1. **Welcome/Meeting Opening – Introduction**

   Guests: To present their responses to the Interim Report: Dr. Gerry Buckley, NTID President, Dr. Alan Hurwitz, Gallaudet University President, Carol Fisher, Director of Grants at Rochester General Health Systems and, via video DVD, Dr. Thomas Pearson, Senior Associate Dean for Clinical Research and Director, Clinical and Translational Science Institute University of Rochester School of Medicine and Dentistry

2. **Task Force Updates**

   **Sam Atcherson** attended a conference sponsored by Johnson & Johnson which focused on the nursing shortage and how to get people into that profession. There is a high turnover in that profession so there is constant job availability. Attention needs to be paid to minorities and men entering this profession. There was no mention of people with disabilities. Johnson & Johnson has a campaign to attract high school students with scholarships. Nurses are needed for lab work and education work, as well. There are different possibilities within that profession for deaf and hard-of-hearing people if access and course modification is possible. Online teaching opportunities are a possibility.

   **Michael McKee** attended a conference for deaf and hard-of-hearing professionals this summer in Portland, Oregon. While there, he shared some of the Interim Report goals. There were 120 students and professionals and some interpreters and 2-3 people who were curious about how to handle accommodations at different schools. Education is becoming more successful because doctors and nurses are getting into more schools. But there were still issues with accommodations which was disappointing to learn..

   **Sam Atcherson**: Compared to past years, the conference seemed to have more of a focus on two major barriers: getting into programs and getting jobs. One concern related to the amplified stethoscopes and how they are measured related to effectiveness. We need more audiology research in that area. This year alone we have had two companies develop clear face masks, one is plastic. When you put it on and start talking, you are muffled. The other one, still in the development stage, has paper around the sides, but the presenter did not provide an example of what it looked like. I will have the opportunity to see that in two weeks.
and do some testing on that. There is some excitement but we have to hold our enthusiasm first. Those two things will be a major breakthroughs to help students and professionals.

3. Goals of the day
1) To receive reports from the four founding institutions about the June 30th “Building Pathways to Health Care Careers for the Deaf and Hard-of-Hearing Community: Interim Report.
2) To clarify the intent and direction for the culminating White Paper due in March 2012 and agree on a preliminary draft outline of that paper’s structure and scope.
3) To finalize the White Paper vision/goals and pivotal recommendations for achieving the goals by each of the subcommittees.

4. Dr. Gerard Buckley, National Technical Institute for the Deaf (NTID) President and Vice President and Dean, Rochester Institute of Technology (RIT) – Summary of Presentation

25-30 years ago, I would never have imagined having this discussion. Today we are seeing possibilities happening. We have D/HH professionals leading us in health care. I am delighted. As we welcomed the 300 new students for SVP, it was exciting to hear them talk about their visions and dreams. Many of them talked about becoming doctors, nurses, lawyers, and a variety of leadership roles.

We have started a dialogue related to this vision by setting up the Task Force. I am honored to support that effort. Alan and I and Tom have already begun a dialogue about how to support the recommendations.

I have identified areas where NTID may take the lead. We have additional ideas on how we can work together to be sure the recommendations you propose are used. When Alan went to Gallaudet and I took over here, that set the stage for these two sister institutions to really pursue collaboration. We are in regular contact with each other. It is a new era of collaboration.

The federal funding picture looks like “Hurricane Irene”. We do not know where it will hit yet. We do not know exactly how to protect ourselves but we know change is coming. We are having a lot of discussion internally. All the four institutions that are sponsoring the Task Force are having the same discussion. But this Task Force remains a priority from my perspective. I go back to 30 years ago and then to now. I see the opportunities and the young deaf and hard-of-hearing students arriving here. We want to be sure we prepare them for the future appropriately.
1. **Maximizing Information Dissemination**
   - **IA:** NTID will create, develop and maintain website
     - Using NTID’s Educational Design Resources
     - With ongoing support & contributions from Task Force members
   - **IB:** GU will develop and carry out PR plan
   - Result: Joint PR & information dissemination by NTID & GU regarding health care career opportunities
   - Collaboration in both initiatives with key organizations as described in recommendation ID

2. **Enhancing Educational Curricula & Training Programs**
   - **IIA(1):** NTID, GU and other partners will incorporate a health care career dimension in the summer programs
   - **IIA(2):** NTID will work with RIT’s Institute of Health Sciences and Technology (IHST) to explicitly target individuals in all middle/high school outreach initiatives
   - **IIA(4):** NTID will adapt *Project Fast Forward* to strengthen math & science skills within the context of preparation for health care majors
   - **IIB(2):** NTID will establish through NCE a Health Care Careers clearinghouse & mentoring/advising center
   - **IIB(3):** NTID will create a Health Care Career Scholars Program to provide support for students pursuing health-related majors
   - **IIB(4):** NTID will collaborate with RIT’s IHST to develop additional opportunities for students to train for health care careers
   - **IIB(7b):** NTID will analyze feasibility of:
     - New NTID career-focused AOS programs in high-growth, low-cost area of health care careers
     - New joint associate’s program with MCC in a health care field already offered by MCC
     - New NTID AS/AAS transfer degree program (with RIT IHST and GU in health care-related fields)
       - Possible 3+2 program linking GU to RIT/IHST
   - **IIB(9):** NTID will lead discussions with other institutions regarding establishing a joint Consortium Center of Excellence in Health Care Education, and develop a formal proposal to respective institutional leaders
   - **IIC(1):** NTID, through NCE, and in collaboration with other institutions, will identify mentoring opportunities for new graduates with D/HH health care professionals

3. **Creating Employer Awareness**
   - **IIIA(1&2):** NTID, through NCE, will assume leadership to sponsor a national pilot for health care employers
IIIIB: NTID, through NCE, in collaboration with GU and national partners, will develop a list of potential partners and employers who could be tapped as students enter the health care career pipeline

4. Promoting Accessibility and Technological Solutions
IVA(1-8): NTID will develop an action plan for implementing:
   • Including basic elements of Medical interpreting within the BS Interpreting program
   • Expanding current certificate program in Medical Interpreting, possibly with distance-learning offerings
   • Offering highly specialized advanced track for Medical Interpreting that may lead to a Master’s degree
   • IVC & D: Promoting awareness of technological innovation in delivering access services, and establishing a health care access and communication consulting service

5. External Funding, Government Relations, Sponsored Research
VC: NTID will assume central leadership in collaboration with the other founding institutions on:
   • Instructional and curricular innovation related to health care preparation & professional development
   • Advancements in providing access services related to health care preparation & professional development
   • Employment outcomes & career trajectories related to health care careers

5. Dr. Alan Hurwitz, Gallaudet University (GU) President – Presentation
I have some comments to share with you. I would really like to applaud the four institutions for working together. It is amazing what you have done over that short time. It is a great thing for you to work together and calibrate on something that has never been done in the past.

Maybe we need to do it on a smaller scale, project by project, but we have many people coming together here from the four institutions. Rochester General Health System is very excited to see us all work together. Every time I go to the Department of Education or visit Congress they always ask us what we are doing to work with the other institutions.

We want to be sure Gallaudet and the National Technical Institute of the Deaf (NTID) are working together. Together we have so much to offer society. To see that happening is wonderful. I want to keep the momentum going. I want to applaud you all.

The interim report was outstanding. I have tried to respond to the questions. We are not quite ready to give a full report yet. We are expected to provide our report by October 1. It is a work
in progress. I want to thank Gerry for sending me his preliminary report. That gave us a good head start after we reviewed that.

We have had some discussions with cabinet members, the administrative team at Gallaudet. That includes 11 people. We have all reviewed the report and had some discussion. Don Biel is my chief of staff at Gallaudet. He has participated in your meetings regularly.

One reason I am so impressed with the interim report is you all are looking for action. It is not something that we just produce (the report) and put on the shelf. It is something you want to know what we can do in the short term and long term and maybe some things we are not capable of doing for whatever reasons.

I have asked our provost, Steve Weiner, and his two academic deans, Carol Erting, who is the Dean for the Graduate School and Professional Programs, and Isaac Agboola, who is the Dean for the College of Liberal Arts, Science, and Technology, to make a report on the areas they believe we can do something with and the next steps we can make in the next few months.

I want to respond to specifics and give you some specific reactions to the plan. We are not prepared to respond to all of them, but I applaud NTID for giving this very comprehensive plan to give us a sense of where we are going and recognizing that NTID has a close tie with RIT which is already on the cutting edge of education.

RIT has established the new College of Applied Health Science Technology and our relationship with the Rochester General Health System. There are so many good things happening as well as have the partnership with the University of Rochester. In Washington DC we have Howard, Georgetown and George Washington University. Those are in the lead in the health care industry and a wealth of resources in DC with the NIH. We have opportunities there.

I see a lot of potential with Gallaudet and NTID and RIT and all the resources that can be leveraged here. We can set the stage with Washington DC and other universities around the country, as well as at the University of California, San Diego. There is opportunity around the country to have better collaboration in the future.

1. Maximize Information Dissemination. We agree NTID can take the lead on the Internet. I would be happy to provide support and partnership to make sure that happens. Second is the public relations campaign. Gallaudet can take the lead in that. We can do and partner with NTID so that is a coordinated approach that is united. We believe we can work with
NTID to provide information to different organizations that are deaf and hard-of-hearing and professional organizations and federal agencies.

2. **Curricular and Training Endeavors.** We believe we focus on pre-college and NTID has a good start with its outreach to underage students. We believe that it is very important to expose students to career opportunities as young as 6th, 7th, 8th grades to prepare them for their college years. We have a K-12 school program at the Clerc Center, which is outstanding. Number two focuses on direct instruction and the second focus is a national mission for K-12 to work with all schools for the deaf as well as K-12 and that is an opportunity for us as well.

3. **Create Employer Awareness.** NTID has always done a wonderful job in career awareness and career training and preparation and workshop for employees. At Gallaudet we can offer that too. We can sit down and look at our common areas of focus and leverage our strengths in the areas of the medical field. I want to mention that last week, in my welcome back address to the Gallaudet community, I talked about the transformative issues to prepare young people in their careers and the vision adopted by Gallaudet University mentions that Gallaudet will be a premier Liberal Arts University to focus on career preparation. That was a charge given to us by our Board. We talked about the possibility of establishing majors with emphasis on preparing for professional careers like pre-med, pre-law, and pre-architecture and areas such as that where Gallaudet can encourage students to think about those careers. We want to encourage students to keep going. Go to med school or law school. That is our commitment going forward.

4. **Accessibility & Technology.** Gallaudet is on par with NTID. There is a lot of opportunity for collaboration there. We have GIS - Gallaudet Interpreting Services, we have real time captioning, we are involved with a Video Relay Service on campus and we have research based technology accessibility where they do wonderful research. Dr. Christian Vogler (technology accesses program) has a PhD in computer and information sciences. Maybe the two institutions can work together in that regard.

5. **Funding.** We are in Washington DC and go to the Hill almost every day to meet with federal agencies. We are happy to collaborate with NTID. I think the five of us have much potential to work together. We also want to spread this to other universities as well. Thank you for your attention.

6. **Carol Fisher, Rochester General Health System (RGHS) - Presentation**
   The short-term recommendations were very impressive and intimidating. First we were unsure where we would fit into this. There are many ways we can partner, more than we thought originally. Maybe we can try to implement training individuals for different positions in the medical field.
1. **Maximizing Information Dissemination.** We have an internal and external website. Being an employer we can educate our staff related to educating and employing deaf and hard-of-hearing people. We are at the beginning of what that means. It can be expensive, but it is exciting to have that initial thought and conversation. Providing opportunities for deaf and hard-of-hearing students to shadow medical providers to have experience in the field is a possibility. Another possibility is that of training interpreters for specialization with different medical professions. We certainly have ways to collaborate.

2. **Enhancing Curriculum Training.** We do not do too much training but we do have residents and also two programs with high school programs. We have a youth apprenticeship to give high school students an opportunity to see what it is like to work in the medical field. They go to school and then rotate throughout the hospital and have a sense of what it is like to be maybe a dental hygienist. There is a second program called Envisions. We would love to find ways to make that opportunity available to deaf and hard-of-hearing students. We tried to include students with learning disabilities and it added a bunch of other things we had to deal with and it was surprising to us. Those are things we have to work through.

3. **Employer Awareness.** We are the employer in this case. We work with staff, and we talked about having someone from NTID come and work with our staff to create awareness. Also when you do that, sometimes it makes it easier for people who are patients. I was contacted by someone in our cardiac department because a deaf and hard-of-hearing person came in for a procedure. Patients take home a video to tell them about the medication and what to look for in complications. The video was not made with deaf and hard-of-hearing individuals in mind so we got a small grant to have it subtitled. Until we had that one patient we never thought about it. Now we are looking at how we can participate in those things. We are also looking at a co-op program with NTID.

4. **Promoting Accessibility Solutions.** We do not know what the options are and what is out there. It is something we want to explore.

5. **Investigating External Funding.** I think there are a lot of research opportunities with NIH and other funders who might be interested in education and implementing different programs within health care providers. One might have two months from the time of the research opportunity request and when you have to submit a proposal. You have to put the whole program together in that time and get buy-in from the organization. What we need to find is a champion who, if the opportunity comes along, say they will do it. I am excited though because there have been some really interesting opportunities. Moving forward I am sure we can do some good things.

7. **Dr. Thomas Pearson, University of Rochester Medical Center – DVD**
   (Transcript of the DVD)
I am pleased to comment on the Task Force Report on behalf of the University of Rochester and its National Center for Deaf Health Research. Unfortunately, I have a long-standing commitment outside of Rochester and have elected to reply with this video recorded message. I would begin with my congratulations to the Task Force on their progress to date, with much hard work completed. The Interim Report has been shared with the NCDHR Executive Committee, which includes representatives from our Deaf Health Community Committee. A discussion including Drs. Pollard and McKee was held to provide comments about the recommendations of the Interim Report. More recent materials received in early September have been incorporated, with a review of comments by the Executive Committee prior to completion of this video recording.

The NCDHR strongly supports the mission of the Task Force, namely: “to provide recommendations that will increase career opportunities for Deaf and Hard-of-Hearing individuals in healthcare professions.” The University of Rochester and its Medical Center has a vested interest in this mission, playing several roles: 1) It is the largest employer in the Rochester region and the sixth largest private employer in New York State; 2) It has nationally ranked post-baccalaureate programs in the health sciences, including professional degrees in medicine and nursing and academic science and engineering programs at the Masters, Doctorate, and Postdoctorate levels; 3) It has the largest NIH-funded biomedical research program in Upstate New York, and the world’s only research center devoted to the improvement of health in Deaf persons. Therefore, the perspective of NCDHR and U of R focuses on only a part of the education and career development spectrum addressed by the Task Force, especially that in college and professional school. We would ask the Task Force to consider other training and career preparation that seems to have been overlooked, namely postdoctoral training of health professionals and PhD scientists in preparation for academic positions. Moreover, the Task Force Report does not really address training scientists and engineers involved in research and development of health promotion tools and technologies which could be developed, tested, manufactured and marketed in Rochester by Deaf and Hard-of-Hearing inventors and investigators. This seems to be a very large and viable health-related field not well addressed heretofore by the Task Force. The Western New York region is increasingly looking for universities to be the next economic engine and we should include these opportunities in the report. The five areas for short-term recommendations seem to be reasonable, with selected areas of interest for NCDHR involvement.
Regarding Field #I, the NCDHR would be most interested in short-term involvement in Recommendations A3, 4, 7, and 8 related to supporting educational programs including postgraduate programs, preparation activities, mentoring of deaf students, and success stories/role models. Recommendation B has no source of funds. Recommendations C2 and 4 would support a listing of health professionals and a speaker's bureau of deaf professionals and scientists.

For Field #II, the interest focuses mainly on the college pipeline, graduate/professional, and postgraduate education. Our center would focus on recommendations A2, B1, 5, 7b, 9, and C 2, 3.

For Field #III, entails employer awareness in Recommendation A2. One suggestion to add to the recommendations is to provide information and assistance with the procedures to acquire ASL interpreter support for projects funded by HHS and other federal agencies.

Field #IV is a disappointment. Final recommendations of the Interim Report could be supported, such as shadowing opportunities (B2) and a clearing house for information. The report appears to miss a major issue on page 22 by not addressing until the final White Paper the issue of funding access services for D/HH individuals in healthcare majors and careers. The Access and Technology Subcommittee Report of June 8, 2011 does not resolve the issue and possibly makes it worse. The advisory for more and better interpreters and access technologies is laudable, and training programs in this area are much needed. However, the fourth bullet point on educating healthcare training programs to help them understand the value of establishing centralized institutional funding mechanisms for access costs such as interpreters is naïve, revealing a fundamental lack of understanding of the problem. The paradox that must be confronted is, on the one hand, the need for Centers of Excellence with critical resources of Deaf professional or research trainees and aggregated resources and technologies to train them well. On the other hand, the development of such a Center would attract disproportionate numbers of Deaf students requiring interpreter services which, by law, should be provided. The business model fails quickly with institutions without a specific mandate and financial support to train Deaf students forced to choose to support the training of one Deaf student versus two or more other students from underrepresented groups. The discussion of “ADA lawsuits” on Page 2 would confirm administrators’ worst fears. Institution-wide pools do not solve the problem unless these are supplemented by earmarked funds to allow the Center of Excellence to recruit ASL- using students without risk of financial ruin. Many institutions around the U.S. appear to have supported a handful of Deaf professional students over the years. No medical school or teaching hospital has opened its doors to large numbers of Deaf students. The language of this section is confrontive, rather
than collaborative, using the “stick” of litigation rather than the “carrot” of support for an institutionally right-sized interpreter program.

For the Policy Committee, Recommendation F needs to be placed in highest and most urgent priority: “Explore funding for the Centers of Excellence model for condensing resources in such a way that other institutions are not precluded from serving D/HH students.”

The Research Questions are useful, and we are especially interested in Education Questions 6-8 related to standardized testing. We have anecdotal evidence of very unfair testing practices related to MCAT and other graduate entrance examinations.

We hope these comments are useful. We would greatly appreciate further thought and advice about the education of Deaf biomedical scientists including postdoctoral training, as another health career opportunity, the inclusion of biomedical technology development not only as tools for health improvement in Deaf people but also as a source of jobs in developing, testing, manufacturing and marketing, and most importantly a further consideration of accessibility of interpreter services so that institutions are not financially prohibited from creating Centers of Excellence in Deaf Health Professional Education. Funding opportunities are currently being pursued to develop programs for education and training of Deaf students at the doctoral level in the life sciences and the education of Deaf medical students.

8. Discussion Final White Paper

C: What happens after the task force is complete, who is going to continue to work. We have two more meetings and then who will continue? Will it all be the responsibility of the 4 institutions or will we all be involved in some way?

C: We are hearing from the institutions that there is interest in setting up something on the web and also there could be a clearing house. We need to identify people who can give advice, not just secondarily run it. It can be others, not necessarily on the task force.

C: Where do we want to go and what do we want to see in 7-10 years on this topic? What is the vision? Remember the cautions on priorities of important areas, the economic climate?

C: One idea for the future is to have perhaps something like the National Science Foundation or NIH that continues to promote and encourage universities to continue with research. If they found a way to improve accessibility they could encourage different universities to apply for grants to support that work in their University. That would help us with the health care and the future of this program. They can let universities know they have money for this purpose and how to improve access and technologies and they can manage that and continue to
grow. I am also concerned if this group ends, we don’t want the work to end. With awarding of grants it can be encouraging to other universities to become involved and benefit deaf students in the end.  
C: Also encourage approaching the FCC, for example we have TTY relay and everyone paid a few cents on a phone call for operator services, but I think we can be assertive with the FCC, and say why limit this to just phone calls between the deaf person and a hearing person outside the building? Why not make it accessible for all. This is our technology. And include in those regulations the concept of specialized interpreters that can handle the language required for science and medical and health care so we get good quality services, not just someone to make a doctor’s appointment. From one doctor to another, at the language level that needs to be done and make that barrier of access more accessible.  
C: Big picture goal: Increase the number of deaf and hard-of-hearing students in the health care professions. It is important to understand the definition of health care. What are we defining it as? A basic level or professionalism or all levels? Like a technician?  
C: As a task force do we want our vision to be that we support these jobs or we think these are the areas we want to see growing? Do we support these locations where we want to see the programs happening? Do we want to become that specific in 7-10 years or do we want to stay global?  
C: It is my understanding that we are supposed to focus on the expansion of jobs in health care for deaf and hard-of-hearing people and we have to look at how that can be accomplished. I have heard about access issues. Alan asked for priority areas. The committees can work on that. Access is one area. What is the meaning of health care? What is the meaning of access? How can different types of access be reframed to indicate it is a normal part of operations and expenses rather than the feeling it is an additional expense. We pay a lot of money for great speaker-phones and microphones so what is the big deal about paying more money for deaf people? It is the cost of diversity? Think about that as we go through this discussion; try to conceptualize your work.  
C: The task force has the responsibility of figuring out what to do short term and long-term. In seven years I want to see deaf and hard-of-hearing students, whether in middle or high school, are just as competitive as hearing people. That means they have just as many skills in math and science and are not going to be discriminated on the basis of their hearing. They are competitive and they have the same chances as everyone else.  
C: That is a vision for the education group. Possibly they can come up with recommendations.  
C: I was also thinking there are simple things we can do to improve awareness of the general public and employers. Maybe one public service announcement that would be powerful. Ten years from now the general public can be aware of effective deaf and hard-of-hearing employees and then maybe other things will follow.
**C:** Ten years from now I hope there is broader compensation so this is seen as the social service it is. I would like the task force to be national and be federally led with representatives from the Department of Labor and Office of Civil Rights and the Institution of Medicine. It is not just deaf and hard-of-hearing, but anyone qualified to do the job. A student who majors in math and science and holds a degree, the reality is that degree is less valuable if you are deaf and hard-of-hearing in the United States. So how do we take that same degree and make it just as valuable? There is work to do, to advocate, to continue a national conversation about equality in access to health careers because for this nation health care is the second largest industry in the United States. The nation has a national interest in this to make sure everyone qualified to do a job gets an opportunity. We can’t lose sight of this part of the vision. It is a social justice issue around health care.

**C:** There is a chance for us to have more scientists and maybe we can open more job opportunities for people coming up. Secondly, our program trains physicians and makes them deaf friendly. It can open up jobs and practices and mentoring positions. If someone can take care of that, the community will draw more patients and they can take more colleagues because their practice will grow. Asking more medical schools to look for proficiency in sign will be a big help to open opportunities.

**C:** Regarding priorities, there are economic restraints. We should have a wish list, but can we talk more about what are the reality kinds of visions we can give them that could be enacted in the next 7-10 years that can make a difference. Can we limit them to 3-4 really important issues? I am asking because I think we are going to be facing this as we write this paper. The short-term had a lot of detail. Do we do the same for the long-term?

**C:** There are a lot of students making it through the educational system, but when they are done it is finding a job that is hard. I am in an institution at the end of the pipeline. I am focused more on the employers. Looking at the educational pieces and making that work, we have to focus on the fact that employers don’t know how to make this work or may not be inclined to make it work. There can be 1,000 different approaches. But that really needs to have a focus. If we are trying to increase the number of deaf and hard-of-hearing in the health care service field, it is not just the education; it is working with the employers to get the next piece.

**C:** Discrimination that is a barrier that pops up again and again. How to provide employers with that information and make them feel safe about hiring deaf and hard-of-hearing people and help them understand the communication issues are not necessarily barriers that cannot be solved. How do we address internalized discrimination? People don’t often realize they are discriminating.

**C:** So where do we go next? That is where I am trying to pull. Where do we take this concept? Do we say I will identify four companies and do an in-depth study? I am asking this group to consider. We have already made many of these recommendations like the public
service announcement. This study of cost is in the sponsored research recommendation we made and NTID is leading that kind of research and publishing and disseminating it.

C: Following that, as we cast out the 7-10 year vision and the white paper, we are standing on the short-term recommendations that have basically already been accepted. What do we want to see in ten years? A quick example, in the short-term recommendations we are asking the four founding institutions to discuss, plan and approve this consortium with multiple entry and exit points. Associates Degree up to post doctorate work. 7-10 years from now I would hope that a consortium on the east coast would be under way and I want to see the same thing happening for a west coast consortium. We want to keep opening the options to other educational graduate institutions. Then we would have strategic recommendations for the founding institutions to start using now so the west coast center would happen. They would include some of the same members so there would be carry over there. That is how we could build on the short-term recommendations and provide the four agents how to create the west coast facet ten years from now.

C: A couple of thoughts - if you are writing a research grant, it is hard if you lack data, you cannot support what you are writing. I do not know what the literacy level is or what the true census data says. I have tried to work with the hospitals. They do not know any data. There needs to be some advocacy to have vertical or horizontal work with children’s hospitals and the OB-GYN. There is a lot of advocacy work without spending a lot of money. I do work around the country and there is a huge middle of the country that we cannot forget.

C: We need to also keep in perspective the cost and impact potential and whether it is a high impact for cost. The second thing is setting up a program for training where people can identify their needs. When hearing is a challenge, and knowing the possible accommodations, many deaf students may say we need an interpreter all the way, but they may recognize they do not. That would allow the costs to have some negotiation. These are key times we need help and then they can modify the requests themselves. What a person must have and what they want to have. That could curtail some of the costs. I just wanted to comment on that.

C: I am hearing some advocacy central position that is necessary as a vision. Then we can ask the four institutions how they want to implement that.

C: I work with a school pharmacy. I have a Dean interested in the community. I want to say I will fight for six slots for deaf students to come here. Will we get enough applicants? I do not have the data for that. Where do I get that data to make that argument? Do I argue for six and then I do not have the data available to support that? We need the data to make these arguments? Can I get six students every year for five years? That would be 30 pharmacists in California. But I do not know if I can make that argument.

C: The follow-up to what you are saying, that is great you can try to get six students per year, but then they graduate that four year program and they cannot get in, a good friend of mine is a pharmacist in Alabama and she struggled with the board of pharmacy because she had to
rely on an interpreter from VRS and they were concerned with privacy issues. But now we can fax except for controlled substances, but that is in the future. How do we get them out of the school into jobs?

C: I think what you said leads to the next issue we need to think about, the legal and policy issues. I have contacted a lawyer who discussed two major issues with me. One was the legislative policy related to HIPAA which is what the pharmacy board and others struggle with. The HIPAA rules apply more to patients than healthcare workers. That is something I will give the policy committee to work on. The other issue is related to access to testing. This is all related to employability. Thinking of the bigger picture with expanding opportunities for the deaf and hard-of-hearing, what are the issues in the steps of the pipeline to make employers willing to hire these people? Getting back to the testing issue, he said there needs to be thought about going to boards or legislatures to address exactly what the tests are measuring. Is it English language content as opposed to something else? That could be a research project, comparing people taking the test as is and then taking a modified exam. Are the people taking the modified test doing as well as people doing the people that took the regular tests and exams? The top thing is employability.

C: That is a vision. If we think in 7-10 years we want to diminish the barriers caused by licensing and examination bias, we could come up with strategies.

C: Also the issue related to functional versus technical standards and similar things.

C: Any other visions we have not talked about that build on what we have done?

C: I agree that we want better data. It could come from the census, health care agencies, and a variety of other sources. That will enable us to better track progress toward our other goals.

C: So you are saying we need a centralized data bank.

C: We have a chance; the 2020 census is not finalized yet. Do we want to try to get something in there? Preferred language used to communicate is all we really need to know.

C: We know how many people are deaf and hard-of-hearing but we do not know how they communicate or their preference for communication.

C: We are a bit of tunnel vision here. Should we try to advocate for all people that are losing their hearing to begin to learn sign language as part of their medical care? We could encourage every deaf person to take a prescribed sign language class. If it is prescribed they will take it seriously. If we make ASL the language of the entire deaf nation; it is ASL after all! We will have more and more folks with hearing challenges in time. Why not make it part of the aging curriculum. Why do not we add it as a program for seniors?

C: There are multiple layers in what will be happening in 10 years. From a physician standpoint, we cannot prescribe anything that would not be paid for. Somewhere as a task force or advocacy body, there has to be a group of people looking at these access issues specifically and starting to peel away the layers about what is blocking things from happening. This physician cannot prescribe it because no one will pay for it; that becomes a CMS issue. That is easily fixed. But if it goes into the abyss it becomes a different problem.
C: I am just learning about the deaf community and what their needs are. But ASL is a concrete need. Someone may be losing their hearing, needs to communicate, needs to keep their job, and needs to stay out of a nursing home. For other disabilities I can prescribe for things to keep them out of the nursing home. But right now no doctor can prescribe ASL. It is a concrete piece. We as a task force need to recommend that the 4 institutions create a national consortium. We need to look at the issues coming forth from the institutions, as they try to adapt short-term recommendations into long-term ones. Someone needs to work on these multiple advocacy ideas being identified.

C: Not only is the career an issue, but promotion and networking and socializing within the career. I have gotten many, many letters about networking receptions. This is just a social function; we won’t provide interpreters for that. If you think of networking in the hospital system or research environment, someone hears about a grant, calls someone and in two months it is done. Sometimes no one knows or never is contacted or wasn’t assertive enough to pursue it. Social functions and promotional and network functions, I don’t want to exclude that as part of the 8-10 year level.

C: That is all part of access. How do we make that happen? It is important to keep in mind. It takes a good 3 years to become fluent enough in ASL to work professionally using ASL. People losing their hearing, if they are young enough they can do it, but older people would find it harder to pick up ASL. That brings up technology like pagers or voice recognition. These all fit into the big umbrella, functionally equally access for everyone.

C: Let’s talk about technology. Tom brought it up in the video. He envisions some place being the hub, either manufacturing or marketing and developing. That is a powerful vision.

C: That is why I mentioned research grant money. If we had a central place to motivate research about deaf and hard-of-hearing workers, that would be a benefit. We would need someone to manage that. Commercialization of technology, we create something here and look for a company to pick it up. We need to get the device promoted. If we had a research grant available, some research would find that some devices are not successful. The ones that are can be moved further and the community will benefit from that.

C: So access to technology, we need to be thinking about that.

C: We need to know how to do that. How do we become a clearing house? I want more research. It should be spread across the United States and we can work collaboratively. But many are unaware of what we are doing. We can offer guidance. Money to get the research going would be provided through a governmental fund.

C: What I would like to know from all of you is what else do you feel you need to know or understand better as we start our work this afternoon. We will be providing instructions and guidelines. We also need to discuss the structure of the paper that is next on the agenda.

C: I think funding accessible technology and interpreting is a tough issue. Let’s spend a few more minutes on that topic. In the DVD, Tom is talking about support for access. What is the vision for 7-10 years? The goal is that the cost of access services would not preclude a deaf
or hard-of-hearing individual from practicing his profession of choice. I don’t think it is a 1-prong approach. We need a multi-prong approach.

C: Another recommendation this morning is to investigate the possibility of recommending a revision to existing ADA requirements so institutions would be responsible for funding up to a point and then those institutions could request funds from some kind of central resource. So enhance the ADA. but as one possible part of an overall approach. We can check with legal experts.

C: PEPNet and a few other resources on campus would be very valuable for the committee.

C: We need to ask you quickly to look at the structure of the paper. We are writing for the four institutions, but these four institutions are part of our audience. Outside people will also read the report to get some ideas for themselves. We think we need to provide more background information and repeat what we said in the short paper. Is what we have on the PowerPoint acceptable?

C: This is a unique opportunity in time. We have technology we never had before. We can intervene right now and get it right. I think that should be part of our report. There is a risk that it can be negative and people put it down and say it is hopeless. I think we should start with positives. This opportunity will get bigger and better. We want to capture it in the incubation period and run with it on behalf of advancement in innovation in health care.

C: I am worried about the overlap between an exclusive focus on deaf and hard-of-hearing in the healthcare industry versus deaf and hard-of-hearing people as consumers of health care services. To what degree does the overlap in the work products and innovations may also benefit the aging population. Previously I wasn’t strongly in favor of a big argument that a really important reason to have deaf and hard-of-hearing medical practitioners is to take care of deaf and hard-of-hearing patients better. How much overlap should we mention and how should that possible overlap be mentioned in a positive way?

C: I can comment about that. I cannot tell you how many times an older adult person comes into my office and I say that I understand! It does make that comfort level go up a notch.

C: We need to set the stage for our vision. I don’t think we can jump right into the vision without that. We can refer to an appendix for details.

C: For the non-deaf community, which this long-term report will touch home with, it is the why should we care question. That is a hard question. We are passionate about what we all are doing. But the truth is, in the seeds of the long term report, we have to plant the seed of why do we care? Because this group is excluded. And why should it matter? If an institution looks at its mission and vision statements, why should anyone care if your institution continues or not, other than the people in the institution themselves? Making that argument succinctly and not filling it with statistics about this or that and there is pain everywhere, but get the opening statement down to something that states why we should work on this.

C: The magic moment is why we should care. Any other comments about the structure? Do you all agree that we set aside a fundamental kind of information, the basic information that
people who don’t know a lot about deafness need to know for later and focus on the vision and hitting the points right away? Is that the consensus here?

C: That is a good idea. I was also wondering why we have two reports. Are they separate or are we trying to merge them into one. Can we refer to the white paper since it contains a lot of information and refer to it and then get to the point?

C: I have read a lot of reports online from different national groups. Like from the Kellogg Corporate. They are doing a succinct executive summary. But then the rest of it goes into a lot of detail. That does not mean we have to follow it. But that is another approach. To have a 10-page executive summary, then the full document with the data, statistics, stories, a summary of what we found. We have a lot of information relative to focus groups and interviews. We have internalized that knowledge. But people out there haven’t heard. That is why we still get phone calls from individuals who can’t get an interpreter. If we have that document with that information it could be useful to other groups.

C: My caution with something like that is a lot of people will only read the executive summary so you have to make it neat and be sure it has everything in there you need people to understand. That is the setting of the stage for the full report.

C: If you do it online, you see a big, blazing 2-3 sentences that are powerful and then a hyperlink for more. It is all there, if you want to go there.

C: Are we planning to have an ASL version? I think we may have a moral and political imperative to do that. Convincing people why they should care is important. Another part of the story is why did this task force happen now? Is it perhaps because now there has been enough time since the ADA and enough health people have begun careers and run into barriers or glass ceilings, and is that why this came up at this point in history? Reflecting on the why now may be helpful to the context.

C: The task force was established by the four institutions so we are looking at where these institutions are going with training and opportunities. There is a lot in the public about the needs of more health care workers. That is part of our story, paired with the story of barriers.

C: One thing that is recommended in the short-term recommendations is the change in the health care laws. That was why we decided we needed to do something.

C: It is important we respond to the national trend in health care. I think we are trying to address the issues that are current.

C: If you sum up those ten pages at the start, and that becomes the translation into ASL that may work. My preference would be the first section might be the only section people will read, and I would like it to be written by a writer, not a report writer. I want it to be literature that has an impact on people. Not just paragraphs that say “research shows...". Let’s make it interesting.

C: So an addendum to that is make sure we include stories in our report. We do not want just a dry report of facts. We have individuals that can intersperse stories.
9. **Instructions for the breakout sessions**
   - This afternoon we will have breakout groups. We will not be back here until 4:30.
   - Your charge is to go back to the June Interim report you initiated where you had fabulous ideas, and now focus on the vision with details for your group so it is very clear where we are going and where we will be in 7-10 years and what are the mechanisms to push the four institutions to that vision.
   - The writing group needs to put it all together. Whatever you produce this afternoon, we will use for the first draft in November. You can review and change it, and then a pre-final draft in January for your approval.

Each room will have flash drives with your previous reports on them. We will come back in this room at 4:30 for closing comments.

**MEETING ADJOURNED**

Next Meeting date:  November 3, 2011  
Meeting location:  Gallaudet University, Washington, DC