>>: Good morning. This might be the most awkward announcement I've made in my career. It is not clear in the program that this is a working session for EHDI coordinators. If you are an EHDI coordinator, I don't know all 59 of you, but this is where you want to be and if you are not in your EHDI coordinator said to come to this, that is good, too. If neither of those apply, this might not be the best session for you because it is not a presentation. It is a working group. Sorry for any inconvenience. We kind of wish this was not in the program so everybody could come but that is the way it is.

Should we get started? Would you come up? Terri, where are you.

This is so not my presentation. Someone had to submit the paperwork that we all put together, and that is me.

Okay. Here are the three of us plus Perry Smith who was double booked. He is presenting right now. He will come join us. We will each introduce ourselves. We put this together and facilitating it together, so I am Arlene Stredler-Brown and I am lucky enough to be the EHDI coordinator in Colorado. Intervention is my background. I am in SLP and a teacher of the death. We hired an audiologist to help with audiology kind of things in Colorado who contracts with us, but this is a real comfortable topic for me and I just want to say that this will be in two parts. We will talk about the relationship between EHDI coordinators, EHDI system and intervention. A very short presentation and then we'll have some discussion. The second part will be all about outcomes and then will add Allison that set each of the group and she will introduce herself when she comes up, and we will have a bit of a presentation and more discussion. That is the format.

To my left, I am Brian Shakespeare and I'm the Idaho EHDI coordinator. I've been with EHDI since 2011 and became a coordinator in 2014. And that is me.

>>: I am Terri Ibieta and on the Louisiana coordinator and since 2002 and I became the court entered 2016. Like Arlene my background is also in early intervention.

>>: Okay,, here we go.

Here we are. So our objectives. The advantages and challenges integrating early intervention into EHDI. That will be first. Looking at different developmental assessments that can be used to document outcomes. Just to give you a preview, Brian is going to present a project in Idaho that he has done with Christy Blaser at Idaho State. And Allison SETI. Stand up or something. (Laughs) will represent the Odyssey project. And as part of that second half, we went to look at ways to capture intervention data into an EHDI database and between Brian and me, to states, two different ways. I bet there are a whole lot of different ways to accomplish it. Again, will give me time for discussion this might be the only slide on this first part I was kind of looking at early intervention big EE, big Y. and there are 70 documents out there, but JCIH has done a pretty thorough job, 2013, 2009, when did they do the intervention one?

SPEAKER-02: 13 or 14 just to EI.

>>: Anyway this comes from just the just EI joint committee statement. This is how the joint committee perceives intervention. It is a lot. Maybe our discussion will come to be around how do you prioritize.

Timely entry into early intervention. I am separating this out. Coordinated entry into intervention. Kind of two things in one. Having a data management system here is another two-part. Timely access to service coordinators. Maybe the most important part is who has specialized knowledge and skills in children who are deaf and hard-of-hearing. Early intervention providers who have the professional qualifications and skill and there is a section there that Mary Pat Moeller, Mary Sessler and I did in 2013 to look at those qualifications. We have a tough situation. We are recruiting from speech-language pathologist, audiology and teachers of the deaf or hard of hearing so we have three preservice training programs, three disciplines who are all early intervention providers.

Number 5 and this is being hit hard by the feds right now, cultural diverse backgrounds and/or people from non-English-speaking homes having quality to the same services. Progress monitoring every six months. Straight from I DEA. Standardized, norm-referenced developmental evaluations. Maybe one of the toughest things to accomplish from what I hear in other states over the years. And that these evaluations are specific to language outcomes. The language, what do you want to call it here says modality of communication. Maybe these days I've been hearing language opportunities and measuring social-emotional development and motor skills and all those measurements would be using standardized norm-referenced evaluations. So hard. And then and I don't think we have touch the tip of the iceberg, but it is of interest to me is fidelity of intervention, developing my next project.

In the way of discussion, that is set for that lead off for this first part. Here is the question. I feel like it is a bit of a question of a good starting point and Brian Terri and me have something to say about it. How do you start there, how do you prioritize all these things. Oh dear it is not an Apple how do you go back? How do you prioritize these items in your state I have been an early intervention since I was in this career starting in 1972. Colorado does not do all of these things. We do a lot of them, but certainly do not have any measurement of fidelity intervention that I am aware of. How do you prioritize based on what you have and what this suggests one would have?

>>: To be honest, I do not be time to say, I am not in and of early interventionists, I am an EHDI coordinator. What I do is how I organize our school of the death with our early interventionists at Ohio State Idaho State University and basically what I have done is connect people and create a way to get the data get the early intervention data gathered and put in a way that we can analyze it and make programmatic decisions I'm going to go into that a little further when it is my turn to talk but really I do not have a lot of specialized knowledge in early intervention specifically.

>>: And Louisiana we certainly do not address all of those criteria, but what we have done and I think we also need to take into consideration as EHDI coordinators, what are our roles and what do we have control of and then when does the handoff happened in early intervention picks up and the coordination they are. What we have done is coordinated our system of referrals. We do have within EHDI and intervention coordinator that is the first contact for families. She is the one that explains the nonPart C and Part C programs available. She also explains family to family support. And then with parent permission, she makes those referrals. Then we correct collect the data from Part C and nonPart C and outcome data from both programs.

>>: To all of you I will walk around to give you the mic because I think this might be manageable for us as a group it would be nice to hear what you do and maybe why you do it, how do you prioritize it, what you don't do, what you want to brag about what you're feeling you need help with so anyone.

>>: This is Julie from Washington State. One thing that we do that works that took a while to get here so our early intervention program called E. set is in in a different agency of the Department of Health. That has been kind of a barrier, but we have a linkage from there database to hours. Our audiologist can place referrals directly to E. fit for early intervention, which is helped a little bit and also we call them family resource coordinators and when they are entering in the IFSP date there is in the child there's different selections for choices of hearing loss they have to select one of those and we get the IFSP information.

When it works, it is amazing. It does not always work. There is always a time where I don't remember when we got data last and there is some jam up in the system. But what we struggle with, and I would love to hear one of you said you get nonPart C data and that is one thing we struggle with is how our state's getting nonPart C data. Because we have no way to collect that from anyone. Every now and then we hear the side receiving services, but we and we mark that, but we don't have any way of getting her moment if for us it is not a huge priority because I don't know how we would handle that. Are focuses mainly on improving data that we get from early intervention and how do we make that easier without us having to do more work to collect it.

>>: I am a little jealous. So it took years. Way back most of you know -- issues of coordinator course for a long time, but for long time I was the focus EI person, and I feel like we have a lot going for us, but when the health department shut down our database and we did not have one for three years in the greatly new database and they shut down the debate database because they were HIPAA violations and moved the health database at the health department into a data division, they don't share. I am jealous. After three years, I think this year we will get an interagency agreement. Sharing data is a big deal.

>>: Arlen, I can address Julie's topic there because we do actually collect data from non-Part C providers. Most of our data collection for the project I'm going to show you in a little bit is collected through our school for the deaf. They do the assessments with families and that data is reported to Idaho State University and then we have a data linkage with them.

Our school for the deaf, every child that they are working with does not necessarily have an IFSP pic that is one way that we are collecting non-Part C data. I'm not going to present on it now because I'm not there yet, but right now I am beta testing a non-Part C reporting system. I have one SLP I am working with so I'm getting non-Part C from one SLP and we are working out the kinks before spread it to the rest of the SLPs in the state. But that is what I'm working on currently. Two different ways that we are getting non-Part C data.

>>: This is Linda hazard, and I'm the EHDI coordinator from Vermont for anyone who does not know me. I have a little bit of a different situation. We only have Part C. We have a single point of entry for early intervention services. Which actually makes it very easy. We have been data sharing since the early two thousands with our EHDI program between our EHDI program and early intervention program. A year ago our early intervention program came under under me as their director as well so we have a nice easy flow of information back and forth between our programs.

>>: Can you hear me? I am Shelley with Texas outreach. We are a state right outreach center and we have access to the Teddy system from a House vote a few years ago. What we have been doing is developing relationships with our three non-Part C providers and then sharing confidential ID numbers so that I can update the system so that we are getting accurate data. It is still not perfect and that is still not everything, but it is a start.

>>: Thank you. So I am from Maryland. My name is Stacy. Our EHDI program is in the department of health and our early intervention is with our Department of Education, but we do share data and the Department of Education has an online referral system for early intervention, so we are able to refer children to early intervention if the provider has not done that or if the parent has not self-referred. One of the challenges that we have, though, is that early intervention will document the child based on the initial diagnosis that qualified them for early intervention services. If the deaf or higher hard-of-hearing diagnosis comes subsequent to there enrollment in early intervention services, that we may not necessarily get that connection. Although we do get that data from the inner early intervention program. And the other thing that I know that you guys said is that you are getting outcome data from Part C. We are absolutely not getting that. Or information pretty much stops at enrollment. I would be really interested in learning more about how you get the outcome data and what you are doing with that. Thanks.

>>: So that is the second half of this our together, looking at a couple models for outcome data. Hold that thought. We will have some discussion on it. Others.

>>: I guess we are little behind on our method because we do spreadsheets with our early intermittent intervention system. We are hoping to have some linking up and everything, but we don't collect any outcome data like Mary Ellen. It is really tough because we really don't, my follow-up nerves fights with EIS services to at least get IFSP dates. It is very difficult to do it the way we do it. Thank you all for doing this class so that we can learn may be a little bit more.

>>: You're welcome. I am Kim Porter with the Florida. We are actually not only in the same department, the Department of Health and Florida, but in the same division with our Part C program administrator for Part C was the EHDI coordinator so that is obviously, we have an amazing relationship with Part C. But we to say Mary Ellen said archaic, we have a data system from 1982. They are currently working on a new data system. We have access to there data system. We have an agreement, but it is very manual process. We do not have access to outcome data because they don't have outcome data in there data system in a meaningful way. They have challenges that of course, it roll down to us. They are working on them and making huge strides that it is definitely an area for us that we need improvement on, and we are also working on being able to collect outcome data for private EI providers. The relationships are there. The readiness is not quite there, but will soon be.

>>: That is pretty exciting. Can I just ask for kind of my own understanding and get a feel among the group: How many states have a part of the system like screening and database and health, because everyone does, right? And also has their EI program, no, yeah, their EI program in the same agency? Wow that is more than I may have thought. This is not totally related, but I can't miss the opportunity. How many states have health as the repository for database but their HRSA grant in a different agency? Only two. I think there are five of us. Thanks.

Since so much of the conversation is about data outcomes, measurement, she would move on to the next segment.

>>: I was just curious what states can say that their EI has access to service coordinators who have specialized knowledge and skills and what does that look like, how is it implemented, what is training? I am pretty sure, West Virginia.

>>: I have to comment on this because it is sort of my life's work. Sorry about that but like they said, EHDI coordinators are among friends and I'm happy to be one of you.

Whenever before Part C happened, long time ago, Colorado developed a system called the Colorado hearing resource here in coordinators. I was on a hike with my audiology friend Karen Carpenter when we coined the name. True story: I was the director from the Colorado home intervention program as the director, I met every single family to enroll them in early intervention. We're talking before universal screening. There were not that many kids. We had the use we will call them specialty service coordinators, and they survived Part C. They survived service Part C service coronation. It was not easy because when Part C did pass, the department in the state that had Part C said we are not going to separate out kids by diagnoses. We serve all kids and we will serve them all the same. It is great today and has been great for a while, but it has been a challenge to maintain, which one it specialty service coronation, third bullet. As been hard and since three or four people raised their hands that his testimony to the fact that it is hard. Call out the names of your states if you're doing it. I'm so glad you brought up that topic and I think it is effective but it is hard to do.

>>: In Vermont our Part C program is under our agency of human services. As well as our Vermont EHDI program. However, the parent infant program is under the University of Vermont medical center so it is a collaboration between the devout the Vermont Department of health and University of Vermont Medical Center. I'm going to go back as far as the 1980s, Vermont has always had teachers of the deaf and hard-of-hearing, educational audiologist, speech-language pathologist that provide the services to our parent infant program and home or in day care settings.

>>: Gwen, I was just going to mention that the only reason that our Part C coordinators have specialized knowledge in hearing loss is because we train them. We provide trainings to our Part C service core Nader's otherwise they would not.

>>: And Washington that is a little bit wishy-washy some counties have those specialized services and other counties do not. A lot for us it is a lot of education for those counties who do not have specialized coordinators to get services from that center for deaf or hard of hearing youth, CDH why. If you don't have it, go to them. A couple one really exciting thing we are doing in Washington is using some of our Maternal and Child Health Bureau BASIC C health grant to make trainings for what we call the FRC, family resource craters and providers and there will be three modules that go online 30 minutes minutes each end will be all about deaf culture, deaf awareness biases and what services are available for children and Washington if they are deaf and heart of hearing. If you are right of the seas maybe one deaf child per year you can go to these last-minute trainings I get the information. Right now our struggle is where do we house this information because our if it program you cannot put on our website and where like it is for you and for your people. True government bureaucracy that is it. But one thing that is what we've heard from her EHDI advisory group these services are not available and we have a King County, which is huge. They are working on their own set of trainings as well for there efforts. If you can provide training or find somewhere that can do training, that makes it a lot more beneficial.

>>: Just throwing it out there that NCHAM has some resources on www.infanthearing.org that we use to train her service providers as well.

>>: Can you call out the names of your states if you have some type of specialty. We have Idaho, Washington, Colorado, Vermont, who else? The service coordination focused on deaf and hard-of-hearing. And don't tell me --

(Overlapping speakers)

I'm not shaking your hand I'm taking your mic.

>>: We do, but we are trying. I would say that we are using HRSA funding to address each and every one of these, but that specialized service coordination is really, really difficult and we are training trying, but I'm not going to say that we have it.

>>: But I know you are working on it. Stephanie, and then we will move on to the second half.

>>: This is going back to some of the things we talked about earlier, but I thought it might be helpful, we were able to change or amend our EHDI role to have under our purple reporting to the debtor the department of health section two state that the department shall have access to infants medical, diagnostic and early intervention records to obtain information necessary to ensure the provision of timely and appropriate follow-up diagnostic and intervention services including CMB congenital CMB is sick while I treatments and anything else deemed it necessary to determine long-term outcomes.

It is in our role in which that has helped us to have the legal backing for us to obtain those this information without them saying no, I am not allowed to share it or whatever. What we can site it is actually in the rule that you can, and in the role we always have confidentiality Alec confidentiality of reporter information that we are not allowed to share in the information is protected under this rule.

>>: I'm so glad that our state is next to yours. This is Terri. I do want to mention one thing that we do have a workaround in Louisiana and our family service coordinators are not knowledgeable about hearing loss, but what we're doing, we actually are doing a PDSA right now and we are having our nonPart C specialized providers from the school to the deaf were setting it up and coordinating Avenue between our Part C program to have those providers who are knowledgeable about hearing loss participate in at least the additional I IFSP meetings.

>>: The reason I ask that the states call themselves out is if you want to talk to a state that is on the move with this, you know who everyone is.

>>: I'm going to make it brief. This is Lisa Van from Rhode Island. We also have a workaround. Our non-Part C around the state contract with directly with early intervention so each non-Part C will go to each agency and develop a contract so that they can provide services. Unfortunately, because of the model EI uses, the family needs to request it. It is not automatic. That is where we are working on is trying to make sure that early intervention offers it and educates the family around it, but we do have at least that in place.

>>: Let me ask all of you, do you want to move on to the second half or recite here? I'm seeing a secondhand. Just a couple of short introductory notions.

But first you should introduce yourself.

>>: Sure hi, everybody, nice to see everybody here. I am Allison Setty and I am Colorado Boulder and I work with Odyssey, which is ODDACE Project it is stands for Outcomes and Developmental Data Assistance Center and we are working with early intervention programs across the U.S. to gather a standard set of standard outcomes. Purposes for EHDI program to include this comes in there database and I'm going to be sharing a little more about that project and what it looks like in our database and our EHDI database in Colorado. Thanks.

I need these more than you.

Documenting development outcomes and kind of two parts. Collecting information, back to this notion and collecting standardized, norm-referenced developmental evaluations. And all these developmental areas.

There is collecting it and then there is entering it into a data system. And we already have some nice comments about how to do that. So, collecting information. There is some generic information, right, like Part C requires assessment. Because at least at least for bilateral hearing loss, kids are categorically eligible for services and most if not all states. You don't need an evaluation of the child to qualify for Part C. At least in Colorado you don't have child data at entry to early intervention.

Then there is the independent private practitioners, nonprofits, option schools, and whatnot that are not Part C. I am pretty sure they're going to be doing developmental evaluations. We are already seeing differences in what one might collect. What about developmental information, assessment information specific to deaf or hard of hearing? Colorado's family assessment and that is an acronym, family assessment of multidisciplinary interactional learning for the young child. It is a project that I was hired to work on in the '80s. Why? I was a consultant with the health department. Prenewborn hearing screening, health department is funded by the legislature, the JVC at the legislature said you are spending money on direct services to children. It was the '80s, health department did more direct services, you have the small population of kids, under 100 kids, you're paying this person, me, and others to run the program, what is your money going toward? How do we know it works? You need to justify that you're getting this money. My hours were increased, and I developed an assessment protocol if you will. It is kind of cool. Has video type and we analyze it for speech and language and me being a very generic week I was at the University for years and Allison is in charge of it. Published it in 92. Christie associate to Nago ran with the. In Colorado there is a notion when it was easy to measure child outcomes to see if children are making six months of growth in six months time. It is hard to wreck it replicated it is a very but the ODDACE Project is in his same space I think. Idaho's project Ojai Perry. And their other inner avenues to collect data. Once it is collected, it is the entering into accounting for it integrating databases and some of what we have already talked about. I will say no more Perry, will you introduce yourself first.

>>: Hello my name is Perry Smith and I am the EHDI coordinator for the state of Nevada. It is great to be here. I walked in late and I was giving another presentation right before that.

>>: We're going to give two examples as I said earlier. Allison with ODDACE Project, more national, and Brian for Idaho, and then again open it up to all of you.

>>: Brian will show this also, but we are collaborating with Idaho also so it is kind of a three way thing happening in Idaho. As I mentioned, I am with ODDACE Project Outcomes and Developmental Data Assistance Center sponsored by the CDC. We are partnering with early intervention programs all across the U.S. and some of them are the states that you work and pick what we're doing is collecting the same set of developmental outcome data from each of these early intervention programs. Most of the programs we work with our statewide programs like the Idaho school for the deaf that Brian mentioned. We're monitoring the kid's progress every six months so going back to the slide that Arlene showed in the beginning with the JCIH guidelines our center is in response to those guidelines. We're monitoring every six months and using the norm-referenced standardized assessment and it is a consistent set. That is part of a problem if you're going to build out fields in the database but all the EI providers are doing the kind of their own thing and picking their own instrument, it is pretty hard to build fields for 20 different assessments and then try to put them all together and make any sense out of them. Honestly,, you can't because each assessment is different in terms of the population it was normed on and how easy it is to that kids tend to score higher low. You can't mix them together. Having that consistency across the program is absolutely critical. Unless you want to have tons of fields and have 10 kids who have this one and two who have that one in 20 who have this one, which would not be all that useful.

Here is our partnering programs. You can take a look up and see if any of these are in your state. We're currently working with 15 different states, a total of 17 different programs. A couple states, Texas and Maine, have two programs that we're working with. Where trying this much is possible to partner with programs that work statewide, so in a lot of cases, that is the school for the deaf. They have an outreach department that -- all over their state, like Idaho, Arizona, Colorado, a lot of states use that model. That is where the specialty providers, and that we are talking about. They may not be the service coordinators, but they ultimately are the person that the family gets connected to that they're getting their home visits from an intervention from.

My hope is that our center and a sense will make it easier for you if you have interest in having outcome data in your EHDI database. I'm going to show what our database looks like in Colorado. Bride is going to talk a little bit about what he is helping to build in Idaho. As Arlene mentioned, there are different routes to getting things into different places, so we have a couple different models that we are using through ODDACE Project they were collecting to use us into EHDI databases. Cut in Colorado because I'm use of the database system I could just use it. If you had, if there is a way in with your EHDI database to have an outside user be able to go in and put the data in our center could do that for you another way to do it in another state that we are working with, we have the families sign an extra release of information so they set of or release of information so the intervention program can send the language outcome data to us. And one of our states that we are partnering with, they also signed a release of information so that we can then send that data out to the EHDI program and they could put in there EHDI database if they wish. That is the one on the left were the intervention to us and we send the information to the EHDI program and they can put that into there database.

We can do that in a variety of ways. It can be old-fashioned manual, here is a spreadsheet and you enter the data it is not usually a lot of numbers to be entered. And a large state that will be cumbersome obviously. Another method and this is what we are are exploring with Idaho now is to send a flat file, a CSV file with the data whether quarterly or couple times a year and that would be uploaded and linked to the data in the EHDI system which would be much more efficient than the manual entry.

Another way of doing that is to be similar to what we're talking about with Idaho is because we are not having the families sign a release further information to go straight to EHDI, the EHDI in the early intervention program have a data sharing agreement so that is the model on the right where would go first from early intervention to ODDACE who would then send the flat file back to the EI program and it was there data to begin with. We have a data sharing agreement that we can send it back and forth to each other and that since they have a data sharing agreement with EHDI, they send the flat file to EHDI. It works this way around and that is easy and not an update hassle or time-consuming at all. I will show you a little bit about what it looks like in our database in Colorado. This is sort of the front facing page and you can see this particular child has had two different assessments actually they had for the two assessments that we do that are norm-referenced and standardized and they also need all the meat of the developmental areas motor, social emotional, language and communication, cognitive, and MacArthur, which is a more specific language measure both standardized and norm-referenced. You can see those at the type practices have been twice for this kid at six-month intervals.

Down to the bottom row we assess the child again I click the bottom row at a new assessment and that we have a new line in there. When I say add a new assessment, it looks like this so here's all the fields and I can look and go that's not much, but you might say that's a lot but you can tailor it to whatever you want in terms of how much information you want to put in there honestly this is really just a summary subset of what we are gathering, but some of the most important pieces which are the percentile ranks, which tell you is the child in the average range or are they not. If you were to pull your data that would be the biggest question you have. What percentage of our kids are their language or motor skills or developmental era you want to look at, is it in the average range or not? I just want to say that if you decide to put out outcome fields in your database whether it is connected to our project or your own deal, I would strongly recommend that you have what I have at the very top, which is to have something were somebody but would be able to indicate if that child had additional disabilities because the data is not going to be all that useful if you're co- mingling kids who have severe other special needs with kids who are deaf or hard of hearing only. Because, of course, with the the kids with severe special needs typically are going to be delayed and very significant ways potentially and if you just glom out altogether you can't really what percentage of the Devon hard-of-hearing has earned the average range will not look favorable because you're off, go get kids with significant needs. I would add that she can disaggregate a lease between those two groups and then you can disaggregate anything else you have in your database. You can cut the age of identification anywhere you want. Let's look at a group of us was identified by three months, six months, let's look at there language outcome spark having those in here or in combination with what you have already have and would be really powerful for looking at subgroups. We are partnering with new programs and new states so if you're thinking this might make things a little easier and make this actually doable for us, I would be happy to be connected with the early intervention program. I will say in most cases, we are looking more with the specialty program, not necessarily with the generic Part C. At some of the states we are working with generic Part C. It is doable potentially either way.

I would be happy to talk to anybody more that might be interested in it and if we have time for questions I will be here to answer them.

>>: Thank you Allison. I just want to say from the start that I've been dreaming about this since I became the EHDI coordinator. How do we know our 1-3-6 guidelines worker for not measuring the outcomes. I've been working on it since 2014 and it is starting to become real and I am super excited.

The second thing I need to mention with this is that these are Doctor Blaser slides as she was originally supposed to come, but she was unable to the last minute. You would have gotten much better presentation. If I misspeak on anything having to do with speech-language pathologist or early intervention, please correct me.

The way we started this program is I'm not sure how many people are familiar with and National childhood Association project. If you're involved with that too Allison at so the funding got cut and Idaho just decided that we are not going to stop doing the assessments. We just kept going and Idaho and changed Idaho collaborative assessment program is so's are schools for the deaf EHDI program at Idaho State University melded funds and kept the project going.

So what we are trying to do is assess our children. These are the seven health regions and Idaho. That is all the slide is about. We can group our children by region and that will come into play in just a minute.

Just like Allison was mentioning, we keep track of all of our children's metrics just like we do at EHDI. Are screened by one month, diagnosed by three months, and rolled in early intervention by six months, and if the child was cleared for hearing aids were keeping track of that, not very well, but I'm going to do back data so we can make this data more robust.

Just like Allison said, we are keeping track of all of these things. You can select the group of children just by what I just mentioned. We started our eye cap data in 2016 and so in 2021 pretty well together and again just like Allison mentioned we are starting we did not think about it were more focused on just continuing to collect the data about where adding the presence of an additional disability this year so we can separate those two groups and that is a fantastic point and I wish I would have thought of it.

These are the scores that we've been keeping. We do the language use inventory and MacArthur base and MacArthur Bates words and sentences the top one is just one individual child's score. This is what Dr. Blaser is really into. She can take these scores from one child find out where their decision sees deficiencies are and send them links to exercises the parent can do with the child of the speech-language pathologist kid focused training specifically, but with a child needs to work on and if you look below you can see that these colors are tied to the states. This is aggregate data for our state. I can look at where children as a whole, groups of children in each region are not doing so well and we can focus our trainings with SLPs and EI outcome providers and we can focus trainings were just in that specific regions. In upper Idaho we are not doing so well on the spirit we focus the trainings and get more tools to our EI programs so we can help those kids. That is about the end, but we started working with Allison in June, Allison; is that correct? And reuse to go from the school of the deaf deaf Dido state and we do have capture fields just like she was showing on our screen I did not get one for EHDI system, but we can build this church. Anyway we are super excited.

>>: And Terri, Perry, do you have any comments about your state and outcome data and databases.

>>: Thank you. Nevada has a very unique situation with our early intervention between EHDI and early intervention. We have always worked very well with our EI services. We have had a data sharing agreement with them for about 15 years plus we have such a good relationship with them. No one would even -- everyone would consider continue to function progress of unique situation in that we have very, very few pediatric audiologists, but our pediatric all the audiologist are all hired by early intervention services so they are in the same building so when somebody, an infant is referred to a pediatric audiologists, they are in the same building as our EI program so once they are diagnosed they walked down the hall and almost automatically enrolled. Our referral rate is something like 97% in the ERI. Enrollment is a little bit less than that, but we have always had a great relationship.

Currently the EHDI program is in the process of updating our EHDI ISS system. We offer the opportunity to expand on the data fields related to the EI information. Any kind of outcome data, right now we do not collect the EHDI program to stop at the EI does and we will not have an information system or we can request that information and put it in to our EHDI ISS. We are in a unique situation to have a good relationship there and we will be building those additional fields in our EHDI ISS so we will will have more outcome data.

>>: In Louisiana are non-Part C program we have a dated sharing agreement and they complete the language development scale twice per year. We teach the students that they serve. They provide each individual teacher who completes the LDS shares the information with our program. We did need to manually enter it into our database, which we have a data clerk who does some other data entry, so that is not too much of a problem with the small population. Then with our Part C program, we have a data sharing agreement, and Part C puts their data on a server in our and our epidemiologist gets the data from the server, does a data match with all the children in our program, and he gets the scores for the but tell, which is completed annually at entry and once per year for each child so we're able to obtain the data from them that way it also needs to be currently manually entered into the database.

>>: Now to all of you for questions of the group or comments in your states. Stephanie, I am heading to you.

>>: Thank you. I had a question of Allison. On the Odyssey project. The instruments, the assessments that are being conducted they are all the same for any of the participating partners is what I understood and my question is did all those partners agree to complete those assessments or somebody from ODDACE doing the assessments.

>>: The first part is a verbally doing the same thing, yes. We have two assessments that have agreed to do and that is what participating is as agreeing to do those two assessments. We are flexible with the program if the program has other things they are required by the state entity if they just want to do one of the two if that is going to be more manageable for them, that is acceptable. We encourage the due which are the daisy in the MacArthur, but they can choose just one of the two if they wish. That we have others who are doing additional assessments and with things we do with each of the programs as we are creating a database for them on our site and that is what we could potentially share back to them to share with you or share directly with you if we had data sharing agreements et cetera. Some of the programs are saying we already do the LDS and the we went data about that too because annually I send them back a report that summarizes how the kids are doing, strengths and challenges, how that looks compared to all the other programs that are in our database and we have 17 programs so they can compare their numbers to the other 16 programs that we are currently partnering with. We might also have the LDS on some of the programs. We have a list of optional assessments completely up to the program whether they want to do them or not, but if they are doing them anyway, they would love that to have that data compiled for them and get that report back.

Was the second question, I'm sorry? Do they do it or do we do it. They do it. They agree to do the assessments, we provide training as needed and in all the states we get at least some training because we also have some other little pieces and how they get it to us et cetera.

Then they are the ones as they work with the family who would do the assessment and then they send that to us. One of the services we offer that some of the programs really appreciate is that we score everything for them. The Daisy if you were to score a by hand, it takes about 15 or 20 minutes to do. It is a lot looking at the manual. They do have a commercial scoring program that speeds things up but anyway we are happy to score four people and we can turn around within two weeks is not like they send us the data and six months later they find out how the child was doing. It is a timely fashion, often within four to six days they have the results back. We make it a nice report for them that they can share it with the family including the child's file, a nice graph that shows the various development areas and where the child's functioning in the different areas. Even though it had some burden to the program to do some extra pieces of paperwork, I hope that is balanced by what we are able to give back to the both of the annual of poor report about the program overall and the individual child reports that we provide.

>>: I would just say, too there is a beauty to the consistency rather than each estate making a decision about okay we will do the statewide if we really want to be able to look nationally, and how children are doing across states, it has to be that Everett has agreed to use at least one thing and common. If you have states where you are collecting outcomes are ready to put them in the database, I would have to talk with your program to see if they are using the same instruments that many other programs across the U.S. are using and if not that would be something that they would be interested in.

>>: We have time for one more comment or question.

>>: This group is never this quiet. Want to shake hands?

>>:

A quick comment just to put in a plug for the ODDACE. We have a number of things related to our HRSA agreement and early intervention. We are looking at that I in EHDI and looking out a bunch of different partners so it is now on the EHDI program. These outcomes obviously, if you're just going to be testing things to improve early intervention you need outcome data so with Alison's help and the ODDACE project, that see the CDC, were able to see if if the things that were trying to prove route to improve and early intervention in Wyoming are working. A plug for Allison a plug for Allison and the opportunity to work together.

And the hundred dollar bill I promised you is right under the tablecloth. Oh did I say that the microphone? Linda.

>>: I just want to follow up with a comment as well. Vermont is involved with ODDACE work as well. It is it is phenomenal and we are excited to start tracking outcome measures. Thank you Allison.

>>: And that was the final word. We are done.

(Applause)

See you later.