

MCHB/DRTE Webcast

Distance Learning:

Using a Variety of Methods for MCH

Professional Development

April 27, 2010

SU LIN: Good afternoon or good morning to those of you joining us from the West Coast and Pacific Islands. Welcome to today's webcast on "Distance Learning: Using a Variety of Methods for Maternal Child Professional Development."

My name is Sue Lin. I'm the Project Officer at the Division of Research Training Education at MCHB for the Distance Learning Grants. Let me just give you a little bit of background of the MCHB Distance learning grant. This is a program that supports the development, implementation, creative utilization, application and evaluation of distance learning opportunities for Maternal and Child Health professionals. Distance learning provides an alternative means for professionals to enhance and advance their analytical, managerial and administrative and clinical skills.

Today, Distance Learning Program grantees will provide a brief overview of the content areas they have adapted for distance learning and professional development programs, particularly using adult learning principles. These content areas include obesity, early intervention, MCH leadership, healthy mental development, suicide prevention, leadership education and developments with disabilities. You will have an

opportunity for further discussion how they have applied various different modalities, especially for folks in remote areas. This particular distance learning opportunity provides more flexible scheduling, decreases travel costs which were -- some of the barriers that have been outlined in the 2008 survey of professional development needs of the programs.

We have a wonderful panel of presenters this afternoon. I'm going to introduce them very, very briefly. Because of the concept of time, I'm going to just go down the list of the folks that will be sharing some aspects of this program with you this afternoon. Let me start off by introducing Cathy Barber. Our second presenter will be Rachel Brady, a research assistant professor at Georgetown University presenting on behalf of Toby Long who is a principal investigator for the early intervention project. Lee Wallace, Project Coordinator at University of Tennessee, John Richards, the Principal Investigator at Georgetown university, Karen Edwards from the New York Medical College as well as Barbara Levitz and Dr. Anita Farel from the University of North Carolina, Chapel Hill.

Now, the presenters and myself are very interested to learn who is in the audience prior to their presentation. They've designed their presentation to be flexible enough to be responsible to the participants of the webcast. So to facilitate this, we're going to pose the following polling question to figure out who is in the audience with us. The selections are Title V programs, MCH training grantees, MCH professional, family member, academics, local public health agency, none of the above. We're going to

give you a couple of moments to answer this polling question and we'll certainly come back and give you a breakdown of who has joined us this afternoon.

Meanwhile, let me give you a little overview of the logistics of this afternoon. The slides will be advanced automatically. We encourage you to ask speakers questions at any time during the presentation.

We will have a white message window on the right of the interface, select question for speaker from the drop down menu, type in your question and hit send. This includes your state organization and your message so we know where you're participating from. So they can be -- you know, any of the questions can be asked any time during the presentation.

Those of you who selected accessibility features when you register will see the text captioning underneath the captioning window.

The interface will close automatically. You will have the opportunity to fill out an online evaluation. We hope you'll take a couple of moments to do so. Your response will help us plan for future broadcasts in this series and improve the technical support that we see.

Looking at the results of the who was in the audience, we know that there's 11% of the folks representing Title V programs, training grantees, 56% of you responded being an

MCH professional and then 22% from academics. OK. Let me turn it over to Cathy Barber and talk about the suicide prevention training.

CATHY BARBER: Thanks, Sue. If we can advance the first slide, an estimated one million people take their lives annually, and in the U.S., among youth ages 15 to 24, suicide which is the green box is the second leading cause of death for white and American Indian use and the third leading cause for black, Hispanic and Asian use. So as the leading cause of death in which 85% of victims below age 65, suicide is a public health issue. How many people teach a course on suicide prevention?

Well, next slide you'll see the answer is none according to a 2003 survey. Preventing teen suicide is, in fact, one of MCH's national performance measures. Back in the 1990's and early 2000s, nearly every state in the nation was developing a statewide suicide prevention strategy and Harvard back then in the early 2002 was working in collaboration with the eight northeast region states on this effort in the research and training partnership. We saw the HRSA distance learning program announcement and applied for the funding and partnership with the Education Development Center and founded the national center for suicide prevention training. So NCSPT provides online training and public health skills to professionals and lay people to prevent youth suicide and currently, there are four workshops up and running.

Next slide: fifth is written and production and a final one in development.

Next slide: So the roles are currently Harvard with HRSA funds, researches and writes the workshops, formats them into Moodle which is the online learning software, pilots them and evaluates them. We've also written a couple of papers and a book chapter with online training on suicide prevention and then SPRC at E.D.C. with funding from substance abuse and mental health services administration hosts the server, maintains and administrators the workshops and we both promote the workshops. So students take a pretest and a post test and complete the evaluation when they finish each course and the courses present a lot of written information which students progress through at their own pace. The courses also include power point presentations, pop quizzes which oddly enough, that's like the favorite component. They include links to resources and downloadable documents and Internet activities and homework assignments. Homework is not checked. The new course includes a training video and students can interact with one another on the discussion forum. When our budget was larger, we also ran a facilitated version where students and faculty came together on conference calls but currently we only do that as we pilot test each new workshop. And then finally, students who pass the post test qualify for continuing education contact hours depending on the workshop. So we've attracted over 6,000 registrants since 2002 from all 50 states and 30 countries. And the strengths of the program are -- it's free, the workshops are accessible, they're used by large numbers of people. The evaluation results by those completing the courses indicate a high satisfaction and good gains in knowledge from pretest to post test, Moodle is free, relatively easy and flexible for the course designer to use. Through the Moodle component I did the last course and if I can do it, anybody can do it. The investment and course development,

our [budget](#) is about \$100,000 a year. It has a long payback period because the workshops continue to be administered indefinitely by SPRC. The limitations, the information really gets out of date quickly. I mean, especially the links to Internet activities. They can stop working. So you have to constantly update those. Technology and expectations about user interfaces change quickly so the courses need to change accordingly. I find Moodle really clumsy to use for evaluation analysis. Issue of attrition between registration and post test needs to be better understood and this is an area where we've been doing some work lately. There's limited interpersonal contact in this self paced type of online workshops and finally, while the courses do sell themselves, it's easy to be seduced by the large numbers into feeling satisfied and not evaluating whether we're, in fact, reaching and making an impact on the intended audience. So that's a very brief summary. I thank you for your attention and I pass you over to Rachel Brady of Georgetown University.

RACHEL BRADY: Thank you. I'm going to talk about cop temporary practices and early intervention. There was a long standing need to provide training for early intervention providers. They worked with the children in the birth to three range. Primarily because they practice in remote or isolated areas, not just in physical States but also we have a cohort here in the District of Columbia that seems to be isolated by the fact that they go into homes and they don't see other professionals a lot. So the isolation can be that way. So we designed a project to meet the need for training in comprehensive and evidence-based intervention practices. The way it was designed, it was designed to have multiple uses through different methods. The folks that will be

taking these courses do have access to technology. They don't use it very often and the users tend to be a pretty basic level of using technology so we had to make sure that there were multiple ways they could do this. It can be used as you go through the modules, it can be a self directed study, we can use the modules and have instructor facilitation, component of an integrated program or it can be embedded into. The design is synchronous or asynchronous. It can be discussions that happen over time and it can also -- we also are incorporating chat and the use of course management software through Moodle or black boards. The exciting thing that we're -- well, the thing we're very excited about is that it can also be used to facilitate a disabilities study program and people can get an advanced certificate or Master's degree in disability studies using that as one component of that program. The other way that we're going to be helping professionals is to give education credits through Georgetown University.

Next slide, please. The features of the contemporary practices in early intervention include the learning modules and on the slide you can see the various learning modules based on the competencies that most early professionals have to meet in their states. There's also going to be a few topic -- special topic mini modules, the first of which that will go up westbound on autism that's in development now and how to develop program plans, the individualized family service plans that you see up there, the acronym is IFSP and one on hard of hearing and one on legislation. We'll also see and have built in case studies around various ages and issues and discussion questions. Each module has a little bit different format to keep the learner engaged. I think one of the things that's going to be really popular and one of the things we've

gotten good feedback on is the tool kit which includes an online primer of disabilities of specific disabilities and we'll have an interactive community of learners attached with it and we've done some fact sheets with the video links for service providers so they can come back and use it as a resource. And then the other thing that we'll be doing, some more of what Cathy talked about was the pre and post test for each module and doing registration through Georgetown University and this is how the C.E.U.'s will be done. We thought it was a really nice match between the needs of the early intervention providers who often are in programs that have decreased funding for personnel education, the providers themselves don't have a lot of time and there's increasing amounts of information and evidence based available that's just not having any time to digest so this will be a place that they can come and think about that and incorporate it into practice. So the benefits are that it's user friendly, it's been really well received by the testing that we've done, it reduces some provider isolation. They feel like they have a community of similar professionals that they can have conversations with and feel less isolated. It's designed to have reflection and share knowledge between providers and it's also designed to be, as I talked about before, flexible in the way people are learning and others can apply it in their professional programs. It's also cost and time efficient, the information stays consistent and we found that it's easily updated. That's an issue with some of these programs. So thank you for your attention. I'll talk about the evaluation pieces a little later in the webcast. Right now I'll turn it over to Lee Wallace.

LEE WALLACE: Thank you, Rachel. Good afternoon, everyone. Here is a very long title of our program and that's what I want to talk to you today, obesity prevention for children and adolescents. This it says of a large, two-day workshop and then converted to online, self paced modules. Since we're a center for disabilities, it was on overweight and obese children for special health care needs but we found there was usually a child or parent themselves who struggled with overweight. And then the obesity crisis among children and adolescents began hitting the news.

So next slide, we came up with the problem. Overweight and obesity in children and youth including those with special health care needs and their siblings. Professionals in the field and public health and schools and doctor offices wanted to know what really worked. And they wanted to know how to find out with their limited resources, how they could attend workshops. Money for continuing Ed is tight and getting tighter and taking time off from work to travel is getting harder but you probably already know that. So our program content listed overbeat and obesity with a public health focus. We designed this program to program professionals with insight into developing strategies grounded in an understanding of the aspects of culture, education, community and other external factors. We proposed this program to have 11 contact hours of interdisciplinary conditioning education. We had preapproval for doctors and nurses, for case managers, for health education specialists, psychologists and we provided certificates, social workers, pediatricians and others. Registered dieticians and nurses are the two biggest groups of participants. These different presentation strategies as well. We had speakers and lecturers, power points with questions and answers

afterwards, case studies, model programs for both community and school and individuals. We had small group discussions at each site. So how did we work all of this distance learning? First thing we did was to schedule a two-day workshop live in Memphis with a small audience. Speakers came here to present and I'll tell you a little bit about that when I talk about the modules. That's what is still available. During the live conference, we used web conferencing. We registered people to attend at a local site so they could participate in the small groups and networking. We thought it was important to bring people together because large part of this issue is knowing your community resources and I'll talk about the different learning sites in a moment.

Third piece is we video recorded the presentations to be adopted into an online course. We hadn't found an alternative software that was good quality recordings. Having live audience was good for the speakers because they had to be a little more animated rather than talking to a webcam. We did have questions and answers for offsite participants. They could submit things through a chat box. Because of the number of people involved, we couldn't always get to all of them. We encouraged them to submit questions at any time but there's always a little flood at the last minute we couldn't get to. Because people were gathered at the distance learning sites, there was time for networking during breaks, lunch, small group exercises. The comments and responses for these exercises were shared at each site. They were shared on screen with all of the sites and also posted them on our website for a few weeks after the workshop and gave the participants a link to see that. Of course, we did evaluations each day. We did pre and post knowledge tests that show an improvement and did all

of the steps. We stopped sending out brochures. We advertised through email, websites and got more people than we really knew what to do with. This is just a look at the map of all of the distance learning workshop sites. We went from four to 15 sites, 80 to 290 participants. There are some programs in California and Washington that wanted to be included and we had eight, nine health departments involved this year as we went to the software that opened up options for us. The online modules which is the last thing I want to tell you about, we converted the two-day workshop sessions into four online modules. Speakers and presentations of either audio or video links, power points are there, a full transcript that includes the questions and answers from the workshop. For the case study, we can't do feedback looking at it alone but when you submit your comments, you can see what the workshop questions were. There's a pre and post test for each module. Currently there's no charge for this. We had a set of a certain number to be free each year. There's going to be a small charge for sustainability for storing the modules and the cost of certificates. We do have four modules available currently that look at the public health problem, the importance of understanding culture, promoting healthy lifestyles in the school setting and evidence based research. They provide from 2.5 to 3.5 contact hours each. That is a quick overview of our program. There's lots of details about the modules as well as links to register and my email on our website. That's what's there. Now I would like to pass this on to John.

JOHN RICHARDS: I would like to talk about a couple of distance learning projects we have at Georgetown university in addition to the work that Toby long and Rachel Brady are doing.

Next slide, please. My group is working on two related curricula and the first is a well child care project that is crossing the boundary between Medicaid and EPSDT and overall well child care. This is where we started out a number of years ago. We started with a state based curriculum we were working on and then applied to MCH to do a national curriculum to expand on the Medicaid benefit that covers children with lower income. What we found, going through this, was really kept stretching. Our projects kept growing as we go on. We learned that EPSDT is good, well child care. So the curriculum morphed over time and now a well child care curriculum based firmly rooted in a bright future tradition. The well child care curriculum covers the full range of the benefits, the EPSDT benefits that are really the components of every good well child visit. You start off as a health history, covers physical exam, screening and risk assessment, laboratory tests, immunizations and anticipatory guidance with a special focus on topics important to the states right now. We focused on developmental and behavioral health, oral health, documentation of culture. This curriculum then, when we focused on the developments and behavior, we realized that we really needed to address this in further detail because this is one of the emerging issues. So our second curriculum is promoting healthy mental development. And this really focuses on the ages and stages of healthy mental development. These are -- this is what to expect. There are components of areas of disorders and some mental disorders briefly as well.

These two curricula are sort of related and follow a self directed learning model. They are -- there are post tests, they are wrapped around a series of online resources as well, including links to state resources and other information. You actually get to see the well child care curriculum and one of the things we learned, even though we're a distancing learning grant, is that people -- users were very interested in printing out material. You want to put it in your pocket to take it with you. We created a pocket guide base to cover this material. You can see the healthy mental development. Each curriculum is composed of approximately 10 modules. They take a half hour to complete. It is self directed. There are, as you can see, links to screening tools, links to assessment tools, resources for providers and as you go to the next slide, there are resources for providers to hand out to parents. We're talking about providers, pediatricians, we're talking about in healthy mental development school counselors, nurses, community workers and these are materials for them to provide to families.

On the next slide you'll see a common model of approach we've adopted for the curricula and we always tell people what they're going to see in the module. We really serve to do a crosswalk of resources. This is really truly evidence based. It will show where we pull information from so we're highlighting CDC resources, aap power statements and guides. On the right you'll see there's always a focus on the family. On the bottom left, these are just pulled from curriculum pages. We really take you to links, to screening tools, practical resources. And then on the bottom right we do sort of this crosswalk of recommendations from the experts in the field. On the next slide, one of the things that we have done, and you'll see here, is we've adapted the curriculum, the

well child care curriculum for specific states. A state will come to us and currently, there are 28 states and territories under specific court orders to provide Medicaid training and this is one way that states can fulfill this requirement so in this case, you'll see we did a customized curriculum for the state of Nevada and included resources specific to their needs.

Next slide you'll see that we've housed everything together in our health information group website. It's not on this page but just www.healthinfo.org and I'll be talking about that in the next session but right now, I would love to turn this over to Karen Edwards. Thank you so much.

KAREN EDWARDS: Thank you, John.

SUE LIN: Karen, if I could interject, this is Sue. I want to remind folks they can submit their questions online through the message on text messaging box. Also wanted to ask the panel of speakers, if your phone is not needed, mute your phones and be conscientious of time. Sorry about that. Thanks.

KAREN EDWARDS: Our next segment concerns distance learning as a medium for professional development for MCH professionals in the U.S. Virgin Islands. Virgin Islands is a medically underserved U.S. Territory that's remote from an academic medical center. We undertook a collaboration with the USVI in the Virgin Islands and also colleagues at the Virgin Islands Department of Health and we undertook this

project to help meet the training needs of MCH professionals in the U.S. Virgin Islands and to develop a model for MCH training that could also be used in other remote locations. Awe approach is called the LEADD map and that's leadership education and developmental disabilities and I created this LEADD map that illustrates that even though trainees and faculty were pretty distance from each other, we all kinds of interactive learning modalities to keep the learning active. So we took the lead at Westchester institute and the New York Medical College and had trainees on both islands, St. Thomas and St.Croix and our collaborator there was the Virgin Islands that has campuses on both islands. It's a 12-credit, two-year, four course graduate certificate from New York Medical College's School of Health Sciences and Practice and uses a blended learning methodology. By that I mean, for instance, we used synchronous methods which were methods which allow all participants to be online and we used web conferencing two to three times a month and also had quite a selection of asynchronous components and these are things that people can use on their own time when it's convenient for them. And so they used a lot of materials and assignments based on the course management system Moodle. They did individual projects and assignments and we also had mentoring by distance one-on-one with a faculty member. We also included a face to face component which was called extended weekends and this was Friday evening -- Thursday evening, Friday evening and the bulk of time on Saturday. These extended weekends which happened once per semester were required for core training but also offered continuing education credits for our health professionals in the Virgin Islands. The LEADD curriculum was modeled after our own training. We customized that curriculum to the needs of trainees

in the Virgin Islands. Lend and LEADD are both based on the national MCH leadership. I've included the course title here. Effective leadership for MCH professionals, public health perspectives on children with disabilities and their families in the Virgin Islands, building family partnerships and developing cultural conference. We had extraordinarily busy professional home and community lives. We were always surprised to hear how much in the way of all of these types of responsibilities are trainees had. And of course, they prefer to spend their precious learning time on learning what's relevant to their work at a time that's convenient for them. Since adults work best when it's active, we selected our technologies and instructional methodologies to help achieve that. This is just a slide to show you our trainees came from a number of disciplines. Nursing, medicine, social work, mental health, physical therapy, most of them work in the department of health or department of health related system and they actively engaged throughout the two-year period in ongoing needs assessment and getting feedback on how the content and the methods of training were working for their need. This just shows you some information about the culminating sort of cap stone training poster presentation that happened at the end of the certificate program recently and you can see from the topics of the training longitudinal projects that they were quite clearly related to health issues of great concern, for instance, obesity and mental health. Based on this LEADD program, we've developed a fair number of resources and we've begun to disseminate the model we developed, curriculum products and resources as well. We presented our work in transforming an integrated curriculum on cultural and linguistic competence and family centered practices last year. The U.R.L. is listed on this page and that's open to the public and I

would be happy to have you go there and use some of our resources. Under development and available most likely by the end of June in Moodle, our course management system will be a web based guide to developing distance training on family, disability and culture for MCH professionals. And the guide is going to provide support and technical assistance to training directors, module directors and course directors who want to provide curriculum on family partnerships and cultural competence at a distance, and incorporate active learning experiences guided by adult learning principles. And now I would like to turn it over to the next presenter, Dr. Anita Farel.

ANITA FAREL: Thank you very much, Karen. I'm going to talk about our online leadership education in maternal and child health. With distance learning training from the MCH Bureau and the UNC General Administration, we launched our new three course 10 credit program and enrolled our first cohort of distance education students in January of 2010. This certificate lays the foundation for an online master's degree program that is equivalent to our residential program. Most of the inquiries about the certificate have indicated in enrolling in a master's program. To date our experiences with the certificate program have substantiated our conviction that online access to graduate studies extends the reach of your MCH leadership training program to previously underserved segments of the MCH work force. In fact, with each project year, we have a more seasoned appreciation for all of the resources that are necessary to develop and sustain a distance education initiative within a graduate training program environment. The target enrollment for initial cohort is purposely

small, eight to so students. With few exceptions, the courses are asynchronous. The course does not need to be online at a specific time. Most distance education courses are reported to take approximately 10 to 12 hours per week for successful completion and that's pretty much what our students report as well. Initially we were interested in proceeding cautiously, giving more limited infrastructure and technical capacity within the department. We were also aware that historically some faculty members resist online pedagogy. Many have not had direct experience with online teaching and contemporary online teaching methodologies. Faculty with greater exposure, memories of clunky technology from five to eight years ago also left unfavorable impressions.

Next slide, please. The three courses that make up the service are our year long foundations of ma certainly and health survey course and the leadership course. As we began to implement the early phase of the certificate, we found positive attitudes and engagement among our faculty and staff. This was cultivated intentionally as the online certificate was irresistible opportunity for culture shift for our department. The majority of our faculty currently guest lecture in either MCH 701 or 702 residentially. So in one fell swoop, by converting foundations to an online format, our faculty's introduction to the techniques used accelerated. This summarizes our first cohort of students. Of 10 individuals we accepted, one considered future illness when she needed to attend a 3 1/2 orientation and leadership workshop conducted in early January. In our school, the typical learning student is on average 35 years of age with 10 years of experience and employed full time while pursuing concurrent graduate course work. Compared to a

typical residential student, distance learning students are older, more experienced and have more demands from work, family and community during graduate studies. Our long-term program commitment to recruiting a diverse student cohort means on average about 20 to 25% of our residential student body consists of students from domestic, underserved minority groups. For the initial online certificate cohort, four of the students or 40% of the admitted students met this category. We also require them to have at least one to two years MCH related experience. The majority of our admitted residential students have five to 10 years of relevant experience. In this regard, the certificate cohort compares favorably with admitted students having an average of about 14 years of prior public health experience and about 18 years of overall professional work experience. All our certificate students were full time. Now I'm going to shift to talking about the modalities used and ask for the next slide. This is a screen shot from black board. All complements with the exception of the MCH leadership seminar have been specifically developed for delivery via the Internet and take place to black board. That's a course management system used to provide the capability for posting documents, communicating with students and hosting discussion boards. Our certificate program replicates the residential classroom experience by using web based courses, lectures, group and individual assignments, papers and exams. They have individual assignments and audio visual tutorials. The most common presentation is by narrated slide presentations using adobe connect. The school of had you been shell group is committed to working with certificate faculty and staff to assure our students and instructors get the maximum benefit from online learning technologies. With over 40 years of combined experience, the oig offers services from consultation to design

and implementation, to maintenance and support. O.I.G. staff members have backgrounds in instruction and design and their expertise has allowed our MCH faculty to focus on course instruction. They prepare the course materials and making sure the online learning experience is dynamic and engaging and effective. For example, the instructional designer decided our presenters in advance. This was an important opportunity to emphasize the rationale for restructuring their traditional presentations to work more effectively in the new medium. The online instruction group in the school provides guidance to the school's faculty and staff. For our certificate programs, staff from the O.I.G. formed a special project team to work directly with MCH faculty and staff to ensure instructional design for the online certificate courses facilitates the achievement of the equivalent learning effective in student competencies of the course counterpart. Given the importance of testing and evaluating online modes of communication and group interaction when piloting new courses. Our certificate program also benefits from extensive use of the multimedia facility which includes a professional quality sound booth for recording as well as assistance for nonlinear educating. The online instruction group has continued to remind us about the principles of online pedagogy. They recommended certain books and key articles such as hort and sweet, technology shrinks the lecture. The slide refers to a few principles that guide our methodology. Creating a sense of place and a predictability environment are essential and doable. We believe it's possible for a cohort of students and instructors to feel a sense of community and inclusion, although physically at a distance. Online students look for markers like black board, help desk, response systems and access to and familiarity with tools. When constructing online courses, use of common design,

communication and navigational features ensure a climate for student engagement. Effective use of technology is challenging in an environment that's alive with possibilities. And the attraction of new bells and whistles can actually be a distraction.

SUE LIN: Thank you so much. Right now we're -- this is a perfect transition Anita has provided us to talk about modalities but before we go into modalities discussion further, I wanted to bring up our second polling question. We're very interested in learning about what type of information have been most useful so you. The next polling question provides a list of choices. So please take a moment when the polling question comes up to respond to that polling question. And let me just give you a brief overview of how the modality presentations will take place. Karen will be providing an overview on e-learning system. Lee will talk about web conference, course management software. John will talk about the web 2.0 world and incorporating experiences into distance learning curriculum and Rachel will finish us off with evaluations and then we'll have a question and answer period. And just to remind you folks that if you have questions at any time, please go ahead and submit them through the text box. So I don't know if folks had a chance to tell us a little bit about the modalities that you have used but let me turn it over to Karen to talk about the e-learning at this point.

Karen Edwards: Thank you. So we're moving to the next segment. We'll look in more detail at e-learning platforms such as Moodle. A number of folks have mentioned that. The goals of the segment or to explore use of e-learning platforms in MCH professional development to promote collaborative learning, active learning, problem

solving, sharing relevant resources and acquisition of MCH competencies. Let's start with the basics. What is an e-learning platform? Official development is that is a software controlled learning infrastructure located on the Internet or an intranet, accessed via web browser. Some programs we've already heard of, blackboard, Moodle, you may have heard of many more and e-learning platforms are also known as learning management systems. Through engaging in the learning activities that we build into our courses and trainings, we are helping trainees to develop some of the skills and knowledge areas that are included. I've listed them all but I think in particular when we use the modalities we're featuring today, we're helping trainees to develop critical thinking, communication skills, developing others through teaching and mentoring and enter disciplinary team building. When developing training for MCH professionals, we're striving to make the content relevant to what they need to know and the skills they need to develop for the current work they're doing. We know that adult learners prefer to use active problem solving while learning and we frequently assess their needs as we go along, asking them how is the training going? How is it addressing your needs? Then we incorporate the results on an ongoing basis into the content and methodology that we choose. E-learning platforms help us to do that. And even though e-learning platforms do have a filing cabinet function and a mailbox function, they aren't just filing cabinets or mailboxes and they're not just for distance learning. The e-learning platform that we have been using for the past two years is Moodle. This just gives you a look at the sign-in screen for Moodle. Moodle is free. It's open source but support of Moodle is not free and for support of Moodle, we're very happy to have our colleagues at the university of Florida who are contracted by the

maternal and child health bureau to provide support for Moodle and a host of other e-learning strategies for MCH supported training programs. So here is my sign-in tape and here's the U.R.L. For those of you who haven't learned -- used e-learning platforms or who haven't used Moodle, here's a peek at one of our course websites for one of the lead courses. You can see that we do use the, you know, filing cabinet function. We post documents, power points but also provided a recording of one of our web conference sessions. We have put up a test quiz to help the trainees learn how to take quizzes in Moodle and we provided places for them to submit assignments. Here is a look at another method we're using. This is an example from our lend program, one of our lend courses and this is another strategy we're using to promote collaborative learning. So for each of our evidence based methods project teams in lend, we created a Moodle site so each time can wink out their own private space, chat back and forth and get work done asynchronously when they have time to do it. Here the arrows are pointing to many ways to incorporate active learning in the Moodle environment. So in addition to assignments, there are discussion boards, chat boards, you can create surveys, trainees can collaborate in making a wiki and you can even import files that are themselves interactive right into the Moodle environment and it would link right to the little grade books or some quizzes that you perform within the SCORM file. I also want to make sure that those of you who are from MCH funded training programs know that in addition to supporting Moodle, the university of Florida group also provides assistance and technical assistance in a number of other areas such as video, web development and digital story telling. This is their website. And I

also want to introduce you to three colleagues that help us with the technical support. So the next presenter is going to be Lee Wallace again.

LEE WALLACE: Thank you. You heard a little bit about course management software systems. I'll talk about web conferencing software here. There are principles of choosing that apply to both. In 1994 there were two software packages. Now there are about a million web conference programs out there. Features change regularly. Costs are highly variable from free to whoa and it all depends on the features you choose. Let's talk about choosing them. When in doubt, start with Wikipedia but you have to be cautious about the accuracy. When I Goggled web conferencing software, I came up 39 million results. That's at the top so it's a place to start but it has difficult to understand warnings so it's not always easy to understand all the time. I've listed two here that I really like but there are a lot of other ones out there. The first one is an I understand website which lists the top five web conferencing packages and then has a total rating of 31 different software products and they have links to their own reviews and then links to the vendors' sites. The next thing is straight talk about business software, another descriptive example, they review the top 10 software packages so there's good information there. By reviewing those, I discovered more available options that I didn't know that existed for features in web conferencing software. You can get unique U.R.L.'s, security packages way beyond just basic password protection. Software may change. What's really important is to know what you need and that's probably different than anybody else. So I suggest that you make a chart for your needs. List all the things that you think you want. Do you want to share your desk top?

Use power point? Have face to face webcam, talking about other people? Do you want chat boxes? Then look at the reviews. See what other options are to oh, that might be good. I would like to have that, too. Sometimes the reviews will give you an idea of costs which helps you focus down. Make yourself a chart of what's important to you. Go to each vendor site. Don't depend on the reviews for this because like I said, things change. See what you're interested in, if it's available in the vendor software package. I think Karen already listed the link to the site where we have some posted resources and I think it's coming up later and I have a sample chart there if you are having trouble visualizing this. But beyond creating that, ask people what they like. Ask your friend, neighbors, colleagues, people you meet at conferences. Ask what they've used, what they participated in, what they don't like. All of that will give you information. And find somebody who is really, really, really into technology and go out to lunch with them occasionally. They can help you keep up with what's going on in the technology world. They can explain terms. Even if you have something you like, something new or cheaper may be along at any moment. Support for the software you use is the key. Karen has mentioned that already. How much can you yourself do? How much help do you need and does your office or agency have that support? Are you going to have to get it from the vendor? That's an important issue. Then you've narrowed your search from the million choices down to five or 10. Contact the vendors about demos or free trials or someone who may be using it that you can talk to or maybe somebody locally who can see what it looks like. I noted lynda.com is free for training. Since money is always getting tighter, there are free versions of web conferencing software out there. Dimdim has a free version for up to about 20 people and then some pro packages that

cost some money. And there are others that are free as well. It's a nice one. This is your cautionary tale. No matter how simple a vendor claims the software package is, something will go wrong. No matter how skilled you think you are or your attendees think they are, things can go wrong. Yet one more cautionary statement. No matter how innovative or wonderful a web conferencing software is, if you can't use it, it's worthless. When we did our web conferencing, for example, we tried to do multiple technology trials for the participating sites to make sure they knew how to work the pieces, they could use the white board, the chat box, they had the connections and invariably it was the sites who thought they knew how to use it and didn't pay attention or who didn't have time to do a trial with us and waited until the web conference. We couldn't stop to work through a lot of details with them. The technology itself is not the miracle cure. Personal creativity and planning is still required and still essential. I review at the bottom here with one of my favorite technology quotes. Thank you. Let me turn it over to John Richards.

SUE LIN If I may interject, I want to let folks know that our webcast production folks are able to share with us the poll results from the type of information sharing modality that has been the most useful to the users. 24% of you reported websites, 30% reported web conferencing, webinar learning environments, 7% reported streaming audio, 7% reported interactive tools such as blogs, wikis and 9% of you reported community building tools like Facebook, social networking sites. 11% reported two-way video conferencing and another 11% reported document sharing, project management and 2% reported mobile web. OK. I'm going to turn it back to John.

JOHN RICHARDS: Thank you very much. That was perfect timing because I was sitting here trying to decide how to structure my web 2.0 interactive or at least responsive discussion and Lee, you also mentioned this. You summed it up perfectly that technology is really not the solution. It's how we use the technology that will enable our programs to reach out to people. So to our first slide, this is not news to anybody but recent studies -- and I pulled from a number of studies first by Internet and American life project and the journal of public health management and practice and it shows that almost everyone is online routinely, almost daily to get help information. When we talk about web 2.0 and new technology tools, what we're talking about is what HHRT says are tools that reinforce personalized health messages. They reach new audiences, built a community infrastructure based on information exchange. This is what we're talking about. Before I even get into exactly more of what is web 2.0, the next slide, why? I get this a lot from people when I talk about -- they say why do we have to go there? We're busy enough. We put stuff up on the website. Isn't that enough for people? Well, this is a sobering fact. In the past year, social media channels, Twitter, Facebook, govloop has increased at over 1,000% growth rate. And while this is a big chunk, it shows that this is becoming a daily feature of life for people. This is how we routinely take information in both for fun, for personal and for professional lives.

So the next slide, I go back to a very simple definition of 2.0 which we sort of have touched on. This is really interactive, this is user centered design and collaboration. If

1.0 was putting your information out on a website and your business called it the great way to get information out, web 2.0 is how to facilitate discussion interaction which we do know combined with other forms of learning is a very effective way for adult professionals to learn. And I'm jumping right ahead to web 3.0 because people are saying what's next on the horizon? OK. I know Twitter is big this year. What is going to be big next year? Well, there's the big question mark and people are talking about web 3.0 as a more of a platform of data being shared without going to multiple sources. You would have one as you might call it the place to get information. We're not there yet and hopefully we won't be there until we as MCH professionals master some of these 2.0 technologies. Really -- and I'm keeping this really to benefit you. You know, the goals with using any of these new technologies, it's really to supplement or to add on to current mechanisms that we use for outreach. We know things that work but looking forward to a new work force, a new generation of our audiences to one by one incorporate communication tools that they're familiar with to get our message out. This brings out challenges. There are a lot of challenges and we can go on and on about them, first from how do we as MCH communication specialists, how too we choose which ones to use? How do we have the time? Our plates are full enough as is. Challenge from the user side is, you know, any time you introduce a new technology, there are people left behind. How do you choose technologies that are appropriate that people can use that they're not denied access to? This is a fine balancing line.

But if you go to the next slide and I'm going to leave you with this, this is a resource my troop has put together which is really a primer of web 2.0 resources. You will see

there's the sort of interactive tool kit and what we've done is breaking up 2.0 technologies into a number of categories. And a lot of the technologies fall under multiple categories but this is really to get your feet wet in looking at technologies, looking at public health examples. How are other people using technologies? You know, blogs. Well, it turns out that this is a perfect way to incorporate this technology into a public health sphere. We also link to the exact tools. So example, under blog we list -- we link you to word press, the blog spot and to other vendors either free or to purchase. Then, of course, be a university based on the resources. So this is the evidence base of what works, what doesn't for each of these technologies and we group them into interactive work, mobile web and enhanced search. And this is sort of a way to get your head around the whole concept of it. So I'm going to leave you with this U.R.L. and it's a resource we will continue to update and it will be archived here and then on our website so please go back and take a look and with that, I will turn it over to Barbara Levitz. Thank you so much.

BARBARA LEVITZ: Thank you, John. I'm going to be talking about today how distance learning can be enhanced by incorporating field experiences using them as a centerpiece to achieve learning goals. This serves how a web course can be designed using field experience in that particular learning course. The family mentorship home visit is a present for more on-site training programs that was developed in LEADD. The family focused disability organization interview, was first developed from LEADD and because of the successful application was later incorporated into our lend training. A complete link to the course materials and resources was included earlier in Dr.

Edward's course presentation. This course in the virgin islands integrated community based active learning into an instructional format using Moodle. They used other resources as well as written assignments with feedback from instructors and faculty mentors and numerous training presentations during webinars which I'm going to talk more about. Each training identified and conducted and guided a home visit with a mentor family who shared their personal story while the trainee listened for information on family needs and concerns, cultural considerations, advocacy and family support and community resources. For the family mentorship experience, they presented reflections on the home visit and how this experience impacted their own practices. After the session, we also changed the subsequent webinar formats from faculty presentations to trainee presentations and allow time for group discussions and feedback. The home visit was also designed for trainees to think about collaborative roles for MCH professionals in the area of family advocacy. The next field information the family focused and community resources. The concluding webinar presentations enabled trainees to identify gaps in services and support as well as potential strategies to address these needs. In summary, the goal of incorporating field experiences into the distance learning curriculum was to enable trainees to directly apply the knowledge gained within their own clinical and program settings, thus improving family centered culturally centered practices. To my peers, my professors, my mentors and the interactive sessions with the families and organizations, I learned valuable lessons that will help me to improve services in the community. Thank you and now let's turn things over to Rachel Brady.

RACHEL BRADY: Thank you, Barbara. At the end of all of this, we're thinking about how do you evaluate what you've done? We thought about it in two ways, how do you evaluate the process to build the modules and the technologies and how do you evaluate the outcome of the courses or the learning modalities that we use? So we -- next slide, please. What we decided to do was think about it in terms of -- and we got this from the Sloan Foundation, the five pillars. The learning effectiveness, student satisfaction, how responsive or interactive and how much they retain over time, faculty satisfaction, the support that they receive to do this and also the technology advancement is a big piece of that to make sure they're learning the technology pieces and learn how to understand them. Cost effectiveness is a big one for everyone and access. The orientations to the different ways to use technology and reducing that digital divide. I think that is both for the students and for myself as faculty. So again, we thought about it in terms of the process and outcome. For the processes, we were building the early intervention curriculum. We thought about a field review. We definitely have to learn if the learners were satisfied with how we were building and how they could use it. With that was the usability testing and also the accessibility testing. Were they able to access what they built? The other thing we considered was an evaluation form so we went back to sort of paper and pencil because again, our target audience had a basic technology knowledge but were also more comfortable with sort of a paper, pencil way to feedback to us. We had focus groups locally in our area in the District of Columbia and we did do an in-person focus group with the folks in Alaska. Then we had a curriculum evaluation forms that we have both -- that we have online for the Moodle platform that you heard folks today talk about and then we

also have evaluation forms for -- if people use this to -- [Inaudible] The pre and post testing you've heard a lot of folks do is one really easy way to get at it and a consistent way to get at what is the learner learning through these modules? Also we built in some self assessment questionnaires, we intend to once the module wants to do follow-up surveys online, we also follow web statistics on YouTube and what part of the modules folks are using and use over time and then get demographic information and discipline specific profiles so we can target and respond to the training needs of the folks as well. So that is in short a lot of the processes that you heard throughout the months modules and the ones we're using and the learners' outcomes. So right now, I will send it over to the moderator Sue.

SUE LIN: Thank you so much, Rachel. Thank you to all of the speakers for the wonderful content that you provided this afternoon. Just wanted to remind folks again about the U.R.L. that contains the information and the handouts that speakers have alluded to this afternoon. I know that Karen has mentioned it in her presentation as well as Lee so wanted to remind folks where they could download some of the power points presentations as well as the handouts that were previously handed out. We're now about to embark on the question and answer session. We have about 15 minutes to do so. We wanted to also ask a final polling question of the audience and let me pose this question to you while you think of other questions to submit through the text messaging feature. The final polling question will be, what innovative social networking tools are you unable to access at your workplace? If our question, the majority answered that you were MCH professionals. I wanted to find out if your office is

blocked from using YouTube, Facebook, Twitter, Dailymotion, streaming audio/video or you're not aware of anything, don't know or haven't tried to see if you were blocked or unable to access the social networking tools from your workplace. We'll give you a couple of minutes to answer this polling question and let's begin the question and answer period. We did have our first webcast question come in and I think this one is for Rachel. The question is, who can access the early intervention distance learning modules? Rachel?

>> Thank you for your question. This is Rachel. Right now we're in the process of building them. We have the first module up and it was on one of the slides when I first introduced our programs was the test site. You'll see the overview and the first module about infants and toddlers with disabilities. John is pointing to me, it's a www.ttui.org. That was www.ttei.org. That's another way to access it. That's a recent development we have out there. We're in the process, there will be six modules and we are in the process now of getting those up and running as we speak. But we did test the first one live with folks here in the district of Columbia and Alaska.

>> Terrific. Thank you so much, Rachel. The next question is for Cathy. The question is, can you provide a little bit more information about the online workshops?

>> Yeah. The common mind workshop is based on an in-person training for clinical providers. We're in the process of putting it into Moodle and making it more in-depth. It's for mental health, mental care, social service providers, how to talk kind of routinely

screen youths who are at risk for suicide for their access to firearms and other lethal means. It's an aspect of suicide prevention that is often left undone because it's so compelling to focus on the mental health issues which are kind of front and center but physicians and other providers often forget to ask about are there any guns at home, the most lethal method of suicide and work with the family to secure them. This is a training and clinical skills and basic skills on understanding firearms and safe storage and understanding lethality of various medications for providers.

>> Terrific. Thank you so much, Cathy. Next question is for Lee. Can you talk a little bit about some of the community solutions from the obesity workshops that you've delivered and how people in different parts of the country have developed solutions?

Lee?

>> Sure. You know, it's different everywhere. There are a lot of interesting partnerships that came up. North and South Carolina in particular had places where universities and public health departments and business partners would get together. We've had that here in Memphis where people talk about the problems and look to see if there are already preexisting programs that might -- they might be able to bring in and address and also the community and that's probably been the biggest thing. When people begin to get together to talk about those issues. There are some resources within the program and I can't bring anything to mind right at the moment that they would be accessible on our website if that is helpful.

>> Thank you so much, Lee. Karen, the next question is for you. You and Barbara. What aspects of culture or cultural competence was adapted for the virgin islands trainees?

>> Barbara, do you want to take that or --

>> Well, I think the first thing that we learned was that it was a natural fit in integrating both family centered practices and cultural competency and what was so important were some of the hands-on, real-life visiting experiences because the trainees really were able to get to know families, ask specific kinds of questions and then bring that back into their day-to-day practices and look at strategies and promote changes within their settings, particularly in terms of cultural issues since this is such a diverse community in the various parts of the virgin islands.

>> Karen, do you ever -- do you have anything to add?

>> No. I think that's good.

>> Next question is for John. How would you encourage MCH professional to become engaged in web 2.0 or eventually web 3.0 technology?

>> I think the first thing to do is to look at what you're using currently for communication methods. Case in point, projects that I work on we do a weekly

electronic newsletter and we've kept it very simple. And it gets sent by email and it's great and we post the archives of it on our website and people love it and that's great. But looking forward, more and more people are not using email as their primary means of gathering information and I still send emails but as we all know, we're overwhelmed with our inboxes. Looking at web 2.0 we're looking at ways to do streaming so people can choose content, say I want this received, this entire newsletter or I want to receive only items of my specific field. Say if you're in oral health, I only want to see oral health topics delivered to either my mobile phone or to my computer or, you know, my hand held device. It's looking in ways that you can augment what you currently have, currently have it in another format. Another way we're doing this for the newsletter is we're posting the same contents or little teasers on a Facebook page and a Twitter page and what that does, it leases a new audience, pulls them back to your resource and your website so it's really about expanding your reach and augmenting the communication methods you're currently using. I hope that helps.

>> That's great, John. Thank you so much. Anita, the next question is for you. In your inaugural cohort for the program, there was folks that had varying years of public health experience. Can you talk a little bit about how the faculty has adapted leadership curriculum or leadership content to adjust for the varying stages of leadership that the participants are in at this point in their careers?

>> Sure, Sue. I would be glad to do that. The leadership course is taught by Claudia Fernandez and she's developed 16 self instructional leadership modules that cover an

array of leadership topics. She conducts a fair bit of the face to face orientation to leadership during early January, before the courses even start and gets to know the students and advises them then in a more personal way about some of the modules. She also does the MBTI, I listed it in the first slide, about the assessments she does. That combined with then the students being able to guide their own learning by selecting modules that are most relevant or interesting to them is the way that she accommodates the variations and their leadership background and leadership interests.

>> Terrific. I think at this time our folks is able to pull up the polling question results. I want to share that with you. Folks have let us know that 11% of you are blocked from YouTube, 17% from Facebook, 3% from memeo, 9% from streaming audio/video and 70% of you don't know and 70% reported having tried. So thank you so much for sharing that with us. I think we're coming to the end of our 90 minute webcast. We have presented all the questions to the speakers at this point. If there's not any other questions, I'm going to go ahead and close this webcast. I want to take the opportunity first to thank the presenters for spending the afternoon with us, sharing very much rich information about the distance learning programs they're implementing at their institution as well as the audience for your time this afternoon, for sharing your input with us as well as submitting your questions online. I hope this has been a rich educational experience for you as well in learning about the MCH supported distance learning programs. Thank you to everyone and hope that when you finish the webcast,

there will be a brief evaluation online. Please complete it and provide that feedback to us to improve our future webcasts. Thank you so much. Bye-bye.