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EHDI Annual Conference 2024 - Topical Session 1 & 2
3/18/24
9:40 AM - 11:55 AM (MT)
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(Captions provided by a live Captioner.)
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START TIME: 9:40 AM

>>DR. GINGER MULLIN: Good morning.

>> Thanks, Stephanie, good morning. We're so happy to see everybody this Monday morning. I'm Ginger Mullin. We're going to talk about EHDI collaborations to support adequately improvement, accessibility and equity. Now we only have 25 meetings, so a little bit of speed dating. We welcome talking after the conference.

She does better dancing than I do. I promise I won't sing. You'll be able to find both of us, we celebrated 15 years with family base organization. She is the mother of five, so her family has grown as our program as grown and we've worked together in the EHDI program for probably 17 years in addition a couple years in addition to the two years been by the side coordinator.

It started we took a chance on one another. We started talking waiting for the bathroom in

the ladies room. So those conversations you have here, take time to get to know people. We both were pretty greenback in the day, we decided we wanted to learn and grow together. How can we grow and learn together, there's so much EHDI is growing and we have to learn what we don't know.

>> It will take time, trust, flexibility. Does anybody work 9 to five in this room?

(Laughter).

>>DR. GINGER MULLIN: She thought about that one.

(Laughter).

>> So, we encourage everybody to be flexible, work at times that work for each other. Today is sprinkled throughout the presentation, I'll be honest about limitations working for the state. It's a barrier that through the collaboration I have opportunities.

So we'll go on next, so like I said, Carrie and I have worked together a long time. Our disclosures are the facts we don't have stocks, bonds, patents, we're here because we have equity of the heart.

So, let me catch up here. They don't have the presenter view, so I can see my notes, so pardon me as I go back and forth. So we're going to kick things off, why we should collaborate. You should collaborate because so many people have a shared vision. We forget about the fact that EHDI isn't in this alone. We can't do everything by ourselves. Nor should we. We should find folks that believe in something similar to us, not identical. Not that we have to be identical, but we have to share like minds and find people who have the expertise and knowledge that we need to help ourselves grow. We're called to think outside the box. We want everyone to have equity to the equality.

We can't give everyone the same thing. We need to give people what they need. We have to have diversity in our collaborations so that we can expand our mind, open doors and

especially to get us out of that old rut of we've always done it this way. Anybody have an agency or a group that says but we've always done it this way. You're not raising your hands. Probably smart. I get it.

You know, I don't do well reading, so let me talk to you guys. The second piece is diversified perspectives of equity. Within our EHDI system, I only have four staff. It's hard to get a lot of diversity packed into four people, so collaborations are the way I find that diversity and equity. I started with my family based organization that pushes me to go beyond to work for the school for the deaf and we're working for the school for visually-impaired in Illinois, the school for the blind. How did you serve DeafBlind students without understanding that perspective.

We have to seek out collaborations we're pushed through funding and sustainability. How many of you can lobby for funding? By collaborative partners can't. So seeking collaborations help us to do things we can't do in Illinois. We collaborate with a partner that can text families. As you know any of the newer generations aren't going to pick up the phone, but answer a text.

Also we can reach additional families and stakeholders by having collaborators. We're not going to do it right now, if I had you all stand up and put your hands out think of this verbal throughout the day, join hands and spread out, look how much further we can reach. Remember by holding hands, you can reach further than standing alone and trying to do it by yourself.

So this one there is no I in EHDI except for in this picture. There seems to be an issue that the I dropped below EHDI. We tell each other when we can do something and when we can't. So thinking that you have to be all things to everybody or prove things to somebody. Not going to serve you well. Carrie's had at that pick up the phone many times when I'm

driving home are work, I can't do this, I can't do this. She helps me come up with a way to collaborate and help get it done.

Some of the other collaborations besides this obvious EHDI and FBO we started thinking as low incidence disabilities. So instead of isolating us to work with kids deaf and hard-of-hearing. We're working with low vision and blindness. There need to be ADA accommodations in place.

We keep reminding them that together with the school for the blind, you have to do that, so it is actually helped us move our initiatives forward. We talk about communication access and we talk about statistics. We look at who can we partner with to actually find out how many kids are deaf and hard-of-hearing in our state? That data is hard to find after you get out of EHDI system in some states and definitely ours.

We talk about the documentation of comorbid conditions, kids that are deaf plus. Do we have a handle on what their needs are. If not, who can we work with to make that happen?

So we have informal collaborations that help us reach more families, if you know me you know I love the star fish program and about making that difference to that one kid. Google that on a break.

We've collaborated with home visiting and early childhood. Guess who has money now guys? How many times have you heard kindergarten readiness. So we need to be there saying we have to identify kids with hearing loss and with vision issues if they're going to be kindergarten ready. If you have a deficit in either of those, hard to get that kid on track.

So we're work on even if you can't give us direct financial support, how can you pay for interpreters and pay for the video or for IT requests that are so hard to get. Jumping on our blood spot, critical, congenital, disorder, we are in the same house as them. We started a new mantra is there equity between blood spot and EHDI?

In our state, there's not. We're grant funded. They have a blood spot fee. We talk about equity and staffing, so starting to bring these things to light and talk about why does the EHDI program not have these services. All about taking time, sometimes that time goes by a clock and sometimes that time actually goes by a calendar, and we pray the time doesn't go by to create these collaborations.

So the other thing that Carrie and I do in collaboration is constantly remind each other about scope creek. We get to many ideas. You're going to leave the conference and go we should did this, this and this and then you look at what's our mission? What's our vision and what are we funded for? Don't put the ideas aside, when opportunities come you go after them. I had an opportunity on a Thursday night to I can't write a grant on a Monday night we could get funding.

We put the ideas on a sheet of paper and developed for weird instances. So, here are just three of the ways that I've seen collaboration happen with FBO programs, whether for events, documents or trainings. Collaboration can be with nearby states, other organizations in your state or even local businesses. I know that one program collaborated with a local cycling shop to create event of detain of the trails for their families. When working with others able to share that workload, those expenses and maybe allowing events to be for free.

And then potentially increasing attendance because you're sharing the marketing of that as well. As far as documents and resources program paperwork, event flyers, all of that to steal one of her favorite phrases, steal shamelessly, share seamlessly. When you collaborate together it allows you to bring out experiences and knowledge of others. Some things I'm better at than she is and vice versa.

That's great. Let's make each other shine. Although trainings are necessary, it can take a lot of time and resources to plan and host that training whether it's in-person or even

virtually. So when you collaborate with others you can reduce those overall costs, it can help with sharing the responsibilities and allows to network with others that they might not have access to and helps you develop other leaders in helping them learn new skills.

So consider partnering up with others at annual team trainings. Maybe new programs that you want to implement. Diversity training, ask EHDI program to train your team. This fosters connections and builds upon the existing partnership and use the Train-the-Trainer model to develop new leaders while increasing competence and skills. This is something we do when we have folks that come from other chapter or our FBO, they have to bring back and re-present to the team something they've learned at EHDI.

I can't make every EHDI session, right? It gives them the chance to do that presentation, take a step out of that direction and have us learn more.

>>DR. GINGER MULLIN: So Carrie calls that pay it forwards. Think about pay it forward. Someone paid for you to get here this happen share this information in a meaningful way. We call lovingly the bingo card, QR cards to different organizations and relevant to this presentation. Take our bingo card full of resources and share with your team and explain I learned this one thing out of the session today.

So the next couple of things could be your within thing you share that you learn. First of all, did you know EHDI, who seems to be my boyfriend for the last 20 years has a girlfriend. The girlfriend should be grace. So grace means you should be working with others, not in your silos. I don't understand when I hear about EHDI coordinators and FBO coordinators working separately or turning each other loose. I can't imagine going a week or two weeks without taking to Carrie. So don't work in silos and have grace with one another and be flexible, respect each other's limits.

In my time as a coordinator and with Carrie I've had weird things happen as had she,

we've had to step back and heal ourselves personally, our own mental health and family health. Always respect our limits. Look for other opportunities. If you can't do it, I can't do it. Who can do it? Our reach goes further. She has friends I don't know about and I have friends she doesn't know about, we can get them to help us when we're struggling.

We don't have to look like Superman or super woman or super person. We need to communicate. Everywhere you see Carrie you see me and vice versa. The last things E to the grace is enjoy it. Enjoy this journey. When work becomes work and not an enjoyment, it's time to re-evaluate. The other thing that brings me a lot of enjoyment is having the diversity and inclusion meeting new families having new perspectives. Meeting families with children with diverse needs, it reminds me why I do what I do. So we have on our team a guide by our side joins our EHDI staff meeting via Zoom on regular basis. They tell their stories, so we can hear that lived experience. I can tell you my staff leaves regenerated. Every time.

They want to work harder because they talk to people that serve.

>>CARRIE BALIAN: We have eight minutes left, so with quality improvement this is the key to diversity, the things that I can do that are harder for her. I host quality improvement groups throughout the year. We have specific groups Spanish-speaking or African-American families so we make sure we're hitting the targeting that are more troublesome. They are paid for their time and we assign specific TAFs, they do some on their own and we get together over Zoom to discuss what they've seen and have an open discussion.

What's worked for us? We have a Google form where which advertise in multiple ways. That has helped us gained interest. I have tons of people willing to do quality work which is amazing. I make sure that group is diverse. Not all with babies or not with older kids. A little bit of variety. So those questions are on Google form. He review the Web site and communication scripting and resources that we've rolled out. All kinds of different things

where it has helped to make sure are we hitting our mark?

So one of the things that ginger often reminds us of is take your goals cut in half and cut in half again. If goals are too lofty it takes forever to get there and you'll run out of the steam. So keep that visual in mind. Yes, ginger says underpromise but overdeliver and don't hesitate. If you have to readjust that rearview mirror because timelines didn't work out or goals shifted or maybe you have different stakeholders in there, don't hesitate to change the path. They might get you to a better place.

Another part of collaboration is the 508 compliance, so anyone funded by federal dollars has to have electronic materials and information that is accessible to people with disabilities. So we've doing to dive into this a little bit. A lot of handout has QR codes that I'll discuss here. So believe it or not there are 38 points, 38 levels of success criteria for accessibility. So not obviously 38 pieces right here. Things to consider, images, your text, having that all text feature, if you put a word in -- like if you put welcome across your page in JPEG not going to work so keep those things in mind.

Audio is it in accessible in visible format and if silent animations are they this audible format.

Captionings are they synced and equivalent to what the material is. Audio descriptions of prerecorded and live media. Visual information, on web pages do you have clear headings and lists and is your text clearly defining the sections of your Web site. We want to make sure that everything is reasonably laid out and it's able to be differentiated. Is there enough contrast between your background and text. Don't use a light gray text on a lighter background.

Sensory, making sure that they're not -- instructions are not conveyed only by sound, shape, size or visual orientation. That prompts are not only conveyed through color. That's

there's a way to stop a video or pause or mute on things that might automatically started playing. Texts and links, you might have seen next to a link a picture of a PDF, that makes you know going to a PDF or a text that has a link to a web circle. You know you're leaving that site to go somewhere else. That's 508 compliance. Keyboard functionality, making sure that you can use the up and downs the tab keys the space bar, why does she know about this? Why do we need to know about this?

Web site of the year, I've been on this committee or numerous years if you don't know what they look or for Web site of the year, look and they'll tell you what we score on. This is on that bingo board handout. Those things are many of the primary things we look at when we score Web sites.

That's why I highlighted those things. Also graphics, making sure diversity in your pictures. Many don't have pictures or they have pictures and everyone looks the same. I know you're using stock photos but we've worked together where we get approvals for families to use pictures of their families. There are other ways besides stock photos.

Accessibility checker, okay where do I even begin? The interesting thing about the accessibility check is that there's 16 different tool that is you can access through this QR code. You might think why do I need 16 different tools to tell me if stuff is it accessible. Some are free, some are costs. Some specifically review certain things such as videos, source code, documents and Web sites themselves.

So there's variance, also, in the ease of the test, so you might need some coding experience to use some of those tools, so it varies on who has that knowledge and ability. They also have tools that assess languages. So if you have things in multiple languages on your site there are tools to analyze that as well. And I'd be remiss to say that through that collaboration we have Web sites between us called Illinois sounded beginnings and it is EHDI

information and FBO information.

We do have our standalone site and public health site and hands of voices chapter site. It's a way to send families to one place to get started and it has a little bit of everything. It has stuff for providers, for families, as you see for facilities. This is a snippet of our page. But I wanted to point out that man icon or person icon in the top right corner, that's our accessibility that we paid extra for.

I want to say $500 for the year, when you click on that icon it opens this pop-up box as you see it has automatic profiles, so for motor impaired, blind, color blind, dyslexia, visually-impaired, cognitive and learning concerns.

For those that have seizure or epilepsy, and then ADHD, so those are automatically you put that icon there it's set to go in less than an hour you have your site be accessible through that service we used. We chose that because we did not have the skill set to do something on our own.

So with that we thank you. We want to remind you that coming together as a beginning, staying together is progress, and working together is success. Thank you, all.

>>DR. GINGER MULLIN: Before we go, does anyone have questions. Check out that Web site or the handout that's attached to our presentation on the Web site. You have all those QR codes for you to use and more.

>> There's a lot of seats in the first two rows, so move on forward.

>>DONALD GOLDBERG: Welcome, don't stay in the back. I'm Don Goldberg. I have a disclosure sheet, and thank you for coming. I did not have a flyer for everyone, but it does have a Web site or more information. I would encourage you to of go march 27 to a party. I'm originally from New York, so I'll get close to 95. Disclosure form I work at College of Wooster

and I'm a contract staff member at the Cleveland Clinic in Ohio, but the most important disclosure is this test is for sale. I don't get much, but that's the nature when you publish something. Blue tree publishing on the flyer is the source of this test I'm going to talk about.

A good professor has an agenda and I will rock on through the agenda. First of all, I oftentimes as dually certified speech-language pathologist, it's auditory teaching for the development of listening and spoken language. I happen to be married to an audiologist. If you have friends or teachers of the deaf, audiologist and speech pathologist, one person can't do it all so the idea of working with interdisciplinary teams is close to the hearts of many people in this room.

I'm not going to spend a lot of time and mostly focus on criteria and test, but I'm assuming that you have some background with auditory hierarchy and it's credited to norm in Australia. He does not like the word hierarchy. It gives the idea that you move on up and we go back and forth. If you know his 1982 book there are arrows showing as hierarchy. Many of you would be familiar with the terms I oftentimes take exam questions on these and my students get things wrong, discrimination, usually in a field of two, like papa is the same and, paba is different.

Recognition when you ask a kid to point. Getting comprehension. Greek mythology. I'm not going to talk about speech audiometry . Many babies we got speech awareness, speech detection and literally the response of brace yourself. That's a raspberry.

Speech awareness tells us something but not a lot of information and testing in the booth is not ear specific. Moving on you've probably heard of SRTs. I don't want to talk about the acoustics that behind the work we should be doing and SRT is vial dependent, low to midfrequency information. Maybe closed set. Pictures are in front of how or open set and it's reflective of a minimum response level versus a true threshold and anything tested in the

booth is in fact the better ear if ear difference exists. So don't be excited because the speaker is pointing to the right ear, you're testing the better ear if there's a difference. That's some of the comments about word recognition and this is not that exciting.

I want to get to the pretty pictures coming up. This is a list, you can't read it, but there are 50 items on this list. Many of you who are in the world of assessment of children are hearing loss are familiar with a few of them, there are very few tests that do the combination of the greatness of many of these individual measures which I took into strong consideration in the development of this measure.

I'm assuming you have background in psycho metrics. It's a measure of a standardization pool. In the world of hearing impairment it's difficult to standardized tests, what devices are they wearing, what are the parents doing with the kid and teaching them, listening, et cetera and then they get hearing aids for a while and CIs for a while and the concept of hearing age has become an asterisky thing. They have hearing aids but he didn't wear them and now he has cochlear implants. So I wanted to clarify this is a measure to be administered on an annual basis, first time is a baseline and then if you can readminister don't tell him the answers but you can readminister this on an annual basis to see how your child may have progressed from year-to-year and so far no 13-year-old has received the ceiling.

I have good models, you can use this up to 13 or higher and at the same time I will mention I have had some success with two years olds on this test, I work primarily with babies and I think I can get most 2-year-olds to work cooperatively.

When I was visiting Sydney, Australia they were not on their mom's lap, so I have had success at two, but don't walk away going try it on two years, one day. They may or may not be cooperative. They get around. As a clinician this is built as a measure or speech-language pathologist, academic classroom instructors. You do not need an audiology booth. You do

need to go calibration. Not norm referenced.

This is Betsy, who's mom is credited with the ESB and this was a very important development. I'm so old I was around when implants went on people's heads and this was revolutionary when we thought about pattern perception as a member of hearer versus a feeler. So important that I acknowledge the importance of pattern perception. Throughout the word I traveled, my favorite story is it when I went to China. A famous educator, Ling is a common name in China. So many people use these sounds but they do the stuff and it's important to understand how tests are and the original credit should go to LING and LING, and it's an important component of what I used.

Whenever my student us use a lower case L, not that bright but it does have a capital L because it is a proper name, so I circle the and put UC for upper case. Anyone ever heard or own it, one of mine was stolen literally outside my therapy toy room at the playroom clinic. It was long and didn't fit in backpack well and it came on a cassette tape and great development and influenced I development. I've been working on this for so long. It stopped being sold.

This is a score sheet and that does have a massive audio trainer down at belly button, I hope there's a microphone so they can hear their own voice. There are users in the room where you don't have to use the TAF. I've been a critiquer of the TAF, but clearly you don't want a cassette tape. I prayed it didn't break I put on a CD and the CD never broke.

The images were ugly, old-fashioned, where is your hearing aid. It was sexist, mom in the kitchen and sister delivering beverages to little brother, that house up in the tree, a Treehouse. Now there's a good SRT. I've been messing up words for 30 years. But who knows.

So I didn't want it to be sexist. We do need to think about DEI issues. The need was hierarchical. I don't know about you but I did not always have success with getting a kid with

subtest 9 and 10, going signal to noise ratio, so these were critiques that I put into consideration. I don't have the time, I do have the energy. Issues of speech science and acoustics is critical and I think as I do run through 19 subtests, you'll get an idea that acoustics was pretty darn important to me as a developed light bulb. My preference for terminology is auditory functioning and it made for a decent acronym TAF for those that wanted a new one we have a TAF.

I got support from my college. I traveled to four continents. I collected data on kids and they all had to speak English but a large number of kids were bilingual speaking Spanish. I did have access to people in Cleveland. I went to auditory visual center of Atlanta and UK Israel and London. And my last stop in Sydney, Australia and described as the elderly man been on the plane for 20 hours and COVID was about to hit. If I had stayed one extra day in Sydney, Australia would have been quarantined for months and months.

While I collected data in Sydney they were taking their temperature and I was wiping with infection control on everything in sight and I enjoy Sydney, but I needed to get home to a wife and child and puppy. It's a criterion-based test, deaf and hard-of-hearing using any technology and in Gen 2 to 13 years of age and as I said the field testing helped me know if the pictures were propose.

The illustrators in China, you'll like her artwork shortly and the easel is sitting up there. I probably should keep hitting the button to advance the slides. If anyone wants to see the TAF, I'll go out in the hallway when the presentation is done. You'll see from the pictures we start with basic level of listening, long versus short, 1A and six B for adults. You don't have to look ice-cream cone and think that's good. It keeps going and going. 17, 18, 19 are in varying signal to noise ratios that get harder and harder. Blue tree publishing. There's a disclosure. The last time I gave a talk I couldn't remember the Web site. The publisher was not amused.

So that is on the flyer.

You'll see pictures of the subtests. So this is number 1 room versus pop pop pop for little ones. Everything is on a USB drive and has a key chain with a puppy drive. Your audio files, paying a buck for a form every time is a little bit harsh. You download a score sheet, download the manual, and as of two weeks ago I have YouTube videos how you administer the subtests including calibration which must be done before you administer the rest of the test. You can download, and you need to measure where the kid's head is and essentially that will be administered at DBA each year to make sure you have the same intensity level.

I need to go fast, this is for the adults don't have to hear VAROOM or a race car. We have guest appearances by my daughter-in-law as well as my oldest grand daughter. This is just pitch, drum, versus a whistle, this is where we come in with my saying as homage to Brady. When my daughter-in-law says because of gender neutrality of Reagan, then we get my grand daughter in childhood voice to say hi my name is Reagan, for male, female, fundamental frequency of three different voices. There it is. Hello, my name is Reagan. That's my homage to my favorite kids.

We do have environmental sounds. I wrestle with this because your vacuum cleaner may not sound like my vacuum cleaner. For those of you with machines that clean your floor, I don't know if they make any noise but they go around table legs. When you tell the kid these are nine of the items, when you hear a dog bark your bog can bark differently. Woof woof, whatever.

Moving on, this is my cell phone. I want to move on, we have lane six sounds and I'm going in the wrong direction. That's bad. Anyway LING, classic pictures and you can point these out, for the adults you don't need to see the ice-cream cone or UMM.

Those of you working with young kids we move like cows but you might need -- you can

tell the kids instructions on the template, my chicken going balk balk balk. We have IUs for the help come ter. I whisper that.

Moving on patency perception one versus three, a variation from the ESP. Classic one syllable versus three syllables, only SPONDEES. It moves on to classic word recognition, show me bed. There's a practice item and you proceed. Show me dirty shoe. Two critical elements. For those of you that know the TAF, four critical elements influenced by a child's auditory memory and I have many a 2 and 3-year-old do two critical elements but got bogged down with four because of memory not listening. You listen to a story and I'll play the last clip.

The family did go camping. Who went camping? What happened next and what happened next, went on zoo train. The last subtest in quiet is a five sentence, all of the items are five sentences long. You're asking to have listening details. Who is the story about, apparently no SKUNKS in Australia, even if you don't have them in Sydney, if you heard about this you did pick bottom left. We have what color are they. Did you know an SKUNK stomps feet before they spray you? They are frightened before they get you.

They like curdled eggs. 17, 18, 19, this is the same concept as sequencing at plus ten and who baked the cake. I did get dad in the kitchen. What happened next? I said icing and frosting, trying to cover my bases and this is my puppy, bottom right is maizely and the story about the little girl licking the spoon. Subtest 18 is a slightly longer story and at plus five a little more difficult than the plus ten and this question was about squirrels. Did you know that a version a breed of a squirrel is a chipmunk. I said I think chipmunks grow up to be squirrels. Oh, Don you're from New York, chipmunks do not grow up to be squirrels. There are 70 versions of squirrels. There are flying squirrels and there is a baby squirrel, jokingly the chipmunk.

The last subtest, I let you listen, I pray, all about prayer, this is a little segment, please

go.

[Video playing.]

>> A chicken egg is kept --

>>DONALD GOLDBERG: You're hearing it soft, but trust me hearing people, including the elderly, includes myself, that is not easy to hear. I may have done a horrible thing, so let's just move on and the question is what was the story about? What's the gestation, how long does it take a chicken before hatching and you learn the season keeping in mind the southern hemisphere for the breaking of a chicken egg and how do they get out of the egg? They do not use a wrench. We're at two minutes. The USB drive has everything you need to know including the score sheets. You do need a color copier because of looking for scoring purposes and there's a summary sheet for how they're doing on subtests. No one starts at one and goes to 19. You're given guidelines where to go. The average time was somewhere between 12 and 15 minutes for field testing, depending on how responding. Guidelines and criteria or subtests and two consecutive fails tells you you're needing to stop. I would suggest as a clinician when a child bursts into tears, don't push them, you might want to stop instead of two consecutive subtest fails. Go to links. Ella is a child bimodal. The first subtest shows you calibration. You can write to me at the college. I also have a separate Web site. This is one of my favorite slids for our kids sky, and that kid's name is ski and sky is the limit for deaf children. I hope this is a limit for many of you. Go to AT bell.org.

7:00 p.m. for those that work. Thank you for your attention and I'll stick around or move outside for any questions. Thanks. I talk fast. Was that okay?

KidScreen - Early Childhood Screenings for Early Headstart/Headstart Programs.

>>SANDRA GABBARD: Hello. Thank you, everybody, for coming. E-mail Sandy Gabbard. I'm on audiologist. I've been involved in hearing screening for decades. My career is focused

on hearing screening. I spent a lot of time on that. In my new role I'm at the Marion Downs Center. Eva Watson is four year fellow. She's working on programs. Aaron Rose wears many hats. We were asked to put in some learning objectives. So hopefully you will feel comfortable understanding our early childhood screening programs. Factors that you may consider if considering implementing a program like this, what kinds of things we have learned and then the administrative functions which is sometimes just as challenging as screening three years olds and Aaron is responsible for those, so he will elaborate. We're a Nonprofit Agency not far from here. We've been around before we were called the Marion Downs Center, it gradually evolved to providing services. Marion was on the board for many, many years, test on the board of nonprofit organization which is part of reason we have named it in her honor.

We do have a perceptual and hearing clinic and we do clinical services for all ages and all economic groups, but we have many programs providing awareness, education, support, community outreach. We try to identify gaps in the community and obviously we have student's training and professional training and we try to share what we do so others can learn from us.

The KidScreen program has been around for many, many, many years and the idea with our KidScreen program is to go into facilities often now it's mostly early head start but we also offer services to charter schools, private schools, day care centers, all places where you find kids that may not be getting screened, because not old enough to enter the number school system or because in facilities that don't have public school screenings.

Our program has more and moreover the past decade been providing services to early head start and head start as I mentioned. Many of you are familiar with that model, the model of early head start, head start, can be in churches, day care centers that offer day care, can

be in schools and all kinds of places. With part of their mandates, federal mandates, are required to screen for significant challenges within 45 days of enrollment.

So that's what we're going to talk about today is early childhood screenings although we screen all ages up to high school. I'm going to turn it over to Eva because she has become an expert in hearing protocols. I want to reinforce why so passionate about hearing screening, we all know newborn hearing screening results in early identification, early diagnosis and early intervention for many, many, many children that do not have typical hearing. But we also know by the time kids enter public consumes the data shows that at least twice as many kids have hearing differences and some of the data shows that in the elementary years that as many as 3% of kids identify with hearing loss that includes transient challenges, often middle ear problems.

In the population screening for trying to find kids that are at risk for transient problems. So that's you a we've evolved our protocols to identify early on in screening process. One of our biggest frustrations is we do not have diagnostic information to share with you. The kids that we refer get sent to various places because of funding source. We see some at our center but many are referred into our places because they have a specific type of Medicaid that requires thinking to a specific clinic. That is a challenge to identify how many kids end up with a diagnosis that involves getting services. We do have anecdotal information that many do make it into the process and having a special service but no programmatic data to share with you. Turn it over to Eva.

>>EVA WATSON: All right. Like Sandy said I'm a 4th year audiology student at Marion Downs Center. I'm going to talk about hearing protocol. The protocol depends on the age of a child, so from birth to three years and 11 months we start with OAEs. It's considered a pass. If they fail OAE we perform tympanometry, we'll go back and rescreen to see if middle ear

problem as resolved. We'll automatically medically refer them if a private site. If they refer on the OAE that's automatic referral to audiology. When we rescreen if still middle ear pathology going on we refer on OAE and tympanometry we refer for middle ear health.

If they pass tympanometry we refer of audiology. So of for children four years and older we complete a screen at thousand hertz. The same protocol follows. This they refer for tympanometry we'll rescreen them. If part of a private site and they refer on pure tones and tympanometry we'll refer for middle ear health. If they refer ear health but pass tympanometry we pass on audiology. If a child can not condition to pure tone we'll follow the birth using OAEs.

Same thing with rescreens, if they refer them, OAEs, tympanometry again we refer for medical. They pass tympanometry we refer audiology. So here's some of our KidScreen data from August of 2022 to November of 2023. These are OAE screening results from children birth, three years to 11 months. 67% passed. About 14% referred on OAE and tympanometry meaning pathology on meddle ear. 3% were referrals we refer the OAEs but pass the tips. 63% unable to test due to behavior, noise, they were crying, they resisted.

And then here are our pure tone results for children four years and older. 70% passed and 22% of children four years and older can not condition to pure tones, meaning couldn't get them to raising hand when he hear the beep and we have to you OAEs. Here's other hearing screening data for children 0 months to 35 months. 10% referred to pediatric audiology. This number does include children who refuse testing. Typically if they refuse testing we'll rescreen them and if they refuse again it's an automatic referral.

14.7% we were unable to test and there's a 35% referral rate among rescreens at early head start programs. This data is from the fall of 2023 for greater kids head start. 42% of head start referrals for middle ear health and one out of every four children referred to

audiology don't follow up.

I'm going to briefly discuss our speech and language protocol. So we start screening for speech at six months and if a child is between six months and 2 years we do a language questionnaire and we give it to whoever is most familiar with the child, so that's typically the teacher in the school environment and we have them answer yes or no to five questions that I expect the child to do developmentally based on their age and if they say no to more than one, that's an automatic referral.

Once a child is two years old we move to the speech card, we point and say what is this, or we ask them to repeat the word and there's a target sound in each word that to he repeat they pass, but if they refer or can't pronoun the sound it's automatic reform. We like to get intelligent answers. We rate their conversational intelligibility.

Some other screenings that we offer are optional language tests which is just a language developmental test in children three years or older and we do developmental screenings which screens development, motor skills, pre-academic or academic testing in math, reading spelling and depending on age and grade of child. Pass on to Aaron.

>>AARON ROSE: Hi, I'm Aaron Rose. The last three years I've spent supporting the program. Mostly I do the protocols for 4th year fellows and audiologists do with hearing and speech. We use early head start kids. The older kids we use acuity. So for the younger children, we see behavior concerns and if they have concerns there's automatic referral. They have long days, typically test their skills like cover their eye as a child and we see if they're tracking. For the older kids, we do the acuity, and shapes. This is kind of 3D see through the shapes with special glasses. See if it's clear or not.

So with that we see if their coordination is and we have to schedule the sights. So the important part that we need to have is the coordination and we see their date of birth, what

class they're in and their age, any other concerns, and which agency they're part of because many agencies essential the same school sites. So that's the first step and have it prepared. The box and speech cards and this helps us keep track of who's been screened. We have reports and we share with the staff and parents. So like I said, before there's a lot of coordination involved we do communication with staff and we meet with them and we have a director, she's the director, her main role is to do the coordination and communication for the staff so they can understand what it is we do, why we do it and help parents understand it. Like I said before, we schedule up to here, because fall is our busiest season, like 45 days from the date of enrollment in August of September. So September, October, screening every day. So staffing needs to be done throughout the year and consider the cost to carry out the screen.

So, there's a cost for screenings for all the sites. So, at the site we have to think about how many students we have and what are their ages, how many kids are four years and up and how many are babies and whose on-site for staff support and who is helping us. So we have to go through all the tests and make sure there's no lights that are too bright and the space is a safe for the kids.

So for babies we do one at a time so there's not many disruptions. If a baby cries, it becomes a domino effect. It's an attempt effort to calm them down. It's a team effort in those situations. So the big picture, effective communication is key for successful screenings. If you have staff, you have to be clear where you're going. So we use a lot of paper. One piece of paper, rip out, and then we enter it into the computer after the fact. Not anymore, we have a new database that allows us to take a laptop and enter the student's record into the data. It helps us report out faster.

So, there's a lot of factors why a kid couldn't get testing, behavior, crying, a lot of factors,

so be prepared for the unknown. Our big concern is kids, parents need to get the support and follow up. There's a lot of resources. We have a diverse population. A lot of them speak Spanish or immigrant families, so there's many factors that include the follow up. So any questions? Get by the microphone.

>> Thank you. So you briefly mentioned cost to the facility or program, so how does that work? What are they charged or what is the consultant fee?

>> The charge, hot button issue for the sites and for us. We have a contract with head start, Denver head start, so we have a contract, so we build them so it's centralized so each site doesn't have to pay. Some sites decide they want to do their own, it's about $22 a kid. It covers the cost of staff. Staffing, obviously we have a lead screener that's a staff person that has some qualifications. Our director is SLP and we have Aaron who goes and they're the lead and we use students from the program but we have trained technicians. One or two that go along with the lead for the day. We charge a little bit more if going to a private site especially if want developmental assessments, so we negotiate with each site.

>> Hi, you briefly mentioned the screening protocol, my question: How long do you guys take before performing a rescreening? Specifically for hearing.

>>SANDRA GABBARD: The head start protocols, we come back every 45 days and they get automatic rescreens. The private site gets to decide if we come back and the majority do not have us come back, so we go right to the recommending a follow up. I should mention with the ROAE protocol we are passing for six frequencies which is a little more sensitive than many of hearing screening devices out there, we partly did that because we couldn't change some of the other parameters of our screeners to be more sensitive, so we're going 4 of 6 and we do tympanometry. We can do high-frequency if a kid is a young baby. The other challenge is we do not know the newborn hearing screening results.

We come in and we are the contractors to the school, not as individual clinician, so we can't really go in the database, because we are not providing direct service to that child, so that's challenging as well. We have a minute or so.

>> Have you found that preschools, themselves, can help with loss to follow up. I'm sure you're coordinating and I want to ask what you sent home with parents about follow up. Is it resources in the area or education materials?

>>SANDRA GABBARD: Good question, so our director who is SLP is on the health advisory for head start and she educates all the staff. She goes to monthly meetings on Zoom and she says something they want to know. We do send a report to the school but the parents get individualized reports. We counsel on school staff to follow up. So many of these kids refer on a lot of things and then you wonder if they need to have IFSP or IEP. If you want to learn more about test results Eva has a poster in the poster area and we gather teacher and parent concern for vision and hearing and we are finding that kids are twice as likely to refer on the actual testing if they have a parent referral in the system. If you can't do anything do parent teacher concern as a referring criteria. Do we have time for one more?

>> Um-hmm.

>> I'm curious which database you have found to be helpful? Did you have to create your own that was custom or find one that exists.

>>SANDRA GABBARD: If I could beat my head against the wall, I'd do it right now. We have not found a great database. We created our database and we're about ready to decide if we want to keep it or not. The nice thing about your database is using the pro and we can enter into from in a user-friendly way. It needs work to follow kids as individuals. One of our biggest challenges.

>>AARON ROSE: The architecture, there's a base we're thinking about after the fact. We're

learning as we go. Learning from a paper version, we have more work to do to improve it. I'm happy with where we are right now, but still a lot of work to do and if you have questions, I'd be happy to answer them like what can you do to have discussions. There's a lot of details.

>>SANDRA GABBARD: I have had a couple of people ask would which be willing to share our database. When it's in good shape, yes, at some point we'd be willing to share. Thanks you guys. If you have questions we'll stick around for a few minutes.

END TIME: 11:51 AM