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The Ripple Effect from a Team Approach

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>> My name is Michele and I'm going to go ahead and introduce this breakout session, and it is a ripple effect from a teach team approach in Ohio, EHDI.

>> My name good morning, everyone. My name is Reena Kothari. I'm an audiologist in the EHDI program, I've been there for 18 years, and I'm excited to talk about the learning committee we've grown in our state and share the learning experiences. So let's go ahead and begin.

So we call this the ripple effect. We know that one very, very small change that began with one person and then by next Tuesday we added another person and following Tuesday, additional people and within a month we had several people around the table. So a drop in the bucket or when you look at a glass and dropping things in the glass and watching it grow and watching that glass be fall, it's been a really exciting opportunity for our state.

Here are the learning objectives that we'll go over today.

And as you know, HRSA required to us develop learning communities in our state, and when we looked at learning communities, we looked at, from the state level, from the EHDI program, a bird's‑eye view. So you're way up here at the top, developing policies s, procedures, and things of that nature but then we have the community level stakeholders and partners. And how do we bring that gap which was coming down from the bird's‑eye level, coming down to a grassroots level, bridging that public health and community‑based partnership.

So we selected one county in our state, it is Lucas County, and we looked at metrics and demographics in order to select a county. Unlike Virginia, we weren't able to spread our learning communities in to six. I think that's a very tremendous effort. And I think that would definitely be a goal for Ohio. But we started with one small county. We looked at health disparities and improving birth outcomes. We looked at infant mortality. We looked at racial disparities and infant deaths and then we looked at some maternal factors, so we looked at age, education, ethnicity and race. And I have to give credit to our researcher who is here who has done a lot of this work for me, so that I can certainly improve the work that I'm doing.

There is a little typo in here. We looked at 2014, 2015, and 2016 screening referral rates lost to follow‑up data for Northwest Ohio. So Lucas County happens to be in the city is Toledo, so it is a little bigger city, but it is a city that and a part of the state that has been underserved in terms of the work that we've done with the state EHDI program.

So here are just some basic demographics. So we looked at maternal age and the median age range for this group was 25 to 34 years with maternal education and ethnicity and race. And so, you know, the maternal education level was high school or a little, or some college or an AS degree, as well as the maternal ethnicity and race were not Hispanic, white, and/or black.

So again, we used some methodology to determine what county to begin this learning collaborative in. And we've had some other parts of the state where we've done NICHQ work and northwest Ohio had not been participating in some of that work so the metrics really helped support our decision to include Lucas County in this learning collaborative.

So, again, we looked at pre collaborative data and we're looking and data ongoing. We also used a ranking order with our HRSA objectives. So once we established the members within this community, we game them, unlike a needs assessment, we gave them the HRSA objectives and asked them to rank the order of priority. And that was a really hard task for this group. We had to provide a lot of foundational information and education regarding our program in Ohio, and just to give you an idea quickly of how large our state is, it is 140,000 births, we have 88 counties, we have 110 hospitals, we have six children's hospitals, and 88 local health departments. So it's a very large state. We identify around 200 babies a year. Our lost of follow‑up rates hover around 20%. We know that we are missing some of those babies. And so we had to provide a lot of education.

Additionally, I do want to mention, instead of the 1‑3‑6 program, we are a 0‑3‑6 program and we highlight that specifically because we do an initial screen in the hospital and then a secondary screening before discharge and then they go automatically to diagnostic audiology evaluation. We have no outpatient rescreening program.

Additionally, once the team was established, we did a team assessment, and I was the NICHQ team lead when we did this project several years ago. So we used some of the same drivers that we use with the collaborative, and around, at 11 months, 10 to 11 months, in to our learning community, we had each member complete this assessment and then we created a summary of that assessment. So, you know, doing ongoing metrics as we are working with the learning collaborative. And then data assessment midway through the collaborative and then once the Ohio Department of Health turns the collaborative over to the stakeholders, we anticipate doing a five‑year post collaborative work, but we don't expect this collaborative work to stop, just that we, ODH, would move in to another role, in to another part of the state and begin another collaborative.

I really like the quote that we have here from NICHQ which is collaboration is the foundation of making substantive improvements in children's health. Every initiative, even the ones that focus, seek to create conclusion solutions for complex challenges with deep‑seated roots. And when I think about this, it's one drop in the bucket, one small change at a time that's made such a significant impact in the time period from November of 2017 until we are currently. So as we know, our EHDI peeps, we want change to happen super fast. We don't ‑‑ we come to a conference, we get super excited, we go back, we think we can implement a change, and there we go, boom. But that's not how it happens. We know that at the state level, it takes a lot of time, it takes a lot of effort, it takes a lot of partnerships, and we know that centering around one county and working very closely with these members and stakeholders within the community, we've been able to make that drop in the bucket, and I'll show you some drops in the bucket in moment.

So, again, this is the formal introduction of the Lucas County learning collaborative, it is a totally grassroots effort. We meet on a monthly basis which is our stakeholders and most of our meetings are on sight, however, northwest Ohio does have some significant challenges with winter weather. So when we are unable to meet, we do virtual on‑line meetings. I use a Doodle poll system to evaluate the best date to meet. Typically our meetings are later in the afternoons or sometimes in the evenings. And we do have a variety of stakeholders. We do want to include parents. So we have several parents and community level stakeholders, audiologists, physicians, teachers of the deaf. I'll show you some of our members in just a moment. So we have two groups of members. We have core members, those who reside and work and live in Lucas County. And then we have supportive ancillary members. Those members are state level members that are from other state agencies or other parts of the state, possibly some guest members who may come in and help us out with workgroup information. But we do have core members, and those members meet on a monthly basis, again, a variety of disciplines, professionals, including parents, around then those supportive ancillary members are also very key in some of our work because sometimes we call upon those members to help with certain projects.

So here's a list of our core member group and, as you can see, there's a variety of audiologists, hospital level coordinators, early intervention service coordinators. We have a really wonderful developmental pediatrician, a parent of a Deaf child. We have a public health nurse. We have a couple of audiologists. We have a family practice physician. We have another EI service coordinator, speech language pathologist who works primarily with pediatrics, parents of deaf children, a deaf and hearing adult who is also the director of the deaf services center. So in making sure that we're including and having that inclusion but also access. Part C coordinator and then obviously the state level EHDI folks.

I do want to give special thanks to Cathy Kooser. She is a licensed social worker at Dayton, Ohio, she was the guest speaker at a patient meeting for us and she really talked about the social and emotional impact of hearing loss and she as a Kooser program which is really adult oral rehab but she was able to turn that program in to a program for parents of children with hearing loss or deafness. And then we have pediatric otologists from nationwide children's, Dr. Malhotra who has assisted us with medical he education for the community.

So, again, I want to spend just a few minutes, and I will tell you that I do not like 25‑minute presentations because I love to talk and share and so I will try to meet my time line and curtail some of the information. I have business cards and some other things up here that we can connect afterwards if we're not able to complete everything. But this is really a complex equation. When we talk about working with families, and this is very we, us, our program. How could we change behaviors? How do we change the perception that is are out there in the community? And again, looking at the state level and being down at the grassroots level, there's a big disparity and a big discrepancy of what we think here at the state level and what actually people's perceptions are about our program, about newborn hearing screening, about diagnostic follow‑up, identification of hearing loss, deafness, is my child going to be able to play soccer, will they grow up and be a successful adult? Lots of concerns out there. How do we change some of these attitudes, behaviors, and belief, and how do we better the system?

So I want to spend just a few moments on the health belief model, and there are six pillars to this, but I don't have time to go in to that. I found this very interesting and fascinating. So if you have some time, I would suggest that you look it up if you're not familiar with it. But I'm going to use some of the information from the health belief model, and this was coined in the 1950s by social psychologists, but it primarily talks about public health and perceived barriers, perceived benefits, perceived susceptibility, perceived severity, and then cues to action, and then self‑efficacy.

So creating weak self‑efficacy and then strong self‑efficacy, so moving from that low confidence level of now my child did not pass a newborn screening, does that mean I stop talking, I stop reading, are they deaf forever? Things of those natures. So is based on how people feel in terms of public based programs. So he when we talk about efficacy, we talk about change over time and increasing those health behaviors.

So when we talk about creating this stronger versus the weak self‑efficacy and we brought this collaborative together, and so I'm really trying to bridge the health belief model to our learning community is that we had to provide a lot of foundational information and education about 0‑3‑6 and beyond. So the learning community is not just 0‑3‑6 and up to three years.

We are working with professionals and stakeholders after that to school age because hearing loss and deafness affects a child in to adulthood and into the entire life‑span. So really when we talk about this, we're trying to make things more positive for families, give them opportunities, give them resources, and we know that this can be a predictor of success for families, if families feel confident, if stakeholders feel confident, if those pediatricians use the wait and see approach, let's wait and see, let's wait and see, that's a barrier for them also because they think oh, we can wait and see and it's okay. So we need to change that belief. We need to change that perception. We know that success breeds success.

So, again, we want to reduce that emotional stress and those concerns and thoughts that parents and stakeholders have, and we can do this by having these community partnerships. We can increase that community level engagement and involvement, coordinate services where services are may not have been coordinated, especially in Lucas County when we looked at other demographic data, we know that services were not coordinated. But we can create that foundation and we can have success at each access point for the child and the family.

So what does the drop look like? When we bring all of these interested parties together, I'd like to show you some of our strategies that we've used and we have found to be very successful. So the first strategy was medical home initiatives and medical home engagement, but medical home engagement by itself isn't going to do a whole lot. So we had to talk about the medical home engagement not only from the pediatric resident point of view but also from the providers that are seeing those families and then bridging that gap over to the parents because the providers are seeing the parents and we can educate the providers but if we have parents that are unwilling to go in for follow‑up or are emotionally stressed, we haven't done a great job. So the first strategy is medical home and then we went to the parents, so I'll talk a little bit about just about some of the things we've done with the medical home.

So we've done several rounds, so three rounds of pediatric resident lectures and two grand rounds lectures and we have another grands round presentation coming up on March 22nd in just a few weeks. This is about an hour and a half presentation, could be two hours, we can reduce it down to an hour. We gave a state EHDI update, so talking about the 0‑3‑6 at every access point. We have pediatric audiologists providing information about the diagnostic evaluation, what test to order, talking about sedation, time lines and age limits and, what how to make referrals to audiology evaluation, whether it's a newborn, whether it's a two year‑old, whether it's an older child. We had a developmental pediatrician talk to our pediatric residence and our physicians and nurse practitioners and PCPs about those medically complex children and how to work with deafness and other deaf plus issues that children and families face, and then we had our ENT lecture from nationwide's children's hospital who came and talked about the pediatric ENT needs, what does a workup look like, what is the process, how do we enhance language and communication, how do we provide those support services? So it was a really fantastic program that we put together. And so we're trying to really build capacity here with the physicians not only in training but also the physicians that are seeing our families, changing those perceptions, changing those beliefs so they can be a partner in our cola rave it, even if they're not sitting at the table understanding the needs of the community and how to make those referrals.

Essentially this is all moving into a medical home toolkit. So we have a medical home checklist. I have a few copies here, and we like to share in EHDI, so this is our final draft. It is going to be tested in Lucas County, so it has not been tested, but if I have copies if you are interested. It is sort of a shared plan of care, in a sense. And we will test this out in Lucas County and then make adjustments to it, continue to make adjustments as we do in PDSA cycles, and then once we do, we'll test on another county and then eventually we hope to sustain and implement a statewide so we have a medical home checklist. We have a video of our lectures that we hope to put on a Ohio AAP website and maybe attach some CMEs to it. So not ‑‑ we're created within a small community, a small learning collaborative, then we're spreading that work throughout the state. Also, CDC milestones, relating it back to bright futures and ongoing surveillance of a child, even if they pass a newborn hearing screening, doing well, we heard earlier that, you know, some of the hearing losses are identified in school age and so we don't want to mess out on those opportunities, so providing Ohio resources, relating it back to bright futures, giving AAP medical home information, and then local Lucas County resources. So all of there is going to be part of the medical home toolkit.

Here's just a copy of what the EHDI medical home checklist looks like, and I have some copies that you're welcome to take with you if you're interested.

So the next drop in the bucket or the next ripple effect was parent engagement. So unlike Virginia we did not do a needs assessment because we only started with one person and by next week we had two people and by next month, we had three people. So we couldn't really do a community needs assessment, you know, at the beginning. But what we did was we did open forums, and our very first meeting for Lucas County, I walked out crying. It was really, really challenging. It was very different. That was an opportunity for all of the stakeholders present at the meeting to share the challenges, the barriers, the successes, there weren't that many, but it was an open forum for learning. And then after we established our learning community, we held two meetings in the libraries for parents at various times, in the middle of the day, late in the afternoon and in the evening over a couple of days. We asked parents to join us. We sent letters to parents. We had information on social media. We talked to all of our members within the community and asked them to invite parents. And we had a really great turn out. And parents told us all of the challenges and barriers that they were perceiving, they didn't understand the system and we had, you know, a mom walk in with twins that were three months old. We had a mom, you know, come with, you know, who has an 18‑year‑old child. So we had varying age ranges of parents attend and give us information. It was very helpful for us and the collaborative.

Learning those social and emotional effects that the family is going through and the child is going through, how can we, as a collaborative, really work harder?

Upcoming, in April, we're having a parent panel. In that panel, we're going to have parents from every age group from zero to three, elementary to milled will school, high school, early adulthood and college, and we're looking for either a deaf teenager or deaf adult to share experiences and resources. We have some play groups happening with the early intervention service coordinator within the area. Two of our diagnostic centers are providing folders upon early identification of hearing loss resources at the state level, at the national level, local level resources. There is a parent guide that looks like the medical home checklist, and I have a little screenshot of that also. So that is more of a parent, you know, a parent could get that upon newborn hearing screening, this he can get it upon diagnosis or follow‑up evaluation or at early intervention. It has got their care team. They can list everything out. They can keep track of their child's hearing loss or if they were home birthed, what their results were. There's early intervention information, ISP eligibility criteria, referral resources, communication options, again, it is not super extensive but it is a start and this, again, is in its final draft. We'll be sharing it with parents and testing it out and then making some adjustments to it.

There also will be a future guide for preschool and above, but that is a work in progress for the learning collaborative.

And we have two parents articles, I have two copies of the articles, Toledo State, I think every city has a parent, you can get them at most places, we did two articles, one is when wait and see is not the appropriate approach and then was an introduction to the Lucas County learning collaborative, and I have the copies of the articles here as well if you'd like to take a look. So that's what they look like. Here's a copy of our parent guides. We do have it electronically in PDF version, if you'd like that, I have cards, and you could he certainly e‑mail a copy to you as well.

And then we have those monthly collaborative meetings. And this is where we sit around the table with our members and we talk, and we educate and we learn from each other. So it is a lot of peer to peer support, learning and growing together, coming up with an idea, thinking about the idea and then moving on with that idea and you know, by next Tuesday we're working harder and harder, in fact, I'm having a call with them tomorrow when I return back to Ohio and I'll be sharing a lot of the information that I learned here from the EHDI conference to see if there are things we could implement within the group as well.

Here's just copies of our parent to parent support meetings. The first one was open forum meetings. The second one was when we had the guest ENT lecture and then our social worker who came and talked about that social and emotional and growth process for families.

And then another drop in the bucket is the EI engagement, and I really should have changed this slide to say EI and beyond because it doesn't just stop at EI, even though our state EHDI program is birth to three, these children have to transition to school age. So having that collaboration among your early intervention professionals, helping those families transition, we are looking at creating an I document which would be an EI guide. And then also, a guidepost early intervention and then school enrollment.

We have a really wonderful educational audiologist. She gives us the end of the information here and then we backtrack and try to figure out the different steps and the different access points and where there were gaps and where there were barriers and how we can fill those gaps. So it is really wonderful having the across the life‑span all the professionals, parents that are working with these children coming together and talking about this so that we can certainly make an important impact.

So let's look just very quickly about our data. So this is three‑year data from 2016 to 2018. The first one is the screening results. So we have six birthing hospitals within this county. We've remained at a solid 98% for screening rates. When we looked at the diagnostic results for referral after screening, our lost to follow‑up rate for this particular county was around 25% in 2016. We started this collaborative in 2017, it dropped to 22%, which is good, and then 2018 data is not yet complete or finalized, but we're looking at 1.3 right now and I'd be really happy if we had that, but I'm sure that number is going to creep up just a little bit. I'm really hoping, crossing my fingers it is going to hover less than that 20%. And we look at the total followups. Our followups have declined a little bit, again, but I'm hoping that that number will go up as we look at 2018 data and finalize it. Some of the challenges that do exist are the EI enrollment, and so we don't have great enrollment. We have about 50% enrollment for early intervention, and that's stayed the same between 2016 and 2018. 2017, it dropped down to 26%, I'm not really sure why. But, again, we are finalizing some of that data for CDC. So these numbers will change and they're relative at this point in time.

Here's just a quick summary slide, and my slides are available on‑line, so please do take a look at them. This is just synopsis of all of the work that we've done with the learning collaborative.

So eventually, we ‑‑ so I facilitate and lead the collaborative. At some point this will transition to some of a community‑level partners, and they will continue the work of the collaborative. They are planning more events and various checkpoints for the collaborative work. So not only at the screening level to follow‑up and identification level, preschool entry in to school age and beyond. And then ODH will duplicate some of the efforts and sustain some of the projects that we've started within Lucas County statewide.

So with that, I just want to say, you know, it has really been a tremendous and incredible effort to work and establish a learning community. We thought it was a really challenging piece when we got our grant, we weren't really is sure with where to begin. But we know just one drop makes one ripple and then you just keep adding those drops and it's just truly amazing to see the impact that we've had in our state.

So with that, you can feel free to contact me. I have some cards up here. And then we do have another presentation about a statewide audiology protocol that's happening later this afternoon. So I hope you have an opportunity to attend. I will take questions. I know I'm out of trial. But thank you very much for all of your time and attention.

(Applause)

>> I can take them. I think. Am I allowed?

>> I really loved your wait and see project with the PCPs. How did you get the PCPs to?

>> That was really challenging. We had one PCP who came and then she just brought her little true of people and we were able to make that drop in the bucket by just one person. So I think you really just have to get to one person and grab their attention and have them share their knowledge and expertise and spread that. And then wow, it's an eye‑opener.

>> Was that through a webinar or?

>> That was on‑site. Yeah, on‑site.

>> Thank you for your presentation.

>> You're welcome.

>> There was a lot of information so I'm furiously taking notes.

>> A I have a question. I know there were two parents involved in the learning community, and I was curious how you plan to engage them further or how you're using your family‑based organization in, like, the activities that you're planning and such. Because it sounded like they were led perhaps by professionals or were they led by parents?

>> So the work is led by both professionals and parents, and we do have Ohio Hands & Voices that's been at the table. So they're an ancillary member, a support member, and then we do have funds for another family‑based organization that's helping us out, and they ‑‑ we ‑‑ because they're based just outside of Columbus, it's really hard for these organizations to travel. So we call upon them at times when we have special events and things like that happening. Again, this is still fairly newborn to us so we are really trying to be much more inclusive in giving access to as many people as we can. There are a lot more parents that are not listed. We have a separate e‑mail group for parents, all of the parents that attended the open forum, so we have a variety of parents who are participating, just not coming monthly together. So I hope that helps answer your questions.

>> Go ahead.

>> I think there's a break now. Is that okay?

>> I think the time is up but they want to come up to you.

>> Okay. That's fine. Thank you.