

# UTS TRAINING TIMES

First Steps

Volume 5 Issue 1

February 2009

## Inside this issue...

- The Service Coordination Workgroup has written an article for providers and Service Coordinators with suggestions on working together to strengthen early intervention teams. A list of Workgroup members and their contact information is included on page 15. If you have a question or concern regarding service coordination in your Cluster, contact your SPOE workgroup member. If your question is regarding service coordination training, please contact Mindy Dunn, UTS Trainer.
- In the original article, *Auditory Processing Disorders in Children*, Suzanne Foley, M.S., CCC-A, explores the causes, signs and symptoms of Auditory Processing Disorders and provides treatment options and resources for professionals and families. Auditory processing deficits can adversely affect a child's academics, communication and life skills.
- Betsy Traub from the Indiana Institute on Disabilities and Community (IIDC) provides an overview of the Indiana Family-to-Family network including a variety of ways that families can access information, resources and support.



The deadline for completing the *Training Times* assessment is April 15th. Since it is tax day it should be easy to remember. Don't forget to check the UTS website <http://www.utsprokids.org> for additional training opportunities. The new Procedural Safeguards distance learning course is now available and several new topical trainings will soon be posted.

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INDIANA'S UNIFIED TRAINING SYSTEM

"Creating Learning Opportunities for Families and Providers Supporting Young Children"

## First Steps Enrollment and Credential Training Requirements

Provider Level—New	Training for Enrollment	Training for Initial Credential
Service Coordinator (Intake and Ongoing) New to First Steps December 2007 and after	SC 101—SC Modules (self-study)	SC 102—SC follow up at 3-6 months (on-site)* SC 103— SC follow up at 6-12 months (on-site)* Quarterly—Training Times Assessment (self-study) First Steps Core Training—one course per credential year (self study or on-site) 10 or 15 points for initial credential
Direct Service Provider (new to First Steps December 2007 and after)	First Steps Orientation or DSP 101—Provider Orientation Course (self-study)	DSP 102—Half day follow up at 3-6 months (on-site) DSP 103— Half day follow up at 6-12 months (on-site) Quarterly—Training Times Assessment (self-study) First Steps Core Training—one course per credential year (self study or on-site) 10 or 15 points for initial credential
Provider Level Credentialed	Training for Enrollment	Training for Annual Credential
Service Coordinator (Intake or Ongoing who has completed initial credential)	SC Orientation and Service Coordination Level 1 or SC 101—SC Modules (self-study)	Quarterly—Training Times Assessment (self-study) First Steps Core Training—one course per credential year (self study or on-site) 3 points for annual re-credential
Direct Service Provider (who has completed initial credential)	First Steps Orientation (on-site or self-study) or DSP 101—Provider Orientation Course (self-study)	Quarterly—Training Times Assessment (self-study) First Steps Core Training—one course per credential year (self study or on-site) 3 points for annual re-credential

\* Replaces Service Coordination Level 2

### Attention New Providers and Service/Intake Coordinators

The Bureau of Child Development Services requires all providers and service coordinators to complete the *Training Times* assessment as part of your mandatory training requirements for credentialing.

New providers must establish an account on the UTS website (<http://www.utsprokids.org>). Obtaining an account is easy.

1. Click on Account Login in the upper right hand corner.
2. On the login page click on Create One Here
3. Enter your information (note that UTS Training Times is mailed to your primary address—you are encouraged to use your home address, especially if it is difficult to get personal mail at your workplace, e.g. hospital system). UTS does not give any of your training profile information to anyone outside of First Steps. The BCDS and UTS will periodically send you email updates regarding First Steps.
4. When all information has been entered click on Update Information.
5. Register for your annual training fee.

6. Once your payment has been posted, you can take the Training Times assessment, under My Quizzes.
7. If you have questions or encounter problems email Meg in the UTS Connect office at: [registration@utsprokids.org](mailto:registration@utsprokids.org)

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Published quarterly by Indiana's Unified Training System (UTS) - Programmatic Training at ProKids, Inc. 6923 Hillside Ct. Indianapolis, IN 46250. Indiana's Unified Training System (UTS) is funded through a grant from Indiana First Steps, Bureau of Child Development Services, Division of Developmental Disability and Rehabilitative Services, FS SA. Subscription fee is included as a part of the annual training fee for enrolled First Steps providers. Copies may be downloaded from the UTS ProKids web page.

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# Working Together to Strengthen Early Intervention Teams

*This is the second in a series of articles on Service Coordination from the Service Coordinator Workgroup.*

Every family in First Steps has a multi-disciplinary early intervention team including, at a minimum, the family, Service Coordinator, ongoing provider(s), ED team, and physician. While cohesive early intervention teams are critical to each child's and family's success, the importance of working together as a team can sometimes be overlooked by individual team members. The Statewide Service Coordination Workgroup would like to offer the following discussion about how Service Coordinators and providers can work together to ensure strong and successful early intervention teams for all First Steps families.

## **When is a team discussion required?**

Although it is beneficial for team members to communicate with one another on an ongoing basis, team discussion and consensus are required before any substantial change to the IFSP may occur. Substantial changes include additions of new services, changes in frequency or intensity (increases/decreases), and termination/discharge (note: families have the right to terminate services at any time without team discussion/consensus). Team communication may be in the form of face to face meetings, emails, and/or phone conversations.

## **What is the Service Coordinator's role?**

The Service Coordinator will initiate a team discussion any time a substantial change to the IFSP is proposed. The Service Coordinator will begin by working to obtain all relevant information from team members (progress reports, medical information, etc.). If a face to face team meeting is held, the Service Coordinator will make every effort to coordinate a mutually agreeable date and time and will make sure all team members have all relevant information prior to the meeting. If the team is communicating via phone or email, the Service Coordinator will make sure all team members have an opportunity to provide input and consensus is reached before moving forward. (Note: any time there is a disagreement that cannot be resolved via phone or email, a face to face team meeting should be held.) Throughout the process, the Service Coordinator will ensure that the family's rights and procedural safeguards are observed. The Service Coordinator will also ensure that state guidelines for service delivery are followed and will complete all required documentation of the team discussion and IFSP change.

## **What is the provider's role?**

Because ongoing progress reports provide the best information on the child's current skill levels, timely and thorough progress reports are critical to ensuring a cohesive team. Progress reports should be submitted to the Service Coordinator on the first day of the third, fifth, ninth and eleventh months of service, and the Service Coordinator will distribute progress reports to the other team members (note: SPOE procedures for the distribution of progress reports may differ from cluster to cluster). This process helps ensure all team members are aware of the child's progress toward IFSP outcomes. Providers should communicate directly with other team members as needed to discuss challenges and successes with a child/family. Providers are also encouraged to contact ED teams directly to provide input and/or clarify questions about a child's eligibility and/or need for service. Providers should notify the Service Coordinator any time a change in service is proposed so a team discussion can be initiated. Because team discussion and consensus are required before any changes to the IFSP can be made, your prompt response to requests for input will help expedite the process. Remember that service decisions must be made by team consensus and should not be made by a provider and family in isolation. Providers should also be cautious not to make promises to families about proposed service changes, but instead reinforce the importance of discussing the points of view of all team members before proceeding.

By working together as team members, providers and Service Coordinators help ensure the highest quality early intervention services for all First Steps children and families. Please contact your local SPOE office with any questions about Service Coordination in your cluster.

***A listing of the Service Coordination Workgroup members and contact information can be found on page 15.***

# Meeting the Need for Family Support in Indiana

## Indiana Family to Family

*Submitted by Elizabeth Traub, Research Associate, IIDC*

Because few things are stronger or more supportive than family-to-family support, the Indiana Family-to-Family (INF2F) network has incorporated a variety of methods to help families access information, resources, and personal supports.

**Listserv:** The Yahoo© INF2F Parent listserv is available for all families of children with disabilities or special needs who are interested in networking with other families. The listserv serves as a forum to exchange information and resource as it relates to transition, therapies, IEP, surgeries, medications, coping and general family-to-family support and encouragement. To join, parents email to INF2Fparents-subscribe@yahoogroups.com. This is a moderated site with over 550 members.

**Newsletter:** *First Words* is an online newsletter that is published bimonthly. It contains short articles of interest to parents, updates on the law, featured resources, upcoming workshops and trainings, and will soon offer Cluster Highlights. *First Words* is available on the Family-to-Family website and by subscription (email beardc@indiana.edu to be added to the list).

**Training Funds:** The Family Involvement Fund (FIF) is a reimbursement fund to support families of children with disabilities (ages birth through 21) to increase knowledge and understanding of their child's disability and/or the systems that provide services. This may include attending a conference or workshops, task force meeting, or online trainings. The FIF also provides financial reimbursement for the purchase of approved print materials and electronic media such as CDs, DVDs, and videos. Separate funding within the FIF is available for parents who are asked to participate as members of their Local Planning and Coordinating Council, its committees and sponsored activities, or other relevant committees. The FIF guidelines and online application form are available on the Family to Family website

**Family Training Series:** The F2F training series includes presentations on topics of interest and need as identified by families. These learning events are presented by topic experts and offered in a variety of ways in order to meet the diverse learning styles of family members. The series is presented face-to-face in two different areas of the state, and as a webinar. At the completion of the training series, all presentations are recorded onto one CD and made available at a minimal cost to families. In addition, free 24/7 access to the interactive, narrated presentations are made available on the F2F website. This year's topics include family support strategies, building skills during family routines and play, building support groups, future's planning and developing advocacy skills. Descriptions of the learning opportunities and dates for both the live presentations and webinars are included in the F2F brochure flyers obtained from each SPOE or on the F2F website. Topic specific flyers are available to share with families and providers are encouraged to inform families about the training series and to utilize the information in their own family training events.

**Parent Liaisons:** Indiana is privileged to have a very active not-for-profit family organization whose entire work is about supporting families of children with special needs. As a collaborative partner in the F2F efforts, **About Special Kids (ASK)** employs, trains and supervises 9 **Parent Liaisons**. Parent Liaisons focus their efforts on supporting individual families as they navigate the early intervention system, and later, the special education system. Parent Liaisons have extensive training

## Indiana Family to Family

in community resources, health insurance, special education law and support organizations in order to work with individual families or with the family's service coordinator or provider to access needed resources.

Recently every Cluster was visited in order to meet with leadership and put together a work plan specific to the Parent Liaison (PL) role. As a result of those meetings, Clusters were able to apply cluster-specific identities to their Parent Liaison so that families and providers alike would benefit from this program.

**Protocol for referrals:** All Clusters have an identified protocol for making referrals to the Parent Liaison. In all nine clusters, families may also contact the Parent Liaison directly. In Cluster CH this is encouraged in order to empower the family to seek resources that support their needs.

Direct service providers who visit with families on a more regular basis and see potential need for additional intervention may contact the child's Service Coordinator to make the referral. In Cluster A, Service Coordinators contact the Parent Liaison via email with a brief reason for the referral. The Parent Liaison then follows-up her visit to the family with an acknowledgment to the Service Coordinator.

While Parent Liaisons usually work directly with a family, In Clusters B and G the Parent Liaisons also are scheduled to visit the SPOE office on a regular basis to brainstorm and problem-solve about how to best meet the needs of the families in their Clusters. Additionally, Service Coordinators may want to brainstorm solutions to some challenges, ask about disability-specific resources, or other resources that may address individually identified family needs.

In Cluster J the Service Coordinator supervisor made a point to accompany the Parent Liaison to meet each of the Service Coordinators. ALL Clusters know that their Parent Liaison can be available to visit the SPOE office and orientate new service coordinators about the role of the Parent Liaison. Parent Liaisons help increase parents' ability to meet their children's needs by identifying community resources, enhancing natural support systems and securing needed services.

In Cluster D, the Parent Liaison has expanded her role to include community outreach activities, to inform doctors, clinics, and service providers of her availability to work with families, including the hard-to-reach families.

**Outreach:** Several Clusters have asked the Parent Liaison to participate on their Local Planning and Coordinating Council. Others have invited the Parent Liaison to attend Cluster meetings or to participate in regular staff meetings. In addition, several Parent Liaisons have been instrumental in facilitating new parent participation on transition committees and parent outreach committees. In both Cluster A and Cluster E, the Parent Liaison attends resource fairs and supports Child Find efforts through participation in various community specific activities.

In both Cluster I and Cluster CH the Parent Liaisons are responsible for large geographic areas and although space is often limited most SPOE offices have offered mailboxes and the temporary use of a desk and phone for SPOE visits. Parent Liaisons are on e-mail lists and are notified of Cluster specific training opportunities or meetings and are provided with meeting minutes. The Parent Liaisons in turn will share resource information with staff including details about upcoming training

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opportunities offered through family support agencies and F2F. Providers are often asked to hand out flyers and to be sure that all families in the First Steps System have a copy of the Family to Family brochure that details the services and resources available through this project.

While there is only one Parent Liaison in each Cluster, First Steps has seen the role expanding. Families continue to want and need the information and support that only a parent who has experienced early intervention services and the on-going challenges of parenting a child with special needs can provide.

**Parent Mentors:** A Parent Mentor is a trained volunteer whose child has exited the First Steps Early Intervention System. Parent mentors provide peer support to parents of children currently in the early intervention system. Peer support includes encouragement and empathetic sharing, and helping a family work through the feelings and concerns of raising a child with special needs. Parent Mentors are also trained by About Special Kids (ASK).

**Website:** The Indiana Family to Family website is located at [www.inf2f.org](http://www.inf2f.org) and is the one place to locate all information about the Family to Family project. Families may access the *First Words* newsletter and Family Involvement Fund application, and sign up for the F2F Listserv. Also, parents can read about the Parent Liaison and Parent Mentor programs, and find local and state training opportunities, and access the online F2F training series. The website also houses written information and fact sheets.

**Funding:** Family to Family is a project of the Indiana University, Indiana Institute on Disability and Community, Early Childhood Center and About Special Kids (ASK). Funding is provided by the Indiana Family & Social Services Administration (FSSA), Division of Disability & Rehabilitative Services, and the First Steps Early Intervention System

If you have questions, please contact Betsy Traub ([etraub@indiana.edu](mailto:etraub@indiana.edu)), Cathy Beard ([beardc@indiana.edu](mailto:beardc@indiana.edu)) or visit the Indiana Family to Family Website at [www.inf2f.org](http://www.inf2f.org).

<b>CSC Covansys Transition Schedule</b>	
1/30/2009 – 2/15/2009	Transition Period – System shutdown
2/3/2009	Last payment made via EDS
2/16/2009	First date for activity with CSC Covansys; Service Matrix, PAM, Provider Enrollment processing, helpdesk/phone support
2/19/2009	First payment made via CSC Covansys

# Winter Driving Tips

**First Steps Providers and Service Coordinators spend a large portion of their days driving. The AAA offers the following winter driving tips. Home visitors should carry a cell phone and always let someone know your appointment schedule. Here are some additional tips.**



1. **A clear view:** Remove snow from all windows. Keep your headlights and tail lights clean and clear of snow. Keep windshield wiper reservoir full and your windshield clean.
2. **Tires:** The most important thing you can do is have good tires. If they're getting close to the wear bars, you should have them replaced. Make sure your tires are at the correct pressure; tires that were at the specified pressure in summer will probably be low with the colder temperatures experienced in winter.
3. **Brake earlier:** Most people think they have more grip than they actually do, which leads to sliding right through the intersection. If you're coming to a turn or a stop, start applying brake pressure twice as early as on dry roads.
4. **Let ABS work for you:** If your vehicle has an antilock braking system (ABS), you may feel a vibration in the brake pedal as the system prevents wheel lock up. Keep firm pressure on the brake pedal until your vehicle comes to a complete stop. Do not pump your brakes if your car has ABS.
5. **Unwind the steering wheel:** As the front tires begin to slip, most people tend to turn the wheel even more. However, the tires already can't cope with the current situation, so asking them to do more isn't the answer. Instead, turn the wheel back slightly and tap the brakes a little to put more weight on the front end to help the front tires regain traction.
6. **Be prepared:** Keep an emergency kit in your vehicle at all times. The kit should contain an ice scraper, cloth or roll of paper towels, battery starter cables, blanket, warning devices such as flares or triangles, window washing solvent, flashlight, snow brush, snow shovel, and a small bag of abrasive material like sand, salt or cat litter for traction.
7. **Seatbelts:** Always wear a seat belt. Keep it low across hips and on shoulders. Sit at least 10 inches away from steering wheel so you have room for emergency steering maneuvers and to give the airbag room to inflate.

Finally, don't let your guard down halfway through the season. According to Craig Layson, owner of Stony Creek Collision in Ypsilanti, Mich., the worst accidents usually happen later in the season: "For the first snow of the year, most people do slow down, and the majority of cars we see have simply slid off the road, with damage limited to their sides and suspension. It's the last snowfall of the season where we see the most damage. People are more comfortable driving in the snow, aren't slowing down like they should, and that usually results in more serious accidents."

## Good Bye Meg, Welcome Janice

For almost three years, Meg Beltrame has served as administrative assistant for the UTS Connect office. Meg recently left this position for an extended period of travel to explore Argentina. On her return to the USA in April, Meg hopes to enter nursing school.

Please welcome Janice Sams as the newest member of the UTS staff. Janice will assist with UTS training, including registration, provider training profiles and distance education courses. Janice was born and raised in Iowa, where she attended the University of Northern Iowa. She moved to Indiana in 1988. Janice served her country as a member of the National Guard. She enjoys dog sports and is a member of the Extreme Insanity Flyball Team. Janice can be reached at (317) 472-6106 or at [registration@utsprokids.org](mailto:registration@utsprokids.org). Welcome, Janice!

# Auditory Processing Disorders in Children

*An original article by Suzanne Foley, M.S., CCC-A*

There is a great little story that has been used often to explain auditory processing. It is based on the old Folgers commercial.....There was a grandmother drinking a cup of coffee and sitting with her young grandson. When the grandmother got to the bottom of her cup, she found a little green toy soldier in the bottom of the coffee cup. She looked at her grandson and he smiled and said "See, Grandma, it's just like the TV, the best part of waking up is *soldiers* in your cup".

Hearing is a complex process. What our ears and brain do in order to hear and understand in such a short amount of time is astounding! We use our hearing to learn, communicate and interact with our environment. It is well known, particularly in children, that hearing is critical to language development and learning. Between 75-80% of all teaching in the classroom is auditory. Traditional academic instruction is based on the assumption that a child can hear, attend and understand a teacher's voice.

There are many variables that can affect a child's ability to listen and attend in a classroom and if a child is having difficulties that appear to be more auditory in nature, it is appropriate to begin evaluating the cause. There are different types of hearing loss that can be identified and remediated. There are language and developmental disorders such as autism, learning disabilities, and attention deficit that cause listening difficulties. An auditory processing disorder is another potential cause.

Over the past few years, auditory processing disorders have been emerging as a "popular" disorder. Unfortunately, there is much misunderstood about the diagnosis and treatment of auditory processing disorders. One initial misunderstanding surrounds the acronym used for the disorder, either CAPD or APD. In the last few years, there have been two major professional consensus conferences that have provided professional guidelines for the evaluation of auditory processing disorders: ASHA (American Speech Language and Hearing Association) task force on auditory processing disorders (1996) and the Bruton Conference (2000). The Bruton conference proposed the change of the label from Central Auditory Processing Disorder (CAPD) to Auditory Processing Disorder (APD). Both acronyms are still used and they are the same disorder.

## **What is an Auditory Processing Disorder (APD)?**

One of the classic explanations of auditory processing is from Katz, Stecker & Henderson (1992). They described central auditory processing as "what we do with what we hear." In other words, it is the ability of the brain to process incoming auditory signals. The brain identifies sounds by analyzing their distinguishing characteristics—frequency, intensity, and temporal features. An auditory processing disorder is caused by a deficiency in those skills that is due to a problem in the auditory system in the brainstem and/or higher up in the brain. There are six identified auditory skills that we use to process auditory information that were identified by the ASHA task force (1996) :

- *Sound localization/lateralization* - ability to tell where sound is coming from
- *Auditory discrimination* - ability to hear the difference between similar sounds
- *Auditory pattern recognition* - ability to hear high vs. low tones and patterns
- *Performance decrements with competing acoustic signals* - trouble listening in background noise.
- *Auditory performance decrements with degraded acoustic signals* - trouble listening in less than ideal situations-in poor acoustic environments (such as classrooms!)
- *Temporal aspects of audition* - timing of auditory information

Auditory processing is not a hearing loss and cannot be identified by a typical hearing test ("raise your hand when you hear the beep"). Auditory processing disorders typically occur in light of normal hearing (normal peripheral hearing). Different auditory processing skill areas can be affected. The incidence of this disorder is approximately 3-5% of the school age population. The incidence increases dramatically with age as almost 70% of people over the age of sixty have some kind of auditory processing deficit due to the effect of aging on the brain and auditory system. There is a gender ratio of two males affected for every female.

# Auditory Processing Disorders in Children

It is critical that the approach to auditory processing be done in a multidisciplinary method through evaluation and consultation with other professionals: i.e., psychologists (private or school-based), speech language pathologists, otolaryngologists (ENT's), the child's physician, physical or occupational therapists, teachers, counselors and parents. If a child has been evaluated or treated by other professionals, it is important to have all the information available regarding previous evaluations, diagnoses and treatment plans in order to integrate the information with a child's auditory processing abilities. Auditory processing can be differentially diagnosed from attention deficit, language disorders and hearing loss. Other conditions (such as low cognitive function, and autism) can have auditory processing weaknesses as part of the umbrella of symptoms consistent with those disorders, but not as a cause of their condition.

## **What are the causes of Auditory Processing Disorders (APD)?**

Causes of APD in children are relatively unknown and can be varied. Some disorders are due to delay in the development of the auditory system. We expect the auditory system to be fully developed at age 12, but this is not always the case. Children with learning disabilities often have delayed auditory maturation. 60% of the children with this type of APD etiology can improve with normal development. The challenge is not to wait until a child is 12 years old to determine if their system will improve, as the weak auditory skills will likely affect academics and communication and can be improved. Chronic ear infections (or congestion due to allergies) may increase the likelihood of processing problems, due to faulty sound perception. Typical high risk prenatal and birth conditions such as lack of oxygen, prematurity, birth trauma, and infections can be considered. Jaundice has been added as a risk factor for APD due to high bilirubin levels being shown to damage the cochlear nuclei (Musiek). Family history plays a factor as many parents of children diagnosed with auditory processing report similar issues in childhood.

## **What are signs and symptoms of Auditory Processing Disorders?**

Children with APD present with behaviors that initially are evident in their listening skills. Some symptoms can also suggest other problems such as learning disabilities, language problems, attention deficit and other developmental delays. The key to being able to identify reported behaviors as suspicious to auditory processing is that behaviors should be linked to specific auditory tasks. For example, a child with APD may exhibit difficulty with:

- maintaining focus when they are in a setting with background sounds,
- difficulty understanding speech in background noise,
- response time (slow or delayed response as compared to no response),
- misunderstanding information that they have heard,
- understanding humor or sarcasm that is "heard" through inflections in voice quality,
- auditory memory or remembering more than one or two instructions at a time,
- sensitivity to loud sounds,
- understanding people with accents or rapid speakers,
- recognizing the direction a sound is coming from and/or reading and spelling difficulties.

When interviewing parents and teachers, it is important to focus on the behaviors that are specific to auditory information. For example, a child who is distracted in situations when it is quiet and noisy and not just when there is background noise may have more of an attention problem than APD. The classic complaint of parents with children suspected of APD is that the child cannot follow multi- step directions. Further questioning of this behavior can help clarify. If parents ask a child to go upstairs and get their coat and meet them in the car, does the child follow one part of the direction and ask for clarification? Does the child ask, "What was I supposed to get? Was I supposed to get a coat or shoes?" or does the child go upstairs, get distracted and start playing video games?

It is not unusual to observe speech and language problems, as well as academic problems (reading and spelling), in children with APD. Not all children with APD will experience these challenges as there is a wide range of variability in the problems experienced by children with APD. It should be recognized that the presence of an APD places the child at risk for developing language and academic problems.

# Auditory Processing Disorders in Children

## How do we screen for Auditory Processing Disorders?

If a child is suspected of having APD based on reported behaviors there are screening mechanisms that can help determine if an evaluation is necessary. Screening can be done by a standardized questionnaire or checklist (Fishers, Sifter, CHAPPS), pattern of test results by another professional, case history, an actual screening test or a combination. Many times other professionals such as speech language pathologists, psychologists or teachers will perform testing that suggests a weakness in auditory, verbal or receptive skills that warrant further evaluation (low auditory memory, receptive language, lower verbal scores than performance on IQ testing).

An audiologist can sometimes be the first professional to see these children because parents suspect a hearing loss and start by scheduling a hearing test. In a given geographic area, there are typically only a few audiologists who specialize in APD. Audiologists who tell a parent there is “no problem” after the child completes a standard hearing test that reveals normal hearing, does a disservice to those parents. Even if the testing shows normal hearing, there is still a valid, realistic, listening problem for this child (enough so that the parent scheduled the hearing test) and the parents should be given direction or counsel by the professional (audiologist) they turned to for help. Similarly, the speech language pathologist may also be in a position to work with these children first due to working in the school system and being the most appropriate professional in that setting. There are tools (Differential Screening Test of Processing from Linquisystems and others) designed for screening purposes.

## How do we evaluate for Auditory Processing Disorders?

An audiologist is the only professional who can diagnose an auditory processing disorder. However, not all audiologists are equipped or trained to evaluate for APD. The audiologist can diagnose the disorder using a variety of test protocols that considers a child’s cognition, attention, memory, physical issues, current and previous medical conditions, environmental factors, family, education, and social skills of the child. Auditory processing skills should be considered in light of all of the above mentioned issues and not separately in isolation.

There are two important reasons to obtain an evaluation for APD. The first is to determine if a disorder is present, to what degree and to identify specific auditory processing skill areas affected. A report outlining that information along with a comprehensive treatment program should be provided, discussed with the parents and shared with the student’s school. For some children (especially adolescents), it is helpful to include them in the discussion of the recommendations. It can help the child understand why they are having difficulty and provide ways for them to apply strategies effectively.

The second purpose for evaluating APD would be to rule out the disorder as a contributing factor to the child’s challenges. It is important that if an evaluation for APD does not result in that diagnosis, specific recommendations be given to the family to continue the search for the appropriate etiology. Audiologists who provide APD evaluations should be educated in the other conditions that may be present other than APD (or in addition to) so that appropriate referrals to knowledgeable professionals can be made.

Testing for APD is done in a sound proof booth using a variety of tests that evaluate as many of the auditory processing skills as possible. The first step is to make sure that the child does not have a hearing loss. A typical hearing test using pure tone and speech testing is completed. Tympanometry and otoacoustic emission testing should be done to determine that the middle ear system and cochlea are functioning normally. Testing is a dynamic process and selection of tests is done as the evaluation proceeds. The test choices depend upon a number of factors, including the age of the child, the specific auditory difficulties the child displays, the child’s language skills and cognitive status.

The test protocols for APD fall into two major categories: behavioral tests and electrophysiological tests. Behavioral tests use stimuli that are acoustically altered (words, numbers, tones, sentences) to measure each ear separately and how the ears work together higher in the brain where auditory information crosses over from the right to the left side by requiring some kind of response from the child during testing. Some of the tests used in an evaluation include monaural low redundancy, temporal processing, dichotic testing (evaluates binaural separation and binaural integration), and binaural interaction. Electrophysiological tests typically do not require a response from the child, but measure the brain’s response to different auditory stimuli. The clinical application of these types of tests is often limited due to the expense and availability of the equipment and time of administration.

# Auditory Processing Disorders in Children

The minimum age that an auditory processing disorder can be diagnosed is six to seven years old. However, there are screening tools that can be used starting at age four that can suggest if a child is “at risk” for APD. The purpose of screening younger children is to implement treatment that can deliberately train and improve function of the auditory system in order to reduce any negative impact on early learning and communication. Research has documented that neuro-plasticity, or the brain’s ability to improve, can happen at any age, however, the younger the child, the more dramatic the changes can be with appropriate interventions.

One of the challenges with the diagnosis of APD is that there is no “gold standard” of testing or criteria for the diagnosis or severity of APD. ASHA and The Bruton conferences have provided professional guidelines and recommendations for more uniform testing protocols and criteria for diagnosis, but more work is needed.

It is important to note that a child can have weak auditory processing skills that do not fall into the criteria of a “disorder” but still impact the child’s potential. In this situation, recommendations for interventions and academic suggestions are still appropriate and important for success.

Many children with hearing loss can be tested for APD as long as they have some hearing (i.e., detection) abilities. There are distinct patterns of test results that can indicate the presence of APD in addition to hearing loss and there are certain tests that the audiologist can use that are not affected by the presence of a hearing loss.

## **TREATMENT FOR AUDITORY PROCESSING DISORDERS**

The individualized treatment program for each child, developed by the audiologist, will depend upon a number of factors, including the exact nature of the APD (which auditory processing and other skills are affected and to what degree), the age of the child, and the co-existence of other disabilities and/or problems. In general, the approach to remediation or management should include three main categories:

- a. Direct treatment options to enhance or improve the individual’s auditory (and/or language or reading) skills;
- b. Strategies to improve the quality of the auditory signal. These can be communication strategies and/or recommended educational modifications.
- c. Home programming that includes activities and suggestions for parents to use at home. Parents have a unique opportunity to provide training on a daily basis.

## **Direct Treatment Options**

Because a child may present with a specific area of weakness that is different from another child, individualized training recommendations should be specifically based on the child’s auditory processing deficits. Treatment goals and activities will be very different for children who have temporal processing difficulties (timing issues) rather than a child with binaural integration problems (left and right sides of the brain are not processing auditory information effectively). There are specific therapy activities available for each type of auditory processing skill deficit.

Individualized therapy is provided by either a speech language pathologist or audiologist. Treatment can be obtained in the school system and/or privately. In many states, APD is not a recognized condition available for formal resource assistance in the classroom nor does it qualify a child for an IEP or 504 education plan. It can fall in the communication disorder realm which can result in time spent with the speech language pathologist at school. Depending on the options available, this may result in treatment for 30 minutes once a week in a group setting, which may or may not be enough. Some children may require more intensive individualized, private therapy.

There are a number of commercially available auditory training computer programs that can be used at home, school or clinic that can be powerful treatment tools for improving auditory function. Two commonly used programs are Earobics and Fast ForWord. More information can be found on these programs at the websites listed at the end. There are also listening therapy programs available by different companies and products. Some of these listening programs have controversies surrounding them regarding efficacy and program implementation. If reading skills are negatively affected as a result of APD, a multi-sensory reading program might be recommended. Lindamood Bell™ and Orton Gillingham™ are both multi-sensory reading programs utilizing visual, auditory and tactile training methods that when implemented with intensity, can be very beneficial in not only improving reading skills but auditory function as well. Younger children with APD can work on phonological awareness and phonological memory activities to improve reading skill development.

# Auditory Processing Disorders in Children

If a child is diagnosed with a type of auditory processing disorder that could be developmental in nature, repeat testing in one to two years is important in order to monitor the development of the auditory system and provide updated recommendations.

Treatment options can include referrals to other appropriate professionals. Depending on the testing profile, further evaluation by other professionals may be necessary. Further evaluation may be needed for attention deficit, vision difficulties, sensory integration disorder, fine motor delays or handwriting difficulties, gross motor problems, or other learning or developmental disabilities. Counseling for the family or child may be necessary or a referral to a physician, otolaryngologist or neurologist may be warranted. If an evaluation does not result in a diagnosis of APD, it is essential that the audiologist provide further direction to the family in referrals to appropriate professions who can help the family and child.

## Communication Strategies

Specific recommendations for strategies and accommodations should be individualized to the auditory processing skill areas affected. There are certain types of APD disorders that do not benefit from the use of FM systems in the classroom, but others will benefit. Some types of APD are consistent with difficulties in listening and writing at the same time, so a typical recommendation to write everything down that the student can hear would not be helpful for them.

The following list is a partial list of potential recommendations and should not be applied generally to every child with APD. Certainly the goal of any communication strategy is to improve a child's access and retention of auditory information by getting the signal (typically, someone's voice) to the child as clearly as possible.

- Try and gain the child's attention before giving directions or initiating conversation.
- Encourage the child to indicate when they do not understand what has been said. If they do not understand the directions, repeat the direction. It is possible that the child did not misunderstand the information but just needs extra time or repetition. They may need the information rephrased if certain words are not understood.
- They should be encouraged to look and listen, especially in the presence of background noise. They should maximize visual cues to supplement any missed auditory information.
- Preferential seating. They should sit close to the teacher or speaker to improve the ability to utilize visual cues, reduce auditory distractions, and access auditory information.
- Give the child short, simple instructions. Avoid giving multi-step directions.
- Use visual cues whenever possible such as gestures, pictures or facial expressions.
- Encourage the child to indicate when they do not understand what has been said. Ask them to repeat the information or clarify what may have been misunderstood. **For example, instead of asking "Did you understand what I said?", ask "What did I ask you to do?"**

## Educational Accommodations

- The school environment of the child is critical to the understanding of auditory information. Open concept classrooms or large classrooms are usually not appropriate for children with APD due to reverberation. Acoustic modifications can be made to a classroom (e.g., carpeting, acoustic ceiling tiles, window treatments) to help minimize the detrimental effects of noise in a class.
- Children can sometimes benefit from using personal assistive-listening devices, called FM systems. These devices serve to enhance the teacher's voice and reduce the competition of other noises and sounds in the classroom. These systems come in different styles. They can sometimes be provided through the school system or purchased privately. There is well documented research on the effectiveness of the use of FM systems for children with auditory weaknesses as well as other academic and medical diagnoses.
- Preferential seating – children should sit close to the teacher or speaker to improve their ability to utilize visual cues, reduce auditory distractions, and access auditory information. They should be encouraged to look and listen.

## Auditory Processing Disorders in Children

- Reduction of background noise – students should be seated away from distracting hall noise, fan noise, or the window. During homework or study time, all extraneous background noise should be eliminated.
- Students should be presented assignments in writing as well as in class.
  - They may not be able to remember an assignment later in the evening that was given during the end of the class when students are packing up and leaving.
  - They should keep an assignment notebook to write any instructions or details given in class. If the student tends to be inaccurate in their recording of assignments or forgets to document homework assignments, the teacher could check it at the end of the day for accuracy.
- They may benefit from extra time to take tests, particularly standardized testing such as ISTEP.
- Modified assignments such as shortened spelling lists and assignments may be helpful for a short time so that they can experience success in the classroom.
- Students will likely benefit from pre-teaching of information and vocabulary. For example, they may receive information ahead of time for vocabulary and work on understanding higher level concepts before they are introduced. This will help the student to know what a word is if it is not heard accurately.
- They may benefit from a note taking buddy. The student can take notes or write information down, but can compare notes for any missed information.
- Older students may benefit from tape recording lectures to review later.

### Home Programming

Parents have a unique opportunity to provide ongoing support and training to children with APD in everyday routines and activities. Parents are typically very interested in learning ways that they can help their child at home. There are specific games that are designed to improve certain auditory and language skills, and again, recommendations should be individualized for each child. Some examples of these games are:

Bop It™	Twister
Simon Game	Red light/green light
Dance or music activities	Simon Says
Piano playing	Telephone Game
Karaoke or sing along videos	Mad Gab™
Catch Phrase™	A Rhyme in Time™
Marco Polo	Password
Karate, Golf, Tennis	

Other home programming ideas for parents include the following:

- Read daily, encouraging the child to discuss the stories while reading. Encourage them to make predictions about what will happen next in the story (e.g., What do you think Goldilocks did after she tried Mama Bear's chair?). Ask thinking/reasoning questions about the stories (e.g., Why do you think Goldilocks was scared when she saw the three bears?). Identify and emphasize new vocabulary words within the story (e.g., *Porridge*. *Porridge* is like oatmeal. You eat *porridge* for breakfast. Do you think you would like to eat *porridge*?). Have them retell the story in own words or act out the events in a role play.
- Take pictures on family outings. Discuss the past events in the pictures such as who was there and what was happening. Have the child put two to three pictures from a single event in proper sequential order. Participate in activities such as cooking or crafts that can emphasize sequential order.

## Auditory Processing Disorders in Children

- Identify and emphasize objects and actions occurring in a child's environment. If a sound is heard such as an airplane, ask them, "What is that? Where is the sound coming from? What other sounds does that make?". Have them describe items by color, shape, texture and smell. Ask comparison questions such as "What other things does it look like or sound like?"
- Younger children can benefit from activities that include rhyming: singing nursery rhymes, reading books with rhyming, watching videos with rhyming songs. Games such as musical chairs help to focus on listening while moving.
- Children with APD should be deliberately taught active listening skills such as looking at the speaker, stopping an activity while listening, and repeating information for accuracy. Family members can help by demonstrating active listening while communicating with their child and each other.

### SUMMARY

Auditory processing deficits can adversely affect a child's academics, communication and life skills. These deficits can co-exist with other disorders, and can be differentially diagnosed if a multi-disciplinary approach is utilized. The evaluation of APD is done by an audiologist with specialized tests that can identify specific areas of weakness and the impact for the child. A comprehensive treatment program should provide interventions and accommodations to improve the child's auditory deficits and provide support in challenging environments. The treatment program should include recommendations for school, home, direct treatment options and any referrals for other symptoms. Home programming is a critical piece to the treatment of auditory processing disorders as activities can be done daily and in a natural environment. There is still much to learn about auditory processing disorders, the relationship to other disorders, how to improve testing protocols and therapy programs. By working with other professionals and with continued research, we can continue to improve our ability to help children (and adults) affected by this disorder.

### RESOURCES:

#### **Books for Parents and Teachers**

Bellis, T. (2002) *When the Brain Can't Hear*, Pocket Books. (A Book for Parents)

Foli, Karen (2002) *Like Sound Through Water*, Atria Books, New York.

Richard, G. (2000). *The Source for processing disorders*. Rock Island, IL. Linguisystems.

Ziegler-Dendy, Chris (2000). *Teaching Teens with ADD and ADHD: A Quick Reference*

*Guide for Teachers and Parents*, Woodbine House, Bethesda, MD. (Great practical advice for parents and teachers who work with children of all skill levels)

#### **Product Websites:**

Earobics: [www.earobics.com](http://www.earobics.com)

Fast ForWord: [www.scilearn.com](http://www.scilearn.com)

Lindamood Bell [www.lindamoodbell.com](http://www.lindamoodbell.com)

[www.learningbydesigninc.com](http://www.learningbydesigninc.com)- Website for Learning by Design, Inc offering educational software, especially spelling

[www.linguisystems.com-offering](http://www.linguisystems.com-offering) educational and speech-language materials

[www.PsychCorp.com](http://www.PsychCorp.com)- Website for the Psychological Corporation, offering psycho-educational speech-language, auditory processing and related materials.

#### **Organizations:**

ASHA (American Speech language Hearing Association) [www.asha.org](http://www.asha.org)

National Center for Learning Disabilities [www.ld.org](http://www.ld.org) / [www.GetReadytoRead.org](http://www.GetReadytoRead.org)

National Institute on Deafness and Other Communication Disorders [www.nidcd.nih.gov](http://www.nidcd.nih.gov)

# Auditory Processing Disorders in Children

## Selected Web Sites for Teachers and Parents



- [www.maelstrom.stjohns.edu-archives/capd.html](http://www.maelstrom.stjohns.edu-archives/capd.html)
- <http://www.angelfire.com/bc2/capd5/>
- [www.tsbvi.edu/Outreach/seehear/spring00/centralauditory.htm](http://www.tsbvi.edu/Outreach/seehear/spring00/centralauditory.htm)
- [www.ncapd.org](http://www.ncapd.org)
- <http://www.kidspeech.com/tips.html>
- [www./pages.cthome.net/cbristol/capd.html](http://www.pages.cthome.net/cbristol/capd.html)
- <http://speialed.about.com/?once=true&>
- [http://titan.sfasu.edu/~g\\_brennantg/aud.html](http://titan.sfasu.edu/~g_brennantg/aud.html)
- <http://home.earthlink.net/~mcoleman/cpdadd.html>

## References

Bellis, T.J. (1996) *Assessment and Management of Central Auditory Processing Disorders in the Educational Setting: From Science to Practice*. San Diego, CA: Singular Publishing Group.

Bellis, T.J. & Ferre, J.M. (1999). "Multidimensional approach to differential diagnoses of central auditory processing disorders in children". *Journal of the American Academy of Audiology*, 10 (6), 319-328.

Chermak, G.D., & Musiek, F.E. (1997). *Central auditory processing disorders: New perspectives*. San Diego: Singular Publishing Group.

Jerger, et al, (2000) "Report of the Consensus Conference on the Diagnosis of Auditory Processing Disorders, in School Age Children". The University of Texas at Dallas, American Academy of Audiology.

Katz, J., Stecker, N.A., & Henderson, D. (1992). Introduction to central auditory processing.

*Suzanne Foley, M.S., CCC-A is an audiologist who specializes in the treatment of auditory processing disorders for adults and children. She is the director of Innovative Therapy Center, a private practice in Indianapolis. She teaches auditory processing disorders and private practice courses at two universities and has presented at numerous local, state and national conferences on auditory processing disorders. Suzanne can be contacted by email at [hear@innovativetherapycenter.com](mailto:hear@innovativetherapycenter.com).*

In 2009, Daylight Saving Time  
begins at 2:00 AM on March 8th.  
Don't forget to spring forward.

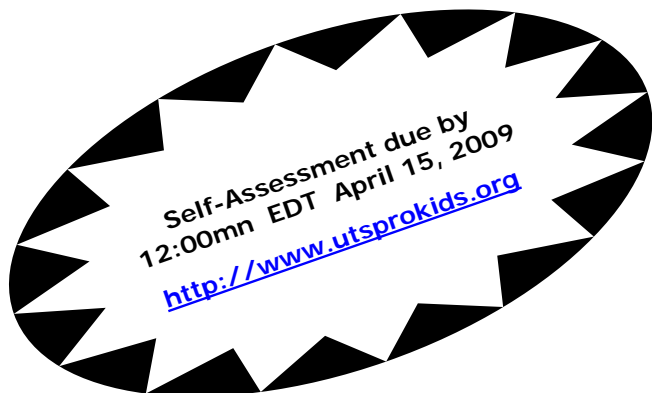


## Service Coordination Workgroup Contacts

Questions or comments regarding the many roles and responsibilities and policies and procedures affecting Service Coordination can be sent to any of the Service Coordinator Workgroup contacts listed below.

- Cluster A: Clare Mann at [cmann@nwifs.org](mailto:cmann@nwifs.org)
- Cluster B: Bridget Sovinski at [bsovinski@neccfs.org](mailto:bsovinski@neccfs.org)  
Pam Schena at [pschena@neccfs.org](mailto:pschena@neccfs.org)
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- Cluster D: Chris Burton at [cb1ststeps@yahoo.com](mailto:cb1ststeps@yahoo.com)
- Cluster E: Angie Jarvis at [ajarvis@awsusa.org](mailto:ajarvis@awsusa.org)  
Kristi Seheer at [kseheer@awsusa.org](mailto:kseheer@awsusa.org)
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- Cluster I: Jane Wirth at [scwest@brsinc.org](mailto:scwest@brsinc.org)
- Cluster J: Becky Haymond at [bhaymond@areaxi.org](mailto:bhaymond@areaxi.org)
- UTS: Mindy Dunn at [mdunn@ustprokids.org](mailto:mdunn@ustprokids.org)

UTS Programmatic Training  
ProKids, Inc.  
6923 Hillside Ct.  
Indianapolis, IN 46250



## CRO Transition Notes...

- At this writing, the CRO transition is in process. It is critical for First Steps Providers to keep up-to-date on CRO changes and timelines. Providers should frequently monitoring their emails **and** the Indiana First Steps web page for important updates and information on the CRO transition:- <http://www.in.gov/fssa/ddrs/2821.htm>.
- The transition timeline is printed on page 6. CRO services will not be available for a two week period from 1/30/09 through 2/15/09 to allow for the transfer of data and transition of CRO responsibilities. The last day for EDS provider payments is 2/3/09. The new CRO will be active on 2/16/09 and CSC Covansys will begin provider payments on 2/19/09. A self-guided provider training will be available in early February. Providers should familiarize themselves with new CRO billing and provider enrollment procedures.
- **Provider Credentialing:** The credentialing extension date of April 1, 2009 now includes providers who are due to credential between January 1, 2009 and March 13, 2009. This had previously applied to providers due to credential between January 1, 2009 and February 28, 2009. ***This is a one time occurrence during the transition period. Beginning in 2010, all original due dates for credentialing will be reinstated.*** This extension does not apply to providers whose credentialing date does not fall within this timeframe.
- All 512 Waivers should be held until after the CRO transition period on February 16th. This is to avoid any misplacement of requests.