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Hearing Aids & Audiological Services Program Update

The Hearing Aids and Audiological Services funding administered by the Iowa Department of Public Health EHDI program was put on hold in October 2009 due to state budget cuts. All children enrolled at the time of the cuts were served. In November, a local family (Ashton Bemberg's family) was featured on the KCCI Channel 8 evening news as a top story. The story served as a reminder that there are families who may have medical insurance, but hearing aids are often not covered by insurance and the costs may present huge challenges for families. The story highlighted this family's struggle, past efforts to secure an insurance mandate, and how other states are passing legislation (14) similar to what has been proposed in Iowa.

There are currently 25 children on the program wait list; however, the program is not currently accepting applications at this time. Provider Claim Systems has been working closely with all providers

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Advisory Update

The next meeting of the Iowa Early Hearing Detection and Intervention Committee is:

April 1, 2009

10 a.m. - 3 p.m., Location: Iowa Altoona Public Library

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Contact Tammy O'Hollearn for special accommodations at least 48 hours in advance of the meeting

Past meeting agendas, minutes and a list of committee members are available online! Visit www.idph.state.ia.us/iaehdi.

Hearing Aid & Audiological Services Program Update

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to pay outstanding claims. If the funding is restored, most of the children on the wait list will be served. If you have specific questions about the hearing aids and audiological services appropriation managed by IDPH, please contact Tammy O'Hollearn at tohollea@idph.state.ia.us or (515) 242-5639.

In addition to efforts to restore funding to the hearing aids and audiological services program, Representative Janet Petersen put forth a bill, HSB 682 (www.legis.state.ia.us/GA/76GA/Legislation/HSB/00600/HSB00682/Current.html), to mandate that hearing aids and audiological services for children be covered by medical insurance. She is working in collaboration with parents, providers, colleagues, lobbyists and the Child and Family Policy Center. The bill made the first funnel deadline and passed out of the Human Resources Committee on Monday, February 7, 2010. It passed on a party line vote and is now eligible for debate on the floor. It will be up to the leadership to decide if the bill will be debated on the floor and put up for vote out of the House in the coming weeks. The new bill number is HF 2404.

If you have specific questions about the bill or next steps, please contact:

Carrie M. Fitzgerald
Senior Health Policy Associate
Child and Family Policy Center
Des Moines, Iowa 50309
(515) 280-9027
carrief@cfpciowa.org

or

Representative Janet Petersen
(515) 281-3221
Janet.Petersen@legis.state.ia.us

By Tammy O'Hollearn, State EHDI Coordinator



A Sound Beginning for Your Newborn Baby

To order additional hearing screening brochures in English or Spanish, please call the Healthy Families Line at 1-800-369-2229. Ask for publication IDPH 131 (English) or IDPH 131(S) (Spanish). The brochure is available free of charge!

Healthy Families Line: 1-800-369-2229

Phones are answered 24 hours a day, seven days a week

Parent Education... An Integral Part of Finley's Nursery

Parent education has been an integral part of the Newborn Hearing Screening Program at Finley Hospital since its inception in 1995. Finley personnel worked closely with Laurie Allen, an audiologist at Keystone Area Education Agency. With her assistance, they developed a pamphlet for all families explaining the purpose of the newborn hearing screening as well as its importance.

Today, newborn hearing screening education begins with a prenatal interview by the Suite Beginnings staff at Finley hospital. The hearing screening program is included in the discussion, questions answered and handouts provided, including a review of speech and language milestones.

During a stay following the child's birth, the newborn hearing screening results are shared with the parents. If necessary, an outpatient hearing screen is scheduled for their child prior to hospital discharge. A letter is mailed to both the family home and the child's primary care provider with the hearing screen results and a copy of language and speech milestones following hospital discharge.

Following hospital discharge, all families receive a postpartum visit by the Suite Beginnings personnel. The appointments are scheduled prior to hospital discharge. The visit takes place in the family home. Suite Beginnings personnel stress the visit is not to evaluate their housekeeping skills, but rather to assess how mom and baby are adjusting and answer any questions that may have come up following discharge. They also check bilirubin levels, if indicated. The visit provides another opportunity for a Suite Beginnings nurse to stress the importance of any needed hearing screening follow up.



Finley Staff:

Left to right: Sharon Powers, Janie Sendt, Nita McLaughlin, Beth Hoefler, Barb White.

Infant Hearing Screening Equipment Loaner Program

Are you having problems with your hearing screening equipment? The Iowa EHDI program has a limited number of loaner screening OAE units available for hospitals to use while their screening equipment is being repaired.

There is no charge for borrowing the equipment.

For information about loaner units, please contact:

Alitta Boechler – (800) 272-7713

Lenore Holte - (319) 356-1168

Emily Andrews - (319) 384-6894

Nick Salmon - (515) 576-5312

Your single point of contact to assist families in connecting with Early ACCESS and community-based services that address specialized child and family needs

1-888-IAKIDS1 or
1-888-425-4371

www.EarlyACCESSIowa.org

Best Wishes

The EHDl program would like to extend our heartfelt thanks and best wishes to Dr. Amy Wallin, American Academy of Pediatrics and Iowa EHDl Chapter Champion. Dr. Wallin has served as the AAP, Iowa EHDl Chapter Champion since 2001. In this role she advised the EHDl program on how to engage doctors in the process and educated her peers on the importance of newborn hearing screening and follow up through newsletter articles, meetings and conferences. Dr. Wallin was a part of the group of professionals who advocated for universal newborn hearing screening and got legislation passed in 2003 to support this initiative.



Dr. Shannon Sullivan, pediatrician at the University of Iowa, will replace Dr. Wallin on the EHDl Advisory Committee and assume the role of Iowa EHDl Chapter Champion.

Welcome Aboard Dr. Sullivan!

Dr. Shannon Sullivan, Clinical Associate Professor of Pediatrics at the University of Iowa Hospitals and Clinics is the new Iowa EHDl Chapter Champion and member of the EHDl Advisory Committee. Dr. Sullivan received her General Pediatrics training at the Children's Hospital of Wisconsin and subspecialty training in Neonatal Perinatal Medicine at the University of Virginia in Charlottesville, Virginia. She joined the Department of Pediatrics, Division of General Pediatrics and Adolescent Medicine at the University of Iowa in January 2000.



Dr. Sullivan's duties include seeing children in the general pediatrics clinics. She also serves as Medical Director of the Newborn Nursery. In this role she functions as a liaison between all services that provide care to newborns born at UIHC. Dr. Sullivan is also actively involved in the education of medical students as well as residents from many different specialties. Dr. Sullivan's other clinical interest is in Adoption Medicine. She maintains an active clinical practice caring for children who have been adopted from abroad.

Dr. Sullivan lives in Iowa City with her husband, Douglas Spitz, two daughters, Julia and Mari, two dogs, one cat, and one hamster (at last count!). When not at work she enjoys time at her cabin in Wisconsin, playing the piano, gardening, reading and going for long walks. She can be contacted at 319-384-7745. She looks forward to her new role as the EHDl chapter champion.

EHDI Hospital Site Visits **Going Well**

The Iowa Early Hearing Detection and Intervention (EHDI) program staff has conducted 24 site visits with Iowa birthing hospitals. Each hospital will receive periodic visits regardless of performance. The goals of the visits are to:

- Identify strengths and best practices in hospital newborn hearing screening programs so they can be recommended to other hospitals
- Clearly understand hospital practices for newborn hearing screening
- Identify areas for improvement in hospital newborn hearing screening programs
- Identify hospital technical assistance (TA) needs
- Identify areas for improvement in the Iowa EHDI program

The hospital site visit team includes the state EHDI coordinator or EHDI follow-up coordinator, audiology technical assistant, and a parent of a child who is deaf or hard of hearing. If a parent is not able to attend, the team has a DVD taped message from a parent of a child identified with hearing loss following the newborn hearing screen at the hospital. Having a personal message from a parent is very effective. The parent reinforces that the screening, communication used at the hospital to convey the results, as well as assistance in helping the family schedule follow up appointments is very important and does not go unnoticed. It also reinforces the need for timely reporting.

Following is a list of strengths and areas for improvement that have been identified by the EHDI team during hospital site visits thus far:

- Sufficient or adequate data entry staff
- Nurses discuss newborn hearing screen results with the mother prior to discharge
- Some hospitals have established a follow up phone call or home visit following hospital discharge to discuss how the child is doing and the importance of follow up appointments, including hearing screening
- A number of hospitals are bringing children born at their hospital who require a repeat hearing screen back to the hospital for the hearing re-screen
- Some hospitals are helping families schedule the hearing re-screens with the AEA or a private audiologist prior to hospital discharge
- Discharge summaries include the results of hearing screens and/or hospitals are sending a separate letter to primary care providers (PCPs)
- A number of our largest hospitals have the lowest refer and miss rates
- A couple of NICUs have obtained AABR equipment as recommended by JCIH as a standard of care; others are looking into obtaining the equipment in the future
- Positive feedback has been provided to EHDI staff on the quarterly newsletter, rubric and hospital site visits

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EHDI Hospital Site Visits **Going Well**

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- Some hospitals have a great relationship with the PCPs and communicate non pass hearing screen results by phone
- More hospitals are importing demographics into eSP which decreases errors and decreases the number of children the hospital misses putting in eSP
- Data entry errors are decreasing in eSP
- Hospitals reporting the correct primary care provider for the child has improved over the last year
- Some hospitals have incorporated hearing screening in their yearly competencies review

Areas for improvement include:

- Some hospitals have no formal procedure in place to ensure the PCP/medical home receives a copy of the infant's newborn hearing screening results in writing. This is now required by law, but some hospitals assume that because they have electronic health records, the physicians access the results from their system. Electronic medical records are not acceptable without some sort of active communication to the PCP, according to the IDPH assistant attorney general
- Some hospitals are still having issues with reporting the PCP who will accept responsibility for the child's care upon discharge
- Some hospitals have no formal process in place to ensure children who referred or were missed receive information to schedule the appointment in a timely manner or assistance in scheduling prior to hospital discharge
- Best practice for rescreening with AABR, if the initial screen was completed with an AABR, is not always implemented because some hospitals do not perform outpatient rescreens and the AEs do not have that technology
- No yearly training or competency testing for newborn hearing screening and/or tracking of high refer rates by screeners
- No adequate quality assurance checks in place to ensure all babies born at their hospital are entered into eSP (e.g., transfers, deceased)

Because of the hospital site visits, the EHDI program staff has identified which hospitals are utilizing best practices; some of which have been highlighted in Iowa EHDI News. In addition to highlighting hospitals utilizing best practices in the quarterly newsletter, the EHDI staff has also shared these practices during other hospital site visits. Each hospital contact and their supervisor quality assurance coordinator, or CEO receives a written summary of the hospital site visit,

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EHDI Hospital Site Visits **Going Well**

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including strengths and recommendations for improvement. This helps reinforce what hospital personnel are doing well with their newborn hearing screening program and where they need additional support by management.

Site visits have been well received by all hospitals visited thus far and many hospitals have already implemented recommended changes. For example, a number of hospitals are now conducting outpatient hearing screens for children born at their facility or helping schedule a hearing re-screen with the AEA or a private audiologist prior to hospital discharge. Other hospitals are working with their AEA to allow scheduling when the AEA is closed. In addition, a few hospitals are revising procedures to ensure all physicians receive written communication in a timely manner, rather than relying on physicians to look up the hearing screen results in the electronic medical record. Other hospitals are contacting the physician or the physician's nurse by phone to let them know the child needs a follow up hearing screen and convey the appointment if it has already been scheduled.

Finally, each hospital was given the opportunity to respond to a survey about the hospital site visit. Of those facilities that responded to the survey to date, 100% said that the site visit was helpful. Additional areas hospitals found helpful included the self rating rubric ("the self rating rubric was a very useful tool to look at our practice and see where we might need to make improvements"), review of the hospitals refer and miss rates data, the Iowa EHDI Best Practices Manual and the report that was sent following the visit which highlighted hospital screening program strengths and areas for improvement.

By Tammy O'Hollearn, State EHDI Coordinator

CHSC EHDI Staff Changes

Several staffing changes have taken place in the last several months in support of EHDI follow up, referral and family support. Peggy Swails was recently hired for the EHDI Follow Up Coordinator position that Erin Kongshaug previously held and Susan Hagarty the Guide By Your Side (GBYS) Program Coordinator position once held by Melissa Carlson. If you have questions regarding EHDI follow up, referral or family support, please contact Vicki Hunting, EHDI Project Coordinator, Child Health Specialty Clinics at (515) 331-0750 or (866) 219-9119, vicki-hunting@uiowa.edu. Ellisa Wenck is providing administrative support to the program as well and can be reached at (866) 219-9119, ellisa-wenck@uiowa.edu. You will learn more about each of these individuals in the summer 2010 newsletter.

Wait a minute! Did you say all deaf babies can be cured?

From time to time, there are stories around from parents saying they took the doctor's advice to try to pave the way for their child to become "normal." This is a much more preferred option among parents because our society values speech and sounds. Vocal communication is preferred. Without proper speech or hearing, how could the baby, child or youth bond with their family, attend school or become an independent community member? The belief that a person who cannot hear is defective goes back to the Greek philosophers who taught that to hear is intellectual.

While this belief is misguided, unfortunately it has never been discarded universally. There is always a yearning by parents to have a child who would hear them make sounds, sing nursery rhymes, and verbally communicate. Infants who do not show that they respond to sounds in the hearing tests, generally bring to reality a parent's worst fear. Their train of thought lead them to want to be told that there is a way to make the infant hear "normally." They seek that hope.

This is the easy option doctors might resort to and find parents delighted to hear. But is it proven? Not in every case. Not in many cases. Even with improved technology and examples of cases where a profound deaf infant can hear music or distinguish between sounds, there is lack of unbiased statistics and research. If one child out of four brings positive results, most doctors or infant test providers will want to refer parents to an audiological option, where the infant or child would hear (or one out of two?). Maybe

he or she would hear some sounds but not distinguish speech sounds that seem alike: "good!" vs. "stop!"

Marlee Matlin, the deaf Academy Award actress who upon being asked if she would like to hear, "Honestly, I never woke up a day wishing I could have something done to fix me to hear." She speaks for tens of thousands of deaf people; some who have had extensive audiology and speech training, as well as some who wear cochlear implants but also feel they belong to the deaf community that uses sign language.

What happens if a parent finds the first doctor or hearing test provider ten or twenty years after finding they followed about every advice given to help their child hear and it's still not working for them? Instead of confrontation, ethical research, or compromise between the two different groups of opinion, there continues to be a great division that supports their own view. Granted, some deaf people are on the opposite side. And some doctors, audiologist or hearing test providers tell parents there is an option to use sign language with their infant/child. But there continues to be a great divide parents are caught up in, often hoping their child would be "normal." No one wants to tell them a deaf baby is normal; does it seem so?

If not, then I am not normal, while I am proud to be deaf!

By Bob Vizzini, Deaf EHDI Iowa Advisory Committee Member, Kirkwood Community College ASL Instructor

Ten Things Parents Should Know Before They Implant Their Child

The following list was compiled by Jessica Hoss who is a mother of a three year old deaf boy, Nathan, who received bilateral cochlear implants (CI) two years ago. Jessica reports she and her husband have learned a lot over the last few years working with their son. She felt this list may be helpful for other parents and professionals to think about when considering an implant for deaf children. Jessica says, "I think that if more parents and professionals know the challenges that we face, they will be better able to prepare and equip themselves and, ultimately, the big winners will be our children!"

- 1 Our child is still deaf, implanted or not. The CI is a tool, not a cure.** We had people tell us, upon hearing that Nathan would receive the CI, "oh how wonderful, now he will no longer be deaf!" That quite simply is not the case. His hearing is entirely artificial. When a cable breaks, a battery dies, or he loses a head piece, he has no hearing. The CI is simply a tool to help him open his window to the world.
- 2 There are no guarantees. The level of success with a CI is determined by many factors, not the least of which is you. How much time, effort, and resources you put into helping your child to use the implant effectively is extremely important.** Your child will need to be taught how to use the implant. You will need to direct him/her to the various sounds in his environment, to pay attention to the differences in sounds and in spoken language. Speech therapy will be needed, creativity will be needed, and opportunities for learning must be seized at every moment or every day.
- 3 You may be largely on your own. There may be few resources in your area. It will fall on your shoulders to not only educate yourself and your child but also the professionals and educators around you.** Nathan was only the second deaf child with CIs to go through our K-12 school district. He was the first deaf child that his speech therapist had worked with, the first deaf child that his early childhood consultant had worked with, and the youngest CI recipient that his hearing itinerant teacher had worked with. Experience was limited with the professionals around him and we needed to work together to figure out the best means through which to teach him. We were very blessed to be able to work with caring and dedicated professionals who were willing to learn and willing to listen to what we had to say. No one from the implant center checked to see that we had engaged a speech therapist, taught us sign, provided us with a list of materials or techniques to use. We, through Internet searches, found our own resources. The Listening Room is an excellent on-line reference as well as the John Tracy Clinic. We have utilized the resources provided through these Web sites to educate ourselves and others who work with our son.
- 4 It is extremely important to give your child a language. You need to sign to them. They need to know that they can communicate and that you are communicating with them.** The CI does not provide instant hearing and comprehension. These skills are built over time and in the interim your child needs to be able to communicate. Sign language bridges the gap until receptive and expressive vocabulary skills can be built up. Nathan has a highly successful CI, but we still rely on sign at times when it is extremely loud, to differentiate between words (example tree and train) when he is swimming or in the bath tub, first thing in the morning and last thing at night.

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Ten Things Parents Should Know

Before They Implant Their Child *continued from page 9*

5 You must have a Plan B. If the implant is not as successful as you had hoped, you need to have a second means of educating your child. Locate the deaf schools in your area. We knew going in that there were no guarantees with the CI. We located the nearest deaf school, did research on it and the community. We made tentative plans to relocate if necessary in order to better serve the overall needs of our child. Do not put all of your eggs in one basket.



6 Talk to other parents. Their experiences can help you to help your child. No. In fact, the contrary is true. Providing a strong conceptual base in ASL can very well improve the child's developing English. Children need opportunities to use each language in natural, social interactions and use English during reading and writing activities.

7 Ask questions! Read, research, and find resources. Ask your audiologist, surgeon, and ENT for information. Contact the deaf community in your area if there is one. We are not fortunate enough to have a deaf community in our area. We are, however, surrounded by caring and dedicated professionals who advocate tirelessly on behalf of our son and who care about him. They have provided additional activities for us to use at home with him, access to additional resources, and referrals to more experienced professionals when needed.

8 Ask yourself what your child would want, not what you want for your child. What is best for your child; not what is best for you. Surrounded by the hearing in both family and community, we believed that Nathan would want to be hearing as well if we could provide it. We knew that we could never change his deafness, but that we could provide him with this tool to adapt to the environment in which he had been born.

9 The CI is a big commitment. It will take patience and hard work as well as financial resources to increase the level of success. Progress will be measured in inches, not in miles; over months, not days. Nearly two years after his first implant, Nathan is hearing sounds as low as 20 decibels, and is scoring at age equivalency for receptive skills. It took a lot of hard work on our part and on the part of the professionals around him. We switched implant centers and primary care physicians, had numerous meetings with teachers and therapists, and talked until we were hoarse. Cables, batteries, and head pieces do not come cheap and inevitably break or are lost; the financial commitment of the CI is a constant part of our daily lives.

10 You can do this! Whether or not you choose to implant your child, you have been granted a wonderful privilege: to be able to parent a deaf child. Embrace it, love it, accept it, and love, embrace and accept him/her! We would not change our son if we could; he is who he is because he is deaf. We have been changed by his presence in our lives and we are better for it.

By Jessica Hoss, parent to Nathan Hoss

NICHQ Update: Testing Small Leads to Big Improvements

Iowa's EHDI system of care is seeing improvements in the system through the implementation of small tests of change. Because of our participation in the National Initiative for Children's Healthcare Quality (NICHQ), Newborn Hearing Screening Initiative sponsored by the Institute for Healthcare Improvement (IHI), we are learning that changes do not have to be big to make a difference. One of the goals we are working towards is to ensure all infants born in Iowa receive a timely hearing screening (by one month of age). To help us meet this goal we have several activities in progress at our pilot sites, Iowa Health-Des Moines, Mercy-Des Moines; and Heartland AEA;



Iowa EHDI System of Care NICHQ Team Members :
Front row: Debra Waldron, MD, MPH, Barbara Khal, MA, Vicki Hunting, Parent, CHSC EHDI Project Coordinator
Back row: Diana Hanson, Audiologist, Tammy O'Hollearn, State EHDI Coordinator

- verifying with the family that the primary care physician (PCP) listed in the birth record is who the baby will see after they leave the hospital
- verifying this information through the physician's office by calling the office to ensure the baby has been accepted into their practice
- making an appointment for a rescreen prior to the baby leaving the hospital
- implementing reminder calls about the scheduled appointment

One of our first small tests with Iowa Health-Des Moines was to ensure that we are collecting accurate PCP information. In our initial sample we found that the PCP listed in the medical record of the child matched what the parents said 92 % of the time. When the PCP on the medical record was incorrect it was often because families had not made a decision as to which physician their child would see for care or the hospital had listed who cared for the child at the hospital. The next step was to call the PCP listed in the birth record to ensure the baby would be coming to their practice. With this test we found that the child was indeed coming to the PCP indicated 94% of the time. By calling the physician to ensure the baby is coming to their practice we can ensure hand off to a healthcare professional and reduce the chance that the baby will miss their follow up hearing screening. Additionally, by making the follow up hearing screening appointment for the families

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NICHO Update: Testing Small Leads to Big Improvements

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prior to the baby leaving the hospital, we reduced the number of days between appointments from 11 days to four. Bottom line, these small tests of change showed us through our data collection that we increased the percent of infants screened by one month of age from 88% when we began, to an average of 91% over a six month period.

Our next steps will be to spread these small tests of change to another location to see if the impact will be the same at another site. Stay tuned for more information on lessons learned and how this initiative can assist you in reducing your refer and miss rates for your location.

By Vicki Hunting, CHSC EHDI Project Coordinator

EHDI Web Site - Another Sound Source for EHDI Information

The Early Hearing Detection (EHDI) Web site is another valuable source for sound and unbiased information for families of children who are deaf or hard of hearing. Information available to parents includes:

- Sound Beginning brochure
- Hearing Checklist
- Risk Factors Associated with Childhood Hearing Loss
- Iowa Hearing Health Care Directory
- List of Audiology Centers in Iowa and Bordering States
- Diagnosis of Hearing Loss Questions
- Iowa Early Hearing Detection and Intervention Family Resource Guide
- Guide By Your Side
- Resources
- Iowa EHDI News

The Web site also offers information that health care providers can use as a guide to assist you in finding information about hearing loss, research, reporting requirements and forms, and Web links to local, state and national resources.

And the winner is... **Cass County Memorial Hospital!**

Cass County Memorial Hospital (CCMH) recently received notification they had won a new Algo3i infant hearing screener from Natus Medical Incorporated. Rita Swanson, Materials Management Director, had entered a drawing for the new equipment, valued at \$14,000, when she was ordering pacifiers for the CCMH nursery.

CCMH delivers about 150 babies per year and has been doing infant hearing screening for approximately 10 years. "Our equipment was getting old and we were looking at possibly getting something new, so this was a great surprise," commented Diann McLaren, RN, OB Nurse Manager. Prior to winning the Algo3i Screener, CCMH was using an automatic otoacoustic emissions system (OAE) for the initial screenings, as well as for re-screening. The new system utilizes an auditory brainstem response (AABR). Neither of these tests makes the infant uncomfortable; they are actually done while the infant is sleeping. The AABR system uses electrodes that are placed on the forehead, shoulder and nape of the neck, while earphones or couplers are placed on the infant's ears. An AABR is an accurate measurement of the auditory system from the external ear through the auditory brainstem. Thousands of soft clicks are delivered to the newborn's ear, which evokes a series of auditory brain-waves from the auditory brainstem. This is then compared with a template in the screener, which is based on the normal hearing of a newborn infant. The Algo3i gives either a pass or refer response. The purpose of the screener is to determine which have hearing within normal limits and which babies require further testing. This more advanced screening technique provides a more accurate hearing evaluation than the OAE method, which can result in some false positives, leading to unnecessary re-screening of infants. The AABR screener should eliminate unnecessary repeat screening, and get those infants with possible hearing problems to a diagnostic center more quickly.



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And the winner is... **Cass County Memorial Hospital!**

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Natus Medical Incorporated supplied a licensed audiologist, Patricia Gillilan, M.S., CCC-A, FAAA, to come on-site to CCMH for staff training on the new Algo3i. Also present was Nick Salmon, M.S., CCC-A, consulting audiologist with the Iowa EHDI Program. Patricia and Nick provided complete training to Diann and the rest of the OB/Nursery nursing staff. "I am so excited about our new system. It is easy to use and more efficient," stated Lisa Burmeister, RN, BSN, audiology coordinator at CCMH. "Our referral rate for re-screening with the OAE is high at 20-21%, so with the new AABR unit I am hoping to get our referral rate below the state's recommended rate of less than 6%. Also, being able to keep our infants and families closer to home for re-screening is always a plus."



As one of just a few facilities in the state to have this advanced screening tool, CCMH is exploring the possibility of providing outpatient screenings for infants who are not born at their hospital. With the AABR, screening can be done on infants less than 24 hours of age or 34 weeks corrected gestational age up to 6 months of age. If we offer outpatient hearing screening for infants born at another location, Tammy O'Hollearn, State EHDI Coordinator will get the word out through eSP, phone and e-mail.

EHDI Survey Results

Look for the results of the survey regarding Iowa EHDI News in the summer newsletter! Thank you to everyone that took the time to respond! We received some great feedback. If you have not yet completed the online survey, you still have time. Please go to www.surveymonkey.com/s/K2XK6XB.

We want to hear from you!

Summer Camps for Deaf and Hard of Hearing Children and Teens

Did you know? The following link (http://clerccenter.gallaudet.edu/Clerc_Center/Information_and_Resources/Info_to_Go/Resources/Summer_Camps_for_Deaf_and_Hard_of_Hearing_Children.html) identifies camps, family learning vacations, and remedial clinics for deaf and hard of hearing children. Some programs are designed for the entire family. Most camp programs require a small application fee to accompany the completed application. Contact the camp sponsor directly for more information about their program.

If you are aware of other camp programs for deaf and hard of hearing children that are not on the list, please e-mail Clerc.Center@gallaudet.edu.

SAVE THE DATE

Iowa Symposium on Hearing Loss: Impact on Children and Their Families

September 17 and 18, 2010

Location: Courtyard by Marriott, 2405 SE Creekview Dr., Ankeny, Iowa

Topics to include:

- Usher Syndrome
- Auditory Neuropathy/Dyssynchrony
- Research on children who are hard-of-hearing
- Newborn hearing screening update for nurses
- Parents, teens and young adult's panel
- How educators and families work together for the best outcomes for children
- Updates on FM systems and assistive listening devices

For more information, contact Sara Patkin at m spatkin@yahoo.com or (515) 963-8664. Registration materials will be sent out in the spring. CEU's will be available!

Contact Information

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**Requests?
Feedback?
Comments?
Suggestions?**

We welcome your questions, comments and suggestions about this newsletter. Please forward any feedback about Iowa EHDI News to:

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Additional copies of Iowa EHDI News are available by contacting Tammy O'Hollearn.