>>: Thank you very much you are a beautiful crowd. All right. One more reminder: Just to be sure this is the EHDI Grant coordinator track. You should have a rainbow with a heart inside and that means you are in the right spot. If you do not have that, we will ask you to leave, please.

We are a little bit behind, so I'm going to get started. My name is Dr. Bradley Hartman Bakken and I'm one of two EHDI coordinating coordinators of the state of Wyoming. We have a newborn screening hearing coordinator and a LOHL, that is who I am. I will let Linda.

LINDA HAZARD: Thank you. I am LInda Hazard I am the program director for the Vermont early hearing detection and adventure program for three years old to 21 years old go 21 years old. My background is audiology, leadership and social policy. We are excited to have you here and listen to our presentation.

DR BRADLEY HARTMAN BRAKKEN: This is the overview that we have cooked up for today. With just a little background on late onset hearing loss as well as both Vermont and Wyoming have existing late onset hearing loss screening systems. We are going to show you two models of this. We will give you some existing resources other than what we have provided in the main part of this talk. Relate what we want to do is help you guys, I believe that is here, provide support so that you can meet that requirement from HRSA to submit a plan to implement zero to three hearing screening expansion in your state or territory. We want to spend the bulk as much time as we can discussing with you taking your questions, throwing around ideas, seeing what we might be able to come up with. That is due at the end of April. Maybe some of you have a good start on it, we don't know but that is why we think we are here.

Just a little background. If you accept that one to two to three out of a thousand kids that number will have approximately doubled in that five-year period. That is late onset hearing loss. Causes are varied and many. They can be delayed onset from a genetic hearing loss, perinatal infections such as CMB neurotoxic drug exposure including some anti-inflammatory drugs. There is hearing loss associated with various syndromes and then, of course, trauma or noise induced and the list and the factors listed in the JCIH list of 2007. We don't need to pounded into the ground, but early detection and early intervention improves outcomes for kids. In the same way for these kids for late onset hearing loss in the same way as it does for education, language, that newborn hearing screening does. That is the why to do it and how kids acquire late onset hearing loss.

These are the different ways that we had Vermont have implemented this. I want you to know, the week before I left here, someone from a little town in a Wyoming said we are having problems with this tempo no matter, I did some troubleshooting with them and I could not figure it out. We had them send it into the person who would take a look and repair it. A couple days later, and the guys like the probe is bad, but this machine is 28 years old. I would not invest a hundred dollars to fix the probe. I always wondered how long we had been doing this. In Wyoming. I think I think that was one of the first pieces of equipment that went to the screening system we've been doing it a long time in Wyoming. Newborn hearing screening was born inside the part C. and part D. 619 same Place department of health that the services are delivered from. It's been a natural fit for us and have been doing it a long time.

Who went to throw out some ideas out there maybe something will stick or look interesting to you and Linda will do much the same for Vermont.

We will start with Wyoming. Here is Wyoming's model. These are things to know. I can be very, very transparent and asked me anything about this and I will be 100% sincere and honest with you. I told you that the EHDI program lives in the same unit of the Department of Health that Part C and Part B 6192. That is why we go up to age five set of stopping at three. The screening program in Wyoming. Sometimes, it goes up and down sometimes there is more money sometimes less but about $70,000 the state of Wyoming spends on this per year. That includes part of my paycheck, it includes helping with calibrations, the equipment has to be calibrated annually. That through me off. I lost my train of thought. I will get back.

We have the supplies during 2020, we still screened kids kids, but it is only $70,000 we are not a big state population wise. We go up to school age and then every developmental screening in Wyoming includes hearing and vision. There is a specific protocol that these Part C and Part B personnel are required to do and it includes these elements, otoacoustic and distant emissions, pure tones acoustic reflects tympanometry. It depends on age. Not every 3-year-old can do pure tones so we use at -- as backup.

Are screening protocols and procedures. At this stuff is pretty cool and I did check this out. This is the entirety of her screening protocols and procedures in a flowchart. We have pass fail criteria and a referral recommendation page. It is laminated. People can write who is responsible for that particular task. If you want to come look at these and take them, I brought some other stuff to, too. We developed these I think in 2012 I think is when we came up with them. It was after the American Academy of Audiology issued their guidance for periodic childhood screenings. We have a reference to that later on. But someone from Wyoming served as a cup consultant to that committee. Like us that we have been doing this a long time.

These are the criteria that will tell you if a child that is very clear to screening if they passed or failed a hearing screening. For each component.

We have a two-tiered screening system. Strike one, you have to get a rescreening and strike to your out. You have to be referred somewhere. This breaks down very clearly, if you passed admittance but failed -- but down at the bottom where you can't read, it depends on whether it is initial or a rescreening it lay set on very, very clearly.

Here is a beautiful little flowchart. It starts on page 1 in school and rescreening. If you need to go beyond rescreening, then we have two options. We have the referral and the flowchart on the right and audiology referral, the flowchart on the left.

Life is not clean. There are kids who are three. Life is messy and there are other situations. Believe it or not we have some guidance for people with families do not go to see the doctor, or cannot get results back from the doctor's office. For example, that is under other. Excuse me.

This is handy for us. Every person who screens in the state of Wyoming for five and under uses the same form. As all of our recommendations at the bottom of the form to use, but everyone uses the same form and collects the same information and uses the same protocol, it is very consistent throughout the state. This is just the back. I can track risk factors as well. We give them a reporting mechanism. They are tied into our EHDI information system. I don't know how easy it is to me, but there are action items very specific to what their screenings are like. The newborn one looks a lot different than what the late onset thing does. This is a reporting mechanism which they Department of Health really likes.

If they have been put in results into that tracking system since the first date I have I think is 2003. Almost 20 years. These are some other things that we do. I am just throwing things out there to see what you might be able to pick up, adopt, adapt. These are on-site, we like on-site wants the best but we do have supporting material online that are approved for CE use. We also couple that with hearing screening mentoring. This is, and is screened kids with them what to say to the kids and the parents, of course, we have just very simple things like educational awareness. English and Spanish. These can go and screening packets. The importance of hearing and language development.

What else do we have? We can provide other information for professionals as well. We train them on how to report into the tracking system. I did mention that we have screening and supplies and we help them manage that. We have a statewide database of all the equipment. We have a repair and replace program. If you send me a piece of equipment that is 13 euros old that is not working and I will send you one that is eight years old that is. Sometimes, we have money in our budget to by new equipment. Sometimes, our audiologist will review screening results as well as audiology reports or for not audiologist to interpret.

These are some pieces of the Wyoming system that I wanted to share with you. I think Linda is going to talk about the Vermont model.

LINDA HAZARD: Thanks everyone. I appreciate everyone being here today. Our EHDI program is different than the Wyoming program and how we have approached birth to three screenings. At this time we are working on a plan as required HRSA deliverable. Our plan started 10 years ago, I want to say almost accidentally because we became involved in a learning community at that point in time for quality improvement initiatives.

One of the biggest challenges at that time in Vermont was that babies who were born at home, and we have a fairly significant number of babies born at home, about 3% of our population, and I will say Vermont is a very, very tiny state, but that still was skewing our results and newborn hearing screening. We decided to try a pilot study with our homebirth midwives and today it is very successful in the sense that they do see CHD, so congenital hearts screening as well. They also do the blood spot would provide them with the O. AE screeners, we provide them with supplies into their calibrations.

At that point because Vermont is very rural and spread out, and we have 11 birth hospitals but things were sometimes hard to access support services. We also started that year a pilot project with our medical homes with primary care. We approached it very much as a polity quality improvement initiative. We started with one primary care than we went to to primary care is then to three primary care's and now we have several primary care is at work with us.

They do several things. They do rescreening and high-risk monitoring of infants that have high risk factors that were identified at birth. The program has been very successful but our equipment is now 10 years old. We are starting to go with the process of replacing that.

Our EHDI program is in the Department of Health division and also the same agency that provides Part C services. Early intervention services were unique in the sense that the early intervention services are part of the University of Vermont Medical Center. In Vermont I am employed by the medical center, I am contracted to the department Vermont Department of Health.

The medical center is our fiscal pastor of. There has been a relationship there since 20 since 2023. About a year and half ago hour intervention program we have always been closely linked, but early intervention for Devon hard-of-hearing at deaf blind children came to me as long as a director along with school-based services as I mentioned I think earlier in my introduction. The medical center, which is not education now houses some Part B services and all of the Part C services for deaf hard-of-hearing at deaf blind. We are kind of an unusual model in that sense. As part of all of this when we started the midwife and primary care project we also worked very closely with the eco- initiative ECHO Initiative under NCHAM and initially in there E. screen is provided to the early head start programs. We also did some support of screeners with our early head start programs as well.

Then our head start programs started to purchase O. AE screeners as well. We have continued over these last eight or nine years to providing training on screening or protocols and follow-up recommendations to our head start and early head start programs.

What is nice is that the Department of Health, our database, is a fairly fully integrated database along with electronic birth records, death records, immunizations, newborn screening, newborn hearing screening, for EHDI. We also have developmental screenings that we capture and I think I also mentioned lead and immunizations. There is not a baby born in Vermont that can escape because somewhere along the line we find them in our database, which is a positive for sure.

As I mentioned a few minutes ago, we did the pilot studies, the ECHO Initiative and that is still going strongly. We will collaborate with our partners to make sure their units are calibrated. We coordinate the calibration of all those units. One other thing I want to mention: In 2010, and earlier from the mid-1990s, we have the program called the hearing outreach program. That was birth to five years old will be held under the Department of Health and the University Medical Center, we would hold clinics all over the state. But in 2010 they were closed because our health department decided we were not going to do clinics anymore in any areas to EHDI areas and move them to other areas. It is one of the losses we had felt. We had built capacity at that point, but then COVID came along and that has been a challenge us on the Sais ransomware cyber attack at our largest hospital. Has definitely been a challenge.

What has happened since then is that children's integrated services, which is our Part C under the state, some of those offices are now requesting that we look at we look at training them on OA screening children enrolled in CIS. We currently have two sites that were working with as part of a quality improvement initiative as well.

We are feeling that that door is being opened again, so that there'll be more opportunities across the state of Vermont.

The other issue we are seeing is not necessarily hearing related is that we have a huge backlog of children enrolled in children's integrated services for early intervention who needs speech and language evaluations, and I am talking about major backups. Like in one of hours its 80 children. We're also identifying ways we can help with providing those evaluations by expanding some of our programs under the University of Vermont Medical Center. That is a separate hat from EHDI.

As part of that, we are recommending that each of those birth to to H3 have a hearing screening and that is another way we are covering. So ongoing trainings mentorship early head start and head start programs. We are really sharing the importance of speech and language and sharing that children have a follow-up hearing screening. We are working with parents and professionals and working with audiologists in whatever way we can do that. One of the advantages that were not has as we do collect early childhood screening data. We have a in our database pick our early head start programs are providing that same information or those screenings to us, which has been really, really helpful.

>>:

(Off mic)

LINDA HAZARD: Yes.

>>: -- if you charge for --

LINDA HAZARD: We do not charge for our trainings, but we have to look at that. The concern we have right now is the replacement of the hearing screening equipment that we have out there that we own. We had a relatively large loaner bake, around 30 units, 30 or 35 units, but they are on X. units so we know they are going to be history. What we are looking at now is how we're going to replace those systems and that will be a challenge for sure. As part of that is we have gonna talk with primary care to find out how how how helpful it would be to have O. AE screeners in their offices. During COVID's saved us. Because they were screening babies that were not even their children to see. They were actually really, really helpful in doing the rescreening's when babies did not pass the initial screening. With midwives, with cover the cost that we have covered the cost of primary care with some of their supplies, not their calibrations. We are slowly transitioning.

Some of our primary care and early head start has totally taken off with buying their own equipment. Some of our primary care's are saying they're willing to replace cares as long as we keep doing the education and training to them annually. But it will be an interesting challenge.

We also went to our primary care and ask the question, we wanted to do a quality improvement initiative and wanted to be able to say would you be willing to screen all of your children birth to three years of age as part of there well-baby visit? They all came came back and said we lack the capacity to do that. We could not find one of our primary care cephalic they could handle that. That is definitely a barrier for universal care for children birth to age three. This is where we go back to hearing screening birth to age three years of age. Who was responsible and where are we going with this query.

It is challenging because right now in our state and many states I'm sure you do not have funding for these types of projects, so where do we find the funding.

Vermont just introduced legislation for early childhood services. This is one area we are hoping and we will be working with and testifying personally to our legislature that we would like to see some funding put into this bill if it passes to help support hearing screening.

The second area that we are also looking at his private insurance and Medicaid coverage and reopening the hearing outreach program, which we fondly call hop everything about hop has been a bunny and that's why have the money here. There are early intervention program with hopefully some grant funding from the state and a combination of reimbursement we would look to open up those clinics and higher staffing to do that.

Again, that is not my EHDI hat. I am coming up with a plan. How we implement it there's going to have to be many stakeholders and collaboration and partnerships to figure out how to move this forward.

Any more questions?

>>:

(Off mic)

LINDA HAZARD: For the screening? Yes. As an audiologist, we can build because we can build two diagnostic code. No, they are not building billing.

>>: Thank you. I was wondering how frequently the children zero to H3 are being screened. Is a annually or at a specific age?

LINDA HAZARD: If they are enrolled in head start or early head start, it is annually. Primary care will screen infant that has the OAEs. They will screen every high-risk infant. We were doing it annually and backed off a little bit because of the JCI recommendations. We had them all doing the annual screening or referring to an audiologist for an annual screening if they were not able to do it in their office.

>>: Thank you. I have another question. I am from Minnesota so our Part C services are separate fan the Department of Education. Separate from the Department of health where I work with the EHDI program. When you all started, some of the stakeholders I've been serving from our plan is our early head start and Part C partners will need more a hearing screening equipment in general. We were looking at adding one time zero to H3 group to do one more screening for those kids. I was wondering if when you all started if you had to foot the cost of buying more equipment and more OAE machines.

LINDA HAZARD: At the time we started the project, all of our equipment was purchased through HRSA through our grant funding. It was one of our goals and objectives. It is still in my goals and objectives to be replacing it every year and so far that has been approved because we been able to do it within the funding amount, but that is not going to be possible going forward. I can see it with the funding restrictions or challenges. Terry?

>>: Linda, what percent of the appropriate kids from that age are you screening? Are you seeing screening of 50% of them or do you have that kind of data?

LINDA HAZARD: We are actually collecting it at the moment to try to figure out. Part of the challenges is reporting into our database system is not as much as we would like it to be, but they are starting to send us the information. I would say about 90% of our high-risk infants are being screened appropriately. I guess I do have some of the data because all of the early head start and a head start children receive an annual screening in Vermont. And then are referred on.

Where hoping with the addition of CIS and the addition of some resources that we will be able to look at spreading out to children who do not fall under head start or early head start or CIS.

>>:

DR BRADLEY HARTMAN BRAKKEN: Just to answer your question Perry in Wyoming as extensive as this program is, it is about 30% of the population before they go to school every year, 30%.

LINDA HAZARD: We are capturing only those in certain programs, but I would probably be able to say that we are about 30%.

>>: Do you capture all of the data for all of the screenings regardless of whether they are pass or fail?

DR BRADLEY HARTMAN BRAKKEN: We do. We have a hearing health history for that child in the system. Pass fail they are required to report results for us.

>>: Does EHDI follow up for that population of children who do not pass?

DR BRADLEY HARTMAN BRAKKEN: No, that is a really good question. We do not. A little bit we do, we help because once those kids are referred out, the documentation of them really drops off. We don't do that, we do not have a late onset follow-up coordinator. But I help us much as I can is the answer. How many kids -- so I will give you some numbers and you can think to yourself about this -- we have, let's see, about 300 kids that need to be referred to a physician or audiologist every year in Wyoming. 300 kids up from the system. That's it. And we do not do the follow-up.

LINDA HAZARD: In Vermont we also do not do the follow-up for early head start or head start. They do report most of the information to us. I won't say all of it. I am working on that. But primarily we recommend that they make sure that primary care is involved and can do some of the follow-up.

If there is a really red flag that it head start program comes to us with or a CIS program, then we will try to help them same thing like Bradley sent. We will help them through the follow-up process and saying that these are the things follow things that need to happen. In my opinion EHDI does not have the capacity to do late onset follow-up, at least not right now.

DR BRADLEY HARTMAN BRAKKEN: Heather.

>>: Thinking about the Bright futures guidelines where you're supposed to screen at four. Duty either of you see a bump in screenings and reported screenings at age four. Are you picking up more kids at that age even though they are at the outside of the plan development age range? Think about what we are aligned to do with what providers do.

DR BRADLEY HARTMAN BRAKKEN: For us, I heard a lot of physician involvement in Vermont. In Wyoming there is zero. Apart from a few that we have placed in specific regions that have trouble with accessing from other places, so no. Has not had an impact in Wyoming, that Bright futures. I can see where in some places, it could.

>>:

LINDA HAZARD: We have definitely picked up some young children who are a little bit older in Vermont because of the screening process and because our PCPs are pretty closely connected to us and we have picked primary care practices that have a larger number of high-risk infants and their practice as well as those that are lowly do not have screenings available to them. But I do have to say as tiny as far as our numbers so we average anywhere from six to seven infants annually that we identify with some type of hearing loss. You might say oh, you might be missing some, but with our database, it is hard from anyone for anyone to hide from us. We are usually out there with the follow-up and referral. We occasionally see another two to three every couple years, but it is really a small number. Our primary care are good at saying this infant is not passing and refer them on for audiology audio diagnostic. -- this movement want to point out something that Linda and I both have an common is that we have told you really small numbers. I said 300 you said six or seven. One thing that I didn't I don't think I really wanted to do this because of the small numbers, but Linda convinced me that it was a good idea because we can represent a little experiments. You could not find two more different states than Vermont and Wyoming in some ways. We have massive land area and no healthcare basically. But we have very small numbers. The things that we have done could be done on a similar scale is scaled up perhaps or just start out small and take advantage of what your organization is in the state. We just happen to both be with the health department. Don't try to change it in your expertise take advantage of your expertise and spread it out a little bit.

LINDA HAZARD: Bradley brings up a good point which I have always over 14 years now at EHDI, over the years I've always said, but we are so little and everyone comes back to me and says, but you are a PD essay plan do say act initiative. You can somebody else took it to last night said there are 640,000 residents and the entire state. We are itty-bitty but sometimes we have more freedom to trial things and find things that work and find things that also do not work. I would to come back to the conversation. Putting a plan together as one thing, but we do not have the resources and we really need partnerships. That is what both Vermont and Wyoming have looked at to do is who can we partner with so that these young children are screened prior to leaving Part B? I even go so far as to say I would love to screen up to age five. That is the area of their progressive or acquired hearing loss' are also happening.

Are there any other questions?

>>: Just a quick comment and I think everybody probably is a little overwhelmed with this whole plan that we need to create. I think we need to remind ourselves that the screening is very important, but what is even more important is educating our childcare providers, educating our physicians, our parents, anybody who has any access to our children to look for the signs and symptoms of a hearing loss.

I think that is way more important, I should not say way more important, and I think it is as equally important as screening every child because that is not feasible. It really is not in any state. I think part of my plan is really going to be to push the education piece of it so that people are recognizing the signs and symptoms of hearing loss.

LINDA HAZARD: Lives, that is a great point and thank you so much. It is equally important along the way. I think I think that is what we have all tried to do is educate and train as well with families.

I think primary care which you mentioned, Bradley, is really a tough place because they may never see a child that is hard of hearing or deaf. It is super helpful if we can figure out how to do that training and robbed not from North Carolina was in EHDI one '01 yesterday 101 and you did a nice talk that primary care needs to be educated. It does not mean us totally. It should be an partnership with all of our stakeholders.

>>: I have the microphone, so I have the power. (Laughs) this is Gina from Michigan. Just to build on the previous comment about education, that is the direction we are looking at as well. Things as far as risk factors, are hospitals talking about that? Is that another way to look at are we truly helping with late onset hearing loss? That was just a comment there.

DR BRADLEY HARTMAN BRAKKEN: That is a good comment. I love that one. Keep going.

>>: I think at the end of the day one of the reasons is that that plants feel so overwhelming to me is that all babies are in one spot when they are born. All babies are in one spot when they go to school, but in the middle, we are throwing darts trying to find where large amounts are that we can screen. It is very different and collaborative. We are looking at in our state, early on, which is our early Part C program, they have equipment that we have no avenue for training. My question is beyond the ECO project that cost the $95 training for otoacoustic emissions is anyone aware of any online trainings that do a screening that do not charge?

DR BRADLEY HARTMAN BRAKKEN: So, Randy Winston, raise your hand if you don't know Randy Winston or EHDI Powell's. This program was looking to help people and parents find appropriate audiology services for their child. Randy Winston has really expanded what EHDI Powells is one of the things that she is talking in this room tomorrow I believe you can look on your schedule, but EHDI Pals is developing in some online tools that will do out of hospital screenings it is intended for newborns, but is an O. AE screening. The answer is I think there is or it is just about to be there there are other resources right?

>>: Georgia mobile Georgia my name is Suzanne. At Georgia mobile audiology. We have a whole training website and. It is for parent navigators it is for newborn hearing screeners and tell audiology. It is three different modules. It is quick and easy. Read the come up with something that was faster than NCHAMs. It go down the resources it is geared or geared towards our state and requirements but pretty much they are universal.

Georgia mobile audiology. Once you go to their site, you will go to resources and then training.

LINDA HAZARD: Thank you for sharing that. I think we will share some other resources with you after this. I know Tara has her hand up.

>>: Yes, this is not so much a resources as it is a different way of doing things. From South Carolina for anyone who does not know, my FPO that I contract with the HRSA grant's beginnings it is not the same as North Carolina beginnings, but they have created a lending library, so they buy OAE equipment and reach out to Headstart and early childhood centers in different places like that and the three to five in schools school districts. Both programs have been borrowing OAE from beginnings. Then I go out with an beginnings when they loan the equipment out and help them do a training on using the OAEs. That has been my contribution to my plan.

>>:

(Off mic)

>>: Honestly, (Laughs) when COVID hit, somebody reached out from ECO asking me if I wanted a bunch of materials. And I said sure and they ship them all to my office that I was not in for 18 months. When I got to my office and I opened up a box of all these ECO materials and flash drives and videos and I handed them over to beginnings and they put something together themselves to do that. I'm sure they won't be pleased with me (Laughs) they gave them to me. But before they relegate to the $95 session so maybe we can work something out. But that is what we do in our state.

>>: One question and then Ginger. Both Bradley and I would love to hear from you as far as part of your state have you started looking at a plan or thinking about a plan or do you have ideas about how you might approach the plan in your state? As we say steal shamelessly and share seamlessly. We really did want this to be an opportunity for you to share ideas as well.

>>: As part of our plan during COVID, we could not allow an screen. We worked with her at AIS vendor and developed a completely separate module to collect aggregate data because we did not know who was screening and how many kids in those kind of things we worked with is called strata and you could push it all the early heads darts how many did they screen and follows the school vision and hearing model, but we created it with federal funds. It is out there if you want to use it. We just wanted to one of the way to collect the data. I think there are pros and kinds of aggregate versus child specific but we are willing to share if you like.

>>: This is Jeannie from Kentucky. I wanted to add what we are currently doing. We got the training before it was being charged for, and I don't know if you just talk to -- for getting us all the training again. Flew we walk our corners and Part C through that so providing training that was provided to NCHAM with the echo materials virtually and we are talking about having it as a standing calendar item that people can attend, new hires and whatnot and expanding it to other providers, whoever we can get to that virtual or in person table. At then if they have OAE equipment in front of them, it walks them through how to set it up and we have an audiologist on the call who can answer questions. Just something to think about even if it was just twice per year and a calendar year we have a virtual training that is broadcast on your website or whatever that people can ask to attend.

LINDA HAZARD: Thank you. Other ideas? Thoughts about your plan? We are all here to help each other. I will forward some resources out after this and Bradley, too. Please feel free to reach out any time to us. And other thoughts about the responsibility and authority of EHDI over birth to age three screening. Bradley, will you send out your little flowchart things?

DR BRADLEY HARTMAN BRAKKEN: I definitely will send that out. We will include it. That chart, if you are interested in adapting it, you will need some pretty good Photoshop skills, but I am happy to send anything.

>>: Florida had some legislation passed last year for targeted CMB screening, and we had some opportunity to propose some additional changes to our legislation this year. I took the opportunity to slide in required reporting for hearing screening up to age three. It is just proposed at this point. I think that will go a long way if we can get it passed it to actually getting the information.

>>: Go, girl.

>>: One other thing we were just talking about is attending our states chapter conference and explain to the pediatricians that we would love it if they could report into the system we know the sum of mother doing the OAE screening and for those who are not encouraging that the last time we were there we provided just some information about late onset hearing loss and considering screening at hearing screening at all child visits since that is an area where you might meet more populations that are not met and early childhood or intervention. Where hoping that might work, too.

>>: Hi, adjustment from Hawaii. We had legislation legislation passed last June for hearing screening to be reestablished in the community. That was exciting because it hadn't gone away in 1995 due to funding at the DOE level. Everyone is always scrambling to get the later onset hearing kid kids diagnosed. Now EHDI is trying to figure how to get all those community partners to report to us so we can then help give them direction how to follow up that I think primarily the bill stated to create a consistent protocol and training for screeners and data collection so there is no reporting piece but I've met with the some of them and that is pretty exciting. Helps to have a community that is doing the work, some of it anyway. That is all. Thank you.

>>: Stephanie from Utah. I have a question are we operating under the assumption that this plan that we are putting together and submitting next month, that we are going to be asked to implement the plan in our next grant project we have you heard anything? Is that a safe assumption? It kind of changes the plan, right, if we know, we can do pie in the sky, this would be the best plan in an ideal situation versus you put this plan in place, we are not going to change your funding and you won't get more funding, but you're going to have to do it now. Does anyone have insider knowledge?

LINDA HAZARD: Stephanie, they have asked us to do a plan, but not to do an implementation. That is my understanding. However, I think this would be a good question to ask a federal partner of the coordinators meeting on Wednesday just to confirm that.

>>: I was going want to echo that and they were you know what works for your state just if you can't do it to say that you cannot can't. I do not think there is a requirement coming down like that, but I could be way over speaking. That us from the horses mouth. --

(Overlapping speakers)

>>: Not to say don't worry.

LINDA HAZARD: I we can for if we confirm that with them on Wednesday, it is always good to say. Exactly. I think we might be out of time and here, but Bradley and I want to thank you all for just coming in listening and sharing ideas. We have an awesome group of people.

(Applause)

>>: This is Angelina before you leave if you would not mind doing the survey information in the app. Enjoy the rest of your afternoon. Thank you.