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Proposal ID: 12225
Proposal Type: General Submission Form
Authors

Order	Disclosure	Author Information
1	No Response	Richard Hurtig (Author who will be presenting at the session) (Submitter) richard-hurtig@uiowa.edu The University of Iowa Philadelphia, PA 19106 United States **ASHA Affiliation:** ASHA Member **Student:** No **Certification:** None **Author Biographical Sketch:** Richard Hurtig is Professor Emeritus in CSD at The University of Iowa. He directs the UI Assistive Devices Laboratory and is president of Iowa Adaptive Technologies. His research includes the development of assistive technologies for individuals with CCN and the development of strategies to facilitate patient-provider communication in acute care.
2	No Response	Rebecca Alper (Author who will be presenting at the session) rebecca.alper@temple.edu Temple University Philadelphia, PA 19002 United States **ASHA Affiliation:** ASHA Member **Student:** No **Certification:** CCC-SLP **Author Biographical Sketch:** Dr. Rebecca Alper is a speech-language pathologist and postdoctoral fellow in the Temple Infant and Child Lab. Dr. Alper's research focuses on clinical training and the role of clinicians and caregivers in early language and literacy intervention, including the impact of psychosocial factors on intervention gains.

Requested Session Format: Oral Session (Seminar 1-hour)

Are you willing to accept a change in format? Yes

Topic Area: Augmentative and Alternative Communication (AAC)

Title of Proposal
The Impact of Communication Barriers on Adverse Events in Hospitalized Patients

Instructional Level: Introductory

Abstract Type: Professional Education
Learner Outcomes
1. Identify common adverse events
2. Describe communication barriers faced by hospitalized patients
3. Explain the impact of adverse events on the US healthcare system

Abstract of Proposal
Hospitalized patients who cannot effectively summon a nurse and communicate are at greater risk of preventable adverse events. It is ethically and financially imperative to reduce preventable AEs through various means including facilitating access and communication. This presentation describes the potential return-on-investment for facilitating communication in hospitalized patients.

Summary of Proposal

The Institute of Medicine report, To Err Is Human: Building a Safer Health System, highlighted to the pervasive problem of adverse events (AEs) in health care (Kohn et al, 2000). A key element of that report was the differentiation of preventable AEs from unavoidable AEs. What was startling was that the preventable AEs may have contributed to somewhere between 44,000 and 98,000 deaths in US hospitals each year. Adverse Drug Reactions, Ventilator Associated Pneumonias, Pressure Ulcers and Patient Falls are among the most prevalent preventable AEs. Over the next decade hospitals' concerted efforts to address the root causes of preventable AEs, did not significantly reduce the frequency of preventable AEs.

The Department of Health and Human Services (HHS) released a report on the incidence of Medicare beneficiaries' adverse events (Levinson, 2010). This report revealed that 13.5% of patients had experienced AEs. One and a half percent of patients had experienced adverse events that contributed to their deaths. Furthermore, as a result of their inability to effectively communicate with medical providers, approximately 15,000 Medicare patients' had died. Landrigan et al. (2010) found that, despite increased hospital awareness of patient safety, the number of patients harmed by medical interventions had remained high (18% of admissions) and the report contended that 63% of those injuries would have been preventable.

Bartlett et al. (2008) reported that hospitalized patients with physical communication problems were 3 times more likely to experience 1 or more AEs than patients who had no communication problems. Changes in Medicare reimbursement make healthcare providers responsible for the cost of treating and addressing the medical errors. It is clear that there are strong ethical and financial reasons for pursuing all avenues, including facilitating access to nurse call and patient-provider communication, to reduce the frequency and/or severity of preventable AEs.

Several studies examining patient-provider communication have indicated that the quality of the communication played a significant role in medical outcomes and in both patient and caregiver satisfaction (Hoffman et al., 2005). Communication barriers have also been associated with AEs among hospitalized pediatric populations (Cohen et al., 2005).

The National Joint Committee's Communication Bill or Rights (1992) identified communication as a basic right and declared that individuals with impaired communication have the right to functional assistive technology.

The Joint Commission (JC) has deemed effective communication, cultural competence, and patient-and family-centered care vital components of safe, quality care (Joint Commission on Accreditation of Healthcare Organizations, 2010; Blackstone et al. 2011). The JC identified strategies that hospitals should undertake as they address the extensive range of their patients' communication needs (JC, 2010).

The JC's recommendations are supported by a range of studies that indicated a relationship between patient-provider communication and health outcomes (Bartlett et al, 2008; Divi et al, 2007; Hurtig and Downey, 2009; Costello, 2000; Dowden, Honsinger, & Beukelman, 1986). These studies identified and highlighted the language-communication barriers that inhibit or impede patients' access to healthcare; participation in treatment planning; participation in critical decision-making involving life or death or quality of life issues; communication with medical providers regarding new or changing symptoms; and the ability to express dissatisfaction with their care. Thus, when healthcare providers fail to address communication barriers, patients are at risk for significant AEs (JC Sentinel Events, 2011).

As patient outcomes and satisfaction have become Medicare reimbursement components, hospitals have begun to assess patient satisfaction and have examined their care delivery models. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCHAPS) and Press Ganey (PG) surveys include a question related to nurse call responses. The quality of patient-provider communication is a key contributor to patient satisfaction. While hospitals have begun to implement strategies to address the need for better patient-provider communication, the absence

of integrated solutions to address the needs of patients has limited progress.

Contacting a nurse is the patient's first and most basic effective communication effort. Unfortunately, because of frailty or paralysis resulting from a traumatic injury or illness, many individuals are unable to independently call their nurses. Zubow & Hurtig (2013) provided the first quantitative estimate of the number of patients who could not access the nurse call system. They reported that 14% of all conscious hospitalized patients, over the age of 3, were not able to independently access the nurse call system (33% of patients in ICUs and 9% of non-ICU patients). Thus, any effort to enhance patient-provider communication must insure that all patients can access the nurse call system. For many critically ill patients, mechanical ventilation renders them incapable of speaking for a significant period of time (Wunsch et al. 2010) Dasta et al. (2005) reported that 36% of individuals admitted to intensive care units required mechanical ventilation. These "silent patients" are incapable of expressing their most basic needs, and are unable to participate in life or death healthcare decisions. Zubow & Hurtig (2013) also reported that 33% of conscious and ventilated ICU patients were unable to communicate with caregivers.

Using values are derived from the AHA's estimate of the total inpatient population (AHA FastFacts 2016) and the Zubow & Hurtig (2013) estimates of the percentage of patients who could not access the nurse call and who could not effectively communicate, one can calculate the total number of patients who may be at added risk of AEs. Utilizing data from AHA and AHRQ one can estimate the incidence and associate costs of each AE and then calculate the savings that would be achieved if one reduced the added risk associated with communication barriers.

The analysis revealed that there would be a reduction of 139,170 AE cases for ICU patients and 408,736 cases for non-ICU patients, totaling to 547,906 fewer AE cases annually across all patients. This corresponds to a potential annual cost reduction of $1.4 billion for ICU patients and $4.1 billion for non-ICU patients, with an overall potential cost reduction of $5.5 billion dollars across all patients.

Facilitating patient-provider communication is both an ethical imperative and an essential part of a multi-pronged approach for reducing the human and financial cost of preventable AEs.

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Time-Ordered Agenda

5 minutes–Introductions and Disclosures

15 minutes–Overview and Background

15 minutes–Presentation data on incidence & costs associated with adverse events

10 minutes–Presentation of data on estimated reduction of adverse events and cost savings

15 minutes–Conclusion, Questions and Wrap-Up

Keywords

Keyword 1: Communication Barriers

Keyword 2: Adverse Medical Event

Keyword 3: Patient-Provider Communication

Keyword 4: Healthcare Costs

Keyword 5: Augmentative & Alternative Communication

Will this submission be of particular interest to any of the following audiences? Students
Public/Consumers
Researchers
Related Professionals

Will this proposed session focus on one specific approach, product or product line, tool, technique, service or model (without mention of or information about other similar approaches, products, services, techniques, tools or models)? No

Would you and/or the presenters of this session be willing to speak with the media about your presentation? Yes

Would you and your co-authors be willing to be recorded (audio synced with slides) so that ASHA can make your presentation widely available through resources such as ASHA's Practice Portal or CREd Library, if requested? Yes

How much of this proposed presentation has been previously presented (I.e., at other meetings or conferences)? 10%

Has this proposal been developed by an ASHA Committee, Board or Council? No

I/We can present on any day (Thursday, Friday, and Saturday). Yes

Would your presentation be of particular interest to local attendees who may only attend in the evening?
No

Is this a panel presentation/discussion? No

Does any presenter listed in the proposal require assistance due to disability? This information will be solely used for scheduling purposes. No

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