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NATIONAL CENTER FOR HEARING ASSESSMENT AND MANAGEMENT

"OUTSOURCING" NEWBORN HEARING SCREENING: QUESTIONS AND CONSIDERATIONS
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800-335-0911
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(Writer standing by.)

>> SPEAKER: I'm going to post a poll for our presenters today to tell us about the role that you primarily play that would bring you to today's webinar so that our presenters have an idea of who we have joining us today. Thank you. Everyone is responding rapidly. We have quite a variety of people on today, which is great to see. We've had a really wonderful response to today's webinar registration, so this is a great opportunity for people all across the country to hear from our presenters today. So, in about a minute or two, we'll get started here. Get yourselves comfortable and adjust the volume on your speakers to your own liking. You'll be communicating with today's presenters using a text field that will be displayed once they open up the conversation for questions, so don't worry about that right now. If you're having any technical difficulty, you'll see in the lower

left-hand corner the NCHAM technical support person who is ready to help you if you're having any trouble. Derrick Saunders is there. His phone number is 435-797-3490. If, for any reason, you're having any problems with today's connection, be assured that this webinar is going to be posted on our website, infanthearing.org, within the next week. So, I see that we are indeed at the bottom of the hour, 1:30 Eastern, 12:30 Center, 11:30 Mountain and 10:30 Pacific, which is our starting time, so if our presenters are ready to go, if you could just say ready to go, then I will initiate the recording and hand it over to Erica.

>> SPEAKER: Ready to go.

>> SPEAKER: Yes, ready.

>> SPEAKER: All right. Erica, are you there?

>> SPEAKER: Ready to go.

>> SPEAKER: Okay, I'm going to take a moment here and initiate the recording and then let you know.

>> SPEAKER: Okay, good morning or good afternoon to all of you. Thank you so much for joining us today. This is our NCHAM webinar series, and today's topic, we're going to be discussing outsourcing newborn hearing screening and reviewing questions and considerations. The intent behind the webinar series is to bring EHDI content to a webinar format, so for those of us who either weren't able to attend all of the sessions at the conference or weren't able to attend at all can have a little bit of EHDI at our desktop. So, today's presenters are Randi Winston

and Jackson Roush. Randi Winston is a consulting audiologist. Her role has primarily involved working with hospital-based newborn hearing screening, early childhood hearing screening programs state-wide. She continues to provide ongoing training and technical assistance with an emphasis on program quality. She nerves on the National Center for Hearing Assessment and Management, the technical assistance network, and she assists states in region 10 with their EHDI network. Dr. Roush is at the University of North Carolina, school of medicine. He also serves as the director -- and is the co-chair for the North Carolina EHDI advisory board. Thank you all and welcome.

>> SPEAKER: Hi, everybody. This is Randi Winston. It's a pleasure to present today. Thank you for joining and listening in. The purpose of our presentation is to provide some questions and considerations for those who may be involved in hospital newborn hearing screening in a number of capacities. There are many outsourcing providers throughout the country with a variety of differing models, and that number is growing. Given that more and more hospitals are embracing an outsourcing model, we think that it's really important for decision-makers to be educated and knowledgeable about what constitutes a quality newborn hearing screening program so that they know what questions to ask and can make informed decisions that are appropriate for their institution. Each hospital has its own identity that identifies them and requires program customization of protocols, policies and

procedures, and the reality is that not all hospital administrators and decision-makers fully understand the program complexities that require consideration for newborn hearing screening. I'll begin the presentation by providing a framework with the critical elements that all newborn hearing screening programs should consider implementing. Whether the program is run internally or it's outsourced, the truth is that, I could talk all day about the specific elements, because there are so many important details within each one, but we'll just briefly touch on them. Jack will follow-up by offering important questions and considerations when considering an outsourcing model.

So, it's important that hospitals who may be considering an outsourcing model conduct a thorough evaluation and analysis of the services that'll be provided, not only to ensure their individual hospital needs are being met but to ensure the quality of services to babies and families is well understood and meets within their institutional mission and standards. So, we hope that you'll find this information beneficial, whether you're listening as an outsourcing contractor or a hospital program coordinator. Maybe you're an administrator considering outsourcing. If you're an EHDI coordinator or part of the state EHDI program, you might consider disseminating this information to the hospitals in your state. So, with that, we'll continue on to the next slide. So, just prior to the 2015 EHDI conference, Leonard Nimoy passed away, and we thought this quote went with what we are

trying to accomplish with the information we are sharing throughout our presentation. The purpose of our presentation is really to review the components of a quality newborn hearing screening program and discuss important questions and considerations related to outsourcing, but what we're not going to do is refer to specific companies, brand names, equipment manufacturers or recommend one outsourcing model over another. It's not within the realm of what we're trying to convey today. So, as you can see, we'll start by laying the foundation, then we can begin to discuss some of the key issues and considerations when outsourcing, and then we'll open up the session for questions and answers.

So, we've been doing this for a long time now, and as a result, almost all babies are screened at birth and all states have passed legislation around newborn hearing screening, and hospitals have a lot of responsibility around this. They need to identify resources to ensure all babies are screened and provide seamless systems of care with multiple coordinated components based on sound policies, and this has placed a burden on hospitals, and they've had to grapple with implementing strategies so that a system for follow-up is in place as well as they need to meet state requirements and mandates. Some hospitals are able to allocate sufficient resources to provide a high quality standard of care while others have very limited resources and can only implement a minimal standard. So, these are the essential components for a quality newborn hearing screening program, in our opinion, and as

you can see, there are many things that need to be considered when talking about this. We'll start with coordination and oversight. There needs to be a designated program coordinator or manager to enforce and update policies and procedures and protocol and make sure that competency-based training occurs with all screening staff, and that includes support staff as well, and we'll get to that a little bit later. Schedules need to be coordinated to ensure full-time coverage occurs and that there's accountability for all nursery admissions.

Equipment needs to be monitored and maintained, and if there are equipment issues, what's the backup plan so that babies don't get missed. Quality indicators need to be monitored, and how the program will run, how the program will be evaluated needs to also be determined. So, that means generating and disseminating program reports and ensuring the hospital is in compliance with all state rules, legislation and mandates, ongoing education and buy-in from key stakeholders and support staff is critical in order to maintain buy-in. The coordinator also needs to service as a liaison between the state EHDI program and the facility. So, let's talk a little bit about key policies, procedures and protocols. We'll start with in-patient screening. We need to look under the hood of an individual hospital's internal workings to really be able to customize these elements so that they're ideal for a particular hospital setting, and that means particularly, like, determining what the average length of stay is so we can decide when the timing

of screening should occur and the number of in-patient screenings or attempts that occur. Protocols need to be in place for external ear anomalies. For example, if a baby's born with a unilateral atresia, is that baby going to get screened or will they be referred straight to audiology? Educated decisions need to be made regarding the screening technology. Some hospitals may choose one or both, and there are a number of factors that are important in making those decisions. Some equipment allows customization of pass/fail criteria, which may need to be investigated and determined, and if a state has a data management system, what's so important is to really be informed about the compatibility with the screening software that's being used, because if the data does not merge seamlessly and communicates seamlessly with the data management system, manual or duplicate data entry may be required by the staff.

This is my most complicated slide, and I have trouble presenting on it because I think that there are so many considerations and it's such a complex and complicated environment with so many moving parts, and there are so many considerations that really affect the quality of outcomes, and we want to make sure that for this population, the quality is the best that it can be, because not only do we know that the prevalence of hearing loss is 10 to 20 times higher in the NICU, but we're also working with medically fragile babies, so we need all of those things to be at the forefront, especially when considering personnel conducting the

screenings and who they are and are they highly trained, can they handle screening medically fragile babies, and what's their presence in the NICU? Do they feel comfortable working in the NICU culture and does the NICU culture accept them and integrate them as part of the team? Support staff all need to be educated on the importance of screening, because we know in the NICU, hearing is not the top priority, so unless there's buy-in from the support staff, there could be, you know, dismantling of program efforts because parents may have diluted messages or get diluted messages which may undermine program efforts. So, it's also important to determine how babies, which babies are eligible for screening and when, and there has to be a system in place to know when a baby is transferred in from another hospital and needs to be screened. Protocols for chart reviews should be in place so auditory risk factors can be known and effectively communicated. This includes implementation of protocols to ensure families are informed of risk factors for late onset and progressive hearing loss.

So, because of many of these complicating issues, having an audiology oversight is a very important consideration. Their role is critical in management of high-risk babies. Documentation of screening results, whether it be for the state or the facility, have to be known and embraced, whether it be through the electronic medical health record or discharge summary or both, and then communication of screening results, how they'll be communicated to families and the message that will be used to

deliver results to the PCP. Tracking and follow-up must include provisions for outpatient rescreen and timeframe. So, all of this must be tracked, when this is going to happen, policies must be in place around all of that, especially for babies who don't pass, and what happens when a baby fails the in-patient screen, what are the protocols, are they using NICU recommendations to schedule outpatient appointments and making reminder calls to make sure that they don't forget, and also faxing results to the PCP. There needs to be a system for babies that fail the in-patient screening to minimize loss to follow-up. How about when a baby fails the outpatient screen? Really strong policies need to be in place for that with regard to communication with families. A seamless hand-off is really of the upmost importance, especially at this point, and we want to be able to expedite referrals and authorization if needed, so faxing results to PCP or a mechanism needs to be in place for getting that information to the PCP so that appointments can be scheduled for audiology and things can flow smoothly. Procedures when an NICU baby fails the screening, we know that at that point, an audiology referral should be made for the high-risk babies, but they don't get another outpatient screen, so how is that hand-off made, what are those procedures and are there standing orders in place, those are good considerations of including in procedures and protocols and management of the hand-off and how that will occur.

Another consideration, institution related policies

have to be implemented in the protocols and procedures. HIPAA, universal precautions, even equipment manufacturer recommendations regarding sanitizing equipment and compliance with risk management and legal institutional requirements. Establish benchmarks, QI, QA, need to be protocols around that, knowledge about what the national best practice guidelines are, state benchmarks and quality indicators and ongoing monitoring of past refer rates, and when there are changes, understanding what factors may be contributing to those changes and past refer rates. For example, if excessively low, it might be babies are getting too many screens, and if excessively high or just too high, may not be getting enough screens prior to discharge. Might the equipment be a problem and might that be contributing to under or over referrals. So, all those things need to be kept in mind and especially the consideration that a low refer rate doesn't guarantee best practices are being followed. Relationships with providers and audiologists and stakeholders, relationship building is critical. Our voices need to be heard, and the only way for that to happen is that there's a lot of relationship building, and if there's an audiologist, policies involving their role, whether it be to oversee the program, conduct chart reviews, conduct inhouse diagnostic testing, a partnership needs to be developed and in place in order for seamless communication and the flow of information between departments so a smooth transition occurs and babies don't get lost within the system, the hospital system itself. It happens

all the time.

So, let's talk about education and buy-in, another important component. Ongoing internal advocacy with hospital administrators and other stakeholders. I can't express or really stress the importance of advocating for the program enough, and it can't be overemphasized, because it really helps to strengthen and provide support for the program and maintain buy-in, and it may be ongoing education with nursery support staff, administrators, stakeholders, such as medical directors and the directors of women and infant health services, discharge coordinators, chief nursing officers, anybody who plays a role really in any part of the infant processes during their hospital stay, and there are a number of stakeholders that that includes, and with regard to maintaining a high standard of care, how will this be monitored within the institution, who will be evaluating the efficacy of a program, not only from the cost perspective, but from a program quality perspective. My last slide is about a partnership with the state EHDI program. It's so important to really collaborate and have a framework for teamwork, and the whole purpose is to provide a safety net to keep babies in the system and to reduce loss of follow-up. So, working together in partnership and having orchestration, that way it really helps to develop methods of strengthen follow-up but not duplicating efforts. So, having a pulse on what is happening at the state level and knowing what resources are available, who to contact if needed and understanding the state EHDI follow-up

efforts, working together in tandem with them to help efforts with the end goal of minimizing loss to follow-up. Some hospitals have score cards, others have quarterly communications about the state EHDI efforts, and some require consent forms for sharing information. There's lots of rules, there's legislation, so hospitals really need to be in a loop on what all of that is. So, and that includes even attending and participating in state meetings. So, with that, I'm going to turn it over to Dr. Jack Roush who will now talk about some of the considerations with outsourcing.

>> SPEAKER: Okay, thanks Randi. Thank you. Randi has reviewed the many components of newborn hearing screening, regardless of who's performing the service, and, so, we turn now to some of the issues that are more specifically related to outsourcing for those who might be considering outsourcing or for those who might be trying to take a closer look at the outsourcing that's already occurring within their states. This term, outsourcing, was really borrowed from the business world. On the slide, you see one of many definitions, but they all tend to be similar with regard to an effort to, in this case, reduce cost by transferring work to outside suppliers rather than completing it internally. I think it's important to point out that reducing cost is not the only reason that outsourcing in some context might also achieve greater efficiencies. When we think of outsourcing, I think we tend to think first these days about the larger corporate entities that might provide a full spectrum that includes metabolic

screening and other laboratory tests, but actually, outsourcing is not necessarily such a new thing with newborn hearing screening. There are and have been for many years various models that include, you know, local arrangements involving regional contractors, community partners or volunteers perhaps of a local audiology practice, so we've seen many models over the years, and they have been implemented in a variety of different ways.

The potential advantages of outsourcing that are often mentioned are that, for the hospital, it is, in some cases, presented as something that could be a turn-key operation or something very simple with regard to providing all of the equipment that is necessary, the hospital is unburdened from the training of the screeners and monitoring their performance, most provide full-time staffing since, as you all know, this does necessitate pretty much a full-time effort on the part of the hospital. Most of the contractors are willing to take responsibility for reporting outcomes directly to the state EHDI programs. Some have actually provided very attractive educational materials and videos that in some cases are available in multiple languages, and all of the above are provided by at least some of the contractors at no charge to the hospital. So, if outsourcing is being considered, there are, first of all, a lot of essential components that Randi went through, and obviously, there are many, but there are also a number of issues that we feel are specific to those hospitals that would consider outsourcing, and we've identified seven there; personnel, some

special considerations for the NICU, the issue of opting in for screening versus opting out, the choice of the hearing technology, the tracking and surveillance, billing and collection, and then institutional missions and how that might influence the issue of whether or not outsourcing is elected.

So, first of all, on the issue of personnel, this means, of course, that someone outside of the hospital is going to be hired to provide the service, so it then begs the question of how the screening personnel are selected, how will they be trained, will there be some competency-based component of this and/or some recertification process, and how will the performance of those screeners be monitored, and what are their specific responsibilities and what will they include, and certainly, there are many within the well baby nursery, even more in the NICU, as you heard, and I'll have a couple of additional comments on that in the next slide, but the all important issue of communication with families, and who talks to the families and what they say. So, you know, how is that information imparted, and then how is the communication handled with regard to those issues that need to be shared with the hospital staff. Randi touched on a number of these issues already, but they are so important that we feel they bear some further emphasis. The higher prevalence of not only cochlear but retrocochlear disorders in this population make it really imperative that the screening and referral are handled optimally. If there's any place we want to make sure we're doing this as well

as it can possibly be done, it's in the NICU, and as Randi said, it's a very complex screening environment. It's so important that the communication be well-coordinated and that people are able to work as a team. Babies are transferred in and out of NICU's, and as they are transferred, that creates a window where it may be a limited timeframe to accomplish the screening. My colleague and I reported at the EHDI meeting, I think it was about 7 years ago, on issues related to screening, not outsourcing, but screening in the NICU, and the number one issue that people said was a challenge was this, and it's sort of ironic that babies are in the NICU longer than they are in the well baby nursery, and yet, there is often a narrow time window and then the communication for follow-up is, at times, challenging, and I think it's fair to say that that continues to be a significant challenge today.

A newer development is that I think more and more NICU's seem to be moving directly to performing the diagnostic ABR by an audiologist for infants who do not pass in the NICU, and some institutions have been doing that for quite some time. So, Randi and I both feel very strongly that the oversight of, regardless of who's doing it, if it's not an audiologist in the NICU, needs to be conducted under the close supervision of a pediatric audiologist, and again, even if only the screening is provided in that NICU environment. Now, the issue of opting in versus opting out, in most hospitals, newborn hearing screening is considered a standard of care, and this means that, you know, unless parents

choose not to for personal religious reasons, I mean, that's always been an option, but it means that nearly all infants are screened prior to discharge, and, you know, those of us who have been at this for awhile know that we really celebrated that point in time when newborn hearing screening became a standard of care, and so I think this issue of opting in versus opting out is an important one and one that we should not take lightly. If newborn hearing screening is outsourced, in most cases, families are asked by the contractor if they want their baby screened for hearing loss, and in many cases, this is a bedside consent, because more and more, at least the well babies, are screened in the room. So, that question then would be how would screening be presented to families and how would refusals be managed? And what is the risk to the hospital if that baby is not screened? And then will declines increase because of concerns regarding additional charges or because of the family's immigration status, whatever reason they might decline, is there a chance under the sort of you got to opt in rather than to opt out model going to be an increase, and we don't have any data on this, but anecdotally, when you talk to people around the country, this is often raised as a concern, or at least a potential concern.

Next, the choice of hearing technology and the instrumentation used. In some cases, the contractor might use the, some of the contractors actually also manufacture equipment, or maybe they have partnered with a specific company to achieve a volume discount on purchase of multiple screening instruments.

That would certainly be logical from a business standpoint, but it could lock the hospital into a specific instrument, even if something, you know, better came along, or with regard to protocols, as Randi mentioned, some hospitals might prefer a two-step protocol, and this could be precluded with some outsourcing contractor models. Next, the issue of tracking and surveillance. I mean, we all know that this is a challenge throughout the nation, that loss to follow-up continues to improve, but it remains one of our most significant challenges, and some of the infants who pass the screening have risk factors, and, so, you know, trying to maintain good tracking and surveillance, we know, takes a lot of time and effort. If newborn hearing screening is outsourced, I think it needs to be addressed. What specific services will the contractor provide and how will they be provided? And who will handle the communication with families and what specifically will they say? And then, finally, how will the hospital ensure that the tracking and surveillance are really done as optimally as possible? Then the issue of billing and collection. So, under the typical outsourcing model, families are billed separately for the newborn hearing screening. So, a good question is how much will the contractor charge and what happens if there's an unpaid balance? Now, all of the contractors that I've talked to have stated clearly that they do not engage in heavy-handed collection efforts, but we know that some families will not express concern and could be burdened with the additional charges, and I've heard, at least

anecdotally, sometimes substantial additional charges. It should be mentioned that some states require screening as part of the birth admission and a separate bill is not allowed, so there are obviously unique situations that occur within each of our states

Then communication within the hospital if outsourcing is under consideration. Some of our hospitals are, you know, they may be tertiary care medical centers, academic medical centers, they may be institutions known for leadership in the area of hearing care for children, and those institutions may prefer to manage the program internally at all levels. There may be concerns else where in the institution about outsourcing, maybe among those individuals who are not even necessarily invested in hearing screening but may have questions or concerns about outsourcing other services. So, if outsourcing is being considered, I think it is vitally important to include all of the institutional stakeholders in the discussion; audiologists, pediatricians, ENTs, the nurses, the hospital administrators. It's pretty clear why nurses and hospital administrators are interested in this. You know, they are busy people and not looking for additional things to do or additional things to be responsible for, and I think it's very logical that they would be interested in this model, but as Randi mentioned, many would not be, most would not be expected to be aware of all of the moving parts that were included in Randi's summary, and I think that is a reason, and it's a reason why we're sharing this information today in the webinar, is to try to, you

know, articulate more specifically what some of those particular issues and concerns are. So, the bottom line, I think, obviously, there are no simple answers. There are advantages and disadvantages of outsourcing as opposed to managing the program internally. I think it depends in part on the conditions that existed prior to outsourcing in terms of what could be gained or lost.

If the institutional commitment and resources are in place, I know that many hospitals value the ownership of that newborn hearing screening program, but the reality is that not all hospitals are willing or maybe in some cases able to make the necessary investment of time and resources. So, you know, and I think it also needs to be acknowledged that health care is changing, and a growing number of hospitals are becoming part of health care systems and are under pressure to try to achieve greater uniformity in the services that they provide, but regardless of who's doing this, the careful consideration of these issues and questions, we think, are vitally important, and just a couple of concluding comments before we open it up for discussion, Randi and I are not opposed to outsourcing, and I hope we have made that clear. What is most important is that our babies are getting screened and that each component of newborn hearing screening is performed as optimally as possible, and that includes the ongoing monitoring needed to ensure that the procedures that are put into place don't slip or morph in ways that become less optimal. When we reflect

on the one, three, six goals for EHDI, I think one of the things that we are all very proud of is that nearly all newborns are now being screened as part of the birth admission. It's a remarkable achievement, and that number, you know, close to 98 percent, it's tempting to assume that we've, you know, mastered the one in the one, three, six, and while screening may be easier in a lot of ways than the three and the six, I hope our presentation has reminded everyone of how many moving parts there are in the screening process and how many opportunities there are to get it right or to get it wrong, and, so, I think we need to remember that the 98 percent, while very impressive, it's a quantity metric, it's not a quality measure, and that whoever is entrusted in this, the first step in the EHDI process, whether handled internally or externally, is committed to the highest level of quality. So, that concludes my prepared remarks Randi, do you have any further comments before we open it up to the audience?

>> SPEAKER: I don't. The only thing that I wanted to mention so that we don't forget is that we have prepared a handout which is a PDF of the important questions and considerations, and it's sort of a checklist, and I don't remember what was said about will it be posted on the website for people who would like to access it. I think it's being sent to everyone.

>> SPEAKER: Maybe Will or Erica can chime in at some point.

>> SPEAKER: Okay. That was the only other thing I

wanted to comment on, but, no, that's it. So, does anybody have any questions?

>> SPEAKER: Or comments? And just reminding everyone, please, of the ground rule that we set forth at the beginning. We said that we were not going to mention by name any contractors or any specific instruments, and we would ask the audience to please abide by the same ground rule here. I'm seeing a question here, a very good one. It says do we have any statistical information on refer rates, loss to follow-up for outsource programs versus inhouse programs. I do not. I think the contractors who provide the service certainly keep track of the numbers, but I'm not aware of any, you know, peer reviewed or any even non-peer reviewed publications that have shared a direct comparison. Randi, have you?

>> SPEAKER: No. I don't know of anything out there at all that's been written-up on that. It is a good question. I'm looking at.

>> SPEAKER: Presenters, please look at the questions on the right side of your screen.

>> SPEAKER: Oh, thank you. I'm not doing that.

>> SPEAKER: Yeah, so the first one is, you know, will a PDF of this power point be available, and the answer is yes. I see that has already been indicated.

>> SPEAKER: Will the outsource vendor be located in the hospital? So, the answer to that, from the models that I have

seen, is that the outsource vendor actually provides the services in the hospital, and if that's what you're asking, which I think it is, they do come into the hospital and they setup the program within the hospital, they hire the staff and bring in the equipment and run the program.

>> SPEAKER: They're usually identified with, you know, some sort of a uniform that looks different than the hospital staff. You know, one of the issues that comes up in that context is, you know, and Randi eluded to this, I mean, there's a lot of things that people need to know in terms of universal precautions and HIPAA and all those. I mean, that applies to anybody in the hospital, so those are things that need to be worked out on the local level.

>> SPEAKER: Jack, have you seen, or can you comment on this question regarding our impression of the reaction of third party payers to a separate bill for newborn hearing screening? I can't comment on that. I have not seen that first-hand.

>> SPEAKER: It was appearing there, and now it has --

>> SPEAKER: Now it went away.

>> SPEAKER: Yeah. Let's come back to that one, because I can see the next one, which says, you know, what would that look like in terms of that, because we had made a pretty strong statement about pediatric audiology oversight in the NICU, and I think the question is saying what if there isn't an audiologist in that particular institution, and, you know, I think, and you comment

on this too, Randi, I think it doesn't necessarily mean that a pediatric audiologist needs to be present, but, you know, the general oversight of the program in terms of what is being done and how it's being done and who's responsible for all of those different components that we mentioned.

>> SPEAKER: Yes, I think that, especially if it's a high-risk NICU, like Jack said, it's not necessary that they're there all the time but that they really have a hand in the processes of especially chart reviews, and whether it's educating on other staff members on how to do that so that auditory risk factors are known and communicated to families. So, I think an audiologist is, you know, has a very important role, especially in the NICU, and it's a consideration, I think, when considering outsourcing, whether that presence will be there.

>> SPEAKER: I mean, we're looking at a prevalence that's at least 10 times higher, and so it just seems really vital to us that there be at least audiological oversight of the procedures that are occurring with regard to hearing screening.

>> SPEAKER: For rural hospitals who birth less than 1,000 per year, what's a good solution? And, you know, a lot of times, rural hospitals, from what I've seen, they're understaffed, they don't have, they often don't have resources that they need to really make sure that all of those things that we discussed at the beginning of the presentation are in place, and also, a lot of times, the contractors may not be interested in outsourcing with a smaller

rural hospital, so, really, it is a conundrum, and we find at those places that employees have to wear multiple hats and the quality of screening is not as high as we'd like it to be, but I'm not sure if that's the question that you're asking, but if there's anymore you'd like to say about that, Jack.

>> SPEAKER: No, I think there's a number of other questions, so we should probably move on. The next one is a very good question about following up click ABR's that are non-frequency specific. I think it's a great question, but I think it's a little tangential to the issue of outsourcing. It's certainly related, and, so, we could come back to that if we have time, but some of the other questions are more specifically related to outsourcing.

>> SPEAKER: What is the next step that needs to be taken to ensure the quality, not just the quantity of screenings?

>> SPEAKER: Right, and if I can comment on that, you know, I think one way to address this, in the introduction, it was mentioned that I'm involved with our EHDI advisory board, I'm sure many of the people on the call are, but I think that is one way to try to get out ahead of this, because I think it's very possible that hospitals will make decisions, and the decision-makers are often, especially in the well baby nursery, are hospital administrators and nurses, and as we both said earlier, while they are certainly good at what they do, no one could expect them to be aware of all of the issues and potential pitfalls of not covering all the bases with newborn hearing screening, so I think, to answer

your question, one way to approach that is to really make this a priority for your EHDI advisory board and to try to take a proactive approach, getting information like, you know, our checklists and the other suggestions that we're making and some that you may suggest to us that we add out before those people who are making these decisions, before they go that route, or as a way to improve an outsourcing model that is already in place.

>> SPEAKER: I would comment on the next question, because it sounds like it's a question regarding screening results and actually looks like interpretation of screening results and how to manage that child in terms of follow-up, and, so, I think my comment would just be we're screening, and, so, we have to, you know, obviously, look at the final outcome as a pass or refer and then respond accordingly, and if there is a screener that's conducting the screening, they won't all be able to look at the results, look at the highs, look at the lows, look at the responses in an ABR screening and then make judgments about what should happen next, so I think that can be very tricky. I don't know if you have anything else to say. I have something to say about the next one, but go ahead, Jack, if you have anything else to add.

>> SPEAKER: No, I don't, so go ahead.

>> SPEAKER: Okay, the uploaded flash drive, I think that we want to do everything to avoid that, avoid using flash drives to transfer patient confidential information from a piece of screening equipment to another computer that might be uploading

results to the state database, for instance. I think that flash drives should, and they are becoming obsolete, and they're becoming more and more difficult to use in a hospital setting because IT will come along and they'll encrypt the flash drive, and then it'll be very difficult to really achieve what you're trying to achieve with data transfers. So, anytime you can have a seamless mechanism for submitting results through the Internet, if it is a web-based system, or another way without a flash drive, that's optimal.

>> SPEAKER: Yeah, and our conference facilitators just reminded us that the audience does not see the questions like we do, so we need to be sure to restate those questions. So, here's one that I'll restate, and the person put it in the form of a question, but I think it could be a statement, and a good one. It says do you think that NCHAM or JCIH would develop a position statement about the rules and responsibilities of a screening contractor, and, you know, my earlier response was geared more at the state level, you know, with regard to an EHDI advisory board, but this is obviously an important enough issue that I'm sure it is of great interest to JCHI. Allison Grimes mentioned to me the other day, she's the current chair of the JCHI, that the next position statement will be coming out in the next year or so, and maybe there's, maybe this issue is addressed, but I think NCHAM, the joint committee certainly on that level is where there can be an impact that is even greater, and again, not to say that the goal is to eliminate outsourcing, but to make sure that it's done as well

as it can be done and that all of the issues that we've been talking about are fully considered.

>> SPEAKER: Next question is do you know if third party payers cover the newborn hearing screening charge if it is separate from the hospital bill, and my answer is there are some that do cover hearing screening. If it is not part of the hospital bill, it can be a line item, and there are some third party payers who will reimburse for this, and then there are others that may not or require a very high, it requires a very high deductible from the family, and, so, I think it's variable. I don't think that there's one answer.

>> SPEAKER: And I would echo that. However, I would say that the most, it appears, and we haven't done formal surveys of this, but anecdotally, it would appear that the most typical scenario would be a completely separate bill and that that patient would be, that family would be responsible for that unpaid balance. As I mentioned, some of the contractors are very careful to state that they don't, you know, engage in aggressive collection practices, and some have said we will write it off, but that's only, and as we stated, there are many, many different large and small entities involved here, it can certainly result in a family getting a substantial unpaid balance that they're responsible for. So, after our EHDI presentation, we actually heard some horror stories that were, you know, individual cases and may not be typical, but it's an issue that I think needs to be carefully examined.

>> SPEAKER: Here's a question here asking about how much federal funding is available for hearing screening and early intervention processes. There's funding, federal funding, that goes out to each one of the states to implement and develop early hearing detection and intervention programs. It's not necessarily specific to newborn hearing screening, but to develop a system within the state EHDI program for all of the different components of an EHDI program, and there's a lot of funding there that states have received and grants, for instance, from the CDC and HERSA to actually develop these programs within the state EHDI framework.

>> SPEAKER: Mm-hmm. We have another question here; do you anticipate NCHAM increasing the role in this area nationally, and, so, Randi, you're a consultant at NCHAM, would you care to address that?

>> SPEAKER: There hasn't been any discussion about oversight. NCHAM really does not play a role in oversight. NCHAM is a technical assistance network that provides lots of resources and information about different things, but not necessarily oversight in a direct way at all.

>> SPEAKER: We have another question that says at what point are the families informed or notified of charges they're responsible for as a result of the non-covered charges. Now, my institution does not outsource the newborn hearing screening, and actually, in North Carolina, we only have a few of the 88 birthing hospitals that have gone that route, so I'm not sure. What I've

heard, just in conversations with people, is that they don't, at the time of the services being rendered, they might ask questions about how much it's going to cost, but in terms of when they actually see that on a bill, that would not occur until, you know, some time later after that bill is sent out, but I think most of the contractors are willing to, you know, inform the family at the time that they're asked whether they want this service provided, how much it's going to be. It might be difficult for that person to say how much of it is going to be, if any, left to the responsibility of the family, but that issue of choosing not to pursue screening because of concerns about, you know, the cost or other factors is one that always comes up in the context of outsourcing.

>> SPEAKER: I think we've just been reminded that we have 6 minutes left, so we are definitely encouraging a couple more questions, but we've also provided our e-mail addresses, so in case a question didn't get answered and you want to further investigate that question with us, please feel free to e-mail us. I think this question regarding tracking for referrals when the insurance provider states that the practice did the test, once the baby leaves the hospital, the tester now out of network and the baby has to be retested by someone who does not do this, and that's really one of the disparities I see in our health care system, is the lack of ability for a seamless hand-off, so that a baby can get follow-up regardless of what insurance they have, and, so, I don't have a good answer to that. I just say that it's a known disparity and it's

a definite issue.

>> SPEAKER: Mm-hmm. I would agree, and I wouldn't have anything to add to that.

>> SPEAKER: Don't most outsourcing companies use flash drives? I don't have an answer to that either.

>> SPEAKER: I don't either.

>> SPEAKER: I know some do, I know some don't. We know that there's a certification, that's a good question for me. We do have a certification, and, yes, I am aware that a recertification process is important, so we will, I'm sorry, we know that there is a certification for newborn hearing screeners provided by NCHAM. Will there be a recertification program? And I know that's been requested, and so the answer to that is yes, we will be working on that in the future. I guess we're out of time, and, so, we'd just like to close by reminding you to go to infanthearing.org to listen to this presentation. It'll be posted on the website I think by next week is what I heard. So, thank you all very much for joining us today.

>> SPEAKER: Yes. Thank you, and as Randi said, our e-mail addresses are there. We would welcome, we won't necessarily know the answers, but we're also interested in what are the questions, you know, and there may be some important issues that weren't addressed by us today, and we would be very interested in your comments as well as your questions. So, thank you for your

interest in this important topic.

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