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National Center for Hearing Assessment and Management
The Who, What, How of Learning Communities
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>> ALLISON: Welcome, everyone. We know that there's been a lot of anticipation around learning communities that are described in the most recent FOA from HERSA. We hope that the webinar today will provide a lot of clarification as well as get your questions answered. So the title of today's webinar is the who, what, and how of EDHI learning communities. We have a good lineup set up for this afternoon. First we'll hear from Sadie Silcott who's the EDHI program director at the maternal and child health bureau. And then Karl white will follow Sadie. We'll hear three excellent state examples of different learning systems that those states are using that are either learning communities or will be morphing into or informing learning communities. So we'll be hearing from Gloria in New York, Tanya Green in Maryland and Brenda Coufal and Melissa Butler in Nebraska. I'll turn it over to Sadie. We'll be doing questions in the Q&A box at the end of the webinar, and so you'll have an opportunity to ask questions toward the end. And let's go ahead and get started. Go ahead, Sadie.

>> SADIE SILCOTT: Thank you, Allison. Before I begin I just want to give the members of the universal newborn hearing screening program a chance to introduce themselves.

>> Hi, this is Sandra, one of the project officers.

>> And Michelle.

>> SADIE SILCOTT: Our branch chief should be joining us shortly. And I just want to extend an official welcome to all of you to this new project cycle. We're very excited to be working on the initiative, some of them new. But we do think it's going to be a productive couple of years. Having said that, the next issue that I'd like to address very briefly before we get into the learning community portion of this are the notice of awards. We do know that some states and territories have -- have received their notice of awards. For those of you who have not received them, please don't panic. We are still working on processing them, and you will -- all of you will receive your NOA eventually.

Okay. So I have a few program updates that I would like to share as it pertains to

the learning community. When it comes onto the data collection portion of the learning community, there are five measures that you will be required to collect on, but we do realize that those measures need to be defined more and there needs to be more clarification around them. So the team and I in conjunction with leadership, we are working on defining those measures some more. Once that has been accomplished, we are going to send those measures to you with the expected reporting date of those measures. So that is something that is in progress on our end.

When it comes onto the initial written learning community report, that won't be due until April 1st of next year. And we will expect to have reports -- written reports regarding the learning community each year thereafter in addition to the non-competing continuation progress report. So when the NCC progress report is due at the same time, the expectation is that you also include a written report about the learning community with that report as well. We will remind you of this throughout the process.

So I wanted to highlight the care coordination piece to the data collection measures again. We do realize that there is -- that there needs to be more clarification surrounding that. And we want to assure you that we are going to have a minimum of two care coordination technical assistance webinars. And part of that will be defining care coordination as well as the care coordination plan. So while we are working on addressing those measures, if you have any questions about care coordination or the measures, you know, we'll be more than happy to -- to -- you can submit them to us. You can submit them on this webinar if you think of them while we're having this discussion and you can also let the project officers know and we'll be sure to incorporate that feedback as we finalize the clarification surrounding that.

Having said that, I also want to let everyone know that if there's any additional topics or challenges that you would like to have us address in a webinar format, please let us know. You all have been really great at providing suggestions to us pertaining to that and we want to be sure that we are, you know, continuing to respond to your needs. May I have the next slide, please? Can we advance this? Okay. Thank you.

So I just wanted to highlight the purpose of the learning community which is to increase the knowledge and engagement of pediatric health care professionals and families within the early hearing detection and intervention system in order to ensure that deaf and hard of hearing children are identified through hearing screening, that they receive evaluation, diagnosis, the appropriate interventions that they may need in order to optimize their language, literacy and social emotional development. When it comes onto the participants of the learning community, they should include pediatric health care professionals and these can be from a range of organizations, community health care centers as well as private practices. So other participants include clinicians as well as family members of deaf or hard of hearing children. And the size of the learning community ideally should be at least 10 to 20 individuals. Having said that, we do realize that -- that the size may vary from state as well as territory. May I have the next slide, please? Thank you.

So in order to achieve the purpose of the learning community, there are several focus areas that we definitely feel as though it would be beneficial to address. There are nine of them. I am not going to go through all nine, but they do include the JCIH1-3-6 timeline, the pair to pair information sharing as well as improving care coordination through the care and center family homes. May I have the next slide, please? Other focus areas include providing family center care, developing collaborative leadership skills for members of family programs or organizations, and just making sure that we're

including our family partners in the child's overall health care. And I just want to be sure that the states and territories know that we do realize that each of you are different. So we do know that some states may choose to focus on topics longer or shorter than other states depending on their needs, and that's completely fine.

I am now going to turn the presentation over to Dr. White.

>> KARL WHITE: Thanks, Sadie. And just to remind all of us when we aren't speaking to put our phones on mute. I think that will help everywhere. So Sadie's already talked a little bit about the goal of the EDHI learning communities. What I want to emphasize on this slide is that we recognize that the FOA requires you to engage in a lot of different activities. The learning communities are just one of those activities, but the learning communities as well as the other kinds of activities that you're doing should all contribute to the overall goal of increasing the knowledge and engagement of all your EHDI stake holders so the outcomes for children who are deaf and hard of hearing are improved. And the overall goal of the grant that you've received should result in achieving increases in the number of children diagnosed before 3 months of age, the number of children referred to early intervention before six months of age, and the number of children actually enrolled in early intervention services.

So even though the learning communities are just one part of that total system, they should also make a contribution to that, but we recognize that the learning communities by themselves will not achieve those goals. So all of the other things you're doing that are related to family engagement and are related to making sure that your screening programs get the kind of support that -- that -- that they need, your work in engaging the medical home providers, your work in -- with the family-based organizations that are assisting you in reaching out to families, all of those things are a part of the larger package. And as important as the learning community is, it's just one part of that package but the activities of that learning community should contribute to that overall goal that you're doing.

Now, Sadie talked about those nine areas that the learning community is supposed to focus on. I just want to, again, make it clear that as you put together your learning communities, they're working on that overall goal and the topics listed here will in some way contribute to that goal. But depending on the situation in your state, you may spend a lot of time on area number five whereas another state may spend very little time on area number five and spend more time on area number eight. So, the even though MCHB expects you to address all nine of those areas at some point during the learning community, you don't need to feel like each one is of equal importance. And in fact, the people who you invite to participate in your learning community should reflect what you see as the most essential areas within your state. So in one state, you may need people as participants in the learning community who are very involved in linking newborn hearing screening data to other database programs such as vital statistics, immunization and blood spot screening, but another state may not have a person on the learning community who's an expert in that area, but they may invite an expert to come in for a limited number of sessions or meetings with the learning community to provide expertise in that area.

So there's a lot of flexibility in how the learning communities will be designed in each state. Sadie mentioned some of the basic expectations in terms of numbers of people and some of the people who should be on it, but the final decisions on how to organize that, as long as you're operating within these parameters, are really left up to you. In addition to the information that was in the FOA NCHAM has put together and it's

in the lower left-hand portion of your screen, a document that provides some beginning resources to address each of those nine areas. And you may want to download that to get an idea of what's included. Those resources are not a road map. They don't provide everything, but they will give you a starting place to begin thinking about these nine areas and how you're going to incorporate that into your work establishing a learning community.

We expect that those learning communities will be fully organized and that the first meeting will be held during the first six months of the grant period because of the initial reduction in funding and the fact that then the full funding, some of you still don't have it, but as Sadie said, I know some states have already received a notice of grant awards. And I'm thinking the other states will receive them fairly soon. But that has delayed some of the timelines that were in the FOA. We sent a letter out yesterday that had been crafted in conjunction with MCHB with some new timelines, so you'll have those in writing. They're consistent with what I'm showing here. But -- so by September 30th, which is six months into the grant period, your learning community should be completely organized, you should have held your first meeting, you should be off and running. And then by the end of the first year, different from what's in the FOA, there will be no reporting on the behavioral measures during the first year, but you are expected to submit a written report to MCHB by April 1st that describes what you've done with the learning community, who's on it, what meetings you've held, what topics you're addressing, any challenges you've encountered, how you've tried to overcome those challenges, et cetera.

And then as Sadie mentioned, you will be getting some more information about the measures that you'll be expected to report on every six months beginning September 30th of 2018. So that will be a year and a half into the grant period. In the letter we sent yesterday, the tentative measures which are pretty consistent with what was in the FOA are listed there, but as Sadie mentioned, you'll be getting some additional information about that in the near future. For the logistics of the learning community, as you read the literature about what makes effective learning community, there's some consistent themes. One of them is that it's important how people are recruited or invited to participate in the learning community. A personal invitation from the state EHDI program director or from even the person responsible for the children with special health care needs program within the state. People need to feel like this is an important activity, which it is, and a good learning community can really contribute to your success in implementing a successful program. So putting some effort into making sure that people realize this is an important activity and that their input is needed and valued is important.

The group needs to be large enough to be inclusive of all of the ski stakeholders, but still small enough to be effective. You notice that the FOAs did not stipulate exactly how many people should be on the learning community and that will be left up to your discretion as state EHDI coordinators to some degree. There were some key people that need to be involved that Sadie mentioned. There needs to be at least one pediatric primary care provider included in that group. There needs to be a care coordinator involved in that learning community. There needs to be a family member. But you may want two pediatric primary care providers or three. You may want multiple parents. You will probably need people from some of the advocacy groups or some of the family-based organizations. You decide who this most important people are to have be a part of that learning community based on what your priorities are in the state for the

learning community to address within the very broad guidelines that MCHB has provided.

People who have been successful in doing learning communities indicate that at least one in-person meeting seems to be important to establish group cohesion and get the group started. The FOA indicates that the learning community can be mostly virtual. There's nothing wrong with that. If you decide it's going to be all virtual because of the logistics in your state, that's within the requirements of the FOA. But we would strongly encourage you to at least consider having one in-person meeting near the beginning to get it started and to establish the cohesion. We don't expect that all members of the learning community will be equally involved in all issues. I mean, there will be -- of those nine issues that the learning community is addressing, some people will be more relevant to some issues than to other issues. But everyone in that learning community needs to be committed to the overall goal of improving services to children who are deaf and hard of hearing and to address those issues which will enable you to increase the number of children diagnosed under 36 months of age or under 3 months of age, excuse me, getting children enrolled in early intervention programs under 6 months of age, et cetera. So it will happen differently in every state, but these are some of the guidelines that you should consider.

In terms of other factors that contribute to a successful learning community, it's important that the people who are participating understand the overall vision of the learning community. Those nine areas that are listed in the FOA are all components that will contribute to that, but they need to understand that the purpose of this learning community is to improve services to children who are deaf and hard of hearing. And you may find that there are other issues in your particular state beyond those nine issues that are critical to improving services to children who are deaf and hard of hearing. And of course you can include other issues in -- if that's what's needed in your state. People need to also feel that they're a part of this team and that there's a collective responsibility to make the learning community successful. Learning communities and the educational literature are often referred to as professional learning communities. And it's important that all members of that team feel equally important even though a family member who's on that learning community may not be working as a professional, quote, unquote, in the field, they are just as professional and just as needed even though they are only a family member. I wish we could do away with that term, "only a family member," because they are the reason that we are doing this.

Making sure that there's opportunity for all of the people to collaborate, that there's mutual trust and respect. That they feel included. And importantly, that there's flexibility in how the community proceeds as you have that first meeting. And subsequent meetings and begin to understand what you're trying to achieve. So good luck. And we'll turn the time over to New York to talk about some of their experiences with a learning collaborative that they've been working on.

>> This is Allison really quick. I do just want to remind people that we will be taking questions at the end of the presentation and so just hold tight and you'll -- you'll have an opportunity to ask questions. I also, again, want to highlight the learning community resource that is down in the bottom left-hand corner. You can click the download button and that will automatically download to your computer, and we will also be e-mailing it to all attendees today and posting it on infanthearing.org. Lori, we'll turn the time over to you.

>> LORI IAROSI: Thank you, Allison. I want to thank you for the opportunity to

present on today's webinar. We're very excited to share the results of our recent learning collaborative. I would like to acknowledge all of the hard work and dedication of the individuals on the slides. It was truly a team effort. So we first began our learning community, we went back to the basics. And we really identified our best practices that were found from the global, across the country quality improvement collaborative that NCHAM did in the late 2000s. We drew upon those best practices and infused all of those efforts into our quality improvement efforts so that we could make sure we were really thoughtful about making sure that our providers were informed about really the best practices at the national level.

So the learning collaborative began with a recruitment process and building the teams of the individuals as Karl mentioned is really instrumental and crucial to the success of the collaborative. The EHDI program was of course the lead agency for the learning collaborative. We also had the support of our NICHQ advisors and largely from the advisory work group across the state from our EHDI program. It was representative of the providers of the EHDI system of care, which included parents of children who are hard of hearing and also representatives from the deaf community. Our hospital teams also were very important obviously to the learning collaborative. And each team must include a newborn hearing screening manager, a birth registrar and an audiologist. And this really, again, speaks to that team approach so that everybody has a voice in the learning community and is kept informed about the progress along the way as well.

So the framework for our learning collaborative really begins with recruitment. As Karl mentioned, it's a very important part of the process. In New York, we were very strategic about the selection of the birthing facilities and audiologists that would be part of our learning collaborative. There was a lot of planning that was done and a recruitment package was compiled with the assistance of NICHQ. It laid out the purpose and goals so that participants knew what their role was, which was important for them to make sure decision about committing to the time period of the learning collaborative. We also had three in-person learning sessions. We conducted monthly coaching webinars, leading those calls and helping to structure and keep us on task in moving forward. The hospital shared their PDSAs and talked with each other about lessons learned and challenges and they really did work together to help each other overcome some common barriers. We also had monthly calls one on one directly with the EHDI program and the local hospital and helped them work through their quality improvement and barriers and challenges.

We compiled informational list and we found that very helpful for communication across all of the providers. Finally, we had a celebration of success at the end of the learning collaborative. We really did recognize all of the great work that was done, and that sets the ground for future collaborations with all of these hospitals and providers. So our learning collaborative was two years, 2015-2016. Phase one was in year 2015. It was focused on improving the newborn screening disposition rates in our information system and then phase two was focused on follow-up. I know that the numbers are very small and you can't read them. It's the goal here is to just let you know that data really did drive our decision for who we wanted to recruit into the first learning collaborative that we had. And we took a look at the prior quarters, initial hearing screening rates and we simply put them on a spreadsheet and we sorted them in descending order. Those that fell to the top were the hospitals that we wanted to recruit because they were missing the most results. There's a clear delineation between the top 29 and the remaining hospitals in the New York state. Those were the hospitals that we invited into

our learning collaborative.

As Karl mentioned, the recruitment letter that you're going to send out to your potential providers is very important. This is a very small snippet from it. We included in this letter the benefits for them in participating in the learning collaborative. So they understood we would be providing assistance and training, resources and tools that would help them improve their reporting and services to their patients. So phase one looking again at the initial hearing screen dispositions, you can see from the dotted line that our hospitals in the quality improvement collaborative started with a baseline of about 72% reporting and they had a marked improvement really close to 98%. Across the continuum of the learning collaborative which is -- represents more than 30,000 babies per year in New York state because our birth cohort is 240,000 babies. So that was a dramatic improvement in their hearing screening dispositions.

Looking at phase two, it didn't start until January of 2016. You can look at that beginning time frame, you can see the improvement that occurred and then the sustained improvement from then to the end of the collaborative. So we had a number of challenges and also lessons learned. Really I want to highlight the challenge that -- that we really worked very hard to overcome was that everybody seemed to be working in silos at the hospital and really team work and collaboration across the departments was a problem. And sometimes the birth registrar had never met the newborn hearing screening manager. So these individuals were able to come together and really work toward a common goal and each contributed in a -- you know, a different way, but truly to the success of the collaborative. It was a very important success. And also for lessons learned, we really want to highlight that communication and feedback to the hospitals was essential. We heard from them often that the data reports were very, very important to them so they could track their progress. And also they really valued the coaching calls and the in-person sessions that were held.

So as we look forward to our learning community that we're building this year, here's a geographic and population map of New York state. We are going to focus in the Buffalo area which is to the western part of the state. We did look at data when we were first organizing our learning community and talking with our advisory group about it, but unlike initial hearing screens where most of the missing results were localized in one area in New York City, we have a widespread problem across the whole state for follow-up reporting. Instead of looking at data, we're looking at where our partners are. We have a number of birthing facilities, pediatric audiologists, we have several family organizations in the western part of the state, a school for the deaf, and a lot of -- plus an AAP chapter champion. So with all of those wonderful partners and the infrastructure really in place to help us kickoff this learning community, we feel that this is the best place in the state for us to really focus for the first year. So we're looking forward to kicking our learning community off in the fall. It will largely be structured similar to the last learning collaborative that we had with using the IHI breakthrough series model and our NICHQ advisors. We're making all those plans and looking at our data. So we're excited to be moving forward and looking at this next phase. So I want to thank you today, again, for the opportunity to present.

>> Thank you, Lori. We really appreciate it. I think it's nice to see how your learning collaborative is working or informing your learning community. I do want to highlight that all of the presenter's contact information, their e-mail in particular, is located on the left-hand side of the screen. Thanks again, Lori. I will turn the time over to Tanya for Maryland.

>> TANYA GREEN: Thank you, Allison. So Maryland was asked to share their current plan for the learning communities moving forward with respect to the current FOA. So that's what I'll be sharing with you today. The Maryland EHDI program's plan for development and implementation of the learning community as required by the current HRSA grant for our beginning stages and plan, we are building upon prior success and quality improvement in learning community. The work was conducted by partners who have worked very closely with our office and with the department of health. And they are a big part of what we will be doing for the EHDI program.

We're including a network of partners and collaborators at the state and regional levels working to improve the leadership and collaborative infrastructure for the system statewide to improve timely identification and EI referral and enrollment of infants. We're working to improve family engagement and leadership in the system of care. For our project team leaders, that would be the EHDI coordinator, myself, also the project director of the parents place of Maryland. Her name is Renee. It's a family to family organization and they were a part of the previous learning collaborative that this model is based upon. There's a family engagement coordinator Sherry Doweling who is associated with the state school for the deaf as well as the parent's place of Maryland. She also heads up the Maryland parent to parent mentor program for parents of children who are deaf or hard of hearing. That program is called parent connection. There's also a learning community coordinator Stacey Taylor. Our content expert is Dr. Debbie Badawi. She's also our Maryland EHDI chapter champion and previously worked for the department of health and was involved heavily in the previous learning community that this model is based upon.

Our partnerships again are with the EHDI program in Maryland, parents' place in Maryland and the university of Maryland school of medicine. Our partners will work to strengthen the bonds and expand their reach to improve service delivery in a way that will reduce barriers to screening, diagnosis and referral, increase access to medical homes, engage families in the EHDI process and improve outcomes for Maryland babies identified as deaf or hard of hearing. The learning community members -- so this slide actually reflects more of our ad hoc advisory committee. So I won't be talking from this slide, and I'll replace that for the posting so that you can post the revised version of the presentation, but the learning community itself will consist of two cohorts of five pediatric practices which are yet to be selected. We're working toward that. We will have a total of ten practices in all. Nursing staff at these practices will be the recruitment target. The focus will be on practices in geographic areas of the state where the loss to follow-up is highest.

Learning community members will also include the Maryland EHDI program, parents' place of Maryland staff as previously described, the university of Maryland physician who is also our AAP chapter champion for Maryland. We will be including community-based care coordinators, family members of children who are deaf or hard of hearing, health care providers which will include audiologists and nurses as well as early intervention providers. The focus of the learning community is to engage health care professionals, families, and other stakeholders. So partners will work with the Maryland EHDI program on quality improvement strategies that will allow participants to effectively contribute and participate in the EHDI system to improve outcomes for all Maryland babies.

We're working to develop curriculum materials and timelines for the learning community. We'll be developing data collection tools and systems to evaluate behavioral

change among learning community participants, obtaining feedback on materials from the participants, including the parents and family members who will be involved. We'll be obtaining CEUs for participants in the learning community. That's one of the bonuses for the community and one of the benefits to them for participating. Again, I will repeat that we're recruiting five primary practices per cohort for a total of ten practices for the learning community and recruiting community stakeholders and families of children who are deaf and/or hard of hearing. We'll be recruiting and training parent partners who will be paired with the primary care practices. We'll share the goals of the project with the learning community partners so that they may provide us with valuable feedback. Technical assistance will be provided to partners who need to improve in their area of the 1-3-6 EHDI process.

Learning communities' progress will of course will reported to HRSA. So in terms of the learning community structure, I've mentioned who will be participating and also the frequency of the meetings. We'll start with more frequent meetings. As time goes on, we'll meet a little less. We will be meeting in person as well as teleconferencing. The meeting facilitator may vary over time. We'll modify as we go along. The EHDI coordinator will be involved in stakeholder outreach as well as involved in the planning. Family engagement strategies, we do have a very detailed plan for family engagement. My time is running out, so I won't go into details about that, but in terms of next steps and lessons learned from the previous collaborative which this collaborative is based upon, they shared that it's important to take advantage of relationships that are already in place. And to be careful not to reinvent the wheel by trying to form new partnerships. Be detailed in your work, document your steps so you can duplicate them, be extremely organized, and level of trust and good working relationships are imperative, particularly when working with parents of children who have special health care needs. That's a quote from Stacey Taylor. She did work on the previous model.

I must thank Josie Thomas, she's the retiring executive director of the parents' place of Maryland. And because she has such impact and great input in the information that I've presented to you today as well as Dr. Debbie and Stacey Taylor, I wanted to give them their due recognition, thank you.

>> Thank you, Tanya, we appreciate it. We're going to now turn the time over to Brenda and Melissa in Nebraska.

>> Thank you, Allison for the opportunity to present today. I also want to thank the Nebraska EHDI team and learning community members for all their work to start this project. Today, I want to share with you our Nebraska tele-audiology learning community. Nebraska EHDI is the leader of this project. Melissa Butler leads the meetings. She started research on this project early 2016 before I started as the new EHDI coordinator in August of 2016. It made the most sense for her to continue and lead the project. I am currently involved by continuing a variety of meetings to gather more information for the project and discuss ideas. Melissa is also on the call today and will help answer questions any of you may have. I just want to also let you know that our first meeting was in November of 2016, so we're just beginning the stages of our learning community. Members of our learning community include several individuals from western Nebraska. They are educational service units, ESU number 13, audiology clinic of western Nebraska, parents Nebraska liaison of the deaf and hard of hearing with educational service unit number nine. The people understand the area and the need.

Other members are also boys town national research hospital, children's hospital

and medical center, Barkley's speech language and hearing clinic. They know what is needed to conduct audiology services and will connect with the site to conduct the diagnostic evaluation. We also want to thank Minnesota EHDI and North Carolina EHDI for taking time to share your information, experiences and joining our work group teleconferences. Our newborn screening is also a member and shares her expertise. We have professionals that have shared what is needed for telehealth, what is the current telehealth status in Nebraska, opportunities and experience with tele-audiology. We did not offer any monetary incentive to the members. Non-monetary incentives include assisting the site with searching for funding and assistance with writing grants, reducing the workload for the one and only audiologist in Nebraska. Assisting family with timely services and Nebraska has built relationships over the years with many of the members in the learning community. They understand the need for more services in western Nebraska.

A focus of the learning community due to data and feedback received from families and early education providers in the area, a learning community was formed to address the need for pediatric audiology services. Data shows that 50% of infants within 200 miles are over 90 days for diagnosis compared to 38% elsewhere in the state due to the lack of pediatric diagnostic facilities in western Nebraska. By December 31st, 2017, our goal is to have tele-audiology services at Scotts bluff to include timeliness and accessibility for pediatric audiology diagnostic evaluations. Our goal is for the percentage of infants to receive diagnostic evaluations over 90 days will decrease from 56% to 38% that receive evaluations at the tele-audiology site.

We're going to track the percent of infants over 90 days for confirmed diagnosis who live within 200 miles of Scottsbluff. And infants who live within 200 miles of Scottsbluff. We'll track the percent of infants receiving diagnostic evaluation compared to the number of infants receiving tele-audiology evaluation by 3 months of age. We have established a learning community work group and engaged members. We have acquired interest for the site in western Nebraska. We have active involvement of the pediatric audiology specialist. We have found spending units through USDA and HRSA for the spoke site. They have shared existing work plans and models. Nebraska EHDI has accurate and complete data to support the need and monitor progress. The challenges and how we are addressing those. Finding a pediatric primary care physician to be a member has been difficult. We are finding that they don't have enough time for the project. We are searching for a part-time, partially retired pediatric physician. We continue to search for funding opportunities. We have connected with USDA representatives to assist with funding.

Also with identifying the spoke site remote and technicians, after reviewing the duties and expectations, they suggested we meet with an affiliated clinic. We are starting at looking to set up that meeting. Funding a detailed job description for the remote technician, we have discussed with other states with the tele-audiology program, we've asked for examples through EHDI chats, obtained a training plan from the NCHAM websites. Also had difficulty finding I.T. telehealth availability and knowing what is needed to modify for tele-audiology. We are working with numerous IT programs across the state. We have obtained information on internet and broad band requirements through funding workshops.

How has the learning community structured? We meet every other month or as needed. Melissa Butler facilitates the meetings and the tasks are shared across members and members volunteer based on their area of expertise. How are families

involved? Parents of children have been recruited to share their experiences to input on issues related to identification and delayed enrollment in early intervention services. They make changes that will prevent this from happening to other children. We keep them engaged by asking their opinions frequently throughout the project and ask them if they want to review documents processes. How does it impact families? Tele-audiology services will give families in western Nebraska access to the same quality of pediatric audiology care that families have in the metro areas of Nebraska.

How are providers involved? There are several audiologists located at the hub sites actively involved with the project and will be reviewing all the processes. The audiologist in western Nebraska is helping us connect with a spoke site in Scottsbluff. He's the only audiology provider for approximately 200 miles and does not have the capacity to see all patients needing audiology care in a timely manner. He has recommended that we connect with a primary care clinic to see if they have the staff and resources to be our spoke site. Strategies used include asking specific questions during the work group meetings needed to move the project forward which allows them to share their expertise. Also asking them to attend other meetings when their expertise is needed and they work on tasks outside of the work group meetings. They are passionate and devoted to this project. We keep them engaged by asking for their input through every step of the project.

I'm not going to discuss the strategies we plan to test, but please contact us if you have questions regarding the information on the slide.

>> Thank you, Brenda. I'm sorry, we're getting a little bit short on time. But I really do appreciate your preparation and information you shared. So our goal today was to highlight three different -- three different learning systems that different states are using as well as where they are in their process. As you probably could tell, New York is a little farther down the road with Nebraska getting started about six months -- six, eight months ago. And then Maryland just getting started. And so that being said, we want to open it up to questions and so it looks like we already have our first question in. Our first question is: What if our -- what if your learning community wants to focus on the screening by one month and diagnostic evaluation by three months and the providers we are working with may not ever see an infant that is diagnosed as deaf or hard of hearing, would we still be expected to report the number of deaf and hard of hearing patients that have a care coordination plan? Sadie, I think that that question would -- would be most likely answered by you.

>> WILL EISERMAN: Remember to take your phone off mute, Sadie.

>> SADIE SILCOTT: I just took it off of mute. Thank you for the reminder. The answer to that question would be yes, that they're still expected to report on that.

>> So if the answer was zero, then it -- that would be their report.

>> SADIE SILCOTT: Then that would be their report, yes.

>> Okay. Great. Thank you.

>> I notice there's another question here about distinguishing between learning collaboratives and learning communities. The ones that have been reported on right now are a little different since they were done prior to the FOA. Would you comment on the differences between collaboratives and communities?

>> SADIE SILCOTT: Sure. Well, a learning community is essentially a group of interested parties that have come together for the purposes of sharing information. And a learning collaborative is a lot more intensive. You usually have a structured time frame, a structured time frame -- let's say it's 18 to 24 months. And your focus on

particular topics, if you will. But at the end of that, you should have a tangible product that you are able to produce. I just want to take a step back and say that with the learning community in addition to sharing information, you're also measuring behavioral change. Again, it's definitely not as intense as a learning collaborative.

>> Thank you, Sadie. Another question is: If a state has multiple learning communities, does each one have to address all nine items or can each of them decide what items in the list of the nine that are most important for that community?

>> SADIE SILCOTT: Ideally, we will prefer for every community to address the nine items. But I think we're hope -- I think we're open that if you have more than one learning community then, yes, you can pick the items that you choose to address.

>> Okay. Thank you. And there's been a couple inquiries about the slides from today as well as the recording. So we will post both the recorded webinar as well -- you know, provided that we did get it recorded, as well as the slides on infanthearing.org within the week. So you'll receive an e-mail when those are both posted.

Our next question is: When, in terms of month, do you expect the care coordination webinar to be held? We don't want to start spending time on this activity before the webinar just to learn that we are on the wrong path.

>> SADIE SILCOTT: Approximately within the next three months.

>> Within the next three months. Okay. So by the end of September. Okay. Our next question is: Is a child individual family service plan or IFSP, the part C services, that focus on primary care provider education, I'm assuming that the question here -- oh. If the IFSP is considered a care coordination plan.

>> Hi, this is Trivie, depending on the contents of the IFSP, it may have the same elements as a care coordination plan, but it may not. There's some key elements that are required for an IFSP that would be -- that are key elements in a care coordination plan as well, but in some cases, the care coordination plan is broader than the IFSP. You know, the IFSP is an educational plan and a care coordination plan incorporates health care more broadly. So there may be some very comprehensive IFSP plans that really do address all of the health care, but those aren't necessarily the requirements. So I would encourage you in these coming planning months to have conversations with both your Part C program and your Title V program to really take time to understand what's involved in a care coordination plan and what's involved in IFSP. Depending on the state, sometimes they're very similar, but not necessarily.

>> Okay. Thank you for that -- that clarification. So it sounds like -- it sounds like we need to just dig into our specific state requirements and go from there. Okay. So the next question is: To the learning community be primarily made up of early intervention providers? Does it have to focus on -- pediatric health care provider education?

>> SADIE SILCOTT: The expectation is that the pediatric health care providers are involved in this. If you want the early interventionists, that's fine. But we still expect for there to be pediatric health care professionals as well as family members of deaf or hard of hearing children.

>> Okay. Excellent. This next question is directed to Brenda and Melissa in Nebraska. So it does say, you know, learning community are a valuable service. However, reaching out to professionals can be hard to achieve. And the person asking the question is recognizing that telepractice is a valuable tool, but is wondering how effective has your tele-audiology in Nebraska been -- been to date and then how do you measure effectiveness and then also if you could share your telepractice work plan with other EHDI coordinators.

>> MELISSA BUTLER: This is Melissa. So we don't -- our tele-audiology program is not underway yet. So we don't really have any measures for our successful it is. We're hoping it's going to be successful, but at this point we can't really answer that question. In the future, we plan to measure the effectiveness of the program by measuring the progress of the 1-3-6 goals, specifically for the western part of the state. And our work plan is not completed yet. We actually have reviewed the work plans from Minnesota and we plan to base our work plan on that. So if the Minnesota EHDI program is on the phone today, we can have them share it or we would be happy to share it with permission from Minnesota EHDI.

>> Okay. Great. Thank you, Melissa.

>> KARL WHITE: Allison, this is Karl. I notice that there are a bunch of additional questions.

>> There are.

>> KARL WHITE: And it's 2:00 Perhaps many of these questions will be questions that MCHB will want to respond to. I'm wondering if we can do written responses and post them on our website. We haven't talked about that previously with our MCHB colleagues, but since they're the ones in charge of this, would that make sense if we provided written responses since we promised people an hour webinar?

>> SADIE SILCOTT: This is Sadie, yes. That would be great.

>> Okay. That -- that is excellent. So what we'll do then is we can sign off in terms of presentation. But I think that there's probably additional questions that we haven't potentially received yet. Is there a way, William or Karl, that people could get us their additional questions, maybe just mailing them to either Karl or myself, and then we'll add them to the questions that we have during the webinar so people are able to get all of their questions answered?

>> KARL WHITE: I think that sounds great. Why don't we say that we'll make sure that any questions that are received by Friday afternoon at the close of business to either Allison or me, we will organize, eliminate the redundant ones and send them to Sadie and then depending on how many there are, we'll get those up in the next week or so.

>> Can I just make one quick final comment? This is really the beginning of the conversation. So I want folks to -- we will answer your questions, we will hold more webinars. We want to make you successful and work with you. So this is not the -- this is not the last word on the learning communities. So we look forward to your ideas and working with you.

>> Okay. Thank you. Well, we'll go ahead and sign off for today. We really appreciate your participation. And of course the presentations by the three states that we heard from. And then we'll look forward to receiving your e-mailed questions and then you can be looking for the posted webinar as well as -- a posted webinar as well as answers to the posted questions within the next week or so.

Thank you, everyone.

[Webinar concluded --

>> There will be an evaluation that will appear on your screen now as we end the meeting. So if you have a moment to complete that, that will be helpful.

>> Thank you, William.

[Webinar concluded at 4:03 p.m. ET]