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THEME—PRACTICAL ASPECTS OF GERIATRIC AURAL REHABILITATION

Aural Rehabilitation for the Aging Hearing Impaired Person

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At the present time, there are an estimated 23.4 million individuals residing in the United States who are ages 65 years and over. These numbers are beyond those predicted even five years ago. By the year 1990, it is estimated that approximately 29 million persons will be age 65 years and over. That will be an increase of over eight million persons in that age category since 1970. And, this population will continue to rapidly increase.

With the great numbers of persons over age 65 years becomming so evident—the result of a lower number of deaths within that population due to advances in medical science, it is interesting to note that sensory deficits as a result of aging have not been curtailed to any degree. Among the most devastating sensory decrements that accompanies aging is that of presbycusis, or hearing impairment as the result of aging. It is currently estimated that perhaps as high as 30-40 per cent of all persons over 65 years possesses some degree of hearing impairment. As many as 90 per cent of the five million persons residing in the nursing home possess hearing impairment which may interfer with communication. Its impact upon communicative function of the aging person is oftentimes overwhelming. The inability to hear and understand what others are saying can be the final blow toward the finality of aging. The frustration, embarrassment and resulting self-imposed isolation can, in the final analysis, lead to social and physical death. Since, for many aging hearing impaired persons, amplification through the use of a hearing aid provides little or no benefit for communicative function, the resulting frustrations and anxieties can become even greater. Whether or not these persons can

benefit from a hearing aid, the alternative of a viable and comprehensive aural rehabilitation is necessary.

Since the majority of older hearing impaired persons possess normal or near normal language function and have heard normally for the greater portion of their life, aural rehabilitation programs can take on a broader scope, and inovative approaches can be utilized. As research on the physical/neurological processes involved in aging expands, this knowledge can be applied to modify approaches to aural rehabilitation for these persons. For example, we now know that elderly persons possess nearly the equivalent capability to learn as young persons. The most noticeable difference between the two populations is simply in the *speed* of processing linguistic information. The factor of speed of processing information should, then, for example, be taken into consideration, along with the compounding central auditory aspect involved in presbycusis when developing and administering aural rehabilitation programs for hearing impaired elderly persons. It appears that one of the reasons some audiologists have refrained from attempting aural rehabilitation programs for elderly persons is the frustration of dealing with persons who possess such a complex auditory disorder as presbycusis. It is, indeed, not a "pure" auditory problem. The typical high frequency component which should, indeed, result in some auditory discrimination difficulties is generally evident. However, the compounding central auditory components of presbycusis which appear to retard speed of auditory processing and synthesis, sequential storage and other aspects of the whole realm of auditory comprehension are discouraging both to the elderly person and to the audiologist. These persons do, however, deserve the audiologists' best assessment and aural rehabilitative efforts. They have years to live and much to contribute to our society. Audiologists who are concentrating their efforts on this population are achieving successes not thought possible before. Many elderly hearing impaired persons who were thought not to be able to benefit from aural rehabilitation programs are experiencing improved communicative function, perhaps at least to the point of more efficient communication with family and friends. Some persons who were previously diagnosed as "confused" or senile, are leaving the nursing home and returning to their communities, not as "confused", but as persons who have been experiencing the effects of auditory impairment and are now learning to communicate efficiently in spite of it.

For those audiologists who *would* desire to provide services for the some 9-10 million hearing impaired elderly persons, the future is looking brighter. For example:

1. Interest among health care facilities in the United States is increasing in regard to initiating community-based itinerant aural rehabilitation

programs (shared among several health care facilities, skilled nursing facilities, etc), paid for by the health care facilities except for auditory assessment which is reimburseable by Medicare and Medicaid. Community based aural rehabilitation programs such as the University of Northern Colorado Community-Wide Program in Geriatric Aural Rehabilitation are serving as models.

2. Interest in the elderly by the Federal government is at a high level. More Federal monies are being released for rehabilitative and preventative programs and research than ever before. It is estimated that over $800 million dollars will be appropriated for research, community programs, training, etc, relative to the aged for the 1977-78 fiscal year. Such agencies as Social and Rehabilitation Services are becoming involved in the area of the aging person.

Such grants as that awarded to the University of Northern Colorado Area of Audiology for the purpose of developing training materials for national dissemination to other university training programs in the area of geriatric aural rehabilitation and the contract awarded to the American Speech and Hearing Association to present eight Regional workshops on "Upgrading Services to the Communicatively Handicapped Person in the Nursing Home" are exemplary of the growing interest by Federal Funding agencies in this area.

3. More graduate training programs in communication disorders are offering coursework specific to the area of communication problems among aging persons than ever before, and those programs are being sought after by students.

4. Increased Federal legislation is emerging from the United States Senate and House of Representatives. For example, Senator Brock of Tennessee introduced two bills in 1975 to expand Medicare coverage to include aural rehabilitative services by the audiologist including hearing aid evaluations, speechreading, counseling and other aural rehabilitative services. Vice-President Mondale, (then Senator) was the co-sponsor of Senator Brock's bill. Congressman John Duncan (Tennessee) introduced bills in the House of Representatives that responded to and supported Senator Brock's bill. Congressman Duncan's bills were co-sponsored by Congressman Abner Mikua. Other Senators such as Floyd Haskell (Colorado) are supporters of legislation that would provide for Medicare reimbursement for aural rehabilitation services.

Since at the present time only audiologic assessment is reimburseable through Medicare, legislation which would provide for reimbursement for aural rehabilitation would certainly facilitate those services being provided for those elderly persons who simply do not possess the funds necessary to pay for them.

REIMBURSEMENT FOR SERVICES

The following information further and more concisely describes some basic considerations regarding the present status of third-party payments for aural rehabilitation services:

At the present time there is no reimbursement for aural rehabilitative services through Federal health insurance, that is Medicare and Medicaid. Assessment of auditory function, however, is reimburseable as a service provided by an ASHA certified audiologist, a licensed audiologist, or one who is eligible for ASHA certification. Audiologic assessment is generally reimbursed directly to the audiologist on an 80 percent basis if the evaluation is deemed justified, if the charge is reasonable and prudent, if the client does not have other co-insurance and if the audiologist has accepted assignment under Part B coverage.

Therapy services by a speech/language specialist are covered by Medicare as long as the disorder is the direct result of the accident or illness that required such services, e.g. a cerebral vascular accident, but only with the direct involvement and monitoring of the client's physician. Speech/language services must be provided in a Medicare approved rehabilitation center, skilled nursing facility, home health agency or a hospital under Part A of the Medicare program, or in a Medicare approved hospital, skilled nursing facility, a home health agency, a clinic, or a rehabilitation agency under Part B, but only through physician certification and recertification of the need for such services.

Aural rehabilitation services are mentioned for the first time in Chapter III, Part 405, Federal Health Insurance for the Aged and Disabled, published in the *Federal Register*, 40, 186, September 24, 1975. The persons who wrote these revisions stated that because aural rehabilitation was not a part of the original law, it was not possible to include it as a reimburseable service at the present time. That is, of course, not true of audiological assessment. That service is covered in any event as long as there is sound reason for the assessment.

Other insurances also provide for reimbursement for audiological asessment. To determine which companies do cover that service, it is advantageous for the audiologist to contact *various companies* in person, review reimbursement forms and procedures, and discuss the procedures for acquisition of a provider number if needed. Many insurance companies presently require a direct referral by a physician or that the audiologist be in the physician's employ before reimbursement can be made for audiological services.

To be eligible for reimbursement through Medicare for audiological assessment, the clinic through which services are provided must be approved by Medicare officials. The Director of the Speech and Hearing Clinic is generally the person who applies for a provider number. The

provider number must in all cases be assigned to a person who is certified by the American Speech and Hearing Association, eligible for such certification, or one who has obtained his/her state license, where licensure is applicable. It is generally best to meet with the Director of Medicare Services of the intermediary insurance company to discuss and confirm billing procedures and services covered, by whom and by who's referral.

For further information on this topic, the author would be happy to speak with those who are interested. It is not possible to include all intricacies regarding establishment of procedures for receipt of payment for services to the elderly hearing impaired client here.

The American Speech and Hearing Association headquarters personnel and the Executive Board are to be commended for their diligent efforts in working to facilitate these important steps relative to increased Federal Health Insurance coverage for audiologists and speech/language specialists. We must remember, however, that we, as audiologists, are a part of an associated health team. Effective cooperation with the client's physician and others who are working with the client toward habilitation/rehabilitation is necessary. As we become increasingly independent in our provision of services and reimbursement through insurances for those services becomes more available to us, that philosophy should be kept in mind.

CONCLUSION

The future looks brighter in regards to the elderly person who possesses perhaps the most devastating disorder that results from aging, i.e. presbycusis. As more and more audiologists become interested in these persons, as health care facilities continue to increase their financial support of aural rehabilitation programs, as Federal insurances increase their financial support through third-party payments for services, and as research increases to determine more effective approaches to aural rehabilitation for these persons, the future will, indeed, become even brighter.

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