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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