Summary: Key Points for Health Service Providers

1. CheckUp has reviewed its funding priorities and policies to ensure they are evidence-based and align with the Queensland Government’s Aboriginal and Torres Strait Islander Child Ear and Hearing Health Framework, Deadly Kids Deadly Futures (DKDF).

2. As a result, CheckUp will no longer provide Healthy Ears – Better Hearing Better Listening funding for new ‘stand-alone’ ear and hearing screening programmes in early childhood and/or school facilities. Any existing ‘stand-alone’ ear and hearing screening programmes will be required to transition to the new model to be eligible for ongoing funding in the future.

3. Funding to enable the delivery of ear and hearing screening programmes in early childhood and/or school facilities will only be considered for new provider bids that meet the following criteria:
   a. Evidence is provided to demonstrate that the burden of middle ear disease and associated conductive hearing loss warrants intervention of the target cohort;
   b. The service provider is able to assure CheckUp that no other provider is delivering the same (or a similar) service to the target cohort;
   c. Funding preference will be given to providers that can demonstrate a screening model that achieves significant coverage of the 0-4 year cohort in the target communities. However, CheckUp acknowledges that population-based screening of this priority group creates practical challenges (see Policy Context section). Where coverage of the 0-4 age group would not be cost effective, the screening service must target all children aged 4-6 years in pre-prep, prep and year one.
   d. The service provider will meet the service delivery standards described in this document.
   e. The screening to be carried out will include the following minimum age-specific test components:

<table>
<thead>
<tr>
<th>Mandatory Elements</th>
<th>Details</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Otoscopy</td>
<td>Visual inspection of pinna, ear canal and ear drum.</td>
<td>All ages</td>
</tr>
<tr>
<td>2. Tympanometry</td>
<td>Categorise into Type A, B or C.</td>
<td>For children older than 6 months</td>
</tr>
<tr>
<td>3. Pure tone audiology</td>
<td>Air conduction screening down to 25dB at 1000, 2000 and 4000 Hz.</td>
<td>Start attempting on children from 3.5 yrs.</td>
</tr>
</tbody>
</table>

Introduction

In March 2016 the Ministers for Health and Education released Queensland’s Aboriginal and Torres Strait Islander Child Ear and Hearing Health Framework, Deadly Kids Deadly Futures (DKDF). That document, which is the result of collaboration from a range of government and non-government organisations, sets out an evidence-based and holistic approach to preventing, reducing and managing otitis media and conductive hearing loss among Aboriginal and Torres Strait Islander children.

CheckUp is proud to be a member of the DKDF Steering Committee, and has been working with the Deadly Ears Programme, the Department of Education and Training, Queensland Aboriginal and Islander Health
council and the Institute of Urban Indigenous Health to review its funding priorities and policies to ensure they promote best practice in ear and hearing health services in alignment with DKDF.

These *Funding Guidelines for Ear and Hearing Health Screening Programmes* (the Guidelines) result from that process. They provide direction to providers wishing to be funded under the *Healthy Ears – Better Hearing, Better Listening* programme and which are considering delivering ear and hearing health screening to Aboriginal and Torres Strait Islander children in early childhood and/or school settings.

The criteria set out this document do not apply to:

- audiology services which are delivered as part of the same provider’s whole-of-child health assessments or Ear Nose and Throat specialist clinics;
- providers delivering whole-of-child health assessments and follow-up, which include ear and hearing checks.

**Service Delivery Standards**

**Pre-Delivery Requirements**

1. **Child Protection**
   The QLD Department of Education and Training (DET) requires that health providers visiting DET early childhood education childhood facilities and/or schools have:
   a) appropriate qualifications to undertake ear and hearing health checks;
   b) a current Blue Card or exemption notice;
   c) completed child protection training as directed by the school principal;
   d) evidence of indemnity insurance;
   e) written endorsement from the manager/principal of the host facility to undertake the work as described in this document.

2. **Consent**
   Where parents/carers will not be present, providers must work with the host facility to obtain prior written consent from the parent/carer which includes:
   a) Question/s on whether there is any existence of or concerns about ear/hearing/speech problems;
   b) Confirmation of whether the child is under a care management plan for audiology/ENT/speech or related issues;
   c) Consent to share results and recommendations with the host facility (ie school/day care/kindy/etc);
   d) Nomination of the local primary health provider if possible;
   e) Advice on how any follow-up treatment or care is to occur, and the responsibilities therein of the provider, parent/carer and host facility.

   A sample proforma consent form is provided in Appendix 1

3. **Agreement with local Primary Health Providers**
   Providers must obtain prior agreement from the relevant local primary health facilities (nominated above) regarding appropriate referral pathways and protocols for children identified with needs arising from the ear and hearing screening.

**Delivery Requirements**

Providers will:
1. Deliver services in line with the national Recommendations for Clinical Care Guidelines on the Management of Otitis Media.
2. Ensure younger children are prioritised for service delivery. Where delivery occurs in schools, children from pre-prep, prep and year one must be seen. Other children, such as those identified with concerns by teachers or parents/carers, may then be seen if capacity allows.

3. Conduct a follow-up review ear and hearing check of all children who “did not pass”, to occur at 3 months after the initial ear and hearing check;

4. Provide a copy of all results and recommendations arising from each ear and hearing check directly to:
   a. the child’s nominated primary care provider using referral pathways and protocols agreed with those providers;
   b. the child’s family/carer; and
   c. the host facility (where consented).

These requirements are reflected in the Deadly Kids Deadly Futures Recommended Ear and Hearing Health Service Pathway diagram provided overleaf.

Note that families may not provide the name of GP or primary health clinic to which the child may be referred if they do pass their check. This may be because they do not have a regular GP or because they have chosen not to provide the name of their GP on the consent form. In such cases, the hearing health check should still be conducted and if the child does not pass:

1. the provider should ask the school whether they have the name of a health practitioner on file for the family (it is an optional field in the state school enrolment form), and
2. if the school does not have that information on file then the child’s family should be provided with a list of local GPs/primary health clinics along with the recommendation that they make an appointment for a clinical assessment.

Otitis Media, Conductive Hearing Loss, and the Role of Ear and Hearing Screening

The rate of otitis media (OM) among Aboriginal and Torres Strait Islander children is among the highest in the world. If left untreated, OM can lead to temporary and sometimes permanent conductive hearing loss (CHL) that can create difficulties in listening, learning, playing and developing relationships. These problems can have a negative effect on the long term trajectory of children’s lives into adulthood.

The aetiology and clinical pathway of OM is complex and poorly understood. In many children, OM and associated conductive hearing loss either resolves or fluctuates, but there is evidence that OM among Aboriginal and Torres Strait Islander children tends to be more frequent, longer-lasting and more likely to lead to long-term problems than in other Australian children.

Screening any population for OM and CHL can never do more than provide a snapshot at a point in time. This is why it is advised that all children who fail their initial ear and hearing health screening test should be reviewed a review should occur three months after the initial assessment.

One-off, stand-alone ear and hearing screening will identify those children with ear and hearing concerns which exist only at the time of screening. Screening involving the checks described above does not diagnose otitis media or hearing loss.

Primary/community health is essential in the assessment, diagnosis and management of children with ear and hearing concerns. It is important to note that children who do not pass ear and hearing screening or audiology (in relation to middle ear disease) are referred to primary health anyway.

As a result, it is imperative that anyone with concerns about a child’s ears and/or hearing must ensure the child is immediately seen by the local primary/community health centre.
Recommended Ear and Hearing Health Service Pathway

This diagram illustrates the ear and hearing health service pathway recommended by the Deadly Ears Program and the Department of Education and Training. It describes actions for providers of ear & hearing health checks (primary care or dedicated ‘screening’ agencies), other health services, and education providers (schools, and early childhood education and care centres). It also shows recommended points of information sharing between those providers.

**Education Providers**
Schools & EEC

- **ECEC centre/school provides classroom adjustments**
  - Classroom teachers provide:
    - reasonable adjustments so that student can access and participate on the same basis as their peers – e.g., using soundfield amplification systems, explicit targeted language instructions
    - support from specialist support staff as required
    - monitoring of students’ hearing behaviours in class and appropriate responses

- **ECEC centre/school monitors and reviews adjustments as needed**

- **ECEC centre/school provides specialist support as required**
  - Educators work with relevant health specialist and the family to determine ongoing student needs including provision of specialist support if required.

**Health Service Providers**
Primary care & specialist services

- **GP clinical assessment**
  - Specialist referral
  - Treat / manage in primary care
  - Primary health review

- **Condition resolved**
  - Refer to specialist ENT and/or Allied Health team

- **Implementation of ENT and/or Allied Health treatment & management plan**
  - Ongoing liaison and information sharing, depending on child’s condition and treatment.*

- **Condition not resolved**
  - Refer to specialist ENT and/or Allied Health team

**Child has ear and hearing health checked**

- **Pass**
  - Inform family and ECEC centre/school*
  - Does child need early clinical assessment by GP?
    - **No**
      - Review in 3/12
    - **Yes**
      - Review and refer
  - If check not conducted in primary care:
    1. recommend to family that child is assessed by GP (if not already done)
    2. refer direct to GP with results of ear and hearing check*

- **Didn’t pass**
  - Re-check at next opportunity

**Ear & Hearing Health Check Providers**
Primary care & ‘screening’ agencies

- **Pass**
  - Inform the family and ECEC centre/school*

- **Didn’t pass**
  - Re-assess at next health check

*Note: consent is required for sharing information at all points marked with an asterix.*
Policy Context

Lack of Evidence for Stand-Alone Screening

There is little evidence to support “stand-alone” ear and hearing screening. The Australian Institute of Health and Welfare\(^1\) (AIHW) cites it as an example of an intervention that “doesn’t work”, stating that, “Population based screening as a sole strategy has not been found to reduce the prevalence of ear disease among Indigenous children. A coordinated approach comprising disease prevention, treatment and management is required.” [p2]

Oberklaid et al (2002)\(^2\) note that “the follow-up of those who undergo a screening test is as important as the test itself” [p19]. A major issue highlighted in evaluations of ear and hearing screening programs\(^3\) has been the lack of follow-up with subsequent care.

Hopkins and Morris (2009) conclude “resources that might be used in screening for otitis media in Indigenous [children] would be better used in... strategies that improve the routine care i.e. surveillance (diagnosis and management) of otitis media in the community setting.” [p.8]

The AIHW also notes that, “an effective surveillance strategy can be built around regular (or opportunistic) child health checks.” [p9]

The DKDF framework’s “best practice model” (appendix A) advocates a move to “embedding ear and hearing healthcare into existing child health services rather than relying on the delivery of stand-alone ear and hearing services such as hearing screening programs conducted in primary schools” and “...it is recommended... [that] the reliance on school-based hearing screening programs as the predominant method of identifying child ear and hearing health is reduced”.

Prioritising Younger Children

The DKDF framework also states that, “the earlier a child with middle ear disease and associated hearing loss is provided with support, the greater the likelihood developmental and functional impacts will be minimised on their speech, communication and learning skills.” For this reason, DKDF and its associated Action Plan prioritise interventions such as routine ear and hearing health checks, and engagement by primary health care, for children aged 0-4 years.

Population-based ear and hearing screening for children aged 0-4 years presents significant practical challenges because only a small proportion of the cohort may attend an early childhood centre on any given day. This is particularly likely in communities which may have lower full-time employment, and therefore parents at home and/or extended family childcare arrangements. For this reason, these funding criteria extend to screening for the 4-6 age group (in accordance with DKDF’s Best Practice Model of Care) because clinical evidence indicates that this cohort also tends to have high prevalence of OM and CHL. Once children aged 4-6 years have been screened, targeted screening of children aged 7 and older can occur for those identified with concerns by teachers or parents/carers.

However, the 0-4 age group remains the priority for prevention and early intervention. CheckUp will prioritise funding for providers who can demonstrate that their screening model is able to reach a significant proportion (75% or above) of 0-4 year old children in any given community.

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**Definition of Terms**

Screening refers to any measurement that aims to identify individuals who could potentially benefit from an intervention for otitis media and/or conductive hearing loss. It is not diagnostic, and requires referral to primary health care for diagnosis and necessary treatment.

**Ear and hearing screening/checks** relate to screening for otitis media and/or conductive hearing loss, and includes the following assessments at age-appropriate stages, plus subsequent recommendations for management and treatment:
- otoscopy;
- tympanometry; and
- screening audiometry.

Stand-alone screening means there is no other health check provided to the child at that time by the service provider, and the service provider does not refer children who fail their ear and hearing health check for primary health assessment and management using referral protocols and pathways agreed beforehand with local primary care providers.

**Audiology** in this context refers to the delivery of diagnostic assessments in relation to middle ear disease and associated conductive hearing loss.

**Surveillance** differs from screening in that:
- It targets many aspects of child health, growth and development;
- It is part of routine care, and the follow-up with intervention when required is inherent;

An example of surveillance in this context would be the inclusion of ear and hearing checks in routine and opportunistic child health checks.

**Delineating between “Screening” and “Surveillance”**
The World Health Organisation says “Screening is often thought of (and in practice often is) a cross-sectional, short-term operation” [eg. one-off school screening] ...“while surveillance conveys rather a long-term vigil over the health of an individual or of a population” [eg. routine age-appropriate child health checks].

**Support for Providers**

Providers can access the following support:

1. The national Recommendations for Clinical Care Guidelines on the Management of Otitis Media is a resource to standardise treatment for Aboriginal and Torres Strait Islander children. They are accessible [here](http://www.healthinfonet.ecu.edu.au/otherhealth-conditions/ear/reviews/other-reviews).

2. Training in Ear and Hearing Checks in Qld is available as follows:
   - a) **The Benchmarque Group** is funded by the Australian Government to deliver accredited training in alignment with the national guidelines on otitis media. It offers the [Otitis media and Aural Health](http://www.healthinfonet.ecu.edu.au/otherhealth-conditions/ear/reviews/other-reviews).

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Care Program. Other courses are also available, including the Audiometry Screening and Assessment Program, and a course in Aural (Ear) Health.

b) The Deadly Ears Program can support GPs, Child Health Nurses, and Aboriginal Health Workers (minimum Cert IV) with training in ear and hearing checks. Please contact its office on 07 3310 7709 for further information.

3. The Australian Government has an arrangement with Sonic Innovations to support services with ear and hearing screening equipment. Please contact this organisation if your organisation requires screening equipment.

4. It is very important to deliver effective health promotion and education about strong ear and hearing health in Aboriginal and Torres Strait Islander children. There are a range of useful resources available to early years staff, educators, health professionals and families available from:

a) The Australian Government’s Care for Kids’ Ears campaign;

b) The Deadly Ears Program; and

5. Providers working under this measure are strongly encouraged to review http://www.cultureawarenessforhealth.com.au/

6. It is also worth checking whether specific education and training supports exist within your organisation.
Appendix 1: Sample Consent Proforma

Ear and Hearing Check CONSENT FORM

Name of School or Day-Care: __________________________

Dear Parent / Guardian

It is important for health staff to conduct regular ear and hearing checks on children. An ear and hearing check simply gives us a SNAPSHO T of your child’s ear and hearing health. It is NOT a diagnostic assessment and further follow-up may be required.

We are asking for your consent to allow your child to participate in this ear and hearing health check. Your consent will provide trained health staff with the authority to:

- Check your child’s ears and hearing, and if needed, re-test and follow-up your child.
- Share results with other health and education staff in your community, such as Health Workers, Child Care Staff, Teachers, Audiologists, Speech Pathologists, and Doctors including Ear Nose and Throat Doctors (ENTs). This will ensure your child receives support from health and education providers.

Your consent applies only to ear and hearing checks, which involves the following procedures:

- **Otoscopy** (This is the first check we do; it shows us how your child’s ear, ear canal and ear drum look.)
- **Tympanometry** (This is the second check we do, it tells us how well your child’s ear drum and middle ear is working.)
- **Audiometry** (This is the final check we do; it tells us how well your child can hear different sounds.)

Results of this assessment will be given to you. The results will also be sent to your local GP as nominated by you below. If we need to use your child’s results in our statistics no one will be able to identify your child.

Prior to providing written consent if you have any questions please contact the service provider who will be conducting these checks on (07) ____________

<table>
<thead>
<tr>
<th>Local GP service:</th>
<th>GP’s Full name:</th>
<th>Address of service:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone number of service:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please complete the questions on this form and return it to your school or day-care provider. An OPTION must be ticked and a SIGNATURE is required. (one child per form)

My child identifies as:  □ Aboriginal □ Torres Strait Islander □ Both □ Neither

My child has a diagnosed hearing problem and is under the care of a specialist:  □ YES □ NO

Please select ONE of the following options:

- □ I give consent for my child to be checked for a 12 month period only. After that, you will need to sign another consent form for this to continue.
- □ I do not give consent for my child to be checked.

Child’s name: __________________________

Other name: __________________________

Child’s sex:  □ Female □ Male

Date of birth: __________________________

Home Address: __________________________

Telephone: __________________________

School: __________________________

Grade: __________________________

Parent’s/Guardian’s name: __________________________

Date: __________________________

Signature of Parent/Guardian:

You can withdraw consent at any time, either verbally or in writing.

CONSENT WITHDRAWN: __________________________

Name of witness / parent / guardian: __________________________

Date: __________________________