Augmentative Communication News

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Upfront

Hordes of baby boomers are on their way to Golden Pond. We are experiencing a well-publicized demographic aging parade,with the beat of the drum reverberating ever louder. Among the many marchers are people destined to develop severe communication impairments in their later years. Individuals with Parkinson's disease, strokes, traumatic brain injury, multiple sclerosis, amyotrophic lateral sclerosis and progressive aphasia will be included in the mix.

The purpose of this issue is to make more explicit the AAC intervention needs of individuals who acquire severe communication impairments as they age. ***For Consumers*** *describes factors likely to affect the success of AAC treatment approaches for such individuals.* ***Clinical News*** *gives examples of AAC practices. The* ***Equipment*** *section considers AAC device features that older people may prefer.* ***AAC-RERC*** *introduces three research projects seeking ways for AAC technology to support positive communication outcomes for older people who acquire severe communication impairments.* ***Governmental*** *gives an update on progress toward Medicare funding for AAC devices in the United States.*

Even in areas where many children and some adults with severe communication impairments are benefiting from AAC, older people often are not. Being over sixty doesn't mean you have nothing to say. In fact, the need to communicate feelings, thoughts, needs and wishes may never be greater than in the "third thirty."[1]

Still, governments and funding agencies that allocate resources to support access to AAC intervention regularly neglect older consumers. In Portugal, for example, only five percent of devices purchased are for adults (almost none for older people).[2] *Australia allocates funds in ways that result in "few adults over 65 having AAC and no one in nursing homes."*[3] *In the U.S.,*

Continued on page 2

inside this issue

For Consumers

Baby boomers head for Golden Pond

The aging segment of the world's population is the fastest growing, most heterogeneous group of people on earth. We know that, although the human capacity for learning and growth continues well into later life, normal aging brings with it reduced capabilities that affect communication skills. These can include a reduction in (a) hearing, (b) vision, (c) motor and (d) cognitive skills, particularly short-term memory and new learning. We also know that the prevalence of illnesses and neurological conditions that cause severe speech, language and communication impairments dramatically increases with age.[4,5] AAC researchers, service providers and manufacturers are beginning to investigate a myriad of factors that are likely to affect AAC treatment approaches with older adults. We are beginning to ask: "Who are these people and how are they different?" "What kinds of AAC approaches do they want and need?" "What factors influence positive (and negative) outcomes, and why?"

One widely accepted theory of aging, the life course approach, tries to account for an individual's (1) personal characteristics, such as skills, interests, type of disability, personality; (2) personal circum-

Continued on page 2

For Consumers, Continued from page 1

stances, *e.g.*, living situation, communication partners, resources; and (3) historical context, *e.g.*, when someone was born, grew up, married or didn't marry, went to work, had a family, and so on.[6] Clearly there are different cohorts among the elderly:

> The older population includes at least two generations. It is no more accurate to speak of 65-year-olds and 85-year-olds as a cohort than to speak of 15-year-olds and 35-year-olds or 45-year- olds and 65-year-olds in these terms.[7]

The life course theory provides a useful framework within which to consider variables affecting AAC treatment approaches for older adults. Currently, however, few factors are well-defined.

Factors that matter

Table I on page 3 lists some of the considerations relevant to the use of AAC approaches with older adults, which are discussed below.

1. Conversational characteristics. In an effort to further define the unique needs of older people, Sheela Stuart and her colleagues studied conversational characteristics and vocabulary use among people without disabilities, ages 65 to 79.[8] They found that topic categories differed somewhat between the younger and older cohorts, and that storytelling played an important role in conversation.

a. Topic categories. Researchers suggested clinicians should add words/phrases that enable people to reference past events and link present and past events. For example, in an election year it would be important to include words and phrases that refer to current candidates and issues, as well as to enable users to make comments, tell stories and give opinions about past election experiences.

b. Storytelling. Storytelling is one way elderly people pass along their long histories, connect socially with others and share philosophy. Available studies, while not yet definitive, suggest that unfamiliar communication partners prefer to interact with storytellers who use voice output AAC devices, rather than their own impaired speech or low-tech communication books.[9]

2. Residual capabilities. Older adults who acquire speech and/or language impairments often retain at least some residual literacy skills, even when they no longer can read or write as before. Other skills, like touch-typing, may also be preserved. Using residual capacities is easier than learning new ways of doing things. Thus, residual skills should be assessed and then used when selecting AAC devices and symbol sets and when designing displays/overlays.

3. "Costs" of new learning. Older people in general, and especially those with cognitive and linguistic impairments, may find it difficult to learn unfamiliar graphic symbols, rate enhancement features and certain alphabet configurations. When older adults (or their caregivers) believe AAC devices or strategies are hard to learn or will require a great deal of practice, some conclude they are not useful, *i.e.*, they are not worth it.

David Beukelman discusses the "cost" of communicative competence.[10] "Cost" refers as much to the time and effort spent on learning to use an AAC approach as it does to the money invested in equipment and therapy. Forthright discussions among team members about these complex issues are important.

4. It takes time. Older people, by definition, have more of their lives behind them than in front of them. However, like anyone else who

Upfront, Continued from page 1

Medicare, the largest insurer of people over 65 years, considers AAC devices "convenience items" and doesn't fund them.

It is a matter of both public policy and simple economics. Without funding, there is no customer base. Without customers, AAC manufacturers are unlikely to make products designed to benefit older adults. Physicians will remain unaware; clinicians will not develop competencies in AAC; and administrators will not encourage AAC programs. All this must and will change.

Are we prepared as a field to meet the increasing communication needs of so many? Probably not. Do service providers, researchers and manufacturers have a growing recognition of the unique needs of elderly people for AAC services and assistive devices? Absolutely. The baby boomers are coming. Old age is being redefined. It's a wake up call. Many thanks to those contributing to this issue: Paul Tippell, Joanne Lasker, Julia King, Audrey Holland, Lew Golinker, Simon Churchill, David Beukelman, Sue Balandin, Bruce Baker and Luis Azevedo.

Sarah W. Blackstone, Ph.D., Author

confronts a serious disability, they need time to adjust to their losses, as well as time to accept compensatory ways of communicating.

It doesn't matter when (or even if) professionals feel AAC treatment should begin. Until and unless the individual and his or her primary communication partners decide to proceed, positive outcomes cannot occur.

In the interim, someone should provide information about AAC and, just as importantly, ongoing support. Then, if and when a decision is made to proceed, additional time will not be wasted.

5. Attitudes and acceptance. Older adults who suddenly or gradually acquire severe communication impairments have well-established patterns of speaking and interacting. As a result, many initially may reject the idea of AAC devices and techniques. Lasker and others report that acceptance is influenced by a variety of psychosocial and circumstantial factors that are both intrinsic and extrinsic to the person and his/her communication partners.[11] [See **Clinical News** for additional details.]

6. Who's in control? Individuals with severe communication impairments cannot maintain control over their lives without access to AAC. When a person gradually or abruptly loses the ability to talk, caregivers tend to take over. After years of living independently, parenting, grandparenting, working, managing finances and taking care of a home, losing control of day-to-day decisions can be more devastating than the disability itself.

Family members who are strong advocates can help to ensure that their spouse/parent/sibling has a way to communicate and stay involved in making plans and decisions. Experience shows, however, that not all family members (or other caregivers) see AAC devices and strategies as positive steps; and some do not support them.

Table I. Ten factors influencing AAC use by older adults

1	Conversational characteritics.
2	Residual capabilities.
3	Costs of new learning.
4	It takes time.
5	Attitudes and acceptance.
6	Who's in control?
7	Caregiver support.
8	Design of AAC technology.
9	Access to expertise.
10	Funding Issues.

Because family members and/or paid caregivers often play a prominent role in the lives of older people, it is important to address their needs and concerns. At the same time, it is important to advocate for people with acquired disabilities who are at risk of losing access to communication, which will influence their quality of life.

7. Caregiver support. As with most groups, AAC treatment outcomes are likely to depend, in part, on caregiver support. Caregivers often maintain equipment and make sure the person has access to it every day. Caregivers need to learn about equipment and ways to facilitate interaction. Because they have so many other responsibilities, AAC interventions must be efficient.

8. Design of AAC technology. In 1993, Stuart, Vanderhoof and Beukelman reported:

> Most of the present voice output communication aids incorporate elements such as small graphic displays, small, gray on darker gray LED displays, synthesized speech and beeping feedback which may pose a problem for elderly AAC users.[12]

While today's devices have more flexibility with regard to visual and auditory features, few are designed with older people in mind. Future AAC technologies will need to accommodate the changing needs and communication patterns of older adults who use AAC. [See **Equipment**.]

9. Acccss to expertise. Most older people who acquire severe communication problems have never heard of AAC. This reflects the fact that (a) few physicians are aware of AAC approaches and (b) most service providers with expertise in AAC work in major rehabilitation centers, hospitals and university clinics. Thus, until community-based professionals who serve adults become more aware of AAC and develop more expertise, older adults will have limited access to AAC treatment approaches.

10. Funding issues. Current funding policies are such that older people in many countries cannot afford to buy an AAC device or receive AAC services. Efforts are underway to break down the discriminatory barriers that restrict access to AAC intervention for older adults. [See **Governmental**.]

Summary

Many factors currently influence and restrict the use of AAC by older adults with acquired disabilities. However, the world's changing demographics and the differences in life experiences of the cohort now approaching their "third thirty" make it likely that older adults will soon be looking toward the AAC community for more help. They will expect us to respond.

Clinical News

AAC for older adults

There are at least three groups of elderly people who can benefit from AAC treatment approaches:

1. Long time AAC users. These augmented communicators either are developmentally disabled or have acquired disabilities in childhood or as younger adults. Typical diagnoses include cerebral palsy, traumatic brain injury, stroke, autism, Down syndrome and other conditions affecting speech and language. This group has well-established interaction patterns and methods of communicating. AAC goals are to maintain and/or modify AAC systems to meet changing needs and circumstances.

2. Older AAC users with acquired severe speech and physical impairments (SSPI). These individuals have relatively intact cognitive and language skills and diagnoses of severe dysarthria/anarthria secondary to motor neuron disease, brainstem stroke, *etc.*. Treatment goals focus on developing sophisticated, multi-modal, high- and low-tech AAC approaches to communication, in order to compensate for the loss of speech and writing abilities.

3. Older AAC users with acquired severe speech and cognitive/linguistic impairments (SSCI). These individuals may (or may not) have significant motor and sensory impairments. They have diagnoses of severe dysarthria, apraxia and/or aphasia secondary to Parkinson's disease, progressive aphasia, cortical stroke, traumatic brain injury, late stages of multiple sclerosis and so on. They often rely heavily on their partners for communication support, so partner training is important. Treatment goals focus on AAC strategies that support functional communication, including speech output devices.

Intervention model for AAC

Yorkston, Miller and Strand propose a five-stage intervention model for people with acquired speech and/or language impairments.[13] Their model identifies changes in speech or language so that clinicians can determine when (and what kinds of) AAC approaches are necessary. [See Table II below.]

AAC treatments are typically used during Stages IV and V. In Stage IV, for example, AAC strategies/devices support an older adult's residual natural speech and language skills. In Stage V, when speech and language problems preclude natural communication, AAC approaches often involve low- and high-tech strategies and devices.

Acceptance of AAC

Researchers are developing ways to consider factors related to the acceptance or rejection of AAC treatment approaches for adults with acquired disabilities.[9] Lasker and Bedrosian, for example, propose an Acceptance Model for adults with acquired disabilities and their partners. The model incorporates both intrinsic and extrinsic factors:

Intrinsic factors for users and partners include consideration of: (1) attitudes (affective, behavioral and cognitive aspects); (2) personality traits and emotional status: (3) age and age cohorts and (4) skills (communication status, language, cognition, literacy, technology and speech perception).

Extrinsic factors for users include consideration of: (1) contextual variables, support services and funding options; (2) intervention history and knowledge of AAC and (3) communication and life needs.[11]

These researchers are developing clinical tools to guide future practice and data collection in this area. They hope to determine ways to weight factors related to acceptance across user/partner dyads.[14] Stay tuned.

AAC protocols for older adults with SSCI

AAC treatment protocols for older persons with severe speech and cognitive/linguistic impairments

Table II. AAC intervention model for older adults with acquired conditions (Yorkston, Miller and Strand, 1995)

Stage of Intervention	Speech Impaired	Language Impaired
STAGE I	No detectable speech disorder. When someone has a progressive disease, the goal is to educate the patient, family and caregivers regarding the course of the disease and future communication needs and options.	No detectable language/communication disorder. The goals are to instruct listeners, prevent fatigue and schedule communication events.
STAGE II	Obvious speech disorder with intelligible speech. The goal is to reduce the impairment through strengthening muscles related to speech production and range of motion exercises. Behavioral compensations include rate control, increased loudness, and exaggerated articulation. Prosthetic compensations include voice amplification and palatal lifts.	Obvious language/communication disorder with few communication breakdowns. The goals reflect traditional aphasia interventions.
STAGE III	Reduction in speech intelligibility. The goals are the same as above. In addition, interaction strategies can be introduced to both speaker and listeners *e.g.*, establishing topics, signaling turns).	Residual natural spoken language with regular communication breakdowns. The goals are the same as Stage II above.
STAGE IV	Residual natural speech and AAC. The goals are to supplement natural speech and teach compensatory strategies to individuals with impaired speech and their partners. Strategies may include establishing topics with an AAC system and using a first letter cueing strategy.	Residual natural spoken language with AAC supplementation. The goals are to use AAC treatments that involve drawing, AAC devices and low-tech displays and aphasia protocols.[16]
STAGE V	Loss of useful speech. The goal is to provide a multi-dimensional AAC system including devices, instruction in use of AAC devices, instruction of listeners (when necessary) and ongoing maintenance and support of the individual's communication needs.	Little useful spoken language. The goals are to provide compensatory strategies and, in some cases, devices to increase functional communication.

(SSCI) are beginning to emerge. Examples of efficacious approaches include:

1. Intervention model for severe aphasia. Garrett and Beukelman's intervention model for severe aphasia is now widely used to guide AAC treatment for people with chronic aphasia. Strategies are described for five types of communicators: (1) Basic choice, (2) Controlled situation, (3) Comprehensive, (4) Specific need and (5) Augmented input. The model suggests activities for both augmented communicators and their partners to facilitate interaction and enhance participation. An in-depth description of this approach is available in several publications.[15,16]

2. Situation-specific therapy. The goal of this approach is to teach individuals with severe speech and language problems a small set of specific responses related to a functional goal. For example, ordering food in a restaurant, making a grocery list, calling a taxicab. This approach to treatment, say Hopper and Holland, reflects today's realities:

> Gone are the days when therapists could provide treatment for months at a time. In this era of cost-containment in health care, clinicians frequently are asked to provide evidence that their patients have certain communication skills that enable them to function more independently and safely after only days or weeks of therapy.[17]

Their study focused on teaching two patients with Broca's aphasia to call 911 and report an emergency (pictured on a stimulus card). Data show that treatment was effective and efficient, *i.e.*, both patients improved within a limited time frame (ten 45 minute sessions). In addition, the individuals generalized the skill to untrained emergency pictures and maintained it following completion of therapy.

Holland reports this protocol also was successful with a man with global aphasia (after a stroke), who was non-verbal and used a voice output communication device. The man learned to communicate various emergencies to unfamiliar listeners over the phone, using his Cheap Talker. He also maintained the skill over time.

Researchers further demonstrated the efficacy of situation-specific therapy using a disability-based outcomes measure (ASHA-FACS). Specifically, all study participants improved on pre- and post-treatment ratings on "Gets help in an emergency," from a rating of 1 (Does not do) to a rating of 7 (Does).[18]

3. Memory wallets and books. Michelle Bourgeois describes the use of several techniques that support people with memory impairment during conversations. The purpose is to prompt recall of factual information. Strategies must (1) be simple and obvious; (2) be used consistently and frequently and (3) facilitate positive interactions and feelings. Two examples are memory wallets and memory books:

> Memory wallet: The wallet has two covers and 20-30 index cards (3 x 5 inches) that are 2-hole punched and held together with 1 inch metal rings. Each card has a picture and words (large lettering). Cards are arranged by topic (with tab inserts) or chronologially.
>
> Memory book: An enlarged version of the wallet designed for people who are not ambulatory or who remain in one setting. The book uses a three-ring binder with 8 1/2 x 11inch pages and plastic page holders.

Research demonstrates that these memory aids facilitate participation and encourage social interaction.[19,20]

4. Managing primary progressive aphasia. AAC treatments for primary progressive aphasia (PPA) typically progress from using gestures and writing, to a communication book, to an AAC device. Researchers also report an increasing reliance on partner-focused communication strategies as language skills decrease and recommend early integration of AAC when treating people with PPA.[21]

Cress and King describe two individuals with PPA and no dementia.

> 1. A 60-year-old woman with significant receptive and expressive difficulties could spell some words, refer to items in her purse and ask questions. After assessing how she facilitated verbal expression and collecting and analyzing a language sample, researchers conducted intervention trials. The trials included use of a preliminary communication book with maps, a calendar, a family tree, a people page and the layout of her house. She also learned to use a recipe card strategy for grocery shopping.
>
> 2. A 60-year-old man with severe auditory comprehension deficits was unable to use letter or written cues. Treatment strategies focused on (a) augmented expression in routine and familiar contexts with familiar and unfamiliar listeners and (b) cued comprehension with familiar and unfamiliar isteners. A low-tech board for receptive communication included frequent topics and activty mangement phrases. Family members pointed to symbols, as well as used gestures during interaction. The expressive board included symbols for "chatting" and topics for storytelling. Partners also used maps and phtographs during conversations. Strategies were most effective with familiar partners.[22]

Summary

We have learned a lot more about AAC interventions with older adults over the past several years. In fact, nine of the ten citations in this section were published in the last five years. Now the task is to put some of this new knowledge into practice.

Equipment

AAC technology for older people

More than 50 companies manufacture and distribute AAC devices. I asked manufacturers what features currently benefit elderly people, particularly those with cognitive/linguistic impairments. Simon Churchill (of Toby Churchill, Inc. in the United Kingdom) replied thoughtfully:

> Elderly adults experience some of the common effects of old age: Impaired vision, impaired hearing, reduced ability to learn new skills, and failing memory. Depending on the level, combination and configuration of these impairments, elderly adults may find today's conventional communication aids difficult or impossible to use.
>
> Older adults often do not have experience with computers or similar high technology equipment. In fact, elder users, more than other groups, tend to experience some degree of technophobia. This often means that the more simple and easy to use an AAC device seems to be, the more readily elderly users will accept it.

As a result of his 26 years of experience, Churchill also believes:

> An important aspect of technophobia is the user's spouse or carer. Quite often they express the opinion that the user won't be able to "get on" with the communication aid, when in fact they are expressing their own doubts about supporting the system after the equipment is all set up and the professional is at arm's length. Users often prove more capable and willing to break down learning barriers than the spouse or carer because they have a vested interest in using the device successfully.

Churchill points out that deterioration of cognitive, motor or sensory skills often requires special considerations:

> A lot of older adults have never used a keyboard and find the QWERTY layout confusing, preferring an ABC layout. Equally, many people with aphasia lose QWERTY skills and find an ABC layout much easier (the way they learned the alphabet as a child). Many people with Parkinson's disease experience micrographia and need a means of written communication. Therefore, if they are using a communication aid, it is useful if it can connect to a printer.
>
> For keyboard users with both visual and cognitive impairments, as can occur in MS, it is helpful to have a device with a feature that enables the first press of a key to provide auditory feedback of that key, announcing what function that key will have if pressed a second time. This enables users with visual impairments, who do not learn to touch type, to auditorily "fish around" the keyboard with ease and select only the desired keys.
>
> For AAC users with physical disabilities who can use a keyboard, key delays and tremor controls applied to the keyboard can help to avoid inadvertent key selection. For those with arthritis, keyguards can both increase efficiency and reduce effort.

Finally, Churchill holds that elderly people with severe physical impairments who require switches to access technology need user-friendly ways to learn to use a device:

> People who must use switches and scanning software need systems they can learn to operate without needing to hold a manual and read the instructions. It is helpful when instructions and learning modules are available on the computer.

Churchill notes, "This is a much easier problem to identify than to solve!"[23]

Future AAC devices

According to the AAC-RERC proposal:

> The next generation of device development must challenge conventional AAC approaches and improve the way new technologies incorporate and blend principles of communication theory and engineering. Addressing the unique needs of elderly people is a part of that challenge.

One example of a device designed for a targeted group of non-speaking aphasic and brain injured people is the PCAD (Portable communication aid for people with dysphasia). The PCAD, under development by a consortium funded by the European Union, is supported on a Windows CE platform, and will work on any compatible palmtop or laptop computer. The R & D phase ends in December and the device should be available for purchase in 2000. It will include a computer, PCAD software, application programs, CD-ROM vocabulary resource database, training and support options. Features are a color touchscreen, good quality sound amplification, communicative drawing, a news page, phonemic cueing, built-in QWERTY keyboard and more.

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Other examples of AAC devices designed to accommodate the needs of adults with acquired disabilities are the Minspeak Adult Quick Learning Systems (iconic or alphabetic version), now under development. Designed to meet the needs of literate AAC users (*e.g.*, those with ALS), the alphabetic application has a limited number of icons (300 core and 200 fringe words) and takes approximately 15 hours to learn. The iconic version is more powerful and more efficient with regard to keystokes. These will be available on Prentke Romich devices.

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The AAC-RERC

Nebraska projects

The University of Nebraska is one of six collaborative partners of the AAC-Rehabilitation Engineering Research Center (AAC-RERC). Researchers there are conducting three exciting projects related to elderly people who use AAC.

1. *Attitudes of AAC users, peers and service providers toward AAC technology use by elderly persons.* [David Beukelman, (PI), Laura Ball, Joanne Lasker, Melanie Richter, Rebecca Burke.] This project investigates the attitudes of four groups of adults: (1) AAC users with diagnoses of amyotrophic lateral sclerosis, aphasia and Parkinson's disease; (2) their peers; (3) their family members and (4) AAC service providers. Because the success of AAC intervention often depends on the attitudes and acceptance of all four groups, it is important to know more about what each thinks. The project team is preparing three videotapes. One highlights an individual with amyotrophic lateral sclerosis (ALS), the second features a person who has Parkinson's disease (PD) and the third shows someone with aphasia. In each video, individuals tell a story to a partner using three different methods of communicating: (a) their residual speech, (b) a low-tech AAC notebook and (c) a high-tech AAC device. Researchers plan to have four groups of subjects view each tape. For example, the ALS tape will be viewed by: (1) individuals with ALS who use AAC, (2) their peers, (3) their family members and (4) service providers who work with individuals who have ALS. Groups that view the PD tape and the aphasia tape will be similarly configured. All viewers will answer questions about their attitudes toward each method of communication and will rank order their preferences. Focus groups will explore reasons for these rankings.

2. *Organizational strategies for three groups of AAC users.* [David Beukelman, (PI), Katie Hustad, Laura Ball, Michelle Gutmann, Rebecca Burke, Janice Light.] This project seeks to better understand how (1) older individuals without communication impairments, (2) people with ALS, (3) individuals with traumatic brain injury (TBI) and (4) people with aphasia approach the task of using AAC devices and techniques to communicate. These studies aim to identify better ways to design AAC technology that will insure the greatest possible use and reduce some of the learning requirements. Two groups of older persons with normal cognitive and linguistic capabilities (elderly and ALS) and two groups of people with cognitive/linguistic impairments (PD and aphasia) will be asked to recall and retrieve messages. Researchers are interested in how each group organizes "cognitive-linguistic space" to interface with AAC technology. Lexicons will be arranged in four configurations:

1. Semantic (family, food, *etc.*).
2. Spatial/geographic (kitchen, office, bedroom, *etc.*).
3. Episodic/theme (eating at a restaurant, going to the doctor, making a phone call, *etc.*).
4. Alphabetic.

Both low-tech displays and high-tech devices will be used, and subjects will be asked to locate specific words (text) on each type of display. Subsequently, they may use devices/displays in role-playing situations.

3. *Development of a "menu-based" AAC interface for the elderly and adults with recall limitations.* [David Beukelman (PI), Chih Yang, Robert Tice, Katie Hustad, Rebecca Burke, Jeff Higginbotham.] Current AAC technology places high demands on recall memory. This is a problem for people with cognitive disabilities associated with stroke, TBI, dementia, *etc.*, and perhaps for the elderly. This project is developing an AAC interface to manage orthographic and graphic information in ways that enable AAC users to rely extensively on recognition, rather than recall memory.

Researchers have developed AAC-Menu software that allows the user to formulate messages on a buffer screen and to have a device speak. An expert committee of AAC users is reviewing the orthographic version. Researchers will conduct field tests with people who are severely speech-impaired secondary to TBI, and their non-disabled controls. Subsequently, the software will be tested with other populations and compared to other dynamic screen programs. Preliminary programming is underway for a graphic version of the interface.

For more information, contact Dr. David Beukelman, P.O. Box 830732, 202 Barkley Center, University of Nebraska-Lincoln, Lincoln, NE 68583-0732. (phone) 402-472-5462. dbeukelmanl@unl.edu

Also, visit the AAC-RERC Website at: http://www.aac-rerc.com and the University of Nebraska's AAC Website at http://aac.unl.edu

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Governmental

Medicare Update

As this issue of ***ACN*** goes to press, a group of AAC professionals and advocates in the U.S. is working to prepare information for the Health Care Finance Association (HCFA), which will pave the way for Medicare funding of AAC devices.

Specifically, HCFA informed the group in June 1999 that they felt the AAC Medicare Guidance (which called AAC devices a "convenience item") needed to be reviewed. They asked to be provided with information that would enable them to develop a new Guidance that would essentially fund AAC devices for Medicare eligible beneficiaries. In addition, HCFA appears already to have reached the conclusion that AAC devices should be considered "durable medical equipment" under Medicare (not prosthetic devices).

Lewis Golinker, an advocate and attorney who is spearheading this effort, has been informed that, if the information submitted is complete, a new Guidance may be available by the first of the year and would be implemented in the first quarter of 2000. There may still be additional work to be done before the process works smoothly, but Golinker believes a working relationship is now established with HCFA staff, so that future policy refinements can be discussed and resolved efficiently.

In the meantime, two items are available: (1) a booklet that explains the Medicare appeals process and describes how to get Medicare benefits and (2) information about an April 99 decision that funded an AAC device, despite the existing Guidance. Golinker says: This represents the first time a digitized speech device was approved and means that all major sub-classes of AAC devices have been approved: Computer based; synthesized and digitized speech.[24]

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