I’m in recovery. I’m back home from the Twelfth Annual EHDI Meeting in Phoenix, and I’m recuperating from the excitement and the energy.

I’m learning every year. Sometimes I’m relearning the things that I’ve heard before but have never quite absorbed. Sometimes I’m even unlearning the things I thought to be true, newly realizing that my truths were wrong, or at least they were a lot more complicated than I had ever imagined.

In Phoenix, I learned about the difficulty in assessing whether hearing aids are fit appropriately for infants who require amplification. About how tele-intervention can overcome geographic barriers for the hard-of-hearing child and their family. About the promise of newborn screening tests for cytomegalovirus disease, a promise that has yet to be fulfilled despite tireless efforts. About expanded blood screening panels for genetic determinants of hearing disorders. About the potential for community hearing screening programs to identify delayed-onset sensorineural hearing loss in the 2-year-old or the 3-year-old child whose unmet needs might otherwise wait until later discovery in elementary school.

I learned about big numbers, like the 30 million word gap that exists in the first few years of life between children living in poverty and their less impoverished peers. I learned about small numbers, like the exceedingly tiny number of infants with auditory neuropathy who come from the well-baby nursery rather than the NICU.

I learned an ever-deeper appreciation for signed language, and how it can support rather than undermine early efforts at oral language. And I learned of the success stories of deaf college students, as they related their very different paths into and through the world of higher education.

I learned about ongoing unsolved dilemmas like the baby that retains middle ear fluid for many months after birth, and the disagreements among professionals concerning how to best evaluate and manage this vexing problem, and the disagreements about when and how to intervene with amplification or with surgery.

As with every annual meeting, I rejoice in our achievements. It has been a ground breaking effort over these last two decades, and so many of the attendees at our national meeting have been responsible for grabbing a shovel and collectively breaking that ground! After years of rolling up our sleeves and getting dirty, we have much to show for our sustained efforts.

And, with every annual meeting, I return home with just a little pocket full of melancholy. Sadness that I couldn’t attend so many of the topical sessions and learn more from others. Sadness that I didn’t meet as many new attendees as I had hoped, or spend a few minutes extra with those good friends I have made along this adventurous journey. Sadness that I don’t know American Sign Language, and that, as a result, I never adequately connect with the many Deaf attendees, colleagues who communicate with a demonstrative and dance-like physicality that I can only envy.

And I learned, this year more than most, that budgets, like the cochlea, can be so very fragile. More than most years, so many individuals and departments seem to be holding their breath, as the national climate of budgetary constraint begins to threaten the status quo. I have no easy answers, except perhaps one—The work will go forward, because it can’t be stopped. We have something that can never be subjected to sequestration. We have inertia! Carry on, friends.

- Albert Meh, MD
Were you able to connect with your state EHDI coordinator while in Arizona? If the answer is no, Directors of Speech and Hearing Programs in State Health and Welfare Agencies (DSHPSHWA), an organization whose membership includes a large number of state EHDI coordinators would like to help you. For assistance in linking with your respective state EHDI coordinator, contact DSHPSHWA at dshpshwa@hotmail.com for introductions and facilitation of collaboration.

If you were able to connect with your state EHDI coordinator while in Arizona, GREAT! A logical next step in cultivating your relationship with your state EHDI program (not just the coordinator) is to attend the next state EHDI Advisory Committee Meeting or Newborn Hearing Task Force Meeting. In your state, this may be called something slightly different, but it is a periodic meeting of EHDI stakeholders, usually arranged and set by the EHDI coordinator. In some way, try to participate in the meeting, either by phone or in person. Ask to be put on the agenda and use this as an opportunity to share the Chapter Champion Work Plan you developed recently. The group will welcome your participation. JULIE BEELER, CCC-A/SLP (TN), PRESIDENT, DSHPSHWA

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**CONTEXTUAL CONDITIONS FOR EXPANDING PERIODIC EARLY CHILDHOOD HEARING SCREENING**

William Eiserman, PhD, Early Childhood Hearing Outreach (ECHO) Initiative, National Center for Hearing Assessment and Management

A number of studies have demonstrated the efficacy of providing periodic otoacoustic emissions (OAE) hearing screening to children 0-3 years of age in education and healthcare settings. Across these studies, children with permanent hearing loss are identified at a rate of 1-2 per thousand, similar to the rate of identification in many newborn screening programs. These findings lead to discussion about the relative value of offering hearing screening to larger numbers of young children as well as to speculations about potential barriers to universal preschool hearing screening, particularly in healthcare settings.

The viability of expanding periodic hearing screening to more children does not necessarily hinge on universal adaption nor is it linked to any single, specific service setting. Rather than asking whether periodic hearing screening can be justified as a universal practice, it may be more fruitful to focus on identifying the contextual conditions within which periodic hearing screening is a “natural fit” and can complement, rather than compete with, other important services provided.

Demonstrations to date suggest that OAE screening can be integrated successfully into a variety of early childhood educational and healthcare contexts when the following specific conditions are met: 1) easy and repeated access to children and families; 2) access to follow-up medical and audiological services; 3) capacity to track children requiring follow up; 4) stable staffing; 5) a budget to permit purchase of equipment and supplies; 6) programmatic emphasis on monitoring language development and hearing; and 7) interdisciplinary collaboration and coordination with other entities promoting hearing health and development (e.g., state EHDI programs). When these contextual conditions are present in an early childhood educational or healthcare system, periodic OAE screening can often be integrated seamlessly and with great success. If these conditions are not present, it may not make sense for providers to purchase screening equipment or attempt to implement a hearing screening program.

Perhaps one day, all children can have their hearing screened during the critical, early, language-learning years, but in the present moment, it is likely we can extend the benefits to many more than ever before within settings where it is a natural fit.

Read more about these contextual conditions to determine if a specific setting is a “natural fit” for implementing OAE screening with children birth to three years of age. For more information visit www.infanthearing.org/earlychildhood/docs/Expanding-Hearing-Screening.pdf.

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**References**

HEARING AID CHALLENGES REPORTED BY PARENTS

The Journal of the American Academy of Audiology recently published a study, “Parent hearing aid experiences in the United States”, in which parents were surveyed on the timeliness of service delivery, hearing device access and hearing aid management. Results from the survey provide valuable information in identifying existing challenges for these components of the EHDI system. According to the study, for children born between 2007 and 2010, the top three challenges parents reported in obtaining hearing aids were 1) paying for hearing aids, 2) accepting the need for hearing aids, and 3) wait time for an appointment. The authors noted that almost one-half (48%) of the parents reported that they did not receive adequate support from their audiologist in how to check the function of their child’s hearing aids. They concluded that while significant progress has been made over the past two decades in reducing the age of hearing loss identification and hearing aid fitting for children who do not pass the NHS, many children continue to experience delays between hearing loss diagnosis and hearing aid fitting. Those delays exceed Joint Committee on Infant Hearing recommendations. The experiences parents reported provide valuable information about areas that need further investigation to improve the process for children with hearing loss. Source: Muñoz K, Blaiser K, Barwick K. Parent hearing aid experiences in the United States. J Am Acad Audiol. 2013;24(1):5-16.

SHEADING LIGHT ON THE ETIOLOGY OF UNILATERAL HEARING LOSS (UHL)

Virginia Commonwealth University Medical Center researchers have recently published the results of a study concerning UHL. In this retrospective review, the authors analyzed the presence of Joint Committee on Infant Hearing (JCIH) risk factors and co-occurring birth defects (CBDs) in children with UHL. Using the statewide registry of universal newborn hearing screen data for all children born in Virginia from 2002 through 2008, the study investigators looked at 371 children with confirmed UHL.

Of these children, 362 (97.5%) were identified through a failed universal newborn hearing screen. Of these 362 children, 252 (69.6%) had no JCIH risk factors and 110 (30.3%) had 1 or more risk factor reported. Craniofacial anomaly was the most commonly reported JCIH risk factor in 48 children (43.6%). A family history of permanent childhood hearing loss was present in 24 children (21.8%). Twenty children (18.2%) had stigmata associated with a syndrome including hearing loss. Of the 110 children with UHL and a JCIH risk factor, additional CBDs were identified in 83 (75.5%).


NEW RESOURCE

“Principles and Guidelines for Early Intervention after Confirmation that a Child is Deaf or Hard of Hearing”—the Joint Committee on Infant Hearing (JCIH) supplement to the 2007 JCIH Position Statement. For online version click here.

Early Hearing Detection & Intervention Pediatric Audiology Links to Services (EHDI-PALS)

WORDS OF INSPIRATION…

With the new day comes new strength and new thoughts.

~Eleanor Roosevelt
Distribution Information:

The AAP EHDI Program implementation staff send this e-mail update to the Academy’s EHDI Chapter Champions, other interested AAP members, staff and state EHDI coordinators. For additional information on hearing screening and to access previous editions of the EHDI E-mail Express, click on the following link http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/PEHDIC/Pages/Early-Hearing-Detection-and-Intervention.aspx. Previous e-mail updates are available upon request from Faiza Khan, fkhan@aap.org or (847) 434-4924. If you would like to unsubscribe to the update, please notify staff by responding to this e-mail.