2023 Annual Report

Language and Literacy Outcomes for Children Who are Deaf and Hard of Hearing in the State of Georgia

Report to the Governor and General Assembly as required by OCGA § 30-1-5 (h)

Co-Authored by:

Kelly Jenkins, MBA
Georgia Department of Education
State Schools Division
Language and Literacy Initiative Consultant

Stacey Tucci, PhD
Georgia Department of Education
State Schools Division
Language and Literacy Initiative Director

Alison Morrison, AuD, CCC-A
University of Georgia
Clinical Associate Professor
UGA Speech and Hearing Clinic
Audiology Clinic Coordinator

Melanie Morris, AuD, CCC-A
Georgia Department of Public Health
Division of Women, Children, and Nursing Services
Child Health Deputy Director and Referral and Screening Programs Director

Brandt Culpepper, PhD, CCC-A
Georgia Department of Public Health
Division of Women, Children, and Nursing Services
Early Hearing Detection and Intervention (EHDI) Program Manager

Kevin Byrd, M. Ed.
Georgia Department of Public Health
Division of Women, Children, and Nursing Servies
Babies Can't Wait (BCW) Director/Part C Coordinator

Michael Lo, MSPH
Georgia Department of Public Health
Division of Epidemiology
Newborn Surveillance Epidemiologist

For more information:

Georgia Commission for the Deaf or Hard of Hearing
Amy Lederberg, Chair
https://dhs.georgia.gov/gacdhh

Kurt Bryan
LEPSI Project Manager
Office of General Counsel
Georgia Department of Human Services
47 Trinity Avenue SW
Atlanta, GA 30334
(M) 470-715-4261
kurt.bryan2@dhs.ga.gov

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Executive Summary

As stated in the OCGA § 30-1-5 Year 1 report, Georgia's children who are Deaf of Hard of Hearing (DHH) have both the ability and the right to achieve every educational outcome that children with typical hearing can achieve. However, this achievement is dependent on equitable access to timely diagnosis and appropriate early intervention (EI) and school-age services.

The authors are pleased to report that progress has been made in many indicators over the past 12 months. For example, teleaudiology diagnostics have increased two-fold since last year due to many efforts - including the Georgia Department of Education's (GADOE) continued investment in Georgia Mobile Audiology (GMA) and their coordination with Georgia Department of Public Health's (DPH) Early Hearing Detection and Intervention (EHDI) program. In addition, compliance with the State Electronic Notifiable Disease Surveillance System (SendSS), which reports on children diagnosed with hearing loss from birth to 5 years of age, has drastically improved over recent years improving identification and enrollment into state early intervention as a result of ongoing efforts within DPH's EHDI program. This metric is notable, as enrollment into early intervention is a known factor in determining language outcomes for children who are DHH. In fact, many children who are enrolled in early intervention promptly achieve language proficiency approximating their peers with typical hearing.

While this progress should be celebrated, it is critical not to declare a premature victory. With the exception of newborn hearing screening, overall success metrics are far below national benchmarks as illustrated in the Language and Literacy dashboard. Georgia's rankings when compared to the rest of the nation remain in the bottom third. Therefore, close attention and investment must continue to ensure Georgia children who are DHH achieve age-appropriate language and literacy.

Key accomplishments are as follows, and details of each will be highlighted in this report:

- **Georgia's Nationwide On-Time Diagnostic Ranking Has Improved by 5 points since 2019 moving from #41 to #36**
- **Percentage of Children Diagnosed Before 3 Months of Age Among those Identified with Hearing Loss has Increased from 54% in 2019 to 67% in 2022**
- **Percent of Babies with Permanent Hearing Loss Enrolled in Early Intervention by 6 Months of Age has Increased from 22% in 2019 to 26% in 2022**
- **Georgia's Nationwide On-Time Early Intervention Enrollment Ranking Has Improved by 8 points since 2019 moving from #38 to #30**
- **DHH Literacy Proficiency in 3rd Grade Decreases by 3% in School Year 2021-22:** DHH students in Georgia continue to exhibit increases in 3rd grade reading achievement with post-pandemic achievement levels continuing to show improvement over pre-pandemic levels.
- 23 of the 120 students (19%) currently enrolled in special education with a primary eligibility of DHH were reading on grade level according to Grade 3 Milestones English Language Arts (ELA) assessment for the 2021-22 school year.
- **SendSS 7-Day Reporting Compliance Has Improved from 59% in 2019 to 72% in 2022**
- **Number of Infants Served by Teleaudiology has Doubled from 2021 to 2022**
- **$10,000 GaCDHH Grant Allocation:** A $10,000 grant was received by the Georgia Commission for the Deaf or Hard of Hearing from the McGowan Charitable Foundation.
- **One New Appointment to the GaCDHH**
- **Continued Increase in Cross Agency Collaboration:** DPH and the GaDOE began monthly meetings after the publication of the Year 3 Annual Report. These meetings have continued and have greatly improved communication, synergy, program improvement, and most importantly, child and family outcomes.

Rationale for Report and Legislative Charge

On May 8, 2018, HB 844 was signed into law as Act 462 and amended Chapter 1 of Title 30 of the Official Code of Georgia Annotated (OCGA) by revising Code Section § 30-1-5. This legislation was sponsored by Representative Penny Houston and former Senator P.K. Martin, both longtime advocates for Georgia's DHH community. The revisions stipulate ten key deliverables listed below which aim to improve the language and literacy outcomes for Georgia's children who are DHH. One of the key deliverables required by this legislation is for the GaCDHH to deliver a report to the governor and General Assembly annually to measure progress towards age-appropriate language and literacy outcomes for children who are DHH:

> *A report detailing the provision of early intervention (EI) and school-age services and the language and literacy outcomes for children who are Deaf or Hard of Hearing between the ages of birth and eight years shall be completed on or before September 1, 2019, and a similar report shall be completed on or before September 1 every year thereafter. Such report shall be jointly authored by the Department of Public Health (DPH), the Department of Early Care and Learning (DECAL), and the Department of Education (GaDOE) and approved by the commission (GaCDHH) and the advisory committee. The commission shall make the report available to the public on its website and present this report to the governor and General Assembly no later than September 15, 2019, and every September 15 thereafter.*
>
> OCGA § 30-1-5 (h)

Below are the key deliverables and their status as stipulated by OCGA § 30-1-5.

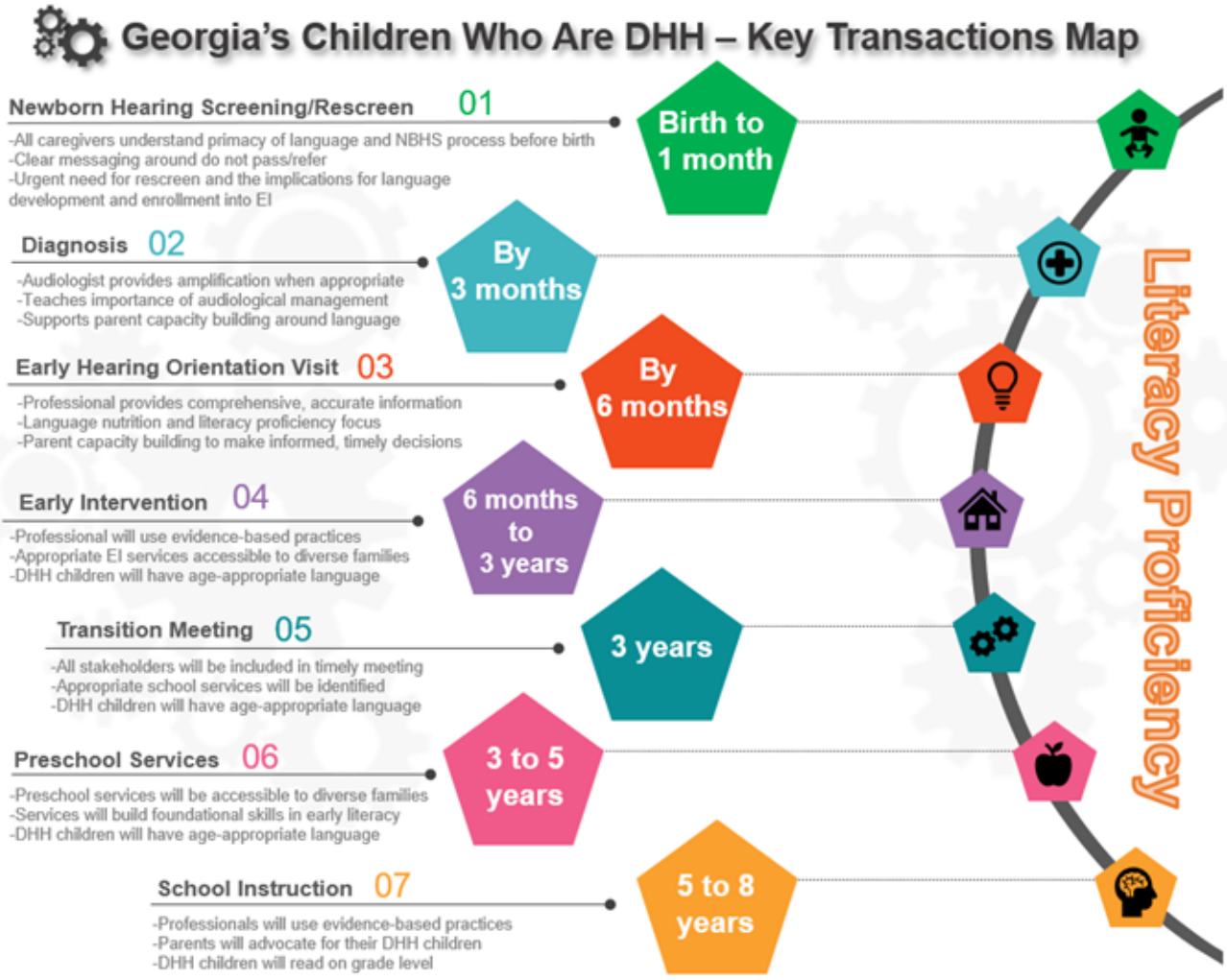
OCGA § 30-1-5 Deliverable	OCGA § 30-1-5 Reference	Status
1. Changes to the GaCDHH	(b)(1)(A)	Complete
2. Establishment of Multi-Agency Task force	(c)(1) through (4)	Complete
3. Establishment of Stakeholder Advisory Committee	(d)(1) through (3)	Complete
4. Georgia Testing Identifier (GTID) process and implementation	(g)(1) and (2)	From August 2018 to July 2023, 1,706 GTIDs have been assigned to infants identified with permanent hearing loss. Data sharing agreements among programs and state agencies are in development to ensure the assigned GTID number is included in all birth to literacy transitions.
5. Web and print based parent/professional resource	(e)(2)	Complete. See https://dhhpathways.georgia.gov.
6. Create List of Developmental Milestones	(e)(1)	Language Developmental Milestones for Spoken Language (English), American Sign Language (ASL), and Print were created by the GaCDHH Stakeholder Advisory Committee (SAC). A parallel document from the state of Indiana will be used to modify and finalize the milestones created by the SAC.

OCGA § 30-1-5 Deliverable	OCGA § 30-1-5 Reference	Status
		These milestones will be published on the GaCDHH website at https://dhs.georgia.gov/gacdhh and will be made publicly available on the DHH website provided by OCGA §30-1-5 (e)(2) at https://dhhpathways.georgia.gov during the 2023-24 school year.
7. List and Implementation of Biannual Language and Literacy Assessments	(e)(3)	American Sign Language (ASL) assessments are now available statewide to all DHH children from birth to 3rd grade. • Visual Communication Sign Language Assessment (VCSL) – A cohort of 4 Deaf Assessors were trained to administer and score the VCSL for DHH children aged 0-5 years. This is an observational checklist of developmental milestones for prelinguistic behaviors as well as receptive and expressive sign language. • American Sign Language Expressive Skills Test (ASL-EST) – A cohort of 10 assessors (i.e., 8 Deaf and 2 hearing) was trained to administer and score the ASL-EST for DHH children aged 4-13 years. This is a standardized test normed on Deaf children with age appropriate ASL. • The ASL-EST has been administered in the following counties/schools: o White County o Habersham County o Floyd County o Brooks County o Marietta City Schools o Cobb County o Clarke County – NEGA RESA o Glynn County o AASD – All students o GSD – All students Spoken Language Assessments will be targeted in the 2023-24 school year.
8. Development and Implementation of an Individualized Child Report (birth to literacy)	(e)(4)	In Progress. A database is being created by the State Schools' Outreach Program with assistance from the DOE's Technology Services Department. This database will be the data source for a future implementation of an individualized child plan and will include key transactions at the child level including Milestones data so that additional intervention can be provided to children who are not meeting critical transactions towards age-appropriate language and literacy.

OCGA § 30-1-5 Deliverable	OCGA § 30-1-5 Reference	Status
9. Interagency Collaboration, Provision of Seamless Services and Data Sharing from birth through high school graduation	(g)(1)	Representatives from DPH and the DOE have been and will continue to meet monthly to focus on diagnoses and EI enrollment progress among other items such as Georgia's high hospital referral rate.
10. Annual Legislative Report	(h)	Complete

Key Transactions for Children who are DHH

The transaction map below provides guidance for families on their journey from birth to literacy. Seven key transactions are identified based on best practices (as determined by the Joint Committee on Infant Hearing (JCIH), the Centers for Disease Control (CDC), DPH, DECAL, and the GaDOE and are presented in chronological order along with a brief description of what should occur within each transaction as well as the critical period for completion.[1] [2] [3] If the state ensures every child who is DHH can complete these transactions in a timely and coordinated manner, Georgia's children who are DHH will be able to achieve proficient language and literacy skills in significantly greater numbers.



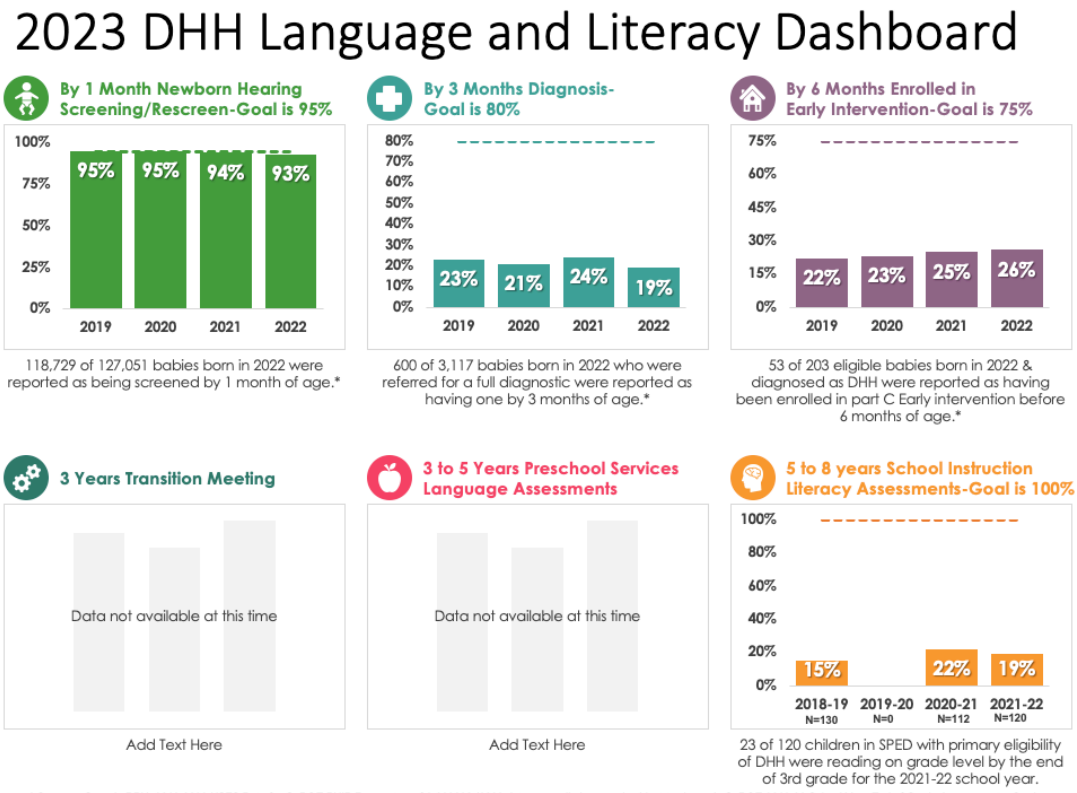
[1] Hugh W, C., Fey, M. E., & Proctor-Williams, K. (2000). The relationship between language and reading: Preliminary results from a longitudinal investigation. Logopedics Phoniatrics Vocology, 25(1), 3–11. https://doi.org/10.1080/140154300750045858

[2] Easterbrooks, S. R., Lederberg, A. R., Miller, E. M., Bergeron, J. P., & McDonald Connor, C. (2008). Emergent Literacy Skills During Early Childhood in Children with Hearing Loss: Strengths and Weaknesses. The Volta Review, 108(2), 91–114. https://doi.org/10.17955/tvr.108.2.608

[3] Dickinson, D. K., McCabe, A., & Essex, M. J. (2006). A window of opportunity we must open to all: The case for preschool with high-quality support for language and literacy. Guilford Press.

The 2023 DHH Language and Literacy Dashboard

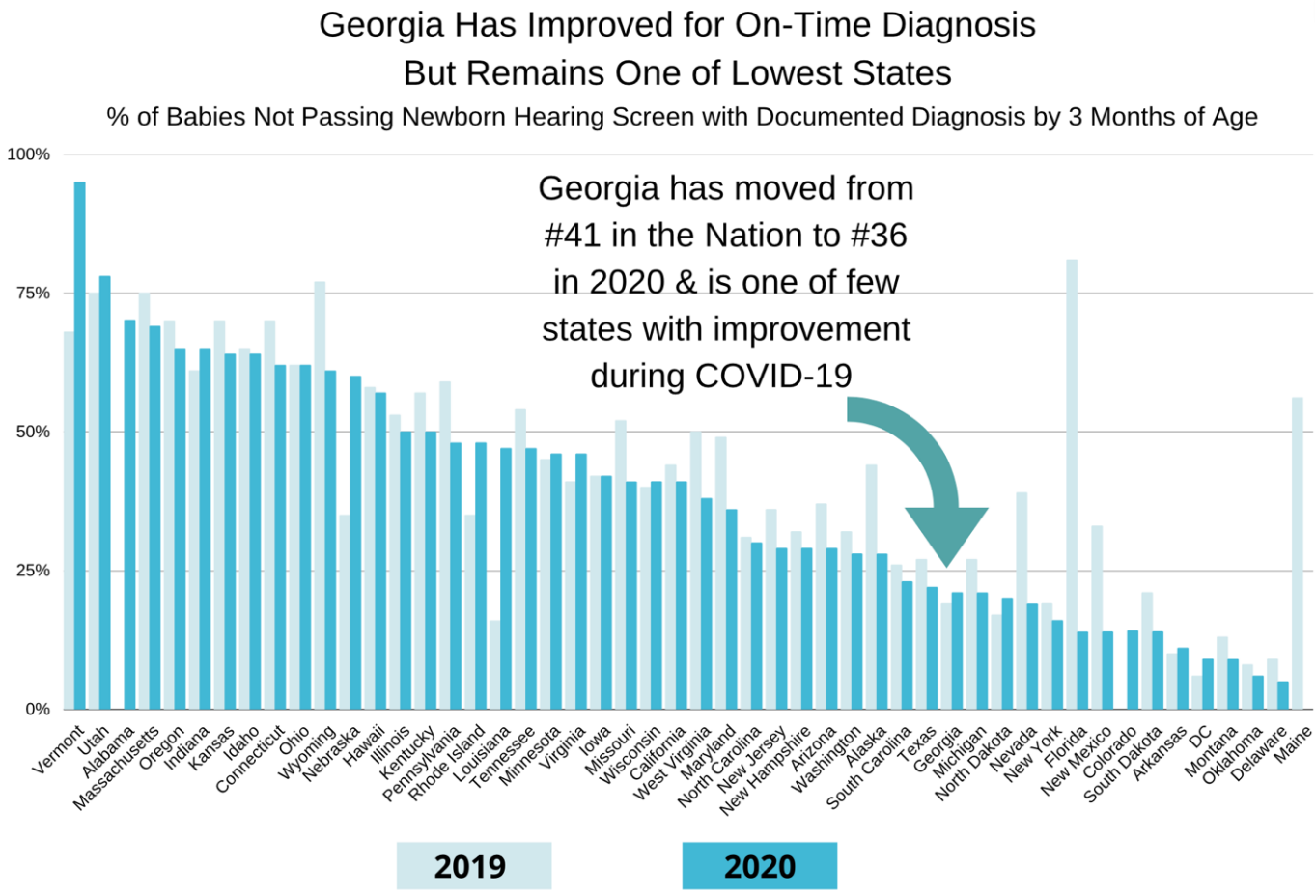
In the 2019 Annual Report, the authors developed the DHH Language and Literacy Dashboard. This dashboard was designed to determine the current state of language and literacy outcomes and to measure progress towards age-appropriate language and on-grade-level literacy. The current dataset in this report includes data for 2019, 2020 and 2021 provided by DPH and the GaDOE. 2022 Georgia DPH EHDI data are reported as preliminary as children born in 2022 are still actively being followed by District EHDI Coordinators. Follow up for infants born in 2022 does not end on December 31, 2022, but continues well into 2023. For example, a child born on December 31, 2022, has until January 31, 2023, to meet the 1-month screening benchmark; March 31,2023, to meet the 3-month diagnostic benchmark, and June 30, 2023, to meet the 6-month EI enrollment benchmark, assuming the EHDI 1-3-6 benchmarks are met in a timely manner and are documented in the SendSS database. In addition, early intervention data below represent enrollment only for Individuals with Disabilities Education Act (IDEA) Part C Early Intervention (i.e., Babies Can't Wait) and does not include data for other EI providers in the state such as Georgia PINES. As these numbers are under reported, they are likely understated. While newborn hearing screening results are positive and close to meeting the EHDI 1-month benchmark, all other indicators are still well below national JCIH benchmarks and the Get Georgia Reading campaign's goal to have every child in Georgia on the path to reading proficiency by the end of 3rd grade.



Annual Progress Detail

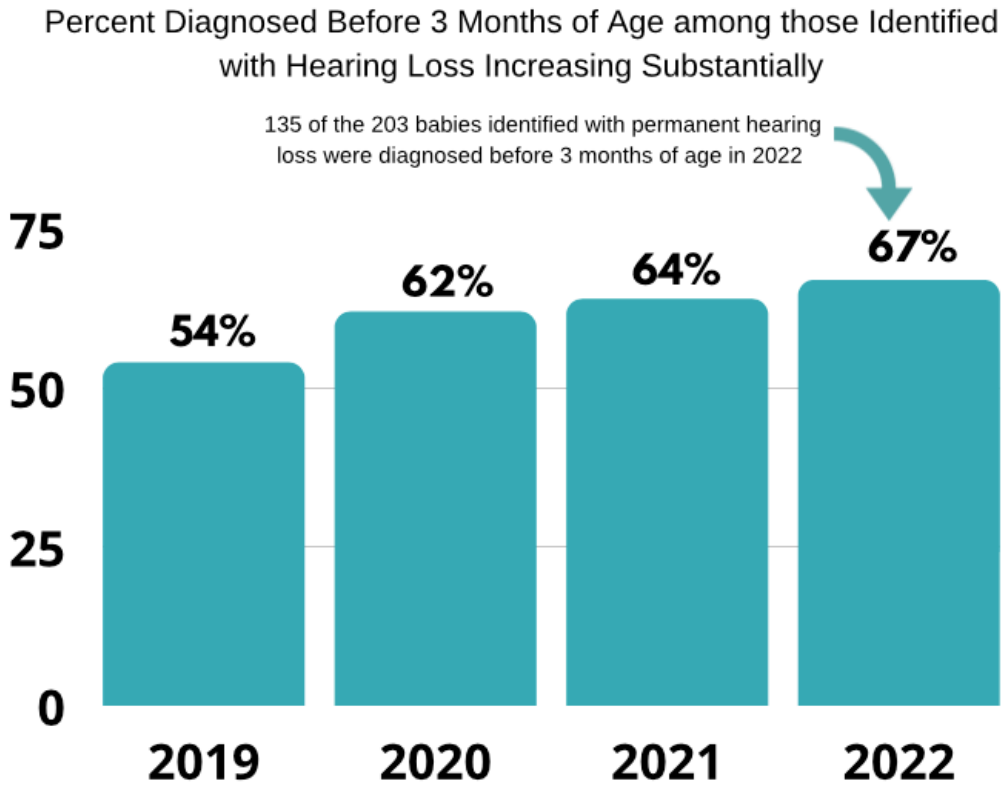
Georgia's Diagnostic Ranking in the U.S. Improves – Leapfrogging 5 States

While Georgia remains in the bottom third of the nation in terms of on-time documented diagnosis, it has leapfrogged five states moving from #41 in the nation to #36. This is considerable improvement over the course of 12 months. In addition, Georgia was one of very few states to show improvement during the COVID-19 pandemic. While there is certainly room for continued improvement, Georgia should be commended for this achievement.



Source: 2020 CDC EHDI Hearing Screening & Follow-up Survey (HSFS). Includes cases of normal hearing and hearing loss. Alabama and Mississippi did not report in 2020.

This improvement is also reflected in state level data provided by the Georgia Department of Public Health. Over the past four years there has been a substantial increase when looking at children who are identified with permanent hearing loss annually. In 2019, 54% of the babies who were identified with permanent hearing loss were identified by 3 months of age, meeting the 3-month diagnostic benchmark. This has increased by 13 points over the past 4 years. This is a huge milestone and reflects the diligent work of the Early Hearing Detection and Intervention Program – especially during pandemic years.



Source: Georgia Department of Public Health; 2019-2022 HSFS Data for GaDOE PHIP Request as of 8-29-2023. 2022 Data Preliminary.

The Diagnostic Referral Rate and DPH EHDI Birthing Facility Compliance Enhancement Project

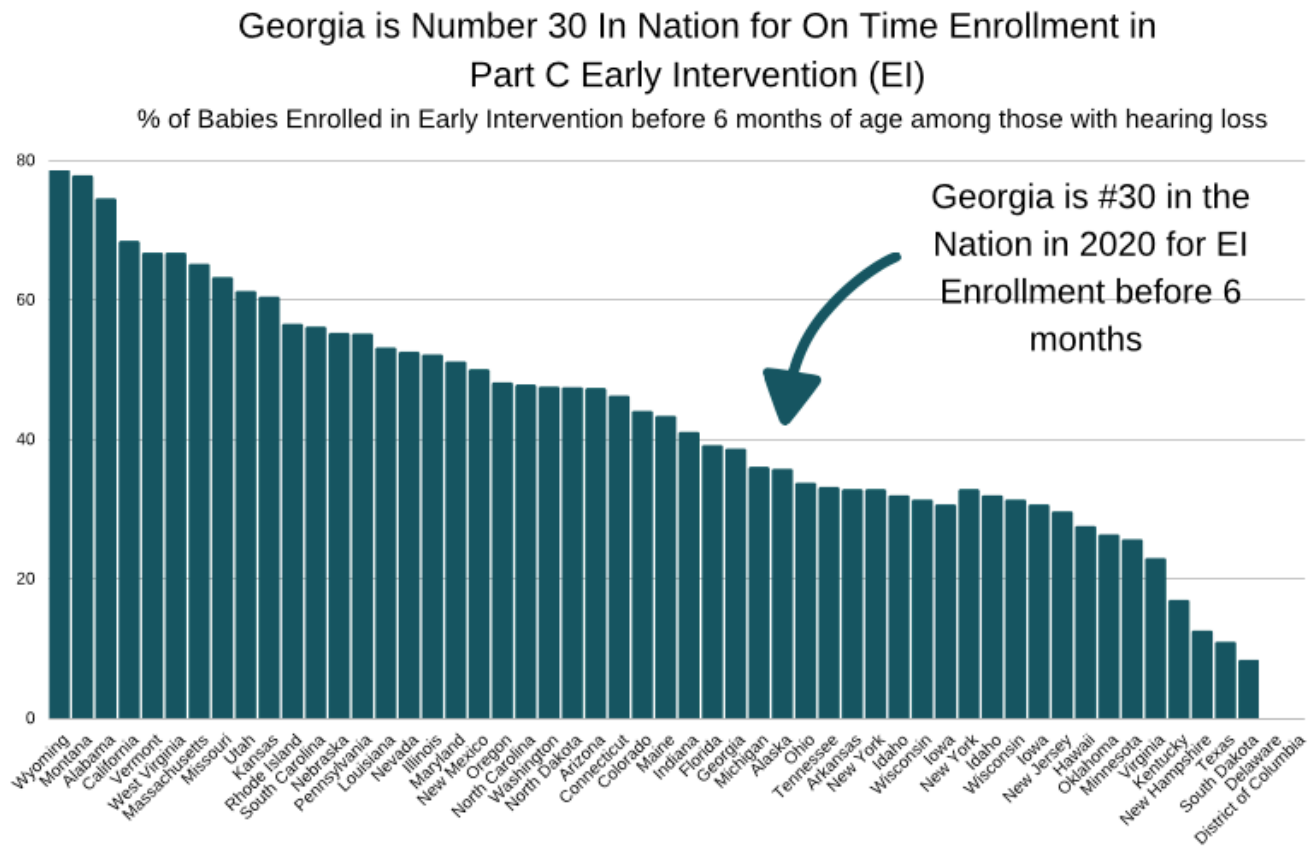
In last year's annual report, the authors noted that the number of babies referred for follow up diagnosis is increasing year over year. In recent years, the number of referrals has increased from 2,510 in 2019 to 3,117 in 2022. This year, DPH has investigated whether potential hospital over-referrals have contributed to a lack of progress with regards to on-time diagnostic rate. As aptly put by Mackey et al. (2022), "Systematically high referral and loss-to-follow-up rates reduce the effectiveness of newborn screening programs, as more infants with normal hearing are referred and fewer infants with permanent hearing loss are detected."

Maintaining a newborn hearing screening refer rate of <4% is crucial to prevent undue stress on families and healthcare resources. As of 2021, a significant proportion of Georgia's birthing facilities reported referral rates surpassing the recommended threshold, with some even reaching rates of up to 23%. The geographical distribution of these high referral rates revealed a concentration in rural regions, compounding the challenges for families who already have limited access to audiologists in these areas. Further investigation highlights the crucial role of audiologists within the Newborn Hearing Screening Program. However, most rural birthing facilities lack audiologist involvement due to the scarcity of available professionals in those areas.

DPH 'EHDI Birthing Facility Compliance Enhancement' project plan aims to improve newborn hearing screening quality and hospital reporting consistency around the State by providing audiology assistance to birthing facilities that lack access to an audiologist or require additional support. The project's phases include strengthening expertise by hiring a Child Health Audiologist to establish direct communication with hospitals, collect and monitor hospital reporting data, provide tailored training and ongoing technical support to hospitals, and measure progress while collaborating with the EHDI Program. Key outcomes include achieving decreased referral rates and streamlining the reporting process for improved data integrity. Through expert resources, data analysis, and collaborative efforts, this strategic project contributes to advancing EHDI compliance and ultimately improving access to on-time infant hearing diagnosis.

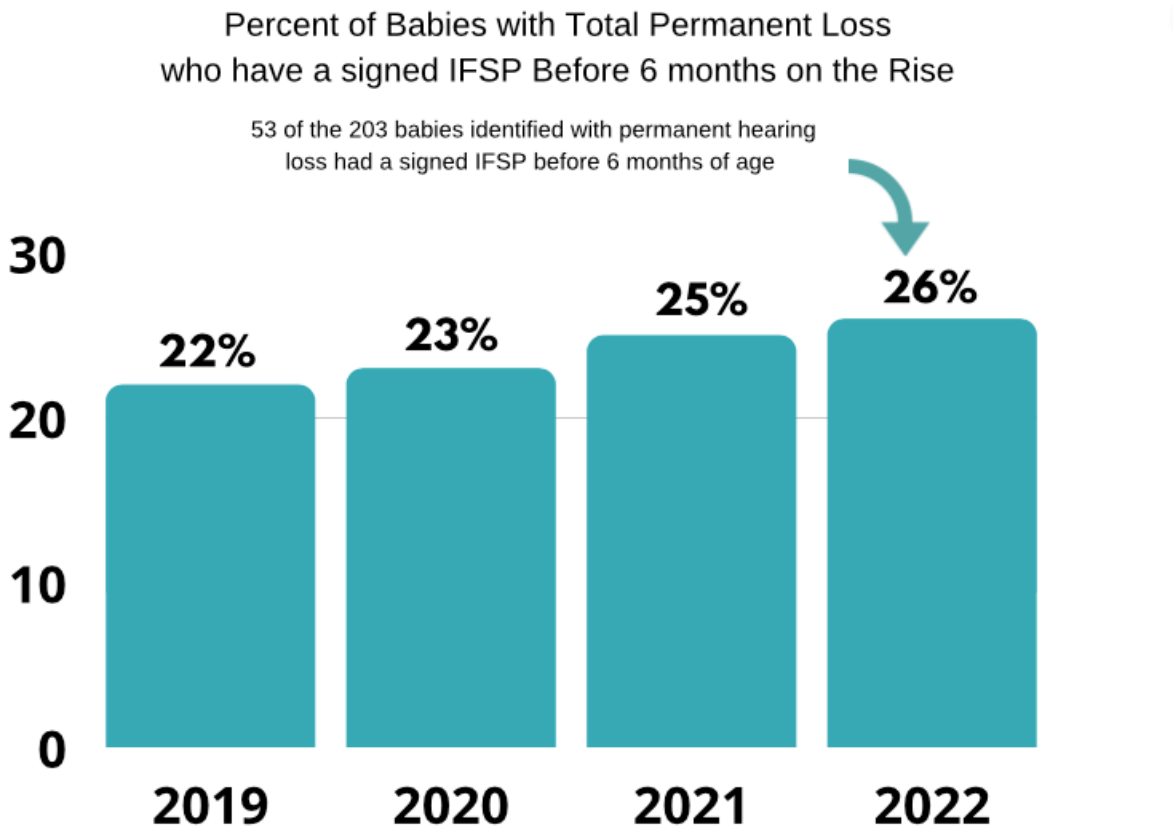
Georgia's Early Intervention Rankings – Improvement of 8 points since 2019

While most recent years' reports have focused on diagnostic rates in the state, this year's report will begin to expand focus on the early intervention (EI) landscape in the state. Future reports will begin to study language outcomes for various EI providers. Today, according to the CDC, Georgia ranks #30 in terms of on-time enrollment into Part C EI (by 6 months of age) per JCIH's 1-3-6 guidelines. While this is higher than Georgia's diagnostic ranking, it still places Georgia in the bottom half of the U.S. However, Georgia's ranking was #38 in 2019 and has risen to #30 in 2020 – an 8-point improvement which is a tremendous gain in one calendar year. Note that these data do not include enrollment in non-Part C EI (Georgia PINES), which is the main EI provider for Georgia's children who are DHH.



Source: 2020 CDC EHDI Hearing Screening & Follow-up Survey (HSFS).

Statewide data also indicate that there has been a slow but steady improvement with on-time enrollment into Part C early intervention with a total increase of 4 points since 2019. The authors recommend periodic communications between the EI providers in the state to begin to understand underlying issues contributing to the overall low enrollment rates for children who are DHH.



Source: Georgia Department of Public Health; 2019-2022 HSFS Data for GaDOE PHIP Request as of 8-29-2023, 2022 Data Preliminary.

The Early Intervention Landscape in Georgia

The current EHDI guidelines state that infants should obtain a hearing screening by 1 month of age, receive an audiologic diagnosis by 3 months of age, and enroll in early intervention (EI) services by 6 months of age. Previous studies have shown that children with hearing loss who promptly begin EI following a screening and diagnosis of hearing loss attain better language outcomes.[4] [5] [6]

Because babies who are born with hearing loss do not receive and interpret auditory and linguistic stimuli as well as normal hearing infants, they often experience delays in their speech and oral language acquisition skills.[7] EI programs aim to minimize these delays by providing infants with hearing loss (and their families) with interventions and tools that focus on accessing linguistic stimuli and increasing overall communication skills. When children with hearing loss begin early intervention services before 6 months of age, they are more likely to develop and maintain age-appropriate language skills by 5 years of age. Therefore, meeting EHDI's 6-month early intervention guideline minimizes the negative effects that a hearing loss diagnosis may have on one's communication abilities later in life.

The critical importance of having every baby identified with hearing loss (HL) enrolled into EI by 6 months cannot be overstated. In fact, recent studies show that entering EI by 6 months of age is the only unique predictor of spoken language outcomes among children with HL. One study showed that 100% of the early diagnosed children achieved age-appropriate language outcomes by 5 years of age.[8] Another study also showed that children with HL in earlier-enrolled intervention groups achieved vocabulary scores that approximated peers with normal hearing (Moeller, 2000). It could be argued that if every baby in the state identified with hearing loss were enrolled in quality EI by 6 months of age there would not be a literacy epidemic among DHH children in Georgia.[9]

State data show improvement with regards to enrollment into Part C EI by 6 months of age with 53 out of 203 (26%) babies identified with hearing loss being enrolled within the recommended timeline. However, this still falls far behind the goal of 75%. A combined focus on both diagnostics and early intervention is critical in order to realize a meaningful improvement in language and literacy outcomes for children who are DHH. For example, it would be helpful to understand the average length of time between diagnosis and EI enrollment, and these data will be requested for next year's report. In order to better understand EI service provision, the authors fielded a survey to known EI providers in the state. Not all recipients completed the survey, but the results below are from the largest four providers in the state and representative of most EI services available.

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[4] Meinzen-Derr, J., Wiley, S., & Choo, D.I. (2011). Impact of early intervention on expressive and receptive language development among young children with permanent hearing loss. *American Annals of the Deaf,* 155, 580-591. https://doi.org/10.1353/aad.2011.0010

[5] Moeller, M.P. (2000). Early Intervention and language development in children who are deaf and hard of hearing. *Pediatrics, 106,* Article e43. https://doi.org/10.1542/peds. 106.3.e43

[6] Vohr, B., Jodoin-Krauzyk, J., Tucker, R., Topol, D., Johnson, M. J., Ahlgren, M., & St Pierre, L. (2011). Expressive vocabulary of children with hearing loss in the first two years of life: Impact of early intervention. *Journal of Perinatology, 31,* 274-280. https://doi.org/10.1038/jp.2010.110

[7] Cole, E.B., & Flexer, C. (2016). *Children with hearing loss: Developing listening and talking, birth to six* (3rd ed.). Plural Publishing.

[8] Fulcher, A., Purcell, A.A., Baker, E., & Munro, N. (2012). Listen up: Children with early identified hearing loss achieve age-appropriate speech/language outcomes by 3 years-of-age. *International Journa of Pediatric Otorhinolaryngology, 76,* 1785-1794. https://doi.org/10.1016/j.ijporl.2012.09.001

[9] Excerpt from Grey, Brittany, Deutchki, Elizabeth K., Lund, Emily A., & Werfel, Krystal L. (2021). Impact of Meeting Early Hearing Detection and Intervention Benchmarks on Spoken Language. *Journal of Early Intervention.*

Auditory Verbal Center (AVC)

The Auditory Verbal Center (AVC) is a nonprofit that teaches DHH children to listen and speak without the use of sign language. The AVC serves children and families, young adults, and seniors throughout Georgia.

The AVC provides early intervention through a family education model as studies have shown therapy to be more effective when parents are involved. Families receiving early intervention attend 1-hour weekly sessions with their child for 2 or more years. The AVC serves DHH children with and without additional disabilities. Age-appropriate expressive and receptive language are the goals for all children in the program; individual language evaluations are completed every six months. The AVC early intervention program serves on average 150 children annually with 94 attending virtually via teletherapy. 58% of the children served have additional disabilities and 65% qualify for Medicaid. The AVC provides financial aid or scholarships to 70% of their families. Additionally, the AVC aural rehabilitation program serves on average 27 children annually; these children are typically 14 years of age and older.

The AVC accepts Medicaid and various other health insurances such as all CMOs, Tristate and both private and commercial insurance. The AVC employs therapists who are Speech-Language Pathologists (SLPs) with additional certification in Listening and Spoken Language/Auditory Verbal Therapy (LSL/Cert. AVT). The AVC offers SLPs who are working towards their LSL/Cert. AVT the opportunity to earn clinical hours while working under the mentorship of certified staff. The AVC employs an audiologist who provides audiological support, hearing aid fitting and support, and cochlear implant mapping. The AVC houses and manages DPH's Loaner Hearing Aid Bank which provides hearing aids to Georgia children aged birth to 3 years of age for 6 months to 1 year.

The Katherine Hamm Center (KHC)

The Katherine Hamm Center (KHC) at the Atlanta Speech School is a program for children who are DHH and their families. The KHC offers full day, preschool programming for children 14 months of age through PreK. Approximately 50 children are enrolled in the KHC's preschool program. Preschool Programming is tuition-based, and financial aid is available for both preschool services and auditory verbal therapy (AVT).

The KHC also offers 1-hour weekly Auditory-Verbal Therapy sessions for children of all ages with the majority of students being 1 to 8 years of age. The KHC serves approximately 55-75 children annually with 14 participating remotely via telehealth. Roughly 25% of children have additional disabilities, and 43% of AVT families benefit from Medicaid. The KHC accepts Medicaid, CMOs, and Aetna and Blue Cross Blue Shield for AVT services.

The KHC employs licensed LSL/AVEd and AVT therapists, Teachers of the Deaf/Hard of Hearing, Occupational Therapists, Speech-Language Pathologists, Special Educators, Preschool Counselors, and Educational Audiologists. The KHC program provides LSL/AVT therapies, IFSP development support and IFSP/IEP transition support. The Atlanta Speech School also provides the following services available to DHH children enrolled in their program: speech-language therapy, occupational therapy, audiological services, hearing aid fitting and support, cochlear implant mapping, and tutoring.

The KHC conducts language evaluations on children every 6 months in both their preschool and AVT programs.

Georgia Parent Infant Network for Educational Services (Georgia PINES) – GaDOE

Georgia PINES is a division of the GaDOE and is an early intervention program that specializes in serving families whose children are blind and/or DHH. Georgia PINES is a part of the State Schools Division of the Georgia Department of Education, and their services are provided completely free of charge to all eligible families. Services include in-home and/or virtual visits to families which focus on language development for the child and information and empowerment for the family. Georgia PINES sees 260 children annually, and roughly 50% of these children have additional disabilities. 130 children attend sessions via telehealth. Georgia PINES also completes language evaluations and is open to sharing data for future reports.

Babies Can't Wait (BCW) – Georgia DPH

Babies Can't Wait (BCW) is a program within DPH and is Georgia's Part C EI program that offers a variety of coordinated services for infants and toddlers with special needs, including unilateral or bilateral hearing loss, from birth to three years of age and their families. Eligible children and their families receive a minimum of four service coordination visits each calendar year. In addition, families may receive weekly services such as special instruction, occupational therapy, physical therapy, and speech-language therapy as determined by the child's individual needs identified in the Individualized Family Service Plan (IFSP). BCW interventionists work with a wide range of children with disabilities and are not specifically trained to work with children who are DHH. BCW refers children with sensory disabilities (i.e., DHH, DeafBlind (DB), Vision Impairment (VI), DHH with other disabilities, and VI with other disabilities) to the above-mentioned Georgia PINES. Georgia PINES provides additional services and Deaf Mentor services specific to the unique needs of a child who is DHH. BCW saw 280 DHH children from 0 – 36 months of age during the 2022 calendar year. Of these enrolled children, 63% were screened by one month of age, 75% diagnosed with HL by 3 months of age and 71% enrolled in their services by 6 months of age. Twenty-one percent (21%) of these children qualified for Medicaid. BCW provides IFSP services, nursing services, occupational therapy, physical therapy, service coordination, special instruction and speech-language pathology. A higher percentage of children who are enrolled in BCW are meeting the JCIH's 1-3-6 milestones as compared to the total population of children identified with hearing loss. The authors hope to better understand this discrepancy.

Below are results of the survey contrasting the programs above. Also, it should be emphasized that each of the programs provide unique service offerings. Many DHH children are enrolled in multiple programs. For instance, it is not uncommon for child enrolled at the KHC or the AVC to also be receiving services from both BCW and Georgia PINES as well.

2023 Early Intervention Survey Results

EI Provider	Public/ Private	# DHH Children Served Annually (birth to 3)	% with Additional Disabilities	Service Times	Telehealth Clients	% Receiving Financial Aid	% on Medicaid	LSLT or AVT Licensed Therapists
Auditory-Verbal Center	Private	106	58%	1 hr/wk	94	70%	65%	Yes
Katherine Hamm Center	Private	56	25%	Preschool - 2 to 5 days/wk AVT - 1 hr/wk	14	40%	40%	Yes
Georgia PINES	Public - GaDOE	260	50%	1 hr/wk	130	NA - No Cost	Not Available	No
Babies Can't Wait	Public - GA DPH	280	Not Available	Not Available	Not Available	Family Cost Participation	21%	No

Auditory-Verbal Therapy Provision in the State of Georgia

Auditory Verbal Therapy (AVT), also known as Listening and Spoken Language (LSL) therapy, is a specialized, evidence-based approach to helping individuals with hearing loss, particularly children, develop spoken language and communication skills. This therapeutic method focuses on maximizing a child's listening abilities and encouraging the development of clear and natural speech using hearing technology like cochlear implants or hearing aids. LSL/AVT therapists work closely with families to empower them with the knowledge and techniques needed to create a rich auditory environment for the child, emphasizing active listening and spoken language development. By promoting early intervention and intensive auditory training, AVT/LSL aims to help children who are DHH reach their full potential in oral communication.

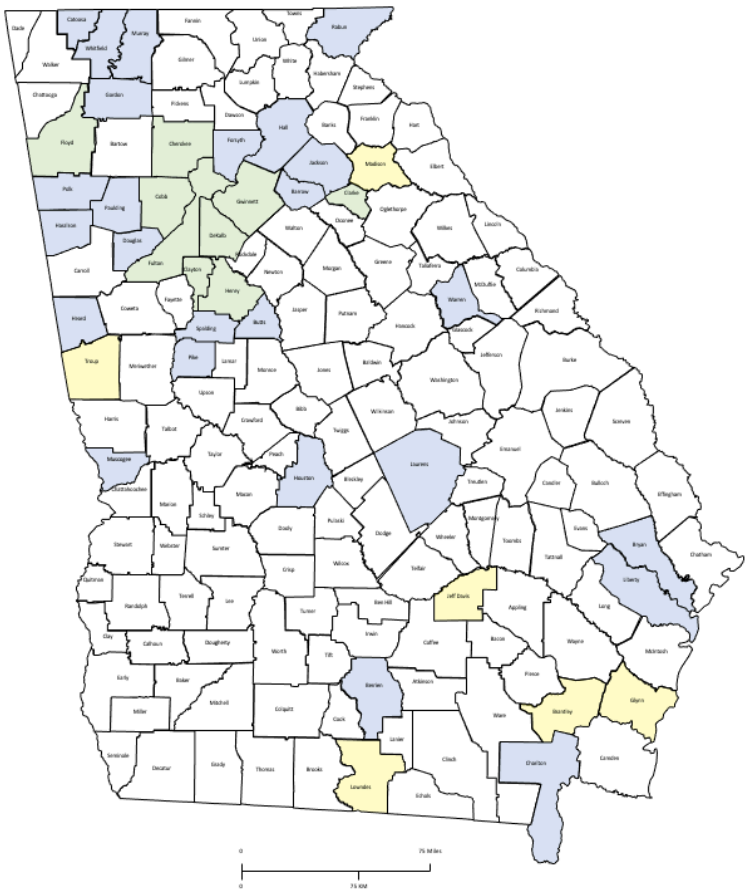
Only two private providers in the state provide AVT / LSL services to children who are DHH. Based on survey responses, it does not appear that either service is provided via state programs with professionals licensed as LSL/Cert. AVT or LSL/Cert. AVed therapists. The Katherine Hamm Center at the Atlanta Speech School is located in Fulton County and operates both as a traditional preschool providing LSL classroom instruction 3-5 days a week as well as an outpatient clinic providing AVT/LSL one time per week. The Auditory Verbal Center has physical locations in both DeKalb and Bibb counties and operates exclusively as an AVT/LSL clinic seeing patients one time per week. Both private practices focus exclusively on teaching children who are DHH to develop listening and spoken language with the aid of hearing amplification such as hearing aids or cochlear implants. Children who are enrolled before six months of age typically develop listening and spoken language outcomes similar to their hearing peers.

2022-2023 Auditory-Verbal Therapy Provision

Katherine Hamm Center & Auditory-Verbal Center

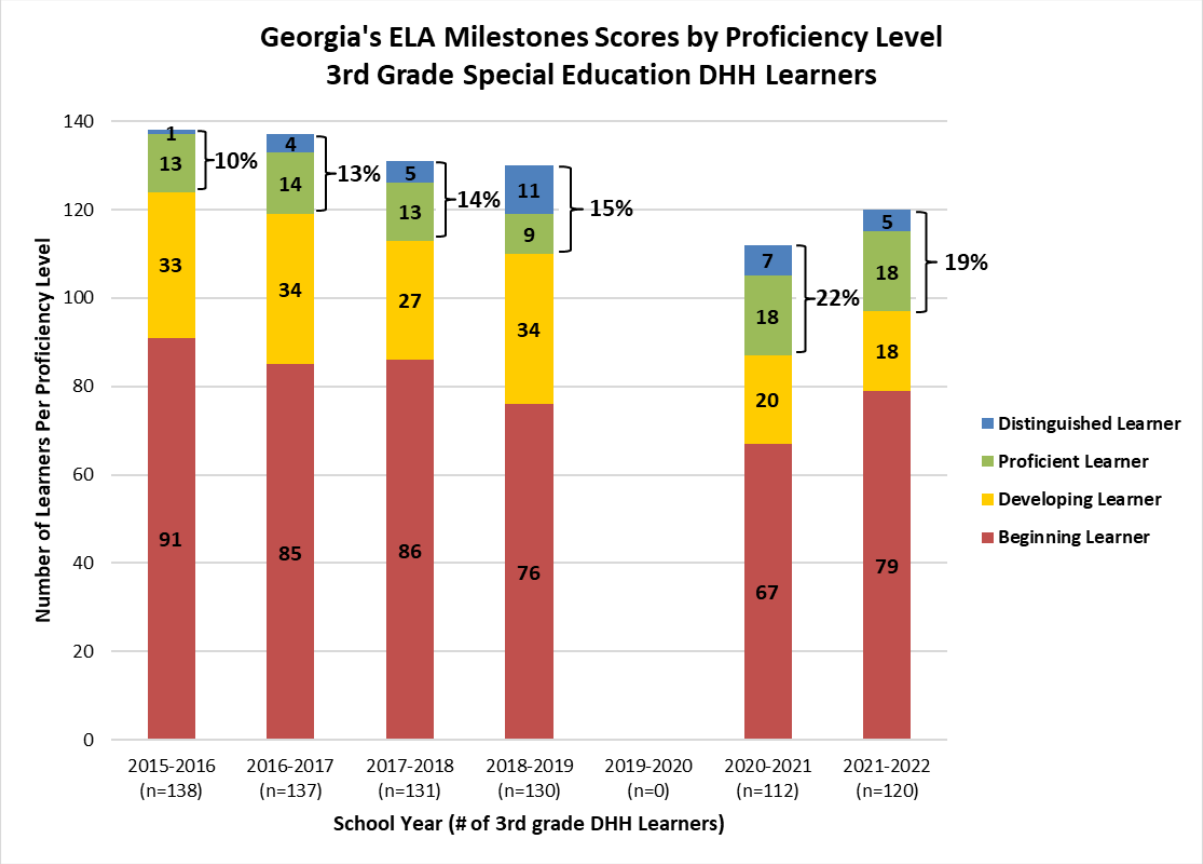
Katherine Hamm Center

Auditory Verbal Center



DHH Literacy Proficiency Improvement in 3rd Grade Holds Steady

In the 2021-22 school year, 19% of Georgia students in special education with a primary eligibility of DHH read proficiently at the end of grade 3 (see Georgia ELA Milestones graph below). While this represents a 3% decrease from school year 2020-21, it is important to note that the number of students reported as taking the Milestones ELA assessment in 2020-21 was significantly lower than any other reported year; the smaller sample size likely slightly inflated the achievement percentage reported in school year 2020-21. DHH students in Georgia continue to exhibit an increase in 3rd grade reading achievement – with the percentage of proficient readers doubling over the past seven years. Given the significant challenges students, families, and schools continue to face in the aftermath of the pandemic, this is a remarkable performance trend. While Georgia's DHH students have exhibited increased performance, their outcomes are still not acceptable. The Commission welcomes the State's focus on early reading instruction and assessment, parent notification of reading challenges, and required reporting of reading data for all students enrolled in grade kindergarten through 3rd (HB 538/SB211). This recent legislative effort further supports a statewide accountability framework that is necessary to ensuring each DHH child in Georgia receives a birth to literacy plan as required in § O.C.G.A. 30-1-5.



Note: 2019-2020 data unavailable due to waiver from US Department of Education for all state assessments due to COVID-19

Georgia Milestones ELA Performance for 3rd, 5th, and 8th Grade – Deaf and Hard of Hearing (DHH) Students Statewide

In an effort to address the need for continuing remediation instruction and supplementary intervention for striving readers after grade 3, future Annual Reports will include Milestones English Language Arts (ELA) Performance data for DHH students in grades 3, 5 and 8. The data displayed in the table below indicate that the majority of DHH students continue to perform well below grade level expectations throughout their middle school years. In fact, the majority of all children tested are scoring in the beginning level of their summative grade level assessment. For some DHH students, particularly those who are using two instructional languages (i.e., American Sign Language (ASL) and English), those with significant language delays, and those with multiple Special Education eligibilities), grade-level reading achievement may require several years of specialized instruction to close the achievement gap. It is important to report reading achievement data beyond 3rd grade outcomes if the state is going to effectively address the reading needs of our DHH students.

2021-22 School Year (SY22) Georgia Milestones Assessment System (GMAS)
ELA Performance by Grade

		Beginning	Developing		Proficient	Distinguished
GMAS ELA SY22 Grade 3 DHH Statewide	n=120	79 66%	18 15%		18 15%	5 4%
		Reading Below = 81%			Reading At or Above = 19%	

		Beginning	Developing		Proficient	Distinguished
GMAS ELA SY22 Grade 5 DHH Statewide	n=132	81 61%	27 20%		20 15%	4 3%
		Reading Below = 82%			Reading At or Above = 18%	

		Beginning	Developing		Proficient	Distinguished
GMAS ELA SY22 Grade 8 DHH Statewide	n=139	81 58%	42 30%		15 11%	1 1%
		Reading Below = 88%			Reading At or Above = 12%	

Service Delivery Models for DHH Students in Georgia

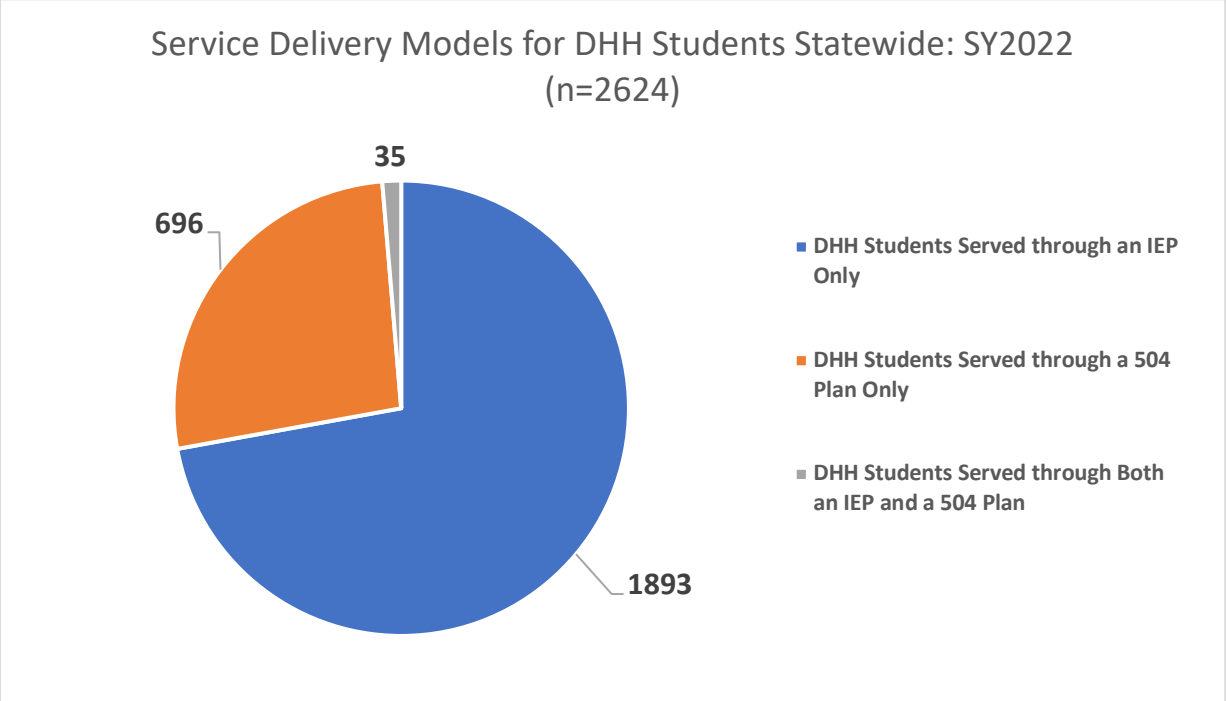
Federal legislation known as The Rehabilitation Act of 1973 guarantees certain rights to people with disabilities. A 504 Plan, named for Section 504 of the Rehabilitation Act, is a legally binding document developed at the school level in conjunction with a student's parents to customize a student's learning environment to meet their specific needs.[10] The purposes of 504 Plans are to ensure classrooms are accessible and that students with disabilities are not excluded from participating in federally funded programs, including elementary, secondary, or post-secondary schooling. Students who receive services through 504 Plans do not receive modified instruction as do students who receive services through an Individualized Education Program (IEP). Instead, 504 Plans address specific accommodations or

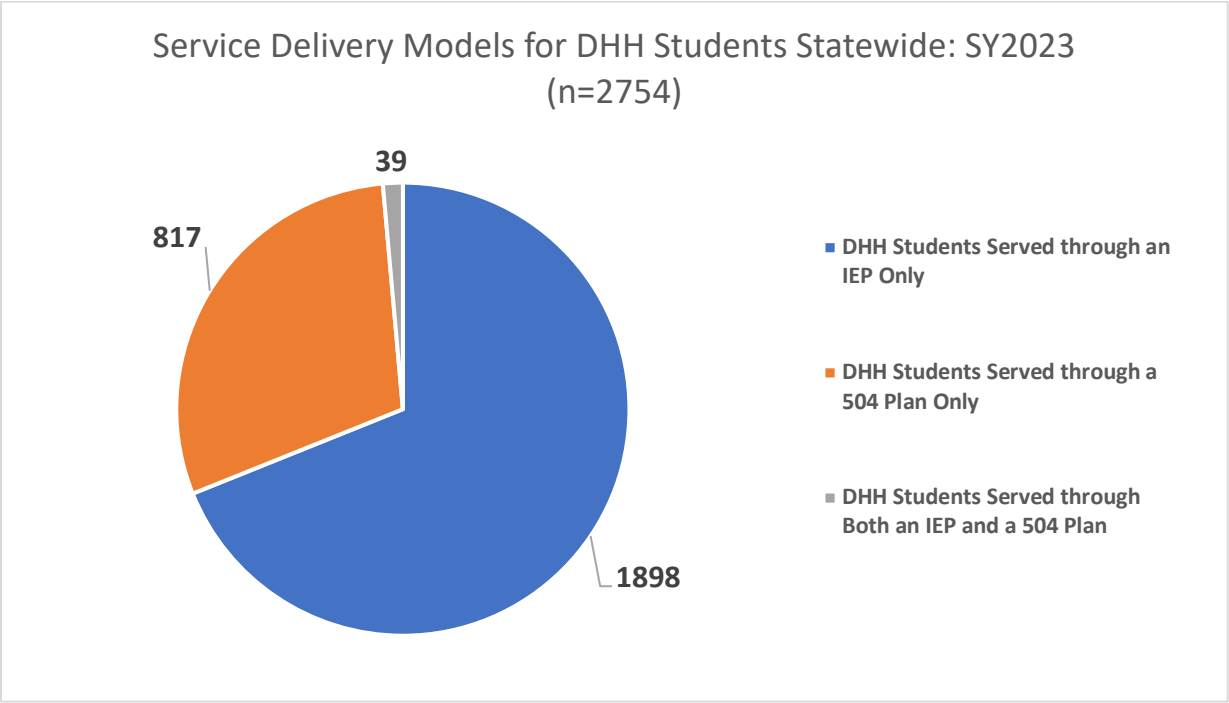
[10] Citation: U.S. Department of Education. Disability Discrimination: Overview of the Laws.

requirements that make it possible for a student to succeed in a general education program (e.g., a nut-free classroom for a child with a severe peanut allergy).

Conversely, an IEP is intended for students with specific needs who require special education services, which may include accommodations for and modifications to academic instruction and achievement expectations. IEPs were introduced in 1975 with the passage of the Education for All Handicapped Children Act (EHA) which recognized the right of students with disabilities to attend public schools. In 1990, the name of the EHA was changed to Individuals with Disabilities Education Act (IDEA). An IEP is a legally binding document that includes individualized learning objectives and goals, accommodations, modifications, and a description of an agreed-upon educational setting. IDEA requires that IEPs be designed with parental approval to meet the individualized needs of students with disabilities.

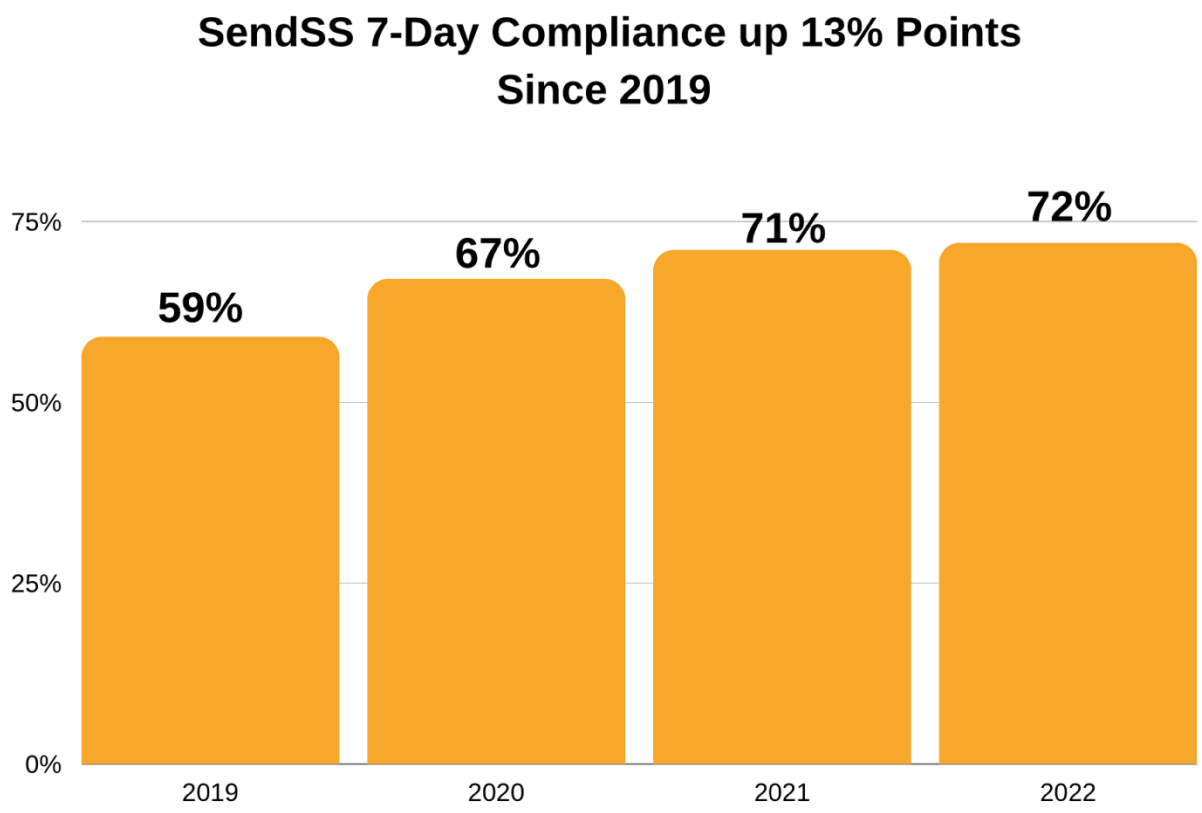
Due to recently passed legislation, Georgia schools now report the eligibility category for students receiving services through 504 Plans. The following graphs display the number of DHH students receiving services through IEPs only, 504 Plans only, and those receiving services through both an IEP and a 504 Plan. The GMAS ELA data sets presented above only include students who are served through an IEP. Based on the graph below, this likely represents approximately 70% of currently enrolled students. In future reports, the authors plan to include DHH students served by 504 plans in addition to students served by IEPs in order to provide a more accurate count of the number of DHH students in Georgia public schools and measurement of literacy outcomes. The graphs below do not include DHH students enrolled in public schools who are not served by IEPs and/or 504 Plans or those who are educated in private schools or homeschooled.




Service Delivery Models for DHH Students Statewide: SY2023
(n=2754)
39
817
1898
DHH Students Served through an IEP Only
DHH Students Served through a 504 Plan Only
DHH Students Served through Both an IEP and a 504 Plan

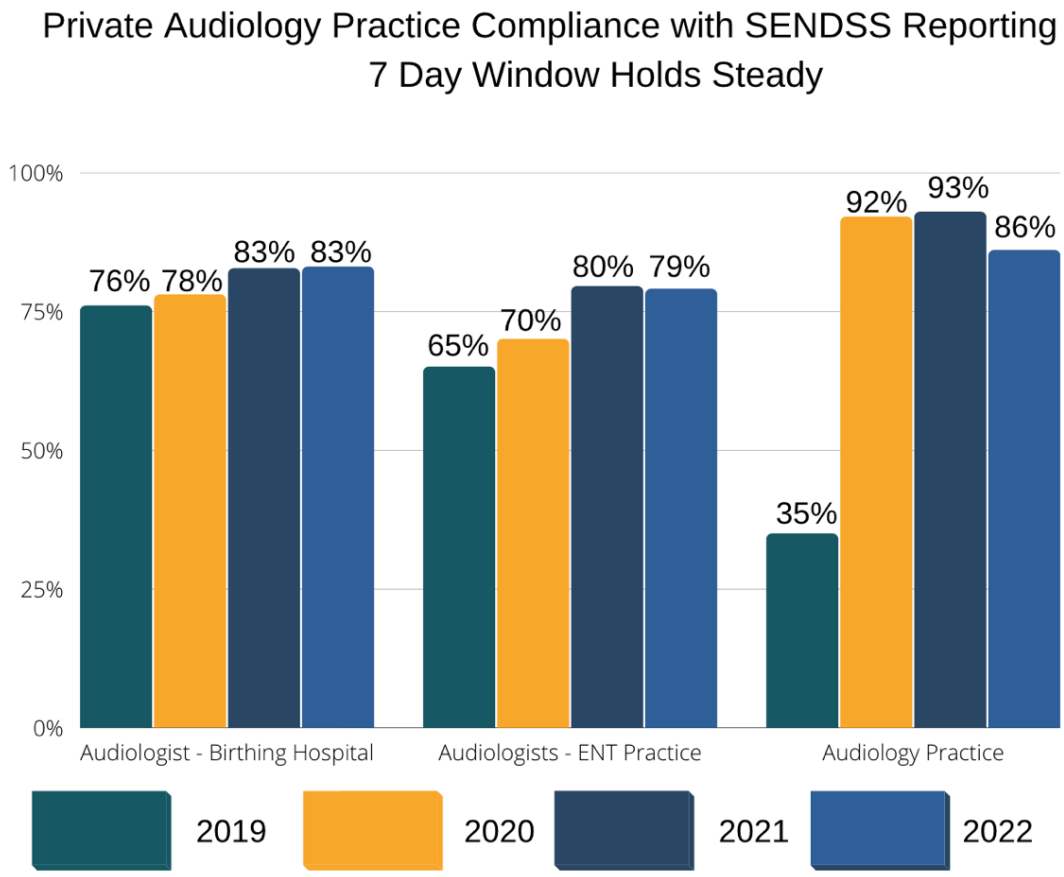
SendSS 7-Day Reporting Compliance Has Drastically Improved Over the Years

In the Year 3 Report, SendSS database reporting of children diagnosed with hearing loss non-compliance was highlighted as a critical roadblock to on-time diagnosis, identification and enrollment into early intervention services for children who are DHH. The current law requires that birthing hospitals/centers report hearing screening results on every infant. The law also requires that the results of all follow-up diagnostic hearing evaluations be reported within seven days of testing for children birth to age 5 years. The authors are pleased to report that there has been a drastic improvement in 7-day reporting compliance due to multiple collaborative interagency efforts. Overall, year over year SendSS 7-day reporting compliance has increased 13% points from 2019 to 2022.



Source: GA DPH/EHDI Reporting to SendSS as of 8-25-2023. 2022 Data Preliminary.

Compliance of audiologists in private practices continues to be a driving force behind SendSS compliance and reflects cross-agency efforts to educate audiologists on how to sign up and use the SendSS audiology portal as well as the law requiring reporting within 7 days. In fact, the 7-day compliance window for reporting children who are DHH among private audiologists has more than doubled from 2019 to present. In addition, for these practices, the median number of days from 1st diagnosis to reporting in SendSS is just 1 median day – well below the 7-day mandated window.



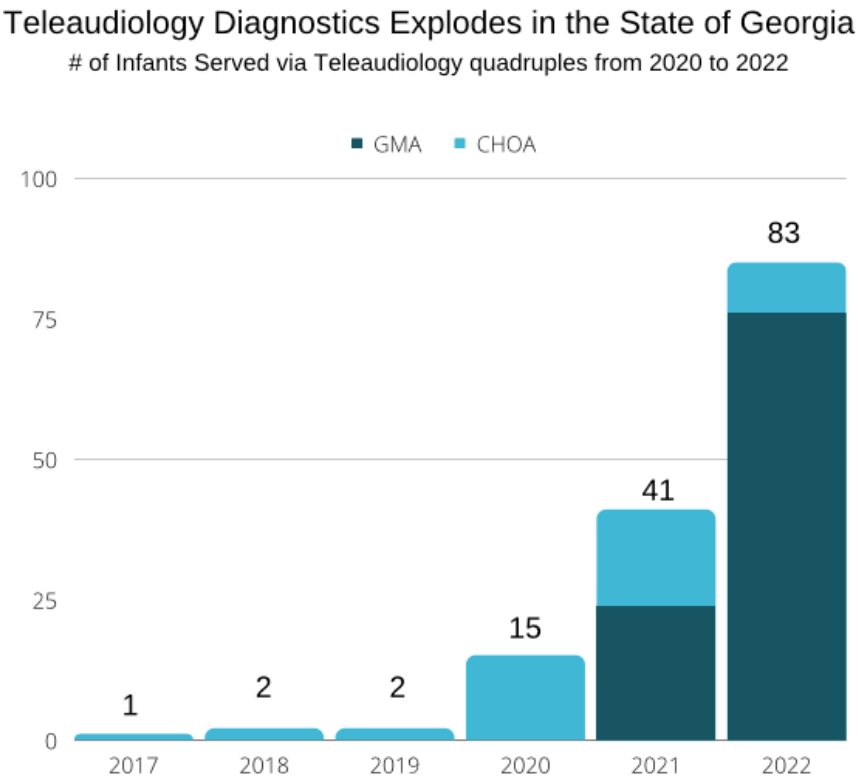
Source: GA DPH/EHDI Reporting to SENDSS as of 8-25-2023. 2022 Data Preliminary.

Expansion of Teleaudiology Diagnostic Services Continues to Explode Year over Year

Currently, Georgia ranks #45 for audiologist/SLP availability and #41 for on-time diagnoses based on 2019 CDC estimates. [11] [12] In the Year 3 Report, the authors emphasized Georgia's lack of pediatric audiologists and resources, especially in rural areas. Other organizations such as Augusta University have also highlighted the lack of services and its negative impact on DHH child outcomes (See Appendix D for open letter). Last year, the authors emphasized the need for the state to continue its investments in teleaudiology service models to address the extremely low rate of reported diagnostic testing. This investment seems to be paying off as the number of teleaudiology diagnostic evaluations has *doubled* over last year.

In 2021, EHDI added the option for audiologists to specify if teleaudiology was used when reporting an infant's diagnostic data into the SendSS database. The data presented here are likely underestimated as tracking is reliant on audiologist self-report.

The data collected to date indicate that teleaudiology services are growing rapidly in the state. The number of infants served via teleaudiology has grown exponentially from 2020 to 2022 according to DPH SendSS data due largely from the efforts of the GaDOE's Georgia Mobile Audiology program.



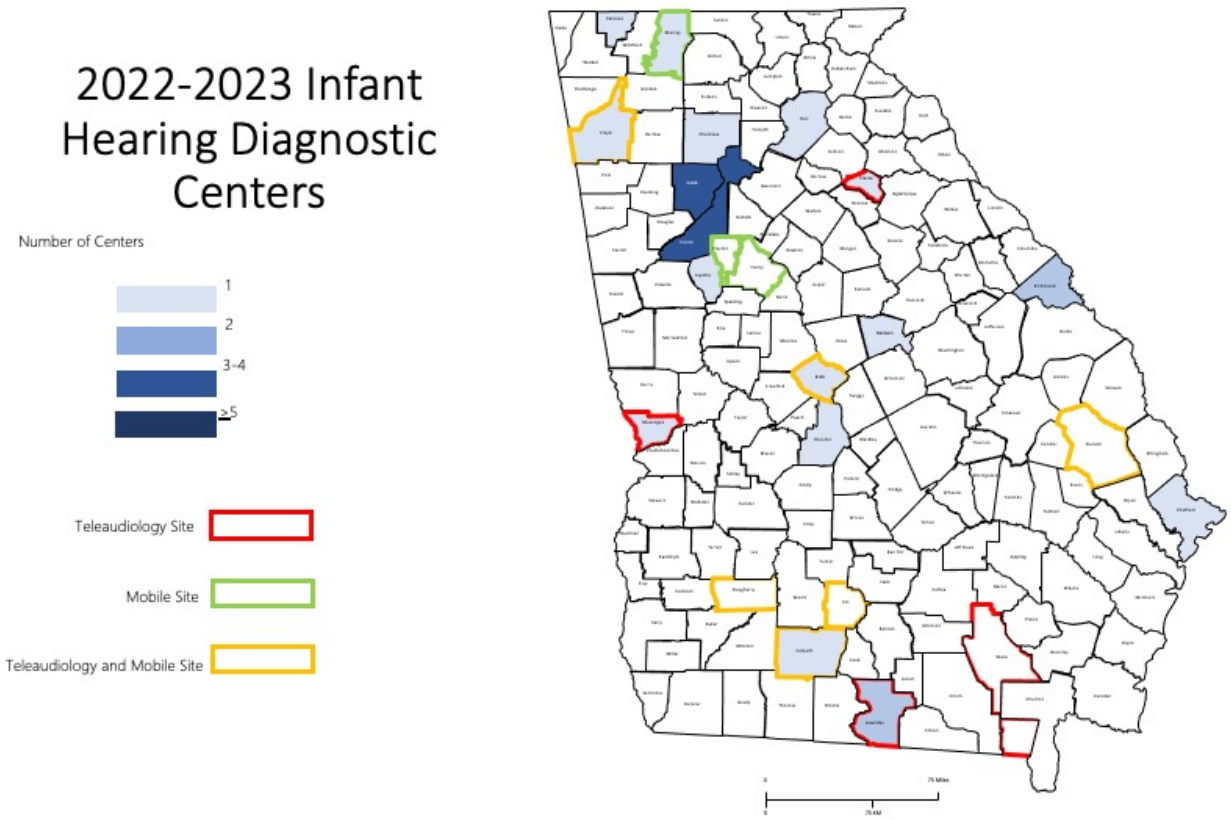
Source: Georgia DPH EHDI Teleaud and GTID Assignments for Year 5 as of 8-25-23. 2022 Data Preliminary.

[11] Brook, Gail P. Annual Workforce Data: 2021 ASHA-Certified Audiologist and Speech Language Pathologist to Population Ratios. American Speech-Language Hearing Association, July 2022.

[12] 2019 CDC EHDI Hearing Screening & Follow-up Survey (HSFS). Includes cases of normal hearing and hearing loss. Alabama, Mississippi and Colorado did not report in 2019.

The map below illustrates the current availability of diagnostic services in the state. There continues to be a lack of services particularly in rural areas of the state. Over the past three years, there has been an overall improvement in the availability of diagnostic service locations. However, a notable decline in brick-and-mortar facilities is evident, especially in areas south of the metropolitan Atlanta region.

Private practice audiologists are finding it difficult to provide diagnostic services to infants and young children, primarily due to the risk of financial loss. The cost of equipment and supplies are high, and reimbursement rates are low. The amount of time needed to complete a diagnostic hearing evaluation for an infant is often double or triple that required for older children and adults. Reimbursement rates often are not adequate for covering the time and effort for testing, counseling families about results, care coordination for follow up referrals, and reporting.



Ongoing Barriers and Efforts

Medicaid Barriers Related to Timely Access to Audiologic Care

As is clear from the Language and Literacy Dashboard reported above, many children in the state of Georgia experience challenges in achieving prompt identification of hearing loss. After diagnosis there are also barriers to uninterrupted hearing aid or cochlear implant use. These barriers directly lead to problems with achieving age-appropriate language and literacy outcomes. It is well-documented that children who have Medicaid insurance are more at risk for not receiving timely diagnosis and subsequent access to quality audiological services than other children.

During the last year, GaCDHH Commissioners formed a task force to examine Georgia Medicaid policy-related issues which affect timely care. Working with audiologists around the state, they identified eight barriers that make timely care challenging for audiologists who serve children with Medicaid insurance. Many of these Georgia policies differ from neighboring states, such as Florida and Kentucky, which have better EHDI 1-3-6 outcomes than the state of Georgia. The task force prepared a report entitled *Enhancing Access for Deaf or Hard of Hearing Pediatric Georgia Medicaid Recipients: Identifying Obstacles and Suggesting Improvements* (available in Appendix E). The report received support from multiple organizations including the Georgia Chapter of the American Academy of Pediatrics, the Georgia Department of Education Division of State Schools and Georgia Mobile Audiology.

The report was sent to staff at the Georgia Department of Community Health (DCH). On August 16, 2023, members of the taskforce met with leadership from the Policy, Compliance, and Operations Office who agreed to review each recommendation in the report to determine what actions were required to remediate the barriers. On September 18, the task force was delighted to hear from DCH representatives that the recommendation regarding reimbursement for Auditory Brainstem Response (ABR) testing was accepted. ABR testing is the primary way to diagnosis infants with hearing loss. Previously, Medicaid only reimbursed audiologists for one ABR per year. More than one diagnostic ABR is frequently needed to confirm hearing loss in infants, and the new policy will allow up to three tests per year. This change represents a positive step towards improving access to diagnostic services for Georgia pediatric Medicaid recipients. DCH leadership continues to evaluate the other seven recommendations from the report. The GaCDHH task force is excited to continue this productive collaboration.

Budget Allocation for the GaCDHH

In 2022, Governor Kemp and the General Assembly allocated $20,000 to the GaCDHH via line 2644 under the Georgia Vocational Rehabilitation Agency (GVRA). Funds have been transferred from the GVRA to DHS and will be used for the operation of the GaCDHH. The GaCDHH is incredibly grateful to Governor Kemp and the General Assembly for this allocation.

In addition, the GaCDHH has received a one-time $10,000 grant from the McGowan Foundation. These funds are to be used for GaCDHH expenses such as ASL video production, dues and fees and any other expenses as determined by the Chairperson and voted on by the GaCDHH. The GaCDHH is deeply grateful to the McGowan Foundation for their critical support.

Appointment to the Georgia Commission for the Deaf or Hard of Hearing

Currently, there are two open positions to be appointed by the Speaker of the House of Representatives and Governor Kemp. The GaCDHH hopes to have these appointments made within the next 12 months and will forward resumes of those interested. See Appendices A, B and C for a complete list of appointees for the GaCDHH, the Multiagency Taskforce and the Stakeholder Advisory Committee.

In addition, Dr. Melanie Morris was appointed to the GaCDHH via the Senate Office of Appointments. Dr. Melanie Morris is the Child Health Deputy Director and Referral and Screening Programs Director at the Georgia Department of Public Health. With a background as a pediatric audiologist, Melanie has implemented innovative methods like mobile and teleaudiology to serve children and families across Georgia. She is passionate about providing services to under-served populations and promoting early intervention. Melanie's work focuses on improving accessibility to child health services, raising awareness about the importance of early intervention, and driving positive change in child health and well-being throughout the state.

A Continued Partnership Between DPH and the DOE

A key recommendation in last year's report was to develop a tight collaboration between the GaDOE and DPH. A core team meets monthly to discuss child and family outcomes as well as any potential barriers to implementing strategies identified in each annual Language and Literacy Report. The group consists of the GaDOE State Schools Division leadership, DPH Division of Women, Children, and Nursing Services, EHDI leadership, and other DHH partners as appropriate. Data needs, necessary process improvements, staffing, partnerships, and new initiatives are discussed at these monthly meetings. Clearly, the progress shown in this report illustrates the power of collaboration and shared resources, and these meetings will continue as we seek to improve the state's on-time diagnostic ranking. Over the next 12 months, this collaborative will develop a list of key diagnostic performance indicators in order to track progress more regularly and identify and address gaps in service provision.

Additional Recommendations

Below is a list of potential efforts to be considered over the next 12 months as professionals in the state continue to work together to improve language and literacy outcomes for children who are DHH.

- Explore a statewide school-aged hearing (and vision) screening mandate similar to many other states in the country.
- Develop online learning tools for audiologists and hospital screeners to improve the quality of services and reporting compliance.
- Continue collaboration and referrals between EHDI and Georgia Mobile Audiology
- Assemble working team of Early Intervention providers to discuss ways to collaborate, share data, standardize data definitions, better understand barriers to prompt EI enrollment and create a more family centered landscape.
- Continue to explore changes to Medicaid coverage for children's hearing and language services and secure funding as necessary.
- Continued work and reporting on DPH EHDI Birthing Facility Compliance Enhancement Project

Thank you to Governor Kemp and Georgia's General Assembly

The Georgia Commission for the Deaf or Hard of Hearing (GaCDHH) sincerely thanks Governor Kemp and the General Assembly for the intentional and intensive focus on Georgia's children who are DHH. Special thanks must be given to Chairman Penny Houston whose tireless efforts to support and advocate for Georgia's children who are DHH have resulted in multiple pieces of legislation, policy changes, public assistance programs, funding, and many other efforts designed to improve child and family outcomes.

This is an exciting time to be working for the future of Georgia's children who are DHH. The GaCDHH, DPH, the DECAL, and the GaDOE thank each of you for your time and commitment to Georgia's children who are DHH. With timely and effective support, our children CAN achieve their full potential.

Appendix A: Appointees for the Georgia Commission for the Deaf or Hard of Hearing and Update (GaCDHH)

The GaCDHH is comprised of 12 members, ten of whom are appointed by the governor. The Senate Committee on Assignments appoints one member, and the Speaker of the House of Representatives appoints the final member. The GaCDHH serves as the principal agency of the state to advocate on behalf of persons who are DHH by working to ensure those persons have equal access to the services, programs, and opportunities available to others. The GaCDHH assists children who are DHH and their parents in advocating for equal access to services, programs, and opportunities, advises the governor, General Assembly, Commissioner of Human Services, and the Commissioner of Community Health on the development of policies, programs, and services affecting people who are DHH and on the use of appropriate federal and state moneys for such purposes.

Position	Appointed By	Current Commissioner
DHH adult – ASL	Governor	Jimmy Peterson
DHH adult – English	Governor	Jennifer Clark
DHH adult – English and ASL	Governor	Ellen Rolader
DeafBlind Adult	Governor	Anne Mcquade
Late deafened (after 18 years)	Governor	Ibrahim Dabo
Parent of DHH Child – English	Governor	Vacant
Parent of DHH Child – ASL	Governor	Deshonda Washington
Otolaryngologist or Audiologist	Governor	Dr. Alison Morrison
Private Provider of Services for DHH	Governor	Dr. Paula Harmon
Person involved w/Programs for DHH	Governor	Dr. Amy Lederberg
At Large	Senate Committee on Assignments	Melanie Morris
At Large	Speaker of the House	Vacant
Current Chair	GaCDHH Votes	Dr. Amy Lederberg

Appendix B: Appointees for the Multiagency Task Force

Created within the GaCDHH is a multiagency task force for the purposes of establishing a system of collaborative governance responsible for:

- Making recommendations to the General Assembly and the governor regarding essential improvements to the statewide system of developmental and educational services that support age-appropriate language and on-grade-level literacy proficiency for children who are DHH from birth to third grade,
- Engaging with stakeholders at the Department of Public Health (DPH), the Department of Early Care and Learning (DECAL), and the Georgia Department of Education (GaDOE) to ensure a seamless, integrated system of care from birth to literacy for children who are DHH, and
- Developing and supporting interagency practices and policies that support the implementation of individualized birth to literacy plans for each child who is DHH.

Position	Current Representative
Chair of GaCDHH	Dr. Amy Lederberg
Executive Director of Task Force	Dr. Stacey Tucci – GaDOE Language and Literacy Director
GaDOE – Direct authority over Deaf Education	Dr. Kenney Moore – Executive Director of GaDOE Division of State Schools
DPH – Direct authority over Early Intervention	Kimberly Ross – DPH Child Health Director Dr. Melanie Morris – DPH Child Health Deputy Director and Referral and Screening Programs Director Kevin Byrd – DPH Babies Can't Wait Director/Part C Coordinator
DECAL – Authority over Preschool Programs	Jennie Couture – Practice and Support Services Director
DPH – State EHDI Program Manager	Dr. Brandt Culpepper – DPH Early Hearing Detection and Intervention Program Manager
DPH – The Division of Epidemiology – Direct Responsibility over Data Management	Michael Lo – DPH Newborn Surveillance Epidemiologist
GaDOE – Direct Responsibility over Data Management	Nicholas Handville – Chief Data and Privacy Officer
State Board of Education Member	TBD – State Board of Education Chair
Georgia Technology Authority	Steve Nichols – Chief Technology Officer Nikhil Deshpande – Chief Digital Officer Cameron Fash – Director of Intergovernmental Relations

Appendix C: Appointees for Stakeholder Advisory Committee

A Stakeholder Advisory Committee was created to provide information and guidance to the multiagency task force regarding the following deliverables:

1. a list of developmental milestones necessary for progressing toward age-appropriate language and English literacy proficiency by the end of third grade
2. a comprehensive and accurate web and print based resource for parents and professionals
3. a list of currently available assessments appropriate for evaluating an individual child's progress towards age-appropriate language and English literacy proficiency
4. an individual report of a child's current functioning, developed in collaboration with professionals and the parents or caregivers, that will be used for the purpose of monitoring a child's progress toward age-appropriate language and English literacy proficiency by the end of third grade

The stakeholder advisory committee is comprised of 13 members appointed by the GaCDHH based upon the following criteria for each member as described in the table below.

Position	Current Representative
Parent of DHH Child under 10 – ASL (child's language)	Krystle Wilson
Parent of DHH Child under 10 – Spoken English (child's language)	Katie Hope
Parent of DHH Child under 10 – English as second language (home language)	Lauren Sangaline
DHH Adult – ASL	Vyron Kinson
DHH Adult – Spoken English	Jonathan Brilling
Early Interventionist – ASL	Lisa Collis
Early Interventionist – Spoken English	Debbie Brilling
Early Interventionist – non-Metro Area	Dr. Heidi Evans
Teacher – Spoken English, non-Metro School	Kathy Lyons
Teacher – ASL and Spoken English	Cherie Wren
Deaf Teacher – ASL, Atlanta Area School for the Deaf	Wende Grass
Teacher – Spoken English, Metro School	Lesley Cauble
Pediatric Audiologist	Dr. Jill Maddox

Appendix D: Augusta University Letter Regarding Audiology Shortage

Augusta University, Medical College of Georgia
1120 15th Street
Augusta, Georgia 30912
September 15, 2023

To Whom It May Concern:

Nearly 2,500 children in Georgia are classified as deaf or hard of hearing[1]. In 2020, 215 children were diagnosed with permanent hearing loss, though only 132 received the diagnosis before 3 months of age.[2] Timely diagnosis of hearing loss is essential for providing children and families with access to early intervention services. Without such a diagnosis, they are ineligible for most private, federal, and state-supported early intervention programs. Unfortunately, 68% of infants who do not receive a diagnosis or who receive a late diagnosis will develop *preventable* language delays because of delayed diagnosis and intervention.[3] Studies have shown that children who receive timely intervention tend to catch up quickly and demonstrate language skills and cognitive abilities that are on par with their peers.[4]

The nationwide standard put out by the American Academy of Pediatrics (AAP) Early Hearing Detection and Intervention (EHDI) are:

- Ensure every child with hearing loss is diagnosed and receives appropriate, timely intervention.
- Enhance pediatricians', other physicians', and non-physician clinicians' knowledge about the EHDI 1-3-6 guidelines—screening by 1 month of age, diagnosis of hearing loss by 3 months of age, and entry into early intervention (EI) services by 6 months of age.
- Ensure newborn hearing screening results are communicated to all parents and reported in a timely fashion according to state laws, regulations, and guidelines.
- Incorporate EHDI into an integrated, medical home approach to child health.

Georgia has yet to meet these guidelines.

The rate of infants with a documented audiologic diagnostic evaluation varies greatly across Georgia's public health districts, with some school districts only achieving a 20% diagnostic rate, while others reach over 80%. This disparity in outcomes highlights the urgent need to improve access to audiological services statewide.

One of the primary contributing factors to these disparities is the shortage of audiologists available to provide follow-up audiological services to infants referred from the Early Hearing Detection and Intervention (EHDI) programs. Georgia ranks 43rd in the nation for the ratio of certified audiologists to the population, with only 3.4 audiologists available for every 100,000 people. Additionally, Georgia lacks audiology graduate programs so every fully trained audiologist we do have, has been recruited from training programs outside the state.

To put this into perspective, neighboring Tennessee ranks 7th in the nation with a more favorable ratio of 6 certified audiologists per 100,000 residents and boasts 430 certified audiologists in total. Tennessee also has 6 CAA* certified audiology programs. In a similar vein, Alabama has 372 certified audiologists, resulting in 5.2 audiologists per 100,000 residents and 2 CAA* certified audiology programs ranking 18th nationally in audiology services. Colorado currently carries the #1 rank with 448 audiologists in 2022 and 7.7 audiologists

per 100,000 residents.[5] There are currently 103 healthcare facilities that provide audiology services to children in Georgia. However, there are no pediatric audiologists available south of Macon, GA.

To address these pressing issues and improve the lives of Georgia's children with hearing loss, we advocate for the establishment of the first AuD program in the state. This initiative is imperative to bridge the gap in on-time diagnosis, improve access to audiological services, and ensure that all children in Georgia have a fair chance to achieve age-appropriate language and literacy skills.

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*Accreditation held by The Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA) of the American Speech-Language-Hearing Association (ASHA).

Sincerely,

Sarah Hodge, MD
Division Chief – Otology and Neurotology
Medical Director of Audiology
Augusta University, Medical College of Georgia

Jason May, MD
Associate Professor - Pediatric Otolaryngology
Augusta University, Medical College of Georgia

J. Drew Prosser, MD
Division Chief – Pediatric Otolaryngology
Augusta University, Medical College of Georgia

Sarah King, AuD
Chief Audiologist
Augusta University, Medical College of Georgia

Heather Koehn, MD
Assistant Professor - Pediatric Otolaryngology
Augusta University, Medical College of Georgia

Sneha Chauhan, BS, MS3
Augusta University, Medical College of Georgia

References:

1. Year 2019 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs. Journal of Early Hearing Detection and Intervention, 4(2), 1-44. DOI: 10.15142/fptk-b748
2. 2020 CDC EHDI Hearing Screening & Follow-up Survey (HSFS)
3. Georgia DPH 2016-2020 HSFS Data for PHIP referenced by Georgia Commission for the Deaf or Hard of Hearing Language and Literacy Report (2021)
4. Mary Pat Moeller; Early Intervention and Language Development in Children Who Are Deaf and Hard of Hearing. Pediatrics September 2000; 106 (3): e43. 10.1542/peds.106.3.e43
5. American Speech-Language-Hearing Association. (2022). Member and Affiliate Profile: 2022 ASHA-certified audiologist- and speech- language pathologist-to-population ratios. www.asha.org

Appendix E: GaCDHH Report on Medicaid Barriers and Suggestions

Enhancing Access for Deaf or Hard of Hearing Pediatric Georgia Medicaid Recipients: Identifying Obstacles and Suggesting Improvements

Georgia Commission for the Deaf or Hard of Hearing

Summer 2023

Co-Authored by:

Alison Morrison, AuD

Commissioner, Georgia Commission for the Deaf or Hard of Hearing

Melanie Morris, AuD

Commissioner, Georgia Commission for the Deaf or Hard of Hearing

Stacey Tucci, PhD

Executive Director, Georgia Commission for the Deaf or Hard of Hearing

Amy Lederberg, PhD

Chairperson, Georgia Commission for the Deaf or Hard of Hearing

Paula Harmon, MD

Commissioner, Georgia Commission for the Deaf or Hard of Hearing

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STATE

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DIVISION OF State Schools

Georgia State University

Summary of Problem

Children with hearing loss in the state of Georgia are currently experiencing a language and literacy crisis with only 22 percent of children who are deaf or hard of hearing (DHH) meeting age-appropriate reading levels by the third grade[1], much lower than the 36.5 percent of hearing Georgia third graders who meet age-appropriate reading levels. The variables contributing to these concerning outcomes are multifactorial. Because early identification and intervention for hearing loss is critical for achieving language and academic skills commensurate with cognitive potential, each event in the process from the state-mandated newborn hearing screening in the birth hospital through school-age transaction points must be examined. For example, only 21.4 percent of infants in Georgia who do not pass the newborn hearing screening at birth and require a diagnostic hearing evaluation are meeting the national benchmark of receiving this evaluation by three months of age[2]. This is well below the 80 percent timely follow-up goal recommended by the Centers for Disease Control and Prevention (CDC). Georgia is among the bottom ten performers in the nation, ranking 41 out of the 50 states in on-time diagnosis[1]. In comparison, 81% of eligible infants in Florida receive their diagnostic hearing evaluation on time. Furthermore, early hearing aid fitting has been shown to promote better language outcomes even during the preschool years, and consistent, uninterrupted hearing aid use is positively associated with greater improvement in language over time[3]. Many children in the state of Georgia experience challenges in achieving early and uninterrupted hearing aid use due to various factors, some of which are outlined in the following report. The CDC provides resources for improving identification and intervention for infants with hearing loss, including the recommendation that professionals and policy makers review Medicaid policies and practices to address barriers related to the referral process and/or availability of Medicaid providers. Certain barriers to timely and appropriate hearing healthcare exist specifically for pediatric Medicaid and Medicaid CMO recipients in the state of Georgia.

Because of their significance, benchmark data (including 1 month screen, 3-month diagnosis, and 6-month early intervention rates) are required to be reported annually to the State (including the Governor's Office, General Assembly, Department of Public Health, and Georgia Commission for the Deaf and Hard of Hearing) and the CDC and are a significant predictor of later language and literacy achievement for DHH children.

Additionally, multiple published studies have demonstrated that children who had Medicaid insurance received hearing evaluations and hearing loss diagnoses later than their peers with private insurance, were less likely to receive hearing aids or cochlear implants than their peers with private insurance and demonstrated lower scores on measures of functional listening skills than their peers with private insurance[5]. Investing in Medicaid and focusing on factors that will allow more clinics to serve Medicaid recipients are critical to helping to overcome these challenges related to timely and accessible care. Georgia has a limited number of clinics providing pediatric hearing healthcare, and not all of these clinics serve Medicaid patients due, in part, to the issues listed in this report.

Lastly, House Bill 462, which amended existing code OCGA § 30-1-5, was signed into law in 2018. The amended law requires interagency collaboration and shared responsibility for improving language and literacy outcomes for Georgia children who are deaf and hard of hearing (DHH) which includes ensuring equitable access to hearing healthcare (medical and audiological). One deliverable from the law is an annual report to the Governor and the General Assembly each September regarding DHH children's language and literacy outcomes, including information about the state's DHH ecosystem. This year's report focus on the state's DHH ecosystem will address barriers to hearing healthcare.

An outline of some barriers that contribute to poor language and literacy outcomes are listed below with suggested recommendations for ameliorating these obstacles for this vulnerable population. A comparison to neighboring states, *all of which have more timely follow-up rates than the state of Georgia*, is included in the table below. The information contained in this report will be included in the OCGA § 30-1-5 required Annual Report to the Governor and the General Assembly.

It should be noted that the following requests are all in compliance with Georgia law and regulations, federal regulations, and best practice guidelines.

1. 2022 Annual Report: Language and Literacy Outcomes for Children Who are Deaf and Hard of Hearing in the State of Georgia. *Report to the Governor and General Assembly as required by OCGA §30-1-5(h)*
2. 2020 CDC Annual Data, Early Hearing Detection and Intervention (EHDI) Program
3. Tomblin, J.B., Harrison, M., Ambrose, S.E., Walker, E.A., Oleson, J.J., Moeller, M.P. (2015) Language Outcomes in Young Children with Mild to Severe Hearing Loss. *Ear and Hearing.* DOI: 10.1097/AUD.0000000000000219
4. Centers for Disease Control and Prevention, Children with Hearing Loss. Articles and Key Findings: Infants with Suspected Hearing Loss May Not Receive Timely Diagnosis or Early Intervention: www.cdc.gov/ncbddd/hearingloss/features/infants-suspected-hearing-loss.html
5. Kingsbury, S., Khvalabov, N., Stirn, J., Held, C., Fleckenstein, S.M., Hendrickson, K., Walker, E.A. (2022). Barriers to Equity in Pediatric Hearing Healthcare: A Review of the Evidence. *Perspectives of the ASHA Special Interest Groups. DOI*: 10.1044/2021_persp-21-00188

Barrier	Comparison	Recommendation
Physician order required for ordering/billing earmolds - Earmolds are generally a required component for hearing aids to function for infants and children. - It is within the scope of practice of an audiologist to determine when new earmolds are needed, either due to child outgrowing the current earmolds or damage to earmolds, and to take impressions and order them. - Requiring a physician order introduces an additional barrier to ensuring full-time hearing aid use, and for many children, long delays in acquiring appropriate orders from pediatricians who have no experience with hearing aid care lead to *time periods where children are unable wear their assistive devices.*	Audiologists who are Medicaid providers in FL, AL, TN, SC, and KY do not need to obtain physician order to be able to order and bill Medicaid for earmolds. Prior authorization is also not required for replacement earmolds.	**NO COST:** **Remove requirement for physician order for new and replacement earmolds.**
Barrier	**Comparison**	**Recommendation**
Physician order required for dispensing hearing aid batteries. - Batteries are generally a required component for hearing aids to function for infants and children. - Hearing aid batteries are a covered provision for Medicaid recipients when dispensed through an audiologist, however, a physician order is required before batteries can be dispensed. - Requirement for physician order introduces an additional barrier affecting full-time hearing aid use, and for many children, long delays in acquiring appropriate orders from pediatricians who have no experience with hearing aid care lead to *time periods where children are unable wear their assistive devices.*	Audiologists who are Medicaid providers in AL, FL, TN, and KY are able to dispense hearing aid batteries to existing hearing aid users without a physician order (patients in SC receive them directly through Children with Special Healthcare Needs program).	**NO COST:** **Remove requirement for physician order for batteries.**
		continued

Barrier	Comparison	Recommendation
CPT codes 92567, 92550, 92587, 92588, 92650, 92651, 92652 require signed physician order for payment. - Georgia employs Early Hearing Detection and Intervention (EHDI) coordinators for each public health district whose responsibilities include calling parents/families to advise and assist them with scheduling follow-up services if their infant did not pass the state-mandated newborn hearing screening. - EHDI coordinators and parents cannot self-refer to a follow-up facility for testing if they receive Medicaid because Medicaid requires a signed physician referral. - Additionally, clinics are unable to solicit a referral from the PCP for follow-up testing due to the federal Anti-Kickback Statute.	Audiologists who are Medicaid providers in at least FL and SC can complete newborn screening follow-up testing without a physician order.	**NO COST:** **Remove requirement for physician order for follow-up from state-mandated newborn hearing screening (codes 92567, 92550, 92586, 92587, 92650, 92651, 92652; note: several codes included because there are multiple accepted procedures for follow-up testing).**
Barrier	**Comparison**	**Recommendation**
ASHA CCC-A Certification is required to dispense hearing aids through Medicaid (See Appendix A). The American Speech- Language Hearing Association (ASHA) offers a Certificate of Clinical Competence in Audiology (CCC- A) through its organization. Georgia Medicaid requires that at least one audiologist in each practice hold this certification in order to dispense hearing aids but does not require it for other audiologic service delivery such as diagnostic audiometry or infant hearing evaluation. There is no obvious justification for this certification requirement, as certification is not otherwise required for licensure or practice (and other optional certifications through other organizations are also available). Initial certification costs the provider $455, and annual renewal costs $255 each year. This is a significant cost and barrier for many audiologists to obtain this certification. In fact, in 2020 the state of Georgia had one of the lowest rates of CCC-A audiologists to population ratios in the nation (ranked 43rd lowest of 50 states) with only 3.4 CCC-A audiologists for every 100,000 persons. *Requiring audiologists to hold this certification may further reduce the pool of otherwise licensed and qualified audiologists and practices who would be able to serve patients with Medicaid.*	Audiologists in at least FL, KY, and NC report that this certification is not required by Medicaid to dispense hearing aids.	**NO COST:** **Remove the requirement for audiologists to hold an active CCC-A certification to dispense hearing aids to Medicaid recipients.**
		continued

Barrier	Comparison	Recommendation
Medicaid providers are required to pay for replacement of lost hearing aids and to insure replacement hearing aids if the Medicaid recipient loses the (Medicaid-owned) hearing aid (see Appendix B). - Hearing aids are dispensed with a one-time loss and damage warranty through the manufacturer. - If the Medicaid recipient loses his/her (Medicaid-owned) hearing device, the *provider* is required to pay the warranty fee AND insure the replacement device for subsequent loss before dispensing a replacement to the patient. - *This is not otherwise standard practice in hearing aid dispensing and may be an additional deterrent in providers serving patients with Medicaid.* - *This requirement also significantly delays the process of dispensing replacement hearing aids because the clinic/provider must go through another insurer to establish insurance before dispensing replacement. This delay introduces additional time when the child may have limited access to everyday conversational speech and language due to lack of hearing device.*	Providers in FL, AL, NC, SC, KY, TN are not required to insure lost devices.	**Remove requirement for Medicaid providers to insure replacement devices. Continue to require that devices are dispensed with one-time loss/damage warranty through the manufacturer.**
Barrier	**Comparison**	**Recommendation**
CPT code 92652 Diagnostic ABR limited to 1x per year. Historically, the Georgia CIS fee schedule covered more than one Diagnostic ABR per year. More than one diagnostic ABR is frequently needed to confirm hearing loss in children. Reasons may include: child awoke before test complete, transient middle ear problem (i.e. fluid in ears) found on first test requiring re-evaluation, and/or child has specific medical risk factors for progressive hearing loss during infancy requiring close monitoring. Currently providers cannot be reimbursed for the second evaluation, often a 2-hour appointment. Georgia is experiencing a shortage of audiologists trained in performing ABRs, and limiting reimbursement for medically necessary evaluations may further decrease access to care for patients with Medicaid. Additionally, this limitation may increase referrals for sedated ABR services which ultimately add additional risk to the child (potentially deterring parents from completing follow-up care) and cost to determining hearing status.	Medicaid providers in FL, AL, NC, SC do not have frequency limits for CPT code 92652 in their fee schedule. Providers in KY can submit for prior authorization if CPT code 92652 services are required more than once.	**Increase allowable code to 3x per year** to match other codes used for infant evaluations in the State of GA.
		continued

Barrier	Comparison	Recommendation
Hearing aid follow-up visits (CPT codes 92592/92593) are no longer covered services. This means while the hearing aids are under warranty (previously a 3-year and currently a 5-year period for many Medicaid devices), providers cannot be reimbursed for hearing aid check appointments which are required to ensure that the devices are working appropriately for the child. Additionally, Medicaid recipients cannot easily transfer care to a new clinic if they move or have other needs because the new clinic cannot be reimbursed by Medicaid for these ongoing services. This may impose barriers related to access and distance for Medicaid recipients. Historically this code was covered by Georgia Children Intervention Services (CIS) for many years. Of note, while the cost of hearing aid devices has increased for providers, hearing aid reimbursement has not increased since at least 2005, and requiring providers to include 5 years of follow-up visits in addition to the bundled consultation, dispensing/programming, in-house repairs, in-house replacement of parts, and loss & damage replacement cost of the hearing aid is not feasible for most providers, especially as the frequency of follow-up visits is dependent on the individual patient and family.	Audiologists in AL, NC, SC, and KY are able to bill for multiple hearing aid check appointments and conformity evaluations each year to ensure devices are working appropriately.	**Include CPT codes 92592/92593 (monaural/binaural) and/or 99212 (previously reimbursed at $25.12) in the approved Medicaid fee schedule for audiologists. Should be included with a service limit of no less than 6 units per year.** Actual used units will be dependent on individual patient age and needs.
Other	**Comparison**	**Recommendation**
CPT code 92556 (speech audiometry threshold with speech recognition) is not a covered code through Medicaid. This procedure is part of a comprehensive audiometric assessment for children and includes assessment of word recognition performance. A lesser code (92555) which tests only a speech reception threshold is paid by Medicaid, but when speech recognition testing is added, this code is not included. For children who received an OAE-method newborn hearing screening, it is particularly important to perform word recognition testing during a comprehensive audiogram to establish neural synchrony (absent in children with Auditory Neuropathy Spectrum Disorder and would not be detected by speech reception threshold alone). Evaluating speech understanding, separately from pure tone hearing sensitivity, is also critical for management of children with hearing loss. Understanding speech (accessing language auditorily) is necessary for children to develop spoken language.	**CPT code 92556 is a reimbursable code in AL, SC, NC, and KY with reimbursement ranging from 13.24 to 18.49 for this code.**	**Add 92556 to Medicaid fee schedule for audiologists.**

Conclusion

In conclusion, implementing minor modifications to existing requirements, many of which come at no direct cost to Medicaid, holds the potential to greatly enhance the capacity of healthcare providers to effectively serve pediatric patients covered by Georgia Medicaid or Medicaid CMOs. Simplified access to early hearing detection and intervention services is crucial for ensuring these vulnerable children can achieve their maximum developmental potential. Furthermore, we urge the Department of Community Health to consider the inclusion of an audiologist liaison in their team to provide ongoing support for audiology-related code decisions. The Georgia Commission for the Deaf or Hard of Hearing wholeheartedly appreciates the thoughtful consideration of these proposed changes.

Sources: 2022 Medicaid fee schedules for surrounding states including Florida, Alabama, North Carolina, South Carolina, and Kentucky were reviewed. Tennessee Medicaid fee schedules were not readily accessible to non-participant review. Additionally, representatives from large children's hospitals or other large audiology clinics were consulted to verify or further inform information obtained from Medicaid sources. The information listed above is provided in good faith with the intention to provide the highest level of accuracy possible.

d) Fitter

A facility must have at least one (1) practitioner who is licensed to supervise unlicensed staff. Fitters must obtain certification by successfully completing courses available in their field and mandated by the licensed CO or CP.

A fitter that has successfully completed the three (3) week ABC Mastectomy Fitter course may enroll as a provider and provide mastectomy services only: L8000, L8001, L8002, L8015, L8020 and L8030. **PLEASE NOTE: L8035 may only be provided by a facility with a licensed practitioner.**

Prosthetics Providers

(1) A facility must have at least one (1) practitioner licensed and certified at the level of certification required by the Division, (or a higher certification level), as indicated in Appendix D for each service, to provide and bill the service. For example: a facility providing services L6920 to L7405 must have a practitioner who is ABC-CP. Codes requiring a CP may be a practitioner who is ABC-CP or BOC-CP.

(2) A facility must have a fitting room which meets minimum standards as outlined in Section 903.

Ocularist Providers

A facility must have at least one (1) practitioner who is certified by the National Examining Board of Ocularists, Inc. A Board Certified Ocularist BCO) may provide and bill for services V2623 to V2628 only.

Hearing Aid Providers

A facility must have at least one (1) practitioner who is certified by the American Speech-Language-Hearing Association. A practitioner holding a Certificate of Clinical Competence-Audiology (CCC-A) credential may only provide L8615-L8699 and V5014-V5299 hearing services for members who are less than twenty-one (21) years of age.

b) The CMN must be signed and dated by the physician **and** (certified ocularist CCC-A) and must include the certification number of the ocularist.

c) A copy of the certification of the ocularist must be attached to the CMN.

d) Documentation of absence of an eye due to trauma or surgical removal must be submitted to support medical necessity.

e) Written diagnoses must include the associated ICD codes (On or before 09/30/2015 report ICD-9-CM codes; on or after 10/01/2015 report ICD-10-CM codes.

f) Replacement is covered every five (5) years unless documentation supports medical necessity of more frequent replacement.

g) Polishing and resurfacing is covered on a yearly basis and does not require prior approval.

h) One enlargement (V2625) or reduction (V2626) of the prosthesis is covered. Additional enlargements or reductions must be supported with additional documentation.

805.8 Hearing Prosthetics

Hearing aids, batteries, repairs and any additional items or services pertaining to hearing aids are only covered for members under twenty-one (21) years of age, this includes external replacement components and repairs for cochlear implants.

Covered Services

Hearing Aids

A first time or initial order for aid is covered for members less than twenty-one (21) years of age if the member does not currently have a hearing aid that meets the functional needs of the member for the ear being fitted for the device. Reimbursement for the hearing aid(s) are limited to one unit per three (3) years. The hearing aid(s) must be dispensed with at least a one (1) year factory warranty.

Georgia Medicaid only provides coverage for new hearing prosthetics. Each new hearing aid must have a manufacturer's warranty and be covered with loss/replacement insurance coverage for no less than three (3) years. All hearing aids, including replacement hearing aids, must be dispensed with replacement/loss insurance coverage. The total cost of insurance for the required three (3) years is considered to be included in the reimbursement of the hearing prosthetic. It is the responsibility of the provider to renew the insurance each year for each member serviced.

If a hearing aid(s) is lost and uninsured, within three years of the purchase of the device, the Division will require the provider to replace the device free of charge. If a hearing aid(s) is lost and replaced through warranty, the provider must purchase replacement insurance on the newly issued device(s). If the hearing aid(s) is lost and replaced through the provider purchased insurance, then the member (family or guardian) should pay for the replacement insurance **before** the provider issues the new hearing aid(s). Providers may request that the member (family or guardian) pay for the new replacement insurance only after the warranty or initial provider purchased insurance has been utilized to replace the lost hearing aid(s).

Prior Authorization for Hearing Aids is contingent upon the following:

a) For new/initial hearing aids; a medical consultation and recommendation by a licensed physician specializing in ear(s), nose, and throat (ENT), and prescribing hearing aids and/or audiograms. The consultation report or certificate of medical necessity (CMN) form must document the member's medical diagnosis and condition supporting the recommendation for the hearing aid(s).

   or

   For replacement hearing aids; a medical consultation and recommendation written by a licensed primary care physician (PCP). The consultation report or certificate of medical necessity (CMN) form must document the member's medical diagnosis and condition supporting the recommendation and necessity for the replacement hearing aid(s).

b) An audiological examination (audiogram) or auditory brainstem response (ABR) was performed by a licensed audiologist that supports the recommendation for an ENT consultation and the hearing aid(s); (*If the audiogram exceeds one (1) year, pending an ENT evaluation, the audiologist may sign and date a letter stating that repeating the audiogram will not change the outcome and is therefore unnecessary.*)

c) The Georgia licensed audiologist must determine and recommend the most appropriate hearing device through assessment;

d) Only a Georgia licensed audiologist is allowed to evaluate, fit, and dispense the hearing aid(s) for children three (3) years of age or younger;

e) The prescription for repairs must be signed and dated by the licensed audiologist or hearing aid vendor.

f) Providers must keep on file a complete record of all repairs, including the manufacturer's invoice. The Division has the right to request this information.

Appendix F: Glossary of Terms

1-3-6 EHDI Guidelines – National best practices/guidelines established by EHDI encouraging screening by one month of age, diagnosis of hearing loss by three months of age, and entry into EI services by six months of age.

504 Plan – The 504 Plan is a plan developed to ensure that a child who has a disability identified under the law and is attending an elementary or secondary educational institution receives accommodations that will ensure their academic success and access to the learning environment.

AAA – American Academy of Audiology

AAP – American Academy of Pediatrics

ASL – American Sign Language

AtL – Access to Language (AtL) initiative at Grady Hospital

ASTra Program – Advocacy Support & Training (ASTra) Program – Program available through Georgia Hands and Voices which provides parents with training on educational law and how to effectively advocate for their child, an advocate to assist them with IEPs, IFSPs and transition services and additional services and supports as needed.

AtL – Access to Language

AVC – Auditory Verbal Center

BCW – Babies Can't Wait – Provides services to improve developmental potential of infants and toddlers birth to age 3, with developmental or chronic health conditions. Provided under DPH.

BIBS – Babies Information and Billing Services – web-based central repository of case management data on children enrolled in and served by BCW.

BVI – Blind-Visually Impaired

CACDS – Georgia's Cross Agency Child Data System (CACDS) aligns critical data from programs and services for children zero to five and their families. The purpose of the system is to identify services gaps, create opportunities for analysis and research, and provide an integrated and aligned approach to demonstrate how the state is meeting the needs of its youngest learners. Data are sent to the system from four partners currently, three agencies and Head Start grantees across the state. All participating programs are represented by a Governance Committee that meets regularly to discuss priorities for Georgia's CACDS (www.gacacds.com).

CDC – Centers for Disease Control and Prevention

DHH – Deaf or Hard of Hearing - A student who is Deaf or Hard of Hearing is one who exhibits a hearing loss, whether permanent or fluctuating, that interferes with the acquisition or maintenance of auditory skills necessary for the normal development of speech, language, and academic achievement. [Refer to 34 CFR 300.7 (3), (5)]

DB – DeafBlind

DECAL – The Department of Early Care and Learning – Also referred to as Bright from the Start, Georgia Department of

Early Care and Learning is responsible for meeting the childcare and early education needs of Georgia's children and their families.

GaDOE or DOE – The Georgia Department of Education or the Department of Education **–** Oversees all aspects of K-12 public education in the state. The GaDOE is also responsible for the education of Children who are DHH ages 3 - 22. Includes Atlanta Area School for the Deaf and Georgia School for the Deaf.

DPH – The Georgia Department of Public Health – Lead agency in preventing disease, injury, and disability; promoting health and well-being; and preparing for and responding to disasters from the health perspective. Includes Maternal and Child Health (MCH) which oversees newborn screening and Early Hearing Detection and Intervention (EHDI) which provides services for Children who are DHH birth to 3.

EHDI – Early Hearing Detection and Intervention – Provided under DPH, EHDI maintains and supports the statewide screening and referral system. This includes screening for hearing loss in the birthing hospital; referral of those who do not pass the hospital screening for rescreening; diagnostic audiological evaluation as appropriate, as well as linkage to appropriate intervention for those infants diagnosed with hearing loss.

EI – Early Intervention – The provision of services to infants and young children with developmental delays and disabilities and their families. May include speech therapy, physical therapy, and other types of services.

FERPA – The Family Educational Rights and Privacy Act of 1974 (FERPA) is a federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education.

Georgia Hands & Voices - A parent driven non-profit organization that provides peer to peer support to families of children who are Deaf or Hard of Hearing regardless of communication modality. Children are served from birth-21.

Georgia PINES – Georgia Parent Infant Network for Educational Services – EI program for families of children birth to three years with a diagnosed hearing loss and/or visual impairment. Georgia PINES' Sensory Kids Impaired – Home Intervention (SKI-HI) program provides weekly services for children who are DHH. Georgia PINES may serve children up to age 5. Children 4-5 years are small percentage of those served by Georgia PINES and typically occurs when a child is late enrolled to the program.

GaCDHH – Georgia Commission for the Deaf or Hard of Hearing – Created in 2007 to advocate for DHH persons, and work with state and federal agencies to promote economic development for DHH persons, and to recommend legislation to the governor and General Assembly.

Gen ED – General Education

Georgia Milestones English Language Arts (ELA) Assessment – A comprehensive, summative assessment program spanning grades 3 through high school which measures how well students have learned the knowledge and skills outlined in the state-adopted content standards in English Language Arts.

Georgia Pathway to Language and Literacy – A group of stakeholders founded Georgia Pathway in 2010 to advance the literacy proficiency of Georgia's children who are Deaf or Hard of Hearing (DHH).

GKIDS – Georgia Kindergarten Inventory of Developing Skills – A year-long, performance-based assessment used to provide teachers with information about the level of instructional support needed by individual students entering kindergarten and first grade. GKIDS data is recorded based on the school system's curriculum map or report card schedule. Individual student reports are generated at the end of the year based on the data the teacher has entered throughout the year.

GLRS – The Georgia Learning Resources System – Network of 18 regional programs that provide training/resources to personnel and parents of students with disabilities to support academic achievement and post-secondary success. Provided under the GaDOE.

GMA – Georgia Mobile Audiology

GTA – The Georgia Technology Authority – Manages delivery of IT infrastructure services to the 85 Executive Branch agencies.

GTID – Georgia Testing Identifier – A unique, unchangeable, random ten-digit number assigned on a permanent basis to each student enrolled in a publicly funded K-12 Georgia school or program.

Healthy People 2020 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. For 3 decades, Healthy People has established benchmarks and monitored progress over time to encourage collaborations across communities and sectors, empower individuals toward making informed health decisions and ensure the impact of prevention activities. https://www.healthypeople.gov

HIPAA – Health Insurance Portability and Accountability Act of 1996 – is federal legislation that provides data privacy and security provisions for safeguarding medical information.

HRSA – Health Resources and Services Administration – The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, is the primary federal agency for improving health care to people who are geographically isolated, economically, or medically vulnerable.

IDEA – Individuals with Disabilities Education Act – Passed in 1990, it replaced the Education for All Handicapped Children Act (EHA), which was passed in 1975 to replace the Rehabilitation Act of 1973. IDEA replaced EHA in order to place more focus on the individual, as opposed to a condition that individual may have – plus make many other improvements on the EHA, such as promoting research and technology development, details on transition programs for students post-high school and programs that educate children in their neighborhood schools, as opposed to separate schools.

IEP – Individualized Education Program **–** Framework for determining the meaning of the term a "free, appropriate public education" (FAPE) in the least restrictive environment (LRE), which is developed and reviewed annually and must be in effect at the beginning of each school year in accordance with IDEA (Individuals with Disabilities Education Act). This is an education document for children from three to 22 years of age.

IFSP – Individual Family Service Plan – Serves children birth to three years of age with a focus on family involvement. When a child moves from BCW to special education, the IFSP is replaced by an IEP.

INSITE – An EI program for children who are DHH, VI, or DB and who have additional disabilities and administrated through Georgia PINES.

JCIH - Joint Committee on Infant Hearing – National committee within the American Speech-Language-Hearing Association which addresses issues that are important to the early diagnosis, intervention, and follow-up care of infants and young children with hearing loss. Created the 1-3-6 Guidelines.

LSLS – Listening and Spoken Language Specialist Certification – Awarded by the AG Bell Academy which is the global leader in Listening and Spoken Language Certification. The requirements for the Listening and Spoken Language Specialist (LSLS) Certification set universal professional standards for knowledge and practical experience providing listening and spoken language intervention for children who are DHH and their families.

MCH – Maternal and Child Health

NIH – National Institutes of Health

Part B Services – Provision of services for children with special needs from three years to 21 years as specified by IDEA.

Part C Services – Provision of services for children with special needs from birth through age two as specified by IDEA.

RESAs – Regional Educational Service Agencies – 16 agencies strategically located in service districts throughout the State of Georgia. The agencies were established for the purpose of sharing services designed to improve the effectiveness of the educational programs of the member school systems.

SendSS – State Electronic Notifiable Disease Surveillance System – DPH's information system for reporting screening, laboratory, and diagnostic results for notifiable diseases, including permanent hearing loss in children birth to five years of age.

SI – Sensory Impairment

SLDS – Statewide Longitudinal Data System (SLDS) - The Statewide Longitudinal Data System is designed to help districts, schools, and teachers make informed, data-driven decisions to improve student learning. SLDS is a free application that is accessed via a link in the district's Student Information System (SIS). It provides districts, schools, and teachers with access to historical data, including Assessments, Attendance, Enrollment, Courses, and Grades beginning with the 2006-2007 school year.

SPED – Special Education

TWMB – Talk with Me Baby – A collaboration of six leadership organizations including DPH, the GaDOE, and the Campaign for Grade Level Reading working to bring the concept of language nutrition into public awareness and to educate caregivers on the importance of talking with their baby every day. This program is not specific to Children who are DHH.

TDHH – Teacher of the Deaf or Hard of Hearing

UNHS – Universal Newborn Hearing Screening – 1999 Georgia law requires that no fewer than 95% of all newborn infants born in hospitals in the state be screened for hearing loss at birth and that local birthing hospitals and audiologists must report data to DPH/EHDI when infants do not pass the initial hearing screen or are diagnosed with hearing loss.

VCSL – Visual Communication and Sign Language Checklist – A developmental checklist of visual (ASL) language development.

VI – Visually Impaired

VR – Vocational Rehabilitation - A set of services offered to individuals with mental or physical disabilities designed to enable them to attain skills, resources, attitudes, and expectations needed to gain employment.