

Nebraska Early Hearing Detection & Intervention Program Advisory Committee Meeting Nov 14, 2019

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EARLY HEARING DETECTION & INTERVENTION PROGRAM

Helping People Live Better Lives.



- ✓ Welcome & Introductions
- ✓ Review of Agenda
- ✓ Review of May 9, 2019 Meeting Minutes-Action

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EHDI Program Updates & Action Items

NE-EHDI Advisory Committee Meeting
Nov 14, 2019

Brenda Coufal

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Recognition of an EHDI Team Member



for receiving the DHHS-Public Health Excellence in Leadership Award!

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Congratulations to an EHDI Team Member

Congratulations NICE GOING!
GREAT! Way to Go!
Yea! FELICITATIONS
CHEERS Take A BEST
BOW! WISHES!

Jen

for accepting an Audiology Externship at Yale New Haven Children's Hospital!

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Advisory Committee Member Status

- **Johnna Lygrisse** – a parent representative has moved out of state
- **Joanna Webster**, Audiologist with Children’s Hospital is a new member
- **Discuss member capacity as stated in the NE-EHDI Charter**
 - The Charter currently states –
 - **The Advisory Committee shall consist of not more than 20 voting members**
 - Discussion to increase to 30 voting members
- **Vote**



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NE-EHDI Funding Sources & Grant Goals

- **EHDI Funding Sources**

- HRSA
- CDC
- MCH Title V Block Grant



- **See handout for current HRSA and CDC Grant Goals**



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Sustainability and Legislation Proposal to DHHS Update

- Submitted a Legislation Proposal to DHHS July 2019
 - Proposed NE-EHDI to receive a \$5 administrative fee per infant screened
- Met with some of those who were actively involved with passing LB15 (Adopt the Children of Nebraska Hearing Aid Act)
- Proposal received internal support
 - Did not make the final cut among many legislative bill proposals submitted
- Approved to utilize more HRSA MCH Title V Block Grant funds



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HRSA Grant Accomplishments (Since May 2019 Meeting)

- Continued collaboration efforts for providing Family Support with
 - **Hands & Voices/Guide By Your Side Program**
 - **HearU Nebraska**
- Tele-Audiology was implemented late May 2019 for hearing screenings and diagnostic services
- Developed an Infographic Education Document for Primary Care Providers (Partnered with the Newborn Screening & Genetics Program)
- Submitted HRSA Performance Report July 2019
- Submitted HRSA Financial Report July 2019
- Parent Perspective Video was completed August 2019 & developed a Newborn Hearing Hospital Champion Campaign



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HRSA Grant Accomplishments & Future Work



- Dr. Heather Gomes, NE-EHDI Chapter Champion gave a brief presentation about EHDI at the Annual Otolaryngology Meeting Oct 2019
 - EHDI Team also provided an exhibit display
- Dr. Heather Gomes and Dr. Pam Zegers gave a presentation to Complete Children's Health Pediatric Group Oct 2019

- Contracts for **4 parents** to attend the EHDI Annual Meeting in Kansas City, March 2020
- **Sub-awards for:**
 - Roots & Wings - hosted by Boys Town (Feb 29 & Mar 1, 2020)
 - Hands & Voices – new sub-award will start 4/1/2020
 - HearU – new sub-award will start 4/1/2020



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CDC Grant Accomplishments & Future Work

- Submitted Year 2 Evaluation Report & Financial Report
- NE-EHDI creates a variety of Data Reports
 - ✓ Annual report for the legislature
 - ✓ Data reports are presented to the advisory committee
 - ✓ Annual Quality Assurance (QA) report for hospitals
 - ✓ Data is submitted to CDC annually
 - ✓ Report to D/HH Regional Programs Statewide Stakeholders meeting
 - ✓ Annual QA report for main pediatric audiology clinics
- Other **IDEAS** of ways to disseminate EHDI data?
- Meetings and E-mail Updates & Reminders
 - EHDI Team will present to the UNL Auditory Electrophysiology Class (again March 2020)
 - Annual meetings with audiologists for program improvement (Mar – June 2020)
 - Biannual E-mail to Audiologists who see pediatric patients (Dec/Jan)



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2019 Exhibits

- **Minority Health Conference** (York – April 2019)
- **Spring Baby Love (Baby Fair)** (Omaha – April 2019)
- **DHHS Health Fair** (Lincoln – September 2019)
- **Fall Baby Love (Baby Fair)** (Omaha – September 2019)
- **March of Dimes Prematurity Summit** (Omaha – September 2019)
- **Boys Town Newborn Expo** (Omaha – October 2019)
- **Nebraska Nurses Association Conference** (Kearney – October 2019)
- **Annual Otolaryngology Meeting** (Omaha – October 2019)
- **Nebraska AWHONN Conference** (Omaha – October 2019)
 - Association of Women's Health, Obstetric and Neonatal Nurses



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2019 Presentations

- **Sertoma Club** (Omaha – January 2019)
- **2 Poster Presentations at EHDl Annual Meeting** (Chicago – March 2019)
 - Parents Making a Difference in Improving the NE-EHDl Program
 - Parent Perspectives – A Valuable Part of the EHDl Process
- **UNL Auditory Electrophysiology** (Lincoln – March 2019)
- **NCHAM Coffee Break Ql Webinar– PDSA Cycle for the Parent Perspectives Hospital Training Video** (June 2019)
- **Dr. Gomes – Annual Otolaryngology Meeting** (Omaha – Oct 2019)
- **Dr. Gomes and Dr. Zegers – Complete Children’s Health Pediatric Clinic** (Lincoln – Oct 2019)
- **NSLHA Conference** (Omaha – October 2019)
- **Recharge for Resilience Conference** (Kearney – October 2019)



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Other Work with Partners

- **8 Hospital Visits since May 2019**
- **Updates about the 2020 Annual EHDI Meeting in Kansas City, MO**
 - **Collaboration to submit a poster presentation abstract about Tele-audiology**
 - MeLissa, Sara Peterson and Hannah Ditmars
 - **Awarded 4 Parent Scholarships**
 - **Nebraska State Stakeholder Meeting**



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Work Starting January 2020

- **Discuss collaboration ideas with the state Leadership Education in Neurodevelopmental and Related Disabilities (LEND) Program**
- **Children's Physicians Newsletter** (Sent to all Children's medical clinics every 2 weeks)
- **EHDI partner with ENT and/or Audiologist to discuss EHDI during Grand Rounds at Hospitals**
- **Lincoln Public Schools Special Education Program Meeting** (held twice a year)
- **More presentations to educate PCPs and ENTs**

IDEAS for other collaborations?

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JCIH 2019 Position Statement

- 2019 position statement builds upon the 2007 Joint Committee on Infant Hearing (JCIH) guidelines and 2013 JCIH supplement on Early Intervention.
- The publication has updated best practices through literature reviews and expert consensus opinion on screening; identification; and audiological, medical, and education managements of infants, young children and their families.
- Stresses continued surveillance of auditory and speech-language development in all infants, regardless of outcome of newborn hearing screening.

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JCIH 2019 Position Statement

- EHDl states who meet the 1-3-6 benchmark **should strive to meet a 1-2-3 month timeline.**
- An endorsement, for **well-born infants only**, who are screened by automated auditory brainstem response (AABR) and do not pass, that rescreening and passing by otoacoustic emissions (OAE) testing is acceptable, given the very low incidence of auditory neuropathy in this population.
 - Re-screening with OAE after failing an AABR is acceptable with the caveat that a baby with auditory neuropathy in the well-baby nursery will be missed using this protocol.
 - The recommendation to rescreen using only AABR technology for the infant who fails initial screening performed with AABR technology continues to be the JCIH preferred protocol.

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JCIH 2019 Position Statement

- Regardless of previous hearing-screening outcomes, all infants with or without risk factors should receive ongoing surveillance of communicative development beginning at 2 months of age during well-child visits in the medical home (AAP Committee, 2017).
 - This recommendation provides an alternative, more inclusive strategy of surveillance of all children within the medical home based on the pediatric periodicity schedule (AAP Committee, 2017).
- An endorsement of **rescreening** in the medical home in some circumstances.
 - If the rescreening is performed in the provider's office, the provider is responsible for reporting results to the state EHDI program.

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JCIH 2019 Position Statement

- **Recognition that some families may benefit from infant mental health supports.**
 - **Infant mental health is a field of research and practice that focuses on optimizing social, emotional, behavioral, and cognitive development of infants in the context of the emerging relationships between parents and infants.**
- The early identification period of learning, gathering resources, and making decisions can be stressful for families.
- Infant Mental Health specialists and Home Visiting programs may be a useful resource when families are dealing with significant and/or lingering and unresolved life stressors.
- World Association for Infant Mental Health (<http://waimh.org>) and the HomVEE (<https://homvee.acf.hhs.gov/>) websites provide more information.

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JCIH 2019 Position Statement

- **Recognition that Congenital Cytomegalovirus (cCMV) has a larger impact than previously recognized.**
 - CMV infection is a leading cause of congenital infection & leading cause of non-genetic unilateral or bilateral sensorineural hearing loss.
 - About 25,000 infants are born each year in the United States with cCMV infection, 10–15% of whom develop sensorineural hearing loss.
 - Children with cCMV can develop late onset sensorineural hearing loss.
 - JCIH supports urine and saliva swabs for cCMV testing.
 - A standardized, high-throughput test suitable for cCMV newborn screening does not currently exist.
 - A research priority is antiviral treatment of newborns that have cCMV.

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CMV
STOPS
with me

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JCIH 2019 Position Statement

Risk Factors for Early Childhood Hearing Loss: Guidelines for Infants who Pass the Newborn Hearing Screen

Assisted
Ventilation
Removed
Separate
line items

New
Separate
line item

	Risk Factor Classification	Recommended Diagnostic Follow-up	Monitoring Frequency
	Perinatal		
1	Family history* of early, progressive, or delayed onset permanent childhood hearing loss	by 9 months	Based on etiology of family hearing loss and caregiver concern
2	Neonatal intensive care of more than 5 days	by 9 months	As per concerns of on-going surveillance of hearing skills and speech milestones
3	Hyperbilirubinemia with exchange transfusion regardless of length of stay	by 9 months	
4	Aminoglycoside administration for more than 5 days**	by 9 months	
5	Asphyxia or Hypoxic Ischemic Encephalopathy	by 9 months	
6	Extracorporeal membrane oxygenation (ECMO)*	No later than 3 months after occurrence	Every 12 months to school age or at shorter intervals based on concerns of parent or provider

Note. AAP = American Academy of Pediatrics; ABR = auditory brainstem response; AABR = automated auditory brainstem response.

* Infants at increased risk of delayed onset or progressive hearing loss; **Infants with toxic levels or with a known genetic susceptibility remain at risk

Syndromes (Van Camp & Smith, 2016); *Parental/caregiver concern should always prompt further evaluation.

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JCIH 2019 Position Statement

Removed HIV & hepatitis B

Separate line item

New

8 - Replaced anomalies with malformations, added ear dysplasia, included white forelock here, removed pinna, ear canal, ear tags, ear pits

9 - Before listed common syndromes

7	In utero infections, such as herpes, rubella, syphilis, and toxoplasmosis	by 9 months	As per concerns of on-going surveillance
	In utero infection with cytomegalovirus (CMV)*	No later than 3 months after occurrence	Every 12 months to age 3 or at shorter intervals based on parent/provider concerns
	Mother + Zika and infant with <u>no</u> laboratory evidence & no clinical findings	standard	As per AAP (2017) Periodicity schedule
	Mother + Zika and infant with laboratory evidence of Zika + clinical findings Mother + Zika and infant with laboratory evidence of Zika - clinical findings	AABR by 1 month AABR by 1 month	ABR by 4-6 months or VRA by 9 months ABR by 4-6 months Monitor as per AAP (2017) Periodicity schedule (Adebanjo et al., 2017)
8	Certain birth conditions or findings: • Craniofacial malformations including microtia/atresia, ear dysplasia, oral facial clefting, white forelock, and microphthalmia • Congenital microcephaly, congenital or acquired hydrocephalus • Temporal bone abnormalities	by 9 months	As per concerns of on-going surveillance of hearing skills and speech milestones
9	Over 400 syndromes have been identified with atypical hearing thresholds***. For more information, visit the Hereditary Hearing Loss website (Van Camp & Smith, 2016)	by 9 months	According to natural history of syndrome or concerns

Note. AAP = American Academy of Pediatrics; ABR = auditory brainstem response; AABR = automated auditory brainstem response.

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Syndromes (Van Camp & Smith, 2016); *Parental/caregiver concern should always prompt further evaluation.

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JCIH 2019 Position Statement

Removed mumps & viral labyrinthitis

11 - included both bullets in 1 & removed "that requires hospitalization" from 1st bullet

	Perinatal or Postnatal		
10	Culture-positive infections associated with sensorineural hearing loss ^{***} , including confirmed bacterial and viral (especially herpes viruses and varicella) meningitis or encephalitis	No later than 3 months after occurrence	Every 12 months to school age or at shorter intervals based on concerns of parent or provider
11	Events associated with hearing loss: <ul style="list-style-type: none"> • Significant head trauma especially basal skull/temporal bone fractures • Chemotherapy 	No later than 3 months after occurrence	According to findings and or continued concerns
12	Caregiver concern ^{****} regarding hearing, speech, language, developmental delay and or developmental regression	Immediate referral	According to findings and or continued concerns

Note. AAP = American Academy of Pediatrics; ABR = auditory brainstem response; AABR = automated auditory brainstem response.

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Syndromes (Van Camp & Smith, 2016); *Parental/caregiver concern should always prompt further evaluation.

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JCIH 2019 Position Statement

- The child who has a passing result on newborn hearing screening may develop, or show evidence of childhood hearing loss.
- Surveillance of hearing throughout the early childhood years up until and including kindergarten entry (continuous childhood screening), even in the absence of known risk factors for hearing loss is recommended, since the prevalence may double by school-age.
 - **This may reflect delayed-onset hearing loss as well as missed conductive, sensory, or neural hearing loss at the time of newborn hearing screen.**
 - 1-2 infants out of 1,000 are diagnosed as DHH & another 1-2 per 1,000 will be later diagnosed as DHH.
 - The rate of being DHH is known to increase from approximately 1.79 per 1,000 in newborns to 3.65 per 1,000 in early school age.
- Infants with minimal/mild hearing loss are likely to pass newborn screening.

JCIH 2019 Position Statement

- Hearing screening may be achieved through OAE screening in the medical home or other pre-school settings up to age three –
 - and use of pure tone audiometry screening in the medical home along with a developmental checklist for speech and language milestone assessment is appropriate throughout early childhood.
- UNHS has been a successful initiative in part because almost all infants are born in a hospital, and hospital-based programs have the potential of capturing 95% or more of all newborns in a screening program.
- The majority of children enter a public school system around age five, and school-based programs have demonstrated similar successes at screening the hearing of an entire population.
- During preschool years there is no similar common door through which almost all of the children pass.

JCIH 2019 Position Statement

- The physician's office is a setting that potentially would capture most preschool-aged children for a mass screening program , but not all children receive medical care in a timely way.
- **Hearing screening in pre-school facilities or through home visiting programs could be an alternative mechanism**, and such programs have been demonstrated with **Head Start** and through other preschool hearing screening initiatives.
- A significant portion of the population of preschoolers in the United States may be enrolled, at least at intervals, in larger daycare or preschool settings.
 - The proportion of children enrolled in the overall preschool population would be far less than the 95% of newborns who are born in a hospital, and so the success of a proposed universal hearing screening program in this setting would be limited.

JCIH 2019 Position Statement

- While acknowledging the concern about delayed onset hearing loss presenting during preschool years, **the JCIH finds that there is not adequate data to presently justify a broader recommendation for universal hearing screening during the preschool years.**
- Further research and technologic advances may allow for an expanded recommendation in the future.
- Continued surveillance of language development by the family, caretakers, and the primary care provider, as well as observations of the child's responsiveness to auditory stimuli, is essential for recognition and timely diagnosis of delayed-onset hearing loss during preschool years.

New Requirements of HRSA for Next 4 Year Grant Cycle

- **Expand our capacity to support hearing screening, diagnosis, and enrollment into EI for those infants who pass a newborn hearing screen but later develop hearing loss up to 3 years of age (data collection and reporting)**
 - ❑ Required to develop a plan by 3/31/2022
 - ❑ Starting discussions to partner with Early Head Start Programs
 - ❑ Presenting at the Early Head Start Association Meeting in April 2020
 - ❑ **Other ideas of programs or agencies who are providing early childhood hearing screens?**

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New Requirements of HRSA for Next 4 Year Grant Cycle

- **Develop a plan to address diversity and inclusion in the EHDI system by 3/31/2022**
 - **Ensure NE-EHDI system activities are inclusive of and address the needs of the populations it serves -**
 - including geography, race, ethnicity, disability, gender, sexual orientation, family structure, socio-economic status
 - **NE-EHDI will make a list of all procedures, forms, letters, brochures, videos, social media, and website to evaluate**
 - **A work group will be established to evaluate each item NE-EHDI has identified to ensure information and procedures are inclusive**

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New Requirements of HRSA for Next 4 Year Grant Cycle

- Implement or expand a DHH Role Model or Mentor Program
 - *Using data collected from year 1 as baseline data:*
 - Increase by 10% the number of families enrolled in DHH adult-to-family support services **by 9 months of age by 3/31/2024.**
 - HRSA has no definition for age of adult
 - Required to be a trained DHH adult

Plan to survey/interview parents statewide to find out needs and wants

Establish a work group

(Parents, Deaf Community, Hard of Hearing Individuals, Deaf Educators, Audiologists, EI professionals, agencies/programs who serve DHH, agencies/programs who provide family support and any other individuals interested)

Other ideas?



New Requirements of HRSA for Next 4 Year Grant Cycle

- Continue to improve the 1-3-6 goals
- Reduce LTF/LTD
- Continue to allocate 25% of funding for family engagement and family support activities
- Increase by 20% from the year 1 baseline the number of families enrolled in family-to-family support services by 6 months of age by 3/31/2024
- Increase by 10% from year 1 baseline the number of health professionals and service providers trained on key aspects of the EHDI Program by 3/31/2024

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Presentation for Next Advisory Meeting



1.

2.

3.

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Future Advisory Meeting Dates

- **2020 Spring Meeting will be May 14, 2020**
 - Nebraska Children's Home Society - 4939 S. 118th Street - Omaha
- **2020 Fall Meeting will be Nov 10, 2020**
 - Nebraska Educational Telecommunications - 1800 N. 33rd Street – Lincoln
- **A doodle poll will be sent out in January to select the meeting dates for May & Nov 2021**

MeLissa will send Outlook meeting notices for your calendars.

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THANK YOU

for all the work you do!

I look forward to working together more in the months ahead!

Brenda Coufal

NE-EHDI Program Manager

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402-471-6770

<http://dhhs.ne.gov/Pages/EHDI>



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Parent Perspective Video

Premier

Melissa Butler

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Update on Learning Communities-Hospital Training Video

REFRESHER: This is a parent lead *Learning Community* whose purpose is to develop a script and training protocol that helps hospital staff understand the best way to communicate results of the NBHS to families, especially when a baby refers inpatient.



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NE-EHDI Statistics

Jim Beavers

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1-3-6 Nebraska vs National Average

Screening by 1 Month	DOB Year	Nebraska	US Avg.
	2016	98%	96%
	2017	98%	NA**
	2018	97%*	NA**

*Preliminary Percentages for NE-EHDI

** NA: Not available yet on CDC website

1-3-6 Nebraska vs National Average

Diagnosis by 3 Months	DOB Year	Nebraska	US Avg.
	2016	59%	76%
	2017	63%	NA**
	2018	72%*	NA**

*Preliminary Percentages for NE-EHDI

** NA: Not available yet on CDC website

1-3-6 Nebraska vs National Average

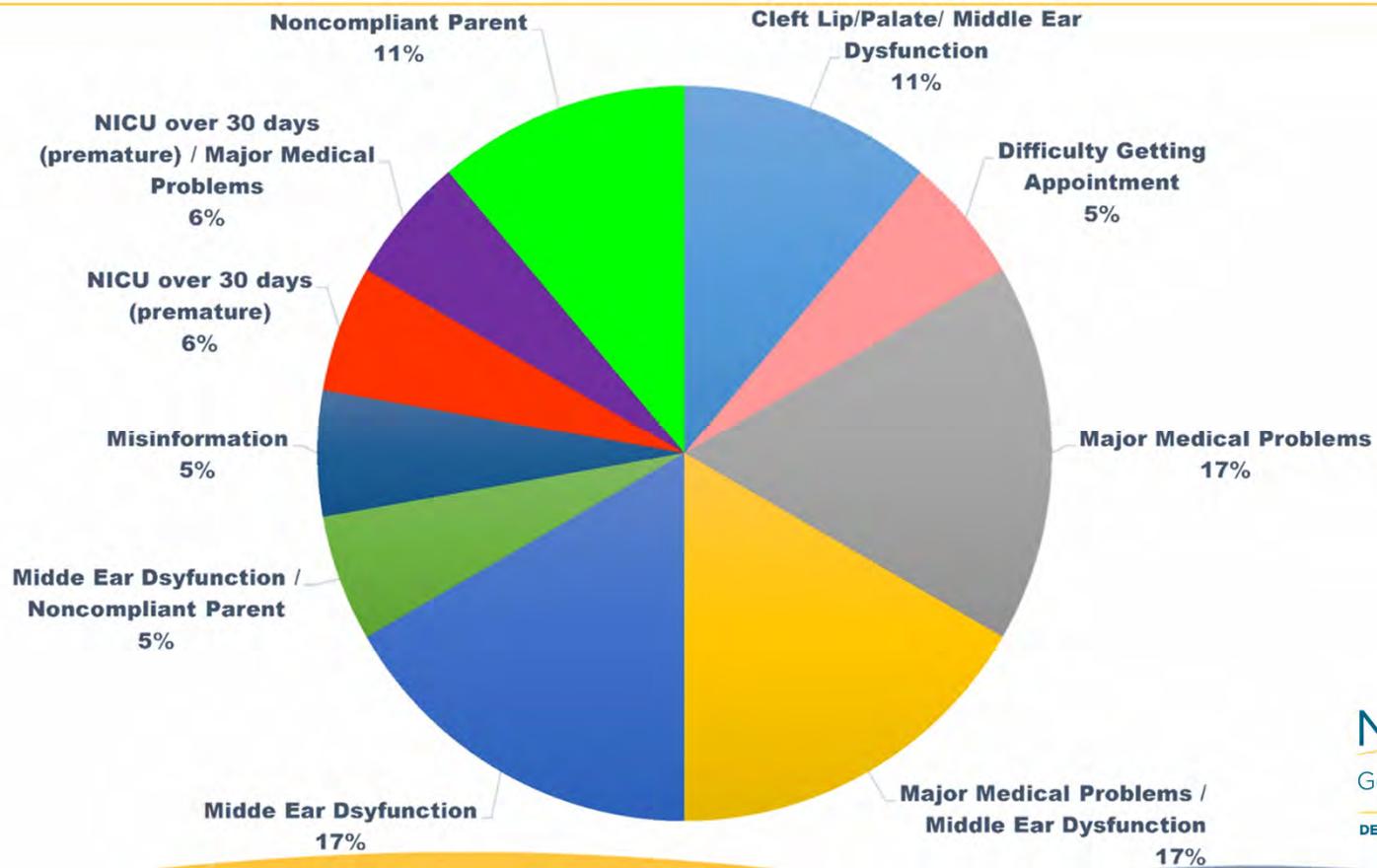
<p>Early Intervention by</p>  <p>Months</p>	DOB Year	Nebraska	US Avg.
	2016	78%	67%
	2017	78%	NA**
	2018	89%*	NA**

*Preliminary Percentages for NE-EHDI

** NA: Not available yet on CDC website

61%* of Deaf/HH enrolled in NE-EDN for 2018 DOB (US avg. of 67% for 2016 DOB)

Delayed Identification



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Late Onset Analysis – Reason for follow-up

- **Parent Concern** (Family History, Speech Delay)
- **Auditory Neuropathy**
- **Abnormal Middle Ear**
- **Multiple Medical Issues**
- **Meningitis**
- **Down Syndrome**
- **Frequent Ear Infections**



Jr. NAD Presentation

LINSAY DARNALL JR.

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Jr. National Association of the Deaf- Nebowa Chapter

**NE EHDI Advisory Committee
November 14th, 2019**

What is Jr. NAD?

- Junior National Association of the Deaf
- Chapters in each states
- Nebraska School for the Deaf Chapter 1998
- Nebowa Chapter established in 2003



Core Values

- Scholarship
- Leadership
- Citizenship



What does Jr. NAD do?

- Meetings at the Omaha Association of the Deaf Hall biweekly



Opportunities

- Attend National Jr. NAD Conferences
- Youth Leadership Camp in Stayton, Oregon
- Jr. NAD Page Program



What do we do?

- Earn Experience- Get involved!
- Fundraising, Midnight Madness, etc.
- Networking Opportunities

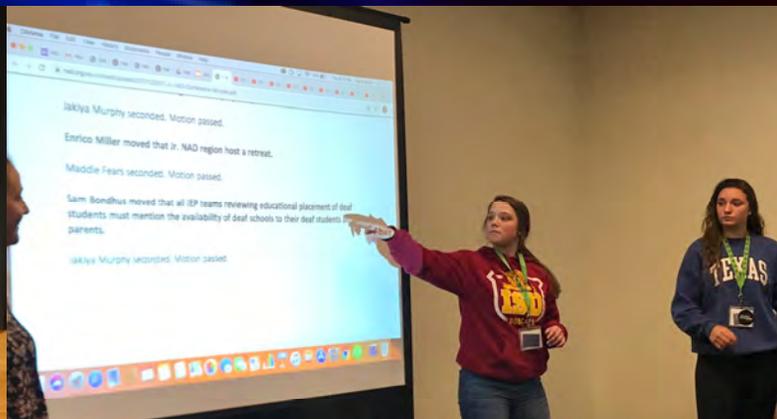


We get Involved!

- Attend both Nebraska Association of the Deaf and National Association of the Deaf Conferences
- And More!



Members in action



Why is this Chapter unique?

- Mix of Deaf and HH
- ASL, Oral, SEE
- From different Schools and States (NE & IA)
- Have more Advisors than other Chapters (4)
- Have support from State and Local Associations (NeAD & OAD)

Our Alumnus

- Jessica Greene
- Robb Dooling
- Sadie Kulhanek
- Cody McEvoy
- Carly Weyers
- Johanna Scherling
- Isabella Graves
- And more...



Jr. NAD Teaches us to Set Goals

- Planning for Events
- Planning our Education
- Planning for our Community
- Planning for our Future



Jr. NAD Teaches us
To set the right Attitude

- It's OK to be Deaf or HH
- We can do anything that we set out to do
- Nothing about us without us



THANK YOU!



Hands & Voices Update

EHDI Follow-Up & Family Support Events

Jessica Hoss

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HearU NEBRASKA

Stacie Ray

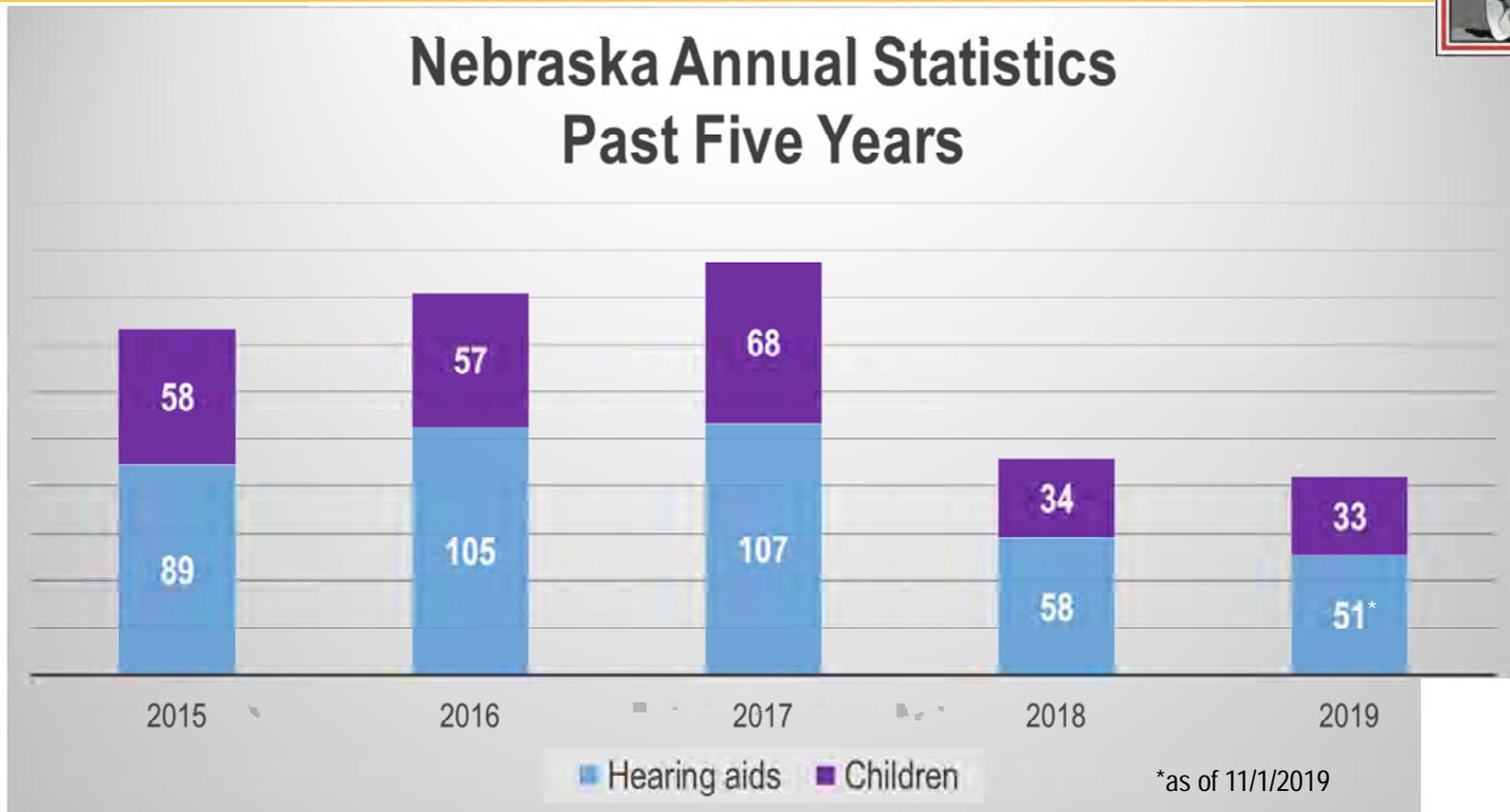
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HearU NEBRASKA



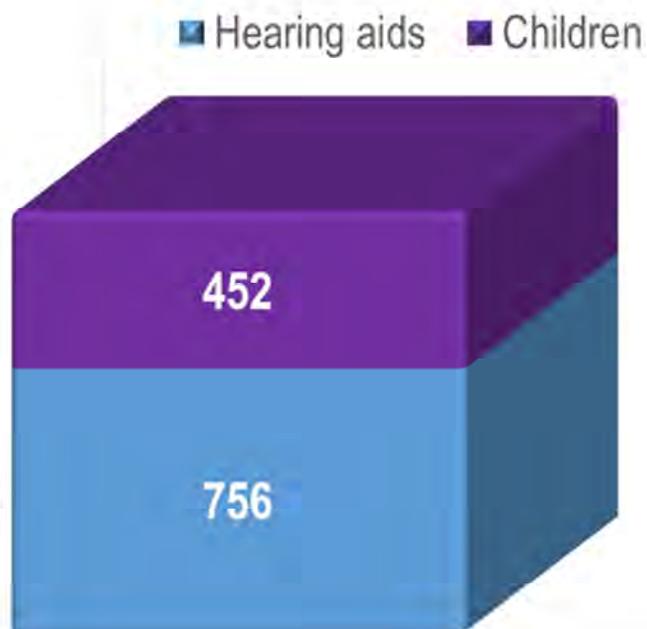
Nebraska Annual Statistics Past Five Years



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HearU NEBRASKA

2008 to Current Hearing Aids Dispensed

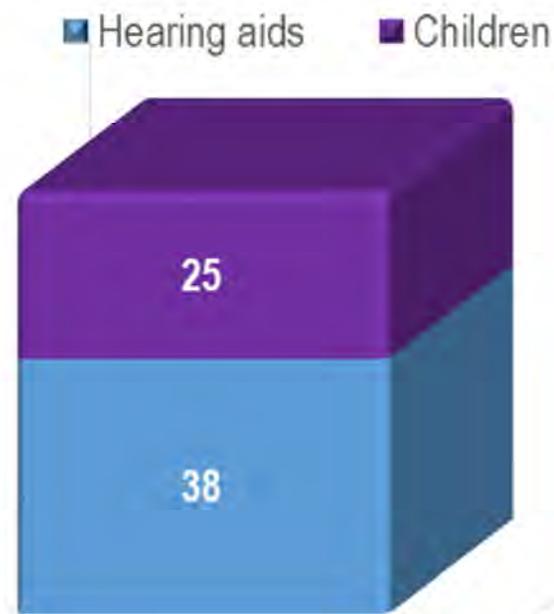


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Since May 2019



Ages 2 month through 18 years →



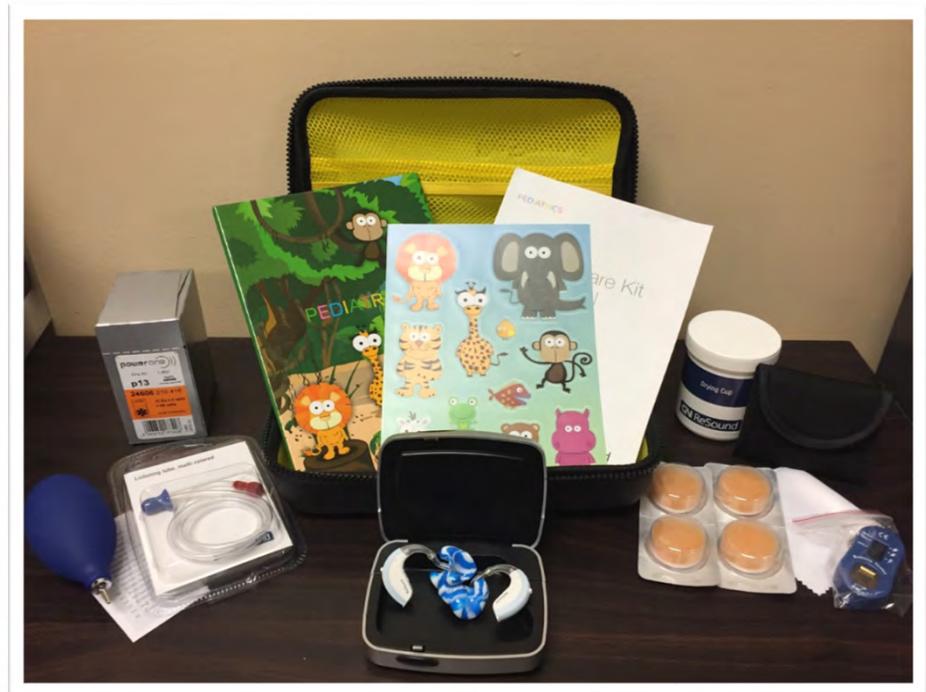
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HearU NEBRASKA

What's new at HearU

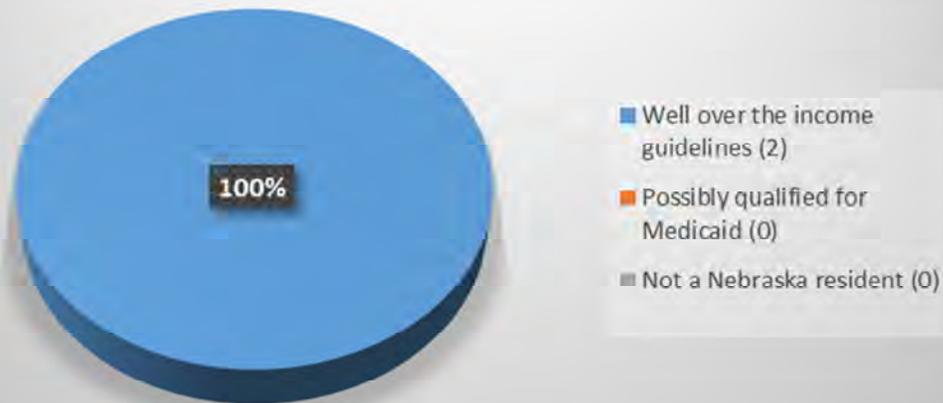
- HearU purchased 30 new hearing aids from Phonak in September, 2019
- HA's were purchased in a variety of models and colors



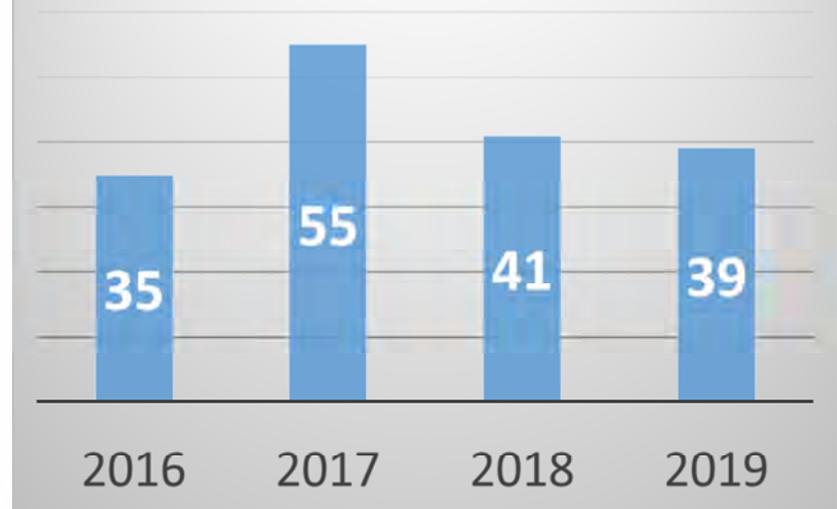
HearU NEBRASKA

New Financial Criteria (As of 01/01/2018)

Application Denials since May 2019
(2 total)



HearU Application Numbers by Year



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HearU Nebraska

- **Started as a short-term loaner bank in 2008**
 - **Collaboration between UNL and NDHHS Early Hearing Detection and Intervention Program**
 - **Was set up as a fund within the University of Nebraska Foundation in 2011**
 - **Funding: EHDI, grants, private donations**
 - **Has provided over 750 hearing aids to children ranging in age from 3 weeks – 18 years**
 - **Children reside in 96 different communities across Nebraska**
-

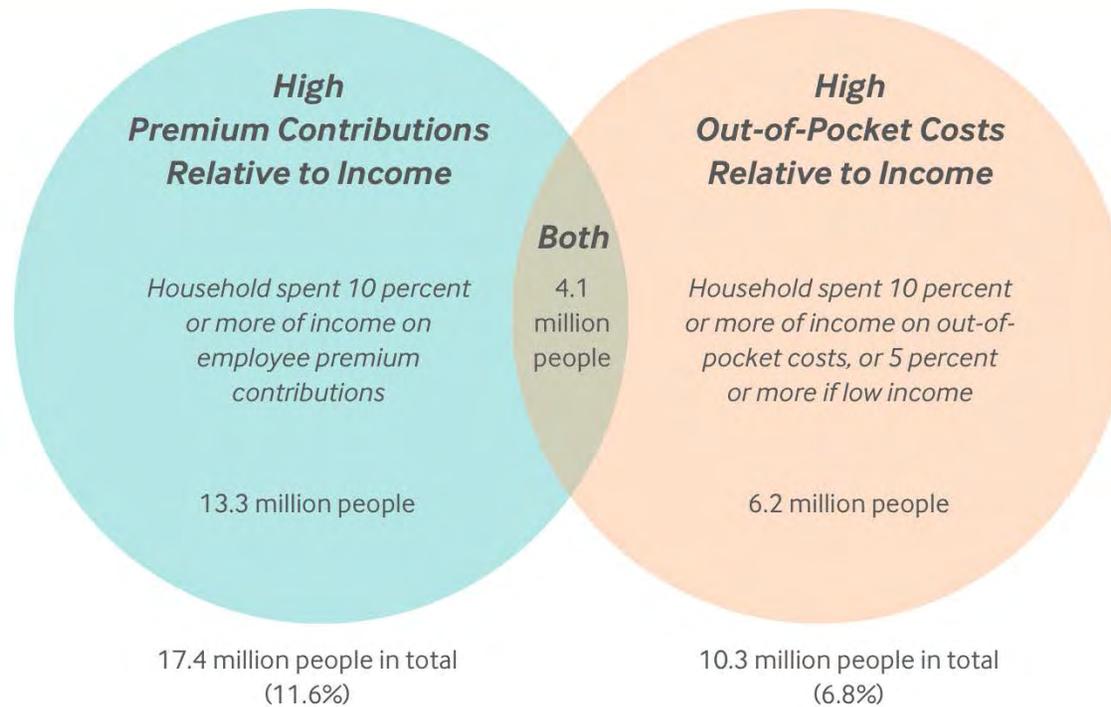
LB15 and HearU Nebraska

Working together for Nebraska

- **Some health insurance plans are exempt**
 - **Small businesses**
 - **Some children are uninsured**
 - **Some families may not have the resources to pay high out-of-pocket costs (deductibles, coinsurance, co-pays)**
 - **Example: child diagnosed at the beginning of the year with out-of-pocket costs of \$5,000**
 - **Accessibility and Continuity of Care**
 - **Not all providers are contracted with all insurance plans**
-

- **Anyone can refer**
- **Application has two sections:**
 - **Parent(s)/caregiver**
 - **Audiologist**
- **Hearing aids are purchased through Phonak, Oticon, & Widex**
 - **Hearing aids are mid-level current technology**
 - **BAHA's have been purchased or partially reimbursed**
 - **HearU has also helped with costs associated with Cochlear Implants**





Of 150.5 million people in households of individuals under age 65 with employer coverage



Tier One

What is covered?

- **Hearing aid(s)**
- **Care Kit**
- **Earmold(s)**
- **Batteries (1 year supply)**
- **Dispensing fees (commensurate with Medicaid rates)**
- **HA repairs and replacement earmolds (must be pre-approved and will depend on funding)**

Note: Parents are responsible for paying provider any charges above Medicaid rates, or charges can be written off.



Tier Two

What is covered?

- **Hearing aid(s)**
- **Care Kit**

Parent(s) are responsible for all other items and dispensing fees

- **Fees are set by the provider and directly billed to the parent(s)**
-

Tier Three

Child does not qualify based on reported family income above the qualifying limits.

Hearing Aid Replacement

- **Lost Hearing Aids: In Warranty**
 - Parent(s) are responsible for paying loss and damage fee (invoice) to HearU and paying any service fees charged by provider
 - **Lost Hearing Aids: Out of Warranty**
 - Parent(s) must complete a new application to HearU
 - Parent(s) will be responsible for paying a fee equal to that of a in warranty loss and damage
 - **Upgrading Hearing Aids**
 - Waiting period of 5 years unless hearing aids are no longer appropriate
 - **Parents will be responsible for dispensing fees, earmolds, batteries, for all replacement hearing aids**
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Hearing Aid Repairs

- **In Warranty**
 - Send hearing aid(s) to HearU for repair
 - **Out of Warranty: Application >1 year**
 - Parent(s) must complete a new application to HearU
 - If child qualifies, send hearing aid(s) to HearU
 - **Tier One:**
 - HearU will cover repair (invoice)
 - Parent(s) are responsible for paying provider for any service charges
 - **Tier Two:**
 - Parent(s) will be responsible for paying the invoice cost of repair to HearU *and* for paying provider for any service charges
-



What HearU Cannot Do

- **Pay or reimburse parents directly**
 - **Pay or reimburse practitioners for hearing aids**
HearU negotiates prices and places bulk orders to keep costs down, which allows us to serve as many children as possible
 - **Reimburse practitioners more than Medicaid Rates**
 - **However, there are no billing restrictions placed on practitioners**
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Contact information

- <https://cehs.unl.edu/secd/nebraska-hearing-aid-banks/>
 - <https://www.facebook.com/HearUNeb/>
 - <https://ncdhh.nebraska.gov>
 - hearingaidbanks@unl.edu
 - **(402) 472-0043**
-

HearU NEBRASKA



website: <http://cehs.unl.edu/secd/nebraska-hearing-aid-banks/>

email: hearingaidbanks@unl.edu

phone: 402-472-0043

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

Helping People Live Better Lives.

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Thank you for coming!

See you May 14, 2020

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