Oh Baby! New Expanded Indications for Children with MED-EL Cochlear Implants: A MED-EL Signature Series Webinar

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Hi, Good afternoon everyone. Today's session is going to be on Med El's new pediatric candidacy criteria. We're going to start this session going through the new candidacy criteria and a little bit of the background. And then for the second part of today, we will have a roundtable discussion with pediatric audiologists who participated in the FDA clinical trial. So let's get started.

My name is Amy Gross and I manage FDA clinical trials at Med El. Before coming to Med El, I worked as a pediatric cochlear implant audiologist, so I have a passion for research with children.

As we talk today and hear from other audiologists, I want you to think about how this approval may impact your patients in clinical practice. Who are the referral sources for CI evaluations in your area? Have you seen referral delays and what do you think causes referral delays in each population?

Patients, families and professionals can all experience insurance delays and denials? What insurance battles have you faced and what have been your biggest challenges? How do you deal with insurance denials?

Insurance companies often base coverage decisions on outdated FDA indications. The purpose of Med El's research and approval on expanded indications was to align FDA indications with current clinical practice and research.

Pediatric cochlear implant indications changed very little over the years, with incremental steps that were few and far between. Even after the explosion of research and professional standards from 2000 to 2020, clinicians agreed that FDA changes haven't gone far enough. But Med El's new indications provide major changes to candidacy from age, hearing and speech criteria from infants to adults.

Ultimately, the goal of expanding indications is to improve cochlear implant referral rates and insurance coverage to improve CI uptake. At the National Early Hearing Detection and intervention conference in

2024, Jace Wolf presented that only 50% of eligible children in the US get a cochlear implant, compared to about 90% in other developed countries.

Another goal is to improve outcomes for children of all ages, not just the youngest candidates. Older children can experience progressive or sudden hearing loss, and hearing aids may not be enough. In 2015, Carlson and colleagues said that children with residual hearing who continue to struggle with hearing aids may be the group that would perform best.

Our hope is that Med El's new indications will remove barriers and expand access for more children to meet their full potential.

Let's look at each age group in more detail, starting with children implanted at 7 to 11 months old.

Bilateral indications for this age group include profound sensorineural hearing loss defined by a 3 frequency pure tone average or PTA 3 of 90 dB or worse at 500, 1000 and 2000 Hz. These children should also show a lack of progress or plateau in auditory skill development.

Research on brain development in early infancy shows the importance of motor and sensory systems developing together like ingredients in a recipe. The motor and sensory systems rely on one another for normal brain development. Let's think of this like baking bread. Our ingredients for bread include flavor, flour, water, yeast, and salt. For our analogy, these ingredients are the motor, hearing, sight, and touch centers in the brain.

Each ingredient develops in the brain independently before birth, including hearing at about 20 weeks gestation.

After birth, our ingredients rely on one another for healthy brain development. The motor and all sensory systems form critical connections in the first months of infancy. Crawl and colleagues call this multimodal interactions or brain connectivity. But what would happen if we mix our dough without water or add it after the bread is already baked? According to Krall and colleagues, delayed access to hearing during the critical period for brain connectivity can have irreversible consequences.

They identify nine months as a key milestone in brain development and recommend access to hearing before nine months of age.

We also know that critical periods for speech and language development are not all the same. The sensitive period for phonological skills is earlier than word learning, which is earlier than auditory processing, and the sensitive period for language development is earlier than speech perception.

This is why some studies show correlations with age at implant and others don't. Many tests and studies look at speech perception, which isn't always sensitive enough to show a correlation with implantation at younger ages, especially under 12 months. But tests of functional listening skills, language development, and speech production are more sensitive and have shown that children implanted before nine months outperform children implanted at nine months and and older.

We all love a cute baby, but we can't overlook the importance of timely and appropriate intervention for older children. The new bilateral indications for children 1 to 5 years old include a PTA 3 of 55 dB or worse at 50010002000 Hz and thresholds of 70 decibels or worse at 2000 to 8000 Hz. Children without speech recognition skills should show a lack of progress or plateau on auditory skill development, and children with speech recognition should score 40% or less on a developmentally appropriate test of word recognition based on the child's age and developmental abilities. This might include the esp, mlnt, lnt, pbk, or even CNC words.

It's important to note that children need better audibility, bandwidth and signal to noise ratios than adults to reach age appropriate speech understanding. According to Wiseman and colleagues, children with an aided speech intelligibility index or SII less than 0.61 are at risk for spoken language delays, and Leal et al. Showed that children need an aided SII of 0.65 or better for optimal language development with hearing aids for many years, cochlear implant indications have been the same for toddlers through 17 years of age. Med EL's candidacy criteria at 6 years of age and older are now the same as our adult expanded indications. Bilateral indications include a low frequency pure tone average greater than 40dB at 250, 500 and 1000Hz and thresholds of 65dB or worse at 3000 to 8000Hz.

They should score 50% or less in the ear to be implanted on recorded monosyllabic word recognition. For children getting just one cochlear implant, monosyllabic word scores in the non implant ear should be 60% or less.

Older children with steeply sloping progressive or sudden hearing loss should have the same chance at success as adults. Research shows that waiting three or more years between meeting candidacy and implantation can have poor outcomes.

If hearing aids can't provide enough gain for high frequency speech sounds, then children will have poor sound quality and clarity for word discrimination and speech understanding in noise. Studies have shown that children with preoperative residual hearing perform better with cochlear implants than hearing aids regardless of hearing preservation.

So with expanding indications, it might be hard to know when it's time to think about a cochlear implant for children using hearing aids. A working group of about 30 professionals formed the Cochlear Implant Patient Access to Hearing or CI Path Initiative. They recommend referral for a CI evaluation based on three key criteria with a cutoff of 60 for each. The recommendations, called CI360, include a 4

frequency pure tone average of 60 dB or worse, an aided SII less than 0.60, and an aided word recognition score of 60% or less. These referral criteria don't mean that the child will qualify for a cochlear implant they just indicate that the child should be evaluated for CI candidacy.

Med El conducted a multicenter FDA clinical trial that included 247 children implanted at eight cochlear implant centers across the U.S. safety data showed that all complications were known risks of cochlear implantation.

The number and rate of major complications were comparable to the literature or less than 6%, and children implanted before 12 months did not have more device related complications than children 12 months and older.

Efficacy data showed high rates of clinical success. Over 86% of children met strict performance goals by 12 months after activation. This includes 91% of children implanted before 9 months and 85% of children implanted at 9 months and older. 93% of children with a preoperative PTA better than 90dB and 86% of children with a pre op PTA of 90dB or worse also met predefined performance goals.

For the rest of our time today, we want you to hear directly from pediatric audiologists who took part in the multicenter study to expand Med El indications. Thanks. I'd like to introduce our guest speakers, including Victoria Gonzalez from the University of Mississippi Medical Center, Lisa park from the Children's Cochlear Implant center at the University of North Carolina, and Krisanda Sanchez from the University of Miami.

Hi everyone. My name is Barb Foster. I'm director of education and training here at Med El and I'll be facilitating this roundtable with our experts. We're so happy to have you here and really hear about your experience with cochlear implants in children, especially related to this groundbreaking change in candidacy with MED elimination. So let's get this conversation going.

Dr. Sanchez, I'm going to start with you. What are you seeing with newborns as far as cochlear implant candidacy goes? What is your experience?

My experience, one of the biggest challenges that we faced was really when we meet these patients that are seeking intervention. Historically, our program down in Miami, we functioned like largely as a tertiary referral center. So if infants would be diagnosed or followed at multiple clinics and then were referred to us much later, sometimes that meant that we were seeing them well after a year old or even in some cases closer to two or three. However, since participating in this trial, our clinical landscape has actually changed quite a bit. And we now oversee a very large newborn hearing screening program at our on campus birthing hospital, which essentially means that we're meeting many of these families when they are babies and they're just days old, beginning this journey very, very early, which is wonderful.

And so that earlier access allows us to implement comprehensive diagnostic testing really right away, including use of our EBRs and objective measures. And then those tools are incredibly reliable. And so then we can allow us to make confident clinical decisions much earlier than we historically have. Think. The other thing that's really powerful about seeing families this early in the newborn phase is that it allows a full, comprehensive, multidisciplinary approach, including the use of Our social worker, our psychologist, our speech language pathologist, to really work together with this family really early on so they can understand and prepare themselves for the journey ahead.

And we can support those families, monitor their progress, and demonstrate the importance of early auditory access. So, so the shift isn't really just in the candidacy criteria, but it's really about that earlier identification, earlier collaboration, and earlier action for those kiddos. Thank you.

Dr. Sanchez just spoke about especially those early, early diagnosis for the newborns. Dr. Park, I'm going to shift gears a little bit and ask you about challenges that are faced really with kids that are a little bit older, specifically school age children with progressive hearing loss. Those are the kids that can be really tricky because they're the ones that you're going to see in the clinic and think that they're doing fine, you're having a conversation with them, everything seems to be swell, they're doing all right in school. But what gets forgotten is number one, the number of supports they have to be able to be doing well in school, school, how tired they are, how if they have a language delay. A lot of these kids are not getting regular speech and language delays and there may be a language delay that is kind of hiding underneath there.

So with those kids, we really want to make sure that we are getting them in early and getting them in on time.

And also we are not the kind of people who are just looking for. Okay. Right. We want all of our kids to meet their full potential. So, so we get them in here if they're worried about surgery.

We have that multidisciplinary team that Dr. Sanchez was talking about. We have social workers who will work with them. If we can just get them in the door and get evaluated, we can take it from there and get them feeling more comfortable and understand what they can get out of a cochlear implant.

Thank you so much. Dr. Sanchez talked about early intervention and same with Dr. Park. Dr. Gonzalez, I'm going to ask you about your opinion. What are the challenges when maybe you have an early diagnosis, but the parents might want to wait? What's your experience?

Yeah, so I think that's the biggest struggle we have with that population is the buy in from the parents. The kids might be struggling, as Dr. Park mentioned, they're tired, they have a significant amount of auditory fatigue, although they have some residual hearing that kind of gives the perception that they

have access to sound. They are typically using a great deal of visual cues to also have that communication and also to increase their educational development. And so this population may seem like they're performing, but they're struggling both in school and social situations. And parents sometimes don't see that.

I think the risk of maybe potentially losing that residual hearing can be scary for parents. And a lot of times, maybe the kids recognize where they're at a different disadvantage, but the parents don't because they feel like they have enough. But like Dr. Park also mentioned, we don't want to settle for okay. We want these children to excel at the best of their abilities and to be able to have all the communication opportunities. And most of the time, it is the parents that we're trying to convince that there is a risk, but there is greater reward.

And Dr. Sanchez, what do you see in your clinic related to challenges when parents might want to wait? Yeah, I think we share a lot of similar experiences, I'm sure, around all of our clinics. For us specifically, one of the biggest challenges that we face is recognizing that oftentimes a family's hesitation will come from a much deeper influence than the medical information that's being provided to them or the diagnosis. Sometimes for us specifically, we serve a very high minority population, and it's related to cultural beliefs about a disability in general, family dynamics or religious perspectives about medical intervention, especially surgical intervention. And so in other cases, there's also just denial that happens across humans that doesn't really discriminate amongst populations and the hope that a child will just get better and they'll grow out of it.

And this comes from many sources, especially, you know, well meaning friends and family members that give the families reassurance, like, oh, this is too early to do anything. You know, let's just wait. And so they end up taking a more reactive approach than a proactive approach. They'd rather wait until the delays happen. We also see external influences like social media and maybe community narratives

or conflicting advice from other people, other medical, you know, maybe people that are other referrals that are not very clear on.

On giving guidance. And all of those voices can really make this process so difficult for families who are just trying to digest this information and make a very overwhelming decision for their infants, especially when we talk about the very little ones. I think in this role, our role as clinicians is to not really push families, but to guide them with clear information and support. Like Dr. Park mentioned, we really just need to get them in the clin and even if they're not ready to make a decision, we have to be willing to make sure that we're giving them all that information so they can make an informed decision. And if they choose to wait, we have to be willing to see them when they come back and meet them where they're at.

And that's really essential and critical because that builds trust. And that's really the only way you're going to get a family who's going to buy into the intervention that we're trying to recommend. That's both evidence based and really the target of trying to get their children to meet their full potential.

Thank you for that example. I know implanting children is not new to any of you since you work in a pediatric landscape, but what might you learn or what might have you learned from this study, participating in this study? I'm going to start with Dr. Park. Can you give me an example of something that or does a case study stand out to you about something you might have learned about participation in this particular pediatric study? I had a really stark example of how important that early input can be.

We had a family who the little one qualified for the study when they came to us. There's an older sister. An older sister was not able to get cochlear implants, but both the older sister and the baby had Usher syndrome. So it's really important to be able to get them that bilateral hearing as early as possible because they're going to lose another sense. We want to be able to make sure that that hearing sense is as strong as it can possibly be when that happens.

We were able to get the little one implants very, very early, and we would not have been otherwise able to do that without the study. Now she's thriving and she signs with her sister and the rest of the family, but she's also able to use spoken language in English and Spanish, which is very fun. So, yeah, it was just a really strong example of how important this early implantation is. Thank you. And Amy, I think you also mentioned something that surprised you a little bit about running this study.

What was that? Yeah, we actually really struggled to enroll the older kids. It was pretty easy to enroll the young ones because everyone agrees that earlier is better. But what all of our guests have been describing about delays and referral or parents that aren't ready, the older children that had some residual hearing were the hardest group to enroll. So it took a lot more effort and a lot more time to get enough of those kids enrolled to have a good data set.

And Dr. Sanchez, I'm going to go to you next. What surprised you about the enrollment numbers? You know, I think we were pleasantly surprised to see how motivated families were to participate I don't know if that came from just a preconceived notion or just an assumption, but for us specifically in the state of Florida, we cannot get children on Medicaid implanted under the age of 12 months. So we had a really high population aligned with what Amy said of the very young ones who were very eager to do this, because without access to this trial, they would have not been able to be implanted young. They'd have to wait until they were at least a year old to start the process.

I think the other thing that surprised me the most is that so many families recognized that participating in the study was not only going to help their child, but help the future of pediatric hearing loss and other children. And I think the other thing personally, and something that really rings home to me in the clinic that I serve, is that it really reinforces how important it is that clinical research is accessible to diverse patient populations, such as the minority populations that we serve here in Miami, because these minority populations are often subject to the greatest health disparities. So giving them equal access

and equal opportunity is really critical for our team. And that's really what I was pleasantly surprised to be a part of. I think that's.

That's a great outcome and something good to be surprised about. And Dr. Gonzalez, I know in your clinic was slightly different. Can you give an example of how that might be different than what Dr. Sanchez experienced? Yeah. So our payer mix kind of was the opposite.

So for us, we are able to provide some better access for our Medicaid patients, but it's actually some of our private payers here in the state where there are some barriers of getting early implantation. And so those are the parents who we were able to enroll in our study. And they are also families that had access and were incredibly motivated and thrilled to participate because they definitely did their research and understood how early implantation led to early access to sound and speech language goals. And they were very willing to participate in all of the study measures and also, also actively participate in early intervention.

It's interesting to see how things change in different parts of the country. So I appreciate you sharing your experiences. And I think as an industry, all of us are aware that the incidence of adults and children who are candidates for a cochlear implant far outweigh the number of persons who actually receive a cochlear implant. So my question is, how do you think these expanded indications may change that? And I'll start with you, Dr. Park.

I think it'll probably take a little While for all the information to kind of trickle down and become standard of care for our referral populations. But I think it'll happen especially. But I think we need to make sure that as CI providers, we are staying in touch with those referrals, referring providers so that they can see what the outcomes were for that child and feel confident with the next child that they want may want to refer. I know at our center we're working to get that information out. We are doing some outreach to some other clinics in our state to share information on that CI360 specifically that Amy

shared.

So in order to get that word out and just get things started and hopefully this webinar will be part of that. So hopefully that's a positive step in the right direction. And Dr. Gonzalez, what about you? How do you think these expanded indications may change the incidence of the population who choose to pursue a cochlear implant? Yeah, we think the incidence rates are going to increase.

Increase. You know, I think right now the estimate is about 50% of children who need a cochlear implant will get them. And I think it will increase the numbers. I think families may be slightly discouraged by the time frame when we identify to where they had to wait until 12 months and shortening it, we feel like it'll get continue to have them in, involved and enrolled and in the door. When they didn't see progress with the hearing aids, we kind of felt like they kind of became disconnected from the process.

But this earlier indication will keep them involved in a way that will keep them motivated and start seeing hopefully improvements and outcomes much sooner than they were previously able to. That's a great point. Point. Thank you. And I think our next question, I'd like to get all of your experiences of what you do at your clinic and that is about how do you do your testing from especially the small ones, the itty bitties from six months and up.

And what do you do when you get a referral from a Referral source? So, Dr. Gonzalez, I'm going to start with you.

Sure. So most of our referrals are coming from the birthing hospitals. So failed newborn hearing screenings, since we're one of the few pediatric centers in our state. And I think that's a little different than Dr. Park and Dr. Sanchez. And so typically we are diagnosing the children at at their ABR diagnostic testing and then moving our patients through fitting of hearing aid trial and then on to testing

and questionnaires and any other information to help assess their candidacy once they are around Six months of age.

We will also attempt all of the behavioral testing necessary to move them forward with cochlear implant candidacy. And Dr. Park, what about at your clinic at UNC? What do you do when you get a referral and how are you incorporating the testing? For even our youngest populations, we have a family care coordinator who's also a social worker. She's amazing.

So all the referrals come to her and then she calls the family and she talks through everything with them, what's going to happen. And she's able to try to coordinate all of those appointments too, because there's so many appointments there in the beginning and so many of our families come from so far. North Carolina is a long skinny state. So many come from four or five hours even away. So we try to get as much done in one day as we possibly can because they need to see the physician, they need to get imaging done.

If they haven't had an ABR and they're very little where we want to repeat that ABR that they had outside, which we will do, they're going to go over to our diagnostic team first to get that done. Because we here we just do cochlear implants and hearing aid that's over here. We don't do the diagnostic piece. We have extra experts who can do that. So they'll make that happen and then they come to see us.

One of the things that we do to try to be proactive with our little ones is that they, once they've been identified as potential candidates, like especially our no response ABR babies, they get a surgery date and we work backwards from there to try to fill everything in, get that behavioral testing done so that we can get them implanted quickly. Because if we're waiting and at the six month mark, we're like, yep, there's that behavioral testing. We're not going to be able to get them sound by 7 months of age or by 8 months of age. Now we have to wait for a surgery date for our older kids. We follow similar to the

pediatric minimum speech test battery.

We do a lot of aided testing, we do a lot of questionnaires, and we make sure that those hearing aids are fit appropriately before we do anything else so that we make sure that we are targeting kiddos who need a cochlear implant. It's just another part of the continuum of hearing care. So we just need to get them the right technology.

Thanks. And then Dr. Sanchez, tell us a little bit about the Miami approach. Yeah, we. We have some commonalities across, you know, getting children from the newborn, hearing screening and starting them very young and really focusing on their objective physiological testing such as abrs and just using all of this objective information to allow the families to have some guidance on really where we're expecting. Especially like Dr. Park mentioned, with a no response ABR, we, we know what that trajectory looks like.

We do focus on the imperative need for imaging, especially when we have Those no response ABRs or ABRs that suggest some retro cochlear pathology like neuropathy. We do have a little more kind of, we raise an eyebrow to those cases, but we still are very clearly guiding the families and counseling them towards that. Cochlear implants will likely be that destination for them. I think there is a debate in the, in the pediatric audiology world of, you know, waiting until we can do like reliable and repeatable behavioral testing. And behavioral testing is imperative and critical to correlate with your objective testing.

But the beauty of an indication at seven months is that we can wait until if, you know, if the provider is more comfortable to wait until six months, they, they can do so. Our team tends to put babies, especially with our children who have a profound abr. We're putting babies in the booth at about four and five months and focusing more on behavioral observation responses, which is not the most kind of reliable form of audiometry, but it does tell us and the family a lot of information and I think that's critical.

The families need to see while they're holding their infant in the booth that we are playing sounds very loud with their hearing aids on that are appropriately fit and the baby is not responding, they're not changing their sucking pattern, they're not looking up, they're not making any visible reaction where, whereas that family might be startling in the booth, the baby really demonstrates nothing. And sometimes that's critical to buy in with that family.

I agree. We also do the same process where when we identify a child, we have a family navigator who helps navigate their care at that point from the ABR forward, which includes securing imaging, getting a physician appointment and a possible surgery date within the timeframe where we want these child, these children implanted for outside referrals, we are a little more critical and we definitely need to repeat testing. That is something we do internally as well. We always get one to two tests on children anyway. But sometimes that inherently can delay a child because they're already coming from the outside with a cluster of information that we often have to repeat.

We are very grateful and fortunate to work with, with Team members who understand that when we have kind of a child who's a little later in age, maybe they're closer to two, which honestly sometimes a two year old is more difficult to test than a baby, that we're really reliant on needing another abr, what have you. And our team sort of fast tracks. We have a fast track CI protocol where our physicians allow overbooks and we have a fast track CI protocol for the imaging. So we know that these are stat orders and everyone kind of collaborates on these kiddos to make sure that we are not further delaying those kids once they get to our clinic that we can actually help them. That's great and really important, obviously, especially as we know the earlier intervention, the better.

Now for following, we talked about what happens with the referral and identifying these children.

Dr. Sanchez, I'm going to start with you about postoperatively children after they get the cochlear implant. How are you following their progress and what are you seeing? Yeah, so when we're for the

very young ones, I think we start at the very fundamental audiology auditory hierarchy of just making sure they're detecting and getting good auditory access because that's critical to their speech and language development. But the really kind of cool thing about getting the opportunity to be in this trial and implanting kids really young is that we do indeed follow the pediatric minimum speech test battery. And we were seeing that children were advancing through that hierarchy much faster, of course, because they were implanted earlier.

And so we tend to follow this. Whatever the child had at their eval, we always want to repeat post as their first baseline test, just as clear comparison. And then moving from there, we start utilizing the pediatric MSTB and we use questionnaires to track auditory skill development in a very standardized way. And we try to be very consistent and periodic with that measurement. And we follow them frequently toward following the timeline of the MSTB so that we can ensure that these children are still meeting their speech and language milestones.

And this is in conjunction with support from our SLPs and really that child's entire care team. That's great. Dr. Park, I know you have a unique approach at UNC. Tell us a little bit more about your cotreating protocol. Yeah, so we have four listening and spoken language certified speech pathologists on staff for all of our kids who are under three.

They will come into our appointments and do what we call co treating. So they'll do some of those questionnaires with the families, especially for the little ones. We do the Flip the functional listening index, which I really, really like because it really closely follows development of auditory skills. So before you're even seeing words, you have all of these things that you can look forward to and make sure that they're progressing through. And they will also see how things are going at home with therapy, kind of check in.

And they'll also, after the visit, they will call their early interventionist and kind of touch base with them to see how things are going. We're lucky. Here in North Carolina. We have a lot of really great early interventionists. But keeping in touch like that and being able to toggle between home and the clinic is really great and very helpful, especially for the little bits.

Thank you. I'm going to move to our last question for all of you, and that is how can we, as a cochlear implant industry, improve awareness and referrals for in particular, any cochlear implant candidate? But especially today, we're talking about kids. And what do you want pediatricians or general ENT physicians or audiologists who may not work with cochlear implants? What would you want them to know or what do you think is important for them to know as this candidacy continues to expand?

I'm going to start with Dr. Gonzalez.

Yeah, so I think the sooner the better. I think sometimes these physicians who are maybe unaware of some of the expanded indications or even kind of a grasp of what they are even to err on the side of referring sooner than when they really start to see true barriers that these children are facing because we want to identify them. And even if maybe they're not a candidate to start, at least they've already been through kind of an initial evaluation and we can continue to keep track with some of these children. So I think a lot of times outside providers who are unsure, they tend to wait, but we actually would like to see see them kind of sooner than they typically do make their referrals. And what about you, Dr. Sanchez?

You know, agreed that earlier the better for us. Specifically, I think it would really be impactful to educate, or rather re educate our early interventionists and those pediatricians. You know, I just got off the phone today with a pediatrician I was advocating for, actually a family friend whose child has a speech delay. And the pediatrician refused to put an order for an audiogram until the child was 2 because they did tympanograms that were normal. And even me trying to I was on the phone and it

was so eye opening to me that there are this mindset that we have to wait until 2.

The physician told me on the phone that we are unable to get reliable testing on children until they are two, which I obviously have my opinions on that as we're representing audiologist himself. But it's to the point that that kind of life experience happened today because that perception still exists in our pediatric community. And we need to be on a unified kind of mindset of let's allow these specialists to do what they do. And if the family has concerns, we really need to endorse that concern and rule out any possibility that hearing isn't contributing to that speech delay. We think of children who have progressive hearing loss.

So despite them passing their newborn hearing screening, I think early interventionists and pediatricians alike can often depend on the newborn hearing screening and think that that is foolproof. Or we think about the impact of the precipitously sloping hearing loss and how they are struggling, but, you know, they're not, perhaps not struggling enough to the. To the perspective of the medical provider that that's serving them. So really, just reinforcing that audiology needs a seat at the table, especially for children who present with speech and language delays is imperative. And referring them earlier to Dr. Gonzalez's point is only going to yield more information for the medical team to make a decision for that child.

Well, I think we could. Couldn't agree more with you, as we're all audiologists. Dr. Park, do you have anything else to add from your perspective? Yeah, I think we need to focus on the referral process, just like my colleagues have mentioned, and making sure that our colleagues here know that we do not. They do not need to know what the candidacy is because a lot of us have our own candidacy criteria within our programs.

They just need to know that it's all about access. And if a child doesn't have enough access to sound with their hearing aids to be able to meet their full potential, we have something else that could be

better for them and so they can come check it out.

Well, I just want to say thank you to all of the experts on our call today for this roundtable discussion. I. I hope that it's really valuable to those of you listening, and it's really an exciting time as med el continues to advance our industry so that more children can get access to the amazing technology that we uniquely offer. So thank you very much and we'll see you next time.