REALTIME FILE

NCHAM - Utah State University
Expanding the Scope of EHDI to Include Screening Children up to Three Years of Age
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All right, I think we should go ahead and get started.
Well welcome everybody to today's webinar entitled expanding EHDI for children up to three years of age.
My name is Will Eiserman and I am the associate director of the EHDI NTRC, the national technical resource center at Utah State University.
And I'm joined today by Dr. Terry Foust who is a pediatric audiologist who has worked along with me and other team members here at the EHDI NTRC.
So we'll be drawing from a lot of experience that we've had working in community-based programs over the years.
This webinar is being recorded so if anything disrupts your full attention or if you have any kind of technology problem during our time together today, know that you can go to infanthearing.org in the next couple of days and you'll be able to access it again.
And that's a good thing to keep in mind if there are any team members or others you might know of that might benefit from today's webinar.
You can direct them there as well.
I want to give a shout out to our captioner.
We always appreciate the time and talents that you bring to events like this that allow us to make this more accessible.
So thank you.
That's a real live person who is providing that service to us and we always want our real live support people to feel appreciated.
And that goes for also our technological support people who are with us as well, Lenore and Gunnar.
So thank you.
So for about 20 years, the ECHO initiative which is the early childhood hearing outreach initiative -- you know I'm going to take myself off the screen.
I'll let you just be able to see the slides from here forward.
It's a little less distracting I think.
So for about 20 years, the ECHO initiative received generous funding from the office of Head Start to support staff in implementing evidence-based hearing screening and learning practices.
The ECHO initiative which stands for the early childhood hearing outreach initiative focused on early childhood populations.
And those are the populations that we're talking about today.
We learned a lot and want to share what we can that may be helpful to you as you think about this expansion in your respective states.
The funding received from the office of Head Start ended about 18 months ago.
We're delighted to make those resources and learning opportunities available to anyone from early care and education centers that can put these to use.
We'll be able to show you where you can direct people to continue to access these resources.
My little advance button turned off so let me fix this.
So there's Terry and me.
You'll see us again when we open up for questions at the end of our presentation today.
Terry, do you want to say hi?
>> Yes, hi, good afternoon everyone.
Appreciate the chance to be here with you.
>> I asked Terry to join us for today's webinar because he's a close partner and to also be available as an audiologist if there's anything of a technical nature that may come up during our webinar today.
The topic of this webinar is expanding EHDI to include children who are deaf or hard of hearing up to three years of age.
As you're probably already aware, the reauthorization of the early hearing detection and intervention act of 2017 expands the scope of EHDI to include the identification of children who are deaf or hard of hearing up to three years of age.
Notice of funding opportunity or NOFO for the grant period that you're currently in the second year of, really coming to the end of.
And which at least in part funds your state program included some specific expectations pertaining to this unfolding expanded scope of EHDI.
The expectation in the NOFO reads as you see here to develop a state or territory plan to expand infrastructure including data collection and reporting for hearing screening for children up to three years of age by the end of year two.
And that's been changed to the end of year three.
This plan should outline the resources, stakeholders, partnerships and services necessary to implement the plan.
A public health approach that aligns with other public health and/or service programs within the state should be proposed as well as the role of the EHDI program.
Partnering with and they list all of these potential partners that you might want to work with.
As you're probably also aware, on October 26th they sent an email to EHDI programs extending that program for you to submit a plan to expand the state infrastructure to March 31, 2023.
That's the end of year three.
Now this extension is intended to provide you with more time to develop comprehensive plans that are informed by what you learn about key partners in your respective states as well as existing resources that are available to support activities in the area of birth to three screening.
And importantly I would suggest a plan also identifies resources that are needed for implementing the plan.
They have indicated they will be disseminating some additional clarifications about this plan in the next few weeks is what they've told us.
So we want you to keep an eye out for that.
In response to a number of questions that we have received from some of you, we did ask them whether there are any budgetary parameters within which state plans should be developed.
That's kind of an obvious question and they indicated that while states could potentially conceive of various potential tiers of funding in the future, they didn't want to make this more complicated at this time and instead are encouraging the grantees to make a budgetary tier and make assumptions based on that and prepare a plan within those parameters.
What that means is you could have a plan where you have no additional funding or you have a plan where there's a modest increase or maybe one with a more significant increase.
And then your plan would just reflect what kind of a budget you had also envisioned.
But again I want to encourage you to watch for this upcoming clarification because it may help with that question.
Recognizing that there are a variety of questions about this expanded expectation and different directions you could take.
We wanted to offer this webinar as an opportunity to share our experience in the area of birth to three screening and some ideas about the various ways that states may approach the development of this plan.
If you have specific questions related to this expectation, we're happy to pass those on.
So once we open up the questions field, you can put your question in there and just put HRSA at the beginning of the question, H-R-S-A.
So let's start by trying to put all of our minds at ease about what the current expectation is and is not.
It is to develop a plan to expand.
A plan for growing the EHDI effort.
This suggests a yet to be defined period of expansion and a yet to be mentioned funding mechanism for this expansion.
You are not currently expected to implement a universal screening program for all children up to three years of age.
So take a deep breath about that.
This is about being strategic about how we can start expanding EHDI to include the identification of children who are deaf or hard of hearing up to three years of age which is going to take some time and resources.
And this can be grown in many different ways over time from many potential starting points.
It's important to point out that birth to three, this birth to three age group is different from the newborn population in some notable ways.

Most significantly there isn't an existing primary service point like hospitals and birthing centers where it's currently reasonable to expect all children in this birth to three age group can uniformly receive a hearing screening.
There are however a variety of potential service points where hearing screening either already does occur or where it may occur for certain populations of children.
Improving those practices or expanding their access to a broader range of children may not take substantial additional funding.
So partnering with those additional programs may be the most effective.
Some of you already do a fair bit of this.
Some of those existing programs were mentioned in the NOFO.
And we'll address them here today.
We kind of think of those opportunities as low hanging fruit where some strides can be made without substantial additional resources.
So I don't want to suggest that we don't dream or even plan big for the long term.
But we also need to consider that we can build upon all already existing efforts and can start to serve more children up to three years of age more effectively in the short term.
So with that said there are many activities that can contribute meaningfully to this very large new area of work, small, medium, and large undertakings, and we want to help you think about what those might be to think about activities that are truly feasible to build into a plan, who some of your potential collaborators may be.
And some of the resources that may already exist you can use to make progress in your respective states and communities.
Just for clarity's sake, we will occasionally be referring to birth to three screening today.
And when we refer to this timeframe, we're not intending to include newborn screening.
We are actually talking about the screening timeframe after newborn screening up to three years of age.
And when we use the terminology related to hearing screening, we're talking about screening to identify children who may have a permanent hearing loss.
So during today's webinar, we're going to discuss the rationale for ongoing hearing identification activities for children up to three years of age.
And that's something that you'll probably be facilitating conversations about yourselves.
We'll be talking about the use of the OAE screening method for children in this age group.
And what you may want to share with your potential collaborators.
We'll be talking about who potential state and local level partners are for increasing the early identification of children with late onset hearing loss.
And strategies that may be used for implementing state and local level capacity for identifying children with late onset hearing loss including information outreach activities, pre-training program level planning, training, and follow up technical assistance.
Because we want to give you a lot of food for thought today, we realize that we run the risk of overwhelming you with this task.
So we invite you to take a breath.
You've just been given an additional year to work on developing a plan.
And it is just a plan.
And what we're going to cover here today, if it's helpful to you, is available for you to review again in both video format and in print.
So we hope you can use this as an opportunity to think about the big picture of how you want to approach developing your plan.
And some of what we have to offer may be useful, maybe some of it won't.
We don't want to suggest for a moment that we have all of the answers.
There is no single way to make this plan.
And HRSA told us that they aren't going to give a template for this because they really want to see what you all come up with and what seems reasonable to you.
From our perspective, we've worked with the early childhood population for some time and want you to have the benefit of what we've learned in that process.
So I'll show this several times for you during the webinar.
But this is where you can go to review everything we're covering today.
Both in video and print format.
So this is our website.
It's actually the early childhood part of infanthearing.org.
But you can get there directly by just typing in kidshearing.org.
This right here is where you'll find a training module expanding EHDI for children up to three years of age which covers a lot of the same information we'll be reviewing here today.
And then alongside that, you'll see these leadership and planning tools which include a lot of the resources we're going to be suggesting you take a look at today as you think about ways you might interact with potential collaborators in your respective states.
One of the conversations you'll very likely be having is about the rationale behind ongoing screening.
So let me take a moment to share how we like to discuss this and know that this information is available for you to download and share yourselves.
Obviously newborn hearing screening is an excellent way to identify congenital hearing loss in the population.
We as a nation have invested heavily in the provision -- some might say as important as newborn hearing screening is, we've hung our hat on newborn screening to do more than it actually can.
Because not all cases of early childhood hearing loss can be identified at birth through the newborn screening process.
We can't just stop at newborn hearing screening and expect that all young children who are deaf or hard of hearing will be identified in a timely fashion.
And that's because hearing loss can develop at any time in a child's life as a result of illness, physical trauma, or environmental or genetic factors.
In fact the research suggests that the incidence of permanent hearing loss doubles between birth and school age.
These set of children are often described in a group as having late onset of hearing loss.
If we use that as the rationale for newborn hearing screening, that rationale is equally as compelling as the rationale for the importance of early childhood screening.
That increase of potentially identifiable hearing loss is occurring during these critical early years during which children are actively acquiring language for the first time.
Now obviously most parents in early care and education providers are very aware of the importance of language development during these early years intentionally creating language-rich environments with the explicit purpose of supporting language acquisition.
Part of which is noticing and even celebrating words that children first start to utter and use.
We certainly do a lot to promote all of this expressive language.
The development of expressive language is highly dependent however on receptive language abilities and opportunities.
Which for the majority of our children is largely a function of hearing.
All too often it is just assumed that children are hearing at levels we would typically expect.
Currently there is no uniform system whereby young children continue to receive hearing screenings during this birth to three period as a matter of standard practice.
Despite the tremendous emphasis placed on the importance of early language and so many early care and education settings.
It comes as a surprise I think to a lot of parents and even professionals that even though a child may be seen during regular well child visits with a health care provider, evidence-based hearing screening is thought typically occurring during this period.
According to the bright future guidelines by the AAP, after the newborn period an objective hearing screening isn't recommended again as age four as a matter of standard practice.
That's a big gap during these really critical period where language acquisition is so essential.
This underscores the importance of the reauthorization of EHDI Act of 2017 which expands the scope of EHDI beyond the newborn period to include the identification of children who are deaf or hard of hearing up to three years of age.
This change has the potential to dramatically increase the impact of the EHDI system by identifying up to twice as many children as have been identified in the past.
Now that expansion is going to take time and resources, but there are many children who stand to benefit.
And one way to look at the current expectation of developing a plan for expansion is as an opportunity to strategically think about how expansion can occur.
What already is in place to be built upon what is missing, et cetera.
So let's go to the next topic.
Once we've addressed the rationale behind EHDI and the EHDI expansion, one of the next questions that people will want to discuss is how.
How do we screen this population, what method is recommended for this group?
So I'm going to ask Terry to address this.
Everyone this is Terry Foust, he's a pediatric audiologist, speech language pathologist who's worked with us on the topic of birth to three screening for, oh several decades along with us.
>> Thank you, William.
Just a quick note, I've had some jets going over so hopefully that won't happen while we're reviewing this but just to let you know, we'll try and work around that.
Many of you already know but for those of you that don't, I want to take a moment and talk about what hearing screening method is recommended for use with this birth to three population.
Keeping in mind we will likely be talking about screening opportunities where it will be lay individuals conducting the screenings.

Now again as you probably know, otoacoustic emissions or OAE screenings is one of the common methods used in newborn hearing screening.
But it's also the primary method that's recommended by the American Speech Language Hearing Association, the American Academy of Audiology as well as the American Academy of Infant Hearing for screening children up to three years of age.
We'll do a quick walk through right now.
So to conduct an OAE screening, we first as you can see right here, we're going to take a thorough look at the outer part of the ear simply to make sure that there's no visible sign of infection or blockage.
Then we'll take a small probe on which a disposable cover has been placed.
And that probe is then inserted into the ear canal.
And that probe delivers a low volume or quiet sound stimulus into the ear.
A cochlea or that inner snail shape portion of the ear, a cochlea that's functioning normally will respond to that sound by sending the signal to the brain while also producing an acoustic emission.
This emission is analyzed by the screening unit and in about approximately 30 seconds or so, the result appears as either a pass or a refer.
So you get either a pass or refer.
And it really does with the normal functioning inner ear, it is really quick.
Now as I just mentioned, every normal, healthy inner ear produces an emission that can be recorded in this way.
>> This is William.
As I've alluded to, we've already had considerable experience with many early care and education providers training them to implement OAE screenings with the populations that they serve.
So take a look at these photos here.
These children are being screened using the OAE method.
If you have been acquainted with the OAE screening method but primarily in newborn screening settings, you'll notice some differences that may even be surprising to you.
The first thing you'll notice here is these children are being screened in educational, home, and healthcare environments.
Those doing the screenings are their teachers, medical assistants, nurses.
There are some excellent equipment options available now that permit us to go to where children are already happily engaged in play or being held or even sleeping while the screening is completed.
In fact the screening works best when children are familiar and comfortable with the adult doing the screening and where they can continue to do whatever they were already doing.
As you know from your use of OAEs in the newborn population, the screening does not require the individual being screened to provide any kind of behavioral response and does not require the person doing the screening to interpret results.
So all of this means we can use OAEs quite successfully with this early childhood population under a variety of conditions.
Of course those doing the screening with this population are people who are already skilled at working with young children, teachers, home visitors, and others.
But with some training, they can do great.
This short video here is an actual real time screening.
You'll see having a separate adult is always helpful to manage the child's behavior a little bit.
But let's watch really quickly and you'll see how under nice conditions how quickly this process is completed.
Oh sorry, William, go ahead.
>> No, you go ahead.
>> I was just going to say let's take a minute and talk about why OAE screening is the most recommended method for this age group.
It's the most appropriate because it's accurate, it's feasible.
And what I mean by that is it doesn't require a behavioral response from the child.
So that allow us to screen children under three years of age as well as preschoolers who are older but who don't have the ability or can't follow instructions to complete an audio metric screening.
It's also quick and easy.
As you've seen here, most children can be screened in just a minute or two and sometimes as little as 30 seconds per ear.
It's also a flexible tool.
And what I mean by that is it's one that can be used in a variety of environments and those environments can include classrooms, home or healthcare settings.
And it's also effective.
It's effective in identifying children who may have a mild hearing loss or a loss in just one ear as well as those that have a severe bilateral or hearing loss in both ears.
Our data on the 0 to 3 screening, excuse me, in early Head Start settings, our data found that children with permanent hearing loss were being identified at a rate of about 2 to 3 per thousand.
That's an outcome that was highly dependent on a quality follow up documentation and collection system.
One of the things you'll want to consider as you think about a plan is you'll need to think about documentation and data sharing between those doing the screenings and the EHDI system.
Here's an important caveat, while there is strong professional consensus that OAEs are the recommended method for the birth to three age group, we have to acknowledge that there's no screening method that's perfect.
OAEs are no exception.
They're used to identify the most common types of hearing loss found in early childhood.
That's a good thing.
There may be other conditions that OAE testing does not pick up.
So we always tell people that whenever a parent or a caregiver has concerns about a child's language or a child's hearing, that a referral to an audiologist is warranted even if the child passed a recent hearing screening.
>> Thanks, Terry.
So we've talked about the rationale for early childhood screening and the recommended method.
Now let's talk about who might be involved in making this all happen.
Partners in the identification of early childhood hearing loss may come from different service systems and programs and each may play a different role in the effort.
So let's first talk about healthcare settings.
As we mentioned a moment ago, many parents and even some professionals assume that healthcare providers examine a child's ears during -- that when they examine a child's ears during well care visits they're actually screening a child's hearing.
But in reality healthcare providers are generally looking at the general health of the inner and outer ear and usually don't have the training needed to conduct evidence-based hearing screening for children between birth and three years of age.
Engaging healthcare providers as individuals or groups may represent potential partners you could elect to collaborate with as a part of your plan.
Now to be honest, we haven't yet had the opportunity to work intensively with healthcare providers and incorporating hearing screening into their work scope.
In fact it is precisely because there hasn't been much movement in that area that our focus has been on early care in education settings.
That could be a fairly significant undertaking.
But some of you may consider incorporating healthcare settings into your initial plans.
While there may be any number of individual providers or early childhood programs with whom collaborations may be warranted to increase quality periodic early childhood screening.
As I mentioned earlier, it's important to point out two early childhood programs that already exist in every state where collaborations might be especially fruitful.
Early intervention programs operated under part C of the Individuals with Disabilities or IDEA Act and Head Start programs that specifically target children under three years of age.
We highlight these because an important part of the process is largely already in place.
They are already supposed to be helping identify hearing loss through screening or evaluation efforts.
Your task can potentially be to help them fulfill this role and then to establish ways for data and information between them and the EHDI system to be exchanged more effectively.
Let's discuss each of these programs so you know a little bit more about them.
We'll start off with part C.
The federally funded early intervention program for infants and toddlers with disabilities is known as part C of the Individuals with Disabilities Education Act or IDEA.
This program entitles eligible children birth to three years of age and their families to a range of services to promote early development.
In addition to serving children with disabilities identified through other avenues such as the newborn hearing screening program, part C programs are required to actively engage in identifying children with developmental delays or disabilities.
When a parent or early care or education provider has concerns about a child's development, the child may be referred to the part C program.
These referrals are made to the mandated component of part C where the child receives a multidisciplinary evaluation focusing on five developmental domains.
Cognitive development, physical development including vision and hearing, communication development, social or emotional development, and adaptive development.

That evaluation is then used to determine if the child meets the state's definition of having a developmental delay or disability and to determine if the child is eligible for early intervention services.
Since part C of IDEA stipulates that hearing being concluded in the evaluation, this can potentially be a critical point at which a late onset hearing loss may be identified.
Often without anyone necessarily explicitly suspecting a hearing loss.
Let's talk about Head Start.
Head Start is another program found in every state that includes a hearing screening requirement for children being served.
As a federally funded program, Head Start promotes school readiness for children in low income families by offering educational, nutritional, health, social and other services.
The overarching program title Head Start actually includes several population-specific programs including Head Start sometimes casually referred to as regular Head Start, early head start, migrant head start, and American Indian/Alaska Native Head start.
Those are most relevant to the EHDI programs and those are the ones you see identified here with the arrows.
While considerable investment in training and TA has been made during the past two decades to help early head start programs adopt OAE screening, not all programs have done this and even those that have often require ongoing training and technical assistance to maintain those practices.
Turnover is a very big issue.
So we're always providing ongoing training and TA.
State EHDI programs have a potential opportunity in promoting and supporting the use of evidence-based hearing screening practices across part C and early Head Start programs.
A logical starting place for part C collaboration would be to meet with the state part C coordinator who provides oversight to the state part C system and local recipients of federal funding for this program.
Head Start on the other hand is not managed at a state level like part C is.
Instead each local program receives funding directly from and reports directly to the federal office of Head Start.
Each state does however have a federally funded Head Start state collaboration office that is charged to facilitate collaboration between Head Start programs and other services and systems in the state.
While every state has part C and head start programs, states may have other programs like that may include early childhood hearing screenings.
These may reside in local Health Departments, school districts, health visiting programs or as we said healthcare settings.
In addition to identifying providers of actual hearing screening services, it may be helpful to identify service systems that may partner with EHDI programs in outreach activities to help you promote periodic early childhood hearing screening and the importance of follow up when screenings have been completed by somebody else.
There are any number of potential partnerships you could incorporate into your plan including partnering with local Health Departments, school districts, home visiting programs, or health care settings.
In addition to identifying providers of actual hearing screening services, it may also be helpful to identify service systems that may partner with the EHDI programs.
Like those you see here.
They can work in more general ways such as outreach activities to promote periodic early childhood hearing screening.
The importance of follow up.
So as you plan you may want to keep your eye out not only for partners who may be able to provide actual screening services but for other programs who may be able to help more generally in the cause of reinforcing awareness efforts supporting follow up, et cetera.
While there is no single best approach to improving the availability of periodic screening for children up to three years of age.
Let's go over quickly some strategies that could be helpful.
Keep in mind our goal is to give you some ideas of different kinds of activities you could incorporate.
So these are kind of like a menu of ideas.
Some different strategies would include outreach, planning at the programmatic level, training or technical assistance.
And I'll say a bit more about each of these quickly here.
Outreach activities can often include providing and gathering information and can target a variety of audiences including those at the state level or at community levels, or even the general public.
It can be advantageous for the state EHDIs to meet with any system that may be engaged with early childhood hearing screening including the state part C coordinator or the director of the Head Start collaboration office as mentioned ago.
And these meetings, the participants could discuss a wide variety of things like learning about each other's programs, sharing information about current practices, strategizing means for identifying late onset hearing loss, discussing documentation and data-sharing agreements, and outlining what is and isn't known.
Outreach activities can also target the program or provider level which is part C and Head Start programs.
Including both sharing and gathering information about current hearing screening practices as well as technical assistance and training needs.
Public awareness resources on infanthearing.org can be identified and shared as a part of outreach activities.
So we've got ready to use handouts, short video clips and even an outreach survey that you could disseminate to early childhood programs if you wanted to find out what their current screening practices are.
So be sure to check those out and you'll find them on our website right here.
So have a look at those things.
So general outreach is one category.
Let's say you have a program though that indicates a very serious commitment to developing or maintaining evidence-based hearing screening practices.
An important first step that perhaps you could help with is to complete a set of planning activities.
Rather than starting with training, planning activities ensure that appropriate groundwork has been prepared prior to training so that the content of the training is responsive to the needs of participants and that arrangements have been put in place that will permit those being trained to shortly turn around and actually use what they've learned in a timely manner.
Here are some important planning questions that you could use to facilitate a planning process with programs should you decide to embrace that kind of activity with certain collaborators or partners.
You might explore is there a local pediatric audiologist who could work with them.
Which children will be screened, when, where, and by which staff?
How many pieces of screening equipment will be needed and is there a budget for this?
When will the equipment be in hand?
How will outcomes be documented in children tracked?
How will results be shared with parents or others?
And what results will be shared with the EHDI program and how?
In order to be helpful, you don't have to control any of these things.
You can just be there as an expert guide to help them think through these things.
How will training be obtained?
How often will training be available to staff?
We've got this handout planning checklist for implementing OAE screening programs which is found on our website right at that same place.
So you might want to have a look at that, this is where you'll find that checklist right in this list here.
It's right there.
So we've discussed outreach and program planning activities.
The next category of activities you may plan to be engaged with is helping programs to obtain training.
Now that doesn't necessarily mean you have to go provide the training they need.
But you may help them access it through other resources you know about.
As a part of your outreach and planning activities, you'll want to make sure people understand that implementing evidence-based hearing screening practices is more than just simply using a designated piece of equipment or method.
To implement evidence-based practices that equipment must be used according to a prescribed set of steps under controlled conditions.
Each step of which is carefully documented and that requires obtaining quality training.
So just to give you a quick idea of what an effective training should include, it will prepare the learner to explain the rationale for annual hearing screening, to describe the auditory system, describe how OAE screening works, to care for and operate OAE screening equipment.
To demonstrate the screening process step by step.
To demonstrate strategies for eliciting cooperation from children.
Documenting ear screening results.
Sharing results with parents and professionals.
Describing a recommended follow up protocol when children don't pass the screening.
And accessing resources to support successful screening and follow up.
A word of caution, when purchasing OAE equipment, it's not uncommon for sales representatives to offer training which usually focuses solely on the functions of the device itself.

Rarely will a sales rep be prepared to cover all of the essential elements and experiences that we just described here for becoming a competent screener and establishing a complete screening practice.
So you'll want to help them look beyond what the equipment rep is offering when it comes to training.
So again on our website kidshearing.org, one of the things you'll find is a whole set of resources pertaining to planning, accessing training, screening resources, follow up resources, a full gamut of what is needed to help programs build a successful evidence-based practice.
Again you don't need to provide them with the training yourself, but simply point them to resources like this.
And again that's at kidshearing.org.
Once providers or programs are underway in implementing OAE screening, there may be ongoing TA needs which is our last group of potential activities.
You may meet people who are already at this point and don't need any of the other things.
And some of the things that areas where technical assistance is needed may be on screening techniques, interpreting error messages or dealing with other equipment issues.
Tracking the process of follow up for children.
Communicating with health care providers, sharing results with parents and monitoring program quality, their initial pass and refer rates for example.
So there are many ways that you can go about expanding EHDI to include the identification of children up to three years of age who are deaf or hard of hearing.
Those were a variety of different things just to get your thoughts going in the right direction.
Engaging in outreach, building partnerships, helping programs access assistance and planning and connecting early care and education providers with training and technical assistance, all of those things can contribute to expanding the impact of the EHDI system.
Depending on the potential partners and their needs.
You may collaborate with some in one way and others in another way.
For some you may follow the sequence of outreach, planning, training, and TA.
With others you may only engage with them in one of these areas.
Or you may focus only on one of these areas more uniformly across all of your potential partners.
So as you think about how you want to develop your plan, keep in mind that there are many different and potentially helpful directions you can take to expand the benefits of early identification.
This is going to be a process over time.
We hope that in addition to this, we can give you ideas to consider as well as help you access some of the existing resources that we have that you can put to use.
Our goal as the EHDI NTRC is the same as yours; that children with late onset hearing loss are just as likely to benefit from early identification as are children with congenital hearing and have benefited so richly from the EHDI systems you all have done such a wonderful job overseeing.
Take a look at our website.
Again this is it.
And let us know if we can provide you with any further assistance.
So the Q&A box is opened up.
And Terry and I are going to show our faces again I guess for a minute or two here.
And Gunnar, it says I can't start my video.
>> You may need to stop screen sharing.
>> Oh probably, right.
Well I didn't before.
There we go.
Somebody made a comment, Terry, that you may want to think about and respond to.
I think we need to be careful about saying OAE screenings rule out mild hearing loss.
>> Yeah.
Thank you, William.
I think I would first go back to where we had mentioned earlier that there's no perfect screening method.
However and I will quote the American Speech and Language and Hearing Association which states OAEs can reliably distinguish ears with normal hearing from those with hearing loss as well as all of the early Head Start data has shown that well again not perfect, it does identify most of those degrees of hearing loss.
But again it's not a diagnostic test, it's simply a screening to identify those that are at risk that should go for further diagnostic testing.
>> Yeah, that's one of the things that is a real challenge, right, Terry, as we step back and think about screening programs and for those of you who are trained, it does take some really intentional thinking about how to think macro when establishing a new screening effort recognizing that we are going to miss some children.
But we're looking at the efficiency of finding the most children in the most efficient manner.
You want to add anything to that, Terry?
>> No, I really agree.
It's really those, we really when we look at a public health paradigm where we need to have good sensitivity and specificity meaning that the screening test is going to reliably help us identify those at risk.
We are looking at how we can apply that to as many children as possible.
So we have to kind of take off those diagnostician hats and look at it in that kind of viewpoint.
Yeah, thank you.
Another question is what is the schedule for rescreening these children.
If you look on our website, there is a detailed protocol which Gunnar, does my arrow actually show where I'm looking here?
My cursor.
>> I cannot see it, no.
>> I cannot either, William.
>> It's under screening resources, the second one down there.
Protocol guides and forms shows the protocol that we've used in early Head Start and Head Start settings for that follow up.
But basically when children don't pass the initial screening given that there is a fairly high rate of middle ear conditions, we recommend that they screen the child again a second time and then progress through a follow up process there.
But maybe now as I look at your question you are asking more globally about how often are children screened.
In the Head Start world, screening typically happens annually as they get re-enrolled each year.
So I think that's what you are asking.
But if you want to look at the protocol, now you know where it is.
Any other questions?
Someone is asking about the clarification from HRSA if I could say that again.
Yeah, we have been asking HRSA whether they were going to provide any additional clarifications about this expectation.
And in addition to clarifying that it's up to you to figure out what kind of funding parameters you want to work with whether you want to conceive of a plan with current flat funding or whether you want to envision a plan that requires some increase is up to you.
They are going to be issuing some kind of additional clarification about all of this in the next weeks ahead.
So keep your eye out for that and we're all going to be interested to see what they have to say about this new expectation.
Any other questions or comments before we sign off for today?
Well we really appreciate the time that you're all giving to this and want you to know that we are here if there are resources that we can help point you to after you've taken a look at kidshearing.org, we hope that you'll remember that we're here to support you in this effort and remember also that today's webinar has been recorded so that if you or any others of your staff could benefit from reviewing this again, you'll find it on infanthearing.org.
And there are print documents as well that correspond with this that you'll find there.
Before you sign off in the chat there is an evaluation and a certificate generator for your attendance to today's webinar.
If you could go to the chat, click on that link and it will give you a chance to give us feedback and to generate a certificate of attendance for your time today.
Again a shout out to our captioner, to our support staff, Gunnar and Lenore.
And thank you, Terry, for your time and expertise as always.
Thank you everybody.