SOURCE OF FUNDS, HOW EXPENSIVE THOSE PROGRAMS ARE, THINGS THAT COULD HELP US MAKE A RECOMMENDATION?

>> WE SURE DO. WE HAVE ALL THAT BROKEN DOWN FOR ANYBODY WHO WOULD LIKE THAT. AS A MATTER OF FACT, NICOLE AND ASHLEY HAVE WORKED ON THE BREAKDOWN OF THE PROGRAM THAT WE DO HAVE ACROSS THE NATION AND CAN CERTAINLY PROVIDE THAT TO YOU.

>> TWO MORE QUICK ONES. SO ARE THE SSPs THAT WE'RE TALKING ABOUT ONLY FOR DEAF BLIND CONSUMERS? BECAUSE I IMAGINE THAT THERE'S AN ANALOGOUS ARGUMENT FOR PEOPLE WITH OTHER KINDS OF DISABILITIES.

>> CORRECT. SSP, THE ACTUAL TERM CAME FROM THE AMERICAN ASSOCIATION FOR DEAF BLIND BACK IN THE '70s. YES, AN SSP ARE ONLY FOR CONSUMERS WHO ARE DEAF BLIND, AND THAT'S THE LEGAL DEFINITION OF HEARING AND VISION LOSS. SO YEAH, CORRECT. WE DO GET THAT, THAT OTHER INDIVIDUALS WITH VARIOUS OTHER DISABILITIES ARE REQUIRING THE SAME NEED, BUT OF COURSE, A LOT OF OTHER PROGRAMS THAT ARE AVAILABLE FOR THEIR SERVICES.

>> LAST QUESTION. IS THERE MUCH OF A PROBLEM NATIONALLY WITH FRAUD OR ABUSE WITH SSP PROGRAMS? WE'VE SEEN SOME HISTORY OF THAT IN SOME OTHER KINDS OF STATE AND FEDERAL PROGRAMS ACROSS THE COUNTRY AND IN NORTH CAROLINA. THIS USUALLY COMES UP AROUND PERSONAL CARE SERVICES AND I'M CURIOUS IF THIS IS SOMETHING THAT HAPPENS MUCH IN YOUR EXPERIENCE WITH SSP PROGRAMS .

>> SO AS FAR AS THIS HAPPENING MUCH, NO. WE HAVE NOT HAD A LARGE RESPONSE FROM THE COMMUNITY AS FAR AS NEGLECT OR ABUSE ON OUR CONSUMERS, BUT AS WE ALL KNOW, WE HAVE TO BE CAREFUL. WE DO HAVE A THOROUGH-- WELL, I DO KNOW FOR US HERE IN OUR STATE BUT IN SEVERAL OF THE STATES I DO COVER, THEY HAVE A THOROUGH SCREENING PROCESS TO ENSURE THAT WHOEVER IS PROVIDING THAT SERVICE IS ABIDING NOT ONLY BY BACKGROUND CHECKS BUT ALSO CONTINUAL EVALUATIONS AND SAY FOR INSTANCE IF A CONSUMER JUST FINISHED UTILIZING AN SSP FOR AN APPOINTMENT, THEY HAVE TO GIVE US A FEEDBACK AND EVALUATION OF THAT

APPOINTMENT. SO TO CONSTANTLY LET US KNOW AND THEY HAVE CONTACT WITH THEIR DIRECTOR COORDINATOR IF NEEDED. IT'S NOT HIGH BUT IT'S DEFINITELY OUT THERE. WE JUST DON'T KNOW THE NUMBERS. THANK GOODNESS, WE DON'T HAVE A HIGH NUMBER OF THEM.

>> THANK YOU. JAN HAS A QUESTION OR COMMENT.

>> YEAH. THIS IS JAN. I'VE GOT JUST TWO COMMENTS. FIRST OF ALL, FOR YOUR INFORMATION, ASHLEY, AS YOU KNOW, HAS INFORMATION FROM A WIDE VARIETY OF STATES AND SHE IS NOW IN THE PROCESS OF PULLING TOGETHER ALL OF THAT INFORMATION TO PRESENT TO ME WITH POSSIBLY SOME RECOMMENDATIONS FOR WHAT NORTH CAROLINA COULD ADOPT, SOME DIFFERENT OPTIONS THAT WE MIGHT PURSUE. AND I'D BE VERY HAPPY TO RUN THAT UP THE CHAIN OF COMMAND TO SEE WHERE WE WANT TO GO WITH WHAT'S RECOMMENDED. NOW, SECOND THING IS I JUST LEARNED YESTERDAY FROM RON TODAY OWEN-- FROM R-HONDA OWEN THAT NORTH CAROLINA MEDICAID HAS A SERVICE CALLED NON-EMERGENCY MEDICAL TRANSPORTATION AND WE ARE EXPLORING THAT AS AN OPTION FOR SSP DRIVERS.

>> YES. THIS IS DAVID SPEAKING. HELLO, MARILYN.

IT'S GOOD TO TALK TO YOU AGAIN

>> HI, DAVID.

>> MY QUESTION IS RELATED TO THE TRAINING OF THE SSPs AND THE TRAINING OF THE PCAs FOR PEOPLE WITH DISABILITIES. DO PERSONAL CARE ASSISTANTS AND SSPs GET SIMILAR TYPES OF TRAINING? IS ONE SET OF TRAINING MORE IN DEPTH THAN THE OTHER SET OF TRAINING? ARE THERE CERTIFICATES GIVEN FROM THAT TRAINING?

>> SO THIS IS MARILYN SPEAKING. ON THE BASIS OF SSPs AND OVERALL SUPPORT SERVICE PROVIDERS ACROSS THE UNITED STATES, THAT IS, A SUPPORT SERVICE PROVIDER IS GIVEN AN EXTENSIVE TRAINING. WE TRY TO ENCOURAGE TO HAVE A TRAINING BASED WITH AN SSP, CURRENT SSP AND AN INDIVIDUAL WHO HAS VISION AND HEARING LOSS AS WELL. WE HAVE TO COVER THE FULL SPECTRUM OF OUR POPULATION SINCE WE KNOW THAT A MAJORITY OF OUR POPULATION ARE NON-SIGNERS, SO WE HAVE TO BE SURE THAT EVERYBODY IS COVERED, AND THAT TRAINING THAT WE PROVIDE HERE IN NORTH CAROLINA ARE FULL-DAY TO EVEN A FULL-WEEKEND TRAINING TO BE SURE THEY UNDERSTAND THE FULL CAPACITY NEEDED FOR OUR CONSUMERS. NOW AS FAR AS PSA OR PEER ATTENDANTS, THAT'S DIFFERENT BECAUSE THAT REQUIRES THEM TO INTERVENE

AS AN SSP, THEY'RE NOT TOINTERVENE. THEY'RE ONLY TO PROVIDE OPTIONS AVAILABLE TO CONSUMERS SO THEY CAN MAKE THEIR OWN INFORMED CHOICE. WHILE A CARE ATTENDANT OR A PERSONAL CARE ATTENDANT, THEY WOULD BE PROVIDING A LITTLE BIT MORE OF THE SERVICE OF DOING FOUR RATHER THAN WITH AND THAT REQUIRES A LITTLE BIT MORE MEDICAL ATTENTION THAT WE DO NOT COVER.

>> OKAY. THANK YOU.

>> HI, MARILYN. THIS IS TOVAH HERE. CAN WE TALK MORE ABOUT THE FUNDING. ? I IMAGINE THAT PROVIDERS HERE HAVE BEEN OVERWHELMED WITH LEARNING ABOUT INTERPRETERS AND NOW YOU WANT TO THROW AN SSP INTO THE MIX, RIGHT? WE HAVE TO ADDRESS THAT. WHAT HAVE BEEN SOME OF THE FUNDING MODELS THAT MIGHT HAVE WORKED OR THAT COULD WORK? CAN WE SPEAK TO THAT A LITTLE BIT?

>> SURE THING. SO THERE'S A FEW THINGS. IN SOME STATES, THE DEPARTMENT OF HEALTH WILL TAKE CARE OF THE SUPPORT SERVICE PROVIDER AND ASSIST IN PAYING FOR THAT SERVICE. WE DO HAVE SOME OF MY STATES THAT DO PRIVATE, HAVE A PRIVATE AGENCY THAT PROVIDES THAT SERVICE. IT IS NOT A SERVICE THAT IS PAID FOR THROUGH THE MEDICAL , ANY FORM OF MEDICAL SERVICES WHATSOEVER. THE MEDICAL OBLIGATION, AS WE KNOW, IS THE INTERPRETING SERVICES, AND TO ENSURE, YOU KNOW, THAT IT'S UNDERSTOOD AND AGAIN, WE JUST GOT FINISHED TALKING ABOUT THIS MORNING WITH LEE'S MOTHER AND UNDERSTANDING THAT IT'S NOT ALWAYS THE MEDICAL PROVIDER WHO DOESN'T UNDERSTAND THE USE OF AN INTERPRETER, IT'S USUALLY HAVING TO GO THROUGH THE BUSINESS OFFICE AND UNDERSTANDING THE NEED FOR SPECIFIC, QUALIFIED, CERTIFIED INTERPRETERS WHO CAN DO THE WORK BECAUSE IN TIME, WHEN I WAS A SOCIAL WORKER IN THE PAST, I WOULD SHOW UP TO AN APPOINTMENT AND I WOULD SEE THE SSP WOULD DRIVE THE CONSUMER TO THE MEDICAL APPOINTMENT AND I WOULD BE THERE TO ADVOCATE AND I WOULD SEE THE INTERPRETER COME IN WHO IS NOT EVEN CLOSE TO QUALIFIED TO PROVIDE THE SERVICE FOR OUR CONSUMER. AND THEN THEY WOULD LOOK TO THE SSP AND SAY, WELL, YOU'RE QUALIFIED BECAUSE YOU WORK WITH DEAF BLIND. CAN YOU INTERPRET? AGAIN, THAT GOES TO A LITTLE BIT OF EDUCATION AND UNDERSTANDING. UNDERSTAND, THIS IS A PROTECTION FOR THE CONSUMER SO THEY CAN ACTUALLY GET TO THE APPOINTMENTS AND CAN ACTUALLY HAVE-- RATHER THAN HAVING A FAMILY MEMBER THERE, THEY CAN GO INDEPENDENTLY TO THESE MEDICAL APPOINTMENTS AND NOT MISS THEM. I DO WANT TO STRESS TO EVERYBODY IN THE ROOM, WE'VE HAD IN THE PAST FEW YEARS SEVERAL CASES OF CONSUMERS WHO HAVE PASSED AWAY, FOUND IN THEIR HOMES SEVERAL DAYS LATER BECAUSE THEY WERE UNABLE TO GET THE MEDICAL ATTENTION THEY NEEDED. THEY DID NOT GO TO MEDICAL APPOINTMENTS. THEY DID NOT GET THE SERVICES THAT THEY NEEDED. SO INSTEAD, THEY WERE HOME AND HAD NO IDEA HOW TO GET THESE APPOINTMENTS. AND SO IT'S FOR US TO GET THE CONSUMERS TO THE APPOINTMENT AND CONNECT IT WITH THE APPROPRIATE INTERPRETING SERVICES. OKAY. SO JUST THE EASE THERE AS FAR AS SSP AND HAVING TO PAY FOR THAT, IT'S NOT NECESSARILY THAT IS WHAT IS NEEDED WAS THE SUPPORT AND UNDERSTANDING THAT WE NEED THE SERVICE IN THIS STATE AND WE NEED THE SUPPORT OF ALL PROVIDERS TO LET US GO AHEAD AND ADVOCATE TO HAVE THIS SERVICE ACTUALLY DONE IN A-- THROUGH A PAID SERVICE FOR NORTH

CAROLINA RATHER THAN VOLUNTEER. THIS IS MARILYN AGAIN. I WANT IT ADD ONE MORE THING. EVEN THOUGH THE NORTH CAROLINA DEAF BLIND ASSOCIATES DOES HAVE SSP SERVICES, AGAIN, I HAVE TO EMPATHIZE, IT'S VOLUNTEER SERVICES. AND EVERYBODY WHO IS ON THAT LIST EITHER WORKS , THEY'RE A STUDENT OR A FAMILY MEMBER OUT THERE TRYING TO HELP OTHER FAMILY MEMBERS. THEY ARE UNABLE TO DO THIS FOR THEMSELVES BECAUSE OF THOSE OTHER AREAS THAT THEY HAVE TO TAKE CARE OF. IF THIS WAS A PAID SERVICE AND ACTUALLY SIGNED UP TO WORK, THEN, OF COURSE, WE COULD GUARANTEE THIS AN SSP WOULD BE THERE. WHEN WE SEE THAT WE HAVE 70%, THAT MEANS ACCESS FOR HEALTH CARE, IF WE HAD JUST A SMALL AMOUNT OF SSPs WHO ARE PAID TO DO THE JOB, THAT COVERS SEVERAL OF OUR CONSUMERS ACROSS THE-- INCOME McWHO REQUIRE THAT NEED. -- ACROSS NORTH CAROLINA WHO REQUIRE THAT NEED.

>> I HAVE A LITTLE DIFFERENT QUESTION AND MAYBE SOME FOLKS IN THE ROOM CAN HELP, OR YOU, MARILYN. I'M WONDERING, YOU KNOW, ALL OF OUR RECOMMENDATIONS THAT ARE SORT OF MORE GENERAL AROUND COMMUNICATION ACCESS AND PROVIDER RESPONSIBILITIES AROUND COMMUNICATION ACCESS, I THINK WE PROBABLY NEED TO INCORPORATE LANGUAGE ABOUT THE UNIQUE NEEDS OF DEAF BIND CONUM SOARS AND I'M WONDERING WHAT OUR RESOURCES LOOK LIKE IN NORTH CAROLINA TO MEET THOSE NEEDS. HOW MANY QUALIFIED MEDICAL QUALIFIED DEAF BLIND INTERPRETER DOES WE HAVE? IF I'M A HEALTH SYSTEM AND I REGULARLY PARTNER WITH GAVE OR SIX INTERPRETER AGENCIES OR, ARE ANY OF THEM GOING TO HAVE A DEAF BLIND INTERPRETER AVAILABLE? WHAT DO WE KNOW ABOUT THE INTERPRETER WORKFORCE FOR THIS PARTICULAR POPULATION?

>> YOU WANT ME TO THROW IT?

[LAUGHTER]

THAT'S A GOOD IDEA.

>> THIS IS LEE. THIS IS LEE. I HAD TO PUSH TALK ON THE ALD. YEAH. AS WE'VE BEEN TALKING ABOUT THE SHORTAGE OF INTERPRETERS, IN GENERAL, YOU CAN IMAGINE WHEN YOU GET INTO SPECIALIZATIONS, THE SHORTAGE EVEN GETS MORE OF A CONCERN. FORTUNATELY IN NORTH CAROLINA, WE HAVE BEEN DOING A LOT OF INTENSIVE TRAINING FOR INTERPRETERS WITH-- TO OBTAIN DEAF BLIND INTERPRETING SKILLS, BUT THERE IS A SHORTAGE. I THINK TRAINING WILL RAMP UP EVEN MORE. INTERPRETERS, WHEN WE-- SPEAKING FOR MYSELF AS AN INTERPRETER AND FOR WHAT I SEE IN OUR PEERS IN THE PROFESSION IN NORTH CAROLINA WHEN WE SEE A CERTAIN TYPE OF INTERPRETING SERVICE NEED ARISE, A LOT OF OUR INTERPRETERS WANT TO GET THAT TRAINING. SO THEY WILL PURSUE IT. I THINK IF AN OPPORTUNITY WAS THERE OR A NEED WAS SHOWN FOR MORE DEAF BLIND INTERPRETING SERVICES BECAUSE NOW IT'S BECOMING MORE ACCESSIBLE FOR DEAF BLIND INDIVIDUALS TO GET TO THE APPOINTMENT, I THINK YOU'LL SEE MORE INTERPRETERS TAKE

THAT TRAINING AND DSDHH PROVIDES THAT TRAINING AND WORK ALONG WITH MARILYN TO PROVIDE SOME REALLY GOOD TRAINING. THAT'S ALL I CAN SAY ABOUT THAT RIGHT NOW. WE DO HAVE TRAINING AVAILABLE.

>> THIS IS MARILYN. I WILL ADD TO THIS. YOU KNOW, ON A NATIONAL LEVEL, THE AMERICAN ASSOCIATION FOR DEAF BLIND AND HELEN KELLER HAVE TALKED FOR SEVERAL CAREERS AND WE TRIED SEVERAL TIMES TO GET RIDs TO DEVELOP A SPECIALIZATION FIELD *FLDINST CXINC CERT FLDRSLTIFICATION FOR DEAF BLIND INTERPRETING. THEY HAVE FOR MENTAL HEALTH. THERE'S A TRAINING IN ALABAMA THAT SPECIFICALLY FOCUSES ON MENTAL HEALTH INTERPRETING AND THAT'S A WEEK-LONG TRAINING. YOU'RE TALKING ABOUT LIKE 40 HOURS OF TRAINING FOR THAT CERTIFICATION. IT WOULD BE GREAT IF WE WERE ABLE TO JUST CONTINUE TO EXPAND THAT AND DO MEDICAL AND HAVE DEAF BLIND, BUT WE ARE FORTUNATE HERE IN NORTH CAROLINA TO HAVE THE AVAILABILITY OF INTERPRETERS TO HAVE QUALIFIED. IT'S JUST THE MEDICAL PROVIDERS, THE BUSINESS OFFICES, WHEN THEY CALL FOR INTERPRETING SERVICES, THEY SAY WE HAVE A DEAF CONSUMER HERE, AND THAT'S IT. AND THEN WE SHOW UP AND THEY SAY, WELL, THEY DIDN'T TELL ME THAT THE CONSUMER WAS DEAF BLIND. I DIDN'T KNOW THAT THE PATIENT WAS DEAF BLIND OR THAT THEIR FAMILY MEMBER IS DEAF BLIND WHO IS SITTING THERE WITH THEIR DEAF HUSBAND. AGAIN, WHEN THEY'RE PROVIDING INTERPRETING SERVICES, IT'S NOT JUST FOR THE PATIENT, IT'S FOR THE FAMILY MEMBER, HUSBAND, WIFE, WHO ARE THERE AS WELL. IT'S THE UNDERSTANDING OF, AGAIN, KNOWING HOW TO REQUEST THE SERVICE, KNOWING WHAT YOU'RE ASKING FOR AND WHY IT'S SO IMPORTANT THAT VRI IS NOT GOING TO WORK.

>> GREAT. THANK YOU. OTHER QUESTIONS ABOUT THIS ISSUE FOR MARILYN OR OTHERS IN THE ROOM? I KNOW WE WANT TO GET BACK TO OUR RECOMMENDATIONS. I WANT TO MAKE SURE WE ADDRESS IT.

>> I DO.

>> WE HAVE ONE MORE QUESTION, HANG ON.

>> I'M SORRY.

>> SOUNDS GOOD.

>> THIS IS JULIE BISHOP WITH THE HEARING LOSS ASSOCIATION OF NORTH CAROLINA. I CAN'T GET OVER THIS CONFUSION ABOUT NUMBERS. ASHLEY SAID EARLY ON THAT THERE WERE 83,000, RIGHT, DEAF BLIND PEOPLE IN NORTH CAROLINA. HOW MANY OF THOSE ACTUALLY NEED THE SERVICES OF A DEAF BLIND INTERPRETER? BECAUSE I KNOW THE DEFINITION IS VERY BROAD AND IN FACT, I WONDER FUNDAMENTAL I COULD BE DEAF BLIND BECAUSE I HAVE A COCHLEAR IMPLANT AND I HAVE THE BEGINNING OF RETINAL-- IT'S ACTUALLY MILD LIKE HIS MOTHER. ANYWAY, WHAT'S THE ACTUAL NUMBER OF PEOPLE IN NORTH CAROLINA THAT WOULD ACTUALLY NEED A SIGN LANGUAGE INTERPRETER THAT IS ALSO DEAF BLIND CERTIFIED?

>> I DON'T SEE ANYBODY PUTTING THEIR HANDS UP TO ANSWER YOUR QUESTION, JULIE.
>> THIS IS KATHY DOWD. I JUST KNOW FROM THE COUNCIL MEETING LAST FRIDAY WHERE THEY PRESENTED ON THIS WITH THE 83,000 THAT THERE WERE 200 AND SOMETHING THAT NEEDED SOME MORE INTENSIVE SERVICES AND I MAY BE UNCLEAR AND THEN 65 PEOPLE IN THE STATE THAT NEEDED SSPs, BUT THAT'S WHAT I UNDERSTOOD FROM THAT MEETING. AND I MAY BE WRONG. THAT'S WHAT I TOOK AWAY FROM THE MEETING.
>> THIS IS MARILYN. I WAS AT THE COUNCIL MEETING TWO WEEKS AGO OR SO, AND JUST TO LET YOU KNOW THAT 83,000 COVERS FROM BIRTH ALL THE WAY UNTIL YOU'RE TALKING 90s, 100. I THINK THE PERSON WAS. WE HAVE TO REMEMBER IT'S THAT DUAL SENSORY LOSS THAT IMPEDES YOUR DAILY LIVING. SO AS FAR AS THOSE THAT REQUIRE INTERPRETING SERVICES, WE DON'T HAVE THAT BROKEN DOWN AS FAR AS THE CONSUMERS WHO REQUIRE A SIGN LANGUAGE INTERPRETER, BUT AS FAR AS SSP SERVICES ON THE OTHER SIDE, WE HAVE TO THINK OF IT THIS WAY. MANY FAMILIES, MANY CONSUMERS HAVE NO IDEA THAT THE SERVICE CAN EVEN BE AVAILABLE. WHEN YOU ARE LIVING IN A STATE THAT HAS SEVERAL AREAS THAT ARE VERY RURAL TO ACTUALLY GET AN SSP TO COME THERE OR VOLUNTEER IS VERY DIFFICULT. SO WHEN WE'RE LOOKING AT THE NUMBER OF 200 OR SO, THIS WAS ACTUALLY BASED OFF THE NATIONAL DEAF BLIND EQUIPMENT DISTRIBUTION PROGRAM, AND THAT NUMBER IS BASED OFF THOSE INDIVIDUALS WHO SIGNED UP FOR THAT PROGRAM WHO RECEIVED ACCESS TO DISTANCE COMMUNICATION FOR TECHNOLOGY, WHICH IS A NATIONAL FEDERAL PROGRAM THAT WAS SET UP. SO WHEN WE'RE ACTUALLY LOOKING INTO THE NUMBER OF SSPs, WE'RE LOOKING AT CONSUMERS WHO ARE UTILIZING THAT SERVICE NOW AND THOSE CONSUMERS THAT WE'RE LOOKING AT ARE ABOUT 100 OR SO. THOSE ARE THE ONES WHO COME TO CAMP.
THOSE ARE THE ONES WHO COME TO CONFERENCE. THOSE ARE THE ONES WHO COME TO THE SUMMER EVENTS FOR HELEN KELLER AWARENESS MONTH IN JUNE. YOU'RE LOOKING AT AN AVERAGE OF 100, 150 OR SO, BUT AGAIN, THERE'S SO MANY CONSUMERS THAT AREN'T EVEN BEING-- AREN'T AWARE OF WHAT'S AVAILABLE AND HENCE, WE HAD MY MOTHER-IN-LAW'S FRIEND WHO WAS ACTUALLY PASSED AWAY IN HER TRAILER HOME BECAUSE SHE DIDN'T GET AN SSP, DIDN'T RESPOND UNTIL IT WAS TOO LATE FOR HER TO GO TO A MEDICAL APPOINTMENT. AGAIN, THE ACCESS, THE CONNECTIONS TO BE ABLE TO GET THOSE SERVICES, THERE'S A LOT MORE OUT THERE THAT WE DON'T EVEN KNOW ABOUT.
>> I'M STILL CONFUSED. THERE'S GOT TO BE SOME SORT OF DEFINITION AS WHO QUALIFIES BEING DEAF BLIND. I MEAN, FROM WHAT I HEARD ASHLEY SAY EARLY ON, IT WAS PRETTY BROAD AND GOSH, I KNOW SO MANY. STEVE, YOU MAY BE DEAF BLIND.
[LAUGHTER]
I DON'T MEAN TO BE FUNNY ABOUT THIS. YOU KNOW, I THINK WE HAVE TO KNOW-- IT HELPS TO

KNOW THE NUMBERS THAT WE'RE DEALING WITH AND IT JUST HELPS TO MAKE PROPER DECISIONS AND YOU KNOW, MAYBE WE'VE GOT A BIG OVERLAP OF PEOPLE WHO ARE SOMETIMES DEAF AND THEN SOMETIMES BLIND AND THEN SOMETIMES BOTH. THE NUMBERS ARE VERY CONFUSING TO ME, THAT'S ALL-- I DON'T KNOW HOW TO GET OVER THAT. IT SEEMS TO ME THAT THERE'S GOT TO BE A DEFINITION OF WHO FITS INTO THAT CATEGORY.

>> JUST TO LET EVERYBODY KNOW, THE NATIONAL FEDERAL DEFINITION FOR DEAF BLIND, OKAY, YOU HAVE TO-- YES. MANY OF US DO FIT INTO THAT CATEGORY. IF IT IMPEDES OUR DAILY LIVING, A FUNCTIONAL ASSESSMENT CAN BE DONE AND TO DETERMINE WHETHER OR NOT SOMEBODY HAS A HEARING AND A VISION LOSS THAT WILL IMPEDE THEIR DAILY LIVING, OKAY. AND NOT ABLE TO DRIVE, UNABLE TO MAINTAIN EMPLOYMENT, UNABLE TO MAYBE SIT DOWN AND WATCH TV, A SHOW, YOU KNOW, HAVING THE NEED FOR ACCESSIBILITY MAGNIFICATION, EFFECTIVE EQUIPMENT TO BE ABLE TO ACCESS THAT. THERE ARE A LOT OF PEOPLE WHO REALLY DON'T REALIZE THAT THEY DO FIT THAT CATEGORY.

>> JULIE, I THINK YOUR POINT IS A GOOD ONE. I THINK I'M HEARING SOMEWHERE BETWEEN 100 AND 83,000 IS PROBABLY THE TRUTH BUT I THINK THAT OUR EXPERIENCE IN OTHER STATES WILL REALLY HELP US. I THINK AS YOU SAY MARILYN, WE DON'T KNOW OF THE 1500, 150 DEAF BLIND CONSUMERS THAT GO TO CONFERENCES. FOR-FOR EVERY ONE OF THOSE, THERE MAY BE ONE, TWO, OR THREE PEOPLE THAT NEED SERVICES AND DON'T KNOW THEY EXIST AND ONCE YOU OFFER SERVICES, YOU MAY FIND A LOT MORE CONSUMERS. I THINK IF WE CAN LEARN ABOUT WHAT OTHER STATES THAT ARE DEMOGRAPHICALLY SIMILAR TO NORTH CAROLINA HAVE EXPERIENCED IN TERMS OF PROGRAMS ONCE THEY EXIST, I THINK WE CAN HAVE A BETTER INFORMED DISCUSSION ABOUT WHAT THE FINANCIAL IMPLICATIONS MIGHT BE FOR THE RECOMMENDATION, WHICH I THINK IS REALLY IMPORTANT. WE'LL TRY TO GET THAT INFORMATION FROM ASHLEY WHEN IT'S AVAILABLE.

>> WE'LL DO. I WILL DEFINITELY GIVE YOU ALL THE FINAL FEEDBACK ONCE WE COLLECT IT ALL.

>> PERFECT. THANK YOU FOR JOINING US AND DIALING IN. I THINK WE'RE GOING TO MOVE BACK TO OUR RECOMMENDATIONS. I WILL HAND THIS OVER TO ROB.

>> I WILL TURN THE VIDEO OFF AND I WILL BE ON THE PHONE.

DRAFT Recommendation Review (Cont.)

>> THANK YOU. SO WE ARE GOING TO MOVE BACK INTO RECOMMENDATIONS. BEFORE WE PASSED THE FIRST ONE, I HAD A COUPLE QUESTIONS ASKING WHAT THIS LOCALIZED CONSORTIUM MEANT. I THREW THIS IN THERE-- I'M SORRY, 1H, I BELIEVE. WE DIDN'T TOTALLY WANT TO GET RID OF THE HOSPITAL CONSORTIUM IDEA WE HEARD FROM MINNESOTA. THE THOUGHT ABOUT THIS WAS THAT IF THE

DIVISION OF DEAF AND HARD OF-- DIVISION FOR DEAF AND HARD OF HEARING THOUGHT THIS COULD BE A GOOD IDEA TO HAVE A CLUSTER OF LOCAL PROVIDERS OR HOSPITAL PROVIDERS, WHATEVER IT WOULD BE, WE WERE LETTING THEM KNOW THAT THIS IS NG IS THAT EXISTS AND IT IS A NEW PAYMENT MODEL FOR INTERPRETERS AND WE DIDN'T WANT TO GET RID OF THAT ALTOGETHER. IT'S A WAY AND A TOOL THAT WE CAN USE WHEN WE CREATE THESE PARTNERSHIPS TO OFFER THEM AND THAT IS SOMETHING THAT CAN BE DONE, AND WE HAVE DATA PROVING THAT IT WORKS AND A MODEL THAT WORKS BEHIND IT. I WILL PHRASE THAT A LITTLE BIT DIFFERENTLY SO THAT IT REFLECTS WHAT WE HAD PRESENTATIONS ON. SO NOW I'M GOING TO MOVE DOWN TO 1A. THESE ARE THE RESOURCES THAT WILL COME FROM THE DIVISION IN THESE PARTNERSHIPS IN THE TOOLKIT, AND WE WROTE THIS AT A VERY HIGH LEVEL BECAUSE EVEN THOUGH LIKE GREG OFFERED MAYBE AT AN ANNUAL MEETING THAT THIS PRESENTATION CAN BE DONE, I DON'T THINK WE SHOULD GET THAT SPECIFIC. I THINK WE WANT TO INCLUDE EVERY MEDIUM THAT WE CAN OFFER A PRESENTATION AT, AND THOSE STRATEGIC PARTNERSHIPS CAN FIGURE OUT THE BEST WAY TO GET THEM TO MEMBERS OR LICENSEES. THAT'S HOW THIS SECTION WAS WRITTEN. ANYTHING ON 1A?

>> I WOULD ENCOURAGE TO YOU KEEP MOVING BECAUSE I DIDN'T SEE HANDS GO UP.

>> UNLESS I GET STOPPED, KEEP MOVING. NUMBER 2, FACILITATE BETTER UNDERSTANDING. SO THIS IS TRYING TO TRAIN THE ALLIED HEALTH PROFESSIONALS, FUTURE PROFESSIONALS. SO THIS IS GETTING INTO MEDICAL SCHOOLS, RESIDENCY TRAINING PROGRAMS, NURSING PROGRAMS, THE ONES LISTED. WE'VE GOT ADDITIONAL RECOMMENDATIONS TO INCLUDE AUDIOLOGY PROGRAMS, MENTAL HEALTH PROGRAM PROGRAMS, SOCIAL WORK, SUBSTANCE ABUSE, COUNSELORS, PSYCHOLOGY. SO WE CAN DEFINITELY ADD MORE OF THOSE IN THERE, BUT I THINK THE THING TO THINK ABOUT WITH THIS ONE IS DAVID IS NOT HERE ANYMORE BUT HE WAS TELLING ME THAT THERE ARE SPECIFICALLY FOR THE FIRST ONE, MEDICAL SCHOOLS AND RESIDENCY PROGRAMS, THERE'S DEANS AT EVERY UNIVERSITY SYSTEM AND THAT DEAL WITH THE CURRICULUMS, SO IT WOULD BE CREATING PARTNERSHIPS WITH THOSE PEOPLE, THOSE DEANS TO KIND OF TRY TO GET THIS IMPLEMENTED INTO THE CURRICULUM AND THE RESIDENCY TRAINING PROGRAMS. I'M NOT SURE IF YOU WANT TO SPEAK MORE TO THIS, ADAM.

>> I THINK THIS IS BOTH SUPERIMPORTANT AND A REAL CHALLENGE. BECAUSE THERE ARE MANY, MANY NURSING PROGRAMS. THERE ARE-- I DON'T KNOW. WE HAVE SOMETHING LIKE 88 COMMUNITY COLLEGES AND MAYBE HALF OF THEM HAVE NURSING PROGRAMS. ALL OF OUR REGIONAL UNC CAMPUSES HAVE HEALTH PROFESSION TRAINING PROGRAMS AND THERE'S NOT LIKE A UNIFYING EARPIECE, SO TO SPEAK. WE DON'T HAVE IN THE SAME WAY THAT WE MIGHT GO TO THE HEALTH CARE ASSOCIATION IF WE WANT TO WORK WITH HOSPITALS. WE DON'T HAVE THE SAME SORT OF UNIFIED EARPIECE. SO WE OFTEN MAKE RECOMMENDATIONS TO TRAINING PROGRAMS BECAUSE THAT'S HOW YOU TRAIN THE FUTURE WORKFORCE, BUT I DO THINK THESE RECOMMENDATIONS ARE CHALLENGING

BECAUSE WE DON'T HAVE NECESSARILY A DIRECT RELATIONSHIP WITH EVERY ONE OF THEM. WE HAVE RELATIONSHIPS WITH SOME OF THEM.
IT'S AN OKAY THING TO RECOMMEND. I THINK WE PROBABLY SHOULD. I THINK IF THERE'S LIKE ANY GROUP THOUGHT ON THE BEST WAY TO ACTUALLY GET INTO ALL HEALTH PROFESSION TRAINING PROGRAMS, I THINK THAT'S WHAT WE COULD USE HELP WITH.
>> TOVAH HERE. WITH RESPECT TO THE LAST OF PROGRAMS YOU'RE TALKING ABOUT, I THINK I MADE THE RECOMMENDATION SUGGESTING, REALLY, A QUESTION TO ALSO INCLUDE ALLIED HEALTH CARE PROGRAMS, LIKE MENTAL HEALTH, SUBSTANCE ABUSE BECAUSE PSYCHOLOGISTS, SOCIAL WORKERS, SOME OF THEM ACTUALLY SPECIALIZED IN HEALTH CARE, YOU KNOW, HOSPITAL SOCIAL WORKERS OR PSYCHOLOGISTS WHO WORK WITH PSYCHIATRIC HOSPITALS, STUFF LIKE THAT. SO I WONDER IF THOSE GROUPS SHOULD ALSO BE INCLUDED IN THIS PROCESS OF DEVELOPING ACCESSIBILITY, UNDERSTANDING ACCESSIBILITY.
>> I'M READING OFF TO THE SIDE, THE COMMENT ABOUT AUDIOLOGY PROGRAMS. PERHAPS THIS LIST COULD INCLUDE THESE DOCTORAL PROGRAMS AND SPEECH THERAPY AND AUDIOLOGY BECAUSE THEY DON'T REALLY RESIDE UNDER CATEGORY A, MEDICAL SCHOOLS.
>> JUST QUICKLY. IN SOME CASES, THEY DO. I KNOW I TAUGHT AT UNC CHAPEL HILL AND WE WERE PART OF THE SCHOOL OF MEDICINE.
>> ONE WAY YOU MAY GO ABOUT THIS IS TRYING-- AS YOU DEVELOP THE TOOLKITS FOR FOLKS WHO ARE ALREADY OUT IN THEIR CAREERS, MAKING SURE THAT WE TRY TO PROMOTE THOSE TO PEOPLE WHO ARE IN TRAINING AS WELL. YOU ARE GOING TO RUN INTO ISSUES. JUST LOOKING AT IT FROM MEDICAL SCHOOL AND RESIDENCY PROGRAMS. ALL OF THOSE ARE GOVERNED EITHER BY THE ACGME, WHICH IS AMERICAN COLLEGE OF MEDICAL GRADUATE EDUCATION AND THEY TELL EVERY RESIDENCY PROGRAM WHAT HAS TO BE IN THAT CURRICULUM. ANYTHING THAT IS BEYOND WHAT ACMGE HAS TO HAVE IN THE CURRICULUM GETS DIFFICULT TO GET INTO THE CURRICULUM. THAT DOESN'T MEAN IT'S IMPOSSIBLE. SAME WITH MEDICAL SCHOOLS AND WHEN YOU LOOK AT RESIDENCIES, JUST IN FAMILY MEDICINE, THERE ARE 17 FAMILY RESIDENCIES IN THE STATE. THERE MAY BE 100 OR 200 RESIDENCIES OF SOME KIND MATT STATE. SO IT DOES BECOME A DIFFICULT TASK, BUT IF WE HAVE SOMETHING THAT'S AVAILABLE AND WE PROMOTE IT, LIKE IN MY CASE, I CAN PROMOTE TO THE RESIDENCY DIRECTORS OF ALL 17 FAMILY MEDICINE RESIDENCY PROGRAMS, THIS IS AVAILABLE IF YOU WANT TO USE IT. IT'S TURNKEY, IT'S EASY, THEN YOU KNOW, YOU AT LEAST MAY GET SOME HEADWAY THAT WAY. GOING SCHOOL BY SCHOOL OR RESIDENCY PROGRAM BY RESIDENCY PROGRAM IS GOING TO BE DIFFICULT UNLESS SOMEBODY LIKE THE ACGME SAYS THIS HAS TO BE PART OF YOUR CURRICULUM.
>> ONE THING THAT'S NEW IS WE SORT OF REBUILT OUR KIND OF STAKEHOLDER DATABASE THIS YEAR, AND WE DO NOW HAVE IN OUR DATABASE THE DEANS OR OTHER APPROPRIATE OFFICIALS OF HEALTH

AFFAIRS ON EVERY CAMPUS AND COMMUNITY COLLEGE CAMPUS ACROSS THE STATE. SO WE CAN MAKE SURE THAT THEY ALL GET A COPY OF OUR REPORT. THAT'S LIKE AN EASY THING TO DO. NOW GETTING A COPY OF OUR REPORT AND OPENING IT UP IS TWO ENTIRELY DIFFERENT THINGS. WE HAVE TO ACKNOWLEDGE THAT. I THINK IF THERE ARE IDEAS FOR MORE ENGAGEMENT, WE WANT TO HEAR ABOUT IT.

>> THIS IS SHELLEY CRISTOBAL BALL. I LIKE THAT IDEA ABOUT PUTTING IT ON THE ORGANIZATIONS, THE PROFESSIONAL ORGANIZATIONS AND MAYBE EVEN INCORPORATING THE WORDING THAT SAYS, PROFESSIONAL ORGANIZATIONS ARE NOT JUST PROMOTING THIS TO THEIR MEMBERS BUT ALSO TO THE ACADEMIC PROGRAMS RELEVANT TO THEIR FIELD, WHETHER THAT'S NOT JUST THE NURSES BUT NURSING ASSISTANTS IN THE COMMUNITY COLLEGE PROGRAMS.

>> THAT'S A GREAT IDEA.

>> THAT SORT OF BREAKDOWN.

>> WE HAVE SEVERAL PEOPLE HERE THAT REPRESENT MEMBERSHIP ASSOCIATIONS. DOES THAT SEEM LIKE A NATURAL FIT? YEAH. WE HAVE NURSING. WE HAVE THE MEDICAL BOARD, FAMILY PHYSICIANS, PHYSICAL THERAPY, OCCUPATIONAL THERAPY SOMEWHERE. DOES THAT MAKE SENSE? IS THAT A NATURAL?

THIS IS BETHHOODWAY WITH NCTA, AND I'M NOT SURE HOW OTHERS ARE STRUCTURED BUT WE DO HAVE AN ACADEMIC LIAISON PERSON ON OUR BOARD WHO HAS CONTACT WITH ALL THE OTHER ACADEMIC PROGRAMS AND ANOTHER THOUGHT I HAD WAS STUDENT ASSOCIATIONS IN THESE PROFESSIONAL SCHOOLS. THEY MIGHT BE WILLING TO TALK-- YOU WANT TO REACH THE FUTURE PROVIDERS. SO STUDENT ASSOCIATIONS, DEFINITELY THE-- LIKE NCOTA, NCPTA. I KNOW THE OTHER ASSOCIATIONS WOULD HAVE A DIRECT LINK TO ACADEMICS.

>> ARE THERE THOUGHTS ABOUT THIS RECOMMENDATION, OR KEEP MOVING? OKAY.

>> I'M ACTUALLY GOING TO THROW ONE MORE THOUGHT IN, TOO. THE MEDICAL BOARD WITH THE MEETING THEM SUGGESTED TO US THAT THERE'S PATIENT EXPERIENCE TRAINING, TOO, IN THESE CURRICULUMS. SO EVEN USING A DEAF PATIENT AS THE MOCK PATIENT OR HAVING AN INTERPRETER IN THE ROOM, THINGS THAT DON'T NECESSARILY CHANGE THE CURRICULUM BUT ACTUALLY JUST GIVE THEM EXPERIENCE IN THE ROOM WITH A DEAF PATIENT, I THINK ARE VERY EASY TO DO.

>> YES. THIS IS JAN SPEAKING. I WOULD LIKE TO ADD JUST VERY QUICKLY TO THAT DOING SIMULATION EXPERIENCE EXPERIENCE, TOO. YES.

>> SO MOVING ON. THIS WAS ON THERE, THOUGHTS ON RECOMMENDING A LEGISLATIVE STUDY BUT I DON'T THINK WE NEED-- DO YOU THINK WE NEED TO DISCUSS THIS? NO. OKAY. SO I TRIED TO WRITE THIS NEXT PART IN A WAY THAT'S LEAST CONFUSING TO EVERYBODY, BUT THE RECOMMENDATION THAT'S FOLLOWING THIS, I FELT, IS THE TOOLKIT OTHER HALF FROM THE BEGINNING. SO IT'S THE

OTHER SIDE OF WHAT THE DIVISION OF SERVICES FOR DEAF AND HARD OF HEARING WOULD BE DOING AND LIKE IT HAS BEEN SAID, WE WANT THIS TO BE UNIFORM BUT ALSO IN A WAY THAT CAN BE TAILORED SO IT MAY BE PRESENTED IN DIFFERENT WAYS TO PHYSICIANS THAN AT AHEC. WE WANT THE SAME CONTENT INFORMATION, THE SAME LOOK AND FEEL OF THE TOOLKIT, BUT ALSO THAT THERE'S OPPORTUNITY FOR IT TO BE PERSONALIZED A LITTLE BIT. SO I HAVE THREE SECTIONS ON HERE, EDUCATING HEALTH CARE PROFESSIONALS, EDUCATING HEALTH CARE SYSTEMS AND I SECTIONED OFF EDUCATING LONG-TERM CARE FACILITIES DIFFERENTLY THAN THEM. SO WE HAVE THESE DIFFERENT ORGANIZATIONS UNDER EACH OF THESE, AND HOW THESE RECOMMENDATIONS WOULD GO IS THIS NEXT RECOMMENDATION WOULD BE WRITTEN OUT SPECIFICALLY, IF NEEDED, TO THE ORGANIZATION THAT WE HAVE UNDER EACH OF THESE SECTIONS. SO THE FIRST PART OF THIS, EDUCATING-- YEAH. QUESTION.

>> I WAS JUST GOING TO SAY THAT I DON'T KNOW YOU NEED TO GET REPETITIVE UNDER EACH OF THOSE BECAUSE I THINK FOR THE MOST PART IT'S GOING TO BE THE SAME AND THEN LIKE WHAT WE DO WITH OUR EDUCATION, ANYTIME WE'RE DOING EDUCATION, WE HAVE A FAMILY PHYSICIAN REVIEW WHATEVER WE'RE GOING TO DO AND THEN MAKE IT MORE APPROPRIATE FOR FAMILY MEDICINE. SO THAT'S JUST-- I THINK MOST EDUCATIONAL, THAT'S SORT OF STANDARD OPERATING PROCEDURES. SO LIKE IF YOU WANTED A FAMILY PHYSICIAN TO REVIEW IT ON THE FRONT END, I COULD GET SOMEBODY TO REVIEW IT ON THE FRONT END BUT EVEN IF WE DIDN'T HAVE SOMEBODY REVIEWING IT ON THE FRONT END, WHEN IT CAME TO DELIVERING AT OUR MEETING, IT WOULD GET REVIEWED BY A FAMILY PHYSICIAN TO SEE IF THERE'S ADDITIONAL CONTENT THAT'S SPECIFIC, YOU KNOW, THAT TYPE OF THING. I THINK IF YOU HAVE-- I DON'T THINK YOU NEED TO WORRY ABOUT IT GETTING 100%. IF YOU HAVE IT 85 OR 90%, THAT LAST 10% --

>> OKAY.

>> SO THE FIRST PART OF THIS RECOMMENDATION IS WE WANTED TO, AGAIN, WHEN WE WERE AT THE MEDICAL BOARD, WE WANTED TO MAKE SURE THAT THE ORGANIZATIONS THAT WE'RE TASKING WITH GIVING THIS EDUCATION TO THEIR MEMBERS ARE ACTUALLY ABLE TO OFFER THESE SERVICES THEMSELVES. SO THE MEDICAL BOARD'S WEBSITE, THEY REALIZE THAT THE VIDEO THEY HAD EXPLAINING ON HOW TO FILE A COMPLAINT WASN'T CAPTIONED AT ALL OR THERE WASN'T AN ASL ONE AVAILABLE. MAKING SURE THAT THOSE SYSTEMS WERE IN PLACE ON THEIR END FIRST BEFORE THEY EDUCATE THEIR MEMBERS OR LICENSEES IS IN PLACE, AND THEN THE SECOND PART OF THIS FIRST ONE IS CUSTOMIZING THIS TOOL KIT WHICH GETS INTO 1A. AND AGAIN, THIS IS ALL PRETTY MUCH JUST THE OPPOSITE SIDE OF THAT FIRST RECOMMENDATION F WE HAVE ANY QUESTIONS FROM COMMENTS ON THE SIDE OR ANYTHING? OTHERWISE, I WILL KEEP SCROLLING. DAVID?

>> YES, ONE COMMENT. IF THE TOOL KIT IS OPEN TO THE PUBLIC OR IF IT'S ONLY TO SPECIFIC PEOPLE?

SO WHAT DID WE DECIDE ON THAT?
>> YEAH. I THINK THAT'S A QUESTION TO DISCUSS. WE HOPE, I THINK, THAT THIS TOOL KIT WILL BE SOMETHING THAT'S SIGNED OFF ON BY EACH OF THESE ORGANIZATIONS PARTNERED WITH. I WOULD THINK IT WOULD BE. I LEAVE IT TO THE ROOM TO ANY COMMENTS.
>> THANK YOU. THIS IS BETH WITH THE STATE HEALTH PLAN. JUST AS A STATE AGENCY, IN GENERAL, IF THERE WAS A WEBSITE OR A TOOLKIT THAT OTHER STATE AGENCIES THAT PROVIDE SERVICE TO THE PUBLIC COULD UTILIZE AND ALL YOU WOULD REALLY NEED TO DO IS TO COMMUNICATE AND FIGURE OUT A WAY AND THERE ARE GREAT COMMUNICATION CHANNELS TO GET OUT TO STATE AGENCIES OF THINGS THAT ARE AVAILABLE. IT MIGHT NOT BE SPECIFIC TO JUST OPEN TO THE PUBLIC. IT MIGHT BE GEARED TOWARD MORE HEALTH CARE PROVIDERS AND AND THAT SORT OF THING AND IT WOULD BE HELPFUL INFORMATION FOR PEOPLE, JUST IN GENERAL.
>> THIS IS JENNIFER GILL WITH LEADING AGE NORTH CAROLINA. IF WE DO DECIDE TO LIST INDIVIDUAL ORGANIZATIONS, I WOULD ADD LEADING AGE NORTH CAROLINA UNDER D.
>> LET ME JUST GO BACK TO DAVID'S QUESTION AND BETH'S COMMENT. THIS IS ADAM SPEAKING. I THINK THAT IT'S A LITTLE HARD FOR ME TO HAVE AN OPINION UNTIL I KNOW EXACTLY WHAT THE CONTENTS ARE LIKE, BUT I'M WONDERING IF, FOR EXAMPLE, EDUCATING PROVIDERS ON MALPRACTICE RISKS AND MECHANISMS FOR REGISTERING COMPLAINTS WHEN THEY'RE NOT PROVIDING SERVICES ADEQUATELY MIGHT BE AN IMPORTANT PART OF THE ORGANIZATION BUT PROVIDER ORGANIZATIONS MIGHT NOT WANT THAT BE TO IN THE EDUCATION IF IT'S OPEN TO THE PUBLIC. SO I'M WONDERING A LITTLE BIT ON THE UNINTENDED CONSEQUENCES OF SAYING PUBLIC CONSUMPTION. BUT MAYBE THERE NEEDS TO BE SOME EDUCATION NEEDED THAT'S DIFFERENT FOR HEALTH PROFESSIONALS. I'M SEEING PEOPLE NOD. THAT JUST MEANS MORE WORK, RIGHT?
[LAUGHTER]
>> ALSO, WE DO HAVE THE PART THAT'S EDUCATED CONSUMER SO WE CAN TAKE THAT AND PUT THAT IN THERE AS WELL.
>> THIS IS MARK BENTON, AND THIS IS A QUESTION MAYBE FOR JAN TO CHECK MY MEMORY, AND THAT WAS A COUPLE OF WEEKS BACK, WE ACTUALLY HAD A ONE-ON-ONE MEETING WITH MEMBERS OF THE NORTH CAROLINA HEALTH CARE ASSOCIATION USED TO BE THE HOSPITAL ASSOCIATION, AND ONE OF THE THINGS WE TALKED ABOUT PARTNERING WITH THEM IN THEIR ROLE AS THE PATIENT SAFETY ORGANIZATION TO BE ABLE TO SORT OF BETTER UNDERSTAND THE NEXUS BETWEEN HEARING LOSS AND PERHAPS ERRORS OR POOR QUALITY CARE THAT COULD BE-- THAT COULD BE AS A RESULT OF THAT, AND SO I DON'T KNOW HOW WE MAY WANT TO LIST THAT IF IT'S NOT ALREADY IN THESE RECOMMENDATIONS.
>> THIS IS JAN, YES, EXACTLY. YES, THANK YOU.

>> WE'LL MAKE SURE THAT WE INCORPORATE THAT. THAT'S A GOOD POINT.
>> YES.
>> THIS IS EILEEN CARTER WITH NORTH CAROLINA PT ASSOCIATION. I WANT TO POINT OUT TO YOU THAT NOT ALL PROFESSIONAL ASSOCIATIONS HAVE 100% MEMBER OF ALL LICENSEES AND SO THAT GOES ACROSS THE BOARD FOR NORTH CAROLINA. SO I TWO--I WOULD POSSIBLY MAKE A PROJECTION, AT LEAST FOR OUR LICENSURE TO GIVE YOU AN EXAMPLE IS WE DON'T HAVE CONTINUING ED COMPETENCY. WE HAVE CONTINUED COMPETENCY, WHICH MEANS YOU MIGHT VOLUNTEER. YOU GET POINTS FOR THIS, YOU GET POINTS FOR THAT, TO KEEP YOUR LICENSE. IT MAY BE THAT WE KIND OF ENGAGE THE LICENSURE EXAMINERS AND THEIR BOARDS AND THEN MAYBE THE PROFESSIONAL ASSOCIATION. I THINK YOU NEED TO HAVE BOTH. WE'RE INTERCONNECTED FOR PHYSICAL THERAPY. I'M NOT SURE ABOUT OT AND SPEECH AND I DON'T KNOW ABOUT AUDIOLOGY. I KNOW THAT WE'RE NOT 100%. WE'VE NEVER BEEN MANDATED TO BE 100%. WE CAN'T DO THAT. IT'S AGAINST THE LABOR LAW.
>> WE WERE TALKING ABOUT THAT OVER LUNCH. I THINK THE RATES OF PARTICIPATION IN OUR MEMBERSHIP ASSOCIATION SOMEWHERE BETWEEN ABOUT 10 AND 90% DEPENDING ON THE SPECIALTY, AND I THINK THAT IT'S--
>> THAT'S SAD.
>> YEAH, YEAH. THE PROBLEM IS EVEN BIGGER THAN THAT BECAUSE ENGAGING IN THE BOARDS AND THE ASSOCIATIONS IS GREAT BUT MOSTLY WHAT WE'RE TALKING ABOUT IS VOLUNTARY EDUCATION, RIGHT, AND I THINK THAT, YOU KNOW, AND WE HAD SOME EARLIER DISCUSSION ABOUT MANDATORY EDUCATION, AND THAT IS SO HARD TO GET THROUGH BOARDS. I'M NOT SUPER ENTHUSIASTIC ABOUT IT. I THINK-- I THINK THAT BOARDS AND ASSOCIATIONS CAN BE MOUTHPIECES FOR THE EDUCATION, ITSELF, BUT IT CAN ALSO ENCOURAGE MEMBERS AND NON-MEMBERS TO BE INTERESTED IN THE EDUCATION. I THINK IT'S NOT JUST OFFERING IT. I THINK IT'S PROMOTING IT.
>> I JUST HAD A QUICK THING. THIS IS BETH HATHAWAY AGAIN WITH NCOTA. ETHICS IS A REQUIREMENT FOR LICENSURE, BUT WE'RE TALKING ABOUT AN ETHICAL DILEMMA, AND AS A BOARD, WE'RE ALWAYS LOOKING FOR A WAY TO MAKE ETHICS INTERESTING AND ENGAGING. SO THAT WOULD BE SOMETHING EASY TO ADD TO OUR FALL OR OUR SPRING CONFERENCE TO HELP PEOPLE MEET THAT ONE ETHICS REQUIREMENT FOR THE LICENSURE, THEN IT IS REQUIRED.
>> I THINK THERE'S A WAY TO TALK ABOUT ETHICS, DIVERSITY AND INCLUSION, AND DISABILITY AND LIKE LANGUAGE ACCESS GENERALLY AND SO TO GREG'S POINT, MAYBE THIS FITS INTO A CURRICULAR BUCKET SOMEWHERE AND IT MIGHT NOT ALWAYS BE OBVIOUS TO US, BUT IF WE CALL THAT OUT AT LEAST IN THE BACKGROUND MATERIAL, IT MIGHT GIVE TRAINING PROGRAMS AN IDEA WHERE THIS FITS IN. OH, SORRY

>> THIS IS JAN. BUT I DON'T NEED THE MIC. OKAY. I'M ACTUALLY GOING TO COMMENT ON A DIFFERENT TOPIC, IF THAT'S OKAY, IF WE'RE DONE WITH THIS TOPIC. OKAY. CAN WE GO BACK TO 1A AND LOOK AT THE COMMENTS ON THE RIGHT SIDE? 1A, LET ME SEE. GO UP. WAIT, NO, GO DOWN. I'M SORRY, GO DOWN. GO DOWN. GO DOWN. KEEP GOING. THERE YOU GO. THERE ARE COMMENTS RELATED TO ASSISTIVE LISTENING DEVICES AND PERSONAL AMPLIFIERS. I BELIEVE THE RECOMMENDATION WAS FOR THE PATIENT TO, FIRST, HAVE A HEARING EVALUATION. NOW, I RESPECTIVELY DISAGREE. I BELIEVE THAT THE PERSONAL AMPLIFIERS AND OTHER ASSISTIVE DEVICES COULD BE USED ON A SHORT-TERM INTERIM BASIS AND A LIMITED BASIS IN CERTAIN SITUATIONS AS A BRIDGE WHILE THEY ARE WAITING TORE THAT HEARING EVALUATION. SO I THINK THAT IT'S IMPORTANT TO THINK ABOUT THAT BECAUSE THERE ARE MANY SITUATIONS WHERE THESE DEVICES COULD BE BENEFICIAL. SO I WOULD PREFER NOT TO SEE THOSE TYPES OF RESTRICTIONS THERE. I THINK IT'S IMPORTANT TO ENCOURAGE ACCESS TO BOTH PERSONAL AMPLIFIERS AND HEARING SCREENINGS OR HEARING EVALUATIONS. I DO UNDERSTAND THAT THERE MAY BE SOME SITUATIONS WHERE THEY WOULD NOT BE APPROPRIATELY USED BUT, AGAIN, THAT GOES BACK TO TRAINING.

>> HI. THIS IS KATHY DOWD. I WOULD RATHER HOLD PEOPLE'S FEET TO THE FIRE TO HAVE A HEARING EVALUATION AND THE EXAMPLE I CAN GIVE IS FROM LAST WEDNESDAY. GOING INTO A NURSING HOME AS A VOLUNTEER OMBUDSMAN. THE VERY FIRST ROOM I GO INTO, THE GENTLEMAN IS SEATED IN THE SHADOWS AND I SIT DOWN AND SAY, HI, MR. SMITH, AND INTRODUCE MYSELF AND WHAT I'M THERE FOR, AND HE DOESN'T MOVE. HE KNOWS I'M THERE. I TOUCHED HIS SHOULDER. HE TURNEDDED TOWARD ME. I STARTED YELLING, HI, MR. SMITH, HOW ARE YOU DOING? AND HE SAID, I HAVE TROUBLE HEARING. AND I NOTICED HE HAD AN ALD IN HIS POCKET. EVERYTHING WAS TUCKED IN HIS POCKET, THE EAR-- HEADPHONES AND EVERYTHING. SO I GRABBED HIM AND PULLED IT OUT AND HE , YOU PRESS THIS BUTTON AND IT TURNS GREEN. SO HE AND I WERE PRESSING THE BUTTON. IT WASN'T TURNING GREEN AND I TOOK IT OUT TO THE NURSE'S STATION AND SAID, I THINK-- THIS IS AT 10: 30 IN THE MORNING, THE MIDDLE OF THE MORNING AND SAID TO THE NURSE, I THINK HE NEEDS A NEW BATTERY. SHE SAID, OKAY. WE'LL TAKE CARE OF IT. I CAME BACK AND YELLED IN HIS EAR, I'LL BE BACK TO TALK WITH YOU. SO I WENT AND DID OTHER VISITS. CAME BACK ABOUT 40 MINUTES LATER, HE'S SITTING THERE WITH THE HEADSET ON AND WITH THE THING IN HIS POCKET AND I SEE THE GREEN LIGHT ON. SO I SIT DOWN AND SPEAK NORMALLY AND SAY, HI, MR. SMITH. HE STILL DIDN'T HEAR ME. NO-- NOTHING. SO I START YELLING AGAIN AND HE HEARS ME. AND I'M-- I SAID, HOW LONG HAVE YOU BEEN HERE? HE SAID, TWO AND A HALF MONTHS. HE'S DEAF-BLIND AND TO ME, THERE IS NO EXCUSE. SO I WOULD RATHER HOLD PEOPLE'S FEET TO THE FIRE TO GET THE EVALUATION. IT IS-- IT IS AWFUL FOR HIM TO BE SO ISOLATED LIKE THAT AND I-- I DO NOT LIKE ANYBODY FITTING AMPLIFICATION UNLESS THEY'RE LICENSED AND SO FOR THE MEDICAL STAFF TO PUT AN AMPLIFIER ON HIM, IF HE HAD

GONE TO THE STORE AND PICKED IT UP HIMSELF, THAT'S ONE THING, BUT THEY PUT THAT ON HIM AND SAID, OKAY. WE TOOK CARE OF HIS HEARING PROBLEM AND THEY DIDN'T. SO I AM-- I DISAGREE WITH THAT. ONLY AMPLIFICATION THAT IS RECOMMENDED. ONLY LICENSED PEOPLE SHOULD BE PUTTING AMY MARENICK, M.A. PLIIFICATION ON PEOPLE THAT THEY THINK HAVE A HEARING PROBLEM AND NEEDS TO BE TESTED FIRST. THAT'S MY OPINION. PROFESSIONAL OR OTHERWISE.
>> I DO NEED TO RESPOND. THIS IS JAN SPEAKING. I DO NEED TO RESPOND. I SEE WHAT YOU'RE SAYING, BUT MY STAFF DO ADVISE MANY HARD OF HEARING PEOPLE IN A VARIETY OF SITUATIONS WHERE AND WHEN THEY CAN USE PERSONAL AMPLIFIERS, AND I HAVE HAD MANY PEOPLE REPORT HOW BENEFICIAL THEY HAVE BEEN, EVEN WHEN THEY GO AND SEE THEIR AUDIOLOGIST AND WERE NOT ABLE TO BENEFIT FROM A HEARING AID. THERE ARE SO MANY DIFFERENT SITUATIONS THAT WE CANNOT TOTALLY CLOSE THE DOOR ON THOSE OPPORTUNITIES FOR THESE PEOPLE TO USE THOSE AMPLIFIERS. NOW THAT DOES NOT MEAN THAT WE SHOULD NOT HOLD THEIR FEET TO THE FIRE IN TERMS OF MAKING SURE THAT HEARING EVALUATIONS ARE BEING PROVIDED IN A TIMELY MANNER AND SO I KNOW THAT YOU HAVE SHARED YOUR EXPERIENCE ON DIFFERENT SITUATIONS AND DIFFERENT TIMES WHEN PERSONAL AMPLIFIERS HAVE BEEN APPROPRIATE, TONY. SO IF YOU WOULD SHARE THOSE WITH US, PLEASE.
>> SO I HAVE, WOULDED WITH MANY PEOPLE IN LONG-TERM CARE FACILITIES AND DIFFERENT SETTINGS, EVEN HOSPITALS AND DOCTORS' OFFICES WHO WOULD NOT TOUCH A HEARING AID. THEY DEPART WANT ONE AND THEY WEREN'T GOING TO ACCEPT GOING AND GETTING THE HEARING TESTS OR HEARING SCREENING, NO MATTER WHAT. BUT THEY DID ACCEPT USING A PERSONAL AMPLIFIER AND IT MADE A HUGE DIFFERENCE IN THEIR COMMUNICATION WITH THE STAFF , WITH THE FAMILY, WITH DOCTORS, ET CETERA. I HAPPEN TO KNOW THAT-- I WAS JUST TALKING WITH SOMEBODY THIS MORNING, LIZ BACK THERE. ABOUT CT DOERS WHO-- ABOUT DOCTORS WHO THE VA OFFICES IN DIFFERENT PLACES WHO CARRY A POCKET TALKER WITH THEM BECAUSE THEY KNOW THEY'RE VETERANS AND THEY'RE NOT GOING TO HEAR AND IT WORKS AND IT HELPS. I HAD MANY CONSUMERS WHO I WENT TO GO VISIT AT OTHER HOMES OR IN LONG-TERM CARE SETTINGS WHO SAID I WILL NEVER WEAR A HEARING AID AGAIN, AND WE HELPED THEM TO GET THIS PERSONAL AMPLIFIER. THEY DON'T USE IT ALL DAY LONG BUT THEY USE IT IN CRITICAL SITUATIONS ESPECIALLY WHEN THEIR FAMILIES VISIT, AND THEY'RE ABLE TO COMMUNICATE CLEARLY WITH THEIR FAMILIES AND SO IF WE SAY WE'RE ONLY GOING TO ALLOW A LICENSED PROFESSIONAL TO PUT A HEARING AID ON SOMEBODY OR WE REQUIRE THEM TO SCREEN FIRST, WE'RE GOING TO MISS HALF THE PEOPLE WHO NEED SOME KIND OF AMPLIFICATION. AND IT CAN BE-- IT IS BEING DONE VERY CAREFULLY. WE'RE NOT-- THE PEOPLE THAT WORK IN OUR DIVISION AREN'T JUST GOING AND PUTTING ON POCKET TALKERS ON PEOPLE AND SAY, HERE, YOU GO, AND HAVE IT NOT BE UNSAFE. THE PEOPLE WHO WORK IN OUR

DIVISION ARE ACTUALLY SHOWING PEOPLE HOW TO USE IT AND THESE DEVICES ARE BENEFITING PEOPLE, AND WE ARE TRYING TO BENEFIT PEOPLE HERE. I THINK IT WOULD BE A MISTAKE JUST TO SAY SOMEBODY HAS TO HAVE A HEARING SCREENING FIRST BECAUSE HALF THE TIME THEY'RE NOT GOING TO.

>> I AGREE WITH THAT AND LET'S THINK ABOUT IT. EVEN IN A PRIMARY CARE OFFICE, SOMEONE IS GOING IN FOR A VISIT. MAYBE THERE IS AN AMPLIFICATION DEVICE IN THAT OFFICE THAT THE PHYSICIAN CAN USE WITH THAT PATIENT TO COMMUNICATE AT THAT MOMENT. WOULD YOU RATHER THE FAMILY PHYSICIAN NOT COMMUNICATE AT ALL WITH THEM BECAUSE THEY'VE GOT TO GET THE AUDIOLOGY TEST AND SCREENING FIRST, OR DO YOU WANT THEM TO GET DONE WHAT'S AT THAT VISIT AND GET REFERRED BUT NOT, YOU KNOW, SO IF THEY CAN'T USE A LOOP OR PERSONAL AMPLIFIER OR THINGS LIKE THAT, WE'RE MISSING, LIKE YOU SAID, A TON OF OPPORTUNITIES.

>> THIS IS SHELLEY CRISTOBAL BALL. I'M ANOTHER AUDIOLOGIST. CAN I BE REALLY CONFUSING AND SAY I AGREE WITH BOTH SIDES. I DO THIRD WE NEED TO BE REALLY CAUTIOUS ABOUT OUR WORDING BECAUSE I DON'T WANT THERE TO BE DEVICES, SUCH AS A PERSONAL AMPLIFICATION, A POCKET TALKER ON END USERS AND THEM THINKING THAT'S THE SAME THING AS A HEARING AID. HOWEVER, I WOULD LOVE TO SEE WHAT COMES OUT OF THIS THAT EVERY DOCTOR'S OFFICE, EVERY NONPROFIT CLINIC HAVE A POCKET TALKER WITH BATTERIES AND SOMEONE WHO KNOWS HOW TO USE THEM IN THE DOCTOR'S OFFICE. I THINK THERE'S A BIG DIFFERENCE BETWEEN USING AN AMPLIFIER TO CONDUCT ASSESSMENTS SO THAT YOU CAN GO AHEAD AND DO THE COGNITIVE ASSESSMENT WHILE YOU'RE SCHEDULING THAT AUDIOLOGY APPOINTMENT THE SAME DAY, OR HAVE THEM BE ABLE TO SEE THAT PRIMARY DOC AND TALK ABOUT THE SINUS INFECTION THAT'S GOING ON AND GET THAT PROCESS MOVING ALONG FOR THEM. BUT I JUST WANT US TO BE CAREFUL ABOUT THROWING IT IN WITHOUT MAKING SURE WE HAVE THOSE DISTINCTIONS IN PLACE. BECAUSE THEY DO GET LUMPED IN WITH HEARING AIDS A LOT IN A WAY THAT REALLY IS TO THE DETRIMENT OF THOSE END USERS.

>> A COUPLE OF THINGS TO THAT. I AGREE. A LOT WITH WHAT YOU JUST SAID. I ALSO HAVE SEEN PERSONAL AMPLIFIERS USED AT MEALTIMES WITH PEOPLE IN LONG-TERM CARE SETTINGS AND THEY'RE BENEFITTING FROM THEM. I'VE SEEN THREE OR FOUR AT A TABLE AT TIMES AND PEOPLE ARE BENEFITTING FROM THEM. I ALSO HAVE MANY CONSUMERS WHO HAVE USED HEARING AIDS WITH PERSONAL AMPLIFIERS WITH THE NECK LOOP. SO AND-- AND SOMETIMES PEOPLE IN LONG-TERM CARE SETTINGS WON'T MAKE IT TO AN AUDIOLOGIST. THEY JUST WON'T. IT WOULD BE WRONG TO HOLD THEM TO THAT IF THEY'RE WILLING TO USE A POCKET TALKER AT AN APPROPRIATE SOUND LEVEL FOR A FEW MINUTES. I THINK IT'S IMPORTANT THAT PEOPLE BENEFIT FROM THE TECHNOLOGY THAT WE HAVE OUT THERE. THAT'S WHY IT'S OUT THERE. AND ALSO, ONE MORE THING. MANY TIMES I'VE GONE ON TO ACTUALLY MEET WITH A CONSUMER. WE'LL PUT THIS AMPLIFIER ON, LET THEM USE IT FOR A FEW

MINUTES, I'M READY TO GET MY HEARING TESTED AND SO IT ACTUALLY SERVES AS THAT INITIATOR OFTEN.

>> THIS IS ADAM. I THINK THERE'S A BOTH AND APPROACH THAT WE CAN INCORPORATE. WE WANT TO BE CLEAR NOT TO LUMP THIS STUFF TOGETHER. THANK YOU FOR POINTING THAT OUT, SHELLEY. I'M WONDERING-- I THINK YOU ACTUALLY JUST OFFERED A NEW RECOMMENDATION NOW, AND I DON'T KNOW THAT WE HAVE THIS THAT EVERY DOCTOR'S OFFICE NEEDS A POCKET TALKER, BAT RAYS AND SOMEBODY WHO KNOWS HOW TO USE THEM. DO WE HAVE THAT ANYWHERE?

>> I THINK WE HAVE ONE THAT SUGGESTS A GRANT PROGRAM.

>> WE'LL SAVE IT. WE CAN TALK ABOUT WHETHER THAT'S THE RIGHT WAY TO GO. BUT COOL. SO MAYBE WE CAN KEEP GOING.

>> I'M SORRY. I DIDN'T WANT TO MISS ONE MORE.

>> THIS IS JUST A QUICK ONE. I AGREE WITH SHELLEY FROM THE STANDPOINT IT'S REALLY BOTH WAYS. IF YOU PUT A POCKET TALKER ON ME BACK WHEN I HAD A COOKIE BITE HEARING LOSS AND I HEARD LOW FREQUENCIES AT MINUS 10 DECIBELS, WOULD YOU HAVE BLASTED ME OUT. IT WOULD NOT HAVE BEEN ANY HELP AT ALL REALLY. I'M WONDERING IF MAYBE THIS LIST NEEDS JUST-- WE MENTIONED HOW TO CONTACT AND SCHEDULE ASL AND CART INTERPRETERS AND THEN HOW TO ORDER AND SET UP. CAN YOU PUT IN HOW TO SET UP AN AUDIOLOGY ASSESSMENT, SOMETHING LIKE THAT TO ENCOURAGE THAT TO BE PART OF THE PROCESS?

>> I WILL BORROW-- THIS IS JOHNNY. I WILL BORROW FROM MY PEDIATRIC EXPERIENCE FOR 40 YEARS IN THE PUBLIC SCHOOLS OF NORTH CAROLINA TO SAY THAT THERE'S A FEDERAL MANDATE FOR PUBLIC SCHOOLS THAT THERE IS ONE SINGLE QUALIFIED PROVIDER THAT MANAGES HEARING-RELATED ISSUES AND THAT IS AN AUDIOLOGIST. SO IF WE LOOK AT ALL OF THESE SUGGESTIONS, WHETHER IT IS DIRECT OR INDIRECT SERVICE AN AUDIOLOGIST IS THE QUALIFIED PROVIDER TO OVERSEE PROGRAMS THAT WOULD UTILIZE ASSISTIVE TECHNOLOGY, HEARING ASSESSMENTS, MANAGEMENT AND CARE OF AMPLIFICATION, SO THAT'S MY SOAP BOX. WHO'S MANAGING EVERYTHING?

>> I THINK THIS IS AN IMPORTANT DISTINCTION. IN A SCHOOL SETTING, I GET IT. THAT'S A TOTALLY DIFFERENT KIND OF ISSUE, BUT I WONDER ABOUT IN, SAY, A PRIMARY CARE OFFICE, I THINKS THEY A GOOD EXAMPLE. SHOULD THERE BE-- YOU KNOW, SHOULD THE HEALTH CARE PROVIDERS AND PRIMARY CARE OFFICE BE TRAINED IN USING A POCKET TALKER, OR DOES THAT HAVE TO BE A PROGRAM MANAGED BY AN AUDIOLOGIST?

>> INDIRECTLY, IF YOU LOOK AT THE LATER RECOMMENDATIONS IN OUR DATA, YOU MIGHT SEE A WAY THAT CAN HAPPEN.

>> OKAY. OH, I STOLE YOURS.

>> SO AGAIN, I'LL JUST TELL YOU RIGHT NOW, TOO, AFTER TODAY, WE'RE GOING TO REWORD THESE

AND WE'LL SEND THEM BACK OUT WITH THESE SUGGESTIONS, TOO.
>> YES. THIS IS PROBABLY-- THIS IS GREG FROM THE ACADEMY OF FAMILY PHYSICIANS AND THIS IS PROBABLY MORE OF AN OVERARCHING COMMENT, THAT I THINK WE HAVE TO BE VERY CAREFUL LETTING PERFECT BE THE ENEMY OF GOOD OR BETTER. AND THERE ARE A LOT OF THESE RECOMMENDATIONS THAT WE CAN DO THAT ARE KIND OF WHAT I WOULD CONSIDER GOLD STANDARD RECOMMENDATIONS, BUT HOW FAR ARE WE GOING TO GET ON THEM? AND I THINK THIS GOES BACK TO THE FUND THAT WE'VE TALKED ABOUT IN PREVIOUS MEETINGS. WE CAN SAY THAT THE FUND IS A GOLD STANDARD RECOMMENDATION. THAT IS NOT GOING TO HAPPEN IN THE NORTH CAROLINA GENERAL ASSEMBLY ANYTIME SOON, AND SO WE SPIN OUR WHEELS TRYING TO DO SOMETHING THAT'S NOT GOING TO HAPPEN AND MISS THE OPPORTUNITY TO DO SOME REALLY, REALLY GOOD THINGS, AND I THINK EVEN AS WE LOOK AT THIS IN ALL OF OUR RECOMMENDATIONS, THERE IS WHAT WOULD BE IDEAL, BUT WE DON'T LIVE IN AN IDEAL WORLD, SO I DON'T WANT PERFECT TO BE THE ENEMY OF REALLY IMPROVING CARE, AND I THINK WE ALL NEED TO REMEMBER THAT AND WHAT CAN WE PRACTICALLY DO TO MAKE THE SITUATION A HECK OF A LOT BETTER THAN IT IS TODAY.
>> OKAY. I WILL KEEP MOVING. THIS NEXT ONE IS THE LAST ONE IN THIS SECTION IN EDUCATING CONUM SOARS. FOR THIS, WE FIRST HAVE WHAT THEY WOULD BE EDUCATED ON AND WHAT WE WOULD BE EDUCATING THEM-- YEAH. WHAT WE WOULD BE EDUCATING THEM ON BUT THEN ALSO, WE NEED TO FIGURE OUT THE WAY TO DO IT. SO WE CAN GO BACK TO THE BEGINNING. THIS ONE DOES INCLUDE DISCIPLINARY RIGHTS NORTH CAROLINA AND THIS CORYE AND JEN HAVE UK THATTED OFF-LINE. WE WILL SAVE THIS AND REWARD IT AND PUT YOUR FEEDBACK IN UNLESS THERE'S PRESSING COMMENTS AND I WILL GET IT TO YOU REWORE-- R-- REWORDED WITH THAT FEEDBACK BEFORE DISCUSSING ANY CHANGES TO IT.
>> YOU HAVE ONE HAND UP.
>> THIS IS (INAUDIBLE) FROM BLUE CROSS. I WANTED TO HIGHLIGHT IN TERMS OF (INAUDIBLE) IF-- AND I SEE IT LISTED AND THERE ARE ALREADY REQUIREMENTS AND I WANT TO MAKE SURE WITH RESPECT WHATEVER IS DONE WITH RESPECT TO THE EDUCATION, WE SYNC IT UP. AND THIS GOES BACK TO SOMETHING (INAUDIBLE) FROM AN INSURANCE PERSPECTIVE PURSUANT TO THE ACA AND OTHER THINGS, WE HAVE A NOTICE THAT GOES OUT ALREADY AND WE HAVE ENOUGH OTHER WAYS IN WHICH WE'RE REQUIRED TO COMMUNICATE NOT ONLY HOW FOLKS CAN ACCESS INFORMATION FOR DIFFERENT NEEDS AND THE SERVICES BUT ALSO HOW TO FILE A COMPLAINT AND HOW TO DO SO IF THERE'S A CONCERN.
>> TOVAH HERE. IN EARN ITS OF EDUCATING CONSUMERS, I'M AWARE THAT DSDHA HAS A PROGRAM FOR PEOPLE COMING IN OR IDENTIFIED TO THE REGIONAL COORDINATORS AND THE CENTRAL OFFICE FERTION BUT IN TERMS OF THE POPULATION WE'RE TALKING ABOUT, MOST OF WHOM ARE ACTUALLY

OVER 55 GROUP AND MANY OF WHOM ARE IN DIFFERENT RESIDENTIAL SETTINGS, YOU KNOW, INDEPENDENT LIVING ALL THE WAY UP TO HOSPICE CARE, I WONDER IF THERE IS SOME WAY TO ENCOURAGE OR EVEN REQUIRE THAT ALL THESE PLACES INCLUDE EDUCATION AND CONSUMER ADVOCACY TO THE RESIDENTS OF THESE PLACES ESPECIALLY WHEN THEY FIRST COME IN TO KNOW NOT ONLY THEIR RIGHTS, YOU KNOW, PATIENT RIGHTS AND STUFF, BUT ACTUALLY WHAT THEY CAN DO OR HOW THEY CAN APPROACH SITUATIONS THAT THEY NEED HELP WITHIN TERMS OF, FOR EXAMPLE, HEARING/COMMUNICATION ISSUES, FOR EXAMPLE.

>> I THINK THAT'S AN INTERESTING IDEA. I KNOW THAT IN HEALTH CARE SETTINGS THAT HAPPENS BUT IT'S NOT DONE EFFECTIVELY, RIGHT? IT'S PART OF YOUR CONSENT FOR TREATMENT AND POSTED ON THE WALLS OF HOSPITALS, THAT THIS IS WHAT TO DO IF YOU HAVE A CONCERN ABOUT YOUR CARE, BUT YOU HAVE TO READ IT. YOU HAVE TO-- YOU KNOW, IT'S-- DOES THAT HAPPEN IN OTHER SETTINGS IN NURSING HOMES AND ASSISTED LIVING FACILITIES, I WOULD IMAGINE.

>> THAT'S ONE OF THE THINGS WE LOOK AT AS AN OMBUDSMAN TO MAKE SURE PATIENT RIGHTS ARE VISIBLE AS YOU WALK IN THE DOOR. SO YES.

>> BUT IT DOESN'T MEAN IT'S ADEQUATE.

>> THIS IS TOAIVE

>> THIS IS TOVAH AGAIN. I DON'T MEAN JUST PATIENT RIGHTS BUT WORKSHOPS OR ACTIVITIES THAT WOULD ENCOURAGE-- INCREASE AWARENESS OF SELF-ADVOCACY OR YOU KNOW, INCLUDING FAMILIES AND STUFF. THERE ARE ACTIVITIES, YOU KNOW, THERE ARE ALL KINDS OF ACTIVITIES THAT ACTIVITY THERAPISTS DO, FOR EXAMPLE, AND MAYBE THAT CAN BE SOMETHING ADDED IN ON A MORE REGULAR BASIS IN SOME OF THESE PLACES.

>> YEAH. I DID HAVE A COMMENT. WHILE I APPRECIATE THE PURPOSE BEHIND THAT RECOMMENDATION, I TWO--I WOULD NEVER, FRANKLY, TRUST THAT TRAINING TO BE HELPFUL IF IT'S OWNED BY THE PEOPLE THAT THE ADVOCACY IS TO BE DIRECTED AT.

>> WELL, WASN'T THAT OPTIMISTIC.

[LAUGHTER]

>> SORRY, THAT'S MY JOB.

>> THIS IS VICKI AND BUILDING ON WHAT CORYE SAID AND MAYBE GIVING IT A LITTLE BIT MORE CONTEXT, WHY WOULDN'T IT NECESSARILY BE HELPFUL. YOU'RE ASKING PEOPLE WHO ARE SEEKING HELP FROM A PROFESSIONAL ABOUT A HEALTH CARE NEED THAT THEY HAVE AND THEN THEY DON'T GET IT, BUT IT MIGHT STILL BE THEIR ONLY OPTION IN TERMS OF A PROVIDER AND THEN WE'RE THEN-- SO AS CONSUMERS ARE VULNERABLE WHEN TAKING ON PEOPLE WHO ARE SUPPOSED TO GIVE THEM CARE AND SOMETIMES THERE'S NO WAY TO EVALUATE THE QUALITY OF THAT CARE UNTIL IT'S WELL BEYOND, BUT THAT SAID, THERE DOES NEED TO BE SOMETHING, CERTAINLY DISABILITY RIGHTS

DOESN'T HAVE THE CAPACITY TO TAKE ON EVERY SINGLE REFERRAL AND SO I THINK SOMEHOW IN THESE RECOMMENDATIONS THERE DOES NEED TO BE A COMPONENT THAT MAKES IT SAFE FOR PEOPLE WHO AREN'T GETTING WHAT THEY NEED FROM A MEDICAL PROVIDER TO FILE A COMPLAINT TO FOLLOW UP. AND WORDS ON A-- YES, ALL THE FACILITIES HAVE A BIG PLACARD. SOMETIMES YOU CAN READ IT. SOMETIMES YOU CAN'T. SOMETIMES IT'S RIGHT IN THE LANGUAGE. IT CERTAINLY ISN'T GOING TO DO SOMEONE WHO IS VISUALLY IMPAIRED IN ANY WAY TO BE ABLE TO READ THIS FINE PRINT, AND YOU KNOW, SO IT'S A DILEMMA. WE NEED TO FIGURE IT OUT. IT NEEDS TO BE IN HERE, BUT I DON'T KNOW EXACTLY HOW TO DO IT.

>> HI. HOLLY RIDDLE. I EXPECT VICKI SMITH AND I AND MAYBE CORYE DUNN HAVE SPENT THE BETTER PART OF OUR PROFESSIONAL LIFETIMES TRYING TO CREATE SELF-ADVOCACY GROUPS AND PEER-TO-PEER SUPPORT FROM THE COMMUNITY TO THE COMMUNITY AND I WOULD TAKE A GANDER THAT IT IS IN ROBUST SELF-ADVOCACY GROUPS AND THE CAPACITY TO CONTACT A PEER WHO IS TRAINED THAT THE ANSWER MAY LIE.

>> HOLLY, I MAY BE JUST PHRASING WHAT YOU'RE SAYING A DIFFERENT WAY, BUT I THINK THERE'S SOME VALUE IN EDUCATING THE WIDER PUBLIC, AS MUCH AS SOMEONE WHO IS CURRENTLY HAVING THEIR APPENDIX RUPTURE IS NOT SELF-ADVOCATING AND SOMEONE WHO DOESN'T IDENTIFY AS HAVING HEARING LOSS EVEN THOUGH THEY HAVE MODERATELY SEVERE HEARING LOSS IS NOT SELF-ADVOCATING. IF THIS EDUCATION IS OUT HERE, BUT IF 1 IN 20 OF THOSE INDIVIDUALS IS WILLING TO SPEAK UP, IT GIVES ME AS A PROVIDER ACCOUNTABILITY. I KNOW ONE OF THEM MAY SPEAK OUT AGAINST ME SO I MIGHT AS TREAT THEM ALL WELL.

[LAUGHTER]

IT'S A NEGATIVE WAY TO PUT IT. IN ALL FAIRNESS, THAT'S THE LEVEL OF ACCOUNTABILITY ON THE PROVIDERS IF SOMEBODY OUT THERE KNOWS WHAT THEIR RIGHTS ARE, THEN I BETTER TREAT EVERYBODY LIKE THEY KNOW WHAT THEIR RIGHTS ARE. THAT'S A HARSH WAY TO PUT IT. I THINK THERE'S REAL VALUE TO THAT.

>> I AGREE WITH THAT 100% AND REMEMBER WITH MOST OF THE BOARDS, I KNOW ABOUT THE NORTH CAROLINA MEDICAL BOARD, BUT IT MIGHT NOT BE TRUE WITH ALL BUT AT LEAST WITH MOST, A COMPLAINT CAN BE FILED ANONYMOUSLY AND THE MEDICAL BOARD HAS TO INVESTIGATE EVERY COMPLAINT. I DON'T THINK IT TAKES MANY COMPLAINTS BEING INVESTIGATED ESPECIALLY IF THEY GO VERY FAR BEFORE WORD GETS OUT BECAUSE IF ONE EVER ENDS UP IN A PUBLIC LETTER OF CONCERN OR ANY KIND OF PUBLIC DISCIPLINE, THAT GOES OUT IN THE NORTH CAROLINA MEDICAL BOARD BULLETIN AND THE NAME'S ON THERE AND YOU CAN LOOK IT UP ON THE PUBLIC WEBSITE. SO IT DOESN'T-- AGAIN, IT DOESN'T HAVE TO BE 20. IT MAY BE ONE THAT JUST GETS ENOUGH ATTENTION TO REALLY BRING SOME THINGS. I DON'T THINK YOU CAN UNDERESTIMATE THE POWER OF THE LICENSING

BOARDS, YOU KNOW, TO REALLY START LOOKING AT BEHAVIOR CHANGE. I THINK DAVID SAID TO HIS KNOWLEDGE, THERE HAD BEEN ONE COMPLAINT OVER SOMETHING LIKE THIS IN HIS TIME AT THE MEDICAL BOARD AND SO IF FIVE COME OUT OF THIS MEETING-- THIS THINK AND IT MADE SOUND LIKE LEGAL EDUCATION. IT

>> THIS IS TOVAH SPEAKING. OKAY. I WILL START AGAIN. I THINK THAT I DIDN'T JUST MEAN, YOU KNOW, CONSUMER EDUCATION IN TERMS OF ADVOCACY AND THE LEGALISTIC KIND OF STUFF. I MEANT MORE IN TERMS OF ABOUT HEARING IMPAIRMENT AND HEARING LOSS AND COMMUNICATION THINGS BUT DONE IN A WAY THAT KIND OF-- I WON'T SAY ENTERTAINING BUT MORE POSITIVE OR MORE FUN IN SOME WAY. ACTIVITY THERAPISTS, AND I HAVE WORKED IN A NUMBER OF NURSING HOMES AND ARE ALWAYS LOOKING FOR THINGS TO DO. IT'S LIKE 00 DAYS A YEAR THAT THEY HAVE TO COME UP WITH THINGS TO DO WITH THE PATIENTS AND THE RESIDENTS. ONE OF THOSE THINGS COULD BE HAVING A SERIES OF, LET'S SAY, ACTIVITIES OR PROGRAMS THAT ADDRESS THESE ISSUES IN A WAY THAT MAKES IT MORE USER FRIENDLY, MAKES IT MORE, YOU KNOW, POSITIVE AND INCLUDES MORE PEOPLE SO PEOPLE CAN RELATE TO EXAMPLES OR INCIDENTS OR SITUATIONS OR JOKES OR DO EXERCISES THAT WOULD PRACTICE DIFFERENT WAYS OF COMMUNICATING WITH EACH OTHER, STUFF LIKE THAT. I WOULD IMAGINE THAT IS SOMETHING THAT WE COULD RECOMMEND AS PART OF A TOOLKIT OR AS PART OF WHAT RESIDENTIAL FACILITIES CAN DO.

>> YEAH. THIS IS DAVID SPEAKING. YOU WERE MENTIONING SOME KINDS OF ADVOCACY PROGRAMS AND ACTIVITIES. I DON'T KNOW IF NORTH CAROLINA HAS WHAT YOU CALL COMMUNITY HEALTH WORKERS. I DON'T KNOW IF THERE'S SUCH A THING HERE IN NORTH CAROLINA, COMMUNITY HEALTH CARE WORKERS?

>> WE WILL UNDER MEDICAID REFORM. MEDICAID TRANSFORMATION, THE PHPs WILL BE USING COMMUNITY HEALTH WORKERS FOR A NUMBER OF THINGS. IT'S AN OPPORTUNITY FOR PEER SUPPORT AND OTHER KINDS OF NAVIGATION SERVICES.

>> IT'S RIGHT NOW--

>> ESPECIALLY FOR DEAF AND HARD OF HEARING.

>> INTERESTING IDEA. SO JUST TO FILL IN WHAT CORYE WAS SAYING. IT'S RIGHT NOW, A VERY HETEROGENEOUS MOSTLY VOLUNTEER WORKFORCE, BUT I THINK OVER THE NEXT TWO YEARS, WE'RE GOING TO SEE INCREASING TRAINING PROFESSIONALIZATION, DEPLOYMENT IN RURAL COMMUNITIES AND DEPLOYMENT UNDER MEDICAID REFORM. I THINK WE'RE MOSTLY TALKING ABOUT COMMUNITY HEALTH WORKERS IN THE AREAS OF CHRONIC DISEASE MANAGEMENT, SOMEWHAT IN MATERNAL HEALTH CHILD POPULATIONS AND I DON'T THINK I'VE EVER HEARD OF ANYBODY TALKING ABOUT IT IN THIS KIND OF CONTEXT. I THINK IT'S KIND OF INTERESTING.

>> WE'VE MADE SOME RECOMMENDATIONS FOR USING IT AS A SIMILAR KIND OF PEER NAVIGATION

KIND OF SUPPORT IN THE BEHAVIORAL HEALTH CONTEXT, AND I THINK IT MAKES A LOT OF SENSE TO PARALLEL THAT FOR FOLKS WHO ARE DEAF AND HARD OF HEARING.

>> THERE IS ACTUALLY A MODEL BEING DEVELOPED AT JOHNS HOPKINS THAT IS BASED ON THAT COMMUNITY HEALTH WORKERS MODEL FOR INDIVIDUALS WITH HEARING LOSS AND WORKING WITH BASIC DEVICES OR OVER-THE-COUNTER DEVICES UNDER THE DIRECTION OF AN AUDIOLOGIST, BUT HAVING THOSE BEING THE FOLKS ON THE GROUND, THAT IS OUT THERE. IT WAS BRIEFLY TOUCHED ON IN ONE OF OUR PRESENTS AS TWO MONTHS AGO MAYBE.

>> OKAY. IS THAT IT FOR THIS ONE? I'M GOING TO MOVE ON TO TWO ON THIS BECAUSE 1A AND B ALSO HAD TO DO WITH DISABILITY RIGHTS NORTH CAROLINA. SO TWO IS EDUCATING NOW THE SAME THING, EDUCATING PATIENTS ON THE HEALTH CONDITIONS THAT COULD ARISE WITHOUT THE PROPER HEALTH CARE OR RESOURCES, SO COMMUNICATION ACCESS AND EFFECTIVE SCREENINGS AND THIS WAS JUST TAKEN OUT OF THAT FIRST PART AND PUT INTO ITS OWN. SO IT'S A DIFFERENT TYPE OF EFFORT, BUT THREE IS THE WAYS THAT WE WOULD GET IT TO CONSUMERS. SO ALL OF THIS INFORMATION, WE HAD HEARD THAT HLAA IS BIG IN NORTH CAROLINA. I WANTED TO KNOW IF THERE ARE OTHER ORGANIZATIONS THAT YOU THINK WOULD BE HELPFUL IN REACHING CONSUMERS WITH THIS TYPE OF INFORMATION. JAN?

>> I WAS GOING TO SAY MAYBE HEARING LOSS ASSOCIATION.

>> THAT'S BASICALLY WHAT HLAA DOES. IT'S A CONSUMER EDUCATION IS ONE OF THE THREE MAIN THINGS THAT IT DOES. AND WE'VE BEEN FAIRLY SUCCESSFUL WITH THAT IN LIMITED SORT OF WAY IN THAT WE ONLY HAVE ABOUT FIVE CHAPTERS ACROSS THE LARGER CITIES GENERALLY, BUT WE'VE BEEN SUCCESSFUL IN COOPERATING WITH DSDHH IN THAT RESPECT AS WELL. THEY'RE HELPING US TRY TO GET A CHAPTER RESTARTED NOW IN GREENSBORO AREA. THEY HELPED SUPPORT US WITH FUNDING FOR CAPTIONING AND WE CREATE PROGRAMS AND HAVE SPEAKERS COMING TO OUR MEETINGS THAT EXPLAIN TO ACTUAL CONSUMERS WHAT THEY CAN DO. IT'S A PEER-TO-PEER RELATIONSHIP WITH THOSE PEOPLE. IT WORKS VERY WELL FOR THE VERY SMALL NUMBER OF PEOPLE THAT WE CAN ENTICE OUT TO A MEETING. WE HAVE AN EXTENSIVE WEBSITE THAT PROVIDES INFORMATION TO CONSUMERS AND ALL OF THAT IS WHAT HLAA ACTUALLY DOES. WE WOULD LOVE TO BE ABLE TO DO IT IN EASTERN NORTH CAROLINA WHERE WE DON'T HAVE A CHAPTER OR IN NORTHEAST NORTH CAROLINA, FOR EXAMPLE. WE USED TO HAVE A CHAPTER IN WILMINGTON. WE WOULD LOVE TO HAVE ANOTHER CHAPTER DOWN THERE. PEOPLE AGE OUT AND LEADERS ARE DIFFICULT TO FIND SOMETIMES IN VOLUNTEER SITUATIONS, BUT WE WOULD BE HAPPY TO COOPERATE WITH DSDHH IN GOING OUT TO OTHER REGIONS IF WE COULD ARRANGE FOR MEETINGS, EVEN IF THERE'S NOT A CHAPTER OUT THERE. WE COULD SUPPORT PRESENTATIONS FOR CONSUMERS ON A PEER-TO-PEER RELATIONSHIP THERE. BUT IT'S BEEN A PRETTY SUCCESSFUL SITUATION SO FAR.

>> HI. IT'S JENNIFER GILL, LEADING AGE NORTH CAROLINA. I WONDERED ABOUT PHARMACIES. I MEAN, THAT'S A PRINTED PIECE SO YOU DON'T REALLY ADDRESS THE VISUAL, BUT IT'S PEOPLE WHO MAY NOT IDENTIFY AS HAVING HEARING LOSS. I MEAN, EVERYBODY GOES TO THE PHARMACY AT SOME POINT OR THE OTHER. I WONDER ABOUT REACHING CONSUMERS THROUGH THE PHARMACY. I WONDER ABOUT VIDEOS THAT PLAY IN YOUR DENTISTS' OFFICES, AND ANYWHERE YOU ARE WAITING TO BE CALLED. THAT'S THE PASSIVE EDUCATION. IT'S HAPPENING. YOU'RE NOT TURNING OFF THE TV. VIDEOS NEED TO BE CAPTIONED PROBABLY, BUT YOU KNOW, JUST WONDERING ABOUT JUST SOME REALLY REGULAR ENVIRONMENTS WHERE WE ALL GO DAY TO DAY AND HAVING THAT KIND OF INFORMATION AVAILABLE IN THOSE SETTINGS.

>> JAN?

>> YEAH. THIS IS JAN SPEAKING. I WAS THINKING ALONG THE SAME LINES, JENNIFER, IN TERMS OF HOW TO REACH A WIDER POPULATION BEYOND HLAA. IS THERE AN ASSOCIATION OF CCRCs? YOU. OKAY. OH. WELL, I KNEW THAT YOU WERE RELATED TO AGING BUT I DIDN'T REALIZE THAT WAS AN ACTUALLY AN ASSOCIATION OF CCRCs. GREAT. WE CAN DO THAT. WE CAN GET THE WORD OUT THAT WAY TO FOLKS 55 AND ABOVE, THAT'S A LARGE NUMBER OF PEOPLE AND THEY CAN BECOME PEERS TO THOSE WHO ARE GOING INTO THOSE HIGHER SKILLED NURSING FACILITIES AND SUCH.

>> YES.

>> FANTASTIC.

>> HI. IT'S EILEEN RAYNOR. I WAS THINKING ON A WIDER SCALE OF MAYBE PARTNERING WITH THE AARP BECAUSE THEY HAVE A VERY BROAD SCOPE. THEY HAVE MONTHLY PUBLICATIONS. THEY GO OUT TO A LOT OF RETIREES AND PEOPLE WHO ARE NOT RETIRED BUT ARE 50 PLUS. ADDITIONALLY, YOU CAN WORK WITH COMMUNITY ORGANIZATIONS, LIKE RELIGIOUS ORGANIZATIONS AND SENIOR CENTERS AND I THINK THERE'S A LOT OF OPPORTUNITIES OUT THERE. MY PARENTS ARE RETIRED IN CHARLOTTE AND THEY GO TO THIS MONTHLY SPICE MEETING WHICH IS FOR PEOPLE WHO ARE 55 AND OLDER, AND THEY HAVE SPEAKERS WHO COME IN. I THINK THERE ARE LOTS OF AREAS WHERE WE COULD REALLY GO OUT AND BRING THIS INTO THE PUBLIC AWARENESS.

>> THIS IS VICKI. I THINK THAT THIS IS WOULD BE IMPORTANT TO HAVE THE IN THE TOOLKIT AND MAKE SURE THAT IT'S SOMETHING THAT CAN APPEAL TO ALL DIFFERENT TYPES OF MEDIA MECHANISMS, INCLUDING PUBLIC SERVICE ANNOUNCEMENTS AND INCORPORATE THAT INTO THE LAUNCH IDEA, BUT I THINK THE IDEA IS YOU WANT TO HAVE SOMETHING THAT YOU COULD SEND OUT THROUGH AN EMAIL, POST ON A FACEBOOK PAGE, HAVE ON THE TELEVISION AS A PUBLIC SERVICE ANNOUNCEMENT AND REALLY THINKING ABOUT THOSE OF US WHO DON'T YET ACKNOWLEDGE THAT WE'RE HARD OF HEARING, SOW DON'T WANT TO LIMIT YOURSELF TO A SPECIFIC GROUP OF PEOPLE. YOU WANT TO SEND IT OUT TO THE GENERAL POPULOUS, AND SO WIDE, VARYING TOOLS, AND THEN JUST SEND IT

OUT TO EVERYBODY AND ASK THEM TO SHARE IT.

>> HI.

THIS IS LIBBY WITH DHSR, AND ONE OF THE COMMENTS IS I UNDERSTAND VERY MUCH FUNDAMENTALLY THE NEED TO ADDRESS THE NEEDS OF PEOPLE ONCE THEY ENTER SOME TYPE OF FACILITY, WHETHER IT'S A NURSING HOME, WHETHER IT'S AN ADULT CARE HOME, BUT ONE OF THE THINGS THAT I THINK VICKI MADE A GOOD POINT IS THAT SOME PEOPLE AREN'T WILLING TO ADMIT WHEN THEY NEED CERTAIN THINGS, AND ONE OF THE THINGS WE OBSERVE IN THE POPULATION THAT COMES INTO ASSISTED LIVING FACILITIES IS OFTEN PEOPLE ARE VERY, VERY DEBILITATED ONCE THEY GET TO THE FACILITY BECAUSE THEY HAVE BEEN VERY ISOLATED. THEIR HEALTH CARE NEEDS HAVE NOT BEEN MET AND NOT ONLY MAY THEY NOT HAVE A HEARING-- THEY MAY HAVE A HEARING DEFICIT, BUT THEIR BLOOD SUGAR IS OUT OF THE ROOF OR THEY HAVE ALL OF THESE OTHER COMORBIDITIES GOING ON WITH THE INDIVIDUAL THAT, TO BE PERFECTLY HONEST WITH YOU FROM OUR STANDPOINT WHEN WE RECEIVE A COMPLAINT, IT IS MUCH MORE-- IT IS VERY EGREGIOUS WHEN SOMEONE IS NOT RECEIVING THEIR WARFARIN OR INSULIN, AND AND THAT BECOMES VERY FOCAL TO US BECAUSE THAT IS IMMINENT DANGER TO SOMEONE. I MEAN, THEY CAN DIE. AND FOR-- OFTEN WHAT WE SEE AND MY BOSS ACTUALLY FOR OUR SECTION, HER HAD HISTORY WAS WORKING IN A CCRC AND WE HAVE THIS EXPERIENCE IN OUR CULTURE WHERE PEOPLE DON'T WANT TO ADMIT THAT THEY ARE AGING. I'M SURE NONE OF YOU DO EITHER AND BECAUSE WE DON'T LIKE TO ADMIT THAT, IF WE CAN LIVE IN A SENIOR APARTMENTS OR A HIGH RISE INDEPENDENT LIVING THAT THE COSTS ARE VERY LOW, THEN WE STAY THERE AS LONG AS POSSIBLE AND SO WHEN I, EARLIER IN THE PRESENTATION THIS MORNING TALKED ABOUT OUR CATEGORY OF MULTIUNIT ASSISTED HOUSING BUT IF YOU GO AROUND RTP, THERE ARE HUNDREDS OF SENIOR LIVING COMMUNITIES WHERE PEOPLE LIVE THAT THEY NEED TO BE MAKING THEIR CHOICES AND GOING TO THE AUDIOLOGIST NOW WHERE THEY CAN ENJOY SO MUCH MORE INDEPENDENCE THAN WHEN THEY GET TO THE POINT THAT THEY HAVE DEMENTIA AND MAYBE THEIR HEARING LOSS CONTRIBUTED TO THAT, BUT IF YOU LOOK-- AND SO MANY PEOPLE USE THE INTERNET. SO IF YOU LOOK AND YOU JUST LIKE GOOGLE DIFFERENT-- THERE ARE DIFFERENT WEBSITES, CARE.COM, SENIORLIVING.NET, AND THERE ARE ALL THESE PLACES AND WHAT THOSE WEBSITES ADVERTISE ARE A WHOLE CONTINUUM OF WAYS TO GET INFORMATION TO THOSE PEOPLE BECAUSE I WANT PEOPLE TO BE ABLE TO GET WHAT THEY NEED AS SOON AS POSSIBLE AND NOT WAIT UNTIL IT'S BECAUSE THEY HAD A HIP FRACTURE AND WENT TO THE NURSING HOME AND NOW THEY'RE LIVING IN A NURSING HOME, AND NOW THE NURSING HOME HOME IS RESPONSIBLE FOR GETTING THEM TO THE AUDIOLOGIST. WHAT IF THAT PERSON COULD HAVE ENJOYED A HIGHER LEVEL AND PART OF IT IS CONSUMER CHOICE. THE GENTLEMAN OVER THERE TALKED ABOUT PEOPLE DON'T WANT HEARING AIDS. WELL, AND THERE'S TWO THINGS I'LL SAY. IF YOU PAID ATTENTION AND I KNOW THINGS ON TELEVISION AND HOW

THAT HAS TO BE HANDLED WITH CLOSED CAPTION AND THINGS, BUT LIKE WHEN THE STATE WAS ENCOURAGING PEOPLE TO GET FLU SHOTS, THE PUBLIC SERVICE ANNOUNCEMENTS, THEY WERE VERY CATCHY, THEY WERE VERY SHORT. I DON'T KNOW ABOUT YOU, BUT I PAID ATTENTION TO THEM. ALSO THE THINGS ABOUT SIGNALING WHEN SOMEONE HAS A STROKE, THE SMILE TEST, I MEAN, THERE ARE LITTLE THINGS OUT THERE THAT IF YOU CAN JUST GRAB PEOPLE'S ATTENTION AND MAYBE IT WON'T GET-- IT WON'T TAKE CARE OF 50 BUT MAYBE IT WILL GET 25 PEOPLE'S ATTENTION AND THEN THAT CAN START THIS HAPPENING AND GETTING THAT QUALITY OF LIFE IMPROVING MUCH EARLIER.
>> GOOD POINT. SO PUBLIC EDUCATION, EARLIER EDUCATION, AND MAYBE LAST COMMENT AND KEEP GOING BECAUSE I THINK WE'RE ON THE BOTTOM OF PAGE 7 AND WE HAVE NINE PAGES TO GO.
>> YOU ARE GOING TO BE TIRED OF HEARING FROM ME. WHEN I EDUCATE PEOPLE ABOUT HEARING LOSS, I FIND IT EFFECTIVE TO TARGET 40 TO 45 DEMOGRAPHIC BECAUSE WE FOCUS ON MAKING PARENTS MAKE THEIR HEALTHCARISH ISES AND WE NOTICE OUR PARENTS MISSING THINGS BEFORE THEY'RE WILLING TO ADMIT IT THEMSELVES AND WHEN THAT CONVERSATION STARTS AT HOME AND THEN GOES PRIMARY CARE, IT STILL MAY TAKE SEVEN YEARS TO GET SOMEBODY INTO SOME HELP BUT IF SEVEN YEARS STARTS FIVE YEARS EARLIER WE'VE GAINED SOME THERE. . SO WE'LL MOVE ON TO THE NEXT SECTION AND REMINDER THIS WHOLE FIRST PAGE WAS EDUCATION SECTION. WE'RE GOING TO GET INTO NOW THE SYSTEM'S PRACTICE SECTION, TOO, AND THAT'S WHERE A LOT OF THIS CAN COME IN, TOO, AS WELL. . OKAY. SO FOR THIS ONE, REPRESENTATIVES FROM THE HEALTH CARE ASSOCIATION AND THAT'S LICENSING BOARD, INTERPRETING SERVICES CONSORTIUM. I REACHED OUT TO A INTERPRETING COORDINATOR AT I BELIEVE ATRIUM HEALTH AND HE HAD TOLD ME THAT THERE'S A CONSORTIUM BETWEEN ALL THE BIG MAJOR HOSPITAL SYSTEMS IN NORTH CAROLINA, AND THEY HAVE LIKE ANNUAL MEETING EVERY YEAR. SO THAT IS WHERE THAT COMES FROM TO TRY TO GET THEM INVOLVED IN THIS , SHOULD COMMIT TO CONVENE WITH THE DIVISION TO DEVELOP AND DISSEMINATE A UNIFORM ASSESSMENT FORM FOR HEALTH SYSTEMS AND INDIVIDUAL PROVIDERS. THE THING I GOT MOST COMMENTS ABOUT ON THIS ONE WAS VOLUNTARY. THIS WORD WAS PUT IN THERE BECAUSE AFTER MEETING WITH THE MEDICAL BOARD AND OTHER AGENCIES THAT IT'S VERY HARD-- IT'S EASIER AND MORE-- IT'S EASIER TO GET PEOPLE TO DO THINGS IF THEY'RE FEELING NOT BEING MADE TO DO THEM. THAT'S WHY THIS WAS PUT IN HERE BUT WE CAN GO THROUGH THE LANGUAGE HERE. I WILL GO THROUGH THE RECOMMENDATION BEFORE WE GET TO COMMENTS. THIS FIRST PART IS REALLY ALLOWING-- THE SURVEY WOULD ALLOW ALL FACILITIES THAT THIS GOES TO TO KIND OF ASSESS WHAT THEY HAVE. ONE OF THE BIGGEST THINGS ABOUT-- THAT CAME UP WITH THIS TASK FORCE IS WE DON'T HAVE A LOT OF DATA SURROUNDING WHAT'S ACTUALLY GOING ON AND ALSO THAT IT'S DIFFERENT TECHNIQUES BEING USED AT ALL DIFFERENT FACILITIES. THIS WAS CREATED IN A WAY THAT WE CAN GET THE-- WHAT EVERYONE IS DOING AND CREATE BEST PRACTICES OFF OF WHAT WE SEE IS ALREADY

BEING DONE AND CAN BE DONE IN NORTH CAROLINA. BUT YEAH. IT'S ABOUT PROPER VRI CAPABILITIES. DO THEY HAVE THE SYSTEMS IN PLACE TO PROVIDE VRI? CULTURE AWEIRNESS TRAINING, APPOINT A PERSON TO WORK WITH IF THEY HAVE-- IF THEY ARE FLAGGED AS DEAF, HARD OF HEARING OR DEAF-BLIND PATIENT. THINGS LIKE THAT. FOR THIS FIRST PART, THAT IS THAT ASSESSMENT AND THEN THE SECOND PART-- THIS IS A LITTLE DIFFERENT AND IT BREAKS DOWN THAT A LITTLE BIT MORE AND THEN THIS IS THE SYSTEM OF FLAGGING PATIENTS AND WHY I PUT THIS IN HERE IS BECAUSE AFTER TALKED WITH THE MAN AT ATRIUM, ALL OF THEIR SYSTEMS AND AFFILIATE SYSTEMS FALL UNDER THE SAME UMBRELLA. WHEN THEY HAVE A PATIENT INTAKE, THEIR COMPUTER SCREEN ASKS DID THE PERSON OR PARENT NEED HEARING ACCOMMODATIONS AND WHAT DID THEY REQUEST, AND THERE'S A SECTION. THEY CAN'T GET PAST THAT SCREEN UNLESS THAT INFORMATION IS FILLED IN. IT TAKES AWAY THE TURNOVER AND ALL OF THAT ON THE JOB AND THAT QUESTION ALWAYS HAS TO BE ASKED FOR WHEN SOMEONE NEW IS COMING IN. BY DOING THIS, AND THIS WAS AN EXAMPLE OF BEST PRACTICE AND THEN EVENTUALLY SHARE WITH ALL THE OTHER HOSPITAL SYSTEMS AND HEALTH PRACTICE MISNORTH CAROLINA THAT TECHNOLOGY IS AVAILABLE AND USABLE AND CREATE THAT STOP, THAT LITTLE THING MAKES ALL THE DIFFERENCE THAT THAT QUESTION IS ALWAYS ASKED NO MATTER IF THE PERSON IS TRAINED ON IT TO ASK FOR NOT. BUT YEAH. SO THIS IS IF THEIR CURRENT SYSTEMS ARE FLAGGING THE PATIENTS AND LIKE I SAID, THE HARD STOPS AND THIS LAST PART, WHAT ACTS ARE TAKEN TO ENSURE ONCE THEY ACTUALLY REQUEST IT TO ENSURE THAT THE INTERPRETER OR THAT COMMUNICATION ACCOMMODATION IS AVAILABLE AT THEIR APPOINTMENT. FOR THIS SECTION, DID WE HAVE ANY COMMENTS? ADAM, DO YOU HAVE A COMMENT?

>> I WAS GOING TO HELP YOU WITH THE MICROPHONE. IT LOOKS LIKE DAVID HAD A HAND UP.

>> YES. THIS IS DAVID ROSENTHAL. I GUESS THIS IS ONE THING I WOULD LIKE TO ASK REGARDING COMMUNICATION BETWEEN THE PATIENT AND THE HOSPITAL AND THE ACTUAL NURSE'S STATION AND WHAT YOU HAVE IN HERE THAT MIGHT ADDRESS THAT PARTICULAR COMMUNICATION.

>> CAN YOU REPEAT THAT?

>> YES. SO SO AS AN EXAMPLE , I HAD THE EXPERIENCE BEFORE I AM IN A HOSPITAL ROOM BY THE WINDOW AND YOU HAVE THE TWO BEDS WITH THE CURRENT, RIGHT, IN SOME OF THE HOSPITAL ROOMS AND THAT CURTAIN IS OFTEN CLOSED AND THE PERSON IN THE NEXT BED, LIKE WHEN THEIR SPOUSE WOULD COME IN, THEY WOULD ALWAYS CLOSE THE CURTAIN SO I COULDN'T BE SEEN FROM THE DOOR AND THE NURSE WOULD COME IN AND SAY SOMETHING FROM THE DOOR TO CHECK ON THAT PATIENT AND MOVE ON AND I HAD NO IDEA THE NURSE WAS EVEN THERE AND THEY NEVER WERE CHECKING ON WHAT I NEEDED. ANOTHER SITUATION WHERE I WOULD HIT THE CALL BELL AND NO ONE WOULD COME FOR A LONG TIME AND THEN I WOULD LOOK AND FIND OUT THEY HAD BEEN TALKING THROUGH THE INTERCOM, AND THAT OBVIOUSLY DOES NOT WORK FOR DEAF PATIENTS AND

THAT'S WHAT I'M TALKING ABOUT. WHAT ARE WE ADDRESSING FOR COMMUNICATION BETWEEN THE PATIENT AND THE NURSE'S STATION.
>> SO I THINK THAT CAN DEFINITELY GO IN THE FIRST PART OF THIS IN KIND OF ADDING, IS THERE A SYSTEM IN PLACE FOR THAT ASKING THAT. IF NOT, WE'LL SEE WHAT THE BEST PRACTICES ON THAT OR IF THERE IS A ONE.
>> I THINK YOU SHOULD REGISTER A COMPLAINT WITH THE DIVISION OF HEALTH SERVICES REGULATION.
[LAUGHTER]
I'M KIND OF SERIOUS. IT MIGHT HAVE BEEN IN MINNESOTA, THOUGH. THE ONLY OTHER THING I WAS GOING TO SAY IS DO YOU THINK WE CAN MAKE THIS LANGUAGE A LITTLE BIT STRONGER? I KNOW CALLING IT OUT AS MANDATORY IS NOT HELPFUL BUT CALLING IT VOLUNTARY IS ALSO NOT HELPFUL. INSTEAD OF USING VERBS LIKE ALLOW LIKE MAYBE HEALTH CARE SYSTEMS SHOULD AND I THINK WE CAN WORK ON MAKING THE LANGUAGE A LITTLE BIT STRONGER.
>> OKAY. SO MOVING ON, THIS IS THEN JUST REINFORCING THAT AND WE WOULD ASK THE HEALTH CARE ASSOCIATION-- AGAIN, WE MAY HAVE TO PLAY AROUND WITH THE WORD ADVISE BECAUSE I THINK I WAS TOLD ADVISE MEANS UNLESS IT'S REGULATORY OR A LAW YOU CAN'T REALLY ADVISE, SO IT HAS TO BE RECOMMEND. WE CAN PLAY AROUND WITH THAT WORD. THIS IS THAT THEY COMPLETE THAT FORM. SO WE WANTED TO DISSEMINATE IT BUT ALSO WE WANT THEIR PROFESSIONAL ORGANIZATIONS TELLING THEIR MEMBERS ABOUT IT AND THAT IT EXISTS AND IT'S SOMETHING THAT THEY SHOULD PASS ON IN AN EFFORT TO GET THEM MORE RESOURCES AND BE ABLE TO BETTER HELP THEIR PATIENTS AND DO IT IN THAT LIGHT. ONE THING-- ONCE WE HAVE THESE FORMS, I THINK THAT'S A QUESTION WE NEED TO DISCUSS IS WHERE THE FORMS WOULD GO. UP HERE, GOING TO THE DIVISION OF SERVICES FOR DEAF AND HARD OF HEARING, BUT I'M NOT SURE IF THAT'S THE RIGHT ORGANIZATION TO SEND THIS INFORMATION TO TO AGGREGATE THE DATA THAT WE WOULD GET FROM THEM.
>> QUESTION. HAVE YOU HAD MORE CONVERSATION WITH SARAH OR JULIO? CAN WE RECOMMEND THIS TO THE HEALTH CARE ASSOCIATION AND LET THEM FIGURE OUT HOW TO DO IT, AND THAT WAY, WE DON'T HAVE TO IMPLY OR CREATE AUTHORITY THAT DOESN'T EXIST AND TELL THEM TO ASSESS THEIR MEMBERS. I WANT TO KNOW THAT THERE IS WILLINGNESS TO PARTNER ON THAT. THAT'S WHY I'M ASKING.
>> I WILL REACH OUT ABOUT IT.
>> I WOULD LOVE IT IF THE HEALTH CARE ASSOCIATION'S WILLING TO DO THAT. I WOULD QUESTION WHY THEY WOULD BE WILLING TO PUBLICLY SHARE THAT DATA AND SO THAT'S A DIFFERENT--
>> TOTALLY AGREE.

>> THAT'S A DIFFERENT PROBLEM.

>> YEAH. SORRY.

[LAUGHTER]

FORCE OF HABIT.

>> YEAH. THIS IS JAN SPEAKING. I GET IT. I UNDERSTAND. IT'S COMMON TO GIVE ME THE MICROPHONE. I THINK IT'S FUNNY. BUT THIS IS JAN SPEAKING. WE CAN CONTINUE TO BE AVAILABLE AS SUBJECT MATTER EXPERTS ALWAYS. SO FEEL FREE TO PUT THAT IN.

>> YES. SO THIS IS, AGAIN, THE SAME THING, BUT WE'LL FORWARD THESE RECOMMENDATIONS TO THESE APPROPRIATION ASSOCIATIONS AS WELL TO SEE THE SAME THING THAT WE'RE DOING WITH THE HEALTH CARE ASSOCIATION.

>> I DON'T KNOW HOW THE HEALTH CARE ASSOCIATION COUNTS MEMBERS, BUT THEY DON'T HAVE VERY MANY. WHEREAS, ARE YOU KNOW, I'M LOOKING AT THIS RECOMMENDATION THREE AND THINKING IF WE SEND THIS OUT TO ALL PHYSICIANS IN NORTH CAROLINA, YOU'RE GOING TO GET A REALLY LOW RESPONSE RATE. I THINK THE LIKELIHOOD OF GETTING GOOD INFORMATION DECLINES. SO I WONDER HOW IMPORTANT THIS IS, IF THIS IS WHERE WE WANT OUR BOARDS AND TRADE ASSOCIATIONS TO BE SPENDING THEIR EFFORTS. I'M ASKING GREG AND PEOPLE WHO REPRESENT PTOT, IS THIS A GOOD USE OF TIME?

>> THE ONLY REASON I DID PUT THEM IN IS GETTING HOSPITAL SYSTEMS IS NOT GETTING PRACTICE PROVIDERS.

>> YEAH. I GET IT.

>> I THINK YOU ARE GOING TO HAVE A LOT BETTER LUCK WITH HEALTH CARE SYSTEMS. THERE ARE SOMEWHERE IN THE NEIGHBORHOOD OF 60,000 LICENSED PRACTICING PHYSICIANS IN NORTH CAROLINA INCOME AND YOU KNOW, GETTING MUCH BACK FROM THAT IS GOING TO BE DIFFICULT. NOW, ABOUT 50% OF THOSE WORK FOR INTEGRATED HEALTH CARE SYSTEMS SO IF YOU-- AS YOU LOOK AT THIS, I WOULD ENCOURAGE YOU TO HAVE THE HEALTH SYSTEMS ASSESS BOTH THEIR INPATIENT AND OUTPATIENT SYSTEMS AND HOW THEY'RE DEALING WITH THIS AND THAT MIGHT BE A WAY OF GETTING A VERY GOOD RESPONSE AND A GENERAL IDEA, AND THEN I MEAN, WE COULD ALMOST DO CONVENIENCE SAMPLES OF OTHER SUBSETS OF PRIVATE DOCTORS, YOU KNOW, JUST TO SORT OF GET AN IDEA OF WHAT'S GOING ON OUT THERE. LIKE IF I SENT IT OUT TO-- OUR MEMBERS ARE INDIVIDUAL MEMBERS. THEY'RE NOT PRACTICE MEMBERS, AND I DON'T EVEN ALWAYS KNOW WHO PRACTICES TOGETHER IN THE SAME PRACTICE SO. I'M GOING TO SEND IT OUT TO 4,000 PEOPLE AND I PROBABLY WON'T GET VERY MANY BACK. I PROBABLY CAN-- I KNOW ENOUGH PRIVATE SECTOR DOCTORS THAT AREN'T AFFILIATED WITH SYSTEMS THAT I CAN SAY, HEY, WOULD YOU DO THIS VOLUNTARILY JUST SO WE CAN GET AN IDEA OF WHAT'S GOING ON AND SEND IT OUT TO A GROUP THAT I KNOW ACTUALLY

WOULD RESPOND AND AT LEAST GIVE-- AND THERE ARE PROBABLY OTHER ASSOCIATIONS THAT WOULD BE WILLING TO DO THAT, TOO. I DON'T THINK IT MAKES SENSE TO SEND IT OUT TO 4,000 PEOPLE BECAUSE I DON'T THINK YOU WILL GET BACK MEANINGFUL INFORMATION.
>> TOVAH HERE. THIS SECTION IS WHERE I RAN INTO THE CONFUSION I HAVE ABOUT ALL THESE DIFFERENT ORGANIZATION S, NORTH CAROLINA HEALTH CARE ASSOCIATION, DEVELOPING CONSORTIA AND ALSO A HEALTH CARE COMMUNICATION ACCESS COALITION. IT LOOKED TO ME LIKE THE PROPOSED ACNCHC IS THE MOST BROAD GROUP. AND I'M WONDER YG THAT WOULDN'T BE THE FIRST THING YOU WOULD SET UP WHICH WOULD INCLUDE ALL THE AGENCIES YOU'VE MENTIONED THROUGHOUT THE WHOLE SET OF RECOMMENDATIONS, AND HAVE THAT GROUP DO THE WORK IN TERMS OF-- I MEAN, THE GROUP WOULD INCLUDE ALL THESE AGENCIES AND FOLKS AND THEREFORE, THERE COULD BE CHITTIES THAT WOULD WORK ON DIFFERENT THING-- COMMITTEES THAT WOULD WORK ON DIFFERENT THINGS LIKE THE PROCESS WHICH WOULD INVOLVE THE HEALTH CARE ASSOCIATION AND THEN REPORT BACK TO THE LARGER GROUP WITH ALL THEIR FINDINGS SO IS IT POSSIBLE TO CONSIDER MAYBE PUTTING THAT WHOLE COALITION UP FRONT, AND THEN HAVING DIFFERENT PEOPLE, DIFFERENT AGENCIES IN THE COALITION IMPLEMENT THE DIFFERENT RECOMMENDATION?
>> YEAH. I THINK THAT IS AN IDEA. THE REASON IT IS SEPARATED OUT IS BECAUSE I ALSO DIDN'T WANT THESE RECOMMENDATIONS TO BE SOLELY RELIANT ON ONE HAPPENING. SO IF THAT COALITION DOESN'T END UP WORKING OUT, I THINK THIS ASSESSMENT FORM IS SOMETHING THAT SHOULD HAPPEN. IT WAS BROKEN OUT. I THINK THE RESPONSES TO THE ASSESSMENT SHOULD BE REVIEWED BY THAT IF IT IS SOMETHING THAT COMES TO BE, BUT ALSO IT WAS JUST A WAY OF BREAKING IT OUT AND TO ENSURING THAT THESE IMPORTANT THINGS STILL HAPPEN AND ALSO EVEN IF THAT'S NOT IN PLACE.
>> YEAH. THIS IS DAVID SPEAKING. I WAS A FORMER PRESIDENT OF A TELEPHONE ASSOCIATION WHERE WE SENT OUT A SURVEY TO MEMBERS AS PART OF OUR TELEPHONE ASSOCIATION AND WE DIDN'T ALWAYS GET RESPONSES BACK, BUT WE WOULD TAKE IT UPON OURSELVES TO CALL THEM, TO GET THE INFORMATION THAT WE NEEDED SO THAT WE HAD A COMPLETE SET OF DATA TO WORK FROM, SO I'M WONDERING IF MAYBE WE COULD ADD LANGUAGE THAT WOULD MAKE THOSE ASSOCIATIONS SEND THAT INFORMATION OUT TO THEIR MEMBERS AND ALSO FOLLOW UP IF THEY DID NOT GET AN APPROPRIATE RESPONSE TO THE MAXIMUM EXTENT POSSIBLE.
>> IF WE HAD TO DO THAT, THAT WOULD BE ALL-- I HAVE A STAFF OF MYSELF AND FOUR OTHER PEOPLE, IT WOULD BE A YEAR'S WORTH OF WORK FOR FIVE OF US TO CHASE IT DOWN AND WOULDN'T DO ANYTHING ELSE FOR OUR MEMBERS THE WHOLE TIME. SO THAT'S JUST NOT VERY FEASIBLE, I THINK, FOR MOST ASSOCIATIONS. AS I SAID, I AM WILLING TO CHASE DOWN A SEGMENT OF MY MEMBERS THAT I KNOW CAN BE A CONVENIENCE SAMPLE TO GIVE US SOME GOOD DATA.

>> AND AS ONE OF HIS MEMBERS, I WOULD SAY IF HE SPENT ALL YEAR CHASING ME DOWN TO RESPOND TO HIS SURVEY, IF IT WAS ABOUT ANYTHING ELSE, I WOULD QUIT. RIGHT?
>> RIGHT.
>> IT IS A VOLUNTARY MEMBERSHIP.
>> EXACTLY. AND THE JOB OF THE ASSOCIATION IS TO SERVE ITS MEMBERS. I WANTED TO JUST RESPOND TO SOMETHING, YOU SAID, GREG, ABOUT SURVEYING HEALTH CARE ASSOCIATIONS. WE ASKED THIS WHEN WE MET WITH THE HEALTH CARE ASSOCIATION AND APPARENTLY, THE SORT OF FINANCIAL MODEL, RELATIONAL MODEL AND RESPONSIBILITY MODEL OF INTERPRETING SERVICES FOR THE PRACTICES ASSOCIATED WITH HOSPITAL NETWORKS VARIES, AND EVERY SINGLE ONE IS DIFFERENT. SO IF YOU HAD SOMEBODY FROM INTERPRETER SERVICES AT THE MOTHERSHIP, THEY COULDN'T EVEN ANSWER A SET OF QUESTIONS FOR THE PRACTICES IN THEIR LOOSELY AFFILIATED NETWORK.
THERE'S JUST TOO MUCH VARIETY.
>> THERE ARE WITHIN THE SYSTEMS, THERE ARE TYPICALLY -- LIKE UNCPN, UNC PHYSICIANS' NETWORK, I WOULD SEND IT TO THE SYSTEM AS A WHOLE AND SEND IT TO OUTPATIENT PHYSICIAN NETWORK AND SAME AS DUKE PDC, THEY'RE SIMILAR AT ATRIUM. IT'S ALMOST LIKE HAVING TO SEND IT TO AN INPATIENT OR OUTPATIENT PERSON PROBABLY THEN IN EACH SYSTEM.
>> IT GETS YOU A LITTLE CLOSER, BUT THESE ARE SOMETIMES LOOSE AFFILIATED MANAGEMENT AGREEMENTS THAT WOULD JUST BE MESSY.
>> THERE ARE ABOUT 50% OF THE PHYSICIANS IN THE STATE WHO ARE EMPLOYED BY, NOT LOOSE MANAGEMENT AGREEMENTS.
THIS IS LIKE-- SO ANOTHER 25%--
>> GOT IT. TOVAH, WAS YOUR HAND UP? I THOUGHT I SAW A HAND OVER HERE. NO. OKAY. KEEP MOVING.
>> YEAH. SINCE WE'RE CLOSE TO OUT OF TIME. I DID WANT TO MAKE SURE WE GOT TO THIS ONE BECAUSE I KNOW THERE'S A LOT OF ACRONYMS IN THESE RECOMMENDATIONS AND I APOLOGIZE FOR IT, BUT THIS IDEA WAS ORIGINALLY HOUSED FOR THE COUNCIL OF DEAF AND HARD OF HEARING, BUT IN THE SPIRIT OF ALSO THAT WE WANTED THIS TO BECOME A COLLABORATIVE EFFORT AND AND THAT PARTNERS, IT SHOULD BE-- THERE SHOULD BE STRATEGIC PARTNERS, WE-- THIS IDEA CAME UP OF CREATING AN ACTUAL COALITION OF WHERE EACH OF THESE ORGANIZATIONS WOULD SERVE AND KIND OF BE RESPONSIBLE FOR, AS YOU CAN SEE ON THE FIRST ONE, HOSTING THE MEETING THAT WE GO OVER ALL OF THESE THINGS AND THE IDEA IS CREATING A COALITION OF THE MEMBERS AND THIS IS NOT EXHAUSTIVE OF DRNC, DIVISION OF SERVICES FOR DEAF AND HARD OF HEARING, HEALTH CARE ASSOCIATION, LICENSING BOARDS, PROFESSIONAL ASSOCIATIONS, AND THIS COULD BE EXPANDING OR HOWEVER IT'S RUN, BUT HERE IS WHERE THEY WOULD DISCUSS ALL OF THESE THINGS AND THE FIRST

ONE, ANY COMPLAINTS, QUESTIONS OR REQUESTS FOR ADDITIONAL RESOURCES, I THINK IT'S IMPORTANT THAT WE REALIZE THAT WHILE A CONSUMER CAN FILE A COMPLAINT AT THE MEDICAL BOARD, I THINK IT WILL BE IMPORTANT TO SHARE THAT THE MEDICAL BOARD ALSO GOT AN INQUIRY AND ASKING WHAT THEY SHOULD HAVE DONE IN THIS SITUATION. THAT IS SOMETHING THAT IS IMPORTANT TO COLLECT AS WELL, AND AN OPPORTUNITY FOR THEM TO ALSO-- FOR THE BOARD TO SHARE WITH THEM THAT THERE'S EDUCATION OPPORTUNITIES AVAILABLE AND I'M SURE THE DIVISION WOULD LOVE TO GO OUT AND SPEAK WITH THEM ABOUT DIFFERENT HEARING ACCOMMODATIONS. SO I THINK THAT THIS AGENCY OR COALITION, WHATEVER IT'S GOING TO END UP BEING CALLED IS A PLACE WHERE IT PUTS ENOUGH SKIN IN THE GAME FOR EACH OF THESE ORGANIZATIONS AND THEN IT'S A WAY TO CONTINUE THE PARTNERSHIP AND SHARE THIS INFORMATION GOING FORWARD. THE BULLET POINTS UNDER OF WHAT THEY WOULD DISCUSS, AND I CERTAINLY THINK THIS VOLUNTARY ASSESSMENT, WHETHER IT'S DONE ON A BIANNUAL BASIS, THEY DISCUSS THAT IN THE FINDINGS AND WHAT TO DO WITH IT AND THEN ALSO I DID WANT TO MENTION THIS THE COMMUNICATION ACCESS FUND CAME UP A LOT TODAY AND ONE OF THE REASONS THAT WE SEEM TO GET AWAY FROM IT AND GO MORE TOWARD EDUCATION IS WE DIDN'T HAVE ENOUGH DATA TO BRING THIS TO THE GENERAL ASSEMBLY FOR SOMETHING IT COULD MEANINGFULLY GO FORWARD, AND I THINK PUTTING IN A REMARK LIKE THIS WE CAN WORK ON THE WORDING WHERE WE DO THESE RECOMMENDATIONS FOR A COUPLE OF YEARS, AND IF WE SEE NO CHANGE OR FINALLY GETTING MORE DATA ON WHERE THIS IS HAPPENING IN NORTH CAROLINA, THAT'S WHEN THIS COALITION CAN DISCUSS THE NEW GOLD AROUND-- NEW GOLD STANDARD, I'LL BORROW YOUR PHRASING, WORK ON A RECOMMENDATION TOWARD THAT. THOUGHTS ON THIS? ANY COMMENTS?

>> I WOULD ONLY-- I LIKE THE WAY YOU'RE THINKING. I WOULD ONLY SAY AROUND THAT AS YOU WORDSMITH IT TO SAY IF FEASIBLE, BECAUSE I HATE TO BE PESSIMISTIC, BUT WITH THE CURRENT MAKEUP OF THE GENERAL ASSEMBLY, UNLESS THAT CHANGES DRASTICALLY, I DON'T THINK YOU ARE GOING TO GET VERY FAR ON THAT BECAUSE THEY'RE GOING TO SEE THIS AS A NEW TAX AND THEY'RE ALL ABOUT CUTTING TAXES, NOT ADDING TAXES AND FEES. THE MEDICAL BOARD WITH EVERYBODY IN AGREEMENT COULDN'T EVEN PUSH THROUGH A FEE INCREASE TO THE LICENSING FEES OF DOCTORS AND PAs. EVEN THOUGH THE MEDICAL SOCIETY AGREED, THE OTHER PROFESSIONAL SOCIETIES AGREED, THE MEDICAL BOARD AGREED, THE PAs AGREED, SOMEWHERE, IT STILL GOT IN THE GENERAL ASSEMBLY WHERE, NOPE, NO NEW TAXES, NO NEW FEES, NO EXTRA, YOU KNOW, AND SO I DON'T-- YOU KNOW, IF WE FIND THAT IT'S FEASIBLE TO GO FORWARD, THAT'S GREAT, BUT IF THE SITUATION DOESN'T CHANGE FROM WHERE IT IS TODAY, YOU'RE STILL SPINNING YOUR WHEELS WITH THAT. .

>> YES.

THIS IS JAN SPEAKING. I UNDERSTAND WHAT YOU'RE SAYING AND THAT'S BEEN MY OBSERVATION OF

THE GENERAL ASSEMBLY AS IT CURRENTLY IS, TOO. MAYBE WE COULD COME UP WITH LANGUAGE THAT SAYS THAT WE SHOULD REVIEW PROGRESS TO DATE AND REVIEW THE DATA COLLECTED TO DATE FOR THE PURPOSE OF EXPLORING OTHER COMPLIANCE SOLUTIONS, AND WE CAN MENTION SUCH AS OR MAYBE NOT JUST COMPLIANCE BUT OTHER SOLUTIONS TO SUCH AS A COMMUNICATION ACCESS FUND. I DO NOT WANT TO TAKE IT OFF THE TABLE, BUT BASED ON WHAT THE CIRCUMSTANCES ARE WHEN WE REVIEW THAT PROGRESS AND THAT DATA TWO OR THREE YEARS FROM NOW, THEN WE CAN REVIEW IT.

>> I HAVE A QUESTION FOR THE GROUP.

THIS IS ADAM. THE WAY THIS COALITION IS DESCRIBED, IT LOOKS LIKE THEY'RE IN CHARGE OF ASSESSING RESOURCES, EDUCATION, AND COMPLIANCE, AND I WONDER IF WE WANT TO FOCUS ON EDUCATION. I'M CONCERNED THAT MANY OF THESE LICENSING BOARDS AND MEMBERSHIP ASSOCIATIONS MAY BE MORE HESITANT IF THEY THINK THAT THIS PLAYS A REGULATORY ROLE, AND I THINK THAT WHAT WE REALLY ARE AFTER IS INFORMATION SHARING FOR THE PURPOSE OF PROMOTING RESOURCES AND GIVING EDUCATION. DO WE WANT TO TAKE SOME OF THAT LANGUAGE OUT, OR DOES THAT MAKE THE COALITION'S JOB TOO WEAK? WHAT DO YOU THINK?

>> TOVAH HERE. ALL ALONG, I HAVE MIXED FEELINGS ABOUT THE RELATIVE ROLES OF EDUCATION VERSUS COMPLIANCE BECAUSE I THINK THAT THERE REALLY HAS BEEN A LOT OF EDUCATION. I MEAN, I'VE BEEN IN THIS FIELD FOUR YEARS, AND I CAN TELL YOU A WHOLE LOT HAS CHAINED IN 40 YEARS IN EARNS IT OF EDUCATION THAT WE HAVE AND WHAT HAS NOT CHANGED UNFORTUNATELY IS COMPLIANCE. I THINK THAT WHAT WE HAVE-- IT IS MY HOPE THAT WE CAN FIND SOME WAYS TO INCREASE THE FEASIBILITY OF COMPLIANCE, AND THAT IS GOING TO INCLUDE EVERYTHING FROM POSITIVE ENCOURAGE AND SUPPORT AND SUGGESTIONS AND INFORMATION TO LEGAL ENFORCEMENT. THE FACT IS THAT MUCH OF THE PROGRESS WE'VE MADE WITH DEAF SERVICES IN THE STATE OF NORTH CAROLINA HAS BEEN THROUGH LAWSUITS. YOU KNOW, WHAT HAPPENS IS WHEN YOU START GETTING LAWSUITS, THAT'S WAY MORE EXPENSIVE THAN FINDING WAYS, EITHER LEGISLATIVELY OR THROUGH AVAILABLE FUNDING AND YOU KNOW, VOLUNTEER EFFORTS TO ADDRESS THESE NEEDS AND WE DON'T REALLY WANT TO BE WAITING AROUND FOR MORE LAWSUITS. AND THE MORE EDUCATION YOU PUT OUT THERE, THE MORE THE CHANCES GOING TO BE OF HAVING LAWSUITS INSTEAD OF ACTUAL REMEDIAL ACTION

>> GREG, DID YOU WANT TO--

>> I GO BACK TO THE LICENSING BOARDS, WHILE THAT PROCESS ISN'T ALL THAT EXTRAORDINARILY QUICK, IT'S A LOT QUICKER THAN LAWSUITS. YOU KNOW, I THINK US NOT UNDERESTIMATING THAT ROLE THAT THEY PLAY AND YES, THERE'S PROBABLY BEEN A LOT OF EDUCATION, BUT I CAN TELL I HAVE LEARNED A TON SITTING HERE. DAVID HENDERSON HAS LEARNED A TON SITTING HERE. I AM ANXIOUS

TO GO BACK AND TRY TO BETTER EDUCATE OUR MEMBERS BECAUSE YOU LIVE IN THIS WORLD EVERY, EVERY DAY. I DON'T LIVE-- I LIVE IN THE WORLD OF FAMILY MEDICINE EVERY DAY. I DON'T THINK MY MEMBERS ARE VERY WELL EDUCATED. I DON'T THINK THEY'RE EDUCATED NECESSARILY ABOUT OPTIONS. I DON'T THINK THEY'RE EDUCATED ABOUT ADA AS WELL AS THEY SHOULD BE. DO THEY HAVE SOME BASIC EDUCATION? ABSOLUTELY, BUT I THINK WE UNDERESTIMATE. SO MAYBE THIS NEEDS TO BE EDUCATE AND ASSESS AND THEN SOMEWHERE IN THERE WITH THE BOARDS, MENTION THAT THE LICENSING BOARDS HAVE A COMPLIANCE ROLE, BUT FOR THIS BROADER COALITION OF A COMMITTEE, EDUCATION AND ASSESS WHERE WE ARE MAY BE A A BETTER LANGUAGE.

>> YEAH. AND I AGREE WITH YOU, TOVAH. I THINK WE NEED TO FIND THE TEETH IN COMPLIANCE. I'M JUST NOT SURE THIS IS IT BECAUSE I WANT THE MEMBERS OF THIS COALITION TO BE WILLING, SO THAT'S WHERE I JUST THOUGHT IT WAS WORTH RAISING THE ISSUE.

>> ONE LAST COMMENT.

>> I THINK JOHNNY AND THEN ROB'S GOING TO WRAP US UP. JOHNNY AND THEN LEE, BUT WE HAVE TO BE QUICK.

>> I'LL BE QUICK. I ALSO WANT TO SAY THAT I'VE LEARNED A GOOD BIT FROM GREG AND DAVID FROM YOUR PERSPECTIVES AND YOUR CONSTITUENTS, AND I DO LIKE THE APPROACH OF MAYBE PULLING BACK A LITTLE BIT ON SOME OF THE LANGUAGE AND THOUGHING THAT WE CAN COLLABORATE AND COORDINATE WITH A FOCUS ON EDUCATION AND THAT MORE THINGS WILL BE ACCOMPLISHED ALONG THE WAY. SO I APPRECIATE WHAT YOU GUYS BRING TO THE TABLE.

>> I JUST WANTED TO CONCLUDE WITH MY STORY SINCE WE STARTED WITH MY STORY. NO. DURING LUNCH, THE PHYSICIAN CALLED ME, WHICH WAS GREAT BECAUSE THE PHYSICIAN HAS NO IDEA WHAT GOES ON IN THAT PRACTICE. THE PHYSICIAN WORKS MAINLY FOR THE PRACTICE IN THE TRIANGLE AREA, THE OFFICE IN WILSON IS NOT PART OF THE LARGE PRACTICE. NOW THE PHYSICIAN IS FULLY EDUCATED. I DID A QUICK FIVE-MINUTE EDUCATION. HE TOTALLY GETS IT. HE'S TOTALLY ONBOARD. AND NOW HE WILL BE ADVOCATING WITH THE PRACTICE. SO IT'S AN EXAMPLE OF-- WHAT WE SEE THE FRONTLINES FOLKS, THE NURSES, EVERYONE THAT THE PATIENT INTERACTS WITH PERSONALLY, I THINK WHEN THEY INTERACT, THEY KIND OF GET IT. SO IT'S A SYSTEM'S ISSUE AND I THINK ONCE WE KIND OF-- IT'S LIKE YOU MOANED, WE WORK THROUGH THE LICENSING BOARDS. THE DOCTORS REALIZE THAT IT IS AN ISSUE AND WE WORK THAT WAY AND HOPEFULLY WE CAN HAVE RESULTS LIKE I HAD TODAY.

[APPLAUSE]

>> THAT'S A GREAT RESULT.

[APPLAUSE]

Looking Forward to Meeting 6 and Next Steps

SO ROB'S GOING TO WRAP UP AND WHILE I WALK THE MICROPHONE TO HIM, I WANT TO SAY I THINK WE'RE AT PAGE 11 WHICH MEANS YOU ALL HAVE HOMEWORK AND WE NEED COMMENTS, FEEDBACK, SUGGESTIONS, CRITIQUES ON THE NEXT-- I THINK IT'S 15 MORE ON FIVE MORE PAGES.

>> I WAS GOING TO SAY THE SAME THING. I WANT TO RETOOL THE LONG-TERM CARE RECOMMENDATIONS AT THE END AFTER THE PRESENTATIONS TODAY. I THINK THEY CAN BE ORGANIZED A LITTLE BIT BETTER ON THE SECTIONS THAT WE HEARD FROM TODAY. SO I WILL WORK ON THAT. BUT YES, YOUR COMMENTS ON THINGS WE WENT OVER TODAY OR DIDN'T GO OVER TODAY WILL BE GREATLY APPRECIATED. WE DO HAVE ONE MORE MEETING SO HOW THE REST OF THE TIME LINE IS GOING TO WORK IS THAT I'LL GET COMMENTS ON THESE RECOMMENDATIONS ONE MORE TIME. I WILL SEND THEM OUT TO YOU ALL. BUT THEN IN A COUPLE OF WEEKS, WITH GOING TO BE SENDING THE DRAFT VERSION OF THE REPORT SO THAT'S GOING TO HAVE THE BACKGROUND INFORMATION AS WELL TO THE STEERING COMMITTEE MEETING, TO THE STEERING COMMITTEE AND THEY'RE GOING TO REVIEW IT. WE'LL DISCUSS IT AT A MEETING ONCE I GET THOSE COMMENTS, WE'LL GET THAT TO YOU ALL AND THIS WILL ALL BE BEFORE THE NEXT TASK FORCE MEETING. AAT THE LAST TASK FORCE MEETING, WE'LL GO THROUGH THIS REPORT AND FOCUS MORE SO ON THE SECOND HALF OF THESE RECOMMENDATIONS JUST BECAUSE WE HAVEN'T HAD EYES ON THEM YET. BUT YEAH, THAT'S WHAT'S LEFT GOING FORWARD AND--

>> AND THE NEXT MEETING IS THE--

>> IT'S THE 24th, JAMES? SEPTEMBER 24th. SO YEAH. THANK YOU. I LOOK FORWARD TO YOUR

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