Extended Abstract:
It is now recognized by many communication specialists across the globe, that the inability to communicate when in hospital (poor patient-provider communication) impacts patient care and safety; patient comfort, participation and recovery; family satisfaction and success of authentic communication between patient and providers. The literature reveals that reduced patient-provider communication threatens patient satisfaction scores (Hoffman et al., 2005), length of hospital stay (Bartlett et al, 2008), active patient participation discharge compliance (Tarkan, 2008), quality of care, personal well-being (Patak et al., 2006), and contributes to sentinel events (The Joint Commission 2012). Indeed, the 2012 Joint Commission mandates and new reimbursement models with the Affordable Care Act in the United States, coupled with heightened awareness and development of innovative models across the globe, has primed AAC specialists, worldwide to team with hospital leadership to address improving patient-provider communication.

Although the need for effective communication is often recognized and despite the motivation of many communication specialists to implement, there are numerous reports of barriers to successfully fostering a hospital culture that values a patient’s ability to communicate and proficiently access augmentative communication/assistive technology. Limited resources, decreased staff awareness of effective communication as a vital contributor to medical management, lack of organizational investment, and availability of training are challenges to establishing and sustaining this evidenced based initiative. Changing a hospital’s culture of communication takes time.

The successes, challenges, failures and lessons learned of several pediatric hospital based speech language pathologists, all of whom are at different phases of patient-provider communication implementation, will be shared in this seminar. Further, it will serve as a forum to empower AAC specialists to champion patient-provider communication change at their facility, despite barriers to implementation and change. Each hospital site is in a different phase of providing bedside AAC service delivery and different levels of success toward implementing overall change in the culture of patient-provider communication enhancement.

1. Hospital 1: A review of an established inpatient augmentative communication program will include overview of successful implementation of bedside AAC service delivery ranging from low tech to high tech solutions. Discussion will target shared strategies for maintaining momentum in program development and an institutional culture of patient-provider communication in the ICU/acute care units.

2. Hospital 2: Early phases of program development will be reviewed from perspective of a pediatric acute care center with initial success launching a
standard, low-tech dynamic communication board placed in PICU rooms and on unit floors. This includes recent focus on program development efforts on increasing awareness of communication supports as a whole in addition to enforcing consistent consideration of mid-high tech augmentative communication supports and alternative access by hospital staff. Sustaining these early successes and advancing the breadth of the inpatient program presents challenges and will be reviewed.

3. Hospital 3: Efforts to begin development of a patient-provider communication program in a pediatric intensive care unit will be reviewed with an emphasis on gaining administrative support, obtaining funding from a grant, and establishing protocols for implementation. Obstacles overcome in launching an inpatient program and early successes will be shared.

Despite recognizing a variety of important considerations that have emerged from each practice, it remains clear that there is no single recommended framework to approach development or operation of an inpatient augmentative communication service, due in part to institutional differences. Still, it is widely recognized that the execution of service delivery and operational responsibilities of the AAC specialist go beyond clinical bedside assessment and intervention or face-to-face patient interactions. There is a fundamental need for institutional support to implement change, team collaboration, staff training, optimal access of resources, communication between providers including referrals and documentation, management of equipment, and consistent patient/family follow-up. For example, in order to ensure patient referrals for consultation, a referral system must be in place with ongoing collaboration with multiple team members. Loaned equipment must be well managed, tracked, and cleaned according to institutional guidelines. Patient status, interventions, and progress should be well documented and staff should be well educated on how to refer patients for consultation services. This includes training to support authentic bedside implementation of recommended interventions. An overarching need is that the AAC specialist is well educated on best practice for AAC assessment and intervention including both aided and unaided strategies.

For many providers, a variety of barriers are evident within the hospital institution. These often challenge efforts to begin implementing AAC services in the inpatient setting. Despite growing awareness of a clear need for communication enhancement at the bedside (Patak et al, 2006), the implementation of strategies in ICU and acute care settings throughout the world is slight (Costello, Patak, and Pritchard, 2010). Institutions may not have staffing, if staffing does exist, referrals to an AAC specialist are often not made, poor patient communication is not often recognized as a negative influence in patient medical state or recovery, and medical providers may simply not have fundamental knowledge of the benefits of communication enhancement strategies. Many hospitals may also not have adequate resources or physical space to support storage and placement of tools.
Presenters will review pathways to success across the participating institutions, common barriers that may challenge efforts to begin, sustain, and/or maintain inpatient AAC service delivery at the bedside and potential solutions to system change, based on shared experiences, will be discussed. Strategies will be suggested for establishing, sustaining, and maintaining inpatient augmentative communication programs and participants will be encouraged to engage in an interactive discussion regarding strategies to sustain momentum of an inpatient AAC program and establish a strategy that matches their organization’s implementation phase.

Learner Outcomes:
After completing this session, participants will be able to:
1. Gain awareness of the communication specialists role in hospital-wide patient-provider communication
2. Understand various barriers for implementation of communication enhancement supports and program development
3. Appreciate the continuum of program development and the efforts to change hospital culture of patient-provider communication across multiple institutions.

Declaration of Interest:
- Tami Altschuler has no non-financial relationships to disclose. She is an employee of NYU Langone Medical Center where she receives a salary.
- John Costello, M.S., CCC-SLP has no non-financial relationships to disclose. He is an employee of Boston Children’s Hospital where he receives a salary.
- Jane Quarles, M.S., CCC-SLP is the author of Dynamic Low-Tech Communication Board. She is an employee of St. Louis Children’s Hospital where she receives a salary.
- Claire Francin, M.S., CCC-SLP has no non-financial relationships to disclose. She is an employee of St. Louis Children’s Hospital where she receives a salary.
- Rachel Santiago, M.S., CCC-SLP has no non-financial relationships to disclose. She is an employee of Boston Children’s Hospital where she receives a salary.

References:


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Keywords:
patient-provider communication
AAC
pediatric
hospital
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Program Planner/Instructional Personnel’s Name: Rachel Santiago

Course Title: Putting Patient-Provider Communication at the Forefront: Overcoming Barriers

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Signature  Rachel Santiago, M.S., CCC-SLP  Date 23-Oct-2015

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Other financial benefit (please describe):

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Program Planner/Instructional Personnel’s Name: Claire E. Francin

Course Title: Putting Patient-Provider Communication at the Forefront: Overcoming Barriers

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Signature: Claire E. Francin, M.S., CCC-SLP

Date: 15-Oct-2015

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Planner/Presenter name: Claire E. Francis

Financial relationship with (name of Company/Organization): St. Louis Children's Hospital

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Program Planner/Instructional Personnel’s Name: Jane K. Quarles

Course Title: Putting Patient-Provider Communication at the Forefront: Overcoming Barriers

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Signature Jane K. Quarles, M.S., CCC-SLP
Date 16-Oct-2015

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Planner/Presenter name: Jane K. Quarles

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- [x] Salary
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For what role? (Check all that apply)

- [x] Employment
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Planner/Presenters name: Jane K. Quarles

Non-financial relationship with (name of Company/Organization/Institution):
St. Louis Children’s Hospital

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What is the nature of the non-financial relationship? (Check and complete all that apply)

- Personal, please describe: 
- Professional, please describe: Author of Dynamic Low-tech Communication Board
- Political, please describe: 
- Institutional, please describe: 
- Religious, please describe: 
- Personal interest, please describe: 
- Bias, please describe: 
- Other relationship, please describe: 

For what role?

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Program Planner/Instructional Personnel’s Name:

Course Title: Putting Patient-Provider Communication at the Forefront: Overcoming Barriers through Phases of Pediatric Inpatient Program Development

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Program Planner/Instructional Personnel’s Name: Tami Aitschuer, MA, CCC-SLP

Course Title: Putting Patient-Provider Communication at the Forefront: Overcoming Barriers

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Planner/Presenter name: Tami Altschuler

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