**North Carolina Council for the Deaf and Hard of Hearing**
**Quarterly Meeting Minutes**
**November 5, 2021**
**9:00 am – 12:00 Noon**
**Virtual Meeting**

**Members Present:**
Linda Amato
Craig Blevins
Antwan Campbell
Rep. Carla Cunningham
Dr. Kathy Dowd
Kevin Earp
Michael Evola
Rebecca Freeman
Dr. Erika Gagnon
Betty Kelly
Mike Lupo
Dr. Claudia Pagliaro
Daphne Peacock
Laurie Ann Rook
David Rosenthal
Elizabeth Strachan
Donald Tinsley Sr.
Rep Diane Wheatley
Christina Armfield
Greta Knigga-Daugherty
Dr. Robert Nutt
Megan Pender

**Ex Officio:**
Jan Withers (Present)

**Liaison:**
Kimberly Harrell (Present)

**Members Absent:**
Meredith DeNaples
Pattie Griffin
Senator Bill Rabon

**Current Vacant Council Seat(s)**

Senate Appointee- President Pro Tempore

DHHS Secretary Appointee – DMH/DD/SAS

**Call to Order:** The meeting was called to order at 9:00 am by David Rosenthal, Chair

**Welcome; Introductions; Ethics Reminder; Approve Minutes from November 5, 2021**

**Motion:** Donald Tinsley (Craig Blevins) moved to approve the minutes from November 5, 2021, Council meeting. **Motion passed.**

None of the members acknowledged having a conflict of interest or appearance thereof on matters listed on this agenda

**David Rosenthal, Chair**

Welcomed 3 members to the Council: Greta Knigga-Daugherty, Randal Lee Hartline, Christina Armfield

**Perspectives on State of Deaf Education in North Carolina**

**Claudia Pagliaro, Ed.D., and Lynne Allen, K-12 Deaf and Hard of Hearing Teacher Licensure, University of North Carolina – Greensboro**

The Deaf or Hard of Hearing Learner

- We see the Deaf or Hard of Hearing (DHH) students as different and in no way in deficit
- What does the individual DHH learner bring to the classroom?
    - Language, mode, proficiency
    - Cognition- experiences, memory, socialization, Theory of mind

Knowledge has advanced, recognizing the impact academically, socially, and emotionally of language deprivation

- Society has changed, offering more opportunities for DHH persons, more access and understanding of Deaf culture. Unfortunately, we still teach DHH children/youth with a curriculum, pedagogy, and mindset, that does not recognize the Deaf learner

The State of Education of the Deaf in the US and North Carolina

- More DHH children in integrated settings
- Quality licensed teacher shortage
    - At least 13 K-12 teachers of the Deaf vacancies in NC
- Conflicts between licensure requirements, university requirements and best practices
- Pay for NC Teachers of the Deaf is 18% less than US average
- Teacher preparation programs (TPPs)
    - 51 total DHH TPPs across the US
    - 1 in NC (UNCG); 6 in surrounding states (GA 2, SC 1, TN 2, VA 1)
- Lack of placements
    - Deaf, Teachers of color and Deaf Teachers of color needed

K-12 DHH Teacher Preparation at UNCG

- Concentration area under Professions in Deafness major
- 120 credit hours; practicum/field experience each semester
- Levels of Requirements
    - Professional Standards & Evidence-based practice
    - State
    - University/School of Ed/Collaborative of Education Professionals
    - Program

Actions to Assist

- Make it attractive to come to NC and or stay in NC
    - Increase salary comparable to surrounding states
    - Support ($) for pre-service preparation tuition
- School-State-University partnerships
- Recognize each other as a valuable resource
- "Grow your own"

**NCCDHH Committee Reports**

**Audiology by Erika Gagnon**

There are some recent updates to the CDC and the ADA recommendations regarding Diabetes and hearing loss. The recommendation is that everyone diagnosed with Diabetes have a baseline hearing test and annual assessments. With that, there were no basic guidelines or recommendations given for balance or fall risk prevention.

With the recent shift to NC Medicaid with managed care, one of the managed care groups, WellCare, contracts with a third-party group called HEAR USA for hearing technology services. They are capable of fitting hearing aids, however, HEAR USA does not contract with any providers in NC. Therefore, anyone who has that policy in NC isn't getting access to that technology. Furthermore, if NC audiologists do end up contracting with them, the level of technology that is available is reduced with a shorter warranty than what other Medicaid policies are authorizing. So, the service isn't consistent across all policies. This is causing delays in young children and older patients getting the available technology.

Finally, we're hoping to look further at the dynamic of the IEP process and the recommendations that are being made from the academic and the medical perspective.

**Disability/Diversity by Donald Tinsley**

The current minimum provisions of Patient's Bill of Rights (10A NCAC 13B .3302) do not include disability as an area that cannot be discriminated against regarding the right to medical and nursing services. There also is not a provision to ensure that Deaf and Hard of Hearing have access to effective communication accommodations when receiving medical and nursing services.

- **Current Rule**: “A patient has the right to medical and nursing services without discrimination based upon race, color, religion, sex sexual orientation, gender identity, national origin or source of payment”
- **Proposed update**: “A patient has the right to medical and nursing services without discrimination based upon race, color, religion, sex, sexual orientation, gender identity, national origin or source of payment or **disability**”
- **Current Rule:** “A patient who does not speak English shall have access, when possible, to an interpreter” 10A NCAC 13B. 3302 (14)
- **Proposed Addition**: Add Rule 10A NCAC 13B .3302 (15) to read, “A patient who is Deaf or Hard of Hearing shall have access to effective communication accommodations when receiving medical and nursing services”

Recommends a motion be made to have the Council Chair send a letter to the Medical Care Commission requesting an amendment to the Patient’s Bill of Rights to include the right to interpreters

**Education by Mike Lupo**

Currently we are addressing the following:
HB-317- data collection sent to DPI. This collected data is on Deaf and Hard of Hearing children as it pertains to education progress.

- Why are we colleting this data and sending to DPI?
- Who is determining what data to collect and how it is used?
- What is being sent to DPI? Is it being held in a repository system, in an archival database that would allow access to the statistics and reports that are user friendly?

Deaf Parents concerns with access in public schools

- Deaf parents want to participate in meetings, whether it be IEP meetings or parent/teach conferences. They continue to have barriers to communication access (i.e., interpreters) in these situations. The issue is ongoing.

EIPA concerns

- Is the requirement of the score of 3.5 enough to cover the general education curriculum?

**Health by Dr. Robert Nutt**

We continue to be somewhat of a brainstorming group and support health oversight in collaboration with the other committees. We continue to work closely with Kathy and the Audiology Committee to try to figure out how to improve hearing screening, not only in Diabetes but the aging population and the newly diagnosed pediatric disorders and conditions that may involve an additional diagnosis of being Deaf and/or Hard of Hearing be caught and screened for. Brainstorming solutions to larger systems not having time to incorporate hearing screening in the discharge planning for newly diagnosed Diabetes. The easy target would be for the larger health systems to incorporate the protocol for specialist. We believe those recommendations would be aligned with the NCIOM’s recommendations and action items. We are also actively discussing the issue of mental health during COVID and the effect of social isolation. I have talked to the Council Chair about the possibility of having combined committee

meetings with Audiology and Disability/Diversity to talk about some of the issues together.

## Social Isolation

**Rebecca Freeman, Consumer Affairs and Legislative Liaison, Division of Aging and Adult Services**

In April 2020, the Division of Aging Adult Services (DAA), initiated an internal social isolation workgroup in response to the shutdowns that were occurring. We evolved to include partners such as other DHHS divisions and stakeholders. We looked at one-on-one direct support, access to group engagement, and what could be done from the state level policy and funding perspective. We received a grant to support our efforts.

Through our work with researchers, we learned that the primary risk factors for suicide are perceived burdensomeness, and no belongingness were linked to being isolated and lonely, so we expanded our focus to include elevated suicide risk. It's important to distinguish between the objective terms of social isolation and loneliness. One can experience one independent of the other. It becomes a problem when the person who is experiencing that isolation also has that subjective feeling of being lonely.

A recent survey of 10,000 people reported that 3 in 5 adults, regardless of age, now struggle with feelings of loneliness. It would be incomplete to not also add elevated suicide risk. In addition to the emotional and mental impacts, research has linked social isolation and loneliness to higher risk for a variety of physical and mental conditions, thus providing the same increase of mortality as smoking 15 cigarettes a day. Long term illness and disabilities may prevent a person from engaging with others, making them a higher risk for social isolation and loneliness.

Recommendations from the University of Michigan to help address this issue are to:

- Recognize the issue
- Increase efforts to identify those who might be isolated or lonely
- Provide safe opportunities for those people to engage with other and with nature

Two Initiatives came from our workgroup

- Surveying our network and part of DHHS' network and train staff from our network in two interventions that help address social isolation, loneliness, and elevated suicide risk
- Contract with the NC Center for Health and Wellness at UNC Asheville to develop a statewide social engagement web resource

**Social Isolation Among Hard of Hearing, Deaf and Deafblind Adults**
**Katie Franklin, Division of Services for the Deaf and Hard of Hearing**

The four key factors in reducing loneliness depending on the cause:

1. Increase access to social interactions
2. Increase social support
3. Change unhelpful thought about social situations

4. Improve social skills

Research shows that hearing loss in older adults is linked with increased social isolation, depression, lower self-efficacy, loneliness and decreases in social functioning. Amplification research shows that the use of a hearing aid improves these conditions dramatically. The lack of a requirement for clinically recommended best practices for hearing screenings in long-term care facilities is a concern, since most residents in long-term care are age 65 and older with prevalence of hearing loss estimated to be 70-90%.

Recommendations for prevention of isolation and loneliness include regular hearing assessments, proper treatment of hearing loss, appropriate amplification and fitting, audiologic rehabilitation, support of family and friends, ongoing hearing health support and ongoing education for long-term care.

Isolation among the Deaf and Deafblind is often caused by communication barriers and lack of support service provider (SSP) services.

Long-Term Care Facility Solutions for Deaf and Deafblind:

- Updated procedures
- Staff education
- Accessible activities
- Deaf/Deafblind facility

Environmental Solutions:

- Open floor plans
- Captioning
- Loops
- Visual Alerts
- Curved halls
- Lighting
- Telecommunications
- Reverberation

**Deaf Isolation in Children (age 0-5)**
**Dora Tin, Mental Health Clinician**

Imagine children without language access. How can they develop their social skills such as sharing, cooperating, listening, following directions, respecting personal space, making eye contact, and learning manners without language?

Language deprivation:

- Limited communication access at critical age (0-4)
- Absence of access to ASL
- Minimal access to auditory input

Language deprivation syndrome

- Mental health difficulties
- Difficulty with abstract thinking
- Limited health literacy
- Lower quality of life
- Cognitive and language problems

- Higher level of trauma

They don't have support or anyone using language to explain things about their behavior, their health or about how to protect themselves from abuse or to report any abuse. As they get older, they lack job opportunities and tend to develop lower self-esteem and quality of life. IN NC, we don't have any specialized programs for children with hearing loss for daycare and preschool. Therefore, they do not have any accessible social interaction with peers. There also are not any private or in-home based programs that provide accommodations either.

**Deaf Isolation in Children (grade school 1-8th grades)**
**Alexandra Ling, School Psychologist**

Look at children entering school in 1st-8th grades: consider the struggles they already experienced up to age 5 and language deprivation. Issues caused by language deprivation become more apparent. They are often behind their appropriate grade level due to not having a strong understanding of language needed to grasp the things they are learning in the classroom. They cannot express their feelings and it becomes difficult to regulate their emotions and the result is what we see as behavior problems.

North Carolina does have 2 residential schools for the Deaf (NCSD and ENCSD). Most Deaf students who do not have comorbidities end up in local or mainstream school environment, where they don't have peer interaction or other Deaf people to socialize with. There is limited recreational access. To participate, requires language access (interpreter) and often that is not provided.

COVID sending students home for remote learning further contributed to feelings of isolation. Community events and camps are not being offered and they are often alone at home. DSDHH has provided DEAF Storytime once a month online. Middle schoolers have been able to attend virtual field trips and students can Zoom chat with signing teachers when possible. Entering high schoolers either unable to read or reading at a very low level experience low self-esteem, a failure to thrive, identity confusion, a low sense of belonging, and poor emotional regulation. There are some programs that focus on helping Deaf students transition into adulthood. One thing that is missing is there are no college prep or summer programs for Deaf child in NC. Students are having to go out of state if they want access to those types of college prep programs and career exploration.

**Serving Military Veterans with Hearing Loss**

**Sean Baker, Veterans Liaison, Division of Services for the Deaf and Hard of Hearing**

My role specifically is to connect veterans through resource access. Not only veterans but also family members and caregivers, helping them connect to their community.

- **Mission:** in collaboration with our partners, promote hearing loss awareness, communication equity and well-being in response to the unique needs of veterans and service members throughout NC.
- **Vision:** North Carolina is a model for all states in empowering veterans to thrive with hearing loss

Accomplishments and Outcomes to date:

- CART services for the Governors Working Group on Veterans
- 120+ State Veteran Service Officer Presentation
- HLAA and American Legion Presentations
- Exposure to key veteran connected audiences
- Expansion of internal capacity to engage veterans
- Cooperation with partners and stakeholders
- Messaging reinforcement
- Direct veteran engagement
- Trust building
- Increased referrals

Partner Focus

- Veteran Centric Engagement Solutions
- Military Culture Training
- Veteran Assistance referrals
- Advise on matters regarding military, veterans, and their families

**Wrapping Up**
**David Rosenthal, Chair**

As it relates to the Patients Bill of Rights, 10A NCAC 138.3302, we require a motion that the Council chair send a letter with an amendment to the Patient's Bill of Rights to include the language of providing interpreters for the Deaf and Hard of Hearing patients.

**Motion:** Donald Tinsley (Craig Blevins) moved to approve **Motion passed.**

I would like to create an annual report to the Governor that provides the Council an opportunity to inform the Governor and the legislators of what issues we've been working on and which ones we feel are critical for their attention and action. I think it is important for the Governor and the legislators to hear from us. We will discuss that with the Council via email.

Thank you to all the wonderful presenters we had today. I am blown away by all of the information that we've received, and I think we have certainly learned a lot that will help us as a Council and our committees can continue to focus on the work they are interested in and address those issues.

For new members of the Council, I will be in touch with each of you as soon as possible to schedule a one-on-one meeting to do an orientation and to help you pick which committees you would like to serve on.

I'd also like to thank our interpreters, our CART provider, and the staff of the DSDHH for all their help with the logistics of this meeting. Thank you to everybody and I will see everyone at our next meeting on February 4th.

Have a wonderful and safe Thanksgiving!

**There being no further business and announcements, the Council meeting was adjourned.**

**Future 2022 meetings: February 4, May 6, August 5, November 4**

Https://www.ncdhhs.gov/divisions/dsdhh/councils-commissions