

>> I would like to ask currently on the line to mute their phone individually please. You can do that by pressing the mute button or if you don't have a mute button, press star 6 to mute your phone. Thank you.

>> For those who have just joined the conference, we're going to be starting in a moment. I would like to ask everyone who is currently on the line to mute your individual phone please. You can do that by pressing the mute button on your phone, if you don't have money, star 6 will mute your phone. This will keep the lines clear and free. Thank you.

>> We're about to start the presentation in one minute. I would like to ask that everyone on the line to mute your phone individually please. It will keep the line clear and avoid unintentional interference on the call. Hit mute on your phone or star 6. Thank you.

>> Let's begin our session on behalf of the early detection for the center of disease control and presentation in Atlanta. Welcome to the findings screening and follow-up survey. Our presenter is Mr. Marcus Gaffney. Before we

begin, let's go over a few logistical items please. We're going to require that each person please mute your phone individually. This will provide privacy for your office and cut down on unintentional interference from phone lines. If you haven't already, press the mute button on your phones or star 6 which will have the same function of muting your phone. I would like to call your attention to the screen in front of you. There are some interesting items that I think worth your attention. You will see an item called Q and A. We will be using this to handle questions today. We will be doing those electronically rather than speaking over the session.

So if you look at that and click on Q and A, you will see a space, a notepad area that you can use to type in your question. After you typed in your question, please ask to send it to the presenter. Mr. Gaffney will monitor the questions and answer as many during the program and at the end of the session. The icon of a spiral notebook to the right near the feedback has a useful web link that you might find helpful. It's access to the data that we'll be talking about today. It will be mentioned by Mr. Gaffney during the presentation. If you have a technical problem during this session or if you don't have the link to the

visual portion of the program on the web, email me at this address. Srichardson4@cdc.gov. The email can also be found next to my name. Steve Richardson in the list of attendees. This session will be recorded visual and audio and available later. To allow maximum time for discussion, here is an introduction of our leader. Marcus Gaffney has a masters in public health. Health scientist with the CDC EHDI team. He's work with the EHDI for eight years. He's also involved in several activities related to lost to documentation and follow-up. You will now turn the program over to Marcus Gaffney. Go ahead.

>> Hello, everyone. I'm Marcus Gaffney. Very pleased to be talking with you today. Just a couple of quick things before I get started. I have to give you a heads-up? Advance. Today's presentation is dry. There's a lot of numbers and charts and things. Not really any pictures. Bear with me. I hope you will find the information helpful though even though it's a bit of a dry format. I'm going to do my best to keep the eye on the questions as they come in. If you type them online, I will do my best to look at those. Thanks to anybody that is joining us from the territory. You will have to get up early on your time for attendance calls. Thank you. With that, we will go ahead

and get started. The first thing I do -- want to say is to thank you all of the state and territory EHDI programs for taking time to respond to the survey for year 2007.

Without you, we wouldn't be anywhere in regards to the service. Thank you, everybody. I know it makes a lot of time and effort to respond. I want to take time to thank for lending a lot of support to the survey and providing feedback. That's much appreciated.

I just want to quickly highlight what the goals of this survey are. ESFS. To give it an acronym. The main goal is to provide accurate and complete data that reflects what can be documented in the U.S. I highlighted the word document because this survey is not interested in gathering estimated data but really information that (can't hear)

The service was developed in collaboration with other partners and gathered 2005, 2006 and 2007 data. Today, we're talking about 2007 data. This was approved by the federal office for management and budget.

There are three components to the survey. Part one, requests information about screening, diagnostics and intervention. Part two, information about the type and

severity of the hearing losses identified. And part three, requests demographic data for items that were included in part one of the survey. One of the reasons for requesting that information is in relation to any objective to helping people in 2010. It's a web-based survey. It does include several error checks. It helps ensure that the status of every birth is accounted for. The number screen, and not screened had to add up to the number of births that were report at the end of the survey. This helps to receive the quality of the data. There is a new version of this survey which is on -- under development. I'm going to talk about that at the end of the presentation today..

>> Just to highlight the recent things of the survey data. It's being used in presentation of the conferences. Various articles. Helpful in responding to public inquiries and providing technical assistance. Give us a better feel for what's going on with EHDI on a national level which is helpful. Being used for educational purposes explaining what the data does and does not show highlighting that to a partner or state things and like that. And also for providing information for healthy people 2010. And actually, before I get into talking about the 2007 data that was collected through this, I want to

know about the differences in how this data can be calculated -- can be calculated.

The slide I have up here shows the three sort of objectives -- sort of objectives for the goal. They are calculated in a particular way is different in how we usually calculate them. You see the hearing screening, newborns receive -- newborns receiving screening before the age. It's showing 81%. It shows how these were calculated on the next slide. The denominator that's used for healthy people is different than the denominator we use. For the screening, total number of births is used as a denominator for healthy people 2010 where the denominator that we commonly used is for determining the screen for one month is the overall number screens. You get different numbers. Basically wherein it's calculated within CDC, you get an 88 screen for one month. The healthy people, the rate is 81% which is quite a little bit lower. I just do this to point out because healthy people numbers -- I believe they are available in the healthy people web site. The 07 numbers are not out there now. I want to highlight why they're different because they're calculated differently. I wanted to highlight that. Moving on now. We did make a couple of minor changes to the survey to collect for 2007 data.

One then we did to clarify the definition of in process which is in the diagnostic section for which people are reporting infants had a diagnosis and process. This came mainly from a recommendation from the data committee. I made provided some explanations to make the definition for in process a little more specific. The two main points of this was, infants must be seen by an audiologist one time for diagnostic things. Scheduling appointment or making a referral is not (someone talking over speaker -- cannot hear). There was a table added to the type and severity section to community for the type of hearing losses on none. The choices for internal race were expanded. (someone speaking over speaker) (not on mute).

>> Moving on to the responses for the 2007 survey, we actually had 50 people respond in all which was great. 48 states and two territories. It took longer to get the data in this year. That's why it's a delay in posting the data online and doing the presentation. There were issues reported with the 2007 data. We had cases where there was limited or no data reported. For example, maybe screening data was reported. There was no diagnostic or intervention data. There was also a couple of respondents who were only

able to provide partial data, half of the data. And in these cases, it was excluded from the analysis of the 2007. It's because it was incomplete and we wanted to present it as complete as possible.

Okay. First thing we're going to talk about is the hearing screen data. This is based on 48 respondents that were able to give us hearing screening data. There was little over 4 million current births based on the 80 symptoms. According to vital records, what was the birth data according to vital records, you can see that that number was nearly 40,000 near births according to vital record. There's potentially some issues in the data with a little bit of incompleteness in the system.

Okay, we're going documented screening. There was about -- regarding documented screening, we had 3,800,000 kids screened. This is documented, not estimated. That gives us about 94% screen.

If we use the birth number from vital records, the overall screening drops from 93.1 which is shown here on the slide. Exclude those infants that were forwarded either dying or parental refusal which was a category on the survey, the

screening percent increases to 94.4%. There was a point of driving this home. There's different ways to calculate the data. It's important to be clear about the data that's being reported. What it's including. This is one of the things that we like, it does give more flexibility than past tense, we had to calculate the data differently depending on the need. I think I did see a question come in about whether the slides will be available after the presentation?

The exact slides will not be made available, I will be happy to answer specific questions if you want to send me email if I don't address something during the presentation. A lot of this data which I'm presenting in the slides are available on the web site. I will provide that link at the end of the presentation.

The pie chart has a breakdown here of the screening. This is showing how the recalculated can affect the 2005 and 2006 screenings. When you exclude the infant death and parental refusals, they can increase by .4%. That might be of interest to you. And this table here shows the progress of hearing screening over the years from 1999 to 2007. Data from 1999 to 2007 was collected using a different

survey from this. It's not strictly comparable to the survey, et will give you an -- it will give you an idea of the trend that's seen over the years.

Now, moving into diagnostics, we're dropping down to 45 respondents. When I was talking about the hearing screening data, that was information for 48 states. We're down to 45. Some states couldn't provide the diagnostic data. Okay. We have about 1.9% of infants who are reported not passing the final screening. Breaks down to a little over 163,000 kids. Out of those children, normal hearing or no hearing is documented in about 37% of them. And hearing cross is documented in -- loss is documented in 6.3%. It's over 4,000 cases that were actually documented. That provides a prevalence of 1.2 per 1,000 infants screened. That's the same prevalence that's recorded on the 2006 survey. I did want to point out the range in the prevalence. There's a big range. Respondents reported anywhere from a prevalence of .4 per 1,000 screened. All the way up to this. There could be several reasons for this.

For those of you who completed the survey, there's a section in there that cases that were of hearing loss that

were not reported in the main section of the survey. This gets laid on set hearing loss cases. They have made initial screenings. There's another 617 infants here that were reported in this category. Some of these could be late onset cases. We're not sure exactly how many. Those 617 cases here they are in addition to the 4,000 that are shown here.

Moving on to the no diagnosis. I told you out of the kids that didn't pass, how many were found with normal hearing and how many were found to have hearing loss. Out of all of those that didn't pass, 57% had no diagnosis for one reason or another. This is under 36,000 kids we're talking about that didn't have a documented diagnosis which is a large percent. This is based on the same 45 respondents. Now, lost documentation number based on that was 44.8%. So 28,000 of those 35,000 kids with no diagnosis had no diagnosis because they were reported a lost documentation. One thing I want to point out here, it's troubling, there's a huge range in the loss of documentation numbers from zero to 96% which raises issues about the quality of this data to be honest. I did want to point that out. On the positive note, the lost to follow-up lost documentation in 07 is -- 07 is slightly lower than '06. It's reading in

the right direction. This was significant because there was revision for the data reporting for the kids in process. I will explain exactly what I mean. Just to clarify how we calculate our loss follow-up to the documentation here, all of the children that were reported with no diagnosis no session due to combine reason of unable to contact, response unknown, that's one category that goes together, all of the infants that were reported in that category, that is divided by the total report not passing the final most recent screenings. In case you're wondering why we report both of those items, you have a lost follow-up slash lost documentation, it doesn't mean possible for states and territories at this point if you had to distinguish on a large scale how much kids were lost to follow-up and how many kids lost to documentation meaning they received the services from the audiologists that they were not reporting to the program. That's why that category is combined.

>> Marcus? I'm able to mute all of the phones and I'll let yours and mine come back in. You will hear that the conference will go into mute and then Marcus will come back on in a moment. That should keep the lines free from interference. Thank you for bearing with us.

>> (the conference is now in silent mode).

>> Marcus, people are able to hear you now.

>> Okay. Great. I saw a question come in asking if we're going to separate out the category for unable to contact for unknown? That's something we're looking at. And I'll talk more about that at the end of the presentation.

Moving on. I mentioned we had issues in the past for the whole in process category. We changed the -- we refined the definition for in process of the '07 survey. In 2006, you can see there was about 15% of kids with no diagnosis were reported of not having a diagnosis because they're in progress. In '07, it was encouraging to see that number decrease by about half. Now, the numbers actually could be considered high. It's showing improvement. This is an area we want to continue to focus on is making sure the kids reported being in process are meeting the criteria for that definition. They have seen an audiologist once. It's not just that they have an appointment. I did want to point that out. And this is just a pie chart again breaking down the diagnostic status of the kids that didn't pass. You can see the lost follow-up number here 44

participant 8% -- 44.8%. How many had normal hearing, et cetera. I would like to move on to the intervention data now.

We in this next, we -- section, we have 44 respondents. We dropped down from 45 respondents in this section. Out of those 44, there were 3,950 kids identified with hearing loss.

Okay. Out of those infants with hearing loss, how many were referred to part C of those with a hearing loss. Just under 86% referred. You see the numbers in blue understood me. The -- under me? Those were a subset of that number. Out of those 86% that were referred, you had 91% that were reported as being eligible for part C and eligibility for part C early intervention varies by state and territory.

Now, the -- there's about 9% of these being reported not eligible for part C or the eligibility is none. Out of those kids, there was 14.5% were not referred to part C or unknown what happened to them. That's how those numbers break down.

Talking about how many were actually enrolled in early intervention.

We're talking about the 3,950 kids with hearing loss. That's going to stay constant. The% that were -- percent that were receiving any intervention. Part c and non-part C. That was over 2,500 kids. There's a huge range from 0 to 100% which obviously points to some issues with the data and the challenges perhaps in getting early intervention data.

The next two numbers I'm going to talk about, and it actually highlights two different ways to calculate the numbers. The percent enrolled. The first number is this. Those are based with hearing loss. 57.9% were enrolled in this part. We can calculate the number in different way. That is based on the number enrolled in part C of only those being reported as eligible. If we do that, the percent increases all the way up to 74.4%. It highlights the different way the data can be calculated for different purposes.

>> There was 6.4% that were reported as receiving non-part C early intervention. Highlighting some of the reasons for not being documented to be enrolled in early intervention, overall, there was 35.7% of kids over 1,400 that were reported as having no early intervention. Out of these,

4.5% were reported as died on the parent's decline. There was 1.8% that we reported as being a nonresident or they moved. The loss of follow-up number is over 29%. Out of all of those with hearing loss, 29% or little over 1,100 were reported to be in this category. We highlight still ongoing issues with this data.

Again, this is just a pie chart showing how these numbers break down.

I wanted to get into the issue with the part one data that I discussed. Issues of classifying refusals versus cases where parents may be unresponsive with something that became apparent in collecting the data for '07 among of how this data should be classified. They have definitions for classifying one case as unresponsive. It's more work that can be done all over the county. We're finding those -- country. We're finding what those cases that the parent are unresponsive. Did it include this? It's an area that we can look at it. It will play a part in further finding the data. Determining the lost to follow-up and loss to documentation is a key issue. A painting data about the children that don't pass the hearing screening and then maybe they go to see an audiologist and found to not have a

hearing loss reporting that information get back to the program continues to be a challenge.

The reporting of in process, as I highlighted, we had a big decrease in the number of kids reported in process from '06 to '07. There's kids reported in that process of '07. We need work on refining that data. Access to early intervention is an ongoing challenge due to several issues and demographic data is quite a challenge to get. And I'll going to be talking about that in a moment.

>> I do want to point out on this call, I'm not going to talk about the type of severity data. Information of that, that will be posted on the web site in the near future. I'm going to be talking about the demographic data and all of the analysis was done by a EHDI consultant with the team here. I'm going to go into demographics. I want to highlight what data was demographic data was requested. There was several categories. Demographic categories were education and race and other categories. You can see here, the data items and the ranges for each of these. Demographic data was collected for selected information for the screening diagnostic and intervention sections in part one. It was not requested for all data

items. For screening, it was requested for the number of current births and infants reported as past and not past.

For diagnosis, normal hearing and hearing loss, intervention. Those enrolled in part C and those enrolled in nonpart C. We tried to collect demographic graph related to the 1-6 plan. But there appeared to be too many limitations at that time with the demographic data available. We made it more general in an effort to improve the completeness and the quality of the demographic data.

Background. 2007, 38 respondents were able to provide some demographic data on the survey. However, only 10 jurisdictions could report complete for screening, on 10 for this and 10 for intervention. The ten states are not the same for each category. There are only 8 jurisdictions that could report complete items. Those are listed here. I think it sort of highlights still some of the limitations and the availability of demographic data and obtaining it.

We're going to talk about all demographic data related to screening. We're going to talk about gender first.

There's not too much difference in screening between male and female. Don't want to spend anymore time on that. I'm going to take a moment to check questions. I'll get some

of those questions at the end. Talking about maternal age now. You can see there's really not a huge difference in the screening by maternal age. This chart here is only showing a narrow range. 95 to 98%. There's no difference from maternal age related to screening. Moving on to maternal education. Not really too many differences we can tease out here on the data.

Going to ethnicity -- Hispanic and nonHispanic, not a lot of differences here. You will notice that some of the columns call it differently here. There's the yellow columns. Those are colored yellow to show those are the subset of the first column called white. The first gray column white with the 97.9 is comprised of nonwhite Hispanic and the white columns. The column is to show they're a subset of that. The same with the bright green colors black nonHispanic and black Hispanic make out the black bar on this. There does seem to be a difference in the percent of them that were screened to the Hawaiian and Pacific islands based on the data here. There are limitations in the completeness of the data to what conclusions we can draw. That's what we can see based on this.

We're going to move into diagnosis now. There's a few more

things that we can point out here. Regarding gender, not too many differences.

But moving on to maternal age, first thing I'm going to point out, you will notice that the maternal age under 15 and maternal age greater than 50, those columns are grayed out because the data was so limited. It really shouldn't be considered too many weight. We're going to concentrate on the pink columns. It appears based on the 15 jurisdictions reported for those instances not passing the final most recent screening, they're more likely to get a diagnosis the older the mother was. There was quite a difference when the mothers were age 35 to 50 years. You had about 35% getting the diagnosis compared to 50% for the older mothers receiving the diagnosis. It's possible. It provides some interesting information there that would need additional years of data and only analysis to really see if that's going to hold true. That's an interesting preliminary finding. Moving on to maternal education. We've also shown here, you can see here data indicated that the more education a mother has, the more likelihood that the child would get the recommended diagnostic testing. You can see that the range is less than high school where 25% of having the evaluation all the way up to 50% in the

education is college education or above.

>> I wanted to move on to maternal ethnicity for diagnosis. There could be a difference between Hispanic and nonHispanic. I want to check questions for a moment. I think there's a question on slide 31 about white nonHispanic and white Hispanic. That was a breakdown of the category that was missing from the '05 and the '06 surveys to provide more detail to the data. Moving on to maternal race for diagnosis. There's a bright blue column and a white column and the same with black and nonHispanic and black Hispanic. There's a subset of the black column. You can see, you know, some possible differences here with maternal race. About how many we're going to diagnosis. It seems low. It seems low in the American Indian category here. It's down only 7.4% which is quite a bit lower than these categories indicating perhaps children born to American Indian mothers. Not getting the recommended diagnosis or at least not being reported. Worth pointing out.

Moving on to the intervention data. As we seen with screening diagnosis, not too much difference when it comes to gender. Moving on to maternal age, we, again, the

column you see here, maternal age greater than 50, there were issues with that data. Even though it's included on here, we're not going to consider it. We're going to pay attention to the pink colored columns. You can see here it seems likelihood of getting child with hearing loss getting into intervention seems to get higher with increasing maternal age. Moving on to maternal education, we can see that it does seem to be a little bit of difference in children getting in more likelihood of getting in to intervention or receiving intervention, I should say as maternal education increases. Moving on to maternal ethnicity. Not difference between Hispanic and nonHispanic based on the data that was reported. You can see it based on 13 jurisdictions. You don't want to generalize this to the whole country. You can see the columns represent being a subset of the white or the black columns.

You can see here, it seems like that the likelihood of getting in to or being reported as being intervention is higher in the American Indian group and why the Pacific islanders have the highest in the nation. It's based on 16 jurisdictions. We're going to talk with limitations on this in a moment, actually, on the next slide. We talk about only a small percentage of states were to provide

complete democratic data. Only eight of the same states could provide complete screening, diagnostic and intervention data throughout the whole section. Data only reflects what states and territories could document, same as in part one. It's not to be based on estimates, but on what actually document. Different states provide data for each category. The states provide it, screening data, screening democratic information is different than the ones provided diagnostic information in some cases. A small sample size with some categories. This is mother is older than 50, it's a small number of respondents. That's part of the reasons that the columns were grayed out in the slides I showed you.

A large amount of data were reported in the unknown fields and also there's a possibility that some babies or infants may have been reported in the wrong category. For example, may have been reported in the other instead of the unknown category. Maybe all of the information for a state for a particular category was reported in the other category. It's probable information was supposed to be reported unknown and that necessitated going back to the state and clarification. There's issue that we're making that the explanation are clear on the survey and correct data is being reported.

Okay. I want to go over some of these conclusions. Although difficult to draw any final conclusions, the data does suggest some rather interesting things. Screening rates do not appear to vary that much across the groups based on the limited data we got. Baby bosh -- born to older educated mothers appear to be less likely to loss to follow-up. Only 7.4% which is 20 out of 271 babies born to Native Americans and Alaskan native were far lower than the categories we saw. We've already pointed out data does widely across jurisdictions. Also, very important to point out that additional data is needed to better assess a relationship between a democratic factors and the receipt of services. This is some that were interested in exploring further as we go further with this survey.

>> Okay. Just a couple of general summary points for the 2007 data overall I talked about. I think first on a positive note, we are seeing steps that measurable progress especially in screening, we're right up there around 94% documented which I think is excellent. And we really had a continued to have an increase focus on data quality. I think those working with different states and territories who are completing the survey, I think they -- it's really

taking a lot of effort to look at their data and, you know, classify it and report it as fast as possible. It's something that we have seen a trend in improving in the last three years which I think is excellent. We're also trying to put more of a focus on data quality which is why some of it was excluded from the analysis and things like that. It's a continuing focus on data quality.

>> And greater understanding of lost documentation be included in the contributing factors. There's a lot of work to be done on this. There's so many different factors going to this. It's a difficult issue to address. It's a difficult issue to make sure data is reported and stand away. I got these huge ranges in the last follow-up rates 0-96%. Even though we had encouraging progress and greater attention, there's issues on relative to classification of this data which feed into the last point that I got up here. Challenges do remain in obtaining this data and reporting it.

And, you know, one of the reasons, you know, there's an increase on actual outcome measures. You know, within CDC here, there's a lot more emphasis placed on the data that can be provided what's happy and the quality of the data

which is one of the reasons we're increasing our focus on data quality because in times of tight budgets where everyone is looking at their dollars a lot more carefully and the results that are gotten for the money that's being put out there. It's a lot more emphasis on providing quality data and being able to to -- (can't understand what he said).

>> A couple of more slides here. I know it's a lot of data. I mentioned in the beginning that we're looking at making some changes to the survey, making changes to the survey in the future. This is because the approval for the OMB approval for the survey is only good for three years. So we're coming up on the end of that. It's a great time to take a step back, look at what we have done with original survey and look at how we can make it better. That's what we're in the process of doing now. It's a collaborative input. They have given us helpful input. EHCI data community and national partners have provided into this. If you have taken this survey and familiar with it and you have ideas for changes and things that need to be done better, please let me know. Send me an email, give me a phone call, I very much appreciate hearing from you.

This new survey, we're planning to collect 2009 data with it. For 2008, we plan to use the same survey. When we go to 2009, we are hopefully using this updated version. We want to as we move the service forward. We want to minimize the reporting burden as much as possible. We're aware that everyone has a busy schedule and it does teak time to -- take time to complete the survey. We want to maintain our focus on maintaining data quality and we want to maintain the comparability with the data. We don't want to make drastic problems. We are not going to be able to compare the data. We don't think that would be helpful. Those are key goals as we go forward on the redesign process. What I listed up here is some of the potential changes for the survey. We're planning on making them. These are based on input and feedback we have gotten from partners, EHDI programs, et cetera. Some of the categories like infant died or parent declined, unknown myths, they're grouped together. We're looking to break them up. Infants die would be a separate field and parents decline would be a separate field. They would not be combined. That's going to give more detail to the data. Enable us to do more with the analysis and the reporting of the data which I think would be of interest.

Also, we are planning to put more effort in reviving the explanations document. That goes along with the survey. Refining some of those definitions especially for things like in process is making sure those definitions are as clear as possible. We're looking at putting a new format in for the type and severity data which is part two of the survey. This is undergoing modifications since we put the survey in place. We hope it's easier to report that's one of our hopes. For demographics even though there's additional information that we would like to capture especially ones related to before one month, we don't feel at this point that that data is going to be available widely across all programs. There are no planned changes to the new demographics and the changes in the survey. When more data is available, we'll take a look at reviving the demographic section. At the current time, we're not planning to make any changes.

I did want to highlight here, a lot of the information I talked about in this presentation is available on the EHDI web site. The web link is right here for you. At the moment, there is a series of several different data reports summarizing data for 2007 that's available on the web site. There's a main summary document that's up there. That's

going to provide you with a table of the breakdown of all of the key data items. It also shows how some of the data items are different depending on how they're calculated. It includes three different pie charts. One each related to screening diagnostics and intervention. Similar to the ones we showed you in this PowerPoint. And the last two pages are all of the formulas of how the data items are calculated so you can see how that data was calculated. There was a series of reports on state by state and territory breakdowns of information related to the hearing screening, diagnosis, loss of follow-up, intervention. They're all up here and they will be posting information related to the type of severity data in the near future.

My last question, thank you so much for paying attention to this call and logging in. I hope this was informative. I know the few questions that came in on email I think I already dressed one -- addressed one I'm not planning to make the slides available. If you have specific questions, let me know. Also a lot of the information is on the web site. And I think that is everything for me. Thank you to everyone. Thank you, Steve.

>> I know there was a question number eight about aware of

any general surveys of intervention use of variables used for EHDI data? Is that something that you could address?

>> Could you say that again?

>> Are you aware of general surveys of early intervention use by any of the variables used for the EHDI data?

>> I have not available anything at the national level. I know there were different efforts going on between some groups of states a organizations looking at this. I'm not aware of one general national survey. I'm not, again, you know -- others may know more on this I'm sure.

>> We had a brand-new question coming in. When will the CDC web site include the -- percent of infants identified by three months of age?

>> I think that's on one of the reports. There's a diagnosis of age summary report on there which I believe has that information in there.

>> Great, thanks. Okay. If there are no further questions, I would like to thank people for coming in and

joining us. We reached the end of the appointed time the transcript of the session is available in the near future. Please let us know what you like about the presentation and what we can change to make future teleconference more useful in our work. Send the comments at gol8@cdc.gov. Thank you for taking part of the teleconference from CDC EHDI. Good-bye. (the conference call has ended)
(captioner is logging off)