>> DR. UMA SOMAN: Good morning, my name is Uma Soman and we will be gathering today for about 3 hours. To hopefully have a conversation about what we consider complex challenges cases.

 Complex and challenging cases.

 And how we can be reframing that thinking into, what is the opportunity here? What is the strengths-based approach here?

 How can we continue to support the family and the child to achieve their desired outcome and their full potential?

 Quote-unqoute inspite of the challenges.

 So I am a teacher of Deaf and hard-of-hearing students by training. I've mostly worked in the school-age setting. I'm an Assistant Professor at Fontbonne University. And I have my own nonprofit called Listening Together that does work virtually around the world. But a lot of it is -- a lot of it is done in India and the Indian subcontinent so what I will be sharing today is coming from those few different contexts.

 Presenters, will you introduce yourself now? Yes, awesome.

 >> DR. JENNA VOSS: Hi, I'm Jenna Voss.

 And I'm from Fontbonne University in St. Louis, Missouri.

 And I'm glad to be presenting with two of my besties today.

 >> DR. ELIZABETH ROSENZWEIG: Good morning, everyone, my name is Elizabeth Rosenzweig. I am an assistant professor of practice at Columbia University. And I also have a private practice where I serve children and families around the world via teletherapy.

 >> DR. UMA SOMAN: Thank you. So what we're going to do today is we are going to start with some general framework to consider these cases. And -- hey, Lynn, can I ask you to sit with someone in groups of three or four?

 Oh, you're just saying hi.

 Sorry.

 I am sorry.

 Start with same framework. And then we're going to each talk about the three types of challenges that we have identified as one being trauma and adversity. One being linguistic diversity in the home environment. And the third being additional disabilities and challenges.

 We looked through the little art word wall that you have all created. And I'm noticing the theme of parent engagement. Parent acceptance. Parent participation. Parent partnership. As being an underlying challenge in all of those.

 And while we are saying these are three different things, of course there's overlap.

 Right? So we will have a conversation about that.

 We hope to save the last 45 to 50 minutes to work on some cases in your groups. And thus, my push for people to sit in groups of three or four.

 Here are the learning objectives. The handout was uploaded a while ago. If you don't have it, please scan the QR code or go to the link. Because you will need it. We could have done this for 8 hours and then we realized, okay, we have only been given 3. But we have so many resources to share so let's do a guided worksheet. What we have done, the three of us in the past few years, is not given out slides but rather a worksheet, that will ask you some questions, give you additional resources so you have something to hold onto when you go back.

 Let me know if the QR code isn't working.

 It's not working?

 Maybe because you're at an angle. Okay. We will figure that out.

 Okay. Good.

 So it's an issue of angle.

 And there is the link if you need to type it in.

 Okay. And now I'm going to talk fast.

 Give me a thumbs up when everybody has this document.

 You could type in the link is probably what you'll have to do.

 Okay.

 It's okay. I think she got it.

 Did you get it?

 Oh, okay.

 Well, we're going to write it down and then you will have it. EHDI23-worksheet. Perfect. Thank you.

 And you really, really need it in the last 45 minutes.

 So we'll get you there.

 Very quickly just to get us all on the same page, what is the goal of family-centered early intervention? We want families to achieve the desired outcomes that they have identified. The families identify strengths and needs of the child and their family.

 And then in terms of negative impact on development in communication and related areas, that could be due to the diagnosis of a hearing loss or the presence of a hearing loss.

 Also, support families in the early years so they can be the primary philanthropy and the advocate of the -- the primary facilitator and advocate of the family.

 Feel free to add to this in your mind, in your worksheet.

 And think to yourself, challenging cases are those that, and for each person a family that is challenging to work with means something else. Think to yourself, what types of families or children am I challenged by?

 Would anybody like to share? Oh, yeah, Jenna has a pass-around microphone.

 Yes, I can do that.

 Anybody want to share what kinds of families they find challenging?

 >> The first thing that came to mind for me is that I don't have the skills for.

 >> DR. UMA SOMAN: Yes.

 >> It's not them, it's me.

 >> DR. UMA SOMAN: Families that I don't have the skills for and I'm seeing some nods in the room.

 Anyone else?

 In the back.

 >> Sometimes it's hard for me when it triggers traumatic experiences in my own child's life.

 >> DR. UMA SOMAN: Yes. Triggers traumatic experiences for you. You know what I didn't ask you all to introduce yourself early on which is something we were going to do I feel like we chitchatted a bit but would you tell us your name and the role you are serving in.

 >> Sure I'm Penny Ecels from Los Angeles Nevada I'm the Guide By Your Side. I'm the liaison for the CHARGE syndrome foundation and I work on the Board of Directors there, as well.

 >> DR. UMA SOMAN: Thank you, Penny. Melissa would you like to introduce yourself.

 >> My name is Melissa Jensen I'm a teacher of the Deaf by training. I currently work at Sunshine Cottage school for Deaf children in their birth to 3 Parent-Infant Program .

 >> DR. UMA SOMAN: So cases that are challenging to us are those that we don't have the skills for. Those that are triggering to us in some way or another.

 Anything else?

 I think you are trying to raise your hand. There we go.

 >> My name is Samantha Goucher I'm a 0 to 3 LSL early interventionist for Arizona schools for the Deaf and blind I do home visits but mostly tele. That's what my families like. I think that's what I'm really good at. Maybe not the best in person.

 So I find it really challenging since I work for a public agency when there are a lot of cancellations, reschedules, no shows. And I look at my CASLs and I'm like I don't know what this child can do because I haven't seen them in 60 days.

 >> DR. UMA SOMAN: Oh, right. So again, that goes back to that engagement and participation, presence. Participation and intervention that is impacting your work as a provider. Because you have nothing to show for the last however many days. Thank you for sharing that.

 Okay. We are going to talk about three challenges, like I said, that are often considered as challenges by many professionals. And again, the unsaid thing here is because many of the professionals in our field are those who are White women middle-aged middle class monolingual.

 Able-bodied.

 Right?

 So this is not describing most of us.

 And thus, something other than me, something that is difficult to relate to, something that I don't feel I have a sense of familiarity and depth in will feel challenging.

 This is something I do with my mentees in India. This is something I have trained them to be thinking about.

 This is not in your document but I'm happy to share it if the QR code doesn't work for anyone. But I'm also going to share it here in a second and I'm going to show you.

 But what you are going to see as you're looking at the QR code is a worksheet that I've been having a lot of my mentees do to think through the family scenario.

 We tried to start with eco maps, and that was too much. We needed to take a step back to really take into account all of the facilitators and barriers that would be necessary to take into account this is not a document we share with families. This is just for us to get started. After we've had one or two early meetings with the family or have reviewed the case study or something like that.

 Is it not working?

 >> (off microphone).

 >> DR. UMA SOMAN: Okay. All right. I'm going to show you what I'm talking about. I've been told how to do this well. Okay. Here we go.

 Okay. Look at this. Can everybody see this?

 Yes? Okay.

 So this is the document.

 It starts with -- oops. Name of the child. Date of birth. Caregivers. And home languages.

 And that is Question No. 3. Because that's the population everybody in India is working with. And dealing with.

 And then it goes into based on your conversation with the families, what were the desired outcomes for communication and language? Short term, long term. And any other hopes, dreams and wishes that the families share.

 We will send them the copy, yes, I can do that when I hand it over to you.

 Yes. Okay. So the plan is if you couldn't access this document, give us your email. And I'm going to email it to you. When I hand the mic over to Jenna.

 And these are just child-related factors that typically impact, is it a facilitator? Is it a challenge? What notes do we have about it? Then always, what do we not know and what do we like to know more about? Caregiver factors. Starting with emotional well-being. And it is at the top for a reason.

 Attachment, availability, ability and so on.

 These are the questions to think about. What is the information family members are asking for? What are some areas that you think parents need more information? What are some strategies that parents seem to be using already? What are some things that you can celebrate?

 And this is happening in the first two, three meetings.

 And then systems-related factors, whether there are facilitators or challenges.

 And there's one more page.

 Really?

 Oh, this is the page.

 Intervention-related factors.

 And how we could be addressing them.

 So one of the things we'll do when we do our scenarios in the last 45 minutes is we will be using this worksheet to be thinking through those scenarios.

 So by then you will all have the worksheet.

 Oh, there is a link for this, too, guess what, I actually did this work.

 So Jenna, will you copy this link real quick? You can write it up there, that's a good idea, Elizabeth.

 It's again the Bitly -- bit.ly -- EHDI casework sheet. I will give it to you.

 Okay. And with that I'm going to hand it over to Jenna who is going to talk us through some trauma and adversity considerations when thinking of them as opportunities.

 >> DR. JENNA VOSS: Okay. Thank you.

 It's good to be with you. I spend most of my daytime teaching Graduate Students in a small seminar.

 So not like standing behind an awkward podium far away from you.

 And so I would just say while I'm going to try to stay on time, this is much more important learning instead of me didacticly blabing things at you to make sense with your connections. So if you have something it's worth us to take a pause and share out and pass the mic.

 So trauma and adversity are terms that are thrown around a lot. And used by different people in different ways a lot so I thought it would be helpful to just share some grounding initially.

 So for the purposes of today, adversity is any experience or event that is causing harm or challenge to someone.

 So we all in our life experience adversity at different moments, at different times. We had a collective experience of adversity through a global pandemic.

 And the trauma is the network outcome that happens because of the adverse experience.

 So if we can think about trauma as the outcome, adversity is not something we can erase or eliminate necessarily. In our roles as professionals or even parents.

 But we would like to put in the right environmental supports to limit the negative impact of that adversity, i.e., the trauma.

 So there are a lot of sources of adversity and I struggle with the language around this because there's a lot of things that harm us, harm us as individuals, harm us as communities. There's a lot of harm that our systems do that we are perpetuating by being players in those systems. That's not the whole extent of this talk so I'll give you in 30 seconds some examples of sources of adversity. So sources of adversity could include things like experiencing childhood poverty where you don't have enough financial resources to meet your daily needs.

 It could be if you experience housing instability or homelessness.

 If you don't have a secure, safe place to lay your head at night, that is an experience of adversity.

 In the United States, and this is different -- we present in different parts of the world, being un or underinensured is an experience of -- underinsured that you don't have access to the same healthcare systems.

 It's an experience of adversity.

 Systemic racism is a form of adversity, it causes harm to people .

 Child maltreatment is one we can think about so like child abuse or neglect.

 Gun violence in your home or community. Spousal violence in your home.

 These are all examples of adversity. That's hard.

 And as I'm teaching grad students, we often talk about, oh, wow, that adversity is really unfortunate. Like that's -- it makes us feel sad and shameful that this happens in our society. But I sort of always want to challenge my own thinking to say like, these are actually forms of injustice.

 Like it is not a just society that individuals continue to experience sustained adversity. When we know better and technically have enough collective resources to do better.

 So it's not just feeling sad or bad for people who experience adversity. But thinking about how unjust is it that this continues to occur.

 Show of hands or otherwise able, if you are familiar with the Adverse Childhood Experience study, the ACEs. So we're not going to dive into this today but it is linked on your guided worksheet .

 I'm basically just an advertisement for you to click on the links in the guided worksheet.

 The Adverse Childhood Experiences study was born out of a primary care physician who was looking at obesity outcomes in his adult patients and he was doing a weight loss intervention. And basically finding that his interventions weren't impacting people in the same way in adulthood.

 So they looked retrospectively at childhood experiences and found major differences in default health outcomes based -- in adult health outcomes based on early childhood experiences with adversity .

 That work was pretty phenomenal and pivotal in scaling to a lot of different disciplines, including developmental pediatrics and even now our fields because it's getting us to know and notice as Early Hearing Detection Intervention practitioners something we see and know deeply and often but understanding it's not just about helping children thrive or flourish right now. But there are significant long-term health outcomes.

 People die earlier when they have greater incidences of early childhood adversity.

 So how can we interrupt that cycle?

 Sorry; I'm jumping all over my slide. Let me bring it back. Look at this, Uma you did put this in. This is my lame analogy of this little puppy in a rainstorm and he's experiencing some adversity.

 He's in the storms of life. So if he lives in a torrential downpour versus like a little rain shower that's both adverse but also sustained storms that flood your home are different than like a rain shower that was bad in this moment.

 Follow my lame analogy here.

 If he -- yeah, there's the storms.

 If we gave him shelter and he could cover up and have a strong place to dry off, that would be one positive interventions that would get him out of that rainstorm. I also had it didn't make it in the slides a hat and some gol lashes we can't always eliminate adverse but there are be things we can do to limit the traumatic impact of that adversity and that's the reframing I would like us to think about today. We cannot eliminate systemic racism in our sphere of influence as early hearing detection practitioners or parents we can fight the good fight but we might be able to provide supports and relationships in fact I'm stealing my own thunder that will buffer someone against the traumatic impact that could be experienced by that adversity.

 So as I mentioned earlier, we all experience adversity or stress, sometimes that stress impacts us in a positive manner that greenish circle implies the stress you feel before you give a presentation before the big -- a big crowd it make sure your talk is ready and motivated and positive and then it goes away you might have a physical manifestation of that your heart rate may increase, you might feel those butterflies.

 When you have also a temporary stress response at the level of tolerable stress in the yellow bucket, it is something that you can manage. And you can especially manage it when you're supported in relationships.

 My example for this one is tolerable stresses like before my kids get their COVID vaccine for example, they feel stressed about that. They don't care for shots. They don't like the idea of this. But they have their loved ones there explaining why this is good for their health and the health of the public and we're going to power through. Then they do it and then -- then they can reregulate.

 The traumatic outcomes come from sustained adversity or something we can call toxic stress . This occurs when there's a prolonged activation of the stress response.

 A physiologic body response over long term.

 So we see increased stress hormones changing our cortisol levels, increased blood pressure and heart rate. Brain changes, we're talking fundamental physical changes due to prolonged adverse experiences.

 In the absence of those protective and nurturing relationships, that toxic stress is why we have negative health outcomes in adulthood.

 So here is that link I was mentioning in your handout to the ACES 2 high. Do not do this while you are -- don't do this now while you're sitting in the presence of friends and colleagues . But you might take a look at this brief 10-question survey to check in yourself or you could answer it on behalf of someone you know or -- you know or love or serve in your role in the EHDI system.

 To appreciate and I don't mean like in a fond way, I mean like really contemplate, the level of Adverse Childhood Experiences that they might be experiences.

 So the survey and data indicate that scores of 4 or more are experienced by folks who have more negative long-term health outcomes.

 But we're not writing them off. We are not writing you off. We are noting that when you experience high levels of early childhood adversity, the best and most supportive intervention we can provide is safe, stable, nurturing relationships.

 So that is the work that we do. And that's the reframing I would like to invite you to today. I wanted to give one mention here about especially when we're thinking about family-centered intervention and our Early Hearing Detection Intervention systems where often the adults who we are interacting with are our learners or our clients, we need to also think about neurologic development and intergenerational adverse experiences.

 So when we are encountering parents and caregivers of young babies who might be experiencing their own adversity.

 So if we're working with a three-month-old they might not have a big ACE score yet because they have only been on this Earth for a few months but the parent we are speaking with or learning with might come with a. Different lived experience than we know or are privy to.

 And so there's some interesting emerging work about how the familial bond or attachment impacts those neurologic pathways that develop in young children so when young children are nurtured, supported and encouraged, and positively reinforced, then we see those positive buffers. Yes.

 >> So I have a question about intergenerational trauma and being non-judgmental.

 So how do we help educate or support families without judgment. It was a couple of years ago they said if it's safe and legal, you have to let it go. So if I would consider what the parent was doing to be adverse but the parent doesn't consider it adverse and I'm supposed to be non-judgmental, what do I do with that? .

 >> DR. JENNA VOSS: That's a good question, Melissa.

 I think we are in interesting spaces when we are invited into families' lives to support their needs.

 And it is a humbling privilege. Because my lived experience often was not a match for the person that I was encountering in that moment and I found my own internal pendulum swinging of like oh, my goodness this is so different than any kind of parenting practice that I see in my social circle, that I engage in as a parent, as how I was parented, like I'm unpacking all of my stuff.

 And is that cultural? Is that this family's choice? Is that this family's rights? Even in the work in child maltreatment, even when I am educating students and other professionals on our rules as mandated reporters, it's not clear.

 And things that you have to report are not always clear to us. So when we're talking about parenting practices and nurturing relationships, those are baked into someone's identity and culture and preference and belief.

 So I guess I would say you're not going to get an answer from me that you like. Which is do this don't do that, do this, don't do that.

 But what I would say is how can you reframe for a parent the impact of the choices they are making? And help them be on their own self-discovery.

 I'm going to give you an off the cuff example that's not fully thought out so I might bumble through this.

 But I was working with a mom who essentially our behavior management strategy, in my -- in my young White girl not yet a parent way felt like she was threatening and shaming her children. So she would give her child with hearing loss who had delayed language development this like death glare. And threaten him with either like a ruler or a wooden kitchen spoon that she had.

 And it was to get him to stop a behavior that she didn't find desirable.

 I was like, oh, my gosh, is this threatening to him and is this maltreatment or is this a parenting style that's really uncomfortable for me.

 So what I thankfully had with this woman was a relationship so I could say things like, you know, I wonder what your son thinks when he sees you looking like this.

 We had to talk about it in the cool, not in the moment. We had to revisit it later and say like, maybe given his lack of receptive language at this point. Like that is really impacting him. And it might work in the short term because he might go I'm not going to do that anymore.

 But is that the kind of -- is that what you intend. So it's complicated. And it was a much bigger conversation that I bumbled through at the time and I don't know how it worked out. But clearly that was a way that she had parented and that her peers and family parented.

 And so was that my job to be telling her not to do? Maybe not. Except that I could bring to this impact on language. So if he can't understand what you're saying the five things that you say it before you threaten him with a wooden spoon then he's at a disadvantage to understand your message so that's where we went with that. Language, which is my comfort zone.

 Yes. Please.

 >> So working in -- working in India spanking is very common practice even therapists are doing it so when people say I spank my kids nobody is really saying anything about anything. So what I've been trying to ask my mentees to ask my parents is, what is the impact on interaction attachment and the child's willingness to continue to communicate with you because you are all doing this so that the child will talk.

 And draw me a line from this to child will talk more.

 And generally there isn't a line.

 And actually I've had multiple mentees say to me, I have stopped using physical punishment for my personal children who are not Deaf or hard of hearing because I see it was just impacting our attachment and interaction. And now that I'm doing it, it's easier for me to talk to my parents. .

 >> DR. JENNA VOSS: I think the other thing you make me think about Uma I too give my kids a real ugly look at them and I even scream at them and the other day I called one of them a bad name across the kitchen I said you're acting like a little -- it's true was that my best parenting moment for sure not so I flipped my lid at the moment. I met my threshold.

 That is not how I would choose to parent on a regular.

 But if you are experiencing yourself sustained adversity all the time and you are in that flip your lid fight or flight mode all the time you don't have all of your really great tools at your ready so you are flying off the handle at every turn so I think that is our role as coaches and guides and supporters to say, what do you need to parent in the way that is how you want to do this.

 And just because what we're observing doesn't mean that is your intended parenting approach and preference.

 So on one hand, good for you that you are let into someone's home and life to see their truth. And on the other hand, how can you help them meet their needs so that they can provide secured, loving relationships and attachments to their children.

 And I'm guessing -- okay. Time is up. 10 minutes.

 Okay. I guess I'm also saying when you are working with a grownup who has experienced that trauma, their brain is different. As well.

 .

 >> Oh, goodness, I want to be able to see your faces but I just want to do a quick summary, if I can. So you're talking about parents. And parents, whether they are threatening or trying to stop a behavior with an action. Now, you can sign no because the child may or may not have communication. So I'm teaching the signs. That's what my role is is to teach parents to be able to communicate using sign by just saying no and signing the word no.

 Instead of -- instead of having a tool to threaten them with like a spoon or whatever.

 >> DR. JENNA VOSS: Yes, thank you.

 I think your example of having language is a really supportive reframing.

 And for us as grownups to be able to use language and meet children at the language level that they are, that takes our own regulation.

 And if you -- we have experienced sustained adversity over time, that brings added challenge. We aren't like a whole and perfect being because we too have experienced sustained adversity. So even the encounter of a conflict with their child who we love deeply might be triggering to our own experiences.

 So when we are providers coming into that dynamic, we can't just be thinking about the child's experience, we have to be thinking about the grownup's experience, too.

 Yes, please.

 Will you mic run for her?

 Yeah, flip it on.

 >> For my kiddos that are language delayed and have behavior problems because they kind of go hand in hand, I have found it -- oh, sorry; for kiddos that are language delayed and therefore typically have behavior problems, I have found it really helpful to keep the receptive language train going by labeling their problem behavior and following it up with the word no.

 Because then I capture their attention with the language. But then their take-home message is, oh, I should stop doing this.

 So just a little thing I've found helpful.

 >> DR. JENNA VOSS: Thank you. Okay. I'm going to try to be on track here but also we could go on and on about this. What do I have, 5 minutes?

 Okay. What is familiar, show of hands or otherwise able, with the social determinants of health? Yes?

 Okay.

 So I'm going to give you a little tutorial on this.

 This is the idea that these are the conditions in the environment in which we live and work and play.

 And age. That impact a range of our health, functioning and quality of life outcomes.

 So there are five domains of the social determinants of health.

 They are depicted in these images and I'm going to tell them to you. Safe housing, transportation and neighborhoods.

 Racism, discrimination and violence.

 The third category is education, job opportunities and income.

 The fourth is access to nutritious food and physical activity.

 Polluted air and water.

 And language and literacy. I might have given the examples that weren't the categories.

 Anyways, it's this idea that there are environmental factors that impact our wellness. These are also things that we as individual practitioners don't always get to control.

 These are things that are if you were drawing like the Bronwyn runner ecological systems theory would be outside of the child and family but still impacting their development and attachment and relationships.

 So some of these social determinants of health help us explain the inequitable outcomes we observe.

 So if you live in a neighborhood where schools are underfunded because there's no corporate tax base, and thus, the buildings that you live and rent in have not been updated because new investors are not coming there, you can see how this story is like much bigger than an individual's choice making. It relates to the circumstances in which they exist.

 So these are not to be dismissed as like inconsequential because in fact they are highly consequential.

 But these are those systemic factors that we as practitioners have to hold both/and. We have to meet our children and families where they are. And establish secure and nurturing relationships with them. And we cannot ignore sort of the soup that we're all swimming in.

 There's some great resources from the Center on the Developing Child at Harvard University I'm not going to tell you anything about them more today except that it may assist you in reframing some of this overwhelming adversity and social determinants of health by staying focused on, well, what can we change, so there's a good resource there.

 So let's practice real quick.

 Reframing our words.

 These are an oversimplification.

 But you can imagine professionals behind closed doors saying relatively pejorative things about the children and families we serve.

 Like what's wrong with them? Why won't they? Fill in the blank.

 So when a client -- I think I'm going to click these up, they didn't come up in a way -- okay, wait.

 So instead of saying, what's wrong with you, what might it be like if we flip the question to what happens to you? Or what have you experienced? And you could change the language of that. Like why do you do that? Well, let's go back a step to like how is this behavior coming out because of something that you experienced?

 I hear a lot of -- especially in audiology circles -- like shame around not showing up for appointments or not showing up on time for appointments. And so when they no show, it becomes like a verb. Like no showing something.

 Versus why were they unable to make it today? What got in the way of their success?

 And then I hear this euphemism all the time.

 They are not buying in. Well, then what am I doing that is making my service delivery a mismatch for their needs because a lack of buy-in or participation if the outcome. And the root might be that we aren't meeting families with their own priorities.

 Uma, I have no idea where we are. I'm going to show you, there's a few other resources.

 I'm a perseverateer and I get stuck in a spiral. This is not my therapy session. But you're having it.

 I lie awake at night thinking about encounters I had where I said the wrong thing or didn't meet someone with the deepest compassion. And I have found this set of questions that are written on your handout so you don't have to frantically write them down to be super helpful in reframing my own negative thoughts.

 Like it takes me out of feeling badly for what I did and sets me back on a trajectory of how can I make it right and restore this.

 So these are in your handout.

 And then I am going to skip through some of this.

 There are -- now we are data on the positive childhood experiences that will serve to balance out some of those Adverse Childhood Experiences.

 And you can read all of them. And they are fascinating. And I would love to give you a different talk on those. But the moral of the story is it's about relationships.

 So the American Academy of Pediatrics put out an update to some of the their earlier messaging on adversity, it's awesome, you should download it. And it's all about establishing safe, stable and nurturing relationships.

 So if you take nothing else from this 30-minute section of today and you can feel overwhelmed by the adversity and the social determinants of health that impact so many of our families, double down on the reframing of focusing on relationships.

 Your relationship with the children and families you serve.

 Their relationship with each other.

 Their relationship with other children and families. Right?

 If we invest in relationships, that is the single handed evidence-based approach to counteract adversity.

 Okay.

 So there it is.

 So I feel like Elizabeth and I did some work in one of the ASHA SIG journal perspectives.

 Sorry; ASHA perspectives.

 And it was about a reframing. We're not going to dig into it today. But if we start with what the families are doing that is working with them, identifying their strengths and vl dating the impact -- validating the impact it's having on their child's development then you can capitalize that and shape their positive interactions and behaviors to yield a new next behavior.

 So again, it's a strategy for reframing a challenge as an opportunity.

 And I guess I want to end before I pass the mic with thinking really about where is your sphere of influence.

 I hope it's in a relationship.

 I hope you can think about what relationships you influence.

 Because we know relationships matter.

 And it is hard not to get stuck in this system like the oh, poor us because we're in this like screwed up and dysfunctional system.

 But if we can pour our energy into our sphere of influence which is in the area of relationships, we will be better for it. Thanks.

 >> Thank you, friend, so we are at 9:30, 9:25. So I'm going to present for about 25 minutes. Then Elizabeth is going to present for 25 minutes. And then we will take a break. Is that okay?

 >> DR. UMA SOMAN: And then we will come back and do the case studies. And you can get up any time you want. Yes, Rena. Oh, sorry; sorry.

 >> Wait, one minute, please. Sorry.

 >> I'm sorry; it sounds like there's some competing noise from the other rooms and it just recently got louder. Is there a way we could --.

 >> DR. UMA SOMAN: Liz, will you look? Thank you, Liz.

 >> If there's a room monitor or something.

 >> DR. UMA SOMAN: Yes, she just left.

 >> Thank you so much.

 >> DR. UMA SOMAN: Thank you, Rena.

 Okay. So I'm going to be talking about linguistically diverse home environments and can I tell you it took a 20 minute discussion to figure out what the title of this slide was going to be.

 Here is the reason why, we didn't want to say bilingual because not everybody is bilingual. In my life and circles, everybody is multilingual so I was okay with that. But that's not always the reality. We didn't want to put a negative statement non-English speaking families because that's not always true we didn't want to say minority home language because that's not always true so we're landing on linguistically diverse. And I think that's part of the problem.

 There's no one formula for bilingual.

 Okay. So currently in the U.S., as of -- oh, I didn't put the citation this is the American Community Survey, 2022. And by the way, check your emails, I have sent you the worksheets. And you should have access to them.

 So what is interesting to me is there are people who speak a language other than English at home. That doesn't mean they don't speak English. Then there are people who speak English less than very well. And then there are people who speak Spanish. I think these numbers are still low because these are numbers based on the people who answer the door when somebody knocked on it. And then answered the questions. Which were almost always in English.

 So I think these numbers are low.

 But as you can imagine, it varies from state to state. I tried to pull the states that I knew we had registrants from.

 Obviously I'm not representing every state in the room.

 But be thinking about it. And if you don't know the numbers in your state or your county, the American Community Survey will drill down to the county level. Again, knowing that these numbers are going to be low.

 This is what I want you to take away today.

 Languages learned while living life -- language is learned while living life, not in a therapy session. Not taught by the professional or the teacher.

 Language is learned while living life.

 Uh-oh, the volume went up again.

 Oh, the button is right here. Perfect.

 >> We'll just do some AV support.

 >> DR. JENNA VOSS: Liz is checking that out right now for us, thank you, room monitor Liz. But she said they don't know how to turn it down in the other room so she's going to do it.

 >> DR. UMA SOMAN: Liz, I'm thinking it's the output rather than the mic gain.

 A little bit of audiology. Audio science. Thrown in.

 Language is learned by living life.

 This statement came from the need to convince parents early on or sometimes a little bit into the process that they were the ones who were going to make the difference, not the one hour spent with the therapist in the home and the whatever in the clinic.

 Or even the three hours spent in the preschool group.

 And there's a very -- I like the image, Carrie Ebert has this image of the M&Ms and there are 14 3M & Ms -- white M&Ms and then there is 1 red M&M which is the one hour of therapy the child received during their waking hours.

 I use that all the time. Be checking that out.

 But language is learned by living life .

 And once we accept that, it is then important to us to understand what the languages are that are being used to live life.

 So I want you to think and share at your table and let us know if you have no friends at the table, we will ask you to regroup just a little bit. And just think about this for a second.

 What is the role and purpose of language within a child and family's life. How does having more than one language impact or change that? What is the impact when the child's home language is different than the majority community language?

 So think pair share. Would you like to join this table? Yes, perfect.

 Take about like 2 minutes.

 .

(Standing by).

 >> DR. UMA SOMAN: Are we ready to share out or would you like to finish your thoughts for another minute? One more minute.

(Standing by).

 >> DR. UMA SOMAN: Okay. Friends, come back. Don't apologize, keep the conversation going but come back for now. Would you like to share? You have two choices, you can share or you can say I'm going to nominate another table to share and that's perfectly fine or you can say come back to me in 25 minutes after I've collected my thoughts. Would you like to share? You could nominate the table next to you if you would like or share.

 >> Communication is the main --.

 (Background talking.).

 >> Communication is the role and purpose of language within the child and the family.

 >> DR. UMA SOMAN: Thank you, anybody at this table? Melissa?

 >> So I think that with families whose language is other than English in America, some families are pushing to not speak their home language. I see that sometimes that they are like, no, no, no, English, we're going to do everything in English. So trying to validate -- which feels like a swing from the way it used to be which is no, you have to do only English and now we're like no, native language and I'm getting some pushback there.

 >> DR. UMA SOMAN: I'm getting a lot of pushback. I'll talk more about that.

 Friends at these tables? Thoughts?

 Okay. Penny, here you go.

 >> Well, language is tied to culture. And when we're talking about the need for intergenerational support, it is important to encourage that native language.

 And then we talked about if a family is not being taught in a language that is easy for them to understand, they will feel like they are being talked to. And not being invited to be part of the team. So that will impact negatively parental self-efficacy because they will not feel empowered.

 >> DR. UMA SOMAN: Thank you. Friends at these tables?

 >> So for purpose we said that communication is the main purpose or role of language. I grew up speaking two languages.

 I don't recall it being very challenging when I was a child. But people tell me, it's challenging to learn two languages at the same time when you're a child. I don't agree with that.

 And I was saying to my colleagues here at the table that I wouldn't even consider -- it wouldn't be a thought in my mind oh do I speak English now or do I speak Spanish now? It was just automatic. And sometimes when I was speaking, and still to this day I'll be speaking Spanish and I'll think what's that word, I can't think of that word, it comes to me in English you know how to say it blah blah and the same thing with English I'm at an advantage because I still know the word or I just can't remember it at that moment in that language. So I don't feel it's a negative at all.

 >> DR. UMA SOMAN: Marisol, right? Thank you. Thoughts.

 >> we said a lot of the same things but yes communication being a key part of the purpose and being able to feel like you're a part of your own circle or family and then just for learning overall, we also talked about feeling included in your own family and your family dialect. But Rena said she speaks two languages, as well. And that can strengthen your brain neurological development. And she didn't feel like it was hard to learn the two languages, like you said, as well.

 And then outside -- the market when home language is different than the ma -- the impact -- when it's different than the majority of the community language, it's just families for families to communicate outside of their family circle .

 So different things like getting a doctor's appointment. Or things that they have to advocate outside of their home. .

 >> DR. UMA SOMAN: Carrie, the last point you made about difficult to advocate, the assumption there is then they don't speak the majority language. But there are families who have a home language and speak the majority community language. And that's how I grew up.

 At the age of 5, I was speaking five languages. My mother didn't even know I spoke one of the languages because she didn't speak that language but my friends at school did.

 So what did she need to know about it?

 So one of my -- I grew up in the Middle East for a little while.

 And I spoke or do you because people speak Ordu and it was important to be able to share lunch and swap tiffin if you didn't speak Ordu you wouldn't get the fun tiffin from my friends and my friend's mother saw my mom at the market she was like your daughter speaks beautiful Ordu she was like excuse me. We had the rule when you walk through the door of home you use the home language you can do whatever you want in the community but the language of the home is the language of the home which is how I developed multiple languages as a child and my Deaf sister was trilingual maybe it was harder for me to learn multiple languages but that was not a choice, you want to live in the world, you have to speak more than one language. That's just that. Marisol, you say you speak two languages, Rena speaks two languages. Any other multi-bilinguals in the room?

 Yes, absolutely.

 And I'm not just saying speak. Use. Any modality, any language. I know people use multiple or know multiple signed languages, as well. All of that.

 And everything -- I didn't say this but anything I'm saying, any time I'm saying language, it's spoken or signed language. Just language.

 I would also like to add going back to what Jenna said the purpose of language to me when you think big is actually to build and sustain relationships.

 Communicate for what? Right? Build and sustain relationships.

 I mean, sure, the purpose of language is to communicate and I've learned the wordplay ground and swing and slide and come and will and you.

 But if I can't say, hey, will you come to the playground with me and play on the swings and then later say, oh, wow that was so much fun, let's do it again, what was the purpose of language if I didn't have that to communicate and then build a relationship.

 So let's see if this slide works.

 5 scenarios.

 You're working with a family where they are a balanced bilingual, fluent home language, fluent English.

 Again home language could mean fluent use of ASL.

 Okay. They are fluent in both languages but the home language is the home language like the rule was in our house. My father could speak English. But that was not what we did at home.

 The home language is a strong one there's some English proficiency but it's somewhat limited. And then there are two languages spoken at the home by two different people. One caregiver, one language.

 And then there's just the home language.

 This is why the slide title took as long as it did. Because this is the reality.

 Melissa don't take a picture, I will make this slide better.

 I finished making this slide at 6:35 a.m .

 Because I wasn't liking it. Take a picture. I can't stop you from taking a picture. But I will make a better slide of this.

 Oh, good idea.

 So that's the next point.

 How do you know what the situation is?

 One of the objectives for this class was understanding the language landscape of the home.

 We do a family interview. This, again, came up because we needed it in India. Because, you know, India. Many languages.

 And we started asking the question, this is based on Robin and PJ McWilliam's routine-based interview template and we started asking the question, tell us all the languages that your child is exposed to during the day.

 The child wakes up. The child spends time with Grandma in the garden, what is Grandma saying? Then the child goes somewhere, okay, what is the language that's happening there?

 And we got a sense of what are the languages spoken during the day. And from that, things were revealed such as, oh, we, parents, speak fluent English. And we want our child to learn English. But while we're at work 10 hours a day, the child is with the nanny who speaks Hindi. Well, we want the child to speak English.

 I was like, okay, let's think through how language is learned.

 So what I want to do is oh, I did write this down, look at that.

 What I want to do is talk through each of these scenarios. And we're going to think about the challenge and we're going to think about the opportunity. And some of that is going to feel repetitive. But don't worry, we're going to get to strategies.

 So the next few slides, if they just go quickly, bear with me.

 The first scenario of the balanced bilinguals, and in your worksheet, all of these terms are defined. You have definitions and informations and additional reading.

 The challenge is choosing the language or the languages.

 And the interaction between the two languages, if that is a factor.

 So when I was in -- working in central Illinois, we worked with a pretty large Amish community and they spoke Pennsylvania Dutch at home. Or German. And English once they got to school.

 And the family was like, oh, can we not speak Pennsylvania Dutch? We were like no, you can speak Pennsylvania Dutch and we'll go the simultaneous -- instead of the simultaneous route, we'll go the sequential route.

 Or simultaneous.

 So choosing the path, exploring the desired outcomes, and making it culturally linguistically relevant.

 These are families who often choose either a mixed language approach, any language, any time, however it is.

 Or a time and space approach.

 We're going to speak in this language at breakfast. We're going to speak in that language at dinner time.

 When we're at the playground, we're going to speak the community language.

 Again, all of this is in your handout in terms of strategies for promoting bilingualism.

 If for whatever reason you cannot find it, email me.

 In the biLange wall case home language at home this is the MLH model, minority language at home.

 You walk through the doors you switch languages for everything.

 And the challenge then becomes choosing the sequence of languages because how long is the child at home? Well, 90% of their life in the first three years, okay, then we might have to go a sequential approach where we focus on the home language first and as they go out into the community, we add the community language. Again the opportunity there is exploring desired outcomes and paths. I was working with an 11-year-old I like to use the Russian children coaching model with teenagers where I let them plan their sessions and I say to them, well, in the next 6 months as we work together, what would you like to know more and do better at the end of 6 months and initially they are like what Mom made me work with you. I was like, I know, but now that we are together, what can we do.

 And one of the kids said to me -- most kids in India have three languages at school, English the interregional language and a -- another language and maybe a fourth language and you just do it she said to me you know what I think I need your help with Hindi I said oh okay. Don't you guys speak hippedy at home. She's like we do but like not book Hindi. I was like, okay.

 I can help with that.

 And she said, guess what, Grandpa sort of speaks book Hindi. He just spoke a more pureer form of Hindi and she said I don't always understand what essays and when he talks -- he says and when he talks in English it doesn't feel like English I was like okay bottom line you would like to have a better conversation with your grandfather we can work on that.

 Again, she was asking me to solve this problem. She's like everybody plays cards with him and I just don't feel like I'm a part of that.

 I was like, done, kid, we can do this.

 Home language is different than English and there's Limited English Proficiency I think the big challenge then becomes in the U.S. connecting them with resources and other families. Identifying the primary language. And even if you as the therapist are not fluent in it as the interventionist figuring out a path. And for that, we like to use the language sampling approach with the family and the parent coaching approach which I'm going to show in just a second.

 When caregiver is using the home language, making sure that we don't gravitate towards the caregiver who is speaking English.

 Somebody said to me, I have a family that speaks English. Mom doesn't, Kate, did you say that? Yeah, so most of the conversations are happening with dad who is spending 5% of the child with the child. And the mom either doesn't have the space or doesn't feel like she has the space or doesn't have the opportunity.

 Then monolingual home language like they speak no English yeah but they speak the language the language they want their child to learn, isn't that a good starting point right there?

 And making sure that we can build that and two things that I have found very helpful for that is to build parent-to-parent support.

 Finding another parent who speaks the language, even if you as the professional don't. And in any case, parent-to-parent support always a good idea irrespective of whether you speak the language or not.

 And then I think it's an opportunity to increase our cultural humility and competence when we get to work with the family who do this. I work -- I observed a session of an early interventionist who was working with a family who is Korean at the time. They spoke Korean to the kid. But they spoke English with her.

 And she was still in the phase of helping the child notice -- helping the family notice the child's communication intent and attempts.

 And just you know was being the broker of communication between the kid saying gaga googoo and her saying look, maybe he wants milk. Why don't you talk to him and ask him and so on and so forth.

 And she said, I will never forget this, she said as the interaction happened, she said, oh, your parents love you so much. I love you, Mommy, I love you, Daddy. And then she asked them how to say it in Korean.

 And the mother was crying just saying those words to her. And she was like, you know what, I didn't think he would ever say that . And I know he's not saying it now. But I can see a path.

 I can see a path when one day he will say what I said to my mother and hopeed that one day my child would say to me.

 Okay. I always lose my place.

 So language sampling.

 This is what we have used Atlislis. Very, very -- at Listening Together. Very, very effectively like I need to shut myself in a cabin in the woods and write this up effectively. Language sampling has always been something we have used where we look at the child's spontaneous utterances and review what it is that the child is doing.

 Our approach has been a little bit different where we're also documenting the parents' utterances. This is like the manual way of doing the Lena. But we're looking at the transcript very carefully. So we start by documenting it and then we ask the parents to document it with us.

 And review. And then we ask the parents to do all of it. By themselves.

 And then just tell us what they see.

 This is the model.

 In Stage 1, you know what I'm the timekeeper and I'm okay still.

 Stage 1, modeling and coaching. Caregiver chooses a daily routine where the child -- where the child is most vocal. They record it. And you know I should change it to interactive because we have now done this successfully with kids who are very preverbal, very prelinguistic but engaging.

 Caregiver chooses a routine where the child is most engaged.

 The provider transcribes the language sample, including the gaga googoo. It's quite fine fun.

 And then use it -- it's quite fun. Use it as a tool to talk to the parent, oh, look, when you talked to him, he said Gaga goo goo. That's him responding to you. And look at what you did, you repeated what you said. And then he smiled .

 Back and forth. Back and forth. Back and forth.

 Okay. Talk.

 How do you --

 >> How do you write down the language sample if you don't speak the language that the parent is using in that routine?

 >> DR. UMA SOMAN: Just phoneticly. And then we ask the parent, so Melissa, here is the thing -- here is the advantage I'm doing it, I'm not doing it in IPA I'm writing it in Murati which is a phonetic script so I'm skipping IPA and I'm just writing it in my home language script which will tell me exactly what was said .

 I'm cheating a little bit and taking a shortcut.

 >> So just phoneticly write it down and then after that say what do you say.

 >> DR. UMA SOMAN: Uh-huh. The other way you can do it is to watch the recording live rather than doing this transcription. The video live. And then that becomes Stage 1 sort of to establish like, look, we can get a sense of your child's language development based on what you say. And what the child does. Stage 2 is where the caregiver chooses a routine. They record. They transcribe. I transcribe. And we talk about it.

 And then generally by this point, the child is a little bit older, has a little bit more language. So we are actually talking like language targets.

 One word. Two-word utterances, syllable approximation, whatever that is. We can do oh instead of just putting his hand out we want him to vocalize when he puts his hand out.

 Or as you do wait time, see if he will change it.

 Like oh, I see you want something, can you tell me what you want?

 It's never like, talk or you won't get the cookie. It's always engagement and interaction.

 And then the third is amazing.

 The parent does the recording. The parent does the transcription. The parent comes to you and says, oh you know, I noticed that the language sentence complexity is changing over time. But I'm not noticing a lot of questions.

 And I wonder if it's because I'm not asking enough questions and just doing comments.

 This happens for real. And not just with one parent. 85% of the parents we're working with get to this stage.

 Some get to that stage in 6 months. Some take a year.

 We haven't yet found a single parent who is unable to notice the complexity of their child's language. And then I feel good about not knowing the language and still being able to support language development. There is a webinar coming soon. There's a request to do modules on this with training and practice.

 As soon as I get home from here, that's my next project. That will take a good four weeks.

 But we'll have this up and running for anybody who would like it. Maybe I'll apply for CEUs. And then there's the generalizing where you just, you know, summarize it and do it.

 Another resource that I like that has been helpful to parents, we call it the AEIOU of bilingualism because for most of our families in India bilingualism is the goal. We say access, can they hear all the sounds of the language?

 Exposure to fluent language models. I should have put that in all caps.

 And this, Melissa, has been very helpful in helping us say which language to choose.

 We have a family, again, I don't have a lot of time to show this, this is what we did with the family.

 This is a family in the south of India, she's a professor of Chemical Engineering.

 She speaks English and teaches at the university.

 She said, I might as well just speak English with my child because he's going to need it in life. My husband speaks English, as well.

 It will be fine.

 And the provider who was working with her at the time, she said, Uma, something is -- it just doesn't feel right. She said, I'm going to try something and maybe it will backfire and maybe not. But I'll try it. And then I'll share with you what I did.

 So she had the mom tell the kid the story of the -- it was either the lion and the mouse or the hare and the tortoise, one of the two, first in English. And she said why don't you do this again tomorrow in your home language and we'll record both and I will transcribe both. The provider happened to speak the language that the mom also spoke. She transcribed it for her and she said check does this look like what you said listen to the recording and check. Mom says, oh, my gosh, I used so many new words and words that I know he wouldn't understand and complex language and questions and explanations when I'm speaking in my home language.

 And we're like, oh, you want to talk to him in that language and we know he will learn English when he's a little bit older? She said, yeah, I think I'm going to do that.

 Then later on or maybe later on that day she said to the provider, she said you know I feel less stressed when I'm talking in my home language.

 And that is where we get the concept of the language of the home. And the heart.

 I've been saying home language. Home language. But we also want to think about the language that the parent is most fluent in.

 I used to teach Indian cooking classes and when I first started I was like, oh, I speak English pretty well. I have none of this vocabulary in English.

 Indian cooking is registered in my brain in my home language. And I was like standing there and then when you, hmmm, put this in the oil -- like I was actively searching for words. Which has not happened to me in a while. English is my second language. But I've speaking it for a while now. So I speak it pretty fluently.

 And then when I started doing professional development in Hindi in India I was like oh, my gosh none of my professional knowledge is in Hindi. It is all in English. And I have to now think this through.

 So the exposure to fluent language models and the fluency of the -- like the strength, the foundation of the thought will translate into the fluency of the language model.

 I'm not going to go into quality and quantity of input matters and all of that. There are resources in your handout for that.

 That's the E. I is interaction children learn through interactions not flashcards let me plug the amazing blog post don't use the F-word with me what's the title. Yeah that's the title. And the F-word here is flashcards. It's a really good blog post you all should read it I assign it to my students. O is the opportunity to use the language. If we expect children to be able to use certain language in certain settings and often that's community and religion and things like that.

 Where the home language might be more salient, more important than in other situations. And then the U is you. How you learn their language learning.

 There's a more detailed blog post for this on our website.

 Also a link in your handout.

 Yes .

 Reflect on the information shared today.

 How does this resonate with you in your practice? How do you want to incorporate this in your practice? What will it take to make this change? We can have great ideas. But if there isn't a path to action, then we just have great ideas.

 We'll revisit this when we get to our case scenarios. But hopefully what you have taken away today is there is linguistic diversity. There are many different scenarios. Not everything has one answer.

 But here are some tools that can help you help the family make some decisions.

 Okay. And now onto what do we want to do, do we want to take a break now 5-minute break and then Elizabeth will talk and we will go right into our case studies. We're at the midpoint.

 Okay it is 10:01 in my watch. Let's come back at 10:11.

 (Break.) .

(Standing by).

 >> Okay. It is 10:11 so we are going to get started. I am going to attempt to talk from over here.

 >> DR. ELIZABETH ROSENZWEIG: Please, if you would, thumbs up or indicate otherwise as you are able if you can see me, the captions, the interpreter. Does this work?

 All right. Beautiful.

 So I am going to -- again, my name is Elizabeth.

 I'm going to speak a little bit about working with children who are Deaf and have additional disabilities. And I always feel like you finish your schooling maybe minimally competent to deal with the boringist normalist kid out there and then you get out into the field and you're like, where is that kid? So that's what we're going to talk about today. Next slide, please.

 Look alive, Uma.

 Okay. So we -- the last kind of Gallaudet Research Institute national survey that we have is dated at this point. But they don't do it anymore unfortunately.

 But what they estimate was about 40% of children who are Deaf or hard of hearing also have some additional diagnoses.

 Whether those are medical. Whether those are physical disabilities, mental health. We're going to talk about it all. Next, please.

 Okay. So why? I think that, again, why are we seeing this? And sometimes why are we seeing these additional disabilities at what we might perceive as being increasing rates?

 Well, one is the reason we're all here which is Universal Newborn Hearing Screening.

 You know, decades ago, if a child was born with a disability that was very apparent at birth, let's say this baby is born with Down syndrome. And then as that child goes through life, their language is kind of lagging.

 Well, what do you think people were going to say? Oh, it's been awz he Down syndrome we can't -- he has -- because he has Down syndrome we can't have such high expectations well now we might be able to identify that yes, this child has Down syndrome but also there is a component of conductive hearing loss .

 So we are figuring out I think in my opinion more children who may just have been written off as, well, their language isn't good because what can you expect from kids who have XYZ to saying, no, actually there are additional complicating factors here.

 We also are getting better, thank goodness, at keeping kids alive. But it is not without cost.

 So a lot of times children may be born not Deaf or hard of hearing but because of medical interventions during a prolonged NICU stay or due to ototoxic chemotherapy for pediatric cancer have developed a hearing loss over the course of childhood. In addition to the aftereffects of whatever they experienced in the NICU. Whatever they experienced during their cancer treatment or treatment for whatever other health condition.

 We are also seeing these children more because we have expanded our definition of who is a candidate for cochlear implants. Who is a candidate for the type of intervention that we provide.

 You know, criteria used to be so narrow and so strict that it had to be just hearing loss. And just profoundly Deaf. And nothing else going on in the quote-unqoute you know perfect family and support system.

 And only that child would have access to cochlear implants.

 And only that child in some cases would have access to the organizations where we work and the types of services we provide. Unfortunately that has expanded. With you then that also means that our scope of practice and our responsibility to be able to capably serve these children and families have expanded, too.

 And I think sometimes our training hasn't always.

 And so we're running to play catchup.

 And what we know, too, is that sometimes, thanks to Universal Newborn Hearing Screening, we catch these multiple qualifying conditions at birth. But there are also children who may pop up on our caseloads later because we are slower to sometimes catch that this child is Deaf or hard of hearing if they already have another diagnosed disability.

 I think about this all the time with the autism hearing loss question.

 Right? Is it this? Is it that? I think our diagnostic overshadowing makes that really, really difficult to pick apart. And so there may be children who have a diagnosis of something else. And we're suspecting. And we're suspecting. And we're suspecting there's something going on with their hearing.

 But often their age of entry into hearing-related services and language-related services is later than we would all hope. Because we were busy dealing with other things.

 Next slide, please.

 Okay.

 So hopefully all of you in this room are familiar with the Joint Committee of infant hear's 1-3-6 guidelines. I've heard the expression before you break your arm trying to pat yourself on the back trying to be proud of yourself we all try to meet these 1-3-6 guidelines but let's talk about when we don't .

 So when it goes well, we identify this child through Newborn Hearing Screening by one month of age.

 But what if the child is born with life-threatening medical conditions, hearing screening is the last thing we are thinking about. Maybe for months and months and months. Because we're just trying to keep that baby alive.

 We'll figure out the hearing part later.

 Then we might also identify the child. But there are complex needs in that family system. That make this family vulnerable for Loss to Follow-up. Maybe it's transformation. Maybe it's language. Maybe it's, I don't have documentation and so I am going to do everything I can to stay off the radar of anyone who is even vaguely Government. I want no part in that system.

 And, as we discussed, maybe we missed this one month benchmark because the child has typical hearing at one month and we caused that hearing loss later on down the line.

 Next slide, please.

 So then we say if you refer on Newborn Hearing Screening by 3 months we want you to have a complete diagnostic audiological assessment. A screening really just tells us pass or refer.

 Do I need to look into this further? So now I want a really complete and accurate diagnostic assessment.

 Well, what if I can't get that on this baby? What if there's a lot of other equipment, a lot of other interventions happening for this child? And it's going to take some time to really pin down what are this child's hearing thresholds? Maybe this child has hearing that fluctuates because there's inner ear involvement because there's neuropathy it's not always as simple to stick a pin in it and say okay, here are the levels we're dealing with.

 Next, please.

 Okay. When it goes well by 6 months we want the child and the family involved in early intervention. Well, what if this is a really complex family situation and there are factors that make tending appointments difficult. There are factors that make really being able to engage in intervention difficult. And I think, you know, Jenna and Uma have already mentioned so many of those. But it is I think one thing that became really apparent to me is that -- and I hope you all share this struggle. I am certainly not Mother of the Year by any standard.

 But it's just really hard to have kids. It's just really, really soul crushingly hard.

 And then you have kids who need extra. And that's just a lot harder. I mean, I have worked with some kids and families who that baby's social calendar at four months of age is busy than I have ever been in my life they have so many appointments and so much going on and even though I think what we do is the most important and exciting work on the planet, quite frankly if the baby is having trouble feeding and not taking in enough calories to stay alive, our appointments are probably going to drop to the bottom of the list. And I think we have a lot of education and conversation to do there.

 You know, I think some families will say, listen, my baby has a G-tube. My baby has a mraij yocephaly helmet. My baby has breathing issues. He's 6 months old. My baby's typically developing 6 month old doesn't talk yet. No 6 month old talks. It's fine, I'll deal with you people later .

 And I think there is so much really exciting precommunicative stuff happening at 6 months. But if I haven't conveyed that to the family, I don't blame them for prioritizing calories in over language in. When the threat to their baby seems so apparent. I also have to say from a totally selfish perspective my goal in working with these really complex families is to make all of the other providers look terrible. It sounds so bad but it's true. My goal is to be the most fun hour of that family's week because a lot of this is just not fun. But I know when I'm stressed and overwhelmed, I will engage in and I will make time for things that feed my soul. Things that pump me up. Things that I want this family to leave that hour feeling like you know what, even if the baby slept the whole time. Even if he cried the whole time. I am leaving with the umph that I need to do this really, really hard work. For another week.

 So I think we can, even when this child is really complex and the family receives a lot of services. I think we can get them to still engage with us. But we have to be a lot more fun. This should be the most positive hour of that family's week.

 Because for a lot of families, they are not getting that many other places.

 Next, please.

 Okay. So when I was in school they would always say kids who are just Deaf are vanilla Deaf.

 Now I want to talk about kids who are the whole sundae. That's not a bad thing sometimes I would prefer a sundae over vanilla ice cream but it's different. It's a different eating challenge. We've got a lot of textures. We've got a lot of flavors. Let's talk about it. Next, please, thank you.

 Okay. So now I think we see with early identification, with early intervention, if all the right supports are in place, these kids who are just Deaf, they can be on and off our caseloads really, really quickly. That's exciting and wonderful.

 But sometimes we get these kids who have a lot of needs. And they are lifers. And that's hard for professionals. That's hard for their families. There's not kind of a clear endpoint of, oh, when his language is within normal limits and he's mainstreamed and all is well and good, that may not be the end of our path for every child. We also know that children who are just Deaf are much more likely to be included in mainstream environments. And not just educational environments.

 But social environments.

 Chances to be involved in their community. Chances to interact with peers. Social organizations. You know, can this child be a part of the scout troop? Or do they say, oh, I don't know. Maybe that's a liability. I can't deal with his equipment.

 And think about all of those really valuable interactions that build our language skills, that build our social skills.

 And sometimes these children are pushed out of those environments.

 It's pretty clear-cut, right, for a kid who is just Deaf. I need a great audiologist, I need a great teacher of the Deaf, I need a great SLP, binge, bang, boom, done.

 When a child needs all of that, and, and, and, and, the team gets really big.

 And we need to coordinate. And we need to be clearer about what is our role. You know, what do we bring to the table as a person who is the language and communication specialist on this team to maybe help some other providers who have never dealt with this.

 You know, the physical therapist who has never thought about well what if I can't give the child instructions, what if he doesn't understand how I tell him to do these exercises. That's the piece we bring to the table in these teaming situations.

 Okay. As we discussed, having a kid is very stressful.

 Having a child who needs more than that is even more stressful.

 And we know that hearing technology has not yet passed the glasses test.

 There's washy Parker for glasses, people wear them as fashion, people wear them electively. We don't have that for hearing technology .

 There is still unfortunately stigma around a child who has hearing aids, who has a BAHA, who has a cochlear implant.

 Now imagine your child has that. And they use an AAC device. And they have mobility devices.

 And they behave in ways in public that people, not knowing their background, are going to judge. Judge the child. Judge you as a parent. There's a lot of stigma and stress that these families are experiencing.

 Next, please.

 Okay.

 So I think the biggest thing -- and again, we can talk and I would love to talk to you all and again how many times have we plugged the worksheet, my email is on the worksheet.

 I would love to talk, okay, what about a child who is Deaf and blind. Deaf and autistic. I have some specific suggestions. And I would love to hear your specific suggestions, for serving each of those children.

 But we don't have time for that today.

 So more broadly, I would like you for yourself and for the families you serve to think about what is the definition of success.

 And I think certainly one thing I hear a lot as a speech-language pathologist who is also an auditory-verbal therapist is you want kids to talk perfect. That's what you're in this for.

 That's not what I've ever been in this for. If I ever am in for that please get the hook, friends, and pull me off the stage.

 Next slide, please.

 Really what we need to think about is that success is so individually defined. So I work with college students and I think when I look in the mirror, I think I'm still their age and they remind me frequently that I very much am not but a while ago there was this meme going around and there would be like little red flag emojis and they would talk about what's a red flag when you're dating someone.

 I am happily married. I don't plan on dating any of you. Though I'm sure you're lovely. But a real red flag to be weary of is anyone who has the certainty to tell you what all Deaf children need beyond anything that all children need. Love, food, shelter, blah blah blah.

 I would like to get advice on financial planning from this person because clearly they are tuned into a level of knowledge that I do not have.

 I am real dumb. I don't know that. I have yet to meet someone who does.

 So instead -- thank you.

 I vote that instead of aiming for perfection, which is unattainable for any human, that we aim for optimization.

 I cannot and do not want to make your child not have Down syndrome.

 Not my goal.

 Also not my capability.

 But I am really good at language.

 And so my goal is that your child with Down syndrome and hearing loss has language equal to their peers who are typically hearing with Down syndrome.

 That's the part where I can help.

 And that child may not scratch the surface of a standardized test. That's okay.

 That just might not be their reality. But whatever their reality is, I want them to live a life where they are thriving in those circumstances. And that's going to look so different for every child and for every family.

 My goal is just that we don't quit until we have optimized whatever that child's outcome will be.

 Next, please.

 Okay. How -- oh, I was fast. Okay. Beautiful.

 Thoughts, questions? I guess we have some time for that.

 >> Amazing, thank you, for giving voice to what Deaf plus parents experience.

 How do you as a practitioner push without pulling.

 I mean, how do you encourage more without being rude or demanding?

 >> DR. ELIZABETH ROSENZWEIG: I've never heard the phrase push without pulling before but I love it. I am going to quote you. That's -- wow. I like that.

 So many thoughts.

 So one is I think you kind of take the temperature of the caregiver and family's capacity. Are you ready to be pushed? And what I always tell families, too, is I'm going to give you strategies.

 You know your child best. And you know when you can push. You know when they are well fed and well rested. Now is the time to push for that language. And you know sometimes it's like I need you to get your shoes on and get out the door. And I'm not going to push. But I think it also goes back to being the most fun one in the room. Like I will work really hard for someone I have a good relationship with.

 And I think it's also helping the family organize their priorities.

 You know, I have had a family say, we're going to take a break from therapy because we're going to a one month feeding intensive and part of me is like oh no your auditory cortex. But you know what, it wasn't their priority right then.

 I always think I didn't put this slide on and another thing I would like to be remembered for please put this on my gravestone I cause it the -- I call the Rosenzweig 3 a.m. barfing theorem the best thing I've come up with in my career it goes as follows, they who clean up the child's vomit when he has a stomach virus at 3 a.m. are they who make language communication and technology decisions .

 Because my life is already a festival of bodily fluids. And I am not volunteering to come to your house and clean up your child's barf.

 So the people who are cleaning up the barf at 3 a.m. are the ones who make the decisions.

 And I don't have to like your decisions or agree with your decisions.

 But I'm also not volunteering to clean up the barf. So that's when I zip my lips.

 >> Can I add one thing? A resource that you might want to dive into is by Dr. Zeretta Hammond, h-a-m-m-o-n-d, she writes: Nothing to do with Deaf vrns about culturally relevant practice culturally responsive practice so she writes a lot about the necessary ingredients in a relationship to maintain and hold someone to high expectations .

 And that feels relevant to me based on your push-pull question.

 Because again, thinking about the adult learners, this is irrespective of hearing status. This is about having relationships with someone where you can maintain high expectations inspite of all of those social determinants of health. So look that one up, too.

 >> So going off the push-pull, I have that same question but in regards to listening spoken language specialists who have been LSL LSL certified longer than I have -- LSLS certified longer than I have been alive and taking this newer mindset and collaborating because I don't want to come across as like this three, four year out of grad school I know everything.

 But if we know better, we can do better.

 Well, you know, he has Down syndrome so I would like you to find a new collaborator that might also have those collaborators behind their name that might be old, as well.

 But really, Samantha, that's like you pick and choose who you recommend and refer to and play with and we have to have some shared values and then it's sort of like a free market there's other people that have knowledge and skills you can bring to the team and just because you have them doesn't mean you're the right people for this family or for this interaction.

 So I get it, we put a lot of people up on pedestals we hold them up there for a really long time and we need to like find some new people for the pedestal maybe.

 >> No, please don't, aim higher.

 But another thing that was really formative and foundational for me back in 2008, I remember I went to a conference and the person who spoke said, you know, families want and deserve my best 2008 knowledge. Not the best knowledge from the person that I really admire. Not the best knowledge from what I learned in grad school. And really the people that I respect so much in this field are the people who have -- who have evolved and who hold themselves to that standard.

 I graduated. I finished my Master's Degree in 2011.

 I sure as heck better be a better professional today than I am then. Families absolutely deserve my best March 8th now Siri is going to try to talk to me they deserve my best March 8th, 2023 knowledge. They absolutely do. They are trusting me with something so sacred and so vulnerable. I would vote for criminal persecution, prosecution, but that's just me.

 Also, Samantha, I have no qualms about being the person who is like three to four years out and a jerk in the room. But I have also heard someone describe it as that profits don't often have friends and it's a hard needle to thread to be a profit with friends. I don't think I've achieved either of those statuses but I think it's a good goal.

 >> Okay, we are the only two Deaf individuals in here and we have the signer in front the interpreter where should I go should I be sitting here or in the front. I'll come around in the front so everyone can see me.

 I love how you interpreted -- oops. I'm in the light there.

 I love how you interpreted the positives and wanting to encourage the family. I love that, I agree with you, you want to be able to work with the family for the needs at the moment and provide services that correlate. And you want to be able to support them.

 It's really what can I do today maybe next week that's going to be different.

 So I need to meet you where you are.

 And it needs to be -- it has to be fun.

 Because if I make it the service fun, then they want more. And that's fine. And they will keep coming back.

 And I'll have my knowledge in my brain that I keep pulling from to be able to relay to them as it comes, as opposed to not a didactic thing but just a one direction type of service with me giving to them but not interacting with them. That's different.

 Then you have -- you can't apply one thing to all the situations.

 It has to be one thing that applies to that situation. And if it clicks and they are going to want more and they will be back and you build your relationship. It's not like the light in the darkness of the world but people are busy and they have things coming at them all the time. And if you can be that one person that stands out where it makes the light is now shined on you, then the family is going to be more receptive.

 And it's not like you're trying to meet the major goals all at once, it's one step at a time.

 >> Okay. I love that thank you so much I was just going to add one thing to the push-pull conversation.

 When I came to the United States in 2002, I was coming from a multilingual environment where all Deaf children learn multiple languages. Again, not a choice. I didn't know that was a choice.

 They learned it at different times with different levels of proficiency.

 But my sister and every single one of her friends had multiple languages.

 I wish they had Indian Sign Language as an option back then. Which was not codified until recently to be an option. I hope children now will have that option, also, but what was fascinating to me again not my therapy session but I came to the States with the clear idea and sort of implicit messaging that I needed to assimilate and I was coming to a more developed country to learn better knowledge. As it relates to Deaf education. And it kept conflicting with what I knew and what my lived experience was and what my gut was telling me about multiple languages. But it took me a while to say I know we are all sort of saying monolingual and when we sit in those -- I don't even remember if we still do this but back in the day when I was at Vanderbilt we had CI candidacy meetings that were multi-professional, surgeon, audiologist, teacher, therapist, EI we would go through this checklist with facilitators and challenges and being bilingual was a no-no. Like that was a problem. And we would discuss how we had to tell the parents to speak English only.

 I've sat in those meetings and said nothing. And do I regret it? Oh, boy, do I regret it to this day.

 I just didn't know better and didn't have the courage

 So if you are in this room who think you have an idea that nobody has thought about or a perspective that nobody has thought about, at least say it outloud. Maybe it goes nowhere but if you say it like 23,000 times, people will be like, uh, she's the one who says children need the language of the home and the heart it's like oh you know the phrase that's good that's a good start.

 So when the push in the U.S. became like oh we should let families choose the language I'm like, yeah, no kidding. Like this is what the rest of the world has known for quite a while.

 And that's the push and pull.

 For me, I didn't want to push because I didn't know what I was getting pulled into by pushing. But I should have. I should have. It doesn't matter that I was just out of college and only a baby teacher, I should have. I didn't have the courage that Elizabeth did to be like, by the way, people,, right. I was too much of an outsider to do anything. And that's the other thing.

 Maybe there are people in your circles and your tables who are quote-unqoute the outsider.

 Because they look different. They have different lived experiences. They may even present differently than what a professional should present as or what a parent should present as in your circle. But that doesn't mean that they are not going to share something that will fundamentally change, influence, enrich a child's trajectory. That is one of the reasons we wanted to present this at EHDI because this is a group, this is a conference where we are not just talking to professionals. We are talking to a variety of stakeholders who, if they signed up for this conference believe that children and family and achieve their full potential and desired outcomes and each person does their role in the work of achieving that goal. So food for thought.

 >> Case studies.

 >> Yeah, I have this set up.

 >> Do you want to give it --

 >> Yes I'm going to show you and then you tell. So this is the worksheet that you have access to. If I make it full screen, does the caption go away? No, it doesn't. It looks good.

 Okay. We're going to give you better access.

 How about this, can we all read this? This is the worksheet you received as a PDF.

 We want you to use this, feel free to share it with others. You have a couple of ways of using it, if you would like to share it just forward it to whomever if you would like to convert it and then translate it, you have instructions for doing that, I cannot guarantee the quality of the translation. But 93% is better than 0. So we'll go with that. In the worksheet you have all of this information. That was shared today.

 Some of us are fans are writing a lot, some of us are fans of not writing a lot, that's just who we are. We're going to do the case analysis piece of things.

 This is what we want you to be thinking about. What are the child and family's strengths and resources? You can use the worksheet that was provided or not. Just discuss.

 What child challenges could we reframe as opportunities? What family and caregiver challenges need reframing as opportunities?

 What social determinants need systemic intervention to support child and family outcomes?

 These were cases that were developed in 2018. Then adapted by Jenna for the purposes of this meeting.

 So we have two case studies. One is Isabelle. And one is Santiago. We're going to all read both. But then half of you are going to do Isabelle. Half of you are going to do Santiago I heard somebody say they needed to leave early we would like groups to be of three or four so if you know you're leaving early merge groups and we'll go from there.

 Okay. Go ahead, Jenna.

 >> DR. JENNA VOSS: Well, we really don't care if you choose to work on Isabelle or Santiago and we might have time to do both so if this table and this table would combine, that would be good. You'll need to pull up the document to read on somebody's device because we're going to scroll back up, if you can, to the questions.

 So what we would like to do is spend a good maybe 20 minutes letting you read and discuss amongst yourselves in this like reframing context.

 And then we will come back to the full group. You don't have to have a formal notetaker and shareer outer.

 But we would like you to be able to think of some collective group discussion at the end to answer these questions.

 So one bonus question that's not on the list is, we've all been talking about fluent language models in the context of nurturing relationships.

 So as you think through this case, that might be a reframing you want to do is think about who are the conversation partners who can serve to bolster the relationships that will be necessary for child and family success. Are there any questions about the assignment? Okay. Then we're going to give you about 20 minutes. And come back together for a brief wrapup. And then an exit. Thank you.

 We'll mingle.

(Standing by).

 >> DR. JENNA VOSS: Okay, we also sent a direct link to the handout if you're not able to find it in the app. And if your email didn't come through or went to spam, come up here and we'll just re-email it to you again.

(Standing by).

 >> Okay if you don't have access to the case study it is being emailed to you. You can do it. Otherwise alternatively I've just put up the two case studies here side by side so you can look at it. .

(Standing by).

 >> Okay.

 How are you going in the conversation? Have you had a sufficient amount of time to chat?

 First one is we weren't intending for you to have time for two if they were hefty enough.

 So we want just a relatively informal shareout briefly. We are happy to get you out of here a few minutes early if you would like. And we have one remaining checkout activity.

 Are we positioned good for accessibility?

 Okay. Then I'm going to walk to each table. And invite you to share whatever reflection is landing on you about the utility of this case activity.

 We know you came with case profiles on your mind. But first we're going to chat about with the exercise we did.

 So you are in close proximity to me, do you mind going first? Are there reflections you want to have you can either address one of the prompts or an overall.

 >> I can start. Hi, everyone.

 Let me see. So I'm not having my back towards everyone.

 I'll sit over here.

 I didn't have the question so my team was super helpful in giving me the case study and then the questions.

 So I was the notetaker.

 So everyone chime in and I'll pass the mic around.

 But overall we felt like this -- Tasha's mom had faced a lot of adversity. So all of those factors of social determinants of health that we talked about. She was facing the majority of those in her caregiving, in her housing situation.

 And then we also talked about a lot of the challenges that she had with her child. And how to reframe those opportunities. Continue to have opportunities in the home for instilling language and communication. And having that language-rich environment in the daily activities and routines.

 Consider involving the grandmother in caregiving. Transportation to appointments.

 And also just daily communication and language.

 We talked about opportunities and resources on considering Early Head Start. Looking into Medicaid and other services, possibly care coordination for the various appointments that she would need to take Tasha to.

 Involving the implant team to work with the family as well as the EI team for support.

 Let's see.

 Also considering working with a social worker to assist with appointments. Determine if transportation was an issue.

 And then when we talked a lot about reframing, like asking her really like what are your barriers? What are they experiencing -- what are the experiences that you're having that are creating some of these challenges for you? So using that reframing mindset of asking her. And then directing her to those resources.

 Let's see.

 Is there anything you want to add?

 >> No.

 >> I love it. So Isabelle's mom Tasha and that case really stuck out that it was that oh, you're not showing up. And so we're going to make an assumption that like you not coming to these appointments is somehow indicative of your intent or commitment to your child's development. When in reality, you're saying, if we flipped that script to what is preventing you from, then we would understand better the context.

 So yeah, thank you.

 Did any other group discuss Isabelle?

 You all did. And you did? Did you all do Santiago? Okay. Well, we're going to go here and then we'll come to you next. So another Isabelle.

 >> Yeah, we just wanted to add that often medical providers believe that their appointment is the only appointment that matters. So you know, this was a family that has tons of early interventionists, tons of appointments. So maybe reframing, this month they missed your appointment but they made it to 17 more.

 So talking to the other professionals about thinking about it as a team.

 We also identified that some people could call her living with her mother and boyfriend a challenge. Because they want their own place. But that's more adults. More people who could transport. More people to give language. More people to open up to going to appointments.

 And we talked about giving Tasha permission to say that she doesn't have to be the only one who goes to everything. Because a lot of times moms take that on. Oh, no, I have to go to every single appointment. That's my job. So saying look at all of these people in your life who love this child, as well.

 Can they be someone who participates in the process?

 >> I love that, too. Because if we're thinking about relationships, then it's not just the only relationship of record that matters. And so inviting Tasha to clarify who those other potential communication partners and relationships are.

 I also think the thing you said about communicating with the team. You know, in grad school we talk about interprofessional practice. And teaming all the time. Ad nauseam. But it's not that we have functional team communication.

 And if a hospital-based audiology Cochlear Implant Team knows that they are on a team together, but that team isn't talking to the early intervention team, or the whatever other providers in the world.

 Then there's also a disconnect.

 So sometimes it's on us, the systems people, to make those cross-team relationships to better meet the family needs.

 You all were also Isabelle. Do you want to add something else?

 >> We were -- we discussed how many people are giving them advice right now.

(Chuckles).

 And we discussed like asking the family how many appointments per week can you -- what is realistic? And also asking how many people do you want in your home at one time. Because also that can be a barrier I work in Phoenix, Arizona so thinking about the CI clinic, a clinic perspective is the families come to me. So there is a little bit of they come to me and they kind of serve me in that manner.

 And so asking what you guys said like they missed you but they kept 17 other appointments, that's amazing.

 But also saying, like, you know, I am an educator of the Deaf that's on her team. Can I go to your CI team meeting. She's not going to be there and let's protect HIPAA, I'll only be there for the 8 minutes you discuss Isabelle.

 But how can we show -- how can we show the CI team that we're all on the same team.

 >> Okay, so now -- yes.

 >> One of the things we also talked about is that it could be that the family, even though the audiologist awed nauseam says why the implant or hearing aid needs to be on but really and truly the family may not really understand how it's impacting outcome. For what that audiologist is -- how they are making determinations.

 So I have a family that wears the CI one hour a day. And when -- during my appointment.

 And so when Mom puts -- when the child has it on, Mom will look at me and say now he hears you and understand you. So what's happening is the CI team is now saying they will not implant the other ear because they are not compliant.

 Really in my heart this is a good mama. And she really I don't think understands really what her decision, how it's impacting the next level. So just kind of working on that education.

 >> Yeah, so you're getting back to the why, why is this behavior that we're observing, what's the source of that as opposed to viewing that as the end result. Good.

 >> Jenna as you're walking I'm going to say one thing, one thing I've trained myself I do well with physically training my body multi-sense -- multi-sense orally for different reactions and behaviors when I read something that's going to be frustrating to me my body will do this and I've trained myself to do this.

 So that I'm not going, ugh, one hour a day. I'm saying one hour a day. And I know this may not work for anyone .

 But it helps me physically reframe my thinking. And the science on this has now been dew bunked but it works for me so I'm okay with it.

 >> Your group discussed Santiago and since not everyone shared that case do you want to discuss themes that stuck out to you or whatnot.

 >> Okay, Santiago, okay, let me get my thoughts straight, he was diagnosed -- diagnosed, he had his audiogram done later at the age of 2 or over 2 years old and he has loaner hearing aids. He goes to an Early Head Start program. Which is Spanish speaking. So he does have his loved home language they do speak Spanish at the home and at the school Spanish and English. And Mom has a visa. Thank you for that.

 Mom has a visa that is not expired and she does work and she speaks enough English so she can talk with her employer but Dad's has expired. He is afraid to basically talk to anyone which then changed our conversation to the experiences that we have or that we have had with families. And afraid to talk to people and what we could do for them. So our conversation, woo, went this way, it was still related but it went that way.

 >> So any insight on reframing that which is sometimes a challenge one of the questions from Russian's book I use in class is how do you coach families who don't come, who aren't even present, how do you support families when they are afraid to be with you. Do you have any words of wisdom there ?

 >> We talked about supporting the people that the family is comfortable accessing so helping that speech pathology that's -- pathologist that's going to Early Head Start learn more about the hearing kids and getting equipment on at school instead of introducing a new system for the family if that's something their worried about.

 >> Oh what an opportunity to revisit what's already working and capitalize and build on that. Thank you.

 >> We talked about both. Our other kind of concern was that toxic level of stress that that might be adding to the family.

 So if he is always worried and that's the No. 1 thing in front of their mind at all times, then they can't listen to anything else.

 So I'm in Texas so we have a "Don't ask, don't tell" policy. We just do our thing. But if the family was open to being guided towards trying to get rid of that stress through applications or things like that, social worker who might be able to help them navigate those systems, and just explaining to them that we worry that the stress is impacting you and your relationships.

 >> Thank you.

 Great, can I wrap it up? So thank you for your participation today.

 We recognize this -- oh, yes, one more comment.

 >> Yeah, so we discussed at this table that there are several families out there that do have adverse -- that have adversity of those paranoias they have in their heads and we want to offer them several different solutions so that way they can actually engage and interact with their kiddos but sometimes that fear really makes them like lose that confidence of working through all of the resources that we give them.

 And Santiago due to, you know, their school situation, being two years old and nine months, having to go right back into school, sometimes parents, you know, they don't want to talk about how their visa is expired or don't want their kiddos to talk about it when they are in school so it's really that schema of, you know, excuse me -- the stigma of being illegal will come up in the school setting.

 And really just going from there.

 >> Thank you, that's related to that social determinant of health of like legal status. Being in the United States and what risk and opportunity are afforded a family in that way.

 So to end today, we don't have more words of wisdom for you. But we wanted to point back to your check-in. We know you sign up for an extra session on the last day after a conference.

 With something on your mind or heart. That made you find our abstract interesting. So we were hoping as a checkout, this is very grad schooly, you might share out with us quickly and briefly one possible reframing that you yourself are going to take away and try to make actionable relative to the case profile that you checked in on.

 So is there something that you learned today or are thinking about differently relative to a challenge that you put in your profile?

 Take a beat to think about that. And I'll take a volunteer. .

 >> I'm going to take away like eliminating perfectionism and striving for optimization for my kids with additional disabilities.

 >> Love it. Thank you.

 >> Yeah.

 >> Boop.

 >> I don't mind running, we don't have to go in order.

 >> I'm going to go back to what Uma talked about the English and the bilingual families. And actually asking like how do you use language throughout the day. And looking at it that way.

 >> Thank you.

 >> So learning objectives 2 and 3, check.

 >> Yeah. I would say I would ask the family -- I would ask them what makes them excited what makes them excited and looking forward to continuing their journey? What are they really enthused by? And really feed that seed of that happy feeling and really allowing that to grow by giving it water and sunlight and really encourage that growth.

 And you know, walk beside the family. And not in front of them or not behind them, either.

 >> Love it, it's that Fostering Joy movement we've been hearing about. So starting with what is joyful now and how can you capitalize on that.

 >> In my work I talk a lot about the whole child. So I like primarily work with Newborn Hearing Screening and state EHDI but I talk about the whole child and I really liked the information presented today because now I'm going to add the whole family and reframe it. Because it's the whole child but it's now the whole family. And looking at all of the different factors that go into what makes that family available for all the opportunities and reframing questions as like how can we help you do better for your child and your family.

 >> Love it.

 >> So I'm going -- my cases are regarding a lot of trauma and probably were only -- we're only being called because of a DCF referral.

 So looking then at being respectful to that trauma. But then also reflecting on probably most likely it's the parent trauma -- the adult trauma in the house as well.

 So just going in as positively as possible honestly.

 >> Thank you. Who else has a checkout?

 >> Hi there. So in the EHDI program we kind of use Loss to Follow-up rates to measure our success. Right?

 Are we at 20? Are we at 18? Are we at 17? You know, striving all the time. So I think the not using no show as a verb anymore is not only rephrasing it as they were unable to make it but also why is that? And so often we document no show, no show, no show, and it's just kind of how can I look further.

 >> Love it. I love what the data -- and what would the data collection looked like if it -- if it wasn't just no show but no show because of or due to or suspecting it would allow our intervention to be more specific. Yay.

 Who else?

 >> Kate, there's an existing model for that in Dr. Matthew Busch's research on health disparities. So maybe you have already -- you have a ready-made survey.

 >> Sorry?

 >> (off microphone).

 >> I'm sorry; I'm so sorry.

 I was just giving feedback to that comment that they just made.

 You know, we often say just no show and that's seen as something that's very negative.

 Oh, no show. Ma means they weren't motivated to show up to their appointments, right?

 But if we were to add like, it's no show because of something, we're actually able to do something in response.

 >> I just want to help that family focus on what the child has already overcome and the family has the resiliency to continue doing that.

 >> I'm really walking away with the optimalization and not perfection that is really helpful. In just looking at look how much progress your child has made inspite of all of these crazy things going on. And look at all of this data that you can take to your audiologist because you guys are so intent with your child.

 >> Okay. Anybody else want to do the checkout activity?

 It's not really like an exit ticket. We're not going to hold you hostage if you don't.

 I think Wellin ger, we thank you for your full participation today.

 And we wish you safe travels home.

 We'll be up here. And obviously we like this conversation -- we would like this conversation to continue. Not just as a session here. So shoot us an email if there's a story that comes to mind or a win that you want us to celebrate with you.

 So thank you.

 (Applause).

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 >> Thank you to our captioner and our interpreters for ensuring access

 (Thank you so much! Take care !)