(Caption Test)

This is a test.

WILLIAM EISERMAN:
For those of you who signed up early, you are in the right place for today's webinar. We will be starting at the top of the hour.

WILLIAM EISERMAN:
This is just an audio check for those of you who signed on reliever webinar today. We will be starting at the top of our webinar? We will start at the top of the hour for our webinar titled: Building on Your Experience with Evidence-based Hearing Screening Practices for Children Ages 0-5.

Again we will be starting at the top of the hour.

We will be starting here in a few minutes, this is will Eiserman from the National Center for Hearing Assessment and Management at Utah State University.

You are in the right place for today's webinar, which is an intermediate level webinar entitled Building on Your Experience with Evidence-based Hearing Screening Practices for Children Ages 0-5.

We will be starting at the top of the hour, just about four or five minutes here.

Be aware that noise webinar, like all of our webinars, is going to be recorded. So if anything disrupts your full attention to today's webinar, you will be able to stream it on our website: www.KidsHearing.org within a couple of days.

For the benefit of everyone who's signed on, we like to have a little bit of levity here as we get ready for our webinars. There is nothing like yanking each other's chains around. Technology in the ways it's challenged us over the years.

TERRY FOUST:
You have me already starting to look at what could go wrong so...

(Laughter)

WILLIAM EISERMAN:
We are going to start here in just a couple minutes, we have people signing in at a fairly rapid pace right now. So we want to give as many people a chance to get signed in and settled. As they transition from one activity to this activity.

We know everybody has more than busy schedules.

 

We are getting ready to start here now. People are signing on pretty rapidly right now, so I'm going to give it another minute or two before we actually kick off. Just so that everyone has an opportunity to adjust the volume to their liking.

This is an EHDI Intermediate Level Webinar: Building on Your Experience with Evidence-based Hearing Screening Practices for Children Ages 0-5.

Daniel, have you prepared to record today's webinar for us?

DANIEL LADNER:
Yes, it is recording right now actually.

WILLIAM EISERMAN:
Great, thank you.

We are going to give it one more minute then we will get started here.

For those of you who just signed on, I am waiting for a few other folks to sign on but I'm going to continue to chat for a minute just so everybody has the opportunity to get the volume adjusted to their liking.

You will also note there is life captioning available, which if you click live transcript on your screen you will be able to see that and adjust its position on your screen to your liking. So know that that is available.

Well, let's get started. I would like to welcome everyone to our webinar today. I'm William Eiserman and I'm the director of Early Childhood Hearing Outreach initiative also known as the ECHO initiative at Utah State University.

This webinar is being sponsored by the ECHO Initiative and the National Center for Hearing Assessment and Management.

Know that this webinar is being recorded, so if anything disrupts your attention to today's webinar, or if you think of people that might benefit from today's conversation, it will be recorded and available on our websites, both infanthearing.org as well as www.KidsHearing.org in the next couple of days. So feel free to share that webinar recording in the next couple of days.

When we are done with our presentation, we will be opening up for questions. So if we haven't anticipated and responded to questions that you have, you will have an opportunity to do that live with us today.

Then at the end of our session today, there will be a short evaluation of today's webinar, as well as a certificate generator that will allow you to produce a certificate of attendance for today's webinar.

 

As I said, the echo out -- ECHO initiative is housed within the National Center for Hearing Assessment and Management at Utah State University where I am the associate director.

NCHAM serves as the Early Hearing Detection and Intervention National Technical Resource Center, which is funded through a cooperative agreement with the maternal Child health Bureau.

Starting in around 2001, and for about 20 years, the ECHO initiative served as a national resource center on Early Hearing Detection and Intervention intervention with a focus -- with a focus on helping Early Head Start and Headstart program staff in permitting evidence-based hearing screening and follow-up practices. We are delighted to be able to continue to make our resources available as well as other learning opportunities to staff from head start programs, as well as to anyone from other early care and education settings who could put these things to use.

Now I am joined today by Doctor Terry Foust, who was a pediatric cardiologist and Speech-Language Pathologist who has served as a consultant and trainer with the echo initiative since its very beginning, so welcome Terry.

TERRY FOUST:
Thank you William, guess as William said, William and I along with other ECHO team staff, as well as many local collaborators have provided training in nearly every state with thousands of staff from Early Head Start, Head Start, American Indian Alaska Native and migrant Head Start, and other early care and education programs over the years.

We are always encouraged, as we are today, by the huge amount of interest that there is in establishing evidence-based hearing screening programs, release of the children with hearing related needs can be identified and served.

WILLIAM EISERMAN:
So we encourage you to be a spokesperson for evidence-based practices. To share what you are doing with other people, and please share our resources with others as well.

You will notice on June 21, we are having a introductory webinar that will be on the topic of evidence-based hearing screening for children birth to five years of age. You can find a link to register for that at www.KidsHearing.org. Share that with folks that really need to have that introduction. If there are folks you want to have understand what you are doing in your program, or if you want to share the evidence-based practices so you can inspire others to do the same.

Before we go on I wanted to give a shout out to our captioners today. These are real people who are keeping up with what we are talking about here, and we really appreciate their time and talents in being able to offer this service as we try to make our presentations as accessible as possible.

Today we are going to organize our time around many of the questions that you will submit it. We will present some information about these topics, and will start with a brief review for our newcomers to

 

evidence-based hearing screening on the purposes – the purpose of hearing screening and what the recommended assets are.

We will then turn our attention to a review of issues pertaining to the Pure Tone Audiometry method, and a question some of you submitted about screening children in the 3-5 year age range using this method.

Since many of you are getting ready for a new round of screenings, we will go over some key steps will want to complete to prepare for this. Then we will review the steps and procedure, and address the questions you raised specifically about puretone screening.

After we address any questions you have about puretone, we will then turn our attention to Otoacoustic Emissions or OAE Screening. Since some of you are also preparing for a new round of screening with a group of children using OAEs, we are going to overview the steps of the OAE process, and then we will review the procedure with some helpful hints for screening that are going to incorporate answers to some of the things you have asked us about. Then we will develop -- delve more into the questions you have about children who may be challenging to screen and other issues you've raised.

Then we will turn our attention to the follow-up protocol, which relates to everyone, regardless which screening method you use. It's the same recommended protocol for what you do when a child doesn't pass the screening. We will address the follow-up steps and questions you had about encouraging parents to follow up, and how to address interfacing with healthcare providers, and things like that.

You're going to wrap up by reviewing some of the resources that we have available online to help you further address any remaining questions that you might have.

So I'm going to put up a sidebar through our session so you can kind of follow along with what our various topics are that we are going to be talking about.

So let's get started, you have likely seen as graphic before. We always like to remind people the work of the ECHO initiative is based on the recognition that each day, young children who are deaf or hard of hearing are being served in early care and education, and healthcare settings, often without hearing related needs being known.

Hearing loss is often thought of as an invisible condition. So how can we reliably identify which children have normal hearing, and which may not?

TERRY FOUST:
You know William, the short answer to that question is that early care and education providers can be easily trained to conduct evidence-based hearing screening, which you can see being depicted here in these photos on your screen.

The ultimate outcome of the hearing screening program is we can identify children who were deaf or

 

hard of hearing, who have not been identified previously.

So you will recognize the procedure on the left as being otoacoustic emissions or OAE hearing screening. Which is the recommended method for children birth to three years of age. An increasingly recommended for children 3 to 5 years of age as well.

On the right you will see the procedure, Pure Tone Audiometry hearing screening, which has historically been the most commonly used screening method for children three years of age and older. And what you will still see in many early care and education settings and providers using.

Was William mentioned we will be talking about both of these methods this afternoon, keeping in mind that the hearing screening process does not diagnose a hearing loss. What it does is it identifies children who need further follow-up evaluation, either by a healthcare provider for an audiologist with that ultimate aim of diagnosing a hearing loss. I hearing loss that in fact exists, and once we have identified that hearing loss, and connecting those children with the intervention services that they need.

So your screening process is really this first important step in that overall process.

WILLIAM EISERMAN:
Yes, and we like to go over this basic training right up front, even if we know you've heard a lot of this before. Because, this is information you probably need to be able to explain to other people, whether that's some of your colleagues, or the parents.

So remembers this information is available to refer to if you need a refresher of this, and it's on our website at www.KidsHearing.org.

So you have asked whether you need to be certified to do screenings. That actually tends to be a state specific issue. We don't know of any states that require that, but there are some state guidelines that can influence your practices. So we encourage you to check that out, and a good way to do that is by contacting your states newborn screening office or newborn hearing stating no one hearing screening office, orally during detection and intervention coordinator also known as the EHDI coordinator. We have a link to those offices on our website which I will be showing you in just a bit.

Now some of you have asked how we can be more effectively encouraging of parents to follow up when a child has not passed the screening. One way to do that is to share information about the incidents of hearing loss, and the fact that a child's hearing ability can change at any time. Often without us even recognizing it.

About three children in every thousand are born with a hearing loss, deaf or hard of hearing. Most newborns in the United States receive a screening for hearing loss using evidence-based methods most often before even leaving the hospital.

But a screening at the newborn period isn't enough. The research suggests that the incidence of

 

permanent hearing loss actually doubles, if not tripled, between birth and school age from about three in 1000 at birth, to about six in 1000 by the time children enter school.

TERRY FOUST:
Yes William, what this means is we cannot only screen for hearing loss at birth, need to be screening throughout early childhood because hearing loss can occur at any time. It can occur as the result of illness, trauma, or environmental or the other genetic factors.

This is often referred to as late onset hearing loss, that simply means it's required after the new board period.

Again, similar to subtle changes in vision that can occur for any of us, a child can experience a change in hearing ability that we want to identify so they have full access to language and all of the information that they are to be exposed to as they learn and grow. Screening, like I said, it's just the first step in identifying a disability such as hearing loss. Since no screening method is hundred percent effective in identifying possible areas of concern, parent or caregiver concern always overrides a passing screening result, no matter what the screening method was that was used.

WILLIAM EISERMAN:
Any conversation we have about screening and follow-up should always begin with a reminder that screening methods are not perfect. Right, Terry? And whenever a parent or care provider expresses a concern about language or hearing, children should be referred for a more thorough evaluation. Even if the child passed the hearing screening. And that is true even with the highly reliable hearing screening methods we are talking about today.

TERRY FOUST:
Yeah, exactly. We also want to acknowledge right up front that for any number of reasons, there is going to be that occasional child that you just cannot manage to screen. After you have tried everything you can do, and you have tried to have a colleague try to screen as well, if possible, you will be faced with the dilemma of what to do. I just could not get this child screen. And here is our recommendation about that question, which some of you raise. And it is this: if you are not successful screening a child, refer the child to someone who can. And often that will be a pediatric cardiologist. -- Audiologist. The children you might have difficulty screening are actually the very ones who might have hearing loss. We really do not want to skip them and just try next year for example.

WILLIAM EISERMAN:
That is such an important point. It gets to the heart of some of the frustrations that we all have faced when screening and running into that kiddo that is just difficult to screen. We just mentioned having a pediatric audiologist in the picture. A pediatric audiologist, if you do not know, is a professional who specializes in the diagnosis and nonmedical treatment of hearing related and other associated disorders of the ear and auditory system. A pediatric audiologist specializes in children. So, having access to a local pediatric audiologist can really be helpful. We recommend that all programs consult with a local audiologist to help develop and oversee their hearing screening and follow-up activities.

 

They can help with equipment questions you might have, consult with you about specific children who are not passing her screenings, and, importantly, maybe one of your resources when you need to refer a child for further evaluation. Or maybe for those kiddos that you just are not able to screen. Now, on our website, Debbie WW.kids hearing.org, you'll find a link to find an audiologist that will help you do just that.

TERRY FOUST:
Thank you, William. Some of you submitted some very specific questions about error to suggest that show up on your equipment. And that will be difficult for us to address individually in a group setting remotely like this. But you should be able to post those questions to the person who sold you your equipment. Equipment distributors and salespeople are not who you should look to for the comprehensive training that you need to develop your screening program, they can absolutely help you understand your equipment functions, the error messages and things like that. So having access to both a pediatric audiologist as William said and a good relationship with your sales rep can be helpful for different reasons.

I would like to just encourage you to have their contact information ready for when you need it. And sometimes the equipment manual can help you as well.

WILLIAM EISERMAN:
Terry, while we are on that topic, I want to jump forward really quickly. Some people have submitted questions about screening children with PE tubes. Let's just answer that question right now. What do you say, Terry?

TERRY FOUST:
Right up front I will say, yes. You absolutely can and should screen whom you know have PE tubes or pressure equalization tubes. It is one of the ways we can find out if the tubes are actually doing the jobs they have been put into do. Children with PE tubes should pass hearing screenings if the rest of their auditory system is functioning normally. So, the tubes would be functioning and the system functioning.

For those of you using the OAE method, you will want to look at your equipment manual to see if you have to push an extra button to adjust the setting for screening and ear who has PE tubes. Be sure you check that out. Some equipment does require a temporary adjustment while other brands of equipment do not. But yes, you can and should screen children with PE tubes.

WILLIAM EISERMAN:
OK, we have two screening methods you want to talk about by way of big picture. If you are responsible for children who are under three years of age, the recommended method is categorically OAE screening which you see on the left ear. If you are responsible for screening children three years of age or older, historically as Terry mentioned earlier, Pure Tone Audiometry has been considered the recommended method for this group. This is that headset screening where the child raises a hand or performs another task each time they hear a sound that is presented into the earphone. You hear -- you see this method on the right here. Kerry some of you --

 

TERRY FOUST:
Some of you have asked why we are no longer using Pure Tone Audiometry with the other population. And have switched to OAE. There is a growing recognition that although the pure tone method has been the most widely used method historically, it may not always be the most feasible method to use with some of these younger children. The research shows that about 20 to 25% of children and that 3 to 5 year age group cannot be screened with this methodology because they just are not developmentally able to follow the directions reliably. And that has really been our experience as well. So in those instances, OAE screening is the preferred method for these children. As we emphasized a moment ago, we want to screen every child. So even the ones we find challenging to screen, right?

WILLIAM EISERMAN:
So what that means, then, is that at a minimum, if you are establishing evidence-based practices for 3 to 5-year-olds and if you are considering using Pure Tone Audiometry screening, you will also need to be equipped and prepared to do OAE on that 20 to 25% who cannot be screened with Pure Tone Audiometry. Or, alternatively, if you are using pure tone screening, you will need to have some other means for systematically referring that 20 to 25% of children to audiologists who can perform the screening. Which, frankly, can be a little bit challenging in its own right if we are referring 20% of the children we have two and all the allergist just because -- audiologist just because they are not that plentiful and there is not a lot of time for them to do screening.

You really do need to figure out a plan for that 20 to 25% in that 3 to 5 age group.

TERRY FOUST:
Yeah, we want to be able to, like I said, screen all kids. The simple five things, more and more of us audiologists recommend the use of OA uniformly with all children three years of age and older because it is quicker than pure tone screening both to learn to do and then to actually implement. It is far more likely to be a method that will work across the board with all children in that 3 to 5 age group that you are screening and it is equally as effective.

WILLIAM EISERMAN:
If you or your program are undecided about which method to use primarily for children three years of age or older, we encourage leave -- we encourage you to carefully review a document we have on our website that compares OA screening and peer tone screening for this exact population.

Here is an important note. Some states do have regulations about what methods are to be used based on age. Requiring pure tone for children three years and older as at least the primary method. You need to check with your state if you are considering OAE for 3 to 5 age group. You can do that by contacting, again, your state newborn hearing screening program and you will find the link to that on our website. I will show you, I promise in a moment, where you will look at that.

On another note, we had a question about whether there are any other recommended evidence-based methods that could or should be considered other than OAE or pure tone. Terry, what do you say?

 

TERRY FOUST:
Not at present. We are doing newborn screening with an additional method such as automated auditory brainstem response Audiometry, but it is not a method that works well with us in early child care settings and so currently it is (unknown term) and pure tone. -- Otoacousitc Emissions and pure tone.

We will jump right in. With pure tone screening, to conduct pure tone screening we will first take a look at the ear. We want to look at it carefully to make sure there is no visible signs of infection or blockage.

By the way, you will always want to do this step first regardless of what screening method you use. And then, if the ear looks normal, then US the screener are going to instruct or condition the child how to listen for a tone and then to respond by raising a hand or placing a toy or something in a bucket. Again. Once you observe that the child reliably response to sounds presented just as you instructed, then the actual screening has started. During the screening process, this listen and respond game is repeated at least twice at three different pitches in each year. Noting the child's response or lack of response after each tone is presented.

If the child respond appropriately and consistently to the range of tones presented in each year, then the child passes the screening. Again, during the screening process, this listen and respond game is repeated at least twice at three different pitches and again we note the child's response or lack of response after each tone is presented. And that is important because as we go and we record responses, we are going to record them at those three different pitches as you see here in this example on your screen.

Again, if they respond appropriately and consistently to the range of tones presented to each year, then the child passes the screening.

WILLIAM EISERMAN:
We want to remind you of some things you want to be sure to address as you get started screening a group of children. To begin with, and this goes for everyone regardless of which method you are using, be sure to refresh yourself in the resources that we have available@kidshearing.org. This is the landing page where you will find a range of resources we are talking about.

Let's go through this here. Right here is where you will find the planning resources. Under that, do you see where it says 'find an audiologist'? If you click on that button right there, it will give you some links to find your state or any coordinator, that is the hearing coordinator who can be really helpful in finding audiologists around the state. In the next group of resources, this is where you can find access to online training courses for OAE and Pure Tone Audiometry training. Check those out if you are not familiar with that, that is the learn to screen courses.

In the next area you have got resources for preparing to screen, checklists, letters to parents, documentation forms, our protocol and guides, referral letters, just about everything you need to implement a hearing screening and follow-up program. And then lastly, monitoring and tracking

 

progress resources. So get acquainted with those and we have those resources both for pure tone and for OAE screening.

So as you prepare for a round of screening using the puretone method, you should walk through the steps and make sure you want overlooking any of them.

You will look at things like setting up the environment. Doing a sound check. Making sure you have all the material supplies that you need. Checking your equipment and setting up the environment where you are going to be doing the screening. Testing out that equipment and making sure it is all operational. It making sure your headphones are working, clean, and that you have done a listening check on them to make sure they are operating appropriately.

This gives you the actual steps to go through in conducting a listening check.

So check out this checklist and make sure you walk through each of these things prior to a screening session to make sure the screening you are about to do is actually based on a knowledge that the equipment is actually working well, and you have the environment controlled so you can conduct the screening without disruption.

So Terry, we pointed out there was a conditioning process prior to the actual screening. And some people on today's webinar have asked how long that conditioning process should take as a part of the total screening. Can you comment on that?

TERRY FOUST:
Yes, while there is some individual variability.

Children who are going to be successfully screened using puretone method, they ought to be able to be screened in about 10 to 15 minutes max. So in that time period, the conditioning should not take much more than five minutes, hopefully less. If you can't condition a child in that amount of time, then you should probably consider using your backup plan, which is either to do the OAE, hopefully right then will you have the child they are, or you can try on another day if you have the flex ability to do that.

Just remember if you can't screen the child, then you will either need to do in OAE or refer the child to someone who will be able to successfully screen the child, probably a pediatric audiologist.

As we said earlier, remember some children that have hearing loss could be the very ones that are the most difficult to condition to do the screening. So one way or another we want to ensure every child a screen. --'s screen.

Once the child is conditioned, they have learned the response, then you start the actual screening process. Like we said earlier, during the screening process, this listen and respond game is repeated at least twice, three different pitches on each year. Again noting the response or lack of response after each town is presented. If they respond properly and consistently to the range of Jones -- tones

 

presented in each year, then they passed the screening.

How it is critical you follow these steps exactly, and we recommend you always start with the right ear, just to avoid any confusion for yourself. If that becomes your habit, you will avoid confusing those ears.

Now the goal of this screening process is to test the child's hearing, like we said, at three pages or frequencies. Those frequencies are 2000, 4000, and 1000 Hz. We test in that order.

The volume level during the screening must be set and remain at the 20 dB level during all these town presentations. You will screen the right year first, then the left.

In order for each year to obtain a pass result for each frequency, the child must indicate the correct response at least two times, giving the child no more than four times to get it right.

In order for the child to pass the screening overall, they must get a pass on every pitch in both ears.

So if this is unclear to you or if you need a refresher, we encourage you to seek some additional training and practice with this because it is really critical that you understand it.

And if the training resources link to on www.KidsHearing.org, they will go into detail on all of this.

What you are seeing here on your screen is an example of the actual screening steps that must be documented for each year as you screen. Based on these results, then the screener determines if each year passes or not.

The device itself does not pass district provided a result as is the case with OAE Screening. You want to make sure you document the results as you go, just as you see here. And our screening form permits you to do just that.

WILLIAM EISERMAN:
This is the screening form you're welcome to download and use from our website. It takes you step-by-step through all the processes of puretone screening Terry outline, helping you to follow the steps exactly.

You will notice the form also includes the rules for obtaining passing results over on the right, so if you don't remember, you just look at the form.

Terry, one of our questions from our participants was, what if a child does fine and responding at first, but then as you are continuing with the screening, they become distracted? Or you observe the child is no longer engaged in the screening. Say after the first couple of pages. What do you do?

TERRY FOUST:
Sure, it's a great question, that can happen.

 

What you want to do is be sure to document, as far as you got. Document as far along in the process as you God, then you can do one of several things. You can use your backup method, though OAE instead, or you can come back to this child on another day and continue where you left off, making sure however you always start by repeating that conditioning process before you continue with the actual screening steps where you left off.

WILLIAM EISERMAN:
You'd have to do that same thing Terry, right? If there is a sudden increase in environmental noise for example that is outside of your control. So if you can't continue to screen at that time, you have to come back at another time, picking up where you left off.

TERRY FOUST:
Absolutely, we have to ensure that auditory background and that environmental noise is not a factor in the screening.

WILLIAM EISERMAN:
So if a child completes the screening and meets the past -- passed criteria, you're done for that child. If they don't pass however, they will refer to the follow-up protocol that we will be coming over in a moment. Which incidentally is identical for both puretone and the OAE method.

Now let's pause here for a minute and see if those of you who are using the puretone method have any other questions specifically about the use of Pure Tone Audiometry, preparing to screen, conditioning children, conducting the actual screening or documenting the results. Let's just see if any of you want to enter anything about that into the question, Q&A box. If not we will just go on. If you think of something later we will answer it at the end.

I'm sure you're all doing really well (Laughs).

Puretone screening is hard. Because in part the lack of automation. So you have to manually step through all of this while you were operating equipment, managing children's behavior, following the protocol and documenting those results. It's a lot to do, and I think that is one of the other reasons Terry didn't really mention why there is a sort of movement toward duping OAE's on this older population, because it's simpler. Especially with these older children who are going to be more cooperative and having OAE screening done with them.

OK, remember, you will find our helpful resources about puretone screening on www.KidsHearing.org. Which you will find right here. OK? That is where you will find training resources if you need training. And then the other things we talked about briefly before.

Be sure to get acquainted with what is there, especially if you are feeling the need to develop something, like a letter or a referral form, or something like that. You may just very well find that that resource or something close to what you are needing is already there.

 

You will notice also there is a checklist for puretone screening. We have them for puretone and OAE Screening which is a quick overview of all of the steps you go through, from preparing, getting ready for screening, to the conditioning phase, all the way through the screening and documentation phase. So you will want to look at that resource on our website as well. And maybe have that with your equipment, just as a refresher.

OK, let's turn our attention to Otoacoustic Emissions or OAE Screening.

As we are ready said, this is the recommended method for, as in Evidence-Based Practice for children birth to three years of age. As we said a number of times now, increasingly for older children as well.

Terry, walk us through this method just as a review.

TERRY FOUST:
Yes, so like I mentioned earlier with any method we are going to use we are going to first take a thorough look at the outer part of the year to make sure there was no visible sign of infection or blockage. We want to see if that year appears to be normal and healthy.

After that, a small probe on which a disposable cover has been placed is then inserted firmly into the ear canal. A button is pushed on the equipment to start the automated screening process. The probe that sits in that year, it sits independently in the air. So we are not holding it. It delivers a low-volume sound stimulus into the air. And a cochlea, or the inner snail shape portion of the air -- ear you see here, and inner ear functioning normally will respond to the sound by sending the signal on through the system to the brain, also producing an acoustic emission. This omission is analyzed by the screening units, and in a proximally 30 seconds or so the result will appear as either a pass or a referral. -- Refer.

And every normal healthy inner ear induces an emission that can be recorded in this way.

WILLIAM EISERMAN:
As you get ready for a round of screening, we encourage you to refresh yourself, just like we said about puretone screening, but going through the resources that we have about OAE Screening. Looking at the checklist that we have. If you need retraining, check out the retraining resources that are there. Under access training. Have a look at the checklist we have on OAE Screening, which again goes through the whole process of preparing for, setting up, I sure you have all of the disposables you need. The other physical materials that you have. Then it walks you through the complete screening process starting with the visual inspection, all the way through documentation.

So in addition to the list of steps of the screening process, you will want to make sure you have paid close attention to having all of the supplies you need in advance. Remember with OAE Screening you need to have those disposable probe covers, and you will want to order them in advance, and you will want to have some adult sized probe covers as well so you can test the equipment on yourself before each screening session to make sure it is operating properly.

 

You also want to make sure your equipment as calibrated on an annual basis, and to make sure you have the benefits of whatever the latest updates are from a software perspective.

And remember, regardless of what hearing screening method you use, you want to make sure you communicate with the parents and other program staff whose cooperation you are always going to be seeking, especially when children don't pass.

TERRY FOUST:
Some of you have asked about how to prepare children for hearing screening. Our main recommendation is to keep it fun. Keep it fun regardless of what method you are using. Rather than referring to the activity as screening or hearing test for example. Call it a listening game. And you can engage teachers or parents, some activities that include may be noticing the child body parts porting two years, nose, mouth, include their ears, maybe expand on the idea of what animals have ears, and they have ears as well.

WILLIAM EISERMAN:
In fact we have a little video if you haven't seen it. If you have a way of showing a video with children, you will want to check out our video on a website called listen up. I will play just a quick portion of it here so you have a sense of what it's like.

(Video Plays)

(Music plays)

(Captioned video plays)

WILLIAM EISERMAN:
That is one little tool, resource, that we have on our website. Be sure to check that and other things out so that again, before you get involved in developing anything, you check and see if it is not already there.

You are free to use all of our resources, to adapt them in whatever way you would like. We develop these over a long period of time in collaboration with folks just like you. So you can know that a lot of this has been put to use my a lot of individuals already. The letters and forms that you we have on our website are available in English and Spanish. Be aware of that as well.

This is where you will find resources about preparing for screening and the 'Listen up' video and some hand up -- handouts for parents and teachers are there. Information for teachers if you are going into classrooms to do screening. And also information you can send out to healthcare providers letting them know in advance of what screening, hearing screenings, you are doing. And that you may be referring children to them as a part of all of that. Be sure to check each of those things out.

Like many skillful tasks, competent screeners make it look so easy. But no matter how much

 

experience you have, you are going to be met with challenges along the way. We all are. A number of you have submitted questions about children you struggled to screen for various reasons. Let's talk about some of the strategies for screening that we have actually learned in part from some folks like you. By hearing and learning from you about what looks, what works well. Let's just start by looking at these photographs here.

The children you see here are all being screened using the OAE method. What do you notice about where they are being screened? They are not being pulled out into an environment that is foreign or strange to them. They are being screened in everyday educational home and outdoor even environment where they are already happily spending their time. And those folks that are doing the screening are often the people they already know. Their teachers, home visitors or health specialists in the program whom they interact with for a lot of different reasons.

Those two elements of going to where children are and having people who they are already familiar with doing the screening makes a huge difference in being able to successfully screen children. Especially the very little ones.

TERRY FOUST:
In fact, the screening works best when children are familiar and comfortable with the adult that is doing the screening and where they can play with a toy, be held, or even sleep while the screening is being conducted. We have a lot of options. Now, it is good to remember that some equipment is more effective than others when attempting to screen in natural environments. But most of them can work just fine under these conditions. There are several key things to remember, several keys to successful screening to keep in mind, though.

And they are: good probe fit, you want a good, snug probe fit. Minimize movement. Minimize internal noise and we also want to minimize the external noise in the nearby environment.

So let's talk about these. With good probe fit, the goal with proper probe placement is that you have a really snug fit. Ceiling out all of the noise from the environment. That means you need to select as large as possible a probe cover so that when you insert the probe into the child's ear, you can totally let go of it and it will stay in place. In fact, you have to let go because if you hold onto it, your touch can loosen it allowing more noise to get in and disrupt the screening process. They are made to be self seated. As you select probe covers, always aim for the biggest ones that will fit in the child's ear canal. There is no great secret aside from experience and being able to make a good seal cover selection. Practice, practice.

WILLIAM EISERMAN:
Some brands of equipment, Terry, have what is called compressible form covers. Which tend to be the easiest to achieve the success. So if there are phone covers available for your particular equipment, you want to try those especially if you are having trouble with getting a good, snug fit.

TERRY FOUST:
Let me interject, William. A little aside about probe covers. You can only use the probe covers that are

 

made and intended for your device. Even though you might see others on the market, you can only use those made for your brand of equipment. They are made and calibrated for your equipment. If you do not, you can get inaccurate results.

WILLIAM EISERMAN:
Some of you have understandably expressed concern that you are worried you could hurt a child, especially when inserting that probe.

TERRY FOUST:
Yeah, William. We understand that concern. We would like to assure you that these probe lengths have been carefully designed so that that is not possible. A child with an active ear infection or ear pain may experience pain with a probe insertion. That is one of the reasons we do want to carefully inspect the ear prior to doing a screening. Otherwise, the probe will not go in deeply enough to harm the child's ear.

WILLIAM EISERMAN:
On our website we have videos available through the online training that demonstrate probe insertion showing, as you see in this photo, how to pull back the ear, the outer part of the ear, inserting the probe in the direction of the child's nose, and then giving it a slight twist to get it snug. And then, we always let go.

TERRY FOUST:
That's right. You always let go and it should stay put. You want to make sure also that the court has been clipped to the child's closing so the weight of the court does not pull the cord out of the ear. Those both are two essentials for getting and keeping a good probe fit.

WILLIAM EISERMAN:
You know, Terry, I think one of the mistakes or errors we have observed is that people forget about that clip. It seems like it is not that important because it is not technical. But it actually is so important because it takes the weight of the cord off of the probe and otherwise that cord can just kind of pull and pull that thing out of the ear.

TERRY FOUST:
Yeah, especially as they move. I also like to clip it at the back, up and out of their way. Just one more thing to keep out of the child's – the thing they are worried about.

WILLIAM EISERMAN:
So they cannot reach and pull it out of their ear.

Of course, as you screen there may be times when you get an error message or a referrer message. Do not worry too much about what the error message actually says. Because of this. Regardless of what the specific error message is, you are most likely going to do the same thing as a response. And then try again. You are going to reposition the probe, you are going to reduce external noise, you are going to check for wax in the probe and clean it or replace it with a new cover, you are going to quiet

 

the environment, and you are going to reduce the movement of the child, and you are going to use a unique, interesting toy to distract the child. And if necessary, you will elicit the help of another adult or screener to a comp at all of those things.

So do not get too hung up on what the individual error messages are that you are reading and just worry mostly about doing these things in response. Would you agree with that, Terry?

TERRY FOUST:
Absolutely. We always recommend to try again and pay attention to these factors.

Now, we have also received a number of questions asking for suggestions on how to screen children who are just challenging. They are challenging to get to sit still or for whom we just cannot seem to complete a screening. So we will go over some strategies, and then if you have any additional questions, we can take those.

So there are several strategies, in our experience, that will help make it a positive experience for the child and for you. One of the first I have already kind of mentioned, but we want to keep a fun feeling around the screening activity. Keep it positive and fun. We want to position the child, yourself and other helpers in a way that is comfortable and allows the child's behavior to be naturally directed. We use toys, distractors and rewards effectively and then we document the screening results accurately.

So let's take a look at each of these for a moment. Creating a fun feeling around the screening. That involves establishing rapport with the children. For example, you may tell a child you are going to play a listening game and include another adult as the first person to be screened, placing the probe near their ear and asking if they hear the little birdie for example. If you are working with a group of children, ask the teacher for suggestions on which child might be the most cooperative and should be screened first? We use that to set the tone, a good example for the children to follow.

I do want to say this year. In our experience, this is what you all are great at. We can teach technical skills but that natural ability to work well with children is something that I have admired as we have worked with many of you.

WILLIAM EISERMAN:
Now, when eliciting children's cooperation, you still want to tell them what you are going to do rather than ask them if they want to participate. Because you do need to get the screening done.

TERRY FOUST:
Yes, this is actually really important, William. We do not want to give them the opportunity to say no. So you direct the screening.

WILLIAM EISERMAN:
You could even suggest to the other children that they have to wait their turn, just like they would for any other presumably fun activity. This often creates the desire to participate and to "be next". Be sure to use terms. Think about your words. And use terms that describe the activity is fun, interesting and

 

avoid phrases like "I am going to test your years" or stating that the activity "won't hurt" or "won't be painful". You do not want to bring the possibility of pain or discomfort up because you are likely to get a response the minute they hear that that is going to be counterproductive.

TERRY FOUST:
Exactly. Moving onto positioning. You want to position yourself to the side of or slightly behind the child. That gives you good access to the years to help facilitate that good probe insertion. If possible, have another adult hold the child snugly, or keep them distracted, their hands occupied, with another activity. It is absolutely great to sit on a floor at the child's level.

Having some good toys as distractors is always helpful. You want to present novel and new toys as distractors at the moment where you most need the child's cooperation. When they lose interest in one toy or distractor, then quickly present another one.

WILLIAM EISERMAN:
Sometimes a gentle caress or playful touching game can distract the child from this sensation of the probe in the ear. Just tapping them on the forehead might be enough to just get their attention off of something that is a little strange that is going on in their ear.

TERRY FOUST:
Yeah, introducing just something else that captions their attention to another sense can help distract them from that.

Also, consider playing a child's song on a portable music device such as presenting and earbud to the ear that is not being screened.

WILLIAM EISERMAN:
Once you are complete with a given child, you want to reward the child with praise and if desired, with a sticker or some other reward. Making sure that that same praise is given no matter what the screening outcome is. We are just rewarding everybody for their cooperation and engagement.

TERRY FOUST:
Yeah, and another thing I will add is that it is really helpful if you have the ability to screen in teams. So where one adult can manage the child where another one is focused on completing the screening.

WILLIAM EISERMAN:
And that is really – that advice applies mostly for the really little ones. Right? As children get older, you will not need that quite as much.

Terry, talk about hands. Children seem to always have busy hands, and that is one of the main things we want to control during the screening process.

TERRY FOUST:
Absolutely, and a really important strategy is to keep those hands away from the probe or the court,

 

and pulling it out. So be ready to redirect a child's – many relate an object. You can safely have some grasp your finger or hand. I will often just directly put toys right in their hand and show them how they work. We want to keep those little hands busy and away from pulling on the probe.

We also want to offer children choices about where to sit or what toy to play with, but we don't offer a choice about whether to be screened. Back to that – the advice William gave. We don't want to give them that opportunity to say no.

WILLIAM EISERMAN:
You can familiarize the child with the probe before attempting to insert it into the ear by touching it to their leg or arm, hand or cheek. Pointing out how soft it is.

For some children who may seem a little reluctant, spending a little bit of time just helping them see what it is you are doing can be a worthwhile investment in time.

You can also visit the child help in pretending to screen one of their dolls, or stuffed animal.

Sometimes a young child will cry when the probe is inserted. You don't want to automatically remove the probe, even though that might be your impulse. Instead, see if the child will relax with the probe still in the year. Have your finger close to the start button on your unit, and be ready to push start the moment the child is quiet. Sometimes you can complete a screening from that moment, even if the child continues to be a little fussy. Some equipment will actually start and stop, and actually continue in between the child's cries. So leaving the probe in that year, -- ear, if you can, may actually help you complete the screening.

TERRY FOUST:
Now if a child is uneasy about being screened, but they can be sued -- can be soothed by a pacifier or snack, you can attempt to screen the child while they are sucking or chewing and the machine will test during process. This does introduce noise however. So if the result is refer, you will need to complete the screening when the child is not sucking or chewing.

WILLIAM EISERMAN:
To clarify, let's just restate that. You can screen a child while they have a bottle, or eating a cracker. And if they pass, great. No worries. But if they don't pass, then you will want to remove that object they are sucking or chewing on and test again. And if they refer when they are quiet, then you can go without result.

TERRY FOUST:
Exactly.

Is a strategy is to consider screening in groups. This can help some children who might be fearful or afraid become more comfortable with the process, as long as they are seeing others having a positive experience. You always wanted to try to start with a child you are the teacher is fairly quiet -- fairly confident will be cooperative and set the example you were hoping for.

 

WILLIAM EISERMAN:
Sometimes children who have been treated repeatedly for ear infections or other conditions may be especially reluctant. And understandably. They have had some pain or discomfort. They may need a little more time to watch other children participate in the process, or to get familiar with the probe. Before an actual attempt to do the screening is made. Maybe it isn't even on the same day, be they need to watch it and have it another day.

If a child remains uncooperative, you may want to try a different screener to attempt to elicit cooperation, or see if you can screen a child while they are asleep. And actually, screening while they are asleep doesn't have to be a backup strategy. You can do that right off the bat if that is a way to screen some of the children, especially the littlest ones.

TERRY FOUST:
And remember with all of this, if you do not get a passing result, as long as the child is cooperative, try the ear again. Making sure you have a good probe fit, and you've minimized internal and external noise.

Of course it is very important once that screening is complete, you be sure to document the results accurately.

WILLIAM EISERMAN:
Terry, one of the questions is do I have to rescreen an ear that I get up past result on.

TERRY FOUST:
Do you have to rescreen an ear you have a passed result on. No, you can have confident district confidence in that result.

WILLIAM EISERMAN:
We have some questions, if any of you have OAE questions you want to add right now this is a great time to do that.

Here is one, R-state EHDI program recently partnered with both early head start and Head Start, and one of our state audiology graduate programs.

We use DPOAE screening for all children, but for the older children we try to screen with Pure Tone Audiometry.

The question is with regard to the recommended follow-up protocol for children that have undergone both screenings and to pass each ear with one methodology but not the other. Any recommendations you can offer? What do you think Terry about mixing methods from one year to the other?

TERRY FOUST:
That's a great question, I hope I am understanding it the way it was intended. There is absolutely the

 

right process if I'm understanding this right, that probably started with Pure Tone Audiometry. Were you were able -- either unable to get that, might? Or might have gotten every friend went to the backup method which was DP OAE Screening. And use that.

If that is the process, that sounds great.

Then I'm not sure if I'm understanding the rest correctly. If they've undergone both screenings and pastiche of...

(Multiple speakers)

WILLIAM EISERMAN:
This is what I think the question is Terry. Let's say they screened a child with puretone successfully on the right ear. Then the child he compensates behaviorally, and they can't screen the left ear with puretone. And so they do OAE on the left ear.

TERRY FOUST:
That would be great. You can then use the pass for both ears.

WILLIAM EISERMAN:
There you go.

Next question, OAE's are often unable to detect minimal to mild hearing loss. What screening level DP are you comparing OAE's to puretone screenings?

TERRY FOUST:
So I think as we said earlier, there is not any one perfect screening method. So our goal is to screen those children that we can.

So not perfect screening method.

Than what we are trying to do his people to have a backup to screen that 20 to 25% of the children that can't be screened with puretone. And we also find a lot of variability that exists within the puretone screening world. There were some protocols that say we are going to screen at 20 dB, which is the quiet level that we are going to screen out. That is for temple with the American speech like which hearing Association.

For some programs that have adjusted that screening level 225 -- two -- to 25 dB and have made adjustments. What I'm saying is there is a lack of consistency with presentation levels. Even with puretone screening.

So what we're trying to do is to find, among the options that we have, the one that will allow us to screen all children. Use it is almost universally so we don't miss kids. Acknowledging there is certainly no perfect screening method.

 

WILLIAM EISERMAN:
Sorry, I was muted.

A couple other quick questions before we move on to the protocol documentation. Is there a standard probe color for certain ages? The answer is no. There are not. Each manufacturer kind of randomly picks colors for their probe covers.

Terry, here is one for you. Teachers are hesitant to let me screen our Early Head Start children while they are sleeping. Any advice or words to use to help encourage them? I'm struggling to get this age group screened because they are very wiggly.

TERRY FOUST:
Absolutely, I feel your frustration to be able to get that done.

Screening while they are asleep is one of our best strategies, especially with very young ones. In fact sleep is what we require for some other methods of testing, even at the newborn period. So it's an accepted and very useful strategy to be able to screen children.

I have even rolled around the block with a child in a car seat and screened them in order to keep them asleep so they didn't wake up.

So I think advice or where it says it's a widely accepted strategy to be able to successfully screen hard to screen children. Young ones.

WILLIAM EISERMAN:
It may be if children can come to the center, and the parents can call in advance and say, "He is asleep in the backseat." Getting creative about when you screen a sleeping child. Maybe it is at the end of the nap, not at the beginning of the nap hour. So if they are awake and from then on it doesn't distract isn't quite as disappointing for the teacher as it would be otherwise.

TERRY FOUST:
I'm wondering if some given identification with the parent, and the parent kind of gives either approval or request to the teacher to be able to work together to get that done.

WILLIAM EISERMAN:
Here is an excellent question, all of these are excellent questions.

This person is writing: from what I understand OAE Screening doesn't read middle ear function. Even if a child passes within OAE, they wouldn't necessarily pass their hearing screener. Wouldn't an automated tympanometry or be more important?

Terry there are some points of clarification here about how middle ear interacts with the screening of OAE, can you expand that briefly?

 

TERRY FOUST:
Yes, tympanometry I'm just going to mention it first. The test that look strictly at middle ear function. And suddenly we originally used it in our protocol, but what we found is those children that have middle ear disorder were not passing their OAE. And we ended up with the very same referral pattern happening. So while OAE Screening does not specifically assessed or screened middle ear function, when that middle ear is not functioning appropriately and it affects hearing, we are able to get a measurable OAE. So we still re-screen according to our protocol and time frames that still has tympanometry been included.

Will is there anything you would add?

WILLIAM EISERMAN:
Our hope is when a child doesn't pass, and they are screen a second time two weeks later, they are referred for middle ear evaluation at that time. And tympanometer would be used as part of the middle ear evaluation to address any middle ear conventions that need to be cleared up. Then the child is screened again once we can assume there is no middle ear disorder that is active.

Here is another question for you Terry. If children are being seen regularly at the doctor's office for well-child exams for birth to two years of age. Should we still screen at the age of one?

TERRY FOUST:
Absolutely, the reason being is even though they are being consistently screened, -- seen, thank you. Consistently seen or having those well-child visits, hearing screening and self is almost always not been conducted.

Now there could be a few providers offices that actually have the equipment and the ability to screen, but we have found that's really not happening.

Any ear check where we look at they are within the scope or your light and look at the physical parts of the ear is actually not a hearing screening. And in most cases it is because it is not being done but it's important for us to screen.

WILLIAM EISERMAN:
This relates to another question we just got, saying many of the times we receive an incomplete hearing exam, or for EHS it will be just checked off under exams and let -- and not an actual hearing assessment for the medical office. So our advice is always, unless the child medical record specifies the hearing screening method, which would be OAE or puretone, don't ever assume a checkmark next to the word ears is equal to a hearing screening having been done, and that a positive result was obtained for both years. A lot of assumptions can be made from a checkmark. You don't want to make that mistake.
Let's go on, Terry, to our next section here.

It is important to document results as you go. So that if you have an ear that does not pass, you are

 

sure to accurately indicate which you did not pass. As you will see in a moment, these forms directly correspond to the recommended protocol. Like we showed you with the pure tone forms, this is the hearing screening form for OAE that follows the recommended protocol.

We have had some questions, Terry, about screening children who have autism or other developmental delays. What do you have to say about the use of OAE's for those children?

TERRY FOUST:
Yes, we have shared a variety of strategies to be effectively conduct OAE screenings across these populations. With children who may be on the spectrum for example, we found an activity that they really are engrossed in or maybe in our experience, teachers they become fixated with. And we for once want to enable that fixation on that activity so that we can screen their hearing. I have screened one, for example, that loves to vacuum. We actually unplugged the vacuum and let him vacuum while we screen. We also find if there is something that is sensory that they like for example, keeping their hands busy with something that they love the feel and the touchup. We have screened while they have been engaged with the computer or handheld devices. But we try to find those outside options and activities that they can be interested in that might allow us to screen.

WILLIAM EISERMAN:
What about for very young infants? We have a question asking if you have any helpful tips for successfully screening infants.

TERRY FOUST:
One of them have -- has been mentioned prior. Similar to eating and sucking. We have successfully screened infants while they are nursing or feeding on a bottle. When they first begin to feed, they are hungrier and so we usually cannot get the OAE done at that time. But when they are getting towards the end of their feeding and a little more satiated and that time period between the sock slows down, we are often able to complete the screening successfully. Sleep is also great with young babies. We may actually work and educate, talk with parents about a little bit of sleep deprivation. Waking them up a little earlier, keeping them awake a little bit longer and then when they fall into that deeper sleep, we want to try and screen them.

So you can really work with the parents to find, for example, when is the usual nap time? We might schedule screening during that nap time. I have mentioned this before, I have actually brought equipment to the car and screen them in their car seat while they were asleep so we did not even have to move them and wake them up.

But you can see, you know, that as far as keeping children as cooperative as possible, there is no single approach that will work with all of the children all of the time. I encourage you to be as creative and flexible as you can.

WILLIAM EISERMAN:
Arabesque screening efforts are only worthwhile -- our best screening efforts are only worthwhile with a follow-up. Let's do a quick walk-through of the follow-up protocol and see if you have questions

 

about that. -- Here he mac the steps --

TERRY FOUST:
Regardless of how old the child is.

WILLIAM EISERMAN:
There is one main rule to remember. The screening and follow-up process is complete when either the child passes the screening on both ears or the child receives an evaluation from an audiologist and you have obtained those results. So the screening and follow-up protocol and the accompanying forms we have for you to download walk you through this actual screening protocol follow-up process. If an ear passes the first screening, the process, as I said, is complete for that year.

If the ear does not pass after several attempts during the initial screening session, we cannot be sure why. Sometimes it could be due to screener error or a temporary condition like a head cold. So it would not be practical for every child does not pass that initial screening to be referred straight to a healthcare provider or to an audiologist. Terry, several participants have asked about how a head cold or congestion can affect screening outcomes.

This is where we might see that, right? Can you just explain that briefly?

TERRY FOUST:
Absolutely. This is related to the question on tympanometry that came in earlier. We know that, say, in the fall, cold and flu season. This can be going around. This is the most common reason that we are going to get a referral. We just want to wait and rescreen them and let that condition clear up. As you will see coming up, we will then have the majority of the children who will be able to successfully pass that screening.

WILLIAM EISERMAN:
We screen in about two weeks for the second time. If they pass on an ear at that point, that ear is considered complete. If it still does not pass the screening, then we want to refer the child for a middle ear evaluation. We expect about 8% of children will not pass that second screening and will in fact need to have their ears checked by a middle ear provider. As Terry said, that is where tympanometry comes in.

TERRY FOUST:
I am just going to interject, William. These numbers are based on thousands of kids such as who you serve. I just, you know, the database is large and the research is sound in these numbers that you are reporting.

WILLIAM EISERMAN:
Sometimes when you get to the healthcare provider, they will find there was a wax blockage and not in your infection or anything work obligated. If that is the case, -- anything more complicated. If that is the case, you can screen right away. But if there is inflammation or in your infection, you will need to get the healthcare provider to tell you how long to wait. Three weeks or a month and then you will screen

 

that child again. And I am going to quickly go through the rest of this, Terry.

You would read screen that child after the middle ear evaluation and if they pass at this point on any previously non-passing year, the process is complete. If they still do not pass, then you refer the child to a pediatric audiologist for a complete audiological evaluation. That bottom line there, the process is complete only when you get a passing result on both ears or the child has been seen by an audiologist.

A middle ear consultation from a healthcare provider this not constitute completion of the protocol. Only about 1% or even less will go all the way to the audiologist. But you will want to be in touch with the healthcare providers and the audiologist and get a complete record of all of those outcomes. So that you can support the family in doing whatever is next after a child has had the evaluation from the audiologist.

So what other questions do you have? We want to make sure that you are aware of all of the resources that we have on our website. We have talked about them a fair bit. We have talked about the importance of documentation. And making sure that you do not spend time developing a form or a letter or an information sheet that may already exist. So take a little bit of time and check out what is there in case there is something more that can support your efforts. Any other questions we can address that would help you as you move forward? Remember that we know that you have a lot of turnover in your program. We know that some of you will screen intensively at one part of the year and maybe not very intensively or at all for a number of months. So refreshing yourself on the training can really be helpful. The training resources that are available through kids hearing.org are able to be accessed on your time schedule. You do not have to wait for a webinar to be offered or some live presentation. If you have a new staff member coming in, they can be brought up to speed. Do check those resources out. It is always great to have a local pediatric audiologist who can also come and screen with you or give you feedback after you have completed the training to make sure they are able to give you some helpful hints, correct anything you did not quite pick up on from the training, so the combination of the online training and the consultation and guidance from a live experienced screener or audiologist can really work well to help you adhere to all of the requirements, whether it is pure tone screening or OAE screening.

Keep in mind that being evidence-based is not just having the right piece of equipment. It is about using that equipment according to the guidelines that have been set for heavy equipment is to be used. And having a follow-up process in place that enables you to adequately follow-up when children do not pass. That is what makes this evidence-based practice.

So, Daniel is going to put in the Chatfield for us the link to our survey and the place. If you click on that Qualtrics link it will generate a certificate of completion or attendance I should say. A certificate of attendance in today's webinar.

Take a moment if you will to do that. Remember that we have got a webinar on next Wednesday at the same time that is an introduction to evidence-based hearing screening. So if you or others that you work with would benefit from that, we encourage you to go to kids hearing.org and look for the

 

registration link for the introduction to evidence-based hearing screening and evaluation practices for children ages birth to five and register their and we will see you on January 21.

Thank you, everybody. Great questions and kudos to you for doing so much to support the development of the children that you get to have an influence over. Terry, thank you. Thank you, Daniel. And thank you to our captioner's for your skills, time and talent.

Again, this has been recorded and will appear on kids hearing.org in the next couple of days.

Live captioning by Ai-Media