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EHDI

Mineral D/E

Audiology Consulting Team: Why More Really Is Better

Casey Judd

3:45-4:10p MT

March 20, 2018

CART/CAPTIONING PROVIDED BY:

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>> Hello, everyone, my name is Debbie Baerlocher. I've been working with the Idaho Sound Beginnings program for over eleven years now. I was pregnant with my oldest when I started. I can have that benchmark in my head all the time. Do you want to say something?   
 >> I'm Brian Shakespeare, I'm the Idaho EHDI coordinator for about five years. We instituted the team my second year there, so we've been doing this about four years. This is our state team. We have a parent outreach coordinator. Andrea Amestoy, she's fantastic. She has two children with Usher's Syndrome and another child with normal hearing. She calls all the parents when they refer on the hearing screen. In Idaho, we have about 22,000 births a year, so... it's about 500 refers. She can pretty much call all of them.

We have Pamela Blessinger, she's our health information specialist. She does a lot of coordinating with programs inside the hospitals. And we have Burdett Hoelzle who managed our database.

>> We were talking last night at dinner, our audiologist consulting team. The concept just means there's a lot of us that can share the workload and we can make it more brains, more opportunities to grow the program and... an opportunity to cover each other. Other than Jay who is kind of new, we were all women. At one point in time, we all went on maternity leave in a six‑month period. It's nice we can do that.

>> It was hectic, it really was.

>> I'm a team lead so... I help divvy up the load if someone's on maternity live. Hillary just came back from maternity leave. Jessica and I covered for her. Hillary covers the Boise, Napa area and Jessica covers the eastern part of the whole state. And we also have contracted, we do screening services out to other hospitals, the biggest hospital system in Idaho. We have one person dedicated to that, the systems are all pretty much the same.

>> Just to add onto that, what Debbie was saying about the maternity leave. Is that when we have, when one of them goes on maternity leave, we can bring in another person from their program and... they have three other people to train them and playback‑up for them so we can get them up to speed really quickly. Oh! And this is my slide.

So... Idaho is divided into seven health regions. Sorry... I thought you were asking a question over there. Oh! By the way, feel free to ask questions whenever you want. You don't have to wait until the end.

We have 29 birthing hospitals. We used to have 31, but two stopped doing births this year. So... we have a huge, 83,642 square miles in our state. A lot of our state is rural. We have three general population centers. We have the Boise area, Idaho Falls and up north. There's not really enough work for one audiologist. I know a lot of states hire an audiologist that provide the audiology supports for screening programs and if we hired one, they wouldn't do a whole lot, most of the week.

So... is there ‑‑ your hours on the next one? So... I think it's the next slide. Okay... anyway... so the, each of the audiologists spend about two hours a week providing all the services we need. It really reduces their, the time that their office managers have to carve out in their schedule to see patients actually in clinic.

So... we have two to three regions per audiologist. So... like I said, we have seven regions in the state. And... each of those audiologists, I guess you covered that, right? One of our audiologists handles all of our midwife clinics and head start programs. Any technical problems they're having with the equipment. Right now, I think we have three head start programs that do screenings and Hillary, who she was just speaking of earlier, that just came back, she instituted all of those from start to finish. She went in, taught them how to screen and do the reporting, all of it. That's it, awesome, next slide, please?   
 >> This is not working.

>> It's not working. No? Sorry... guys. We're not that good with technology. Okay... we can move on, but what do you think we should talk about next? Actually, I do. Just a second. So... we'll catch you guys up on the slides when we get technical assistance, but we're going to keep moving.

>> One of the things that we, that I, as an audiologist would do is a lot of the training for the programs. We go in and train each of the hospitals for screening purposes. We are responsible for checking with them, probably once every couple years to make sure that they know how to screen appropriately. We talk about how they're to do the referral program, how they're supposed to fill out the paperwork. We have risk factors and it's really important to us to monitor that type of information. We'll work on that too.

We also have written education materials for the website, for handing out to nurseries, to doctors, to midwives. We've done that type of thing.

And also... there's a new audiologist that comes into our area, we had two in the region I spent some time last summer. I was in the region three different times, trying to bring in new audiologists that haven't done Pediatrics, to understand how to read ABRs for instance. It's helpful to have somebody mentor with you, especially, you know... [indiscernible] is easy, it's the conductives and sensorineurals that are really hard. If you're not seeing them very often, you typically wouldn't, seen as kind of scary. If you don't have someone to look at it with you, it can be a problem. As long as the audiologists are open to mentoring, I'm more than happy to talk with them on the phone, they can scan stuff to me, I'll even sit online with them as they do an ABR if they want to. That hasn't happened yet, but I'm more than happy to do that.

>> So... Debbie, the new audiologists don't have a lot of experience with Pediatrics in general. She went up, was like six‑hour drive. She went up and did some hands‑on training with them and... you know, they got comfortable with each other and so after that, he was a whole lot more comfortable sending his tracings down to her for advice and you know, for weird cases.

>> I worked for the other one. It just worked, and now it's not. Gosh darn it.

Okay... so one of the things that's really important when you're trying to train a program is to know each hospital's equipment. That's super important. Most of our hospitals have similar equipment. A lot of them use the ALGO. I would more hands‑on with the programs before we outsourced. I was doing more hands‑on training and verifying of that equipment. We have hospitals with different equipment. Part of our job is to know it, we can go up there and demonstrate and show it. We ask if they have a baby so we can do it, a doll isn't the same thing.

Sometimes they procure one for us, which is fun. We'll work with the outsourced companies, so... we have Peloton in our region. It's worked out really well. They've done a good job conforming to our, our protocols, and so we told them, this is what we want to do. We want two screenings, no out‑patient screening. You need to help us here.

>> Yeah... if you click on the bar... it'll take it off the PowerPoint.

>> Oh!  
 >> Just the caption bar. If you move the caption bar, you have to re‑click on ‑‑  
 >> That was my fault. Sorry.

>> Yeah... it's almost like two different screens, kind ‑‑  
 >> Thank you.

>> Thank you.

>> Okay... so... anyway, working with them, they do their own training, but part of what we do is really try to get them to follow what we're doing and I feel very, very excited to actually talk to screeners. We don't have a state law. Everything we do is because of the why, because of the babies, because of the outcomes. We try to light a fire underneath them when we're talking about it. Not just another thing you have to do to check off the box, but something they should do because of the benefits that they could offer to the families.

So... we train screeners on proper techniques, state protocols and tips and tricks.

We also talk about monitoring. We look at the hospital's data. We use high track. We're in the hospitals looking at how many babies they screened, what their referral rate is. We look at data to see how many times they screened a baby and if they find it's more than what will be reasonable, like... more than three, we're taking stock of that and keeping rotation of it and going back and talking to that hospital manager.

We look at the loss to follow‑up rate, that's super important in a rural area, of course. We have an expectation of all of our programs that they're supposed to upload their data, twice a month on the 10th and 25th. We follow‑up on that.

We also make sure they're reporting everything we ask them to. We ask them to explain why this is so important.

Monitoring, Brian came up with a great plan for how much we have to do reports. We used to have to do monthly reports on everybody, which is a lot. We do it based on how many births that hospital has. If it's less than 100, we do it twice a year. Doing it more often isn't going to be overly meaningful to the hospital, but we send an e‑mail quarterly saying "how's it going? We see you have six babies on track, is that the number of babies you've birthed?" We try to make it meaningful to them so they understand what's going on and more than 500, we do that monthly. There's not that many hospitals that require that, but that's okay.

And everybody receives an end of year report, that was developed based on input from the ACT team. We want to give the hospital something meaningful, colorful, something that will get their attention and they'll want to see how they're doing compared to last year. We really want to let them know that we have an expectation, we want you guys to meet it and see how you're doing. And hopefully, hopeful comments with that but set goals for what we want to take the program going in the future.

And... we want to get an idea where they are currently. And we also, every time we report to them whether it's a quarterly, bi‑annually, annual, we like to know how many babies that particular hospital program has identified. We also let them know how many have been identified throughout the state. We let them see how they've contributed to that.

>> The screening programs have told us that's their favorite part. Finding out what we did actually mattered, at least with one child.

>> Definitely. This is just an example of one of the letters we've written. The highlighted sentence says thank you so much, you did a great job, you identified one baby. This is an example of how we do that. That graph is comparing that particular hospital for that time period, compared to all of the Idaho births that were reported during that same time period. We're looking at it based on the goals there. They can see again what it is we're really looking at and lost to follow‑up. Those that didn't get rescreened for whatever reason, refused, deceased, transferred, home births or... whatever other reason would be.

And then, the last one is lost to follow‑up rate. They can see what their lost to follow‑up rate is compared to the whole state and what they've contributed to that particular number.

>> With other partners, we report to them the follow‑up rate because that's what people want to see, but with hospitals, we don't want them to see 75% numbers and think, that's pretty good. You know? So... we report the negative number to them so they know it's something to work on.

>> So... this is just an example. I just finished doing all of my yearly reports for 2017. I'm a little late, but I have no time otherwise. Anyway... I'm looking at the JCH goals, the screen rate, refer rate and lost to follow‑up rate. We upped the ante with our screening, for the most part, hospitals do it. It's awesome. I didn't want to say greater than 95. The decision was made a long time ago to say greater than 99%. So... we tried to let them know, this is our benchmark, this is where we want to be and this is one of the larger hospitals and one of the larger metropolitan areas. For the most part, they're the blue. And for the most part, their screening is awesome. You compare it to the region in red and compare it to the state in green. You can see there's this fluctuation, but you can say to them, you have exceeded network goal, this many years. And this goes from 2012 to third quarter 2017. They didn't have through December. Hopefully more information to see this is what I'm doing. When you happen to refer at this hospital, the screen is really well and the refer rate's pretty low. This is the area where he's in, we're really trying to help the medical community to understand, you have an audiologist who can perform this test, you don't have to send them out‑of‑state, you don't have to send them for two hours away, you have it right here. Wouldn't this be great? We're working on uptake now too.

In terms of monitoring, we're looking at how we can make improvements. It's great to say you did well or didn't do so well. The job is to make sure they have some goals so they can be worked towards. So... that's one of the things we really try to do and taking from the NICU concept, PDSAs we try to work on that (?) We did a huge PDSA.

>> We did it in several states. We're not unique on this one. What we tried to do was start to have hospitals schedule babies that don't pass the hearing screen for follow‑up testing prior to discharge from the hospital. We piloted it with basically four ‑‑ we started at two hospitals, two of the largest hospitals in the state. Because... we started with them because... they had in‑house audiology, they had connect, which is a phone service where the, the screeners can actually call scheduling service, not the actual clinic. And... they were in town, so... it made it easy for us.

>> We also did that because they were at the bedside with the parents.

>> Yes. So that's the other portion. They do the screening at the bedside with the parent and they refer, they call immediately and schedule the appointment.

So... this is our results. This is the difference between 14 and 15. Our first hospital, our largest hospital in the state, it dropped our lost to follow‑up rate by 43% in the first year. Go ahead.

>> [Too far from mic].

>> This hospital is about 3500. So... I just have a couple slides. These are the other four. You'll see crazy charts because of differences in births. This hospital has about 1500 birth a year. We saw 2% drop in lost to follow‑up rate and this hospital has about 1,000 births a year. We saw about the same results. Now show them the crazy one. This hospital has, I don't know, 100 births a year? If that? A lot of times they didn't even have a birth and couldn't have done anything about it, they didn't have a child that referred. They couldn't schedule an appointment for them.

So... we saw a 50% drop in their lost to follow‑up rate. This is the thing we have the audiology team help us out with. We go to the hospital, train them on the procedures and then follow‑up with them, I think in, at the beginning, it was on a weekly basis and then as the PDSA progressed, we spread it out to two weeks, a month and then quarterly. They're still doing this and we don't even call them anymore.

The only time we call them is if they didn't schedule a baby. So... after they schedule, they write it on our screening results form and send it into the EHDI program and we monitor those babies. So... if they don't actually, we set a reminder date in our tracking system. If we don't have diagnostic results within five days of the scheduled appointment date, we contact the clinic and say "did you forget to send us results? What's going on with that?" It's a team effort, started by the audiology consulting team and with EHDI follow‑up.

One of the other things we worked on, like I mentioned, we collect risk factors. We started collecting risk factor data in 2004, we have oodles of data on this. This was just one of the things that we worked on was dividing out the risk factors based on what was most‑relevant. ABR by three months of age for those in class A. We recommend the evaluation for those that are in class B. We're trying to divide and conquer and we sent this to all the hospital programs and they're filling out their forms, how to talk about it with parents.

>> And we have a ton of data on this. Jessica, up here in the front, has done most of our work for us. If you have any questions about these, e‑mail her.

>> We also did the same type of thing for how to do the screening appropriately in the PICU. First hearing screenings, then risk factors, then the new term babies within 28 days. Helping those particular nurses who really, probably wouldn't run into screening a lot, what they need to be aware of.

And we also worked on developing brochures, the original brochure for this, not nearly as cute. We worked to improve how things improve at the center. One side Spanish, one side English. Other products, audiologists have mentioned, ensuring the audiologists across the state are reporting into the EHDI program. And moving audiologists with online reporting. That's how I report all my babies I see. The newborn to first or the nine‑month ERAs. We market the program and services and improving of things we can do to, any professional that will listen to us to move the needle. We moved a lot of hospitals, actually all of them to online reporting now which is super cool.

This will give you an idea of audiology reporting, it's a big deal of what we're trying to work on. This is a couple years of data. Whether or not we reported within five days or not. Again... follow‑up that we are taking a look at and projects we're working on.

Well... Brian mentioned already, how much we're working. The idea is that we support each other and so, we're spreading out the work and... we do trends and just allows us to cover the whole entire state, minimal amount of time, carved out, five of us, including Jess, work in the same department. So... it's easier on the schedules. Questions?

>> No questions? Oh! Just a second.

>> Thank you for sharing what you're doing. It's awesome. I'm from Pennsylvania. In our newborn screening hearing program, our hospital right near our Children's Hospital has 10,000 births a year and they oversee eight other birthing facilities. One thing I found very helpful is to invite the screening staff to follow‑up with an infant who has failed a hearing screening, so they understand what goes on in that visit. Often we educate them to what happens after they come to see us. Just being able to spend two hours with the clinician and of course, the family is grieving, but it's been eye‑opening. I think our staff have become more compassionate.

>> That's part of what I'm doing too, is giving them that follow‑up. I actually identified a baby of a grandmother, she took care of one of my babies and her granddaughter had hearing loss. She said "think of all the babies I said it's probably just fluid and I feel horrible." It really reached onto her.

>> The only question I have is dealing with the rural communities as well, quite a few midwives centers, are your midwife centers provided with referral bases? So they know where to get their Pediatric follow‑up?   
 >> We do. We give them the forms, we actually give them the equipment. We use EHDI‑PALS to encourage all of our Pediatric audiologists to get online with that. We're not saying, you should come to me. Although they should, yes.

>> Anybody else? There we go.

>> Hi, thank you so much for sharing what you're doing in Idaho. I'm from Oregon and... I'm wondering if you have any issues with the staff here, your audiology team having issues with territorialism when they go to other parts of the state and try to give advice.

>> From audiologists? It's whether or not they're open, yes... we do have feedback and pushback from certain audiology clinics. Certain ones are definitely not very open and quite frankly, their performance is showing that. So...

>> When we do the mentoring, if the other audiologist is open to it, they don't just go in and tell them what to do.

>> In addition to that, have you ever had audiologists located in the region they're covering? Have you had prior iterations of this? Have you had someone in a different region of the state be a champion audiologist in that area?   
 >> We haven't had the audiologists that are open and ready for it. People in the north are very new. They really wouldn't be in a place to take that on, but... some day, I'll say "I'm going to be up there, do you want to meet?" Some people we don't want in house, you didn't hear me say that.

>> If you guys have time and want to ask more questions. Thanks for having us.   
[applause]

[Presentation concluded at 6:11:00 p.m. ET/4:11:00 p.m. MT].

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