As detailed in earlier chapters, hearing loss is a common health issue that can be associated with a host of conditions and diseases and can affect the quality of life for Hard of Hearing individuals. Despite the prevalence of hearing loss and the potential benefits of timely hearing screenings, especially in the elderly population, hearing loss in health care settings is often inadequately screened. This also holds true in ***Long-Term Care Facilities (LTCF)***,[t] which provide a variety of services, including both medical and personal care (bathing, dressing, toileting, etc.), for people who are unable to live independently in their home and community. There are two distinct categories of LTCFs: ***Skilled Nursing Facilities (SNFs)***, commonly referred to as nursing homes, and ***Adult Care Homes (ACHs)***, also known as assisted living facilities.[1] Although both types of facilities provide services for adults who are no longer able to live independently, the type of services provided to residents depends on the setting. SNFs provide a wide range of medical and personal care services, including nursing care, 24-hour supervision, and assistance with everyday activities. Rehabilitation services such as physical, occupational, and speech therapy are also available in SNFs. SNF residents normally have ongoing physical or mental conditions that require constant care and supervision, so SNFs have licensed health care professionals on staff to provide care. ACHs serve individuals who need personal care assistance and supervision, but do not require the level of medical care provided by SNFs. ACHs usually do not have licensed health care professionals on staff. ACH staff focus on assisting residents with activities of daily living (e.g., feeding, bathing, dressing) and 24-hour supervision. ACH staff can help residents with medication administration, but other levels of medical care, including primary care, are from outside medical providers.[2,3] Both SNFs and ACHs provide service for adults of all ages, but residents of both types of facilities are on average elderly, with the majority of residents of LTCFs being 65 and older.[3,4] With the residents of LTCFs tending to be elderly, it is no surprise that incidences of hearing loss in these facilities are high, with varying estimates that 70%-90% of residents of LTCFs are Hard of Hearing.[5]

NEED FOR A STATEWIDE AUDIOLOGY SERVICES PROGRAM IN NORTH CAROLINA

In North Carolina, screening for hearing loss in residents of LTCFs is required by regulations at the state and federal levels. The regulations for LTFCs differ by type. The regulatory requirements for SNFs are under federal authority and set by the Centers for Medicare and Medicaid Services[u] (CMS) if they participate[v] in the Medicare and Medicaid Programs.[3] CMS sets the requirements, establishes agreements with states, and provides funds to state agencies to regulate SNFs in their state. The North Carolina Department of Health and Human Services, Division of Health Services Regulation (DHSR)[w] performs the oversight and regulation of SNFs in North Carolina. Per CMS regulations, all SNFs are required to perform an assessment of the physical, cognitive, and psychosocial status of all new residents within 14 days of intake and at discharge.

The standardized form that is used during the required assessment is the Minimum Data Set (MDS)-Nursing Home Resident Assessment. Screening for a hearing loss is required as part of the MDS. A licensed health care professional, usually a licensed nurse, administers the MDS to residents. When assessing for a hearing loss, the MDS administrator can conduct or coordinate the assessment with another licensed professional who is trained in audiological screenings such as an audiologist or speech-language pathologist. However, this is not required, and neither is the administration of a clinically recommended hearing screening (**see Chapter 3**). All that is required is that the resident is asked about their ability to hear (**see table 5.1**) and usage of a hearing aid or assisted listening device (**see table 5.2**). [3,6,7]

TABLE 5.1 Steps for Assessment for Ability to Hear

1. Ensure that the resident is using his or her normal hearing appliance if they have one.

   Hearing devices may not be as conventional as a hearing aid. Some residents, by choice, may use hearing amplifiers or a microphone and headphones as an alternative to hearing aids.

   Ensure the hearing appliance is operational.
2. Interview the resident and ask about hearing function in different situations (e.g., hearing staff members, talking to visitors, using the telephone, watching TV, attending activities).
3. Observe the resident during your verbal interactions and when he or she interacts with others throughout the day
4. Think through how you can best communicate with the resident. For example, you may need to speak more clearly, use a louder tone, speak more slowly, or use gestures. The resident may need to see your face to understand what you are saying, or you may need to take the resident to a quieter area for them to hear you. All of these are cues that there is a hearing problem.
5. Review the medical record.
6. Consult the resident's family, direct care staff, activities personnel, and speech or hearing specialists.

Source: United State Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf

TABLE 5.2 Steps for Assessment for Hearing Aid and Other Hearing Appliance Used

1. Prior to beginning the hearing assessment, ask the resident if he or she owns a hearing aid or other hearing appliance and, if so, whether it is at the nursing home.
2. If the resident cannot respond, write the question down and allow the resident to read it.
3. If the resident is still unable to respond, check with family and care staff about hearing aids or other hearing appliances.
4. Check the medical record for evidence that the resident had a hearing appliance in place when hearing ability was recorded.
5. Ask staff and significant others whether the resident was using a hearing appliance when they observed hearing ability.

Source: United State Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf

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t Throughout this chapter, "Long-Term Care Facilities" is used in an all-inclusive manner for Skilled Nursing Facilities and Adult Care Homes.

u The Centers for Medicare & Medicaid Services (CMS) is a federal agency in the US Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.

v Out of the 438 nursing home facilities in North Carolina, all but nine are certified to receive Medicare and Medicaid funding. The nine that are not certified to receive Medicare and Medicaid funding only accept private pay or payment through private insurance. These nine facilities are only subject to state level regulation.

w Per CMS regulation, DSHR surveys and assesses all SNF in North Carolina annually for regulatory compliance. The assessment of SNF is completed by survey teams composed of nurses, dietary staff, pharmacists, and social workers. Any facilities found to not be compliant could possibly be subject to fines and civil penalties.

Since ACHs are not providers of medical care, and thus do not participate in the Medicare and Medicaid programs, they are not under federal regulatory authority and are completely under the purview of DHSR.[x] Per DHSR regulatory requirements, all ACHs must assess all residents' ability to function and need for assistance with daily living. This includes whether a resident has a diagnosed hearing loss, has a hearing aid, and if they do, whether they can maintain the hearing aid. However, the required assessment is not intended to diagnose any condition such as hearing loss. If ACH staff believe a resident may have a medical issue such as a hearing loss, they are directed to raise the issue with the resident's primary provider of medical care.

Regulatory requirements for hearing loss screenings in residents of either type of LTCF does not meet the "gold standard" of hearing screening to diagnose a hearing loss. The lack of a requirement for clinically recommended best practices for the hearing loss screenings in LTCFs is particularly concerning, with the average resident of a LTCF being elderly and, thus, at a higher risk for hearing loss. Like most health care settings, LTCFs can be noisy environments, with sounds from televisions and other electronic devices, intercom sounds, cart transport equipment, and conversations being held. This further complicates the ability of a Hard of Hearing individual to understand and comprehend speech.[8] In addition, many residents in LTCFs have a decline in cognitive ability, with estimates that 70% of nursing home residents have cognitive impairment[8] and 40% of residents of ACHs have Alzheimer's or related dementia.[3] LTCF residents with a decline in cognitive function may have issues separating speech from background noises and processing speech in noisy environments. This can be further complicated if the LTCF resident suffering from a cognitive decline is Hard of Hearing.[8]

SOCIAL ISOLATION AS A RESULT OF HEARING LOSS *– Ralph's Story*

Ralph is a 72-year-old retired engineer. Last year after a fall, Ralph and his family decided that it would be best if he moved into an assisted living facility. Over the last few years, Ralph's family has noticed that he seems to be having some difficulty following conversations and is socially withdrawn. They have also noticed that he has begun spending most of his time in his room rather than going to the social events and activities that the community hosts. Ralph's doctor has recommended that he be fitted for hearing aids, but his Medicare Advantage plan charges a $700 co-pay per hearing aid which he cannot afford.

Even though the regulations for the assessment of hearing set forth for North Carolina LCTFs do not meet the clinical standard for hearing screenings (**see Chapter 3**), the regulatory requirements put no constraints on the ability of LTCFs to do more stringent and clinically proven hearing screenings. Implementing new regulatory requirements would be challenging. Changes to SNF regulations would require changes to CMS standards and guidelines set for SNFs across the United States and would have to be undertaken at the federal level. State-level change of regulatory requirements of assessments for hearing loss screenings for residents in ACHs would require a change in state regulations and rules, but the lack of licensed health care professionals on staff severely limits what could be done through regulations. However, there is opportunity for improvement and innovation in policies, procedures, and best practices.

While there are various piecemeal strategies that could be used to meet the need for evidence-based services to assess and treat hearing loss among residents of LTCFs, the task force focused on how to create an infrastructure that could bring clinical best practices into LTCFs to improve care for residents who have hearing loss. A statewide system for audiology services in LTCFs could promote and provide hearing screenings as well as consultation and education on hearing screenings, audiological services, and how staff can best meet the needs of residents who are Hard of Hearing. The coordination and development of relationships and partnerships with LTCFs in North Carolina and their respective professional associations will require dedicated staff time at the statewide and regional level. Such a system could be established and housed within the North Carolina Department of Health and Human Services, Division of Services for the Deaf and Hard of Hearing (DSDHH). For such an effort, DSDHH would need increased organizational capacity at its central and regional offices for this undertaking. Full-time staff at the central office would create and implement the efforts of the statewide system for audiology services, and delegate tasks and duties to staff at regional offices as needed.

RECOMMENDATION 5.1:
Improve Care of Deaf and Hard of Hearing Residents of Long-Term Care Facilities

The Division of Services for the Deaf and Hard of Hearing (DSDHH) should coordinate, in consultation with appropriate health care facilities associations, the creation and implementation of a statewide audiology service program to increase the care of Deaf and Hard of Hearing patients in long-term care facilities. To effectively staff the program:

A. DSDHH should submit a budget revision request to the North Carolina Office of State Budget and Management (OSBM) to create up to eight total new positions responsible for creating and implementing a statewide audiology service program for long-term care facilities. These positions should include one North Carolina program coordinator and up to seven regional specialists.

B. DSDHH should develop job descriptions for the program coordinator and regional specialists. Statewide audiology service program coordinator responsibilities should include completing, and/or delegating to regional specialists, the following:

    1. Offer hearing screenings to all residents of long-term care facilities.

    2. Act as liaisons to long-term care settings around audiological concerns.

x The routine monitoring and complaint investigations are by local county Departments of Social Services, while annual and biennial inspections of ACHs are completed by DHSR.

3. Provide recommendations/consultation to these facilities about assistive technology, hearing aids, and communication access.
4. Basic hearing aid care as deemed appropriate by the audiologist.
5. Collaborate with private audiologists already working with residents.
6. Serve as the lead for the long-term care facility capacities assessment (**see Recommendation 5.2**) for quality improvement purposes.
7. Develop and/or locate free training and educational resources for long-term care facilities to use to train their supervisors and/or employees on compliance with communication access laws and cultural sensitivity best practices for delivering care to Deaf and Hard of Hearing individuals.
8. Act as liaison to other organizations that provide training for adult care home providers such as the NC Assisted Living Association, NC Senior Living Association, and Area Agencies on Aging (Ombudsman Programs).

QUALITY IMPROVEMENT AND EVALUATION OF AUDIOLOGICAL SERVICES IN LONG-TERM CARE FACILITIES

As Title III entities under the Americans with Disabilities Act (**see Chapter 2**), LTCFs should have established policies, procedures, or practices for providing interpreting services for Deaf residents. However, like hospitals and health care systems (**see Chapter 4**), data on the quality of interpreting services provided, common practices and procedures for the provision of interpreting services, and complaints from Deaf patients about the quality of the interpreting services provided, or the lack there of, is not readily available. We can assume that Deaf residents of LTCF facilities face similar barriers to communication access and to interpreting services faced by Deaf individuals in other settings. On the national level, there have been several lawsuits, complaints filed, and allegations of denial of interpretation services toward LTCFs over the past decade.[9–15] Without concrete data, it is difficult to objectively measure how well LTCFs meet the communication access needs of Deaf and Hard of Hearing individuals and where there is room for improvement. In order to collect data and evaluate the quality of interpreting services, and the interpreting services policies and practices used by North Carolina LTCFs, data should be collected from these facilities with the goal of implementing quality improvement activities to improve services for Deaf and Hard of Hearing residents.

RECOMMENDATION 5.2:
Survey Long-Term Care Facilities on Communication Access Needs of Patients Who are Deaf or Hard of Hearing

The Division of Services for the Deaf and Hard of Hearing (DSDHH) should partner with long-term care facility professional associations to develop a voluntary and uniform self-assessment on how care is provided for Deaf and Hard of Hearing individuals and their family members to be used by long-term care facilities for quality improvement purposes. In order to do this:

A. The DSDHH statewide audiology program coordinator should partner with Division of Health Services Regulation (DHSR) and long-term care facility association representatives to identify effective methods to disseminate the voluntary and uniform self-assessment form to facilities. The self-assessment should be designed for long-term care facilities for quality improvement purposes.

B. Communication should also include information on ADA legal requirements and quality improvement resources, including the availability of technical assistance from DSDHH to help facilities better meet the communications needs of patients and their families.

C. The DSDHH statewide audiology program coordinator, in conjunction with long-term care facility associations, should collect the results of this assessment and share them with the Coalition and the NC Council for the Deaf and Hard of Hearing.

There is much room for improvement for LTCFs that currently do not adequately screen for hearing loss. In order to ensure that residents who have a hearing loss are identified and receive treatment, LTCFs in North Carolina should consult and partner with DSDHH's Statewide Audiology Program Coordinator to assess and update their procedures and practices related to hearing screenings for their residents, and update them to meet clinical guidelines for hearing screenings as needed.

RECOMMENDATION 5.3:
Update Procedures and Practices Pertaining to the Care of Deaf and Hard of Hearing Residents of Long-Term Care Facilities

The Division of Services for the Deaf and Hard of Hearing statewide audiology program coordinator should lead an assessment of:

1. Hearing assessment procedures for the initial resident assessments in long-term care facilities
2. Referral patterns for when a resident is identified as Deaf or Hard of Hearing and what type of periodic review of the resident is being performed
3. Deaf and Hard of Hearing-related regulatory citations in long-term care facilities by gathering data on previous violations committed and their outcomes and evaluating opportunities for educational programs in lieu of penalties when a violation occurs
4. Findings and recommendations to be presented to the NC Council for the Deaf and Hard of Hearing

As detailed in preceding chapters, Deaf and Hard of Hard of Hearing individuals have unique needs and communication modalities, and, often, staff in health care settings are not aware of the communication access and cultural/behavior needs of Deaf and Hard of Hearing individuals. To ensure that staff in LTCFs have the requisite knowledge to provide communication accommodations and culturally appropriate care to Deaf

and Hard of Hearing residents in long-term care settings, statewide educational efforts could improve understanding, knowledge, and skills of administrators and staff in LTCFs. Partners in this effort could include DSDHH, long-term care facility professional associations, and the Department of Health and Human Services, Division of Adult and Aging Services[y] Long-Term Care Ombudsman Program.[z] The Long-Term Care Ombudsmen provide a variety of services to LTCF residents and staff **(see Table 5.3)**, including training sessions for LTCF staff on residents' rights and other issues.[16] As a statewide service that already engages and educates LTCF staff, they would be a key partner in these educational efforts.

TABLE 5.3 Services Provided by Long-Term Care Ombudsman

- Answers questions and gives guidance about the long-term care system
- Educates long-term care providers and community groups on residents' rights, restraint use, care planning, activities, and new laws
- Investigates and assesses matters to help families and residents resolve concerns and problems
- Works with appropriate regulatory agencies and refers individuals to such agencies when resolutions of concerns or grievances are not possible through the Ombudsman
- Raises long term care issues of concern to policymakers

Source: https://www.ncdhhs.gov/assistance/adult-services/long-term-care-ombudsman

RECOMMENDATION 5.4:

Educate Administrators and Staff in Long-Term Care Settings on Providing Appropriate Services and Care to Deaf and Hard of Hearing Residents

The Division of Services for the Deaf and Hard of Hearing, the Division of Health Services Regulation, and the Division of Aging and Adult Services should collaborate to identify and leverage opportunities to expand and/or strengthen training on communication access and cultural/behavioral sensitivity for direct care and administrative staff in long-term care settings.

y The Division of Aging and Adult Services works to promote the independence and enhance the dignity of North Carolina's older adults, persons with disabilities, and their families through a community-based system of opportunities, services, benefits and protections. The Division of Aging and Adult Services provides monitoring and assessment of aging and services programs in North Carolina and provides training to support adult programs and services. Source: https://www.ncdhhs.gov/divisions/daas

z The Long-Term Care Ombudsman Program consists of the Office of the State Long-Term Care Ombudsman and 16 offices of Regional Long-Term Care Ombudsmen housed in Area Agencies on Aging. The Long-Term Care Ombudsmen provide advocacy for LTCF residents, assisting them in exercising their rights and mediating grievances between residents, families, and facilities.

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