



JCIH 2019 Position Statement Frequently Asked Questions

◀ Newborn Hearing Screening ▶

Q: The definition of universal newborn hearing screening is the screening of all newborn babies “prior to being discharged”. Under certain circumstances the hearing screening was not completed “prior to discharge” but those babies were given an appointment within 7 days as outpatients for their first screening. Is this method appropriate?

A: It is appropriate to provide services to the best of your abilities. The JCIH position statement is meant to detail best practices but if staffing and equipment needs do not allow you to meet these guidelines you should strive to provide services as close as possible to those outlined in the statement.

Q: Is it accurate to say that if a baby passes the screen in both ears regardless of when each ear was tested as an inpatient, that this should be sufficient? Or should both ears be screened at the same time?

A: Both ears must be screened at the same time and both ears must yield pass results at that screening session to be considered an overall pass.

Q: We do not agree with not screening the ear opposite a unilateral atresia. Parents are typically upset by the atresia and want to know if the baby can hear in the "normal looking" ear. Since wait times for diagnostic testing can be approx. 3 months at our local Children's Hospital, it seems that waiting that long to screen the "normal" ear goes against the EHDI spirit. If parents know that the baby passes in the typical ear, there will likely be much relief. Why is atresia an automatic fail?

A: Atresia in one ear is an automatic failed screening. As a result, the baby needs a diagnostic ABR regardless of the results of the “typical” ear.

Q: When referring to preterm babies, does the committee mean actual age or adjusted age in their example of the 3-month-old in the NICU? Does this answer affect the recommendation?

A: The 1-3-6 benchmarks are based on full term newborns. Should the baby be premature, decisions about timing for diagnostic evaluation should be discussed with the physician and the pediatric audiologist.

Q: Our current practice in the NICU is to allow two screens total unless they refer in both ears on the first screen then they have only that screen and get scheduled for an outpatient diagnostic full ABR. Is this compatible with the new JCIH guidelines?

A: The JCIH position statement does not specify a limit to the number of re-screens that can occur in the NICU, but the number of overall rescreening attempts should be limited to avoid delaying diagnostic assessment. The involvement of an audiologist in the NICU phase is a strength and will likely prevent prolonged duration for a complete hearing diagnosis. JCIH think that limiting the number of rescreening and including an audiologist during the NICU phase is consistent with the spirit of the position statement when it comes to rescreening.

The recommendation for referring an infant in the NICU to the diagnostic phase is based on the overall concept in the document to avoid multiple re-screening attempts that could delay the diagnostic assessment. The document talks about this concept on Page 10 in the context of outpatient rescreening. Rescreening in the NICU phase does not extend the timeframe that it might take an infant to get a diagnostic. In fact, if an audiologist is involved in the NICU rescreening process, that is completely in alignment with the intent of the document.

Q: If AABR is required for all infants in the NICU regardless of length of stay, are the recommendations for follow-up the same?

A: NICU stay of 5 days or greater is a risk factor in itself that requires follow-up with behavioral testing at 9 months. NICU stay less than 5 days, follow-up is recommended only when there is 1 other risk factor.

Q: What is the difference between a special care nursery vs NICU and how do we delineate that with regards to the JCIH recommendations?

A: The answer to this depends on the hospital. For some systems, the NICUs and special care nursery are placed under the same category. It is recommended that you consult with your hospital as well as with your state's policies and procedures.

Q: Could you provide clarification about the timing of hearing screening or other recommendations related to use of Loop Diuretics in the NICU?

A: The 2019 JCIH Position Statement does not specifically mention loop diuretics because they are frequently utilized in the management of premature babies who are already at a heightened risk level for hearing loss suggesting the need for hearing screening/assessment. These children often have multiple risk factors, and it is difficult to tease apart those factors specifically related to hearing loss. Loop diuretics are known to be in the class of ototoxic medications, however there is not strong data to provide robust guidance on late onset hearing loss after discontinuation of loop diuretics. Each child's unique constellation of risk factors is an important clinical consideration for managing hearing health.

Q: The previous position statement stated that if AABR was utilized as a screening method subsequent screening should be completed using AABR as well. The new statement approves the use of OAE following AABR for the well-baby population. Why?

A: Following AABR with OAEs in babies from the well-baby nursery was deemed acceptable because the incidence of Auditory Neuropathy/Auditory Dysynchrony (AN/AD) in the well-baby population is low. If (A)ABR is mandated as follow up, if the initial screening was with AABR, it may result in second screens being postponed, not happening because (A)ABR equipment may not be readily available.

Q: Our facility has a difficult time making the 1-3-6 benchmarks. What if we cannot make the 1-2-3 benchmark?

A: If your facility is currently meeting the 1-3-6 benchmarks, the next step would be to try to reach 1-2-3 benchmarks. It is reasonable for facilities to aspire for 1-2-3 for an individual child. It may not be possible for every child given medical, social, audiologic, etc. reasons. For facilities that are not meeting 1-3-6 benchmarks, they should first aim for 1-3-6. The committee recognizes that 1-2-3 is an aspirational program goal.

