PREFACE

In recent years many changes have confronted speech-language pathologists practicing in medical settings. Changes in the patterns of reimbursement and expectations of third-party payers and the adaptations of medical settings in response to these changes in reimbursement have all resulted in a medical environment in flux. A decade ago, speech-language pathologists who worked in a community or teaching hospital that had a rehabilitation unit might have expected to treat patients with cerebral vascular accidents in acute care for a few weeks, which might be followed by several weeks or months of rehabilitation. Today, lengths of stay for such patients have been dramatically shortened. Also changed are the expectations of the medical staff, family, and medical administrators, all of whom are looking for short-term, observable progress. Furthermore, the levels of care that a patient may receive have increased markedly. Many new care level settings have emerged in an effort to meet these changing needs and reimbursement limitations. Finally, medical facilities, accrediting agencies, and third-party payers are demanding that all treatments have clearly stated outcome expectations that relate to patients' functional independence and well-being in their eventual posttreatment living environments.

With all of the changes in levels of medical care, reimbursement limitations, and outcome expectations have come demands on health-care providers to adjust or adapt older assessment and treatment approaches to accommodate the rapidly changing health care system. This issue of *Seminars in Speech and Language* was developed to assist speech-language pathologists in making such adaptations when assessing and treating patients with right hemisphere dysfunction (RHD). Five articles are included. The first two were written by the speech-language pathology team of the Evanston-Northwestern Healthcare and provide a framework for tailoring assessment and treatment needs to patients' specific levels of care, from acute care through long-term rehabilitation settings. The second article presents screening procedures for patients with right hemisphere brain damage that the authors use in acute and transitional care units to determine whether patterns of RHD are present in a given patient and, if so, what the patient's potential for rehabilitation is. The third article, by Penelope Myers, presents a framework for combining functional outcome and process-oriented treatment approaches for right hemisphere brain–damaged individuals. Her article stresses the importance of considering both the theoretically derived psychological processes believed to underlie patients' right hemisphere symptoms and the functional outcomes in all treatment approaches used with this clinical population. In the fourth article, Mary Boyle and Shari Strikowsky-Harvey discuss areas of management in which duplication of a patient's services are likely to occur among treatment teams in varying rehabilitation settings and provide documentation and treatment guidelines for avoiding duplication of patient services and third-party payer confusion in interpreting the documentation of care for RHD. To conclude, Gloriajean Wallace discusses cultural diversity issues that should be considered in the treatment of individuals with right hemisphere impairments and how these issues may be included in such patients' clinical management.

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Guest Editor

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