Transcript for NCIOM Task Force Meeting on 5.03.19

Health Services for Individuals who are Deaf or Hard of Hearing

Introductions:

>> GOOD MORNING, EVERYONE. I'M HAPPY TO SEE ALL OF YOU HERE. SO BEFORE WE GET STARTED, MY NAME IS DAVID ROSENTHAL. I AM THE CO-CHAIR FOR THIS TASK FORCE AND UNFORTUNATELY, I UNDERSTAND THAT MY PARTNER CO-CHAIR, MY RIGHT WING, AS IT WERE, IS NOT ABLE TO BE HERE TODAY BECAUSE HE IS FEELING ILL. SO I'M SORRY TO HEAR THAT. BEFORE WE BEGIN WITH ROB, I WOULD LIKE TO MAYBE TAKE A MOMENT TO INTRODUCE EVERYONE REALLY QUICKLY, JUST THE NAME AND AGENCY THAT YOU'RE HERE TO REPRESENT, AND WE'LL ALSO ASK PEOPLE ON THE PHONE TO DO THAT AND THEN WE WILL TURN IT OVER TO ROB. SO I THINK WE'LL START TO MY RIGHT. .

>> SHOULD WE BE SPEAKING INTO--

>> YES.

>> GOT IT. I HIT THE BUTTON. DO I HOLD IT DOWN?

>> IF IT'S RED. .

>> NOW IS IT WORKING?

>> GOOD MORNING. THIS IS ADAM ZOLOTOR WITH THE NORTH CAROLINA INSTITUTE OF MEDICINE.

>> GOOD MORNING. MY NAME IS BETH HATHAWAY, AND I'M PRESIDENT OF THE NORTH CAROLINA OCCUPATIONAL THERAPY ASSOCIATION.

>> HI. MI NAME IS MILLY KAUFMAN AND I'M HERE-- GO AHEAD. I'M HERE WITH THE NORTH CAROLINA NURSE'S ASSOCIATION.

>> HI. I'M SHELLEY CRISTOBAL AND I'M AN AUDIOLOGIST WITH THE NORTH CAROLINA AUDIOLOGY ASSOCIATION AND HAVE A PRIVATE PRACTICE WORKING WITH AGING ADULTS WITH HEARING LOSS.

>> GOOD MORNING. I'M KATHY SMITH. I'M WITH THE ASSOCIATION FOR HOME AND HOSPICE CARE OF NORTH CAROLINA.

>> GOOD MORNING. I'M MARTI WOLF, CLINICAL PROGRAMS DIRECTOR AT THE NORTH CAROLINA COMMUNITY HEALTH CENTER ASSOCIATION.

>> GOOD MORNING, EVERYONE. I'M EILEEN CARTER. I'M A MEMBER OF THE NORTH

CAROLINA PT ASSOCIATION.
>> GOOD MORNING. I'M BETH HORNER, AND I'M WITH THE NORTH CAROLINA STATE HEALTH PLAN.
>> GOOD MORNING, EVERYONE. MY NAME IS ASHLEY BENTON. I AM THE DEAF/DEAF-BLIND SERVICE COORDINATOR WITH THE DIVISION OF SERVICES FOR THE DEAF AND HARD OF HEARING AND I'M REPRESENTING THE DEAF-BLIND COMMUNITY.
>> GOOD MORNING. MY NAME IS JAMES COLEMAN AND I'M WITH THE NORTH CAROLINA INSTITUTE OF MEDICINE.
>> MY NAME IS SAM CLARK. I'M WITH THE NORTH CAROLINA HEALTHCARE FACILITIES ASSOCIATION REPRESENTING NURSING FACILITIES IN THE STATE.
>> GOOD MORNING. I'M STEVE BARBER FROM HEARING LOSS ASSOCIATION OF NORTH CAROLINA. ACTUALLY HEARING LOSS ASSOCIATION OF AMERICA NORTH CAROLINA.
>> HI THERE. I'M KAREN GRAY WITH THE NORTH CAROLINA PSYCHOLOGICAL ASSOCIATION.
>> I'M KATHLEEN THOMAS. I STUDY MENTAL HEALTH SERVICES AT UNC CHAPEL HILL.
>> HELLO. IM ANDREW. I'M HERE WITH BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA.
>> GOOD MORNING. I'M JEFF MOBLY WITH THE DIVISION OF SERVICES FOR THE DEAF AND HARD OF HEARING.
>> GOOD MORNING. I'M RON TODAY OWEN. I WORK WITH THE DIVISION OF-- DIVISION OF HEALTH BENEFITS. YOU CAN TELL I'VE BEEN THERE A LONG TIME. WE ARE THE NEW DIVISION OF HEALTH BENEFITS AND I'M THE PROGRAM MANAGER FOR THE HEARING AID PROGRAM AND AUDITORY IMPLANT PARTS PROGRAM.
>> GOOD MORNING. I'M KELLY OWENS, EXECUTIVE DIRECTOR OF COMMUNICATION SERVICES FOR THE DEAF AND HARD OF HEARING IN GREENSBORO, NORTH CAROLINA.
>> HEY, I'M LIZ BELK ROBERTSON. I'M A SIGN LANGUAGE INTERPRETER AND I ALSO REPRESENT CODA, WHICH IS CHILDREN OF DEAF ADULTS.
>> GOOD MORNING. I'M MELISSA SPECK AND I AM WITH THE BLUE CROSS/BLUE SHIELD NORTH CAROLINA.
>> HI. I'M GREG GRIGGS, I'M WITH THE NORTH CAROLINA ACADEMY OF FAMILY PHYSICIANS.
>> HELLO. I'M LISA WAINWRIGHT AND I'M WITH TRILLIUM HEALTH RESOURCES AND

I'M REPRESENTING THE COMMUNITY-BASED MENTAL HEALTH INTELLECTUAL AND DEVELOPMENTAL DISABILITY AND SUBSTANCE USE SERVICES MANAGED CARE ORGANIZATIONS.
>> HELLO. I'M LEE WILLIAMSON.
I'M WITH THE DIVISION OF SERVICES FOR THE DEAF AND THE HARD OF HEARING.
>> CORNELL WRIGHT, OFFICE OF MINORITY HEALTH.
>> BERKELEY YORKLY, NORTH CAROLINA INSTITUTE OF MEDICINE
>> LAWRENCE SHOCKEY, AS OF NOVEMBER 1st, RETIRED OF THE SERVICES OF DEAF AND HARD OF HEARING, LICENSED INTERPRETER AND A PARENT OF A CHILD WHO IS DEAF AND WITH AUTISM.
>> GOOD MORNING. I'M DR. CANDICE FROM (INAUDIBLE) HOSPITAL AND PROGRAM DIRECTOR FOR DEAF SERVICES THERE.
>> HI, MY NAME IS TOVAH WAX. I'M GOING TO SIGN AND START WITH THE INTRODUCTION AND VOICE FOR THE REST OF MY INTRODUCTION. SO I AM REPRESENTING THE COUNCIL FOR DEAF AND HARD OF HEARING AND I AM ALSO CONTRACTED WITH THE DIVISION OF SERVICES FOR THE DEAF AND HARD OF HEARING . SO THAT'S ME.
>> HI, GOOD MORNING. I'M JAN WITHERS, DIRECTOR OF THE DIVISION OF SERVICES FOR DEAF AND HARD OF HEARING
>> DAVID HENDERSON WITH THE NORTH CAROLINA MEDICAL BOARD.
>> HI, GOOD MORNING, EVERYBODY. I'M DONNA NICHOLSON. I'M WITH CARY MEDICAL MUTUAL COMPANY AND WE INSURE PHYSICIANS AND PHYSICIAN PRACTICES AND I'M THRILLED TO BE HERE.
>> JUST TO MAKE SURE EVERYBODY KNOWS WHAT WE'RE PASSING AROUND AND WHAT DEVRYS WE MIGHT BE USING TODAY THIS IS A MICROPHONE FOR PERSONAL AMPLIFICATION DEVICE FOR PEOPLE WHO NEED THAT TECHNOLOGY. WE ALSO HAVE THESE STICK MICROPHONES FOR CONFERENCE SERVICE AND SOMETIMES PEOPLE ON THE PHONE MAY HAVE A HARD TIME HEARING WE MAY PASS THIS AROUND. ROB HAS A MICROPHONE AT THE PODIUM FOR THE PERSON SPEAKING. WE WILL BE PASSING AROUND DEVICES TO MAKE SURE EVERYBODY CAN HEAR WHAT THEY NEED TO HEAR. DO WE HAVE FOLKS ON THE PHONE? WHY DON'T WE GO THROUGH THOSE INTRODUCTIONS?
>> YES, HELLO, GOOD MORNING. THIS IS FAMILY WITH DIVISION OF REHABILITATION.
>> GOOD MORNING.

>> HI. CAN YOU HEAR ME?
>> YES.
>> YES.
>> I'M ANNA FROM CHARLOTTE, NORTH CAROLINA. I'M A LICENSED INTERPRETER HERE IN THE STATE OF NORTH CAROLINA AND REPRESENTING INTERPRETING AND ALSO INTERPRETER EDUCATORS. THANKS.
>> GOOD MORNING. GO AHEAD.
>> GOOD MORNING. THIS IS HOLLY RIDDLE. I REPRESENT SAM HENDRICK TODAY FROM TRANSITIONS TO COMMUNITY LIVING AND OFFICE OF THE SECRETARY OF DEPARTMENT OF HEALTH AND HUMAN SERVICES.
>> HI. THIS IS CORYE DUNN WITH DISABILITY RIGHTS, NORTH CAROLINA.
>> THIS IS JENNIFER GILL WITH LEADING AGE NORTH CAROLINA.
>> HI. THIS IS CRYSTAL BOWE, FAMILY PHYSICIAN IN GASTON COUNTY, NORTH CAROLINA.
>> GOOD MORNING. THIS IS HANK BOWERS, ASSISTANT DIRECTOR, DIRECTOR OF AGING AND ADULT SERVICES.
>> DO WE HAVE ANYBODY ELSE ON THE PHONE? GREAT. WELL THANK YOU FOR JOINING US BY PERSON AND BY PHONE.
>> I'M ROB. I'M WITH THE NORTH CAROLINA INSTITUTE OF MEDICINE AND I'M THE PROJECT DIRECTOR FOR THIS TASK FORCE. I FIRST, JUST WANTED TO ASK CORYE ON THE PHONE, ARE YOU PLANNING TO COME IN, OR ARE YOU PRESENTING REMOTELY?
>> YEAH. I HAD ANOTHER MEETING THAT RAN UNTIL 10:00. I'M ON MY WAY IN. [LAUGHTER]

Recap TF Meeting 2/Timeline for remaining meetings/Terms List:

>> THANK YOU. SO THE FIRST THING I WANT TO GO OVER IS WHAT YOU HAVE IN YOUR PACKETS TODAY. YOU HAVE THE AGENDA FOR THE DAY. YOU HAVE THE TERMS HANDOUT THAT WE'RE GOING TO GO OVER. THIS IS THE HANDOUT WE WERE UK TAKING ABOUT THAT HAS THE LEGAL DEFINITIONS THAT WE WANT TO STAY CONSISTENT WITH . SOME DEFINITIONS ABOUT THE ACCOMMODATION SERVICES THAT ARE AVAILABLE AS WELL. JAMES WAS KIND MUFF TO CREATE A LICENSURE BREAKDOWN FOR EVERYONE. THIS HAS EVERY LICENSED MEDICAL PROFESSION NORTH CAROLINA. THEIR LICENSING FEE, HOW MANY PROFESSIONS ARE-- HOW MANY ARE LICENSED IN EACH OF THOSE PROFESSIONS AS WELL, AND THIS IS GOING TO BE USED WHEN WE'RE TALKING ABOUT THAT COMMUNICATION ACCESS FUND

THAT WE HOPE TO TALK ABOUT IN OUR DISCUSSION A LITTLE BIT LATER ON AND MAYBE GET A LITTLE BIT FURTHER AHEAD ON MAKING A RECOMMENDATION ON THAT. YOU HAVE A PRESENTATION THAT IS GOING TO BE DONE BY KATHLEEN THOMAS ON COMMUNICATION ACCESS IN HEALTHCARE. WE HAVE A CHALLENGES IN ADVOCATING FOR COMMUNICATION ACCESS THAT JAN IS GOING TO PRESENT. WE HAVE A LITIGATION AND LEGAL ADD ADIRONDACK VOTE CASEY PRESENTATION THAT CORYE DUNN WILL HOPEFULLY BE HERE AND PRESENT. YOU HAVE THE DISCUSSION QUESTIONS FOR SESSION ONE AND TWO. SESSION TWO IS ON THE BACK SIDE OF THAT. THAT'S GOING TO BE FOR THE AFTERNOON SO THE FIRST SIDE WILL BE FOR THIS MORNING'S SESSION AND THAT WILL GET US THROUGH LUNCH. YOU HAVE A PRESENTATION ON THE QUALIFICATIONS AND AVAILABILITY OF SIGN LANGUAGE INTERPRETERS IN NORTH CAROLINA PRESENTATION, AND THEN INTERPRETER AND PIPE LINE EDUCATION CHALLENGES. THIS IS NOT INCLUDED, BUT THIS IS SOMETHING THAT KELLE OWENS WILL COME AND TALK TO US A LITTLE BIT. FINALLY, YOU DON'T HAVE THIS EITHER. THIS IS NAD POSITION PAPER. I'M GOING TO BRING THIS UP ON THE SCREEN AND EVENTUALLY, WE CAN SEND IT OUT TO EVERYBODY, BUT I FIGURED IT WOULD BE BEST TO FIRST GO THROUGH AND GIVE EVERYONE AN OVERVIEW OF IT BEFORE WE SEND IT OUT AND THEN WE CAN KIND OF COME BACK WITH OUR COMMENTS ON IT IN ANOTHER MEETING IN THE FUTURE. SO BEFORE WE GET TO THE TERMS LIST, I KIND OF JUST WANTED TO EMPHASIZE THAT AFTER THIS MEETING-- YEAH. QUESTION.

>> THIS IS TOVAH. EXCUSE ME FOR INTERRUPTING, BUT AT THE POINT OF EDUCATION AND LOGISTICS, I WOULD LIKE TO SAY THAT IT'S HARD FOR SOME OF US, ME FOR EXAMPLE TO SEE THE CART SO I NEED TO MOVE SOMEWHERE I'D LIKE TO JUST SUGGEST THAT IT BE ADJUSTED DURING THE BREAK OR SOMETHING.

>> DO YOU WANT TO SWITCH WITH HER NOW?

>> THIS IS JAN. I JUST WANTED TO LET YOU KNOW A LITTLE BIT ABOUT DEAF CULTURE. WE CALL THIS DEAF MUSICAL CHAIRS.

[LAUGHTER]

>> IS ANYBODY ELSE HAVING ANY TROUBLE SEEING THE MACHINE PRESENTATIONS? OKAY. SO I JUST WANTED TO MAKE A POINT THAT AT OUR NEXT MEETING, WE ARE GOING TO SHIFT AND BEGIN IN FOCUSING ON OLDER ADULTS AND HEARING LOSS. AND NCCRC IS LONG-TERM CARE. WE WANT TO DO THIS BY, FIRST, HAVING A PANEL WITH HARD OF HEARING ADULTS AND CHILDREN, ADULT CHILDREN OF NURSING

HOME RESIDENTS. WE WANT TO ALSO EXPLORE THE LINK BETWEEN HEARING LOSS AND PHYSICAL COGNITIVE ELEMENTS OR CONDITIONS. INCLUDING AN OVERVIEW OF HLAA, AND FINALLY, WE'RE GOING TO TALK A LITTLE BIT ABOUT HEARING LOSS AND DIABETES, HEARING LOSS AND FALLS, COCHLEAR IMPLANTS AND AN OVERVIEW ON THE DEPARTMENT'S WHITE PAPER ON OLDER ADULTS WITH HEARING LOSS. SO THE-- HAD IS KIND OF GOING TO BE ONE OF OUR LAST MEETINGS ON THESE TOPICS UNTIL WE GET BACK TO RECOMMENDATIONS, BUT THEN WE'RE GOING TO SHIFT THE FOCUS ONTO OUR OTHER TOPICS THAT WE HOPE TO COVER WITH THIS TASK FORCE. SO NEXT, I'M GOING TO BRING UP THIS DEFINITION SHEET THAT YOU ALL HAVE, AND THIS IS A VERY ROUGH DRAFT OF WHAT I WANTED TO PUT TOGETHER, BUT I THINK THAT, FIRST, WE'RE GOING TO NEED SOME INPUT ON PIT TO MAKE SURE THAT ALL THE DEFINITIONS ARE CORRECT. SO AFTER A QUICK READ, IF YOU HAVE QUESTIONS, WE CAN GO THROUGH THAT TODAY, BUT I ASK YOU TO PLEASE EMAIL ME OR JAMES WITH ANY CORRECTIONS YOU'D LIKE TO SEE, ANYTHING DIFFERENT YOU WOULD WANT TO SEE ON HOW WE'RE GOING TO BE HE CAN DESCRIBING THESE TERMS AND THIS WILL BE USEFUL WHEN WRITING THE REPORT IF WE ALL ARE MAKING RECOMMENDATIONS AND THE REASONING IS DONE WITH UTILIZING THESE TERMS WITH A SET OF DEFINITIONS AND WE CAN ALSO INCLUDE THIS IN THE RECOMMENDATIONS REPORT SO PEOPLE KNOW THAT THESE ARE OUR SET DEFINITIONS. I TOOK THESE FROM THE POWERPOINTS THAT YOU ALREADY DO HAVE AS WELL EXCEPT FOR THE SECOND PAGE, BUT THIS LEFT SIDE OF BASIC TERMS, I'M NOT SURE. I CAN REFER TO JAN. I'M NOT SURE IF WE NEEDED MORE DEFINITION ON THIS OR THAT IT IS TERMS THAT YOU WANTED PEOPLE TO BE AWARE OF. I NOTICE THAT HEARING IMPAIRED IS CROSSED OUT, SO IF THAT'S SOMETHING THAT WE WANT TO MAKE SURE THAT IS NOT USED.

>> THIS IS JAN SPEAKING. IT REALLY DEPENDS ON THE INDIVIDUAL. BUT GENERALLY SPEAKING, PEOPLE TEND TO USE DEAF AND HARD OF HEARING OR DEAF-BLIND TO REFLECT THEIR COMMUNITY PREFERENCE. NOW DR. WAX HAS A WHITE PAPER THAT WILL INCLUDE DEFINITIONS AS WELL OF SOME OF THOSE GROUPS WITH A LITTLE BIT MORE EXPLANATION OF THE DIFFERENCES, SO I THINK, FOR NOW, IT CAN BE LEFT AS-IS. DO YOU AGREE, DR. WAX?

>> OKAY. SO ONCE WE DO THAT AND ONCE WE GO OVER THAT, WE CAN DEFINITELY READJUST THIS AND REVISE IT AND ADD THOSE. THIS COLUMN TO THE RIGHT IS THE LEGAL DEFINITIONS. THESE ARE FROM HOWARD'S PRESENTATIONS. I THINK THOSE

WILL BE IMPORTANT WHEN DESCRIBING AND TALKING ABOUT THE ADA, TOO. THIS IS DIRECTLY FROM HIS PRESENTATIONS AND THEY WERE ALL QUOTED SO IT'S THE EXACT LANGUAGE IN THE ADA. I THOUGHT IT WAS IMPORTANT TO ALSO INCLUDE THIS CHART, UNDERSTANDING PEOPLE FIRST LANGUAGE, AND THIS WAS IN JAN'S FIRST PRESENTATION ON HOW-- WHEN WE'RE WRITING THE REPORT SPECIFICALLY ON HOW IT'S GOING TO BE WRITTEN AND TO MAKE SURE THIS PEOPLE FIRST LANGUAGE CONCEPT IS FOLLOWED. AND THEN I TOOK THE LIST OF COMMUNICATION ACCESS ACCOMMODATIONS AND I DID A, TO BE HONEST, A GOOGLE SEARCH ON ALL OF THESE AND KIND OF TOOK THE BEST DEFINITIONS I THOUGHT I COULD FIND AND THIS IS WHERE I THINK I'M GOING TO NEED THE MOST TASK FORCE INPUT IS BECAUSE I TRIED TO USE THE MOST CREDIBLE WEBSITES AS WELL, AND I TOOK THE DEFINITIONS FROM THEM, BUT I THINK IF WE WANT THEM EXPLAINED IN DIFFERENT WAYS THEN WE CAN CERTAINLY DO THAT AND YOU CAN PROVIDE YOUR NOTES TO ME AND I'LL MAKE THOSE CHANGES. BUT THE ONE THAT I COULDN'T FIND ANYTHING ON HOW TO DESCRIBE A PERSONAL AMPLIFIER WITH A NECK LOOP. I'M NOT SURE IF I WAS OVERTHINKING IT OR NOT.

[LAUGHTER]

>> TELECOIL WOULD PROBABLY BE THE SYSTEM YOU'RE REFERRING TO THERE AND THAT CAN BE SEVERAL DIFFERENT THINGS AS WELL.

>> OH, OKAY.

>> YES THIS IS JAN SPEAKING. WE WOULD CERTAINLY BE HAPPY TO PROVIDE YOU WITH MORE DETAIL ON THOSE AT A LATER TIME. WE HAVE STAFF WHO ARE EXPERTS THAT WOULD BE ABLE TO EXPOUND ON ANY OF THOSE. I WOULD LIKE TO POINT OUT ONE THING RELATED TO DEAF INTERPRETERS. THE DEAF INTERPRETERS ARE ACTUALLY DEAF PEOPLE WHO ARE FUNCTIONING AS AN INTERPRETER. SO KEEP THAT IN MIND.

>> OKAY. SO TOO MUCH ON THIS RIGHT NOW BUT IF YOU HAVE COMMENTS THROUGHOUT THE DAY AND YOU WANT TO JOT THE FORM DOWN OR SEND ME AN EMAIL AT ANY TIME. I THINK THIS CAN BE A WORKING DOCUMENT AND WE CAN ADJUST IT AS WE GO THROUGH THE MEETINGS ACCORDINGLY. SO THAT IS ALL I HAVE AS AN INTRODUCTION.

Communication Access in Healthcare Study:

I THINK WE'RE GOING TO MOVE NEXT TO OUR FIRST PRESENTATION FROM KATHLEEN AND SHE IS GOING TO BE PRESENTING ON, AGAIN, THE COMMUNICATION ACCESS

AND HEALTHCARE STUDY. I RECEIVED A DIFFERENT PRESENTATION THIS MORNING. SO YOU'LL SEE A LITTLE BIT DIFFERENCES IN THE PRESENTATIONS YOU HAVE. THAT'S THE REASON, BUT THE CONTENT IS THE SAME.
>> WE CAN PUT THE UPDATED PRESENTATION ONLINE AND IF THERE'S ANYBODY THAT NEEDS A PRINTED COPY OF IT, LET US KNOW.
>> AM I ONLY TALKING INTO THIS MICROPHONE?
>> YES.
>> DO YOU THINK WE SHOULD HAVE HER USE THE REGULAR MICROPHONE WITH THE LAVALIER? PEOPLE IN THE BACK, DO YOU THINK REGULAR MICROPHONE WOULD BE HELPFUL? I CAN YELL. I DON'T KNOW IF KATHLEEN YELLS LOOK I YELL. JUST THIS? OKAY. THANK YOU. HAND ME THE LIPSTICK MIC FOR THOSE WHO CAN'T HEAR WELL. LEAVE IT HERE.
>> ARE WE SET? OKAY. SO I'M GOING TO TALK ABOUT SOME WORK THAT WE DID AS PART OF THE DIVISION OF SERVICES FOR DEAF AND HARD OF HEARING TO ASSESS COMMUNITY-- COMMUNICATION ACCESS AMONGST PEOPLE WHO ARE DEAF OR HARD OF HEARING IN NORTH CAROLINA . I'D LIKE TO ACKNOWLEDGE THE TEAM. OUR GROUP FROM THE DIVISION OF-- FROM THE DIVISION, INCLUDES JAN WITHERS, DIRECTOR, LEE WILLIAMSON, COMMUNICATION ACCESS MANAGER, AND GLENN SILVER, PROGRAM BUDGET ANALYST, AS WELL AS MARK MYERS FROM GALLAUDET UNIVERSITY, AND THIS WORK WAS FUNDED THROUGH THE DIVISION. SO WE KNOW THAT THERE ARE CHALLENGES FACED DAILY BY DEAF ASL SPEAKERS AND THAT THEY ARE PARLY UNDERSTOOD BY HEALTHCARE PROVIDERS AND POLICYMAKERS, SO OUR OBJECTIVE WAS TO DESCRIBE THESE BARRIERS, TO QUALITY COMMUNICATION BETWEEN DEAF ASL SPEAKERS AND THEIR PROVIDERS AS WELL AS TRY AND UNDERSTAND WHAT SOME STRATEGIES MAY BE TO ADDRESS THEM. WE CONDUCTED TWO SEPARATE SIDES TO OUR STUDY. WE COLLECTED QUALITATIVE DATA THROUGH INTERVIEWS AND QUANTITATIVE DATA THROUGH AN ONLINE WEB-BASED SURVEY. I'LL TALK ABOUT EACH OF THOSE IN TURN. SO FIRST, WE HELD COMMUNITY FORUMS WITH INDIVIDUAL INTERVIEWS.
THESE WERE DONE BY MARK MYERS, WHOSE PICTURE IS UP THERE. MARK CONDUCTED INTERVIEWS IN LEXINGTON, RALEIGH, WILSON, AND MORGANTON FROM LAST SUMMER, JUNE 2018 THROUGH FEBRUARY OF THIS YEAR. THE INTERVIEWS WERE VIDEO RECORDED FOR CODING AND TRANSLATED INTO ENGLISH FOR PRESENTATION, AND INCLUDED 54 PARTICIPANTS. THE DISCUSSION PROMPT THAT

MARK USED OR PROMPTS WERE THESE. HE ASKED, WHAT ARE YOUR EXPERIENCE IN COMMUNICATION WITH YOUR DOCTORS? WOULD YOU DESCRIBE A TYPICAL EXPERIENCE? WERE YOU SATISFIED? AND I'LL REPORT ON WHAT PEOPLE SAID IN RESPONSE TO THAT. MARK USED OPEN CODING TO IDENTIFY SALIENT THEMES IN THESE DATA . THIS IS JUST A BRIEF OVERVIEW OF SAMPLE CHARACTERISTICS. YOU CAN SEE, WE HAVE PRETTY GOOD VARIATION AND IT LOOKS QUITE SIMILAR TO CHARACTERISTICS IN OUR STATE. THESE ARE THE MOST IMPORTANT THEMES THAT CAME OUT OF THOSE INTERVIEWS. EVERYONE ALMOST TALKED ABOUT VIDEO REMOTE INTERPRETING, ALMOST EVERYONE TALKED ABOUT LIVE INTERPRETERS, HALF OF THE PEOPLE DISCUSSED WRITING BACK AND FORTH, A QUARTER OF THE PEOPLE BROUGHT UP SCHEDULING AND NEEDING TO RESCHEDULE APPOINTMENTS AND THEN ADDITIONAL THEMES WERE LIP READING, INTERPRETERS NOT SHOWING UP, ISSUES WITH HOSPITAL CONTRACTS, AND COMMUNICATION ACCESS IN LOBBIES AND OPEN SPACES. SO I'M JUST GOING TO GO THROUGH AND SHARE WITH YOU SOME ILLUSTRATIVE QUOTES FROM ALL OF THESE INTERVIEWS. THERE WAS A LOT OF CONSISTENCY IN WHAT PEOPLE WERE SAYING. SO FIRST OF ALL, MANY PEOPLE SAID, SOMETIMES VRI CAUSES TECHNICAL PROBLEMS. SUCH AS BREAKDOWNS OR FROZEN SCREEN, WHICH IS FRUSTRATING. PEOPLE SAID THAT OVER AND OVER AND OVER AGAIN. FOR EXAMPLE, THEY SAID VRI INTERPRETERS ARE DIFFICULT TO FOLLOW OR UNDERSTAND. THE DOCTOR AND THE NURSE TALK TO EACH OTHER WHILE THE VRI SCREEN WAS TURN ADD WAY FROM ME. AND MANY PEOPLE SAID SOMETHING TO THE FACT THAT VRI IS A WASTE OF TIME. IN CONTRAST PEOPLE TALKED A LOT ABOUT THE VALUE OF LIVE INTERPRETERS. ONE PERSON SAID I STILL PREFER PROFESSIONAL SIGN LANGUAGE INTERPRETERS WHO ARE CERTIFIED TO INTERPRET ASL. THEY SAID, FOR EXAMPLE, A LIVE INTERPRETER CONVEYS MORE FEELING AND UNDERSTANDING OF WHAT WE COMMUNICATED. A LIVE INTERPRETER SHOWS MORE ACTION WITH FACIAL AND BODY EXPRESSION. A LIVE INTERPRETER IS EFFECTIVE AND EFFICIENT IN GETTING THROUGH THESE HEALTHCARE VISITS. IN CONTRAST TO PEOPLE'S VALUE OF LIVE INTERPRETERS, THEY TALKED ABOUT THE NECESSITY OF WRITING NOTES. ONE PERSON SAID, WRITING BACK AND FORTH SOMETIMES CAUSED A MENTAL BLOCK. IT'S HARD FOR ME TO EXPRESS MY FEELINGS OR THOUGHTS WHEN WRITING BACK AND FORTH. IT'S MUCH EASIER TO EXPRESS MY FEELINGS AND THOUGHTS IN MY OWN ASL THROUGH LIVE INTERPRETERS. ANOTHER PERSON EXPLAINED, I NEED LIVE INTERPRETERS. NOT WRITING BACK AND FORTH BECAUSE I DON'T UNDERSTAND

ENGLISH. THEY GAVE ME NOTES . PEOPLE TALKED A LOT ABOUT SCHEDULING AND RESCHEDULING. ONE PERSON SAID, I SAID, NO. WE WANT A LIVE, IN-PERSON INTERPRETER. THEY RESPECTED ME BUT I HAD TO WAIT ONE OR TWO HOURS. THEY DID NOT CALL FOR INTERPRETERS UNTIL I ARRIVED. ANOTHER PERSON SAID, I HAD TO STAND UP AND ASK STAFF AT THE FRONT DESK TO RESCHEDULE MY APPOINTMENT BECAUSE THAT INTERPRETER WAS NOT CERTIFIED. PEOPLE TALKED A LOT ABOUT HAVING INTERPRETERS THERE WHO WERE NOT CERTIFIED AND WERE NOT UNDERSTANDABLE. OKAY. THEN THE INTERVIEWS DID A REALLY GREAT JOB OF CAPTURING FOR US NUANCES OF PEOPLE'S EXPERIENCES, BUT WE ALSO WANTED TO GET A BROADER VIEW OF WHAT'S GOING ON ACROSS THE STATE WITH SOME STRONG NUMBERS BEHIND IT SO THAT YOU CAN USE TO MOTIVATE THE CHANGE YOU'RE WORKING ON. SO TO DO THAT, WE DID A WEB-BASED SURVEY. THIS WAS A CONVENIENCE SAMPLE OF PEOPLE WHO REPORTED THEY PREFER ASL AS THEIR PRIMARY FORM OF COMMUNICATION AND WHO ARE ON THE MAILING LISTS OF THE SEVEN REGIONAL CENTERS OF THE DIVISION. WE COLLECTED DATA AND YOU CAN SEE LEE HERE, THROUGH A WEB-BASED SURVEY WITHIN A VERY INNOVATIVE WAY WITH EMBEDDED ASL VIDEO CLIPS AND WE DID THIS FROM MARCH-- MAY 2018 THROUGH MARCH 2019 AND WE GOT 189 RESPONSES. AND IF I CAN MANAGE TO DO THIS, I'M GOING TO SHOW YOU AN EXAMPLE. OKAY SO THIS IS JUST ONE QUESTION IN THE SURVEY. SO YOU CAN SEE THAT FOR EACH QUESTION, WE WROTE IT OUT IN ENGLISH. WE HAD THE RESPONSE CATEGORIES IN ENGLISH, BUT THERE IS ALSO THIS EMBEDDED CLIP THAT I'M GOING TO TRY TO PLAY FOR YOU. WE DID TEST IT OUT.
[LAUGHTER]
AH!
>> GO TO THE LOWER LEFT, TRY PRESSING. SO THE QUESTION IS, WHAT PRIMARY MODE OF COMMUNICATION DO YOU USE AND THE OPTIONS ARE LISTED, GESTURING, SPEECH READING, ET CETERA.
>> PRESS THE ESCAPE KEY, TOP, LEFT.
>> OKAY. IT'S VERY RARE THAT SURVEYS HAVE BEEN CREATED THIS WAY AND WE'RE REALLY PROUD OF THIS ACCOMPLISHMENT. SO ONCE WE GOT THE DATA, WE USED LOGET MODELS TO EXPLORE RELATIONSHIPS BETWEEN COMMUNICATION, SATISFACTION WITH COMMUNICATION AND UNMET NEED FOR CARE. OKAY. SO THIS JUST SHOWS SOME OF THE BASIC DEMOGRAPHICS OF PEOPLE WHO TOOK THE SURVEY. WE HAVE NICE VARIATION ACROSS AGE, GENDER, RACE, EDUCATION,

INSURANCE STATUS. YOU CAN SEE, THOUGH, THAT THE PEOPLE THAT WE REACHED AND WHO WERE WILLING TO TAKE THIS SURVEY WERE MORE LIKELY TO BE MORE HIGHLY EDUCATED, WHITE WOMEN THAN IS TYPICAL IN OUR NORTH CAROLINA POPULATION. SO KEEP THAT IN MIND AS WE INTERPRET OUR FINDINGS. THIS SHOWS OUR SAMPLE CHARACTERISTICS IN TERMS OF HEARING STATUS. 81% OF THE SAMPLE WERE DEAF. ALMOST 5% WERE DEAF-BLIND. 83% OF PEOPLE SAID THAT THEIR PRIMARY FORM OF COMMUNICATION WAS SIGN LANGUAGE OR CUED SPEECH. WHEN WE ASKED THEM THE QUESTION YOU JUST SAW ABOUT THEIR COMMUNICATION WITH DOCTOR OR PROVIDER COMMUNICATION, ABOUT HALF THE PEOPLE SAID THEY WERE SATISFIED AND THEY FOUND IT EASY TO COMMUNICATE. HALF OF THE SAMPLE, EVEN AMONGST HIGHLY EDUCATED PEOPLE SAID THEY WERE LESS THAN COMPLETELY SATISFIED. SO NEARLY 11% SAID THEY WERE NOT AT ALL SATISFIED, THAT IT WAS DIFFICULT TO COMMUNICATE AND 37% SAID THEY WERE JUST SOMEWHAT SATISFIED. SO THAT'S WHAT WE NEED TO FOCUS IN ON. WE ASKED PEOPLE, HOW THEY PREFERRED TO COMMUNICATE WITH THEIR CLINICIANS AND THEY ACTUALLY COMMUNICATED WITH THEIR CLINICIANS. ABOUT 60% OF THE SAMPLE SAID THAT THEY PREFERRED A PROFESSIONAL SIGN LANGUAGE INTERPRETER, BUT YOU CAN SEE ABOUT 60% OF THE SAMPLE DIDN'T GET IT. SO THEN WE LOOKED AT MODELS TO LOOK AT THE ASSOCIATION BETWEEN THE CHARACTERISTICS AND EXPERIENCES AND PREFERENCES IN OUR SAMPLE AND DISSATISFACTION WITH COMMUNICATION. PEOPLE WHO LIVE ALONE AND WHO PREFERRED TO COMMUNICATE VIA SIGN LANGUAGE DIRECTLY OR VIA INTERPRETER WERE MUCH MORE LIKELY TO EXPRESS DISSATISFACTION WITH COMMUNICATION. HOWEVER, WHEN PEOPLE SAID DID GET TO USE A SIGN LANGUAGE INTERPRETER WITH THEIR PROVIDER, THEY WERE LESS LIKELY TO BE DISSATISFIED. THAT WAS A GOOD THING. THEN WE LOOKED AT UNMET NEED FOR CARE AND WE SEE THAT THOSE WHO ARE MORE HIGHLY EDUCATED AND MEN WERE LESS LIKELY TO SAY THEY HAD UNMET NEED FOR CARE, BUT PEOPLE WHO DIDN'T USE A PERSONAL DOCTOR FOR THEIR USUAL SOURCE OF CARE AND PEOPLE WHO LIVED ALONE WERE MORE LIKELY TO SAY THEY HAD UNMET NEED FOR CARE. THIS NOTION OF HAVING A USUAL SOURCE OF CARE THAT'S A PERSONAL DOCTOR KIND OF IS A THEME THAT COMES UP THROUGHOUT OUR DATA THAT I THINK WE NEED TO FOCUS IN ON . TO SUMMARIZE, ASL USERS PREFER TO USE A PROFESSIONAL SIGN LANGUAGE INTERPRETER TO COMMUNICATE WITH CLINICIANS. MOST ACTUALLY USE SOME OTHER FORM TO COMMUNICATE. HALF OF THE

RESPONDENTS WERE NOT COMPLETELY SATISFIED WITH COMMUNICATION AND PARTICULARLY PEOPLE EXPRESSED DISSATISFACTION WITH VIDEO REMOTE INTERPRETING. PEOPLE WHO PREFER TO USE SIGN LANGUAGE AND WHO LIVE ALONE ARE MORE LIKELY TO REPORT DISSATISFACTION WITH COMMUNICATION. THOSE WHO ACTUALLY GET TO USE SIGN LANGUAGE WITH THEIR CLINICIAN ARE LESS LIKELY TO REPORT DISSATISFACTION. IT MAY BE THAT HAVING A FAMILY-- FAMILY MEMBERS COME IN, THEY CAN SUPPORT COMMUNICATION. WE NEED TO EXPLORE THAT MORE, CLEARLY, THAT'S NOT PEOPLE'S IDEAL. PEOPLE WHO GO TO A PERSONAL DOCTOR ARE ALSO LESS LIKELY TO REPORT UNMET NEED FOR CARE. IT MAY BE THAT PEOPLE WHO HAVE THE CHANCE TO ESTABLISH AN ONGOING RELATIONSHIP WITH THEIR DOCTOR MAY HAVE IDENTIFIED TOGETHER WITH THEM, A FORM OF COMMUNICATION THAT WORKS, AND SO ONE THING AS A STATE SYSTEM WE CAN THINK ABOUT IS HOW TO CONNECT PEOPLE WITH A HOME WHERE THEIR COMMUNICATION IS BETTER SET UP. AS I MENTIONED EARLIER, THERE ARE SOME LIMITATIONS THAT WE SHOULD BE AWARE OF IN THESE DATA AND IT HELPS US THINK ABOUT WHAT WE NEED TO DO NEXT. OUR STUDY SAMPLES WERE SMALL. HIGHLY EDUCATED AND THEY WERE ALL CONNECTED TO THE NORTH CAROLINA DIVISION OF SERVICES FOR THE DEAF AND HARD OF HEARING. WE DID SEE VARIATION. A LOT OF VARIATION IN SATISFACTION, BUT LOTS OF OTHER THINGS BUT IT'S IMPORTANT TO REMEMBER THAT COMMUNICATION ACCESS IS LIKELY WORSE FOR THE PEOPLE WHO WE DEPART REACH. NORTH CAROLINA COULD BENEFIT FROM A LARGER, MORE STRUCTURED SURVEY THAT'S NOT A CONVENIENCE SAMPLE. ONE THING THAT I'D LIKE TO RAISE IS THAT THERE ARE CURRENT EFFORTS UNDERWAY AT THE UNIVERSITY OF KANSAS AND UNC CHAPEL HILL TO ESTABLISH A LONGITUDINAL NATIONAL SURVEY ON HEALTH REFORM AND DISABILITY, AND THIS MAY BE A WAY-- AN AVENUE THAT WOULD BE AN EFFICIENT STRATEGY TO GENERATE HIGH QUALITY DATA IN THIS AREA. IF WE GOT MORE NORTH CAROLINIANS INVOLVED IN THAT SURVEY, IT WOULD GIVE US THE OPPORTUNITY TO COMPARE HOW WE'RE DOING IN NORTH CAROLINA TO OTHER STATES, WHICH WOULD BE VALUABLE. SO IMPLICATIONS THAT WE DRAW FOR NORTH CAROLINA. NORTH CAROLINA NEEDS TO PUT IN PLACE STRATEGIES TO ASSURE COMMUNICATION ACCESS. YOU ALL KNOW THAT. THAT'S WHY YOU'RE HERE. AT THIS POINT, VIDEO REMOTE INTERPRETING IS NOT WORKING WELL FOR PEOPLE. AND SOMETHING THAT WE SHOULD THINK ABOUT MORE ESTABLISHING A RELATIONSHIP WITH THE PERSONAL DOCTOR MAY HELP IN MAKING

COMMUNICATION PREFERENCES KNOWN AND RESPECTED. THANK YOU.
[APPLAUSE]
DO YOU WANT ME TO TAKE QUESTIONS NOW?
>> SURE, YEAH.
>> OKAY. TOVAH.
>> THIS IS TOVAH TALKING. THANK YOU VERY MUCH FOR THAT PRESENTATION. AND I'M HAPPY TO SEE THAT WE HAVE SOME HARD DATA NOW TO WORK WITH, BUT I DID WANT TO COMMENT ABOUT THE SURVEY IDEA, THE NATIONAL SURVEY IDEA. ONE OF THE THINGS I'VE BEEN WORKING ON TRYING TO FIND DEMOGRAPHICS ABOUT HEALTHCARE ACCESS AND EXPENDITURES FOR DEAF AND HARD OF HEARING PEOPLE. NOW THERE ARE SEVERAL CENSUS DATA, LIKE THE NHIS AND THE MPS--
>> MEDICAID EXPENDITURE SURVEY.
>> YEAH. THEY HAVE DATA IN THERE BUT IT'S VERY HARD TO GET IT BECAUSE THAT IS DATA THAT SHOULD BE LINKED WITH THE NHIS. I DON'T KNOW IF THAT WOULD BE ANOTHER AVENUE TO EXPLORE ON A NATIONAL BASIS TO TRY TO GET THAT DATA SO WE HAVE MORE INFORMATION ABOUT HEALTHCARE ACCESS AND EXPENDITURES OF PEOPLE WITH HEARING-- WHO HAVE HEARING LOSS.
>> THE MPSES IS DESIGNED USING THE NATIONAL HEALTH SURVEY AS A FRAME. SO IT IS POSSIBLE TO LINK THE TWO DATA SETS. THE STATE-LEVEL DATA ARE PROTECTED AND THE SURVEYS ARE NOT SET UP TO PROVIDE STATE-LEVEL STATISTICS, BUT IT IS-- SOME STATES HAVE MORE-- LARGER SAMPLES AND IT IS POSSIBLE TO GET STATE ESTIMATES. IT'S DEFINITELY AN EFFICIENT THING THAT WE COULD ALSO EXPLORE.
>> I'M CURIOUS IF THERE WAS ANY REGIONAL BREAKDOWN OF THE NUMBERS. I KNOW IT WAS A SMALLER STUDY, BUT HEALTHCARE ACCESS IN NORTH CAROLINA IS SO DIFFERENT IN RURAL AREAS COMPARED TO IN THE TRIANGLE AND THE TRIAD. WAS THERE ANY-- WAS THERE THE ABILITY TO LOOK AT THAT SEPARATELY?
>> YEAH. WE DID ASK PEOPLE TO GIVE US THEIR ZIP CODE AND SO FAR, WHAT WE'VE DONE IS BREAK IT DOWN BY RURAL, NOT RURAL. THERE'S NOT TOO MANY PEOPLE WHO SAID THEY WERE LIVING IN RURAL AREAS, SO THERE'S NOT A LOT WE CAN SAY BUT WE CAN--
>> GOTCHA. WE WANT TO.
>> I KNOW. THANK YOU.
>> FOR FOLKS ON THE PHONE, WE JUST MUTED Y'ALL'S PHONES BECAUSE WE'RE

LISTENING TO SOME CROSS-TALK. WE'LL UNMUTE IN A FEW MINUTES BECAUSE WE DON'T WANT TO EXCLUDE YOU FROM THE CONVERSATION.
>> THIS IS DAVID. IS THERE ANYONE ON THE PHONE THAT WANTED TO ASK A QUESTION?
>> WE'RE GOING TO UNMUTE THE PHONE. GLFER THIS IS CRYSTAL BOWE.
>> HI, CRYSTAL.
>> DO WE HAVE ANY DATA-- HEY. DO WE HAVE ANY DATA ON THE NUMBER OF VISITS THAT ARE BEING USED THROUGH SIGN LANGUAGE INTERPRETERS, EITHER VRI OR IN-PERSON, LIVE INTERPRETERS ACROSS THE STATE? IS THERE ANY WAY TO GET THAT KIND OF DATA?
>> WE DO NOT HAVE THAT LEVEL OF DETAIL. WE DO HAVE MORE DETAIL THAN I PRESENTED ABOUT THE MODE OF COMMUNICATION. SO WE DID ASK PEOPLE ABOUT VRI VERSUS OTHER THINGS, BUT WE DON'T HAVE VISIT COUNTS. THE MEDICAL EXPENDITURE PANEL SURVEY THAT TOVAH JUST MENTIONED DOES A GREAT JOB OF CAPTURING COUNTS OF VISITS, BUT IT DOESN'T HAVE THE INFORMATION ON MODE OF COMMUNICATION.
>> DAVID IS RECOGNIZING ASHLEY.
>> THIS IS ASHLEY BENTON. I APPRECIATE SEEING THAT DATA, BUT I WOULD ALSO LIKE TO SAY SOME IMPORTANT THINGS. THIS SURVEY MAY NOT CAPTURE THE ENTIRE DEAF COMMUNITY, THE RURAL AREAS MAY NOT BE CAPTURED BECAUSE THE SURVEY WAS DISTRIBUTED TO MOST OF OUR CONSUMERS, DSDHH CONSUMERS, AND SOME OF THOSE PEOPLE IN DEAF COMMUNITIES ARE OPPRESSED AND THEY STRUGGLE AND SO THEY JUST KIND OF GIVE UP. I THINK YOU'RE MISSING SOME OF THAT DATA, AND THERE IS ONE PERSON AT THE LAST MEETING WHO GOT IT ON THE SPOT, WHO SAID THAT INTERPRETER AVAILABILITY IS-- DOES NOT PROVIDE READY COMMUNICATION. SO REMEMBER THE BARBER JOKE WHERE PEOPLE WERE REQUESTING THAT BARBER OVER AND OVER BECAUSE THAT PERSON WAS AVAILABLE. SO THERE'S A LOT OF DATA MISSING BECAUSE THERE ARE PEOPLE WHO ARE NOT REQUESTING INTERPRETERS BECAUSE OF THE STRUGGLE THAT THEY FACE AND SO THEY JUST ACCEPT WRITING NOTES AS ONE FORM OF COMMUNICATION BECAUSE THEY KNOW THAT'S AVAILABLE TO THEM. REMEMBER THAT, PLEASE. EVEN THOUGH WE'RE COLLECTING AS MUCH DATA AS WE CAN, WE HAVE A LOT OF INFORMATION THAT'S MISSING AND THERE ARE SOME GAPS.
>> WE AGREE THAT UNDOUBTEDLY THERE ARE PEOPLE WHO ARE NOT CONNECTED

TO THE SYSTEM WHO ARE LEFT OUT OF THIS SURVEY. WE ARE-- WE HAVE MIXED FEELINGS ABOUT THE FACT THAT EVEN AMONGST THE PEOPLE WE DID REACH WE SEE PEOPLE WHO ARE SATISFIED AND PEOPLE WHO ARE NOT SATISFIED WITH LOTS OF INFORMATION JUST AS YOU SAY ABOUT PEOPLE WHO ARE FORCED TO USE WRITING BACK AND FORTH AND NOTES TO COMMUNICATE AND WE HAVE THE OUTCOMES OF THAT THAT THEY EXPRESSED SO WE HAVE HOPE THAT THIS CAN BE A GOOD START TO TRY AND HIGHLIGHT WITH STRONGER NUMBERS THAT THIS IS AN ISSUE IN OUR STATE AND AS THAT GAINS MOMENTUM, I HOPE WE CAN DO AN EVEN BETTER JOB OF REACHING A GREATER SAMPLE OF PEOPLE.

>> I HAVE ONE ADDITIONAL QUESTION.

>> DAVID IS RECOGNIZING STEVE.

>> HAS THERE BEEN ANY ATTEMPT TO SURVEY PHYSICIANS IN NORTH CAROLINA ABOUT THEIR--

>> EXCUSE ME. I DON'T MEAN TO INTERRUPT. PAMELA HAS A QUESTION. THIS IS PAMELA. I HAVE A QUESTION WHEN YOU GET A CHANCE.

>> LET ME RESPOND, FIRST, TO THE QUESTION ABOUT PHYSICIAN INTERVIEWS. WE'VE TALKED A LOT ABOUT THAT AND WE AGREE THAT'S REALLY IMPORTANT, TOO, AND I THINK THAT JAN PROBABLY WILL BE EXPOUNDING ON THAT FURTHER BECAUSE THE WHOLE NOTION OF HOW TO PAY FOR INTERPRETERS, WHOSE RESPONSIBILITY IT IS, HOW REIMBURSEMENT IS HANDLED IS REALLY CRITICAL HERE.

>> THIS IS CRYSTAL ONE MORE TIME. I WILL SAY I DO THINK THOSE THINGS ARE IMPORTANT. MANY OF THE PHYSICIANS I SPEAK WITH, PARTICULARLY IN RURAL AREAS, ARE ALSO FRUSTRATED WITH ACCESS TO INTERPRETERS AND ARE CONCERNED ABOUT THE WAY THEY CAN COMMUNICATE WITH PATIENTS AND I THINK SOME OF THE INFORMATION, PARTICULARLY FOR THE RURAL AREAS, WILL SHOW NEITHER PARTY IS SATISFIED WITH THE SYSTEM THE WAY IT WORKS AND THEY WORRY ABOUT BEING ABLE TO COMMUNICATE EFFECTIVELY WORK WITH THEIR PATIENTS AND MAYBE THEY HAVE SOME OTHER INFORMATION AS TO WHY INTERPRETERS ARE AVAILABLE, WHAT THE CONCERNS ARE, HOW THEY'RE GETTING THOSE INTERPRETERS, THAT MIGHT HELP IMPROVE THE SYSTEM GOING FORWARD.

>> THANK YOU. WE AGREE.

>> WE'RE GOING TO RECOGNIZE HERE AND THEN PAM ON THE PHONE.

>> STEVE BARBER, HLAA. I'M INTERESTED IN THE CHARACTERIZATION OF THE PEOPLE IN YOUR SURVEY THAT WERE HARD OF HEARING IN TERMS OF WHAT

COMMUNICATION MODES THEY NEEDED. WHEN WE USE THE WORDS DEAF AND HARD OF HEARING, THAT GETS A LITTLE CONFUSING BECAUSE MANY PEOPLE WHO ARE DEAF AND USE ASL AS A PRIMARY LANGUAGE MIGHT SAY THAT THEY'RE HARD OF HEARING BUT THEY'RE NOT-- PEOPLE THAT ARE HARD OF HEARING UNDER HLAA, ANYWAY, ARE ALMOST NEVER SIGNING PEOPLE. SO THEY'RE USING TEXT OR THEY'RE USING ASSISTIVE LISTENING SERVICES, NECK LOOPS, HEADPHONES, PERSONAL AMPLIFIERS, FM, A THOUSAND DIFFERENT WAYS TO COMMUNICATE. SO WE'RE WERE THE PEOPLE IN YOUR CATEGORY REPRESENTING PEOPLE USING THOSE MODALITIES, OR WERE THEY DEAF PEOPLE THAT SAID THEY WERE HARD OF HEARING?

>> THE LATTER. IN THIS CASE , THE FIRST QUESTION THAT WE ASKED PEOPLE IS WE WANTED TO GET PEOPLE WHO PREFER TO USE ASL AS THEIR PRIMARY LANGUAGE. SO YOU RAISE AN IMPORTANT POINT. THE PEOPLE IN OUR SAMPLE WHO CHARACTERIZE THEMSELVES AS HARD OF HEARING ARE NOT REPRESENTATIVE OF A FULL HARD OF HEARING COMMUNITY. THANK YOU.

>> THIS IS DAVID. PAMELA, GO AHEAD.

>> GOOD MORNING, EVERYONE, AGAIN. THIS IS PAM. I APPRECIATE THE DATA. I THINK THE APPROACH WITH VRI IS, IS IT WORKING? I KNOW WE'RE FACING THAT. IT'S NOT A ONE SIZE FITS ALL WHEN IT COMES TO THE DEAF COMMUNITY. WE KNOW MANY OF US DO REALLY PREFER ONION SITE OR LIVE INTERPRETER IN REALTIME SO DEAF PEOPLE-- SOME PREFER VRI. MAYBE IT'S MENTAL HEALTH COUNSELING. MAYBE IT'S CRITICAL CONVERSATION AND THEY DON'T WANT THE LOCAL INTERPRETERS TO KNOW THEIR FAMILY BUSINESS. MAYBE THEY'RE NOT COMFORTABLE WITH THAT. THEY'RE MORE COMFORTABLE WITH THE STRANGER THAT THEY HAVE NO RELATION TO WITHIN THEIR COMMUNITY. I KNOW A LOT OF FRIEND-- A FRIEND WHO EVERY NOW AND THEN WILL USE VRI INTENTIONALLY. THEY FEEL CONFIDENT AND RELAXED THAT THEY ARE WITHOUT SOMEONE IN THE ROOM WITH THEM BECAUSE THAT INTERPRETER WON'T KNOW THEIR BUSINESS, AND OF COURSE, THEY DO HAVE THEIR CODE OF ETHICS THEY HAVE TO FOLLOW BUT IN REALITY, THE DEAF PERSON, EVERY NOW AND THEN, MAY PREFER A STRANGER. SO WE CAN'T JUST DISREGARD VRI AND SAY THAT IT DOESN'T WORK BECAUSE ACTUALLY, SOME PEOPLE DO PREFER IT DEPENDING ON THE SPECIFICS OF THE SITUATION.

>> THAT'S A REALLY INTERESTING POINT AND CERTAINLY THE ISSUE OF PRIVACY IS IMPORTANT. IT ALSO RAISES THE QUESTION OF OTHER WAYS TO MEET PEOPLE'S COMMUNICATION NEEDS WITHIN IN-PERSON INTERPRETER WHICH THEY EXPLAINED

THEY THOUGHT PROVIDED HIGHER QUALITY COMMUNICATION AND THINK OF SOME WAYS TO PRESERVE PRIVACY MAYBE BY BRINGING IN AN INTERPRETER THAT'S NOT LOCAL FOR THAT KIND OF VISIT .

>> THIS IS DAVID. JUST LOOKING AT THE TIME. I THINK WE'RE GOING TO NEED TO MOVE FORWARD BECAUSE I THINK WE'RE A LITTLE BEHIND SCHEDULE. SO IF YOU'LL BE HERE FOR A WHILE.

>> THIS IS PAMELA. THANK YOU FOR YOUR TIME.

>> YES. I'LL BE HERE THROUGHOUT THE DAY.

>> OKAY. GREAT. SO YOU'LL BE ABLE TO ASK SOME QUESTIONS FOR THE PEOPLE THAT ARE HERE LATER, IF YOU HAVE AN OPPORTUNITY. SO THANK YOU SO MUCH FOR PRESENTING THAT, AND I THINK NOW I TURN IT OVER TO JAN.

>> THANK YOU.

Challenges in Advocating for Communication Access:

>> GOOD MORNING, EVERYONE. THIS IS JAN SPEAKING. GOOD MORNING, AND WHERE IS KATHLEEN? OH, THERE YOU ARE, KATHLEEN. THANK YOU SO MUCH FOR YOUR EXCELLENT PRESENTATION. WE HAVE BEEN VERY FORTUNATE TO HAVE KATHLEEN WORKING WITH US AND ALSO DR. MARK MYERS FROM GALLAUDET, WHO HAS ALSO BEEN WORKING WITH US ON THIS PROJECT. WE DO RECOGNIZE THAT WE DO ALSO NEED TO FOCUS ON THE HARD OF HEARING COMMUNITY AND THEN WE NEED TO DO THE SAME KIND OF WORK WITH THE DEAF-BLIND COMMUNITY, SO THAT WE CAN GET THE EXPERIENCES OF ALL THREE GROUPS AND ALSO WE WANT TO GET THE PERSPECTIVE OF THE PROVIDERS AS WELL BECAUSE THAT'S IMPORTANT, TOO, BUT AGAIN, THANK YOU. SO NOW I WANT TO TALK A LITTLE BIT ABOUT THE EXPERIENCE OF DSDHH STAFF AS THEY TRY TO ADVOCATE FOR COMMUNICATION ACCESS. IF YOU WILL RECALL MY PERSONAL STORY THAT I SHARED WITH YOU FROM THE VERY FIRST TASK FORCE MEETING WE HAD WHEN I SHARED THAT I HAD TRIED TO ADVOCATE FOR MYSELF UNSUCCESSFULLY, SO I REACHED OUT TO A STAFF PERSON FROM ONE OF OUR REGIONAL CENTERS UNDER THE DIVISION OF SERVICES FOR THE DEAF AND HARD OF HEARING AND THAT WAS BEFORE I STARTED WORKING WITH THE DIVISION OF SERVICES FOR THE DEAF AND HARD OF HEARING AND NOW I REACHED TO THE STAFF PERSON AT THE REGIONAL CENTER. THEY ADVOCATED FOR ME AND GOT IMMEDIATE RESULTS. THE PERSON THAT I WAS TRYING TO REQUEST INTERPRETING SERVICES FROM SAW ME AS BASICALLY SOMEONE OF LITTLE IMPORTANCE WHEN THEY GOT THE REQUEST AND THE ADVOCACY EFFORTS FROM THE STATE

GOVERNMENT AGENCY THEN THEY WERE IMMEDIATELY RESPONSIVE AND THE SAME THINGS HAPPENS WITH OUR STAFF. I DO WANT TO EXPLAIN TO YOU ABOUT MANY SO OF THE CHALLENGES OUR STAFF FACE AS THEY TRY TO DO THESE ADVOCACY EFFORTS AND I WANTED TO GIVE YOU A BETTER SENSE OF WHAT THE CHALLENGES ARE TO ALSO HELP YOU FIGURE OUT HOW TO COME UP WITH SOLUTIONS WHEN YOU ARE READY TO MAKE THOSE RECOMMENDATIONS DURING THE LAST TASK FORCE MEETING. NOW BEFORE I DESCRIBE THE BARRIERS TO ADVOCACY THAT WE'VE IDENTIFIED, I DO WANT TO SHARE A COUPLE OF THINGS WITH YOU. FIRST OF ALL, WE DO A LOT OF CAPACITY BUILDING. STARTING WITH INTERNAL STAFF TRAINING ON HOW TO APPROPRIATELY ADVOCATE. WHICH IS A LOT EASIER SAID THAN DONE. THERE ARE SEVERAL STAFF MEMBERS THAT FEEL THAT ADVOCACY IS A FORM OF CONFRONTATION. AND THEY DON'T LIKE CONFRONTATION. YOU KNOW, OUR STAFF ARE HERE TO SERVE PEOPLE AND SO CONFRONTATION CAN BE UNCOMFORTABLE AT TIMES SO THAT'S A CHALLENGE. NOW IN TERMS OF EXTERNAL CAPACITY BUILDING, WE TRAIN HEALTHCARE PROVIDERS ABOUT THEIR OBLIGATION TO PROVIDE ACCOMMODATIONS. AND HOW THEY CAN FIND THE APPROPRIATE ACCOMMODATIONS TO MEET THE NEED AND HOW THEY CAN WORK WITH SIGN LANGUAGE INTERPRETERS AND WHATEVER COMMUNICATION MODALITY HAPPENS TO BE PROVIDED. NOW THAT'S A CHALLENGE BECAUSE, FIRST OF ALL, THERE ARE A LOT MORE HEALTHCARE PROVIDERS THAN STAFF THAT WE HAVE AND ALSO THERE'S A LOT OF TURNOVER IN A LOT OF THE PLACES THAT WE GO AND PROVIDE TRAINING. SOME PEOPLE ARE VERY INTERESTED IN MAKING A DIFFERENCE. SOME PEOPLE ARE NOT QUITE SO INTERESTED IN DOING THAT SO WE MEET A WIDE VARIETY OF INDIVIDUALS WHILE WE'RE TRYING TO DO THAT TRAINING. ANOTHER BARRIER, AREA OF BARRIER IS INFORMATION AND EDUCATIONAL ADVOCACY. NOW, WE CAN PROVIDE INFORMATION AND EDUCATION. WE CANNOT PROVIDE LEGAL ADVOCACY. WE HAVE TO BE VERY CAREFUL ABOUT THAT BECAUSE THAT IS NOT OUR AREA OF EXPERTISE. WE HAVE TO LEAVE THAT TO PEOPLE LIKE DISABILITY RIGHTS OF NORTH CAROLINA, THE ATTORNEY GENERAL'S OFFICE AND THE DOJ. AND NOW I WOULD LIKE TO SHARE WITH YOU SEVERAL DIFFERENT TYPES OF BARRIERS TO ADVOCACY THAT MY STAFF FACE ON A REGULAR BASIS. FIRST OF ALL, SOME HEALTHCARE PROVIDERS ARE NOT WILLING TO LISTEN AT ALL. THEY'RE NOT OPEN TO CHANGING THEIR POLICIES TO REFLECT THE ADA. THEY MIGHT BE RESISTANT TO PROVIDING A WIDE VARIETY OF MEASURES. THEY MIGHT WANT TO TAKE A ONE-SIZE-FITS-ALL APPROACH BY

PROVIDING, FOR EXAMPLE, ONLY VRI OR ONLY WHATEVER ACCOMMODATION THEY CHOOSE. THEY EXPECT THE PATIENT TO MEET THE WAY THAT THEY DO BUSINESS NOT THE OTHER WAY AROUND. SO THAT'S A BARRIER. ANOTHER ONE IS THAT OFTENTIMES, MY STAFF NEED TO TALK WITH SOMEONE HIGHER UP IN THE CHAIN BUT THEY CAN'T EVEN GET PAST THE RECEPTIONIST. SO THE RECEPTIONIST SOMETIMES IS A BARRIER. SOMETIMES THE PROVIDER IS NOT WILLING TO TAKE THE TIME TO LEARN HOW TO LOCATE A SIGN LANGUAGE INTERPRETER. SOMETIMES THEY PUSH OUR STAFF TO PROVIDE THE INTERPRETER FOR THEM EVEN THOUGH WE TAKE THE TIME TO EXPLAIN THAT THAT'S NOT WHAT WE DO. THAT THE HEALTHCARE PROVIDER HAS THE RESPONSIBILITY OF LOCATING AND PROCURING THOSE INTERPRETING SERVICES AND TO TAKE CARE OF THOSE ARRANGEMENTS ON THEIR END. AND EVEN AFTER WE EXPLAIN THEIR RESPONSIBILITY, THE PROVIDER SEEMS TO NOT UNDERSTAND WHAT IT MEANS TO HAVE A HEARING LOSS. THEY DO NOT UNDERSTAND WHY LIP READING IS NOT ENOUGH, EVEN WHEN WE EXPLAIN THAT ONLY 30 TO 35% OF ENGLISH IS VISIBLE ON THE LIPS, THE REST OF IT IS ALL GUESSWORK, THEY DON'T UNDERSTAND WHY LIP READING IS NOT AN EFFECTIVE MEANS OF COMMUNICATION AND THEY ARE RESISTANT TO CHANGING THEIR WAY OF THINKING. THERE'S ALSO A PERCEPTION THAT PROVIDING AN ON-SITE OR WHAT MANY DEAF PEOPLE CALL A LIVE INTERPRETER, IS NOT A A REASONABLE ACCOMMODATION. THEY VIEW VRI AS BEING A REASONABLE ACCOMMODATION. THEY SEE PROVIDING AN ONLINE-- AN ON-SITE OR LIVE INTERPRETER AS GOING THE EXTRA MILE TO PROVIDE AN ACCOMMODATION. SO NEXT SLIDE, PLEASE. WE HAVE ALSO RECEIVED CALLS FROM PATIENTS WHO HAVE SHARED WITH US PREVIOUS EXPERIENCES, ADVERSE EXPERIENCES WITH THEIR DOCTORS AND THEN WHEN MY STAFF MAKE FOLLOW-UP CALLS TO THE PROVIDER, OFTENTIMES, THE PROVIDER HAS A HARD TIME UNDERSTANDING THAT WHATEVER ACCOMMODATION THEY JUST PROVIDED WAS NOT SUFFICIENT. AND THAT CAN BE UNDERSTANDABLE. IT CAN BE UNDERSTANDABLE THAT MANY TIMES PEOPLE HAVE A HARD TIME UNDERSTANDING WHAT CONSTITUTES A QUALIFIED INTERPRETER. THEY MAY SEE AN INTERPRETER. AN INTERPRETER MAY BE LICENSED AND CERTIFIED BUT NOT ALL LICENSED CERTIFIED INTERPRETERS ARE QUALIFIED. THEY'RE NOT ALL TRAINED TO INTERPRET IN HEALTHCARE SETTINGS. SO WE HAVE TO DIFFERENTIATE THAT AND THAT CAN BE DIFFICULT FOR HEALTHCARE PROVIDERS TO TEASE OUT. OFTENTILES, HEALTHCARE PROVIDERS WILL CONTRACT WITH ONE INTERPRETER SERVICE AGENCY, WHICH

LIMITS THE POOL OF INTERPRETERS AVAILABLE TO THEM. AND IT ALSO LIMITS THE QUALITY OF INTERPRETERS THAT ARE AVAILABLE. WE HAVE HEARD OVER AND OVER AGAIN FROM CONSUMERS THAT INTERPRET SERVICE AGENCIES ARE JUST SENDING A WARM BODY . UNFORTUNATELY, IT'S OFTEN THE CASE THAT THE HEALTHCARE PROVIDERS DON'T REALIZE THAT, THAT THE INTERPRETER'S NOT QUALIFIED. AND SOMETIMES-- WELL, THERE IS ONE-- THERE'S ONE INTERPRETER ON MY STAFF WHO TOLD ME SEVERAL MONTHS AGO THAT INTERPRETER WILL OFTEN GET CALLS FROM AN AGENCY WHERE THEY'RE TRYING TO GET AN INTERPRETER WITH LESS THAN 72 HOURS BEFORE THAT APPOINTMENT, WHICH MEANS THAT DOESN'T GIVE US MUCH TIME TO TRY TO RESOLVE THE SITUATION AND TO ADVOCATE WITH SUCH A SHORT TURNAROUND TIME. OFTENTIMES, OUR STAFF WILL TRY TO, IF THEY CAN GET PAST THE RECEPTIONIST, GO UP THE CHAIN TO TALK TO THE APPROPRIATE PERSON THAT CAN ACTUALLY MAKE A DIFFERENCE. ONE TIME THAT DID LEAD TO A VERY SUCCESSFUL RESOLUTION BUT IT TOOK MY STAFF AND PARTICULARLY LEE ON MY STAFF , HOW MUCH TIME? IT TOOK SEVERAL WEEKS OF YOUR TIME, RIGHT? TO FINALLY GET UP THE CHAIN TO THE VICE PRESIDENT OF POLICY AT A NATIONAL HEADQUARTERS WHICH WAS LOCATED IN ANOTHER STATE TO FINALLY APPROVE A DEVIATION FROM A POLICY THAT THEY HAD ALREADY CREATED AND THIS WHOLE SITUATION, THOUGH, ENDED UP LEADING TO A VERY POSITIVE OUTCOME FOR A PATIENT AND THE VICE PRESIDENT WAS WILLING TO CHANGE THEIR POLICY TO RECOGNIZE THE INDIVIDUAL NEEDS OF EACH PATIENT AND TO MAKE SURE THAT ACCOMMODATIONS WERE PROVIDED THAT WOULD FIT EACH PATIENT'S NEEDS. NOW THIS NEXT POINT IS A LITTLE BIT DIFFERENT. ONE THING THAT MY STAFF HAVE TRIED TO DO IS THEY WILL TRY TO REACH OUT TO PROVIDERS SUCH AS HOSPITALS OR HEALTHCARE SYSTEMS TO JUST DO A COLD CALL TO OFFER TRAINING TO THEIR STAFF, NOT RELATED TO ANY SPECIFIC CASE OR PATIENT , BUT JUST MIXING A COLD CALL, JUST TO OFFER THAT WE, AS DSDHH STAFF ARE HERE TO ASSIST THEM TO MAKE SURE THAT THEIR SERVICES ARE ACCESSIBLE TO DEAF AND HARD OF HEARING PEOPLE. NOW, THOSE COLD CALLS TEND TO RESULT IN A LOT OF RESISTANCE. OUR STAFF HAVE A STRUGGLE TRYING TO GET THROUGH TO ACTUALLY BE ABLE TO GET IN THE DOORWAY TO PROVIDE THAT TRAINING. SO ALL OF THESE BARRIERS ARE BARRIERS THAT MY STAFF FACE ON A REGULAR BASIS, SO AS YOU ARE THINKING ABOUT POSSIBLE RECOMMENDATIONS AND SOLUTIONS AND RECOMMENDATIONS FOR ALL OF THESE DIFFERENT ISSUES THAT WE'RE TALKING ABOUT, THINK ABOUT

ALL THESE DIFFERENT BARRIERS BECAUSE I'M LOOKING TO YOU, PARTICULARLY THOSE OF YOU IN THE HEALTHCARE INDUSTRY TO HELP US REMOVE THESE BARRIERS. ANY QUESTIONS?
>> YES, ADAM.
>> YES
>> I'M WONDERING IF--
>> EXCUSE ME.
>> IF THERE'S A DIFFERENT APPROACH THAT WE NEED TO TAKE WITH SMALLER PRACTICES VERSUS LARGER HEALTH SYSTEMS ? I'M THINKING, FOR EXAMPLE, HAVING TROUBLE GETTING THROUGH THE SECRETARY AT A SMALL PRACTICE AND CRYSTAL, DR. BOWE'S COMMENTS EARLIER, ABOUT PROVIDER COLLEAGUES AND I THINK IN SMALL PRACTICES, IT'S ACTUALLY THE OFFICE MANAGER THAT HOLDS THE KEY TO HOW THE PROTOCOL WORKS TO BE ABLE TO MEET ANYBODY'S ACCOMMODATIONS THAT COMES INTO THE FRONT DOOR. I'M JUST THINKING FROM THE PERSON CALLING OR COMING INTO MAKING AN APPOINTMENT AND WHO THEY TALK TO AND WHAT THE PERSON DOES AT THE FRONT DESK. I'VE SPOKEN TO SOME OF MY COLLEAGUES ABOUT WHAT THEY DO IN THEIR PRACTICES WHEN THEY'RE SEEING A DEAF OR HARD OF HEARING PATIENT, AND THE ANSWER FOR MOST OF THEM HAS BEEN, I DON'T KNOW, IT HASN'T COME UP IN SUCH A LONG TIME. I THINK THAT'S OFTEN BECAUSE THE FRONT DOOR IS HARD TO GET THROUGH. I'M WONDERING, GREG, OR CRYSTAL, IF WE'RE THINKING ABOUT SMALL PRACTICES AND NOT JUST MEDICAL PRACTICES BUT THINK ABOUT PHYSICAL THERAPY AND OCCUPATIONAL THERAPY AND PHARMACY, IS THERE A DIFFERENT APPROACH? ARE WE REALLY TALKING ABOUT THE HEALTHCARE PROVIDERS? ARE WE TALKING ABOUT MANAGEMENT?
>> THIS IS CRYSTAL BOWE SPEAKING. I THINK YOU'RE HITTING THE NAIL ON THE HEAD HERE AND THE PHYSICIANS THIS I SPEAK WITH, I HAVE A PHYSICIAN IN EASTERN NORTH CAROLINA WHO IS AN ADVOCATE WHO HAD A PATIENT. SHE WANTED TO SEE AND HE WANTED TO SEE HER BUT HAD TO GO TO GREENVILLE BECAUSE THEY COULDN'T GET AN INTERPRETER, LIVE INTERPRETER TO THE OFFICE AT A TIME THAT HE COULD COME AND VRI DOESN'T WORK A LOT IN EASTERN NORTH CAROLINA AND SO IT WASN'T EVEN REFLECTIVE OF THE RECEPTIONIST OR PROVIDER AND IT JUST COULDN'T WORK. SOMETIMES COMING INTO THE LOBBY IS AN ISSUE BECAUSE THE RECEPTIONIST DOESN'T KNOW ENOUGH AND THAT'S A PROBLEM. THAT

HAPPENS WITH ALL PATIENTS. THEY HAVE OUTCOMES THAT THEY DON'T LIKE. SOMETIMES IT'S THE SYSTEM IN PLACE THAT LEADS TO BOTH THE PATIENT AND THE PROVIDER HAVING AN OUTCOME THAT WAS NOT SATISFACTORY AND WASN'T TO THE BENEFIT OF THE PATIENT AND SOMETIMES IT IS ABOUT A CULTURE OF EDUCATION AND UNDERSTANDING BUT IT TAKES EVERY SITUATION REQUIRES SOMETHING DIFFERENT. THE SITUATIONS THAT I HEAR ABOUT IN EASTERN NORTH CAROLINA, THEY'RE ASKING FOR INTERPRETERS BUT THEY CAN'T GET THEM. THEY CAN'T GET ANYBODY AND THEY CAN'T EVEN USE VRI. THAT REQUIRES DIFFERENT ADVOCACY THAN PLACES WHERE THE RECEPTIONIST DOESN'T KNOW THAT WE NEED TO A SIGN LANGUAGE INTERPRETER OR EVEN SITUATIONS WHERE THE OFFICE WILL BE WILLING TO DO IT BUT THE PATIENT COMES IN AND THEY'RE SO INTIMIDATED BECAUSE WE DON'T HAVE THINGS IN THE LOBBY AND YOU GUYS MENTION EARLIER, OPEN SPACES THAT MAKE IT A WELCOMING ENVIRONMENT WHERE IT'S EASY TO SCHEDULE APPOINTMENTS. EVEN IN MY OFFICE, SEEING ME, ONCE YOU'RE MY PATIENT AND WE KNOW AND WE HAVE THOSE ACCOMMODATIONS BUT IT'S HARD TO MAKE THE ACCOMMODATIONS THAT EVERYBODY COMING THROUGH THE DOOR HAS THEM THERE TO MAKE SURE COMMUNICATION IS EASY AND OPEN FROM THE MOMENT YOU WALK IN AND THOSE ARE CHALLENGES THAT ARE OUTSIDE ATTITUDES THAT WE WILL NEED HELP FROM THE HEALTHCARE SYSTEM TO ADDRESS AND YOU TALK ABOUT QUALIFIED INTERPRETERS AND I CAN'T GAUGE THE INTERPRETERS ARE GOOD ENOUGH UNLESS THE PATIENT TELLS ME AFTER THE FACT AND IF THEY DON'T TELL ME BECAUSE I DON'T SIGN, I HAVE NO WAY OF SAYING I AM PROVIDING GOOD INTERPRETERS OR GIVING MY PATIENTS A POOR EXPERIENCE THAT THESE INDIVIDUALS ARE TALKING ABOUT.

>> THIS IS GREG GRIGGS WITH THE NORTH CAROLINA ACADEMY OF FAMILY PHYSICIANS AND I CAN'T ADD A WHOLE LOT MORE TO WHAT SHE SAID. ON SMALL PRACTICES, SOMETIMES IT CAN BE EASIER TO CHANGE POLICY IF YOU GET THROUGH THE. AS YOU GET TO BIGGER AND BIGGER SYSTEMS OF CARE, THERE'S SO MANY LAYERS, IT BECOMES MORE DIFFICULT TO CHANGE THE POLICY, BUT IN OUR ORGANIZATION, MANY OF OUR SMALL PRACTICES ARE IN MORE RURAL AREAS SO THEY ARE GOING TO HAVE POTENTIALLY MORE TROUBLE ACCESSING INTERPRETERS AND ONE OF THE THINGS I WAS GOING TO MENTION BEFORE IS THAT WHERE IS THE VRI GOING TO BE WORSE IN RURAL AREAS THAT HAVE LACK OF BROADBAND SO YOU ARE GOING TO HAVE MORE FREEZING OF THE VRI IN THE SAME AREAS WHERE YOU

HAVE FEWER INTERPRETERS AS WELL. GLFER OKAY. ALL VALID POINTS AND I AGREE. YOU ARE RIGHT. ABOUT ALL OF THOSE THINGS. MY INTENTION IS TO SHARE WITH YOU THAT THESE ARE ALL OF THE BARRIERS THAT WE FACE SO THAT WE CAN REALLY BEGIN TO BREAK DOWN ALL OF THESE BARRIERS AND FIGURE OUT EXACTLY WHAT WE CAN DO IN TERMS OF SOLUTIONS AND RECOMMENDATIONS, AND I BELIEVE, LIZ, YOU WANTED TO MAKE A COMMENT.

>> YEAH. THIS IS LIZ. HI. THIS IS LIZ ROBBERSON. I WANTED TO ADD TO THE TYPES OF BARRIERS TO ADVOCACY. I'VE BEEN INTERPRETING SINCE 1979. SOME OF YOU WERE NOT BORN. BUT I HAVE ALSO BEEN A CERTIFIED INTERPRETER SINCE 1982 AND NATIONALLY CERTIFIED. I HAVE BEEN THROUGH LOTS OF TRAINING, MENTAL HEALTH TRAINING, MEDICAL INTERPRETING TRAINING, BLAH, BLAH, BLAH. I HAVE LIFE EXPERIENCE WITH MY PARENTS BEING DEAF. I HAVE BEEN IN ASSIGNMENTS TO WHERE I AM-- I'M GOING TO JUST SAY IT, I WAS THE BEST INTERPRETER FOR THAT ASSIGNMENT, AND I ASKED THE DOCTOR TO HOLD ON A SECOND AND LET ME GET CLARIFICATION AND I WAS ASKED, WHO ARE YOU AND WHAT KIND OF LEVEL OF INTERPRETER ARE YOU BECAUSE YOU HAVE TO STOP ME WHILE I'M TALKING? THE INTERPRETER PRIOR DIDN'T STOP ME AT ALL. WELL, THAT'S PART OF THAT EDUCATION FOR PROVIDERS BECAUSE MY PURPOSE OF STOPPING THIS PROVIDER WAS TO GET CLARIFICATION OF THE TERMS THAT THEY WERE USING, EVEN THOUGH-- I'VE HAD MEDICAL INTERPRETER TRAINING, I DON'T USE IT ENOUGH TO BE THAT REALISTIC WITH IT AS FAR AS I WANT TO MAKE SURE THAT WHEN THE DOCTOR SAYS YOU ARE GOING TO BE USING A SUSPENSION I'M NOT GOING TO SIGN THE WORD THAT SUSPENDS SOMETHING OR HOLD OFF ON SOMETHING BUT I'M GOING TO ASK FOR CLARIFICATION AND SAY, WHAT DO YOU MEAN BY SUSPENSION, AND THE DOCTOR SAYS, OH, A LIQUID FORM. OH, OKAY. I CAN USE THE SIGN THAT MEANS THIS MEDICINE FOR DRINKING. WHEREAS ANOTHER INTERPRETER WHO MAY NOT BE AS QUALIFIED WOULD SIGN SUSPEND, WHICH THE DEAF PERSON WOULD SAY-- IN THEIR MIND, THEY'RE GOING TO SAY I'M NOT GOING TO TAKE THIS UNTIL YOU TELL ME TO AND TO GO BACK ON CRYSTAL COMMENT, HOW'S A DOCTOR TO KNOW? HOW ARE THEY TO KNOW? SENDING WARM BODIES FROM AGENCIES SOMETIMES THEY SEND THE CHEAPER INTERPRETER INSTEAD OF THE MOST QUALIFIED INTERPRETER. SOMETIMES DOCTORS AND PHYSICIANS ONLY WANT TO PAY FORTH CHEAPER INTERPRETER INSTEAD OF THE MOST QUALIFIED INTERPRETER BUT HOW DOES A DOCTOR OR PHYSICIAN OR ANYBODY IN THE MEDICAL FIELD REALLY KNOW WHAT WE

DO AND WHAT OUR QUALIFIES ARE. SO EDUCATION IS IMPORTANT.
>> CAN I MILWAUKEE A COMMENT?
>> HOLD ON THE PHONE JUST A MOMENT.
>> THIS IS DAVID SPEAKING. WE WILL TAKE LAWRENCE'S COMMENT, ONE FROM THE PHONE AND IN THE INTEREST OF TIME, WE WILL MOVE ON TO THE NEXT PRESENTATION. LAWRENCE?
>> THIS IS LAWRENCE. I WANTED TO POINT OUT, PROBABLY OBVIOUS TO EVERYBODY, BUT THE QUESTION WAS, HOW DOES THE PROVIDER KNOW THAT? AND IF YOU HAVE AN INTERPRETER AND YOU'RE HAVING DIFFICULTY FINDING AN INTERPRETER AND YOU GET AN INTERPRETER AND IT'S A LOUSY INTERPRETER, HOW DOES THAT DEAF PERSON LET YOU KNOW THAT? THROUGH THE INTERPRETER? DO THEY SIT AND TALK ABOUT THE INTERPRETER THROUGH THE INTERPRETER? [LAUGHTER]
THAT'S THE ISSUE I HAD WITH THE ADA. IF YOU HAVE COMMUNICATION ISSUES, TALK TO YOUR DOCTOR. HOW DO YOU TALK TO YOUR DOCTOR IF YOU DON'T HAVE AN INTERPRETER OR QUALIFIED INTERPRETER. IT COMPLICATES THINGS.
>> THIS IS DAVID SPEAKING. OKAY. ON THE PHONE, YES.
>> HI. YES. THIS IS ANNA AND I JUST WANTED TO FOLLOW UP ON SOME OF THE COMMENTS ABOUT THE LACK OF AVAILABILITY OF INTERPRETERS AS WELL AS SOME OF THE PRACTICES OF INTERPRETING AGENCIES THAT SEND LESS THAN QUALIFIED PEOPLE. I THINK THAT THESE ARE REALLY KEY BARRIERS AND THIS IS PART OF THE STAKEHOLDER GROUP THAT WE NEED TO GET INVOLVED IN CREATING SOME RESOLUTIONS BECAUSE THERE IS SURVEY DATA THAT WAS DONE WITH THOSE DEAF CONSUMERS AND WITH SIGN LANGUAGE INTERPRETERS IN 2006, 2009, 2012, SO THESE ARE A LITTLE DATED BUT MY EXPERIENCE TELLS ME THAT THE INFORMATION IS STILL APPLICABLE AND NATURAL SURVEY OF INTERPRETERS INDICATED THAT ONLY 40% OF CERTIFIED INTERPRETERS ARE EVEN WILLING TO WORK IN HEALTHCARE SETTINGS. THAT MEANS THAT 60% OF THEM ARE NOT. WHEN YOU LOOK AT YOUR AVAILABLE POOL OF INTERPRETERS, YOU HAVE TO REDUCE THAT NOT JUST BY, ARE THEY AVAILABLE? THEY COULD VERY WELL BE AVAILABLE, BUT THEY WOULD BE UNWILLING TO WORK IN HEALTHCARE SETTINGS. YEAH. SO I REALLY FEEL THAT PART OF THE SOLUTION HAS TO BE ENGAGING INTERPRETERS, INTERPRETER EDUCATORS, AND INTERPRETER REFERRAL AGENCIES, INTERPRETING AGENCIES, IN GENERAL, IN HELPING TO FIND SOME OF THESE SOLUTIONS. THANKS.

>> THIS IS DAVID. THANK YOU ALL, AND I'M SORRY THAT WE ARE RUNNING OUT OF TIME BUT I DO NOT WANT US TO GET TOO FAR BEHIND SCHEDULE. THANK YOU ALL FOR YOUR COMMENTS AND WE HOPEFULLY, WILL GET TO YOUR QUESTIONS LATER.

Litigation and Legal Advocacy:

ALL RIGHT. SO THE NEXT PERSON ON OUR AGENDA WILL BE CORYE DUNN WHO IS HERE TO TALK ABOUT LITIGATION AND LEGAL ADVOCACY. CORYE?

>> GOOD MORNING. THAT'S NOT A MIC.

>> WHICH END IS THE MIC ON? IT'S NOT CLEAR. I'M NOT SURE WHAT END TO TALK TO.

[LAUGHTER]

SO WE'RE GOING TO TALK A LITTLE BIT ABOUT WHAT TOOLS ARE AVAILABLE WHEN NONLEGAL ADVOCACY ISN'T EFFECTIVE AND WHAT WE CAN DO AT THAT POINT, AND WHAT WE HAVE DONE IN THE PAST AND WHAT WE HOPE TO DO GOING FORWARD. SO I AM THE DIRECTOR OF PUBLIC POLICY FOR DISABILITY RIGHTS NORTH CAROLINA. IF YOU'RE NOT FAMILIAR, DISABILITY RIGHTS NORTH CAROLINA IS THE STATE'S PROTECTION AND ADVOCACY AGENCY FOR PEOPLE WITH DISABILITIES. WE ARE AN INDEPENDENT PRIVATE NONPROFIT. WE HAVE BEEN AN INDEPENDENT PRIVATE NONPROFIT P&A FOR NOW 13 YEARS-- 12 YEARS, AND WE HAVE CERTAIN AUTHORITY FROM FEDERAL LAW. THERE'S AN AGENCY LIKE OURS WITH THIS AUTHORITY IN EVERY STATE AND TERRITORY OF THE U.S. SOME OF YOU MAY RECALL THAT THERE USED TO BE A GOVERNOR'S ADVISORY COMMITTEE ON PEOPLE WITH DISABILITIES THAT PREVIOUSLY HAD THE P&A AUTHORITY AND THEN IN 2007,, THAT AUTHORITY WAS DESIGNATED OUT TO A NONPROFIT LEGAL SERVICES ORGANIZATION CALLED CAROLINA LEGAL ASSISTANCE, AND THAT BECAME DISABILITY RIGHTS NORTH CAROLINA. SO FOR THOSE OF YOU WHO ALWAYS WONDERED SORT OF HOW DID THAT THREAD GO, THAT'S WHO WE ARE. FEDERAL LAW REQUIRES THAT EVERY STATE AND TERRITORY HAVE ONE OF THESE ENTITIES SO THAT THERE IS SOMEONE ACTING A WATCH DOG FOR THE RIGHTS OF PEOPLE WITH DISABILITIES. AND OUR MANDATE IS VERY BROAD. SO WE ARE RESPONSIBLE FOR ADVOCATING FOR PEOPLE WITH DISABILITIES ACROSS THE LIFE SPAN, ACROSS ALL TYPES OF DISABILITIES, COVERED BY THE ADA AND THE REHAB ACT. AND MOSTLY, I THINK PEOPLE ARE FAMILIAR WITH THE FACT THAT WE PROVIDE LEGAL ADVOCACY IN THE SENSE THAT WE REPRESENT PEOPLE WITH DISABILITIES WHEN THERE'S A DISPUTE RELATED TO THEIR DISABILITY. BUT IN ADDITION TO THAT, WE SPEND A GOOD DEAL OF TIME USING OTHER TOOLS.

SO LET'S TALK ABOUT HOW WE WORK. AND I APPRECIATE THE FOLKS WHO ARE TELLING ME WHERE--HOW TO STAY OUT OF THE CART LINE OF SIGHT. SO KEEP POINTING TO WHERE I NEED TO BE. SO WE ARE PRIMARILY FUNDED THROUGH EIGHT SEPARATE FEDERAL PROGRAMS. IN SOME STATES AND TERRITORIES, THERE ARE NINE. IN NORTH CAROLINA, ONE OF THE PROGRAMS STILL LIVES IN STATE GOVERNMENT, BUT IN-- BUT FOR THE OTHER EIGHT, THEY LIVE WITH OUR AGENCY, AND THOSE FUNDING STREAMS RUN THROUGH SEVERAL DIFFERENT FEDERAL AGENCIES AND EACH HAVE SPECIFIC REQUIREMENTS ABOUT HOW WE SPEND THOSE FUNDS. THERE ARE FOUR THAT ARE DESIGNATED BY DISABILITY. THREE OF THOSE ARE THREE OF OUR FOUR LARGEST. THOSE ARE-- I'M GOING TO USE THE ACRONYMS. IT IS NOT IMPORTANT THAT ANY OF YOU EVER LEARN THESE WORDS.
[LAUGHTER]
FOR SIMPLICITY SAKE'S, PAD SERVES PEOPLE WITH INTELLECTUAL AND OTHER DEVELOPMENTAL DISABILITIES. PAMI SERVES PEOPLE WITH MENTAL ILLNESS, AND PAER SERVES PEOPLE WITH ALL OTHER DISABILITIES EXCEPT FOR TRAUMATIC BRAIN INJURY AND THERE'S ALSO A PATBY FOR TRAUMATIC BRAIN INJURY. SO YOU MAY RECOGNIZE THAT EVERYTHING IN THIS GROUP AND EVERYTHING ELSE THAT HAS TO DO WITH SENSORY IMPAIRMENTS, MOBILITY IMPAIRMENTS,, A WIDE VARIETY OF DISABILITIES, GOER IN TIFF, COGNITIVE DISABILITIES IN OLDER ADULTS, CHRONIC CONDITIONS THAT MANY OF US DON'T THINK OF AS DISABILITIES BUT ARE COVERED BY THE LAW, THOSE ARE ALL FUNDED UNDER THE ONE FUNDING SOURCE OF PAER WHICH IS SIGNIFICANTLY LESS THAN A QUARTER OF OUR BUDGET. SO WE ARE OFTEN ASKED WHY WE CAN'T TAKE A PARTICULAR CASE , AND IT IS BECAUSE EVERY DOLLAR IN OUR AGENCY HAS A JOB. SOME OF THOSE DOLLARS BELONG TO CERTAIN COMMUNITIES AND WE ARE NOT ALLOWED TO MOVE THEM AROUND. JUST SO FOLKS UNDERSTAND KIND OF THE STRUCTURE OF OUR FUNDING. THE OTHER FUNDS THAT I DIDN'T MENTION, THE OTHER FOUR FEDERAL PROGRAMS THAT I DIDN'T MENTION ARE NOT DESIGNATED BY DISABILITY BUT BY FUNCTION. P AND WHAT I MEAN BY THAT IS THAT THERE IS PAVO, WHICH IS ADVOCACY AROUND THE VOTING RIGHTS OF PEOPLE WITH DISABILITIES, ALL PEOPLE WITH DISABILITIES . PABS, WHICH IS ABOUT GETTING BENEFICIARIES OF SOCIAL SECURITY BACK INTO THE WORKFORCE OR INTO THE WORKFORCE FOR THE FIRST TIME. THAT ONE THAT I CANNOT PRONOUNCE, PASSRP, WE HAVE NOT COME UP WITH A CLEVER NAME FOR IT YET, IS ADVOCACY ON BEHALF OF PEOPLE WHO ARE BENEFICIARIES OF SOCIAL SECURITY WITH RESPECT TO

THEIR REPRESENTATIVE PAYEES. AND THEN THE FINAL ONE, PAT, IS ADVOCACY AROUND THE AVAILABILITY AND ACCESSIBILITY OF ASSISTIVE TECHNOLOGY. SO YOU CAN SEE THAT WE HAVE-- WE'RE PULLED IN A LOT OF DIFFERENT DIRECTS JUST BY THE NATURE OF THE PROGRAMS THAT CREATED US. BUT WE DO HAVE MORE TOOLS THAN JUST LITIGATION. I WANT TO POINT OUT THAT WE ALSO DO INVESTIGATIONS AND MONITORING. ONE OF THE JOYS OF BEING THE P&A, YOU GET ACCESS AUTHORITY. WE AUTHORIZED TO ENTER ANY PLACE WHERE PEOPLE WITH DISABILITIES ARE RECEIVING SERVICES IN ORDER TO ASSESS HEALTH, SAFETY, AND ABUSE AND NEGLECT. AND ACCESSIBILITY. SO WE HAVE A REALLY BROAD ACCESS AUTHORITY THAT ALLOWS US TO GO INTO FACILITIES THAT, IN MOST CASES, DOESN'T HELP HERE BUT I'LL GET TO WHERE WE'VE USED IT IN THIS CIRCUMSTANCE IN JUST A MINUTE. WE ALSO DO A LOT OF POLICY ADVOCACY. THAT, OF COURSE, IS MY JOB. THERE ARE TWO OF US, THOUGH, AND SO ALL THOSE AREAS OF THE LAW THAT WE JUST TALKED ABOUT, ALL THOSE DISABILITIES, ALL THOSE SERVICES AND ADD IN THAT WE COVER EDUCATION, EMPLOYMENT, HEALTHCARE, COMMUNITY ACCESSIBILITY, CRIMINAL JUSTICE AND I'M SURE I'M MISSING SOME STUFF, COURTS, GENERALLY, CIVIL LEGAL SERVICES, WE HAVE A PRETTY BROAD SET OF ISSUES THAT WE COVER. INVESTIGATIONS AND MONITORING USES THAT ACCESS AUTHORITY I MENTIONED TO INVESTIGATE COMPLAINTS OF ABUSE AND NEGLECT AGAINST PEOPLE WITH DISABILITIES, LARGELY IN FACILITIES WHERE THEY'RE RECEIVING SERVICES AND ALSO TO MONITOR IN FACILITIES WHERE PEOPLE WITH DISABILITIES RECEIVE SERVICES. WE MONITOR IN EVERY STATE-OPERATED FACILITY EXCEPT AT THIS POINT FOR THE ADATC, WHICH ARE THE INPATIENT SUBSTANCE USE DISORDER TREATMENT FACILITIES RUN THE BY THE STATE. SO THAT'S JUST A BIG PICTURE OF WHO WE ARE AND WHAT WE DO SO I THINK THAT'S HELPFUL FOR CONTEXT. I WAS ASKED WHY WE ARE NOT ABLE TO TAKE ALL THE CASES THAT COME TO US. IF YOU TALK TO ANY ATTORNEY IN OUR OFFICE, THEY'RE VERY--THEIR FAVORITE LEAST THING TO DO IS TO TURN DOWN A CASE. IT IS THE THING THAT PEOPLE LOSE THE MOST SLEEP OVER IS THE CASE THEY DIDN'T TAKE, AND FUNDAMENTALLY MONEY EQUALS CAPACITY FOR US. EVERY DOLLAR, AS I SAID, HAS A JOB, AND EVERY-- AND EVERY SERVICE THAT WE OFFER HAS A COST IN TERMS OF STAFF, RESOURCES, YOU NAME IT. WE ALSO HAVE FAIRLY SPECIALIZED KNOWLEDGE AMONG OUR STAFF. SO FOR EXAMPLE, THERE ARE THREE ATTORNEYS WHO FOCUS ENTIRELY ON SPECIAL EDUCATION AND COMPLIANCE WITH THE INDIVIDUALS WITH DISABILITIES

EDUCATION ACT AND THE NORTH CAROLINA CONSTITUTION WITH RESPECT TO PUBLIC SCHOOLS. THAT'S IT. RIGHT? SO PAER IS THE ONLY FUNDING AVAILABLE FOR THIS WORK. IT'S THE SMALLEST OF THE THREE MAIN DISABILITY DESIGNATED FUNDING SOURCES AND AS I MENTIONED, IT HAS TO COVER A REALLY BROAD RANGE OF CONCERNS AND SO WE-- WE DO WHAT'S CALLED TARGETING. THIS IS REQUIRED BY OUR FUNDERS AND IS ALSO JUST A GOOD IDEA. EVERY YEAR, WE DECIDE ON A SET OF TARGETED EFFORTS BECAUSE WE COULD TAKE RANDOM INDIVIDUAL CASES UNTIL WE WERE BLUE IN THE FACE AND NEVER MAKE ANY DIFFERENCE IN THE STATE. SO OUR TARGETED WORK ALLOWS TO US FOCUS ON IMPACT LITIGATION, THAT IS, WE GENERALLY ONLY TAKE CASES THAT WILL MAKE SYSTEMIC IMPROVEMENTS IN ACCESS TO THE COMMUNITY. RIGHT? SO FOR EXAMPLE, WE FREQUENTLY HEAR THE SAME COMPLAINTS OVER AND OVER ABOUT A SINGLE ISSUE. WE TYPICALLY WILL NOT TAKE THOSE COMPLAINTS SEPARATELY. WE MAY LITIGATE THEM TOGETHER EITHER AS A CLASS ACTION OR AS A NON-CLASS ACTION BUT SYSTEMIC EFFORT. WE CAN ONLY DO THAT WITH OUR CLIENTS ARE AMINABLE TO THAT. WE CAN'T DECIDE THAT A CLIENT'S CASE IS GOING TO BE A SYSTEMIC CASE. WE CAN ONLY SAY TO A CLIENT, WE MAY BE ABLE TO TAKE THIS CASE BUT WE WOULD NEED TO BE ABLE TO, YOU KNOW, INCLUDE THE FOLLOWING POLICY CHANGES, FOR EXAMPLE. SO THAT'S PART OF THE SORT OF CALCULATION ABOUT WHAT WE CAN AND CANNOT TAKE. I WANT IT TALK FOR A SECOND ABOUT ACCESS TO CIVIL LEGAL SERVICES. HOW MANY OF YOU ARE FAMILIAR WITH LEGAL AID? I HOPE ALL OF YOU. LEGAL AID IS A FANTASTIC PROGRAM. IT IS TERRIBLY IMPORTANT IN OUR COMMUNITIES , AND ONE OF THE THINGS IT DOES IS SEEKS TO PROVIDE ACCESS TO CIVIL LEGAL REPRESENTATION. THAT IS, OUR CONSTITUTION REQUIRES THAT THERE BE APPOINTED COUNCIL IN IT MOST CRIMINAL CASES OR IN MANY CRIMINAL CASES BUT THAT IS NOT TRUE IN CIVIL COURT, OKAY. SO IF YOUR RIGHTS ARE VIOLATED AND IT WAS NOT A CRIMINAL ACT, THERE'S NO GUARANTEE OF COUNCIL IN OUR CONSTITUTION. LEGAL AID AND SIMILAR ORGANIZATIONS TRY TO FILL THE GAP THERE AND THEY DO AN ADMIRABLE JOB WITH ENTIRELY TOO FEW RESOURCES. WE ARE NOT CIVIL LEGAL SERVICES IN THE TRADITIONAL SENSE. OUR JOB IS NOT TO PROVIDE SERVICES TO AS MANY PEOPLE AS POSSIBLE BUT TO GET AS MUCH IMPACT AS POSSIBLE WITH THE DOLLARS THAT WERE ALLOCATED AND THAT MEANS THAT OFTEN WE WILL TAKE A CASE THAT TAKES UP AN ENORMOUS AMOUNT OF TIME BECAUSE WE THINK THAT IT WILL GIVE BIGGER SYSTEMIC IMPACT THAN TAKING

MANY INDIVIDUAL CASES. SO SOME OF YOU HAVE-- HAVE BEEN PART OF OUR DISCUSSIONS WHICH CASES TO TAKE AND WHAT TO WORK ON. TARGET'S OUR ANNUAL PROCESS FOR DECIDING WHERE TO FOCUS OUR RESOURCES. I ENCOURAGE YOU ALL TO WEIGH IN. EVERY YEAR, WE DO A SURVEY AND COMMUNITY ENGAGEMENT AROUND WHERE WE SHOULD DEVOTE OUR RESOURCES IN THE COMING YEAR, AND OF COURSE, MANY OF THESE PROJECTS ARE MULTIYEAR. I THINK WE'VE BEEN ASKING FOR A COMMUNICATION FUND FOR AT LEAST FIVE YEARS NOW, MAYBE SIX. SO I WANT TO-- I WANT FOLKS TO UNDERSTAND THE DIFFERENCE BETWEEN ACCESS TO CIVIL LEGAL SERVICES WHICH IS IMPORTANT BUT NOT WHAT WE DO AND IMPACT LITIGATION. AND THEN I WOULD SAY THAT THE LAST THING THAT IS REALLY A FACTOR IN WHAT WE CAN TAKE IS THE LACK OF AN ADEQUATE REMEDY. SO LAWYERS ARE ONLY HELPFUL WHEN THE LAW IS GOOD. WE CAN HELP YOU MAKE SURE THAT PEOPLE COMPLY WITH EXISTING LAW, BUT LITIGATION IS USELESS IF THE LAW IS BAD. SO WE CAN USE POLICY ADVOCACY TO RYE TO IMPROVE PROTECTIONS FOR PEOPLE WITH DISABILITIES, BUT LITIGATION ONLY HELPS US ENFORCE EXISTING LAW. SO IN MANY CASES WHERE WE'RE TALKING ABOUT-- WHERE WE'RE TALKING ABOUT FAILURE TO PROVIDE COMMUNICATION ACCESS , THE ONLY REMEDY THAT'S AVAILABLE WOULD BE AN ORDER FROM A COURT FOR A SPECIFIC PROVIDER TO PROVIDE SERVICES. THAT IS ALMOST IMPOSSIBLE TO GET IN A TIMELY FASHION, AND SO FOR MOST CASES, IT'S NOT USEFUL AS A TOOL. LITIGATION IS NOT USEFUL AS A TOOL TO HELP ME GET A HIGH QUALITY INTERPRETER FOR MY MOTHER'S APPOINTMENT NEXT WEEK. NOR IS IT HELPFUL TO GET ME HIGH QUALITY INTERPRETING SERVICES WHEN-- WHEN I NEED TO SEE A NEW SPECIALIST AND I'VE NEVER HAD TO EXPLAIN TO THAT PARTICULAR SPECIALIST JUST YET THEIR OBLIGATIONS UNDER THE ADA. ALL OF THAT WORK IS ONGOING, AND AS JAN MENTIONED, IT IS A CONSTANT EDUCATION PROCESS WITH PROVIDERS AND OTHERS IN THE COMMUNITY AND EVEN IF THERE ARE A FEW PEOPLE IN A MEDICAL PRACTICE OR OTHER HEALTHCARE PRACTICE WHO UNDERSTAND THAT OBLIGATION, IF THEY'RE NOT THE PERSON WHO ANSWERS THE PHONE, AS SOMEONE JUST MENTIONED, YOU MAY STILL RUN INTO TROUBLE. SO THERE ISN'T AN EASY REMEDY THAT IS ACCESSIBLE THROUGH LITIGATION FOR MANY OF THESE CASES. SO WHAT WE DO INSTEAD IS PROVIDE SUPPORT FOR SELF-ADVOCACY, REFERRAL TO APPROPRIATE NON-LEGAL ADVOCACY RESOURCES INCLUDING THE DIVISION AND USUALLY THOSE METHODS ARE FASTER. WHEN THOSE METHODS FAIL SOMETIMES WE THEN CHOOSE

TO TAKE LEGAL ACTION. I WANT TO TALK ABOUT ONE PARTICULAR CASE. IN 2015, WE FILED A CASE AGAINST A DENTIST AND THE DEPARTMENT OF HEALTH AND HUMAN SERVICES HERE IN NORTH CAROLINA. THE PATIENT WAS DEAF AND REQUESTED A SIGN LANGUAGE INTERPRETER FOR HER DENTAL APPOINTMENT. OF COURSE, FEDERAL LAWREQUIRES THE DENTIST TO PROVIDE EFFECTIVE MEANS OF COMMUNICATION WITH THE PATIENTS AND THE DENTIST TOLD THE PATIENT TO HIRE HIS OWN INTERPRETER OTHERWISE HIS STAFF WOULD COMMUNICATE WITH HER IN WRITING. I DON'T KNOW ABOUT YOU, BUT I'M IN NO POSITION TO WRITE IN A DENTIST'S CHAIR.

[LAUGHTER]

I CAN'T IMAGINE THAT BEING AN ADEQUATE FORM OF COMMUNICATION FOR ANYONE REGARDLESS OF DISABILITY. SO WE ASSISTED THIS PERSON WITH FILING A COMPLAINT WITH THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES AND BECAUSE, OF COURSE, THIS IS A V A VERY CLEAR VIOLATION. AFTER A YEAR, WE HAD NO RESPONSE FROM THE DEPARTMENT, AND SHE HAD NO RESPONSE FROM THE DEPARTMENT. AND SO OUR NEXT STEP WAS TO EMPLOY A PROTESTER AND WHAT THAT MEANS IS THAT WE GOT SOMEONE TO CALL THE DENTIST'S OFFICE AND MAKE AN APPOINTMENT AND ASK FOR AN INTERPRETER. GUESS WHAT. STILL DIDN'T GET AN INTERPRETER OFFERED AND WE'RE, IN FACT, TOLD WE ARE NOT TAKING ANY NEW PATIENTS AFTER SHE ASKED FOR AN INTERPRETER AND THE DENTIST IS GETTING READY TO RETIRE. SO WE'RE NOT ACCEPTING ANY NEW PATIENTS AND THANK YOU, GOOD-BYE. SO WE EMPLOYED ANOTHER PROTESTER WHO WENT BACK AND SAID, I'M A NEW PATIENT. I NEED AN EXAM. AND DID NOT ASK FOR AN INTERPRETER AND LO AND BEHOLD, THE DENTIST WAS ACCEPTING NEW PATIENTS. I KNOW YOU'RE ALL SHOCKED.

[LAUGHTER]

SO WE DESCRIBED THAT AS NO IMPROVEMENT SHOWN. WE TOOK THESE ENRICHED FACTS BACK TO DHHS. THIS IS, BY THE WAY, MEDICAID-ENROLLED DENTIST AND A MEDICAID ENROLLEE SEEKING DENTAL SERVICES. SO IT'S NOT JUST ABOUT ENFORCING THE ADA IN THIS CIRCUMSTANCE, IT'S ABOUT ENFORCING THE MEDICAID REQUIREMENTS. AND IT IS A CONDITION OF PARTICIPATION FOR PROVIDERS IN MEDICAID THAT THEY COMPLY WITH THE ADA AND OTHER ACCESSIBILITY LAW. SO HERE, WE HAD ANOTHER REMEDY AVAILABLE TO US, NOT JUST TO GET A COURT TO ORDER THE SINGLE DENTIST TO CHANGE HIS BEHAVIOR, RIGHT, BUT BECAUSE IT WAS

A MEDICAID-ENROLLED DENTIST, WE HAD THE OPPORTUNITY TO GET DHHS TO CHANGE HOW THEY RESPOND TO THESE CIRCUMSTANCES AND THAT'S WHY THIS WAS A GOOD CASE FOR US TO TAKE. THE OUTCOME OF THIS CASE WAS THE DEPENDENTIST DID RETIRE. I UNDERSTAND HE PASSED AWAY LAST MONTH AND-- I ACTUALLY LOOKED HIM UP BEFORE THIS PRESENTATION BECAUSE I KNEW SOMEONE WOULD ASK IS HE STILL PRACTICING AND-- BECAUSE PEOPLE HAVE ASKED EVERY TIME I TOLD THEM ABOUT THIS CASE, IS HE STILL PRACTICING? HE IS, IN FACT, NOT STILL PRACTICING BUT IT DID LEAD TO THE DEVELOPMENT OF AN ADA COMPLAINT PROCESS AT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES. I THINK THAT WAS IMPLEMENTED IN 2016 OR EARLY 2017. I WOULD NOT SWEAR TO IT. IF SOMEONE HAD A BETTER ANSWER, I WOULD LOVE FOR YOU TO SHARE THAT. I COULDN'T FIND THAT ACTUAL DATE. THIS COMPLAINT PROCESS HAS NOT BEEN AS SPEEDY AS ANY OF US WOULD LIKE, I THINK.

IT'S MESSY STUFF BECAUSE IT'S NOT JUST ABOUT COMPLAINTS ABOUT A PARTICULAR KIND OF PROVIDER IN THE MEDICAID PROGRAM. IT IS A GENERAL IF SOMEONE BEING PAID BY DHHS OR UNDER CONTRACT WITH DHHS IN SOME WAY DISCRIMINATES AGAINST SOMEONE WITH A DISABILITY THAT MIGHT BE A ADA VIOLATION AND IT'S A CATCH-ALL PROCESS. THE IDEA IS THERE TO BE A SINGLE POINT OF ENTRY AND FOR IT TO GET SENT OUT TO THE DIVISION THAT IS RESPONSIBLE. FOR PROVIDING THOSE SERVICES IN AN ACCESSIBLE MANNER AND FOR THERE TO BE AN ACCOUNTABILITY LOOP. AND THAT'S A HUGE IMPROVEMENT OVER WHAT WE HAD BEFORE, WHICH WAS CALL THE DIVISION AND THE DIVISION-- CALL THE DIVISION THAT'S RESPONSIBLE FOR THE SERVICES. I DON'T MEAN DSDHH. AND ASK FOR THEIR ADA COORDINATOR. SO THAT'S BEEN AN IMPROVEMENT, BUT IT IS STILL A CLUNKY PROCESS, I THINK, BECAUSE OUR SYSTEM IS COMPLICATED. AND SO I WOULDN'T SAY THAT IT IS AN IDEAL SOLUTION BUT WE DO NOW HAVE A MECHANISM FOR MAKING THESE COMPLAINTS AND THAT ALSO SHOULD BE A SOURCE FOR DATA GOING FORWARD. THOUGH, I CAN'T SPEAK TO HOW THEY CAPTURE THAT DATA AT THE DEPARTMENT. THAT WOULD BE A GOOD QUESTION FOR OTHER FOLKS. I WISH I COULD SAY THAT ANY OF THIS IS UNUSUAL. IT'S NOT. YOU ALL KNOW THIS BY NOW. THIS IS PERFECTLY ORDINARY AND SHE WAS NOT MORTAL PERIL AND SO THE CONSEQUENCES WERE MINIMAL AND THAT'S ALSO WHY THIS A USEFUL CASE BECAUSE IT WAS SHE COULD BE OFFERED ACCESS TO THIS PROVIDER DOWN THE ROAD BY THE PROVISION OF AN INTERPRETER. SHE WASN'T GOING TO DIE

FROM HER CAVITY, FORTUNATELY. AND SO, YOU KNOW, THERE ARE VERY SPECIFIC CIRCUMSTANCES WHEN LITIGATION IS A USEFUL TOOL FOR THESE PROBLEMS. I WANT TO TALK ABOUT SOME OF THE CASES WE HAVEN'T TAKEN. WE HAVEN'T TAKEN ANY NON-MEDICAID COMMUNICATION ACCESS CASES. THAT IS THOSE WOULD NECESSARILY JUST BE PROVIDER BY PROVIDER. THERE ISN'T REALLY A SYSTEMIC SOLUTION EXCEPT WHEN YOU'RE DEALING WITH A LARGE HEALTHCARE SYSTEM, WHICH WE HAVE TAKEN, AND I'LL TALK ABOUT IN A SECOND. SO IF YOU CAN CHANGE THE POLICY OF A SINGLE, LARGE HEALTHCARE SYSTEM, YOU CAN MAKE AN IMPACT, BUT WE ARE NOT GOING TO GO SMALL PRACTICE BY SMALL PRACTICE AND LITIGATE AGAINST PROVIDERS WHO CLEARLY HAVE, YOU KNOW, THEIR OWN BARRIERS THAT THEY'RE FACING THAT WE'VE ALL SEEN IN THE PROCESS OF THESE CONVERSATIONS. IT'S JUST NOT THE MOST EFFECTIVE WAY TO GET RESULTS FOR OUR CLIENTS AND FRANKLY, IN MANY OTHER STATES THAT HAS BACKFIRED AND THERE'S BEEN BACKLASH BY PROVIDER AGENCIES TO MINIMIZE WHAT IS CONSIDERED-- WHAT'S CONSIDERED A REASONABLE ACCOMMODATION. SO I WANT TO TALK ABOUT A RELATED CASE. THIS IS NOT A DEAF CLIENT. A PATIENT IS BLIND AND RECEIVES INPATIENT TREATMENT IN A HOSPITAL THAT IS PART OF A LARGE SYSTEM. HOW MANY OF YOU, YOURSELF, OR A LOVED ONE HAVE GONE INTO A HOSPITAL FOR INPATIENT TREATMENT AND FOR MONTHS AFTERWARD, THESE BILLS TRICKLE IN? ARE YOU FAMILIAR WITH THIS PROCESS? ARE THEY ALL FROM YOUR HOSPITAL? NO, THEY'RE NOT. WHO ARE THEY FROM? ANYBODY. DO YOU HAVE ANY IDEA IF THE ENTITIES THAT ARE BILLING YOU EVEN PROVIDED YOU SERVICES? HAD YOU HEARD OF THEM BEFORE THEY BILLED YOU? NO, YOU HAVE NOT. I GOT BILLS FROM AN ANESTHESIOLOGY PRACTICE, SURGICAL PRACTICE, RESPIRATORY THERAPY PRACTICE. I DON'T EVEN KNOW MEDICAL SUPPLY COMPANY, YOU NAME IT. THERE'S A LIST A MILE LONG BUT WHEN YOU'RE IN THE HOSPITAL BED NO ONE SAYS , HI, I'M HERE FROM RESPIRATORY THERAPY AGENCY X . YOU'LL BE RECEIVING A SEPARATE BILL FROM US. NO ONE DOES THAT. YOU JUST THINK YOU'RE GETTING SERVICES FROM THE HOSPITAL WHEN YOU'RE SITTING IN THE HOSPITAL BED, RIGHT? WELL, WHEN THOSE BILLS STARTED COMING IN, THEY WERE NOT ACCESSIBLE FOR THIS MAN. SO IT'S NOT JUST THE PROVISION OF THE HEALTHCARE SERVICES THAT'S INACCESSIBLE, FOR SOME FOLKS IT IS THE INFORMATION ABOUT THE HEALTHCARE SERVICES. IT TOOK A WHILE FOR HIM TO GET HIS MEDICAL RECORDS IN AN ACCESSIBLE FORM, BUT THE HOSPITAL SYSTEM HAD THOSE ALL IN ONE PLACE,

RIGHT? BECAUSE WE HAVE A MECHANISM FOR THAT, BUT THERE IS NO CENTRALIZED BILLING PROCESS AND SO WHEN YOUR INSURANCE COMPANY DENIES A CLAIM, HOW DO YOU FIGHT IT? DO YOU APPEAL IT? DO YOU CALL THEM ON THE PHONE? DO YOU SUBMIT THE BILL TO THEM? MIGHT YOU HAVE TO REVIEW THE BILL AND EXPLAIN TO THEM WHY IT IS VALID? YOU CAN'T DO HE IN OF THAT IF YOU CAN'T READ THE BILL. SO THIS PERSON NEEDED LARGE PRINT OR BRAILLE. HE GOT NEITHER. OR EVEN AN ELECTRONIC FORMAT THAT WAS SCREEN READER ACCESSIBLE, ALSO NOT AVAILABLE. AND WAS TOLD THAT IT WAS NOT THE HOSPITAL'S RESPONSIBILITY TO ENSURE THAT OTHER PROVIDERS OFFERED ACCESSIBLE COMMUNICATION IN THEIR BILLING. THEY ACKNOWLEDGED THEIR RESPONSIBILITY FOR PROVIDING ACCESSIBLE COMMUNICATION IN THE HOSPITAL, BUT DID NOT ACKNOWLEDGE ANY RESPONSIBILITY FOR THE COMMUNICATION ACCESSIBILITY OF THE BILLING PROCESS. SINCE THE BILLING ENTITY IS NOT DISCLOSED TO THE PATIENT AT THE TIME THAT THE SERVICE IS PROVIDED, IT'S IMPRACTICAL TO EXPECT THAT THEY WILL HAVE, YOU KNOW, A WRITTEN REQUEST FOR ACCESSIBLE COMMUNICATION HANDED OUT TO EVERY SERVICE PROVIDER THAT THEY ENCOUNTER. IN FACT, YOU MAY NOT EVEN SEE A HUMAN BEING FROM PLACES LIKE DURABLE MEDICAL EQUIPMENT SUPPLY COMPANY. SO HOW DO WE ENSURE ACCESSIBLE BILLING? THIS IS AN ONGOING CASE. IT'S NOT RESOLVED. I SUSPECT IT WON'T BE RESOLVED THIS WEEK OR THIS MONTH OR MAYBE THIS YEAR. IT MAY BE RESOLVED FOR THIS INDIVIDUAL , BUT THE SYSTEM WILL NOT BE CHANGED SOON ENOUGH. SO THESE ISSUES ARE PERVASIVE ACROSS-- ACROSS DISABILITY, ACROSS COMMUNICATION OPPORTUNITIES SO SERVICE SETUP, SERVICE PROVISION, POST-SERVICE FOLLOW-UP, AND BILLING AND ACCOUNTING, AND IF YOU ARE IN THE PRIVATE INSURANCE MARKET, THERE TOO. RIGHT? I THINK WE HAVE TO INCLUDE ALL OF THAT IN THE SAME BUCKET OF INACCESSIBILITY BECAUSE IF YOU CAN ACCESS THE SERVICES BUT CAN'T NEGOTIATE THE FINANCIAL BACK END OF ALL OF THIS, YOU ARE STILL EFFECTIVELY LEFT WITH REALLY SERIOUS PROBLEMS, AND LIKELY WILL NOT BE ABLE TO CONTINUE TO ACCESS HEALTHCARE SERVICES AND MAY END UP IN MEDICAL BANKRUPTCY OR OTHER SERIOUS FINANCIAL PROBLEMS. SO I JUST WANTED TO RAISE THAT AS A PIECE THAT WE HAVEN'T TALKED ABOUT IN HERE, THAT IS RELATED, THOUGH, NOT SQUARELY WITHIN THE CHARGE OF THIS GROUP. SO I WANT TO LEAVE A MINUTE FOR QUESTIONS.

I DON'T KNOW IF THAT'S REALLY TRUE ANYMORE. WE MAY BE OUT OF TIME. ANY

QUESTIONS?
>> THIS IS DAVID. I'LL GIVE YOU ABOUT FIVE MINUTES.
>> OKAY. IT'S UP TO YOU. I'M GOING TO LET SOMEBODY ELSE. DAVID
>> DAVID IS RECOGNIZING ASHLEY. ONE MOMENT.
>> THIS IS ASHLEY. IT'S NOT A QUESTION. IT'S MORE OF A COMMENT. I APPRECIATE YOU TALKING ABOUT THIS BLIND PATIENT HAVING ACCESS TO HIS BILLING AFTER HE RECEIVE SERVICES. NOT ALL BLIND PEOPLE KNOW BRAILLE, TOO. WE HAVE TO THINK ABOUT DIFFERENT READING MATERIALS AND MAYBE THEY LOST THEIR VISION LATER IN LIFE AND HAVEN'T LEARNED HOW TO READ BRAILLE YET. SO THAT IS A BARRIER, TOO. READER-- A READER MIGHT BE AN ACCOMMODATION THAT IS COVERED BY THE ADA, BUT HOW DO WE MAKE THAT POSSIBLE TO MAKE SURE THAT THE BLIND OR DEAF-BLIND PATIENT HAS ACCESS TO READERS FOR SITUATIONS LIKE THAT? I APPRECIATE YOU SHARING THAT. I THINK IT'S IMPORTANT FOR NCIOM TO REALIZE THAT IT'S NOT ONLY READERS BUT TRANSPORTATION, GOING TO HEALTHCARE APPOINTMENT OR IF YOU HAVE SURGERY, AFTERCARE ISSUES THAT YOU HAVE TO FOLLOW UP WITH, NUTRITION AND THE LIST GOES ON. HOW CAN THEY HAVE ACCESS TO ONGOING CARE AFTER THE INITIAL VISIT? SO THAT IS AN ISSUE TO CONSIDER ABOUT BLIND AND DEAF-BLIND PATIENTS.
>> THIS IS DAVID. I WANT TO CHESK ON THE PHONE. DO WE HAVE ANYONE ON THE PHONE WITH A QUESTION?
>> WE'RE FINE OUT HERE. THANKS.
[LAUGHTER]
>> EXCELLENT. THANK YOU. JUST WANT TO MAKE SURE WE'RE INCLUDING EVERYONE THAT'S ON THE PHONE. LAWRENCE?
>> THIS IS LAWRENCE SPEAKING AND IT'S MORE OF A COMMENT THAN A QUESTION, BUT AS WE'RE THINKING ABOUT THAT, THE BILLING JUST TRIGGERED MY MIND IS WHAT ABOUT THE BROCHURES WE'RE HANDING OUT OR THE PAM PAMPHLETS FROM THE PHARMACY? I PERSONALLY HAD AN ISSUE CALLING IN AND GETTING INFORMATION ON MEDICATION FOR MY SON AND THEY INSISTED ON SPEAKING TO HIM AND I TOOK HIM UP THERE AND THEY COULDN'T COMMUNICATE WITH HIM AND THEY WANTED TO HAND HIM THIS TECHNICAL INFORMATION. THAT'S PART OF THE HEALTH SYSTEM, TOO, WHAT KIND OF INFORMATION ARE WE HANDING OUT?
>> YES, BERKELEY
>> THIS IS BERKELEY. I WAS INTERESTED, YOU SAID YOU MIGHT TAKE A CASE

AGAINST A SYSTEM. HAVE THERE BEEN ANY CASES THAT WERE CLOSE THAT YOU ALL CONSIDERED SORT OF-- WE HEARD A LOT OF STORIES ABOUT SYSTEMS NOT BEING ACCOMMODATING OR HAVING VRI AND NOT ENOUGH BANDWIDTH DEVOTED TO IT FOR IT TO BE REASONABLE. I WAS WONDERING.
>> WE HAVEN'T-- THIS IS CORYE. WE HAVEN'T YET HAD COMMUNICATION ACCESS CASE FOR A DEAF, HARD OF HEARING OR DEAF-BLIND INDIVIDUAL WHO WAS AT A LARGE SYSTEM AND THE BARRIER WAS VRI OR SIMILAR. WE'VE TAKEN THOSE DENIAL OF INTERPRETER SERVICES CASES AND WE HAVE DONE A LOT OF TECHNICAL ASSISTANCE OR SELF-ADVOCACY ASSISTANCE FOR FOLKS WHO ARE IN THE MOMENT AND ARE, YOU KNOW, MY SON IS IN THE E.R. AND THEY'RE NOT TALKING TO ME. THEY'RE NOT COMMUNICATING WITH ME, DEAF PARENT, WHO IS-- WHO IS AT A LOSS FOR HOW TO ENGAGE WITH HER CHILD'S HEALTHCARE PROVIDERS. WE HAVE DONE SOME TECHNICAL ASSISTANCE FOR THOSE, BUT LITIGATION IS NEVER GOING TO BE THE RIGHT TOOL FOR THOSE. WE OFFER, YOU KNOW-- IT CAN BE AS SIMPLE AS, HERE'S A MODEL LETTER FOR HOW YOU ASK FOR HELP. THIS IS HOW YOU ASK FOR A REASONABLE ACCOMMODATION. OR IT CAN BE JUST, YOU KNOW, HERE'S THE LAW, A PARENT CALLING US AND SAYING, DO THEY HAVE TO TALK TO ME? I THINK THEY SHOULD HAVE TO TALK TO ME. WE SAY YES, THEY HAVE TO TALK TO YOU. THEY HAVE TO COMMUNICATE WITH YOU. HERE'S A PIECE OF PAPER THAT SAYS THAT AND SOMETIMES IT'S THAT SIMPLE AND SOMETIMES WHAT THEY NEED IS A REFERRAL TO A LOCAL ADVOCATE WHO CAN ENGAGE AND MAYBE ALREADY KNOWS THE RIGHT PEOPLE IN THE SYSTEM. THE BILLING CASE IS A HOSPITAL SYSTEM, IT'S A LARGE SYSTEM. IT'S A SMALL HOSPITAL BUT A LARGE SYSTEM. SO WHILE-- THAT'S THE OTHER THING. I THINK THAT IN LARGE SYSTEMS, EVEN IF THEY GET IT RIGHT IN THE MOTHERSHIP THEY DON'T ALWAYS TRAIN ALL THE WAY OUT TO THEIR NEWER ACQUISITIONS AND SO THAT'S SOMETHING THAT WE'RE LOOKING OUT FOR IS THAT, YOU KNOW, WE KNOW THAT THE GENERAL COUNCIL AT MISSION OR DUKE OR UNC OR CAROLINAS IS GOING TO UNDERSTAND THE OBLIGATION. WE KNOW THAT. BUT HAVE THEY TALKED TO-- I DON'T KNOW WHAT THEY'VE AIRQOOD THIS WEEK. RIGHT?
[LAUGHTER]
HAVE THEY TALKED TO THE SMALL HOSPITAL THAT, YOU KNOW, HAS NOT DONE THIS FOR A LONG TIME?
>> THIS IS ADAM. I'M CURIOUS, CORYE, HOW YOU WOULD RESPOND TO ASHLEY'S COMMENT ABOUT, SAY, TRANSPORTATION NEEDS. THERE ARE SOME INSURERS THAT

PROVIDE FOR TRANSPORTATION NEEDS, BUT I SEE THAT AS A CRITICAL ISSUE AND ONE THAT I HAVEN'T THOUGHT MUCH ABOUT. I THINK IT LARGELY FALLS OUTSIDE OF THE ADA, I THINK. I'M CURIOUS HOW DISABILITY RIGHTS NORTH CAROLINA WOULD THINK ABOUT THAT.

>> SO THIS IS CORYE. I DO THINK THAT TRANSPORTATION IS AN ESSENTIAL PART OF ACCESS TO HEALTHCARE, BUT YOU'RE RIGHT. IT FALLS GENERALLY-- GENERALLY FALLS OUTSIDE OF THE ADA, THAT IT IS NOT IN THE SCOPE OF WHAT THE PROVIDER IS REQUIRED TO PROVIDE. NOW, I THINK OUR UNDERSTANDING OF WHAT IT MEANS TO PROVIDE ACCESS TO HEALTHCARE-- OUR UNDERSTANDING OF THAT IS EVOLVING TO INCLUDE THINGS LIKE HOUSING, TRANSPORTATION , AND MEANINGFUL OPPORTUNITIES TO ENGAGE IN YOUR COMMUNITY. I THINK THAT MEDICAID IS THE PLACE WHERE IT'S EASIEST, FRANKLY TO SET THOSE POLICIES AND IT'S NOT EASY THERE. I WANT TO BE REALLY CLEAR. BUT IT'S THE PLACE WHERE IT'S EASIEST TO TALK ABOUT THAT BECAUSE YOU HAVE MORE SIGNIFICANT GOVERNMENT OVERSIGHT AND YOU HAVE A GOVERNMENT PAYER AND SO YOU HAVE PUBLIC DOLLARS ON THE LINE, AND ELECTED OFFICIALS ARE ENGAGED IN IT. WHEN YOU'RE TALKING ABOUT PRIVATE INSURANCE COMPANIES, YOU HAVE TO DEAL WITH THINGS LIKE INSURANCE REGULATION AND YOU KNOW, FEDERAL-- FEDERAL REGULATION FOR PURPOSES OF THE MARKETPLACE, SO YOU KNOW, THERE'S-- IT DEPENDS ON WHICH TOOLS YOU WANT TO USE. I THINK THAT LARGE EMPLOYERS, FRANKLY, HAVE MORE POWER IN THE PRIVATE INSURANCE MARKETPLACE THAN THE DEPARTMENT OF INSURANCE A LOT OF DAYS SO IF YOU CAN GET LARGE EMPLOYERS TO DEMAND THAT HEALTHCARE BE ACCESSIBLE, YOU ARE GOING TO HAVE MORE, I KNOW, I KNOW, YOU'RE GOING TO HAVE MORE ACCESS IN THE PRIVATE INSURANCE MARKET THAN GOING THE LONG, ARDUOUS ROUTE OF DOI OVERSIGHT, WHICH NOT THAT WE SHOULDN'T DO MORE ON THE REGULATION SIDE, IT'S JUST CLUNKY AND NOT ALL OF OUR INSURANCE COMPANIES ARE LICENSED IN NORTH CAROLINA BECAUSE AND MORE AND MORE, OUR EMPLOYERS ARE MULTISTATE ENTITIES, RIGHT AND THEY'RE USING AN INSURANCE COMPANY THAT IS NOT EVEN LICENSED HERE AND SELLING POLICIES OUT OF PENNSYLVANIA, NEW YORK, DELAWARE, AND IOWA AND SO WE'RE NOT GOING TO GO STATE BY STATE AND DO THIS. I THINK PRESSURE FROM THE CORPORATE WORLD WOULD BE REALLY MEANINGFUL. I THINK THAT A FEW STRONG EMPLOYERS COULD MAKE A BIG DIFFERENCE IN SOME OF THE LARGEST HEALTH INSURANCE PROVIDERS.

>> THIS IS CRYSTAL. I WANTED TO ADD SOMETHING ABOUT TRANSPORTATION. BECAUSE I THINK IT'S A MODEL WE CAN USE GOING FORWARD. I CAN SAY A PROVIDER IN NORTH CAROLINA TRANSPORTATION TO AND FROM THE DOCTOR'S OFFICE, NOT TO OTHER PLACES IS NOT THE BIGGEST ISSUE THAT WE HAVE BECAUSE FOR FOLKS WHO HAVE MEDICAID AND EVEN NOW MEDICARE, I CAN CONNECT THEM WITH SERVICES THAT ARE COVERED TO GET THEM TO AND FROM THE DOCTOR AND SO THE MODEL THAT MEDICAID AND MEDICARE PUT FORTH HAS BEEN USEFUL FOR HELPING PATIENTS GET TO AND FROM THE DOCTOR. THEY HAVE SET THE TONE AND THEY'RE COVERING THIS SERVICE AND I THINK IT IS HELPING PATIENTS AND WHEN THEY SET THOSE STANDARDS, OTHER FOLKS TEND TO FOLLOW. IF WE CAN HAVE THAT TYPE OF MODEL FOR SERVICES THAT PROVIDE ACCESSIBILITY, I THINK IT WILL BENEFIT THE PATIENT POPULATION.

>> THIS IS CORYE, ABSOLUTELY, CRYSTAL.

>> CAN YOU HEAR ME?

>> HEY, HOLLY.

>> HEY. CORYE, I JUST WANTED TO FOLLOW UP ON YOUR POINT ABOUT THE IMPORTANCE OF WORKING WITH BIG BUSINESSES. I WOULD REALLY ENCOURAGE A CONNECTION BETWEEN THIS GROUP AND THE NORTH CAROLINA BUSINESS LEADERSHIP NETWORK. CORYE, I KNOW THAT YOU KNOW THAT GROUP OF PEOPLE. THEY HAVE A VERY STRONG EXEC RIGHT NOW AND WHAT A FABULOUS ISSUE TO TALK WITH HER ABOUT. FOR THOSE OF YOU WHO DON'T KNOW

>> **NICK:** BLM, IT'S A GROUP OF BUSINESSES COMMITTED TO PROMOTING VOLUNTARY COMPLIANCE WITH THE ADA AND DISABILITIES.

>> THANKS, HOLLY.

>> LAST ONE.

>> ALL RIGHT. THIS IS DAVID. WE'LL TAKE ONE MORE FROM ASHLEY.

>> THIS IS ASHLEY. SORRY TO TAKE THE LAST COMMENT. I HOPE IT'S WORTH IT FOR YOU.

[LAUGHTER]

I WANT TO TALK ABOUT TRANSPORTATION AGAIN. WE HAVE MEDICAID TRANSPORTATION AND OTHER OPTIONS FOR TRANSIT, THOSE FOR THOSE WHO HAVE DISABILITIES BUT THE BIG PROBLEM WITH DEAF-BLIND IS COMMUNICATION ACCESS. WE HAVE HEARING DRIVERS WHO DON'T SIGN. I AM DEAF-BLIND, AND I USE TACTILE SIGN LANGUAGE AND THE DRIVER AND I CAN'T COMMUNICATE. THE DOCTOR TOLD

ME TO GET MEDICAL SUPPLIES AFTER MY APPOINTMENT. I NEEDED TO STOP AT THE STORE, AND I CAN'T SEE WHAT'S IN THE STORE TO FIND THINGS AND IT ACTUALLY HAPPENED TO ME WHILE I WAS PREGNANT. I WAS ON-- I HAD A KIDNEY PROBLEM AND I NEEDED A CATHETER. I NEEDED TO GO TO THE MEDICAL SUPPLY STORE TO FIND A CERTAIN BAG TO ATTACH TO MY LEG AND SPECIAL CLEANING SUPPLIES THAT NEEDED TO GO WITH THAT. I COULDN'T SEE IN THE STORE, AND I WAS LUCKY I HAD A SUPPORT SYSTEM. MI FAMILY MEMBER WENT WITH ME TO HELP ME, BUT THERE ARE DEAF-BLIND PEOPLE WHO DON'T HAVE A SUPPORT SYSTEM OR HAVE FAMILY MEMBERS AND THEY'RE STUCK. TRANSPORTATION IS PART OF IT. YES, IT IS AN OPTION BUT COMMUNICATION ACCESS IS NOT THERE WITH THE DRIVERS BUT THE DEAF-BLIND CONSUMERS AND THERE ARE THOSE WHO HAVE ISSUES THAT COME UP OFTEN BECAUSE OF THE COMMUNICATION BEAR CAREERS WITH THEIR TRANSPORTATION. I HAD ONE PATIENT WHO IS ON DIALYSIS AND HAD A VAN STOP BY HER HOUSE THREE TIMES A WEEK AND MISSED HER APPOINTMENT BECAUSE THEY MISSED THE HORN HONKING AND THREE DAYS OF MISSING DIALYSIS IS NOT GREAT. CAN YOU IMAGINE THAT? COMMUNICATION BARRIER. HONKING THE HORN DOESN'T WORK FOR A DEAF-BLIND INDIVIDUAL. IN THE HOME, THEY DON'T KNOW THE DRIVER IS THERE TO PICK THEM UP. I THINK WE NEED TO CONSIDER THOSE OPTIONS FOR DEAF AND DEAF-BLIND PATIENTS FOR TRANSPORTATION. SUPPORT SERVICE PROVIDERS THAT, YOU KNOW, A PERSON WHO IS TRAINED AND KNOWS HOW TO WORK WITH DEAF-BLIND INDIVIDUALS SO THAT THEY CAN COMMUNICATE WITH THAT PERSON AND HELPING PROVIDE ENVIRONMENTAL INFORMATION THROUGH COMMUNICATION SYSTEMS. NOW IT'S SOMETHING THAT WE NEED TO CONSIDER FOR OUR PATIENTS.

>> THIS IS CORYE. CAN I SAY ONE THING?

>> QUICKLY.

>> THE ACCESSIBILITY IN TRANSPORTATION IS SOMETHING THAT WE HEAR ABOUT A LOT AND OFTEN PATIENTS ARE CHARACTERIZED AS NON-COMPLIANT WITH TREATMENT AND LOSE ACCESS TO PROVIDERS BECAUSE OF THAT AND SO WHEN YOU HEAR THAT, OH-- WE HEAR FROM PROVIDERS, IT'S SO HARD TO TREAT THIS POPULATION BECAUSE THEY'RE NON-COMPLIANT, WHAT THAT OFTEN MEANS IS THAT THE DRIVER HONKED THE HORN AND THEY DIDN'T HEAR IT SO THEY DIDN'T GET IN THE VAN AND NO ONE KNEW TO PRESS THE DOORBELL THAT WOULD FLASH THE LIGHTS OR USE A BUZZER.

>> THANK YOU.

>> THIS IS DAVID. THANK YOU. YES, IT'S ALWAYS MORE THAN MEETS THE EYE IN THESE HEALTHCARE SITUATIONS. IT'S IMPORTANT TO REMEMBER THAT. P WE'RE RUNNING VERY SHORT ON TIME AND I'M GOING TO SHORTEN OUR LUNCH HOUR A LITTLE BIT. AND THEN TRY TO SEE IF WE CAN SQUEEZE EVERYTHING IN THAT WE HAVE ON THE AGENDA FOR THE DAY.

Communication Access Fund Questions and Discussions

SO THE NEXT ITEM WE HAVE IS COMMUNICATION ACCESS FUND. AND WE WILL HAVE SOME QUESTIONS AND DISCUSSIONS ABOUT THAT SO QUICKLY, I JUST WANT TO SUMMARIZE THE MEETING THAT TONY DAVIS, LEE WILLIAMSON AND I HAD WITH PAM WILLIAMSON FROM ASLIS AND PAM IS THE OWNER OF ASLIS AND THAT IS A COMPANY THAT IS UNDER CONTRACT WITH THE CONSORTIUM TO PROVIDE EMERGENCY INTERPRETING SERVICES. AND OTHER PERSON WE TALKED TO WAS MELISSA HARTMAN FROM PARK NICOLETTE AND THESE ARE BOTH IN MINNESOTA. MELISSA IS AN INTERPRETER COORDINATOR IN A HOSPITAL SYSTEM AND BY THAT, I MEAN, HANDLING ALL INTERPRETER NEEDS NOT JUST AMERICAN SIGN LANGUAGE BUT SPOKEN LANGUAGE, ANY LANGUAGE INTERPRETER NEEDS, LARISSA HANDLES THOSE IN THAT SYSTEM. LARISSA IS ALSO THE CENTRAL POINT PERSON, CONTACT FOR THE CONSORTIUM. THEY COVER NINE HOSPITAL SYSTEMS. SO THE WAY THAT ALL OF THIS CAME UP THERE IN MINNESOTA IS THAT IN 2005, THERE WERE PEOPLE IN THE COMMUNITY WHO WERE JUST FED UP WITH A LACK OF COMMUNICATION ACCESS AND THEY FINALLY BROUGHT A LAWSUIT AGAINST THE HOSPITAL AFTER SEVERAL WARNINGS AND SEVERAL OTHER ATTEMPTS TO GET RESULTS, THEY FINALLY CHOSE TO PURSUE LITIGATION AND WHAT ENDED UP COMING OUT OF THAT WAS THIS CONSORTIUM THAT WAS WAS FORMED TO PROVIDE SERVICES. AND THE CONSORTIUM IS LIMITED TO PROVIDING 24/7 EMERGENCY REQUESTS FOR SIGN LANGUAGE INTERPRETING SERVICES. SO THAT COULD BE IN AN E.R.
IT COULD BE A WALK-IN, URGENT CARE SETTING, AND ALSO THE FIRST 24 HOURS OF A HOSPITAL ADMISSION. AND THEY DEFINED EMERGENCY SERVICES AS REQUESTS FOR ANY UNPLANNED OR UNFORESEEN SITUATION WHERE COMMUNICATION NEEDED TO OCCUR BETWEEN A PATIENT OR FAMILY MEMBER WHO IS DEAF. SO THIS CONSORTIUM DEVELOPED AN RFP AND ENDED UP SELECTING A CONTRACT WITH ASLIS TO PROVIDE THOSE SERVICES. THE CURRENT MODEL THAT THEY HAVE AT THE CONSORTIUM IS A FLAT HOURLY RATE OF $138 AN HOUR AND THAT KICKS IN WHEN

THE INTERPRETER IS CALLED. THEY HAVE THE ON-CALL SERVICES. BY DOING IT THAT WAY, THE HOSPITALS WERE EFFECTIVELY TRANSITIONING THE RISK OF INTERPRETER PROVISION TO AN AGENCY SO IT WAS MORE SORT OF AN INSURANCE FOR THE HOSPITAL, SO INSTEAD OF THE HOSPITAL BEING RESPONSIBLE FOR SECURING THOSE SERVICES, THEY WERE CONTRACTED WITH THIS OUTSIDE GROUP TO PROVIDE IT AT A CONTRACTED FLAT RATE. THE ONCALL COVERAGE HAS-- IS TWO TO FOUR INTERPRETERS DEEP, AND MEANING THAT&THOSE INTERPRETERS HAVE A VARIETY OF HOURS SO MAYBE A SPECIFIC TIME IN THE MORNING, THEY'LL HAVE TWO INTERPRETERS ON CALL AND THEN THEY'LL HAVE ANOTHER ONE THAT COMES ON AT 8: 00 AND ANOTHER THAT COMES ON AT 9:00 AND THEY CYCLE OFF SO THERE'S TWO TO FOUR INTERPRETERS AVAILABLE ON-CALL AT ALL TIMES. FOR OVERNIGHT HOURS, THEY MAINTAIN TWO INTERPRETERS ON-CALL. AND THE INTERPRETERS ARE PAID TO BE ON CALL. SO IF THEY'RE ON CALL OVERNIGHT THEY'RE PAID $100. FOR ALL DAYTIME HOURS, IT'S $125 AND $150 AN HOUR ON CALL PAID FOR WEEKENDS. AGAIN THERE ARE ALWAYS TWO INTERPRETERS ON CALL OVERNIGHT. BUT LET'S SAY THOSE ON CALL INTERPRETERS HAVE ALREADY BEEN CALLED AND THEY ARE NOW WORKING AND THEY NEED TO PULL IN OTHER INTERPRETERS. THOSE INTERPRETERS WOULD THEN BE PAID A 10% DIFFERENTIAL ABOVE THEIR REGULAR HOURLY RATE FOR THE EMERGENCY REQUEST AND A 20% DIFFERENTIAL ABOVE THEIR NORMAL RATE FOR EMERGENCY ROOM SPECIFICALLY. AND EACH OF THE HOSPITALS IN THAT CONSORTIUM USE ASLII TO PROVIDE FOR THOSE EMERGENCY REQUESTS. NOW THIS ISN'T FOR APPOINTMENTS. IF THERE ARE APPOINTMENTS SET UP, EACH INDIVIDUAL HOSPITAL OR OFFICE IS REQUIRED TO PROVIDE THEIR OWN TO SECURE THEIR INTERPRETING SERVICES AND THEY HAVE TO SET THEIR OWN CONTRACTS WITH WHATEVER AGENCY OR COORDINATING SERVICE THEY CHOOSE TO USE IN SECURING THOSE INTERPRETERS, SO AHEAD OF TIME APPOINTMENTS ARE NOT WHAT THIS CONSORTIUM HANDLES . ALSO THE CONSORTIUM COVERS-- THEY SAID LAST FEBRUARY COVERED 200 REQUESTS FOR INTERPRETERS FOR A TOTAL OF 776 HOURS. OF THOSE REQUESTS, 179 OF THE INTERPRETERS WERE AVAILABLE TO ARRIVE WITHIN LESS THAN AN HOUR. 19 ARRIVED WITHIN LESS THAN 2 HOURS AND THERE WERE 2 REQUESTS THAT WERE CANCELLED. AND THE REASONS FOR THOSE WERE NOT DISCLOSED . ASLIS ALSO PROVIDED VRI SERVICES TO HOSPITALS AND MOST OF THE TIME THOSE ARE PROVIDED TO RURAL AREAS. IN METRO AREAS , THE REQUESTS WERE GENERALLY FOR A LIVE INTERPRETER, 90 TO 95% OF THE TIME, SO THAT

MEANS YOU HAVE A LOT OF IN-PERSON INTERPRETERS THAT HAVE TO BE CALLED IN THE METRO AREAS. ASLIS DID ALSO OFFER A CART SERVICE AS A PILOT PROGRAM AND THEY STARTED THAT THREE MONTHS AGO, SO AN ON-SITE CART PROVIDER IN THAT PROGRAM WAS BILLED AT $270 AN HOUR AND IF THEY SET UP A REMOTE CART SERVICES, VIA A LAPTOP FOR SOME SORT OF TABLET, THE SERVICES WERE $140 AN HOUR. BUT THAT DID NOT INCLUDE PROVISION OF PERSONAL AMPLIFICATION DEVICES THROUGH ASLIS. ALSO DID NOT INCLUDE PROVISION OF SUPPORT SERVICE PROVIDERS, DRIVERS, BUT THERE'S A BLIND DRIVER PROGRAM THAT'S AVAILABLE THROUGH MEDICAID THERE. ASLIS ALSO COLLECTS DATA ABOUT MONTHLY REPORTS AND PROVIDES THAT IN A SUMMARY TO THE CONSORTIUM. JUST LOOKING DOWN AT THIS LIST. SO I WANT TO TALK-- I DON'T WANT TO HIT ON THE PIPE LINE BECAUSE I THINK LEE IS GOING TO COVER THAT IN HIS PRESENTATION, BUT IN MINNESOTA, THEY HAVE 650 CERTIFIED-- RID CERTIFIED INTERPRETERS IN THE STATE. THEY HAVE 75 INTERPRETERS WHO ARE CONTRACTED WITH ASLIS IN METRO AREAS. AND THERE ARE A FEW INTERPRETER TRAINING PROGRAMS IN THE STATE, TWO-YEAR PROGRAM, YOU BELIEVE, THERE ARE TWO OF THOSE AND AS FAR AS A FOUR-YEAR PROGRAM, ONE TWO-YEAR PROGRAM AND TWO FOUR-YEAR PROGRAMS IN DULUTH AND ST. KATHERINE'S. AND ONE OF THE THINGS WE NOTICED ABOUT THEIR PROGRAM IS THAT THERE ARE ACTUALLY A LOT OF HIGH SCHOOLS IN MINNESOTA THAT HAVE AMERICAN SIGN LANGUAGE CLASSES THAT ARE TAUGHT BY DEAF TEACHERS. THAT PROVIDES POTENTIALLY A LOT OF REFERRALS TO THOSE INTERPRETING PROGRAMS, SO WE HAVE SEEN IF THEY'RE SUCCESSFUL AT LEARNING AMERICAN SIGN LANGUAGE IN HIGH SCHOOL, THEY'RE LIKELY TO GO TO AN INTERPRETING PROGRAM AND BECOME AN INTERPRETER. THAT'S PART OF THEIR PIPE LINE IN MINNESOTA. ALSO HAVE A FEW QUESTIONS THAT WE HAVE PROVIDED.

>> HI. THIS IS ROB. I WAS THINKING THIS MIGHT BE BETTER TO PUSH AFTER LUNCH BECAUSE PEOPLE ON THE PHONE DON'T HAVE THESE QUESTIONS AND I CAN GET EVERYONE A COPY OF THE SHEET AND THE DISCUSSION WILL BE MORE MEANINGFUL AND PEOPLE CAN LOOK OVER IT IN THE NEXT HALF HOUR OR SO.

>> OKAY.

>> DOES THAT WORK?

>> YEAH.

>> THIS IS BERKELEY. CLARIFYING QUESTION, DAVID. HOW IS THE COMMUNICATION ACCESS FUND RELATED TO THE ASLIS PROGRAM THAT YOU WERE JUST TALKING

ABOUT? IS DOES THE COMMUNICATION ACCESS FUND FUND THEIR WORK? BECAUSE YOU TALKED ABOUT THE CONSORTIUM AND I CAN'T FIGURE OUT HOW THAT'S RELATED TO THE COMMUNICATION ACCESS FUND?
>> YES, THAT'S A GOOD QUESTION. I WASN'T CLEAR ON THAT. SO ONE THING THERE, THE HOSPITALS GOT TOGETHER TO SET UP A CONSORTIUM AND THE INFORMATION I SUPPOSE I DIDN'T PROVIDE IS THE WAY IT WAS SET UP BEFORE THEY PROVIDED THE CONSORTIUM WAS THAT THE HOSPITALS WOULD PAY EACH MAYBE $500 A MONTH INTO A FUND AND IF INTEREST WAS ANY OVERAGE THEN THAT WAS BILLED OUTS AAS A PERCENTAGE TO DIFFERENT PEOPLE AND THE REASON THEY DECIDED TO CHANGE THAT SYSTEM AND PUT OUT AN RFP-- WELL, SORRY, LET ME BACK UP A LITTLE BIT. SO FROM 2005 TO 2015, I BELIEVE, MORE OR LESS AROUND 2015, THE COMMUNICATION SERVICES FOR THE DEAF FOR PROVIDING INTERPRETING REFERRALS AND THAT ORGANIZATION GOT OUT OF THE BUSINESS AND AT THAT TIME, THEY DECIDED TO CHANGE TO THIS CONSORTIUM MODEL TO FIND A DIFFERENT WAY SO THAT'S WHY THEY PUT OUT AN RFP LOOKING FOR AN INTERPRETER REFERRAL AGENCY AND ASLIS IS THE AGENCY IN MINNESOTA THAT SECURED THE BID FOR THAT AND THEY GOT THAT CONTRACT. SO THEY ARE THE ONES THAT AND COORDINATE THE INTERPRETING SERVICES FOR THE CONSORTIUM. AND THE HOSPITALS PAY THAT HOURLY RATE THROUGH THE CONSORTIUM.
>> THAT'S SEPARATE FROM THE COMMUNICATION ACCESS FUND?
>> LEE, DO YOU WANT TO ADDRESS THAT?
>> HI THIS IS LEE. YEAH. WHAT THE CONSORTIUM BASICALLY DID WAS SET UP THEIR OWN INTERNAL COMMUNICATION ACCESS FUND. IT WAS A RESULT OF LAWSUITS. SO ALL THE NINE SYSTEMS AT FIRST SET UP A SYSTEM WHERE THEY EACH PAID INTO THE FUND $500 A MONTH WHICH DOESN'T SOUND LIKE A LOT BUT THERE WAS ALSO A STIPEND OF $30,000 A MONTH THAT WAS ALSO PART OF THE FUND AND THAT $30,000 WAS BILLED OUT TO EACH HOSPITAL ACCORDING TO THE PERCENTAGE OF USE OF INTERPRETING SERVICES THAT THEY HAVE OF THE ON-CALL INTERPRETERS, AND THEN AT THE NEXT RFP IN 2015, IT WAS TOO COMPLICATED FOR THE BUDGET FOLKS AND HAVING TO DEAL WITH STIPENDS AND PERCENTAGES AND SO FORTH. SO THEY CAME UP WITH-- THEY DID THE MATH AND CAME OUT WITH A FLAT FEE. INSTEAD OF HAVING TO PAY THE $500 A MONTH AND EVERYTHING ELSE, THEY WENT WITH A HIGHER HOURLY RATE FOR INTERPRETING SERVICES. INSTEAD OF THERE BEING A FUND, THEY WERE ALL IN AGREEMENT IF EMERGENCY SERVICES WERE

NEEDED, ASLIS WOULD PROVIDE AN INTERPRETER FOR ANY EMERGENT REQUESTS WITHIN AN HOUR AND THAT HOURLY RATE WOULD BE $138 AN HOUR.
>> THIS IS OUTSIDE OF THE COMMUNICATION ACCESS FUND?
>> CORRECT. BUT IT'S-- IT'S--
>> THERE WASN'T ONE, SORRY.
>> THERE WASN'T REALLY A FUND BUT IT'S A MODEL OF HOW ONE COULD BE DONE WITHIN HOSPITAL SYSTEMS. I THINK THAT WAS WHAT WE LEARNED FROM MINNESOTA BECAUSE A COMMUNICATION ACCESS FUND TO BE USED FOR LARGE SYSTEMS WOULD BE VERY EXPENSIVE. YOU WOULD HAVE TO BE HAVE A LARGE POT OF MONEY F WE LOOKED AT SOMETHING FOR HOSPITAL SYSTEM TO USE, THIS WOULD BE A GOOD MODEL FOR THAT AND FOR THE SMALL, PRIVATE PROVIDERS I COULD SEE WHERE A FUND THAT'S MAYBE BEEN MANAGED BY MAYBE ONE PROVIDER, FOR EXAMPLE IN MINNESOTA, ASLIS, IF THEY MANAGE OR ARE RESPONSIBLE FOR PROVIDING THE INTERPRETING SERVICES MAYBE PERHAPS IF SOMETHING WERE SET UP LIKE COMMUNICATION ACCESS FUND FOR SMALLER PROVIDERS, ASLIS OR SOME TYPE OF ENTITY COULD ALSO MANAGE THE FUND AS WELL. SO YOU HAVE ONE PLACE FOR ALL MEDICAL HEALTHCARE INTERPRETING REQUEST TO COME OUT OF.
>> THANK YOU.
>> YES, JAN.
>> THIS IS JAN. JUST VERY QUICKLY AND I KNOW EVERYONE IS READY FOR LUNCH. DAVID, YOU MENTIONED THAT THE CONSORTIUM WAS FOR EMERGENCY REQUESTS SPECIFICALLY. AND THEN FOR REGULAR APPOINTMENTS, EACH HOSPITAL WAS RESPONSIBLE FOR SECURING THOSE INTERPRETERS. I LOOK BACK AT THE WAY WE'VE TALKED ABOUT THIS IN THE PREVIOUS TASK FORCE MEETINGS. IT WAS MENTIONED AND ACTUALLY TWO DEAF PEOPLE SHARED BY VIDEO ABOUT-- NO, SORRY. IN THE VIDEO, ITSELF, BUT I WAS AWARE THAT THERE WAS MORE TO THE STORY AND SOME OF THAT WAS ABOUT HOW THEY REFERRED TO OTHER DEPARTMENTS WITHIN SAME HOSPITAL SYSTEM AND THEY HAD TO ADVOCATE FOR THEMSELVES THROUGH THAT PROCESS AND EXPLAIN TO THOSE DIFFERENT DEPARTMENTS AND THEN THEY WOULD BE REFERRED TO ANOTHER DEPARTMENT AND HAVE TO CONTINUE TO ADVOCATE FOR THEMSELVES WITHIN THAT DEPARTMENT AND KEPT BEING SHUFFLE THE AROUND. I WONDER IN MINNESOTA IN THAT HOSPITAL SYSTEM, WHERE DID THEY PUT SOMETHING IN PLACE TO MAKE SURE THAT DIDN'T HAPPEN, THAT IT WAS

VERY CLEAR AND UNDERSTOOD WHAT STAFF ARE SUPPOSED TO DO AND THAT THEY MADE EFFORTS TO PREVENT DEAF PEOPLE FROM HAVING TO ADVOCATE FOR THEMSELVES OVER AND OVER?
>> THIS IS DAVID. THAT IS A GOOD QUESTION. FROM MY KNOWLEDGE OF WHAT THEY DID IN MINNESOTA, EACH HOSPITAL HAD AN INTERPRETER REFERRAL ENTITY THAT THEY WORKED WITH WITHIN THAT HOSPITAL SYSTEM. AND WITHIN THE HOSPITAL THEY WOULD HAVE ONE DEPARTMENT RESPONSIBLE FOR SCHEDULING INTERPRETERS FOR THE ENTIRE SYSTEM FOR EACH APPOINTMENT, AND THEN THAT DEPARTMENT WOULD ALSO BE RESPONSIBLE FOR ANY TRAINING NEEDS THAT CAME OUT OF THAT. SO THAT'S AT LEAST MY UNDERSTANDING OF HOW THEY WERE HANDLING THAT IN MINNESOTA. I HAD SURGERY IN MINNESOTA ONCE AND THE HOSPITAL IN THAT PARTICULAR HEALTHCARE SYSTEM, THEY HAD THEIR OWN INTERPRETER REFERRAL PERSON AND CAME AND TALKED TO ME AND MADE SURE I HAD ACCESS FOR ALL OF MY APPOINTMENTS THROUGHOUT THE WHOLE PROCESS. THEY WERE ABLE TO PROVIDE INTERPRETERS FOR EACH APPOINTMENT AND I HAD NO ISSUE.
>> THIS IS JAN. I CAN TELL I HAVE NEVER HAD THAT EXPERIENCE AT DUKE. [LAUGHTER]
AND TO MY KNOWLEDGE, THERE IS NO SYSTEM LIKE THAT ANYWHERE IN THE STATE OF NORTH CAROLINA IN ANY HOSPITAL SYSTEM.
>> YEAH, THAT IS UNIQUE TO MINNESOTA. ASHLEY.
>> THIS IS ASHLEY HERE. I'M CURIOUS ABOUT MINNESOTA'S QUALITY OF INTERPRETERS, THE QUALIFICATIONS. MY EXPERIENCE USING SPECIFIC INTERPRETING AGENCY, THEY HAVE LIMITED POOL OF INTERPRETERS THAT THEY USE. I ASSUME BECAUSE IT'S MINNESOTA THE CONSORTIUM REALLY HAS INTERPRETERS WHO SPECIALIZE IN HEALTHCARE INTERPRETING BUT I'M ALSO THINKING ABOUT DEAF-BLIND INDIVIDUALS. ARE THERE INTERPRETERS SENT QUALIFIED TO WORK WITH DEAF-BLIND INDIVIDUALS? I'M CURIOUS IF YOU HAVE THAT INFORMATION TO MAKE SURE INTERPRETERS ARE QUALIFIED TO MEET THE PATIENT'S NEEDS. .
>> THIS IS DAVID. TONY, WERE YOU GOING TO SAY SOMETHING?
>> I HAPPEN TO KNOW THAT ASLIS DOES TRAINING ALL THE TIME FOR THEIR INTERPRETERS SO THEY HOLD REGULAR TRAININGS FOR THE INTERPRETERS TO HELP THEM BE ABLE TO QUALIFY FOR DOING THAT TYPE OF INTERPRETING AND SO

THAT'S A REALLY GOOD THING AND THE OTHER THING THAT ASLIS DOES AS A CONTRACTOR FOR THE STATE OF MINNESOTA IS THAT THEY HOLD REGULAR EVENTS WHERE THEY INVITE COMMUNITY MEMBERS OUT AND THEY TEACH THE COMMUNITY MEMBERS HOW TO ADVOCATE FOR INTERPRETING AND THEY EDUCATE COMMUNITY MEMBERS HOW TO PASS OUT BUSINESS CARDS, HOW TO SAY THIS IS WHAT I NEED, THIS IS WHO YOU CALL TO GET AN INTERPRETER FOR ME. LET'S SAY THAT WE'RE GOING TO GO TO A DOCTOR AND THE DOCTOR SAYS, WELL, I DON'T KNOW WHAT TO DO. HERE, CALL ASLIS AND THEY'LL HELP YOU. SO THEY REGULARLY SCHEDULE EVENTS TO TEACH THE COMMUNITY AND THEY REGULARLY SCHEDULE TRAININGS TO TEACH THE INTERPRETERS. THAT'S WHAT ASLIS WILL DO.

>> THIS IS DAVID. I KNOW THAT THERE'S ALSO ACCESS THERE, TOO, RESOURCES IN THE COMMUNITY. FOR EXAMPLE, ST. KATHERINE UNIVERSITY HAS THE CATE CENTER AND THAT FOCUSES ON INTERPRETING IN MEDICAL SETTINGS AND THAT'S ALSO SOMETHING GREAT THAT THEY HAVE ACCESS TO AS WELL AND THERE ARE A LOT OF OTHER RESOURCES. INTERPRETERS THAT I HAVE RUN INTO IN THE HOSPITALS THERE OBVIOUSLY, THEY PREFER TO HAVE-- THOSE ARE THE INTERPRETERS THAT PREFER WORKING IN MEDICAL SETTINGS AND SO THEY HAVE A LOT TO KEEP THEM BUSY THERE CERTAINLY.

>> YES. HI THIS IS SUZANNE. MINNESOTA IS CERTAINLY UNIQUE AS FAR AS THE PROCESS. I MEAN, SINCE EVEN THE '60s AND '70s AND THE ADVOCACY AND THINGS GOING ON ARE GREAT. I USED TO LIVE THERE. I MOVED TO CHICAGO WORKING IN MENTAL HEALTH PROGRAMS IN HOSPITALS IN SOUTHERN CHICAGO. AND THERE WERE THREE DOCTORS, PRIMARY CARE DOCTORS THAT SIGN AND SO THEY HAD A LOT OF PATIENTS THAT WOULD COME IN BUT WE WOULD FIND SOME OF THESE PLACES WOULD HAVE INTERPRETERS ON STAFF BUT THE ACTUAL OTHER STAFF MEMBERS WEREN'T TRAINED IN HOW TO COMMUNICATE, AND SO THEY ACTUALLY WOULD SET UP AN ORIENTATION ON A MONTHLY BASIS FOR NEW STAFF THAT WERE COMING IN TO THE HOSPITAL SO WHEN THERE WAS TURNOVER AND THEY WOULD HAVE NEW STAFF, THEY WOULD TAKE 15 OR 20 MINUTES EVERY MONTH TO EDUCATE THOSE NEW STAFF ABOUT THE NEED FOR INTERPRETERS BECAUSE THAT HAD BEEN AN ISSUE, BUT IF YOU THINK ABOUT DOING SOMETHING LIKE THAT EVERY MONTH, THE PEOPLE THAT LEAVE EVEN THE ONES THAT AREN'T THERE ANYMORE, THEY HAVE THAT KNOWLEDGE BASE OUTSIDE OF THAT HOSPITAL SYSTEM SO THAT'S SOMETHING THAT MAYBE WE COULD BE DOING AS PART OF THE HOSPITAL SYSTEM'S

ORIENTATION.
>> THIS IS DAVID. OOMPH GOING TO GO TO DR. WAX.
>> TOVAH WAX HERE. MY QUESTION ACTUALLY RELATES BOTH TO SOMETHING THAT JAN WITHERS SAID IN HER PRESENTATION ABOUT ADVOCACY AND THE ISSUE OF COMMUNICATION ACCESS FUNDING OR SUPPORT. LICENSED PROFESSIONALS, WE TALKED MOMENTARILY SOME TIME AGO ABOUT LICENSING FEES BEING USED TO CREATE ACCESS FUNDING. MY UNDERSTANDING IS THAT FEDERALLY AND STATEWIDE LICENSED PROFESSIONALS ARE REQUIRED TO TAKE COURSES IN ETHICS AS PART OF THEIR LICENSURE REQUIREMENT. IS THERE ANY VALUE IN REQUIRING, FOR EXAMPLE, CORES IN ACCESSIBILITY, SO FOR EXAMPLE, DEAF ACCESSIBILITY, MAYBE OTHER ACCESSIBILITY AS PART OF LICENSURE RENEWAL, THAT WAY PEOPLE WOULD GET AN EDUCATION AND ALL PROFESSIONALS WOULD BE GETTING EDUCATION THAT COULD BE ON AN ONGOING BASIS TO INCREASE AWARENESS AND ABILITY TO PROVIDE THIS KIND OF SERVICE.
>> THIS IS DAVID. CERTAINLY SOMETHING TO CONSIDER. GOING TO GO TO GREG.
>> THIS IS GREG. I THINK ONE OF THE THINGS I'M TRYING TO GET MY HEAD AROUND A LITTLE BIT IS NOT ON THE EMERGENCY SIDE LIKE WE WERE TALKING ABOUT IN MINNESOTA, BUT ON, HOPEFULLY, KEEPING PEOPLE OUT OF THE EMERGENCY ROOM AND GOING BACK TO HAVING THAT LONG-TERM RELATIONSHIP WITH A PROVIDER AND I MISSED THE LAST MEETING SO I APOLOGIZE FOR THAT, BUT I'M TRYING TO UNDERSTAND, YOU KNOW, OF THE FOLKS WHO HAVE HEARING LOSS IN NORTH CAROLINA, HOW MANY REQUIRE AMERICAN SIGN LANGUAGE VERSUS ASSISTED TECHNOLOGY VERSUS OTHERS TO-- BECAUSE I'M LOOKING AT THE AVERAGE FAMILY PHYSICIAN ON THE LOW SIDE SEES ABOUT 4,000 PATIENT VISITS A YEAR. SO IS IT 1% OF THE POPULATION THAT WOULD REQUIRE AN AMERICAN SIGN LANGUAGE INTERPRETER? IS IT, YOU KNOW, I'M JUST TRYING TO GET MY HEAD AROUND THAT TO TRY TO FIGURE OUT LARGE COST SITUATION.
>> THIS IS DAVID. I'M GOING TO DEFER TO JAN BECAUSE I'M NOT AS FAMILIAR WITH NORTH CAROLINA.
THIS IS JAN. THAT IS A GOOD QUESTION. UNFORTUNATELY, IT'S NOT REALLY FEASIBLE TO HAVE A GOOD, PRECISE COUNT OF ALL THE DEAF AND HARD OF HEARING AND DEAF-BLIND PEOPLE IN THE STATE BUT WHEN WE CAN DO IS MAKE SOME ESTIMATES, AND THE ESTIMATE IS CURRENTLY THAT WE HAVE ABOUT 1.2 MILLION PEOPLE WITH HEARING LOSS OF ANY KIND, ANYWHERE ON THAT SPECTRUM,

AND THE VAST MAJORITY OF THOSE WOULD BE HARD OF HEARING, AS IN THEY WOULD NOT USE AMERICAN SIGN LANGUAGE. THERE COULD BE AT THE LOW TEND 13,000 TO AS MANY AS 20,000, POTENTIALLY MORE THAT USE AMERICAN SIGN LANGUAGE, AND THEN THE DEAF-BLIND POP LAYING, AGAIN, USING A BROAD DEFINITION OF WHAT THAT COULD BE, WHICH COULD BE ANY LEVEL OF VISION OR HEARING LOSS COMBINED FROM MILD LOSSES IN BOTH TO SIGNIFICANT LOSSES IN BOTH THAT USE TACTILE SIGN SIGN LANGUAGE AND COULD BE 83,000 IN THAT SPECTRUM AND FINDING WHERE THOSE PEOPLE ARE IS THE PROBLEM BECAUSE WE DON'T KNOW WHERE EVERYONE LIVES AND ALL OF THOSE PEOPLE REQUIRE DIFFERENT TYPES OF HEALTHCARE AND SOME TEND TO STICK WITH ONE PROVIDER AND SOME JUST DON'T ACCESS THE HEALTHCARE SYSTEM. THEY JUST DON'T GO TO THE DOCTOR. THERE ARE ALSO MANY WHO DON'T WANT TO SEE A DOCTOR UNLESS IT'S ABSOLUTELY DIRE BECAUSE THEY DON'T WANT TO DEAL WITH ALL OF THAT DMIEWNCATION ACCESS SYSTEM SO DEPENDING ON WHAT KIND OF SPECIALIST THEY'RE SEEING, THAT COULD CHANGE THAT. I MENTIONED THIS, I BELIEVE, AT THE LAST MEETING AS AN EXAMPLE, THAT I'VE SEEN A CHINESE MEDICAL PROVIDER THAT WAS WONDERFUL. SORT OF ALTERNATIVE MEDICINE, IT'S VERY, VERY SPECIALIZED AND SOMETHING THAT I WANTED TO GO TO BUT MAYBE NOT SOMETHING THAT APPLIES BROADLY, SO REALLY, WE'RE JUST DOING THE BEST WE CAN DO GETTING THOSE NUMBERS.

>> LEE, DID YOU HAVE SOMETHING TO ADD? THIS IS DAVID AND THEN ONE MORE COMMENT.

>> JUST TO GIVE YOU A BASIC NUMBER AND I'M GOING TO RELY ON KELLE AND HER AGENCY AND I ASKED HER, IN HER AGE IS A, THEY PROVIDE INTERPRETING SERVICES TO THE TRIAD ARE AREA AND SOMEWHAT TOWARD THE TRAININGLE AND SHE SENT ME ONE MONTH OF JUST MEDICAL. I REMEMBER IT WAS LIKE A YEAR AND A HALF AGO AND JUST OFF THE TOP OF MY HEAD THERE WERE 400 REQUESTS FOR INTERPRETING SERVICES THAT WERE HEALTHCARE RELATED, I BELIEVE. KELLE CAN GO INTO MORE DETAIL. SHE'LL BE SPEAKING SOME AFTER LUNCH AND THAT WILL BE GOOD FOR HER TO SHARE AND SHE WILL GIVE YOU MORE DETAILS AND AGAIN, THE TRIAD AREA IS NOT LIKE EASTERN NORTH CAROLINA OR WESTERN NORTH CAROLINA, BUT I THINK IT WILL GIVE A GOOD REPRESENTATION.

>> THIS IS DAVID, WE'LL HAVE ONE LAST QUESTION FROM KATHLEEN.

>>> THANKS. I JUST WANTED TO SAY THAT YOU'VE TOUCHED ON A REALLY

IMPORTANT TOPIC WHERE THERE'S NO AGREEMENT ACROSS THE U.S. PEOPLE DISAGREE ABOUT HOW TO DEFINE WHO WE'RE COUNTING AND THERE'S NO GOOD PREVALENCE RATE, AND SO JAN'S NUMBERS FOR NORTH CAROLINA ARE, YOU KNOW, HIGH QUALITY FOR WHAT'S ADVILABLE AND WE DON'T HAVE A GOOD WAY TO COMPARE IF WE'RE REALLY IN THE BALLPARK OR IF WE'RE MISSING PEOPLE.
>> THIS IS DAVID. OKAY. WE NEED TO GO AHEAD AND BREAK FOR LUNCH NOW. SO IF EVERYBODY COULD BE BACK AT 1:00. OH, AND LUNCH, IF YOU GO OUT THE DOOR HERE TO THE FRONT, RIGHT SIDE OF THE ROOM, RESTROOMS IF YOU GO OUT THE BACK DOOR AROUND TO THE LOBBY. SO CARRY ON. AND LET'S TRY TO BE BACK AT 1:00.
TEST TEST TEST TEST TEST.
>> THIS IS DAVID SPEAKING. OKAY. HELLO, EVERYONE!
THANK YOU VERY MUCH. WE'D LIKE TO GET BACK TO OUR AFTERNOON SESSION. IF EVERYONE CAN GET BACK IN THEIR SEATS AND GET READY TO START. AND OUR FIRST PRESENTER ON THE AGENDA FOR THIS AFTERNOON IS LEE WILLIAMSON, AND HE WILL TALK ABOUT THE AVAILABILITY OF INTERPRETERS IN NORTH CAROLINA AND I DON'T THINK LEE NEEDS ANY INTERDUKS.
>> THIS IS ROB. I DIDN'T KNOW IF WE WANTED TO GO INTO THOSE DISCUSSION QUESTIONS FIRST. MAYBE A SHORTER VERSION OF THE TIME ON THE AGENDA BUT STILL GO INTO THEM A LITTLE BIT.
>> MY UNDERSTANDING WAS WE WERE GOING TO DO THAT AFTER KELLE'S PRESENTATION.
>> SET OF DISCUSSION QUESTIONS.
>> GOTCHA. OKAY.
>> ALL RIGHT. THIS IS DAVID SPEAKING. ALL RIGHT, EVERYBODY. HANG ON A SECOND . OKAY. LET ME CHECK IN WITH PEOPLE ON THE PHONE. I'M HOPING THAT PEOPLE ON PHONE ARE CONNECTED. OKAY.
>> YES, WE ARE. IT'S HOLLY, HI.
>> GREAT. THANK YOU. AND YOU WERE ABLE TO GET THE QUESTIONS THAT WERE EMAILED BY ROB DURING LUNCH, CORRECT ?
>>
>> THIS ISLE HO LIST AGAIN. GREAT LUNCH.
>> WONDERFUL, OKAY.
>> ALL RIGHT. SO WE WILL START WITH OUR DISCUSSION QUESTIONS RELATED TO

THE COMMUNICATION ACCESS FUND AND/OR THE CREATION OF A BILLING CODE FOR MEDICAID, AND THAT WAS SOME OF THE DISCUSSION THAT WE HAD BY EMAIL AMONGST THE GROUP RELATED TO A BILLING CODE SPECIFICALLY FOR MEDICAID. SO, ARE THERE ANY QUESTIONS RELATED TO MEDICAID, PRIVATE INSURANCE COMPANIES, OR OTHER BEST PRACTICES?
>> YES.
>>> ARE THERE NO IC10 CODES FOR DEAF-HARD OF HEARING?
>> AND I DO NOT KNOW. I DON'T BELIEVE SO. DOES ANYBODY KNOW? YES, ADAM. SORRY.
>> THERE ARE ICD10 CODES FOR DIFFERENT TYPES OF HEARING LOSS BUT DEGREE OF HEARING LOSS SPECIFYING-- IT HAS MORE TO DO WITH THE MECHANISM OF THE HEARING LOSS THAN THE DEGREE OR IMPLICATIONS OF THE HEARING LOSS. ICD10 CODES REALLY DON'T SUIT HOW WE HANDLE HEARING LOSS OR HOW IT AFFECTS LIVES.
>> DAVID'S RECOGNIZING JAAP
>> THISING JAN
>> THIS IS JAN SPEAKING. LET ME OFFER A LITTLE EXPLANATION. THIS CODE IS SPECIFIC TO AUDIOLOGICAL ISSUES OR CONDITIONS. WITH WE'RE TALKING ABOUT COMMUNICATION ACCESS, I HAVE BEEN IN DISCUSSIONS WITH PEOPLE WITHIN THE DIVISION OF HEALTH BENEFITS IN TERMS OF SETTING UP A SEPARATE STAND-ALONE SERVICE FOR COMMUNICATION ACCESS. SO LET ME GIVE YOU A GOOD EXAMPLE USING MYSELF AS AN EXAMPLE. A COUPLE OF YEARS AGO, I HAD KNEE SURGERY. KNEE SURGERY HAS ABSOLUTELY NOTHING TO DO WITH MY HEARING LOSS. MY HEARING LOSS WAS NEVER DISCUSSED. NOW IT'S THERE SOMEWHERE IN MY RECORD THAT I HAVE A HEARING LOSS JUST AS AN FYI FOR COMMUNICATION PURPOSES. NOW CURRENTLY, WHEN-- WELL, PHYSICIANS DO GET REIMBURSED FOR SIGN LANGUAGE INTERPRETING SERVICES BUT ONLY AS PART OF THE GENERAL PACKAGE, THE GENERATE THAT THEY CURRENTLY GET, WHICH IS NOT SUFFICIENT TO ADEQUATELY REIMBURSE THE PHYSICIANS FOR THOSE SERVICES, SO WE ARE LOOKING AT CREATING A SEPARATE, STAND-ALONE SERVICE SO THAT WE CAN BETTER MANAGE THE RATE FOR SIGN LANGUAGE INTERPRETING SERVICES.
THAT'S WHERE WE ARE NOW WITH THAT. BERKELEY.
>> SO HOW DOES THAT-- SO DOES THAT-- IF THERE WERE A SEPARATE RATE FOR REIMBURSING FOR INTERPRETING FOR MEDICAID-ENROLLED PATIENTS, DOES THAT

CAUSE SOME CONFUSION OR ANY PROBLEMS FOR THE FACT THAT UNDER THE ADA PEOPLE ARE SUPPOSED TO BE PROVIDING INTERPRETING SERVICES AND THEREFORE, IF YOU START PAYING FOR IT FOR ONE SET OF PATIENTS, DOES THAT CREATE PROBLEM FOR ACCESS FOR OTHER PATIENTS? OR, ARE WE CONCERNED THAT CAN HAPPEN? BECAUSE THEN YOU'RE GETTING REIMBURSED FOR SOME PEOPLE AND NOT OTHERS, DOES THAT CAUSE FURTHER CONFUSION? OR DO YOU WANT TO GET TO THE POINT WHERE YOU ADVOCATE FOR PRIVATE INSURANCE TO PAY FOR INTERPRETERS VERSUS WHAT THE CURRENT LAW SAYS. I'M CURIOUS OF WHAT THE IMPLY KAY-- IMPLICATIONS OF THAT ARE.

>> THIS IS JAN SPEAKING. I UNDERSTAND YOUR CONCERN. CURRENTLY WITH THE AMERICANS OF DISABILITIES ACT AND THE 1983 REHABILITATION ACT, HEALTHCARE PROVIDERS ARE REQUIRED TO PAY FOR COMMUNICATION ACCOMMODATIONS . INCLUDING SIGN LANGUAGE INTERPRETERS AS AN EXAMPLE. AND-- WELL, TO ANSWER YOUR QUESTION, THINK ABOUT DIFFERENT DISABILITIES. THEY SHOULD HAVE ALREADY BUILT A RAMP IN THEIR OFFICE FOR THOSE WHO NEED A RAMP. THAT'S A ONE-TIME EXPENSE. THEY SHOULD BE PROVIDING LARGE-PRINT MATERIALS WHICH IS PROBABLY A ONE-TIME EXPENSE OF PRINTING DIFFERENT DOCUMENTS, AND THE COST IS MINIMAL. THE BIG ISSUE FOR SIGN LANGUAGE INTERPRETERS OR CAPTIONING SERVICES IS THE HIGH COST. THEREFORE, WE'RE LOOKING AT TRYING TO TAKE THAT OUT OF THE GENERATE AND SEPARATE IT FROM THE GENERATE AND TO MAKE IT A STAND-ALONE SERVICE SO THAT WE'RE PAYING SEPARATELY FOR THIS RECURRING SERVICE. BUT WE'RE NOT LOOKING AT OTHER DISABILITIES BECAUSE WE-- BUT WE DON'T SEE IT AS EXCLUDING THEM BECAUSE THEY'RE NOT PER-VISIT EXPENSES FOR THOSE TYPES OF ACCOMMODATIONS, WHERE THIS ONE IS A PER-VISIT EXPENSE. DOES THAT MAKE SENSE?

>> TOVAH WAX HERE. I WANTED TO ADD A LITTLE BIT TO THE ANSWER HERE. MEDICAID DOES REIMBURSE AND DOES HAVE A LINE ITEM FOR REIMBURSEMENT OF INTERPRETER SERVICES. THE PROBLEM IS THAT GENERALLY IT IS A UNIT-BY-UNIT. YOU PAY BY UNIT. IT'S A 15-MINUTE UNIT. NOW MOST INTERPRETING SERVICES-- I'M NOT TALKING ABOUT EMERGENCY SERVICES BUT NORMAL INTERPRETING SERVICES ARE IN TWO-HOUR BLOCKS, SO IF YOU GO TO A DOCTOR'S APPOINTMENT AND YOU SPEAK TO THE DOCTOR FOR 15, 20 MINUTES, THEN THE INTERPRETER STILL HAS TO BE PAID FOR TWO HOURS OF SERVICE IN CASES SO EVEN THOUGH THERE IS A BLOCK OF SEPARATE ITEMS FOR REIMBURSEMENT IS USUALLY NOT ENOUGH TO COVER THE

COST OF THE INTERPRETER. SECOND OF ALL, YOU HAVE TO PAY FOR TWO HOURS ANYWAY IN MOST CASES. IT DOESN'T WORK AS FAR AS INTERPRETING SERVICES GO VERSUS MEDICAID SERVICES.

>> THIS IS JAN SPEAKING. REGARDING PRIVATE INSURANCE COMPANIES, I AM NOT AN EXPERT ON THIS, BUT TO MY KNOWLEDGE, KAISER PERMANENTE IS THE ONLY INSURER, I BELIEVE-- DEFINITELY THE LARGEST THAT I KNOW OF, THAT ACTUALLY REIMBURSES PHYSICIANS FOR INTERPRETING SERVICES AND KAISER PERMANANENTE IS MANAGED CARE FACILITY IN CALIFORNIA AND THEY PAY FOR INTERPRETING SERVICES THERE. I AM NOT AWARE OF ANY PRIVATE INSURANCE COMPANIES THAT PAY FOR INTERPRETING SERVICES. I TALKED WITH HOWARD ROSEBLUM ABOUT THAT AND HE SAID THERE WERE DRAWBACKS. CIEZ KERR DO THAT BECAUSE OF THEIR SIZE AND HOW THEY'RE STRUCTURED BUT THERE ARE SO MANY INSURANCE COMPANIES PLUS THERE ARE SO MANY PATIENTS WHO DON'T HAVE INSURANCE AT ALL BUT THEY ARE EQUALLY ENTITLED TO SERVICES AS MUCH AS ANYONE ELSE IS. ESPECIALLY IF IT'S AN EMERGENCY SERVICE.

>> HI. THIS IS MELISSA WITH BLUE CROSS/BLUE SHIELD. FROM A PRIVATE INSURANCE PERSPECTIVE, I THINK I SHARED LAST MEETING OR THE MEETING BEFORE LAST, WE'RE OBLIGATED JUST AS PROVIDERS ARE WITH RESPECT TO THE ADA, WITH RESPECT TO WHAT I REFER TO AS SECTION 1557 WHICH IS PART OF THE AFFORDABLE CARE ACT ALL BASED ON THE RECEIPT OF FEDERAL FUNDS AND/OR INTERACTING AND CONTRACTING WITH MEDICARE, WITH THE ACA, NON-EXCHANGE BUSINESS, ET CETERA, AND I'M CHALLENGED BECAUSE THERE'S THE EMOTIONAL SIDE OF ME AS I SIT HERE AND LISTEN TO ALL OF THESE DISCUSSIONS ON THE NEED TO INSURE THAT FOLKS ARE RECEIVING THE CARE AND HAVING EFFECTIVE COMMUNICATIONS AT THE RIGHT TIME, AT THE RIGHT PLACE, ALL OF THOSE THINGS BUT I'M ALSO CHALLENGED WITH THE BUSINESS SIDE OF IT WITH REGARD TO CREATE A CODE, FOR EXAMPLE, OR IF WE'RE TALKING ABOUT THE FUND AND WHO PAYS INTO IT BECAUSE THE MONEY HAS TO COME FROM SOMEWHERE. AND SO FROM AN INSURER PERSPECTIVE, WE REFER TO IT AS SQUEEZING THE BALLOON, RIGHT, IN TERMS OF TAKING IN -- IF YOU TAKE AND COVER SOMETHING HERE, THEN YOU'RE GOING TO BE SQUEEZING THE BALLOON AND IT'S GOING TO POP UP IN TERMS OF AN INCREASE SOMEWHERE ELSE, AND WHEN IT REALLY GETS DOWN TO IT, IT GETS DOWN TO THE PREMIUMS AND AFFORDABLE OVERALL. I'M NOT SAYING THAT ONE INDIVIDUAL TYPE OF SERVICE IMPACTS IT, BUT IT'S THAT CUMULATIVE EFFECT,

WHICH IS WHERE YOU AND I HAD SIDEBAR CONVERSATIONS. I'M REALLY INTERESTED IN THE DATA. I'M REALLY INTERESTED IN UNDERSTANDING WHERE THE PROBLEM LIES AND THEN INSURING THERE'S A BALANCE. THE ADA, WHEN IT WAS PUT INTO PLAY, IF CONGRESS WANTED CERTAIN FOLKS TO BE RESPONSIBLE FOR PAYING FOR PIECES OF IT, THEY WOULD HAVE THROUGH CONGRESSIONAL INTENT AND THROUGH THE STATUTE HAD SAID X, Y OR Z, THEY MADE IT BORNE BY ACROSS ALL ENTITIES, WHETHER YOU'RE RETAIL, WHETHER YOU'RE HEALTHCARE, WHETHER YOU'RE AN INSURER OR OTHERWISE. I JUST WANT TO BE ABLE TO SHARE A LITTLE BIT OF PERSPECTIVE AS I'VE BEEN LISTENING TO THE CONVERSATION.

>> WHAT DO YOU ALL THINK IS THE MOST EXPENSIVE ACCOMMODATION THAT PRACTICES HAVE TO MAKE ASIDE FROM SIGN LANGUAGE INTERPRETING? I'M JUST CURIOUS. LIKE WHAT CAN WE LEARN FROM THE NEXT MOST EXPENSIVE THING?

>> I'M NOT SURE THERE'S ANYTHING THAT'S CLOSE. THIS IS GREG. MOST OF THE THINGS ARE LIKE ONE-TIME EXPENSES. WHEN YOU'RE BUILDING A BUILDING OR RETROFITTING A BUILDING. PROBABLY THE NEXT CLOSEST THING IS THE LAW REQUIRES THAT YOU PROVIDE INTERPRETING SERVICES FOR ANY LANGUAGE BARRIER, SO YOU ALSO HAVE TO HAVE SPANISH LANGUAGE. WOULD YOU HAVE TO HAVE MONG. YOU WOULD HAVE TO HAVE FRENCH, DEPENDING ON WHAT YOUR PATIENTS ARE, THOSE, HOWEVER, ARE-- CAN BE SOLVED IN A LOT LESS EXPENSIVE WAYS WITHOUT AS MUCH TECHNOLOGY. MANY OF THE TIMES IF THERE'S A LARGE HISPANIC POPULATION IN THE COMMUNITY, THEY WILL HAVE SOMEBODY ON STAFF WHO DOES MEDICAL INTERPRETING OF SPANISH, BUT IT, TOO, HAS TO HAVE MEDICAL INTERPRETING THAT, FOR INSTANCE, WE HAD A PRACTICE SEVERAL YEARS AGO THAT WE WERE WORKING WITH ON A PROJECT IN THE HISPANIC COMMUNITY WHERE THEY HIRED SOMEONE ELSE-- THEY HIRED SOMEBODY FROM THE HISPANIC COMMUNITY FOR A JOB THAT WASN'T FULL-TIME INTERPRETING AND THEY GAVE THEM MEDICAL INTERPRETING SKILLS AND WHEN THEY HAD A PATIENT THAT NEEDED IT, THEY WERE ALREADY THERE SO THEY-- SO THEY SORT OF HAD TWO JOBS ARE&WERE FILLING TWO ROLES. THAT'S VERY DIFFICULT WITH AMERICAN SIGN LANGUAGE. ANOTHER EXAMPLE IS IF IT'S A LANGUAGE THAT YOU DON'T SEE VERY OFTEN, YOU CAN GET TELEPHONEICALLY INTERPRETED AND YOU'RE NOT AS WORRIED ABOUT BANDWIDTH AS YOU DO WITH VIDEO. THAT'S THE CLOSEST THING AND IT'S STILL NOTHING LIKE WHAT THIS REQUIRES.

>> THANK YOU.

>> I DON'T KNOW IF THAT WAS A GOOD ANSWER OR NOT.
>> OTHER COMMENTS?
>> I JUST WONDERED WHAT STATES IT SAID HERE 14 STATES REIMBURSE FOR INTERPRETIVE SERVICES, FOR MEDICAID. DO WE KNOW WHAT THOSE STATES ARE AND WHAT THE COST THE STATE HAS INCURRED, THAT TYPE OF THING?
>> THIS IS LEE. YEAH. I'VE LOOKED INTO WHAT OTHER STATES HAVE DONE. THE 14 STATES THAT REIMBURSE FOR MEDICAID, YOU CAN-- A LOT OF THE STATES WILL REPORT THE DATA OF HOW MUCH THEY SPEND AND 80% OF IT IS SPENT ON SPOKEN LANGUAGE INTERPRETING SERVICES BECAUSE THAT'S THE MAJORITY OF IT. BECAUSE OF THAT, THE WAY MANY STATES HAVE ESTABLISHED THEIR REIMBURSEMENT RATES, THEY'RE A GOOD FIT FOR SPOKEN LANGUAGE INTERPRETING SERVICES. THEY PAY FOR TELEPHONE INTERPRETING SERVICES, FOR VIDEO REMOTE INTERPRETING SERVICES AND THE PAY SCALE OR THE PAY RATE IS SET SO LOW FOR SIGN LANGUAGE INTERPRETING SERVICES THEY DON'T EVEN PARTICIPATE. SO YOU HAVE A FEW STATES THAT ARE REALLY UNIQUE. THE STATE OF TEXAS IS THE ONLY STATE IN THE COUNTRY THAT WE REIMBURSE FOR SIGN LANGUAGE INTERPRETING SERVICES BUT ONLY FOR PRACTICES THAT HAVE 15 OR FEWER EMPLOYEES. THAT'S THEIR LITTLE ROLE. THAT'S THE ONLY THAT I FOUND OUT THERE THAT DEALS WITH SIGN LANGUAGING INTERPRETING SERVICES ONLY. WASHINGTON STATE DOES REIMBURSEMENT FOR SIGN LANGUAGE INTERPRETING SERVICES IN A RATE THAT SIGN LANGUAGE INTERPRETERS DO PARTICIPATE. I HAVE A CONTACT THERE AND I PLAN ON REACHING THEM TO FIND OUT. I'M NOT SURE OF ANY OTHER STATES THAT ARE REALLY ACTIVE WITH INCLUDING SIGN LANGUAGE INTERPRETING SERVICES. THAT'S BEEN THE BIG CHALLENGE.
>> DAVID HENDERSON.
>> I'M INTRIGUED. THIS IS DAVID HENDERSON WITH THE MEDICAL BOARD. I'M INTRIGUED WITH THE CONSORTIUM CONCEPT IN MINNESOTA AND I'M WONDERING, HAS THERE BEEN ANY DISCUSSIONS WITH THE HEALTHCARE ASSOCIATION OR WITH ANY PARTICULAR HEALTHCARE SYSTEM IN NORTH CAROLINA TO TALK ABOUT DOING SOMETHING SIMILAR HERE?
>> YES, JAN.
>> THIS IS JAN SPEAKING. I CAN ANSWER THAT. AND THE ANSWER IS NO. WE HAVE NOT APPROACHED THEM YET. I SEE THIS TASK FORCE AS THE STARTING POINT TO BEGIN THAT WORK. SO WE WANTED TO MAKE SURE THAT YOU ARE AWARE OF THE

ISSUES AND WE WANTED TO INVITE YOU ALL TO HELP US COME UP WITH THOSE GOOD SOLUTIONS.
>> THE CONSORTIUM IDEA IS REALLY INTERESTING. I THINK MINNEAPOLIS ST. PAUL IS GEOGRAPHICALLY AND SYSTEM-WISE A LOT DIFFERENT THAN OUR NORTH CAROLINA HEALTH SYSTEMS. I'M WONDERING IF ANYBODY KNOWS WHAT A LARGE HOSPITAL DOES AROUND EMERGENCY INTERPRETING SERVICES IN NORTH CAROLINA? WHAT DOES DUKE, UNC OR WAKE MED? DO THEY HAVE ANYONE ON CALL OR IN-HOUSE? I KNOW WHAT THEY DO FOR SCHEDULED APPOINTMENTS OR IS IT VRI? WHAT ARE WE DOING IN OUR LARGE HOSPITALS IN THE EMERGENCY ROOM? WE CAN FIND OUT.
>> THIS IS LEE. EVERY HOSPITAL, MAJOR HOSPITAL SYSTEM HAS A DIFFERENT SYSTEM. MOST OF THEM WILL CONTRACT WITH ONE INTERPRETING AGENCY, BUT CURRENTLY, MOST HAVE VRI IN THE EMERGENCY ROOM. YOU WALK IN. YOU HAVE VRI AND A CALL MAY BE MADE TO AN AGENCY. IT'S NOT VERY CONSISTENT RIGHT NOW. SO IT'S REALLY HARD TO SAY WHAT EACH AGENCY DOES. I'M SURE OUR FREELANCERS WHO ARE WORKING HERE TODAY CAN PROBABLY TELL YOU BUT THEY CAN'T BECAUSE THEY'RE WORKING. I'VE BEEN OUT OF THE FREELANCE FIELD FOR A WHILE. SO VRI WASN'T AROUND WHEN I WAS FREELANCING.
>> THANK YOU.
>> OUR QUALITATIVE DATA HAS STATEMENTS FROM PEOPLE SAYING THEY GO TO THE EMERGENCY DEPARTMENT AND THEY HAVE TO WAIT A COUPLE OF HOURS TO GET THE INTERPRETING SET UP.
>> AND I THINK THAT SPEAKS TO YOUR POINT, DAVID. I'M IMAGINING IF WE HAD AN INTERPRETER IN RALEIGH AND WE WERE TRYING TO SHARE THAT PERSON WHO WAS ON CALL IN DURHAM AND CHAPEL HILL AND THEY HAVE TO, YOU KNOW, THEY HAVE TO BE CALLED. THEY HAVE TO GET DRESSED AND DRIVE OVER TO THE EMERGENCY ROOM IN CHAPEL HILL, I DON'T KNOW HOW MUCH TIME IT SAVES IN A LARGER GEOGRAPHIC REGION WHEN YOU HAVE A CONSORTIUM LIKE THEY DO IN MINNEAPOLIS VERSUS CONTRACTING INDEPENDENTLY WITH AGENCIES BUT MAYBE YOU GET OVER SOME OF THE FINANCIAL BARRIER BY DEVELOPING THE CONSORTIUM. YEAH.
>> THIS IS DAVID AGAIN. MORE AND MORE PHYSICIANS AND OTHER HEALTHCARE PROVIDERS, AS YOU ALL PROBABLY KNOW ARE EMPLOYED BY HEALTHCARE SYSTEMS. IF YOU ARE LOOKING FOR LOW-HANGING FRUIT THE BEST WAY TO GET TO

THE MOST PATIENTS WHO NEED, YOU KNOW, COMMUNICATION ACCESS SERVICES THAT WOULD SEEM TO BE A GOOD PLACE TO START AND IT MIGHT BE GOOD TO HAVE SOMEONE FROM THE HEALTHCARE ASSOCIATION INVOLVED. I KNOW WE DON'T HAVE TOO MANY MEETINGS LEFT, BUT THEIR INPUT MIGHT BE HELPFUL.
>> THIS IS JAN SPEAKING, AND I AGREE WITH YOU, DAVID. I DO WANT TO MAKE ONE COMMENT. I THINK IT'S IMPORTANT THAT WE FIND OUT FROM ALL OF THE DIFFERENT HOSPITAL SYSTEMS HERE IN NORTH CAROLINA WHETHER OR NOT THEY PAY FOR INTERPRETING SERVICES FOR THE CLINICS THAT APPEAR TO BE INDEPENDENT FROM THEM, OR DO THEY REQUIRE THE CLINICS TO PAY FOR INTERPRETERS ON THEIR OWN? SO I THINK THAT'S A QUESTION WE NEED TO ASK.
>> JUST TO LET YOU KNOW, DAVID, WE HAVE INCLUDED THE HEALTHCARE ASSOCIATION IN THIS TASK FORCE. THE MEMBER HAS HAD TROUBLE WITH SCHEDULING AND WE'RE GOING TO BE SCHEDULING AN INDEPENDENT MEETING TO UPDATE THEM IN THE NEXT FEW WEEKS. WE'RE TRYING.
>> THIS IS BERKELEY. ON A SLIGHT TANGENT BUT RELATED TO ALL THIS, THE OTHER THING I DON'T WANT US TO LOSE WHEN HOWARD WAS HERE HE SAID THEY DEVELOPED GUIDELINES FOR VRI AND WHAT THE MINIMUM STANDARDS YOU NEED, AND I THINK PURSUING THAT IS ALSO AN IMPORTANT PART OF THIS. IF WE KNOW IT'S BEING HEAVILY USED, WE SHOULD DEFINITELY DISCUSS AND PURSUE HOW TO MAKE A RECOMMENDATION AROUND THAT AS A TASK FORCE AND NOT JUST LET IT GO.
>> THIS IS JAN, YES, I ABSOLUTELY AGREE.
>> DAVID RECOGNIZING LEE.
>> LEE HAS BEEN RECOGNIZED.
[LAUGHTER]
YEAH, PART OF MY PRESENTATION, I'M GOING TO TALK ABOUT THE VRI AND JUST KIND OF HIGHLIGHT SOME OF HOWARD'S-- NAD'S RECOMMENDATION AND I THINK ROB IS GOING TO SHARE THE POSITION PAPER THEY HAVE AND IT GOES GREAT DETAIL OF THEIR RECOMMENDATIONS, AND THAT WOULD BE GOOD. SIDEBARRING WITH KELLE A MOMENT AGO AND KELLE, THEIR AGENCY DOES PROVIDE SERVICES TO UNC AND THEIR SYSTEM. KELLE, IF YOU WANT TO SHARE BRIEFLY WHAT KIND OF SYSTEM DO THEY HAVE IN PLACE? SOMEONE WALKS INTO THE EMERGENCY ROOM, WHAT'S IT LIKE?
>> THIS IS KELLE. IT'S NOT PERFECT AND IT'S IMPROVING EVERY DAY BUT GENERALLY UNC USES A DISPATCHING SYSTEM CALLED SERVICE HUB AND I DON'T

KNOW IF YOU'RE FAMILIAR WITH THAT AND THEY USE IT FOR THEIR SPOKEN LANGUAGE INTERPRETERS SO ANY STAFF MEMBER ON ANY UNIT IN ANY OFFICE PRACTICE CONNECTED TO WITH SERVICE HUB PUTS THIS A REQUEST IN THE COMPUTER FOR SIGN LANGUAGE INTERPRETER. IT'S THEN SEEN BY THE PATIENT RELATIONS DEPARTMENT, COULD BE ANOTHER DEPARTMENT, WHO TAKES THE REQUEST AND ACTS UPON IT. SPEAKING SPECIFICALLY FOR OUR AGENCY, WE'VE CONTRACTED WITH THEM FOR A LONG TIME AND THEY HAVE LINKED US INTO THEIR DISPATCHING SYSTEM SO THE MINUTE A REQUEST IS PUT IN FOR A SIGN LANGUAGE INTERPRETER, WHETHER IT'S RIGHT THIS MINUTE OR IN SIX MONTHS, IT IMMEDIATELY GETS ALERTED TO OUR OFFICE AND WE RECEIVE AN EMAIL DOCUMENTATION AND WE CAN SEE JUST BASIC INFORMATION. WE DO HAVE TO CALL AND FOLLOW UP AND GET OTHER DETAILS BUT THAT'S WHAT UNC USES FOR THE MAIN HOSPITAL. SLOWLY INKING OUT INTO THEIR PHYSICIAN NETWORK AND CLINICS OUT IN THE FIELD BUT THAT'S PRIMARILY FOR THE HOSPITAL.

>> THIS IS LEE SPEAKING. UNC SEEMS TO HAVE SOMETHING THAT'S FAIRLY GOOD IN PLACE. YOU CAN GO NEXT DOOR TO DUKE AND I DON'T THINK THEY HAVE ANYTHING ANYTHING AS COMPLEX TO THAT OR SOPHISTICATED. KELLE, DOES THAT INCLUDE REX HOSPITAL THAT'S PART OF THE UNC SYSTEM? ISN'T REX PART OF THE UNC SYSTEM?

>> YES, REX IS PART OF THE UNC SYSTEM AND ANOTHER PREVIEW OF WHAT I WAS GOING TO MENTION IS CONE HEALTHS HAD A DIFFERENT SYSTEM WITH EPIC, WITH THEIR ELECTRONIC MEDICAL RECORDS, AND I BELIEVE IT'S THROUGH THE CADENCE FEATURE IN EPIC. I'M NOT WELL VERSED IN THAT. WHAT HAPPENS WITH THAT IS THE PATIENT HAS THE RESPONSIBILITY TO IDENTIFY IN THEIR PROFILE WHAT THEIR LANGUAGE OF CHOICE IS. WHEN THEY IDENTIFY SIGN LANGUAGE AS THEIR MODE OF COMMUNICATION, ANY TIME AN APPOINTMENT IS MADE FOR THAT PATIENT, IT AUTOMATICALLY ALERTS, AGAIN, THE PATIENT RELATIONS OFFICE AND STARTS TO GENERATE THAT PROCESS FOR COMMUNICATION ACCESS. THE PATIENT HAS TO IDENTIFY. WE NEED TO EDUCATE AND ADVOCATE TO FOLKS TO MAKE SURE THEY DO THAT. IT DOES START THE BALL ROLLING IN THAT RESPECT ALSO.

>> THIS IS ADAM. HAVING THE BENEFIT OF WORKING IN THE UNC SYSTEM, I KNOW WHERE IT FALLS SHORT. AFTER OUR FIRST TASK FORCE MEETING, THE FOLLOWING WEEK I WAS SEEING A PATIENT THAT SIGNS AND THERE WAS NO INTERPRETER THAT APPEARED AND I WAS HOPPING MAD BECAUSE I JUST HAD THIS TASK FORCE

MEETING AND WHAT HAPPENED WAS I FOUND OUT THAT ONE OF OUR NEW MEDICAL ASSISTANCE SCHEDULED THE APPOINTMENT AND SHE WASN'T TRAINED ON SERVICE HUB YET. BY MAKING IT PASSIVE, YES, THE PATIENT STILL HAS TO IDENTIFY OR SOMEBODY HAS TO HELP THEM IDENTIFY THEIR LANGUAGE OF CHOICE BUT AT LEAST IT CREATES A SYSTEM THAT IS HARDER TO MESS UP.
>> THIS IS DAVID. SO IN MINNESOTA, FOR EXAMPLE, I WAS PART OF THE HEALTHCARE EAST SYSTEM. AND I BELIEVE THEY USED EPIC AS A PLATFORM AS WELL. BUT THE PROVIDER THEMSELVES, SOMEONE AT SOME POINT PUT IN THE RECORD THAT I WAS DEAF SO IT COULD POP UP THAT ANYONE THAT LOOKED AT IT WOULD KNOW I NEEDED TO SCHEDULE AN INTERPRETER. THE INTERPRETERS COULD SEE THAT AND EVEN IF THE OFFICE DIDN'T REQUEST IT, THE INTERPRETER WOULD SHOW UP BECAUSE IT WAS IN THE SYSTEM. SO SOMEONE ELSE WAS MAKING THAT HAPPEN. THAT WAS ONE OF THE WAYS THEY RESOLVED THAT.
>> THIS IS EILEEN CARTER. I REPRESENT THE NORTH CAROLINA PHYSICAL THERAPY ASSOCIATION . I THINK CAN SPEAK FOR MY OTHER COLLEAGUES THAT PROVIDE OT AND SPEECH, LET'S REMEMBER THAT WE REPRESENT NOT JUST THE MAJORITY BUT WE HAVE TO REPRESENT THE MINORITY. SO LET'S NOT-- I MEAN THIS IS WONDERFUL ABOUT THE BIG HOSPITALS BUT WHAT ABOUT THE LITTLE FOLKS OUT IN THE RURAL AREA THAT HAS BEEN BROUGHT UP MANY, MANY TIMES THROUGHOUT ALL OF THE MEETINGS THAT I'VE ATTENDED AND I'M HONORED TO BE HERE BUT WE NEED TO REMEMBER THAT. I MEAN, I'M IN SMALL-- WILSON IS NOT THAT BIG BUT IT'S CONSIDERED RURAL BY FEDERAL LAW. WELL, I CAN TELL YOU THAT FINANCIAL BARRIER WAS A BIG PIECE FOR ME AS AN OWNER OF A PRIVATE PRACTICE WHEN THEY TOLD ME THAT THE MINIMAL I COULD HIRE THEM FOR WAS THREE HOURS AND IT WAS $95 AN HOUR. WELL, I'M NOT GOING TO SEE A PATIENT FOR THREE HOURS. SO YOU SEE, THERE'S A FINANCIAL BARRIER FOR THE LITTLE FOLKS THAT ARE IN THAT RURAL AREA TRIKING TO GET THOSE INTERPRETERS IN. SO I SEE IT AND I'M NOT GOING TO SPEAK FOR MY COLLEAGUES, BUT I SEE IF WE CAN LOOK AT OUR STATE LICENSURE AND HAVE AN APPORTIONMENT OF THAT STATE LICENSURE TO GO INTO THE BIN OF FUNDS, WHATEVER WE WANT TO CALL IT, AND BE ABLE TO PROVIDE THAT RESOURCE, THEN WE ARE GOING TO REACH THE PEOPLE OUT IN THE RURAL AREA AND WE'RE GOING TO MEET THE MINORITY OR THE MAJORITY. I THINK IF WE HAVE THAT FUNDING THAT WE'VE TALKED ABOUT MANY, MANY TIMES I THINK THAT'S A GREAT IDEA, IF WE CAN JUST WORK IT OUT FROM THIS TASK FORCE PERSPECTIVE.

THANK YOU.
>> THIS IS BETH HATHAWAY WITH THE OT ASSOCIATION. I JOKED LAST TIME THAT MY MOM ASKED ME WHY YOU GUYS ASKED ME HERE, AND LAST WEEK, IT BECAME A LITTLE MORE CLEAR BECAUSE WHEN WE START TALKING ABOUT LICENSURE FEES , IT WAS LIKE, OH, THAT COULD BE WHERE I GET INVOLVED. I SPOKE WITH MY LOBBY-- OUR LOBBYIST AND HER KNEE-JERK REACTION WAS DIFFERENT THAN MINE. MINE WAS SIMILAR TO YOURS, EILEEN, I WAS LIKE, YEAH, MY LICENSURE FEES HAVEN'T GONE UP AND I'VE BEEN AN OT FOR 35 YEARS SO YEAH, RAISE IT BY $10, BUT THE LOBBYIST SAID AND I THINK THIS IS A POINT WORTH CONSIDERING, IF YOU DO THAT FOR THIS GROUP OF PEOPLE, THERE'S LOTS OF OTHER GROUPS OF PEOPLE IN LINE WAITING FOR FUNDING OR THAT NEED FUNDING, SO THAT WAS HER PRIMARY HESITATION IN TERMS OF JUMPING IN WITH BOTH FEET.
>> THIS IS TOVAH WAX HERE. I THINK SO FAR WE HAVE BEEN TALKING ABOUT PROVIDING THE ACCESS FOR WHAT APPEARED TO BE MOSTLY PHYSICAL, MEDICAL TYPES OF CONDITIONS. THERE ARE QUITE A FEW CONDITIONS, BOTH MEDICALLY AND IN THE MENTAL HEALTH AREA THAT ARE MORE THAN ONE SESSION OR MORE THAN A FEW SESSIONS AND THAT HAS TO ALSO BE TAKEN INTO ACCOUNT BECAUSE WE STILL HAVE LAWS ON THE BOOKS THAT MAKE MENTAL HEALTH ON PARODY WITH PHYSICAL HEALTH ISSUES, THEREFORE, THE COST OF THAT OT, PT, MENTAL HEALTH, SUBSTANCE ABUSE, ALL THESE THINGS ALSO HAVE TO BE TAKEN INTO ACCOUNT, AND I WANTED TO COMMENT ON-- ABOUT THE QUESTION REGARDING THE USE OF LICENSING FEES. WE HAVE ANTICIPATED THAT QUESTION AND WE UNDERSTAND THAT OTHER GROUPS MIGHT JUMP ON-- MIGHT WANT TO JUMP ON THAT BANDWAGON BUT THE FACT REMAINS THAT COMMUNICATION ACCESS IS STILL ONE OF MOST EXPENSIVE THINGS THAT WE HAVE TO DEAL WITH.
>> THIS IS KELLE. IT MAY HAVE GOTTEN MENTIONED LAST TIME WHEN I WASN'T HERE BUT THE NORTH CAROLINA BAR ASSOCIATION DOES REIMBURSE FOR SIGN LANGUAGE INTERPRETERS AND THEIR FEES COME FROM THEIR PARALEGAL CERTIFICATION PROGRAM. I'M NOT SURE WHAT KIND OF NUMBERS AND INFORMATION THERE MIGHT BE. THERE ARE LOTS OF DIFFERENT LICENSES AND TRAINING PROGRAMS THAT MIGHT BE POTENTIAL OPTIONS FOR FUNDING. GLF THIS IS SHELLEY CRISTOBAL. I'M AN AUDIOLOGIST AND I SEE LOTS OF FOLKS WHO DO HAVE VARIOUS HEARING CONCERNS BUT I'M A PRIVATE PRACTICE OWNER, SO I ACTUALLY PAY MY PROFESSIONAL FEES PERSONALLY, AND ONE CONCERN OR ONE

HESITATION I HAVE HERE IS MY EMPLOYEES WOULD ARE PROVIDERS WOULD BE PAYING THEIR PROFESSIONAL FEES PERSONALLY FOR INTERPRETING SERVICES THAT WOULD BE PRESUMABLY MY BUSINESS' EXPENSE CURRENTLY AND THAT'S JUST AN INTERESTING CONTRAST. IT'S LESS OF A CONCERN IN MY SMALL PRACTICE, I'LL COVER COSTS. I USUALLY DO REIMBURSE FOR SOME DEGREE OF THOSE EXPENSES BUT I KNOW IN THE LARGER SYSTEMS, IT'S UNC HEALTHCARE'S RESPONSIBILITY TO PAY FOR INTERPRETERS NOT THE PROVIDER PERSONALLY SO THAT MAY BE SOMETHING WE RUN INTO AS A BARRIER HERE WHEN WE'RE LOOKING AT TALKING INDIVIDUALS IN OUR ORGANIZATIONS INTO TAKING ON THIS EARN ANDAL COST. I DO THINK IT'S GOING TO TAKE US BEING EXCITED ABOUT IT AND GETTING OUR FOLKS ONBOARD IF WE'RE GOING TO MAKE IT HAPPEN THIS WAY. GLF MY TAME IS MILLY KAUFMAN AND I'M WITH THE NORTH CAROLINA NURSE'S ASSOCIATION. I HAVE BEEN THINKING ABOUT THIS A LOT, TOO, AND I DID THINK ABOUT MAYBE PUTTING IT ON LICENSING FEES. MY PROBLEM IS THAT-- I DON'T WANT ANYTHING THAT SOUNDS LIKE A TAX. I THINK THE PERSON WHO SAT IN THIS CHAIR LAST MEETING SAID THAT, ANY TIME YOU SAY TAX, PEOPLE GET UPSET. I THINK THAT IF WE SAY, YOU KNOW, MAKE IT A MANDATORY FEE OR SOME KIND OF TAX, IT'S UPSETTING. I'M WONDERING AND I ALSO HAD THE THOUGHT THAT YOU BROUGHT UP ABOUT OTHER DIFFERENT NEEDS ARE GOING TO BE BROUGHT UP FOR THE SAME KIND OF THING. WELL, IF THEY CAN PAY INTERPRETING SERVICES, CAN THEY PAY FOR OTHER THINGS? BUT I WAS WONDERING IF IT COULD BE MADE SOMEHOW VOLUNTARY. LIKE WHEN YOU PAY YOUR FEDERAL INCOME TAX, THERE'S A BOX YOU CAN CHECK AND IT SAYS, DO YOU WANT TO GIVE $5 OR WHATEVER TO THE PRESIDENTIAL ELECTION FUND BECAUSE THAT WAY, YOU KNOW, EVEN PEOPLE WHO NEED THE SERVICES OR FAMILY MEMBERS WHO HAVE PEOPLE WHO NEED-- WHO HAVE DEAF AND HARD OF HEARING FAMILY MEMBERS OR PEOPLE WITH DISABILITIES, HE COULD CHECK THAT BOX, TOO, AND IT COULD COME RIGHT OUT OF THEIR TAXES WITHOUT BEING AN EXTRA EXPENSE. REALLY AND TRULY, THE STATE WOULD BE PAYING FOR IT, BUT IT WOULD BE OPTIONAL FOR PEOPLE TO BE INCLUDED IN THAT. I THINK PEOPLE, OUT OF THE GOODNESS OF THEIR OWN HEART, WOULD HELP PAY FOR THAT AND IT WOULDN'T BE A BURDEN FOR PROVIDERS ESPECIALLY.

>> THIS IS RON TODAY OWEN. I WANT TO APOLOGIZE, I REALIZED AFTER I PASSED MIC THAT I USED AN ACRONYM. I'M WITH THE DIVISION OF HEALTH BENEFITS, NORTH CAROLINA MEDICAID AND THE GENTLEMAN THAT SPOKE ABOUT THE FUND AT THE

LAST MEETING THAT JUST MADE ME VERY CURIOUS ABOUT THE NUMBER OF BOARDS THAT THERE ARE FOR MEDICAL PROFESSIONALS IN NORTH CAROLINA. SO MYSELF AND SOME STAFF JUST DID A LITTLE BIT OF RESEARCH AND I COMPARED IT TO THE LIST THAT WE HAVE HERE AND THERE WERE ABOUT-- LET ME LOOK, TWO, FOUR, FIVE MORE BOARDS, RESPIRATORY CARE, SOCIAL WORKERS, RECREATIONAL THERAPISTS, HEARING AID DEALERS AND FITTERS, MASSAGE AND BODY WORK THERAPY THAT WE COULD ADD TO THE LIST AND OPTICIANS, OPTOMETRISTS AND SPEECH AND LANGUAGE AUDIOLOGIST AND ON OUR LIST IT SAYS NOT APPLICABLE BUT THOSE ARE ALSO LICENSING BOARD AND WHAT WE FOUND WITH THE NUMBERS THAT WE HAD, WHICH ARE SIMILAR TO THE ONES ON THE REPORT THAT WE HAVE HERE, IS THAT IT WAS ABOUT 330,000 MEDICAL PROFESSIONALS THAT ARE LICENSED IN NORTH CAROLINA AND IF SOMEHOW THERE WAS A WAY FOR EACH OF US $5 MORE ON OUR LICENSURE AND THERE BE A LAW-- THIS IS VERY SIMPLIFIED BUT CAPTURED THAT $5 TO GO INTO THE FUND, THAT'S ABOUT $1.6 MILLION A YEAR. THERE'S DEFINITELY POTENTIAL THERE TO DO THAT BUT I ALSO LIKE THE IDEA OF HAVING A BOX TO CHECK SO THAT PEOPLE OUTSIDE OF THE PROFESSION MIGHT BE ABLE TO CONTRIBUTE TO THAT, TOO, AND I STILL CAN'T GET PAST THE DIFFERENT, DIFFERENT WORLD. I JUST KEEP THINKING IF THERE'S A WAY TO SET THAT UP IN THE LEGISLATIVE HALLS, FOR THE HOUSE AND THE SENATE, JUST TO HAVE THAT THERE AND AVAILABLE, A SCHEDULED TIME WHERE LOBBYISTS ARE INVITED AND SENATORS AND HOUSE OF REPRESENTATIVES, AT THEIR LEISURE, AS THEY'RE COMING IN AND OUT, HAVE AN OPPORTUNITY TO HAVE THAT 15, 20 MINUTES OF EXPERIENCING SOME OF THE THINGS THAT I WAS ABLE TO EXPERIENCE AT THAT FIRST MEETING. I THINK IT'S EXTREMELY POWERFUL FOR PEOPLE TO BE ABLE TO HAVE THAT.

>> THIS IS DAVID. WE DO NEED TO MOVE FORWARD TOVAH, CAN YOU BE QUICK? OKAY.

[LAUGHTER]

>> THIS IS TOVAH HERE. HOW MANY OF YOU KNOW ABOUT VIDEO RELAY PHONE SERVICES FOR DEAF PEOPLE TO USE THE TELEPHONE? HOW MANY OF YOU KNOW HOW THAT'S FUNDED? YEAH. RIGHT. EXACTLY. SO IT'S LIKE 14 CENTS I THINK NOW PER TELEPHONE BILL. EIGHT CENTS. I THOUGHT IT WENT UP TO 14. SO 8 CENTS PER TELEPHONE BILL. SO IF WE CAN DO THAT, WHY CAN'T WE THINK ABOUT WAYS OF IMPOSING A SMALL CHARGE TO EVERYONE FOR ACCESSIBILITY SERVICES, WHETHER IT IS COMMUNICATION OR ANY OTHER KIND OF ACCESS?

>> THIS IS DAVID. THIS IS ALSO INCLUDING SOME OF THE CONVERSATION ABOUT THE COMMUNICATION ACCESS FUND, BUT PART OF THAT IS WHO WOULD BE ADMINISTERING THAT FUND AND PROVIDING THE SERVICES TO THE DEAF AND HARD OF HEARING. ONE SUGGESTION WAS DSDHH, THE DIVISION OF SERVICES FOR THE DEAF AND HARD OF HEARING BUT ESSENTIALLY THE DISCUSSION IS WHO PROVIDES OVERSIGHT TO THAT FUND? I JUST WANTED TO PUT THAT TO EVERYONE HERE. WHAT DO YOU THINK ABOUT THAT? WHO WOULD BE IN CHARGE OF ADMINISTERING THAT? NO OBJECTIONS.
[LAUGHTER]
YES. KELLE.
>> THIS IS KELLE. SORRY, LEE, BUT I HAVE WORKED WITH ANOTHER LARGE HOSPITAL SYSTEM WHO CONTRACTS OUT TO PRIVATE INTERPRETING AGENCIES EVERY COUPLE YEARS, THE RUNNING OF THEIR SERVICE AND THAT IS NOT THE WAY TO GO TO CONTRACT IT OUT. I DEFINITELY THINK IT WOULD BE BETTER MANAGED BY A NEUTRAL ENTITY SOMEHOW. IT WOULD COST A LOT OF MONEY BUT IF YOU'RE REMOTELY LOOKING AT IT, YOU NEED TO KEEP IT IN A NEUTRAL LOCATION, I THINK, FOR IT TO BE ADMINISTERED.
>> THIS IS WHERE I FEEL LIKE WE'RE SORT OF WHAT A LOT OF US DO. OUR LEGISLATORS WHO HAVE BEEN AT SOME OF OUR EARLIER MEETINGS MAY HAVE SOME USEFUL INPUT OR HAVE SOME ADDITIONAL SUGGESTIONS THERE.
>> I WOULD THINK THE DIVISION OF SERVICES FOR DEAF AND HARD OF HEARING SIMPLY BECAUSE OF THEIR CONNECTION TO THE POPULATION BUT ALSO THEY HAVE HANDS AND FEET AND HEARTS THROUGHOUT THE STATE WITH THE REGIONAL CENTERS.
>> I ALSO THINK IT WOULD DEPEND ON HOW IT WAS SET UP TO WORK. IF IT WAS, ARE YOU REIMBURSING INDIVIDUAL DOCTORS? ARE YOU TRYING TO SET UP A SERVICE TO HELP THEM LOCATE AND THEN PAY FOR OUTSIDE OF THEM EVER HAVING TO PAY FOR IT? IF IT WAS A REGIONAL THING, MAYBE THE REGIONAL CENTERS, BUT I THINK IT-- A LOT OF IT WOULD DEPEND ON HOW IS IT SET UP TO WORK AND HOW IT WOULD MAKE SENSE TO HAVE THE MONEY AND PAY FOR IT.
>> THIS IS JAN SPEAKING. I WOULD LIKE TO TRY TO GET BACK TO A PARTICULAR POINT AND THAT IS-- OH, OKAY. SO KIND OF BARCLAY'S POINT, AND THAT'S A GOOD QUESTION. BUT I WANT TO GET BACK TO THE ESSENTIAL POINT OF THIS ENTIRE TASK FORCE IS HOW DO WE GET RID OF THESE BARRIERS BECAUSE THERE'S GOT TO BE

SOME WAY TO REMOVE THESE BARRIERS AND WHATEVER SYSTEM WE COME UP WITH THAT ASSURES THAT IS THE GOAL.
>> I DON'T KNOW. THIS IS MILLY. I'M JUST GETTING-- I DON'T THINK THE WORD IS GOOSE BUMPS BUT I'M GETTING THE CHILLS THINKING ABOUT WHEN YOU SAID WHO'S GOING TO ADMINISTER THIS MONEY BECAUSE SO OFTEN, THERE'S ANOTHER DEPARTMENT AND SO MUCH OF THE MONEY THAT IS MEANT FOR A GOOD CAUSE GETS EATEN UP IN ADMINISTRATIVE COSTS, AND I THINK WE'LL HAVE TO BE CAREFUL ABOUT THAT, TOO. GLF SO IT SOUNDS LIKE PART OF THE HIGH COST OF INTERPRETING SERVICES IS A LITTLE BIT OF AN INEFFICIENCY THAT IS THE REALITY OF THE SITUATION. AN INTERPRETER MAY NEED TO DRIVE AN HOUR TO PERFORM HELP SERVICES FOR 15 MINUTES TO THEN DRIVE ANOTHER 45 MINUTES TO A DIFFERENT LOCATION TO PROVIDE SERVICES . ESPECIALLY WITH THE NATURE OF OUR STATE BEING RURAL FOR SO MUCH OF THE AREA, IF BY CENTRALIZING IT, WE JUST TOTALLY REWROTE THE WAY THINGS ARE SET UP AND HAVE IT SUCH THAT INTERPRETING SERVICES WERE AVAILABLE AT A COUPLE OF DIFFERENT SITES-- I'M FROM DOWN EAST, THEY'RE IN ROCKY MOUNT ON MONDAYS AND WILSON ON TUESDAYS AND NIGHTDALE ON WEDNESDAYS.
>> (INAUDIBLE) I'M GOING THE WRONG DIRECTION.
>> THAT'S NOT EAST YET. COLUMBIA IS EAST.
>> YEAH. EXACTLY. KINSTON IS WHAT WAS IN MY HEAD BUT NIGHTDALE CAME OUT OF MY MOUTH. BY CENTRALIZING, IF WE COULD MAKE IT MORE EFFICIENT AND BE ABLE TO HAVE MAYBE EVEN SALARIED INTERPRETERS WHO WERE AVAILABLE IN SOME WAY THAT CONDENSED THE PROCESS, BUT STILL MET THE NEEDS OF CARE BECAUSE, OF COURSE, SOMEBODY IS GOING TO WALK IN ON TUESDAY AND NEED STITCHES SO THE REALITY OF MEDICAL CARE LEAVES LOTS OF LIMITATIONS BUT AT LEAST THERE'S SCHEDULED VISITS THAT WE CAN MAKE A LOT LESS EXPENSIVE BY HAVING AN INTERPRETER BE ABLE TO ASSIST WITH FOUR OR FIVE PATIENTS IN A ROW IN ONE LOCATION.
>> TOVAH HERE. I THINK JAN IS RIGHT. WE HAVE TO LOOK AT WHAT ARE SOME OF THE BARRIERS AND THE BARRIERS ARE ALSO IN SOME WAY UNIQUE TO NORTH CAROLINA. WHEN I WAS DOING SOME RESEARCH ABOUT SERVICES FOR DEAF AND HARD OF HEARING, OLDER PEOPLE ACROSS DIFFERENT STATES, I FOUND THAT GEOGRAPHY IS VERY IMPORTANT. SOME STATES ARE SMALL AND SQUARE AND EVERY CORNER CAN BE REACHED EASILY FROM A CENTRAL LOCATION BUT NORTH

CAROLINA IS LONG AND SKINNY AND YOU HAVE EAST, MIDDLE, AND WEST. SO IT'S POSSIBLE THAT CENTRAL MAY MEAN SOMETHING DIFFERENT IN NORTH CAROLINA THAN IT DOES IN, SAY, ARIZONA, OR OKLAHOMA, FOR EXAMPLE, SO WE MAY HAVE TO BE LOOKING AT SOMETHING THAT INVOLVES ADDRESSING RURAL NEEDS, ADDRESSING GEOGRAPHICAL NEEDS, NOT JUST ONE CENTRAL ENTITY BUT PERHAPS TWO OR THREE THAT WORK TOGETHER SOMEHOW IN NORTH CAROLINA.
>> THIS IS DAVID. SO I KNOW IT'S GOING TO TAKE SOME TIME TO FIGURE OUT HOW THAT WOULD WORK, BUT WE CERTAINLY WANT TO THINK ABOUT THAT. I'M GOING TO GET ONE MORE BEFORE WE MOVE ON.
>> THANK YOU. THIS IS LISA. I WAS GOING TO SAY THE IDEA OF THE MEDICAID CODE OR ANYTHING LIKE THAT WE ARE GETTING READY TO LAUNCH THIS BRAVE, NEW EXPERIMENT IN NORTH CAROLINA WITH FULL-BLOWN MANAGED CARE AND THINKING ABOUT HOW WE INCORPORATE THESE KINDS OF NEEDS AND REQUIREMENTS INTO THAT EXPERIMENT BECAUSE YOU'VE GOT BIG PLAYERS COMING IN FROM OUT OF STATE WHO HAVE WORKED, YOU KNOW, DO THIS IN LOTS AND LOTS OF STATES AND PROBABLY HAVE SOME NEW AND INNOVATIVE IDEAS AND PUT THIS ON THE TABLE AS SOMETHING WE WANT TO SEE INNOVATION AROUND AND THAT, AT LEAST, COULD START THINGS WITH THE MEDICAID POPULATION AND MAYBE GIVE US A LABORATORY TO SEE WHAT ARE SOME THE THINGS THAT WORK AND WHAT MIGHT WE THEN TAKE INTO THE COMMERCIAL SPACE OR SOME PLACE ELSE, AND YOU KNOW, THAT STARTS IN NOVEMBER. SO IT'S NOT TOO FAR AWAY TO DO SOMETHING.
>> ALL RIGHT. SO AGAIN, THE ISSUE IS ALWAYS MORE COMPLEX THAN IT SEEMS, BUT I THINK THAT'S BEEN A GOOD DISCUSSION TO HELP US KIND OF FRAME SOME DIFFERENT WAYS THAT WE CAN THINK ABOUT ADDRESSING THIS AND LOOKING AT DEVELOPING SOLUTIONS AND AS JAN MENTIONED AND TOVAH ECHOED, REALLY, WHAT WE'RE LOOKING AT IS HOW TO BREAK DOWN BARRIERS AND FIND WAYS TO DO THAT. AND THAT'S REALLY PART OF WHAT THIS PROCESS IS ABOUT.
>> THIS IS ROB. I WANT TO SHARE ONE THING. I'M ASSUMING WE'RE GOING TO MOVE ONTO LEE AFTER THIS. JAMES DID A LOT OF THE SAME WORK THAT I THINK RON TODAY AND HER STAFF HAD DONE AND PUT TOGETHER ALL THE LICENSING BOARDS AND YOU GUYS HAVE THIS, TOO, AND HE PUT TOGETHER THEIR FEES, THE NUMBER OF PHYSICIANS, NUMBER OF PROFESSIONALS THAT ARE LICENSED IN NORTH CAROLINA AND ONE THING THAT WE NOTICED WHEN DOING THIS IS ALL OF THE LICENSING FEES ARE IN THEIR STATUTES AND A LOT OF THEM ARE UP TO A CERTAIN

AMOUNT THAT THE BOARD IS ALLOWED TO CHANGE THE FEE TO BUT A MAJORITY OF THEM, I THINK ALL OF THEM BESIDES DENTISTS, ARE ALREADY AT THAT CAPACITY THRESHOLD. SO TO INCREASE THAT FEE IN ANY ONE OF THESE WOULD REQUIRE A CHANGE IN LEGISLATURE. I THINK THAT'S WHERE THE PROBLEM COMES IN IN INCLUDING EVERY SINGLE ONE OF THESE BECAUSE YOU WOULD HAVE TO GO THROUGH EACH ONE OF THESE AND MAKE THOSE CHANGES. SO IF WE CONDENSE IT TO CERTAIN PROFESSIONS, MAYBE DENTISTS, DOCTORS, WHATEVER WE END UP DECIDING ON, I THINK IT MAKES IT MORE REASONABLE AND A MORE REASONABLE RECOMMENDATION AND THAT'S WHAT WE GOT FROM THIS RESEARCH, WE CAN SEND THIS OUT AS AN ELECTRONIC VERSION, TOO, SO YOU CAN BE LINKED TO ALL THESE STATUTES AND THIS INFORMATION AS WELL.

Qualifications and Availability of Sign Language Interpreters in NC:

>> THIS IS DAVID. THANK YOU. WE'RE GOING TO MOVE ON TO THE NEXT PART OF OUR AGENDA THEN SO LEE WILLIAMSON, IF YOU WILL COME UP AND TALK ABOUT THE PIPE LINE OF INTERPRETERS. ALSO DEALING WITH THE QUALITY AND AVAILABILITY OF INTERPRETING SERVICES.

>> WELL, FIRST, ON BEHALF OF DSDHH, I REALLY DO APPRECIATE THE ENGAGEMENT THAT YOU GUYS HAVE PUT INTO THIS DISCUSSION. WE LIVE AND BREATHE THIS EVERY DAY. AND SO WE APPRECIATE HAVING MORE ALLIES WITH US AND I REALLY SENSE THAT OF ALLYSHIP ALREADY HAPPENING HERE. A LOT OF MY PRESENTATION JUST FROM THE DISCUSSION I'VE HEARD TODAY, I THINK YOU GUYS ARE REALLY AWARE OF SOME OF THE THINGS I AM GOING TO TALK ABOUT SO I MAY RUN FEW A THINGS SO WE CAN GET BACK TO DISCUSSING MORE. I AM GOING TO TALK ABOUT IF PROVIDING INTERPRETERS IS ONE OF THE SOLUTIONS TO REDUCING THE BARRIERS, WE NEED TO KNOW HOW MANY INTERPRETERS WE HAVE, HOW ARE THEY QUALIFIED, ARE THEY QUALIFIED, AND ALL OF THAT GOOD STUFF? THAT'S BASICALLY WHAT I'M GOING TO TALK ABOUT TODAY. OF COURSE, THANKS TO THE ADA, WE'RE HAVING THIS DISCUSSION. OF COURSE, WHEN YOU THINK OF EFFECTIVE COMMUNICATION, YOU ALWAYS HAVE TO CONSIDER THE NATURE, LINK, COMPLEXITY AND CONTENT OF THE SITUATION TO DETERMINE WHAT TYPE OF ACCOMMODATION YOU'RE GOING TO PROVIDE. THEN YOU THINK ABOUT THE METHOD OF COMMUNICATION AND EVENTUALLY, THAT WILL HOOD YOU TO THE TYPE OF AIDE OR SERVICE YOU NED. IN MY TOP, IMAGINE ALL OF THAT INKING OUT TO NEEDING A SIGN LANGUAGE INTERPRETER. WHEN YOU NEED A SIGN LANGUAGE INTERPRETER, ADA DEFINES

QUALIFIED, YOU ARE TO PROVIDE A QUALIFIED SIGN LANGUAGE INTERPRETER. DOESN'T SAY LICENSED OR CERTIFIED BUT QUALIFIED. THE DEFINITION IS VERY BROAD BUT IT DOES SAY THE QUALIFIED INTERPRETER IS SOMEONE WHO INTERPRETS EFFECTIVELY, ACCURATELY AND IMPARTIALLY, RECEPTIVELY AND EXPRESSIVELY, USING ANY OF THE SPECIALIZED VOCABULARY. SO ONCE WE DETERMINED THERE IS AN INTERPRETER NEEDED, WE MAKE SURE THAT THEY'RE QUALIFIED AND THIS IS AN EXAMPLE THAT I'VE SEEN USED SEVERAL TIMES WHEN YOU TRY TO PICTURE IN YOUR MIND WHAT ASL AND WHAT ENGLISH IS AND HOW THEY'RE DIFFERENT. ENGLISH IS LINEAR. YOU CAN SAY IN A SENTENCE, LUNCH WILL BE SERVED IN THE HALLWAY TO YOUR LEFT. VERY LINEAR. LUNCH WILL BE SERVED IN THE HALLWAY TO YOUR LEFT. FOLLOWING A ROPE. BUT IN ASL, IT'S LIKE TAKING THAT BALL, THAT LINE AND BALLING UP THE STRING. IT'S VERY COMPLEX. THERE'S A LOT OF THINGS GOING ON. IT INVOLVES ALL THE PARAMETERS OF SIGN LANGUAGE. YOU HAVE THE HAND SHAPE. YOU HAVE MOVEMENT. YOU HAVE ORIENTATION OF HOW YOUR PALM IS SHAPED THAT SENTENCE OF LUNCH WILL BE SERVED IN THE ROOM TO YOUR RIGHT COULD BE SIGNED WITH ALL THESE MOVEMENTS SO LUNCH PROVIDED OR SERVED THIS WAY AND I JUST WENT TO MY LEFT BUT IT'S TO YOUR RIGHT.

[LAUGHTER]

THIS WAY AND THEN THERE. I WOULD GO LUNCH AND THAT'S IT. SO IT'S VERY VISUAL. ALL THIS IS COMPLEX AND IT'S NOT LINEAR LIKE WE ARE. IT'S VERY DIFFICULT FOR US AS SPEAKERS OF ENGLISH TO LEARN A DIFFERENT LANGUAGE THAT'S IN A DIFFERENT MODALITY. IT'S NOT LIKE ENGLISH TO SPANISH OR ENGLISH TO CHINESE EVEN. IT'S SO DIFFERENT, AND ANOTHER THING TO KEEP IN MIND ABOUT HAVING A CEAFED INTERPRETER-- ABOUTING HAVE A QUALIFIED INTERPRETER, OF THE INTERPRETING PROFESSION, WE'RE THE ONLY LITTLE GROUP WHERE WE'RE NOT NATIVE SPEAKERS OF THAT LANGUAGE. A LOT OF PEOPLE WILL SAY HEARING CHILDREN OF DEAF ADULTS ARE NATIVE OF ASL BECAUSE THEIR PARENT WERE DEAF AND THAT MAY BE TRUE FOR SOME BUT A LOT OF US, MYSELF HAD DEAF PARENTS BUT I GREW UP WATCHING CAPTAIN KANGAROO. MY MODEL LANGUAGE WAS CAPTAIN KANGAROO. WHO REMEMBERS CAPTAIN KANGAROO? ALL RIGHT. MY MAN. THAT WAS MY LANGUAGE, SESAME STREET AND GRANDMOTHER WHO TALKED IN EASTERN WAKE COUNTY ACCENT.

[LAUGHTER]

YOU HAVE TO THINK ABOUT ALL THESE THINGS THAT WHAT WE HAVE WITH SIGN LANGUAGE INTERPRETERS, WE DON'T HAVE SOMEONE WHO EVEN IF THEY LEARNED TO BECOME A PROFESSIONAL INTERPRETER AND SAY, IF YOU'RE A SPANISH INTERPRETER AND YOU GO TO SCHOOL AND YOU LEARN SPANISH , PART OF THAT EDUCATION PROCESS WILL PROBABLY INVOLVE A PERIOD OF TIME WHERE YOU'RE IMMERSED FOR A YEAR OR SO IN THAT CULTURE, IN THAT LANGUAGE. IF YOU'RE A SPANISH MAJOR, YOU WENT TO SPAIN OR CENTRAL AMERICA OR SOUTH AMERICA WHERE THE LANGUAGE IS SPOKEN AND PARTICIPATED IN THAT. IN TODAY'S TIME, THE WAY INTERPRETER EDUCATION CHANGED, IN SOME WAYS IT WAS LIKE THAT, INFORMALLY, BECAUSE THE DEAF COMMUNITY WERE THE GATEKEEPERS. THEY DETERMINE WHO'D BECAME INTERPRETERS AND WHO DIDN'T. A HEARING PERSON WILL BEING BECOME PART OF THE DEAF COMMUNITY. THEY WOULD INTERACT. THEY WOULD PICK A LANGUAGE AND THE DEAF-- BECAUSE THERE WAS NO ADA AND THEY NEEDED AN INTERPRETER, THEY WOULD ASK THEIR HEARING FRIEND TO COME WITH THEM OR HEARING FAMILY MEMBER TO COME WITH THEM AND BE THE INTERPRETER. NOW IT'S AS TIME HAS CHANGED, THE DEAF COMMUNITY IS NOT AS MUCH ENGAGED OR INTERPRETER EDUCATION HASN'T KEPT THE DEAF COMMUNITY AS ENGAGED IN ED EDUCATING INTERPRETERS. WE HAVE INTERPRETERS COMING IN NOT KNOWING AMERICAN SIGN LANGUAGE. THEY'RE LEARNING THE LANGUAGE AND THE NUANCES AND BECOME INTERPRETERS OF THAT LANGUAGE. THEY'RE NOT NATIVE. THE FLUENCY ISN'T THIS. THERE'S DISCUSSION IN THE PROFESSION, ARE SIGN LANGUAGE INTERPRETERS FLUENT IN ASL. THERE'S DIFFERENT LEVELS OF FLUENCY, YOU CAN SAY THEY ARE PRETTY MUCH. THERE ARE DIFFERENT LEVELS OF FLUENCY EVEN FOR US. IF YOU ASKED INTERPRETERS IN THE ROOM, WHEN WE LEARNED IT OR HOW WE LEARNED, EVERY ONE OF US HAVE A DIFFERENT STORY. IT'S VERY UNIQUE AND A COMPLEX SITUATION TO DETERMINE EVEN WHAT QUALIFIED MEANS. I DOESN'T INCLUDE THE KNOWLEDGE OR FLUENCY OF A LANGUAGE BUT FOR A QUALIFIED INTERPRETER ALSO INVOLVES YOUR KNOWLEDGE OF THE ENVIRONMENT THAT YOU'RE GOING TO BE INTERPRETING IN. YOUR KNOWLEDGE OF THE CONTENT, THE INFORMATION, ALL THE CONTROLS THAT ARE HAPPENING WITHIN ALL THE DEMANDS THAT ARE GOING TO BE PLACED ON YOU WHEN YOU GO INTO A CERTAIN TYPE OF SETTING TO INTERPRET, ARE YOU PREPARED? DO YOU HAVE THE KNOWLEDGE? THE PRACTICAL EXPERIENCE, THE ABILITY TO CONTROL THINGS THAT WILL BE PLACED ON YOU WHEN YOU INTERPRET IN THAT ENVIRONMENT? THOSE ARE

THINGS THAT HAVE TO BE CONSIDERED. EARLIER TODAY, WE TALKED A LOT ABOUT MINNESOTA. IT SEEMS LIKE THE PLACE TO BE. I WISH THE WEATHER WASN'T SO BAD UNLESS YOU LIKE SNOW. I MENTION MINNESOTA BECAUSE ST. KATHERINE'S UNIVERSITY IS IN MINNESOTA AND THEY HAVE THE CATE CENTER THERE AND ST. KATHERINES HAS A GOOD INTERPRETING PROGRAMMING AND THEY HAVE A FOCUS ON HEALTHCARE INTERPRETING. THEY DID A STUDY AND FROM THEIR WORK IN RESEARCH AND SO FORTH, THEY'VE COME UP WITH A BASIC DEFINITION OF WHAT A QUALIFIED HEALTHCARE INTERPRETER SHOULD LOOK LIKE, AND BASICALLY, THEY'RE SAYING IT SHOULD BE AN INTERPRETER WHO HAS MAYBE THREE YEARS OF RECENT INTERPRETING EXPERIENCE IN VARIOUS SETTINGS. JUST INTERPRETING EXPERIENCE, THREE YEARS OF THAT, A BACHELOR'S DEGREE, A MINIMUM BACHELOR'S DEGREE, HAVING RID, NAD, OR BEI CERTIFICATION, THOSE ARE THREE TYPES OF INTERPRETER CERTIFICATION. NAD NO LONGER PROVIDES THEIR CERTIFICATION. AND RID IS THE NATIONAL REGISTRY OF INTERPRETERS FOR THE DEAF. THAT'S THE ONE THAT MOST INTERPRETERS WILL HAVE A NATIONAL CERTIFICATION THAT IS FROM RID. IT WILL BE NIC OR YOU MAY HAVE AN OLDER CERTIFICATION WITH CICT, CERTIFICATE OF INTERPRETATION AND CERTIFICATE OF TRANSLITTERRATION. I DON'T KNOW IF ANYONE IS STILL ALIVE--

>> YEAH, WE ARE.

>> CIC BUT IT'S RID CERTIFICATION. BAS WAS DEVELOPED IN TEXAS, REHAB ASSOCIATION-- IT WAS DEVELOPED IN TEXAS BUT IT'S A TEST, VERY GOOD TEST AND MANY STATES HAVE ACTUALLY PURCHASED THAT PRODUCT AND PROVIDE THAT ASSESSMENT TO INTERPRETERS. OF COURSE, FOR HEALTHCARE, YOU NEED YOUR INOCULATIONS AND A LOT OF HOSPITALS REQUIRE THAT BEFORE YOU WORK IN THE HEALTHCARE SYSTEMS TO SHOW THAT YOU HAVE IMMUNIZATIONS AND ALL OF THAT STUFF. OF COURSE, SECURITY BACKGROUND CHECKS AND A LOT OF HEALTHCARE ORGANIZATIONS REQUIRE THAT ESPECIALLY HUGE HOSPITAL SYSTEMS. THEY'LL HAVE THEIR OWN SPECIFIC REQUIREMENTS FOR TO YOU WORK IN THEIR SYSTEM. THAT'S VERY DEMANDING ON INTERPRETERS. IT'S GOOD TO ALREADY HAVE THAT. FORTUNATELY, NORTH CAROLINA, WE HAVE LICENSURE WHICH COVERS THAT BACKGROUND CHECK. AND THEN, OF COURSE, YOU HAVE TO HAVE SOME HEALTHCARE EXPERIENCE. SO 50 HOURS OF OBSERVING HEALTHCARE INTERPRETING. THAT'S WHAT THEY CONSIDER TO BE A QUALIFIED INTERPRETER IN HEALTHCARE. IF WE LOOK AT NORTH CAROLINA, NORTH CAROLINA HAS LICENSURE

OR INTERPRETERS. IF YOU CHANGE OUR FEE, IT MAY REQUIRE LEGISLATIVE CHANGE. OUR FEES ARE HIGH ALREADY. IN NORTH CAROLINA, THERE ARE TWO TYPES OF LICENSURE, PROVISIONAL LICENSURE AND FULL LICENSURE. MOST INTERPRETERS CURRENTLY GET INTO THE SYSTEM IF THEY DON'T MOVE FROM ANOTHER STATE AND AREN'T ALREADY NATIONALLY CERTIFIED AND IF THEY COME UP THROUGH THE EDUCATION SYSTEM, THEY WILL BE A LICENSED INTERPRETER. I WILL START ON THE RIGHT SIDE THE REQUIREMENTS. NA. DID, NATIONAL ASSOCIATION FOR THE DEAF, USED TO OFFER AN ASSESSMENT SO IF YOU DO HAVE THAT OLD ASSESSMENT SCORE OF LEVEL TWO OR THREE, WHICH IS ABOUT AN INTERMEDIATE OR BELOW INTERMEDIATE LEVEL COMPETENCY, YOU COULD QUALIFY FOR PROVISIONAL LICENSE AND BELOW THAT, HOLDING NORTH CAROLINA QUALITY ASSURANCE ASSESSMENT SCORE OR SCORE OF LETTER C, THAT'S AN OLD TEST THAT WE HAD. I THINK THAT TEST ENDED IN 2001 MAYBE, AND RIGHT AROUND 2000. NORTH CAROLINA DID HAVE ITS OWN STATE ASSESSMENT. IT WAS FAIRLY-- I THOUGHT IT WAS A GOOD TEST. IT WAS TIERED SYSTEM WHERE YOU HAD LEVELS A, B, AND C, AND A BEING THE HIGHEST, A LOT OF US OLD INTERPRETERS HAD THAT ASSESSMENT IF WE WORKED BACK IN THE '80s AND '90s. PROBABLY '90s. ANYWAY, SO SOME HAVE THAT. YOU CAN QUALIFY IF YOU HAVE A LETTER C, LEVEL C. NEXT, YOU COULD HAVE ANOTHER TYPE OF ASSESSMENT CERTIFICATION FROM THE EIPA, EDUCATIONAL INTERPRETER PERFORMANCE ASSESSMENT. THIS IS AN ASSESSMENT MADE SPECIFICALLY FOR INTERPRETERS IN CLASSROOM SETTINGS. SO THIS IS A TEST THAT SOMEONE CAN TAKE TO DETERMINE THEIR QUALIFICATIONS TO INTERPRET IN SCHOOLS. YOU TAKE THE TEST. YOU CAN EITHER BE TESTED IN ELEMENTARY SETTING OR SECONDARY SETTING AND SCORES RANGE FROM, I THINK, ZERO, ONE, TWO, THREE, ALL THE WAY UP TO FIVE. IF YOU SCORE A THREE OR ABOVE, AND THREE IS INTERMEDIATE, THAT'S LIKE A STUDENT OR THE RECEIVER OF THE INFORMATION OF AN INTERPRETER WHO HAS LEVEL THREE IS GETTING 50 TO 60% OF THE INFORMATION THAT IS BEING COMMUNICATED. THAT'S PUT IN THIS AT A LEVEL 3 BECAUSE CURRENTLY IN THE SCHOOL SYSTEM MISNORTH CAROLINA THAT'S THE MINIMUM REQUIREMENTS TO BE AN EDUCATIONAL INTERPRETER IN THE SCHOOLS TO HAVE A LEVEL THREE. SO IF YOU HAVE A THREE, YOU CAN GET A PROFESSIONAL LICENSE. IF YOU HAVE A TWO-YEAR, MINIMUM OF TWO-YEAR INTERPRETING DEGREE, YOU CAN GET A LICENSE, WITHOUT ANY TYPE OF ASSESSMENT OR CERTIFICATION. IF YOU HAVE A DEGREE FROM INTERPRETING OR ACCREDITED INTERPRETING

PROGRAM, YOU CAN GET A PROVISIONAL LICENSE AND THEN FINALLY, YOU MAY HAVE-- IF YOU ACCUMULATED OVER 200 HOURS PER YEAR OF INTERPRETING SERVICES IN THIS STATE OR EVEN IF ANOTHER STATE BUT TOTALING 400 HOURS IN THE PAST TWO YEARS, YOU CAN QUALIFY. YOU CAN GET A PROVISIONAL LICENSE. PROVISIONAL LICENSES

<A>: FOR ONE YEAR. THEY'RE RENEWABLE FOR ANOTHER YEAR UP TO TWO TIMES AND A TOTAL OF THREE YEARS. AFTER THREE YEARS, THE PROVISIONAL LICENSE, IT'S EXPECTED THAT YOU HAVE ACCOMPLISHED YOUR WAY UP TO BECOMING FULLY LICENSED MEANING YOU HAVE TAKEN THE NATIONAL CERTIFICATION. IF NOT, YOU CAN REQUEST EXTENSIONS AND I THINK TWO EXTENSIONS ARE GRANTED BUT YOU HAVE TO EXPLAIN WHY YOU ARE REQUESTING THE EXTENSION, WHETHER IT'S YOU'VE BEEN OUT OF THE PROFESSION FOR A YEAR DUE TO HEALTH REASONS OR MILITARY DUTY OR ANY OTHER CIRCUMSTANCE. SO ACCORDING TO WHAT THE CATE CENTER SAYS, PROVISION LICENSE INTERPRETER DOESN'T MEAN THE REQUIREMENTS OF BEING QUALIFIED. FULLY LICENSED INTERPRETERS, YOU CAN GET THE NAD,S THEY A HIGHER LEVEL ASSESSMENT, OR IF YOU HAVE RID, NATIONALLY CERTIFIED INTERPRETER, OR YOU HAVE THE OLDER NORTH CAROLINA LEVEL A OR B, THEN YOU GET YOUR FULL LICENSE. I'M GOING TO LOOK AT FULL LICENSE INTERPRETERS FOR THE REMAINDER OF MY PRESENTATION TO TALK ABOUT MANY QUALIFIED INTERPRETERS WE HAVE IN NORTH CAROLINA. NOT SAYING THAT A PROVISIONALLY LICENSED INTERPRETER MAY NOT BE QUALIFIED BECAUSE THERE ARE A LOT OF PROVISIONALLY LICE EXED INTERPRETERS WHO HAVE THAT PROVISIONAL LICENSE FOR VARIOUS REASONS AND MAY NOT HAVE ANYTHING TO TO WITH THEIR SKILL SET AT THE TIME OR WHAT TYPE OF-- IT MAY JUST BE WHERE THEY ARE IN THEIR PLACE AND TIME. THEY JUST DO NOT HAVE-- HAVE TAKEN THE NATIONAL TEST YET BUT YET THEY HAVE THE QUALIFICATIONS TO DO IT. BUT WE'RE GOING TO LOOK AT THE NUMBERS OF FULLY LICENSED INTERPRETERS. IN NORTH CAROLINA, THERE ARE ABOUT 530 LICENSED INTERPRETERS IN NORTH CAROLINA. 325 HAVE A FULL LICENSE. OF THOSE 325, 62% RESIDE IN EIGHT COUNTIES OF NORTH CAROLINA. OF COURSE, INTERPRETERS CAN WORK OUTSIDE OF THEIR HOME COUNTY BUT THIS GIVES YOU A DEMOGRAPHIC PICTURE. THOSE EIGHT COUNTIES I WILL SHOW ON A MAP LATER ON. 45% OF THOSE 325 INTERPRETERS RESIDE IN FOUR COUNTIES AND I DO LIST THOSE COUNTIES, WAKE COUNTY, MECKLENBURG COUNTY, WHICH YOU WOULD EXPECT, GUILFORD COUNTY AND YOU MAY EXPECT AND THEN BURKE COUNTY YOU MAY

THINK IS KIND OF ODD, BUT BURKE COUNTY IS WHERE THERE'S A RESIDENTIAL SCHOOL FOR THE DEAF. SO SCHOOL FOR THE DEAF IS IN BURKE COUNTY. THAT'S MORGANTON, NORTH CAROLINA. 46% OF OUR COUNTIES HAVE NO INTERPRETERS, NO FULLY LICENSED INTERPRETERS. 46% IS HOW MANY COUNTIES?
>> 46.
[LAUGHTER]
>> YES, 46 COUNTIES. YOU GUYS ARE GOOD.
[LAUGHTER]
YOU ALL ARE EDUCATED. THAT MEANS AT LEAST-- AND FINALLY, 31% OF NORTH CAROLINA COUNTIES HAVE AT LEAST ONE OR TWO INTERPRETERS. SO NO INTERPRETERS IN, I THINK, COLUMBIA IS HYDE COUNTY. NO INTERPRETERS IN HYDE COUNTY. THERE'S ONE IN PASAQUATANC AND THAT'S ELIZABETH CITY, AND HERE'S WHERE THEY ARE. IF YOU CAN SEE THE GRAPH. THE VERY DARK-COLORED COUNTIES ARE A TOTAL OF 144 INTERPRETERS. SO WE HAVE A 144 INTERPRETERS LOCATED IN WAKE COUNTY, GUILFORD COUNTY, MECKLENBURG COUNTY AND BURKE COUNTY. WAKE COUNTY AND MECKLENBURG COUNTY HAVE BY FAR THE MOST. MECKLENBURG AND WAKE HAVE APPROXIMATELY 50 EACH. GUILFORD COUNTY HAS IN THE UPPER 20s AND THEN BURKE COUNTY HAS AROUND 20 OR SO FULLY LICENSED INTERPRETERS. THE NEXT LEVEL WHERE YOU SEE A LITTLE LIGHTER SHADE OF BLUE. THESE COUNTIES HAVE 10 TO 16 FULLY LICENSED INTERPRETERS. I WON'T LIST THEM ALL BUT IF YOU SEE-- YOU CAN INDIANA KIND OF SEE A TREND OF WHERE THEY ARE. I WAS SPEAKING TO SOMEONE EARLIER TODAY AND IF YOU BASICALLY JUST DREW A LINE DOWN I-95, WHICH KIND OF CUTS RIGHT DOWN-- RIGHT THROUGH JOHNSTON COUNTY WHICH IS THE 5 TO 9 FULLY LICENSED INTERPRETERS AND LOOK WEST AND FOLLOW I-40, I-85 TO GREENSBORO AND I-40, I-85 SPLIT TOWARD ASHEVILLE AND TOWARD CHARLOTTE, THAT'S WHERE ALL THE INTERPRETERS LIVE. WE LIKE TO LIVE ON THE INTERSTATE. WE'RE LIKE TRUCK DRIVERS. WE NEED TO GET ON THE ROAD AND GO. THAT'S WHERE WE ALL LIVE. A LOT OF THESE LITTLE POCKETS YOU'LL SEE ARE BECAUSE-- ALSO THE POPULATION OF THE DEAF COMMUNITY. YOU HAVE RESIDENTIAL SCHOOLS FOR THE DEAF IN WILSON AND IN MORGANTON, SO YOU MAY SEE LARGER POCKETS OF INTERPRETERS THERE. PITT COUNTY HAS QUITE A BIT OF INTERPRETERS.
EAST CAROLINA UNIVERSITY AT ONE TIME HAD A FAIRLY LARGE NUMBER OF DEAF STUDENTS SO A LOT OF INTERPRETERS ACTUALLY CAME OUT OF THAT PROGRAM.

THEY DIDN'T EVEN HAVE INTERPRETER EDUCATION PROGRAM PER SE BUT THEY HAD ASL CLASSES, STUDENTS THERE WERE PART OF THE ASL CLUB. THEY INTERACTED WITH CLASSMATES WHO WERE DEAF AND A LOT OF INTERPRETERS CAME OUT OF THAT AREA AND CHOSE TO STAY THERE. VERY FEW INTERPRETERS IN THE RURAL AREAS, OF COURSE, IF YOU LOOK AT THE SOUTHEASTERN PART OF NORTH CAROLINA, WILMINGTON, NEW HANOVER AREA, VERY, VERY FEW INTERPRETERS AND THERE IS QUITE FAIRLY LARGE DEAF POPULATION IN THAT AREA. FOR SOME REASON, WE DON'T HAVE A LOT OF INTERPRETERS WHO LIKE THE BEACH. I DON'T KNOW WHAT'S UP WITH THAT. NOW ALL OF THESE INTERPRETERS AND EARLY THIS MORNING, ANNA, OVER THE PHONE, MENTIONED THAT STUDIES HAVE SHOWN THIS A LOT OF FULLY LICENSED INTERPRETERS ARE CERTIFIED INTERPRETERS MAY NOT BE INTERESTED IN DOING HEALTHCARE INTERPRETING. ONE OF THE THINGS ABOUT OUR PROFESSION IS THAT YOU WORK TO BECOMING CERTIFIED THROUGH THAT EXPERIENCE, YOU KIND OF LEARN WHAT YOU LIKE, WHAT YOU SPECIALIZE IN AND WHAT YOU'RE GOOD AT SO WE IT END TO GRAVITATE TOWARD CERTAIN AREAS WITHIN OUR PROFESSION WHERE WE ENJOY DO OUR WORK. AND ONCE YOU BECOME A FULLY LICENSED INTERPRETER OF NORTH CAROLINA, YOU CAN KIND OF HAVE THOSE CHOICES

SO WE HAVE INTERPRETERS WORKING IN ALL TYPES OF SETTINGS. THERE ARE BUSINESS AND PROFESSIONAL SETTINGS WITH THE GOVERNMENT, VOCATIONAL REHAB, EDUCATION SETTINGS, VIDEO REMOTE INTERPRETING. WE TALKED A LOT ABOUT VRI. IT'S A BOOMING INDUSTRY AND A LOT OF INTERPRETERS WHO LIVE IN ISOLATED AREAS AND THEY WANT TO STAY THERE, THEY'RE PICKING UP VRI WORK BECAUSE THEY DON'T WANT TO MOVE. THEY HAVE FAMILIES. THEY MAY BE IN A CERTAIN AREA FOR WHATEVER REASON. WE'RE STARTING TO NOTICE THAT WITH SOME OF OUR INTERPRETERS WHO LIVE IN THE FURTHER AREAS, FURTHER-- FAR RURAL AREAS AND THEY'RE TAKING ON VRI WORK. AND VRS. WE HAVEN'T TALKED ABOUT VIDEO RELAY SERVICES AND INTERPRETING REMOTELY THROUGH PHONE CALL, INTERPRETING PHONE CALLS AND THAT'S A HUGE THING. NORTH CAROLINA IS VERY UNIQUE IN THAT WE HAVE, I FIVE AND I THINK MORE NOW AND FROM ONE COMPANY, FIVE VIDEO RELAY CENTERS IN NORTH CAROLINA. SO WE DO HAVE THAT AND THAT'S A VERY-- VERY POPULAR PLACE FOR INTERPRETERS TO WORK BECAUSE YOU'RE GUARANTEED HOURS THERE AND THE NEED AND THE DEMAND IS SO HIGH. IT'S SO FUNNY WHEN I TALK TO PEOPLE ABOUT WHAT I DO AS A SIGH LANGUAGE INTERPRETER BEFORE AND THEY'LL SAY, I NEVER MET A DEAF PERSON. AND I WILL

GO TO A CENTER AND IN 25 MINUTES I WORKED FOR 25 DEAF PEOPLE AND IT'S AMAZING. IN THE ALL INTERPRETERS WORK FULL TAME. OF COURSE, IT'S JUST LIKE ANY OTHER PROFESSION. YOU HAVE FULL TIME, PART TIME. YOU MAY MOONLIGHT AS AN INTERPRETER. I DON'T WORK ALL DAY AS AN INTERPRETER. I SIT AT A DESK ALL DAY AND I DO RELAY SERVICES PART TIME. I'M GOING TO BRIEFLY TALK ABOUT VRI. IS VRI A SOLUTION THEN? IF WE DON'T HAVE ENOUGH INTERPRETERS AND WE DO ESTABLISH SOMETHING AND THE TASK FORCE MAKES RECOMMENDATIONS, RESULTS HAPPEN AND ALL OF A SUDDEN, WE HAVE HEALTHCARE PROVIDERS ALL OVER THE STATE REQUESTING SIGN LANGUAGE INTERPRETERS, DO WE HAVE THE ABILITY TO PROVIDE ALL OF THAT? WITH WHAT I JUST SHOWED YOU, WE PROBABLY DON'T. BUT WITH VIDEO REMOTE INTERPRETING, THAT CAN BE A SOLUTION FOR A LOT OF ISSUES. THEY ARE THINGS THAT WE NEED TO WORK OUT FIRST. OF COURSE, THE PROVIDER IS GOING TO SEE VIDEO REMOTE INTERPRETING AN EASIER WAY TO ACCESS AN INTERPRETER. YOU SAVE TIME. YOU SAVE COSTS. NORMALLY YOU'RE PAYING PER MINUTE INSTEAD OF A CHUNK OF TIME LIKE TWO YOUR HOES WHEN AN APPOINTMENT IS ONLY 15 TO 30 MINUTES. IF IT'S A LIFE-SAVING SITUATION, YOU CAN PROVIDE INFORMATION RIGHT THERE TO HELP SAVE SOMEONE'S LIFE. THE PATIENT'S PERSPECTIVE IS THAT THEY SEE IT AN INTERIM SOLUTION. THEY DON'T LIKE IT TO BE, OKAY THIS IS WHAT I'M GOING TO GET. ESPECIALLY IF IT'S A LONG-TERM HEALTHCARE VISIT. IF I'M GOING TO BE IN THE EMERGENCY ROOM AND I KNOW THERE'S MORE STUFF, A DEAF PERSON IS GOING TO THINK FINE FOR THE TRIAGE AND FOR YOU TO TELL ME WHAT'S WRONG WITH ME, THAT'S FINE BUT WHILE WE'RE DOING THIS, BRING AN ON-SITE INTERPRETER IN. VRI IS INACCESSIBLE FOR MANY DEAF PATIENTS DEPENDING ON THE SITUATION. THE SITUATION I SHOWED BY VIDEO THE LAST MEETING WHERE THE COUPLE TALKED ABOUT VRI WAS BEING PROVIDED TO HER HUSBAND AND HE WAS LYING ON HIS BACK. HE WAS LYING ON HIS BACK AND HE WASN'T ABLE TO ACCESS THE VIDEO. HOWARD ALSO EXPLAINED SOME SCENARIOS WHERE VRI WAS NOT SUCCESSFUL IN HOSPITALS. OF COURSE, WE HEARD ABOUT THE LIMITATIONS TO THE TECHNOLOGY. DEPARTMENT OF JUSTICE, IN 2010, THEY INCLUDED VRI AND EXPLAINED THAT VRI COULD BE CONSIDERED AS A REASONABLE ACCOMMODATION BUT THEY SAID TO GET REALTIME, FULL MOTION VIDEO AND AUDIO, HIGH-SPEED INTERNET CONNECTION, THE IMAGE HAD TO BE CLEAR TO DISPLAY. THE INTERPRETER JUST THE HANDS, FACE AND TORSO, AND THAT'S IT. I THINK HOWARD EXPLAINED A LOT OF THAT LAST TIME. AND THEN THE

NATIONAL ASSOCIATION OF THE DEAF WROTE RECOMMENDATIONS FOR VRI WHICH WILL BE SHARED YOU AND THEY WENT INTO MORE DETAIL WITH WHAT THE DEPARTMENT OF JUSTICE RECOMMENDED. NAD, ON-SITE INTERPRETER IS PREFERRED AND RECOMMENDED. FROM THE DEAF COMMUNITY, NATIONAL ASSOCIATION FOR THE DEAF, AN ON-SITE INTERPRETER WHO IS QUALIFIED IS ALWAYS THE FIRST APPROACH. SHOULD ALWAYS BE CONSIDERED THE FIRST APPROACH. ALSO IF VRI IS USED IN THE ABSENCE OF AN AVAILABLE ON-SITE INTERPRETER, IT HAS TO BE USED PROPERLY. JUST USE IT THE WAY IT'S MEANT TO BE USED AND WHAT WE'VE SEEN IN OUR RESEARCH AND INTERVIEWS WITH INDIVIDUALS, IT'S NOT DONE OR USED CORRECTLY. AND THE COMMENT ON THE LEFT WAS BASICALLY FROM NAD'S POSITION PAPER, BUT WHAT THEY SAY IS THE MOST CONTROVERSIAL USE OF VRI HAS BEEN IN THE MEDICAL SET WHERE THE USE OF VRI HAS EXPLODED WITHOUT INPUT OF THE DEAF AND HARD OF HEARING COMMUNITY AND WITHOUT MEANINGFUL REGULATION OF HOW VRI TECHNOLOGY IS USED IN THE SETTING. SO SOME BASIC RECOMMENDATIONS THAT I WOULD LIKE TO PROPOSE AND WHAT I'VE READ FROM NAD'S POSITION STATEMENT JUST FOR YOU TO DISCUSS WHEN CONSIDERING VRI, IF WE WANT TO CONTINUING VRI OR HOWEVER YOU WANT TO PUT IT INTO YOUR RECOMMENDATIONS, KEEP IN MIND THAT VRI VENDORS AND THE ENTITIES THAT CONTRACT WITH THEM, THEY'RE THE ONES THAT ARE DEFINING THE QUALITY OF SERVICES THAT ARE BEING PROVIDED AND THEY'RE DOING IT WITH LITTLE OR NO INPUT FROM THE DEAF AND HARD OF HEARING COMMUNITY. THAT'S THE MOST IMPORTANT THING TO KEEP IN MIND. MAKE SURE THAT THE PROVIDER GIVES THE OPPORTUNITY FOR THE PATIENT, THE DEAF AND HARD OF HEARING PATIENT TO DETERMINE WHAT IS APPROPRIATE COMMUNICATION FOR THEM, WHAT WOULD BE THE REASONABLE COMMUNICATION. MAKE SURE THAT THE NETWORKING AND CONNECTIVITY STANDARDS ARE SET AT A LEVEL WHERE IT'S ENSURED THAT THERE IS A GOOD, CLEAR CONNECTION, THROUGHOUT THE ENTIRE VIDEO TRANSMISSION. STANDARDIZED TRAINING WOULD BE KEY. THAT IS WHAT WE'RE NOT SEEING. I'VE HEARD SO MANY STORIES OF NURSES MANY BECAUSE THEY'RE THE ONES ESPECIALLY IN INPATIENT AND HOSPITALS, SOME HOSPITALS WILL PUT THE VRI EQUIPMENT IN THE PATIENT'S ROOM AND NURSES REFUSE TO USE IT. ER IN FRUSTRATED WITH THE TECHNOLOGY. THEY ARE AS FRUSTRATED AS PATIENTS ARE AND THEY DON'T LIKE TO USE IT. A LOT OF NURSES DON'T USE IT AND PATIENTS DON'T WANT TO DEAL WITH IT BECAUSE THEY GET FRUSTRATED WITH IT. MAKE SURE

THERE'S TRAINING. WE'VE HAD--I'VE HEARD SEVERAL TIMES AND KELLE SHARED THIS STORY THAT SOME NURSES HAVE TOLD WHEN HER AGENCY IS DOING SOME ADVOCACY WORK FOR DEAF INDIVIDUALS RELATED TO VRI USE, NURSES WILL SAY OR HEALTHCARE PROVIDERS WILL SAY, YEAH, WE HAVE THAT INTERPRETING iPAD THING BUT IT DOESN'T DO SIGN LANGUAGE BECAUSE IT'S SO OFTEN FOR SPOKEN LANGUAGES BECAUSE THAT HAPPENS ALL THE TIME BUT THEY DON'T REALIZE IT CAN BE USED FOR SIGN LANGUAGE. A LOT OF TRAINING NEEDS TO HAPPEN. THAT'S IT. JUST TO KIND OF CHANGE, WHAT DOES THE PIP LINE LOOK LIKE FOR INTERPRETERS COMING INTO THE PROFESSION TODAY? IN NORTH CAROLINA, WE DO HAVE ONE FOUR-YEAR INTERPRETER EDUCATION PROGRAM THAT YOU COME OUT WITH A DEGREE IN INTERPRETING AND THAT'S UNC GREENSBORO. GARDNER WEBB UNIVERSITY HAS AN ASL STUDIES DEGREE AND YOU CAN GET A MINE MERE INTERPRETING THIS, BUT WITH THE CURRICULUM AT GARDNER WEBB, THE STUDENTS COP OUT WITH FAIRLY GOOD ASL SKILLS AND THEY'RE REALLY GOOD AT THE LANGUAGE AND INTERPRETING MINOR THEY DO PICK UP SOME OF THAT AS WELL. WE TO HAVE FIVE TWO-YEAR PROGRAMS IN WILSON, CAPE FEAR IS IN WILMINGTON, CENTRAL PIEDMONT IS IN CHARLOTTE, WESTERN PIEDMONT IS IN MORGANTON AND BLUE RIDGE COMMUNITY COLLEGE IS HENDERSON-- NOT HENDERSONVILLE, BUT NEAR ASHEVILLE. WHAT WE'RE SEEING FROM OUR GRADUATES RIGHT NOW IS HE TYPICALLY DON'T DEMONSTRATE FLUENCY IN ASL. THE GRADUATES ARE TYPICALLY THEIR SENIOR YEAR OR WHEN THEY'RE COMING OUT THEY WILL TAKE THE EIPA AND WITH THE EIPA, THEY MAY SCORE A 3.2, 3.3, AND THAT'S WHAT WE'RE SEEING THE GRADUATES GETTING THERE. ALSO, THE STUDENTS--- THANK YOU. ALSO THE STUDENTS THEY'RE JUST VERY LIMITED IN THEIR RANGE OF WORKING WITH VARIOUS POPULATIONS. THEIR EXPOSURE TO DIVERSE POPULATIONS, WHICH YOU'RE SEEING MORE AND MORE WITH IMMIGRATION, MORE VARIETY, MORE DIVERSITY IN THE DEAF COMMUNITY, AND BECAUSE OF THEIR LIMITED FLUENCY IN ASL AND COMFORT LEVEL IN INTERPRETING IN DIFFERENT ENVIRONMENTS, THEIR ABILITY TO WORK IN SOARN SETTINGS ARE LIMITED. I HAVE A FOUR-YEAR DEGREE, I WANT TO INTERPRET AND I HAVE NEVER INTERPRETED IN ANY OF THESE SETTINGS BEFORE. IT'S REALLY CHALLENGING FOR OUR INTERPRET GRADUATES AND CURRENTLY, THERE'S NO FORMAL SYSTEM IN PLACE TO HELP GRADUATES GET TO THAT LEVEL OF BECOMING CERTIFIED. SO IF YOU SCORE LIKE A 3 OR 3.5 ON AN EIPA SCORE, IF YOU USE THAT AS TO WHAT THE STUDENTS ARE

AVERAGING, IF YOU CONSIDER A 4 OR HIGHER, SOMETHING ELIVE LENT TO A NATIONAL CERTIFICATION AND IT ISN'T BECAUSE IT'S STILL IN AN EDUCATIONAL SETTING, BUT THEIR ASL FLUENCY COMPARED TO A NATIONAL CERTIFICATION LEVEL, IT'S DIFFICULT TO GET FROM A 3.3 TO A 4. IT TAKES A LOT OF TRAINING AND WE DON'T HAVE ANYTHING FORMAL IN NORTH CAROLINA. DSDHH IS WORKING ON A MENTORING PROGRAM. WE FINISHED TWO-WEEKEND TRAINING FOR 25 INTERPRETERS TO HELP THEM BECOME MENTORS. THIS COMING WEEKEND OR NEXT WEEKEND, WE WILL HAVE ANOTHER TRAINING FOR OUR PRE-CERTIFIED INTERPRETERS, OUR PROVISIONALLY LICENSED INTERPRETERS AND WE WILL HAVE THEM COME IF AND GIVE THEM BASIC GROUNDWORK ON ASL FUNDAMENTALS, HELP GET THEM KICK STARTED INTO EDUCATION KIND OF FEEL AND HOPEFULLY WE CAN PAIR THEM UP WITH MENTORS AND START A MENTORING PROGRAM. IT'S VERY SMALL BUT IT'S A GOOD WAY TO START. WE'VE ALSO GOT PLANS TO TRAIN DEAF INDIVIDUALS TO BECOME LANGUAGE MENTORS FOR INTERPRETERS WHO NEED MORE WORK WITH ASL SKILLS AND DEVELOPMENT. THAT'S STILL NOT OFFICIALLY STARTED YET. IT'S STILL IN THE PLANNING PROCESS. SO INTERPRETERS ARE GRADUATING. THEY HAVE A DEGREE. THEY'RE READY TO FIND A JOB. MOST OF THEM ARE GOING STRAIGHT INTO THE SCHOOL SYSTEM BECAUSE THEY WILL HAVE THE 3.0 MINIMUM. THEY WILL GO INTO THE SCHOOL SYSTEMS WHERE THERE'S NO SUPPORT FOR OUR INTERPRETERS. EDUCATIONAL INTERPRETERS PAY-WISE ARE EQUIVALENT TO TEACHER ASSISTANTS IN A LOT OF AREAS. YOU CAN IMAGINE A GRADUATE LOOKING AT FULLY LICENSED INTERPRETERS AND SEEING A POTENTIAL, FRUITFUL CAREER EARNING GOOD MONEY, HAVING AND MAKING A LIVING AND THEY'RE IN THE SCHOOL SYSTEM AND THEY HAVE NO SUPPORT, THEIR SKILLS AREN'T IMPROVING. IT'S REALLY CHALLENGING. SO WHAT WE'RE SEEING IS A LOT OF OUR PROVISIONALLY LICENSED INTERPRETERS NOT COMPLEATING THE WHOLE CYCLE OF RENEWING THEIR PROVISIONAL LICENSE AND WORKING TO A FULL LICENSE. WE SEE A LOT OF THEM LEAVING THE PROFESSION. HOW MANY OF YOU ARE WORKING IN THE CAREER THAT YOU GOT YOUR DEGREE IN? IT MAY BE THAT A LOT OF US AREN'T. IT'S NOT THAT UNCOMMON THAT A PERSON HAVINGAAN INTERPRETING DEGREE DOESN'T END UP BEING AN INTERPRETER. THE PROBLEM IS WE HAVE SO FEW OF US GRADUATING THAT IT HURTS AND 50%, 50% OF AMERICANS DON'T WORK IN THE DEGREE THEY GOT THEIR JOB-- WHATEVER DEGREE THEY'RE IN, THEY'RE WORKING IN A DIFFERENT PROFESSION

IF THE AVERAGE IS 50%, IF THAT'S THE SAME FOR INTERPRETERS, THAT'S A BIG NUMBER FOR NORTH CAROLINA. I KNOW THIS YEAR OUT OF THE TWO AND FOUR-YEAR PROGRAMS, WE HAVE 34ED GRA THE WHATS AND WE HAVE 34 GRADUATES FROM FOUR-YEAR OR TWO-YEAR. 50% MAKE IT, THAT'S 17 INTERPRETERS. OF COURSE, THEY ALL NEED MENTORING. MENTORING CAN BE DONE IN A LOT OF WAYS. SOME UNTAPPED PATHWAYS. WHERE CAN WE GET THIS PIPE LINE GOING? WE CAN LOOK AT PEOPLE WHO ARE ALREADY FLUENT IF ASL OR HAVE KNOWLEDGE OF ASL. LOOK AT CHILDREN OF DEAF ADULTS. WE CAN SET UP A RECRUITING SYSTEM AND REALLY LOOK AT PROVIDING THIS AND PROMOTING THE INTERPRETING PROFESSION TO INDIVIDUALS WHO ARE EITHER SIBLINGS OF DEAF INDIVIDUALS OR FAMILY MEMBERS OF DEAF INDIVIDUALS WHO HAVE THAT LANGUAGE BASE AND THEY GO NO AN INTERPRETING PROGRAM AND THEY CAN ACHIEVE LICENSURE, FULL LICENSURE MUCH QUICKER. ALSO A NEW-- IT'S NOT NEW. THEY'VE BEEN AROUND FOR MANY YEARS BUT DEAF INDIVIDUALS INTERPRETING. IT'S JUST LIKE ANY-- IF YOU THINK ABOUT IT. MOST INTERPRETERS ARE-- THEIR STRONGEST SUIT IS THEIR NATIVE LANGUAGE. WHY NOT USE DEAF INDIVIDUALS AS INTERPRETERS. YOU MAY THINK THAT'S ODD. BUT DEAF INTERPRETERS ARE VERY EFFECTIVE. WHO ELSE IS BETTER AT KNOWING THE NUANCE OF SIGN LANGUAGE THAN A DEAF INTERPRETER. IT CAN WORK IN A LOT OF ENVIRONMENTS. WHAT WE'RE TRYING TO DO IN A LOT OF ENVIRONMENTS AND WE'RE-- WE'RE RYING TO DO IN NORTH CAROLINA IS RECRUIT DEAF INTERPRETERS AND WE HAVE SEVEN INDIVIDUALS WHO ARE PROVISIONALLY LICENSED. THERE IS A TEST FOR CERTIFIED INTERPRETERS.
THAT TEST IS IN A MORATORIUM. IT'S BEING RE-CREATED AND A NEW TEST IS GOING TO BE AVAILABLE FOR THEM AND THEY CAN TAKE TAKE THAT AND BECOME FULLY CERTIFIED INTERPRETERS. ANOTHER POTENTIAL FOR US TO BRING IN THE PIPE LINE IS IN HIGH SCHOOLS. OFFERING ASL AS ONE OF THE FOREIGN LANGUAGES. IT IS CONSIDERED ONE OF THE WORLD LANGUAGES IN THE DPI'S FOREIGN LANGUAGE CURRICULUM. THE PROBLEM IS WE DON'T HAVE ENOUGH TEACHERS WHO HAVE THE CERTIFICATION AND I HAVE A SENSE AND I HAVEN'T LOOKED INTO IT IN DETAIL BUT I THINK THERE ARE BARRIERS THAT ARE PREVENTING QUALIFIED TEACHERS FROM TEACHING IN THE HIGH SCHOOLS. THAT'S SOMETHING TO LOOK AT AS A PIPE LINE. STATE OF MINNESOTA, WHEN WE TALKED TO PAMELA, THE OWNER OF ASLIS WE ASKED HER ABOUT THE PIPE LINE. SHE SAID OUR PIPE LINE IS THE HIGH SCHOOLS. IN THE TWIN CITIES AREA, THERE ARE TEN HIGH SCHOOLS. ALL TEN HAVE ASL CLASSES

TAUGHT BY DEAF TEACHERS. WE DON'T HAVE THAT IN NORTH CAROLINA. WE MAY HAVE LIKE FIVE, IF THAT, FIVE SCHOOLS IN THE WHOLE STATE THAT MAY BE TEACHING ASL. HAND IS UP.
>> THIS IS BERKELEY. CAN I ASK WHAT MIGHT BE A SILLY QUESTION. A HOW DO DEAF PEOPLE BECOME DEAF INTERPRETERS?
I NEED A LITTLE BIT MORE EXPLANATION THERE.
>> SURE. WELL, IT DEPENDS ON THE SITUATION. FOR EXAMPLE, IN THE ROOM RIGHT NOW, WE HAVE DEAF-BLIND INTERPRETER WORKING TACTILELY AND INTERPRETING FOR ASHLEY. THAT COULD BE A DEAF INTERPRETER INTERPRETING FOR ASHLEY. ALL THE DEAF INTERPRETER WOULD DO IS WATCH THIS INTERPRETER, OUR PLATFORM AND INTERPRET WHAT'S BEING SAID OR COULD LOOK AT THE CART AND INTERPRET OR TRANSLATE REALLY FROM WRITTEN ENGLISH TO AMERICAN SIGN LANGUAGE THAT'S ONE WAY A DEAF INTERPRETER WOULD WORK. ANOTHER WAY A DEAF INTERPRETER WOULD WORK IS ON THE PLATFORM WHERE NIKKI COULD BE THE DEAF INTERPRETER. JENNIFER WOULD BE INTERPRETING TO NIKKI WHAT I'M SAYING MORE OF A TRANSLITTERRATION OR ENGLISH WORD ORDER SO THE ENGLISH VOCABULARY AND MANY GRAER ISN'T MISSED AND THE DEAF INTERPRETER WHO IS MORE FLUENT IN ASL THAN ANY INTERPRETERS BECAUSE IT'S THEIR LANGUAGE AND LIVE IT AND BREATHE, THEY CAN PROVIDE AMERICAN SIGN LANGUAGE THAT IS BEAUTIFUL.
>> PROBABLY NOT IN A MEDICAL SETTING
>> IN A MEDICAL SETTING, IT COULD BE BENEFICIAL.
>> YES.
>> WOULD YOU HAVE A TEAM.
>> TWO? BERKELEY IS SAYING TWO?
>> HE WHY. THIS IS SOMETHING THAT WE WOULD HAVE TO EDUCATE AND TEACH, MEDICAL SETTINGS, LEGAL SETTING, ANY SITUATION WITH A CHILD THAT IS DEAF AND USES SIGN LANGUAGE, I WOULD HIGHLY ENCOURAGE DEAF INTERPRETERS ESPECIALLY FOR THE GRASS ROOTS DEAF INDIVIDUAL WE'RE ENGLISH, WE'RE HEARING INTERPRETERS AND WE GO IN AND JUST DON'T HAVE THE ABILITY TO COMMUNICATE IN A WAY THAT COMPLEX MEDICAL TERMINOLOGY IN THE WAY A DEAF PERSON WOULD. SOMETIMES IN A MEDICAL SITUATION, IT'S STRESSFUL. SOMETIMES JUST HAVING SOMEONE LIKE ME IN THE ROOM TAKES AWAY A LOT OF THE STRESS AND THE CLARITY AND COMMUNICATION THAT HAPPENS. MEDICAL

SETTINGS, LEGAL SETTINGS, AND ESPECIALLY, YOU KNOW, SOCIAL WORKERS, DSS INTERVIEWING CHILDREN, YOUNG DEAF CHILDREN, DEAF INTERPRETERS ARE VERY, VERY MUCH ENCOURAGED ANDS THEY A NEW-- NOT A NEW TREND BUT IT'S BECOMING SOMETHING THAT'S BEING MORE ACCEPTED NOW. JAN?
>> THIS IS JAN. YES. I WANT TO MAKE A COMMENT AS WELL THAT MAY HELP YOU CONCEPTUALIZE THAT. MOST INTERPRETERS THAT WE'RE USING DON'T GROW UP WITH AMERICAN SIGN LANGUAGE. IT'S NOT THEIR NATIVE LANGUAGE. IT'S ONE THEY LEARNED LATER. THEY MAY NOT HAVE THE SAME ACT EITHER RECEPTIVELY AND EXPRESSIVELY AS A NATIVE USER AND IN CERTAIN SITUATIONS, THAT'S ABSOLUTELY NEEDED.
>> WHEN WE GOT IT MULTIPLE PEOPLE, IT MADE MORE SENSE IN A MEDICAL SETTING. THAT'S THE PART I DIDN'T UNDERSTAND. SO THANK YOU.
>> YES.
>> TOVAH.
>> I HAD A QUESTION. DO HE IN OF THESE PROGRAMS FOR-- DO ANY OF THESE PROGRAMS OFFER ACTUAL INTERNSHIPS OR PRACTICUM WORK THAT INTERPRETERS ARE REQUIRED TO DO IN CONTEXT? AND ALSO, IS THERE ANY SENSE TO HAVING POST-GRADUATE TYPE OF LIKE FELLOWSHIPS OR INTERNSHIPS THAT PEOPLE WOULD HAVE TO DO BEFORE THEY COULD BECOME LICENSED OR CERTIFIED OR WHATEVER?
>> THIS IS LEE. IN TERMS OF INTERNSHIPS, I THINK ALL THE PROGRAMS REQUIRE INTERNSHIPS. NOW WHAT THEY LOOK LIKE AND WHAT CONTEXT THEY'RE DONE IS VERY DIFFICULT. IT'S VERY DIFFICULT TO FIND PLACEMENT FOR OUR INTERPRETERS. LOTS-- OFTEN PROGRAMS WILL CONTACT DSDHH AND OUR REGIONAL CENTERS WILL PROVIDE SUPPORT AND INTERNSHIP OPPORTUNITIES. AS FOR POST-GRADUATE OPPORTUNITIES, THAT'S WHAT WE'RE TRYING TO WORK ON. THE ISSUE NOW WITH LICENSURE IS TO HAVE A PROVISIONAL LICENSE, THERE'S NO SUPERVISION REQUIRED AND THEY DON'T HAVE TO HAVE SUPERVISION. ALL THEY'RE REQUIRED TO DO IS COLLECT A NUMBER OF CEUs, CONTINUING EDUCATION UNITS, PER YEAR, AND THAT'S 20 HOURS WHICH ISN'T ANYTHING BUT IT USUALLY MAY NOT HELP THEM MUCH WITH SKILL DEVELOPMENT OR HAVING THAT TYPE OF MENTORING AND THE CHALLENGE IS THEIR SKILL SET AND KELLY MAY SPEAK TO THIS MORE THAN I DO BECAUSE KELLY WORKS WITH UNC GREENSBORO AND THEIR INTERNS A LOT THERE AND KELLE WILL HAVE TO BE ABLE TO SHARE MORE WHAT SHE IS HE SEEING WITH

NEW GRADUATES AND SHE MAY BE ABLE TO ANSWER THAT IN MORE DETAIL.
>> ADAM?
>> I LOVE THE CONVERSATION IN THIS ROOM. YOU ALL HAVE SUCH GREAT QUESTIONS. I'M LOOKING AT THE CLOCK AND THINKING MAYBE WE CAN HAVE KELLE PRESENT AND THEN WE HAVE A FEW MINUTES ASK QUESTIONS OF THE TWO OF YOU BECAUSE THERE ARE THINGS THAT WE'RE THINKING THAT KELLE MIGHT ADDRESS.
>> DAVID SAID, THANK YOU ADAM, THAT'S WHY I CAME UP HERE. PERFECT.

Interpreter Education and Pipeline Challenge:

WHILE THEY'RE PULLING UP MY POWERPOINT, I'M KELLE OWEPS, THE EXECUTIVE DIRECTOR WITH COMMUNICATION SERVICES FOR THE DEAF AND HARD OF HEARING IN GREENSBORO. I'M ALSO ADJUNCT LECTURER ARE AT THE UNIVERSITY OF NORTH CAROLINA GREENS--
>> DO I NEED THE MICROPHONE?
>> YES. ALL THE WAY BACK. START OVER? I'M KELLE OWENS WITH COMMUNICATION SERVICES FOR THE DEAF AND HARD OF HEARING IN GREENSBORO, ALSO WORK PART TIME WITH UNCG PROFESSIONS IN DEAFNESS, SPECIFICALLY WITH THE INTERPRETER TRAINING PROGRAM AND ADVOCACY TRAINING PROGRAM. SOME OF THE IDEAS THAT LEE AND I TALKED ABOUT RECENTLY ON THE PHONE IN PREPARATION MIGHT BE DUPLICATED HERE SO I'LL JUST KIND OF SKIP THROUGH THIS IN THE INTEREST OF TIME AND TRAFFIC AND EVERYBODY NEEDING TO GET ON THEIR WAY PRETTY SOON. SO I JUST KIND OF ENTITLED THIS THOUGHTS FROM THE FIELD. THERE IS SOME INTERESTING DATA AT THE END THAT LEE MENTIONED EARLIER BEFORE LUNCH THAT YOU MIGHT LIKE TO SEE. ONE THING THAT'S REALLY IMPORTANT THAT I WANTED TO POINT OUT AS AN ADVOCATE, I DO A LOT OF WORK AS AN ADVOCATE. I'M NOT A LICENSED INTERPRETER, BUT LET'S NOT FORGET WHEN WE TALK ABOUT ACCESS TO HEALTHCARE THAT A PERSON WHO USES SIGN LANGUAGE INTERPRETER OR HAS A HEARING LOSS MAY NOT ALWAYS BE THE PATIENT IN THE SCENARIO. THEY ARE CAREGIVERS. THEY ARE PARENTS OF CHILDREN WHO HAVE A HEARING LOSS, OR WHO DO NOT HAVE A HEARING LOSS SO ACCESS TO HEALTHCARE COMES IN ALL SHAPES AND SIZES AND IT'S VERY IMPORTANT THAT WE MAKE SURE SOMEONE WHO IS DEAF THAT MIGHT BE ADMITTING THEIR PARENT TO A NURSING FACILITY AND NEED TO COME UP WITH A PLAN OF CARE OR ACCESS TO REGULAR MEETINGS, THEY NEED ACCESS TO COMMUNICATION JUST AS IF THEY WERE A PATIENT IN A MEDICAL SETTING. OUR ORGANIZATIONS IN GREENSBORO ESTABLISHED IN 1975 AS A

NONPROFIT ORGANIZATION, WE DO PROVIDE INTERPRETING, ADVOCACY, SOME CAPTIONING SERVICES THROUGHOUT THE STATE, ALSO SIGN LANGUAGE CLASSES TO PEOPLE IN THE COMMUNITY WHO MIGHT BE INTERESTED IN A CONVERSATIONAL LEVEL OF COMMUNICATION. IN ADDITION, WE PROVIDE A NUMBER OF COMMUNITY ACCESS PROGRAMS FOR FOLKS WHO ARE DEAF OR HARD OF HEARING. I MENTIONED RECENTLY ABOUT CAREGIVERS NEEDING ACCESS. THEY MAY NOT ALWAYS BE THE PATIENT IF THEY HAVE A HEARING LOSS. ONE THING THAT I SAY VERY REGULARLY AS AN ADVOCATE IS VRI DOES NOT EQUAL FACETIME. AS A HEARING PROFESSION-- AS A HEARING PEOPLE, EVERYBODY USES FACETIME. YOU CHAT ABOUT YOUR NEW HAIR-DO. YOU SHOW OFF YOUR GRANDKIDS AND CHAT WITH YOUR NEIGHBOR, YOUR KIDS. THAT'S GREAT AND THAT COMMUNICATION IS FINE HOWEVER, DO YOU WANT TO GIVE CONSENT FOR A MEDICAL PROCEDURE THROUGH A VIDEO? DO YOU WANT TO FIND OUT YOU HAVE A SERIOUS DIAGNOSIS THROUGH VIDEO? BY IN LARGE, THAT'S-- THAT'S THE FEELING OF INDIVIDUALS WHO NEED TO RELY ON COMMUNICATION ACCESS THROUGH SIGN LANGUAGE INTERPRETERS. THROUGH A VIDEO IS NOT EFFECTIVE AS YOU'VE HEARD TODAY AND YOU'LL HEAR ABOUT MORE AND MORE. THERE ARE LOTS OF CHALLENGES WITH TRAINING INTERPRETERS. LEE TALKED ABOUT LANGUAGE FLUENCY. FOUR YEARS IS NOT ENOUGH. IT'S JUST NOT ENOUGH. TWO YEARS IS NOT ENOUGH TO TRAIN AN INTERPRETER. WE REALLY HAVE TO START VERY EARLY AND I'LL GET TO A COUPLE OF SUGGESTIONS AT THE END. ANOTHER CHALLENGE THAT I FACE REGULARLY WITH INTERPRETERS IS REALITY AND SHOCK TV. I SAY ALL THE TIME TO INTERSTOOS, INTERPRETING DOES NOT LOOK LIKE UNTOLD STORIES OF THE E.R. AND IT DOES NOT LOOK LIKE CRIMINAL MINDS. DON'T IMAGINE THAT'S WHAT YOU'RE GOING TO SEE. THAT MAY SCARE THEM AWAY BUT IT MAY EXCITE THEM SO THEY MIGHT TAKE A ROUTINE PROCEDURE OR SOMETHING THAT SHOULD BE CALM AND LOW KEY AND HAVE SEEN ALL OF THESE THINGS ON TV AND NETFLIX AND EVERY OTHER FORM OF MEDIA AND THAT'S WHAT THEY IMAGINE IT'S GOING TO BE LIKE WHEN THEY WALK IN A HEALTHCARE APPOINTMENT. THAT IS NOT THE CASE. CRITICAL THINKING, THE ABILITY TO PROBLEM SOLVE, HAVE LIFE EXPERIENCE, TO APPLY TO A SITUATION THAT YOU FIND YOURSELF IN AS A HEALTHCARE INTERPRETER. , THAT IS KEY. WE CAN SIMULATE SOME EXPERIENCES TO START TO GET A FEEL FOR THINGS BUT WE CAN'T SIMULATE EVERYTHING. THANK GOODNESS DOCTORS AND NURSES DON'T GET THEIR DEGREES THROUGH SIMULATION ONLY. THEY HAVE YEARS AND YEARS IN TRAINING, UNDER QUALIFIED

PROFESSIONALS WHERE THEY'RE MONITORED AND SUPERVISED BEFORE THEY'RE ALLOWED TO GO ON THEIR OWN AND PROVIDE DIRECT CARE TO PATIENTS. THAT'S VERY IMPORTANT WHEN WE THINK ABOUT TRAINING INTERPRETERS. ALSO INTERESTINGLY, LOTS OF PEOPLE HAVE A FEAR OF BLOOD AND NODELES, AND THEY DON'T WANT TO SEE IT AND THEY'RE AFRAID TO LOOK AT IT AND I MIGHT PASS OUT AND GRACIOUSLY, THEY DON'T WANT TO DO A DISSERVICE TO THE PERSON WHO NEEDS THE HEALTHCARE, BUT THAT A LOT OF TIMES PROHIBITS THEM FROM EVEN THINKING ABOUT WHETHER OR NOT THEY MIGHT BE ABLE TO DEVELOP SKILLS TO INTERPRET IN THAT KIND OF SETTING. LASTLY, OPPORTUNITIES FOR A SET SCHEDULE VERSUS A VARIABLE SCHEDULE. SINCE I'VE BEEN WORKING IN THIS FIELD AROUND 1997, IT'S CHANGED QUITE A BIT. VIDEO REMOTE INTERPRETING, VIDEO RELAY SERVICE, THAT'S ALL EXPANDED QUITE A BIT. THOSE ARE GREAT JOB OPPORTUNITIES FOR INTERPRETERS BECAUSE INSTEAD OF BEING IN THEIR CAR IN ANY KIND OF WEATHER, DRIVING AROUND, SITTING IN TRAFFIC, YOU KNOW, FACING THE ELEMENTS, THEY CAN DRIVE UP TO A PLACE AND WALK IN FOR THREE, FOUR HOURS AND WORK AND IN CLIMATE-CONTROLLED ENVIRONMENTS AND DRIVE HOME, LIKE THE REST OF US. UNFORTUNATELY, THE PROFESSION USED TO NOT BE THAT I WHAT. LEE SHOWED THE MAP OF INTERPRETERS PRETTY MUCH LIVING ON THE MAIN HIGHWAYS AND BIWAYS, AND THAT'S KIND OF HOW THE PROFESSION HAS SUCCEEDED FOR A LONG TIME. INTERPRETERS ARE WILLING TO TRAVEL FOR THE MOST PART AND THEY HAVE TO. IN CHAPEL HILL WE SAY THAT ALL THE TIME, WE PROVIDE A LOT OF SERVICE IN CHAPEL. INTERPRETERS DON'T LIVE IN CHAPEL HILL. MAYBE'S IT'S THE COST OF LIVING BUT PEOPLE WHO INTERPRET AT ALL THE MAJOR MEDICAL CENTERS ARE DRIVING THERE ARE FROM RALEIGH, GREENSBORO, NOT EVEN FROM HILLSBORO, FROM BEYOND THERE. IT'S REASONABLE TO THINK THAT PEOPLE ARE DRIVING AN HOUR TO PROVIDE A SERVICE THAT'S VERY NECESSARY. HEALTHCARE REQUIREMENTS FOR INTERPRETERS, WE HAVE THE JOINT COMMISSION AND LOTS OF OTHER BODIES TO THANK FOR THIS. MANY INTERPRETERS DON'T JUST WANT TO DEAL WITH IT. THEY DON'T THINK IT'S-- WHY? WHY DO I NEED TO GIVE YOU MY CHILDHOOD IMMUNIZATIONS? TDEP, FLU SHOT, OH, MY GOSH, DO YOU WANT ONE MORE THING? AND EVERY YEAR, WE HAVE TO VALIDATE IT'S ACCURATE. I CAN ONLY SPEAK FOR MY ORGANIZATION, BUT I SIGN STANDARD CONTRACTS FOR MEDICAL FACILITIES THAT SAY, DUE TO OUR JOINT COMMISSION REGULATIONS, WE ARE AUDITED WITHIN TWO HOURS, YOU MUST PRODUCE THE FILE ON THAT

INTERPRETER AND IT MUST BE COMPLETE, ALL OF THEIR CHILD IMMUNIZATIONS, ALL OF THEIR BACKGROUND CHECKS, ALL OF THEIR OIG CHECKS AND EVERYTHING ELSE THAT'S NEEDED, DRUG TESTS, BLAH, BLAH, BLAH. SO AS AN INTERPRETING AGENCY, WE TAKE ON THAT RESPONSIBILITY, SO DO OTHER AGENCIES. HOPEFULLY, THEY TAKE IT SERIOUSLY BUT THAT'S ONE FACTOR THAT REALLY INFLUENCES AN INTERPRETER ON WHETHER OR NOT THEY WANT TO PROVIDE INTERPRETING IN THE HEALTHCARE SETTING. AND MANY PEOPLE WHEN THEY THINK ABOUT ALL THAT PAPERWORK AND PAYING FOR THOSE FEES AND HAVING SOMETHING INJECTED INTO THEIR BODY VERSUS GETTING BACK IN THE CAR AND DRIVING UP TO THE CLIMATE CONTROLLED BUILDING WHERE THEY CAN WALK INSIDE AND PROVIDE INTERPRETING, THEY CHOOSE THE CLIMATE CONTROLLED FACILITY AND NOT OUT HUSTLING AROUND IN HEALTHCARE SETTINGS. WHEN I THINK ABOUT MEDICAL INTERPRETING, I THINK OF DIFFERENT KINDS OF ASSIGNMENTS. THE INTENSITY OF THE ASSIGNMENT, WHETHER IT'S ROUTINE PRIMARY CARE, ACUTE, LITTLE JOHNNY'S BEEN SICK FOR THREE DAYS WITH WHAT MIGHT BE THE FLU, OR SOME SORT OF TRULY EMERGENCY SITUATION. ALSO WHAT'S THE PURPOSE OF THE CARE? IS IT ROUTINE PRIMARY? SPECIALIST, MAYBE I'M GETTING REFERRED TO AN ORTHOPEDIC DOCTOR FOR SOMETHING. I NEED A DIAGNOSTIC, OR I NEED SOME KIND OF PROCEDURE. ALL OF THESE THINGS, AGAIN, RELATE BACK TO WHETHER AN INTERPRETER WANTS TO WORK IN THE MEDICAL PROFESSION. YOU ALL ANY THAT BECAUSE YOU'RE PROVIDING THIS TYPE OF CARE, BUT HAD WE THINK ABOUT WHO IS QUALIFIED TO FACILITATE THE COMMUNICATION IN THESE KINDS OF ENVIRONMENTS, ALL THAT HAS TO BE CONSIDERED. SO HOW DOES AN INTERPRETER GET A JOB IN A MEDICAL SETTING? I TRIED TO DO A LITTLE VISUAL EFFECT ON THIS . BROADCASTING IS THE BIGGEST WAY INTERPRETERS GET JOBS. SOMEONE SITS IN AN OFFICE SOMEWHERE, TYPES IN AN ASSIGNMENT, BLASTS OUT TO EVERY INTERPRETER ON THEIR LIST AND IT'S FIRST COME, FIRST SERVED. WHOEVER GRABS IT HAS THE JOB. THAT'S WHO SHOWS UP IN THE HEALTHCARE FACILITY TO INTERPRET. LOTS OF FOREIGN LANGUAGE COMPANIES, SPOKEN FOREIGN LANGUAGE COMPANIES PROVIDE SIGN LANGUAGE INTERPRETING, OH, AN ADD-ON. WE HAVE SOFTWARE TO BROADCAST JOBS AND WE HAVE SOFTWARE TO SCHEDULE APPOINTMENTS AND LET'S JUST ADD SIGN LANGUAGE BECAUSE THIS HOSPITAL OR DOCTOR'S OFFICE WE MIGHT WORK WITH ALSO NEEDS THAT IN ADDITION TO MANDARIN OR SPANISH OR WHATEVER THE CASE MAY BE. BROADCASTING IS HOW

PEOPLE ARE GETTING THESE JOBS. DISPATCHING, SOME PEOPLE DISPATCH INTERPRETERS. ANY HAVE A SMALL GROUP OF PEOPLE THEY WORK WITH, AND IN A LOT OF NORTHERN STATES, THEY HAVE PAID, FULL-TIME STAFF INTERPRETERS ON SITE AT MANY HOSPITALS. I'M NOT AWARE OF ANY IN NORTH CAROLINA THAT HAVE THAT, BUT THERE ARE SOME THAT DISPATCH AND THE SMALLEST PRINT WOULD BE A DIRECT MATCH. THAT'S HOW OUR OFFICE WORKS AND A FEW OTHER SMALLER ENTITIES. HERE'S THE APPOINTMENT. OKAY. HERE'S WHAT I KNOW ABOUT THE APPOINTMENT. HERE'S THE LIST OF INTERPRETERS. WHO WOULD BE A GOOD COMMUNICATION MATCH. BEFORE I EVEN THINK ABOUT WHO IS AVAILABLE, WHAT'S THE COMMUNICATION OF THIS PERSON? DO I KNOW THEM? ARE THEY KNOWN TO MY AGENCY? OKAY. WHAT KIND OF COMMUNICATION ACCESS AND THEN WHO WOULD BE A GOOD MATCH?

>> KELLE.

>> COULD YOU EXPLAIN WHAT A GOOD MATCH MEANS?

>> A GOOD MATCH MEANS A QUALIFIED SIGN LANGUAGE INTERPRETER, A GOOD MATCH TO ME, MEANS A QUALIFIED SIGN LANGUAGE INTERPRETER WHO IS ABLE TO EFFECTIVELY COMMUNICATE, HAS THE NECESSARY QUALIFICATIONS, HAS THE NECESSARY BACKGROUND INFORMATION I SHOWED EARLIER AND ALSO HAS THE CREDENTIALS . THERE ARE SO MANY DIFFERENT STEPS THERE. ALSO A QUALIFIED SIGN LANGUAGE INTERPRETER FOR ME HAS TO BE AN ACTIVE INTERPRETER, NOT A PASSIVE INTERPRETER. NOT SOMEBODY WHO IS JUST GOING TO WALK IN AND BE VOICE ACTIVATED AND HOLD UP THEIR HANDS LIKE THE EXAMPLE LIZ GAVE EARLIER WITH SUSPENSION, WHEN THE DPOCTER SAID, WHY ARE YOU ASKING ME WHAT THAT MEANS? NO ONE ELSE ASKED ME WHAT THAT MEANS, THAT'S AN ACTIVE INTERPRETER AT WORK. SOMEONE WHO IS FOCUSED ON WHAT THEY'RE DOING. NOT SOMEONE WHEN IS JUST PASSING A MESSAGE BACK AND FORTH. ASHLEY, DID I SEE YOUR HAND?

>> THIS IS ASHLEY. I WANTED IT SAY WHAT A GOOD MATCH FOR ME IS SOMEONE WHO UNDERSTANDS. I HAVE INTERPRETERS WHO ARE CERTIFIED, LICENSED, QUALIFIED, AND THEY MIGHT NOT KNOW THE SPECIFICS THAT RELATE TO TACTILE INTERPRETING AND I DON'T UNDERSTAND WHAT THEY'RE SAYING. SO I DON'T UNDERSTAND THEM AND THAT MEANS THAT THEY'RE NOT A GOOD MATCH FOR ME BECAUSE THEY DON'T UNDERSTAND ME.

>> THANK YOU.

>> DAVID.
>> THIS IS DAVID. ALSO A GOOD MATCH CAN OFTEN MEAN WHO IS THE DEAF PERSON'S PREFERENCE? WHO ARE THEY COMFORTABLE WITH? AND THAT SOMETHING THAT AN AGENCY MAY KNOW IF THEY TAKE THE TIME TO DO THAT. IF YOU SEE AN APPOINTMENT COME UP WITH THIS SPECIFIC PERSON, YOU MAY KNOW WHO MEETS THE CRITERIA FOR A GOOD MATCH.
>> THIS IS JAN. ANOTHER EXAMPLE, IF YOU HAVE A MALE PATIENT, THEY MAY PREFER A MALE INTERPRETER OR AN INTERPRETER WHO IS GOOD WITH CHILDREN THERE'S A LOT OF THINGS THAT GO INTO THAT.
>> THANK YOU.
>> ALSO, HAVING AN UNDERSTANDING OF CONFLICTS OF INTEREST THAT THEY MAY HAVE IN THAT SETTING OR THAT INDIVIDUAL.
>> ABSOLUTELY. MANY INTERPRETERS WILL DECLINE AN OPPORTUNITY BECAUSE IT WILL BE A POTENTIAL CONFLICT OF INTEREST. THEY MIGHT BE FRIENDS IN THE SAME CARD GROUP. THEY MIGHT BE NEIGHBORS. THEY MIGHT INTERPRET FOR THAT PERSON IN A PROFESSIONAL SETTING AND PROBABLY RESPECTFULLY ASSUME THAT PROFESSIONAL DOESN'T WANT THEM TO SEE IN THEIR PRIVATE MEDICAL APPOINTMENT ANYTHING ABOUT THEM THAT WOULD BE SEPARATE.
>> OH, SORRY. OTHER BARRIERS TO QUALIFIED INTERPRETERS, SCHEDULE, AS I I TALKED ABOUT, EXPERIENCE, AND AND I GAVE THE CLIMATE CONTROLLED EXPERIENCE THAT I TALKED ABOUT EARLIER. TOWARD THE END, LEE MENTIONED EARLIER SOME DATA THAT I SHARED WITH HIM QUITE A WHILE AGO. THIS IS FROM JUNE OF 2017. I CAN PROVIDE UPDATED DATA LATER. I THINK ROB ASKED ME ABOUT THAT, BUT THIS WAS JUST A A MOMENT IN TIME FOR HEALTHCARE INTERPRETING. I WILL GIVE YOU A SECOND TO LOOK OVER IT . SO IN THE MIDDLE WHERE IT'S TALKING ABOUT TOTAL EXPECTED TIME, TYPICALLY, ASSIGNMENTS ARE ALLOTTED IN TWO-HOUR BLOCKS. MEANING THE INTERPRETER NEEDS TO BE AVAILABLE TO THE HEALTHCARE PROVIDER OR THE EMPLOYER FOR A MINIMUM OF TWO HOURS. WHETHER THE ASSIGNMENT TAKES 15 MINUTES OR AN HOUR AND 47 MINUTES IS DETERMINED LATER BUT THE INTERPRETER COMMITS TO A FULL TWO HOURS OF TIME. SO YOU CAN SEE THE ACTUAL EXPECTED HOURS AND THEN THE ACTUAL DURATION OF HOURS THERE. DID I SEE SOMEONE'S HAND? NO. ANY QUESTIONS ABOUT THIS DATA?
>> JUST TO FOLLOW UP ON WHAT PEOPLE SAID ABOUT THE NUMBER OF HOURS. YOU

BLOCK IT OUT AS TWO-HOUR CHUNKS. WHAT'S BILLED IF IT ONLY TOOK 264 HOURS, WHAT IS IT BILLED?
>> IT'S BILLED AT THE SCHEDULED PERIOD OF TIMES, SO TWO HOURS. OVER TWO HOURS, 15-MINUTE INCREMENTS.
>> SO THERE'S PAID FOR UNUSED HOURS. THAT'S A HUGE AMOUNT OF WASTE.
>> WHEN I TALK ABOUT NEW FOLKS ON THE PHONE WHO ARE CONSIDERING WHETHER OR NOT TO PAY FOR SIGN LANGUAGE INTERPRETER, MY STRATEGY IS I DO NOT SAY TWO-HOUR MINIMUM AND I DON'T ALLOW THE STAFF TO SAY TWO-HOUR MINIMUM BECAUSE TO ME, THAT AUTOMATICALLY TURNS OFF THE PERSON ON THE OTHER END WHO NEEDS TO PAY FOR IT. I SAY THE INITIAL FEE FOR THE INTERPRETER TO ARRIVE AT YOUR APPOINTMENT AND TAKE CARE OF THE ASSIGNMENT COVERS UP TO TWO FULL HOURS OF INTERPRETING SERVICE. WHETHER IT'S 17 MINUTES OR AN HOUR AND 57 MINUTES, IT'S THE SAME PRICE. THERE'S NO ADDITIONAL FEE. THERE ARE SOME VARIED BUSINESS PRACTICES IN OUR PROFESSION WHERE SOME AGENCIES WILL CHARGE AN ADDITIONAL FEE IF IT'S LAST MINUTE, LESS THAN 24, 48 AND SOME LESS THAN 72 HOURS NOTICE. ALSO SOME WILL CHARGE AN ADDITIONAL FEE FOR TIME AFTER 5:00 OR 6:00 P.M. THOSE ARE INDUSTRY STANDARDS FOR INTERPRETING. THEY VARY A LITTLE BIT FROM REGION TO REGION ORGANIZATION IS A TO AGENCY. WHAT WE AT OUR ORGANIZATION BECAUSE WE'RE A NONPROFIT AND OUR GOAL IS ACCESS TO COMMUNICATION, WHAT WE EXPLAIN TO PEOPLE IS , FROM OUR UNDERSTANDING, DOCTORS PRIMARILY HELP SICK PEOPLE. THEY SHOULD NOT BE PUNISHED OR CHARGED EXTRA BECAUSE A DEAF PERSON GOT SICK AND NEEDED CARE. IF WE CAN PROVIDE AN INTERPRETER THAT MEETS THE NEED. THAT'S THE GOAL. IF WE DON'T HAVE ANYONE AVAILABLE AT THAT TIME, WE WILL GLADLY REFER THEM TO ANOTHER AGENCY BUT I THINK A LOT OF EXPERIENCE IN THE WORLD WHEN YOU TALK ABOUT SMALL FAMILY PRACTICES AND SOMEONE DISCHARGING FROM THE HOSPITAL WHO NEEDS IN-HOME HEALTH OR SOMEONE GETTING ADMITTED TO HOSPICE CARE, THOSE THINGS AREN'T PLANNED. THEY'RE LAST MINUTE. ALREADY THE INDIVIDUAL NEEDS COMMUNICATION ACCESS AND THERE'S A FEE ASSOCIATED, IT'S REALLY UNFORTUNATE THAT IN SOME CENSUS AN ADDITIONAL FEE IS ADDED BECAUSE THERE WASN'T ADVANCED NOTICE AND THAT'S A STRUGGLE WHEN YOU ADVOCATE FOR INTERPRETING SERVICES. TWO LAST RECOMMENDATIONS, WORKING TOWARD A SOLUTION, I MENTIONED ONE EARLIER WITH ELECTRONIC MEDICAL RECORDS. CONE HEALTH USES EPIC, AS I MENTIONED, AND I TEXTED AND THEY GAVE

ME PERMISSION TO MENTION IT WHILE I WAS HERE TODAY. THEY'RE HAPPY TO PROVIDE MORE INFORMATION BUT IF THE PATIENT IDENTIFIES AS A SIGN LANGUAGE USER IN THEIR PROFILE, IT AUTOMATICALLY GENERATES A TRIGGER FOR COMMUNICATION ACCESS. ANYTIME THAT PERSON MAKES AN APPOINTMENT. SO THEY HAVE AN OFFICE THAT MONITORS ALL OF THOSE REQUESTS THAT CAN PULL A REPORT DAILY OR MULTIPLE TIMES A DAY FOR ANYWHERE COMMUNICATION ACCESS IS NEEDED. UNC REX USES SERVICE HUB WHICH DEPENDS ON THE INDIVIDUAL PROVIDERS, WHETHER IT'S THE NURSE, OT, PT, THE DOCTOR, ER STAFF TO INPUT THE REQUEST EVERY TIME A PATIENT PRESENTS IN FRONT OF THEM. THEY EITHER NEED TO INPUT OR IN SOME CASES, THEY'LL WHEEL IN THAT VIDEO iPAD THING WHICH IS WHAT THEY CALL IT, AND THEY'LL USE THAT FOR COMMUNICATION ACCESS. SO ONE SOLUTION IS I THISSING ABOUT ELECTRONIC MEDICAL RECORDS AND HOW STARTING TO BUILD A SYSTEM AND A FOUNDATION WOULD REALLY HELP RAISE AWARENESS ABOUT ACCESS TO HEALTHCARE. ANOTHER ONE IS EXACTLY WHAT LEE MENTIONED WITH INCREASING THE WORKFORCE, ADVOCATING FOR AMERICAN SIGN LANGUAGE TO BE TAUGHT IN PUBLIC SCHOOLS. IT'S ALREADY APPROVED IN NORTH CAROLINA. IT'S JUST NOT HAPPENING. THERE ARE EIGHT OR LESS HIGH SCHOOLS IN NORTH CAROLINA THAT OFFER THAT. I BELIEVE 415 HIGH SCHOOLS IN NORTH CAROLINA, THAT'S A LOT OF POTENTIAL. IT WON'T HAPPEN OVERNIGHT BUT IT'S A SYSTEM THAT CAN BE BUILT FOR THE PIPE LINE TO MEET THE NEEDS SO THAT BY THE TIME THESE INDIVIDUALS GET TO COLLEGE, THEY'VE ALREADY GOT A REALLY GOOD HANDLE ON THE LANGUAGE AND INSTEAD OF TWO OR FOUR YEARS TEACHING LANGUAGE, YOU CAN ACTUALLY TEACH AN INTERPRETING SKILL AND CRITICAL THINKING. LASTLY SOMEONE ASKED ABOUT INTERNSHIPS, FOR THE FOUR-YEAR PROGRAM AT UNCG, IT'S 400-HOUR INTERNSHIP FOR 12 CREDITS. I JUST HAD FOUR STUDENTS FINISH YESTERDAY. THEY'RE PLACED IN EDUCATIONAL SETTINGS FOR FOUR WEEKS UNDER SUPERVISION WITH EDUCATIONAL INTERPRETERS AND DEAF ED TEACHERS, AND THEN THEY'RE PLACED IN COMMUNITY SETTINGS WITH OUR AGENCY AND ANOTHER FOR-PROFIT INTERPRETING AGENCY FOR SEVERAL WEEKS WHERE THEY'RE PAIRED TO GO OUT INTO THE COMMUNITY AND SEE A LOT OF INTERPRETING, GET MEANTER HANDS UP, BUT EVEN 400 HOURS IS NOT ENOUGH. YOU SAW THOSE HOURS THAT WEREN'T USED. PERHAPS A PATIENT DOESN'T MAKE IT TO THEIR APPOINTMENT BECAUSE OF TRAFFIC OR THEY

>> **KEITH:** CANCEL THEY CANCEL AND THEY'RE OUT THERE IN THE FIELD TRYING TO

GET EXPERIENCE, BUT IT'S NOT ENOUGH. I HAD AN INTERPRETER FROM LIBERTY UNIVERSITY WHO WORKED WITH US THIS SEMESTER, THEIR FOUR-YEAR DEGREE IS A THREE-CREDIT HOUR INTERNSHIP THAT REQUIRED 160 HOURS. SO THAT'S A BIG DIFFERENCE OUT THERE IN THE WORLD OF WHAT'S REQUIRED FOR INTERNSHIPS. LIZ?

>> I KNOW OF A TWO-YEAR COLLEGE THAT THEIR INTERN REQUIRED HOURS ARE 50, AND THAT'S A TWO-YEAR COLLEGE. THEY COME INTO A TWO-YEAR COLLEGE NOT KNOWING ANY SIGN LANGUAGE. THEY LEARN SIGN LANGUAGE AND THEY DO AN INTERNSHIP AND THEY CAN'T GET HANDS UP BECAUSE THEY'RE NOT PROVISIONALLY LICENSED BUT IT'S 50 HOURS OF OBSERVATION, THEY GRADUATE FROM THE TWO-YEAR PROGRAM IT AND THEY'RE IN THE FIELD.

>> U IN. UNCG IS WORKING WITH ST. KATHERINES ON AN EDUCATION PROGRAM AND THERE'S SEVEN STUDENTS IN THAT PROGRAM WHO GRADUATED WITH IN THE LAST YEAR AND THEY'RE RECEIVING EXTENSIVE TRAINING AND MENTORING THROUGH 2019. THEY TOOK SOME BENCHMARK TESTING AT THE BEGINNING. THEY WILL TAKE BENCHMARK TESTING AT THE END IN HOPES THAT THEY WILL PASS THE TESTING. WILL THAT MAKE THEM 100% QUALIFIED? PROBABLY NOT YET BECAUSE THEY DON'T HAVE ALL THE LIFE EXPERIENCE, BUT IT'S A STEP IN TRYING TO CONTINUE TO BUILD THE FOUNDATION OF WHAT IT MEANS TO HAVE ACCESSIBLE QUALIFIED INTERPRETERS IN HEALTHCARE.

>> THIS MIGHT BE A MULTIPART QUESTION. DO THE INTERPRETERS THAT WORK WITH YOUR AGENCY WORK FOR YOUR AGENCY, OR ARE THEY CONTRACT?

>> THAT'S A GREAT QUESTION. WE HAVE TWO STAFF INTERPRETERS AT OUR AGENCY AND THEN WE HAVE ABOUT 70 CONTRACTED INTERPRETERS. I WOULD SAY OF THE 70 PROBABLY 20 ARE FULL-TIME FREELANCE INTERPRETERS MEANING THEY DON'T HAVE ANY OTHER COMMITMENTS. LIKE VRS OR EDUCATIONAL INTERPRETING, POST-SECONDARY INTERPRETING AND 20 MIGHT BE KIND OF HIGH FOR THAT NUMBER, BUT IF THAT GIVES YOU A PICTURE

>> DO YOU HAVE THE WORKFORCE THAT YOU NEED TO MEET THE DEMANDS OF YOUR CLIENTS?

>> ABSOLUTELY NOT. NO.

>> SO ARE YOU NOT ABLE TO MEET THE DEMANDS OF YOUR CLIENTS OFTEN?

>> YES. YES.

>> THANK YOU.

>> HELLO. EILEEN WITH NORTH CAROLINA PT ASSOCIATION. COULD YOU GO BACK TO THE HIGH SCHOOL LINK? I'M PART OF THE BUSINESS IT'S BASIC A TASK FORCE AND THIS IS MANDATED BY THE STATE OF NORTH CAROLINA THAT YOU HAVE TO MATCH IN YOUR COMMUNITY WHAT YOU'RE TEACHING IN THE HIGH SCHOOLS TO WHAT YOUR BUSINESSES ARE IN THAT COMMUNITY. YOU SAID THAT IT IS SUPPOSED TO BE PROVIDED BUT WE'RE NOT PROVIDING IT YET, IS THAT WHAT YOU JUST SAID?
>> IT DOESN'T HAVE TO BE PROVIDED, IT'S APPROVED TO BE TAUGHT AND ACCEPTED AS A FOREIGN LANGUAGE JUST LIKE SPANISH, FRENCH OR GERMAN.
>> SO COULD WE IN SOME WAY AS A TASK FORCE MAKE THAT AS A RECOMMENDATION AND THAT COULD BE A BRIDGE TO THIS OTHER TASK FORCE BECAUSE IT'S MANDATED BY FEDERAL LAW RIGHT NOW? JUST A SUGGESTION. THANK YOU.
>> TOVAH HERE. I'M TRAINED AS BOTH A PSYCHOLOGIST AND SOCIAL WORKER AND IN BOTH CASES I HAD TO DO PRETTY EXTENSIVE INTERNSHIPS BEFORE I COULD EVEN PRACTICE IN MY FIELD. I WONDER IF-- THESE WERE PAID INTERNSHIPS, BY THE WAY. SO I WONDER IF WE SHOULD BE THINKING ABOUT WAYS IN WHICH INTERPRETERS WHO GRADUATE FROM FOUR-YEAR PROGRAMS IN PARTICULAR, COULD GET PAID INTERNSHIPS OR FELLOWSHIPS AND COULD BE GRADUATED IN A WAY THAT INCREASES THEIR LICENSING STATUS OR SOMETHING.
>> THAT SOUNDS LIKE A GREAT IDEA. IT WOULD TAKE A LOT OF WORK WHICH HOPEFULLY THIS TASK FORCE CAN HELP WITH LEADING OFF, BUT WITH SO MANY LARGE, MAJOR MEDICAL CENTERS HERE IN NORTH CAROLINA PARTICULARLY IN THIS AREA, WHO ARE ALREADY TEACHING FACILITIES, IT SEEMS LIKE MAYBE IT COULD BE A REASONABLE GOAL TO START SOME KIND OF PARTNERSHIP WITHIN THOSE FACILITIES TO TRY AND PROVIDE MORE TRAINING TO INTERPRETERS. ANY OTHER QUESTIONS FOR ME OR LEE? I KNOW OUR TIME ABOUT OUT.
>> THIS IS DAVID. YES, THE TIME HAS RUN OUT, BUT THANK YOU SO MUCH FOR YOUR PRESENTATION, KELLE.
[APPLAUSE]

Discussion/VRI Guidelines+ Closing Thoughts:

SO WE'VE GOT ABOUT FIVE MINUTES LEFT. I DO WANT TO TAKE A MOMENT TO ASK EVERYONE IF POSSIBLE IF WE COULD MEET A LITTLE EARLIER AT THE NEXT TASK FORCE MEETING. IF WE COULD START AT 9:00 INSTEAD OF 10:00 SO WE WOULD

PROVIDE MORE TIME FOR DISCUSSION IN THE AGENDA. DOES THAT SEEM POSSIBLE FROM EVERYONE? CAN I GET A SENSE FROM THE ROOM? IT SEEMS LIKE I'M GETTING A LOT OF AFFIRMATION FOR THAT. JAN IS SUGGESTING A VOTE. THIS IS DAVID. THAT'S SOMETHING THAT THE STEERING COMMITTEE CAN DISCUSS BEFORE THE NEXT MEETING.

>> I THINK-- THIS IS ROB. GOING OFF THAT AS WELL, I THINK SOMETHING ELSE WE CAN DO AND I CAN TALK WITH LEE AND PUT AN ONLINE FORM FOR THE DISCUSSION QUESTIONS SO YOU CAN PROVIDE FEEDBACK AFTER THE MEETING IS OVER, TOO AND GET THEM UP BEFORE THE MEETING, TOO, IF WE'RE NOT ABLE TO BE HERE SO YOUR COMMENTS ARE ABLE TO BE SHARED AT THE MEETINGS AND JUST THIS LAST THING BEFORE WE LEAVE. I WANT TO GO OVER THIS POSITION PAPER THIS I'M GOING TO SEND TO ALL OF YOU NOW. I TOOK IT OFF-LINE AND CREATED A TABLE OF CONTENTS FOR IT BECAUSE I THINK IT'S EASIER TO FOLLOW. I'M GOING TO GO THROUGH IT VERY QUICKLY. THIS FIRST SECTION IS JUST SOME BACKGROUND, THE ADA, WHAT VRI IS, AND THEN IT'S GETTING INTO THE USE OF VRI IN THE MEDICAL SETTING AND I HIGHLIGHTED A COUPLE POINTS THAT I THOUGHT WERE IMPORTANT AFTER GOING THROUGH READING IT AND I THINK IT WILL BE BENEFICIAL IS AS YOU GO THROUGH IT, YOU DO THE SAME AND WE CAN KIND OF AGGREGATE ALL OF THE POINTS BECAUSE IT SEEMS LIKE WHAT'S GOING TO COME OUT OF THIS IS A RECOMMENDATION ON WHAT WE WANT THE VRI STANDARDS TO BE OR SOME CERTAIN STANDARD SO IF WE USE THAT AS A BASELINE, WE CAN GO FROM THERE AND HAVING THESE ALREADY ON PAPER AND ONE OF THE BIGGEST THINGS IS THERE IS NO INPUT FROM THE DEAF AND HARD OF HEARING COMMUNITY, SO I THINK THIS IS WHERE THIS TASK FORCE COMES IN ON THAT THOUGHT. MOVING ON TO ASSESSING THE COMMUNICATION NEEDS FOR VRI AS A LAST RESORT. I THINK THIS POINT GOES TO A LITTLE BIT OF A-- THE COMMUNICATION REQUEST FORM, THIS GOES TO A LITTLE BIT OF WHAT KELLE IS SAYING, WHAT CONE HEALTH IS DOING WITH THEIR USING EPIC, KIND OF HAVING THIS FORM TO SEE WHAT THE PREFERRED LANGUAGE IS OF THE PERSON COMING IN. BUT IT SEEMS LIKE A DIFFERENT AVENUE OF DOING THAT. IF WE SCROLL A LITTLE BIT BEFORE, AGAIN, THESE JUST SOME OF THE THINGS THAT LEE WENT OVER, THE DOJ ISSUED THE FOLLOWING MINIMUM REQUIREMENTS. BUT IT DIDN'T PROVIDE THE EXACT WHAT WAS NEEDED FOR THE NETWORK AND OTHER THINGS SO WHAT THIS PAPER DOES IS GOES INTO THE ACTUAL BANDWIDTH AND EVERYTHING THAT IS NEEDED TO ACTUALLY RUN ONE OF

THESE IN AN EFFECTIVE MANNER AND IT GOES EQUIPMENT NEEDED ALSO TO DO SO. THIS POINT, I THOUGHT WAS IMPORTANT, TOO, IS THAT THE QUALIFICATION OF THE VIDEO INTERPRETER COULD COMPORT WITH THE STATE LICENSURE LAWS, IF ANY, THAT AFFECT SIGN LANGUAGE INTERPRETERS IF THE SETTING IN THAT STATE. SO EVEN IF THEY ARE OUT OF STATE INTERPRETERS PROVIDING VIDEO REMOTE INTERPRETATION THAT MAKE SURE THEY'RE QUALIFIED TO PROVIDE WHATEVER THE THRESHOLD IS IN NORTH CAROLINA. JUST SOME MORE ON WHAT SHOULD BE AVAILABLE UPON REQUEST.
>> IS THERE A WAY FOR US TO SEE WHAT VRI LOOKS LIKE? I HAVE NEVER SEEN IT? A YOUTUBE VIDEO OR SIMULATION FOR THOSE OF US IN THE ROOM?
>> I DON'T THINK-- THIS IS ROB. I DON'T THINK THAT'S A BAD IDEA AT ALL. JAN IS POINTING.
>> LEE, DO YOU WANT TO?
>> THIS IS LEE. LIZ JUST GAVE A GOOD EXAMPLE. IF YOU LOOK AT OUR INTERPRETER WHO IS UP ON THE SCREEN UP IN THE CORNER UP THERE, SEE, HOW THE FRAMES PER SECOND IS MUCH SLOWER? THAT'S VRI. THAT'S WHAT VRI. PICTURE THAT ON AN iPAD AND THAT'S KIND OF WHAT YOU'D SEE. YEAH. ON AN iPAD.
[SCATTERED VOICES]
>> THIS NEXT SECTION IS MINIMUM REQUIREMENTS FOR PROCEDURES AND STAFF TRAINING. I THOUGHT THAT WAS IMPORTANT. I THINK IT WAS TOUCHED ON TODAY ON TURNOVER RATE OR ANYTHING IN OFFICES THAT YOU SHOULD HAVE SOMETHING IN PLACE TO ENSURE THAT IT'S NEW EMPLOYEES ARE ALSO GETTING TRAINED ON THIS . AND I THINK THIS IS SOMETHING THAT WE TOUCHED ON, TOO, IS THERE WASN'T A LOT OF ROOM, A LOT OF PLACES THAT POSTED INFORMATION ON HOW TO PROVIDE FEEDBACK IF SOMETHING WASN'T WORKING PROPERLY, AND IT MAY BE IN THE MEDICAL SETTING IF YOUR INTERPRETER WAS NOT AS EFFECTIVE AS YOU MAY HAVE THOUGHT AND MAYBE SOMETHING THAT YOU DON'T WANT TO BRING UP WITH THEM OR BRING UP WITH THE PHYSICIAN IF IT'S SOMEONE THAT THEY REGULARLY USE. SO MAYBE YOU WANT A THIRD PARTY OR ANOTHER WAY OF DOING THAT. AND THEN JUST A CONCLUSION, AGAIN, I'LL SEND THIS OUT AND I THINK IT WILL BE BENEFICIAL TO READ THIS BEFORE THE NEXT TIME WE GO OVER VRI AND THAT WILL PROBABLY BE IN A COUPLE OF MEETINGS FROM NOW BECAUSE, LIKE I SAID IN THE BEGINNING, WE WERE GOING TO SHIFT TO FOCUS ON OLDER ADULTS WITH HEARING LOSS AND OLDER CARE AND I THINK WE'RE FINISHED FOR TODAY UNLESS ANYONE

HAS ANYTHING ELSE. IF YOU CAN LEAVE YOUR NAME TAGS HERE, WE'LL TAKE CARE OF THOSE FOR YOU. THANK YOU TO THE PRESENTERS AND EVERYONE ELSE FOR THE INPUT. THANKS.

>> IRVED TODAY SAYS THANK YOU TO THE INTERPRETERS AS WELL.