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WEDNESDAY WEBINAR SERIES:
FAMILY CENTERED PRACTICE FOR INFANTS AND TODDLERS WITH HEARING LOSS
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Good afternoon everybody. Welcome to our webinar this afternoon. Maybe you are having it over your lunch if you are on the east coast. Our topic today is **Family Centered Practice for Infants and Toddlers with Hearing Loss**: *What have virtual home visits taught us about coaching and family centered early intervention*. I'm Jan Gatty. I'll be your moderator today. And I'm going to introduce our speakers – we have Barbara Hecht. Barbara is the director of our Clarke Schools in Boston. She's also the president of OPTION International and the co-director of a project we'll be talking about today using telepractice. Barbara? Would you like to say hi?

BARBARA HECHT: Hi Everybody.

And also we're joined by Elizabeth Cole. Elizabeth is the Director of CREC Soundbridge which is a program for the hearing impaired using listening and spoken language in Connecticut she's the author of a book children with hearing loss developing listening and talking and it's a book that we use in many of our teacher training programs around the country and Elizabeth is co-directing this project on telepractice that we're

doing with Soundbridge. Elizabeth do you want to say hi.

ELIZABETH COLE: Hello, everyone, welcome.

You've been introduced to this faculty before if you've attended our webinars but we have some other visitors today I want to introduce Marian Hartblay the Director of early childhood services at the Clarke Schools for Hearing & Speech and she's a practitioner in our telepractice program.

Hello, everyone. We're also joined today by Tracy Osbahr she's the Director of specialty services in Massachusetts which is in the Department of Public Health by training she's a speech and language pathologist for many years she ran an early intervention program in our area. Do you want to say hi.

TRACY OSBAHR: Good afternoon.

I'm going to put our Mission Statements on the screen. There's the Mission Statement for Clarke and one for CREC Soundbridge. And I'll let you read those on your own. I think the thing I want to point out is that we are a public and a private school but our mission is very similar. It's to help children who have hearing problems hearing loss develop listening and spoken language when that's the choice of their family.

This is the fourth of the series of four webinars. These webinars were really designed to update early intervention professionals who were in programs -- early intervention for those who have -- may not have specialty in training in deaf or hard-of-hearing children they are designed for introductory in nature and give an overview of current technology practice and research and our faculty here is expertise in using listening and spoken language with children with hearing loss and so that's what you'll be hearing about today. But when you're working with a very young child families are usually part of their process of learning to know their child and figuring out the best way to raise them is they are going to consider many options for communication. So we are aware of that and work with families who are maybe trying other approaches. But this will talk primarily about the oral aspects if they choose that with their kids.

I want to let you know today that I hope you have questions along the way. We're only talking for an hour so we're not going to have time to deal with those questions verbally -- verbally or virtually. However, you can make note of them it and there will be a way for you to send them to us via e-mail and we are good about responding to each and every question so I encourage you to do that this is the fourth of three -- fourth of four webinars but I thought we would summarize in case you didn't come to the earlier ones the topics that were addressed were advances in Early Hearing Detection and

Intervention. An update on the state of the art diagnostic tools and sensory aids. Then there was a webinar on brain development and particularly the development of the listening brain and how that contributes to learning and perceptual development and language acquisition.
A running thing has been partnership with parents and professionals and we'll talk more about that today and our last webinar was specifically looking at ways to develop listening and spoken language in children who are deaf and hard-of-hearing.

Most of us are teachers here as good teachers we have learning goals for you today so by the end of the hour you should be able to do the following: You should be able to identify the benefits of adding telepractice as a component of your EI service delivery.

You should be able to give a nice operational definition of family-centered practice. List some components of telepractice that promote family center practice and also describe what the potential impact is of using telepractice on your on your work with families with young deaf and hard-of-hearing children.

And I think now I'm going to turn the microphone over to Barbara Hecht. And she's going to continue to talk about family center practice.

DR. BARBARA HECHT: Hi, everybody, it's great to be back with you. We really have a crowd of people here with us today. Who will all be contributing to this webinar and we hope that you enjoy the opportunity to hear from a number of new voices, as well.

There is in the past couple of decades we actually have a growing accumulation actually of very impressive research that suggests that the environment in which a child is -- this really has an enormous impact on their development. So when we talk about family centered practice today and think about how family centered practice can work in a virtual medium we're really focusing on it because we know that outcomes for children are so dependent on the capacity and the skills and the knowledge and the comfort level of parents.

When we look at all of the research we've been accumulating over the past few years, it's very clear now that the amount and quality of language that is addressed to children predicts language skills cognitive development, IQ and is actually even more predictive than some of those traditional predictors like socioeconomic status or parent education this is true of children who are typically developing as well as children who have hearing loss.

So as we looked today at family-centered practice we're trying to optimize parents ability to provide that language rich environment that will help their children grow. At the turn of the millennium Mary Pat Moeller a colleague actually but she published an article in pediatrics looking at the impact of various factors in early intervention on language incomes that were five years old what she found was family involvement was the most important of all of those factor it explained most of the variance in language scores for children.

Age of enrollment in early intervention also was a key factor. But what was most important was that age of enrollment together with family involvement.

So it's not just entering any kind of early intervention. It's entering early intervention in which families are engaged and involved and able to help their children.

This past year we mentioned in an earlier webinar this study. And we do suggest you look it up if you can Quittner et al. It was published in Pediatrics just a few months ago this was a paper that was published based on an ongoing multi-site study around the country. It's a national study. Following up on children with cochlear implants.

And they were looking at language gains and language levels four years after cochlear implantation. And they found that high parent sensitivity, this measure of parent ability to interact and engage with their children in a sensitive and responsive way was the most -- the strongest predictor of language gain.

It also -- also the parents ability to provide linguistic and cognitive stimulation. And when you took those things together the parent engagement and the ability to stimulate their children cognitively and linguistically there was a huge difference in the language outcome just four years later. And really a one and a half year difference between the children who had parents who were able to do this well and parents who were not so skilled.

So this really compels us, this kind of research compels us to focus on families as we provide early intervention.

As we have been saying throughout this webinar series, language is learned and acquired with somebody who absolutely adores the children in the course of everyday life. It doesn't happen during language time or therapy time. It happens throughout the child's day. And especially when it's adapted to when the child's focus of attention is and what the child is interested in.

You also if you've been attending our other webinars, you've seen this pie chart before. We're going to show it to you one more time. Because in a way it's one of the most compelling reasons to focus on family centered practice.

If we're providing early intervention to a family, maybe two hours a week, maybe a little additional time with a toddler group, we are providing that intervention for a very tiny slice of the infant and toddler's waking hours so the best way for us to optimize our impact is to leverage that time by teaching parents what they can do throughout the child's day.

So what is family-centered practice? There are many definitions, many ways of thinking about this. But we like to think of family-centered practice as a way to build parent and caregiver confidence, competence and their effectiveness and there are really two primary components to this practice. One is to provide the emotional support to parents to be a good listener to be there to provide that counseling and support role. Sometimes when we go into an EI session with our whole lesson plan, that lesson plan gets tossed out the window if the parent has just had a bad experience at the audiologist office or somebody made a comment in the supermarket about their child's hearing aid so

we have to be there to provide that emotional support in order to help parents be able to be most effective and then certainly parent education and parent education comes in all forms but our goal is to provide information but to really make parents knowledgeable, skilled and also to be good advocates for it their children.

So if we compare family centered or parent centered practice we compare that to more traditional child focused therapy we're really talking about a different role between the parent and the professional. It is a true partnership where what the professional brings to the table is specific expertise. Hearing loss on how to read an audiogram, on how a hearing aid works, all of those pieces of content. And the parents are the experts on their child and our goal is really to make them feel they are really the experts on their child. Sometimes when hearing loss comes into the picture, parents often feel that they are not equipped to provide the kind of nurturing and support that the child needs. And our job is to give that content back to the -- confidence back to the parent.

So as professionals we play a coaching role a cheerleader role and the presentations are really the ones that we want to see as the active facilitators in the relationship.

Key to family centered practice is also that technique really of coaching and again there are many definitions of coaching and we have looked at a lot of the literature but this is one quote that we really like. We think of coaching in family centered practice as a way of increasing caregivers capacity to build on their existing abilities and to help them build new skills and new practices and also to help them to be able to reflect on their own practice.

So actually when we're in a session with a family, what does coaching look like? I've always said that if you're watching an early intervention session, you can tell if it's a coaching family centered session if the parent is the one who is doing most of the interacting with the child. So we really do want the parents to take the lead.

The professional often will demonstrate but then quickly turn the responsibility back to the parent.

And the coach is really there to observe and encourage, make suggestions, help the parent think through what went well, what didn't go so well, what they want to change.

But our role as coaches is to ensure that the parents have opportunities to practice new skills while we're there so that they can continue to use them when we're not.

For those of us who are engaged in early intervention, we know that there are many, many challenges we face in trying to ensure that all families have access to the kinds of services that they really need. And what makes it particularly difficult is that there is a critical shortage of specialized professionals who know about hearing loss specifically. And who also have the skills and the knowledge to really be adult educators.

As we look around the country there are Centers of Excellence and expertise but there are few and far between and often geographically inaccessible to many families.

And so families often have very limited access to specialized services especially if a

family is trying to choose a particular communication modality where there may not be an expert nearby.

And what we have heard from families and what we have heard from our colleagues out there is that there are many, many barriers to getting good access, distance is certainly a big one but also traffic, parents often have many, many appointments and if their child has additional special needs their appointment schedule can be daunting there are economic pressures on families and just the cost so there are many reasons that families have limited access even if the service provision is in their home.

Many of our colleagues around the country are turning to one solution to this access issue, which is what we have been calling virtual home visits or teleintervention.

This is a method of providing services. It's really a new medium for providing services. Family centered practice. Using video conferencing technology. And in particular, most of the time we're talking about using a high speed Internet connection, personal computers, laptops, tablets, webcams, microphones and using telecommunications software like Skype or FaceTime or something that is actually fairly familiar to families.

So as Jan mentioned, we have Elizabeth Cole and Jan and I and many of our colleagues at Clarke and CREC Soundbridge have been engaged in a project a teleintervention project that we call the tVISIT project. This is an acronym actually to -- the little T is teletherapy virtual intervention sessions for infants and toddlers as we said it's a collaboration between Clarke and Soundbridge and we're reaching three southern New England states Connecticut, Rhode Island and Massachusetts.

Our goal is to reach up to 80 families in rural areas, in urban areas and suburban areas.

Because the families are all receiving services Part C services, we really in this tVISIT project are using a hybrid model so the families are getting face-to-face typical visits as well as teletherapy visits. And this really allows us and the families to compare and contrast what happens in a person-to-person visit versus a virtual visit.

At this point in our three states, telepractice is not third party reimburseable so our project is privately funded through a foundation that really is quite interested in bringing about systemic change and to help ensure that this kind of service is ultimately sustain able through the usual reimbursement mechanism. That's really one of our long-term goals.

And before we go on then, we would like to take a moment to ask you a question as you're listening to us how many of you out there are already providing services via telepractice. And this is just a yes-no poll. The poll is now open. And if you could let us know how many of you are already providing telepractice. Okay. I think we'll close the poll.

As most of -- as you can see most of you are not currently offering telepractice so

our goal then today is really to give you a little bit of a taste of what this is like, what it looks like. And especially just to help you think through whether this is something you want to add to your current practice or advocate for adding to your current practice. I'll now turn the mic over to Elizabeth Cole who will talk to you a little bit about some of the components of our tVISIT telepractice project.

ELIZABETH COLE: Thank you, Barbara. I think it is a -- it's a really good thing for us to talk a bit about our project because this would be a good way for anyone who is considering doing telepractice to get -- be able to benefit from our experience in figuring out what all of the components need to be and make it all go smoothly. The first thing is there needs to be training of the professionals who are involved. Of course and the use of technology -- of these specific technologies for doing tVISITS but also on effective family centered practice.

To ex -- two extremely important areas in order to make this a successful endeavor. Another component of the project is that we're providing equipment and broadband access to families as needed. And we're also gathering experience and data in order to drive systems change that truly is one of our ultimate kinds of agendas here.

And we're also I guess another piece of this is another piece of our project is our sample of potential people to be involved our sample of people of people are being involved actually in the project is quite large relative to many of the other projects so far that have been published anyway in that we are going to have up to 80 families perhaps even a few more. And our sample is very diverse in terms of socioeconomic levels, educational levels.

So we're getting a lot of really valuable experience on what's needed for trying to provide teleintervention to quite a variety of different family constellations and family characteristics.

The other thing we're doing is systemic evaluations with help from the Donahue Institute at the University of Massachusetts. Kinds of things that we and this lovely little baby are collecting information on include quantitative things like the number of visits that we're making of course and the time required. In terms of both travel time that's being saved by not having to actually travel to the homes for these sessions. Also how much time is involved in preparation. Because there is potentially significant preparation time. And how long does -- do the sessions last for? And we don't have requirements on that.

So these sessions can be anywhere from you know five or ten minutes up to an hour. And could be longer if that was appropriate for a particular session or particular situations. And also what kind of follow-up is happening.

Another thing we're keeping numbers on is numbers of cancellations. Because our hypothesis originally was that if families didn't have to travel there would be fewer cancellations not travel so much -- if there weren't face-to-face sessions that there wouldn't be cancellations due to illness I didn't really mean to say if families had to travel necessarily. It's really if there's sickness in the home, it's not a good idea for the

sessions to happen with a therapist who might then go to another home and take the sickness with them.

But also of course if another child in the family is sick, sometimes parents don't want to have the actual face-to-face session, either. But they could do it through teleintervention.

The number of families who enroll and who continue is another important aspect because we're offering this to all families. But there's no pressure or necessity for them to be involved.

In Connecticut this is a value added kind of service so that it's on top of whatever other services they are getting. So they don't have to be involved. So it is really interesting to see which families choose to do it.

Family measures then. What kind of access parents already have to technology and what do we need to provide them with. And also what is their satisfaction? We will be asking that I think at the end exactly how -- you know how satisfied are they, how happy are they with doing televisits, doing the tVISIT that is versus face-to-face ones.

And of course the same thing for the practitioners. Their satisfaction and also their self evaluation. And we're also keeping track of what kinds of training and mentoring needs they have as we're going along.

Some of the questions that we're specifically particularly interested in are what are the characteristics of families who find telepractice to be a suitable form of intervention and also conversely what about the practitioners? These are things -- areas we're really interested in. And -- in and have had some surprises about that we'll talk about a little bit later. So the goals then are of this tVISIT project are to expand access to intervention. The potential for families is that there would be that increased access to qualified providers who are few and far between. Also that there would be reduced travel constraints and reduced health related cancellations and interestingly the family involvement would be more -- would be intensified.

For a couple of reasons. Related to the coaching and related to the fact you can't reach into the computer and take over. The families have to be involved. And increased family ownership of the intervention process and increased skill development, too.

The other thing is increased opportunities for multi-team professional support because it's possible to have audiologists standing there with you when you're talking to the parent about the child's brand-new hearing aids and whether or not the air molds are fitting properly why there's feedback and so on, it doesn't have to be just the therapist who is on one end with the parent on the other end you can have more than one person there.

The other major goal besides expanding access is improving practice. The potential is there through -- through our tVISITS for specialists to increase their use of coaching, the reasons we just spoke about. And also to be really very reflective and to guide parents in being reflective both.

This of course would mean that caseloads could be somewhat larger and productivity increased because the practitioner isn't driving all over the state or states.

And when the sessions are recorded, it allows the potential for mentoring and direct supervision and training that is much easier than if they are all face-to-face and spread out all over the state, the sessions I mean.

So there are a number of different kinds of things which can happen as part of a tVISIT. It could just be a plain old conversation with the family. It could be follow-up for something that you already discussed in a face-to-face session. It could be review of an assessment that's been done.

It could even be going through a checklist. We have lots of those in Part C. Lots of checklists or lots of assessments that need to be done not necessarily just on language but on all different areas where a parent can answer those questions just as well in a tVISIT as they can face-to-face.

Another kind of thing can be troubleshooting the child's equipment that perhaps there would be a problem with a child's equipment in between two face-to-face sessions and it certainly is beneficial to be able to show exactly what the difficulty is for the parent to be able to show and to get advice about what they might be able to do to fix it.

TVISITS also are wonderful for being able to observe normal parent-child interaction. And they are also good for counselling of various kinds. And for team consults that can also happen and also it's possible to do a regular early intervention session, too. That's what I wanted to go through a little bit here in a little bit more detail that is and talk about some of the components that could be part of the session that's a regular kind of therapy session.

You would start off of course as you would with any session I'm going to put all of the pieces up here.

I think the beginning and the end would be the same regardless. You're going to sort of check in, see how things are going and get updated on the child's recent progress. And you might end with a review of what had just happened in the session and what kinds of things the parent is going to do during the week and what is the practitioner going to get to do before the next time you get together but in between there that -- there could be the other elements here. Reviewing whatever the plan is for the session so that you're both kind of on the same page for what's going to happen during the next few minutes of that session.

Talk a bit more about the planning in just a second.

But it could be that during the tVISIT sessions there could be an introduction of new concepts or practice. It could be observation of something. Just the child and the -- or it could be the parent feeding the child for example. And then perhaps some coaching afterwards where you discuss what has just happened and how it went and make suggestions potentially for doing things in different ways.

So those are the kinds of things that might be part of a tVISIT session.

Before that visit even happens, we found it really useful to have a planning exchange, whether it's on the telephone or by e-mail with a parent about what's likely to be happening during the tVISIT. And that could be that tVISIT could be one where the parent has specific things they want to talk about it's nice for the practitioner to know that ahead of time so that then they can have materials ready and/or they might be able to scan and send some articles or just some checklists or whatever to the parent depending on what the topic is.

So that's useful. And then during the tVISIT discuss them.

It might also be that the practitioner is going to be giving some suggestions for ways of addressing particular parent objectives for the child. And that then by having discussed it ahead of time allows the parent to get the toys or materials together ahead of time so that things go smoothly and there's no wait time while the parent goes to find a book to read with the child.

So here is a little example of a tVISIT session starting off with getting up to dates and so on and this would be something that would be sent to the parent ahead of time for them to know what's going to be happening in the tVISIT session.

So starting off with getting up to date. But then working on specific objectives, parent objectives for the child. Like auditory ones for example that the parent wants the child to get better at paying attention to sounds and responding to a calling voice or maybe reaching for toys that make a sound. So you might send them something like this. For them to be able to prepare for that kind of event to be happening in the tVISIT itself.

Another goal, a parent goal for the child might be that you know they want to increase the amount of vocalizing the child is doing. And the idea would be that they would play with them in ways that they have -- are already playing with them. And the ways being -- ways of helping the child smile and vocalize more. And it could slide right into doing rhymes and songs and the routines like patty-cake and peekaboo and so on because sometimes those are times children really do lots of vocalizing, too.

But also the value of doing rhymes and songs with babies and young children, it's another thing that could be emphasized by the practitioner.

And then one other thing, this is you know in this particular session the decision was to do some book reading together. The idea would be to warn the parent or at least to talk to the parent together agree that this is something that might be happening. And that they would then have a couple of books available so they can make a choice for what they are going to do. And that could become part of what happens in the tVISIT, too. So I'm going to turn the mic back over to Jan and she's going to actually talk about an example of book reading.

>> JANICE GATTY: Thanks, Elizabeth. So the first thing I want to call your attention to is the image on the screen it looks different than the other pictures we've used. This is a still shot that's captured from a tVISIT session.

The equipment -- we can't really show you the videotape with the software that we're using today. But you can see the family is on the right. And they are -- in their home environment. And I'm in my office on the left.

And the background is that the family brought their little girl for a hearing test. She's a little over a year. And the dad said he really wanted to know when she was going to start to develop language because he had just bought a book of grim's fairy tales and was anxious to read it to her so it was all good and I said there would be some steps before he got to the fairy tale she was just beginning to babble but reading was an activity that they did in their family a lot so I asked them to select some books she typically would read at home so the session started out where he's reading her a book so I waited until the end of that and then I commented on what was good about it which there was a lot that was great about it he was very engaged his proximity was good she was referencing things with him he was talking about the text of the book.

And then I said -- made some suggestions about how he could make it even more accessible to her with her hearing and mostly her motor movements she was very involved in turning the pages and waiting for him to finish reading so we talked about saying turn the page, turn the page so that became incorporated in her activity. And then he read the book again. This time the baby moved to her mom's lap and he read the book and actually I could observe he incorporated all of the suggestions quite naturally in his own way. So that's one example of what a session could look like.

We found out that there were things that we hoped would be accomplished in a tVISIT but we weren't sure.

And so what we figured out is that it is possible to establish relationships with parents even though you're doing it virtually -- most of us -- well all of the interactions have a face-to-face component so the relationship is usually not started virtually but it's easy to maintain it that way it was possible to discover sensitive issues and work through decision making processes with parents. It was easy to be more didactic in your teaching you could explain the ear, the audiograms, preparation for cochlear implant surgery how to troubleshoot equipment even practice some sort of advocacy skills.

We can do some nice global assessment of child and parent interaction in order to do some careful speech perception you'll have to get a good microphone and hear the accuracy of the child speech mechanism moving but you can make a lot of comments about pragmatics of language and play skills and turn taking. In through a tVISIT. And also if you're working with a family for which English is not the primary language at home can work with an interpreter so that the session is really accessible. So I'm going to turn the microphone over to Marian and her cohort and she's going to talk to you about that.

>> Thank you, Jan. Let me make an introduction, also, stepping up to the microphone with me is Jennifer Santa Bria.

>> Hello, everyone.

>> Jennifer is an administrative assessment here at Clarke Northampton she's a fine

multi-tasker and one of the things she does is interpret for our Spanish speaking families and our practitioners so she's right here by my side. And in this next slide this is a still shot, also, of a tVISIT that took place with Jennifer interpreting.

And what you can see is the split screen with the family on the right and myself watching and Jennifer by my side.

And so just as you will experience now

(Speaking in non-English language).

>> Jennifer is nearby and interpreting all of what I say in English to Spanish for Mom. And then from Spanish to English for me.

And that's kind of how it works.

And so you can see that you get a flavor that using an interpreter for a family centered session requires just a little bit adjustment in dynamics but it can be very effective. And helpful actually. Because I need to pause more and I'm also watching for everyone's understanding and listening for nuances and emotional content and watching for body language and non-verbal communication that's taking place.

So in addition to improving the communication, I think that using the interpreter really gives the message an authentic message that it's the family culture that is most important and primary to the child's learning. So in this particular session I'll just give you a little more information. Mom and I had planned the activities and actually Mom chose two activities. First she did a snack, had a snack with her little boy. And in this still shot she is looking at a book with him. That she chose. It's a new book. Her son wears a bone anchored hearing aid or Baja on a soft band. And I am sitting back but actively observing in this slide. While they share this activity.

And then when it's time to provide a little feedback, I start out by talking with her about all of the positive things that are taking place in their interaction. And particularly those things that I know that Mom is already sensitive to that are really working well so for instance I begin by pointing out to her that she's talking about what they both see. He's in a wonderful position. He's in her lap. She's close to his microphone. She is labeling things that they see. Sometimes she's pausing to give him a chance to imitate. Sometimes she's even asking him where something is that he might see, also. So those are all things that are working well and they talk about those and then they give a few suggestions. One of the things that I noticed as I was observing is Mom was labeling animals and there was also a train in the book.

But I didn't have a sense of where there was a story line in the book and I didn't know what the title was. It turned out to be The Little Engine That Could so I know there's a story line.so what I realized is that Mom was actually sharing a book that was in English with him. The story may not have been as accessible to her so one of the suggestions I made in addition to her providing labels for him was to talk about what was happening in the pictures and provide a little bit of action and begin to introduce some sequence also but then also she could go to the library and get books in Spanish that would be more

accessible to both of them. And also it's another way of just keeping the awareness alive in a session and bringing cultural sensitivity to the sessions. And in our practice.

So that's a little clip about that. And happy to share that with you and Jan has another example to share with you so we'll just shift again on the microphone.

>> JANICE GATTY: We're changing chairs here we talked about tVISITS serving many purposes the little girl had lost significant amount of hearing that was observable by her parents particularly her mom and she called me was very anxious about it lack of responsiveness came into our center we supported it with behavioral testing but then she quickly arranged to have more objective testing ABR to see how true her observation was and CAT scan to see if there was some physiological reason for reason for shift of hearing so I asked her to call me when all the testing was over so we arranged for the appointment in the evening the earlier clip she poured a glass of wine while putting the baby to bed and came down to join me.

Talked about the results. And also talked a lot about the behavioral changes that were beginning to present because her little girl didn't hear so well and we hadn't changed her hearing devices yet they were disturbing to her and different from previous behavior but it was all very predictable given the change and status of hearing so it was very nice to be reassuring and talking a lot now but during this session I was mostly listening to provide support.

Okay. So I'm going to turn the microphone back over to Barbara.

>> DR. BARBARA HECHT: So I mentioned earlier that -- or I think somebody mentioned earlier that a big part of our tVISIT project is to collect data to help inform and guide practice as we move forward. And one of the things that we're doing is we are actually doing sort of pre and post polling of our families and also of our practitioners.

One of the questions that we ask is whether some of the key elements of family centered best practice, whether some of those key elements actually take place during televisits. So in front of you you see six of these rank from providing emotional support to explaining targeted session goals.

So we asked practitioners who had just begun to offer tVISITS. They have been doing this now for probably -- a couple of months. And so it's fairly early on in their practice but we wanted to get a sense of whether they found they were able to actually provide these sorts of opportunities in televisits.

And so we have just started to get some of that feedback back from our polling. And we found that actually our practitioners are telling us that they actually are finding that there's more parent-child engagement in the tVISITS than sometimes when they show up in the home or the family comes to them. Many of you who provide early intervention can relate to this. Sometimes you show up and the mom said: Oh, good I'm going to go wash the dishes now and it takes some effort to sort of reengage them.

But when you're doing a telepractice visit, you know, they are there with the child and you can't go in and rescue them.

So we're really hearing from our practitioners that in some ways, this medium actually encourages some of those -- that direct interaction and I wanted to just read to you a couple of quotes from our practitioners.

When this practitioner was asked whether she's able to engage caregivers in the activity she said: I'm not in the same room so I can't rescue the parents directly. So I have to coach. I love it.

Another practitioner said: Since I cannot model the activity with the child so easily it necessitates me thoroughly explaining the activity and the targets in detail and it really forces me to be very organized about how I present material.

A third example we had somebody say that this is -- she said there are clearly opportunities to sit back and observe the parent-child dynamic and then provide feedback. It feels a little more awkward to do that when I'm in their home with them, just sort of sit back and watch. But in this kind of a medium, it seems very natural to do that. And then really be able to provide that feedback.

I'm actually sitting here with Tracy Osbahr and really as a kind of representative of the -- of Massachusetts Department of Health and one of the people who will be a decision maker about how we move forward, using telepractice, she's going to talk a little bit about some of the challenges to full implementation.

>> TRACY OSBAHR: Well, to reassure you, there's definitely interest national in use of telepractice for Part C programs not just for children with hearing loss but other children as well there are still questions to be answered as we move down that road one of those is how do we create full access for all.

This project is grant supported which is -- which has been an incredibly wonderful way to get hardware, software and also the technical expertise that one needs to get that hardware and software to work. But helping Part C programs manage to do that when that grant support is not available. Second thing we need to think about is how to ensure privacy and security. As you know Part C programs are under the auspices of HIPAA and regulations and with this particularly delivery model we need to think about the HITECH Act and that regulation, as well.

How will sessions be reimbursed? Across the country Part C programs have very different funding streams. All receive some modest amount of Federal support, which of course is declining these days. Most Federal support is.

Some states have been able to negotiate pretty robust reimbursement systems through private health plans and through the public health plan of Medicaid.

Medicaid is implemented differently in every state. So that will require state-by-state negotiations.

Some states have opted to go the legislative route and get legislation passed that has mandated insurance coverage for telepractice. So that remains to be seen on how it might happen.

Licensed reciprocity is something we all need to pay attention to. Somebody who

has a license in one state doesn't necessarily have the capacity to practice in another.

So if the family that you're working with is in Connecticut and you're in Massachusetts, you may not be able to actively work with them.

This is being handled on a broader national level by representatives of various stage associations like ASHA and APTA and AOTA and the American telepractice group. Which is kind of leading that discussion, as well.

The other thing that is of interest is ensuring that providers have the appropriate skill set to use this methodology as well as you can see from Jan and Marian's key session examples, this is a very reflective practice. It's not something that's innate. Not everyone knows how to do coaching. So we need to be able to define coaching and ensure practitioners have the ability to do it well.

That actually brings us to our next polling question. We know that only about 10% of you are providing telepractice services. But we would be interested if you can take a moment and let us know what the primary funding source is for it those services.

Is it through Part C, public insurance, private insurance, grant funding or are families paying privately.

Great. I think we're going to -- okay.

We'll show you the poll. This is interesting, actually, that a majority of you who are currently providing this service are getting funding through Part C. The -- and then the rest of you are getting grant funding.

What we've been seeing in talking to our colleagues nationally is that most of the large telepractice most of the large telepractice projects are currently grant funded rather than Part C funded. But I think that sort of accounts for when we look at what a small percentage of you are currently offering, the services that probably reflects how early in the process we are to scale up to get Part C funding.

>> ELIZABETH COLE: This is Elizabeth again. Some of the things we've learned about access which is of course one of the things we've been trying to learn are things like that the families do need hardware and software. It's been important to be able to have that funding to be able to provide it. And that people do need training. The families as well as the technicians and technology and assistance with the technological parts.

For breakdowns as well as for being able to use it to start with. And one of the other really important pieces of learning is the bandwidth seems to be key for providing good access to both the video and the audio parts of the message.

In addressing access and the Digital Divide, we have been using equipment providing it -- I'm sorry; we've been providing equipment as it's been needed for families. And experimenting with the best methods not only of what kind of equipment but also best methods for providing broadband access.

Whether it's through providing that access through Internet or through WiFi hotspot devices. We've tried both. And we continue to do that. To try to learn more about what seems to be the best way to do it.

Also with regard to the first item, the equipment, even the software, whether to use Skype or FaceTime, whether to record it and how and so on. Those are all issues we're still working with and of course tech support to help the family and practitioner comfort.

This next slide I want to assure you that despite the fact that these are really rather amusing pictures, we do take these issues extremely seriously. The privacy one is the way that we do sessions -- no, it's not at all.

But these issues are extremely important in trying to make sure that the privacy and security and anonymity of the families as well as of the practitioners is guarded.

The families all are provided -- they all have -- there are informed consent forms that are signed by parents after they are thoroughly informed about what the risk -- the potential risks are and how the equipment is to be used and how we're going to store recordings assuming parents have agreed to have their sessions recorded.

And yeah we're using a lot of us are using Skype, which is encrypted and has AES encryption which meets the requirements.

And so on. There's things like passwords for storage and also for sharing with families and so on and also they can share the videos for educational purposes. But there's no requirements they do so.

Very quickly now because we're getting close to the end, the polling question No. 3 was how much states currently accept and use telepractice to deliver some part of -- some Part C early intervention services. Choices were none, 2, 6 and 12. Unfortunately we are running out of time to such a degree that I'm just going to tell you the answer, which is 6.

This was part of a 2012 study of 26 different states who responded that out of those 26, 6 were actually providing teleintervention at the time.

So I'm going to turn the microphone over to Tracy who is going to talk more about systems change.

>> TRACY OSBAHR: Thanks I'm just going to emphasize one of these in particular. I think we've talked about emphasis on the family system and having the parent involved as a primary treatment partner as something that really is part of OSEPs mantra these days as well as providing services that build on the family routines and daily life as a way of improving child outcomes but I want to talk a little bit about closing this service delivery.gap, which we see here in Massachusetts and I'm sure many other states are dealing with it, as well.

A reminder that hearing loss is a very low incidence condition. That appropriate intervention means bringing providers with really specialized content area to the table for part of that service delivery plan. That is a challenge for all families to have access to communication options that best match the child's needs and the families values sometimes because of geography. And telepractice is the means of getting around that.

It's also to mediate some of the service delivery challenges in urban areas the traffic kind of and parking kinds of issues that are really problematic in rural areas although

Nantucket is a lovely island flying there and then navigating around the island via cabs or whatever is pretty challenging and certainly after a tough winter here in New England, we all were involved with lots of cancellations of services and no one was happy about doing that.

In terms of public policy, I -- just keep in mind that all of the professional organizations have defined telepractice as within the scope of practice of their staff and that we need to consider it a service delivery model.

Jan.

>> JANICE GATTY: Yes I'm come up very fast. So thanks, Tracy I'll sum it up I'll just call your attention to the last slide there's a slide with concluding statements you can read through those if you fell asleep during any of this presentation you'll just be reminded of what's important. I think the thing that we were surprised at is how well the practitioners who were very, very experienced jumped into the project and worked in this venue.

There's also some resources, some virtual resources, some web resources and some print resources if you decide to do more research or investigate this area further.

This will be the conclusion of our webinar series. We've enjoyed it. We hope you have, as well.

All of the webinars will be archived on our Web site at Clarkeschools.org so we would encourage you to check on those if you wanted to review things or if you didn't come to some of the webinars and wanted to see what we talked about.

And the last note is that tomorrow you will be e-mailed a link. And it will request your response and evaluation of this experience, this webinar experience.

So we -- all of those responses are collected by a third party. And are anonymous. So please be open, honest, kind and constructive. And we will issue certificates of participation after you finish that survey. Thanks very much.

>> Bye bye, everybody.

>> Bye bye.

>> Bye.

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