

SB

68

ALASKA STATE LEGISLATURE

Senate
Labor & Commerce
Committee

Senate
State Affairs
Committee

While in Session
State Capitol
Juneau, Alaska 99801
(907) 465-3822
Fax: (907) 465-3756

While in Anchorage
716 West 4th Avenue
Anchorage, Alaska 99501
(907) 269-0144
Fax: (907) 269-0148

SENATOR BETTYE DAVIS

Senator Bettye Davis@legis.state.ak.us
www.akdemocrats.org

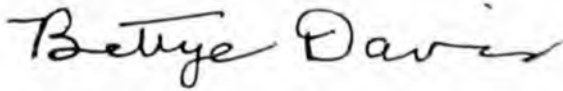
Senator Fred Dyson, Chairperson
Health, Education and Social Services
State Capitol Building
Juneau, Alaska 99801

Dear Senator Dyson,

This is a request for a HESS committee hearing on SB 68, an act relating to newborn hearing screening. I have attached a bill packet for this purpose.

Please, feel free to contact me if you or your staff needs any further information.

Sincerely,



Senator Bettye Davis

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Sponsor Statement for SB 68 Sponsored by Senator Bettye Davis

SB 68 will make infancy hearing testing mandatory for all babies born at a medical facility or as soon after birth as they see a physician.

Alaska has 10,000 births each year. Statistically, 30-40 of these births will have some form of congenital hearing loss. However, statewide, only 80% of the infants born each year are being tested for hearing loss. The children born with congenital hearing loss who are not detected at birth are usually not detected until they are 18 months to three years of age. The cost for treating a child who does not have their hearing loss detected early is an estimated \$420,000 per child. The cost of doing the screening at birth is \$20-\$60.

When hearing loss is not detected until the child is 18 months to 3 years of age, irreparable harms occur. There is significant impact not only on language and speech abilities, but also on cognitive and psychosocial behaviors. Recent studies have shown that upon entering kindergarten, children who have their hearing loss detected before 6 months of age are 1-2 years ahead of children who have their hearing loss detected after 6 months of age.

SB 68 would require that all infants have their hearing tested at birth or as soon as possible thereafter. In addition, if the infant has a negative result for the hearing screening, they are required to be given a follow-up test, and the parents are to be notified of the results.

I urge your support of SB 68.

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Sectional Analysis SB 68 *Sponsored by Senator Bettye Davis*

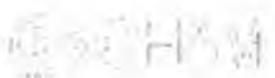
- Section 1.** 47.20.095 (a). The physician at the birth of the child, or the person attending to the newborn child, shall perform a hearing test on the child, unless there is a medical reason to not test the child.
- 47.20.095 (b). If the hearing test indicates that there may be hearing loss, the child shall be referred to get follow up tests done and the parents shall be notified of the results and the implications of that.
- 47.20.095 (c). The department shall determine the protocols for administering the hearing tests.

Why is Mandatory Newborn Hearing Screening and Reporting So Important?

1. Everyday, 33 babies (or 12,000 each year) are born in the United States with permanent hearing loss, or 3 in every 1,000 births. In Alaska, approximately 10,000 babies are born each year and according to statistics 30-40 will likely have some type of congenital hearing loss.
2. The evidence for the benefits, practicability, and cost-efficiency of universal newborn hearing screening is so compelling that 38 other states have passed legislative mandates requiring that newborns be screened for hearing loss.
3. Hearing impairment is the most common disability in newborns, with a higher incidence than Cerebral Palsy, Down Syndrome, and severe mental retardation.
4. Hearing impairment is approximately 30 times more prevalent than PKU and hypothyroidism, screened through the metabolic disorder screening programs, and mandated by law in all 50 states.
5. The cost of identifying a newborn with hearing loss is less than 1/10th the cost of identifying newborns with metabolic disorders such as PKU and hypothyroidism, for which screenings are required in every state. For most birthing hospitals, the cost for newborn hearing screening per child is between \$20-\$60 and continues to decrease. Many birthing facilities in Alaska, implementing newborn hearing screening voluntarily, include the cost in the total labor and delivery package cost.
6. Children not detected at birth or soon after, will not be detected, on average, until 2-3 years of age, and the most critical period for speech and language development is from birth to three years of age.
7. When children are not identified and served early, special education for a child with hearing loss may cost an additional \$420,000, and deafness has an estimated lifetime cost of approximately \$1 million per individual. These savings in special education costs will pay for universal newborn hearing screening many times over.
8. If left undetected, hearing loss can impair a child's language, speech, psychosocial and cognitive development. Recent research has compared children with hearing loss who receive early intervention and amplification (i.e. hearing aids) before 6

months of age versus after 6 months of age. By the time they enter first grade, children identified earlier (prior to 6 months of age) are 1-2 years ahead of their later-identified peers in language, cognitive, and social skills.

9. If it remains undetected, even mild hearing loss or hearing loss in only one ear has substantial detrimental consequences. For example, research shows that children with hearing loss in one ear are ten times as likely to be held back at least one grade compared to a matched group of children with normal hearing.
10. The American Academy of Pediatrics, the National Institutes of Health, the American Academy of Audiology, the Joint Committee on Infant Hearing, and the National Association of the Deaf have recommended that all babies be screened for hearing loss before they leave the hospital.
11. To date, 23 of 23 communities in Alaska with birthing hospitals have voluntarily implemented universal newborn hearing screening programs. The majority of the screenings are performed in hospitals by nurses prior to discharge. However, in some smaller communities, public health nurses perform the screenings during home visits after hospital discharge. As of December 2003, the total number of newborns in Alaska that received hearing screening was approximately 80%.
12. Even though 80% sounds like a large number of Alaska's newborns, because newborn hearing screening is not mandated and the screening, reporting and follow-up is not institutionalized in facilities across the state, Alaska remains in the "unsatisfactory" category when rated nationally.
13. Due to Alaska's large geographic size, high staff turnover occurs as well as difficulty recruiting and keeping healthcare providers in many of its more rural communities. And because the screening and reporting is not mandated, it is often times not a priority at birthing facilities and among providers. As a result, it is increasingly difficult to keep nurses and other providers with the knowledge necessary to maintain a newborn hearing screening program. Gaps in screening occur in hospitals, thus babies miss their screening and are not followed for high risk factors.



Home > United States > UNHS Summary Statistics

State Summary Statistics: Universal Newborn Hearing Screening		
(Numbers as of January 2004)		
State	Total # of annual births	Percent Screened
AK	9,938	81.1%
AL	58,967	95.0%
AR	37,437	91.3%
AZ	87,837	95.0%
CA	529,357	66.0%
CO	68,418	97.0%
CT	42,001	99.8%
DC	4,498	98.0%
DE	11,090	98.0%
FL	205,579	98.0%
GA	133,300	98.0%
HI	17,477	98.0%
IA	37,559	80.0%
ID	20,970	97.0%
IL	180,622	98.0%
IN	85,081	99.9%
KS	39,412	95.0%
KY	54,233	99.5%
LA	64,872	93.2%
MA	80,645	99.7%
MD	73,323	85.2%
ME	13,559	98.0%
MI	129,967	95.0%
MN	68,025	92.0%
MO	75,251	97.7%
MS	41,518	98.0%
MT	11,049	95.0%
NC	117,335	98.0%
ND	7,757	92.0%
NE	25,383	97.0%
NH	14,442	90.0%
NJ	114,751	98.3%

NM	27,753	94.0%
NV	32,571	97.0%
NY	251,415	96.7%
OH	148,720	33.0%
OK	50,387	94.0%
OR	45,192	94.0%
PA	142,850	95.7%
RI	12,894	99.6%
SC	54,570	98.1%
SD	10,698	85.6%
TN	77,482	90.0%
TX	372,450	99.0%
UT	49,182	98.2%
VA	99,672	99.7%
VT	6,387	95.0%
WA	79,028	85.0%
WI	68,560	95.0%
WV	20,712	95.0%
WY	6,550	98.0%
Data collected by NCHAM from State EHDI Coordinators in April 2004.		

Last Modified: 06/29/2004