>>: Thank you, everyone. We're going to go ahead and get started. My name is Brian Shakespeare and I am the Idaho EHDI coordinator. This is our risk factor presentation. I just want to give everybody a headset that we have a fabulous audiologist, pediatric audiologist to give us a presentation on risk factors and differences between the 2007 and 2019 JCIH statements. I'm going to give you a warning. She has a flight that she has to catch and she is walking out of this room by at least four '04 05:00 p.m. on the dot. Let's get started.

>>: I'm going to put this up here. All right. My name is Jessica. And I am a pediatric audiologist in St. Luke's and Boise Idaho. I've been working there for 16 or 17 years and I've been working with EHDI program sound beginnings since I started as a grad student in '06. We have no disclaimers to discuss. Our learning objectives today, you will have the ability to identify JCIH from the 2019 position statement. Identify the difference between a class a, and class B. indicator from the Idaho EHDI risk factor tool and you will be able to educate parents on follow procedures for each risk factor for early onset or progressive hearing loss.

I don't know if some of you were in the presentation right before this about Pep I believe it was, but that we did a really nice overview of JCIH in the position statements. I will not get into this, it is a lot of history, but I I could talk forever about the slide, but I won't.

Important to know and there's a typo there that in 1973, actually was the first year that JCIH had a position statement that discussed risk factors and as things went on over the years, each position statement did address risk factors in a different way. And now we are to the current 2019 risk factor position statement. That I will discuss.

This is the wrong slide. So, just getting. Apparently the slave did not get updated correctly. It is in the appendix of the J. CH 2019 position statement. These are actually the 2071. In the 2019 statement, it looks at each individual risk factor and it tells you kind of a guidance of when they should be recommended for follow up. A lot of this was based on which it risk indicators had more hearing loss associated and which once it did not.

It highlights in the 2019 statement some more aggressive follow up for certain risk indicators. One of the things that I wanted to highlight on that statement auto toxic exposure. That is something that has been back and forth over the years from position statement. At one point it was any amount of photo toxic medication would be considered a risk factor and that it was switched to a certain specific amount and has gone back and forth currently in the new 2019, which is not appear right now, it indicates that it has to be more than five days. As audiologist we know that there is, there has been genes identified that have a higher risk of photo toxic exposure causing hearing loss it is just very hard that Numbers is very small and hard to identify so as of right now, the risk indicators as 2019 states it has to be more than for day five days.

In Idaho we started monitoring risks in the '07 the edited a long time to get our physicians on board with 87 monitoring. We have not changed things much in our state. We did not update our class a or class B. risk form. I have talked to several neonatologist about this we are continuing to leave it as it because it is hard to go backwards some time with some of our physicians and telling them to do less of something when we already got them on board with what they were doing so at this point in time we have not changed that to say five or more days. And other risk indicator and this came up recently. On the 2007 it specifically states craniofacial anomalies including ear tags, ear pits craniofacial anomalies involving the pinna. On the 2019, which is not appear again. It does not indicate all of those. Actually on that risk factor assesses certain birth conditions or findings, craniofacial malformations including micro shut atresia, and then there are a few others listed including temporal bone abnormalities. It does physically spell that out but if you actually read the position statement and I could give you the page number, I had to explain this to one of our physicians because they were trying to drop your pits and your tax as something to consider, again, the document itself is says that number 8 risk factor the craniofacial anomalies was formally includes all of five and six from the '07 statement. It did not exclude them specifically, but did not call them out spell them out specifically in the appendix where most people will look. That is what our physician had done and he said it is not there and we're going to drop it. And we said wait wait wait. I don't understand why it is a risk factor, but it is a risk factor because we have other syndromes like brachial photo renal that your tags in your pits can be associated with and there is a reason for monitoring those kids.

Why am I even talking about this? Idaho, like I said I've been around for a few years and Idaho and we have done a lot of work to get a medical community on board with us which took some time, and then to make our ideology committee following certain criteria's. One of the things we looked at in '07 is a study specifically that looks at the incidence of how often risk factors are occurring in a population and how often those risk indicators present with hearing loss.

This is one of the slides I present to physicians and our state about most commonly occurring versus least commonly occurring risk factors. Specifically, ototoxic meds in this particular study was occurring in over 70% of the events. There is another study out of OHS you that showed that specific amount of that 80% of the '80s born in the U.S. in 2015 out of 600,000 interests had aminoglycosides treatments. That number is high. From our experience in Idaho we have seen that number slipping down, and not slipping but slowing down. Because of different stream is that physicians have been using and being a little bit more cautious with aminoglycosides. We are not saying a ton of it, but it is a number that has changed a little bit in our stay in my hospital specifically over the last couple years.

If we look at these, ototoxic meds, NICU babies are basically the kids that are falling in this left side, the kids are coming to us most frequently versus looks kids with craniofacial anomalies, bacterial meningitis, those are not kids we are seeing as often it just the general population.

When we look at this data here and then we compare it to who is having, who has the highest incidence of hearing loss, craniofacial anomalies and ECMO treatments, the group that is occurring the least as having the most frequent hearing loss associated with that.

In Idaho we saw this and decided we have to do something about this because there is a need to screen and follow some babies more closely than others. We don't want to release any of the babies or give anything up. We just need to hone in on who is most important at that time. Apart we developed at this is from 2011 big wave been using this a long time. Myself in a NICU physician came up with the idea of a Class A and Class B. This is what they really wanted on the medical side of it. They wanted it to be called that, clasp a class and Class B and that is what the doctors felt like was a term they used. Who put the risk factors into two categories. Of your Class A, you're recommending to have follow up if you pass your newborn hearing screening around three months of age versus the Class B, those risk indicators are coming in closer to there first birthday so about nine months of age.

Like I said earlier the reason we are not giving up some of the things that have changed slightly in the 2019 is we have by and for most of our physicians in the Treasure Valley, which is the Boise area but even across the state. Not all of the state, most of our state. Some rural places we do not. We'll redo have by end, we do not want to lose traction that we already have that are physicians are making good referrals. We just want to continue on that track.

Prevalence and incidence of infants of infants and incubators. How many kids were coming in with risk indicators or how many kids where we identifying in the state of Idaho over a period of time per week will looked at two different types of data pick the started in '07. Like I said, that is when the position statement was released by JCIH. Right after that was really our push to get physicians on board. You can see in 2007, it was 3.1 percent of infants, but as we did training over the years across the state our numbers jumped way up to at 1.11.4% of our infants in the state were getting referred. That shows that education is huge I don't know what if's other states look like for this we were finding those kids and getting referred better after we educated our physicians.

This just shows you and this was a chunk of data from '07to 2013, and as we looked at a recent chunk of data that are presented on in our state, our numbers are pretty similar and are little bit lower, which couldn't be related to the aminoglycosides getting reduced then use, but or just better referrals, meeting trained nurses and hospital staff on what kind of family history they're going to ask for and what other questions and how to get those risk factors identified. I'm hoping that is what that is what got these numbers to be stable over the past few years.

(this is kind of a narrative for the next two slides. This is looking at data from 2014 to 2021. In this data pulled from Idaho, if you know anything about JCIH we just looked at risk indicators and only catch about 50% of hearing loss. If you look at this slide, that shows that those bar graphs half of those kids roughly give or take have congenital hearing loss with a risk and in the blue part of the bargraph and the orange are the kids with congenital hearing loss without risk.

Our data kind of match is what has been told what we've been told for many years from JCIH data.

>>: Mind is a lot of data sorry. This next slide looks at a lot of but similar in the same population acquired hearing loss. These are kids who have been passed over in screening and later, identified with some degree of hearing loss. You can see even in this population, acquired hearing loss, we had 26% without any risk indicator. That has a population I am really as an audiologist concerned about because how do we find those kids. They passed their hearing screening and did not have a risk identifier for hearing loss.

Apart these are my favorite two things my favorite two slides. I love this data that we pulled a few years back and we just replicated. And you will see that on the next slide pick the stocks again about that risk factor versus no risk factor. If we look at the the yellow and the grading so that is 56% so half of the graph, these are kids who passed or failed their newborn hearing screening and had risk for hearing loss or the other half, the 44% had no risk for hearing loss and either failed or passed. (again that 3% of the population, those kids passed and have no risk factor for hearing loss. We're here to talk about risk factors so the more important part is that 56% do have some risk for hearing loss and presenting.

This is an '07 ore to 2015 we did a presentation it wanted to see what is happens is 2015 to practice our data replicate itself or is it even close? And what we found is that it is pretty close. A little bit different the failed category with risk factors is a little bit bigger but we do have a lot of siblings in our state that get diagnosed. A lot of our families have multiple siblings and multiple siblings getting diagnosed with hearing loss and we put them in that high risk category because of a family history. You can see that 63% of our families of children who are born with a risk factor. The data looks similar which is really exciting because these are thousands and thousands of babies. In this data pool.

Sorry, I have to run. But I left four minutes. I have my ovaries here and if you have questions or have to take off.

>>: You have my e-mail also. It is on the sly.

>>: Do you have any data on the accuracy of your risk factors? I know and Washington, family history is very and actually how it is reported and I wondered if he had it in the same issue or data on that creek.

>>: As an audiologist I do diagnostics and see a lot of the kids it's get referred in our area for that. Four M. anecdotal data, we see a high number of kids who are misrepresented as a family history, which is incorrectly asked. However. The hard thing is with risk data, I would say are lost to follow rate is high. We're probably missing some of the kids, too who do not get identified until later. I think that is one of the hardest thing is things as family history. We're getting better at it though, because we try to tell families that family history of hearing loss, did somebody wear training technology of some sort to hone in on the referrals.

But bar I apologize if you said this and the I missed to. I know you showed the risk factor with the Class A and Class B.

How the risk factors getting reported to you and into your system? Is it from the screeners or the audiologist.

>>:

There is a slide that missing apparently. We have a referral form that our hospital screeners fill out and so when a baby passes and has a risk factor, the referral form will get filled out. Any baby who passes and has no risks do not fill out the form, but anybody else in the hospital they would fill out the referral form, which goes to Brian and then Brian gets them to the audiologist.

SWE went so it is a screen report basically.

>>: I believe are screeners entering in high track as well.

>>: Our largest hospital system does have an option to do it, but they still fill out the form as well so we can double-check.

>>: Do have time for any more just.

>>: Probably one more.

>>: I really just had a comment on the difference from 43% to 56% could it be the viability of younger and younger preemies.

>>: Surviving with more issues.

>>: Absolutely. That is very high probability paragraph one of the things that we're really working hard on in my hospital and this I felt so guilty because this is partly on my bed as I get called up to the NICU and the PICU all the time for very sick babies with cancer, meningitis, and would where doing that as audiologist, we are not even thinking about risk factors and filling out forms and things like that. Are data, I know Brian. Is partly, we probably have a lot more hearing loss in the older population of acquired hearing loss that we actually mess just because of audiology reporting data and not thinking about all those chemo baby babies I probably should have sent the foreman. The nurses do it for the screening of the newborn period and then it is conned of on audiologist to do it and I think we're worried about other things and forget that, but I think that that data would be even higher.

>>: Thank you and don't miss your flight.

>>:

(Applause)

>>: So I have to apologize for interpreters my name is Brian Shakespeare from Idaho.

We also have Mary Ellen Whigham from Alabama. And Daphne Miller from Georgia. I am so sorry. She is from Virginia. If you have any other questions for Dr. Stich Hannah and I am happy to give you her e-mail address. At some of the questions I can answer because I've been working with her most of the time and it would be from a EHDI Creator perspective rather than audiologists, but I would be happy if you have anything about like the screening results form and I can answer through that I needed out through EHDI Chats to you. It was supposed to be on the slide. I took it up to the screen already and when they updated the wrong PowerPoint for us. I apologize for that as well.

Other than that we're going to show you a couple tools that each of our states use and how we treat risk factors a bit differently from an EHDI perspective for. For part when a child has risk factors or late onset hearing loss in Idaho, if they are the Class A, like Dr. Stich Hannon was talking about, we treat them just like they failed to hearing screening so we get them into diagnostics at three months of age and all along six-month if they get diagnosed with that loss if they have a Class B risk factor, we send the parent of a letter and this is hard to read I can give you the PDF one well it is letting them know it is suggested that they go in for diagnostic testing between nine and 12 months of age. And we also send them a physician letter letting them know that their patient is at a risk of hearing loss and the same suggested timeframe.

We had a signature line for them so they could either tell us this is not my patient, and we could do further research trying to find them at some other directories we have access to, or they signed the thing and let us know have or will discuss this with their patient. Or the patient's parents technically.

I think Mary Ellen, you are up.

>>: And Alabama, we are not too much different. We send letters as well for our risk factors. We do have a little disadvantage in the fact that our upload machines in the hospitals do not upload data to our database. It does it collects it, but does not upload it. We have to do a lot of reading between the lines. We have to look at the birthweight, prematurity date we have to look at when the hearing screening was done and know when the babies were in their potential NICU time based upon the dates we are given.

We send out a little extra. We send out a milestone. It is a double backed card to the families to let them know what their baby has been doing. I can tell you that this is my baby and that is very rewarding to me personally considering I have a child that was considered late onset before newborn screening hearing so that is one of the things that that makes my passion and drive for that. And everything because you just never know. And I've had parents call and say if I had not gotten your letter I would have keep kept ignoring the symptoms. My first response is if you have any concerns whatsoever, you call your pediatrician right now and tell them that I said you need an audiologist now because it is considered an emergency if you're as if your baby has been like this. They will say it's been gone for six month and not speaking as much as they should.

We kind of a condensed hours down, our risk factor card to less than an 8th grade reading level because that is our general population. It is our general population for NICU babies because we have one of the highest incidences of NICU babies in neonatal infant mortality and we have a high incidence of teenage births. We had to get it down to where, hopefully, most of them can understand what we were saying. This is our condensation of all of that huge page of JCI H. that they send out to help families understand. That is what we try to do and, of course, caregiver concern is the number 1, it does not matter what we have it is the number 1.

Next slide. Same thing with our letter. Bryans is nice and pretty and mine is condensed down for the educational level that our state faces. On a daily basis I can't tell you how long our phone rings after the letters go out and saying this what does this letter mean I don't understand it. Why I guess I need to work on it more because I thought it was pretty understandable then when I tell them they are like oh. So it is not saying that my baby has hearing loss. No, your baby has the potential for hearing loss and that is one of the things that you know we try to get across to our families, our disparate Hispanic parents have the most difficulty of understanding and comprehending. That is what we have for Alabama and as a nurse, for all of us that work in our EHDI follow-up is nurses we really hone in on the charts like everybody else were kind of in cubes and so we talk above and over them and Leah will holler out and say what is this one a, is this one a risk factor query at the Nancy's like you need to come over here because she is the furthest away so that we can determine as a group, we group analyze it because we do's do take these risk factors so seriously and want to show our families that it is important to have that risk factor screening done.

Thank you.

>>: I'm going to share a little bit about how we support families in Virginia that have risks and I have late onset hearing loss. We have been collecting risk indicators probably since 2010 with the goal to get children back for a diagnostic evaluation. Currently we have a system called EHDI Independent Verification and Validation but ours is called visits and that it allows us to track children in Virginia and monitor them and we monitor them up to 36 months of age. One of the ways one of the ways that we at we identify risks is at the birthing center hospital hours system catches the information and the nurse or hearing screener or whoever is testing the child will put the information in the system whether it is risk payout pass with risk affair with risk. Based on those results, the results that they enter, it determines the fact card that the family will get. You probably have a fact card at your table pure. Those of the fact card for failed with risks. We also have one with pass with the risks and miss with the risks that determines what that screener or whoever is doing the testing of the hospital, that allows parents to get the information right away, but also allows them to have a QR code on it where they can scanned it in the phone to get a video and tells them really quickly with they should do next steps.

Additionally, these are entered sometimes by audiologist who may be later down when the child goes for audiology, and they determine there is a risk indicator that was risk that was missed the audiologist can also report that into our system.

Who has access to our system visits, which is our EHDI Independent Verification and Validationis hospital staff, audiologist and then the EHDI team children at risk with irrevocable data points, but I will tell you that in (201) 221-2021 -- percent were born with risks. The most common risk factor for the past five years was a NICU stay of five days or more.

The way we communicate risks I know many of you like us have a lot of children, we have over 5000 that we have miss with risks are passed with risks and that is hard to follow up or for that many children with the staff at that we have. What we have done as we send letters out. To letters, went to the parent initially and went to the provider. At the same time, that happens, we send a Robo call to the family letting them know that their child is at risk and then we also do a text message to a family.

This is just initially so the parent will know that their child's results, but we do repeat this. Let's say a child return does not return within 18 months our system will automatically send them a letter a reminder letter, and a reminder text and a reminder Robo call that it is time to go back.

Additionally, we communicate that to the providers as well.

Looking at 2021 finally, SATA 2200 children passed with risk and almost 400 failed with the risks these graphs show the number of calls, text, and letters from 2020 to 2022. With risks in these two categories. That is all I have. I will pass back over to Brian.

Questions.

>>: Sorry does anybody have any questions for Daphne we I will get started. How did you automate all of those things. A sound so cool.

>>: With a wonderful team. What we did was we worked with and you are automatic letters and our system automates all of those things so we have worked with the information team to get set up with Wick and we have a presentation a few minutes ago about -- and one of the things we found that we were frustrated with is that sometimes, you may not have the staff. You have turned over and things happen and you cannot do the things you were able to do before.

That drove us to automating these things. With the funding that we have from CDC we automated, our letters were already automated and we added the Telco piece of it. It will work to get the text with the system and we worked with the team to the OEM team.

I am going to e-mail you. I have way more questions. We're going to go ahead and move on.

Mary Ellen.

>>: Do have any expertise you can share with us about getting permission to text or was that easy for you? Did you have to go through your Attorney General or anyone? Your HIPAA team.

>>: I'm going to be honest. It was not very hard to get it done. We came back from a conference and I think it was Georgia who was texting and we sell their presentation and it was like we are going to do this.

At first, we put a PowerPoint together. We did do some research on how many people are texting versing versus calls. We put it together and presented it to her leadership and said, hey, we want to do this.

What was easy about it is that WIC was already texting. What we did was got with the WIC program. They were already texting within the Department of help in our leadership helped us connect to their texting and then we did not have to create anything on our own, it was already happening.

With the HIPAA, we had to make the case that we are not going to provide any information that is sensitive. We're not going to provide any PHI. After we kind of gave the case, it was a no-brainer. Yeah.

>>: Actually this is for I only got to see have the presentation because I was at another one. I'm trying to cram it all in. Does everyone send a letter when children have risk factors to the position? I know that we do, but I was wondering if the other to do.

>>: By Mr. Presentation Brian and Mary Ellen do you send it to physicians.

>>: We do not send it to the physicians because 95% of the time we were and we stopped it because 95% of the time those letters were being returned saying not our patient. We decided to stop waste wasting funds. We send out on average about 6000 a year risk letters and say you figure that doubles the postage when you add pediatricians. We stopped that a couple years back for that reason.

In Idaho, yes, we do send a letter to the position and we get a good return rate. At either the physician telling us that this is no longer they're patient or that they have or we'll discuss their screening results with their patient's family.

>>: We do to too now at a first they were not too thrilled about it, but we continued. We kind of ignored that. We get a good one now. How soon do you send them out to the families and the physician for the families you guys serve.

>>: We send them out at nine months. We used to send them out at a months because I thought the physicians would like time to discuss it with their patient, but I actually got feedback from the position from the physician saying I don't want this letter until it is time for me to tell them this. So we opted to nine months. Since then weave not heard any complaints.

>>: We are the same way. We send them out at nine months to the families and stuff. Unfortunately, with the database system that we need to upgrade our system, some have been going out at one year and everything. Is still piques the interest of families and I go by the philosophy better late than never to know this information. If I'd had this with my child, and my have been a different story if I had known sooner. That is what we do.

>>: Have any of you thought about e-mailing to families.

>>: I was just about to say that. We just looked at our postage really lately, all of our letters we spend over $20,000 worth of postage per year. What we could do with that money, right? One of the things we are working on is being able to send a link to families in the text message with the letter. We will still be able to send it out if they don't open the link and then we will also do it with the PCPs.

Now we have PCP's who have access to our system so they can actually get the letter in our system. We only have 100 who signed on bid I am grateful because that is 100 more than we had. But the push will for us is going to e-mail them or giving them a link to our system to open up the letters in the future. Very near future.

>>: In our state legal eagles, that is not a good thing for HIPAA so the answer was no. I did not even get past first bass. The answer was no.

>>: In Idaho we would love to use their e-mails, but we basically that is on the parent report so we get actual e-mail addresses on our screened results form. Somewhere between five and 10% of the time and about half of those e-mails bounced back to us. They are giving us just a fake e-mail address. I would love to.

>>: Anyone else.

We have some discussion questions and, hopefully, we're going to run it kind of like we are right now so if you have a question, comment, that is totally okay. We just want to answer your questions and make sure that everybody can get all the information they need.

Oh, no. The questions are gone.

I know one of them and I will pull up my laptop so I will get us started and then I will have the rest of the questions in just a second.

Does anybody have any pushback from physicians when you're trying to talk to them about risk factors for late onset hearing loss.

>>: I'm going to jump in and share the fact that I have a new 13 month old at my house and he is a risk factor baby because his data has hearing loss and his mama has hearing loss. His pediatrician brushed my daughter-in-law off and brushed my letter off and told her that he did not need it because he passed has his hearing test at birth until he was to or whatever. I've yet to decide if I put my Delco on and go to that pediatrician's office and have a fit. I know all of them outside of the healthcare world so I would like to do that so I know that Noah's hearing is fine because he hears soft voices very, very well end, but it does not mean that we can't have something that is going on and something that is going to be a problem. Personally yes, we have problems from the Gulf Coast to the north part of the Tennessee line, problems with physicians referring those babies.

I spoke at AAP last fall. I did not get in is one of their primary speakers, but I did get in is one of their workarounds for their office management staff. I have seen an improvement and son of of those, but I think it is going to take a lot more to get physicians on board as a matter of fact at the AAP conference I saw Caleb's pediatrician. He will be 27 next week. From 27 years ago and when she found out, I have not seen her since we moved and everything so she had no idea that Caleb had hearing loss and her first words where I missed it. And I was like no you did it because it was before newborn screening was ever known about. I don't hold you responsible. What you said was appropriate and I took it, but when the time came to investigate, I went up the chain and investigated it. We do have a lot of trouble in our state with pediatricians giving pushback.

>>: I have a group of physicians and MySpace that do not believe that congenital hearing loss exists. They don't think children should be tested unless they are three years old and they've got e-mails from my chapter champion we actually went up to visit them so he could present to them in person and they canceled the trip. It is an eight-hour drive and we were about four hours into the trip. They canceled it. This is also an appropriate place if you have any suggestions to jump in. Anyway.

>>:

(Off mic)

>>: Adjustments us what makes them think they know better? I don't know because I don't answer e-mails.

>>: One of the things that I tell all of my parents and my advisory board and places is that each one, teach one. When you go to the pediatrician's office, educate them, take a few minutes to educate them and eventually they will get it if enough parents are going in and telling them what needs to happen and what needs to be done. Fortunately, I had a pediatrician who came in when I was doing a site visit and doing education and he informed me, he walked in and introduced himself and says how can my office help you? And I was like you just put your foot out there. I am ready for your. I told him everything. At your people can start getting these babies scheduled immediately with an audiologist. It is a rural town. Where my going to send them? You're going to send them to their tree having Gadson. About 30 minutes. Not a problem. The irony of that is as they've been doing a good job and calling me so the hospital's equipment went down because we found out our hearing equipment is now obsolete in that hospital and they can't get the equipment to update it.

 apart his nurse manager was on an e-mail to me immediately. Did you know...?" Here's the plan I need you to follow through with the planned forming. She's like got it, we're doing it and everything because the hospital's telling the families were going to have our equipment piece any day now and I told him to stop telling them that and send them straight to CRS and get that initial screen done ASAP about the doctor's office now to follow up on that first visit. That is what they are doing now appear that each one teach one rule is slow. It is slow, people, but it does work. Eventually I figured by the time I get ready to retire, maybe they will all be doing the right thing.

>>: This is borrow from Wyoming. This is so close to the question you posed we collect Rusk factor information, but we don't do a really great job of longitudinal tracking and identification that way. One of the things I'm thinking about is you Brian seem to have good confidence in the accuracy of the risk factor information that maybe other people do as well, but we provide training to the screeners who would report that how did you train them? How did you train them to have such good confidence is my question.

>>: We have been training them since 2005. If you looked at our earlier, data I would not say that I had so much confidence in that but now I think we are pretty good. We do hospital visits and during COVID obviously, with online trainings but every single time we do a hospital visit, we do them at least every other year. We try to go every year but sometimes they give us pushback there like our staff is not changed. We're like okay watch this webinar then. The times we get to the all the hospitals will have 31 hospitals and I get the capacity to do that. Not every state can. Risk factor training happens in every single training. We talk about how to do it like Dr. Stichannen was saying we are involved about how we talk about family hearing loss and we are refining down a little bit and understanding when the screeners understand, I just had a brain -- we have just been doing it for just over 15 years and it consistently and we can see our numbers increase and the reporting become more consistent the longer the screener stays on that facility.

>>: We definitely do the training and we do twice a year maybe conference calls and things like that, but we seem to get turnover of staff and not good by hands because it seems like you've been doing this a long time and you are good at it. We have a lot better luck with that than screener scripts. Aesthetic telling Everett telling everybody that the baby is fine. Training on a risk factor seems to empower our screeners part this is something I could do to help and it does not make people feel bad it is just a risk factor. They seem to take it in the more retrain the more consistent it gets.

>>: I would add to that that we also send out periodic e-mails to the nurse managers and folks, which are nurses a lot of times. That do the reporting. We also remind them of the importance of risk factors and some of those kind of things so we do send them gentle reminders on why it is important in those kind of things. You might do that occasionally as well.

You asked how do we get people to do a better job of this and that kind of thing? Again and I brought this up before it goes back to having public service announcements with our big national partners addressing these things. That would be something easily that they could add in there that the past does not mean the past for life and if they have these risk factors. That is one thing that could be done there.

>>: After Tammy said that we do send reminders as well. Are hospital reports get a quarterly monthly or annual, biannual report depending on their birth count. When we have enough births to make sense to give them statistics, then we do and there is always a blurb and not about risk factors and this is kind of unrelated but it is cool. We always let them know when a baby was identified with hearing loss from there facility. Just to keep them involved and show them that what they are doing matters.

We specifically call it out if they were identified because of the risk factor report.

>>: All right. We're going to jump back a little bit picked that was one of the questions away from Iran. How many states actually collect risk factor data.

>>: Almost everybody. That is better than I thought it would be. Good job everyone.

What are some of your challenges? We have discussed some of them already. IRA really like Crystal's comment about how do you know that they are being reported accurately does anybody have any advice on that? I am probably know better than anyone else on the outside of our training.

>>: We do get risk factors, but I don't have very much confidence in it because it is coming from our screeners and they are entering it into the equipment. We have a hard time with our screeners getting that risk factor information. I am curious how you are even getting it, how are your screeners approaching the families to ask them about their risk factors? Are they looking at their charts to get some of that.

>>: It depends on the facility honestly, pick the bigger facilities actually do chart reviews, but most of it is by patient interview. They have a list of risk factors and go through them with the mom and the data in the room. If they are both there obviously. We train them on how to ask this question so we get better answers, more accurate, not better.

I am happy to put you in touch with Dr. Stich-Hennen as she was the one who designed most of her risk trainings in regards to risk factors.

This is Tara from South Carolina. We collect them and have some facilities that are really good about providing them. Not everybody does. We often have to go back after we get an audiology report and go back to back track and put it in. My favorite is when I have to go back and put in micro OSHA atresia like they didn't see that or notice that. That is a physical thing. That being said, we did do a quality improvement project with the hospital several years ago and browbeat the risk factor thing even though it is something that was always part of our protocol but since before I even started back in 2005. When we were doing the risk factors they were kind of like oh, I did not know. Oh, yeah, you did. But then we did not have some things that were big and they asked us to hone and so we developed a tiered system kind of like at the quiz mentioned you had to tears, Class A class be, so tier one is treated as if they did not pass and tier two they go three months and if they go three and they go six months. When DCH went all the way and the other direction, I chose not to do that in our state. I felt it was important to make sure that they still made contact with the audiologist for a first visit shortly after birth and let the audiologist at there professional discretion decide how frequently they needed to see them after that.

Relying on the physician was not going to happen. It is just not going to.

>>:

One other thing that we did Krista as we had a team of audiologist that help monitor the programs throughout the state so they are each assigned a specific region full of hospitals. Those audiologists review hospitals report of risk factors every month and send them an e-mail. I noticed you have not been reporting risk factors. Is there some help you need to order training on that? We are constantly contacting hospitals about risk factors.

>>: I am in Georgia we have a children's children first program for the social workers at the hospital fill out a children first of forms that have all the risk factors and then they send that to us especially if they are in the queue for more than five days. That is how we tend to know are risk factors because our they are --is sends to our system.

>>: Thank you. Anyone else.

>>: We talk about is there a strategy you have used in your state that has particularly worked or when that you discarded almost immediately? Like you tried it and were like this is not working.

>>: One of the things that we found that worked in Virginia is we were sending letters out and they just said you had a risk indicator. What we did is we added the risk indicators to the letter over time so when the letters print they got the parent does have to call us they didn't make me aware of what the risk indicator was in the hospital so it can be three or four risk indicators that all come out on the letter so they will have the information.

>>: Anyone else? We have time for a couple more maybe.

>>: Thank you Tammy can you wait for communication access.

>>: We also included with the risk factor is and that has been really good because sometimes we are contacted by the physicians office because they will go we don't see anything like that in any of our reports or that kind of thing. I am like one of the hospital reported that to us. If it is not accurate, we want to know that because we want to make sure to remove it from that child's record. Occasionally the parents do, but usually not. We do get phone calls after our letters go out from physicians offices as well as parents sometimes. Sometimes, parents are just because they don't know if you put over toxic medications there like what ototoxic medications you could name it or say it was an antibiotic for that of the. Oh they're like oh, yeah, I remember that or no, I do not pick than I referred them back to the physician to have a discussion about that. Then we always follow-up too with the hospital if there is one that is reported that is not accurate to make sure that the child's physician and the hospital are on the same page as far as risk factors.

>>: I think you may be clairvoyant Tammy. The next question is what are your communication methods for parents physicians and other stakeholders? Does anybody have any other comments.

We also include the specific risk factor that the child has on both of our letters to her parents at our and our physicians.

Daphne, do you have anything to add.

Daphne is saying that I clicked the button on the Robo call and that is what made the crazy noise. Let's have some fun.

That one? Hello this is Virginia and this is a reminder to schedule an appointment for a hearing test when a child is 12 to 24 months of age for audiologist in the area this is the Virginia Department of Health website at VDH at dot Virginia dot GOP forwards hearing or call us at 8042123020 phone ski thank you and have a good rest of your day. Cool. Anyway that is all the time we have. I believe you guys will be available at the EHDI coordinator meeting tomorrow or catch us in the hallway and were happy to answer any other further questions. Thank you all for coming.

(Applause)