ASHA
American
Speech-Language-Hearing
Association

October 5, 2020

Alex H. Krist, MD, MPH
Chairperson, U.S. Preventive Services Task Force
USPSTF Program Office
5600 Fishers Lane, Mail Stop 06E53A
Rockville, MD 20857

RE: Draft Recommendation Statement Hearing Loss in Older Adults: Screening

Dear Chairman Krist:

On behalf of the American Speech-Language-Hearing Association (ASHA), I write to offer comments to the U.S. Preventive Services Task Force (USPSTF) on its Draft Recommendation Statement Hearing Loss in Older Adults: Screening.[1] Specifically, ASHA is concerned with the USPSTF's recommendation that additional research is needed to determine the balance of benefits and harms of hearing loss screenings for adults over 50. Thus, ASHA urges the Task Force to revise its recommendation to Grade B.

ASHA is the national professional, scientific, and credentialing association for 211,000 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 assessing hearing and balance disorders as well as providing audiologic treatment services related to hearing aids and cochlear implants.

The USPSTF Draft Recommendation determined that current evidence is insufficient to assess the balance of benefits and harms of hearing screening for older adults. However, evidence exists that shows the value, accuracy, and multi-faceted importance of early detection of hearing loss to prevent further loss and mitigate the impact on other essential health and social outcomes. Hearing screenings are non-payable services by health care plans, which do not add a per member per month cost to health insurance premiums; yet, the benefits of early identification improves further hearing loss prevention, treatment, and quality of life outcomes that extend far beyond hearing screening alone.

ASHA urges a Grade B recommendation that would encourage providers to screen persons ages 50 and older for hearing impairment, and to further specify that:

- Screening should be conducted in health care settings by staff who are appropriately trained to use the screening test(s) and with procedures in place for appropriate initial referral and follow-up.
- Failed screening should be followed by an audiologic evaluation to diagnose the severity and cause of any potential impairment, and suggested treatment or referral as appropriate.

Early identification of hearing loss directly improves the ability to mitigate future hearing loss as well as addresses identified impairment to improve functional outcomes for patients and improves other health and social outcomes such as isolation and depression. The American Association of Retired Persons (AARP) found that isolation and depression cost the federal government $1,608 each year for older adults with increased isolation and more than $6.7

billion in additional spending for the Medicare program.[2] Additionally, research by Karlsmose, Lauritzen, and Parving supports the recommendation of hearing screens for more adults and urges that, "general practitioners should take a more active part in primary prevention, early detection of hearing impairment and early referral for rehabilitation."[3]

The USPSTF Draft Recommendation risks reinforcing the unfortunate reality that many Americans and health care providers mistakenly ignore the initial signs and symptoms of hearing loss as an unavoidable result of aging. Early identification of hearing loss is critical to avoiding additional loss and mitigating the function impairment individuals experience with mild to moderate hearing loss. Many health care providers do not appropriately screen and refer patients for additional evaluation, treatment, and mitigation when appropriate, even when the patients are at elevated risk for hearing loss as a result of heightened occupational or social risk factors. Without broader screening requirements, the full value of hearing screening adults cannot be fully appreciated as has been demonstrated by universal newborn hearing screenings.[4]

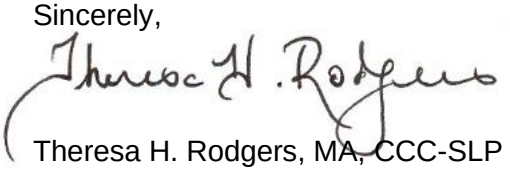
The "I" recommendation will undermine existing efforts to ensure appropriate provision of hearing loss screenings for adults and will exacerbate the problem of those with hearing loss seeking treatment only after their condition has progressed to the point where a functional impairment is clearly identifiable and, unfortunately, often more difficult to treat successfully and cost effectively.

The USPSTF Draft Recommendation conclusion seems to approach the question of efficacy strictly related to a disease-centric perspective on addressing hearing loss itself as the end result. However, when adopting a broader, more holistic health perspective the balance of benefit versus harm clearly reveals the benefits—both potential and realized—for screening additional adults for hearing loss. Hearing screenings have the potential to improve overall health outcomes and enhance quality of life for adults over 50. Failure to identify and address hearing loss in seemingly asymptomatic adults with mild hearing loss does nothing to help resolve known impairments that can lead to isolation and depression.

ASHA urges the USPSTF to reconsider its evaluation of the benefit of hearing screenings for adults over 50 and upgrade the recommendation from Grade I to Grade B to help ensure health care professionals offer and provide hearing screenings to their patients over 50. The known and potential benefits to patients both directly related to hearing loss, as well as other health outcomes, clearly outweigh any theoretical harms.

Thank you for the opportunity to provide comments on the USPSTF's Draft Recommendation Statement Hearing Loss in Older Adults: Screening. If you have any questions or would like additional expertise regarding practical implementation of hearing screens, please contact Tim Nanof, ASHA's director of health care and education policy, at tnanof@asha.org.

Sincerely,



Theresa H. Rodgers, MA, CCC-SLP
2020 ASHA President

[1] U.S. Preventive Services Task Force. (2020, September 8*). Draft Recommendation Statement; Hearing Loss in Older Adults: Screening*. https://www.uspreventiveservicestaskforce.org/uspstf/draft-recommendation/hearing-loss-in-older-adults-screening-2021.

[2] Frank, D. (2017, November 29). *The High Price of Social Isolation*. AARP. https://www.aarp.org/health/medicare-insurance/info-2017/isolation-higher-medicare-fd.html.

[3] Karlsmose, B., Lauritzen, T., Parving, A. (1999). Prevalence of hearing impairment and subjective hearing problems in a rural Danish population aged 31-50 years. *British Journal of Audiology 33*(6), 395-402. doi: 10.3109/03005364000000107.

[4] Sachdeva, K., Sao, T. (2017). Outcomes of newborn hearing screening program: A hospital based study. *Indian Journal of Otolaryngology and Head & Neck Surgery, 69*(2),194-198. doi: 10.1007/s12070-017-1062-0.