



MARYLAND EARLY HEARING DETECTION AND INTERVENTION PROGRAM

**Best Practices Guidelines for Hospitals and Birthing
Center Staff, Midwives, Physicians and Staff,
Audiologists and Early Intervention Providers**

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Preface

This document was prepared by the Protocol Workgroup of the Maryland Early Hearing Detection and Intervention Advisory Council and has undergone review by the Maryland Department of Health. It contains valuable information on best practices and formal requirements which are both designed to ensure early language development for all children in Maryland.

Many thanks to all who contributed to this document and for the many families and stakeholders who work to ensure that Maryland's newborns and infants are screened early to determine their hearing status and to implement needed intervention at the earliest age possible to allow for early language development.

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SECTION 1

MARYLAND EARLY HEARING DETECTION AND INTERVENTION PROGRAM

On July 1, 2000, Universal Newborn Hearing Screening legislation was passed in Maryland requiring all birthing hospitals to conduct a newborn hearing screen prior to discharge. Insurance coverage for the hearing screening was also mandated under this law. The legislation required hospitals to report results and any risk factors for late onset/progressive hearing status that could affect language acquisition to the Maryland Department of Health.

The Maryland Early Hearing Detection and Intervention (MD EHDI) Program was established within the Maryland Department of Health (Department) to promote the best communication outcomes for children with a hearing status that could affect language acquisition, by creating and maintaining systems of care that identify the infant's hearing status and ensure referral to appropriate intervention services at the earliest possible age. The MD EHDI Program is housed in the Office for Genetics and People with Special Health Care Needs, part of the Department's Prevention and Health Promotion Administration.

The MD EHDI Program tracks and monitors the newborn hearing screen status of babies in Maryland and ensures that needed follow-up occurs. Babies who pass the newborn hearing screen are followed if they have risk factors for late onset or progressive hearing status.

The MD EHDI Program collaborates with its valued stakeholders to meet the national 1-3-6 guidelines developed by the Joint Committee on Infant Hearing of the American Academy of Pediatrics (JCIH, 2007):

- 1** – Screen by 1 month of age
- 3** – Confirm hearing status by 3 months of age
- 6** – Enroll in early intervention services by 6 months of age if identified with a permanent hearing status that could affect language acquisition

MD EHDI Program staff provide follow-up services by contacting families and staff at hospitals, birthing centers, primary care physician offices and other healthcare facilities to ensure that Maryland babies receive the newborn hearing screen and necessary follow up. Program staff ensure referral to early intervention services for infants who are reported to MD EHDI as having a permanent hearing status that could affect language acquisition. Newborn hearing screen and follow up data are entered and maintained in a secure web-based data system, accessible to providers for babies in their care. MD EHDI Program staff also assist families with navigating the EHDI process throughout all steps.

Each year, approximately 80 to 100 infants are reported to MD EHDI as having a permanent hearing status that could affect language acquisition. This identification rate is consistent with the

national average of 2 to 3 babies per 1,000 being identified with a permanent hearing status that could affect language acquisition.

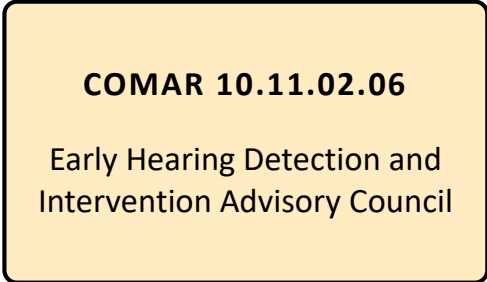
The website for the Early Hearing Detection and Intervention Program can be found at https://phpa.health.maryland.gov/genetics/Pages/Infant_Hearing_Program.aspx.

SECTION 2

MARYLAND EARLY HEARING DETECTION AND INTERVENTION ADVISORY COUNCIL

The MD EHDI Advisory Council supports the MD EHDI system by providing information to, consulting with, and advising the Maryland Department of Health to ensure that all newborns receive appropriate, high quality early hearing detection and intervention services. Originally established in 1985 (Chapter 402, Acts of 1985), the Council currently operates in accordance with the Annotated Code of Maryland, Health General Article § 13-603 and the Code of Maryland Regulations (COMAR) section 10.11.02.06 (see Figure 1). These authorize the Council to make recommendations for operations of the program and advise the Department on setting program standards, program monitoring and review, and provision of quality assurance for the program.

Figure 1. Link to COMAR 10.11.02.06



SECTION 3

STAKEHOLDER ROLES AND RESPONSIBILITIES

EHDI stakeholders are generally those individuals, groups or organizations that have an interest or concern in the early identification and intervention of children with a permanent hearing status that could affect language acquisition. This includes Deaf or hard of hearing individuals and others who can or will be affected by the actions, objectives, and policies of the EHDI system.

Generally, this includes but is not limited to:

- Parents and other family members of those infants
- Professionals (including speech-language pathologists, audiologists, physicians, educators, researchers and other academic experts)
- Government representatives
- Deaf or hard of hearing adults

- Organizations and agencies involving any of the above

It is essential for all stakeholders to fulfill their responsibilities within the EHDl law and/or protocols developed by the State EHDl system to ensure children with a permanent hearing status that could affect language acquisition are identified and enrolled in early intervention services in a timely manner.

The following sections discuss roles and responsibilities of different EHDl stakeholders. The information presented in each section includes:

- Relevant background information
- Formal requirements as contained in the COMAR
- Best practices identified by the Protocol Workgroup of the Maryland EHDl Advisory Council

Responsibilities of Birthing Facilities & Initial Screening Providers

Birthing hospitals and alternative birthing sites include a licensed or accredited unit of a hospital or a freestanding birthing center as defined in [COMAR 10.05.02.01](#). Birthing hospitals and alternative birthing sites shall henceforth be collectively referred to as “Birthing Facilities” in this publication.

Initial screening providers include those staff at inpatient birthing facilities for whom newborn hearing screening is within the person’s training and scope of practice (i.e. audiologist, fully-trained audiology assistant, registered nurse, licensed physician, screening technician). It also includes outpatient screeners as noted below. Regardless of where the infant is screened, certain documentation is required to be entered in the Department database and provided to the family, in accordance with COMAR section 10.11.02.07 (Figure 2).

Figure 2. Link to COMAR 10.11.02.07

COMAR 10.11.02.07
Procedures for Birthing
Hospitals and Alternative
Birthing Sites

Best practices

Birthing Facilities / Initial Screen Providers

Birthing Facilities will:

- Designate an employee of the facility to be responsible for the administration of newborn hearing screen testing in that institution.
- Provide hearing screening for the newborn prior to discharge, except in the following circumstances:

- The newborn is transferred for acute care prior to completion of the hearing screening. In this situation:
 - The birth hospital will notify the receiving hospital of the status of the hearing screening.
 - The receiving hospital will complete the newborn hearing screening prior to discharge of the newborn from the nursery.
- The newborn is born with a condition that is incompatible with life. If the infant dies prior to discharge, the birthing hospital will enter the infant as deceased in the data management system.
- The newborn has a bilateral ear anomaly that prevents screening (e.g., complete atresia of both ears), in which case the infant is referred for a diagnostic auditory brainstem response (ABR) test. Infants with unilateral anomalies are screened once in the unaffected ear and then referred for a diagnostic ABR to assess the affected ear.
- Ensure newborn hearing screenings are performed by an audiologist, fully-trained audiology assistant, registered nurse, licensed physician, screening technician or other professional for whom newborn hearing screening is within the person's scope of practice.
- Report hearing screening results and any identified risk factors for late-onset hearing status to parents *objectively* in a culturally sensitive manner through dialogue in the parents' preferred language and in writing with the goal of accurately communicating to parents whether follow up is needed based on the results of the screening.
- Remain *neutral* in the delivery of the results because it is *only* a screening. The only thing that should be emphasized is whether there is a need for follow up, next steps if applicable, as well as monitoring milestones for hearing and/or speech/language development.
- Send newborn hearing screening results directly to the primary care provider's office.
- Assist parents in scheduling any needed follow up appointments for hearing rescreening or high-risk monitoring and connect families to a primary care provider/medical home if they are not already connected.
 - If the baby does not pass an automated auditory brainstem response (AABR) screen, the birthing hospital will arrange for rescreening at a location that uses AABR. Rescreens using otoacoustic emissions (OAE) are not recommended under these circumstances.
- Ensure that all actions required under COMAR 10.11.02.07 (see Figure 2) are completed and fulfill timeliness requirements, including screening refusals and cases where a baby has been transferred to another facility or has died.

Note: It is also important to update the Department database if the baby has been transferred to the neonatal intensive care unit (NICU) and is not yet eligible for a hearing screening.

Outpatient Initial Screen Providers

Outpatient screen providers may include birthing centers, diagnostic centers, or other qualified personnel with appropriate equipment, training, and management (see Birthing Facilities / Initial Screen Providers section above) to complete screening and refer to a diagnostic center as needed.

Outpatient initial screen providers will:

- Complete the screening or schedule the screening within 30 days of the newborn's discharge from the birth facility. If the parent does not attend the appointment, the facility shall document the missed appointment in the medical record and shall report the missed appointment in the Department database.
- Ensure that all actions required under COMAR 10.11.02.07 are completed, including documentation of screening refusals and cases where a baby has been transferred to another facility or has died.

Out-of-state scenarios

Figure 3 presents best practices for different birth and residence scenarios.

Rescreening process

For babies that require a hearing rescreen, birthing facilities and outpatient screen providers will:

- Retest both ears, even if the baby referred in only one ear.

Figure 3. Best Practices for Out-Of-State Scenarios

The MD EHDI Program provides follow up for Maryland residents to ensure the newborn hearing screen and any recommended follow up is administered and documented; however, sometimes families will access medical care in neighboring states. Best practices for different birth and residence scenarios are given below.

Infants born in Maryland but who reside outside Maryland

If the infant misses or does not pass the newborn hearing screen, the MD EHDI Program sends documentation of the birth event and screen results to the EHDI program in the infant's state of residence. It is the responsibility of the state of residence to provide all post-discharge follow up.

Infants born outside Maryland but who reside in, or move to, Maryland

The out-of-state EHDI program notifies the MD EHDI Program of infants who miss or do not pass the newborn hearing screen, or otherwise need post-discharge follow up. It is not necessary for out-of-state EHDI Programs to notify the MD EDHI Program of infants who pass the newborn hearing screen in both ears.

Infants who are born and reside outside Maryland but receive follow up in Maryland

The EHDI Program in the state of residence is responsible for all post-discharge follow up. Any relevant reports are received directly from the Maryland healthcare provider.

Infants who are born and reside in Maryland but receive follow up out of state

The out-of-state healthcare provider provides follow up data directly to the MD EHDI Program.

- Use AABR for babies who do not pass an AABR for their birth screen. These babies should not be rescreened with OAE alone.
- If one or both ears refer on the rescreen using OAE or AABR, make referrals to a pediatric audiologist for diagnostic testing.

Responsibilities of Audiologists: Screening & Diagnostic Procedures

Audiologists are qualified to serve in many different roles for newborn hearing screening programs, including: developing and/or managing newborn hearing screening programs, providing quality assessment, and assisting with service coordination. Audiologists provide great value to the infant hearing screening system:

- Audiologists are the most qualified professionals to provide follow up testing and evaluation for infants who do not pass the initial screening. Audiologists can provide outpatient hearing screenings with OAE or AABR equipment as appropriate, as well as diagnostic audiological assessments to determine if a permanent hearing status that could affect language acquisition is present, including the type and degree of hearing status.
- Audiologists help ensure that parents understand the significance of their child’s hearing status and discuss habilitation and sensory device management options appropriate for the child. Audiologists can recommend the appropriate intervention for diagnosed hearing status, including assessing candidacy for sensory devices and assistive technology.
- The audiologist plays a key role in immediately referring parents to experts in language development, as it is well documented that language deprivation can have a lifelong impact on a child’s development.
- Audiologists provide timely fitting and monitoring of amplification or assistive devices.
- Audiologists may also serve as liaisons between the child/family and other professionals, as part of the medical home.

Figure 4. Link to COMAR 10.11.02.08

COMAR 10.11.02.08

Procedures for Audiologists
and Licensed Professionals
Conducting Audiological
Screening or Evaluations

Screening Procedures

Screening tests can be provided by trained professionals under the supervision of an audiologist, as well as by audiologists whose practices are equipped with OAE and/or AABR hearing screening equipment. Families may consult with their pediatrician or the MD EHDl Program to locate practices appropriately equipped to provide newborn screening follow up.

Types of screenings:

OAE and AABR are the two methodologies accepted as effective for newborn hearing screening.

1. AABR reflects the activity of the cochlea, auditory nerve, and lower auditory brainstem.
2. OAEs reflect the activity of the outer hair cells in the cochlea. Transient evoked otoacoustic emissions (TEOAEs) or distortion product otoacoustic emissions (DPOAEs) are appropriate for newborn hearing screening in well baby populations without risk factors.

Pass Criteria:

Pass criteria for OAEs can vary based on type of OAE testing and equipment. Audiologists and screening personnel should consult with manufacturers for best practices and screening guidelines.

In addition to consultation with manufacturers, the following suggested guidelines were developed based on review of OAE literature:

Suggested Pass Criteria: (based on Norton, et al., 2000 and Gorga, et al., 1997)

TEOAE with stimulus set to +/-3 dB of 84 dB peSPL (depending on equipment)

- Signal to noise (SNR) ratio of 6 dB above the noise floor at 4000 Hz and at least 2 other frequencies

DPOAE with stimulus set to 55 and 65 dB SPL

- SNR of 6 dB above the noise floor and DP value greater than -5 dB SPL
- Present OAEs (see above) at 8 or more frequencies (for 12 frequency screening) including 2000-4000Hz

Best practices

Screening procedures:

- Testing is completed on a quiet and calm infant; testing is usually completed while the infant is sleeping.
- The ear is examined for any abnormalities, including drainage in the ear canal. Otoloscopic examination may be completed prior to OAE testing if possible.

Outpatient rescreening:

Audiologists may provide rescreening and follow-up screening services to those infants (see exceptions for NICU babies) that did not have a newborn hearing screen or did not pass their initial newborn hearing screen. Birthing hospitals may also perform rescreening on an outpatient basis.

- Rescreening occurs prior to one month of age.
- Even if the infant referred for only one ear, both ears are rescreened during the follow-up screening to ensure accurate results.
- If the rescreen results indicate the need for further testing, the infant is referred for a diagnostic evaluation. Another rescreen is *not* scheduled. If the clinic does not provide diagnostic evaluations, please refer to the EHDI program for appropriate referral sources.
- If the initial test used an OAE, rescreens are conducted with TEOAE, DPOAE, auditory brainstem response (ABR, AABR, BAER, ABAER), or a combination of both measures.
- If the initial test used ABR, rescreens are conducted with only ABR to avoid missing a neural hearing status that could affect language acquisition (i.e. auditory neuropathy spectrum disorder).
- Behavioral observation audiometry is not a sufficient hearing screening or diagnostic approach for infants.

Figure 5. Best practices for special considerations within newborn hearing screening, rescreening, and referral

- When risk factors are present, infants are referred for a diagnostic evaluation to be conducted by 12 months of age, rather than a rescreening. Risk factor guidance can be found in Appendix 2 of the [Joint Committee on Infant Hearing Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs](#).
- Infants admitted to the NICU for more than five days are screened using AABR at their initial hearing screening.
- Infants who do not pass AABR screening in the NICU are referred directly to an audiologist for a diagnostic ABR rather than a rescreening.

Figure 5 presents best practices for special considerations within screening, rescreening, and referral.

When reporting hearing screening results to parents, it is important to be mindful that screening results should be relayed objectively in a culturally sensitive manner with the goal of accurately communicating to parents whether follow up is needed based on the results of the screening.

Diagnostic Procedures

Audiologists are the best qualified professionals to diagnose a hearing status that could affect language acquisition, help ensure that parents understand the significance of their child’s hearing status, and discuss habilitation and sensory device management options appropriate for the child.

Best practices

Diagnostic evaluation protocol:

A. Audiological Assessments: Birth to Six Months of Age

In order for timely referral to early intervention services to occur, all infants who have not passed a hearing rescreen receive a diagnostic audiological assessment to determine hearing status. This assessment includes:

- Detailed child and family case history.
- Auditory brainstem response measures may be performed under natural sleep for very young infants or under sedation for older children. **At the minimum**, reverse polarity click at a high intensity to rule out Auditory Neuropathy Spectrum Disorder (ANSD) and tone bursts at 500 and 2000 Hz are administered. Bone conduction testing is completed whenever a permanent hearing status that could affect language acquisition is suspected. This may take more than one appointment to complete. Both ears are tested even if only one ear referred.
- DPOAE or TEOAE is used as a cross check measure.
- Tympanometry using a 1000 Hz probe tone is performed to help determine middle ear status.
- Acoustic reflex testing at a minimum of two activator frequencies (1000 and 2000 Hz) at a probe tone of 800 or 1000 Hz is completed ipsilaterally or contralaterally.
- Behavioral measures are used as the child begins to actively search for sound, around six months of age. When reliable behavioral responses cannot be obtained, infants are referred for a sedated ABR.

B. Audiological Assessments: Six to 36 Months of Age:

For timely referral to early intervention services to occur, all infants who have not passed a hearing rescreen receive a diagnostic audiological assessment to determine hearing status. This assessment includes:

- Detailed child and family case history, including parent report of auditory and visual behaviors and communication milestones.
- Behavioral audiometry, which is likely to include visual reinforcement audiometry (VRA) and/or conditioned play audiometry (CPA) throughout this age range. Although some children will be intolerant of earphone placement, every effort is made to obtain ear-specific thresholds.
- DPOAEs or TEOAEs are used as a cross check measure.
- Otoscopy and tympanometry are used to help determine middle ear status.
- Acoustic reflex testing is performed.
- ABR testing is employed if results are questionable or if behavioral audiometry does not yield reliable results.

For additional details regarding diagnostic evaluations, refer to the American Academy of Audiology guidelines for Pediatric Diagnostics.

Reporting:

- All actions required under COMAR 10.11.02.08 are completed and fulfill timeliness requirements.
- All infants who are identified as or strongly suspected as Deaf or hard of hearing receive early intervention services as soon as possible after diagnosis, but at no later than 6 months of age.
- The Local Infants and Toddlers Program (ITP) in the infant’s jurisdiction of residence is the family’s single point of entry for Early Intervention Services for children from birth to age 36 months. A referral to ITP can be made at <https://referral.mditp.org/> For children older than 36 months, the family should contact their local school to begin the Child Find process for intervention services.

Responsibilities of Professionals Caring for Children and their Families

Parents and families hold the most important roles in the child's life. It is critical that early intervention specialists and healthcare personnel share screening and assessment results in a direct and impartial way that is both professional and family-friendly. Often what is most important is not *what* results are shared, but *how* results are shared. When communicating hearing screen results to parents, information should be provided verbally and in writing. Providers are strongly encouraged not to use the word “fail” when communicating results to parents. It is recommended to indicate the baby is being referred for additional testing.

The goal at each step of the EHDI process is to empower parents and families to make decisions about follow up care for their child. Professionals should be aware of their own biases regarding communication mode and should strive to always provide information to parents in a clear and unbiased manner. The way in which results are shared with parents has a powerful impact on their decisions and the life of their Deaf or hard of hearing child. Professionals should be careful not to make assumptions about how the information may be received by the family.

It is also important that each professional is equipped with information and resources to provide to families based on their individual needs. Legislation passed in 2019 allows parents of children who are Deaf or hard of hearing to take a course that teaches a language or communication mode at a public institution of higher education without paying tuition (see [Section 4](#), item 3 for a link to Maryland statute).

Best practices

The following best practices are for professionals working with parents at any stage of the EHDI process:

- Share screening results in a positive manner and emphasize the next steps for follow up. The goal of this process is to provide a positive foundation for intervention (if necessary) and to help parents recognize and follow the screening process.
- Present information and resources in a clear manner. Explain the screening process and encourage parents to follow next steps in the screening process, including a follow up screening or an ABR.
- Convey screening and diagnostic results in clear language without professional jargon. Professionals are responsible for providing a clear and unbiased view of screening and diagnostic results.
- Emphasize the critical period of language development and the need for immediate exposure to language for every child who is Deaf or hard of hearing.
- Empower parents to make decisions by providing resources immediately. Maryland EHDI resources are available to families and professionals. Families are strongly encouraged to seek guidance from family support services for families of children who are Deaf or hard of hearing. A list of resources is presented in Section 4.
- Provide parents with information on ways to communicate and bond with their baby who is Deaf or hard of hearing. Communication is an important way for parents to bond with their baby.
- Share with parents the importance of early intervention and the availability of family-centered early intervention services at no cost. Inform parents that their local Infants and Toddlers Program may be contacted at any point if they have concerns about any aspect of their child's development.

Responsibilities of the Medical Home

The medical home, which includes the pediatrician or other primary health care professional is responsible for monitoring the overall infant and child health and development (JCIH, 2007).

Best practices

- The medical home ensures that infants who do not pass the newborn hearing screening receive appropriate audiological and medical referrals and outpatient testing as indicated to determine the infant's hearing status. Middle-ear status is closely monitored because of the negative impact that middle-ear effusion can have on hearing.

- The medical home partners with other specialists including otolaryngologists, audiologists and language development experts for children who are Deaf or hard of hearing to facilitate and coordinate care for the infant and their family.
- The medical home offers referrals for genetics evaluations for all children with a permanent hearing status that could affect language acquisition (JCIH, 2007).
- The medical home assesses the infant’s medical and family history for the presence of risk indicators for delayed-onset or progressive hearing status, and ensures that when present, an audiological evaluation is completed for these children no later than 12 months of age. **Infants with specific risk factors who are more highly associated with permanent hearing status that could affect language acquisition (e.g., cytomegalovirus) may be referred for follow up at an earlier age and monitored more closely.**
- The medical home provides ongoing monitoring of parent concerns about hearing, auditory skills, and language development for all infants regardless of risk status. The medical home consults and coordinates with experts on language development of children with a permanent hearing status that could affect language acquisition.

Responsibilities Related to the Intervention & Referral Process

Intervention is a critical part of the EHDI process as delays in exposure to language can lead to language deprivation, which could have lifelong impacts on the child’s development. Timely referrals to early intervention and implementation of early intervention services are an essential part of the EHDI process. This process and the critical importance of timely referrals to early intervention are discussed in *Early Intervention Services for Children Who Are Deaf or Hard-of-Hearing and Their Families*, a Technical Assistance Bulletin from the Maryland State Department of Education.

Best practices

Referral Process:

- The professional completes a referral to the Local Infants and Toddlers Program for the jurisdiction where the family lives. A referral may be submitted online at <https://referral.mditp.org>. The Maryland State Department of Education provides phone numbers and addresses for [Local Infants and Toddlers Programs](#).
- Families are informed that their child is eligible for Early Intervention services and that a referral will be made and are told to expect to be contacted by the Local Infant and Toddler Program. Families are provided with *A Family Guide to Early Intervention Services in Maryland*.

- Families are informed that, based on their priorities and needs, they may receive services from their Local Infants and Toddlers Program, the [Maryland School for the Deaf](#), or both. An Individualized Family Services Plan will be developed with the family's participation.
- For children over age three, parents should contact their local public school to begin the process of evaluation for special education services.

Role of Early Intervention Providers in Educating Parents:

- Parents are informed that early language intervention is critical in the first few years of life for a child with permanent hearing status that could affect language acquisition. They are advised that there are many professionals to support them through Infant and Toddler Programs throughout the state.
- Professionals with expertise in this area work with parents to ensure exposure to language immediately so that children do not miss this critical developmental period. Services are provided by local Infants and Toddlers Programs and/or the Maryland School for the Deaf.
- Parents should understand that early parent education, access to language (spoken and/or visual), early amplification and auditory training can play an important role in their child's language development. Parents are provided information, guidance and support in all these areas to make informed decisions that best fit their child's and family's needs.

SECTION 4

ADDITIONAL RESOURCES

1. Maryland Statute: [Early Hearing Detection and Intervention Program](#)
2. Code of Maryland Regulations - [Early Hearing Detection and Intervention Program](#)
3. Maryland Statute: [Tuition exemption for parent of deaf or hard of hearing child](#)
4. American Academy of Pediatrics, Joint Committee on Infant Hearing. [2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs](#)
5. National Center for Hearing Assessment and Management: [A Resource Guide for Early Hearing Detection and Intervention \(2019\)](#)
6. American Speech-Language Hearing Association: [Guidelines for the Audiologic Assessment of Children From Birth to 5 Years of Age](#)

7. American Academy of Audiology: [Pediatric Diagnostics](#) (position statements and practice guidelines)
8. Maryland Department of Health: [Early Hearing Detection and Intervention Program](#)

Links to letter sent by MD EHDI to parents of babies identified as Deaf or hard of hearing:

[Letter in English](#)

[Letter in Spanish](#)

9. [American Sign Language video](#)
10. [Maryland AG Bell Chapter](#)
11. [Setting Language in Motion](#)
12. [Laurent Clerc National Deaf Education Center's Early Intervention Clearing House Resources](#)
13. [Maryland School for the Deaf](#)
14. [Governor's Office of the Deaf and Hard of Hearing](#)
15. [Maryland Association of the Deaf](#)
16. [National Association of the Deaf](#)
National Association of the Deaf: [Early Intervention for Infants and Toddlers](#)
17. [Deaf Culture Digital Library](#)
18. [Language Equality and Acquisition for Deaf Kids \(LEAD-K\)](#)
19. [ASL Connect](#) (Free American Sign Language Classes)
20. *Sign It!* Online ASL classes are available for **free to families in the US who have a child 36 months or younger who is Deaf or hard of hearing**. Apply at [MyDeafChild.org](#).
21. *Sign It!* Online ASL classes available for purchase
22. [Whyisign](#)
23. [ASL Nook](#)

References

Gorga, M. P., Neely, S. T., Ohlrich, B., Hoover, B., Redner, J., & Peters, J. (1997). From laboratory to clinic: a large scale study of distortion product otoacoustic emissions in ears with normal hearing and ears with hearing loss. *Ear Hear*, 18, 440-455.

Joint Committee on Infant Hearing. (2007). Year 2007 position statement: Principles and guidelines for early hearing detection and intervention. Available at <https://pediatrics.aappublications.org/content/120/4/898>.

Norton, S. J., Gorga, M. P., Widen, J. E., et al. (2000). Identification of neonatal hearing impairment: transient evoked otoacoustic emissions during the perinatal period. *Ear Hear*, 21, 425-442.