



ASHA
American
Speech-Language-Hearing
Association

June 21, 2019

The Honorable Susan M. Collins
Chairman
U.S. Senate Special Committee on Aging
G31 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Robert P. Casey, Jr.
Ranking Member
U.S. Senate Special Committee on Aging
628 Hart Senate Office Building
Washington, DC 20510

RE: Special Committee on Aging Request for Information on Prevention and Management of Falls and Falls-Related Injuries

Dear Chairman Collins and Senator Casey:

On behalf of the American Speech-Language-Hearing Association, I write to respond to the request for information on the prevention and management of falls and fall-related injuries that will be used to develop your annual report.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 204,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. Audiologists specialize in preventing and evaluating hearing and balance disorders as well as providing audiologic treatment, including aural rehabilitation and hearing aids. Speech-language pathologists (SLPs) identify, evaluate, and treat speech and language problems, functional cognitive impairments and swallowing disorders.

ASHA provides the following comments for your consideration:

Reporting and Follow-Up

The Aging Committee seeks feedback on the extent to which falls go unreported among older Americans and what strategies can be employed to encourage patients to inform health care providers of a fall. Risk factors such as depression, hearing loss, medications, cognitive impairments, and poor sleep can all impact a patient's risk for falls and their ability to report them in a timely fashion. Good clinical practice dictates that audiologists and SLPs identify these risk factors when present in the patients they treat. For example, SLPs play a critical role in assessing cognitive-communication and cognitive deficits for patients of all ages including those who have had a stroke, a traumatic brain injury, or suffer from a neurodegenerative condition such as Parkinson's Disease. By understanding how cognitive deficits impact a patient's safety (e.g., falls risk), SLPs can work with patients and caregivers to develop compensatory strategies such as memory aids and cues to follow safety precautions and self-regulate impulsive behaviors.

Hearing loss and related social isolation are strongly correlated with depression that can increase falls risk. Hearing loss itself also serves as an indicator of increased falls risk. For these reasons, audiologists are required to submit quality measures related to falls risk and depression screening under Medicare's Merit-Based Incentive Payment System.

In research performed by Frank Lin and Luigi Ferrucci, it was determined that patients with even mild hearing loss had triple the risk of an accidental fall. Falls risk increases as the degree of hearing loss worsens.¹ A second research study found that patients with depression have a 1.6 times greater chance of experiencing a fall.² It is critical that patients and providers identify and report these risk factors in a timely fashion to more effectively identify and reduce the number and severity of falls for older adults treated by audiologists and SLPs.

Tools and Resources

There are several federal policy barriers that make it difficult to offer tools and resources to prevent patient falls. One barrier is statutory exclusion of audiologists from treating Medicare beneficiaries for hearing loss and balance issues, which are within an audiologist's scope of practice. Under current policy, if an audiologist identifies a balance issue with a patient, they must refer the patient to another clinician for treatment. This burdensome process delays care and puts the patient at avoidable risk. Therefore, Congress should enhance Medicare coverage by including both diagnostic and treatment services provided by audiologists within their scope of practice.

A second barrier is Medicare's requirement for a physician order before covering diagnostic and testing services—such as hearing and balance evaluations—provided by an audiologist. This creates a barrier to patients accessing diagnostic services critical to determining medical conditions and risk factors related to falls. An audiologist completes a doctoral program and has the clinical education and experience necessary to evaluate and treat patients. While audiologists value a collaborative relationship with physicians and other health care providers in meeting the needs of patients, ASHA recommends that Congress eliminate the outdated, unnecessary, and costly referral requirement for diagnostic testing, which is within the audiology scope of practice and performed almost exclusively by audiologists. Modernizing Medicare in this manner will improve beneficiary access to more timely care, eliminate physician visits for administrative purposes, and result in cost savings since the same care is ultimately being provided after a referral.

A third barrier established under federal law is a restriction on the types of providers, including audiologists and SLPs, allowed to provide services via telehealth to Medicare beneficiaries. Audiologists and SLPs are recognized by a wide range of payers to provide telehealth services. Twenty states have included provisions in licensure laws that explicitly authorize audiologists and SLPs to perform services via telehealth. Medicaid programs in 27 states and private insurers in 30 states have established similar policies to cover telehealth services provided by audiologists and SLPs. Covering telehealth would enhance access to hearing, balance and cognition services for Medicare beneficiaries in rural and medically under-served areas.³ Beyond the direct impact of improved access to care for falls risk factors directly related to audiology and speech-language pathology services, increasing access to these services would help consumers to better understand and express their medical needs resulting in increased compliance and improved patient outcomes.⁴ Therefore, Congress should expand the list of clinicians who are eligible to provide services via telehealth under Medicare to include audiologists and SLPs.

Polypharmacy

Audiologists and SLPs perform medication reconciliation as part of the standard of practice to help determine if medications might impact the patient's health. For example, if a patient reported to an audiologist that he was experiencing dizziness, the audiologist might discover

that seizure medications prescribed to the patient is one of the root causes of the dizziness or a medication review may find that the combination of two medications has a side effect of dizziness. An SLP may draw similar conclusions about the functional impact of a medication on a patient's attention, memory, or processing speed during a cognitive evaluation. The SLP could then facilitate discussions with the patient's medical team and assist in developing safety strategies. In both scenarios, medication review can identify and reduce risk factors for falls. CMS has recognized the important role audiologists and SLPs play in reviewing patient medications by requiring submission of quality measures related to medication documentation for both professions.

Transitions of Care

Managing effective transitions of care is critical to reducing preventable negative health outcomes, such as falls. Transitions can be from one setting of care to another (e.g., a hospital to a post-acute care (PAC) facility) or from a health care setting back to the community and home.

One of the primary challenges of transitions from one health care setting to another is the missing, limited, late, or inaccurate information the initial setting provides to the next setting of care. For example, ASHA members working in skilled nursing facilities (SNFs) report that the medical records from the hospital provide limited diagnostic information making it challenging to develop a timely plan of care or even to accurately categorize the patient's primary reason for admission. On occasion, ASHA hears that the medical record does not make it to the next setting until well after the patient arrives if the record makes it at all. ASHA encourages the Aging Committee to consider recommending that facilities' discharge plans be required to include timely, accurate, and comprehensive information to discharge destinations.

Additionally, when planning to discharge a patient back to home, acute and PAC entities responsible for discharge may conduct a home visit to assess for risk factors that could lead to falls and other risks. However, this level of discharge planning does not always or even often occur. Congress should incentivize health care settings to perform such site visits when clinically appropriate.

Finally, Medicare requires that inpatient rehabilitation facilities (IRFs) conduct a weekly interdisciplinary team meeting. The IRF payment from Medicare covers the cost of this meeting. Congress should revise payments to SNFs and home health agencies in order to appropriately compensate and ensure that similar weekly interdisciplinary team meetings take place in all PAC settings to avoid poor health outcomes such as falls.

Post-Fracture Care

Comprehensive and accurate diagnosis coding is a critical element in preventing falls and understanding the risk factors that contribute to falls. Only by gaining this complete picture of the patient can we guarantee appropriate post-fracture care and prevent additional falls and associated injuries. For example, a hip fracture patient may receive cognitive treatment from an SLP, and the reason might not be clear on initial inspection of the claim. However, we note that hip fractures resulting from a fall may have ultimately been caused by a cognitive impairment underlying the fall.

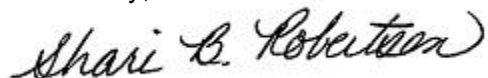
Unfortunately, due to challenges with establishing a link between fractures and their underlying causes through current coding practices, clinicians may be denied payment under Medicare. It

is critical that denials based on what are perceived inaccuracies in diagnostic coding are prevented. ASHA seeks to prevent these denials with educational resources targeted for our members. CMS should conduct similar education with the Medicare Administrative Contractors (MACs) to make sure they accurately review the associated medical record and not simply deny services on the claim alone.

Conclusion

Thank you for the opportunity to respond to this RFI. ASHA supports the Aging Committee's efforts to ensure Medicare beneficiaries have access to timely, quality care to avoid falls. We encourage you to recommend improvements to the Medicare program that would allow audiologists to practice within their full scope of authority under state law, allow audiologists and SLPs to treat patients via telehealth, when clinically appropriate, and incentivize health care providers to engage in additional care coordination. If you or your staff have questions, please contact Jerry White, ASHA's director of federal affairs, health care, at jwhite@asha.org.

Sincerely,



Shari B. Robertson, PhD, CCC-SLP
2019 ASHA President

¹ Lin, Frank and Ferrucci, Luigi. "Hearing Loss and Falls Among Older Adults in the United States." *Arch Intern Med*. 2012;172(4):369-371. doi:10.1001/archinternmed.2011.728.

² Iaboni, Andrea, Flint, Alistair. "The Complex Interplay of Depression and Falls in Older Adults: A Clinical Review." *Am J Geriatr Psychiatry*. 2013 May; 21(5): 484-492. doi:10.1016/j.jagp.2013.01.008.

³ Cusack CM, Pan E, Hook JM, Vincent A, Kaelber DC, Middleton B. (2008). *The value proposition in the widespread use of telehealth*. *Journal of Telemedicine and Telecare*. Retrieved from <https://journals.sagepub.com/doi/10.1258/jtt.2007.007043>.

⁴ Institute for Healthcare Communication. (2011) *Impact of Communication in Healthcare*. Retrieved from <https://healthcarecomm.org/about-us/impact-of-communication-in-healthcare/>.

⁵ Health Affairs Blog. (2018). *Older Adult Falls—Costly But Not Inevitable* Hortern, K, Dwyer, G. Seiler, N. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hblog20180402.25780/full/>.