>>: Good afternoon, everybody. I hope you enjoyed your lunch. This session is Standardized Site Visits: Collaborating with Hospitals, Audiologists, and /or Family Support.

Site visits or something we can easily adapt to any of those audiences. This session is designed to be a working session for state and territory EHDI coordinators or their designees. We have a little note. Hopefully, everyone in here if you are not, just know that this is a working session designated for coordinators and their designees.

I am Marcia Ford and I am from North Carolina and serve as the EHDI coordinator. In North Carolina just a quick summary of our EHDI team. We have 10 regional consultants. They are either audiologists or SLPs and without looking at a map, I cannot off the top of my head how many of each. We have two parent consultants, one of whom is native Hispanic Spanish speaker from Guatemala, so that has been very helpful to our program. We have a HRSA project court Nader who serves as the PI on the HRSA EHDI Grant. We have a data manager and then myself as the coordinator.

Briefly that is just a map we have our state divided up for our regional. Regional staffing cover hospitals audiologists families health departments, anything in their assigned region. They are responsible for reaching out to. Regional staff are the ones who actually do the site visits in our program.

I will also mention that any of these materials that you have any interest in, we will be happy to share. I did not bring copies with me, but I think other people did. But we will certainly share that anything that any of you want to see.

In North Carolina for our hospitals and birthing's facilities, we have what we call a compliance guide and an annual review. So the regional consultants do a review with each of our hospitals once per year unless there is a need for improvement somewhere and then we do do a second visit to follow up.

What I've shared on the slide, we have a full document that is a manual for the compliance guide. We share that with the hospitals and with our staff so everybody is on the same page about what the expectations are. We also have a document that is an implementation plan, which outlines kind of a standard operating procedure for our regional staff so that they all implement the compliance guide in the review in the same manner across the state. Then we also created, the regional staff created discussion points, things that they can ask when they are at the meeting with the birthing facility to stimulate conversation and get information that we may need or that may help us know where they may need more assistance or where they are really shining.

I took something off of this slide and I don't remember. I apologize if it looks funny. We also created a fillable PDF form that they fill a during the site visit itself. This is a format that can be used for in person visits and easily adapted for virtual visits as well. our part we have a fillable PDF form, we have the birthing facility profile information, so just general information about the birthing facility so that we know all of the pertinent contact names and phone numbers.

We include the EHDI coordinator, the metabolic screening follow-up person at the hospital, and the CC HD, critical congenital hard to disease contact for the hospital because EHDI gets contacted for everything, newborn screening in North Carolina so we wanted to have a record of who those context were at the various hospitals.

We also have a section for inpatient screening, outpatient screening and the particulars of what goes on at the hospital. We ask them about their equipment, when it was calibrated and things like that. We do have a scoresheet that we use, and I have included that summary page there. We include a section for strengths and weaknesses, and then we have signatures. We write this up, I say my team writes this up, they send it to me, and I get to review, which lets me know what is going on in each of our hospitals. I personally do not have regular contact with the hospitals that my regional consultants do. But I do sometimes get phone calls so it helps me to have the information. We have the regional consultant who did the review signs it, I signed it, and a representative from the hospital so the we know everybody has in theory seen the report and is in agreement with what is on it.

That is a really quick summary for North Carolina, and I'm doing that because we have lots of other information to share. Question? How many hospitals do I have? It is somewhere between 86 and 92 right now. They come and go regularly. It hovers around 88. It is helpful that I can divide this task up with 10 people. Brian? I will upload the documents online where everybody can have access, yes.

On the EHDI sight? I am.

>>: I'm not sure if it be there, but I will make sure that everybody knows that I will get with Bradley.

>>:

(Off mic)

>>: The question was and I don't know if we have a second microphone in here, the question was do we do anything different with small rural areas than we do our metro areas like Raleigh or Charlotte. We use the same compliance guide, but we do note that the data can shift dramatically based on one baby in our small hospitals. We make note of that. The points are the points that they are, but if it is related to that one baby kind of thing and a small hospital, we make note of that in the comments.

Hang on. Thank you.

For that scoresheet, who is that disclosed to.

>>: It is shared with and I'm going to look at my team to nod at me. It is shared with all of the people who attend the compliance guide review. Anybody else.

>>: Cannot hospitals see each other's scores.

No, no. We do not make them public. It is only within the EHDI system really in that hospital. --

(Overlapping speakers)

>>: We have not been allowed to publicize anything in any way, rank or delineate hospitals against hospitals.

It is just the EHDI program and people at the individual hospital.

>>:

(Off mic)

>>: This is a program that I have wanted to start in Georgia. If you are looking at your hospital and in that meeting, can you say that we are ranking in the bottom 25% of the hospitals that I am scoring? Can you give them any kind of information to where they rank to the other hospitals in your state.

>>: We would be able to give them some feedback without being too specific. And we have particularly if we have somebody in the lower realm. Rachel.

>>: Who is at the table for those compliance meetings? Is that anyone other than the people actually doing the screenings at the hospital? Are there any hospital administration staff that are present at those meetings.

>>: That varies from hospital to hospital. The regional consultant does the inviting. The minimum requirement is the person that the hospital has designated as their site EHDI coordinator. If it is a hospital that uses outsourcing, and I don't have much of that in North Carolina, but if it is one of the hospitals without sourcing particularly they have a representative present.

Sometimes, a nurse manager comes. Probably not, I'm looking at my team, we probably don't get anybody above nurse managers. But, yes, we will have multiple people at the table. We will have a representative from the NICU sometimes, and well baby and sometimes they are really small meetings and sometimes several people.

>>: Hello, this is Gina Cooper, the EHDI coordinator for Michigan. Fabulous resource. We have started in Michigan we have done about 20 site visits in the past six months and also have a score and a rubric that we use, but getting to a point where now I am trying to follow up to make sure that they have implemented. Do you have any type of guidance in there regions for following up with the hospitals after a site visit.

>>: We do. If they have areas that need improvement, we schedule a follow-up visit six months later. My regional team is fabulous, and they reach out. They have very regular contact with her hospitals, so they are reaching out and prompting when improvement is needed, but we schedule a formal follow-up visit if there is something significant. I'm going to ask the three people from my team before sitting out here to raise your hands up really high if you guys have any questions about the North Carolina version, they will be happy to also help answer and in the interest that we get to all of our presenters, I am going to hand off to Indiana.

>>: I am Suzanne Foley from Indiana. We also are housed in the Department of Health, Maternal and Child Health Bureau also partner with our genomics newborn screening team. And a lot of these efforts particularly for hospital visits we also have a regional audiology consumes the do our hospital visits. We have a leader regional audiologist that trains every new reporter to every hospital with a virtual visit. We also have parent consultants and other than Julia, who was an audiologist and the audiology consultants all of our in-house staff or parents of deaf or hard-of-hearing children. That I just have to make a plug it makes a difference in our program in a positive way.

We do visit our hospitals once per year. We have about 80 hospitals and eight -- centers. I have put a template on the next slide and I tried to uploaded to the app. If not it is we will make it available and that is also a fillable PDF. We also monitor hospital stats quarterly. I will show you with that report looks like from our data system and if there is a problem, the regional audiologist reach out between that time. We do monthly e-mails to the staff that is responsible for reporting, and someone brought up a good question as to who is at the table. Sometimes, our reporters don't do screenings print they might be a unit secretary or somebody else so when we do visits we do ask if it is somebody who is not doing screenings that there is a nurse manager present at our meetings because that reporter does not have a lot of poll to get nurses to get nurses to do different things for going to make sure that somebody's at the table if there's a problem with the screening.

We do start last your training every new reporter. One of the staff turnover is an issue in our hospitals. We have already reduced to many errors on our reporting by training each person that comes in when they get access. We have also developed an Indiana specific training on newborn screening procedures. Previously would require any new reporter to do the NCHAM, but it is long and if those reporters are not doing screenings, it is a lot of times that we have developed one specific to Indiana.

We also are frontage fortunate to have loaner hearing screening available to hospitals on indefinite loan for so when we have an annual review of those hospitals to make sure that the equipment is working and if they need to return it to us.

I do want to also say that we work very closely with our Maternal and Child Health Bureau's surveyors from the Department of Health that are responsible for hospitals level of care in terms of state legislation. If you have a hospital that is having difficulty we put them on an audit, which then alerts their nurse surveyor, which gives us a little bit more teeth in terms of a follow-up, and we also do schedule a follow-up to monitor what is going on with them.

Not a great picture, but this is our visit, it is four pages long. It is a lot. Meaning they literally go through every point and have to fill in certain things, where they are referring kids, what problems they are having, data, we track, if they were reporting in it timing timely and if they reporting pass and risk factors.

The stats that we use quarterly, the most recent ones are used in the report when they go to the meeting and they discuss those.

The cysts are stats that we look at. It tells us in any range we can pull this all the statistics so we can say for five out of six months you did not report on time, or you had a high referral rate, let's look at your equipment, screeners, let's see what's going on so we can keep everyone in that range. We do pull that report and send that to the regional audiologist for each of there facilities.

We do have what we call a comprehensive audio ladle audiology list, which is a list of audiologists that are equipped to test babies. We do meet with them annually. The regional audiologist does pick for example, just came out with a new best practice for pediatric audiology and reviewed that with them, each of the facilities. That was one of the requirements of being on our list that if we are going to offer your services to our hospitals, here are some things you need to do for us.

Similarly, we have loaner diagnostic equipment that we require them to check in annually on the equipment. We do send monthly e-mails and then we sponsor with our Center for deaf of hard-of-hearing and annual topics in audiology I present it at every speech and hearing Association early intervention conference and early childhood conferences. Not a visit, but just a way to get out there and talk about our screening and follow up.

And there is my contact information.

Any questions about that? Or any more questions you have for Marcia or any others? I will say that we used to do them all in person. That is why we had regional and obviously, during COVID, we have been trying to go back and person and we get some pushback because hospitals like being virtual and don't have to take the time to see us, but our nurse surveyor sits Department of Health have asked us to be an person because they say it is much more effective. We have to see the equipment, calibration day, have to see where the screenings are taking place, have to go through procedures, look for newborn screening, or to have this record. We're slowly going back and person for lease visits.

Yes, question.

>>: I'm going to ask everyone this question so if you could just address it, the documents that you're putting up here are you going to make them available to the group.

>>: Yes, I hate for everyone to have to e-mail.

>>: We can share on EHDI Chats.

We can absolutely share it on EHDI chats. I will even take our level off and dig up at your level on. I will send it in a Word and PDF document. Similar to Marcia's, they are pulldown screens, fillable, you can tab through to make it easy.

>>: You have a group of audiologists that are not standardized and I went to look at everybody's in pick and choose.

We do not have a score to put it down. We do have the audit process where it follows more specific things, but I can tell you that our genomics team does score and they do not share that with other hospitals, but they often say that you are in the lower 25% are top 10% are top 10, to validate the ones that are doing a great job, but to give them a range of where they are. Any other questions? Feel free to reach out to any of us if you're starting this process. Obviously, we have learned a lot along the way so please don't hesitate to reach out via e-mail if you have questions.

>>: Phthisis outside the scope of this topic but because you put the plug-in about having parents how are you able to do that with working with the state health department because with our position classifications, and our recruitment, we cannot specify that we want to hire somebody with a lived experience.

>>: That is a good question. They are all contractors, but they are not state employees, which may make a difference. The contracting companies I give them the job description and it says you have to be the parent of a deaf or hard-of-hearing child as part of our requirement just like the director has to be an audiologist. I give that bit is a contract, not a state picked they may be a difference in that. I may not be able to speak to that. We've had a NR job description. I acknowledge that sometimes, depending on the parent having a parent work for EHDI is not helpful. We can say that out loud, right? I am lucky that the parents I have are very neutral. I don't have to train passion one bit. I can go away for six weeks and come back and they are still working so hard. Almost too hard sometimes. I have to reel them in a little bit. We have to stay in our lane. You can't go to the house and take that baby to the appointment if mom is not going to kind of thing. I sure because I find is so unbelievably beneficial to our program.

>>: I don't know how to ask the question, this is Karen from Florida. We don't put a NR position description, but we do include it as a qualifying question and it gets more weight. It is not necessarily a make or break kind of thing, but it lets us look for parents in a row way and it gives more they get more weight for the scoring of applications.

>>: And this is Marcia in North Carolina were similar we have the flexibility to hire through a temporary agency and so we specify that it has to be a parent, and we can actually select who we want and named them as the candidate.

>>: Our next presenter will be Arlene from Colorado.

>>: Let me give you a little background on this part of Colorado's system. When it comes to FTE, we have one FTE at the health department who is implementing the database that launched two years ago, the new database. She gets a little part-time help from a data person, and that is it for the health department.

Then we have the HRSA grant and we have one point to FTE for all aspects of the system. We have sole responsibility for site visits because the health department makes none they don't see it is their job or provide oversight, the coordinator there is not an audiologist and the powers that be helpful if the situation as such. And that we have some contract money for audiologists through the HRSA grant, and through the parent through Hands and Voices, through the HRSA grant and a lot of volunteers.

So, we had a new database, October 2020 a little over two years ago. What are hospitals doing? They are on their own, they collected their own data for three years while we were between databases. And it was COVID.

We adopted NCHAM's virtual site visit curriculum. And we were one of six pilot sites. We followed NCHAM's a curriculum, but Randy said straight out, do whatever you want. Take it all use it all use parts of it whatever. The way you do is they designed it when you do virtual site visits, it would be the EHDI coordinator and apparent and we decided that we wanted to keep the model that had been in place with the regional audiology coordinators who are now not funded and what they were doing when they were making in person site visits as they would have a parent like we do, an audiologist, I am not an audiologist, we contract with want to do that. I would be there, too. They wanted the hearing resource coordinator, like the specialty service correlator to be there. We wanted a physician to be there because CC MV is a happening thing and our state and then we wanted the hospital representatives. So we have 18 hospitals at the moment who contract with either Envision HSA or pediatrics and we have 15 hospitals because if you do the math that leaves, however, many hospitals out of a total of 52 that have their own programs..

We started doing the site visit there today, we have had 17 hospitals participate, 59% are in rural area, 41% in urban areas. We took the NCHAM form and may be tweaked it 10% for wording or edit a question or two or took away a question or two. I'm happy to share we have. We turned it into a Google doc and use Google Sheets and have her own database. Being a collectively the audiologist we work with works at CU Boulder in the speech language hearing department and we have students and fellows who worked who work and help us with this project for free.

Who are we going to see? The health department shares no data with anyone except the hospital. Since October 2020, they have now distributive three quarterly reports to hospitals. Even the hospitals do not have a lot of data yet, but health is working on getting quarterly reports.

In a perfect world, you go to the hospitals that are underperforming and maybe within the year we will have an interagency agreement so that health will share data with us we are in human services, but currently we do not. We only get the data about hospital after the site visit, if they have it, and right now it is not current.

It is unfortunate because we are seeing whoever will meet with us. We are not going to the low performing hospitals because we don't know who they are. This whole site visit thing with a 17 hospitals is kind of informing us about what we need to do statewide that will help the hospitals that we know have problems from the site visits, but maybe help everybody else at, too. I will tell you with those initiatives are.

I am not bragging about this model. This model is sort of in survival mode. I want to be more like you guys. We will get there. We need money, we need to FTE, we do not have a CDC grant because the health department did not apply for one. Like I said, we are in survival mode. I think it is okay because we are learning some stuff.

We get the data the students of because it is their lend capstone or both of the 17 hospitals, about half run their screening program with nurses doing the screening and the we have to hospitals for we have technicians and five hospitals one has medical staff CNA's somebody. Rural hospital I guess I am learning are like that. And to hospitals did not answer the question. We found out that there is a lot of turnover. Eight out of the 17 hospitals so not every hospital is in the slide for 61% of hospitals have a high turnover rate. That said to us, we have to push a training curriculum, and we do push the NCHAM training curriculum. I took it. I have never screened a baby. Did I just admit that? I am an SLP, a teacher of the deaf, I know about it, I have not done it. But I will tell you that I did the training curriculum and learned a ton. And my mind if I went to the hospital I was going to screen someone I I ought to do at least 10 or 15 was someone watching me because I don't think it is that simple. If we have 61% of hospitals have a high turnover rate, of newborn hearing screeners, we figured education is really important. Would push the curriculum.

We have about training have about 60% we have have hands on training bases and screener. 20% each from a nurse preceptor or a medical group so would be pediatrics or Envision HSA.

Scripts. We do know because we are so intimately involved with the early intervention that some parents get a message of probably fluid, did not follow up one bad air still have one good ear, parents did not follow up I'm not going to reach preach to the choir we know how the message results and parents follow up. 36% of hospitals do not use scripts we decided statewide it is an issue and are screening task force is writing the scripts, we are taking it from NCHAM and tweaking it a little bit, packaging it differently because we want to give every hospital a gift of some kind of flashy colorful cool cards that they can maybe hang on the testing equipment CART or something to say use these scripts and please don't say these things.

That is an outcome of this collective data.

41% of hospitals do not have an informational brochure. We were at one. The health department took the newborn hearing hearing screening brochure in 2018, 2019 to the newborn screening panel so there's another panel for hearing and screening itsy CHD. We did not think it was enough. Are screening task force wrote a brochure. That we print and distribute to hospitals.

We found that 71% of hospitals use OAE. 20 a percent OOAD are. We were so glad to see this bottom thing, 100% we'll rescreen both ears if you don't pass in just one air. People were really concerned about that so he made a big pitch for it and everybody's doing it. We were concerned overlaying concerns to healthcare providers. 11 hospitals is only on the discharge sheet. We don't think that is enough. Their needs to be something like what all of you guys do. You give a card to the parents or inform the doctor that a mechanism is that of putting it on the discharge sheet. We want to do something more, better. We're in the game for CC NV. It was in our 2018 legislation that the health department has to do something about CCN V. and we'll have a very active group to the AAP in Colorado. 65% provide targeted screening urine or saliva when the child does not pass the screening. At 35% do not. The pediatrician on the site visits asks these questions, talks about her availability, we'll go to any hospital they have materials and share them.

Our point is to follow best practice guidelines and rescreening both ears if you do not pass in one ear. Is a success. There is some kind of hands-on training. We feel good about that but are areas of improvement, there are more bullet points and in our successes. Screener background. Because there is some documentation that may be nurses are not really that comfortable doing it so how do we get them more comfortable wheat the training that I talked about, the turnover I talked about, scripts, I've actually talked about all of those things that become initiatives that once again we announce, provide to every hospital. We have a newborn hearing screening monthly. It is on our website co EHDI.org. Every issue is on that we have been doing for about two years. Our audiologist takes topics from this list. She has a really cool picture every month. A one page, one topic, you can read it two and a half minutes. It goes to every screening name that we have. We do get those names from the health department, but that list is updated every two months. I hear they like it, so we keep doing it. We will never run out of topics. It is a mass statewide initiative, which will hopefully become a more targeted initiative.

We want to get more hospitals finished with the first visit before we go back and do a second visit. We do give them a report. It is full of here is what you are doing well, here is JCIH best practice and thinks you might consider, here is where you get those resources, the brochure is free, you can get electronic, printed, unilateral info graphic. We will send that to you. We tell them all about resources that are accessible to them.

Questions.

>>: Ryan.

>>: So I left all of your data. I just had a question on how you collect it, how do you figure out whether screeners follow the scripts and the percentage. It sounds like a great project.

>>: Fun project NCHAM created their curriculum and they say give this questionnaire and it is lengthy, to the hospital before you meet with them we decided not to do that because when we did an interview process for one, they did not fill it out. It was too long. We did not have a before the visit. So we do it through interview. Are a UD lend at the fellow is usually in on the call also. Someone is asking questions, someone is taking notes and filling in the form, Google Docs live on a shared screened screen. Some of these questions have a more specific breakdown like high turnover, not high turnover, but there are some gradients in there and the data analysis they lump them together.

Everything goes from the Google doc into Google Sheets and the students just create these data reports. Sorry about that.

>>: I guess asking the screeners for if they follow a script, the self-report, I don't understand how you got that data and I'm just really curious.

>>: We say do you use a script and some people say no. Some people say, yes, and we say what script do you use? Than they have to say we use the NCHAM or pediatrics will say we use our script. And some people say I've been doing this for 25 years, I don't have a script. Then we say what about the people who were there the days that you are not there. We train them I trained them here we consider that no script.

>>: That is the biggest thing we hear from parents oh, they told me it was just fluid in the air we don't need to go to diagnostics, and I really want that to stop.

>>: Our task force who was working on the scripts unanimously said, yes, on the do not pass one, include a list of I think it is seven or eight things, do not say this. Do not say, you had a water birth it is probably fluid. Do not say it is the machine. Do not say I am new. Is that it deviation from the NCHAM stuff? Do they have a do not say list? Anyway, we do.

>>: On your newborn hearing screening monthly one topic one page, who did you say is doing that within your EHDI program, and who was it being sent to, you are e-mailing it.

>>: It is being done by the audiologist we contract with. I get the edit. We have a communications person who designs it. She is cool. It looks really pretty. We send it to every contact and the health department's database for every hospital. So 52 birthing facilities in the state, we have more hospitals than that they just don't know birth kids any more. With pediatrics, we sent it to the pediatrics folks and the nurse manager or whoever is listed as the hospital contact that the health department gives us. We e-mail it.

I will stay later if you no more questions.

>>: All right, everyone. We are going to move really fast for this because I have some things to add about hospital site visits, but then I wanted to talk to you about audiology site visits.

We did hospital site visits way back before there was ever a virtual platform created so I shared all the information with them, they took some of the information to use, I am happy to share anything.

I don't think I said I am Tammy O'Hollearn in the department of health or, which is now become Department of Health and Human Services. I've been with the program's 17 and a half going on 18 years. I'm happy to talk to anyone. I did put a packet of information about the quality improvement site visits that I'm going to talk about here back on that table back there. There are about 25 copies so help yourself to those. It is copies of our memo to people and some of those kinds of things. Make sure you grab one of those because I don't want to take them back in my suitcase. Just to add to about the site visit stuff, we did a very detailed thing in advance of the visit. We reviewed their data in advance of the visit, and had them complete a rubric. The rubric actually covered their compliance with the law, and what they do with there quarterly reports or even if they use their quarterly reports. It also covered some of the processes. Are they screening in both years, those kinds of things.

When they got to the visit we actually covered each of those things with them because sometimes what they would say they did in the rubric that came back to us was actually different than our experience was with them. Then we would address it at the meeting. We did a lot of site visits and. At the time I was doing them, we have had 81 birthing facilities. Some days we would do to and we were driving to these places to do them. We tried to be very accommodating accommodating into them at any time of day to get the most people there. Some people as you heard appear some hospitals were really good and had a lot of people at the site visits and other times it may only be a couple. Usually we could walk in and tell within the first five or 10 minutes if it was a well-run program or if there were definitely issues. The one thing I think would be difficult for us now doing them virtual is you miss out on body language. You miss out on some of those little details were someone will say no and another person will say, yes. You don't know necessarily to probe more. Those are some of the advantages to in person when you can do them. We cannot do them anymore because we do not have the funding to be able to do them anymore. We are going to miss out on some of those things.

I will say that we also do quarterly reports that go to the hospitals and that was something we review in advance besides the individual hospital stuff. Someone asked about kind of like a report card, we do have report cards. They are by a hospital level. They don't necessarily know who their peers are, but for a while we also put the names on there. We don't put the names any more. We have a number. We would not be fearful of putting it out there. It should be public information. The quarterly reports are really about best practices. It is like referral rates, missing babies that they did not report. Those are babies that may be transferred out and they forget to enter them in the art our data system. Missing information in the system and I can't remember with the other one. I'm always happy to share any of the information with you as well. Anyway I have a whole packet of information that I can share with the group about our hospital site visits too, but those are not the ones I brought today. Are brought wants to talk about this quality improvement initiative and we actually did this virtual with one of our hospitals that diagnosis the most kids in our state. Because we were frustrated with the lack of movement on moving the needle on making progress on the three-month goal. We targeted providers after we looked at the data. We looked at our list, try to figure out that is how we identify who we wanted to target first. What we really found is that we needed to target this hospital. I say, "target" I do like them, but I am not trying to be mean, but we really had to say to them we cannot move forward as a state if you don't move forward as a program. What can we do to help? We really tried to turn it into a more collaborative thing. I think they have been very appreciative now. One thing I should back up and say, we did this with each hospital on this, but we did do a survey to ask the folks when we left was a helpful and those kind of things. What would you change about the site visit and that stuff we did some of the same things that other people did which we wanted to see the calibration, and where they screened so Ralph could find out if there is too much noise in the room, if there was lots of things. I am all over the place I wanted to throw that in because it is important and it helps you to figure out if you need to modify your visit a little bit as you go along.

We really took our data and what we learned from and when we were looking at socioeconomic factors, all those kinds of things, that is where we turned it into action. We thought how can we convince people that they need that they need to change how they do business. We looked at the data and gathered it and our epidemiologist actually presented the data we wrote them in e-mail asked about meeting with us those kinds of things. We talked about who should be there. We again try to be flexible because we know they are very busy. We covered data in the first visit and talked about their data as a whole, and then in the second meeting, because we only did these as for an hour and on the second visit we wanted to talk to the processes to learn more about what are the steps you take when a child does not pass at the hospital, then likely the hospital that we visited to talk about the audiology piece of too they also do not do a good job of getting them back in for the hearing rescreened. We were able to address two different issues through that.

In the second meeting we really talked about the process and that kind of thing and what got them thinking about what are the next steps, what is something you could do based on the conversations we have had in the next few months to look at and make changes to.

I will skip past that. This is an example of some data we provided to them to really show where they were at versus or other people or add. That is data's power. If you are an entity that sees the most amount of kids but there are people who see almost as many kids as you and they are doing much better, what would be the motivation to make you change we did share this data and sharing their data is really good because then you can go back and share new data and did they make progress or not. After something someplace.

We ask in this case that they had the audiologist and the lead audiologist, we ask that they had the NICU staff because we wanted to address with them JCIH recommendation of actually getting the diagnoses done before those NICU babies and go home because they do not and do not even attempt to or did not at the time. We wanted to address that.

We also asked, we actually asked for a quality improvement coordinator to be there. They did not come, but we asked for his supervisors to also be there because we know sometimes it is not the people who are doing the work that are in the trenches that can make a change it has to be somebody higher up. We had a couple of them come. One of them was a supervisor who is also a professor and he reached out to us afterwards, not to make changes, but to include that in with his presentation that he was doing on something. You never know what you're going to get. Laugh (Laughs).

Included the first invitation e-mail, we did the second meeting, and then we really tried to walk through the processes discussed with the berries are because we need to understand what they view as their barriers. Can we provide data to some of the people that are higher up that will help convince them to make changes within your hospital? We discussed the quality improvement strategy.

Then we met with them and went later on and scheduled a meeting for three months after that. In the meantime, we shared resources with them pick one of the questions that people asked was who attended. Myself attended, we had to parents attend, and audiologist attend obviously, for the best practices piece, that kind of thing. That is really who was in attendance on our end. Again,, their group changed a little bit along the way.

Lessons learned. We said level of engagement may vary. We have some that they did not seem like they were paying attention but then later on we would get questions from them and/or they would make changes. When we have a follow-up meeting they were much more engaged. I think sometimes the data is a bit overwhelming at the epidemiologist that we had at that time was really good about breaking things down and made herself available if they had additional questions and things like that. We also said what can we did help me move things forward? It was not just about them making change, but will kinds of things that can we give you to help them move forward in those things.

We told him to keep keep the change small and offered to be part of the solution then build rapport. Lessons learned, document progress throughout, prioritize work obviously, can't do everything all at once we told them don't be afraid for them to use their data to tell their story. Data actually was powerful, so I want to say it was important for us to celebrate their win. This place that we went to they actually it was six months later they had made a little bit of of progress in my and nine months later a little bit more and one year later they finally we're moving the data forward up to a higher level to get additional staff hired. To be able to do some of the things we talked about. They asked us for updated data for them to be able to take because our data is always a little bit behind. They asked for us to do updated data and that was information they could take forward, and they were able to get another staff person hired. They got a three quarters staff person hired and audiologist and they are in the midst of hiring another full-time audiologist.

So far everyone has been very receptive at first people were skeptical and crabby about in but once they met with us they found out that we really where there to support them and figure out what kind of changes they could make, what little things they could do to make a difference, and we are saying that children are actually being served in a more timely manner, they are getting in there. They did retraining with the schedulers for them because there were some problems with that. There has been a lot of positive that has come out of it since then.

Again, I gave you a packet of information that we sent out. I am happy to share or talk to anybody further about that because I know we are out of time, but I wanted to tell you a little bit about our audiology visits. We set them up kind of similar to or in person site visits and both have been successful. I will say that it will be nice to go there in person but since we don't have the funding to do that we have been trying to do it virtually the other thing that we had to slow ourselves down about is we can only take on so much because we have such a small staff so it was like we can't be doing five of these at the same time. We need to do to. Is plenty. Once we get people moving along and we can do a check and then we can take on another one as well.

If anybody has any questions, I am happy to take them or talk to you afterwards.

Here is my contact information, too.

>>: In Georgia we have a contractor providing services in hospitals that we have had issues with, do you have say that company personnel who is doing the hearing screening at the meeting and hospital administration there.

>>: For hospital site visits we no longer have anyone that has a third party that is doing. When we did they would have been required to be there. Yeah, yeah. And our state the hospitals ultimately, are responsible. They can contract with the third-party but ultimately they are the one who is held responsible, which is why some of them have moved away from that.

>>: Great. Thank you, everybody. As we've all said we are here if you have more questions and we will get our materials uploaded in a way that you can get to them just as quickly as we can. I am just curious I know several of you have been in several of the sessions that have been designed this way, is this format of session, are you feeling like it is helpful? Okay. Just curious. Thank you and enjoy the rest of your day.