>>> We can get started.

Good afternoon. My name is Wendy

Jumonville and I am the director of

screening for hearing the screening

soldiered and I'll move to the next

slide and tell you about us of my

colleague is with me, Ashley Schilling

the assistant director for HSA. So we

are an out sourcing company and we

provide services to hospitals from

coast-to-coast, and we are here to talk

to you about one of the tools that we

use that we feel directly impacts our

ability to have a low loss-to-follow-up

rate at our hospitals.

The structure of our teams include the

local screening team, specific to each

hospital, and then we have hospital

supervisors across the country and they

monitor the screening teams and

those supervisorrers include 17

audiologists and wean us all we have 241

years of combined expert so we have a

passion for what we do and that is what

drives every single decision that we

make at HH S because of that passion.

So the first step is to meet the 1-

36 and as an out sourcing company we

know that screening is our job baa

because we have the 17 audiologies we

don't stop at the one, we follow those

babies until they bet to the three and

get to the six. In your

case Ashley Schilling knows the name of

every one of her referring babies. My

memory is not as good but that's what

the job of those 17

audiologists so to track that

loss-to-follow-up and ensure that every

baby that refers is seen and diagnosed

by the three and then an intervention at

six. Again, what is the benefit of what

we're going to talk about, so we're

going to talk about the factors that we

feel is important are those relationships

we develop with our community

audiologist partners so in every

facility that we are? We develop a

partnership with the local community of

audiologists, where our babies are

going to be seen after they refer. And

we can streamline the resultings that we

tell them and we have better

communication with those families, so

those 17 audiologists on our supervisory

team have those relationships with these

do it audiologistings and that is what

helps Us with that

communication, so it's audiologists

talking to

audittologies, do you need my lead

serene screener to call that family so

each hospital had a lead screener on

that team so we involve that lead screener

so that's the way we feel the meets

this need. So Ashley is going to talk

about our statistics.

>> So I'm Ashley Schilling, I'm an

audiologist and I will be honest. In

grad school I was going to be a

pediatric audiogeologist audiologist

until the V.A. stole me, I had no

interest in working with new borns and

Wendy pulled me into HSA. I didn't know

what this meant when we lose babies to

follow up so in my first responders few

weeks of training on the job I was like,

then what? We do this birth screen and

then what? And so I realized very

shortly that there weren't a lot of

people doing good work in follow up so

we have made that a huge priority of our

screening teams, again we have 17

audiologists so it is a huge part

of our day that we follow these babies

until we know what happened.

Our lead screeners are involved so our

first step when we go into a hospital I

say I need to know who your diagnostic

audiologists are and we'll get NFL

from the state EHDI and we have to cold

call offices, we want to find out who

the practicing pediatric audiologists

are and with make those relationships

from day one. These are three states

that we chose two, Texas and

Louisiana where H SA does the screening

and Utah has fewer but we wanted to show

you stats on states where we have a

large presence and states where it's a

smaller prejudices. So in Texas

23 birth homes it's actually 22 I think

now so we have screened 32,000 babies

in the state of Texas and our overall

refer rate was 2.7 so if you saw is it

overall loss follow up rate for Texas it

is quite high so I'm proud that in our

hospitals we can have this ten percent

up there. For Louisiana very similar in

your opinions, we have 17 hospitals

there again low refer rate, 2.8 and thenth

even more impressive 0.3 for loss to

refer, loss-to-follow-up, again low

refer rate, so incredibly proud of the

work we do and we weren't just

checking the newborn hearing screening

box.

I think we instill the passion that we

have into our lead screeners, we see

have some EHDIs that will say please

don't have your people call our babies

and we're like, aren't they our babies

too? They're all of our

Barbie babies so our lead screeners

have that relationship with the family.

They're the one seeing the baby back for

the out patient rescreen, they're making

that relationship with mom. Id just

had -- and I'll read it, one of my lead

screeners sedimentedded to let you know

ingots this text from a mom, says Hey

Susan -- this is a lead screener, it

says hey Susan thank you for checking in,

that is so sweet of you they determined

our baby has a permanent

hearing loss in his left here and we

have our appointment with the ENT and I

can't wait to find out what our best

intervention is.

The silver lining right ear is normal

and thank you so much for checking on me

and that's huge to me and that's why the

numbers are so great is we have that

follow-up. This is by far my favorite

slide, I think this is huge; we have

tracked in our two big states went we

did diagnose -- we had fornine babies

with confirmed hearing loss in 2021,

diagnose less than one month of age, 12

less than two, 14 less than three and

over 312 babies so we have as many

babies diagnosed before one month of age

as we did after three months of age so

incredibly proud of that and again numbers

for Louisiana so pretty impressive. So

in keeping with again, encouraging our

leads about the importance

of loss to follow up we want to show you

one of our recent videos so I want to

take this opportunity -- we have two of

our trainers here.

The Kinsey is the one who does these

videos Ashley is one of the trainers on

our team and both of these lady go

across country and travel for us training

and doing retraining, but several

months ago I asked Kinsey if she could

develop a consistent what I'm going to

call a CE U for our screeners that could

be delivered via text message and that

lasted 60 seconds long in a video

that screeners could receive on the

first of every month so this most recent

one was the importance on LTF/D so this

video goes to our 300, 400 plus screeners

across the country and it went out on

March 1. I just want you to -- okay how do I start it?

They said it was going to work. Can you

all hear it? Kinsey, do you want to

come up and.

>> It's playing.

>> Yeah, but with want to hear it.

The music is so cute. Well, you'll just

have to read it. You won't be able

to hear the . . . hear. Sorry you couldn't hear the

cute music. But vast majority of our

hospitals the patients come back to the

hospital for that first rescreen and we

do have some hospitals where we refer

that first screen out to the audiologist.

Particularly if there is a hospital

audiologist when we go to that

individual, so because of that because

we do the majority of those rescreens

the babies come back to the same

place and we all no that's the best

option to get that family to come back

to the same parking lot so in

most cases that's the best way for it to

happen. Questions?.if we do that

first rescreen at that point if they

refer -- for sure. That better?

Thank you. So if baby refers at

that out patient rescreen the lead

screener calls the audiologist that we

have made contact with and gets an

appointment right there, so the family

leaves that out patient with their next

step. We are currently finalizing our

current project where we are going to be

delivering a consistent message to each

refer family. That's what we've been

working on and again we're almost in the

final stages of that project, but that's

our goal. That every refer family

hears the same message..

>> Can you go back to one of the data

slides for 2021? So my question is

those numbers are amazing, you know, so

my question is you have a

[indiscernible] but the last four are so

different, so I'm just wondering what

kind of -- why they are so different,

you know how Texas is percent and

Louisiana is 16 percent and Utah is

.03 percent, almost zero so amazing job

and I want to know is the same people?

What made the difference in that?

>> I think it's just differential each

state, each hospital we're all -- when

we refer out, Wendy said some hospitals

it member the audiologist downstairs and

we can get more results like in

Houston we have several diagnostic homes

so in some states it's easier to go the

results back as usually what it is when

we have high refer rate -- now these

ten percent we're still track

stop-and-go our numbers are

always challenging so in Utah they have

easier access too results. And I also

think the

demographics of the population we're

dealing with too, that could be a factor

as well.

>> I'm from Utah and I have a comment

not to downplay what HS.C does but we

are also -- our follow up coordinator is

also adamant about following up on all

the babies, so there's a lot of work to

get them back in.

>> Great. That's exactly right it's a

partnership and I think in these three

states that we talked about excellent

partnerships with the EHDI

programs so EHDI is in my blood

andUtah has a fabulous relationship so

thank you so much for that

commencement.

>> I said I heard you say your able to

schedule the babies right

away, in our state we have to get

authorization from medical Medicaid in

order to schedule the baby so that's one

out of our biggest challengings is that

ising taking longer than the 1-3-but do

you also have to wait for authorization

or underconsider how

does that work.

>> Ashley can adds to this but it's

because those audiologist and those

different offices can allow us to do

that schedule whether they don't meet

the authorization

it's because of that.

>> I was going to say we'll work on the

back end because we want mom to have

that location before she leaves the

hospital so with a lot of our diagnostic

audiologists

we need to have an appointment, what do

with need to do to help you, we'll have

mom work on getting on the back end so

when they leave they have that appointments, but then the

diagnostic clinic will work on the

referral in the meantime. So it's a lot

of work but again we all have the same

goal and so we've been really.

-- I'm in Houston so we have a

really great relationship there with the

diagnostic audiologist so it's the

probably easier than most places.

>> Is all of your tracking system online

or is it

paper based.

>> it's online.

>> Yeah we have an online database.

>> Thank you. So I was looking at the

slides and I noticed D -- did not pass.

I noticed that statement, and its says

don't say refer but did not pass, don't

say fail, says so I think that's a

better interpretation of that, in my

opinion being deaf and family can

everything involved audiologists should

use that instead of fail instead of

did not pass. So the moment the baby is

born the test, they're like, they didn't

pass, it causes parents to feel very

depressed and very sad so

are they willing to change their phrasing?

Would you be willing to change your

phrasing? Like, hearing status would

be -- something positive. Anybody have

any ideas? Just something like hearing

status is something, having audiologist

measurement. What word do

you use to provide that?

>> I call parent and I know notify

them they need nor testing and I

always say your baby needs more testing

and they seem to accept that much better

than any other terms.

>> And that is something that is

said, your baby needs further testing.

>> and first some to that what do you

say -- [indiscernible].

>> There was a.

That I know they were talking about using

the term just refer but the issue is

serge you want to be sensitive and deaf

friendly. At the same time you want

clear and specific information so when

they revise the JC IH guidance, you know

some of the language that they talked

about for example they were using

identified instead of hearing loss and

while that makes sense to us in our

community of providers for deaf and

hard of hearing that was confusing to

families so they actually went back to

use the term for hearing loss and I

understand that's frustrating from a

cultural the perspective but we want to

move families to action, I think do not

fast is a compromise because you're not

saying failed but you're also settling

up a clear course of action and that

may be more specific to them

rather than passive.

>> Thank you. First of all I really

applaud what you do and I know I was

having a conversation with you Ashley

yesterday, I'm really glad

you're requesting two different phone

numbers to follow up with families

because I think part of the huge problem

we have in Texas, the loss-to-follow-up

is so high because we don't have punches

and a lot of times we get stub stuck

because we don't have an accurate phone

number but the Spanish speaking

population in Texas is so high we send

text messages to families but you need

to make sure if the family is

bilingual that they get that information

in their native language so they have an

idea what expect.

>> All our forms are in English and

Spanish and [indiscernible] guide by

your side.

>> Ashley texted her in Spanish and the

mom responded this morning in Spanish

.

>> We go the extra mile to make sure

we're translating and we know if we --

we just do the extra mile to make sure

we know that they speak another language

and what they want to do and also

if they're a part of that community or

they have parents that do not want

intervention we have a it well documented

but yes I just had a parent text me

back I've been waiting for her for two

months ago and I was waiting patiently

and my little heart finally favor up and

she texted me and

was like I'm ready to schedule that

appointment now but it was an amazing

moment.

>> I think we're down to two minutes.

Sorry.

>> Okay, thank you very much for your

sometime and information you've given.

Oh goodness -- so with the audiologists,

they're the front line individual, so

they're the first person who goes in and

tests the baby for the the hearing loss,

so at the same time what does the

audiologist do with the information, the

results of these tests? Do they

give them directly to them or diagnose

it and be done with it? What is your

approach to that, the role.

>> A couple of thing the audiologist is

not performing the screening that is a

hearing screen tech so our

audiologistings supervisor that program

but it is a screening tech t. We

give the results to the parents at

bedside, they get a hard copy so either

a pass form or a follow up form and they

get a verbal, again your baby did not

pass, if that is the case and at that

point they make aflame appointment to

either come back or see the audiologist

at that point. Does that make sense.

>> I didn't know if they provided

different options like language

access, just different resources for

them.

>> So it's not a diagnosis, so the

screen separates the population of

people who have a potential for a

disorder from the -- that is no

potential for the disorder so we are not

diagnosing at bedside, we are just

providing the screen that says this

child did not pass our screen

and needs further testing and the the

next step is the

when the diagnose is confirmed or the

hearing is confirmed.

>> But I was also wondering too with the

audiologist the future -- as the future

changes and evolves just being able to

provide the parents with

different options for a

cochlear.

Plant our cued speech, are

you willing to provide that to the

parents so they know? Do you do that?

Would you do that as an audiology group?

>> I can only speak for myself, I was a

pediatric audiologist at Denver children's

and can I've always given parents the

options out there so I think generally

that's what we hope, the audiologist do

so when a diagnosis is made parents

should receive the options. , yes our

company we only refer to audiologistings

who we have a good relationship who do

that very thing.

>> I just wanted to speak, I am with the

company, I also represent the

manufacturer of the ABR automated ABR

equipment. I wanted to make a clarification, there's

no demands made by individuals. It's

100 percent relying on

the machine to make an intention so with

that it minors that there is a small

percentage of that the machine is unable

to make a determination, and from a

manufacturer's standpoint that's the

phraseology that we tend to lean toward

even in the international community.

The equipment being automated is up

unable to make a determination in a

small percentage so it needs to always

make sure as a manufacturer we do the

best to get as close to 100 percent but

we never can get to a hundred percent in

the automation and that's when we talk

about having infants that need to move

forward into a diagnostic.

>> Thanks, Duane. He's our national

sales directorT thank you so much for

your time. We are out of time.

Appreciate your questions.