Introduction

Forum on Augmentative and Alternative Communication in Acute Care

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This forum provides some insights into the process of initiating a clinical service to enhance patient–provider communication. It also provides a report of a large-scale clinical trial that introduced augmentative and alternative communication (AAC) tools in an acute-care setting.

A significant percentage of people who are hospitalized face a communication barrier, and patients who cannot communicate with caregivers are at a heightened risk of experiencing a preventable adverse event (AE; Bartlett, Blais, Tamblyn, Clermont, & MacGibbon, 2008). The Joint Commission, which accredits U.S. hospitals, has recognized the critical role of patient–provider communication in patient care and safety and has promulgated standards that require hospitals to assess the communication needs and preferences of all patients (The Joint Commission, 2010). There has been a growing realization that augmentative and alternative communication (AAC) strategies and tools can be used to support the communication needs of children and adults who are hospitalized, regardless of their premorbid condition or the cause of their admission (Blackstone, Beukelman, & Yorkston, 2015; Costello, Santiago, & Blackstone, 2015).

To bolster the argument for increasing support for providing AAC services in acute care, a recently published article in *Perspectives of the ASHA Special Interest Groups* (Hurtig, Alper, & Berkowitz, 2018) estimated that the cost to the U.S. health care system of treating preventable AEs was more than $29 billion per year. The authors suggested that by addressing communication barriers, hospitals can not only reduce patient suffering but also achieve considerable savings (more than $6 billion) by reducing the costs associated with having to treat preventable AEs. It is important to recognize that a linguistic barrier can also put patients who have limited English proficiency at a heightened risk of experiencing an AE (Hurtig, Czerniejewski, Bohnenkamp, & Na, 2013).

Although the major focus of most speech-language pathology AAC services has been on helping clients overcome the physical and cognitive barriers that restrict effective communication, ASHA's *Scope of Practice in Speech-Language Pathology* (ASHA, n.d.) can be interpreted to cover provision of services to a wide range of patients to ensure effective patient–provider communication.

Hurtig, Alper, Bryant, Davidson, and Bilskemper (2019) report on a clinical study that looked at the impact of patients' ability to independently summon their nurses and to effectively communicate with them. Their study examined both patients' and nurses' perceptions of the patients' ease of summoning help and effectively communicating about their needs. The study used a between-groups design to compare (a) patients who could summon their nurses and effectively communicate without AAC (*full-access group*); (b) patients who prior to discharge were unable to independently access the nurse call or communicate with their nurses (*no-access group*); and (c) patients who were provided AAC technology that enabled them to independently access the nurse call and to communicate with their nurses (*noddle group*). The study revealed significant differences between (a) those patients who could summon their nurses and communicate with them and (b) those who could not. As in any AAC service setting, the keys to achieving a high-fidelity implementation involve not only evaluation, strategy/tool selection, and patient training but also staff training.

Marshall and Hurtig (2019a, 2019b) present a two-part series of case studies illustrating the barriers that must be overcome to support patients with complex communication

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needs. The authors describe the establishment of a collaboration between (a) speech-language pathologists (SLPs) working in an outpatient AAC clinic and (b) the SLPs and other staff working on the adult and pediatric inpatient units. These cases highlight the strategies used to overcome the barriers that clinicians encountered in introducing an AAC service to meet patients' needs. The authors described these barriers as follows:

- *Patient specific* (e.g., physical, language, cognitive, end-of-life)
- *System specific* (e.g., physical location of the clinic relative to the hospital, consult identification, scheduling, discharge planning)
- *Training and implementation related* (e.g., nursing shift changes, staff time and knowledge, room and unit changes, positioning changes)
- *Technology related* (e.g., role of low-tech equipment, equipment availability, and equipment management)

The three papers taken together provide an evidence base to support the use of AAC in acute-care settings. They also provide a realistic picture of the developmental process that must unfold if an institution wants to establish a culture that will reduce the risks associated with communication barriers and improve patients' satisfaction with their care. These articles make the case that hospital SLPs who provide AAC services can have a significant impact and that success comes from working collaboratively with nursing and other health care professionals.

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