

## Performance Narrative

### 1. Project Identifier Information

Grant Number: H61MC00043

Project Title: North Carolina's Early Hearing Detection and Intervention (EHDI) Follow-up

Organization Name: North Carolina Department of Health and Human Services

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### 2. Accomplishments: Significant accomplishments during the 2014-2015 year included:

- Created a state Quality Improvement (QI) Team and Local Action Teams (LAT) for each test of change. Teams met regularly. Initiated eight of 11 QI tests.
- Developed a web-based new-user Hearing Link training.
- Increased utilization of teleaudiology services.
- Conducted 11 trainings for the Part C, Early Intervention (EI) agencies to assure that appropriate referrals were made to the Early Learning Sensory Support Program for Children with Hearing Impairments.
- Mailed parent-developed awareness posters to obstetricians and Ear, Nose and Throat (ENT) providers across the state.
- Collaborated with a social marketing class to create an EHDI social marketing plan.
- Expanded Better Hearing and Speech Month (BHSM) activities to include the use of Twitter. Twitter followers saw the tweets 4,000+ times.
- Increased family engagement through the collection of written personal stories, photographs and production of a video of four families sharing their EHDI journey.
- Initiated a strategic plan that addressed the gap caused by retirement and attrition of staff.

**Barriers:** The EHDI Program experienced a number of barriers that have the potential to influence the program going forward.

- Key reduction in personnel included: the retirement of the EHDI Program Manager and the Section Chief for Women and Children's Health; the attrition of a key data analyst responsive to EHDI program data needs and the resignation of a part-time Child Health Audiology Consultant (CHAC) in the Southeastern part of the state.
- The Mission Children's Hospital Audiology Clinic opened in July of 2013 and filled a great need in the Western part of the state, however, the Pediatric Audiologist that worked in this clinic recently moved, leaving a vacancy.

**Strategies Taken to Overcome Barriers:** These strategies included realignment of staff due to vacancies. The Genetics and Newborn Screening Unit (GNBS) Manager assumed program administrative duties, including staff supervision. The EHDI program created new committees (Data/Tracking, Training/Technical Assistance, Family Engagement/Public Awareness and Planning), to oversee and lead the program's activities. A new EHDI business model, systems management, was adopted.

The C&Y Branch/GNBS Unit prepared job postings to fill key vacant positions. In addition, the program enlisted the help of key stakeholders in the recruitment process for the CHAC position.

The Mission Children's Hospital Audiology Clinic is actively recruiting for a Pediatric Audiologist. Several candidates have been interviewed. Infants that would have received services at this clinic are being referred to two pediatric audiology practices in the area.

### **3. Goals and Objectives by March 31, 2015:**

QI methodology is being employed at each step of the EHDI process in an effort to reduce loss to follow-up/loss to documentation and to increase the number of infants receiving appropriate and timely follow-up. Plan-Do-Study-Act (PDSA) cycles are being utilized to test, revise and spread change strategies when appropriate. Data is being collected and used to determine the success of the strategies, the need for further testing of change ideas and to determine the efficacy of spreading the change for sustainable improvement in the program. The change strategies being tested are summarized under the system goal in this document.

A state QI team assembled in early 2014 meets quarterly to guide the QI strategies in the grant, ensure that the tests of change are realistic and successfully executed, and to evaluate the data to see that successful changes are spread throughout the EHDI system. Team members include: two parents; an advisory committee member; a hospital EHDI coordinator; a lead early intervention teacher; EHDI Parent Consultant (PC) and other EHDI administrative and regional staff. The newly identified EHDI Chapter Champion joined our program during the summer of 2014 and will be invited to join the state QI team.

LATs have been established for each test of change and are comprised of EHDI personnel and local stakeholders who are familiar with the characteristics of the population they serve, as well as the services and resources available in the area. Each LAT designated a lead who is also a member of the state QI team. The lead person is responsible for PDSA cycle oversight, documenting progress, collecting the data, preparing reports, and updating the state QI team.

**Note:** The baseline data used for the grant came from the 2011 CDC (Centers for Disease Control and Prevention) EHDI Hearing Screening and Follow-up Survey (HSF). The most recent published data were taken from the 2012 CDC HSF survey. Analysis of preliminary 2013 and 2014 data from Hearing Link was delayed due to de-duplication and integration of the North Carolina (NC) birth certificate information into Hearing Link and the concomitant lag in the data cleaning process.

**System Goal 1 (G1): Newborn hearing screening will be completed on all infants born in NC hospitals prior to discharge, and for those infants needing a follow-up screening and those born at home, screening will be completed by 1 month of age.**

**Objective 1:** *Maintain the percentage of 97.5 for infants who were screened by 1 month of age.* The overall screening rate for infants born in NC remains well above the Healthy People 2020 goal (90.2%). In 2011 the rate was 97.5% and in 2012 it was 97.8%.

**Objective 1.2:** *Reduce the percentage LTF/D by 1% for those babies needing rescreening.* In 2011, 227 out of 877 babies (25.9%) who did not pass the inpatient screen, did not complete the rescreen. Final 2012 data showed that 312 out of 854 infants (36.5%) needing a rescreen, did not complete it. These infants account for a significant proportion of the LTF/D in the state.

*Objective 1.2a: Increase by 2% the percentage of infants that complete the needed rescreen at 1 month for of age. Of those infants needing a rescreen in 2011, 62.4% were completed by one month of age. 2012 data shows an increase in the percentage of infants completing the rescreen by one month of age to 68.4%; a six percent increase.*

**Key Continuing Activities:** The Speech Language Consultants (SLCs) continued to provide training, technical assistance, education and resources to all 86 birthing facilities during hospital visits (at least twice/year) and development of annual Hospital Program Plans. They continued to share Hearing Link data to highlight the strengths and weaknesses of the hospital's newborn hearing screening program, and used these visits to reinforce best practices and compliance with the Joint Committee on Infant Hearing (JCIH) standards.

The NC newborn hearing screening brochures and the hearing healthcare maps were provided to the hospitals as needed. Electronic versions of the brochure in eight languages were available to download from the program website, [www.ncnewbornhearing.org](http://www.ncnewbornhearing.org). EHDI received a request from one birthing facility for a Japanese translation of the NC newborn screening brochure, however, the request was deemed not necessary by the requesting party.

Ten birthing facilities elected to use the rescreen reminder cards developed by the program for hospitals. They were self-addressed by the family prior to discharge and included the date and location of the infant's rescreen appointment and contact information if families needed to reschedule their appointments. Based on initial results, hospitals that elected to incorporate the rescreen reminder cards had a higher rescreen rate than hospitals that did not elect to use the reminder cards (87.5% compared to 82.5%). Additional information will need to be collected to see if the rescreen reminder card improved the overall rescreen rates at the hospitals using them.

SLCs continued to work with midwives to develop newborn hearing screening procedures. As new screening equipment was purchased for EHDI personnel, older equipment combined with training were offered to midwives to support screening of homebirth infants in a timely manner. SLCs performed hearing screenings for infants born at home as a safety net.

A web-based Hearing Link training targeting new hospital personnel is under development. Completion of the training will be required before a Hearing Link account is assigned.

In collaboration with the CDC EHDI Cooperative agreement, the program created a birthing facility-specific quality assurance report that illustrated individual hospital performance on national EHDI 1-3-6 standards and compliance with state reporting rules. The desired outcome was improved timeliness, completeness and accuracy of data entry/reporting and adherence to newborn hearing screening and follow-up best practices. Reports were sent to 10 birthing facilities as part of a pilot study. Seventy-nine percent stated that the report information was clear and 71% were very likely to use the data to self-evaluate. Based on the success of the pilot study, birthing facilities will receive this new performance report on a quarterly basis.

**G1: QI Change #1: Develop a system to utilize faxing as an effective means of communication with medical homes regarding newborn hearing screening results and needed follow-up.** Three hospitals in the Western part of the state, with a higher than desired no-show rate at the time of rescreen appointments, were selected for this test of change. The birth

rate and the number of providers that care for children from these facilities were factors in the selection process. Data collection began on July 1. The fax was sent to 27 medical homes after the first missed outpatient rescreen appointment. Of the 27 infants that failed the initial screen at the three hospitals, 22 (81.5%) completed the rescreen. This was a 1.5% increase over 2013 data. One facility had a 100% return for the rescreen as compared to 80% in 2013. The next PDSA cycle will be tweaked to send the fax to a designated contact at the medical home.

**G1: QI Change #2: Collaborate with the Women Infant and Children (WIC) Program to have questions about completion and results of newborn hearing screening asked at the first WIC appointment after the birth of a baby.** An existing strong collaborative relationship between the regional consultant and two WIC offices expedited the initiation of the first PDSA cycle. As WIC was unable to add EHDI questions to their current electronic intake form, a separate form was developed by the LAT to collect the needed information. WIC staff agreed to log the hearing screening results where babies did not pass or test results were unknown and fax the log monthly to the SLC. Data will be collected for a period of three months.

**G1: QI Change #3: Have screeners and tracking staff ask for and use the best means of contact (phone, email, text, etc.) identified by the family when a baby does not pass the initial newborn hearing screening, and enter the information into Hearing Link.** The state QI team decided to delay the start of this PDSA testing until 2015 when staff will have more time to identify facilities that are willing to participate in the initial PDSA.

**System Goal 2 (G2): All infants who “refer” on their final newborn hearing screening and neonatal intensive care infants who fail their initial screening will receive an audiological diagnosis by three months of age.**

*Objective 2.1: Reduce by 3% the percentage of infants LTF/D at the diagnostic step.* Data in 2012 showed a slight increase in the LTF/D rate from the previous year (34.3% in 2011 and 37.8% in 2012). Per the CDC data, the average national LTF/D rate for 2012 was 35.9% as compared to 35.3% in 2011. The increase reflected higher quality data gathered using clear definitions of cases to be reported as LTF/D.

*Objective 2.1a: Increase by 3% the percentage of infants that complete the needed diagnostic evaluation by three months of age.* Final 2012 data showed a 5.2% increase in the percentage of infants completing the diagnostic by three months of age (2011: 47.4% and 2012: 52.6%). Efforts will continue utilizing four QI strategies and successful activities to further improve the number of infants completing a diagnostic evaluation by three months of age.

*Objective 2.2: Increase the number of Teleaudiology appointments to 20 per year.* Since April 2014, twelve infants received services at one of the telemedicine sites. At this pace, we will reach our goal of 20 appointments by the end of this funding year. Six of the seven test sites were utilized. The Robeson county site was not utilized due to the CHAC vacancy. One infant completed a rescreen and eleven infants had a diagnostic evaluation. Of the eleven tested, nine were found to have normal hearing, one was found to have a conductive hearing loss and two had incomplete results. Five of the infants were tested by three months of age, five were tested between three months and four months of age and two were tested later than four months of age.

**Key Continuing Activities:** NC maintains an updated list of pediatric audiologists who provide diagnostic evaluations for infants. The teleaudiology sites were added to the list in 2013 so that families and professionals had the location and contact information for this service. Emphasis was placed on promoting the use of teleaudiology to augment services at the local level. It was also posted on the program website, [www.ncnewbornhearing.org](http://www.ncnewbornhearing.org) and provided to birthing facilities and medical homes that refer infants for audiological evaluations.

The SLCs continued to provide family support from failed rescreens through the completion of diagnostic appointment(s). The SLCs made 356 contacts with families over the past six months either by phone or written correspondence. When necessary, primary care providers were also notified when a child did not pass the rescreen.

Teleaudiology services continued to be implemented through a contract with East Carolina University (ECU) and their Telemedicine Center. EHDI personnel communicated regularly with the ECU personnel to determine more efficient and effective means of providing the services. ECU personnel continued to: provide assistance in the development of protocols; provide training, technical assistance and trouble-shooting for EHDI program staff at the remote site; and provide assistance to remote staff on the procurement, installation and usage of telemedicine equipment. Expansion of teleaudiology services will continue as new sites are established.

**G2: QI Change #1: When a child does not pass their hearing screen or rescreen, send a letter to the medical home about the child needing a diagnostic evaluation, including information about measures that will help keep the infant asleep during the procedure.**

This change was initiated in 2013 by a Pediatric Audiologist at the largest diagnostic center in the Eastern part of the state. Baseline data were collected. During the first PDSA cycle, letters were sent to four primary care practices for six children who were referred for follow-up testing. Subsequently, families surveyed, reported that their doctors did discuss the measures with them and that they (the families) used the measures. Five of the six infants completed the needed testing in one visit. Based on the successful results, the LAT is working on identifying another diagnostic site for a second PDSA cycle.

**G2: QI Change #2: When a letter is sent to the family about their child needing a diagnostic evaluation, note in the letter that the same information is being provided to their medical home.**

Beginning in April, the revised letter was sent to families in one NC County for children referred for a diagnostic evaluation; excluding babies born weighing less than 1500 grams. Baseline data from the fourth quarter of 2013 showed that six out of nine babies referred for a diagnostic evaluation were diagnosed by three months of age. By the end of three months, six out of seven infants met the 3-month diagnostic guideline. Data will be collected for an additional three months.

**G2: QI Change #3: When a letter is sent to the family about their infant needing a diagnostic evaluation, include the EHDI PC contact information as a parent-to-parent resource.**

Because letters are not routinely sent to families when a child refers on a rescreen, the LAT decided to verbally share the PC contact information with the parents they talk to and to communicate the same information by mail with families the SLCs were unable to reach. In October, the PC contact information was shared with three families. To date, the PC had not been contacted by the families. This ongoing PDSA cycle will conclude in January.

**G2: QI Change #4: Following a failed rescreen, send Teleaudiology Program information to the primary care provider with information that the child needs a diagnostic evaluation.** The EHDI Program Manager provided the oversight for the Teleaudiology Program. After her retirement in July, oversight was transferred to two regional consultants. During this transition, the state QI team decided that it was best to postpone the start of this test of change until 2015.

**System Goal 3 (G3): All infants who are found to have permanent hearing loss will receive amplification, if recommended, and begin receiving EI services by 6 months of age.**

*Objective 3.1: For infants diagnosed with hearing loss, reduce the percentage LTF/D by 1%.* The overall rate of infants born in 2011, who were diagnosed with hearing loss and received EI services, was 74.4%. In 2012, infants receiving EI services rose to 84.7%.

*Objective 3.1a: For infants diagnosed with hearing loss, increase by 1%, the percentage of babies enrolled in early intervention by six months of age.* In 2011, 64.8% of infants identified with hearing loss were enrolled in EI by six months of age. Data shows that in 2012, 74.5% were enrolled by six months of age. Although this exceeds the Healthy People 2020 goal, additional improvement is desired.

**Key Continuing Activities:** In 2012, a new requirement that a child had to enroll in Part C Early Intervention in order to receive services from the Early Learning Sensory Support Program was instituted. In response to this change, the EHDI program and BEGINNINGS for Parents of Children Who are Deaf or Hard of Hearing have conducted joint trainings about the EHDI process and EI needs of children who have been diagnosed with hearing loss for the Children's Development Service Agencies (CDSAs), and Part C Early Intervention providers, to assure that appropriate referrals were being made to the Early Learning Sensory Support Program. There are 16 CDSAs across the state. Three trainings were conducted in 2013 and 11 were completed in 2014. Two trainings are planned for 2015.

CHACs continued to provide training, technical assistance, education and resources to audiologists providing infant diagnostic evaluations. Four-hundred Twenty-two technical assistance contacts with audiologists were completed between April 1 and Sept. 30 of 2014. CHACs provided family support and education about the need for EI when a child was identified with hearing loss. The CHAC's made 374 contacts with families over the past six months either by phone or written correspondence. If there were concerns about the child or family, a home visit might be necessary.

**G3: QI Change #1: Call the family within two weeks of their child's diagnosis and explain the value of EI for a child with hearing loss.** Baseline data were collected for the period July 1, 2013 through Dec. 31, 2013 showing that 13 infants in the region were identified with hearing loss, and of the 13 infants, six were enrolled in the Early Learning Sensory Support Program by six months of age. The CHAC and an EI teacher developed a script for explaining the EI process and program services to families. Data collection began Oct. 1, 2014 and will continue through February 2015.

**G3: QI Change #2: Provide access to the Parent Phone Tree by including business cards with the Parent Consultant's contact information with other materials being sent to the**

**family following their child's diagnosis.** The state QI team decided to postpone this test of change until 2015. The team wanted to see some results from the other test of change involving the PC business card, before proceeding with this test.

**System Goal 4: Targeted education about newborn hearing screening and means of reducing loss to follow-up will be provided to appropriate populations.**

**Objective 4.1:** *Provide educational opportunities and materials for 200 individuals or stakeholder groups each year of the grant.* Thirty-three training sessions on newborn hearing screening, early identification of hearing loss, and speech/language development were conducted between April 1 and Sept. 30, 2014 for key stakeholders. These opportunities increased the visibility of the EHDI program, created networking opportunities, strengthened collaborative relationships, and raised awareness about the importance of newborn hearing screening and timely follow-up.

Parent-created posters focusing on the importance of newborn hearing screening and follow-up were mailed to 145 ENT providers and 574 obstetricians across the state. The letter accompanying the posters explained the EHDI 1-3-6 goals and stressed the importance of timely follow-up when a child does not pass a hearing screening.

In an effort to increase the visibility of the EHDI program and to continue to educate providers about newborn hearing screening and follow-up, the program was presented at three NC conferences: the NC Speech-Language and Hearing Association, the NC Exceptional Children's conference, and, the NC Pediatric Nurse Practitioners.

Magnets explaining the steps to take if an infant refers on an initial hearing screen or a rescreen were developed. They were distributed at conferences and mailed to medical home providers as a reminder of what they need to do if a child does not pass a hearing screening.

EHDI continues to work closely with the Early Learning Sensory Support Program on ways to assist families with or at-risk for hearing loss. The Early Learning Sensory Program and parents assisted EHDI in the development of a Parent Organizer that provides structure for organizing appointment and educational information. Since April, 128 notebooks were distributed.

The EHDI PC is working with EI teachers, EHDI personnel and parents to coordinate two CARE workshops this funding year, one in the Southwestern and one in the Eastern part of the state.

BHSM (May 2014) provided an opportunity to raise awareness about pediatric hearing health issues and the services offered by the EHDI program. Initiatives included: 1) an article co-authored by the EHDI Project Coordinator and the DHHS Division of Services for the Deaf and Hard of Hearing was published in the Department of Health and Human Services (DHHS) newsletter; 2) program-developed Public Service Announcements (PSAs) were added to the EHDI website; 3) an outreach article authored by the Program Manager, titled, "Why Do Newborns Need Newborn Hearing Screening" was widely distributed; 4) Tweets were developed and tweeted via the NC Department of Public Health (DPH) account; 5) families across the state were invited to share their personal journey with the program, of which eight provided written

stories and numerous photographs. The EHDI PC facilitated the publication of three of the stories in the family's local newspaper; and, 6) EHDI staff conducted seven community hearing screening events that reached over 60 children, and they conducted 12 presentations on speech and hearing, the EHDI program, and hearing conservation, reaching over 200 individuals.

**G4: QI Change #1: Develop a newborn hearing screening training module for NC medical center residency programs in Family Practice and Pediatrics.** A third year pediatric resident student collaborated with EHDI, NCHAM and the CDC on the development of two on-line training modules: one about newborn hearing screening and hearing loss and one on speech-delays. The modules will be pilot-tested and evaluated in early 2015.

**G4: QI Change #2: Incorporate video clips of parents sharing their personal stories into training sessions for key stakeholders.** The EHDI PC and Project Coordinator, in collaboration with the DHHS videographer, and a Hitch-Up (Hearing Impaired Children and Toddlers Have Unlimited Potential) family support group developed a plan to capture video clips of families. Four families volunteered to answer structured questions about their experience from the newborn hearing screening in the hospital, through the diagnostic evaluation, enrollment in early intervention services and beyond. This was a great success. The raw footage is available and with additional carry-forward funds (awaiting approval), we propose to work with a local videographer to edit and create short clips for EHDI training purposes.

**System Goal 5: The NC EHDI Program will promote collaboration among agencies and individuals working in the interest of identifying and serving children who are deaf or hard of hearing in a culturally and linguistically competent manner.**

*Objective 5.1: Develop new and strengthen existing collaborative relationships with programs and agencies involved with families who have a child with or at risk of having hearing loss.*

**Key Continuing Activities:** The EHDI Advisory Committee continued to meet quarterly to discuss service gaps, possible solutions and QI strategies. It continuously evaluates data from the CDC EHDI HSF Survey and Hearing Link. Members of the committee participate on the state QI team and the newly created Planning Committee.

EHDI personnel attended quarterly service coordination meetings with EI providers and representatives of large pediatric audiology practices. EHDI team members also promoted participation and engagement of diverse families on DHHS and community advisory boards. The EHDI PC participated on the NC Agenda for Deaf Education committee as well.

EHDI continues to strengthen collaborations and increase utilization of C&Y Branch expertise, inclusive of support from: 1) the Coordinator for Minority and Special Population Needs on conducting effective outreach and service delivery to various ethnic, and socio-economically/culturally diverse groups; 2) the Best Practices Unit (BPU) on systems thinking training for EHDI staff in preparation for the new business model; 3) the Children with Special Health Care Needs (CSHCN) Helpline personnel on use of EHDI reference materials to better assist callers with hearing-related questions; the GNBS Unit Public Health Educator on the development of resource materials; 5) the School Health Nurse Consultants on dissemination of noise-induced

hearing loss fact sheets and parent-developed posters to school systems, and 6) from the medical consultant on the identification of a Co-EHDI Chapter Champion.

The EHDI Project Coordinator and PC collaborated with a graduate-level social marketing class on the development of a comprehensive social marketing campaign to reduce loss to follow-up. Two posters and a PSA created for EHDI will be adopted and funded by carry-forward dollars.

**4. Significant Changes** Due to the Program Manager vacancy, the Branch is committed to assisting the EHDI team with the realignment of program responsibilities so that grant deliverables are met. Dr. Gerlene Ross, GNBS Unit Manager has been appointed the Interim EHDI Program Manager and this key personnel change has been approved by HRSA. As a result of the significant personnel changes, a strategic analysis of the EHDI program's strengths, weaknesses, opportunities and threats was necessary in order to continue as a robust resource for families and children with hearing impairments. As a consequence, the EHDI team has adopted a new business model based on a systems management approach where team members focus on professional practice facilitation through information dissemination and training with key stakeholders. Internal and external changes are being addressed *via* this paradigm shift designed to create efficiencies in how staff operate. Staff members continue to provide services to families and clients and have been given lead responsibility for specific tasks previously handled by the Program Manager.

**5. Plans for Upcoming Budget Year (Note: System Goals are described in section 3, Objectives below are by March 31, 2016).** In the coming grant cycle, 11 tests of change will continue. PDSA cycles will further test, revise and spread change strategies in order to sustain modifications that improve program outcomes and reach the grant goals as outlined in the application. The state QI team will consider initiating additional change ideas proposed in the grant as well as newly identified changes or those proposed by program stakeholders. Key continuing activities will focus on practice facilitation for all engaged stakeholders to meet program goals and objectives.

#### **System Goal 1**

*Objective 1.1: Maintain the percentage of 97.4 for infants who were screened by 1 month of age.*

*Objective 1.2: For those babies needing rescreening, reduce the percentage LTF/D by 3%.*

*Objective 1.2a: Increase the percentage of infants that complete the needed rescreen by 1 month of age by 3%.*

- Provide training and technical assistance to birthing facilities on effective strategies for reducing loss to follow-up.
- Launch/evaluate new user on-line Hearing Link training.
- Strengthen the capacity of midwives to conduct newborn hearing screening.
- Explore use of electronic medical records to communicate hearing screening results to medical homes.

#### **System Goal 2**

*Objective 2.1: Reduce the percentage of infants LTF/D at the diagnostic step by 5%.*

*Objective 2.1a: Increase the percentage of infants that complete the diagnostic evaluation by 3 months of age by 5%.*

*Objective 2.2: Increase the number of Teleaudiology appointments to 24 per year.*

- Continue to provide support to families of children that do not pass the hearing rescreen.
- Provide assistance to overcome barriers in getting their child to a diagnostic evaluation.
- Utilize public education, social media and agency collaboration to targeting populations with a high loss to follow-up.
- Continue and expand teleaudiology services.

### **System Goal 3**

*Objective 3.1: For infants diagnosed with hearing loss, reduce the percentage LTF/D by 1%.*

*Objective 3.1a: For infants diagnosed with hearing loss, increase the percentage enrolled in EI by 6 months of age by 2%.*

- Provide training, technical assistance, education and resources to diagnosing pediatric audiologists, primary care providers, and early intervention providers and other early childhood agencies and programs.
- Continue strong collaboration with early interventions programs in the state.
- Continue to provide family support and education about the need for early intervention when a child has been identified with hearing loss.

### **System Goal 4**

*Objective 4.1: Provide educational opportunities and materials for 200 individuals or stakeholder groups each year of the grant.*

- Provide training to key stakeholders (medical home, head start, home visiting programs, and others) on the hearing screening process, use of hearing screening equipment, resources for children suspected or identified with hearing loss and normal speech development.
- Engage the new AAP Chapter Champion to increase collaboration with medical homes.
- Develop and expand collaborative parent support networks and outreach using traditional and culturally appropriate social media outlets.

### **System Goal 5**

*Objective 5.1: Develop new and strengthen existing collaborative relationships with programs and agencies involved with families who have a child with or at risk of having hearing loss.*

The EHDI program has developed strong collaborative relationships with family leaders, birthing facilities, pediatric audiologists and EI providers throughout the state. Collaborative relationships with other key stakeholders, including the home visiting programs, will be strengthened during the upcoming year. New collaborative relationships will be explored with the Sertoma organization and the Delta Sigma Theta Sorority. Both organizations work to improve the quality of life for those at risk or impacted by hearing loss. The Advisory Committee will continue to regularly receive program and grant activity updates and to monitor the progress made toward reaching program goals. The PC will continue to explore new and creative ways to engage families across the state in EHDI program activities. EHDI program personnel will continue to participate in quarterly service coordination meetings. Quarterly email updates will be shared with key stakeholders.