

## **AMCHP 2008 ANNUAL CONFERENCE**

### **WE ARE MAKING A DIFFERENCE:**

#### **Alaska's Newborn Screening Information Integration**

March 1st to 5th, 2008

THALIA WOOD: I'm Thalia Wood. I'm with the Children's Health Unit manager for the state of Alaska. A little bit about my background, real quickly, I have a Bachelor of Science in Health Science and I have a Masters of Public Health and Maternal Child Health but my background is medical laboratory. I have more than 30 years of medical laboratory experience. So I became the Newborn Metabolic Screening program manager for the state of Alaska and now I manage the Children's Health Unit which oversees the EHDI program, the genetics clinic and the specialty clinics. And so I oversee several different programs at this point. I'm going to refer to this as the newborn metabolic screening program even though I know a lot of people have heard, especially at other venues of this conference, newborn bloodspot screening, but in Alaska we still call it the metabolic screening program even though, of course, we screen for endocrine disorders and hemoglobinopathies and cystic fibrosis. And Lura's going to introduce herself here.

LURA DAUSSAT: And I am Lura Dausat. I'm a program coordinator with OZ Systems out of Dallas and we work with information management and software

systems for newborn blood spot screening early here in detection and early education programs. My background is, since I work for non-profit for a few years after being a Peace Corps volunteer and coming back and getting my graduate degree in Public Health, so I just moved to OZ Systems and I've been working closely with Thalia to develop this system that we're working on presenting today.

THALIA WOOD: And this is a kind of a disclaimer, this is obviously not, we're not trying to promote anyone database vendor or system but since we work very closely with this particular vendor, I refer to her as the vendor throughout the day just because I want to make sure it's clear that we're not trying to promote anyone's system but we want to show you what we've been able to do with this database.

Okay, so why is newborn screening important? Of course, it's important because every 100,000 babies born in the United States, as you can see from the statistics on here, there's going to be hearing loss occurs in 300 of those children. And if you take all the rest of those disorders that are found with the metabolic screen, they don't even add up to what we find with hearing screen. Hearing screening is the most common thing that we're going to find on infants when we're doing the screening programs. That being said, I will give a little bit of a caveat because in Alaska, I don't know if anybody has heard me speak before, I often speak at the National Newborn Screening and Genetics symposiums and when we expanded our panel in Alaska to screen for the tandem mass spec

disorders, we are finding an extremely high incidence of CPT1 deficiency in the Alaskan native population and out of about 10 to 11,000 births a year, we always have at least 30 kids identified each year with CPT1. And there's a lot of ongoing interest and study and so forth going on to try to determine what this means. These kids are asymptomatic sometimes so it's not just a benign condition. It is one of the fatty acid oxidization disorders.

So I always like to show a little bit about Alaska. I'm going to show another map here in a minute but this is a map of Alaska, and if I had a laser pointer, I could show you exactly where the roads are which you could imagine are very far and few roads because there's not a lot of road systems. Most of the villages especially to the north and to the west are only accessible by air. Even if you wanted to take a boat there, it would take a long time and there's often ice around those areas. So it's very interesting because a lot of health care delivery is, a lot of the people in the wintertime can only get to a health clinic or see a provider by dogsled or by snow machine.

This is the slide I really like to show most frequently because I love to come to these conferences and listen to smaller states talk about access issues. Nobody really understands access issues unless you see how big we are. When I moved to Alaska in 1976, we had four time zones. Eventually, and I think some time in the '80s, they said, okay, it's light all summer, it's dark all winter, it doesn't matter what time it is. And Anchorage which is probably about right here and our capital

is over here, so the capital was actually two hours ahead of Anchorage. It was where most of the people live. And it was a real problem then when people in Anchorage wanted to call their legislator or deal with somebody in Juneau in their same division that they worked for and they'd forget that they're already closed because they were two hours ahead. So sometime in the '80s we consolidated the state into one time zone. And in Anchorage we moved up an hour and in Juneau they moved back an hour and way over in the Aleutian Islands over there which are south of California on this map, they had to come forward two hours and so now we have just what's called Alaska time and just one time zone. But like I said, as you can see, we have, I had listened to somebody from Maine one time talked about their access issues and getting people into genetics clinics, I thought, oh, they have no idea.

So a little bit about the history of newborn screening in Alaska. We started screening, metabolic screening was implemented in the 1960s and as most of you are aware, of course, that was started because of PKU, phenylketonuria. Dr. Guthrie developed the test for this because he had, I think, it was niece that had PKU who was mentally retarded and he knew that there must be a way to be able to diagnose these kids earlier and get them into treatment. Over time we, of course, increased more and started screening for more conditions just like most states did until when I took over the program in 2001, we were screening for six conditions at that time. We screened for PKU, MSUD, CAH, we have a very high incidence of congenital adrenal hyperplasia and the Alaskan native population as

well, hyperthyroidism, biotinidase and galactosemia. And then, it says on the slide, in 2003, we decided to add the tandem mass spec disorders. We do have our screening done at the Oregon Public Health Lab. And this is done because we don't have enough births in Alaska to justify actually doing this screening at our own public health lab. So we do have an intergovernmental agreement and have organ donor screening so when the slides or when the blood spots are collected in Alaska, they're shipped to Portland, and we do subsidize the shipping to get them there in a quick manner so we could help offset the cost of DHL shipping or FedEx shipping so that they can get down there in a timely manner because we don't want to have these kids go too long without a diagnosis.

So when the Oregon Public Health Lab decided in 2002 that they were going to expand the panel for organ, they really encouraged the rest of the states in their region that they screen for metabolic screening to also add the tandem mass spec disorders because organ screens for Idaho, Hawaii, Nevada, New Mexico, Oregon and Alaska and that these have several federal installations as well, military bases and some hospitals in Guam. So we added the tandem mass spec disorders in 2003 and then last year in 2007, we did add cystic fibrosis. Then we got the A Plus, I think, for the (inaudible) is having all the conditions that the (inaudible) has recommend, so.

Hearing screening became the standard of care throughout the late 1990s and the early 2000s in Alaska. Several hospitals were very innovative in trying to get the hearing screening developed and get implemented in their hospitals but we didn't get all the birthing hospitals onboard with it until the beginning of 2004. And that's because, as you can imagine, we don't have a lot of people in Alaska. It's a big state as you saw from the map but we only have 670,000 people in our entire state. And a lot of our birthing hospitals only have 20 or 30 births a year. So they just didn't feel like they could justify getting the screening equipment because they had few births. So what we did for, the last hospital to come onboard actually was Barrow, Alaska, which is the furthest, most northern community in the United States. And what we did is we encouraged the hospital to approach the Lion's Club there to get the screening equipment which is what they did and then they implemented the screening. So that's why at the beginning of 2004, all of the birthing hospitals in Alaska were onboard with hearing screening. We have 24 hospitals and 21 of them are birthing hospitals. And then the legislation was passed in 2006 mandating newborn hearing screening and it actually went into effect just this year in January. And that's what these handouts are, when people are coming up for the handouts in case you're wondering, we don't, like Lura said, we do not have handouts of the actual PowerPoint that will be on the AMCHP Web site but I do have copies of the law for newborn hearing screening as well as the regulations supporting the law. And then there's copies of the poster that Lura and I and John Cartwright from our department presented in New Orleans last week at EHDI conference. And the poster is about the same

kind of information that we're presenting here today. And I'm going to let Lura take over this slide.

LURA DAUSSAT: Just to give you some background on the newborn hearing screening which many of you, if you come from a nursing background maybe familiar with, but there are two technologies used, otoacoustic emissions and auditory brainstem response. One is done, this a picture of an ABR and in a second, we'll have one that measures the sound from the outer ear all the way to the brainstem, and that's the ABR. And the otoacoustic emission works with the hair cells that line the inside of the ear. And those are the two screening technologies that were developed initially and we transmit those test results that are used in the nursery directly into the databases that we'll be talking about. And this a picture of an ABR and it's actually one of our colleague's new baby so, but it was a good, it demonstrates how the ABR works. Okay, I'm going to pass the mic for you.

THALIA WOOD: Okay, so once the screening materials were developed and the screening itself became standard of care, then of course, the next step is following up on those (inaudible) and babies that have a refer on one or both ears. And so we had to try to figure out how are we going to try to find these kiddos that need to go back and be rescreened or get into diagnostic evaluation. We started by trying to develop an in-house database. This was back when we had our very cohesive maternal child family health section at the time in Alaska

and so our own IT staff started developing a database. But then we had a new governor and a reorganization, I'm sure many of you have gone through in your own states, and so IT became centralized and we no longer had a direct resource then to work with within our sections. So then we had to try to decide how we were going to proceed with this because we knew that the best way to try to start following up on these children was to develop a database for tracking. So the decision was made then to put out an RP for a database and we developed an RFP and put it out on the Web and various vendors responded but only one ended up meeting all of our program criteria outlined in the RFP and was totally responsive to the things that we've wanted in the database. So that vendor was chosen and the decision was made to have the vendor host the Web-based database as well. We decided on that because in that way, it's hosted on their own server and we don't have to worry about the state of Alaska server issues or anything, any server changes. And it's been a very good decision for us to have them host this actually.

This is the original page for the database. It does no longer looks like this and we'll show you the new one in a minute. Up in the upper right hand corner where it says Alaska EHDI Program, this was a logo that was taken off of the materials that had been developed for the EHDI program. We have kind of a standard look and feel to all of the materials that were developed, the parent brochures, the provider manuals, the parent resource manuals, have kind of the same look and feel for the graphics on those items. So we wanted to have the same thing

appear on our database as well. So the vendor was actually able to take that piece of, one of the brochures and put it onto the Web site. So this was how the original Web site looked like when we first started with this database. We brought up somebody from the database vendor up to Alaska in 2005 and training began on the database for the screeners, managers and audiologist then in May of 2005. We had four days of training. We had one day just for audiologist and three days were for screeners or managers. We brought people in from around the state so that it could really have a full day of getting to know this database. And then we went live with the database on June 1st 2005. Most of those birthing hospitals began right away to enter their newborn hearing screening data. It was very exciting to see that they really took it to heart. I mean, you have to realize that at this point, it wasn't even mandated yet in our state. But they really took it to heart and were started putting their data into the database, so it was very exciting to see.

Screening equipment was also placed at that time or before that time, actually, in eight public health nursing offices and areas of Alaska where there's high home or midwifery center births. What we did is, some of those hospitals like I mentioned to have very, very few births, they just didn't have the resources to actually buy the equipment, so for some of those really small communities, we placed it with the public health nursing office and they kind of share with them with the hospital to make sure that all the kids born in their community are screened. Because like I said, some of these hospitals only have 10, 20 births a

year, so that way the public health nurses in those communities know which families have a new baby and they make sure those kids get screened. So we also brought in nurses from those centers to also get trained on the database and enter data which they have been doing.

So this is just showing a little, I'm getting my heel's poked for, and I like this because it actually shows how we want the bloodspots to look but I do for following up in that program is an even saturation. The newborn metabolic screening problem measure was also the EHDI surveillance measure which, that was me. At that time, I have, I kind of a dual role and I still do all the follow for the newborn metabolic screening program which consist, of course, to making sure that the kids that had either a poor collection or an abnormal screen get rescreened. And of they have a presumptive positive that they get diagnostic testing if they have diagnostic testing, it's positive that they get into the genetics clinic, see a metabolic specialist, get in contact with the nutritionist, whatever, whichever those steps is appropriate. Yes?

UNKNOWN SPEAKER: What's your turnaround time when you send from Alaska to Oregon?

THALIA WOOD: That's a good question. We actually, Oregon has a standard for, they have a practice profile, they call it, that they developed that they give to all the program managers for the states in the region. And they want the samples to

get there within five days of collection. They consider an “error” if it gets there in more than five days. So, but most of them are getting there right away. I do a lot of education around the state and one of the things I really stress is that make you let the blood spot air dry but only for about four hours and then ship it within 24 hours. When I first took over this program, there was one facility who had very, very poor deliver times to Oregon and what I found out is they were batching them and only shipping them twice a week. And when I explained to them that they just could not do that, they had to ship them every day then their profiles got much better. It’s still an issue for some communities and just one in particular that I worked with, well, for years, it seems like, and it’s just, I can’t seem to figure out why they can’t get them there in a timely manner but they’re just not. And then Oregon, they log them in and they do the screening right away. For instance, the last Maple Syrup Urine Disease child, I’m trying to remember, I think, the child was seven days of age when we got that result and called the doctor and got the kiddo right away on treatment so usually it’s pretty good that we can usually get these kids diagnosed pretty darn quickly when they have a particular disorder.

UNKNOWN SPEAKER: Do we have a standard, though, like 72 hours?

THALIA WOOD: No, we can’t really do it that way in Alaska because we have a contract with another government to do the screening. Like I said, the main thing is for us to tell the hospitals to get those samples in the DHL bag or the FedEx

bag as quickly as possible but we don't actually have a standard just like, like I said, my education is within 24 hours of collection, get them sent off. There's still some issues with the fact that they don't always get to Oregon or something like that. One of the things we do is I have a health program associate who actually does a match. We get birth listing from the hospitals every week. They're going to a database and then he sends that list down to Oregon to match up with birth samples. And if I show that one particular hospital that the samples didn't get there, I contact them. And for instance, there was a bag that's out there floating around missing from one hospital, and I said, there's something wrong here, five of your samples did not get to Oregon yet. And sure enough, it was a bag that had gone astray so we try to do the little checks and balances that way but it's not something that is always successful.

So right now, newborn metabolic screening follow-up is being done through a very simple Excel spreadsheet that I set up. It's just a way of tracking the children who, the infants who still need a repeat sample for whatever reason, whichever those reasons that I mentioned, and that's all I've been using to follow up on these kids. So it doesn't always work really well I can't really run reports off of this, I can go in and I can query to see how many children had different conditions or if it was a bad sample but it's not like you can run really meaningful, useful reports for other entities.

So the decision was made to work with the EHDI database vendor to include metabolic screening into the same database since we have this shared goal. Unlike some states, these programs are in the same section, in fact, the EHDI program manager and myself, we work just down the hall from each other, so unlike states where metabolic screenings done at their lab and the hearing screening program manager is maybe even in another city, we work closely together because we're right there. We're right there the same building, we work together on the same, both on the children's health unit, so we work very closely together.

So we made the decision to work with the database vendor to try to incorporate the metabolic screening data into the same database. We wanted to see if this was going to work for us, plus it one of the goals and the CDC guidance that was for the EHDI grant, the current EHDI grant that we have through the CDC, that was one of the stated goals in their guidance, is that to aim for this kind of integration. And so we wrote that into that application. So we really began working earnest and trying to make this a reality in 2006.

So why should we integrate these information systems? We want to assure a thorough and accurate care for each child that is born. We want to assure that they're both in there, they're both getting followed up what they need to be. We want to connect those information silos that contribute to just joining the care for the child and his family and raise the performance bar for both of these

programs. And I'm going to go ahead and let Lura talk about this part of the database.

LURA DAUSSAT: And this AKMBS database is the newborn blood spot but this is also the integrated EHDI database. And just to give you some background, originally when we did the metabolic part that we want to integrate it, we added a component for metabolic where it was just drop-down menu and so it was user selected. That proved not to be the most efficient way to enter test results. So we worked with the Oregon lab and she said to establish this. But it is confidential, secure and we take our security very seriously and it's backed up numerous times. And as she said we host it but with that we have very varied levels of security to ensure that the data is kept confidential. It is HIPAA compliant and FERPA compliant. You saw that log in screen originally? Each individual user has to have an individual user name and log in. And with that authorized access, they can get online but each place where they go in the database is determined by their access rights so it's role-base permission. So if you're a hearing screener, you may not need to see those metabolic test results, so you won't have access to that information. And it was designed to reduce data entry errors as well as ensuring that each child is cared for, so we import electronically the demographics often from a hospital to make sure that all those patients get entered because all babies and then electronically import the hearing screening results and then the lab results therefore reducing data entry error and just human error.

And so this is what the new screen looks like. It is very similar to the old screen but it's not a lovely brown and orange color, or brown and blue color. It's a nice purplish blue. But again, you can see there's a user name and log in and there's helpdesk support always available.

And this is the hearing journey page and I just thought we'd give you some background on how this works with the database. This is kind of designed to show how a patient would move through the hearing screening system. So let's start by added whether it be electronically imported from hospital data registries or admissions registries or they can be manually added and as often is the case in Alaska because their births are so small at some facilities. Then they can be screened, the capturer's newborn hearing screening results, outpatient's screening results. You can import your test results and you can make appointments so the system will trigger you to do follow up if a patient was passed both ears and didn't have risk factors that would go under the risk monitoring screening. And what these do is you can click on each button and it will generate a list of patients that you need to follow up, so if you clicked on outpatient screening, that would generate the list for all the patients that need to come back in for outpatient screening. It has the ability to print letters and then the complete care process is just where the babies are once they're finished.

This is just an example of the child information page. At the top is all the demographic information and the primary contact details. This can be anything from father, grandparent, foster parent and it is searchable so if a mother's name does change or contact is changed, it is searchable and the note section. It's same with first name and last name, there's often many name changes when babies are born and before they leave the hospital, it change numerous times. So this information is also searchable. Professional contacts, each provide associated with the patient record is added in this section. And then you'll see the hearing section and the metabolic section. And like I said, if a person doesn't have the right to view the metabolic section, they won't see it and vice versa with hearing. But ideally, eventually, providers will be able to log on and if they have access, they could see a completely centric record with all the newborn hearing screening results and all the blood spot results as well.

And this is an example of the hearing details. It captures everything from birth screen to early intervention. Here, this child is referred at their audiological assessment rehab. The database has a very enhanced assessment place where audiologist can enter detailed information while the screening that they do or the testing that they do during an audiological assessment. You can see the date and time of the screens and then that this patient needs three different types of referrals for ENT early intervention and rehabilitation. One more thing on this, each patient and it's, you can't really see it here, there's a clipboard at the top next to testing sample, if you were to click on that it would open up and generate

a confidential ID number. That's a unique patient identifier. It's used throughout the system. So regardless what facility this patient is located in, that confidential ID can be used at the state level to search for that patient, so the state can contact the hospital and say I'm looking for information on this particular patient. It's confidential ID number one, two, three and they'll be able to look it up if they're unable to view the medical record number.

And this is the metabolic journey. It's very similar to the hearing patient journey where you can go in and it'll click on one of these buttons and it will generate a list of patients that need follow up, so no results. The way that it works is hearing screeners will enter their data and you would click on numbers or see babies that had not received the results from the Oregon lab as of yet. So if John or Thalia were doing follow-up and they wanted to see which kids were not yet screened or had a blood spot attached with their record yet, they could click on the no results and look at the date of birth and see, okay, it's been three weeks, this child doesn't have a specimen, what happened? Assigning specimens, there's a matching algorithm that when the data is imported from the lab, it matched up with the patient records automatically. If they don't match up automatically for various reasons, they're placed in the assigned specimens list. And then this is just a simple way to view patients that repeat specimens as would be transfused or unsatisfactory specimens. Disorder detected are those that are not super critical and these were words that we worked with together to define and then

critical would be those are urgent cases. The biggest (inaudible) are a fast way to log in and just click on a list and it generates that for you.

Okay, so a little bit more about the import data from Oregon Public Health Lab. We import these on a daily basis with Oregon Public Health Lab and we've worked very closely with them to ensure that every result we import is displayed properly. And we do it using HL7 messaging and an XML file. Specimen match, results match automatically using that matching algorithm. It's last name, date of birth and mother's last name and one or two other, but it's a matching algorithm based on that. They've been doing fairly well when it comes into importing. And then specimen data displays as it's entered from the lab, it's completely uneditable so that way it's imported and just displayed only and a hearing screener or a metabolic screener couldn't go in and change that information.

And this is the summary of the metabolic section. This particular child had a disorder detected by hemoglobinopathy of a probable (inaudible). And it just gives you a basic summary of how and what this child's test results are. And this is detailed information that comes in directly from the lab, so this is basically the specimen card that was sent to lab. The lab populated their database and we've pulled it over and populated it here so it displays the hospital levels. So either the state can go in or a primary care provider if they've accessed and viewed this information.

And these are the test results, the specimen details. These are the tests, this one doesn't display TSH because this particular patient didn't have it. The last course, yes. And then this Alaska resource is up at the top as an external link, so if a provider saw this and saw, oh, this child has hemoglobinopathy. I'm not sure what to do with this child, they can click on the Alaska Resource is it takes it to the Alaska home page which is the page that Thalia has developed and is their department or division of public health Web site.

THALIA WOOD: I just wanted to say real quickly that part of the way this works also is you'll find in the regulations, one of the things we put in the regulations is that we want the hearing screening hospitals, the birth hospitals to put the information in the database at least at a minimum on a weekly basis because otherwise that's what's happening is that if they don't put the hearing screening results and the demographics end there and the metabolic screening gets done then that's why there's nothing for it to match up with and that's what those unassigned specimens are, is they're waiting for the hearing screening results to get entered into the database. So we can, made sure we put that in the regulations that we, one of our expectations is that they'll put these information into the database, the hearing screening at the hospital level, at least on a weekly basis.

LURA DAUSSAT: Okay, other aspects of the database. You have the ability to enter case notes and with the integration of the hearing and the metabolic we

actually have to split the case notes and the hearing, metabolic in general because they are specific to each program. And so that was one of the changes but like I said those are searchable so if they do change it, the patient's last name, you can go into the general section and search there. You can also make appointments, follow-up appointments, generate letters that are preloaded and they both take elements from the database directly and populate just Word documents with those, it works similar to a mail merge where it just populates those field directly. And then you can run reports on hearing and metabolic. In metabolic, reports are not currently active but they will be shortly.

THALIA WOOD: And one thing we did too and we're training all of the hearing screeners, when they came in to Anchorage for the screening, we encouraged them to give the vendor their actual letterhead from their facilities so on their states, there are specific sites, for instance, if it's Providence Hospital, Alaska, they could go in when they generate their letters. It'll say Providence Hospital, Alaska at the letters and in that section of the database. But no other hospital have access to those letters. Each hospital has just the access to their own letters with their own letterhead that way.

So some of the benefits, of course, from this integrated system are that it's Web-based and I think a lot people are moving towards Web-based database systems and I know that that's kind of, one of the things that the state of Alaska is really trying to move towards more Web-based database because you can then access

it from any where that you have access to the Web. The fact that it's HIPAA compliant, it meets the needs for both programs was very important to us, of course. And as you probably know there is the whole, with HIPAA and now FERPA, part of the whole issue there is having the user specific and only people that really need to see that information can see that information and that's why when Lura was explaining that, we at the state are the one that give the access rights. And somebody calls up Lura and says I want access, she's going to call me or one of the other program managers and say, is it okay for this person to have access rights and what should they have rights to before any rights are given to those people.

The bloodspot data is pulled directly like Lura said from the Oregon Public Health Lab so this has been a multi-state effort because with the vendor being in Texas and the lab being in Oregon and we in Alaska, we've had lots of multi-state conference calls to make this all work. We were very pleased that Oregon was willing to take that step for us and help make this work as well and they've been very good about doing that. And the import hearing screening data from the hearing screening technology, for instance, most of the hearing screening instrumentation out there, a lot of it, little stuff that's not portable with bigger units can download right into this database off of the hearing screening equipment.

Some of the challenges of integrating it were accessed to specific areas of care meaning the confidential and secured records but I think we've gone a long way

towards making that happen like I said but only granting access rights to those who need it. And the fact that there is that confidential ID number that Lura pointed out and so instead of like if you needed to e-mail somebody, you can just put that confidential ID into the e-mail and you're not putting any kind of patient identifying information into that e-mail, so that records do remain secure.

Developing the appropriate access rights and like Lura said, before we integrated the metabolic screening, there was just one note area and now we've developed a three separate note areas. So they're basically designed so that they're very specific to general notes, to hearing screening notes and to metabolic screening notes so that we've done a lot of education to the providers that are using the database right now to make sure that they understand the appropriate area to put the notes in. For instance, in the hearing screening notes, you might want to say, the patient has failed to show up for a rescreening or they have an appointment with an audiologist, where a metabolic screening, it might be parents refused to have anymore blood spot testing done or refused to seek treatment or whatever you need to put in that area, it's very case-specific. So we really want to encourage everybody to make sure they understood where the specific notes go at this point. And then the (inaudible) to each program was the challenge but we actually work very closely with the people that are using the database to make sure they understand what their rights are and we're only assigning them certain viewing rights.

Public health implications as I mentioned, this does help satisfy one of my goals. It is actually for the CDC EHDI grant which is extremely important for me at that point and ensure that we're actually trying to meet our timelines and guidelines. And for those of you who were at the session yesterday that Karen and Alan and Jan presented, if you were there yesterday morning, they talked about database integration. And even though Alan was saying that he thought EHDI belonged with immunizations and I understand what Alan was saying there. This was a more natural fit for us at this point. Immunizations is actually in a separate section and maybe we can get to get at some point too but I know where he was talking about. But database integration, and I think some states have made greater strides toward making this happen than others and that we're just very excited that we've gotten to this point. And we really feel that with this, we're going to decrease the (inaudible) for not only for EHDI but for both programs and ensuring that all of the infants in Alaska are screened for both. There is a section that we can actually put down if the parents refused either the initial screening or further screening if they don't pass the first screening. And it's another way for us to ensure that we know what's going on with each child by whether why it wasn't complete.

There's our contact information and I guess we really went through this really fast. What we're trying to get access to the Web so we can do a demonstration. I'm not sure if you could get it. She got it in here at one point. Let's see if we can.

