

ROUGH EDITED COPY

National Center for Hearing Assessment and Management
PARTNERING WITH PRIMARY CARE PROVIDERS AND MIDWIVES TO PROVIDE
NEWBORN HEARING SCREENING AND RE-SCREENING DURING COVID-19
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>> WILL EISERMAN: If you have just signed on, you are in the right place for today's Coffee Break Webinar entitled: Partnering with Primary Care Providers and Midwives to Provide Newborn Hearing Screening and Re-Screening During COVID-19. We'll be starting at the top of the hour. That's in about 5 minutes. So for now, just get your volume adjusted to your liking, and you should be set to go.

For those of you who have signed on early, would you mind giving us some feedback on the quality of our audio?

And I'm going to have Linda, could you speak for a minute?

>> LINDA HAZARD: Yes, Will, this is Linda. I can speak for a moment.

>> WILL EISERMAN: All right, good, and Stacy?

>> STACY JORDAN: Good afternoon everyone, this is Stacy Jordan.

>> WILL EISERMAN: Okay, good. Thanks, everybody, for your feedback. It's always reassuring to see that our technology is being friendly with us today. While we wait to get started, if you wouldn't mind answering this poll question giving our presenters a chance to see the perspective that you bring to today's webinar.

What is the primary role that prompted your participation in today's webinar?

And you may need to scroll down to find the one that's the most primary for you.

If you're just signing in, we will be starting in just a few minutes.

Our webinar for today. There's a poll question on the screen that we'd like everybody to answer in order to give our presenters an idea about the perspective that you are bringing to today's webinar.

What is the primary role that prompted you to participate in today's webinar?

If you could select that, that will help our presenters know a little bit about who's here. We will be starting here in just a moment.

Linda, did you see the remark from our captioner over in the Presenter chat?

>> LINDA HAZARD: Yes, I did, Will.

>> WILL EISERMAN: Okay. I'm not sure. If I need to just interrupt you and encourage you, I will.

>> LINDA HAZARD: No problem. I feel like I'm yelling, though.

>> WILL EISERMAN: It's all good. I think one of the good things about this experience with all of this telecommuting that we're doing is that everybody's become a little bit more tolerant and forgiving about what technology can do to trick us and make life even harder, so we're all a bit more understanding around the use of all these different pieces of technology that have to work together. And it's pretty amazing that we're at a place where all of this is so accessible to us. Imagine if we were doing this without this capacity.

>> WILL EISERMAN: If you've just signed on, we're just getting ready for today's Coffee Break Webinar entitled: Partnering with primary care providers and midwives to provide newborn hearing screening and re-screening during COVID-19. Going to start in just a minute or two here.

If you haven't already, take a moment to find the role on the poll question here that reflects your primary role that brings you to today's webinar.

I'm going to initiate recording of the meeting and then we'll get started.

Well, good day, everyone. I'd like to welcome you to today's webinar, Coffee Break Webinar, as a part of our recognition of Better Hearing & Speech Month: Bright Spots and Innovations Related to COVID-19. My name is Will Eiserman, and I'm from the National Center for Hearing Assessment and Management, also known as NCHAM, at Utah State University. This webinar series is sponsored by NCHAM, along with Hands & Voices, and the Family Leadership in Language and Learning project, also known as FL3.

We have a series of webinars that we've been doing as a part of our recognition of Better Hearing & Speech Month. All of these are being recorded and archived on infanthearing.org, so if you missed any of those that we've already done or won't be able to attend any in the future or would like to view them again or share them with others, know that they do exist and will exist on infanthearing.org, so go there again or direct others there to share what you've gotten out of this webinar series.

Today's webinar is entitled: Partnering With Primary Care Providers and Midwives to Provide Newborn Hearing Screening and Re-Screening During COVID-19, and our presenters are Linda Hazard, and Stacy Jordan, both from Vermont.

After they've wrapped up their comments for today, we'll open up the floor for some questions. You'll have a tech screen into which you can type a question or comment for our presenters to respond to. Before I turn the mic over to them, I'd just like to give a shout-out to our captioner today.

We always want to make sure that people realize that that's a real person who is providing that service for us today, helping us achieve our goal of making all of our learning opportunities as accessible as possible. So thank you for your time and talent today in helping us accomplish that.

Know that if anything interrupts your full participation or attention to today's webinar, that you can get this at infanthearing.org in the next day or so, so never fear, if technology or something else disrupts your ability to fully attend today.

So without any other delay I will hand it over to Linda Hazard and Stacy Jordan.

>> LINDA HAZARD: Good afternoon, everyone. This is Linda Hazard, and I am the Program Director for the Vermont Early Hearing Detection and Intervention program, as well as the Director for Deaf and Hard of Hearing Services, Early Intervention through school age. My background is as an audiologist, and also with educational leadership and Social Policy background, as well.

Stacy Jordan, who is joining me today, is the project Coordinator for the Vermont EHDI Program, and is also an audiologist. Thank you for joining us today.

So our journey with primary care providers and with midwives began in 2010. Prior to that, the Vermont EHDI Program had a subprogram called the Hearing Outreach program, or the HOP clinic where we actually as an agency provided hearing screening services, ABR screenings and other follow-up appointments because Vermont just did not have the capacity to provide the services that were needed throughout the state. We're a very rural state, and we are also known as the smallest birth state in the U.S., with a little over 5,000 births.

When I actually started at Vermont EHDI in 2009, we had a little over 6200 births at that time. So we have seen a pretty significant decrease in these 11 years. So in 2010 after closing the HOP clinic we felt that we are in need of partnering with some external stakeholders, particularly around re-screening, and our high-risk babies, so we looked very carefully at our primary care providers throughout the state, and identified those practices that saw the largest number of our high-risk babies had the largest number of re-screenings, and also had the largest number of infants that were either hard of hearing, deaf, or deafblind.

So we used -- we also wanted to use this project as a way of reducing our loss to follow-up screening, sorry, our loss to follow-up, and at the time, we used -- we were part of the NICHQ which was looking at small tests of change using quality improvement, and we implemented that in this process, with both our primary care providers and our midwives. So we started with one practice that eventually, over a couple years, grew to 10 practices with our primary care providers throughout the state of Vermont, and then we started in 2011 with our midwives, our home birth midwives.

Vermont has about a 2 to 2.5% of our babies that are born, are born at home, so that's a fairly significant number of infants that initially we were not getting screening, and re-screening results.

Our program was able to use HRSA funding to help provide the hearing screening equipment and in both the primary care provider and in the midwife project we are using otoacoustic emission screenings.

So in 2011 we began the midwife project. We implemented quality improvement initiatives there as well, so plan, do, study, act. One midwife at a time. We started with one and over the years have built the program to about 18 to 20 midwives, depending on the time. Some move out of state, some move in state. They all seem to know about the project and are now contacting us when they enter the state of Vermont to see if we can provide equipment for them.

Both programs have been very successful and have been running for the last, approximately the last 9 to 10 years, and our partnerships over the years have included trainings and mentoring. In addition to that we have provided something, a quarterly newsletter called Tips and Hints to help them as they're providing services to newborns. Our primary care providers and our Early HeadStart providers have been providing screenings as well up to age 3, and sometimes up to age 5.

So this program is rooted -- there's a lot of strength in this program, so going into COVID-19, we were confident that we were going to be able to work with the providers to help us through this very unprecedented and challenging time that we're in.

So I wanted to give you just a little bit of a map of the state of Vermont so that you could see where our providers are at this point. The yellow squares are our HeadStart programs, Early HeadStart programs. We have four of them. Currently they are shut

down, with COVID-19. And our stars and our circles represent our primary care providers and our midwives so you can see they're pretty much spread out throughout the state.

It's changed a little bit as new providers have moved into the state or out of the state.

So for Vermont, the COVID-19 impact happened early in March. Our Vermont birth hospitals discontinued outpatient hearing screenings and we have some extremely rural areas in the state. Our Audiology Centers closed for both re-screening and diagnostic evaluations and our hospitals essentially closed down for all elective procedures. Governor Scott put in a stay at home orders in place which have existed through May 15th. We've been opening over the last few weeks very slowly and very strategically.

So it's -- so what's happening now is that our birth hospitals, a couple of them are seeing outpatient re-screenings. Our Audiology Centers are starting to come back to I won't say full capacity, because they're spreading out their time, as far as when they're seeing patients, being very clear and careful about how they sanitize the area in between patients, how they see patients, and our primary care providers have all along been seeing well-baby -- had well-baby visits in the morning and typically sick-baby visits in the afternoons, so our babies are coming in, and were able to be rescreened at that time, so they were a mainstay for us in screening our newborn infants that either were discharged from the hospital without a screening, or needed to be rescreened, and several of the reasons behind the re-screenings are partially because a second screening wasn't able to be done as families left the hospitals earlier than normal during the initial stages of COVID-19.

Our midwives continued to screen babies as usual, because they do have OAE equipment in their possession. We ran into a couple of areas where babies -- where equipment went down and we were providing midwives with backup OAE screeners or primary care with new probes or hospitals with whatever they needed from our supply in the office.

Stacy is going to start to talk about the actual data and statistics which she has been invaluable over these last few months in tracking and surveillance of our newborn infants, and ensuring that a follow-up is put in place. But I did want to share with you one very cute story.

We had -- we have two pediatricians that are married. They work in separate practices. One has an OAE screening, has OAE screening equipment, and the other one does not. And the one that does not have the screening equipment had a family that was really anxious because their baby had not passed during inpatient screening, and so they referred the baby to the other's practice in order to get that baby screened, and the baby passed on re-screening.

So there has been a lot of ingenuity used during this time by our primary care providers and midwives to meet the needs for the EHDI Program here in Vermont. So at this point, I would like to turn it over so that Stacy can share our screening information and diagnostic information to date. Stacy?

>> STACY JORDAN: Thank you, Linda. As Linda mentioned earlier, my role with EHDI, or my title, is Project Coordinator. A good portion of the work that I do pre-COVID and definitely since the pandemic is care coordination, is ensuring that families, providers, hospitals, everyone is up to date on what the options are, and what our time lines are, which I did a lot of education and counseling during this time of why we need to wait, and that's really hard to do for a lot of both providers and families.

As Linda showed with Vermont, we're also a border, as all of our state borders so we have a lot of families that actually live in New York that birth in Vermont, and in addition to our own primary cares that we partner with in Vermont there's also a few over the border in New York that we have great relationships with that were able to help provide follow-up as well.

One more note with our midwives besides the amazing care that they give to our families and the families that they, the babies that they birth, they also sometimes we have families that end up either by choice or not by choice, by situation, birthing in a hospital, but their ongoing care and follow-up is done by the midwife care, and so we have had some help in post-hospital discharge or re-screening with the midwives as well, so our partnerships are invaluable.

These next couple slides, which I'll have Linda kind of progress through one at a time, and you can look at the individual numbers. We broke down the numbers on a month by month, so as Linda had shared, we started about early-mid-March when things really changed dynamically in Vermont. We were very fortunate that all of our hospitals did continue to provide hearing screenings as an essential service.

There were some brief hiccups as policies and protocols in infection control needed to be addressed on the inpatient end, as much as we talked about the outpatient end, so early on, I did put together with Linda a communication to both our birth hospital staff as well as our primary care providers who provide hearing screenings about ensuring everybody knows what the results were at discharge, so that if the baby was working and a patient of one of our primary cares that had hearing screening equipment, that that follow-up could happen in the office and be as seamless and timely as possible.

As Linda mentioned, most providers were still seeing babies on a fairly routine basis but there were some that were becoming quite creative in doing some of those early visits, but then families weren't coming back for a month or so, so getting those results communicated clearly to the family and back to the Medical Home were more important than ever.

So overall, during and obviously this is still a current situation, but the data over these next few slides that Linda can go through slowly, so everyone can look at the individual, is we had about 91 infants between March 16th and May 15th that needed an initial screening, because they were discharged without, or a re-screening. We had 26 infants total that were discharged without a screen, and 60 that referred in one or both ears.

The high number of refers as Linda alluded to earlier was a lot of it was related to families wanting to go home as soon as possible, so a follow-up screen or secondary screen was not able to be completed prior to discharge.

Our primary cares provided a lot of screening. Rather than doing individual numbers, I just really can't highlight that partnership enough. They did about 30 to 40% of our initial or follow-up screenings during this time so far, and for me as a follow-up care Coordinator, that is just unbelievably valuable. I just think about all of those families that would have to be on the follow-up appointment list for audiology at this point if our primary care providers were not able to provide that.

And when we put these slides together, our data has changed, as Linda had changed, when we first logged on with our fellow coordinator for this presentation. Our numbers are a moving target, and initially we still had about 7 babies with no follow-up plan when we provided the presentation on Monday for submission, and I'm happy to report that as of today, we only have one family that we haven't been able to connect

with and help coordinate and work with them on a follow-up plan for hearing screening.

So I feel very, very happy, as I've been working with all of these families and providers over the last couple of months, that everyone is feeling that they have a place to be referred, and a lot of appointments have been taking place, and it feels like we're moving forward, which is wonderful.

I think I'm going to hand it back over to Linda at this point.

>> LINDA HAZARD: This is Linda again and I don't want to touch upon the Vermont data for diagnostics, as well, for just a moment. We had 9 babies in 2020 referred to diagnostics, all infants are scheduled now that restrictions are being lifted in Vermont and New Hampshire. 5 babies have received diagnostic evaluations to date and we have fortunate that none of our 2019 babies have been impacted by the COVID restrictions.

>> WILL EISERMAN: Linda, could you speak up just a bit, please? Thank you.

>> LINDA HAZARD: I can do that, yes. My last comment was that of the 2019 babies we were concerned about being impacted by COVID restrictions, we are very fortunate that that later group of 2019 babies has not been impacted.

>> STACY JORDAN: Sorry, Linda. I would say as Linda had mentioned our audiology services have started to re-open over the last week or so, and I want to just give some credit to our audiologists that are always wonderful but they have really stepped up to prioritize helping us get these families scheduled as soon as possible, once they've opened. And that has been absolutely invaluable in helping get all of these babies scheduled and screened.

>> LINDA HAZARD: And just a further comment regarding our audiologists: Our largest Center, our largest birthing center and our largest Pediatric Audiology center is in Burlington, Vermont. The other audiologists are another large center for us is Dartmouth Hitchcock which is in New Hampshire but they are currently not, I believe not seeing babies at this point.

And then we have another site in the middle of the state that has been really helpful, as well. So we are excited with how things are progressing in this recovery period, or phasing-in period, for Vermont and the EHDI Program.

And I just -- I wanted to go through just some lessons learned. We felt this way when we started the projects with our primary care Early HeadStart, and our midwives, in 2010 and 2011, but it has really shown that through such a challenging and unprecedented time with a pandemic, the importance of that collaboration. Our primary care providers as soon as Stacy called them were right there to help and ensure that babies were screened or rescreened, and they did this throughout the entire time of COVID-19 and the stay-at-home orders.

Our midwives continued to screen infants throughout COVID-19, and when some of their babies were actually born in the hospital, they saw the baby after discharge, and screened those babies for us, as well. So we have had an amazing amount of support throughout the state with our external stakeholders, and I think the lesson for us here is just, it's important to keep those collaborations going.

One other -- during the -- when CCHD, congenital heart screenings, became available, when also, our Newborn Screening Program provided us the opportunity for mid waves to screen for CCHD, as well, which has been also extremely helpful during COVID-19.

So I just want to thank all of our partners for their participation in this process with us.

So at this point, Stacy, if you don't have anything else to add, I'd like to open it up for questions.

>> WILL EISERMAN: Great. Thank you. So I'm about to open up the Q&A field, folks. If you'd like to type in a question or comment for our presenters, that's how to do it.

And I have one point of clarification I'd like to ask you both about. As many of you know, I have a special interest in the connection between EHDI and HeadStart programs.

With your external stakeholders, have you had any engagement with Early HeadStart programs through this COVID-19 period?

>> LINDA HAZARD: So, Will, this is Linda. Our Early HeadStart programs are currently closed.

>> WILL EISERMAN: Yeah.

>> LINDA HAZARD: So we have been -- we have recently or Stacy has recently had communication with one of the programs, so --

>> WILL EISERMAN: And all Early HeadStart programs are. I just wondered if maybe some of their screeners might have been available through another mechanism or something, but that's fine, I was just trying to understand that.

And I have another question while we wait to see if others have any. And my question is --

If we went back into a stay-at-home order, what, if anything, would you approach differently than what you described today?

>> LINDA HAZARD: So, Will, I'll let Stacy answer afterwards, as well. I think that we would probably actively look at being able to get our backup, some of our backup, screeners to other practices that may need them during this time. And also to see whether or not -- we laugh a little bit about this but we always joke about having a van that goes around the state that we could also provide some screenings, or even some diagnostic evaluations. I think we have talked about the fact that we don't know what's going to happen or whether we will go back potentially into a stay-at-home order in the Fall or the winter, and we really want to be better prepared than what we currently are, so we're tossing around a lot of ideas. Stacy, anything to add?

>> STACY JORDAN: I don't want to sound all sunshine and rainbows but I really feel like other than learning in the moment because this was very new and trying to get reorganized that we were set up with such a great collaborative support network, and the things that we had to put on hold or couldn't do, I'm not sure that there would have been another solution. Obviously we'll continue to brainstorm, but overall, because we are in constant and collaborative communication with all of our partners on a regular basis, it was really I felt very easy and approachable to talk to people about their capacity, what they could and couldn't do, as well as people stepping up, as Linda had given that example.

We also have a birth hospital who couldn't -- was not doing outpatient but they asked the pediatric office who had equipment in the community if they would be willing to see babies from other practices that weren't birthed at that hospital to help, so the collaborative nature is very strong, and so overall, I feel like we did really, really well.

And besides me wanting to go out and help, which we were not able to do as much as Linda had said, that would probably be the one piece, is being able to step in ourselves as clinicians to do more, if that permission was allowed.

>> WILL EISERMAN: Yes. And we had one question seeking clarification about

your comments regarding PCPs. Did you say that the PCPs are scattered throughout the state? And can you clarify the implications of that?

>> LINDA HAZARD: So this is Linda. Yes, I can clarify that. So we have approximately right now 11 primary care practices in different parts of the state that provide OAE screening, and when we started the project in 2010, we strategically looked at our data, because we wanted to know, one, where was our largest loss to follow-up. Two, what primary care provider practices had the largest number of high-risk infants. And also looking at where our deaf, hard of hearing, and deafblind, what practices those babies are in and the final one was where are re-screenings most needed? So we started with those practices and they have proven to be very helpful.

Over the years, I'll be frank, we have changed some of our primary care providers as the data supporting it or their interest has not been there at certain times as practices have changed.

But the map kind of gave you an idea of we have coverage throughout the entire state with our providers.

>> WILL EISERMAN: I noticed there were two participants who have raised their hands. If you have a question or comment, please use our text field over on the left side of your screen to express your thoughts that you're wanting us to know about.

And if not, I think that might wrap it up for today in the spirit of a Coffee Break Webinar. We know that you all have other things you need to go back and do.

Know that today's webinar has been recorded, and will be posted on infanthearing.org in the next couple of days, and I long with all of the other webinars that we are doing as a part of better speech and hearing month.

I keep flipping that. Better Hearing & Speech Month. We have several more coming up, one this week, and then next, so please check out the calendar for that.

And I think that does conclude our comments for today, but before you all run away, we'd very much appreciate it if you would give us feedback on today's webinar by clicking that link in the middle of your screen and offering us that feedback, and we hope that you'll join us on our future webinars.

Again, a shout-out of thanks to our captioner today, and of course, to our two presenters, Linda Hazard and Stacy Jordan.

Thank you, everybody.

>> LINDA HAZARD: Thanks, Will.

>> STACY JORDAN: Thank you.

[End of webinar]

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