As I celebrated July 4, I thought about how our founding fathers were tremendous thought leaders. They recognized an ineffective system and conceptualized an entirely new approach to government. I am struck by how quickly a simple good idea takes off, and I sometimes wonder how people come up with them.

I want to encourage us—as AAP EHDI experts and advocates—to focus on the concept of innovation. The dictionary describes innovation as, “introduction of new things or methods.” Synonyms of innovation include, “brainchild, concoction, creation, invention, wrinkle.” Wrinkle is an interesting synonym for innovation. It suggests some imperfection or alteration in plans. I wonder about wrinkles in the EHDI system. Likely we can agree there are wrinkles to address, and thus, opportunities for innovation.

Once we have built consensus on priorities for change—what are the gaps we are trying to address? Innovation requires us to see what isn’t there yet. How do we begin thinking outside of the box to change our course or trajectory?

So, I ask you, “Are we satisfied with the status quo?” “Are we satisfied with our current approaches and strategies to optimize family and child outcomes?” “How do we take EHDI to the next level? What should the “next level” look like?”

Should the changes focus on any and/or all of the following:

- Supporting and getting involved in our state EHDI programs and their initiatives
- Effective family partnerships
- Understanding and enhancing child language, social-emotional, and developmental outcomes
- Identifying new approaches to interventions and language learning for children who are Deaf/Hard of Hearing (D/HH)
- Enhancing cultural competency of the EHDI system
- Enhancing our approach for children who are D/HH Plus
- Building upon the strengths and resilience of families and children
- Improved data integration across state systems to understand the public health impact of the EHDI program

Are you overwhelmed by my questions yet?

I recently read about the concept of new ideas occurring when people have an interface, or experience, with people or knowledge outside of their usual field of expertise. (If you Google “cross-pollination,” and you will come across several business sites describing the benefits of this approach to innovation.)
In Ohio, there was a change in the system which promoted new collaborations, or “cross-pollination.” The state moved the early intervention services lead agency. Previously, children who were D/HH received services from specialized Regional Infant Hearing Programs that were within the Ohio Department of Health. These programs had built expertise around the needs of children who are D/HH. They existed prior to the implementation of universal newborn hearing screening, and so the roots were deep. This move was hard, and initially prompted many fears and concerns about the intervention services for children who are D/HH.

In contrast, the new lead agency - the Ohio Department of Developmental Disabilities (DODD) - serves children and adults with developmental disabilities across the lifespan. It is the agency that has historically provided early intervention services to other children enrolled in the Part C system. Despite the initial fears, the changes have enhanced services for children who are D/HH.

At a recent Ohio EHDI state advisory committee meeting, early intervention providers serving children who are D/HH described a specific change in their participation in Individual Family Service Plan (IFSP) meetings. Providers with expertise in children who are D/HH now actively participate in other IFSP meetings with a broad group of interventionists such as speech-language pathologists, occupational therapists, physical therapists, and developmental specialists. By contributing their D/HH related expertise to the care of children who are not on their caseload, they have been able to share their knowledge with the broad intervention team. This has resulted in consideration of previously unrecognized hearing-related needs in children with developmental delays.

This new “cross-pollination” has improved services for many children within Ohio’s Early Intervention Services. It has been described as enhanced teaming for the betterment of all children served within Part C programming (eg, children who are D/HH and hearing). Care is now presented as part of a broader picture, and children receive a more innovative approach to meeting their needs.

This information inspired me to consider how I can personally learn from others, as I firmly believe everyone I meet in life has a lesson to teach me. In this way, I can build my toolkit of strategies in partnering with the families and children I see. First, I should listen for understanding rather than simply the purpose of responding. And when I speak up, I try to remember, the following three questions: Is it true? Is it kind? Is it necessary?

I hope you see where your opportunities are to step up to the challenge and contribute to the next important phases of EHDI!

Clinical Corner

Early Hearing Detection and Vocabulary of Children With Hearing Loss

To date, no studies have examined vocabulary outcomes of children meeting all 3 components of the Early Hearing Detection and Intervention (EHDI) guidelines—hearing screening by 1 month, diagnosis of hearing loss by 3 months, and intervention by 6 months of age. The primary purpose of the current study was to examine the impact of the current EHDI 1-3-6 policy on vocabulary outcomes across a wide geographic area. A secondary goal was to confirm the impact of other demographic variables previously reported to be related to language outcomes. Findings showed that vocabulary learning may be enhanced with system improvements that increase the number of children meeting the current early identification and intervention guidelines. In addition, intervention efforts need to focus on preventing widening delays with chronological age, assisting mothers with lower levels of education, and incorporating adults who are deaf/hard-of-hearing in the intervention process.

Quality Improvement (QI) Buzz

Improving Timely Diagnosis through Teach Back

Nearly all infants in Minnesota are screened before 1 month of age, however less than 50% of infants reach the national standard of being diagnosed by 3 months of age. Moreover, significant ethnic disparities exist for reaching diagnosis by 3 months of age.

In November 2016, the Minnesota EHDI program launched an EHDI learning collaborative. This collaborative included providers that served diverse populations and one birthing hospital, two community health centers, two audiology clinics, and Minnesota Hands and Voices.

The aims of the collaborative were to do the following:

- Increase the percentage of infants who do not pass hearing screening and have complete diagnostic testing before 3 months of age
- Decrease the race/ethnicity disparity for those infants that receive complete diagnostic testing before 3 months

To help reach the aims, one significant area for improvement recognized by all collaborative members was how hospital, clinic, and audiology staff convey to parents the importance of following up on failed hearing screening.

The collaborative hypothesized that the use of the teach-back method would be valuable in helping families understand the importance of follow-up. Teach-back is a tool to make sure that a health care provider explains information clearly to patients. It is used when a provider asks a patient (or family member) to explain in his or her own words what they need to know or do, in a caring way. The provider uses teach-back to check for understanding and, if needed, re-explains and checks again. Thus, the team developed, tested, and refined a tool to assist providers in using the teach-back method specifically for EHDI follow-up.

Preliminary results show that the EHDI teach-back tool, in addition to other changes established during the collaborative, increased the percentage of infants with diagnostic testing before three months from 38% to 75% within the collaborative sites.

Family Partnerships

Family-to-Family Health Information Centers (F2F HICs)

Family-to-Family Health Information Centers (F2F HICs) are family-staffed organizations that assist families of children and youth with special health care needs (CYSHCN) and the professionals who serve them. F2F HICs provide support, information, resources, and training around health issues. F2F HICs are uniquely able to help families because they are staffed by family members who have first-hand experience navigating the maze of health care services and programs for CYSHCN. Pediatricians, families and others may reach out to their state’s Family-to-Family Health Information Center (F2F HIC) to obtain information, emotional support, and other resources.

Visit the Family Voices National Center for Family/Professional Partnerships website to find the F2F HIC in your state and learn more about how these centers provide free services to families of children/youth with special health care needs and the professionals serving them.
Medical Home Resources

Technical Assistance and Support for Pediatric Medical Home Implementation

The National Center for Medical Home Implementation provides free technical assistance and support to pediatric clinicians, practices, Title V programs and other state-based organizations, families, community members, and others interested in implementing high quality primary care for children and youth. Support related to implementation of family-centered care, cultural competence, pediatric medical home transformation, and care coordination is available. All technical assistance requests are answered within 1-2 business days.

And More….

Key Considerations for Improving the Pediatric Primary Care and Specialist Interface

An article in the Journal of Pediatrics titled, “The Pediatric Primary Care-Specialist Interface: A Call for Action” outlines key considerations and solutions for improving relationships between pediatric primary care clinicians and subspecialists. The article summarizes key components of the family-centered care, including access, communication, coordination, and family-centered care; it also provides solutions for enhancing the pediatric primary care clinician and specialist relationship. Successful collaborative care models that can be replicated in other states and health care settings are also described.