Inpatient AACcelerator

A guide to support your bedside AAC service development, from groundwork to growth

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Purpose of this guide

Communication access plays a vital role in supporting safe, equitable, and high-quality care for patients with communication vulnerabilities in acute care hospitals. Yet, despite strong evidence and growing awareness, SLPs often encounter significant challenges when initiating or expanding hospital-based AAC services.

This guide was created by speech-language pathologists who routinely provide bedside AAC care in inpatient hospital settings, lead department and hospital-wide efforts to integrate communication access and patient-provider communication into hospital care, and mentor acute care SLPs across the United States. The *Inpatient AACcelerator* is designed to help clinicians examine current barriers, needs, and solutions to enhance bedside AAC services across operational, clinical, and system considerations.

Throughout the guide, you will find posed questions to consider individually or with colleagues, along with example solutions that can support planning and next steps. When using this guide, we encourage you to think about your priorities, needs, long-term goals, and short-term goals to guide your bedside AAC service delivery. While the guide does not expand upon bedside AAC clinical assessments and intervention practices, we encourage you to get started whenever and however you can.

About the Authors

Rachel Santiago is a speech-language pathologist and Clinical Coordinator of the Inpatient Augmentative Communication Program at Boston Children's Hospital. She focuses on bedside AAC assessment, intervention, and improving communication access in intensive, acute, and emergency care settings. Rachel coordinates program development, research, education, and hospital-wide initiatives that integrate communication accessibility. She also serves on the Board of Directors for the Patient-Provider Communication Network and consults with SLPs on inpatient AAC service development worldwide.

Dr. Jessica Gormley, PhD, CCC-SLP is an Assistant Professor and Research Scientist at the University of Nebraska Medical Center. Through research, she aims to develop and evaluate tools, strategies, and programs to equip people with communication disabilities, especially those who use AAC and their partners to interact effectively in healthcare settings. She practices in the acute care and outpatient setting, providing clinical services, mentoring, and program development. Jessica is the President and co-organizer of the Patient-Provider Communication Network.

Tami Altschuler, M.A., CCC-SLP is a speech-language pathologist and Clinical Specialist at NYU Langone Medical Center, leads efforts to embed communication access in patient care. As a PhD student in Rehabilitation Sciences at NYU, she researches healthcare disparities affecting individuals with communication disabilities. Tami co-organizes the Patient-Provider Communication Network and is a published author and speaker, sharing her work nationally and internationally.

Program Development:
Charting Your Pathway

Setting long term goals and short-term objectives to achieve next steps in your inpatient AAC journey

Think about small, strategic, and doable steps to enhance AAC service delivery and program development. Regardless of where you are in your efforts, consider establishing short- and long-term goals to achieve your next step.

Take a deep breath - although culture and policy shifts take time; you can help create change! By setting short term goals across 3-month intervals (or a time frame of your choosing), you can strategically consider small, achievable steps within your or your program's time and resource allotments.

Examples short term goals:

- Create 5 'general' communication boards for use in the neuro ICU
- Host a lunch-and-learn with nurses on partner-assisted scanning
- Create a starter AAC kit for your SLP department
- Identify 5 patients/month who could benefit from AAC support
- Present a patient story highlighting communication breakdowns and solutions to leadership
- Attend one multidisciplinary round each week
- Identify 3 communication champions and meet to discuss AAC service initiatives.

Sample long and short-term goals for conducting a needs assessment:*

Long term goal:	Conduct an AAC Needs Assessment in my department
Short term goal #1	Create a questionnaire on Microsoft Forms (or other platform) to poll current SLPs on their knowledge, confidence, skills, and perspectives regarding AAC and communication at the bedside
Short term goal #2	Conduct the survey. Gather and analyze responses
Short term goal #3	Share results of the needs assessment with the SLP team at a team meeting. Identify areas of need and growth to inform next steps

***Charting Your Path form is available on page 5**

Charting Your Path

Goal Area:

Long term goal:	**Goal Date:**
Short term goal #1	
Short term goal #2	
Short term goal #3	

Long term goal:	**Goal Date:**
Short term goal #1	
Short term goal #2	
Short term goal #3	

Long term goal:	**Goal Date:**
Short term goal #1	
Short term goal #2	
Short term goal #3	

My Knowledge

Pathways to Progress

Questions & Considerations	Getting Started	Growing	Sustaining
Can I identify which patient populations are at most risk for communication difficulties during their hospitalization?	Review common etiologies that place patients at risk and which units have the highest volume of communication vulnerable patients. Learn AAC tools that are used in acute care and explore hospital resources. Read the regulatory statements on effective communication. Review key literature on communication vulnerability and adverse events, safety outcomes, anxiety reduction, and patient participation. Learn about hospital initiatives such early mobility and delirium prevention.	Communicate with nursing, physicians, and therapy staff to proactively identify patients who may need communication support. Develop or customize tools for specific populations. Integrate policy language into evaluation and treatment notes (e.g., “communication accommodations”). Participate in quality initiatives where communication plays a role (e.g., falls reduction, delirium reduction, mobility programs). Attend interprofessional (e.g., ICU rounds) to build understanding of shared priorities.	Advocate for EMR-based triggers (e.g., mechanical ventilation, delirium orders) that auto-flag communication-vulnerable patients. Lead development of communication toolkits or resource carts for specific units. Advocate for communication access to be included in orientation programs, and quality improvement goals. Lead or co-lead quality improvement or projects related to communication access. Advocate for communication access to be explicitly named in strategic plans or hospital-wide initiatives.
Do I know the range of AAC tools available (low-tech to high-tech) for various units/settings and patient populations (e.g., ICU, pediatric, spinal cord injury, etc.)?			
Am I familiar with Joint Commission, ADA, and hospital policies related to patient-provider communication?			
Do I know how communication access aligns with patient outcomes, patient safety, quality, health equity, and patient experience?			
Am I aware of any other hospital initiatives that may be already addressing communication access or might align well for program development?			

My Skills

Pathways to Progress

Questions & Considerations	Getting Started	Growing	Sustaining
Am I skilled at feature matched assessment for AAC evaluation in acute care?	Learn core components of acute care AAC assessment (motor access, cognition, sensory status, endurance, respiratory support). Learn to modify existing low-tech boards (add pain scales, yes/no, basic needs). Identify champions on your unit who are receptive to AAC and build initial rapport. Practice writing clear care team instructions (e.g., "Place board within reach," "Confirm yes/no method before care"). Participate in bedside rounds or huddles to understand team priorities and pain points. Collect basic data: number of referrals, types of tools used, staff feedback. Learn basic quality improvement concepts (e.g., key driver diagrams).	Independently conduct feature-matched assessments for diverse patient profiles. Create individualized tools based on patient goals, motor access, cultural/linguistic needs, or diagnoses. Use real-time coaching and modeling to support nurses, physicians, PT/OT, and family members. Document specific access method, patient performance, and recommendations. Collaborate on shared goals (e.g., early mobility, delirium prevention). Develop brief surveys for staff. Implement the concept (e.g., key driver diagram).	Serve as a clinical resource to colleagues for complex AAC access questions. Maintain and update tools to reflect new evidence, staff workflow needs, and patient feedback. Develop unit-wide or hospital-wide education pathways (e.g., for orientation, annual competencies). Collaborate on streamlining documentation templates (e.g., smart phrases, checklists, EMR dropdowns). Promote success stories and patient examples to strengthen culture change. Incorporate data into quality improvement projects. Standardize changes across units (e.g., consistent placement of communication tools).
Do I know how to create or adapt AAC tools as needed?			
Can I train bedside care providers effectively on AAC tools and strategies?			
Do I know how to document an AAC evaluation and therapy?			
Can I build partnerships with nurses, physicians, PT/OT, and others to increase AAC use?			
Am I able to evaluate the impact or effectiveness of an AAC program (e.g., surveys, usage data, staff feedback)?			
Do I have experience or support with developing and maintaining a quality improvement initiative?			

My Bandwidth

Pathways to Progress

Questions & Considerations	Getting Started	Growing	Sustaining
How much time can I realistically dedicate to program development beyond my clinical duties?	Identify small, manageable tasks that can fit into existing workflow. Share initial goals with direct leadership and gauge level of support. Explore internal funding sources. Create a workflow for maintaining materials. Create basic orientation materials.	Prioritize projects based on impact and feasibility. Request specific types of support (e.g., meeting time, material development). Apply for small internal funds or partner with units (e.g., Child Life or Nursing) to share resources. Build a shared digital folder with communication tools and templates. Build a structured onboarding pathway for new hires.	Advocate for protected program time or workload adjustments. Incorporate the AAC program into departmental goals or strategic plans. Seek larger grant opportunities (e.g., hospital foundation). Establish a routine review to evaluate and replenish tools. Identify others on the team to co-lead AAC programming.
Do I have administrative/leadership support for this work?			
Are there funding opportunities to support this work?			
Can I commit to maintaining and updating the program over time?			
Do I have a plan for training new staff and ensuring continuity if my role changes?			

The SLP Team's Knowledge, Skills, & Bandwidth

Pathways to Progress

Questions & Considerations	Getting Started	Growing	Sustaining
Is AAC expertise represented somewhere on our team? Who currently has AAC expertise, and who might need support to build it? How will we educate and train our department about AAC? Do we engage in peer mentoring or cross-training to build AAC competence across all staff? Are we connected to external networks or professional groups (e.g., Patient-Provider Communication Network, United States Society on Augmentative and Alternative Communication, ASHA) for resources and learning?	Conduct a needs assessment: Survey the SLP team related to knowledge, skills, and bandwidth. Identify current educational opportunities built into the SLP team schedule (e.g., staff meetings, regular in-service training, etc.). Seek mentorship opportunities with outside hospitals that practice AAC at the bedside. Ask relevant questions and learn about day-to-day experiences and service delivery. Join external networks or professional groups (e.g., PPCN, USSAAC, ASHA).	Create onboarding education for new SLPs. Identify days and times for shadowing SLPs with bedside AAC experience. Consider integrating outpatient SLP guidance on AAC practices. Integrate initial cotreats with experienced SLPs to help guide AAC evaluation and intervention, with faded support. Seek mentorship opportunities with outside hospitals that practice AAC at the bedside. Ask relevant questions and learn about day-to-day experiences and service delivery.	Develop ongoing educational opportunities for inpatient SLP clinicians related to AAC at the bedside. Attend subspecialized conference proceedings on AAC (e.g. ISAAC, ASHA, USSAAC webinars, ATIA). Establish an AAC mentoring process within the SLP team.

Leadership's Knowledge, Skills, & Bandwidth

Needs Assessment

Questions & Considerations	Getting Started	Growing	Sustaining
Do we have the infrastructure and staff training mechanisms to sustain communication access programs once initiated?	Review current staffing, coverage patterns, and communication resources across units. Identify small, low-cost program investments that could jumpstart efforts and learn about internal funding mechanisms. Review available patient experience comments or incident reports related to communication. Identify key stakeholders and champions in nursing, medicine, and therapy services. Identify a small, manageable unit or patient population for a pilot. Observe current workflow demands that reduce bandwidth for program work. Share stories or examples that highlight communication barriers affecting care. Identify low-cost, high-impact needs for initial program development. Identify how much time is needed weekly or monthly to make progress.	Establish workflows for maintaining supplies. Request funding for needed materials and technology. Partner with other service to co-share resources. Track trends that reflect communication barriers (e.g., safety events, complaints, delays in care). Establish communication access as a shared, not siloed, responsibility. Launch the pilot with clear roles, timelines, and measurement strategies. Provide materials, technology, or admin support to reduce burden. Align communication access with institutional priorities (e.g., Joint Commission readiness, safety goals). Apply for internal grants or funding to support materials and technology. Reassess clinician workload to ensure dedicated time is used effectively.	Embed AAC training into annual competencies and orientation. Incorporate AAC related needs into annual budget requests. Share outcomes with leadership to maintain awareness and accountability. Integrate communication goals into multi-unit initiatives (e.g., delirium prevention). Evaluate impact and scale successful pilots to additional units. Incorporate AAC program responsibilities into formal job roles or descriptions. Establish communication access as an ongoing institutional priority. Secure ongoing funding through annual budget lines or operational planning. Expand protected time as program responsibilities grow.
Are we skilled at allocating or advocating for resources (e.g., FTE, funding) that support program development?			
Can we leverage data (e.g., patient experience surveys, safety event reports, quality dashboards) to identify communication-related gaps or opportunities?			
Are we able to collaborate effectively across departments (e.g., ICU, Nursing, etc.) to ensure program success?			
Do we have an established Quality Improvement plan to pilot a new communication access initiative?			
Are we able to identify and remove barriers that limit SLPs' time or resources to engage in program development work?			
Is there leadership buy-in at multiple levels (unit, department, hospital) to prioritize communication access?			
Do we have funding streams that could support AAC program growth?			
Do we provide protected time for clinicians leading communication access initiatives?			

Leadership's Knowledge, Skills, & Bandwidth Continued

Pathways to Progress

Questions & Considerations	Getting Started	Growing	Sustaining
Can we designate point persons or champions in relevant departments to support AAC program development?	Clarify what a "champion" role might include (e.g., identifying patients, locating tools, reinforcing workflows). Begin tracking which units have consistent access and which do not. Assess minimal resources required to keep the program functional.	Provide champions with brief training, resources, and clear expectations. Establish a review cycle (e.g., every 3-6 months) to evaluate tools and identify upgrade needs. Develop written protocols, shared folders, and clear onboarding materials for new leaders and staff.	Develop a rotating or multi-champion system to reduce burnout and ensure coverage across shifts. Expand tools hospital-wide and ensure consistency across multiple units. Secure recurring funding or budget lines.
Is there a formal structure for ongoing review, maintenance, and expansion of AAC tools across units?			
Do we have the capacity to sustain the program through staff turnover, leadership transitions, or budget changes?			

Units' Knowledge, Skills, & Bandwidth

Pathways to Progress

Questions & Considerations	Getting Started	Growing	Sustaining
Are new hires and float staff oriented to communication tools during onboarding?	Add AAC orientation content to an existing checklist or onboarding module. Identify staff who show interest in AAC or are early adopters of innovation. Educate nurses and physicians during rounds. Identify one location for AAC tools and supplies. Provide staff with example phrasing and terminology. Ensure basic AAC tools are consistently available on the unit (e.g., within a communication kit). Assign one person to periodically check supplies. Identify existing clinical pathways (e.g., ventilator liberation, delirium prevention) where AAC fits naturally. Reinforce that communication is a patient-rights and safety issue.	Ensure rotating staff and per diems receive access to the same materials and resources. Clarify the champions' role in AAC program development. Provide examples of when AAC made a difference. Assign a point person to monitor AAC tools and supplies. Advocate to include communication access method in handoff tools. Monitor usage and adjust inventory as needed. Train multiple staff to restock supplies. Pilot a workflow on one unit (e.g., "automatic SLP consult for awake, ventilated patients"). Embed communication access into huddles or safety rounds.	Integrate AAC training into formal unit orientation and competencies. Recognize champions' contributions through leadership. Advocate for EMR triggers or automatic order pathways. Add AAC supplies to the unit's official supply list, so they are maintained through normal processes. Advocate for EMR to include fields that standardize documentation. Develop a maintenance workflow to ensure tools are always stocked. Establish a review process for updates based on new evidence and patient feedback. Integrate AAC triggers into order sets in the EMR. Celebrate improvements through unit newsletters or recognition programs.
Are there unit "communication champions" or super-users who can assist colleagues with AAC setup or troubleshooting?			
Do staff know when and how to refer to SLP for AAC support or evaluation?			
Is there a consistent place where AAC tools and supplies are stored and maintained?			
Do staff consistently document patient communication methods in the EMR?			
Does the unit have readily available communication tools for patients who need them?			
Is there a plan for replenishing or updating communication tools when items go missing or run out?			
Are there workflows or order sets in the EMR that trigger AAC evals for patients who may need them (e.g., trach/vent)?			
Do staff view communication access as part of quality patient care, not just the SLP's responsibility?			

Partnerships & Collaboration

Pathways to Progress

Questions & Considerations	Getting Started	Growing	Sustaining
Do nursing and medical staff recognize communication access as part of patient care?	Speak to multidisciplinary colleagues on communication access awareness and involvement. Identify communication champions including staff who show interest in AAC or are early adopters of innovation (Examples on next page*). Provide just-in-time bedside education to nurses to support carryover of AAC recommendations. Consult relevant departments and/or professionals regarding bedside AAC services and potential integration to existing projects (Examples on next page**). Cotreat with PT/OT and other therapists to integrate your bedside AAC recommendations into therapy care. Attend multidisciplinary rounds.	Work with unit managers, nurse educators, and chief residents to learn about education/in-service opportunities as well as unit capacity, processes, and knowledge. Create signage templates regarding bedside recommendations and communication aids. Meet with the hospital's ADA committee, Patient Safety & Quality program, and/or other programs regarding communication accommodations. Learn about collaborative opportunities. Consult the hospital's Family Advisory Council to support patient and family-centered perspectives and care alongside multidisciplinary providers.	Conduct regular in-service education and/or trainings, alongside multidisciplinary providers, to enhance education & promote partnerships and collaboration. Initiate, collaborate, or lead multidisciplinary initiatives involving communication accessibility and AAC at the bedside. As appropriate, join hospital committees to represent communication access needs. Partner with researchers to measure impact of AAC at bedside.
Do multidisciplinary providers (e.g. OT, PT, child life, social work, chaplaincy, etc.) recognize communication access as part of patient care?			
Do other staff carry over recommended AAC tools and strategies that I/my team have recommended?			
Am I co-treating with other providers *(e.g. OT, PT)?*			
Are there unit "communication champions" or super-users who can help advance staff education and implementation of AAC?*			
Am I/my team currently working on projects with other inpatient teams? Can communication-related topics be integrated?**			

Partnerships and Collaborations

*Example partners and collaborators may include:

- ❑ Physicians
- ❑ Physician leadership
- ❑ Nurses
- ❑ Nursing leadership
- ❑ Physical medicine and rehabilitation
- ❑ Rehabilitation leadership
- ❑ Physical therapists
- ❑ Occupational therapists
- ❑ Social Workers
- ❑ Chaplains
- ❑ Child Life Specialists
- ❑ Psychologists/Psychiatrists
- ❑ Audiologists
- ❑ Clinical Nursing Assistants (CNA)
- ❑ Food services
- ❑ Transport services
- ❑ Environmental Services
- ❑ Security
- ❑ Behavioral Health Professionals
- ❑ Family Advisory Council
- ❑ Patient and Family Services department
- ❑ Other:

**Example projects/partnerships may include:

- ❑ Delirium management
- ❑ Early mobility in the ICU
- ❑ Palliative care
- ❑ Developmental care
- ❑ Tracheostomy care
- ❑ Accessible inpatient TV or technology integrations
- ❑ Other:

Communication Tools

Pathways to Progress

Questions & Considerations	Getting Started	Growing	Sustaining
I currently have access to basic AAC materials: • Low-tech AAC • High-tech AAC • Supportive materials (e.g. color printer, laminator, tablets, etc.)	Learn about feature-matched assessments and begin trialing low-tech communication boards with patients in need. Learn about unaided communication strategies and begin trialing them with patients in need. Learn about varied access strategies, for example direct selection, partner-assisted scanning, and eye gaze Download, print, and laminate low-tech ready-made communication boards. Consider a range of needs that represent your patient population. If your program does not have specialized software, use mainstream software to support low-tech communication board creation (e.g. Powerpoint, Google slides, Canva, etc.) Begin developing a communication toolkit. As part of the needs assessment on units, learn about relevant vocabulary, messages, and communication functions (e.g. spinal cord injury unit may need more resources to support partner-assisted scanning or eye gaze).	Conduct a needs assessment to explore needed equipment and materials relevant to your patient population. Create, print, and laminate custom communication boards relevant to your patient population. Consider varied access strategies (e.g. partner assisted scanning, eye gaze, and direct selection). Create a communication toolkit. This may include a range of low-tech items that all staff can implement and provide for their patients. Identify needed items and explore funding for the future. Designate a central location for 1. Communication toolkits 2. Communication boards. Work with unit managers to identify locations on units. Consider a filing system for ready-made or communication tools in the SLP office.	Expand your range of pre-made low-tech communication boards and communication toolkits. Consider past experiences and patient needs to inform vocabulary and content. Work with AAC vendors to explore utility and procurement of dedicated speech-generating devices and other systems . Continually track dissemination and inventory of equipment and materials. Attend conference exhibit halls to explore evolving technologies and functionality relevant to your hospital setting and patient population.
Does my team (or other providers such as OT/PT) have access to supportive mounting equipment? *(This includes mounts that support physical and visual access to switches, speech-generating devices, tablets, etc.)*			
Does my hospital use communication toolkits? *(This includes materials available to all staff for use at any time with patients in need, which are typically housed in a central location)*			
Does my department use communication-specific software to support materials creation? *(e.g. Boardmaker, LessonPix, etc.)*			
Does my department utilize other software to support materials creation? *(e.g. Powerpoint, Google docs, Canva, etc.)*			
Do I have ready-to-use or ready-to-customize templates for low-tech communication boards?			

Communication Tools Continued

Pathways to Progress

Questions & Considerations	Getting Started	Growing	Sustaining
Is there a designated storage space for AAC equipment and/or materials?	Create a budgetary outline. Prioritize initial needs to get started (e.g. to create communication boards and early access needs. Explore funding options with SLP and hospital leadership to expand AAC inventory. Investigate grants within or beyond the hospital to fund communication tools/materials.	Create a budgetary outline. If indicated, apply for grants to fund communication tools/materials procurement. Investigate the range of AAC applications relevant to your patient population. Work with leadership to explore funding. If loaning equipment, create a system to track equipment dissemination, loan, and inventory. As able, focus on customization of communication tools for patient needs.	
Are there existing grants within or beyond my hospital to help fund acquisition of AAC materials and equipment?			
Has my team used free ready-made communication boards that are appropriate for our patient population?			
Is there a protocol in place for disseminating AAC to patients? *(e.g. signing equipment in & out, designating process for equipment pick up, cleaning protocols, etc.)*			

SLP Staff Education

Pathways to Progress

Questions & Considerations	Getting Started	Growing	Sustaining
Does my SLP team/department host educational opportunities in AAC?	Talk to SLP leadership about education opportunities related to AAC. Find out about the SLP team's current knowledge and comfort regarding AAC assessment and intervention at the bedside. As appropriate, identify a lead SLP/s to support team learning, knowledge, and implementation of AAC at the bedside. Begin implementing simple, low- or no-tech communication strategies with patients in need. Explore learning opportunities across platforms and mediums. Explore ASHA's Communication ACCESS website for evidenced based resources. Join and/or explore AAC specific organizations to enhance regular learning (e.g. USSAAC, ISSAAC, PPCN, etc.)	Participate in continuing education related to AAC and AAC specific to the hospital setting. Provide literature to the SLP team related to AAC and communication access in the hospital. Schedule a journal club or topic discussion as part of staff meetings or other designated learning times. Reach out to companies that manufacture or disseminate AAC materials. Explore in-person consultations for hands-on learning. Connect with hospital based SLPs in your region (or beyond) regarding current practices and guidance.	Schedule interval inservice education for the SLP team related to AAC in the hospital setting. Attend conference exhibit halls and explore aided AAC strategies. Speak directly with vendor representatives and gain hands-on experience with aided tools. Submit a lecture to a relevant conference about your AAC services and efforts.
Do I/my team typically participate in ongoing clinical education?			
Is there someone on my team or in my hospital that can provide hands-on education and training in AAC?			
Do SLPs have foundational knowledge in AAC?			
Do SLPs have knowledge related to no-tech, low-tech, and high-tech communication strategies, augmented input, and adapted nurse-call solutions?*			
Do SLPs have clinical experience with AAC?			
Have SLPs received hands-on training with AAC?			
Are there learning opportunities when SLPs can gain knowledge regarding AAC? (e.g. journal club, staff meetings, conferences, in-service trainings, etc.)			
Is there a lead SLP who supports AAC service delivery?			

Provider Staff Education

Pathways to Progress

Questions & Considerations	Getting Started	Growing	Sustaining
Am I able to survey providers on their perspectives and approaches to supporting communication at bedside? Do I/my team have the ability to provide education to hospital staff? Does my hospital have nurse educators that can help develop a plan for staff education?	Find out which professionals support provider education across identified teams and/or units. Conduct a needs assessment with a sample of bedside providers. Create alongside communication champions if identified. (Example survey on next page) Integrate bedside, just-in-time training into your workflow. Provide demonstration and hands on education to providers during (or following) your bedside sessions. Post instructions at bedside (within HIPAA and hospital guidelines) to educate providers on implementing AAC recommendations Attend multi-disciplinary rounds	Create smart phrases, auto-text, or other pre-written content to use in your daily documentation. Focus on including specific care team instructions to support patient-provider communication. Work with unit managers, nurse educators, and chief residents to learn about education and in-service opportunities. Provide information related to consulting SLPs for a bedside communication evaluation to be included in current provider on-board training/education.	Integrate AAC and patient-provider communication practices into new hire education across disciplines. Conduct education with patient photos and videos (with permission) and hands-on demonstration of AAC strategies. Collaborate with other disciplines to integrate bedside communication practices into *their* trainings and education. Identify avenues for hospital-wide education and awareness. May consider hospital blog, social media pages, or other consumer facing sites that highlight patient success stories.

Provider Staff Education

**Example Staff Survey on Bedside Communication Access*

1. Do you work with patients who have difficulty communicating?
   - ❑ Yes
   - ❑ No
   - ❑ I'm not sure
2. You are struggling to communicate with your patient, and vice versa. How do you typically help? What strategies seem to work best?

3. Have you ever heard of augmentative and alternative communication (AAC)?
   - ❑ Yes
   - ❑ No
   - ❑ I'm not sure
4. Do you routinely consult a speech-language pathologist (SLP) when a patient is having difficulty communicating (including, but not limited to, awake intubation, tracheostomy, non-invasive ventilation, communication disability, developmental disability, etc.)?
5. Have you ever used communication tools with your patients? These might include the following:

   If yes, what types:

1. Have you observed an SLP or family member supporting patients' use of communication tools?
   - ❑ Yes
   - ❑ No
   - ❑ I'm not sure
2. Have you received any education regarding communication access and/or AAC?
   - ❑ Yes
   - ❑ Some
   - ❑ No
3. If yes, what types of education have you received?
   - ❑ Formal in-person training: Hands-on training at the bedside
   - ❑ Video training
   - ❑ Written instructions
   - ❑ Provider-to-provider handoffs
   - ❑ Bedside signage in patient room
   - ❑ Electronic medical record
   - ❑ Other

Patient & Family/Caregiver Education

Pathways to Progress

Questions & Considerations	Getting Started	Growing	Sustaining
Do patients and families receive education regarding communication strategies? What modes of education are typically provided to patients and families regarding communication strategies? Do SLPs provide handouts or written guides related to communication strategies? Do patients and families support carryover of AAC and communication strategies? Is there an existing protocol for patients and families to request communication accommodations? Are communication recommendations documented in the patient's chart?	Talk to patients and families about their communication access experiences. Collect patient and family stories, with permission, related to communication access to highlight successes and challenges. Create template handouts or room signage related to recommended tools and strategies for use when indicated. Learn about family education within the patient portal. Identify areas for AAC/communication access in the electronic health record.	Work with translation services to translate existing (or new) documents. Work with ADA committee, Patient Safety & Quality, the electronic health record personnel, and other related professionals to ensure accommodations screenings include communication accessibility. Create a template "Communication Passport" for patients/families to fill out ahead of a hospital visit/admission. Survey patients and families regarding AAC utility and communication access needs. Analyze data to inform service delivery needs and patient, family, and caregiver education.	Work with family-facing support programs (e.g. Family Advisory Councils, Patient and Family Services) to provide direct educational opportunities. Create family-friendly education sheets. Work with hospital marketing, or related professionals, to ensure compliance to educational standards.* Partner with food services to create accessible menus.

*Types of educational content:

- Family education sheets/handouts related to a specific topic
- Webinar or recorded learning opportunities hosted by family-facing education programs
- Brochure related to service delivery and/or inclusion in unit brochures
- Inclusion in SLP department website with educational resources
- Other

*Patient and Family/Caregiver education should include:

- Simple language: Avoid medical jargon, ensure literacy level is commensurate with hospital policy
- Visual aids as appropriate
- Accessible content: Available in large print, closed captioning and ASL interpreter translation for video content, multilingual translation

AAC Referral Process

Pathways to Progress

Questions & Considerations	Getting Started	Growing	Sustaining
How do SLPs and other providers currently identify patients who may benefit from AAC support (e.g., screening criteria, order sets, or triggers)?	Map out current AAC referral processes to document who is making referrals, how long it takes, does it change with different teams/units, etc. Meet with SLPs, nurses, unit managers, etc. to discuss common profiles of people who need AAC (e.g., trach/vent, aphasia). Create a referral flowchart outlining existing patterns who can refer and how this happens. Then create a flowchart outlining "ideal" patterns. Compare the two with your team. Track referrals for __ weeks to determine a baseline rate for AAC referrals and identify barriers/patterns. Develop an AAC Screening Checklist with questions that can help identify patients who benefit from AAC. Educate staff on how to identify patients who need AAC, who to contact for referrals and how to trigger a referral in the EMR/team.	Identify who your EMR representative or team is to create a standardized AAC referral order set. Create a smart phrase or AAC referral template in the EMR and share with your team and other AAC finders. Identify and train communication champions (e.g., nurse leads) across high-volume units (e.g., neuro) to recognize AAC needs. Pilot screening questions within interdisciplinary huddles, rounds, or check-ins to identify patients with communication access needs. Collect data on referral-to-evaluation times from different departments/units. Identify process bottlenecks. Embed AAC screening questions during nursing admission assessments or speech therapy intake templates.	Maintain or expand EMR triggers for AAC evaluations and refine order sets based on data and user feedback. Work with the EMR team to create a communication access needs flag in the EMR so people with known communication access needs are automatically identified in future hospitalizations. Create a referral dashboard or simple tracking tool to monitor volume and timing for AAC referrals on a weekly or monthly basis. Provide annual refreshers or ongoing onboarding experiences for healthcare team on identifying communication access needs and referral processes. Share AAC referral data and patient experience reports to support the need and impact of communication access processes.
Is there a clear, standardized referral pathway (e.g., EMR order, consult request, or standing protocol) for initiating an AAC evaluation?			
Who can currently initiate an AAC referral—are nurses, physicians, or other allied health professionals empowered to do so? Who would you like to initiate consistent AAC referrals?			
How many AAC referrals have you received in the past ____ weeks/month/year?			

AAC Evaluation Process

Pathways to Progress

Questions & Considerations	Getting Started	Growing	Sustaining
How quickly after admission or a change in status can an AAC consult realistically occur (e.g., SLP staffing), and what barriers delay referrals or completing referrals?	Map out and review current AAC evaluation practices—who conducts them, what tools are available, how long does it take to prepare, complete, and document. Identify barriers that delay or limit evaluation quality (e.g., staffing limits, access to materials, unclear referral pathways). Create a standardized AAC evaluation checklist or protocol for bedside use. If you don't know where to start, contact other hospitals or organizations who do inpatient AAC to say if they would be willing to share materials. Assemble a starter evaluation toolkit (e.g., low-tech boards, access methods, trial devices). Trial simple feature-matching documentation templates or forms for consistent data capture. Begin a small-scale pilot in one unit or patient group (e.g., stroke) to test workflow and timing.	Develop or adapt an electronic AAC evaluation template within the EMR for consistent documentation and data sharing. Establish co-treatment procedures with OT/PT for positioning, access, and physical support during AAC evaluations. Build a decision-making algorithm (flowchart or quick guide) to assist clinicians in matching AAC systems to patient needs. Expand access to trial devices and explore partnerships with vendors or loan programs. Offer hands-on staff training for SLPs to increase comfort and consistency in AAC assessment procedures. Collect evaluation outcome data (e.g., frequency, time-to-evaluation, communication success measures).	Maintain and periodically update the AAC evaluation toolkit and EMR templates based on staff feedback and new technologies. Integrate AAC evaluation standards into orientation materials. Conduct annual quality reviews of AAC evaluations to track timeliness, outcomes, and follow-up rates. Create a peer mentorship system to train new staff or AAC consult team for complex evaluations. Disseminate patient case examples or QI data to demonstrate program impact to hospital leadership. Partner with researchers or QI teams to measure clinical outcomes and patient satisfaction related to AAC assessments.
What happens after the initial referral—are there systems in place to track consults or ensure continuity across shifts/units?			
Do you have paper/electronic protocols or checklists for feature-matched AAC assessments?			
What types of AAC tools (low-, mid-, and high-tech) are currently available during evaluations, and how are these chosen?			
How do SLPs collaborate with nursing, OT/PT, nursing, or physicians during AAC assessments to ensure needs are met?			
How are evaluation results communicated to the interdisciplinary team, patient, and family? How quickly does this happen?			
How is reassessment handled when patients' communication or medical status changes during hospitalization?			

AAC Documentation Process

Pathways to Progress

Questions & Considerations	Getting Started	Growing	Sustaining
Is there a place in the EMR or patient's room to document that the patient has a communication access need?	Review how AAC clinical activities (e.g., progress notes, care plans) & recommendations are currently documented across patient charts. Identify gaps or inconsistencies in documentation (e.g., are AAC recommendations are visible to all care providers, are all SLPs adding this to a note). Develop a standard documentation template or checklist for AAC evaluation and intervention notes. Create a section in your progress notes for areas such as communication methods, recommended strategies, and patient preferences. Pilot bedside signage templates to reinforce documentation in the physical environment.	Collaborate with EMR analysts to build or refine structured fields for AAC and communication access (e.g., dropdowns, smart phrases, flowsheets). Develop standardized terminology for documenting communication access needs, training provided, and follow-up plans. Integrate AAC documentation into templates, care plans, and discharge recommendations to ensure continuity across settings. Add AAC documentation examples to the SLP department intranet page for consistent use. Track documentation compliance and visibility - how often are AAC recommendations reflected in the EMR? Who views them? Partner with nursing or rehab teams to ensure that AAC-related documentation is cross-referenced or visible in their documents.	Standardize AAC documentation practices within SLP departmental policy or clinical guidelines. Integrate quality metrics related to AAC into audits or dashboards (e.g., % of patients with AAC recommendations documented in care plan). Update templates regularly to reflect evolving AAC practices, technologies, and ADA standards. Establish a peer review process for AAC documentation to promote quality and consistency. Advocate for inclusion of communication access fields in hospital-wide initiatives (e.g., safety event reporting, patient experience data).
Is there a consistent EMR section or template for documenting AAC evaluations, recommendations, and interventions?			
How are communication methods and AAC strategies conveyed to all care providers (e.g., in progress notes, care plans, or signage)?			
Do documentation practices support continuity of AAC use between inpatient and outpatient care or across care transitions?			
How do SLPs record patient/family training, staff education, and carryover activities within the chart?			
Are there opportunities to include AAC or communication access metrics in quality or performance dashboards?			

Awareness & Attitudes

Pathways to Progress

Questions & Considerations	Getting Started	Growing	Sustaining
How confident and comfortable are SLPs and other hospital staff in supporting AAC use during routine patient interactions? What perceptions exist about AAC use in acute care—do staff view it as essential to patient care or as optional/extra? How is leadership engagement reflected—do leaders prioritize communication access in quality, safety, or patient experience initiatives? Are there visible champions or advocates promoting AAC awareness within units or departments? What success stories or patient outcomes could be highlighted to shift attitudes and promote buy-in for AAC initiatives?	Using surveys or interviews, assess current perceptions of AAC and communication access among SLPs, nurses, and physicians—what are the prevailing beliefs or barriers? Gather informal feedback or conduct a short staff survey to learn how AAC is viewed (e.g., "extra work," "SLP-only," "important for safety"). Share real patient stories or brief case examples that illustrate communication breakdowns and successful AAC outcomes. Identify unit champions who express interest in improving communication access. Incorporate AAC awareness topics into existing meetings (e.g., staff huddles, lunch-and-learns, patient safety rounds). Begin to normalize AAC use by modeling strategies during your daily bedside sessions and highlighting small wins. Recognize team members when they are successfully implementing AAC strategies or trying something new.	Develop focused awareness campaigns around AAC and communication access (e.g., "Every Patient Has a Voice" week, hospital bulletin posts). Present at unit-based or hospital education meetings to link AAC use with patient safety, quality, and satisfaction metrics. Collaborate with hospital marketing or patient experience teams to feature communication access in broader initiatives. Publicly recognize and celebrate staff champions who promote AAC use (e.g., acknowledgment in newsletters or bulletin boards). Incorporate AAC and communication access into onboarding and annual competency training across disciplines. Collect qualitative data (staff testimonials, patient feedback) demonstrating positive impact of AAC on patient care and staff confidence.	Embed AAC awareness into organizational culture and policy (e.g., quality dashboards or Joint Commission readiness materials). Maintain ongoing visibility through annual awareness events, internal campaigns, and hospital communications. Continue highlighting impact stories (e.g., patient outcomes, safety event reductions, satisfaction improvements). Mentor new champions and emerging leaders to maintain AAC advocacy during staffing or leadership changes. Align AAC initiatives with hospital strategic goals (e.g., health equity, patient-centered care, accessibility compliance). Partner with leadership to include AAC and communication access in staff recognition, accreditation reviews, & QI priorities.