



September 19, 2019

Dr. Vijeth Iyengar
Aging Services Program Specialist
Administration for Community Living
U.S. Department of Health and Human Services
330 C Street, SW
Washington, DC 20416

RE: RFI—Cognitive Health Status Changes Homebound Older Adults

Dear Dr. Iyengar:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the request for information (RFI) on cognitive health status changes for homebound older adults.

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 assessing hearing and balance disorders as well as providing audiologic treatment, including hearing aids. Speech-language pathologists identify, assess, and treat speech and language problems, including swallowing disorders.

ASHA appreciates the Administration for Community Living's (ACL's) efforts to understand how providers assess cognitive status for homebound older adults. In the RFI, ASHA notes that ACL's definition of cognitive health ("a person's capacity to remember, learn, plan, concentrate, and maintain a clear, active mind") complements the definition developed by the National Institute on Aging.¹ While ASHA agrees that "cognitive health" includes the referenced components, ASHA considers cognition to be inclusive of several other component processes as well. SLPs also assess awareness, attention, reasoning, problem solving, processing speed, and executive functioning. Given that all of these factors impact functional cognitive status and the ability to comprehend and communicate effectively, ASHA's responses below reflect the approach SLPs use to assess cognition within the broader context. Furthermore, ASHA recommends that ACL broaden its description of cognition to be inclusive of the additional areas we have identified.

1. What are the characteristics of older adults for whom you conduct cognitive screening tests?

SLPs begin by distinguishing between a screening and an assessment or evaluation. SLPs consider screenings a pass/fail procedure to identify individuals who require further speech, language, and/or cognitive assessment/evaluation or referral for other professional and/or medical services.² SLPs screen a patient for cognitive functioning to determine the need for a full cognitive evaluation. A screening tool, such as the Mini Mental State Examination (MMSE) or the Montreal Cognitive Assessment (MOCA), can be used with patients to identify a possible cognitive deficit. Despite the risk of false positives leading to potential over-identification for further evaluation, the use of screening tools can reduce costs and

improve or avoid negative patient health outcomes associated with the failure to identify a patient with a cognitive deficit.

A cognitive assessment or evaluation is indicated if evidence suggests that a patient has a cognitive-communication impairment affecting function and/or activities/participation.

Assessment/evaluation is prompted by referral by the individual's educational or medical status, or by failing a language or cognitive-communication screening that is sensitive to cultural and linguistic diversity.³ Patients with a cognitive deficit may exhibit the following signs indicating the need for a cognitive evaluation:

- processes information slowly;
- loses track of the topic;
- misses the point;
- repeats information;
- becomes disoriented to time and place;
- has difficulty remembering recent events;
- has difficulty with eating and/or swallowing;
- experiences reduced or less substantive verbal output; and/or
- has difficulty expressing thoughts, wants, and needs.⁴

2. What screening test and/or (psychometric) instruments (e.g., tests of recall, attention, processing speed, etc.) does your organization use to measure cognitive health?

Screenings for cognitive impairment are conducted for individuals exhibiting any condition that increases the risk of cognitive-communication problems. An SLP, audiologist, or other clinician on the interdisciplinary care team working with the individual may conduct the screening.

ASHA members use standardized instruments with demonstrated reliability for cognitive screening that are commonly available. As noted above, these usually include the MMSE and MOCA. These instruments typically assess orientation to time, place, and person. Other tests (e.g., story recall/story retelling) assess episodic memory and can be useful for screening early dementia.^{5, 6, 7, 8} If screening reveals cognitive impairment, the patient is referred to an SLP for a comprehensive evaluation of cognitive and communicative function.

Prior to screening for cognitive-communication disorders, clinicians consider the impact of sensory impairment (hearing and vision), depression, and current medications on cognitive functioning.

SLPs use diagnostic tools to identify cognitive deficits, not to assess cognitive health broadly. When performing a cognitive evaluation, as noted above, SLPs use standardized assessments, supported by patient/caregiver reports, ethnographic interviewing, and observation.⁹ In addition to the MMSE and MOCA, the following are other examples of screening and diagnostic assessment tools that SLPs would use with homebound older adults.

Screening

- Saint Louis University Mental Status (SLUMS)
- Brief Interview for Mental Status (BIMS)

- Cognistat (formerly known as the Neurobehavioral Cognitive Status Examination (NCSE))
- Short Portable Mental Status Questionnaire (SPMSQ)

Assessment

- Cognitive Linguistic Quick Test - Plus (CLQT+)
- American Speech-Language-Hearing Association Functional Assessment of Communication Skills in Adults (ASHA-FACS)
- Communication Activities of Daily Living - 3rd edition (CADL-3)
- Functional Independence Measure (FIM)
- Repeatable Battery for the Assessment of Neuropsychological Status Update (RBANS Update)
- Test of Language Competence - Expanded (TLC- E)
- Western Aphasia Battery - Revised (WAB-R)
- Ross Information Processing Assessment - 2nd edition (RIPA-2)
- Arizona Battery for Communication Disorders of Dementia (ABCD)
- Functional Assessment of Verbal Reasoning and Executive Strategies (FAVRES)
- Assessment of Language-Related Functional Activities (ALFA)
- Brief Cognitive Assessment Tool (BCAT)
- Scales of Cognitive Ability for Traumatic Brain Injury (SCATBI)
- Measures of Cognitive-Linguistic Ability (MCLA)

3. What is the length and format (e.g., in-person, paper-and-pencil, telephone, web-based, tablet, smartphone, etc.) used to administer these screening tests and/or instruments to the population of older adults you test?

A difference exists between the modes of administration of cognitive screening tests and evaluations and the types of evaluation tools administered. As noted above, ASHA makes a distinction between screenings and evaluations. The cognitive evaluation tools used by SLPs can be administered in a variety of ways including in-person or via telehealth (e.g., phone, internet). The method of administration depends on the availability of and access to technology and the clinical presentation of the patient. For example, some patients require in-person evaluations due to safety reasons. The method of administration might also include a caregiver, translator, or extender (e.g., home health aide) to complete the evaluation.

4. What is the frequency with which your organization administers these tests and/or instruments and the duration over which cognitive health is monitored?

A screening tool is used with every patient to identify a potential deficit(s) whereas a cognitive evaluation is only conducted if the screening indicates the need for further evaluation. Additionally, SLPs assess the cognitive presentation of patients at each encounter (ongoing routine assessment) to monitor for any change in status.

SLPs monitor cognitive status across the episode of care outlined in the individualized treatment plan established by the treating clinician to meet the needs of the patient. At a minimum, SLPs assess cognition at admission and discharge from the episode of care.

5. What is your estimate of the general cost per person for administering the test or instrument?

When ASHA considers the cost per person of administering the test or instrument, we include the cost of the test/instrument itself, the time associated with training to be proficient in administering the test/instrument, as well as the time and clinical skill necessary to administer the test/instrument to the patient. The cost of the test and associated training required to administer a standardized test accurately is typically relatively low or free. However, there is an investment in time to learn how to administer the test/instrument. The cost associated with the clinician's time to conduct the standardized evaluation can vary as reimbursement rates vary by payer. For example, the national Medicare reimbursement rate for the cognitive evaluation Current Procedural Terminology (CPT®) code, 96125, is \$112.44 per hour.¹⁰ When developing a charge for the test/instrument, the clinician will consider all of the factors identified above.

6. What happens when changes are detected in a person's cognitive health and how is this information used?

Clinicians will modify a speech-language pathology plan of care to address any newly identified cognitive deficit(s). Once identified, the SLP might refer the patient to a specialist or other clinician(s) to address the specific cognitive impairment, discuss or share findings with the caregiver, and/or address the changes in cognitive status as part of interdisciplinary team care planning.¹¹ Additionally, the SLP might modify the plan of care to directly treat cognitive functional impairments that are within their scope of practice.

7. What are the intended health outcomes (e.g., screening for a research study, early identification and detection, improvement through exposure to new interventions, reductions in re-hospitalization, etc.) sought from monitoring cognitive health over a period of time?

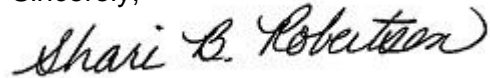
Monitoring a patient's cognitive health ensures timely identification of a potential cognitive deficit that could increase the cost of care and/or lead to negative health outcomes for the patient. Once a clinician identifies a deficit and establishes a prognosis as to the patient's ability to improve or maintain a certain level of function, compensatory strategies could be implemented to avoid negative outcomes.¹²

Because cognition has a direct impact on many other health outcomes, the intent of monitoring cognitive health includes improved patient health outcomes and avoidance of negative health outcomes—such as falls—as well as a reduction in cost due to avoidable health complications. Additionally, monitoring a patient's cognitive health highlights the relationship between cognition and communication such as the patient's ability to communicate their needs and their ability to understand treatment protocols for their safety and effective medication management.

Patients with dementia and other cognitive impairments face increased risk for swallowing and eating deficits. Their ability to recognize, shop for, and prepare food might be limited or they may get distracted during the eating process or forget to eat at all. Similarly, they may not have the ability to use utensils in order to eat effectively. Patients with cognitive impairments and swallowing comorbidities demonstrate increased risk of choking and aspiration pneumonia, which may eventually result in malnutrition, dehydration, and weight loss. Ongoing assessment of cognitive health prevents or addresses the challenges cognitive deficits present for patients.¹³

Thank you for your consideration of our comments. If you or your staff have any questions, please contact Sarah Warren, MA, ASHA's director for health care policy for Medicare at swarren@asha.org.

Sincerely,



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

¹ National Institute on Aging. (n.d.). Cognitive Health and Older Adults. Retrieved from <https://www.nia.nih.gov/health/cognitive-health-and-older-adults>.

² American Speech-Language-Hearing Association. (2004). Preferred Practice Patterns for the Profession of Speech-Language Pathology [Preferred Practice Patterns]. Available from www.asha.org/policy.

³ Ibid.

⁴ American Speech-Language-Hearing Association. (n.d.). Dementia. Retrieved from https://www.asha.org/PRPSpecificTopic.aspx?folderid=8589935289§ion=Signs_and_Symptoms#Impact_of_Cognitive_Changes_on_Communication.

⁵ Bayles, K. A., & Tomoeda, C. K. (1993). *Arizona Battery for Communication Disorders of Dementia*. Austin, TX: Pro-Ed.

⁶ Rabin, A., Paré, N., Saykin, A. J., Brown, M. J., Wishart, H. A., Flashman, L. A., & Santulli, R. (2009). Differential memory test sensitivity for diagnosing amnesic mild cognitive impairment and predicting conversion to Alzheimer's disease. *Neuropsychology, Development, and Cognition, Section B, Aging, Neuropsychology and Cognition*, 16, 357–376.

⁷ Takayama, Y. (2010). A delayed recall battery as a sensitive screening for mild cognitive impairment: Follow-up study of memory clinic patients after 10 years. *Journal of Medical and Dental Sciences*, 57, 177–184.

⁸ Wechsler, D. (2009). *Wechsler Memory Scale—Fourth Edition*. San Antonio, TX: Pearson.

⁹ American Speech-Language-Hearing Association. (n.d.). Assessment Tools, Techniques, and Data Sources. Retrieved from <https://www.asha.org/Practice-Portal/Clinical-Topics/Late-Language-Emergence/Assessment-Tools-Techniques-and-Data-Sources/>.

¹⁰ Medicare Fee Schedule for Speech-Language Pathologists (2019). <https://www.asha.org/uploadedFiles/2019-Medicare-Fee-Schedule-for-Speech-Language-Pathologists.pdf>

¹¹ American Speech-Language-Hearing Association. (2004). Preferred Practice Patterns for the Profession of Speech-Language Pathology [Preferred Practice Patterns]. Available from www.asha.org/policy.

¹² Ibid.

¹³ American Speech-Language-Hearing Association. (n.d.). Dementia. Retrieved from https://www.asha.org/PRPSpecificTopic.aspx?folderid=8589935289§ion=Signs_and_Symptoms#Impact_of_Cognitive_Changes_on_Communication.