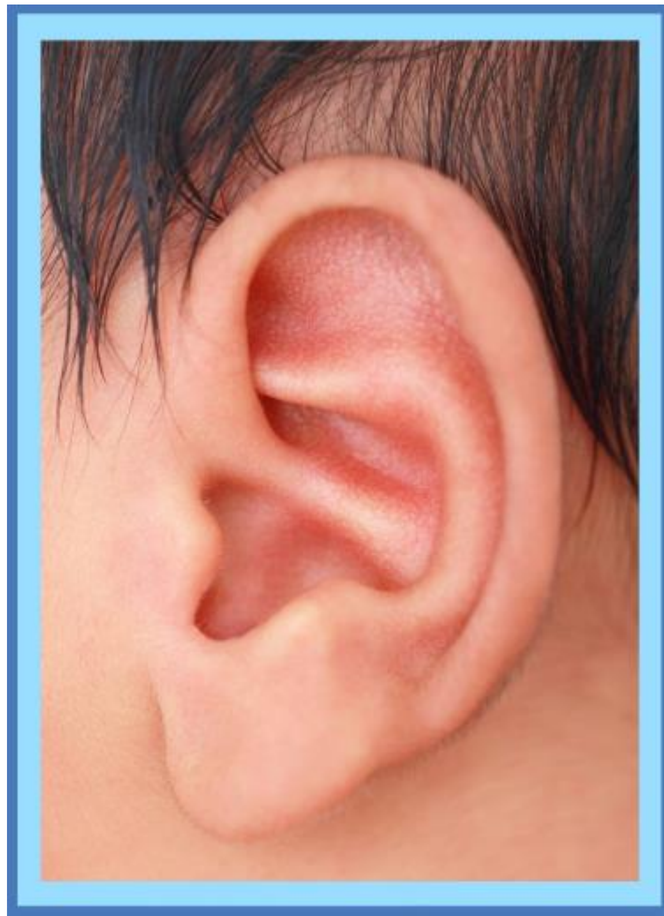
MISSISSIPPI STATE DEPARTMENT OF HEALTH

Early Hearing Detection and Intervention in Mississippi (EHDI-MS)



Policies and Procedures

2019

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Overview of the Early Hearing Detection and Intervention Program in Mississippi (EHDI-MS)

The Early Hearing Detection and Intervention Program in Mississippi (EHDI-MS) was established in 1997 by Mississippi Code 41-90. The Mississippi State Department of Health (MSDH) EHDI-MS collaborates statewide with birthing hospitals, midwives, audiologists, otolaryngologists, primary care providers, and early interventionists to ensure infants with hearing loss are identified by one month of age, diagnosed by three months of age, and enrolled in early intervention services by six months of age. The EHDI-MS also track infants who are at risk for late onset or progressive hearing loss.

The EHDI-MS State office is staffed with a Director, Hearing Follow-up Coordinators (HFC), Data Manager, clerical support, and contractual Outreach and Training Consultants (OTC). The EHDI Director oversees the program, including obtaining and managing grants to fund the program, supervising the HFCs, Data Manager, clerical staff, and OTCs, and writing policies and procedures with input from stakeholders. The HFCs receive and enter screening and evaluation results, with clerical support into the EHDI Information System (EHDI-IS), contact families to ensure they have a medical home and receive ongoing follow-up, and make referrals to early intervention services for infants and toddlers with confirmed hearing loss. The Data Manager assists with cleaning and analyzing data in the EHDI-IS to assist with performance reports, program evaluation, and quality improvement efforts. The OTCs conduct outreach with health care and early intervention providers to ensure they are familiar with the EHDI-MS Program requirements, goals, and practices. Also, they provide formal training and technical assistance to health care and early intervention professionals on collecting and reporting early hearing results, developing and sharing a plan of care, and implementing evidence-based practices to improve outcomes for infants and toddlers who are deaf and hard of hearing (DHH) and their families.

The EHDI-MS Program has an Advisory Committee (EHDI-AC), established by MS Code 41-90-7, of stakeholders to advise the Mississippi State Department of Health (MSDH) about the EHDI-MS. The EHDI-AC members are appointed by the State Health Officer for three years and include hearing screening and diagnostic professionals, primary health care providers, early interventionists, educators, advocates, adults who are DHH, and family members of children who are DHH, as well as leaders of other MSDH programs that collaborate with EHDI-MS. The EHDI-AC meets quarterly and provides an opportunity during each meeting for public comments about any relevant topic or concern. Annually, the EHDI-AC reports to the State Interagency Coordinating Council (SICC) for early intervention to provide recommendations on the identification of infants and toddlers who are DHH and linking them and their families with early intervention services. The EHDI-AC consists

of physicians, audiologists, parents, and others interested parties.

To increase awareness of EHDI and use of best practices, the EHDI-MS State office facilitates Regional Learning Communities of families, primary care providers, care coordinators, and other stakeholders.

To supports families, the EHDI-MS partners with the Mississippi Chapter of Hands & Voices, an organization run by families of children with hearing loss, to provide Peer-to-Peer support through the *Guide By Your Side* (GBYS) program. The GBYS Program provides outreach to families of infants who refer on screenings and access to Parent and Deaf Guides to families of infants with confirmed hearing loss. The GBYS Coordinator and Guides provide emotional support and unbiased information to families. The GBYS Program also provides family training, obtains feedback from families, and recruits family members for leadership roles, including serving on the EHDI-AC and SICC.

Equipment

A. All birthing hospitals must have functional and regularly-maintained newborn hearing screening equipment. Hospitals should use Auditory Brainstem Response (ABR) equipment that is easy to use and elicits fast and objective results.

Training

B. Hospital staff responsible for newborn hearing screenings should receive formal training prior to conducting any hearing screenings and should be provided ongoing training, at least annually, on conducting newborn screening and procedures for reporting to the EHDI-MS Program.

1. Initial Training: The initial training should consist of formal instruction in hearing screenings and communicating with families, observation of trained professions conducting hearing screenings, and being observed conducting hearing screenings.

    a. Formal Training: Hospitals are recommended to ensure all hearing screening personnel complete the training curriculum offered by the National Center on Hearing Assessment and Management (NCHAM). The curriculum is available online for free at http://www.infanthearing.org/nhstc/index.html. Trainees are able to earn a Certificate of Completion, continuing education units from the American Academy of Audiology (AAA), and continuing education contact hours from the National Association of Pediatric Nurse Practitioners (NAPNAP). In addition, the EHDI-MS Program offers training on hearing screening and reporting procedures through annual conferences, regional meetings, and, upon request, onsite visits.

    b. Observational Learning: Hospitals are recommended to ensure all hearing screening personnel first observe a trained professional conduct hearing screenings and share results with families. In addition, all hearing screening personnel should be observed by a trained professional as they conduct at least three hearing screenings and share results with families. The EHDI-MS Program has created a protocol that can be used to record observations.

2. Ongoing Training: Ongoing training should consist of formal instruction in hearing screenings and communicating with families and being observed conducting hearing screenings.

1. Formal Training: Hospitals are recommended to provide refresher training and/or use the NCHAM training curriculum for annual recertification. In addition, the EHDI-MS Program offers training on hearing screening and reporting procedures through annual conferences, regional meetings, and, upon request, onsite visits.

2. Observational Learning: Hospitals are recommended to ensure all hearing screening personnel are observed by a trained professional as they conduct hearing screenings and share results with families at least annually. The EHDI-MS Program has created a protocol that can be used to record observations.

Screening Procedures

C. Hearing screening professionals should conduct infant hearing screenings according to recommendations from an expert panel of the American Speech-Language-Hearing Association (ASHA) and should identify any risk factors for progressive hearing loss according to the Joint Committee on Infant Hearing (JCIH) including a family history of hearing loss; in-utero infection such as cytomegalovirus (CMV), herpes, toxoplasmosis, or rubella; postnatal infection associated with hearing loss; head trauma; craniofacial anomalies including those with morphological abnormalities of the pinna and ear canal; physical findings associated with a syndrome known to include a sensorineural and/or conductive hearing loss; neurodegenerative disorders; exposure to ototoxic medications, loop diuretic, or chemotherapy ; greater than 5 days spent in neonatal intensive care unit (NICU); hyperbilirubinemia with transfusion; ECMO assisted ventilation; and caregiver concerns. (Refer to the latest JCIH Position Statement).

   1. First Screen: An inpatient screening should be completed on both ears simultaneously in a quiet location between 12-24 hours after birth when the baby is quiet and calm.

      a. Pass: If the infant passes on both ears, notify the parents/guardians their child passed the initial hearing screening. Parents/Guardians must also be informed of any risk factors the child has for late onset hearing loss and provided an explanation of normal auditory and speech/language development. Encourage Parents/Guardians to contact their primary care provider (PCP) if they have any subsequent concerns with their child's hearing. Share informational pamphlets and brochures with the family. The EHDI-MS Program provides materials that hospitals can share with families as well as talking points for hospital screening personnel. Record the

screening date and results on the *Hospital Newborn Hearing Screening Log* (Form 1100) which must be submitted monthly to the EHDI-MS Program.

b. Refer/No Results: If the infant refers on either ear or no results are obtained, notify the parents/guardians their child did not pass the initial hearing screening and explain that an additional hearing screening will be conducted prior to discharge. Proceed to Second Screen. Record the screening date and results on the *Hospital Newborn Hearing Screening Log* (Form 1100) which must be submitted monthly to the EHDI-MS Program.

2. Second Screen: If the baby refers on either ear or no results are obtained during the first screening, a second hearing screening should be completed in a quiet location at least 4 hours after the first screening and as close as possible to discharge (no more than 8 hours prior to discharge). Both ears must be rescreened simultaneously even if the child only referred on one ear.

   a. Pass: Follow the pass procedure for the first screen. Record the screening date and results on the *Hospital Newborn Hearing Screening Log* (Form 1100) which must be submitted monthly to the EHDI-MS Program.

   b. Refer/No Results: If the infant refers on either ear or no results are obtained, notify the parents/guardians their child did not pass the hearing screening and may have a hearing loss noting any risk factors the child has for hearing loss. Parents/ Guardians must be provided an explanation of the potential effect of hearing loss on the development of the child's speech and language skills and informed that their child needs a follow-up diagnostic evaluation to determine their child's hearing status before three months of age. Share informational pamphlets and brochures with the family. The EHDI-MS Program provides materials that hospitals can share with families as well as talking points for hospital screening personnel. (An optional third screening may be conducted, at the discretion of the family. Notify the family, this third screening is not typically included under their newborn delivery charges nor is it typically paid for by insurance providers.) Encourage the parents/guardians to contact their primary care provider (PCP) about the need for their child to receive follow-up. Contact a pediatric hearing diagnostic provider to schedule a diagnostic evaluation as soon as possible to ensure the child is evaluated within three months of age. Record the screening date and results on the *Hospital Newborn Hearing Screening Log* (Form 1100) which must be submitted monthly to the EHDI-MS Program. Complete a *Hearing Screening Report* (Form 288) and submit it to the EHDI-MS Program, the child's PCP,

and the scheduled diagnostic clinic within 48 hours. Proceed to Diagnostic Evaluation.

3. <u>(OPTIONAL) Third Screen</u>: If the baby refers on either ear or no results are obtained on both the first and second screening, a third outpatient screening may be scheduled at birthing hospital or with a local provider at the discretion of the family. This third outpatient screening must be conducted within one month of birth. Both ears must be rescreened simultaneously even if the child only referred on one ear.

   a. <u>Pass</u>: Follow the pass procedure for the first screening. Record the screening date and results on the *Hospital Newborn Hearing Screening Log* (Form 1100) which must be submitted monthly to the EHDI-MS Program.

   b. <u>Refer</u>: If the infant refers on either ear or no results are obtained, notify the parents/guardians their child did not pass the hearing screening and may have a hearing loss noting any risk factors the child has for hearing loss. Parents/ Guardians must be provided an explanation of the potential effect of hearing loss on the development of the child's speech and language skills and informed that their child needs a follow-up diagnostic evaluation to determine their child's hearing status before three months of age. Encourage the parents/guardians to contact their primary care provider (PCP) about the need for their child to receive follow-up. Contact a pediatric hearing diagnostic provider to schedule a diagnostic evaluation as soon as possible to ensure the child is evaluated within three months of age. Record the screening date and results on the *Hospital Newborn Hearing Screening Log* (Form 1100) which must be submitted monthly to the EHDI-MS Program. Complete a *Hearing Screening Report* (Form 288) and submit it to the EHDI-MS Program, the child's PCP, and the scheduled diagnostic clinic within 48 hours. Proceed to Diagnostic Evaluation.

   c. <u>No Show</u>: If the child fails to return for the third outpatient screen, notify the parents/guardians their child needs a follow-up diagnostic evaluation to determine their child's hearing status before three months of age. Encourage the parents/guardians to contact their primary care provider (PCP) about the need for their child to receive follow-up. Contact a pediatric hearing diagnostic provider to schedule a diagnostic evaluation as soon as possible to ensure the child is evaluated within three months of age. Record the missed screening date on the *Hospital Newborn Hearing Screening Log* (Form 1100) which must be submitted monthly to the EHDI-MS Program. Complete a *Hearing Screening Report* (Form 288) and submit it to the EHDI-MS

Program, the child's PCP, and the scheduled diagnostic clinic within 48 hours. Proceed to Diagnostic Evaluation.

Reporting Procedures

D. According to Mississippi Code §41-90, hearing screening professionals must report the screening dates, screening results, and other required information to the EHDI-MS Program within the following timelines:

1. *Hospital Newborn Hearing Screening Log* (Form 1100): Record all hearing screening information for all live births for each month and submit completed logs to the EHDI-MS Program by the 5th of the month.

   a. Totals for all live births must be recorded: the total children not screening, breaking out not screened due to infant mortality and to transfer to another hospital; the total children who passed their hearing screening, breaking out who passed before one month of age and those older than one month of age as well as those who passed without risk factors and those that had risk factors; the total children who referred on the hearing screening; and the total *Hearing Screening Reports* (Form 288) submitted.

   b. For each child list: the child's date of birth, sex, name, medical record number, the presence/absence of any risk factors for late onset hearing loss, hearing screening dates, results for each ear, if the screening was conducted as an inpatient or outpatient procedure, if a *Hearing Screening Report* (Form 288) was completed, and any additional comments, such as why a screening was not conducted or a diagnostic provider to whom the child was referred.

   c. Record the hospital, person completing the form, and the month and year.

2. *Hearing Screening Device Download*: Download all hearing screening data from the hearing screening devices for each month and submit electronic data to the EHDI-MS Program by the 5th of the month.

   a. Export a file of all screening results for each month. If using an ALGO device, submit data using the ALGO3 Tab Delimited format:
      1. Start the ALGO5 machine. The Start Screen should be displayed.
      2. Enter user name and password on the Log-in Screen.
      3. Select the Data Management tab.
      4. The Patient Data view will be displayed.
      5. Select the Return to All Patients tab.

6. The Multi Patient View will be displayed.
7. Using the Date Picker for Date of Birth Range at the top of the screen, select the appropriate dates to view.
8. Select the Import/Export tab.
9. Select the Export button.
10. Select the Advanced button to navigate to Advanced Settings.
11. Select the Export selected records in the following format option and using the dropdown menu select ALGO3 Tab Delimited.
12. Select the Export button.
13. The screen should display a message showing the number of files and the number of hearing screening tests exported.
14. Depress the Shift button on the keyboard to select all of the files.
15. Ensure all of the files have been selected on the Multi Patient View.
16. Set the appropriate Destination for the selected files to complete the exporting process.

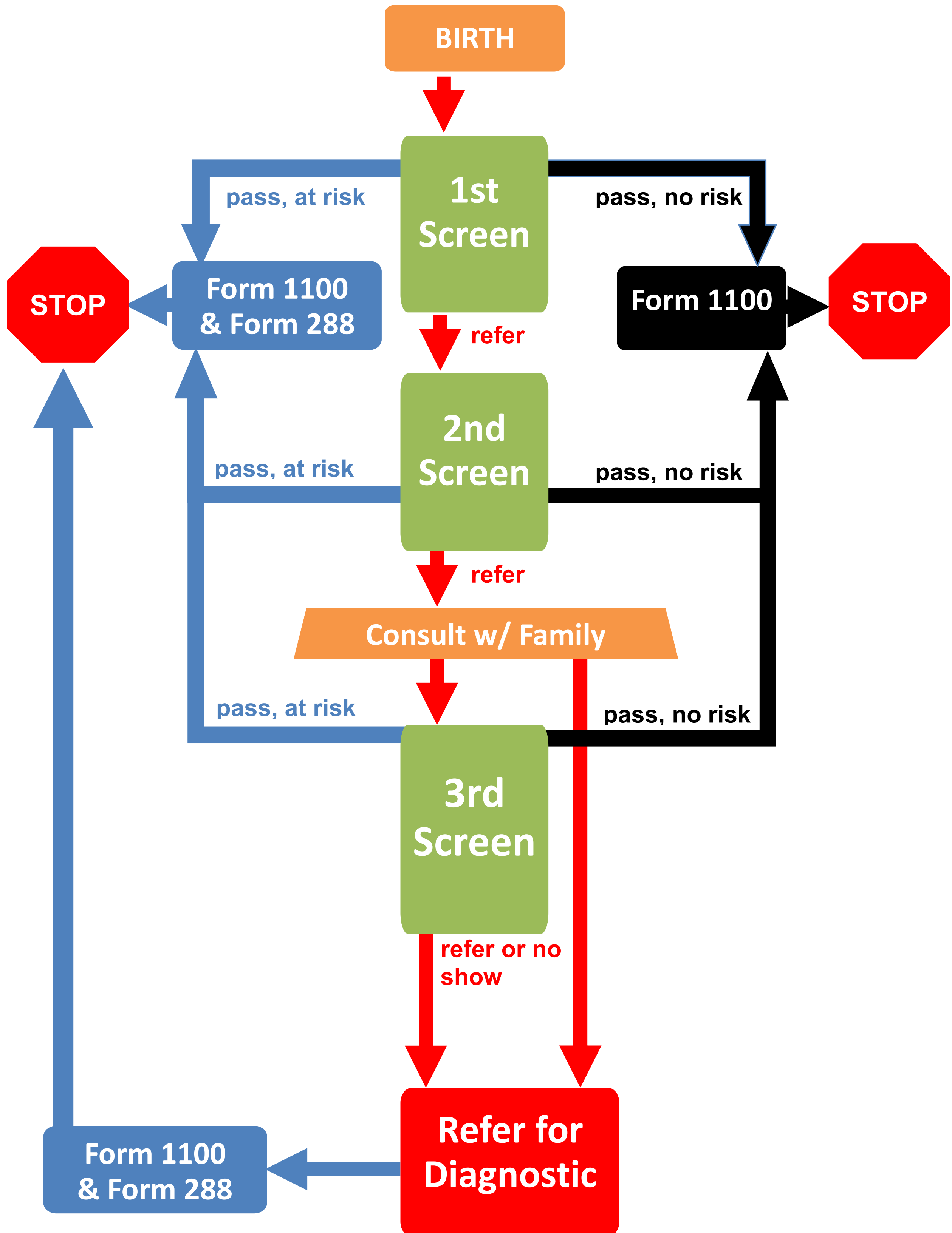
3. *Hearing Screening Report (Form 288)*: Record all individual hearing screening information for all children who referred on their final screening, family refused hearing screening, did not show for an outpatient hearing screening, had risk factors for late onset hearing loss, did not have a hearing screening for any reason, died before discharge, transferred to another hospital, or other issue warranting individual follow-up. Submit completed reports to the EHDI-MS Program within 48 hours of an event requiring a report

   a. For each child list: the child's and mother's demographic information; mother's contact information; primary care provider and insurance information; significant medical history including any ear malformations; reason for reporting; risk factors for hearing loss, if any; hearing screening results; and any referrals made. Also include any additional comments.

   b. Record the person completing the form, facility, and the date.

4. Submit completed reports and device data to the EHDI-MS Program:
   - Mail (using secure disk/drive for device data): Early Hearing Detection and Intervention Program, 570 E. Woodrow Wilson, O-204, P.O. Box 1700, Jackson, MS 39215-1700
   - Fax (paper reports only): 601-576-7540 with a cover sheet listing a callback number and pages
   - MS-HIN: msdh-ehdi@msdh.mshindirect.org using a MS-HIN account

Screening and Reporting Flowchart



Infant Hearing Diagnostic Policies and Procedures

Equipment

A. All providers who conduct diagnostic evaluations of infants must have functional and regularly-maintained hearing diagnostic equipment appropriate for use with this population. Diagnostic providers must have access to equipment to measure Auditory Brainstem Response (ABR) and otoacoustic emissions, an otoscope, and a tympanometer that are easy to use and elicit fast and objective results. Diagnostic providers may also need equipment for performing the following tests: Acoustic Reflexes (e.g., laser Doppler velocimeter), Auditory Steady-State Response, Wideband Immittance, and, as developmentally appropriate, behavioral audiometry. Facilities that lack the necessary equipment should either make referrals to or establish consortial arrangements with facilities that do.

Training

B. Diagnostic providers must be licensed providers with extensive formal training and participate in ongoing professional development. Diagnostic providers are strongly encouraged to participate in their professional associations to maintain professional standards and best practices. In addition, diagnostic providers should participate in training, at least annually, on procedures for reporting to the EHDI-MS Program.

Diagnostic Procedures

C. According to the Joint Committee of Infant Hearing (JCIH), all infants who refer on their Universal Newborn Hearing Screening (UNHS) should receive a diagnostic audiological evaluation no later than 3 months of age. This initial diagnostic audiology test battery should: 1) assess the integrity of the auditory system in each ear independently, even if only one ear referred; 2) estimate hearing sensitivity across the speech frequency range; 3) determine the type of hearing loss; and 4) provide information needed to initiate amplification device fitting, if the family chooses this option.

D. Based on guidelines from the JCIH, the American Academy of Audiology (AAA), and the Mississippi Speech-Language-Hearing Association (MSHA), a complete diagnostic evaluation for children younger than 3 years must include:

1. <u>*Child and Family History*</u>: Collect relevant information from the child's medical and developmental history, including prenatal and perinatal history; newborn hearing screening results; risk factors for hearing loss including progressive/late

onset loss; information on the child's vision and motor, cognitive, and emerging communication development, including milestones achieved and missed; and record parent/caregiver observations of the child's responsiveness to sounds.

2. *Otoscopy*: Conduct an examination of the outer ear to determine if placing earphones or probes in the ear canal is contraindicated and to note any obvious structural abnormalities of the pinna and/or ear canal.

3. *Typanometry*: Conduct tympanometry tests using a 1000 Hz probe tone for infants under 4-6 months of age.

4. *Otoacoustic emissions (OAE)*: Conduct either distortion product (DPOAEs) or transient evoked OAEs (TEOAEs) or both for comparison.

5. *Auditory Brainstem Response*: Conduct the following assessments as needed:

   a. Frequency-specific assessment using tone bursts (500-4k Hz) or narrow band CE-Chirp stimuli.
      1. Due to time constraints, assessment at all frequencies is not always possible. For fitting of amplification, it is recommended that thresholds be obtained for at least one low-frequency and one high-frequency stimulus.

   b. Click-evoked ABR
      1. If response is absent or abnormal at the limits of the equipment, a high-intensity single-polarity click stimulus should be recorded in both rarefaction and condensation to determine the presence of the cochlear microphonic.
      2. For an unfiltered click stimulus, pass criteria should be considered a threshold of 25 dBnHL or better.

   c. Bone-conducted ABR
      1. Thresholds should be measured by bone conduction if air-conducted thresholds are elevated.

E. Supplementary test procedures for a diagnostic evaluation for children younger than 3 years may include Auditory Steady-State Response (ASSR), acoustic reflexes, wideband immittance, and behavioral audiometry, as developmentally appropriate.

F. Diagnostic providers should compile a written comprehensive report including the following information: child's demographic information; assessment information including details about the date, location, and types of assessment procedures performed; graphical test results (e.g., audiogram and tympanogram), when

possible; diagnosis based on results; and follow-up/intervention recommendations. Parents/Guardians should be provided a copy of the written report along with an interpretation/explanation of the results, using understandable language in the family's native language or mode of communication. Copies should also be provided to the child's primary care provider, medical specialists, and all developmental and educational specialists (including early intervention providers).

Reporting Procedures

G. According to Mississippi Code §41-90, hearing diagnostic professionals must report the evaluation dates, evaluation results, and other required information to the EHDI-MS Program within the following timelines:

1. *Hearing Diagnostic Report (Form 53)*: Record all individual hearing diagnostic information for all children who were evaluated, whether confirmed or preliminary results were obtained, when an evaluation could not be completed, or when the family did not show for a diagnostic evaluation. In addition, after confirmed hearing results are reported, follow-up results indicating a change in the type or severity of hearing loss must also be reported.

    a. For each child list: the child's demographic information; mother's contact information; primary care provider and insurance information; name of referral source; newborn hearing screening results and birth hospital; risk factors for hearing loss, if any; evaluation procedures, indicating if an evaluation was not conducted or was refused; hearing diagnostic results, indicating if the results are preliminary; recommended diagnostic follow-up; and any referrals made. Also include any additional comments.

    b. Record the person completing the form, facility, and the date.

    c. With parental consent, attach the comprehensive report provided to the family, if available. (If the report is not available until a later date, please forward a copy to the Hearing Follow-up Coordinator working with the case for the child's EHDI and Early Intervention file.)

2. Submit completed reports to the EHDI-MS Program within 48 hours of an event requiring a report:
    - Mail: Early Hearing Detection and Intervention Program, 570 E. Woodrow Wilson, O-204, P.O. Box 1700, Jackson, MS 39215-1700
    - Fax: 601-576-7540 with a cover sheet listing a callback number and pages
    - MS-HIN: msdh-ehdi@msdh.mshindirect.org using a MS-HIN account

Early Intervention Referral and Follow-up Policies and Procedures

Medical/Technological Intervention

A. Families may or may not choose medical/technological intervention strategies for their child with hearing loss.

B. Amplification may be considered for any type or degree of hearing loss that could possibly interfere with normal development, including unilateral hearing loss, mild/minimal hearing loss, or Auditory Neuropathy Spectrum Disorder, to minimize the negative impacts of hearing loss on communication development and academic achievement.

C. As medical clearance from a physician is necessary prior to the fitting of amplification, children should be evaluated by an ear, nose, and throat physician (otolaryngologist) at the time of initial identification.

D. For families who choose amplification as a component of their child's intervention, appropriate technology should be fit within 1 month of diagnosis. Loaner hearing aids may be provided by medical intervention providers until financing is secured, to avoid a delay in fitting.

E. Based on parent/caregiver preference, children with severe or profound hearing loss, who may not achieve sufficient benefit with hearing aids, should be referred for a cochlear implant evaluation.

F. All potential candidates for a cochlear implant should receive a trial with amplification prior to implantation, to determine if sufficient benefit is obtained from appropriately-fit hearing aids. A finding of "No Response" by auditory brainstem response (ABR) does not exclude a child from hearing aid candidacy, as residual hearing may exist at intensity levels greater than those capable of being elicited using standard ABR. The threshold levels used to prescribe amplification for a no response ABR should be equal to the lowest-intensity stimulus level where no response is observed for each frequency tested, except in the case of children with ANSD where the absence of an ABR does not carry any implications about hearing thresholds.

G. All medical/technological intervention services should be coordinated with a shared plan of care managed by the primary health care provider in the child's medical home.

Training for Medical/Technological Interventionists

H. Medical professionals who provide medical/technological interventions for infants and toddlers with hearing loss must be licensed providers with extensive formal training and participate in ongoing professional development. These medical professionals are strongly encouraged to participate in professional associations and training programs specifically related to working with pediatric populations with hearing loss to maintain professional standards and best practices. In addition, these medical providers should participate in annual training provided by the EHDI-MS Program.

Developmental/Educational Intervention

I. Families may or may not choose developmental/educational intervention strategies for their child with hearing loss.

J. In Mississippi, all children with a confirmed hearing loss of any type or degree are eligible to receive early intervention services under Part C of the Individuals with Disabilities Education Act (IDEA) based on an established condition. As Part C services are voluntary, families may or may not choose to receive these services for their child with hearing loss. Some families may opt for private developmental/educational intervention services.

1. Children with hearing loss referred to the Mississippi First Steps Early Intervention Program (MSFSEIP) should be provided an intake visit conducted by an Early Intervention Service Coordinator within one week of identification. The EHDI-MS Program provides materials that Service Coordinators can share with families as well as talking points for the intake visit.

2. Enrollment in developmental/educational intervention services should occur as soon as possible after identification and within six months of age.

K. All developmental/educational intervention services should be coordinated with a shared plan of care managed by the primary health care provider in the child's medical home.

Training for Developmental/Educational Interventionists

L. Developmental/Educational Interventionists who serve infants and toddlers with hearing loss must be licensed professionals with extensive formal training and participate in ongoing professional development. These early intervention

professionals are strongly encouraged to participate in professional associations and training programs specifically related to working with pediatric populations with hearing loss to maintain professional standards and best practices. In addition, early intervention professionals should participate in annual training provided by the EHDI-MS Program.

1. Professional standards for Developmental/Educational Interventionists are found in the *Supplement to the JCIH 2007 Position Statement: Principles and Guidelines for Early Intervention After Confirmation That a Child Is Deaf or Hard of Hearing*.

M. Early Intervention Service Coordinators should receive formal training prior to working with children with hearing loss and their families and should be provided ongoing training, at least annually, on appropriate Service Coordination practices for these families and procedures for reporting to the EHDI-MS Program.

1. Initial Training: The initial training should consist of formal instruction in hearing loss and skill development for Service Coordination services for DHH populations, including communicating with families.

    a. Formal Training: Early Intervention Service Coordinators are recommended to complete the EHDI Bootcamp modules on intake, development of Individualized Family Service Plans (IFSPs), and transition to school-based services for children with hearing loss and their families. This training is offered for free by the EHDI-MS Program and Mississippi First Steps Early Intervention Program (MSFSEIP). Trainees earn early intervention units. In addition, the EHDI-MS Program offers training for Service Coordinators through annual conferences and regional meetings.

    b. Observational Learning: Early Intervention Service Coordinators are recommended to partner with their Local Service Coordinator Coaches and Regional Quality Technical Assistants to observe and be observed conducting intake meetings, developing Individualized Family Service Plans (IFSPs), and facilitating transition to school-based services.

2. Ongoing Training: Ongoing training should consist of formal instruction in hearing loss, skill development for Service Coordination services for DHH populations, including communicating with families, and best practices in early intervention for children with hearing loss.

    a. Formal Training: Early Intervention Service Coordinators are recommended

to complete training from national and local providers (e.g., NCHAM, AG Bell, Hands & Voices) and may complete the EHDI modules for refresher training as needed. In addition, the EHDI-MS Program offers training for Service Coordinators through annual conferences and regional meetings.

b. Observational Learning: Early Intervention Service Coordinators are recommended to partner with their Local Service Coordinator Coaches and Regional Quality Technical Assistants to be observed conducting intake meetings, developing Individualized Family Service Plans (IFSPs), and/or facilitating transition to school-based services for families of children with hearing loss at least once annually.

Referral Procedures

N. All children reported to the EHDI-MS Program with confirmed hearing loss will be referred to the MSFSEIP by the Hearing Follow-up Coordinator assigned to the case within 24 hours of receiving the *Hearing Diagnostic Report* (Form 53) submitted to the EHDI-MS Program with confirmed results.

O. Diagnostic providers may recommend referral for early intervention services for children with preliminary results if indicated on the *Hearing Diagnostic Report* (Form 53) submitted to the EHDI-MS Program. These children will be referred to the MSFSEIP by the Hearing Follow-up Coordinator assigned to the case within 24 hours of receiving the *Hearing Diagnostic Report* (Form 53) submitted to the EHDI-MS Program recommending referral for early intervention services.

1. To ensure eligibility for early intervention services, a statement of clinical opinion for the need for early intervention services must be completed and submitted to the EHDI-MS Hearing Follow-up Coordinator and the Local FSEIP Service Coordinator.

Reporting Procedures

P. Early Intervention Service Coordinators, with parental consent obtained in accordance with the Family Educational Rights and Privacy Act (FERPA), may provide a status update on the early intervention services provided to an infant or toddler enrolled in the MSFSEIP using the *Status Report* (Form 688).

1. Submit completed reports to the EHDI-MS Program via interagency courier service to: Early Hearing Detection and Intervention Program, Osborne-204, Jackson (Central Office).