MedicalSettle

MEDICAL LEGAL CONSULTING

MedicalSettle Newsletter | Sept/Oct 2024 | Issue No. 7

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QUESTION: *My TBI client has cognitive deficits: how are they tested and what can be done?*

Medical Settle, LLC Response:

A 35-year-old female payroll manager suffered a traumatic brain injury (TBI) after slipping on ice and striking her head. She had amnesia for the event and subsequent problems with memory, cognitive speed, and problem solving. Five months after injury, she was evaluated by a speech-language pathologist (SLP) who administered cognitive tests and found impairments in memory and attention. The client was given cognitive rehabilitative therapy by the SLP twice weekly for eight weeks. The client returned to work during this time but frequently forgot routine daily tasks, needed repetition of instructions, was often inaccurate in her work, and was unable to execute new projects. Two years post-injury, she was unable to function independently as a payroll manager and was forced to resign from her position.

Research shows that after a TBI, recovery of cognitive functioning usually plateaus at 18 to 24 months and thereafter, may even decline. * Obviously, cognitive deficits can significantly impair activities of daily living (ADL), employment, social relationships, recreation, and active participation in the community.

Studies also show that early 'recovery or remediation therapy' within the first five months post-injury results in greater improvement in cognitive function when compared to the subsequent seven months. * Unfortunately, in today's health care system, delays in evaluation and care of cognitive problems following a TBI are common.

The fastest way to initiate cognitive evaluations and care for the TBI client is for the primary care, urgent care, or emergency department provider to promptly refer the individual to a speech language pathologist (SLP), who will evaluate attention, memory, speech and language, cognitive speed, and executive functions (reasoning, problem solving, organizational skills, etc.). In some cases, the client can also self-refer to SLP, and the waiting time for an appointment is relatively brief (days to weeks).

In addition, in the acute period after injury (first three months), the primary care provider can administer initial cognitive screens, like the mini-mental state exam (MMSE) or Montreal Cognitive Assessment (MoCA). * Individuals with abnormalities on screens such as these should also be referred to a neuropsychologist for a complete battery of in-depth cognitive testing and evaluation of psychological factors. Unfortunately, it may take months to obtain an appointment with a neuropsychologist, testing sessions are long (sometimes up to eight hours), and insurance coverage is often not available.

To complicate matters, although the client can be seen promptly by SLPs, their cognitive evaluation may not be standardized. According to one study, (Roitsch 2021), due to time constraints, as many as 48% of SLPs use informal, non-standardized, and observational methods to evaluate the TBI client and initiate care. In contrast, neuropsychologists use standardized cognitive tests, with normative data, that can be compared from visit to visit. The latter approach obviously provides valuable objective measures of the client's cognitive status over time. There should also be a comprehensive follow-up neuropsychological evaluation one-year post- injury because this milestone generally marks the period where most of the natural recovery has occurred. *

Thus, ideally, the TBI client with reported cognitive deficits would initially be evaluated by both an SLP and a neuropsychologist, who would collaborate on an individual cognitive rehabilitation plan for the client guided by objective data. This plan may include additional team members (occupational therapist, physical therapist, social worker, primary care provider, neurologist, psychologist, etc), depending on the client's needs. Note that occupational therapists (OT) are often key in evaluating and treating functional performance in activities of daily living, work-related tasks, and driving skills. Many clients and their families report that their rehab therapists, in addition to providing 'hands-on care,' are their main source of education and psychosocial support throughout their recovery.

After the first five months, the rehab team will usually shift to 'compensatory rehabilitation,' and find ways to offset degrees of impaired functioning with the use of assistive technologies, calendars, electronic memory devices, alarms, or agenda reminders, etc. The rehab team can also determine limits to functional independence, supervision needs, decision-making capacity, driving capability, and whether the client needs to train for an alternative job (vocational rehab).

In summary, if your TBI client reports cognitive deficits, they can be referred by their primary care provider (PCP), or can often self-refer, to a speech language pathologist (SLP) for an initial cognitive evaluation within days to weeks of the referral. The SLP can initiate a cognitive rehab program, and this should ideally be started within the first five months post-injury for optimal improvement. The SLP can request referrals from the PCP for additional rehab team members as well as a referral for full cognitive testing by a neuropsychologist. The latter evaluation may take months to obtain but is more in-depth, includes evaluation of psychological factors, and provides objective standardized measures over time.

*Citations from the medical literature are provided in Medical Settle's formal Medical Opinion Reports.