ACCOMMODATIONS FOR THE DEAF AND HARD OF HEARING MEETING
MEETING SUMMARY

THURSDAY, NOVEMBER 9, 2017
NCIOM – 630 Davis Drive, Suite 100, Morrisville, NC 27560
9:00 A.M. – 11:00 A.M.

MEETING OBJECTIVE:
By the end of the meeting, participants will have shared knowledge of barriers that currently exist in North Carolina that impede effective communication and care for individuals who are deaf and hard of hearing, their health care providers, and interpreters. Participants will also begin to explore opportunities to improve accommodations, assessment, and care for individuals who are deaf or hard of hearing, and will agree upon next steps for the continuation of the discussion.

MEETING ATTENDANCE:
Maggie Bailey, North Carolina Institute of Medicine
Crystal Bowe, family physician, CaroMont Health
Cindy Deporter (via phone), NC DHHS, Division of Health Service Regulation
Kathy Dowd, Audiology Project
Jennifer Gill, LeadingAge of North Carolina
Greg Griggs, North Carolina Academy of Family Physicians
Beth Horner, State Health Plan
Eric Kivisto (via phone), NC Health Care Facilities Association
David Litman, NC DHHS, Division of Services for the Deaf and Hard of Hearing
Brieanne Lyda-McDonald, North Carolina Institute of Medicine
Barbara Morales Burke, Blue Cross Blue Shield
Ronda Owen, NC DHHS, Division of Medical Assistance
Alice Pollard, NC Community Health Center Association
Michelle Ries, North Carolina Institute of Medicine
Maggie Sauer, NC DHHS, Office of Rural Health
Glenn Silver, NC DHHS, Division of Services for the Deaf and Hard of Hearing
Vicki Smith, Disability Rights North Carolina
Melissa Speck, Blue Cross Blue Shield
Kathleen Thomas, UNC Chapel Hill, Sheps Center for Health Services Research
Brad Trotter, NC DHHS, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
Tovah Wax, Chair, North Carolina Council for the Deaf and Hard of Hearing
Lee Williamson, NC DHHS, Division of Services for the Deaf and Hard of Hearing
Jan Withers, NC DHHS, Division of Services for the Deaf and Hard of Hearing
Berkeley Yorkery, North Carolina Institute of Medicine
Adam Zolotor, North Carolina Institute of Medicine

WELCOME, INTRODUCTIONS, AND REVIEW OF MEETING GOALS
Jan Withers
Director, Division of Services for the Deaf and Hard of Hearing
NC Department of Health and Human Services

Adam Zolotor, MD, DrPH
President and CEO
North Carolina Institute of Medicine

Jan Withers opened the meeting, introducing the role of the Division and its vision: that all Deaf, Hard of Hearing, or Deaf-Blind North Carolinians have the ability to communicate their needs and to receive information easily and effectively in all aspects of their lives, especially their health and well-being. Their staff works to ensure that all individuals have equal access and full participation and to enhance the capacity of agencies and providers to serve the needs of the target population. Jan explained the goal of the meeting as beginning to discuss opportunities to improve effective communication and services in health care settings, particularly as it relates to access to qualified ASL interpreters, as well as assessments and care in long-term care facilities.

Adam Zolotor introduced the work of the NCIOM and the North Carolina Medical Journal.

REVIEW OF EXISTING BARRIERS AND CHALLENGES
Problem Description
Jan Withers

Jan first defined effective communication as referenced in the Americans with Disabilities Act as information that is clearly and understandably transmitted between parties, just as it would be for parties that are not Deaf, Hard of Hearing, or Deaf-Blind, and defined the scope of problem in North Carolina today. It is expected that about 1,700,000 people age 18 and over will have hearing loss by 2030; currently, in 2015 there were 1,218,633 people. Hearing loss is particularly prevalent among nursing home residents, with 80% experiencing hearing loss. Although it is a prevalent condition, many individuals lack the knowledge and resources needed to effectively communicate their needs. The lack of insurance coverage for hearing aids make them cost-prohibitive for many, only about 15% of individuals who are Hard of Hearing use hearing aids.

Health Care providers also face barriers to providing services and supports needed for effective communication. Many do not consider themselves knowledgeable about the impact of hearing loss and many do not have hearing specialists that visit their facilities. In addition, the high cost of interpreters can be a financial burden for small practices. These barriers negatively impact the health of affected individuals, and untreated hearing loss has economic costs, including diagnostic and rehabilitation costs, productivity losses, forgone tax revenue, and intangible costs like worsened quality of life. The Division is partnering with the Sheps Center at UNC Chapel Hill and Gallaudet University to conduct a survey to better understand the communication access barriers faced in health care settings. Possible solutions

include expanding access to trainings, streamlining business practices, insurance coverage for needed services, communication access funds, and hearing health as a priority for Healthy North Carolina 2030 to direct more attention to the issue.

Requirements and Challenges under the Americans with Disabilities Act (ADA)
Vicki Smith
Executive Director
Disability Rights NC

Vicki began by stating that there are other laws and policies that include requirements for individuals with disabilities, including deaf and hard of hearing, under Medicaid, Medicare, and education policies, although the Americans with Disabilities Act (ADA) has the widest scope, prohibiting discrimination in all areas of public life. Title II of the ADA applies to state and local governments, as well as entities that receive state and local dollars. Therefore, any provider who is reimbursed by Medicaid is required to provide for effective communication under the ADA. Businesses and nonprofits, which include hospitals and doctors' offices fall under Title III of the ADA. Common services and aids that are provided to comply with the ADA include sign language interpreters, video remote interpreting (VRI), real-time computer aided transcription services, assistive listening devices and systems, videophones, and text telephones. Larger institutions are typically more able to absorb the costs of these services or technologies, although there is not a one-size-fits-all method of effective communication for all Deaf, Hard of Hearing, or Deaf-Blind people, so only having one or two types of assistive services/technology will likely not meet the needs of the entire population. While there is a clause that can take the onus off the provider if there is sufficient evidence of an undue hardship, this typically would apply to small practices. And, the cost of non-compliance that results in malpractice will likely cost more than the cost of providing services.

Access to ASL Interpreters
Lee Williamson
Communication Access Manager, Division of Services for the Deaf and Hard of Hearing
NC Department of Health and Human Services

Lee began by reiterating the definition of effective communication and that in many cases, effective communication requires the services of a qualified sign language interpreter. When interpreting services are necessary, it is the provider's responsibility to provide such services. Qualified interpreters as defined by the ADA are those that interpret "effectively, accurately, and impartially, both receptively (i.e., understanding what the person with the disability is saying) and expressively (i.e., having the skill necessary to convey information back to that person) using any specialized vocabulary." In North Carolina, there is also a distinction between interpreters who are fully licensed versus those with a provisional license. A fully licensed interpreter will have a national certification, while a provisional licensed interpreter will have completed other trainings and credentials, but not be nationally certified. A primary barrier to interpretation services is the geographic distribution of qualified interpreters, as 60% of the interpreters reside in 8 of the 100 counties in the state, and 51 counties have no qualified interpreters. The cost of the services which includes the hourly rates (with a 2-hour minimum), travel reimbursement, and cancellation fees can be burdensome for small practices. Video Remote Interpreting (VRI) is one

possible solution to these barriers, as it can create cost-savings and limit time waiting for an interpreter to arrive. However, this solution creates other limitations, as it is not appropriate for patients who are visually impaired or who have other cognitive or linguistic difficulties.

CMS Requirements for Long-Term Care
Cindy Deporter, MSW
State Agency Director, Division of Health Service Regulation
NC Department of Health and Human Services

Cindy discussed CMS' expectations for nursing home facilities, including that any resident receiving Medicare and/or Medicaid receives an annual assessment and three quarterly assessments. The first part of the assessment establishes if the resident requires language interpreter services; if the resident needs or wants an interpreter the nursing home should ensure that an interpreter is available. The second section assesses for hearing, speech, and vision needs. In order to assess a resident's hearing, staff interview and observe the residents verbal interactions while using his or her normal hearing device (if applicable). This will lead to a hearing care plan, and assessment for a hearing aide, if necessary. Residents are also assessed for their ability to make themselves understood, whether in speech, writing, sign language, gestures, or a combination, and their ability to understand others through spoken, written, sign language, or Braille communication. All of these assessments lead to care plans to address underlying causes of difficulties in any of these areas. CMS stipulates how these assessments are to be completed. Additionally, CMS conducts surveys, either to recertify nursing facilities or to address complaints. These surveys are conducted by a team of 4 surveyors to determine how the facilities are meeting the needs of its residents. Residents with hearing deficits can be included in these surveys using the Communication and Sensory Problems Critical Element Pathway. Cindy provided copies of the various assessments and surveys for participants to cross-reference.

Audiology Services in Skilled Nursing Facilities
Kathy Dowd, AuD
The Audiology Project, Inc.

Kathy discussed the high incidence of hearing loss in nursing facilities (over 80%), due to disease, prescriptions, and age. OBRA requires hearing to be assessed in nursing home settings within the first two weeks of entry into the long-term care system. A variety of providers can complete these assessments, although it is important for qualified audiologists to be involved, and for other staff to be properly trained in assisting residents with hearing aids and other subsequent needs. There is a lack of knowledge, both among providers and the general public, about diseases that can affect hearing, including diabetes, cardiovascular disease, Alzheimer's disease, and infectious diseases like pneumonia; ototoxic drugs can also cause hearing loss. Untreated hearing loss can lead to poor physical, emotional, and mental health, so audiology services can be an important part of prevention.

Small Group Discussions
Participants used the remaining time to discuss barriers they see in their work and possible opportunities to address them in two groups.

Small Group Report Back

Topics of discussion that emerged:

- There are a multitude of barriers that impact access to ASL Interpreters including their geographic distribution, time constraints, and paying for services. Doctors can lose two times as much as they bill due to the cost of Interpreter services.
- Possibility of adding annual screenings to fee schedule to mitigate costs?
- Access to Interpreters is also challenging when trying to address urgent needs. VRI is a possible solution to this, but only in some cases.
- VRI is more difficult in rural communities depending on internet connection capabilities
- Are there opportunities to create programs to increase access to ASL Interpreters? This could involve bringing people who are already fluent in ASL to become health care providers.
- Certain primary care practices are well set-up to provide necessary accommodations, so there may be opportunities to study what works well and what has made it work well, compiling best practice recommendations. Although, another group member pointed out that practices often come to provide services well following legal action.
- There's an overarching culture that largely disregards hearing loss, in all environments not just health care. Education and trainings are a huge piece of removing barriers, so there needs to be more of a push for more trainings and normalizing the need for accommodations in a variety of settings. This also involves broader understanding of the differentiation of Deaf/Hard of Hearing/Deaf-Blind, and that there is not a catch-all service to provide for effective communication.
- These stigmas also affect individuals' choices—people who need hearing aids and are referred to receive them may not pursue getting them, whether due to cost or negative stigma.
- Compliance is mandated under the ADA, but there are not mechanisms in place to make sure that more people are screened/assessed/referred. Only about 13% of physicians ask about hearing loss, so there could be an opportunity to develop a better system to determine if someone needs hearing loss services.

Next Steps

Adam Zolotor and Jan Withers thanked everyone for their time and participation. Division of Services for the Deaf and Hard of Hearing staff and NCIOM staff will debrief and agree upon next steps for these discussions.