

Online Session 4

Aural Hab:
Child



Karen L. Anderson, PhD
Supporting Success for Children with
Hearing Loss

This Week's Learning Objectives You will be able to ...

Develop a foundation for better understanding of the onsite session.
Students will be able to describe:

- 1 Guidelines for Early Intervention after confirmation of infant hearing loss
- 2 Part C of IDEA: A family-centered program of supports and services
- 3 The continuum of communication choices

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Starting with a video

- An introduction to early intervention services.
- <http://www.youtube.com/watch?v=Ad5SmXzuR1M&feature=c4-overview-vl&list=PLCBE09BD900359C53>


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Make It Yours

- What would you say if a family asked you these questions:
- Is it therapy?
- Will I be sure to have someone teaching me/my child who really knows about hearing loss?
- Where do I go to get early intervention?
- What kinds of things will I learn? My child learn?

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2007 JCIH Supplement



From the American Academy of Pediatrics

Statement of Endorsement

Supplement to the JCIH 2007 Position Statement: Principles and Guidelines for Early Intervention After Confirmation That a Child Is Deaf or Hard of Hearing


JOINT COMMITTEE ON INFANT HEARING, Carianne Muse, MPH, Judy Harrison, MA, Christine Yoshinaga-Itano, PhD, Alison Grimes, AuD, Patrick E. Brookhouser, MD, Stephen Epstein, MD, Craig Buchman, MD, Albert Mehl, MD, Betty Vohr, MD, Mary Pat Moeller, PhD, Patti Martin, PhD, Beth S. Benedict, PhD, Bobbie Scoggins, EdD, Jodee Crace, MA, Michelle King, MS, Alice Sette, AuD, and Beth Martin, MA

Key Words:
hearing loss • hearing screening • hearing impairment • deafness • audiology

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2007 JCIH Supplement

- Guidelines developed from:
 - Literature searches
 - Existing systematic reviews
 - Recent professional consensus statements



The ultimate goal of EHDl is to optimize language, social and literacy development in children who are D/HH

These studies indicate that positive outcomes are possible and provide guidance about key program components that appear to promote these outcomes.

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EHDI

- Programs have been established 10 – 20+ years, depending on state
- Most states still are not able to report early intervention outcomes
- No hard data to support that communicative delays are being prevented/minimized
- The 2007 Supplement is designed to provide support for the development of accountable and appropriate EI follow-through systems.
- 12 Goals – desire is to attain 90% of all goals within 5 years

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Best Practice Goal 1

- Establish a timely, coordinated system of entry into EI services following HL confirmation
- Timely Access as defined by 2007 Supplement
 - Referral to Part C within 2 days of audiologic confirmation & Implementation of Early Intervention services within 45 days of referral)
 - Part C regulations (2011) require referral **as soon as possible but in no case more than 7 days after identification** of hearing loss
- Giving families EIP contact information **does not** fulfill this legal requirement
- Audiologists need to obtain parent permission to report to local EIP. Also required to report to state EHDI who will **then contact Early Intervention (states will vary)**.

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Best Practice Goal 1

Per FL Guidelines: The following should be completed immediately after assessment for infants with hearing loss:

- Complete the "Follow-up Diagnostic Evaluation Results Form for Community Audiologists" with copies to be faxed to the Children's Medical Services Newborn Screening Unit
- The "Follow-up Diagnostic Evaluation Results Form for Community Audiologists" form should also be faxed to the local Early Intervention Program within 2 working days of confirmation of hearing loss.
- Audiologists should refer the child to early intervention at the point of confirmation of hearing loss and not delay the referral until complete threshold information is obtained.
- This fax will constitute a referral and will satisfy the requirements of the Federal Law (CFR 303.321d).

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Best Practice Goal 1

- Develop a mechanism access to all available information
 - EI programs
 - Website resources on deaf
 - National organization res
 - Terms/definitions related
 - Infrastructure of state res
 - Services available throug
 - Communication choices, consider



[http://www.floridahealth.gov/AlternateSites/CMS-Kids/home/resources/es_policy_0710/Attachments/6_SHINE_FlaResourceGuideforFamilies-HearingLoss-May2011.pdf#search=Family resource guide*](http://www.floridahealth.gov/AlternateSites/CMS-Kids/home/resources/es_policy_0710/Attachments/6_SHINE_FlaResourceGuideforFamilies-HearingLoss-May2011.pdf#search=Family%20resource%20guide)
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Best Practice Goal 1

- Dissemination of unbiased and accurate information
- **Florida:** SHINE = Serving Hearing Impaired Newborns Effectively
- SHINE provides a framework for services within the Early Steps system to meet the unique needs of children with hearing loss (birth to 36 months) and their families.
- Component 6: EI Services
- http://www.floridahealth.gov/AlternateSites/CMS-Kids/home/resources/es_policy/es_Policy.html
- More info see SHINE Procedural Guidance

SHINE Case Examples
 SHINE Plan of Care Example
 SHINE Outcome Strategy Examples
 SHINE Ass. C. Communication Plan Example
 SHINE Communication Building Blocks
 SHINE Communication Development Monitoring Summary
 SHINE Communication Monitoring Process Manual
 SHINE ICF Questionnaire
 SHINE Family Resource Guide
 SHINE Form for Amplification
 SHINE Role of Hearing Specialist
 SHINE Procedural Guidance

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Best Practice Goal 2

- Timely access to Service Coordinators who have specialized knowledge and skills related to working with DHH
- First point of contact for families
- Oversees development/implementation of the IFSP – Individualized Family Service (Support) Plan
- Coordinates appropriate assessments
- Gathers the 'right people' on the IFSP team

Tend to be social workers or early childhood educators
 Tend to have high caseloads
 Tend toward not staying service coordinators very long
 Challenging to have designated DHH service coordinators

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Best Practice Goal 8

- Families are active participants in the development of EHHI state systems
- Strong emphasis on parent involvement on state and local early intervention program councils
- Strong emphasis on parent-to-parent support
- Some early intervention services have systematized inclusion of parent support:
 - Guide by Your Side
 - Hands and Voices Chapters with designated local contacts for new families

Best Practice Goal 9 – recommends trained families to provide support to new families

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Best Practice Goal 10, 11, 12

- Inclusion of DHH individuals in state EHHI systems development and implementation
- Opportunity for families of newly identified DHH children to receive support/mentoring from DHH individual
 - Deaf Role Models – native language teachers (ASL)
 - Hard of Hearing Role Models
- Fidelity of intervention via implementation of best practices as they are revealed

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Make It Yours

- You just diagnosed a 27-day-old infant from Sarasota with a 75-95 dB hearing loss bilaterally
- What are you required to report?
- The family has probably never heard of early intervention. How will you describe early intervention services to this family?

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So What IS Part C?

- IDEA has 4 parts: A = Introduction, B = school-age, C = birth to 3, D = personnel development
- Part C provides services and supports to families of infants and toddlers with developmental delays and established conditions
 - Developmental Delays – no known reason for delay
 - Established conditions – known condition that is likely to result in a delay without intervention to prevent or minimize delays
 - Hearing loss is an established condition. No delays are required for a child to be eligible.

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So What IS Part C?

- Where Part B requires that children be educated in the least restrictive environment (i.e., mainstream) Part C requires that services be provided within the natural environment (where any typical child would learn, play).
- Even if there are wonderful services at the university or at a local clinic, this cannot be an option for early intervention as services are not in the natural environment
- Only exception is if outcomes have been proven to not be attainable in the NE

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So What IS Part C?

- Where Part B has an IEP with outcome goals and measureable objectives
 - Part C has an IFSP with functional outcomes tied to every day activities and routines
 - The family defines what it is they want the child to do better and strategies are developed that the family/caregivers learn to do
- The outcome SHOULD:
- Enhance the family's ability to care for or to engage in activity with their child.
 - Enhance the child's ability to participate in functional activities (feeding, dressing, moving, communicating, playing, etc.)
 - Should expand on activity settings in which the child already participates successfully.

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So What IS Part C?

Functional Activities are identified by the family and support the child's physical, social, and psychological well-being. In early intervention we do not treat the primary diagnosis but the functional disability.

Examples included the ability to: Feed oneself, Play with toys and people, Communicate with others

Intervention Strategies SHOULD:

- Introduce a resource or adapt materials
- Modify the environment
- Adapt the routine or schedule
- Reframe the adult perspective/interaction
- Change the child's skill level

Functional, measurable, long-term, and short-term goals include the following:

- Performance
- Who (always the child or family)
- Will do what (observable/repeatable with a definite start and end)

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Example Outcomes

EXAMPLES OF FUNCTIONAL OUTCOMES FOR CHILDREN WITH HEARING LOSS (SHINE)

Outcome	Strategy
We want to learn about hearing loss so we can communicate with Sam.	The SHINE provider will share information from the Family Resource Guide and other materials about hearing loss and the materials will be discussed.
	The SHINE provider and the family will discuss basic audiology information about the audiogram and different degrees of hearing loss.
	The parents will participate in play dates with other families of children with hearing loss.
	The family will keep their audiology appointments.
	The SHINE provider the family will work together to complete the ELF as a means to better understand Sam's hearing loss.
	The SHINE provider and the family will discuss amplification options and how much a hearing aid can help Sam.
	The SHINE provider and the family will discuss different approaches to communicating to a child with hearing loss and will provide materials for self-study.
	The SHINE provider and the family will discuss how Sam's hearing loss relates to how Sam can access speech, with and without hearing aids.
	The SHINE provider will discuss information with the family related to: hearing loss and its impact on a family's grief process, sibling experience.
	The parents will learn more about Sam's hearing loss and ways to communicate with him that will lead to completion of the Communication Plan.
	The family will learn strategies for maximizing the parent-child interaction experience.

http://www.floridahealth.gov/AlternateSites/CMS-Kids/home/resources/es_policy/Attachments/6_SHINE_Outcome_Strategy_EXAMPLES.pdf

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Make It Yours

Families will benefit from regular support to keep hearing aids on their child's head, answer questions, learn communication strategies, etc.

All will have a turn to contribute to the questions below

- What are some challenges you see regarding early intervention services for families of children with hearing loss?
- What can you discuss with the family to help them recognize what they need to share/ask when they meet with the early intervention service coordinator?

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Continuum of communication modality

Communication modality needs can change throughout the day

Listening & Spoken Language, Speechreading, Cued Speech, ASL/visual languages

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Communication Building Blocks

- Communication features can be combined in different ways to meet unique needs

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Audition

- With the use of residual hearing, spoken English may be learned through constant use of spoken language in the home and special attention to providing intensive language and listening experiences. The maximum possible use of audition through optimal is a key to potential success of the Auditory-Oral and Auditory-Verbal options. A strong working relationship with an audiologist is vital. Individuals who are most successful with the Auditory based approach have residual hearing, through the use of hearing devices, that allows an auditory feedback loop to develop (able to perceive speech from others and monitor their own speech auditorily). In aural habilitation, the family is instructed in how to help the child to learn to listen and to understand what is heard.

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Speechreading

- In the best environment (good lighting, clear view of the speaker's face, etc.) only approximately 40% of the English sounds are visible.
- Thus, on average, a good speech reader may only be able to distinguish 4 to 5 words in a 12-word sentence. Much of the meaning of conversation is deduced through context and educated guessing.
- Research has shown that the ability to speech read seems to be unrelated to intelligence or motivation.

Conceptual Signs (ASL)

- American Sign Language, or ASL, is often thought of as the language of Deaf people.
- This complete conceptual visual language does not require the use of spoken words or sounds.
- Contrary to the belief of many hearing individuals, ASL is not a way of using gestures to represent English.
- ASL has its own vocabulary and all of the language components of a true language, including grammar and sentence structure.
- It is a completely distinct language from any spoken language, including English. Humor, emotions, philosophical ideas and other abstract concepts can be fully conveyed in American Sign Language.

English Signs (MCE)

- There are a number of communication techniques that code the English language visually.
- Manually Coded English (MCE) is a system of signs (many of which are borrowed from ASL) presented in English word order that are based on words as opposed to conceptual meaning.
- MCE is a visible representation of spoken English and, therefore, it is not a language.
- There are several manually coded English systems included Seeing Essential English (SEE 1), Signing Exact English (SEE 2), and Signed English.
- Signs that are used without full coding of the English language or the use of full conceptual ASL signs, are considered to be Pigeon Signed English (PSE).

Cued Speech

- Cued speech is a visual code based on the sounds used within words. A system of hand-shapes visually represent speech sounds.
- Cued speech is used as a tool to aid speech reading spoken languages.
- This system is believed to encourage the development of reading or literacy through encouraging a child to learn the spoken language as his first language.
- Thus, the Cued Speech approach consists of four main components: Cued Speech, speech reading, speech, and use of residual hearing.
- Cued Speech is not a language nor is it a representation of a language and cannot stand alone; it must accompany speech.

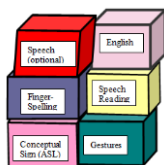
Fingerspelling

- Fingerspelling is also known as a visual alphabet.
- Each of the letters of the alphabet has a distinct hand-shape.
- Many of these hand-shapes were formed to look similar to the written form of the alphabet letters.
- Most persons fingerspell much slower than they can talk, thus slowing down speech and communication in an unnatural manner.
- Fingerspelling is used mostly as a means to introduce new or unknown vocabulary words to individuals that sign as not all words have defined signs.
- This is especially true of proper names or specialized vocabulary, such as in the sciences.

Augmentative Communication

- Augmentative communication refers to use of communication techniques or devices that enhance expression of ideas or understanding.
- Augmentative communication can refer to how an individual looks at a certain symbol to communicate through the use of eye, use of simple switches to turn on lighted toys, or the use of communication boards or electronic voice responders.
- Individuals with multiple disability conditions may use augmentative communication techniques or devices to enhance two-way communication with others.

Options: ASL (Bilingual)



- Bilingual/Biculturalism is designed to give children with hearing loss fluency in two languages – American Sign Language (ASL) and English or the family's native language.
- It also seeks to provide children with knowledge about and acceptance into two cultures – Deaf and hearing.
- American Sign Language, or ASL, is the language of the American Deaf Community.

Family Responsibility

The child must have access to deaf and/or hearing adults who are fluent in ASL in order to develop this as a primary language. If the parents choose this option they will need to become fluent to communicate with their child fully.

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Options: ASL (Bilingual)

Parent /Caregiver Training

- If parents are not deaf, intensive ASL training and education about Deaf culture is desired in order for the family to become proficient in the language.
- Immersion in ASL requires that caregivers develop ASL fluency if there is no at-home parent.

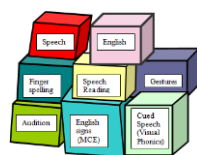
Why choose this option?

- Natural language of the deaf
- This early groundwork of language fosters fluency, literacy, social skills development and later academics.
- ASL is associated with the Deaf culture including the history, language and a society of a group of people

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Options: Total Comm (SimCom)



- children and families are encouraged to use a spectrum of communication techniques
- Manually Coded English (MCE), speech reading, speech and use of residual hearing, cued speech, natural gestures and body language are all encouraged.

Family Responsibility

All family members and caregivers should learn the chosen sign language system in order for the child to develop age-appropriate language and communicate fully with his/her family (and within the child care setting if there is no at-home parent). It should be noted that a parent's acquisition of sign vocabulary and language is a long term, ongoing process.

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Options: Total Comm (SimCom)

Parent/Caregiver Training

Parents must consistently sign while they speak to their child (SimCom). Sign language courses are offered through many adult education providers. Many books and videos are widely available. Signing must be used consistently and become a routine part of daily family communication.

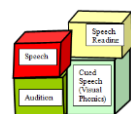
Why choose this option?

Children with some residual hearing may benefit from the combination of the visual code that closely matches what is being said. Also, MCE systems are generally easier for adults to learn than ASL. Taking advantage of all possible techniques is considered least restrictive by advocates.

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Options: Cued Speech



Cued Speech is a system of eight hand shapes that represent groups of consonant sounds and four hand placements that represent groups of vowel sounds used in combination with the natural lip movements of the speaker.

Family Responsibility

Parents are the primary teachers of cued speech to their child. They are expected to cue at all times while they speak. Consequently, at least one parent (and the primary caregiver if there is not an at-home parent), and preferably all caregivers must learn to cue fluently for the child to develop age-appropriate speech and language.

Parent/Caregiver Training

Cued speech can be learned through classes taught by trained teachers or therapists. Although the hand shapes can be learned during a long weekend training session, a significant amount of time must be spent using and practicing cues to become proficient.

Why choose this option?

Many parents find it fairly easy to learn cued speech in a short time as they are not required to learn a completely new language. Intensive 3 to 7 day workshops will equip an individual with enough knowledge to begin to use cued speech.

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Options: Auditory-Oral



- emphasizes maximum use of residual hearing through technology
- uses the auditory channel to acquire speech and oral language based on the assumption that most children with hearing loss can be taught to listen and speak with early, consistent training to develop their hearing potential
- includes the use of speech reading and natural gestures.

Family Responsibility: parents are expected to incorporate learning techniques (learned from therapists) into the child's daily routine and play activities.

Parent/Caregiver Training: Carry over learning techniques to the home. Emphasize optimal environment; development of listening and language.

Why choose this option? If the child is successfully able to master the Auditory-Oral option he will be able to communicate with the general public.

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Options: Auditory-Verbal (LSL)



- The primary objective of the Auditory-Verbal option is to "equip the child to integrate into classrooms and society at large."
- uses the child's residual hearing, hearing technology, and teaching strategies to encourage children to develop listening skills to enable them to understand spoken language through hearing devices
- expected to rely on audition alone during specific teaching times (includes use of hand cues in early training).

Family Responsibility: expected to incorporate on-going training into the child's daily routine and play activities. They must provide a language-rich environment, make hearing a meaningful part of all of the child's experiences, and ensure full-time use of amplification or a cochlear implant.

Parent/Caregiver Training: need to be highly involved with the therapists in order to learn training methods and carry them over to the home environment.

Why choose this option? Eventual communication with the general public.

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Make it Yours!

Review the information on the following website
<http://successforkidswithhearingloss.com/communication-whatever-fits-your-child-and-family>

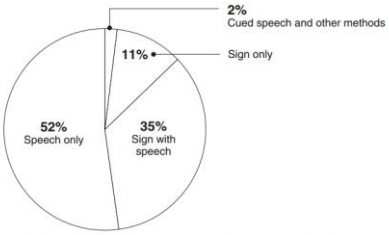
It is expected that you will view the **video samples** of each of the communication options. There are 5 videos that are a minute or less each.

A family comes in with 2-month-old Alex who has a 75 dB HL. They have been told that they need to make a choice about communication option to use at home and are struggling with doing so. What could you do/say?

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Communication Modality

2007-2008 Results of survey of primary mode of commun. used for instruction




Modality	Percentage
Speech only	52%
Sign with speech	35%
Sign only	11%
Cued speech and other methods	2%

Source: Gallaudet Research Institute (November 2008). Regional and National Summary Report of Data from the 2007-08 Annual Survey of Deaf and Hard of Hearing Children and Youth. Washington, DC: GRI, Gallaudet University.

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Information from Choices in Deafness: Revisited


Excerpted from a presentation by Mary E. Koch, MA, CED
 CDC Teleconference, August 23, 2005



- I am committed to connecting with children, one at a time...
- And to helping them learn to express themselves and understand others in the most effective way they can.
- (I speak first as a mother... and then as a professional.)
- AND—I am tired of the methodology wars!

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Choices in Deafness: Traditionally




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Counseling Newly Identified Families

- How might we do it differently?
- Take early brain development into consideration!



The Priority Pyramid

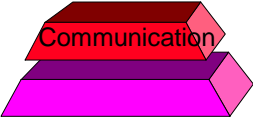


Cognition

The processing of sensation & experience in one's world.

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The Priority Pyramid

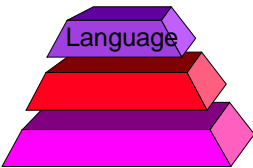


Communication

The transfer of information from one person to another.

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The Priority Pyramid

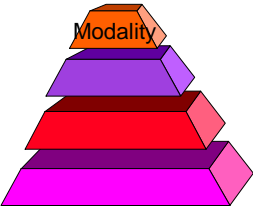


Language

Encoding information into *mutually understood symbols*.

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The Priority Pyramid

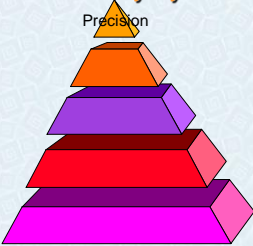


Modality

The *manner* in which language is expressed.

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The Priority Pyramid

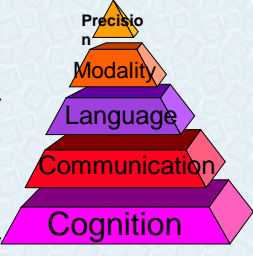


Precision

The *accuracy* with which something is expressed.

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The Priority Pyramid



Precision

Modality

Language

Communication

Cognition

THE BIG 3

Build the Brain – Interact – Develop Language

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What happens when we mix up our priorities???

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EVERYTHING crumbles!

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Counseling Newly Identified Families

Cognition, communication and language should be the focus of counseling with newly identified families—

NOT communication methodology.

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Communication mode - it depends

- On how routine the communication is (get your coat)
- Knowledge of the language used (apples, oranges, pears/bears?)
- On other challenges in the environment (noise, reverberation, fatigue, other distractions)
- Children often compensate in challenging environments by looking for visual clues.
- For children with hearing loss this can develop into the ability to order their own environment and to advocate for communication needs.

EX: Communication Access Continuum

“Do you want orange juice or milk?” **Pause**

Confused look, no response

Let him see your face and emphasize orange juice and milk. Then repeat without emphasis.

‘Auditory sandwich = 2 slices of LISTEN with a LOOK in between’

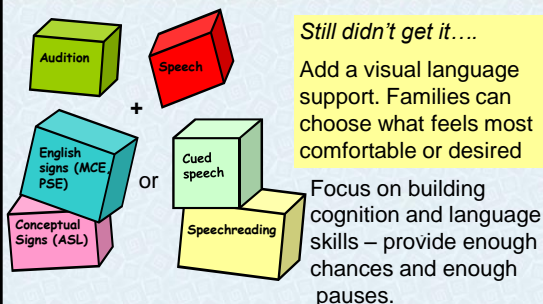
From Communication Building Blocks SSCHL/EI website Dan Goldberg

EX: Communication Access Continuum

Still didn't get it...

Repeat, holding out the cartons and emphasizing the words orange juice and then milk

EX: Communication Access Continuum



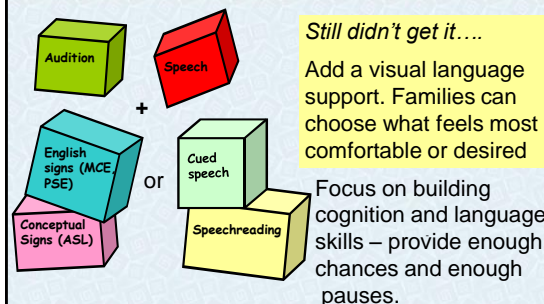
Still didn't get it....

Add a visual language support. Families can choose what feels most comfortable or desired

Focus on building cognition and language skills – provide enough chances and enough pauses.

What input does the child need to progress at a typical pace in language development?

EX: Communication Access Continuum



Still didn't get it....

Add a visual language support. Families can choose what feels most comfortable or desired

Focus on building cognition and language skills – provide enough chances and enough pauses.

What input does the child need to progress at a typical pace in language development?

Every communication opportunity is a chance for learning

- New word? (juice)
- Discriminating 2 vs. 3 syllables?
- New concept? (choice)
- Turn taking?
- Is this a chance to practice saying a word or will pointing be enough in this situation?



Early intervention services should help parents identify specific goals during everyday activities and routines.

Summary: Strategy for Language Learning

1. Parent presents the word, phrase, question auditorily, from a position close to child. Child cannot see parent's mouth.

If he didn't understand/respond

2. Parent presents information again in auditory only, then letting the child see her face, then auditory only (*auditory sandwich*)

If he didn't understand/respond

3. Parent presents the information auditorily, then provides a gesture, baby-sign, or ASL sign, then auditory only

If he didn't understand/respond

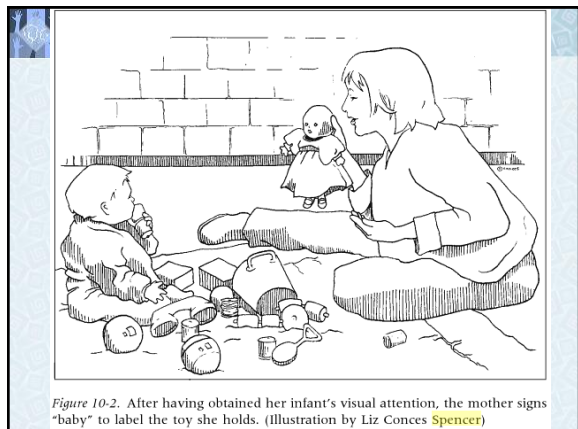
4. Parent obtains the child's visual attention to the object and presents the sign; then brings the object to her mouth; presents auditorily, presents in sign again

Be responsive – follow the baby's lead

- **Notice where the baby is looking or what the baby seems to be interested in. Talk or sign about that object or activity.**
- Move an object (such as a toy) in front of the baby and then move it up toward your own face. When the baby can see your face and the object, communicate about it.
- Tap on an object, perhaps several times, before and after you communicate something about it. This helps the baby know what your communication is about.
- Tap on the baby to signal, "Look at me." Repeat the tapping signal or combine it with moving an object if your first try isn't successful. Remember that babies have to learn to look up when they are tapped. It doesn't happen automatically. It takes time. Be patient while the baby is learning the signal.
- Relax — wait for the baby to look up on her own. You do not have to fill every moment with communication and language. It is more important to follow up on the baby's interests and make sure he or she can see your communication.



Figure 10-1. During the free play situation, this deaf mother tapped her 9-month-old child's shoulder. Failing to get a response, she moved a doll past the child's face and held it next to her own face. The child's gaze followed the moving toy.



Make it Yours!

Alex is now 14 months old and has come to you for an annual hearing evaluation. You check the data logging on the aids and find use averaging only 4 hours a day. Alex does not seem to be communicating and his parents are busy mainly dealing with behavior.

Rather than focusing on the findings of the data logging, you say "Last time you and Alex were here you were in the process of deciding how you were going to communicate with him. What can you tell me about your decision about communication options?"

Think of your counseling skills. What will you try to accomplish with the ensuing discussion?

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Preview for Next Week

Onsite Session – The Early Years

- **Speech and language development of young children with hearing loss**
- **Communication monitoring**
- **What happens in early intervention**
- **CASE STUDIES!**
- **Parent Panel**

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