

Deaf/Deafblind/Hard of Hearing

PROVIDING ACCESSIBILITY AND SERVICES TO SUPPORT DEAF/DEAFBLIND/HARD OF HEARING CHILDREN AND YOUTH AND THEIR FAMILIES

Why It's Important

Nationally about 2 to 3 out of every 1,000 children are born deaf, deafblind, or hard of hearing (D/DB/HH). In Minnesota, 5 per 1,000 children age 3-17 are D/DB/HH with prevalence increasing through adolescence as a result of illness, genetic causes, or injury. The most important period for language development is generally considered the first 3 years of life. Without early identification and early opportunities to learn language, these children will fall behind their hearing peers in communication, cognition, reading, and social-emotional development. Such delays may result in lower educational and employment levels in adulthood.

To reduce risks for delays in development for children who are D/DB/HH, experts recommend following the 1-3-6 recommendations: all infants have their hearing screened no later than 1 month of age; for those infants who do not pass the initial newborn hearing screen, a diagnostic audiological evaluation should be completed no later than 3 months of age; and infants confirmed to be D/DB/HH should be referred for enrollment in Early Intervention services no later than 6 months of age. In order for children who are D/DB/HH to reach their full potential, it is critical that they and their families are connected to comprehensive family support and quality early intervention programs as soon as possible. Early diagnosis and intervention also help families better understand the broad set of options available to them as they choose methods of communication, schools, technology, and more.

“My husband and I are so thankful that we live in a time when hearing loss is identified early in life and intervention can begin right away. I know that Max has been given the same opportunities as any other child due to the early diagnosis and intervention.” – Parent of a child who is D/DB/HH

Up to half of children who are D/DB/HH also have additional special health needs.

Focus on Health Equity

Differences in retention in care

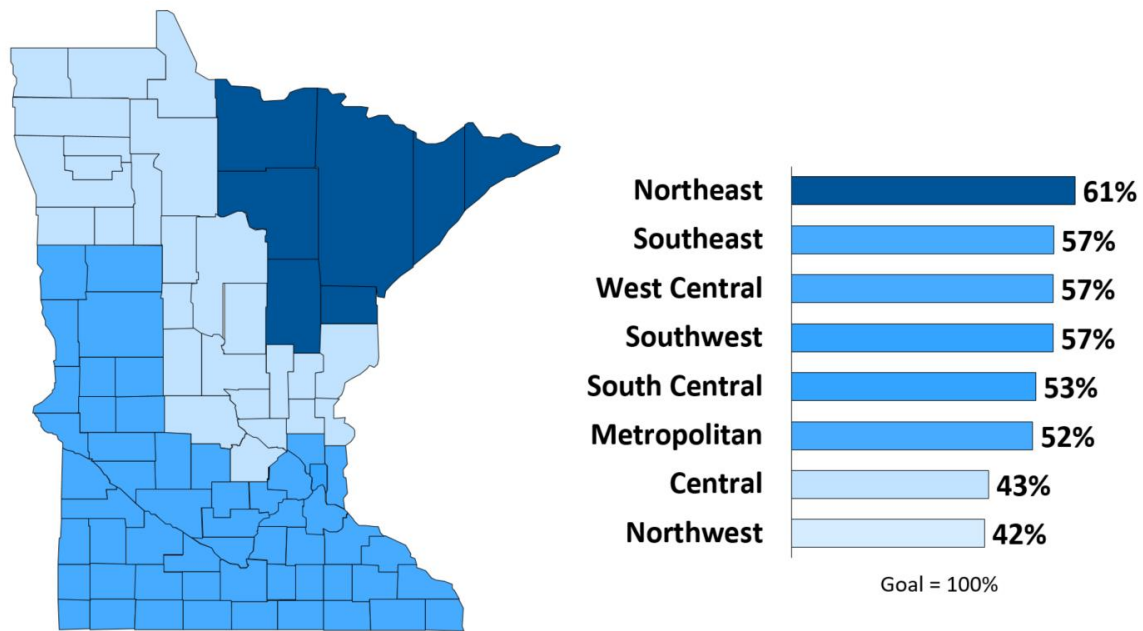
Close to 99 percent of children in Minnesota have their hearing screened at birth. However, some children are more likely to receive necessary follow-up than others. While infants born to African American mothers are only 7 percent of total births in Minnesota, 20 percent are considered lost to follow-up after referring on a newborn hearing screen. Similarly, infants born to Hmong mothers are 3 percent of the births in MN, while 10 percent are considered lost to follow-up. Infants born to White mothers account for the majority of births in MN (75%), yet only account for 35 percent of infants considered lost to follow-up.

Additionally, strong disparities in maternal education are found for children who are lost to follow-up after not passing newborn hearing screening. More than 50 percent of infants lost to follow-up are born to mothers with a high school degree (35%) or less (21%).

Where you live affects your experience

Minnesota falls short of the goal to identify children who are D/DB/HH by three months of age. Families in the metro area face different obstacles than those in rural areas, however the metro area continues to fall short of the 3-month goal. Healthcare facilities with pediatric audiologists on site are limited in rural Minnesota, and families often find themselves driving many hours and incur significant expense for their infants to receive diagnostic testing and, once identified, receive care. Families may also have more trouble connecting to D/DB/HH communities and specialized services when they live in rural Minnesota.

Figure 1. Rates for Complete Follow-up after Hearing Screening by 3 Months of Age Differ by Minnesota Region



Source: Minnesota Department of Health

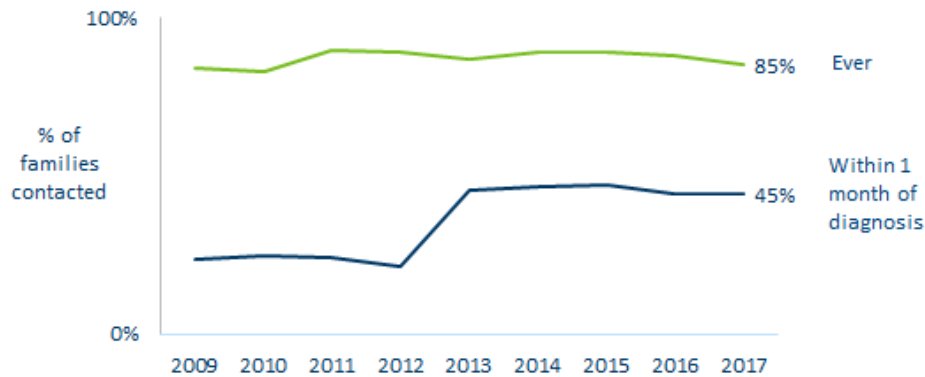
Other equity considerations

A 2017 DHS report to the legislature found gaps in meeting the needs of people who are deaf, deafblind or hard of hearing across a variety of Minnesota’s services.

Additional Data Considerations

Families with children who are D/DB/HH report the most valuable source of support they receive is deaf and hard of hearing specific. Parents also report a preference for connecting with other families that have children who are also D/DB/HH. This parent-to-parent support provides positive assistance in managing the needs of families of children who are D/DB/HH as they seek services for their child. In Minnesota, the majority of families of children newly identified as D/DB/HH receive specific parent to parent support, however less than 50% of families are connected with this support within the first month of diagnosis.

Figure 2. Most Families Receive D/DB/HH-Specific Parent to Parent Support
 Close to half of families are contacted within 1 month of diagnosis.



Source: Minnesota Department of Health

An additional important form of support for children who are D/DB/HH and their families is from deaf and hard of hearing adults. Adult mentors who are D/DB/HH give parents hope for their child’s future. Mentors provide the child a positive adult role model who can help the child learn life skills related to their hearing status and develop a positive self-identity.

Important Note on Equity and Intersectionality

The Minnesota Department of Health’s Title V Needs Assessment team acknowledges that structural (social, economic, political and environmental) inequities can result in poor health outcomes across generations. They have a greater influence on health outcomes than individual choices or a person’s ability to access health care, and not all communities are impacted in the same way.

All people living in Minnesota benefit when we reduce health disparities.

We also acknowledge that the topic addressed in this data story does not exist in isolation— which is important to remember as we do needs assessments and as we start thinking about how we approach solutions. In addition to the needs themselves being intersectional, there are also intersecting processes and systems through which power and inequity are produced, reproduced, and actively resisted.

Citations

1. Centers for Disease Control and Prevention (CDC). Identifying Infants with Hearing Loss - United States, 1999-2007. *MMWR* 2010; 59(08); 220-223.
2. Boulet SL, Boyle CA, Schieve LA. Health Care Use and Health and Functional Impact of Developmental Disabilities Among US Children, 1997-2005. *Arch Pediatr Adolesc Med.* 2009;163(1):19-26. doi:10.1001/archpediatrics.2008.506.
3. MDH Early Hearing Detection and Intervention program data.
4. DHS Report to the Legislature: Analysis of Deaf, DeafBlind and Hard of Hearing Services, January 2017.
5. Communication Service for the Deaf. Retrieved July 2019 from <https://www.csd.org/about/statistics>.
6. Supplement to the JCIH 2007 Position Statement: Principles and Guidelines for Early Intervention After Confirmation That a Child Is Deaf or Hard of Hearing. *Pediatrics* 2013;131:e1324
7. Minnesota Legislature. 2018. <https://www.revisor.mn.gov/statutes/cite/256C.233>

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8. Family Leadership in Language and Learning. Needs Assessment Report. 2018 Retrieved from:
https://www.handsandvoices.org/fl3/resources/docs/HV-FL3_NeedsAssessment_19Jul2018_Final-opt.pdf.

Child and Family Health Division
Title V Maternal and Child Health Needs Assessment
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975
651-201-3589
health.cfhcommunications@state.mn.us
www.health.state.mn.us



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