Measure #209: Functional Communication Measure – Spoken Language Comprehension

2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 16 years and older with a diagnosis of late effects of cerebrovascular disease (CVD) that make progress on the Spoken Language Comprehension Functional Communication Measure

INSTRUCTIONS:
This measure is to be reported once per episode of treatment for all patients with late effects of CVD who are treated for a spoken language comprehension deficit by a speech-language pathologist (SLP) during the reporting period. Only patients who had at least two visits in the reporting period will be counted in the denominator for this measure. This is an outcome measure, and its calculation requires reporting of the patient’s score (see below under numerator) on the measure at the admission to and discharge from SLP treatment for spoken language comprehension. The admission score is noted by the SLP at the conclusion of the first treatment session, and the discharge score at the conclusion of the final treatment session for spoken language comprehension.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure’s denominator. The listed numerator options are used to report the numerator of the measure. The quality-data codes have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. There are no allowable performance exclusions for this measure. Do not report this measure via claims.

DENOMINATOR:
Patients ≥ 16 years and older with late effects of CVD who received SLP treatment for spoken language comprehension

Denominator Criteria (Eligible Cases):
Patients aged ≥ 16 years on date of encounter
AND
AND
Two (2) or more patient encounters during reporting period (CPT): 92507, 92508
NUMERATOR:
Patients whose score on the functional communication measure at discharge were higher than at admission

Definitions:
Admission – The conclusion of the first treatment session for spoken language comprehension by an SLP
Discharge – The conclusion of the final treatment session for spoken language comprehension by an SLP, regardless of whether the patient is also being discharged from the facility and/or other SLP services.
Patient’s Score –
LEVEL 1: The individual is alert, but unable to follow simple directions or respond to yes/no questions, even with cues.
LEVEL 2: With consistent, maximal cues, the individual is able to follow simple directions, respond to simple yes/no questions in context, and respond to simple words or phrases related to personal needs.
LEVEL 3: The individual usually responds accurately to simple yes/no questions. The individual is able to follow simple directions out of context, although moderate cueing is consistently needed. Accurate comprehension of more complex directions/messages is infrequent.
LEVEL 4: The individual consistently responds accurately to simple yes/no questions and occasionally follows simple directions without cues. Moderate contextual support is usually needed to understand complex sentences/messages. The individual is able to understand limited conversations about routine daily activities with familiar communication partners.
LEVEL 5: The individual is able to understand communication in structured conversations with both familiar and unfamiliar communication partners. The individual occasionally requires minimal cueing to understand more complex sentences/messages. The individual occasionally initiates the use of compensatory strategies when encountering difficulty.
LEVEL 6: The individual is able to understand communication in most activities, but some limitations in comprehension are still apparent in vocational, avocational, and social activities. The individual rarely requires minimal cueing to understand complex sentences. The individual usually uses compensatory strategies when encountering difficulty.
LEVEL 7: The individual’s ability to independently participate in vocational, avocational, and social activities are not limited by spoken language comprehension. When difficulty with comprehension occurs, the individual consistently uses a compensatory strategy.
**Numerator Options:**

Score on the spoken language comprehension functional communication measure at discharge was higher than at admission (G8603)

OR

Patient not treated for spoken language comprehension disorder (G8741)

OR

Score on the spoken language comprehension functional communication measure at discharge was not higher than at admission, reason not specified (G8604)

OR

Patient treated for spoken language comprehension but not scored on the spoken language comprehension functional communication measure either at admission or at discharge (G8605)

**RATIONALE:**

Assessment of communication ability is important for determining the patient's capabilities and limitations in expressing their wants, needs, and understanding; their ability to contribute to their plan of care (including consent forms and advanced directives), and their ability to comprehend instructions affecting the success of the rehabilitation process. The results of the assessment may impact the choice of treatment and disposition.

Disorders of communication (i.e., problems with speaking, listening, reading, writing, gesturing, and/or pragmatics) and related cognitive impairments may occur in as many as 40% of post-stroke patients. The most common communication disorders occurring after stroke are aphasia and dysarthria. Rapid spontaneous improvement is common, but early evaluation can identify communication problems and monitor change. If indicated, intervention can help maximize recovery of communication abilities and prevent learning of ineffective or inappropriate compensatory behaviors. Goals of speech and language treatment are to (1) facilitate the recovery of communication, (2) assist patients in developing strategies to compensate for communication disorders, and (3) counsel and educate people in the patient's environment to facilitate communication, decrease isolation, and meet the patient's desires and needs.

**CLINICAL RECOMMENDATION STATEMENTS:**

Aphasic stroke patients should be referred for speech and language therapy. Where the patient is sufficiently well and motivated, aim for minimum of two hours per week. (Scottish Intercollegiate Guidelines Network)

Recommend that the clinician use standardized, valid assessments to evaluate the patient's stroke-related impairments and functional status and encourage patient's participation in community and social activities. Recommend that the standardized assessment results be used to assess probability of outcome, determine the appropriate level of care, and develop interventions. (US Department of Veterans' Affairs; endorsed by the American Heart Association)

Recommend that all patients be evaluated and treated by the SLP for residual communication difficulties (i.e., speaking, listening, reading, writing, and pragmatics). (US Department of Veterans' Affairs; endorsed by the American Heart Association)
Interventions for people with aphasia may include: treatment of phonological and semantic deficits following models derived from cognitive neuropsychology, constraint-induced therapy, and computer-based therapy programs. (National Stroke Foundation of Australia)

It is recommended that patients who are conscious with communication difficulties be evaluated by a SLP who can develop appropriate communication techniques. SLP assessment should include screening for hearing and vision and restoration of glasses or hearing aids. Appropriate patients (with reasonable cognition and language skills) should be considered for alternative or augmentative communication. Patients with communication difficulties should be monitored and assessed regularly to determine appropriateness for speech and language therapy. An appropriate treatment program with a system for monitoring progress should be in place for any individuals receiving speech-language therapy. In developing a communication program, consideration for premorbid communication style, underlying cognitive deficits, environmental context, social needs, and necessary communication aids should be given. (Royal College of Medicine and the British Society of Rehabilitation Medicine)

Where achievable goals can be identified, and continuing progress demonstrated, patients with communication difficulties should be offered an appropriate treatment program, with monitoring of progress. The program should: take into account the patient’s premorbid communication style and any underlying cognitive deficits; give the opportunity to rehearse communication skills in situations appropriate to the context in which the patient will live/work/study/socialize after discharge; include the family and caregivers in developing strategies for optimum communication within the immediate social circle; and consider the need for communication aids including gesture drawing, communication charts and computerized systems. (Royal College of Medicine and the British Society of Rehabilitation Medicine)

The speech and language therapist will be involved in all cases where there are communication problems following stroke. (Republic of South Africa Department of Health; Stroke Foundation of South Africa)

People with aphasia following stroke should be referred to a speech and language therapist for assessment and appropriate management of their communication difficulty. (Stroke Foundation of New Zealand)