

Early Childhood Hearing Screening: Not Just for Newborns Any More



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Introduction

Over the past two decades, tremendous progress has been made in ensuring that newborns in the U.S. receive a hearing screening shortly after birth. This represents a significant achievement in that approximately 1 to 3 children per thousand are being identified with hearing loss shortly after birth that can potentially receive the benefits of early intervention. It is important to remember, however, that of the nearly 2% of children who do not pass the newborn screen, approximately half cannot be documented as having received diagnostic or intervention services (Centers for Disease Control and Prevention, 2007). Added to that, injury, illness or genetic factors can cause hearing loss at any time in a child's life and by school age, approximately 6 to 7 per thousand can be expected to have a permanent hearing loss (Bamford, et al., 2007, National Institute on Deafness and Other Communication Disorders, 2005).

Many parents erroneously assume that their child's hearing is being checked periodically as part of routine well-child visits. In reality, however, health care providers look for common middle ear disorders, but are typically unable to screen for permanent hearing loss. Consequently, the majority of children do not receive any additional hearing screening beyond newborn screening until they are in school.

This article will discuss recent progress in early childhood periodic screening and will review how EHDI professionals, pediatric audiologists and speech-language pathologists can contribute to the development of periodic hearing screening in early childhood programs by: 1) Introducing objective hearing screening; 2) Identifying the most appropriate screening method and equipment; 3) Establishing a screening protocol; 4) Determining who should conduct the screening; 5) Establishing a tracking and follow-up system; 6) Conducting training; and 7) Monitoring program quality.

Recent Progress in Periodic Screening and Opportunities for EHDI Involvement

One setting in which a number of young children are already receiving annual hearing screenings is in Head Start programs that serve economically disadvantaged children. Recognizing that hearing health is central to language development, educational achievement and

socialization, Head Start has demonstrated a long-standing commitment to sensory screening (O'Brien, 2001; U.S. Department of Health and Human Services, 2007). No specific guidance on appropriate hearing screening methodologies has been issued; therefore each local program relies on advice from their own Health Services Advisory Committee. Unfortunately, individuals on these local committees may know little about current hearing screening practices and many Head Start programs continue to employ outdated, subjective methods such as hand clapping, noisemakers, and parent questionnaires (Munoz, 2003).

Since 2002, the Office of Head Start has funded initiatives carried out by the National Center for Hearing Assessment and Management (NCHAM) to help Early Head Start, Migrant/Seasonal and American Indian/Alaska Native Head Start programs to update their hearing screening practices for children 0 – 3 years of age using Otoacoustic Emissions (OAE) technology. As a result, more than 20 states have established Early Childhood Hearing Outreach (ECHO) training teams led or supported by pediatric audiologists and EHDI Coordinators. Data gathered on screening and follow-up suggests that approximately 2 of every 1000 children screened in early childhood settings are being identified with a permanent hearing loss and an additional 18 children per 1,000 are being identified and treated for transient conductive hearing loss (Eiserman, et al., 2008).

The fact that Head Start programs are already routinely conducting hearing screening presents a great opportunity to expand EHDI outreach well beyond newborn screening. Forming partnerships with Head Start and other early childhood programs is a viable way to enhance a state's overall EHDI efforts while at the same time providing critical information to early childhood programs on appropriate hearing screening methods and models. It is important to note that the number of children 0 – 3 years of age being served in Head Start programs nationwide continues to grow. Depending on the guidance they are given, programs serving these children will either implement reliable hearing screening practices or may fall back on outdated strategies.

The materials developed and "lessons learned" as a part of the Head Start ECHO Initiative are described below and can be utilized by anyone interested in supporting the implementation of

appropriate, periodic hearing screening practices for children 0 – 3 years of age in a variety of early childhood educational and health care settings.

Implementing an Early Childhood Hearing Screening Program

When working specifically with Head Start programs, it is valuable to contact the Head Start State Collaboration Office to coordinate activities within a given state. It is also important to discuss and coordinate implementation plans with all relevant individuals within the state EHDI program. A helpful, informative PowerPoint presentation is available at: <http://tinyurl.com/IntrotoECHO>. Strategically sequencing outreach efforts, rather than attempting to provide training and support to all early childhood programs in a state simultaneously, is often wisest approach. Enlist a few individuals who are particularly interested in supporting periodic early childhood hearing screening and link them with specific Early Head Start programs that are eager for assistance. One of the most valuable resources that EHDI professionals can typically offer to Head Start programs is contact with and support from pediatric audiologists in their local areas.

A number of program components that EHDI professionals should discuss with early childhood care providers in implementing successful hearing screening programs with children 0 – 3 years of age are outlined below.

Introducing Objective Hearing Screening.

One of the first steps an audiologist or EHDI professional can take in promoting periodic hearing screening is to share the value of early identification of hearing loss. Although Head Start programs already have a federal mandate to ensure that all children receive a hearing screening, staff may not fully appreciate how high-quality screening and follow-up practices result in accurate identification and appropriate services. It is important to point out that when permanent hearing loss is identified early in a child's life, the detrimental effects of that loss can be minimized significantly through appropriate intervention and support. Periodic hearing screening in early childhood also helps to identify other conditions, such as otitis media, that may cause some degree of hearing loss and may potentially disrupt language acquisition and cognitive and social development.

Staff may need guidance in understanding that some screening techniques are inappropriate and inadequate, including subjective screening methods, reliance on newborn hearing screening outcomes beyond the first year of life, or medical records indicating an ear exam was completed (which typically includes only visual inspection). Ensuring that programs are committed to providing quality periodic hearing screening, using up-to-date methods throughout the early childhood period, is the first step in developing a sustainable screening program.

Identifying the Most Appropriate Screening Method and Equipment.

Audiologists and other EHDI professionals typically need to be involved in identifying the most appropriate screening method available for the population being served and the equipment that is the easiest and most reliable for lay screeners to use.

When screening infants and toddlers 0 – 3 years of age for hearing loss, Otoacoustic Emissions (OAE) is usually the optimal tool because it does not require a behavioral response from the child and is quick, painless, portable and reliable. Audiometry has traditionally been the preferred method for screening older children who are developmentally mature enough to respond to instruction and provide a consistent behavioral response. There are, however, many children 3 - 5 years of age who have developmental delays or difficulty following directions and are therefore unable to complete pure-tone audiometric screening. Thus, for a large percentage of young children, OAE is the most reliable screening method (see Figure 1).



Figure 1.
Child being screened using OAE technology.

A 7-minute video introduction to OAE screening can be found at: <http://tinyurl.com/oeaintrovideo>.

Audiologists who have used OAE equipment exclusively in nursery or diagnostic settings may be surprised to learn that it can also function effectively in educational, home and health-care environments. In addition, non-audiologists who are skilled at working with children can learn to use the technology effectively. It is always important for screening staff to be reminded that screening is not equivalent with a comprehensive audiologic evaluation. Children who manifest ongoing problems with verbal comprehension or speech production, as well as those who do not pass the screening, should be referred to a pediatric audiologist for a comprehensive assessment.

One caveat to keep in mind when assisting programs is that not all screening equipment used with newborns is equally well designed to screen infants and toddlers in early childhood environments. In addition to overall cost of the equipment and associated disposables, key elements in equipment selection include:

- The capacity to screen quickly in settings where there is modest amount of ambient sound.
- A probe that stays seated firmly in the ear canal when a child is in an upright or a prone position. (Disposable foam tips that compress and conform to the ear canal are typically easier for lay screeners to use than plastic covers that have to be matched more precisely to individual ear canal size.)
- Easy-to-understand displays that convey screening results and prompt screeners on what to do if the screening is not proceeding.

Specifically, prior to buying equipment, a program's hearing screening coordinator may want to work with a local audiologist to arrange with equipment vendors to obtain several different brands of portable OAE equipment on loan for a short period of time. During the loan period, the audiologist and program staff can systematically try the equipment with children of different ages and vary the conditions under which the screening is conducted. It is extremely important to note that well-designed OAE screening equipment should allow the screening to be conducted successfully in the child's natural environment. Very loud sounds, such as a child crying or manipulating a very noisy toy nearby, may make it difficult/impossible to complete the screening, but in general, the sound of children talking or laughing within the room should not

interfere significantly with being able to complete the test. This is significant because helping very young children to feel comfortable with the overall screening procedure is one of the most important factors in screening success. The process of trying out equipment in a "real world" environment will allow programs to purchase equipment that is able to perform well under a variety of screening conditions and with a variety of children. A more detailed list of equipment selection criteria can be found at: <http://tinyurl.com/equipmentevaluation>.

If programs need assistance finding funding to purchase equipment, a template that can be helpful in applying for funding can be found at: <http://tinyurl.com/minigranttemplate>.

Establishing a Screening Protocol. An effective OAE screening protocol balances the risk of over-referring children for assessment against the need for timely referrals. In other words, programs will not want to refer children for further follow-up based on screener error or temporary conditions that will naturally resolve within a short period of time (such as common head colds). The multi-step screening protocol, shown in Figure 2, is similar to the two-step protocol often used in hospital-based newborn screening programs with the exception that a health care provider is often involved in resolving common, temporary middle ear conditions prior to referral to a pediatric audiologist.

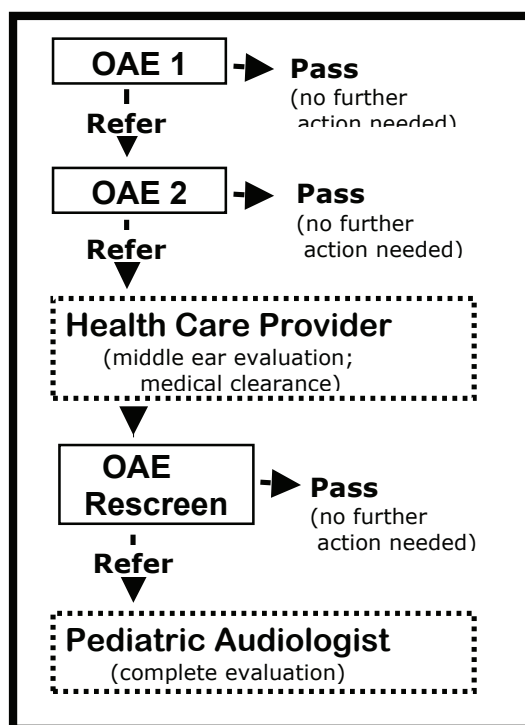


Figure 2. OAE Screening Protocol.

- 1) All children receive an initial OAE screening (OAE 1). Approximately 70 – 75% of children in the 0 – 3 age group can be expected to pass the screening on both ears, with 25% - 30% requiring a second OAE screening.
- 2) Children not passing the OAE 1 are screened again (OAE 2) within two weeks. Approximately 8% - 10% of the total number of children screened initially will not pass either the first or second screening and will therefore need to be referred to a health care provider for middle ear evaluation.
- 3) Children referred from the OAE screening should be evaluated as soon as possible by a health care provider for conditions affecting the outer or middle ear (such as otitis media or impacted ear wax, common causes of an OAE refer). Screening staff will need to communicate with the health care provider about the diagnosis and treatment process so that when medical clearance is given (e.g., observable conditions interfering with OAE screening are no longer present) the child can receive an OAE Rescreen. (Note: If screening is being conducted where health care providers are present, the protocol may be streamlined with a middle ear evaluation being performed immediately upon referral from OAE screening.)
- 4) Children not passing the OAE Rescreen, when the outer and middle ear are clear, are referred to a pediatric audiologist for a full diagnostic evaluation. Less than 1% of the total number of children screened typically requires referral to a pediatric audiologist.

Adherence with completing the screening and follow-up protocol within an appropriate time frame is critical to program success in identifying and treating children with hearing health needs.

Determining Who Should Conduct the Screening. EDHI professionals should be aware that health specialists, nurses, home visitors and teachers can all successfully conduct OAE screening. The most important quality is an individual's ability to work effectively with young children. More than one screener should be trained in a given program to help ensure continuity when personnel turnover occurs. At the same time, limiting how many individuals are trained increases competence because screeners have the opportunity to refine their skills by working with a significant number of children. Home-based and center-based programs may also have different needs depending on the

access that screeners have to children. Thus, there is no specific formula for determining how many screeners or how many pieces of equipment are needed based on child enrollment. The individuals overseeing program planning need to carefully consider the protocol and the availability of staff members to implement it. In general, it is probably wisest to train a small corps of screeners and then increase the number as needed.

Establishing a Tracking and Follow-up System. Head Start programs often need assistance in establishing a mechanism for documenting screening outcomes and tracking children who need further screening or evaluation. Just like newborn screening, the success of an early childhood OAE screening program in identifying and serving children with hearing health needs is dependent on the program's capacity to accurately track children who do not pass the initial screening through subsequent, follow-up steps in the protocol. Therefore, as an initial part of program planning, program staff must think through how screening results will be documented and referrals made to ensure timely and appropriate follow-up.

Many of the generic tracking systems that are used by Head Start programs do not allow staff to enter ear specific data on hearing screening outcomes, nor to easily generate reports that help them to know which children are in need of further screening or referral. It can therefore be helpful to review the materials available at <http://tinyurl.com/OAetrackingtools> with Head Start program staff to determine whether they already have an adequate hearing screening tracking system in place or they need to take advantage of existing paper/pencil and online tools.

Head Start programs should be instructed that any children identified with permanent hearing loss are to be reported to the State EHDI Program. Some State EHDI Programs have gone a step further to develop data sharing agreements whereby local Head Start programs submit their screening outcomes to the State EHDI Program as a mechanism for closing the loop on children lost to follow-up from newborn hearing screening.

Conducting Training. Training materials used in the Head Start ECHO project, including a training video and manual, have proven to be effective in

conveying essential information to screeners in a standardized way. These materials, available in English and Spanish, can be accessed at: <http://tinyurl.com/ecresources>.

Basic training information includes:

- Purpose of OAE screening
- Overview of the screener's role
- Introduction to OAE equipment
- Use of a screening and follow-up protocol
- Equipment care and maintenance

One essential training element is the opportunity for learners to receive supervised, "hands-on" experience screening children. Training therefore needs to be held in a location where children are present to be screened so that instruction can include this practical component (see Figure 3).



Figure 3.
Trainee
learning to
screen in a
natural
setting.

It is highly desirable to have an experienced pediatric audiologist serve as a mentor and trainer. It is also very helpful to teach screeners to work in teams, with one person playfully keeping the child's attention while the other places the probe in the child's ear and conducts the screening. Each screener should have the opportunity to screen a number of children in this supportive, supervised training setting.

Monitoring Program Quality. Similarly to hospital-based screening efforts, there are a number of ways that Head Start program staff can be encouraged by EHDI professionals to monitor the quality of their screening programs:

- 1) Monitor pass rates for the initial screening (OAE 1), which should be approximately 70 - 75%. This rate may be slightly lower when screeners are first learning to screen, but

should improve over time. Referral rates may be expected to increase during cold and flu season as a larger percentage of children are likely to have middle ear issues.

- 2) Have an audiologist, or a highly skilled screener, observe screeners to ensure they are using the techniques they were taught during the training.
- 3) Monitor adherence with the screening and follow-up protocol in terms of the sequence of screening and follow-up activities (i.e., whether the steps for rescreening and referral are occurring in the recommended order) and the timing of follow-up activities (i.e., whether the steps for rescreening and referral are occurring within the recommended timeframe). The more closely programs comply with the sequence and the timing of the steps recommended in the screening and follow-up protocol, the more effective they will be in identifying children with hearing-health needs.

Additional resources, such as an *OAE Screening Skills Acquisition Checklist* and *Monitoring for Program Quality*, can be found at <http://tinyurl.com/ecresources>.

Exploring Periodic Screening in Other Educational and Health Care Settings

The future holds great potential for EHDI professionals to take the lead in a variety of venues that would allow more children to ultimately be identified with hearing loss at the earliest possible time. Some health care providers are beginning to explore the feasibility of providing OAE hearing screening as a part of well child check-ups for young children. Materials tailored specifically for training professionals in health care settings are available at: <http://tinyurl.com/healthcareresources>.

Another area of need where EHDI professionals' experience can potentially improve critical hearing screening efforts is in Part C and Part B/619 programs. Although Part C and Part B/619 Regulations require that evaluation and assessments must include hearing, no guidelines specify how that should be carried out. Many professionals erroneously assume that children being assessed in these programs receive a comprehensive audiological evaluation. That is generally not the case, however: A recent survey of 155 Part C providers from 17 states revealed that the most commonly used methods were

informal observations of the child's response to sounds/noisemakers and family-completed questionnaires. Similarly, of the 175 Part B/619 providers in 11 states who responded, 45% reported using subjective methods with the majority of the children enrolled (Eiserman, Behl & Shisler, 2009). Less than 20% of the programs reported that most of their children received a full audiological evaluation and only a quarter of programs reported that they used Otoacoustic Emissions (OAE) technology as a primary screening/evaluation method.

Although informal, subjective methods continue to be the primary hearing screening/evaluation tool used by many Part C and Part B/619 programs, research data does not support such strategies in identifying young children with hearing loss. One retrospective study found that only 25% of parents of children with significant hearing loss suspected that their child might have a hearing problem (Watkin et al., 1990). Even more worrisome, less than 10% of parents suspected that their child had such a hearing loss during infancy. Likewise, informal behavioral screening using soundmakers has been shown to be far less effective than objective Otoacoustic Emissions (OAE) screening (Chan, 2004). Reliance on outdated, subjective screening methods makes it likely that children with hearing loss will remain unidentified or receive inappropriate interventions. The materials described above for health care professionals could be readily adapted to help Part C and Part B/619 providers conduct OAE screening.

Conclusion

In the decade ahead, there will be an ongoing need, and more opportunities than ever before, for EHDI professionals to become involved in periodic early childhood hearing screening initiatives in a variety of health and educational settings. Efforts in this area will yield positive benefits in reducing loss to follow-up from newborn screening and in identifying post neonatal hearing loss at the earliest possible time.

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