Original Questions:

1. How is minimal hearing loss defined?

2. How is mild hearing loss defined?

3. What protocol should be used to determine if children in this population are fit with amplification?

4. If a child with minimal to mild hearing loss is fit with amplification, what is the audiological management protocol?

5. If a child with minimal to mild hearing loss is not fit with amplification, what is the audiological management protocol?

ORG A

1. Thresholds at 25 dB HL
2. Thresholds at 30-40 dB HL
3. We fit all mild hearing losses unless there is a strong family preference not to fit. I would say we fit a majority of slight bilateral hearing losses, and might choose to monitor a slight unilateral hearing loss.
4. We use the same follow-up protocol for all of our amplification patients, and follow them approximately every 6 months.
5. If we chose to monitor, we would monitor hearing approximately every 6 months or sooner if a concern arose.

ORG B

1. Thresholds of 20-25
2. Thresholds at 30-40 dB HL
3. Unaided SII of 80 or less. Ear canals large enough to allow for vented earmolds. Demonstrated communicative difficulties. Reduced speech perception scores at 60 dB A. (Not necessarily all of these, but these are considered).
4. Baseline surveys (e.g., PEACH, LittlEars) repeated 4 months follow-up. Datalogging check. Comparison of unaided and aided speech perception in quiet and noise depending on child's development.
5. Regular audiological monitoring. Communication with school district to ensure other support services are in place.

ORG C

1. Hearing levels of 15 to 25 dB; some include high frequency sensorineural hearing loss of 20 dB or more for 2 or more frequencies above 2000 Hz and unilateral hearing loss of any degree. We typically use minimal hearing loss for hearing levels of 15 to 25 dB only, and describe high frequency and unilateral hearing loss by the actual degree of loss.
2. Hearing levels of 25 – 40 dB
3. Consider communication and education needs, but studies suggest all children with hearing loss would benefit from some amplification whether that is hearing aids or assistive listening devices (FM / blue tooth systems). At minimum, need ALD for school.

4. We don’t fit hearing aids, so I only know the current guidelines for management which includes f/u every 3 months during first 2 years of amplification use and then every 4 – 6 months. F/u to include: Behavioralhearing testing, current assessment of commuication abilities, adjustment of amplification, periodic electroacoustic evaluations, listening checks, earmold fit check, periodic probe mic measurements, periodic functional measures
5. Would recommend referral for EHDI services to monitor development and/or provide intervention as needed; f/u behavioral hearing testing, monitoring of auditory development and communication abilities through parent questionnaires and assessment every 3 months. If child is not developing skills appropriately, then reconsider amplification.

ORG D

1. We don’t - see #2
2. 25-40 dB HL
3. Multi faceted approach including speech/language development, age, school modifications, academic concerns, number of frequencies with hearing loss
4. 1 month follow up from fitting; then every 3-6 months
5. Monitor every 6 months until age 5 then annually or sooner if changes occur; educational audiology consult also recommended

ORG E

1. Normal hearing is evident when thresholds are 0-20dBHL at low mid and high frequencies in each ear. I would consider a patient to have a minimal hearing loss when they are normal at most of these frequencies in each ear, but perhaps have one or 2 frequencies at 25 or 30 dBHL.
2. 20-40 dBHL
3. If a child is struggling, (difficulty in school, speech delays) we would fit any hearing loss, even minimal, unilateral or bilateral. However, occasionally we will find a child with normal hearing in one ear and a mild (or minimal) hearing loss in one ear. We decide to fit these children on a case by case basis, again based on if they are having difficulty that could be caused by hearing loss. We strongly recommend at least one hearing aid when a child has bilateral mild (or worse) hearing loss. We also strongly recommend a hearing aid with a unilateral hearing loss that is moderate or more severe even with normal hearing in the opposite ear. (Unilateral severe to profound hearing losses are often not fit, given the large discrepancy between good and bad ear and the difficulty in getting good audibility for the bad ear before feedback.)
4. We fit the child with a hearing aid(s) verifying the fit using real ear measures if possible, or at the very least, RECD’s. They return in one month. Often they return in 3 or 6 months after this. Then we see children every 6 months until they are at least 10 years old. (hearing test and hearing aid check) We often see kids every 6 months until they are teens, if they don’t have a stable hearing loss.
5. Monitor every 6 months. (some kids only come annually if they have normal hearing in one ear) Closely monitor their speech, school performance etc. Some kids may have their classrooms equipped with classroom amplification systems, that is up to the discretion of the Educational Audiologist.

ORG F

1. For thresholds between 15 to 20 dB HL and difficulties are noticed by the patient or caregivers reporting difficulties hearing maybe only in specific listening environments
2. For thresholds 20-35 dB HL
3. This question could be read in different ways. In addition to testing (to include speech in noise if possible). For minimal loss: Age, school placement, daily challenges, educational difficulties, delays in Speech, other diagnosis, and caregivers expectations and financial abilities need to be taken under consideration when thinking of personal amplification- Accommodations at school always needed even if no personal amplification is thought out. Trial of amplification should be done prior to fitting. Use of FM system might be sufficient depending on the situation. For mild hearing loss: all of the above with fitting of HA as a STRONG recommendation.
4. Monitor every 3 months. Real ear measures completed at all visits; audio re-eval every 4 to 6 months; measure and include UCL in real ear measures. Subjective questionnaires, reports from caregivers, educators. Comprehensive OAEs at every visit to monitor OHC responses.
5. Monitor every 6 months or as needed if patient experiences more difficulties.

ORG G

1. We are not currently using the minimal hearing loss category at our facility.
2. 16- 40 dB HL
3. 1) These children should be evaluated on a case by case basis for considering amplification. One way to look at candidacy is by using the child's unaided SII. Children with a SII of less than or equal to 80 should be considered candidates for amplification. You would find an unaided SII for the child by entering the unaided audiogram into the Verifit, measuring the child's RECD, and looking at the unaided SII for average speech to see if it is greater than 80. (McCreery & Walker, "Using Audibility To Assess Amplification Candidacy for Children with Mild Hearing Loss". 2) Auditory questionnaires should also be used to evaluate the child's auditory skills and progress (such as LittlEars, SIFTER, CHILD, etc). 3) Other factors that should also be taken into account include: caregiver report and concern regarding hearing and speech-language development, the child and family's motivation to trial amplification, academic progress and teacher concerns.
4. 1. Hearing aid checks every 3-6 months depending on the child's age(or more frequently as needed). 2. Repeat hearing evaluations to monitor hearing sensitivity every 3-6 months depending on the child's age(or more frequently as needed). 3. Educational supports and services, as needed
5. 1) Repeat hearing evaluations to monitor hearing sensitivity every 3-6 months depending on the child's age(or more frequently as needed). 2) Educational supports and services, as needed. 3) Caregiver and teacher questionnaires, such as the SIFTER and LittlEars, should be given to monitor the child's progress.