Audiology Regional Coordinators

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Audiology Regional Coordinator (ARC) Presentation Overview

- History
- Funding
- Roles and Duties
- Case Study
- Challenges

History of Audiology Regional Coordinators

- CSHCN decentralized in 1992
- All local offices had a multidisciplinary team
- The ARC's gave approval for hearing aids for Medicaid
- Never provided direct services
- Expanded from 10 to 18 ARC's in 2008 to ensure coverage across the state and for each hospital (based on analysis of EHDI outcome data)

Funding

- CSHCN and HRSA fund contracts with individual audiologists
- ARC's are educational, clinical, private practice or retired audiologists
- Do not provide direct services (evaluations or hearing aid fittings)
- Each hospital has an assigned ARC

Goals

- Improved NBHS outcomes with technical assistance from local audiologists
- Hospital staff feel the ARC is part of their 'team'
- 56 birthing hospitals in Colorado
  - 6 hospitals with audiologists

ARC Roles and Duties

- Provide technical assistance to birthing hospitals
  - Annual meetings with hospital coordinators
  - Identify gaps in protocol
  - Identify screening equipment needs
  - Assist with staff training

ARC Roles and Duties

- Convene a local EHDI team in collaboration with state EHDI staff.
  - Develop NBHS protocol
  - EHDI team members:
    - hospital coordinator, CO-Hear Coordinator, HCP Team Leader, Part C Coordinator, local primary care physician and other hospital or community stakeholders

ARC Roles and Duties

- Provide technical assistance to the HCP Regional Office
- Communication with EHDI Program Director and the local HCP Team Leader.

ARC Roles and Duties

- Attend ARC meetings
  - Encourage attendance at Colorado Academy of Audiology
  - Quarterly conference calls
- Submit monthly invoices to EHDI Program Director

ARC Experiences

- Contracted with the state
- Seven metro area hospitals
  - Local EHDI team meetings to establish roadmaps
  - Establishing a connection and relationship
  - Understanding protocols, strengths, and areas of needs
  - Providing appropriate, respectful support
    - Statistics

Case Study: Hospital A

- 2008 statistics:
  - Approximately 5000 births
  - Screened: 99%
  - Referred screens: 2.7%
  - Rescreened: 75%
- 2009 statics:
  - Approximately 4600 births
  - Screened: 98.7%
  - Referred screens: 2.3%
  - Rescreened: 55%

Case Study: Hospital A

- Well baby nursery
  - Screened by nurses at 18 hours of life or older
  - OAE and aABR screens
- Level II NICU
  - Screened by NICU secretary as close to discharge as possible
  - aABR screen
- Referred to audiologist

Case Study: Hospital A

- Identify areas for growth
  - Develop plan with hospital staff
- Options for revision of audiology referral process:
  - Call to schedule follow-up prior to discharge
  - Follow-up phone calls from hospital
  - Provide referral information to audiologist
    - Release of information paperwork

Case Study: Hospitals B & C

- Education regarding procedures:
  - Hospital B:
    - Not re-screening more than twice in hospital
  - Hospital C:
    - Schedule with reception desk prior to discharge rather than calling
- Increasing awareness
  - Risk factors for progressive/late onset hearing loss

Challenges to ARC Program

- Individual
  - Connecting with hospital coordinators
  - Improving systems without increasing work
  - Meeting Joint Committee guidelines
- Systematic
  - Having the ‘intentional’ time to meet with local hospitals
  - Valuing the role by locals
  - Utilizing the ARC

Considerations for Rural Communities

- Develop additional training to increase the knowledge of EHDI systems and diagnostic best practices
- Provide more resources to decrease barriers such as transportation to pediatric audiology evaluations
- Work directly with families to identify gaps and concerns

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