Patient-Provider Communication in Inpatient AAC

Ellie Zempel, B.S.
Faculty Sponsor: Aaron Doubet, M.S., CCC-SLP
Fontbonne University- Department of Communication Disorders and Deaf Education

Abstract

This session will provide a definition of effective patient-provider communication and an overview of the barriers to and risks of poor patient-provider communication in an acute setting. The use of augmentative and alternative communication (AAC) supports in inpatient settings to improve patient outcomes and to benefit both patient and provider will be discussed. Strategies to implement AAC tools and the role of the SLP in supporting effective patient-provider communication will be identified.

Learner outcomes:
- Explain the importance of effective patient-provider communication in an acute setting.
- Describe communication barriers and myths which may lead to adverse medical events.
- Identify the role of SLPs in implementing AAC in acute settings.

Effective Patient-Provider Communication

The Joint Commission (2010) defines effective communication between patients and their providers as:

"The successful joint establishment of meaning wherein patients and health care providers exchange information, enabling patients to participate actively in their care from admission through discharge, and ensuring that the responsibilities of both patients and providers are understood. To be truly effective, communication requires a two-way process (expressive and receptive) in which messages are negotiated unti l the information is correctly understood by both parties."

Effective communication is essential to patient-centered care. Due to its impact on the healthcare needs of patients it has been referred to as the "medium" through which quality health care is provided (Burns, Baylor, Morris, McNalley & Yorkston, 2012). Evidence also reveals that successful patient-provider communication correlates positively with patient safety and satisfaction, caregiver satisfaction, better health out-comes, adherence to recommended treatment, self-management of disease, and lower costs (Blackstone, Yorkston, & Beukelman, 2015).

Risks of Poor Patient-Provider Communication

Communication failures (including breakdowns in oral, written, and electronic communication) between and among providers, as well as with patients, rank among the top three leading causes of *sentinel events*, or incidents that result in permanent damage or death (Blackstone & Pressman, 2015).

Poor patient-provider communication can negatively influence (Hurtig & Alper, 2016; Blackstone and Pressman, 2015; Hurtig, Alper, & Berkowitz, 2018):
- The quality of services that physicians, allied health professionals, and other healthcare workers provide
- Medical outcomes
- Length of hospital stay
- Patient safety
- Patient satisfaction
- Caregiver satisfaction
- Health care costs

Communication-Vulnerable Patient Groups

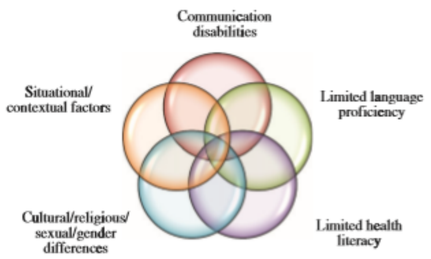

Figure 1. Communication-vulnerable patient groups and converging risk factors. Adapted from Blackstone (2015).

- Patients facing barriers to communication are three times more likely to experience a preventable adverse event (e.g., medication errors) than patients who face no communication barriers (Hurtig et. al., 2018).
- Many people with complex communication needs will have multiple risk factors (Blackstone & Pressman, 2015).

Barriers to Effective Communication in Acute Care

The use of AAC in acute settings is limited due to a variety of challenges (Hurtig & Downey, 2009; Santiago, Altschuler, Howard, & Costello, 2018; Burns et. al., 2012; Gormley & Light, 2019):

Attitude
- Medical thinking; care is easier without interference
- Lack of buy-in from bedside providers

Practice
- Communication is not a priority

Resources
- Access to tools, materials
- Experienced staff
- Financial resources
- Time to create materials

Knowledge
- SLPs knowledge about AAC and short-term implementation
- Other providers knowledge/staff awareness of SLPs role
- E.g., patient unable to participate due to cognitive, motor, or sensory status
- Limited policies

Environment
- Storage limitations
- abundance of medical equipment at bedside

Complicated logistics of rehabilitation care:
- A patient's presentation may change on a daily or weekly basis
- Skills rapidly change and require frequent modifications

AAC Myths in Acute Care Settings

Myths	Realities
AAC should only be considered if all other options have been tried and failed.	AAC should be used whenever needed to aid or replace an existing method of communication
Individuals need to demonstrate a set of minimal skills in order to benefit from an AAC device.	There are no cognitive or linguistic prerequisites for candidacy.
Only individuals with intact cognition can use and benefit from speech-generating devices.	Advances in technology provides access to speech-generating devices to a wider range of cognitive abilities.
Determining AAC candidacy requires a long and time-consuming assessment so use with short-term patients is not feasible.	Given the range of devices and device access methods, even patients with locked-in-syndrome can quickly be started using an AAC system
Learning to communicate with an AAC system requires a considerable amount of time, so it can't occur during short-term hospitalizations.	AAC systems can be introduced to patients at the bedside and they can become functional communicators with only brief instruction.
Adults with acquired loss of speech will reject symbol-based systems.	We live in a world of symbols and icons, so where use of symbols facilitates navigation through an AAC system, symbols are seen as natural and are accepted.
Individuals with acquired losses will reject AAC systems with preset message templates.	When AAC users see that most natural exchanges are often fairly scripted, they come to understand that any form of communication rate enhancement makes their interactions more pragmatically natural.

Figure 2. AAC Myths. Adapted from Hurtig & Downey (2009)

Strategies to Improve Communication in Acute Care Settings

- Simple interventions (e.g., providing hospital owned communication aids to the patient) undertaken in isolation are unlikely to effect significant changes to communication, because the range of barriers to the use of communication tools extend well beyond simply availability (Hemsley & Balandin, 2014)

A set of six strategies to address improving patient-provider communication are suggested (Hemsley & Balandin, 2014)

1. Develop services, systems, and policies to support communication
- Addressing hospital policies around admission and discharge planning for people with a disability
- Providing service co-ordination to help people with a disability, caregivers, and hospital staff to navigate a complex health system.

2. Devote time to communication
- Communication improves with familiarity and frequency.
- Patients/staff who avoid communicating due to difficulty:
  (a) perpetuate dependence upon caregivers for communication
  (b) reduce opportunities for increasing familiarity that could increase communicative competence and success.

3. Ensure access to communication tools
- The physical environment of hospital rooms is restricted and often involves patients communicating in a setting where they are isolated from others
- Ensure access to nurse call system and other communication tools

4. Access to personally held written health information
- Information related to the individual's communication system should be made available to all staff working with the patient.

5. Collaborate effectively with caregivers, spouses, parents
- Caregivers are integral in improving care and communication in hospitals. They often stay for lengthened periods of time and are the patient's primary advocates and communication supports.

6. Increase communicative competence of hospital staff
- Increase the capacity of staff to provide care that relieves family caregiving responsibilities
- Encourage staff to have an open attitude to the possibility of communication being successful, and the intention of applying a range of adaptive strategies in seeking a workable method of communication

Roles of Speech-Language Pathologists to Enhance Patient-Provider Communication

- Adopt and adapt principles of evidenced-based science (Blackstone, Yorkston, & Beukelman, 2015).
- Address the varying communication needs of patients and provide strategies to maximize these individuals' communication skills within desired life roles (Gormley & Light, 2019).
- Develop programs of interprofessional education for students as well as medical practitioners (Blackstone, Yorkston, & Beukelman, 2015).
- Take full advantage of health care policy (Blackstone, Yorkston, & Beukelman, 2015).
- Promote systems change incentives from within health care organizations (Blackstone, Yorkston, & Beukelman, 2015).

References

Burns, M., Baylor, C., Morris, M., McNalley, T., & Yorkston, K. (2012). Training healthcare providers in patient–provider communication: What speech-language pathology and medical education can learn from one another. *Aphasiology*, *26*(5), 673–688.

Blackstone, S. W., & Pressman, H. (2015). Patient communication in health care settings: New opportunities for augmentative and alternative communication. *Augmentative and Alternative Communication*, *32*(1), 69-79.

Blackstone, S. W., Yorkston, K. M., & Beukelman, D. R. (2015). Patient-provider communication: Roles for speech-language pathologists and other health care professionals. San Diego, CA: Plural Publishing, Inc.

Gormley, J., & Light, J. (2019). Providing services to individuals with complex communication needs in the inpatient rehabilitation setting: The experiences and perspectives of speech-language pathologists. *American Journal of Speech-Language Pathology*, *28*(2), 456–468

Hemsley, B., & Balandin, S. (2014). A metasynthesis of patient-provider communication in hospital for patients with severe communication disabilities: Informing new translational research. *Augmentative and Alternative Communication*, *30*(4), 329–343.

Hurtig, R. R., Alper, R. M., & Berkowitz, B. (2018). The cost of not addressing the communication barriers faced by hospitalized patients. *Perspectives of the ASHA special interest groups*, *3*(12), 99–112.

Hurtig, R., & Alper, R. (2016). The impact of communication barriers on adverse events in hospitalized patients. *ASHA*.

Hurtig, R., & Downey, D. (2009). *Augmentative and alternative communication in acute care settings*. San Diego, CA: Plural.

Santiago, R., Altschuler, T., Howard, M., & Costello, J. (2018). Bedside AAC service delivery by SLPs in acute care: Current practice and a call to action. *ASHA*. Boston.

The Joint Commission. (2010). Advancing effective communication, cultural competence, and patient and family centered care: A roadmap for hospitals. Oakbrook Terrace, IL: Author.

Disclaimer: Ellie Zempel has no relevant financial or nonfinancial relationships to disclose.

Abstract

- This session will provide a definition of effective patient-provider communication and an overview of the barriers to and risks of poor patient-provider communication in an acute setting. The use of augmentative and alternative communication (AAC) supports in inpatient settings to improve patient outcomes and to benefit both patient and provider will be discussed. Strategies to implement AAC tools and the role of the SLP in supporting effective patient-provider communication will be identified.

- Learner outcomes:
  - Explain the importance of effective patient-provider communication in an acute setting.
  - Describe communication barriers and myths which may lead to adverse medical events.
  - Identify the role of SLPs in implementing AAC in acute settings

Effective Patient-Provider Communication

- The Joint Commission (2010) defines effective communication between patients and their providers as:

- “The successful joint establishment of meaning wherein patients and health care providers exchange information, enabling patients to participate actively in their care from admission through discharge, and ensuring that the responsibilities of both patients and providers are understood. To be truly effective, communication requires a two-way process (expressive and receptive) in which messages are negotiated until the information is correctly understood by both parties.”

- Effective communication is essential to patient-centered care. Due to its impact on the healthcare needs of patients it has been referred to as the “medium” through which quality health care is provided (Burns, Baylor, Morris, McNalley & Yorkston, 2012). Evidence also reveals that successful patient-provider communication correlates positively with patient safety and satisfaction, caregiver satisfaction, better health out-comes, adherence to recommended treatment, self-management of disease, and lower costs (Blackstone, Yorkston, & Beukelman, 2015).

Risks of Poor Patient-Provider Communication

- Communication failures (including breakdowns in oral, written, and electronic communication) between and among providers, as well as with patients, rank among the top three leading causes of *sentinel events*, or incidents that result in permanent damage or death (Blackstone & Pressman, 2015).
- Poor patient-provider communication can negatively influence (Hurtig & Alper, 2016; Blackstone and Pressman, 2015; Hurtig, Alper, & Berkowitz, 2018):
  - The quality of services that physicians, allied health professionals, and other healthcare workers provide
  - Medical outcomes
  - Length of hospital stay
  - Patient safety
  - Patient satisfaction
  - Caregiver satisfaction
  - Health care costs

Communication-Vulnerable Patient Groups

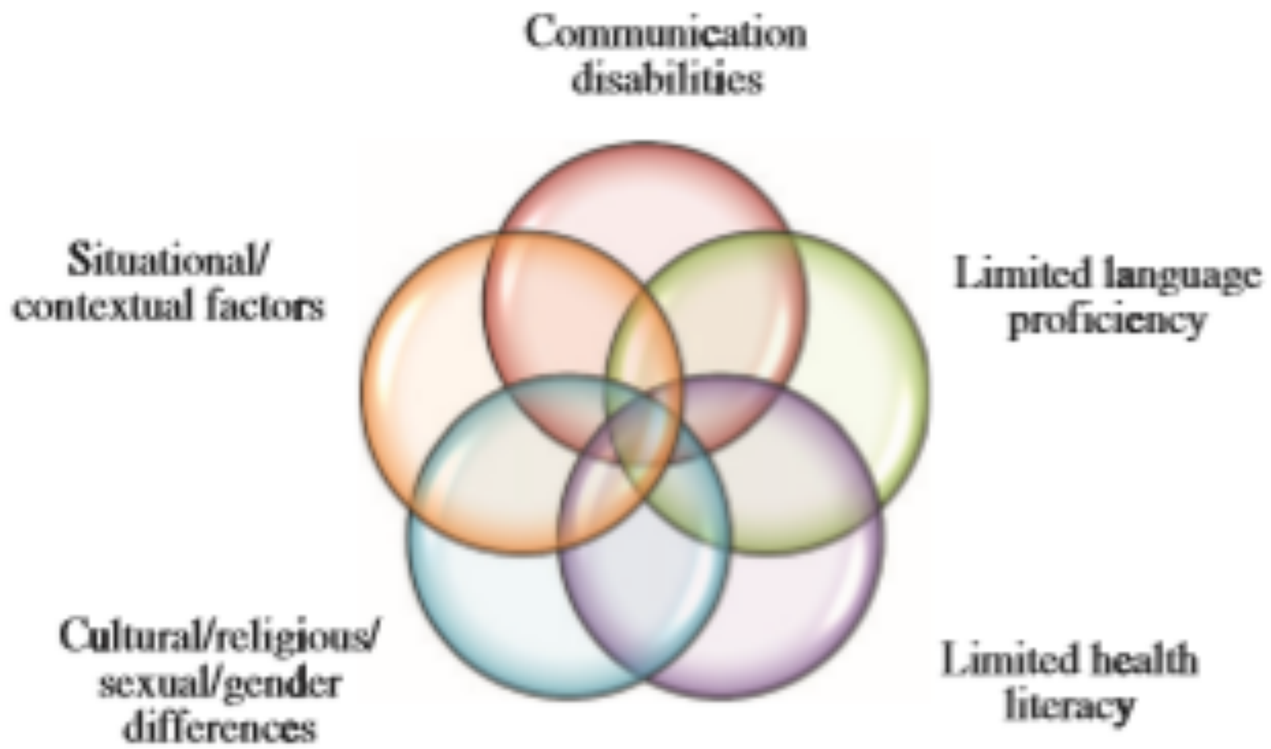

Figure 1. Communication-vulnerable patient groups and converging risk factors. Adapted from Blackstone (2015).

- Patients facing barriers to communication are three times more likely to experience a preventable adverse event (e.g., medication errors) than patients who face no communication barriers (Hurtig et. al., 2018).

- Many people with complex communication needs will have multiple risk factors (Blackstone & Pressman, 2015).

Barriers to Effective Communication in Acute Care

The use of AAC in acute settings is limited due to a variety of challenges (Hurtig & Downey, 2009; Santiago, Altschuler, Howard, & Costello, 2018; Burns et. al., 2012; Gormley & Light, 2019):

Attitude

- Medical thinking; care is easier without interference
- Lack of buy-in from bedside providers

Practice

- Communication is not a priority

Resources

- Access to tools, materials
- Experienced staff
- Financial resources
- Time to create materials

Knowledge

- SLPs knowledge about AAC and short-term implementation
- Other providers knowledge/staff awareness of SLPs role
- E.g., patient unable to participate due to cognitive, motor, or sensory status
- Limited policies

Environment

- Storage limitations
- Abundance of medical equipment at bedside

Complicated logistics of rehabilitation care:

- A patient's presentation may change on a daily or weekly basis
- Skills rapidly change and require frequent modifications

AAC Myths in Acute Care Settings

Myths	Realities
AAC should only be considered if all other options have been tried and failed.	AAC should be used whenever needed to aid or replace an existing method of communication
Individuals need to demonstrate a set of minimal skills in order to benefit from an AAC device.	There are no cognitive or linguistic prerequisites for candidacy.
Only individuals with intact cognition can use and benefit from speech-generating devices.	Advances in technology provides access to speech-generating devices to a wider range of cognitive abilities.
Determining AAC candidacy requires a long and time-consuming assessment so use with short-term patients is not feasible.	Given the range of devices and device access methods, even patients with locked-in-syndrome can quickly be started using an AAC system
Learning to communicate with an AAC system requires a considerable amount of time, so it can't occur during short-term hospitalizations.	AAC systems can be introduced to patients at the bedside and they can become functional communicators with only brief instruction.
Adults with acquired loss of speech will reject symbol-based systems.	We live in a world of symbols and icons, so where use of symbols facilitates navigation through an AAC system, symbols are seen as natural and are accepted.
Individuals with acquired losses will reject AAC systems with preset message templates.	When AAC users see that most natural exchanges are often fairly scripted, they come to understand that any form of communication rate enhancement makes their interactions more pragmatically natural.

Figure 2. AAC Myths. Adapted from Hurtig & Downey (2009)

Strategies to Improve Communication in Acute Care Settings

Simple interventions (e.g., providing hospital owned communication aids to the patient) undertaken in isolation are unlikely to effect significant changes to communication, because the range of barriers to the use of communication tools extend well beyond simply availability (Hemsley & Balandin, 2014).

A set of six strategies to address improving patient-provider communication are suggested (Hemsley & Balandin, 2014)

1. Develop services, systems, and policies to support communication

- Addressing hospital policies around admission and discharge planning for people with a disability
- Providing service co-ordination to help people with a disability, caregivers, and hospital staff to navigate a complex health system.

2. Devote time to communication

- Communication improves with familiarity and frequency.
- Patients/staff who avoid communicating due to difficulty:
  (a) perpetuate dependence upon caregivers for communication
  (b) reduce opportunities for increasing familiarity that could increase communicative competence and success.

3. Ensure access to communication tools

- The physical environment of hospital rooms is restricted and often involves patients communicating in a setting where they are isolated from others
- Ensure access to nurse call system and other communication tools

4. Access to personally held written health information

- Information related to the individual's communication system should be made available to all staff working with the patient.

5. Collaborate effectively with caregivers, spouses, parents

- Caregivers are integral in improving care and communication in hospitals. They often stay for lengthened periods of time and are the patient's primary advocates and communication supports.

6. Increase communicative competence of hospital staff

- Increase the capacity of staff to provide care that relieves family caregiving responsibilities
- Encourage staff to have an open attitude to the possibility of communication being successful, and the intention of applying a range of adaptive strategies in seeking a workable method of communication

Roles of Speech-Language Pathologists to Enhance Patient-Provider Communication

- Adopt and adapt principles of evidenced-based science (Blackstone, Yorkston, & Beukelman, 2015).

- Address the varying communication needs of patients and provide strategies to maximize these individuals' communication skills within desired life roles (Gormley & Light, 2019).

- Develop programs of interprofessional education for students as well as medical practitioners (Blackstone, Yorkston, & Beukelman, 2015).

- Take full advantage of health care policy (Blackstone, Yorkston, & Beukelman, 2015).

- Promote systems change incentives from within health care organizations (Blackstone, Yorkston, & Beukelman, 2015).

References

Burns, M., Baylor, C., Morris, M., McNalley, T., & Yorkston, K. (2012). Training healthcare providers in patient–provider communication: What speech-language pathology and medical education can learn from one another. *Aphasiology*, *26*(5), 673–688.

Blackstone, S. W., & Pressman, H. (2015). Patient communication in health care settings: New opportunities for augmentative and alternative communication. *Augmentative and Alternative Communication*, *32*(1), 69-79.

Blackstone, S. W., Yorkston, K. M., & Beukelman, D. R. (2015). Patient-provide communication: Roles f or speech-language pathologists and other health care professionals. San Diego, CA: Plural Publishing, Inc.

Gormley, J., & Light, J. (2019). Providing services to individuals with complex communication needs in the inpatient rehabilitation setting: The experiences and perspectives of speech-language pathologists. *American Journal of Speech-Language Pathology*, *28*(2), 456–468

Hemsley, B., & Balandin, S. (2014). A metasynthesis of patient-provider communication in hospital for patients with severe communication disabilities: Informing new translational research. *Augmentative and Alternative Communication*, *30*(4), 329–343.

Hurtig, R. R., Alper, R. M., & Berkowitz, B. (2018). The cost of not addressing the communication barriers faced by hospitalized patients. *Perspectives of the ASHA special interest groups*, *3*(12), 99–112.

Hurtig, R., & Alper, R. (2016). The impact of communication barriers on adverse events in hospitalized patients. *ASHA*.

Hurtig, R., & Downey, D. (2009). *Augmentative and alternative communication in acute care settings*. San Diego, CA: Plural.

Santiago, R., Altschuler, T., Howard, M., & Costello, J. (2018). Bedside AAC service delivery by SLPs in acute care: Current practice and a call to action. *ASHA*. Boston.

The Joint Commission. (2010). Advancing effective communication, cultural competence, and patient and family centered care: A roadmap for hospitals. Oakbrook Terrace, IL: Author.

Disclaimer: Ellie Zempel has no relevant financial or nonfinancial relationships to disclose.

Thank you!

Questions?

Ellie Zempel

zempele@fontbonne.edu