Year 1: April 1, 2020-March 31, 2021		
	Activities	Outcomes
Learning Community	• EHDI Coordinator to schedule and meet face to face with the hearing screening programs at each birth hospital at least once a year and more frequently when issues arise • The Birthing Hospital report cards will be created and distributed annually • A quarterly hearing screening newsletter will continue to be provided to birthing hospital hearing screening programs. • A representative work group will be established to update the EHDI website for the Department of Health • EHDI will continue to partner with the Maternal and Child Health program in the DOH to provide training to licensed midwives on the importance of a newborn hearing screen. • Continue support and participation in learning community activities • Adopt and test core set of EHDI process and outcome measures • Test strategies for reducing barriers to needed services • Establish QI process and shared agenda for EHDI work • Identify QI team members • Identify Learning community members • Support and participate in Learning community wide activities with state partners • Identify lead coordinator in participating programs in the Learning community • Test approaches/strategies in NW region for referral to dx • Conduct assessment of current practices in target communities • Evaluate QI activities • Collect, analyze, report on data • Participate in QI activities with state level partners	
Target Community Level	• Test approaches/strategies in NW region for referral to dx • Recruit primary care practices for QI in developmental adherence to EHDI guidelines • Conduct QI with primary care providers on EHDI guidelines • Conduct training on QI • Facilitate training on EHDI guidelines and monitoring of hearing status in childhood • Identify target community members • Participate in Telehealth sessions – screening training for providers and collaborative meetings for stakeholders and learning community partners • Identify lead coordinator if different from county level lead coordinator • Participate in initial QI activities • Participate in learning community activities • Participate in Telehealth sessions – screening training for providers and collaborative meetings for stakeholders and community partners • Develop core set of process indicators to measure early childhood system processes • Develop core set of outcome indicators to measure	

	• population impact around children's developmental health and family well being • Learning community to support efforts in reducing duplicate screens • QI to implement data capture	

Year 2 and 3: Year 1: April 1, 2021-March 31, 2023		
	Activities	Outcomes
State Level	• Analyze NMSD data on use of the Deaf Mentor program and identify challenges and opportunities • Partner with community based family organizations such as Navajo Family Voices, EPICS and Hands & Voices to develop strategies to increase family participation with the Deaf Mentor program • Utilize telehealth to present educational opportunities • Facilitate monthly individual meetings via video to identify local barriers and problem solve by identifying under utilized resources and develop innovative solutions when needed. • Analyze the results of the Hands & Voices survey to understand challenges and opportunities • Analyze the NMSD family engagement activities to understand how families access opportunities to meet/connect with other families. • Develop QI activities based on results of analysis • Utilize the MOU between CMS and FIT to identify children who are DHH in the FIT database to assess IFSP dates for children in the targeted project regions • Increase rural audiology telehealth capacity • provide CME/CEU for trainees and QI participants • Collect, analyze, report on data • Evaluate CoIIN activities • Complete annual report • Test NM CCC process for DHH • Test models in SE region • Stipends for family involvement • Explore alternatives site/format for outpatient screen (e.g. NN, pueblos, apache – such as health fairs) • QI for community screenings • QI for state coordinators • Explore opportunities for funding support for equipment • Test audiology protocol per committee recommendations • Explore and ID risk factors in Cactus • Apply QI to PCP interaction • Continue and expand collaboration with hospitals on improving referrals and follow-up • Develop consent forms/materials for community screening • Continue community learning collaborative (CoIIN) • Continue to develop integrated data tracking system • Test process of receiving data from community providers • Define communication strategies with state stakeholders to be tested in target communities • Establish shared data elements and data in the state system. • Receive data from community providers • Incorporate stakeholders and learning community recommendations to improve EHDI systems	Intermediate-term outcomes: • Model for family engagement prior to age 5 • Model for transition from EI to other services • Model for use of effective social media with community partners • Model for referral/reporting EI enrollment • PCP provider education materials

Learning Community	• Engage healthcare providers, families and state stakeholders in EHDI CoIIN • Identify barriers to needed services revealed in newborn hearing screening activities (• Work to establish shared EHDI data elements and data in the state system • QI for community screenings • QI for Gallup/NW diagnostic telehealth services • Conduct EHDI pop up information sessions at community events to improve parent and caregiver knowledge of EHDI supports in NM • Engage healthcare providers, families and state stakeholders in learning community activities • Conduct Telehealth sessions • Work to establish shared data elements and data in the state system.	
Target Community Level	• Conduct screening training for providers • Conduct QI on 2-generation process • Incorporate shared newborn hearing screening data elements into local data systems (EHR, etc.) • Conduct training and support for local PCPs on EHDI guidelines, referral and follow up • Incorporate shared screening data elements into local data system (EHR, etc.) • Participate in learning community activities • work to establish shared data elements and data in the state system. • Implement Quality improvement work with different providers on coordinated referral and follow up • Identify barriers to needed services revealed in screening activities • Participate in Telehealth sessions – screening training for providers and collaborative meetings for stakeholders and community partners • QI on 2-generation process • Learning community to support efforts in reducing duplicate screens • QI to implement data capture	

Year4: Year 1: April 1, 2023-March 31, 2024		
	Activities	Outcomes
State Level	• Report service utilization monthly and quarterly • Quarterly report to funder and partners • Provide CME/CEU for trainees and QI participants • Collect, analyze, report on data • Evaluate CoIIN activities • Complete annual report • Continue CoIIN activities • Implement and evaluate shared care plan for DSM • •	Long-term outcomes: • EHDI infrastructure • EHDI expansion • Model for PCP – resource guide to share with parents • Birth hospital report card provided yearly or more real time Increase by 1% from the baseline of 95% the number of infants that completed a newborn hearing screen no later than 1 month of age Increase by 10% from the baseline of 38% the number of newborn that completed a diagnostic audiological evaluation no later than 3 months of age Increase by 15% from the baseline of 77% the number of infants identified to be DHH that are enrolled in EI services no later than 6 months of age. Increase by 20% from baseline the number of families enrolled in family-to-family support services by no later than 6 months of age Increase by 10% the number of health professionals and service providers trained on key aspects of the EHDI program. •

Learning Community	• Continue EHDI CoIIN
	• Develop core set of process indicators to measure EHDI system process
	• Develop core set of outcome indicators to measure population impact around children's developmental health as it relates to EHDI
	• Test strategies for:
	  ○ reducing barriers to needed services for children with hearing loss
	  ○ reducing barriers to effective care coordination for CYSHCN
	  ○	

Target Community Level	• Continue Engagement of primary care practices in QI on adherence to EHDI guidelines • Continue QI for Gallup/NW diagnostic telehealth project • QI for newer diagnostic telehealth project(s)	

New Mexico EHDI Project

Problem Statement
Early access to family support services birth to 5
NW and SE regions loss to followup, delay follow, screen/diagnosis (post referral) – because of access and they are not able to get to diagnostics by 3 or even 6 months
Equipment /access to non-sedated ABR

Purpose/Overall Aim: Improve developmental outcomes of children who are DHH by engaging stakeholders, improving EHDI infrastructure, expanding EHDI system, educating health professionals and engaging DHH adults as mentors for families

Target Population
Families of DHH
DHH individuals
Healthcare providers

Assumptions
- Parent survey results
- NM EHDI progress
- New EHDI with strong partnerships
- Collaborative MOU SD EC
- NM EHDI with QI
- Tribal communities have regular community events
- NM DOH Cactus screening data

Year 1 (2020-2021)

Inputs/Internal
DOH CMS
NMSD
NM FIT

Inputs/External
AAP New Mexico Chapter
MSRGN
Presbyterian Ear Institute (PEI)
NM Medical Society
NMCDHH
New Mexico Telehealth Alliance (NMTA)
New Mexico Health Information Collaborative (NMHIC)
DOH Family Infant Toddler (FIT) early intervention program
UNM Center for Developmental Disabilities (CDD) Information Network
Parents Reaching Out (PRO)
UNM audiology
Family Voices
NM-QIP
Hands and Voices
Primary care providers
Audiologists (Practice Board)
The CARE Project
Navajo Nation – Growing in Beauty
Physicians in NW Region
LEND

Short-Term Outcomes
- Model for introduction to mentorship model including adult with DHH
- Model for meaningful interaction with DHH adults

Activities for Short-term Outcomes
- Identify community activities for DHH not related to EI services
- Identify target social media assessed by DHH
- Identify opportunities for DHH mentoring
- Test approaches/strategies in NW region for referral to dx
- Test TH equipment
- Continue community learning collaborative(CoIIN)
- Collect data from 4,5,6
- Identify transportation
- NM ICC parent panel
- Apply QI to PCP interaction
- QI with Gallup screening birth to 3 and late onset
- Continue and expand collaboration with hospitals on improving referrals and followup
- Survey families

Products for Short-term Outcomes
- Adequate telehealth equipment
- Learning community established

Measures/Tools for Short-term Outcomes
# of meetings, site visits, participants
Needs assessment results

Year 2-3 (2021-2023)

Intermediate Outcomes
- Model for family engagement prior to age 5
- Model for transition from EI to other services
- Model for use of effective social media with community partners
- Model for referral/reporting EI enrollment
- PCP provider education materials

Activities for Intermediate Outcomes
- Test NM CCC process for DHH
- Test models in SE region
- Stipends for family involvement
- Explore alternatives site/format for outpatient screen (e.g. NN, pueblos, apache – such as health fairs)
- QI for community screenings
- QI for state coordinators
- Explore opportunities for funding support for equipment
- Test Colorado audiology protocol
- Explore and ID risk factors in Cactus
- Apply QI to PCP interaction
- Continue and expand collaboration with hospitals on improving referrals and followup
- Develop consent forms/materials for community screening
- Continue community learning collaborative(CoIIN)

Product for Intermediate Outcomes
- Plan to address diversity and inclusion

Measures/Tools for Intermediate Outcomes
providers trained, participated, CoIIN activities, use of care coordination and transition tools, provider knowledge, patient satisfaction

Year 4 (2024)

Long-Term Outcomes
- EHDI infrastructure
- EHDI expansion
- Model for PCP – resource guide to share with parents
- Birth hospital report card provided yearly or more real time

Activities for Long-Term Outcomes
- Continue CoIIN activities
- QI for 5 practices on EHDI
- Implement and evaluate shared care plan for DSM
- Track CHUMS use

Products for Long-Term Outcomes
- Standardized screening for birth to 3
- Standardized communication process

Measures/Tools for Long-term Outcomes
providers trained, participated, CoIIN activities, use of care coordination and transition tools, provider knowledge, patient satisfaction, NM Title V survey results