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Application of Intervention Mapping to Address Lost to Intervention in Early Hearing Detection and Intervention

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Abstract

Purpose: Detail the application of intervention mapping as a protocol for developing a novel way to address lost to intervention within the early hearing detection and intervention systems.

Design: Intervention mapping (IM) is an approach to behavior change that is typically used in public health initiatives. This six-step process walks health program developers, researchers, and policy makers through a rigorous research and community-based approach to understanding why a health concern or problem is present in a community. When using IM to address lost to intervention in Early Hearing Detection and Intervention programs, the focus is on why families choose to not enroll in early intervention services covered by part C of the Individuals with Disabilities Education Act of 2004 after identification of their child as D/deaf or hard of hearing.

Results: This process culminated in the development of "Swaddling Ear to Ear" as a novel approach to the implementation of behavior change theory and early intervention access.

Conclusion: Intervention Mapping is posed to support policy makers, care providers, and families with the requisite tools to navigate early intervention services and begin a systematic line of research working to access barriers to care and access inequality for newborns identified via Early Hearing Detection and Intervention programs across the United States. The educational program designed and described here is currently under evaluation.

Keywords: Early hearing detection and intervention, IDEA, Intervention Mapping, Public Health

Acronyms: EHDI = early hearing detection and intervention; IM = intervention mapping; LTI = lost to intervention

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What is EHDI?

Early Hearing Detection and Intervention (EHDI) programs work to screen the hearing of all newborns, identify children who are D/deaf or hard of hearing, and support access to early intervention services with families (Early Hearing Detection and Intervention Act, 2017). These programs typically fall in line with the recommendations of the Joint Committee on Infant Hearing (JCIH, 2019) to screen the hearing of all newborns before they are one month of age, ensure that all children who refer on this screening receive a diagnostic evaluation by three months of age, and those identified as D/deaf and hard of hearing receive early intervention services by six months of age. Early intervention services include a wide range of supports tailored to meet the family's needs and can include the support of audiologists, speech language pathologists, sign language instructors, Deaf mentors, teachers of the deaf, and many more (Individuals with Disabilities Education Act, 2004). These services can be provided by various state agencies under Part C of the Individuals with Disabilities Education Act or those procured privately by families from community providers (Centers for Disease Control and Prevention [CDC], 2021; Individuals with Disabilities Education Act, 2004). Although EHDI programs are called for and funded at the national level as a part of public health law, within required components, each state can build its program to meet the specific needs of its community (Individuals with Disabilities Education Act, 2004).

The success of EHDI programs in the United States during 2019 resulted in the screening of over 97% of births and the identification of 5,934 children as D/deaf or hard of hearing. However, only 3,662 (less than 2/3 of those identified) are reported to have accessed early intervention services (CDC, 2021). This creates a critical population of those who were lost to intervention (LTI). The LTI population is comprised of individuals and families that have been identified as having a potential developmental risk factor and are not accessing the supports to ensure linguistic and emotional development. From a philosophical standpoint, LTI is in direct conflict with the intervention goals of EHDI and negates the success of screening and diagnostic efforts for those who are LTI. The value in screening and identification of children who are D/deaf and hard of hearing is tied to the positive impact that timely identification has on intervention services and supporting the linguistic and emotional development of the child and their families (Yoshinaga-Itano, 1999, 2003, 2013). When children are LTI they have been successfully screened and identified, but that information does not transition into actionable steps and supports. The screening and diagnostic information loses much of its potential impact and value.

With this conflict within the EHDI system, those who are LTI represent a critical breakdown in the support and facilitation of accessible information for children who are D/deaf or hard of hearing and their families. Kingsbury and colleagues (2022) highlight that the language used to discuss when families and children do not make it to the next clinically indicated step does not separate the population of those who are LTI and those who have been found to require a diagnostic evaluation. It is critical to recognize the experiences and needs of families who are LTI are unique to those who have been identified as D/deaf or hard of hearing. Recent work on LTI has highlighted that online information for families preparing to enter early intervention (those on the verge of being LTI) is not written in a manner that is linguistically accessible or in alignment with federal readability guidance (Woodruff & Cienkowski, 2021). Inaccessible information about early intervention compounds with these highly personal decisions across five main domains: family culture, family experience, perceived barriers, perceived benefits, and perceived vulnerability to exacerbate misinformation and misinformation that prevents service access (Woodruff & Cienkowski, 2022b). There is now a critical need to address the challenge of LTI by infusing new research on this population with existing information about the successful implementation of public health programs.

What is Intervention Mapping?

Intervention Mapping (IM) is a protocol that walks through program development to support community-centered, research-driven, and theory-based interventions (Bartholomew Eldridge et al., 2016). This step-by-step protocol has a history in public health as a means of designing and evaluating intervention to change health behavior around topics such as preventative medicine, cardiovascular health, and cancer (Majid et al., 2018). The six steps (Figure 1) that make up IM are a means of making sure that research questions and approaches are consistent with behavior change theory, as well as what clinical providers need and families deserve (Bartholomew Eldridge et al., 2016). This function-driven education makes the use of IM more applicable and supports the use of articles, like this one, detailing the application of the approach within the realm of EHDI.

Purpose

Walking through the individual steps to apply IM to LTI within EHDI chronicles the novel, yet merited use, of the IM procedure. Documenting the multiple components to the application of IM within this area also serves to delineate the level of rigor inherent in this type of work. Future works looking to capitalize on the literature about behavior change in public health may use this article as a formula for the application of IM to topics within the realm of supporting children who are D/deaf or hard of hearing and their families. This article will further the conceptualization of EHDI as an interdisciplinary service, specifically inclusive of public health services and theory.

Intervention Mapping Steps

Step 1

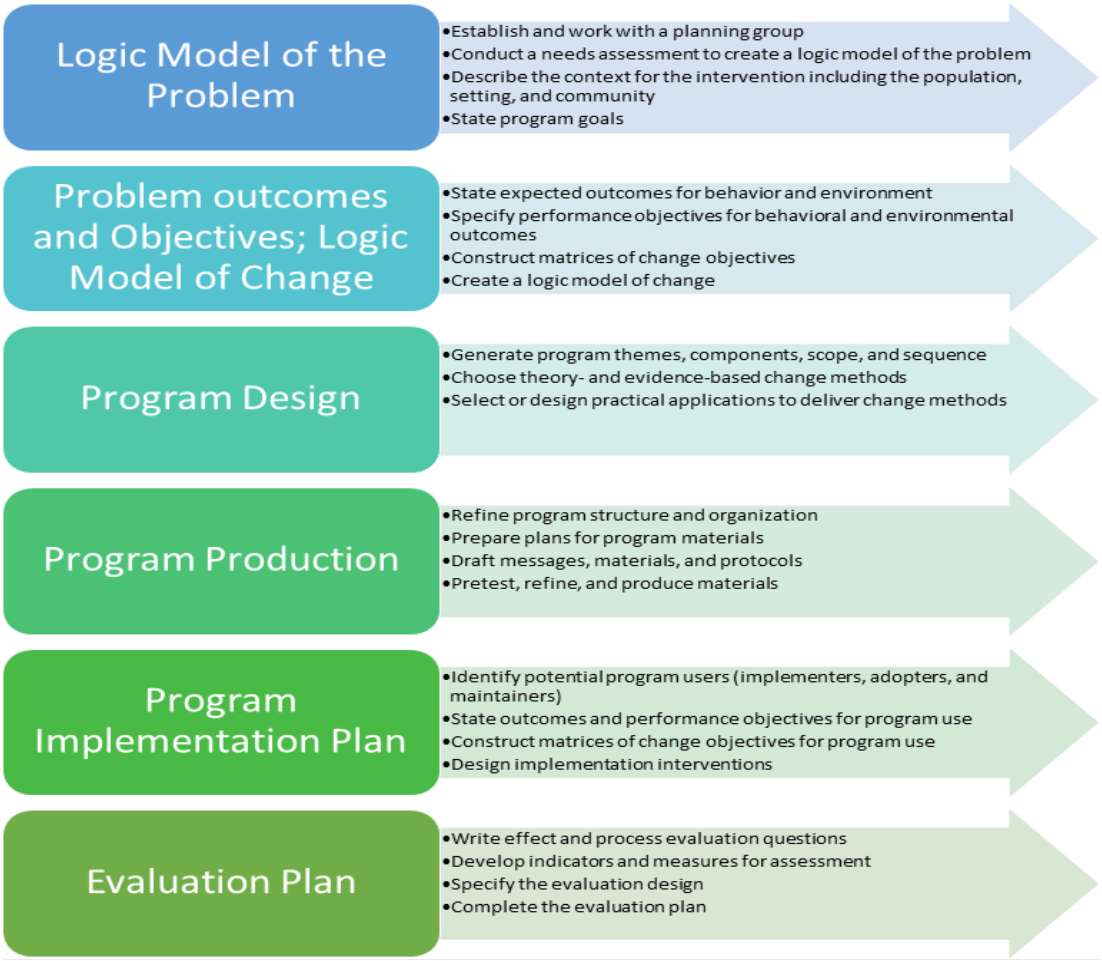
Step 1 of IM explicitly calls for the development of a working group of experts to come together to state the goals of the program (Bartholomew Eldridge et al., 2016). The working group should include individuals from a range of stakeholder groups and specialties that are primed to address the health concern in question (Bartholomew Eldridge et al., 2016). The working group for the current study included experts in the following areas: IM, early intervention in speech language pathology, aural rehabilitation, qualitative research methods, developmental disabilities, and parent education. Additional consultations through this process were made by (a) a culturally Deaf adult who identifies as a racial and linguistic minority and (b) the parent of a child who is under the age of three.

Members of the working group were educated on the problem of LTI by Torri Ann Woodruff-Gautherin through multiple meetings, written documents, and a culminating dissertation prospectus and grant application. To support understanding of LTI and begin the theory driven process of IM, a logic model of the problem for LTI was developed based on the framework from Bartholomew Eldridge et al. (2016; Figure 2). A logic model is a visual representation of the personal determinates and environmental factors that lead to a health problem. In this case LTI, and the larger quality of life concern of this health problem, leads to language deprivation.

This logic model highlights the personal determinates that are relevant to LTI and reinforces that there is a causal relationship between family culture, family experiences, perceived vulnerability, perceived benefit, and perceived barriers of EI and the experience of language deprivation by children and families who do not get the support they are entitled to as a part of EI (Woodruff & Cienkowski, 2022b). The working group of interdisciplinary professionals listed in the acknowledgments collectively accepted

Figure 1

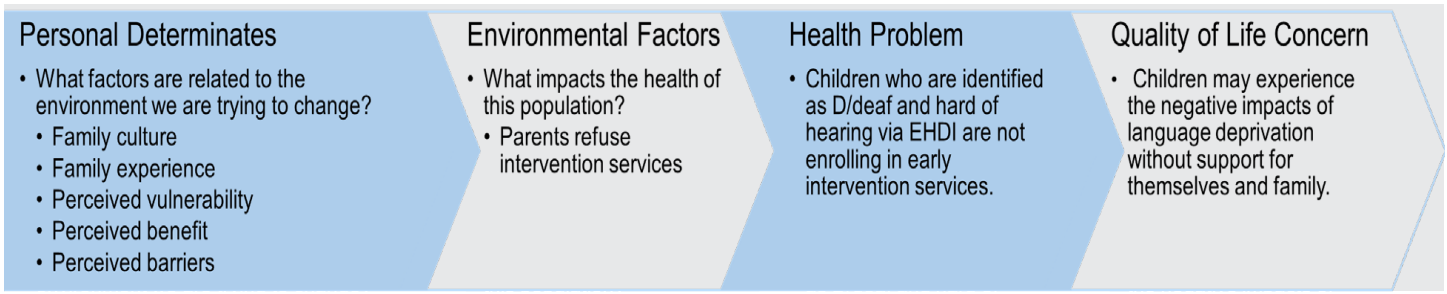
The Six Steps of Intervention Mapping



Note. The information has been adapted from Batholomew Eldridge, L. K., Markham, C. M., Ruter, R. A. C., Fernandez, M. E., Kok, G., & Parcel, G. S. (2016). *Planning health promotion programs: An intervention mapping approach* (4th ed.). Jossey-Bass & Pfeiffer Imprints: Wiley.

Figure 2

Logic Model of Lost to Intervention



Note. Information was adapted from Woodruff, T. A., & Cienkowski, K. M. (2022b). Modeling lost to intervention in early hearing detection and intervention: A modified eDelphi study. [Manuscript submitted for publication]. Department of Speech, Language, and Hearing Sciences, University of Connecticut. EHDI = Early Hearing Detection and Intervention.

the purpose of increasing access to early intervention services through one-on-one parent education for families of children who are D/deaf or hard of hearing. Members provided feedback on the approach to modeling during group meetings as well as individually in some cases. As such, the goal of this program is to address LTI within the state of Connecticut using novel behavior change methods with parents and caregivers to children who have recently been identified as D/deaf or hard of hearing.

Step 2

With the logic model established, the focus of IM moves to individual steps outlined by Bartholomew Eldridge et al. (2016), rather than overarching topics and challenges. The next product is a matrix of performance and change objectives. Performance objectives are the smallest steps that can be taken in this order toward addressing LTI (Bartholomew Eldridge et al., 2016). Some examples are shown in Table 1, column A. Each one of these performance objectives is then crossed with the determinates that were identified in Figure 2. Crossing the performance objectives with each determinate creates a cell in Table 1 where a change objective can be created. Change objectives are the outcomes from the intervention that work to move through the performance objectives while systematically addressing the determinates (columns B and C of Table 1. The goal of combining performance objectives with determinates to develop change objectives is to have distinct skills that participants can demonstrate as a means of having outcome measures for the program and a systematic approach to addressing all facets of the health problem.

Step 3

Once the individual expectations for each participant across all determinates and performance objectives have been identified, the mechanisms to engage each of these change objectives must be selected (Bartholomew Eldridge et al., 2016). Step 3 represents a critical shift in how IM pushes LTI interventions compared to that of current scripting or programs to address lost to screening or identification, given the interactive component with parents and the focus on theory-driven topics (National Center for Hearing Assessment and Management, 2010). This interaction addresses parental disengagement directly by developing an environment where engagement in the educational module is expected and creates an opportunity to practice engagement skills, consistent with the foundational practices of early intervention and the parental behaviors required to enroll in intervention services.

Step 3 develops the mechanics of how the intervention will be implemented with participants. The intervention materials created are focused on transitioning the participant from an educational setting to a point of critical thinking and empowerment to ensure the coordination of services to support access. Each activity to elicit the completion of the change objective is derived from behavior change theory as it relates to the determinate being addressed. Table 2 shows the linkage of a few change objectives and the research-backed approach to changing that at the cognitive level (Bartholomew Eldridge et al., 2016). We called our intervention *Swaddling Ear to Ear* and focused on supporting families in the process of accessing early intervention service. The ultimate goal of Swaddling Ear to Ear is to ensure enrollment in Early Intervention. Once engaged in EI, families will be able to collaborate with self-advocates, professionals, other families, and stakeholders to build the constellation of services that best supports children and families.

Step 4

In Step 4 of IM, the planning moves from theory-based to physical production (Bartholomew Eldridge et al., 2016). We selected online as the method of dissemination. Although there is work to support the use of tangible reminders and reinforcers to elicit behavior change, the unique public health climate of this program could not be ignored. With COVID-19 at the top of many Americans minds and the continued variability in safety for gathering and physical contact, online dissemination methods allowed for the creation of materials that were accessible regardless of current public health guidance. Also, building an online resource to move in tandem with the educational program increases the reach possible for the information. The website itself was built in Google to have compatibility with a variety of web enabled devices, including cellphones. With over 91% of the United States population having access to the internet through their cellphone, this confounding barrier is limited (Statista, 2022).

Table 1

Matrix of Change Objectives

A	B	C
Performance Objective	Determinants	
	Family Culture	Family Experience
Respond/Answer attempts to connect from Connecticut Early Intervention before the child is 6 months of age	• Explain the language used in the home and describe how to request interpretation services. • Describe the unique role of each person in the family as it relates to the Early Intervention (EI) process.	• Express confidence in ability to discuss child's development, needs, recommendations, and current concerns of families and providers. • List the different ways that EI may contact the families. • Add the state hotline for EI referral to phone or address book. • State that their child is at risk for language deprivation as a result of their hearing loss if not addressed through intervention.

Table 2

Change Objectives and Research-based Methods to Address Needs

Change Objective	Method
Add the state hotline for EI referral to phone or address book.	Guided Practice/Implementation Intention
Connect experiences with strengths-based observations provided from other families.	Cultural Similarity
Demonstrate record keeping by retaining notes from the call with EI and appointments in a dedicated handbook.	Chunking/Advanced Organization/Imagery/ Guided Practice/Implementation Intention
Demonstrate the ability to interpret their child's audiogram including type, configuration, and recommendations.	Direct Experience/Guided Practice
Describe the unique role of each person in the family as it relates to the EI process.	Implementation Intention
Diagram the number of different steps of EI referral.	Direct Exposure
Explain the importance of developmental needs and the impact of delayed intervention/language deprivation.	Fear Arousal/Personalized Risk
Express confidence in ability to discuss child's development, needs, recommendations, and current concerns of family and providers.	Role Play
Identify what logistical supports will be needed to meet needs.	Implementation Intention/Guided Practice/ Discussion
List local family support services available in their town or county.	Implementation Intention
List the benefits of EI compared to not accessing services.	Personalized Risk
Match the job title of common EI providers with their general job descriptions, roles, skills, and value of involvement.	Direct Experience/Personalized Risk/Verbal Persuasion
State that EI will only contact them/provide services if they provide consent.	Discussion
State that the family is the most important component of the EI system while working to ensure that children who are D/deaf or hard of hearing do not experience language deprivation.	Repeated Exposure

Note. EI = Early Intervention

Within the website a color scheme and simple branding (Figure 3) were selected to support participants in associating the key components of enrolling in early intervention with their daily lives. The four steps to enrolling in early intervention (knowing your eligibility based on hearing test results, connecting with the service, making relevant appointments, and staying engaged) were each assigned their own graphic and color that permeated the webpage. This consistency and repetition in message are consistent with behavior change work as a whole (Bartholomew Eldridge et al., 2016) and specifically with regards to barriers to early intervention access in EHDI (Woodruff & Cienkowski, 2022b). Once the general structure of the four steps were selected, each step had its own webpage created that featured a graphic organizer at the top of the page with key points and the associated symbol. Below this graphic organizer were prompting questions to help families navigate through the functional steps of addressing these key points.

In line with national recommendations, each page was reviewed for readability to ensure it was written at a 6th

Figure 3

Branding Used for Program

Note. SETE = Swaddled Ear to Ear.

grade or below reading level (Safeer & Keenan, 2005; Sax et al., 2019; U.S. Department of Health and Human Services, n.d.; Weiss, 2006; Woodruff & Cienkowski, 2021). An online accessibility expert was brought on to review all pages on the site for screen reader compatibility and visual contrast acceptability. The videos posted were ensured to have accurate captioning and all images included an image description. Consultations with the parent of a child under the age of three, a culturally Deaf adult with experience in social services for children who are D/deaf and hard of hearing, an IM expert, skilled providers of early intervention services for children who are D/deaf and hard of hearing (audiology, speech-language pathologist, teacher of the deaf) and an individual working at the state-level to implement EHDI were also completed to ensure accuracy of information and presentation. Given that this is a pilot, it is anticipated that following the completion of this study, materials will be further refined by future users.

Steps 5 and 6

Steps 5 and 6 of IM focus on taking the program that is developed in Step 4 and ensuring that it is applicable to the population of interest (Bartholomew Eldridge et al., 2016). Given the unique position of EHDI as a system called for at the federal level but devised to be responsive at the state level, the processes of Steps 5 and 6 should be developed in conjunction with the individual EHDI program and community where the program will be implemented. These steps used in the state of Connecticut are covered by Woodruff et al. (2022a).

Step 5: Development of an Implementation Plan for the Adaptors, Implementers, and Maintainers of the Program

The goal is to ensure that the intervention will be agreeable to those who will use it (Bartholomew Eldridge et al., 2016). An effective intervention requires developing a list of all potential users (implementers who will deliver the messaging, adaptors who will create the community's structure for the program, and maintainers who will keep the program running over time). These individuals will need their own outcome and performance objectives along with change objectives for the use of the program.

Step 6: Point of Evaluation for the IM Protocol

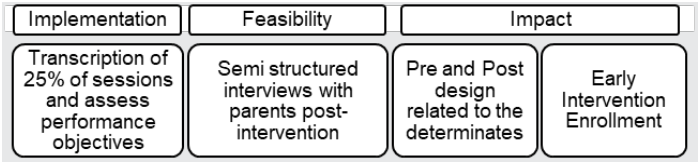
The outcomes for each IM program will be different and need evaluation (Figure 4; Bartholomew Eldridge et al., 2016). For Swaddling Ear to Ear, as a novel behavior change program focused on changing perceptions of early intervention to support engagement for children who are D/deaf and hard of hearing, the evaluation must look at outcomes in terms of behavior and perception of early intervention. Fidelity of the implementation, the function of the implementers (who they are, the training of the implementers, and implementer oversight) is critical to ensure consistency of the program and the control of outside variables. Woodruff et al. (2022a) will cover the evaluation of this program along with more expansive qualitative examples of the content designed for this population.

Swaddling Ear to Ear: Addressing LTI in EHDI

Swaddling Ear to Ear represents the first time that IM has been used to address LTI in EHDI. As a program, Swaddling Ear to Ear is delivered on a one-on-one basis in virtual format. The implementer trained in the program leads a hands-on practice session covering skills related to advocacy. A link to the family-facing website that accompanies this educational session can be found at https://sites.google.com/uconn.edu/early-intervention-swaddling/home?authuser=1. This website includes primarily the educational materials used in the session with the implementer leading the hands-on sessions. The semi-structured script used by the implementer is in the Appendix. An abbreviated example with actors of what one of the hands-on session can look like can be found at https://kaltura.uconn.edu/media/Swaddling+Ear+to+Ear/1_yyfxlz64.

Figure 4

Evaluation Plan for Program



Conclusion

Intervention Mapping exists to bridge the translational gap between behavior change theory, research on behavior change interventions, and public health initiatives (Bartholomew Eldridge et al., 2016). Within EHDI, there is a need to translate what research tells us about the benefits of early intervention into information that is useable by parents and providers when making enrollment decisions. Further, this need is best addressed at the level of the family with the input of system stakeholders, as IM supports. Tapping into IM's history in public health, the application of it to EHDI reaffirms that since EHDI is governed by public health law, it can and should be viewed as an interdisciplinary concept inclusive of public health principles. The inherent connection between IM and public health uniquely poises it to capitalize on the strong tradition of and legislative push for parent, advocate, and professional input on program development in EHDI (Early Hearing Detection and Intervention Act, 2017).

Although Step 6 of IM was described in this article, the actual evaluation of Swaddle Ear to Ear has not yet been completed. It is critical that programs that are developed through IM be subjected to evaluations with quantitative and qualitative rigor to assure the feasibility, fidelity, and utility of these programs. Evaluation procedures provide EHDI programs with publishable data that may be useful for other state programs that are looking to better embody the goals of EHDI while addressing LTI. While under-represented in the literature, these evaluations are critical to ensuring the credibility of IM and further evidence-based work in EHDI to support children and families.

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Appendix

Semi-structured Script for Implementer

Thank you so much for signing up for today! Today we will be using this website and the pages you sent earlier like these. Do you have any questions before we start?

I will tell you a little about me, you can ask me questions, and then I want to know your family.

Name

Student at UConn

Working with Torri

Today we are going to be talking about early intervention for your baby. What is important to know is that everyone you meet on your journey wants to and has to make themselves easy to understand. That can mean getting an interpreter, repeating things, or asking for something to be written down with drawings or handouts. We will be going to this website and I am also sending you a workbook with everything we talked about so that you can look at things again later if you have questions or bring them to your audiologist to use when talking.

Tell how to get to website.

HEARING TESTS

Tell how to navigate to this page.

Hearing differences are not common at birth. Many people may have never met someone with hearing different than themselves.

What experiences does your family have with hearing?

Probe looking to see if they have experience—if yes

What were those interactions/experiences like?

Look to create either positive associations (telling good stories) or create cognitive dissonance between the negative experiences they report and the positive things they plan to do with their baby.

What do you think contributed to that?

If no—normalize that many people do not and that this gives them the opportunity to learn more about hearing.

We asked these types of questions to some people who are similar to you or know people like you. And the things you are feeling are normal.

There has been a lot going on in your life since your baby joined the family! Who have you met related to your baby's hearing?

IF having trouble - Some people you might have met are:

Audiologists

Pediatricians

Hearing Screeners

Each of these people has different but related jobs.

You have seen a lot of people at this point and know different names or phone numbers. If you have any papers, please grab those too! We will add everyone to your phone and figure out what they do for you and your family.

Add each person they already met to their phones.

The next thing I want to chat about is your hearing test and the form they filled out for you. This is called an audiogram and is how your baby's hearing is shown. I think Melissa does a nice job reminding us what an audiogram is.

VIDEO

This is a lot to remember! You can watch this video whenever you want. Audiologists go to school for 8 years to be able to do this! I have this handout for you with a link to that video to review it if you want to later.

What does that mean for when they are learning to communicate?

Go through the audiogram - For a language that uses speech, if they don't have access to high frequencies they might not use *s* or mispronounce words. If they don't have access then they might not develop spoken language.

This isn't going to be the only audiogram your baby gets. As your baby gets older, you will need them less often, but for the next few months, you are going to be with your audiologist a lot. What makes it easier or harder for you to get to these appointments?

For each concern the family brings up, nod, tell them it makes sense, and offer a solution/support from the central 211 line.

Also we have that list in their download.

A lot of the things you mentioned are challenges many families face. You have a newborn! Some big concerns from other families are:

Getting to appointments: There are programs that will pay you back for the miles you drive.

Getting time off of work: Appointments are made around your schedule! People can come to your home or the child's daycare.

Finding child care for siblings: At-home appointments can be done with your whole family there, it is encouraged! We will also work to build a community around you to help with these types of challenges.

Affording this: In Connecticut, early intervention from the state is free. There are also groups that can help you learn sign language, get hearing devices, and much more for no or less cost.

Not understanding what people say: You are the most important person in your child's life. Ask questions. Get hand-outs. Ask for interpreters. All of these are things that you are entitled to. There are also parent organizations who are here to help you understand everything that is going on.

Not feeling ready or sure: This can be a confusing time. All you want to do is love on your new baby. Everyone you are meeting wants to help you and your baby grow. Share what you are feeling with those around you. There are ways to connect with parents who have taken this journey and learn from them.

CONNECT

Tell how to navigate to this page.

You might hear the term language deprivation to describe when someone does not have language access. This does not mean that you are taking anything from your child! All it means is there isn't language access.

Early Intervention services can mean a lot of things when supporting language, and it all depends on what you as a family WANT for the baby. You might also hear it called EI or Birth to Three. These are all the same thing, and you can get them for free in Connecticut because of your baby's audiogram.

Some common things that families ask for to meet goals are:

Hearing Evaluations

Speech and Language Therapy

Sign Language Instruction

Hearing Aids/Cochlear Implants

Family Support Groups

and anything else that the child needs to grow.

What are some of your goals for the baby?

List 3 to start, encourage them!

If you go back into your phone, scroll back to the first contact we put in NAME, and let's write down what goal they can help you with as a note in that contact.

As you open up each contact you can also "link" them to the other providers you know.

Now that we know what early intervention is, it is time to talk about getting it! There is a process for getting early intervention, and everyone involved wants to give your family what you need.

This picture shows how to get early intervention. Since you are in control of early intervention, I thought we could run through how it might go. Who in the family will be in charge of making the appointments and contacting early intervention? Do you have 211 saved on your phone? Great, we are going to do a practice call.

(If one person, have them take on the parent role and the facilitator will be the operator. If 2 people, the person calling is the parent and the one not calling is the 211 operator with the list of questions to ask as seen in the diagram.)

What is important to know is that you are in charge of every step. No one will contact you if you don't agree, and you can ask for as much or as little help as possible.

Early intervention and the phone numbers that you have saved are not the only people here to support you. Who in your family and friends do you feel comfortable talking with or asking for help?

Congratulate for naming people and probe what they think might be the most helpful to ask each person to do.

Talk about family supports.

APPOINTMENTS

Tell how to navigate to this page.

Once you have contacted early intervention that first time, things will move very quickly! You will need to answer your phone when people call—even if you do not know the number. The goal will be to make sure that your family is getting all of the services you want, by the time your baby is 6 months old.

DESCRIBE DIAGRAM and congratulate that they are already ⅔ of the way done.

If we look back on your goals for the baby, each one of those will have a meeting and provider connected to it. We can use this to walk through all the steps, who you will contact, and what that process will be like.

Discuss each point—this is planning intention and key

For when—have them set reminders on their phone

That can be hard to do when you are trying to learn all this information and take care of your baby. With that, I thought we could do a practice of what that might look like. You can ask me a specific question about what we have covered, a goal you have, or a question you want to answer, and I will explain in a "not so clear" way. You should stop me to ask questions, get additional materials, or take notes. This will help you hear the information again and get you used to advocating for your baby!

KEEP GROWING

Tell how to navigate to this page.

Once you are in early intervention, everything is set up to get you where you want to be. With that, you will have to advocate for your baby.

That is a pretty big task. To help wrap your head around that, I want to go over how you advocate. To get that started, you will see that the final page of your download is a "family plan of care." This will be able to go into the front of your planning so that you have all the tools you need to advocate. We will go over this form together, fill it out and consider what it would be like to start a conversation using it.

Talk through and make sure each line is understood—basically what is your role? Then How do you ask for help? Then How do you educate? And such

Ask "How do you start a conversation when you need someone's help?"

Congratulate any step towards advocacy.

Reminder about asking for better explanations, things in writing, interpreters, and such

A reminder that people have to give them this—it is the law.

Reminder they are not alone and do not have to advocate alone—parent groups.

The most important thing for you to know is that you control this. Everyone you meet is here to help you learn. If you ever think the person you are talking to is unclear, you should ask for an interpreter, take-home materials, and follow-up questions.

We have talked about a lot today and have tried to set you up for everything. How can we get through this to-do list?