



Nevada
Early Hearing Detection and Intervention
Annual Report
2020 data
(Preliminary data, subject to change)

BUREAU OF CHILD, FAMILY AND COMMUNITY WELLNESS
NEVADA DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Joe Lombardo
Governor

Lisa Sherych
Administrator
Nevada Division of Public and Behavioral Health

Richard Whitley, MS
Director
Department of Health and Human Services

Ihsan Azzam, Ph.D., M.D.
Chief Medical Officer
Nevada Division of Public and Behavioral Health

Table of Contents

Introduction.....	3
Program Funding.....	3
Partners and Stakeholders	3
Statistical Overview	4
Prevalence of Hearing Loss	5
Challenges.....	6
Race and Ethnicity	9
Improvement Strategies	10
2020 Statistics	11
Recommendations.....	16
Nevada Revised Statutes.....	17
Nevada Administrative Code	19
References.....	20

Introduction

The Nevada Early Hearing Detection and Intervention (NV EHDI) Program is located within the Bureau of Child, Family and Community Wellness, Nevada Division of Public and Behavioral Health in the Nevada Department of Health and Human Services. The purpose of the NV EHDI Program is to ensure all children born in Nevada are screened for hearing loss at birth and those identified with hearing loss receive timely and appropriate audiological, educational, and medical intervention. NV EHDI follows national guidelines, and best practice infant screening procedural flow may be summarized as follows:

Following a “did-not-pass” hearing screen prior to hospital discharge, an infant should receive a second outpatient hearing screen to confirm the initial results. If the second screen is also “did-not-pass,” the infant should be referred to a pediatric audiologist for a diagnostic test to confirm or rule out a hearing deficit. If a hearing deficit is ruled out, no further testing is needed. If the infant is diagnosed as being deaf or hard of hearing (D/HH), the infant is referred to early intervention services. Nevada EHDI tracks these infants throughout the process to confirm they received timely and appropriate services.

Nevada EHDI promotes the national EHDI goals and timelines developed by the Joint Committee on Infant Hearing (JCIH)¹ and the Centers for Disease Control and Prevention (CDC):

1. All newborns will be screened for hearing loss before 1 month of age, preferably before hospital discharge.
2. All infants who screen positive will have a diagnostic audiologic evaluation before 3 months of age.
3. All infants identified with hearing loss will receive appropriate early intervention services before 6 months of age (medical, audiologic, and early intervention).
4. All infants and children with late onset, progressive or acquired hearing loss will be identified at the earliest possible time.
5. All infants with hearing loss will have a medical home as defined by the American Academy of Pediatrics.
6. Every state will have a complete EHDI tracking and surveillance system that will minimize loss to follow-up.
7. Every state will have a comprehensive system that monitors and evaluates the progress towards the EHDI goals and objectives.

Program Funding

Nevada EHDI is solely funded via two federal grants: one from the CDC and the other from the Health Resources and Services Administration (HRSA). The purpose and scope of these federal grants is defined by the grantor, and the state complies with the grants' stated purpose, goals, and accountabilities. The purpose of the HRSA grant is to develop statewide comprehensive and coordinated programs and systems of care targeted towards ensuring newborns and infants receive appropriate and timely services including screening, evaluation, diagnosis, and early intervention. The CDC cooperative agreement is to assist EHDI programs in developing and maintaining a centralized newborn hearing screening tracking and surveillance system capable of accurately identifying, matching, collecting, and reporting data on all births through the three components of the EHDI process (hearing screening, diagnosis, and early intervention).

Partners and Stakeholders

Meeting the goals and purposes of federal funding requires a coordinated effort of multiple partners within the national, state, public, and private sectors. The following entities assist in this endeavor:

- The National Center for Hearing Assessment and Management (NCHAM) serves as the technical resource center for the implementation and improvement of comprehensive and effective early hearing detection and intervention with all state and territory EHDI programs. NCHAM works closely with both federal funders and each state to provide ongoing training, research, and resources.²
- The American Academy of Pediatrics (AAP) also works with both federal funders to provide assistance to physicians, hospitals, state EHDI programs, and parents to meet national EHDI goals. The AAP promotes the medical home concept and has established physician practice guidelines for infant hearing screening and follow-up. Each state AAP chapter designates an EHDI chapter champion to work with state EHDI programs.³
- Nevada audiologists assist Nevada EHDI by providing screenings and diagnostic testing to all infants suspected of hearing loss and reporting those findings to the state.
- All birthing centers and hospitals in Nevada provide hearing screenings to infants prior to discharge and report this data to the state.
- Nevada midwives are currently participating in a pilot project to place hearing screening equipment in midwife practices. Participating midwives report screening data to the state.
- University of Nevada Reno – Center for Program Evaluation assists with evaluation and quality improvement development and implementation.
- Nevada EHDI works closely with Nevada Hands & Voices (H&V), a statewide non-profit, to assist with reducing the number of infants lost to documentation (LTD) and/or lost to follow-up (LTF). Nevada H&V also provides parent mentors who assist families who have a newly diagnosed infant with a confirmed hearing deficit.⁴

Nevada EHDI is a program within the Nevada Division of Public and Behavioral Health and works closely and collaboratively with a variety of public programs and agencies providing support services to a similar population of infants, children, and families. These programs include, but are not limited to:

- Maternal and Child Health Title V Block Grant Program, including the Children and Youth with Special Health Care Needs Program
- Nevada Home Visiting Program
- Nevada Individuals with Disabilities Education Act (IDEA) Part C Office
- Nevada Early Intervention Services
- Nevada Office of Vital Records
- Nevada Office of Public Health Investigations and Epidemiology
- Nevada Department of Education
- Nevada Head Start Collaboration and Early Childhood Systems Office
- Nevada Office of Analytics

Statistical Overview

Prevalence of Hearing Loss

Hearing loss is one of the most common birth defects, affecting approximately 1.4 out of every thousand infants.⁵ The number is estimated to increase to 9-10 per thousand in the school-age population.⁶

For 2020, Nevada observed a rate of 1.2 infants per thousand with documented confirmed hearing loss. With a total of 33,259 births in 2020, 32,159 (96.7%) were documented as receiving a hearing screening. Of those infants without documentation of a hearing screen, 102 died, parents or family members declined services for another 58, and 391 were planned homebirths. The 126 infants in the “Other” category were either unable to be screened due to medical reasons, or they were transferred to another hospital with no record of a screening. Unknown/Loss to follow-up/Loss to Documentation (LTF/LTD) is composed

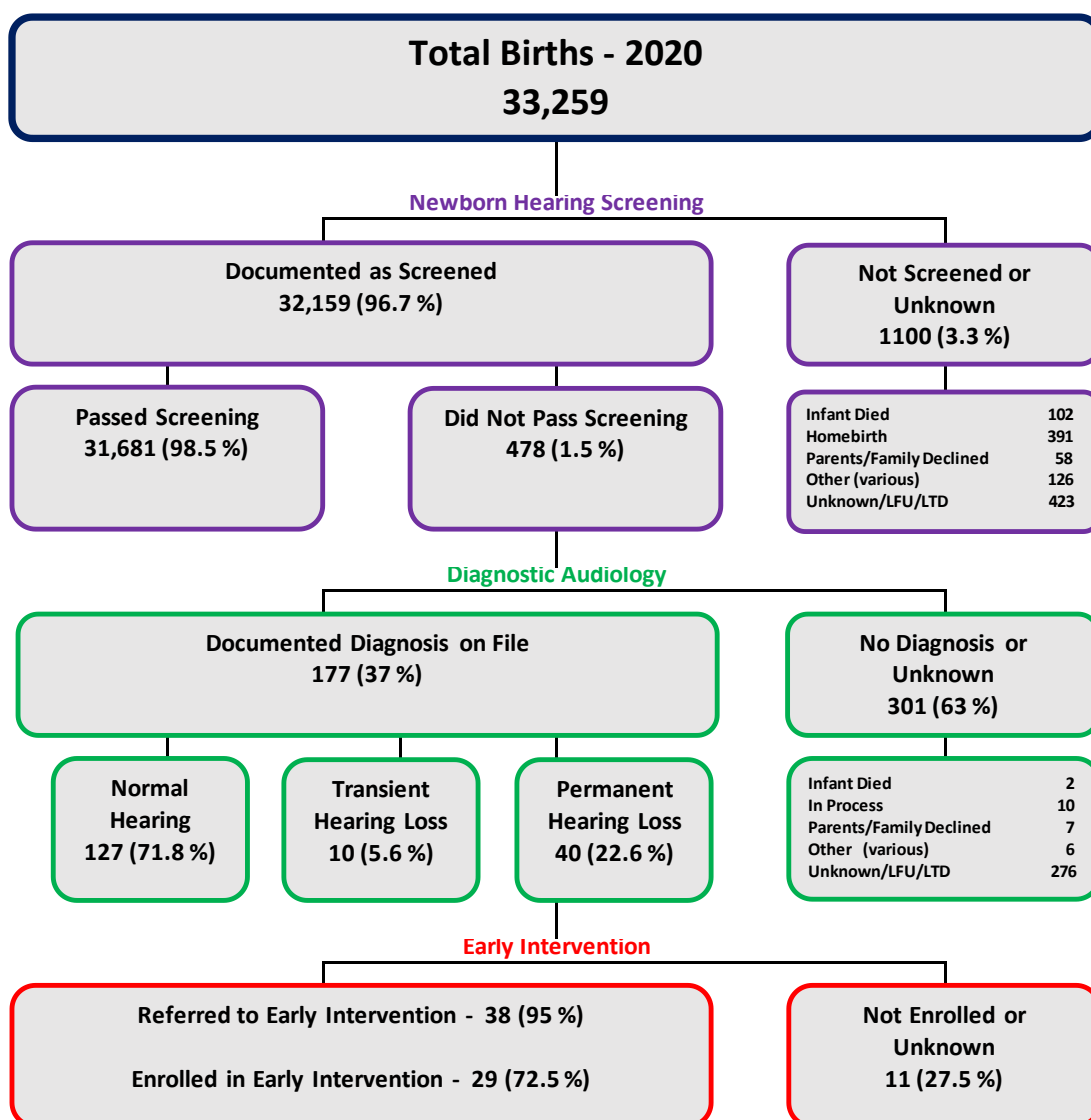


Chart 1 – EHDI Statistical Flowchart: Data from DPBH Office of Vital Records and EHDI

of families who were contacted but were unresponsive and those whose contact information was inaccurate, disconnected, or missing.

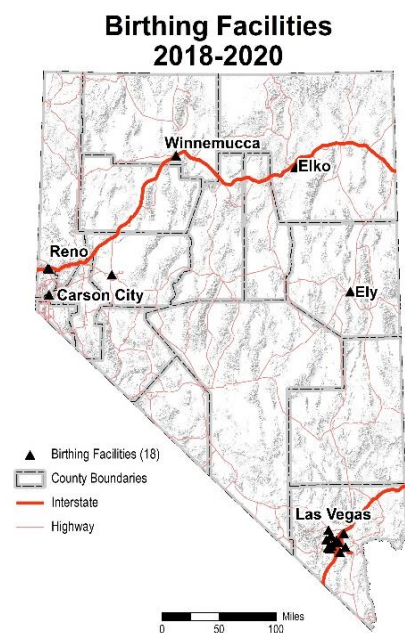
Of all infants screened, 478 (1.5%) did not pass the screening. Further audiologic testing identified 127 of the 478 as typical hearing, 40 as deaf and hard of hearing. Of those with no documented diagnosis, 2 of the infants died; parents or family members declined services for 7 infants; 10 infants were in the process of receiving diagnostic testing, but it had not been completed. The Unknown/Loss to follow-up/Loss to Documentation category is composed of families who were contacted but were unresponsive and those whose contact information was inaccurate, disconnected, or missing.

Of the 40 infants with confirmed hearing loss, 38 (95%) were referred to Early Intervention Services and 29 (72.5%) are documented as being enrolled in Early Intervention (EI). In Nevada, a diagnosis of any degree of hearing loss is a qualifying diagnosis for EI. Parents may decline enrollment due to the hearing loss being mild, loss is in only one ear, or travel time commitments to attend EI sessions. Additionally, parents decline through being unresponsive to follow-up from EI services.

Challenges

Hearing loss is one of the most common congenital birth defects; if left undetected, hearing impairment in infants can negatively impact speech and language acquisition, academic achievement, and social and emotional development. When diagnosed early however, these negative impacts can be diminished or even eliminated through early intervention.

Ensuring provision of health care services to those affected with hearing loss is challenging due to unique Nevada characteristics such as geography, the distribution of population and infrastructure, and the distribution of medical and support services. The following maps illustrate some of the challenges faced by parents, physicians, hospitals, audiologists, and early intervention staff.

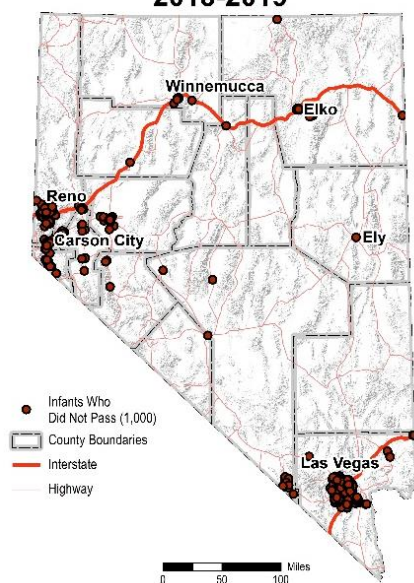


Map 1 – Birthing Facilities

Nevada Birthing Facilities:

- Banner Churchill Community Hospital
- Carson Tahoe Regional Medical Center
- Centennial Hills Hospital
- Henderson Hospital
- Humboldt General Hospital
- Mike O'Callaghan Federal Hospital
- Mountain View Hospital
- Northeastern Nevada Regional Hospital
- Renown Health
- Saint Mary's Regional Medical Center
- St. Rose Dominican Hospital - San Martin
- St. Rose Dominican Hospital - Siena
- Southern Hills Hospital and Medical Center
- Spring Valley Hospital
- Summerlin Hospital
- Sunrise Hospital & Medical Center
- University Medical Center
- William Bee Ririe Hospital

Infants Who Did Not Pass Newborn Hearing Screening 2018-2019



Map 2 – Failed Newborn Hearing Screens

When birthing facility locations (*Map 1*) and location of failed newborn hearing screens (*Map 2*) are compared, it becomes clear many parents are required to travel many hours back to the hospital if their infant requires a follow-up hearing screen.

The parental travel distance and time burden is accentuated further when observing the location of audiologists (*Map 3*) in relation to the distribution of failed newborn hearing screens (*Map 2*).

Pediatric Audiologists 2018-2020



Map 3 – Pediatric Audiologists in Nevada

Nevada currently has five pediatric audiology facilities which have both a trained audiologist and the appropriate pediatric equipment to provide service to infants. With so few resources, comes limited capacity and long wait times for time-sensitive diagnostic appointments.

Communities with Pediatric Audiology Facilities:

- Las Vegas
- Reno

It is not uncommon for an infant to need more than one diagnostic visit to a pediatric audiologist to complete all diagnostic exams.

Early Intervention Facilities 2018-2020



Map 4 – Early Intervention Facilities

Early Intervention (EI) Services are also limited with only three communities having trained staff to work with clients who are deaf and hard of hearing. EI services often entail multiple visits per week for infants ages 1-2 months through 3 years of age, and in the years 2018 through 2020 combined, 151 infants were diagnosed as deaf or hard of hearing (Map 5).

Infants Identified as Deaf or Hard of Hearing 2018-2019



Map 5 – Infants Identified as Deaf or Hard of Hearing

The cost to travel long distances, multiple times, can be a significant impediment to receiving needed and timely medical or developmental support services not provided locally. The lack of readily accessible services has caused families to move from their homes in rural and frontier locations to in-state metropolitan areas or other states. These unique barriers pose a challenge to parents, physicians, audiologists, early intervention staff, and the NV EHDI program to ensure all infants are screened, receive timely diagnostic audiology services, and are enrolled in early intervention before six months of age.

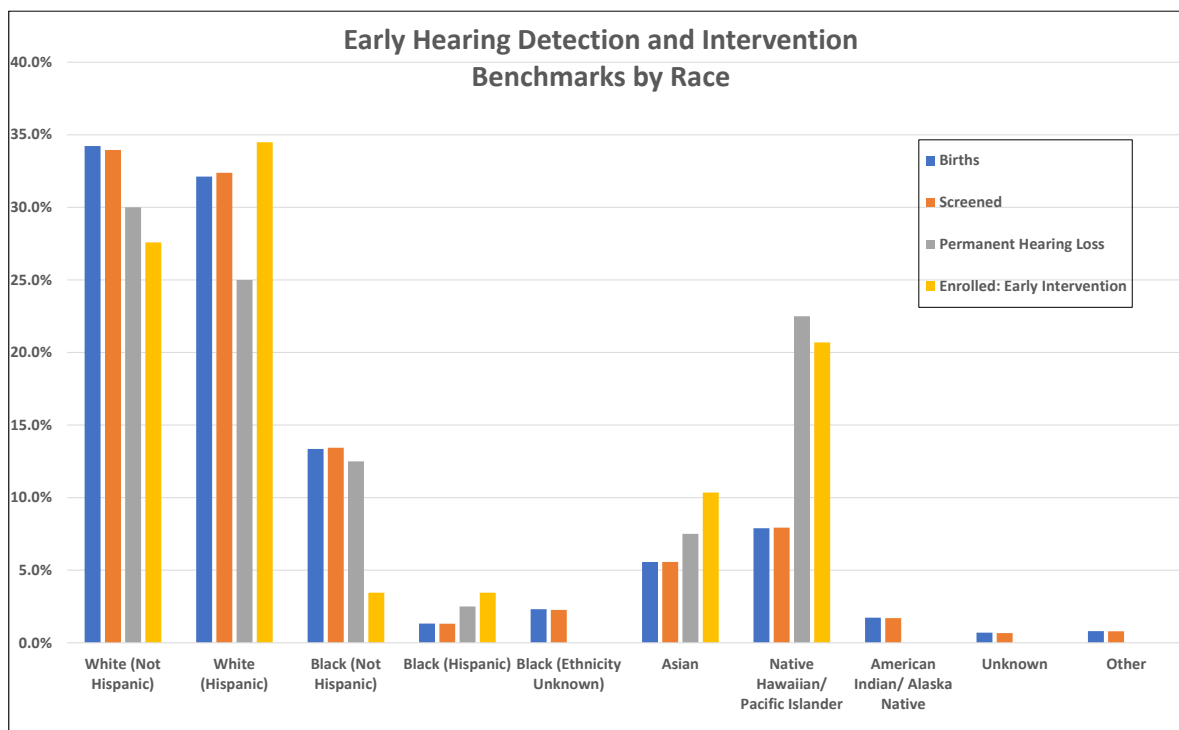
Race and Ethnicity

Maternal race and ethnicity data is collected as a component of the newborn vital records system and is reported along with all EHDI data to the CDC on an annual basis. Race and ethnicity categories listed are those requested by the CDC for all EHDI Programs to report. Table 1 displays race and ethnicity raw data while Graph 1 displays race and ethnicity percentages for births, screens, hearing loss, and enrollment in EI.

Due to the multivariate nature of EHDI data and the low population sample size of permanent hearing loss and enrollment in EI, statistical data should be viewed as descriptive in nature and with caution.

Demographic	Births	Screened	Permanent Hearing Loss	Hearing Loss (per 1000)	Enrolled: Early Intervention
Maternal Ethnicity					
Hispanic or Latino	12590	12265	16	0.77	13
Not Hispanic or Latino	20543	19775	24	0.82	16
Unknown	126	119	0	0.00	0
Maternal Race					
White (Not Hispanic)	11382	10924	12	0.91	8
White (Hispanic)	10683	10414	10	1.04	10
White (Ethnicity Unknown)	0	0	0	0.00	0
Black (Not Hispanic)	4441	4321	5	0.86	1
Black (Hispanic)	438	422	1	0.42	1
Black (Ethnicity Unknown)	769	725	0	0.00	0
Asian	1852	1789	3	0.60	3
Native Hawaiian or Pacific Islander	2623	2550	9	0.28	6
American Indian or Alaska Native	574	547	0	0.00	0
Unknown	232	214	0	0.00	0
Other	265	253	0	0.00	0
Total	33259	32159	40	0.80	29

Table 1 - 2020 Nevada EHDI Race and Ethnicity: Data from DPBH Office of Vital Records and EHDI



Graph 1 – 2020 Race Percentages by Birth, Screened, Hearing Loss, and Enrolled in Early Intervention: Data from DPBH Office of Vital Records and EHDI

Improvement Strategies

Nevada EHDI is meeting these challenges by forming strong collaborative relationships with each of the previously mentioned partners and stakeholders. This collaborative bond is strengthened through regular in-person, virtual and online communication, training opportunities, contractual agreements, and formal data-sharing agreements.

To ensure JCIH processes and associated timeframes are followed with fidelity, the following strategies have been incorporated:

- Facilitate timely and accurate reporting of data to Nevada EHDI by hospitals, birthing centers, audiologists, midwives, and early intervention facilities.
- Facilitate appropriate training to all providers (hospital screeners, audiologists, primary care providers, and developmental specialists within early intervention facilities).
- Educate and encourage all professionals to incorporate current best practice guidelines in their practices.
- Facilitate open communication among all partners.
- Work with the Office of Vital Records to improve the functionality of the Nevada EHDI information system; and,
- Provide accurate and consistent education to parents and families throughout all stages of the hearing detection and intervention process.

2020 Statistics

Data presented in this annual report are for the years 2014 through 2020, unless otherwise specified. Each year's EHDI data is considered preliminary until it is reported to the CDC in the annual EHDI Hearing Screening and Follow-up Survey. In 2021, the CDC requested 2020 data. This delay in reporting allows sufficient time for infants to move through the EHDI continuum (screening, diagnosis, and intervention) prior to data being submitted and released to the public. All data within the following figures is from the CDC, the DPBH Office of Vital Records and EHDI,

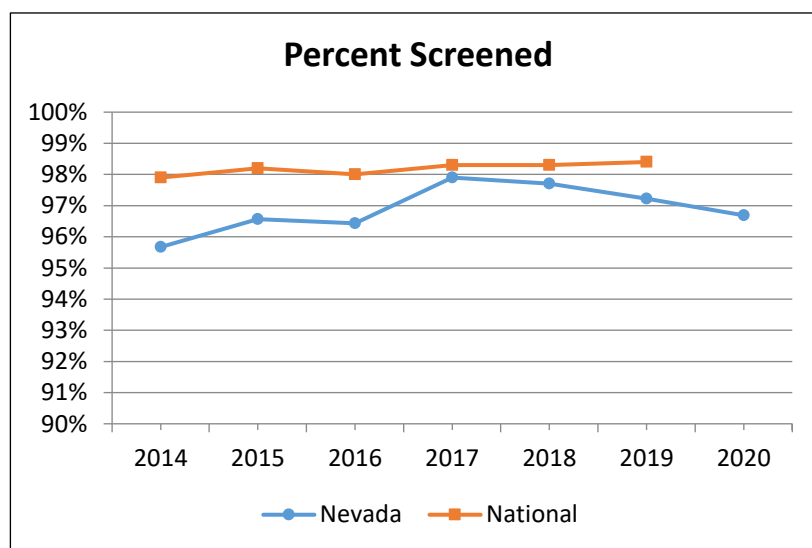


Figure 1 - Total Hearing Screens

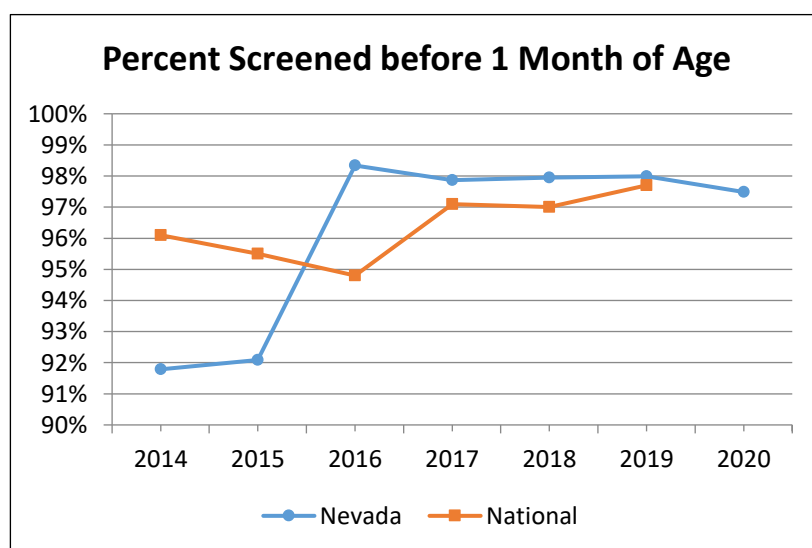


Figure 1 – Total Hearing Screens

Nevada's percent screened is slightly below the national average. Chart 1 (page 5) categorizes results and describes reasons for the lack of screen documentation for some infants. The COVID pandemic significantly impacted all aspects of EHDI systems.

Figure 2 – Percent Infants Screened Before One Month of Age

The national goal is to screen infants prior to one month of age and refer for audiologic testing those who do not pass the screen. These percentages reflect how Nevada screens and refers within the one-month benchmark.

Figure 2 – Percent Screened Before One Month of Age

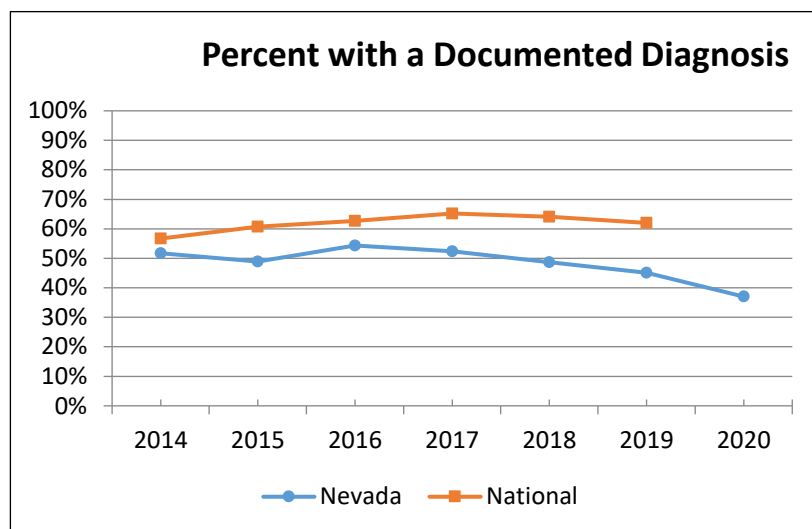


Figure 3 – Percent Infants with an Audiologist’s Confirmed Diagnosis

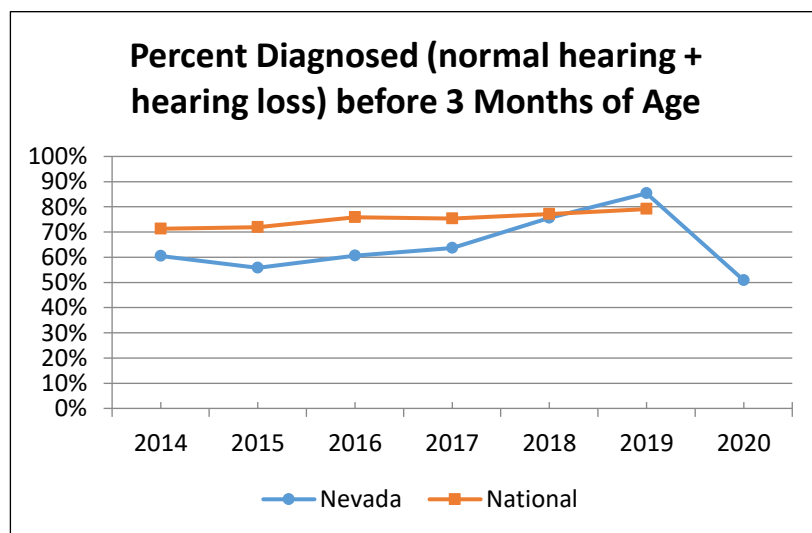


Figure 4 - Infants with a Diagnosis Before Three Months of Age

Figure 3 – Percent Infants with an Audiologist’s Confirmed Diagnosis

This figure represents those infants who did not pass the hearing screen and whose audiological diagnosis has been reported to Nevada EHDI. These diagnoses include those who are hearing, deaf, and hard of hearing. Infants whose diagnostic results have not been reported are included in Figure 5 (page 12)- Lost to Follow-up/Lost to Documentation (LFU/LTD).

Figure 4 – Infants with a Diagnosis before Three Months of Age

The JCIH benchmark for infants to receive an audiologic diagnosis is before three months of age. From 2017 to 2019, Nevada has greatly increased the percentage of infants with a diagnosis before three months of age from 63.7% to 85.4%. During the 2020 COVID pandemic, the state’s pediatric audiology facilities were closed. Other audiologist stepped in to help, but wait times were long and infants were not seen within the 3-month goal.

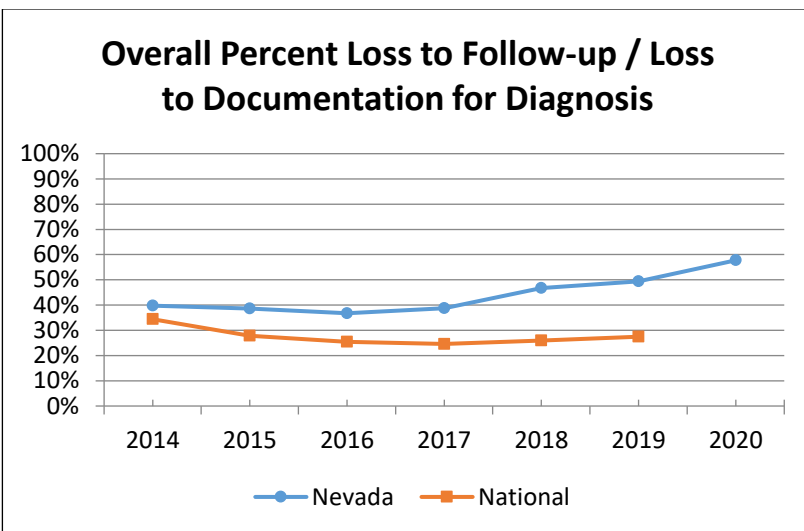


Figure 5 - Infants LFU/LTD for Hearing Diagnostic Evaluation

Figure 5 – Infants LFU/LTD for Hearing Diagnostic Evaluation

The number of infants lost to follow-up (LFU) or lost to documentation (LTD) in Nevada has increased since 2017. The lack of pediatric audiologists in the state plays a large role in this progressive increase. Training with non-pediatric audiologist is ongoing in best practices and reporting to the state diagnostic results. The COVID pandemic contributed to the rise in 2020.

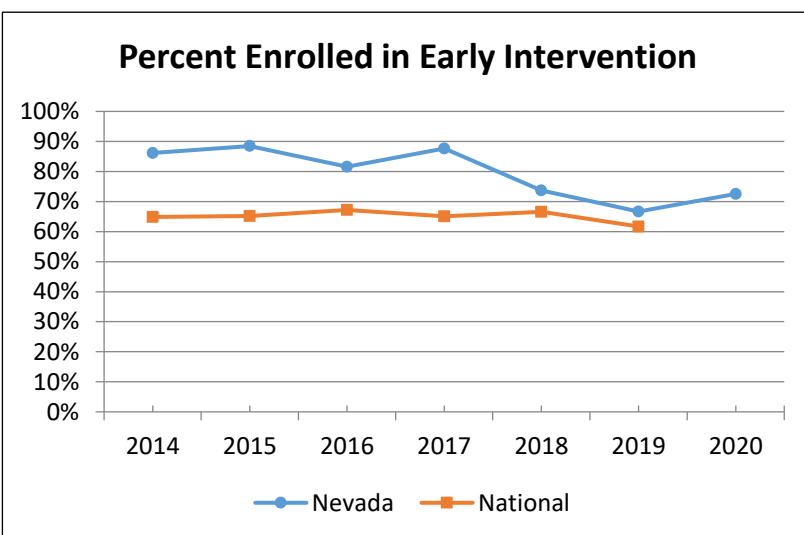


Figure 6 - Infants with Confirmed Hearing Loss, Enrolled in EI

Figure 6 – Infants with Confirmed Hearing Loss Enrolled in Early Intervention

Nevada surpasses 2019 national levels on enrolling deaf and hard of hearing infants into early intervention services (EI). These data are reflective of the close collaborative relationship with pediatric audiologists, EI services, and Nevada EHDI.

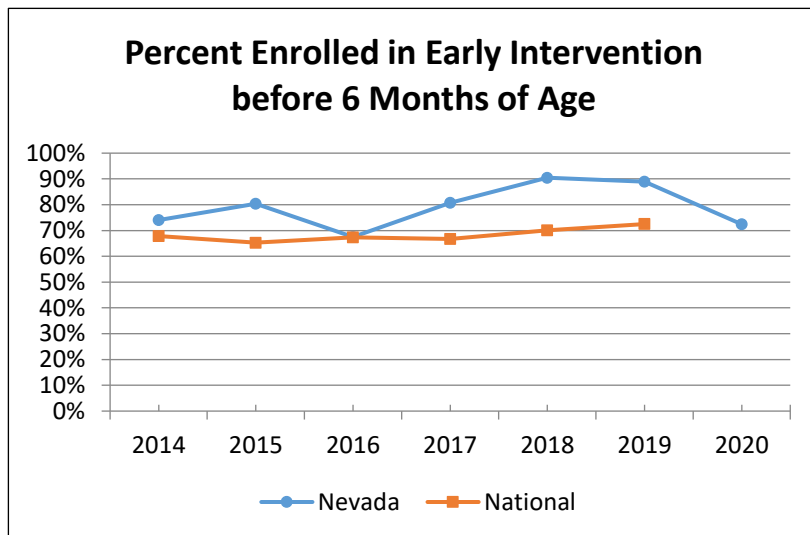


Figure 7 - Infants with Confirmed Hearing Loss Enrolled in Early Intervention by Six Months of Age

Figure 7 – Infants with Confirmed Hearing Loss Enrolled in EI by Six Months of Age

Nevada meets or surpasses national levels on enrolling deaf and hard of hearing infants into early intervention services within the six-month benchmark. During the 2020 COVID pandemic, the state EI facilities were closed for a period of time contributing to the 2020 decline.

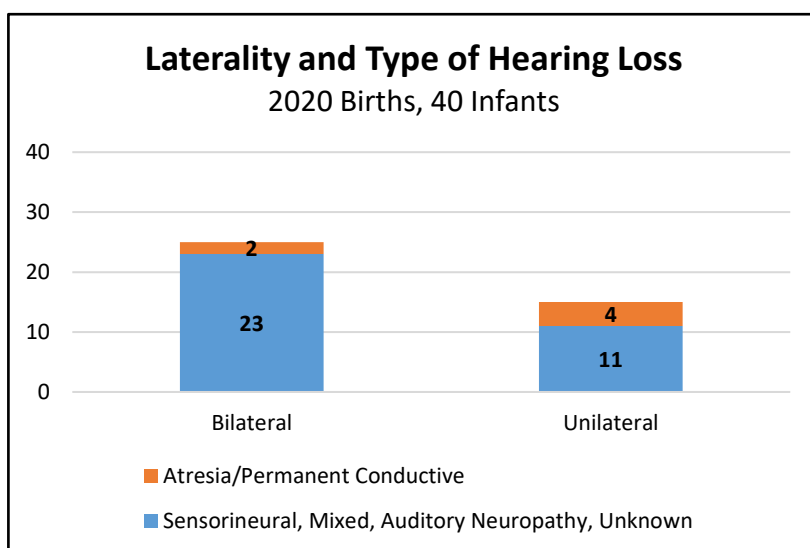


Figure 8 – Laterality of Hearing Loss

Figures 8 and 9 represent the 40 children with documented hearing loss.

Figure 9 – Laterality and type of Hearing Loss

Hearing loss may be bilateral (both ears) or unilateral (one ear) and diagnostically classified as sensorineural, conductive, or mixed

62.5% of hearing loss was bilateral
 37.5% of hearing loss was unilateral
 85.0% of hearing loss was sensorineural
 15.0% of hearing loss was conductive

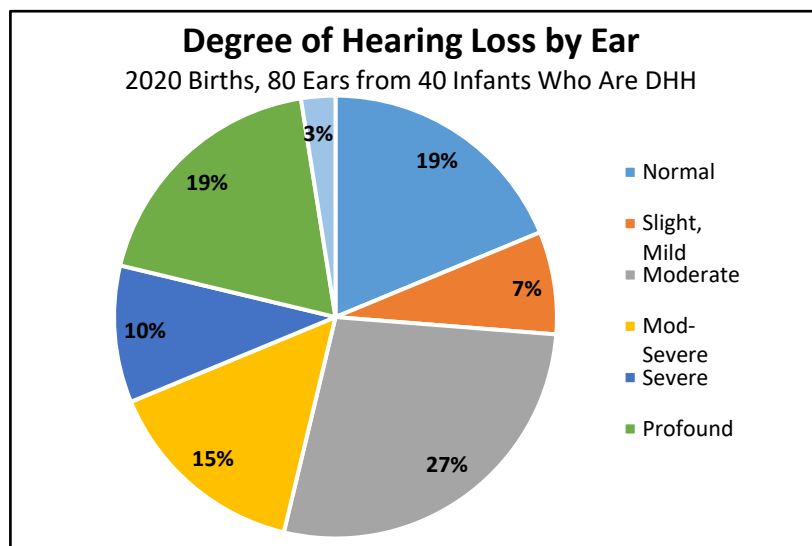


Figure 9 – Degree of Hearing Loss by Ear

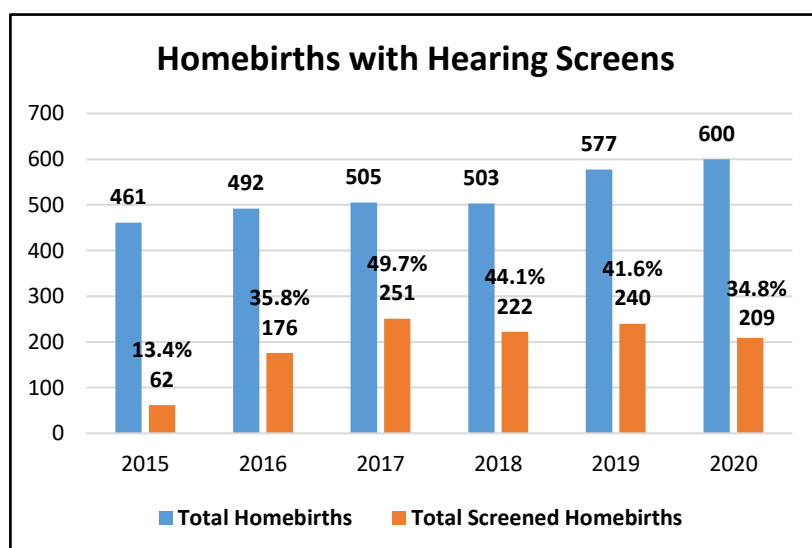


Figure 10 – Homebirths with a Documented Hearing Screen

Figure 9 – Degree of Hearing Loss by Ear

This figure breaks down the degree of hearing loss for each of the 80 ears tested. It must be noted these children often have a different degree of hearing loss for each ear.
(40 infants who are D/HH * 2 ears = 80 ears)

Figure 10 – Homebirth Infants with a Documented Hearing Screen

Nevada EHDI began a midwife pilot project during 2015 of placing hearing screening equipment in a small number of midwife practices. The project has been a great success and is in the process of expanding.

Recommendations

As a requirement of Nevada Revised Statutes (NRS) 442.550(5), the Nevada EHDI program shall provide an annual report to the Governor which addresses the effectiveness of the EHDI NRS provisions and related recommendations.

Current “Screening of Hearing of Newborn Children” statutes were initially adopted in 2001 and were amended in 2021. Over the last 20 years, infant hearing screening and early hearing detection and intervention concepts have evolved and expanded to encompass much more than the intent of the original legislation. Nationally and at the individual level, states have demonstrated a great public health success in the provision of hearing screens at the hospital/birthing facility level. States are consistently screening 96% to 98% of infants. It is now recognized that hearing screening is not a suitable end goal, but only the first step in the process of ensuring infants who are deaf and hard of hearing receive a timely diagnosis and appropriate intervention.

CDC and HRSA now direct state programs to move beyond simply identifying infants to ensure they are receiving appropriate and timely hearing screens. The current national guidelines direct states to also ensure timely and appropriate diagnostic follow-up and intervention services, intervention outcomes, as well as collaborate with community family-based organizations. Screening, diagnostic, and early intervention enrollment data is submitted annually to the CDC.⁷

In accordance with current national standards, modification recommendations to Nevada’s EHDI Program, will address the following:

- Establish best practice standards related to consistent, accurate, and timely data submission to the state by hospitals, birth centers, midwives, physicians, audiologists, and early intervention providers.
- Purchase of an EHDI specific data information system which is:
 - user-friendly to a variety of end-users
 - robust to efficiently handle the large volume of data; and,
 - compliant with CDC EHDI Information System functional standards and data tracking requirements⁸
- Update current pediatric audiology practice guidelines.
- Establish midwife responsibilities related to hearing screening and reporting; and
- Establish responsibilities of all EHDI partners related to timely and appropriate referral practices for audiologic testing and early intervention services.

Nevada Revised Statutes

SCREENING OF HEARING OF NEWBORN CHILDREN

NRS 442.500 Definitions. As used in [NRS 442.500](#) to [442.590](#), inclusive, unless the context otherwise requires, the words and terms defined in [NRS 442.510](#), [442.520](#) and [442.530](#) have the meanings ascribed to them in those sections.

(Added to NRS by [2001, 2460](#))

NRS 442.510 “Hearing screening” defined. “Hearing screening” means a test or battery of tests administered to determine the need for an in-depth hearing diagnostic evaluation.

(Added to NRS by [2001, 2460](#))

NRS 442.520 “Hospital” defined. “Hospital” has the meaning ascribed to it in [NRS 449.012](#).

(Added to NRS by [2001, 2460](#))

NRS 442.530 “Provider of hearing screenings” defined. “Provider of hearing screenings” means a health care provider who, within the scope of his or her license or certificate, provides for hearing screenings of newborn children in accordance with [NRS 442.500](#) to [442.590](#), inclusive. The term includes a licensed audiologist, a licensed physician or an appropriately supervised person who has documentation that demonstrates to the State Board of Health that he or she has completed training specifically for conducting hearing screenings of newborn children.

(Added to NRS by [2001, 2460](#))

NRS 442.540 Certain medical facilities prohibited from discharging newborn child born in facility until child has undergone or been referred for hearing screening; exception; regulations.

1. Except as otherwise provided in this section and [NRS 442.560](#), a licensed hospital in this state that provides services for maternity care and the care of newborn children and a licensed obstetric center in this state shall not discharge a newborn child who was born in the facility until the newborn child has undergone a hearing screening for the detection of hearing loss to prevent the consequences of unidentified disorders, or has been referred for such a hearing screening.

2. The requirements of subsection 1 do not apply to a hospital in which fewer than 500 childbirths occur annually.

3. The State Board of Health shall adopt such regulations as are necessary to carry out the provisions of [NRS 442.500](#) to [442.590](#), inclusive.

(Added to NRS by [2001, 2461](#))

NRS 442.550 Hearing screenings: Persons authorized to conduct; certain medical facilities to hire or enter into written agreement with provider of hearing screenings; documentation to be placed in medical file of newborn child; written reports.

1. A hearing screening required by [NRS 442.540](#) must be conducted by a provider of hearing screenings.

2. A licensed hospital and a licensed obstetric center shall hire, contract with or enter into a written memorandum of understanding with a provider of hearing screenings to:

(a) Conduct a program for hearing screenings on newborn children in accordance with [NRS 442.500](#) to [442.590](#), inclusive;

(b) Provide appropriate training for the staff of the hospital or obstetric center;

(c) Render appropriate recommendations concerning the program for hearing screenings; and

(d) Coordinate appropriate follow-up services.

3. Not later than 24 hours after a hearing screening is conducted on a newborn child, appropriate documentation concerning the hearing screening, including, without limitation, results, interpretations and recommendations, must be placed in the medical file of the newborn child.

4. A licensed hospital and a licensed obstetric center shall annually prepare and submit to the Division a written report concerning hearing screenings of newborn children in accordance with regulations adopted by the State Board of Health. The report must include, without limitation, the number of newborn children screened and the results of the screenings.

5. The Division shall annually prepare and submit to the Governor a written report relating to hearing tests for newborn children. The written report must include, without limitation:

(a) A summary of the results of hearing screenings administered to newborn children and any other related information submitted in accordance with the regulations of the State Board of Health;

(b) An analysis of the effectiveness of the provisions of [NRS 442.500](#) to [442.590](#), inclusive, in identifying loss of hearing in newborn children; and

(c) Any related recommendations for legislation.

(Added to NRS by [2001, 2461](#))

NRS 442.560 Hearing screening not required if parent or legal guardian of newborn child objects in writing; written objection to be placed in medical file of newborn child. A newborn child may be discharged from the licensed hospital or obstetric center in which he or she was born without having undergone a required hearing screening or having been referred for a hearing screening if a parent or legal guardian of the newborn child objects in writing to the hearing screening. The hospital or obstetric center shall place the written objection of the parent or legal guardian to the hearing screening in the medical file of the newborn child.

(Added to NRS by [2001, 2461](#))

NRS 442.570 Physician to recommend diagnostic evaluation if hearing screening indicates possibility of hearing loss. If a hearing screening conducted pursuant to [NRS 442.540](#) indicates that a newborn child may have a hearing loss, the physician attending to the newborn child shall recommend to the parent or legal guardian of the newborn child that the newborn child receive an in-depth hearing diagnostic evaluation.

(Added to NRS by [2001, 2462](#))

NRS 442.580 Lead physician or audiologist: Designation; responsibilities. [Effective January 1, 2022.] A licensed hospital and a licensed freestanding birthing center shall formally designate a lead physician or audiologist to be responsible for:

1. The administration of the Program for conducting hearing screenings of newborn children; and
2. Monitoring the scoring and interpretation of the test results of the hearing screenings.

(Added to NRS by [2001, 2462](#); A [2021, 3444](#), effective January 1, 2022)

NRS 442.590 Written brochures: Creation by Division; required contents; distribution. [Effective January 1, 2022.]

1. The Division shall create written brochures that use terms which are easily understandable to a parent or legal guardian of a newborn child and include, without limitation:

- (a) Information concerning the importance of screening the hearing of a newborn child; and
- (b) A description of the normal development of auditory processes, speech and language in children.

2. The Division shall provide the brochures created pursuant to subsection 1 to each licensed hospital and each licensed freestanding birthing center in this state. These facilities shall provide the brochures to the parents or legal guardians of a newborn child.

(Added to NRS by [2001, 2462](#); [2021, 3444](#), effective January 1, 2022)

Nevada Administrative Code

SCREENING OF HEARING OF NEWBORN CHILDREN

NAC 442.850 Annual reports to Division of Public and Behavioral Health: Contents. ([NRS 442.540](#), [442.550](#)) The annual written report required to be submitted to the Division of Public and Behavioral Health of the Department of Health and Human Services pursuant to [NRS 442.550](#) by licensed hospitals and licensed obstetric centers must include the following information concerning hearing screenings of newborn children conducted at the licensed hospital or licensed obstetric center during the period covered by the report:

1. The name of the licensed hospital or licensed obstetric center.
2. The number of newborn children screened.
3. The number of newborn children who required follow-up services and for each of those newborn children:

- (a) The age of the newborn child at the time the hearing screening was conducted;
- (b) The gestational age of the newborn child at birth;
- (c) The type of hearing screening that was conducted on the newborn child;
- (d) The results of the hearing screening;
- (e) Any recommendations made for the newborn child as a result of the hearing screening;
- (f) Any referrals made for the newborn child as a result of the hearing screening;
- (g) The county of residence of the newborn child;
- (h) The name and date of birth of the mother of the newborn child; and
- (i) The name of the attending physician of the newborn child.

(Added to NAC by Bd. of Health by R191-01, eff. 5-23-2002)

NAC 442.860 Referral of child for certain services: Notification of Division of Public and Behavioral Health. ([NRS 442.540](#)) If a licensed hospital or licensed obstetric center makes a referral for a newborn child because the newborn child needs assistance with accessing diagnostic and treatment services, the licensed hospital or licensed obstetric center shall notify the Division of Public and Behavioral Health of the Department of Health and Human Services of the referral at the time the referral is made.

(Added to NAC by Bd. of Health by R191-01, eff. 5-23-2002)

References

¹ <http://www.jcih.org>

² <http://www.infanthearing.org>

³ <http://www.aap.org>

⁴ <http://nvhandsandvoices.org>

⁵ <http://www.cdc.gov/ncbddd/hearingloss/data.html>

⁶ White, K. (October, 2010). *Twenty years of early hearing detection and intervention (EHDI): Where we've been and what we've learned*. ASHA Audiology Virtual Conference.

⁷ <http://www.cdc.gov/ncbddd/hearingloss/data.html>

⁸ <https://www.cdc.gov/ncbddd/hearingloss/ehdi-is-functional-standards.html>