A Person-Centered Approach to Aphasia Management

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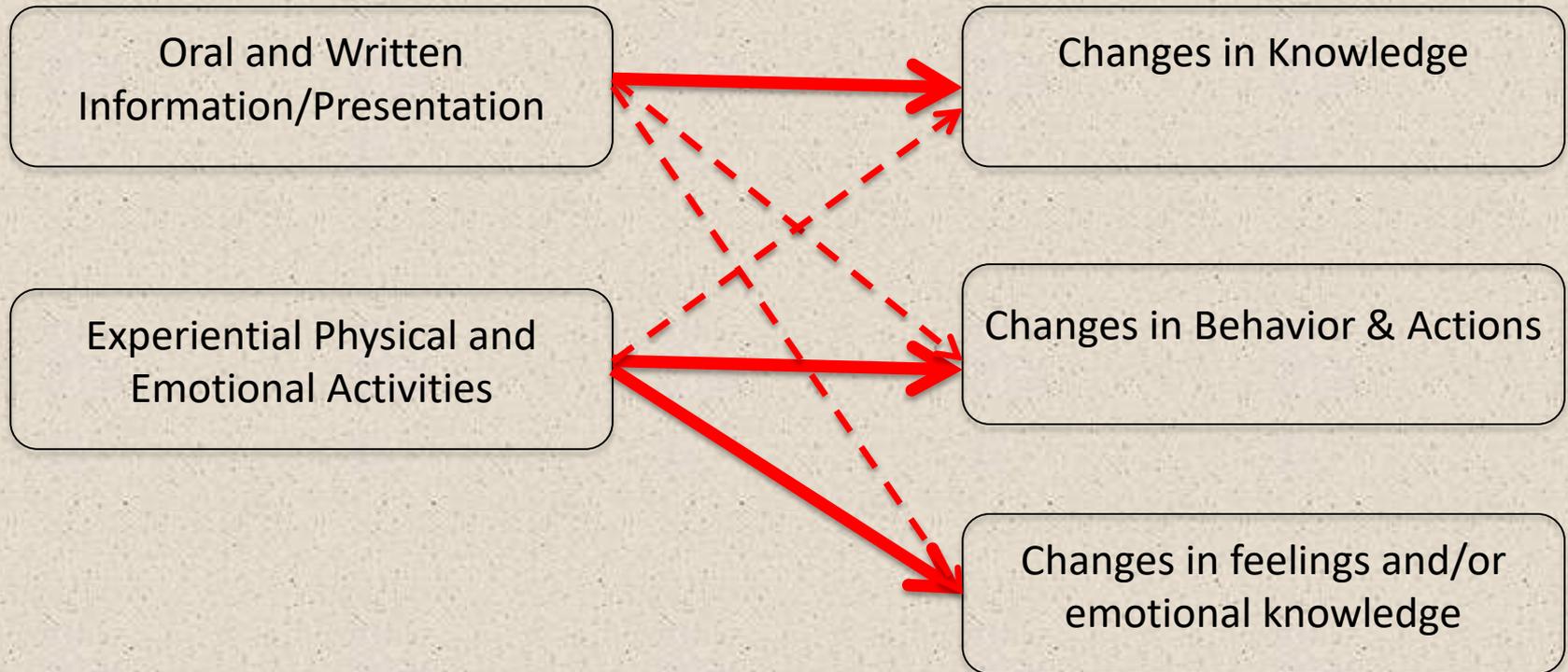Nova Southeastern University

Disclosures

- Relevant financial relationships:
  - Speaker fee for this course
  - Royalties on related CEU courses from MedBridge and Northern Speech Services
- Relevant non-financial relationships
  - Advisory Board Member (nonpaid) National Aphasia Association
  - Certification Board, Academy of Neurologic Communication Disorders & Sciences (ANCDS)

Learner Outcomes

At the end of this symposium, the learner will be able to:

1) define patient-centered care.

2) list 3 elements of a functional, person-centered goal statement

3) describe one example of a functional assessment for aphasia

4) demonstrate the procedures for at least one evidence-based intervention for aphasia

5) identify at least two types of information needed by people with aphasia and their families for long-term successful living

How we are going to achieve our learner outcomes

Oral and Written Information/Presentation → Changes in Knowledge

Experiential Physical and Emotional Activities → Changes in Behavior & Actions

Changes in feelings and/or emotional knowledge

1. Defining Patient-Centered Care

Some Examples and An Activity

Clinician assesses impairments and their consequences

Clinician interprets test results and identify priorities

Clinician sets goals and selects therapy

Clinician assesses and documents progress

Clinician-controlled care
(Leach et al, 2010)

Person – and family-centered care

- A partnership between clients, families, and clinicians or service providers

- Collaborative approach

- Used across disciplines; common to physicians, counselors, allied health disciplines, etc.

Person-centered care

(model modified from Hinckley, 2018)

Client and clinician determine priorities

Client's priorities are primary focus of **clinician's** assessment

Client and clinician set goals collaboratively

Clinician selects treatment based on **client's** priorities and goals

"Patient- and family-centered care is working 'with' patients and families, rather than just doing 'to' or 'for' them."

Institute for Patient and Family-Centered Care: http://www.ipfcc.org/about/pfcc.html

Mr. A. is a patient in a hospital. He was admitted with a stroke. The nurse reports difficulty understanding him.

The clinician administers a speech-language evaluation.

The clinician then documents the presence (or absence) of speech or language impairments, and recommends treatment if warranted.

Is this an example of

A) Clinician-controlled care?

B) Person-centered care?

Clinician-controlled care

Mr. A. is a patient in a hospital. He was admitted with a stroke. The nurse reports difficulty understanding him.

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Clinician assesses impairments and their consequences

Clinician interprets test results and identify priorities

Clinician sets goals and select therapy

Clinician assesses and documents progress

Mr. A. is a patient in a hospital. He was admitted with a stroke. The nurse reports difficulty understanding him.

The clinician interviews Mr. A about his concerns, and tries out some communication strategies.

The clinician gathers additional information from nurses or other professionals about Mr. A's ability to communicate.

The clinician then records information and recommends communication intervention.

Is this an example of

A) Clinician-controlled care?

B) Person-centered care?

Sample interview topics:
Telling about help needed for lifts or transfers, 2) telling about pain, 3) asking questions about current medical situation, 4) ordering meals, 5) asking about medications.
Inpatient Functional Communication Interview, O'Halloran et al, 2004.`

Person-centered care

Mr. A. is a patient in a hospital. He was admitted with a stroke. The nurse reports difficulty understanding him.

The clinician interviews Mr. A about his concerns, and tries out some communication strategies.

The clinician gathers additional information from nurses or other professionals about Mr. A's ability to communicate.

The clinician then records information and recommends communication intervention.

Client and clinician **determine priorities**

Client's **priorities are** **primary focus of** **clinician's** **assessment**

Client and clinician set **goals collaboratively**

Clinician selects **treatment based on** **client's priorities and** **goals**

Patient-centered care: Definition
(Lawrence & Kim, 2011)

- Identifies individual's communication skills and uses appropriate and effective communication strategies in all interactions between health-care professionals and the individual
- Identifies outcomes that are valued and prioritized by individuals
- Identifies outcomes that reflect the desired quality of participation
- Monitors and measures outcomes that are valued and prioritized by individuals
- Uses all of this information to inform the patient/provide clinical decision-making process

Patient-centered care improves health outcomes

- Patients who report a better health care experience have:
  - Fewer symptoms during hospitalization
  - Less likely to be readmitted
  - More trust, more likely to adhere to treatment regimens
  - Better recovery (including family practice/outpatient settings)
  - Better emotional health at follow-up
  - Fewer diagnostic tests and referrals
  (Epstein, Fiscella, Lesser, & Strange, 2010)

Patient-centered care is at the center of improving quality, adding value, and improving patient experience.

So, how can we make sure our practice is patient-centered?

Do you do patient-centered care?

1. Do you discuss treatment goals with the client and family at the beginning of the course of treatment?
   a. Yes, always
   b. Sometimes, when I can
   c. Rarely or never

Do you do patient-centered care?

2. Which of the following do you typically do first?

    a.   administer an impairment-based assessment

    b.   interview (with or without a clinical tool) the patient and/or family about activities, goals, and desires

Do you do patient-centered care?

3. Do you ask the patient and/or family about their rehabilitation goals?

    a.   Yes, usually

    b.   Sometimes, when I can

    c.   Rarely or never

Do you do patient-centered care?

4. Which of the following best describes most of your goal-setting with patients?

    a.   I establish the goals and frequency of therapy

    b.   I suggest goals and the patient and/or family responds

    c.   I engage in a fully collaborative goal-setting meeting whenever possible

Do you do patient-centered care?

5. Imagine that your client was formerly quite politically active, and now after stroke will have significant difficulties physically getting to and participating in political meetings. She expresses her desire to get on the internet as an alternative way to participate in her political efforts, but acknowledges that she doesn't have a computer. Would you include any of this into a rehabilitation goal?

    a.   Yes

    b.   No

    c.   Maybe

Do you do patient-centered care?

<u>Scoring</u>: Score each of your responses with the following points.

1: a = 3, b = 2, c = 1

2: a = 1, b = 2

3: a = 3, b = 2, c = 1

4: a = 1, b = 2, c = 3

5: a = 3, b = 1, c = 2

Add up your scores for the five items.

If you scored 10 or higher, you are taking every opportunity to engage in patient-centered care during goal-setting.

Doesn't the clinician have a pretty good idea of what the client needs?

- The clinician has seen other clients in similar circumstances.

- The clinician is knowledgeable about clinical research that is relevant to the client's situation.

- The clinician knows what is realistic to expect for the patient.

Recovery Preference Exploration

	WITH HELP			NO HELP	
	Completely Dependent	**Some Assistance**	**Supervision**	**Take Longer/Need Device**	**Completely Independent**
Using the toilet	**Completely Dependent**				
Getting in/out of chair/bed	**Completely Dependent**	1			

The left column includes 15 functional areas or activities that are included in the National Health Interview Survey (Stineman et al, 2007).

Recovery Preference Exploration

	WITH HELP			NO HELP	
	Completely Dependent	**Some Assistance**	**Supervision**	**Take Longer/Need Device**	**Completely Independent**
Using the toilet	**Completely Dependent**				
Getting in/out of chair/bed	**Completely Dependent**	1			

The game begins by assuming that you are totally disabled in every activity.

Recovery Preference Exploration

	WITH HELP			NO HELP	
	Completely Dependent	**Some Assistance**	**Supervision**	**Take Longer/Need Device**	**Completely Independent**
Using the toilet	**Completely Dependent**				
Getting in/out of chair/bed	**Completely Dependent**	1			

When we start the game, you will write the numbers from 1 to 15. Only 1 number can go in a single square. Each number represents some "improvement" in one area.

Recovery Preference Exploration

	WITH HELP			NO HELP	
	Completely Dependent	**Some Assistance**	**Supervision**	**Take Longer/Need Device**	**Completely Independent**
Using the toilet	Completely Dependent	2			
Getting in/out of chair/bed	Completely Dependent	1			
Bathing or Showering	Completely Dependent				
Dressing	Completely Dependent	3			
Moving inside	Completely				

Recovery Preference Exploration

	WITH HELP			NO HELP	
	Completely Dependent	**Some Assistance**	**Supervision**	**Take Longer/Need Device**	**Completely Independent**
Using the toilet	Completely Dependent	4	5	6	
Getting in/out of chair/bed	Completely Dependent	1	2	3	
Bathing or Showering	Completely Dependent				
Dressing	Completely Dependent				

Recovery Preference Tool

	WITH HELP			NO HELP	
	Completely Dependent	**Some Assistance**	**Supervision**	**Take Longer/Need Device**	**Completely Independent**
Using the toilet	**Completely Dependent**		🚫		
Getting in/out of chair/bed	**Completely Dependent**	1		🚫	
Bathing or Showering	**Completely Dependent**				
Dressing	**Completely Dependent**				

You may not skip blank squares.
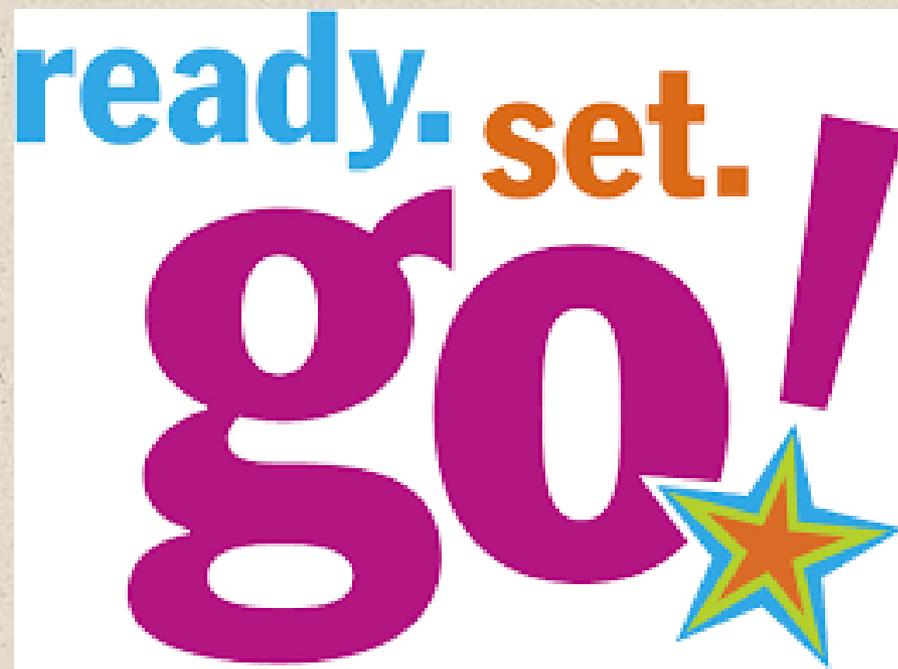
How do your recovery preferences compare to your neighbor's? Same or different?

2. Efficient Functional Assessment: Principles and Techniques

Activity

- Please jot down the assessment tools you used in a recent evaluation.

"The overall objective of speech-language pathology services is to optimize individuals' abilities to communicate and to swallow, thereby *improving quality of life*." [italics mine]

Scope of Practice in Speech-Language Pathology, ASHA.
http://www.asha.org/policy/SP2016-00343/

Person-centered care
(model modified from Hinckley, 2018)

Client and clinician determine priorities

Client's priorities are primary focus of **clinician's** assessment

Client and clinician set goals collaboratively

Clinician selects treatment based on **client's** priorities and goals

Determining the client's priorities

- Interview questions from Appendix 2 of the WHO ICF Checklist (using supports)
- Life Interests and Values assessment
- Key Life Activities

Introduction to Goal-Setting Process to Client/Family by Clinician

Client/Family Identify Goals and Priorities

Formal Clinical Assessment

Collaborative Goal-Setting

Treatment Selection

Tools: ICF Checklist, Appendix 2

http://www.who.int/classifications/icf/icfchecklist.pdf

Appendix 2:

GENERAL QUESTIONS FOR PARTICIPATION & ACTIVITIES

The following probes are proposed as a guide to help the examiner when interviewing the respondent about problems in functioning and life activities, in terms of the distinction between capacity and performance Take into account all personal information known about the respondent and ask any additional probes as necessary. Probes should be rephrased as open-ended questions if necessary to elicit greater information.

Tools: ICF Checklist

Short List of A&P domains	Performance Qualifier	Capacity Qualifier
d3. COMMUNICATION		
d310 Communicating with -- receiving -- spoken messages		
d315 Communicating with -- receiving -- non-verbal messages		
d330 Speaking		
d335 Producing non-verbal messages		
d350 Conversation		

ICF Checklist: Performance Probes

(Performance)

(1) In your present situation, how much of a problem do you actually have making friends?

(2) Is this problem making friends made worse, or better, by anything (or anyone) in your surroundings?

(3) Is your capacity to make friends, without assistance, more or less than what you actually do in your present surroundings?

ICF Checklist: Capacity probes

IV. **Interpersonal Interactions**

(Capacity)

(1) In your present state of health, how much difficulty do you have making new friends, without assistance?

(2) How does this compare with someone, just like yourself only without your health condition?
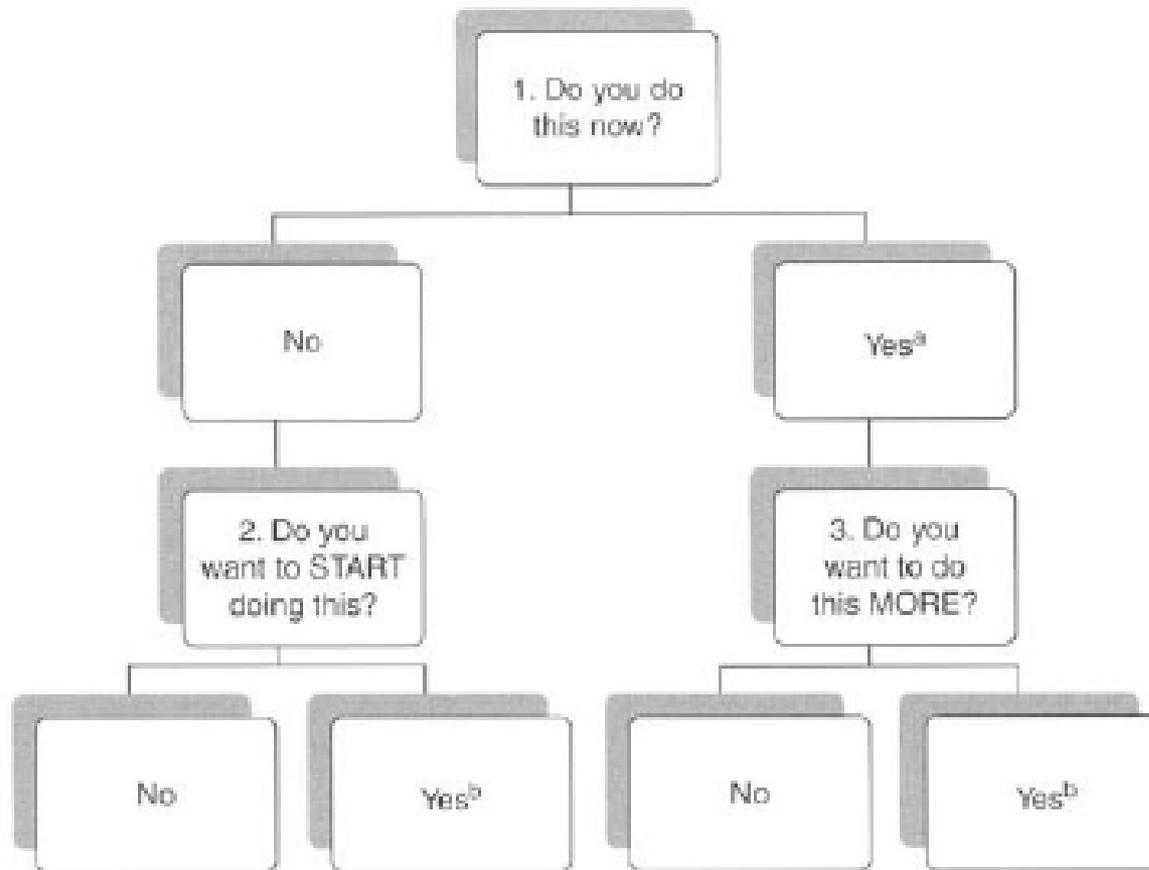
(Or: "…than you had before you developed your health problem or had the accident?")

Life Interests and Values (L!V) cards

- www.liv.org

- Pictorial support for individuals with restricted communication ability to indicate activities and life participation which is most relevant to them
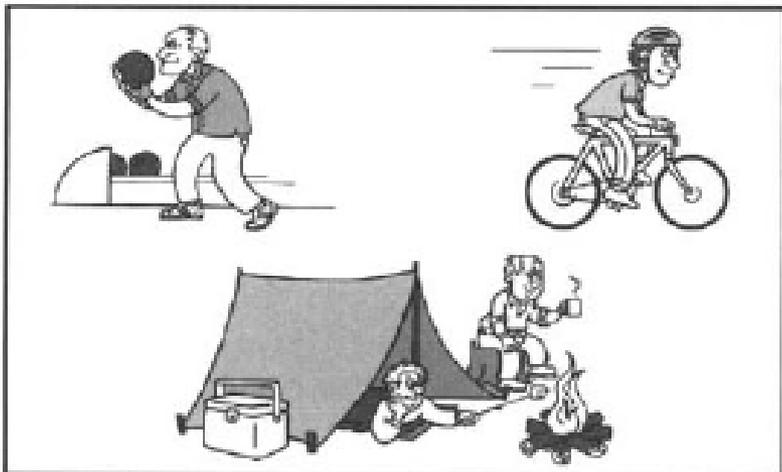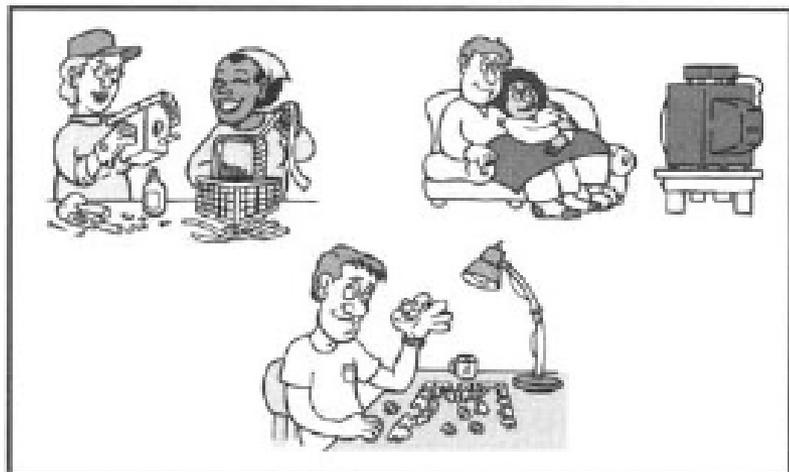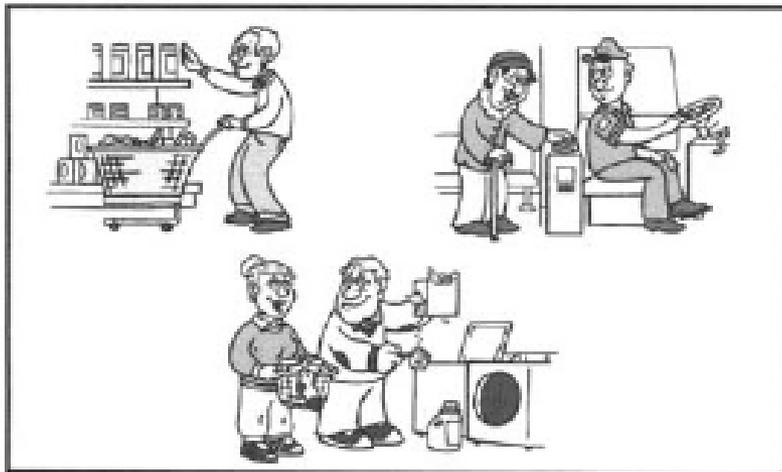
L!V cards: **Interview**

Key Life Activities
(Simmons-Mackie, 2001)

Pre-Onset	Initial Assessment	Outcome Assessment
Teaching 1st grade	Church on Sunday	Preschool volunteer
Church on Sunday		Church on Sunday
Cook for church (Wed)		
Carnival Club Secretary		Carnival Club attendee
Walk 2 miles daily		Walk with friend daily
Prepare family dinner		Host family dinner
Babysit grandchild	Babysit grandchild	Babysit grandchild
Garden Club		
Gardening	Gardening (some)	Gardening (some)
Reading	Reading (some	Reading (some)
	Television	Television

Person-centered care

(model modified from Hinckley, 2018)

→

Client and clinician determine priorities

Client's priorities are primary focus of **clinician's** assessment

Client and clinician set goals collaboratively

Clinician selects treatment based on **client's** priorities and goals

Framework for Outcome Measurement (FROM)

http://www.asha.org/PRPSpecificTopic.aspx?folderid=8589934663&section=Treatment
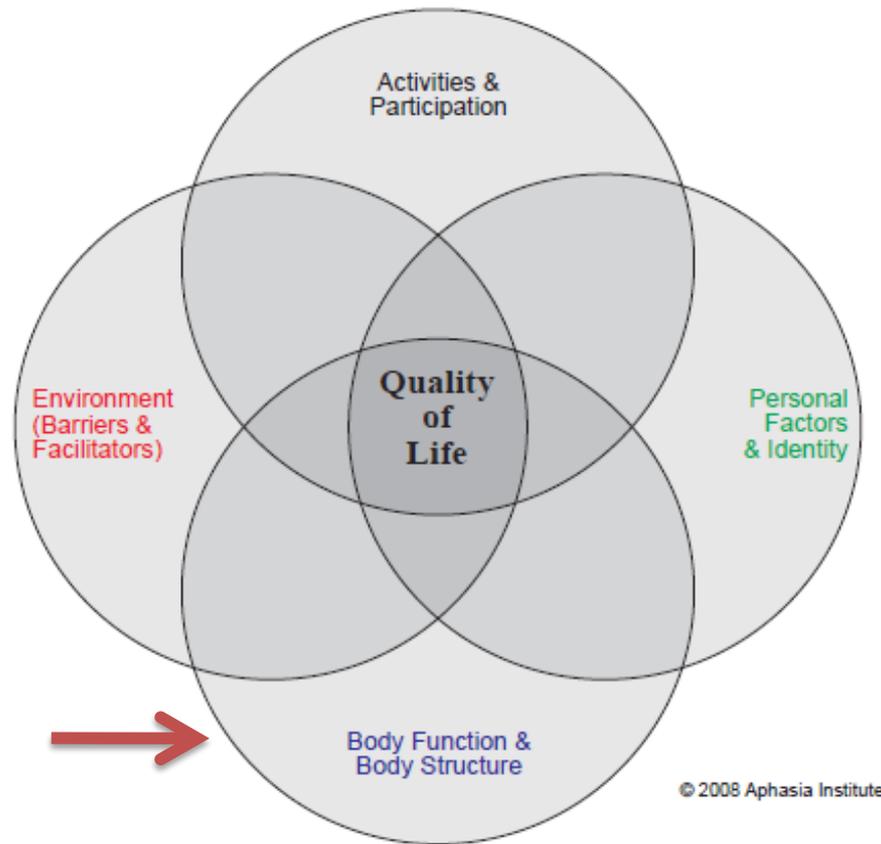
"…measurement of the impairment of aphasia pre- and post-treatment is inadequate for describing its functional outcome." (Holland, 1998, p. 250)
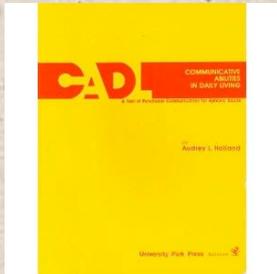
Impairment measures don't seem to *predict* functional abilities

- Although impairment-level performance is related to functional performance at a single point in time, *change* in one does not necessarily equal *change i*n the other (Meier, Johnson, Villard, & Kiran, 2017)

- Impairment measures may also not be associated with daily stress and self-reported communication difficulty (Doyle, Matthews, Mikolic, Hula, & McNeil, 2006).
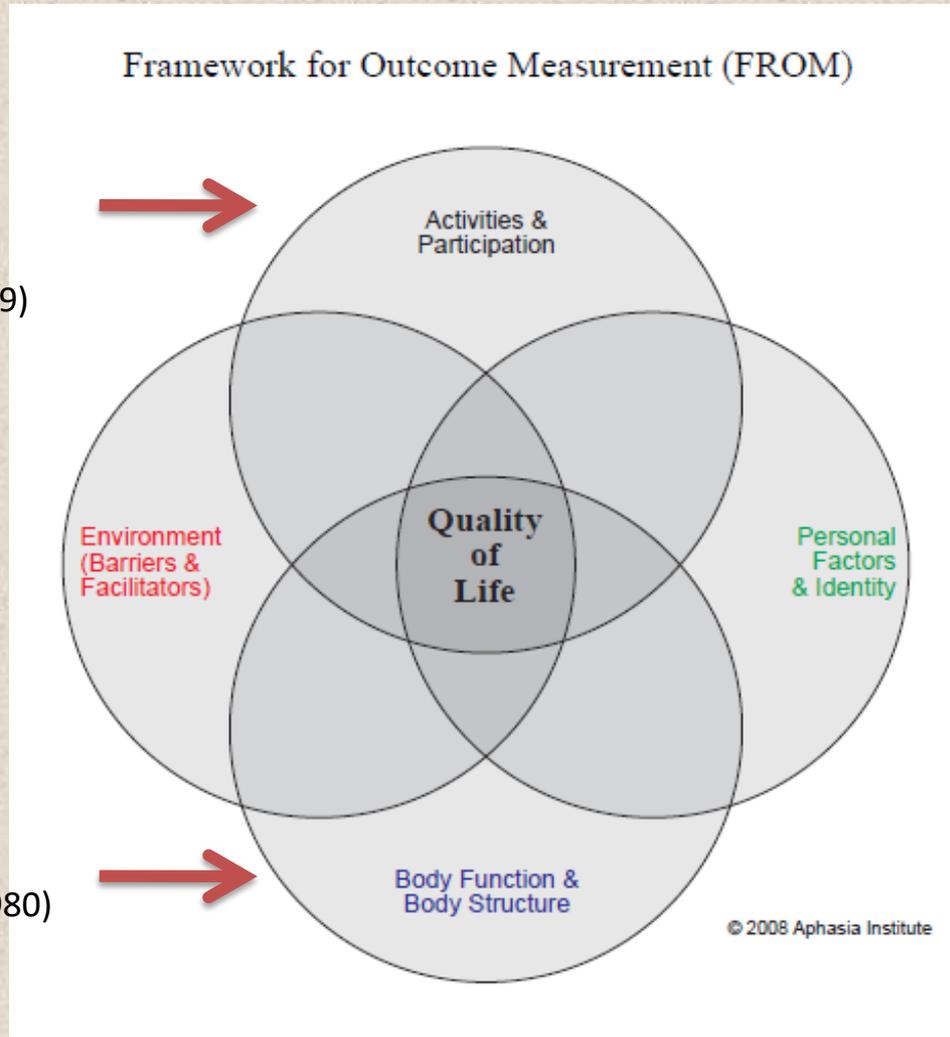
Impairment-focused assessments

- Scores on impairment-focused measures, such as standardized aphasia batteries, will probably not predict functional abilities

- Scores on impairment-focused measures may help the clinician consider underlying skills that will impact functional abilities

Communicative Abilities in Daily Living (Holland, 1999)

Framework for Outcome Measurement (FROM)

Activities & Participation

Environment (Barriers & Facilitators)

Quality of Life

Personal Factors & Identity

Body Function & Body Structure

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Western Aphasia Battery (Kertesz, 1980)

http://www.asha.org/PRPSpecificTopic.aspx?folderid=8589934663&section=Treatment

Activity & Participation

- Overall scores may be somewhat useful in predicting functional abilities

- Item analyses of strengths and challenges may lead to identification of realistic functional goals and outcomes

- Activities that are priorities for the client can be specifically evaluated by relevant items in a non-standardized assessment

Case Example 1: Mr. F
(Hinckley, 2018)

Mr. F is a 63-year-old gentleman admitted 3 days ago with a left CVA. His wife is at the hospital some part of each day.

Mrs. F. is concerned because he is unable to order food that he likes and he is not eating.

Impairment-focused test results:

Naming (BNT) = 5/50 (10%)

Word-picture matching = 19/40 (48%)

Activity & Participation overall score:

CADL-2 = 74%

Can we map these assessment results to client's priority/concern?

- Severely impaired naming and word comprehension skills are probably interfering with ability to understand or express food preferences.

- But overall score on CADL-2 (74%) suggests some preserved abilities in some contexts.
  - What are these preserved abilities?

What can a standardized assessment of activity & participation tell us?

1. A general measure of the patient's ability to do daily tasks
2. Performance on functional tasks relative to others

1. Not a specific measure of any specific task
2. Not performance on functional tasks in the individualized context of that patient

Mr. F example – CADL-2 relevant menu ordering item

- CADL Overall = 74%
- Item #8: "Here's a menu. Find the lunch section. What would you want for lunch?"
  - Points to "cheeseburger"
  - Says "cheeser"
  - Item score = 2
  - Context/support: Visual/written cues

Scoring system
2 = fully communicative response
1 = some errors
0 = completely inaccurate/ineffective
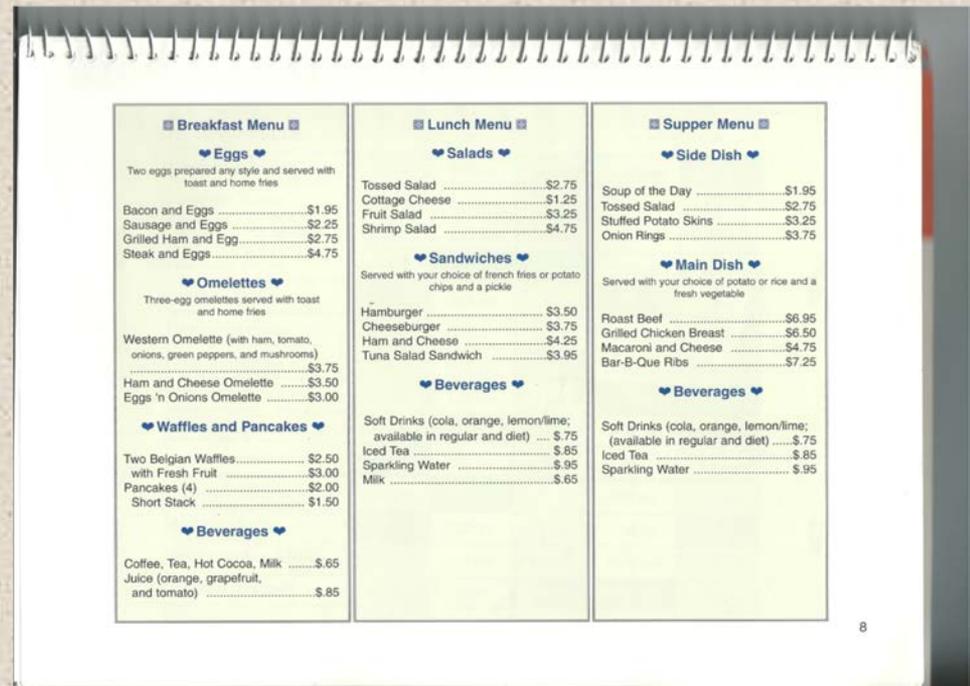
Mr. F example – CADL-2 related item

"You stop in a grocery store. You want to buy a can of tomato soup. Which will you pick?"

Mr. F: Points to "Cup of Soup"

Score: 1

Context: Critical word "can" spoken only – but selected "soup"

Scoring system
2 = fully communicative response
1 = some errors
0 = completely inaccurate/ineffective

Potential changes on nonstandardized assessment/reported outcomes

- Using menus in current environment:
  - Accuracy
  - Time to respond
  - Accuracy under different conditions
    - With written supports
    - Using only pointing/writing
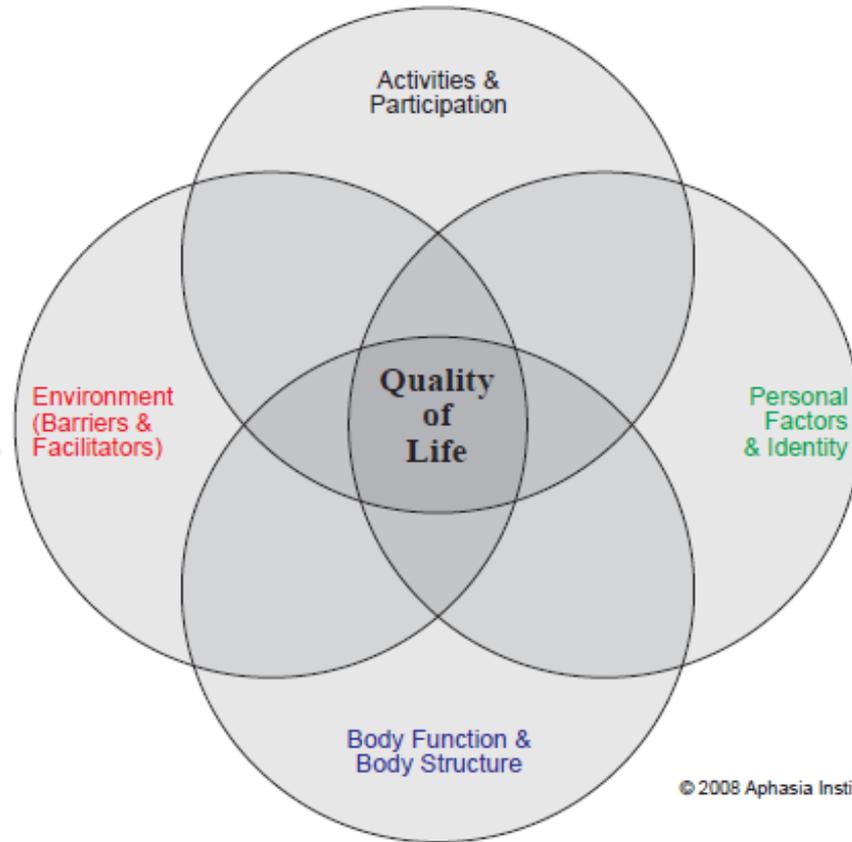   - With/without trained partner

<u>Documentation example:</u>

"On food-related/menu ordering practice items, Mr. F progressed from a score of 1/4 to 4/4."

2 = fully communicative response

1 = some errors

0 = completely inaccurate/ineffective

Framework for Outcome Measurement (FROM)

Activities & Participation

Environment (Barriers & Facilitators)

Quality of Life

Personal Factors & Identity

Body Function & Body Structure

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ICF Checklist
http://www.who.int/classifications/icf/icfchecklist.pdf

http://www.asha.org/PRPSpecificTopic.aspx?folderid=8589934663&section=Treatment

Consider the Environment

- The barriers or facilitators in the environment are critical to considering what activities the person is **most likely** to do
  - Trained vs. untrained partners?
  - Environment supportive or modifiable in other ways?
    - Distractions, noise
    - Scheduling
    - Seating, item placements, communication supports

Mr. F example – Environment

- Menu-ordering in the acute care hospital
  - There may be untrained staff gathering menu preferences
  - The environment may be noisy and distracting
  - There may or may not be supports such as a written version of the menu, OR there may ONLY be a written version without auditory/interctive support

Framework for Outcome Measurement (FROM)
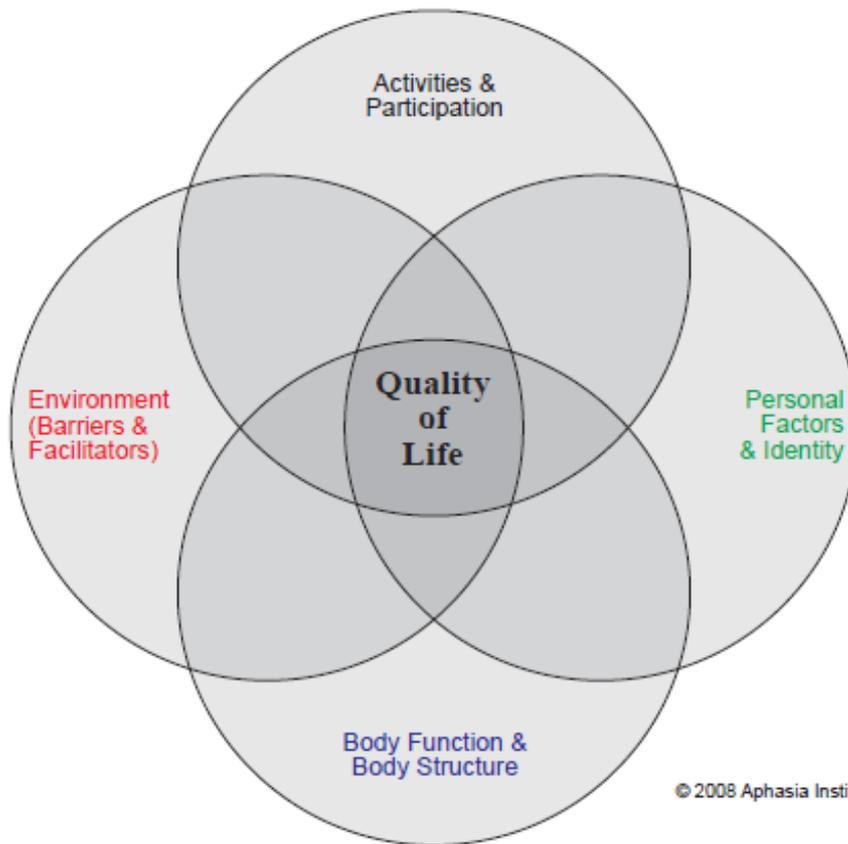
ICF Checklist
http://www.who.int/classifications/icf/icfchecklist.pdf

Example: Self-Efficacy/Communication Confidence

http://www.asha.org/PRPSpecificTopic.aspx?folderid=8589934663&section=Treatment

Personal and Social Factors

- Some examples of personal and social factors:
  - *Visual Analogue Self-Esteem Scale* (Brumfitt & Sheran, 1999)
  - *Communication Confidence Rating Scale for Aphasia* (Babbitt & Cherney, 2010)
  - Measures for depression and mood, such as *Geriatric Depression Screening* (Sheikh & Yesavage, 1986)
- These personal factors also mediate what a person will actually do
  - Someone with mild impairments may lack confidence to try
  - Someone with depressed mood may be unable to initiate
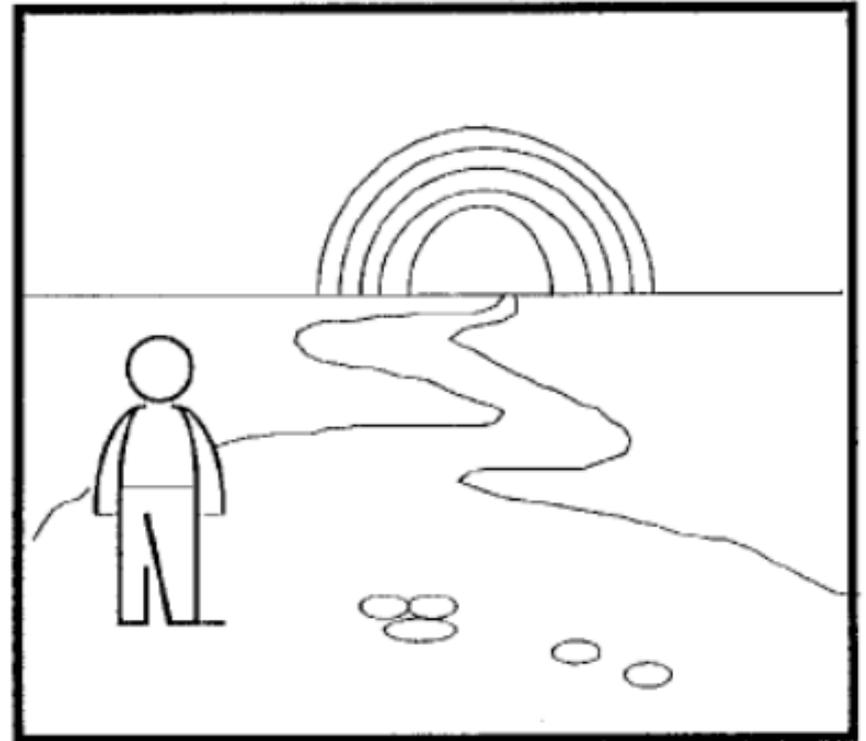
Visual Analogue Self-Esteem Scale
(Brumfitt & Sheran, 1999)

- Aphasia-friendly way to monitor self-esteem over time after stroke.

- Can be used in acute stage to measure baseline of self-esteem.

- Can be used as an outcome measure after an intervention.

Mr. F example – Personal and Social Factors

- The acute care situation
  - Mr. F may still be unclear or unsure about what has happened to him.
  - Mr. F may not yet be able to manage his own compensatory strategies
  - Mrs. F may be shocked and overwhelmed
- These are real factors in estimating functional abilities or outcomes.

A client's functional ability = The **impairment** while doing a particular **activity,** in a particular **environment**, **mediated by** **personal characteristics** such as belief in their own abilities.

Mr. F Example
Severe naming and moderately-severe word comprehension abilities make it difficult for him to make food choices in the noisy hospital environment in the first few days after stroke.

Steps in Selecting a Relevant Functional Assessment

Select a Relevant Functional Assessment

1. Determine the specific activities that are the most important to the client.
2. Identify the primary goal of each activity.
3. Select an assessment that specifically captures the client's ability to do that activity.

Step 1: Determine client's priorities.

- Tools to help you.
  - Activity-focused interview with client and/or family member (Ex: ICF Checklist Appendix 2, Key Life Activities)
  - Aphasia-friendly interview with visual supports (Ex: Life Interests and Values cards)

- Mr. F: Bedside interview with Mrs. F identified specific activity (meal selection) that was a priority and a concern.

Step 2: Identify the real goal in the activity.

- Top-down, goal-oriented task decomposition (Frederickson & White, 1989)

- What is the ultimate goal of this particular activity?

- The ultimate goal can be achieved in a variety of ways.

- Mr. F: The goal of making menu choices is to get the food you prefer so you will keep up your nutrition in the hospital.

Principled task decomposition
(Fredericksen & White, 1989)

- Top-down, goal-oriented task decomposition
  - Example: ordering in a restaurant
    - Goal : Get the food/drink.
      - SubGoal: Tell the waiterperson what you want

  - Seen in this way, there are multiple ways to get your preferred food choices:
    - Have someone else order for you
    - Say what you want
    - Point to what you want
    - Use a device to communicate what you want

Principled task decomposition

Ask three questions to find the optimal strategy to achieve the ultimate task goal:

1. Does the strategy help to achieve the goal without making it harder to achieve some other goal?

2. Does the execution of the strategy reduce or increase the cognitive load of achieving the goal?

3. Does the strategy require the acquisition of complex skills or concepts?

Principled task decomposition

1. Does the strategy help to achieve the goal without making it harder to achieve some other goal?
   - In other words, does the communication strategy get the food without making it harder to achieve independence?
     - ~~Have someone else order for you~~
     - Say what you want
     - Point to what you want
     - Use a device to communicate what you want

Principled task decomposition

2. Does the execution of the strategy reduce or increase the cognitive load of achieving the goal?

– Which of these requires the lowest cognitive load?

- Point to what you want
- Say what you want
- Use a device to communicate what you want

Principled task decomposition

3. Does the strategy require the acquisition of complex skills or concepts?

- Which of these requires the least complex skills?
  - Point to what you want = OPTIMAL STRATEGY
  - Say what you want
  - Use a device to communicate what you want

Principled task decomposition:
From activity to goal

Client's desired activity: Get preferred food choices

Sample goal: Client will <u>point</u> to words and pictures *to request desired items* with XX% accuracy

Maps directly to outcome measures such as:
- ordering lunch on the CADL-2
- QOL items relevant to making one's own choices

Example

- Client's priority activity is talking about travel with friends and visitors

- Sample goal: "Client will maintain conversation about selected personal topic for xx minutes using communication supports"

- "with trained/untrained partners"

Compare:

"Client will name travel words with xx% accuracy"

OR

"Client will correctly label travel photos with XX% accuracy"

Example

- Client's priority activity is talking about travel with friends and visitors
- Sample goal: "Client will maintain conversation about selected personal topic for xx minutes using communication supports"
- "with trained/untrained partners"

Stroke and Aphasia Quality of Life Scale:

"Did you…do your hobbies less often than you would like?

Step 3: Select an assessment that specifically captures that activity.

- Selected item analysis for activity assessment.
  - Mr. F: CADL-2 menu-ordering or similar
  - Role-playing in a set script
- Use multi-dimensional or alternative measurement systems.
  - CADL-2 scoring (0, 1, 2)
  - Latency/duration
- Assess performance under different conditions

Another example: Communicative Effectiveness Index (CETI) (Logan et al, 1989)

- Significant other (primary communication partner) rates the PWA's ability to do specific communication tasks

- Mark an X on a visual analogue scale

- Anchors: "as able as before stroke" – "not at all able"

- Usually considered a measure of social validity

- "Score" is measure of distance between pretest rating and posttest rating

- Designed to assess perceived change over time according to important others

CETI

FIGURE 1. Schematic of the use of the visual analogue scale for rating at initial and repeat testing.

Aphasia-friendly version of CETI
(Rautakoski et al, 2008)

Informal example

Are you able to order food for yourself?

(Is XXX able to order food for himself?)

_____

| Not at all | As able as |
| Able | before stroke |

- Please look back at the assessments you jotted down at the beginning of this section.
- Any new thoughts? Anything to add? Change?

3. Modern Goal Writing

Aspirations, Tricks, & Examples

Person – and family-centered care

- A partnership between clients, families, and clinicians or service providers
- Collaborative approach
- Used across disciplines; common to physicians, counselors, allied health disciplines, etc.

https://www.asha.org/Practice-Portal/Clinical-Topics/Aphasia/Person-and-Family-Centered-Care/

Goal Attainment Scaling

Goal Attainment Scaling is a goal-setting procedure that has the strongest empirical support for its validity and effects

(Hurn, Kneebone, & Cropley, 2006)

Goal Attainment Scaling
(from Malec, 1999)

TABLE 1
Six Steps for the Development and Implementation of GAS

1. Goal selection
2. Weighting goals
3. Designation of follow up time period
4. Articulation of the "expected" level of outcome in objective behavioural terms
5. Articulation of other outcome levels
6. Assessment of GAS level on admission and at follow up

Goal Attainment Scaling
(from Malec, 1999)

TABLE 1
Six Steps for the Development and Implementation of GAS

1. Goal selection
2. Weighting goals
3. Designation of follow up time period
4. Articulation of the "expected" level of outcome in objective behavioural terms
5. Articulation of other outcome levels
6. Assessment of GAS level on admission and at follow up

Goal Attainment Scaling – evaluation

- Most favorable outcome
- More than expected outcome
- Expected outcome
- Less than expected outcome
- Least favorable outcome

+2, +1, 0, -1, -2

OR

0, 1, 2, 3, 4

Goal Attainment Scaling Example – Adult Aphasia (Worrall, 2000)

	Goal 1: Catching the bus
Most favorable outcome	Able to use the bus without assistance without error all of the time
More than expected	Able to use the bus with the help of his wife without error all of the time
Expected outcome	Able to use the bus with the help of his wife with some errors some of the time
Less than expected	Too much help required and too many errors made for continued use of the bus
Least favorable	Unable to use the bus at all

Advantages of Goal Attainment Scaling

- Focused on life participation
- Provides evaluative component
- Provides time limit
- Can be customized to particular social environments
- Structure and process could be internalized by clients to facilitate autonomous goal-seeking

Mr. F: Documentation Example

Mr. F achieved an overall score of 74% on a standardized assessment of functional communication (CADL-2). Mr. F's priority is to be able to express his food preferences. Analysis showed that he can do so given written supports and written choices, and extra time (specify here if possible). Mr. & Mrs. F both rated his ability to order for himself in the hospital environment as very low (1 on a scale of 0-5). Intervention should target including these communication supports in his environment and training relevant partners.

Acute: Case Study

Mr. A is a 58-year old right-handed gentleman who was admitted through the ER last night with difficulty talking and right-sided weakness. The worst of his symptoms were short-lived and the nurse reports he is doing better this morning, sitting up in the chair and talking. You have received orders for a speech/language/swallowing evaluation.

Acute: Therapist-led approach

- Mr. A's speech, language, and cognition are assessed via evidence-based screenings like the MoCA and the Frenchay Aphasia Screening. *See the Directory of Speech-Language Pathology Assessment Instru[] http://www.asha.org/SLP/assessment/Assessment-Introduction/*

- The presence or absence of dysarthria, apraxia, aphasia, cognitive impairments, or swallowing impairments are documented.

- The clinician makes recommendations about further treatment.

Start with formal assessment
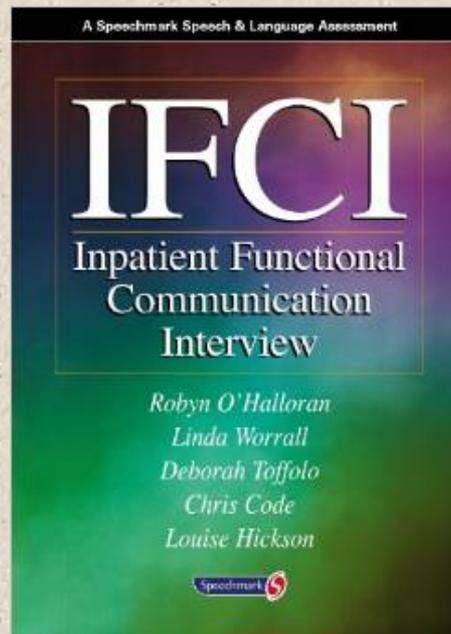
Impairment-based results

Clinician determines goals and therapy

Acute: Patient-centered approach

Inpatient Functional Communication Interview

(O'Halloran et al, 2004)

Introduction to Goal-Setting Process to Client/Family by Clinician

↓

Client/Family Identify Goals and Priorities

↓

Formal Clinical Assessment

↓

Collaborative Goal-Setting

↓

Treatment Selection

Acute Care: Goals

- Mr. A will be able to communicate discomfort and basic needs.

- Mr. A will be able to understand routine medical information (such as medication information)

- Mr. A will be able to express/understand with supported communication (caregiver training)

IFCI: Four steps

1. Review medical records.
2. Conduct the structured interview at bedside, and explores the effectiveness of various communication strategies.
3. Supplement this information by gathering information from other relevant staff, such as nurses or other therapists.
4. Record the findings and recommendations for communication enhancement.

(O'Halloran, Worrall, Toffolo, Code, & Hickson, 2004;
O'Halloran, Worrall, Hickson & Code, 2007)
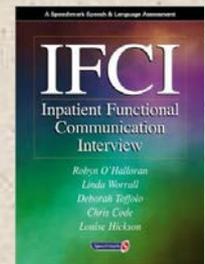
IFCI: Communication situations

1. Gaining patient's attention.
2. Telling if help is needed for lifts or transfers.
3. Telling about social or personal details.
4. Telling about what has happened to bring him/her into the hospital.
5. Telling about pain or discomfort.
6. Asking for something he/she needs.
7. Telling about current medical situation.
8. Telling about something he/she does/does not like.
9. Expressing his/her feelings.
10. Asking questions about his/her medical care.
11. Telling you if he/she is hungry/thirsty.
12. Ordering meals.
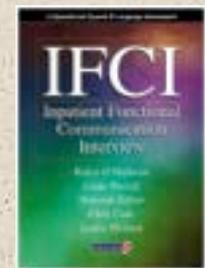
Importance and Prevalence

- Perhaps as many as 88% of individuals admitted into a stroke inpatient ward have some form of disability that affects their ability to comprehend or express health information while in the hospital.

- Approximately 44% of these patients are experiencing at least mild language impairment.

(O'Halloran, Worrall, & Hickson, 2009)

OP: Case Study

- Mr. W is a 51 yo, right-handed male, 6 years post ischemic stroke. He attended numerous residential and non-residential intensive aphasia therapy programs and group therapy programs. He presents with dense right-sided hemiparesis and moderate Broca's aphasia.

OP: Therapist-Led Assessment

- After a short conversation, directly proceed to pre-selected assessments chosen by the clinician.
  - WAB or BDAE
  - Cognitive assessment
  - Results in quantitative measurements + clinical observations

- Write goals based on quantitative measurements

Start with formal assessment

Impairment-based results

Clinician determines goals and therapy

OP: Therapist-Led
Goals

- Examples of real goals based on impairment assessment

Client will produce sentences with appropriate verbs in 80% of opportunities.

To improve spoken sentence length in response to yes/no, choice, and wh-questions

1. ____ will increase auditory comprehension of sentences/short conversation to 85% accuracy independently. – GOAL MET

To improve spontaneous pronunciation of tri-syllabic words
____ identified articulation of multi-syllabic words as a personal goal at the beginning of treatment. Word lists were practiced from *The Source for Apraxia Therapy*.

OP: Patient-Centered Goals

In DW's case, a conversational interview was effective in eliciting life-participation goals:

- He is a father of two daughters who live away from home. He wants to keep in contact with them.

- He enjoys reading the newspaper every morning at breakfast. But he relies on his wife to understand the articles.

- He loves going to movies. He wants to share his recomme

- He was a successful TV beat reporter and corporate trainer. He continues to enjoy talking and presenting to groups.

Introduction to Goal-Setting Process to Client/Family by Clinician

Client/Family Identify Goals and Priorities

Formal Clinical Assessment

Collaborative Goal-Setting

Treatment Selection

OP: Patient-Centered
Goals

- Together, the conversation turned into these stated goals:
    1. Stay in contact with friends and family by writing emails, text messages, blog posts, with more independence
    2. Read and understand articles of interest in the newspaper with greater independence
    3. Attend classes/presentations to practice work-related presentation skill analysis

OP: Patient-Centered
Assessment

- Now assess based on the client's goals!
  - Appropriate portions of normed tests
- I also need to know:
  - Writing ability without AND WITH assistance
    - I will probably use Speech-to-Text in tx so I will evaluate speech sample
  - Reading ability without AND WITH assistance
    - I will probably use Text-to-Speech for goal so I will evaluate reading comp with auditory support
- Client's own rating from GAS

LTC: Case Study

Mrs. C is an 80-year old woman who had been living independently in a senior apartment complex when she had a left hemisphere stroke resulting in a fluent aphasia six months ago. She was admitted to your skilled nursing and received all 3 therapies for 3 months. Now, your rehab director is asking whether you will be continuing her on your caseload, and if so, you will need to write new goals.

LTC: Case Study

- By the end of her three months of rehab, Mrs. C was able to communicate some information, but was unable to request specific items or actions

- Nursing staff complain that Mrs. C "doesn't listen", "doesn't follow directions", "can talk fine when she wants to", and "sometimes she's confused".

LTC: Therapist-Led
Assessment & Goals

- Mrs. C will be able to follow 2-step directions with 90% accuracy

- Mrs. C will be able to name functional/personally relevant pictures with 90% accuracy.

Start with formal assessment

Impairment-based results

Clinician determines goals and therapy

LTC: Patient-Centered
Goals

- Mrs. C enjoyed working jigsaw puzzles, but had difficulty finding them and getting them out. Mrs. C will successfully request activities 80% of opportunities.

- Mrs. C was frustrated by how difficult it was to understand the staff. Mrs. C will request repetition 80% of opportunities to enhance comprehension.

If you focus on activity goals, then...

- Client sees improvements on something important to him/her more quickly
- Client is able to do something, which will increase willingness to go out and do the activity, which will support social engagement and continued improvement
- Activity-focused practice (catalog-ordering, menu-ordering, conversation, script training) transfers to "downstream" skills like word-finding (Hinckley, Patterson & Carr, 2001; Hinckley & Carr, 2005; Boyle, 2011)
- Finally, activity-focused practice may be most effective when treatment time is limited (Hinckley & Carr, 2005)

Activity

- With your neighbor, come up one specific way that you could incorporate more collaborative goal-setting in your practice.
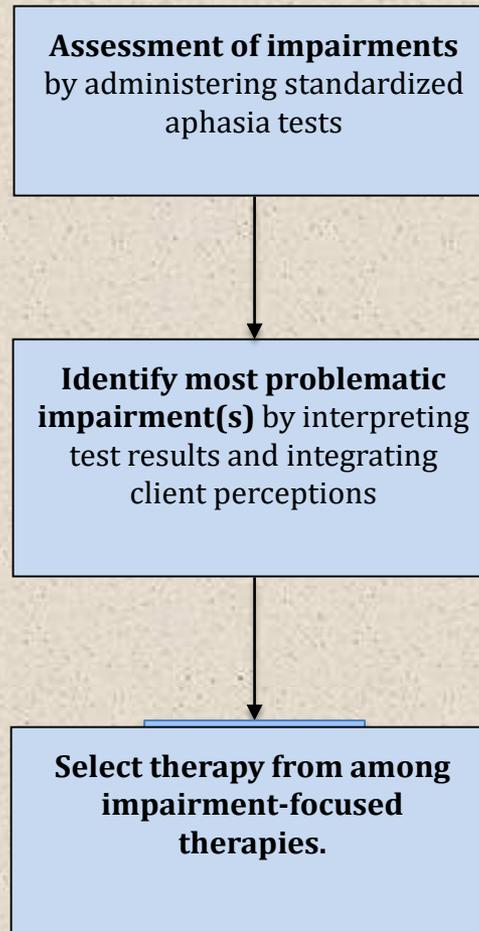
Summary

- Goal Attainment Scaling is a direct link between a client's goals and outcomes

- Focusing on specific activities, and directly targeting what is needed to achieve performance of an activity, will more obviously link to measures of quality of life.

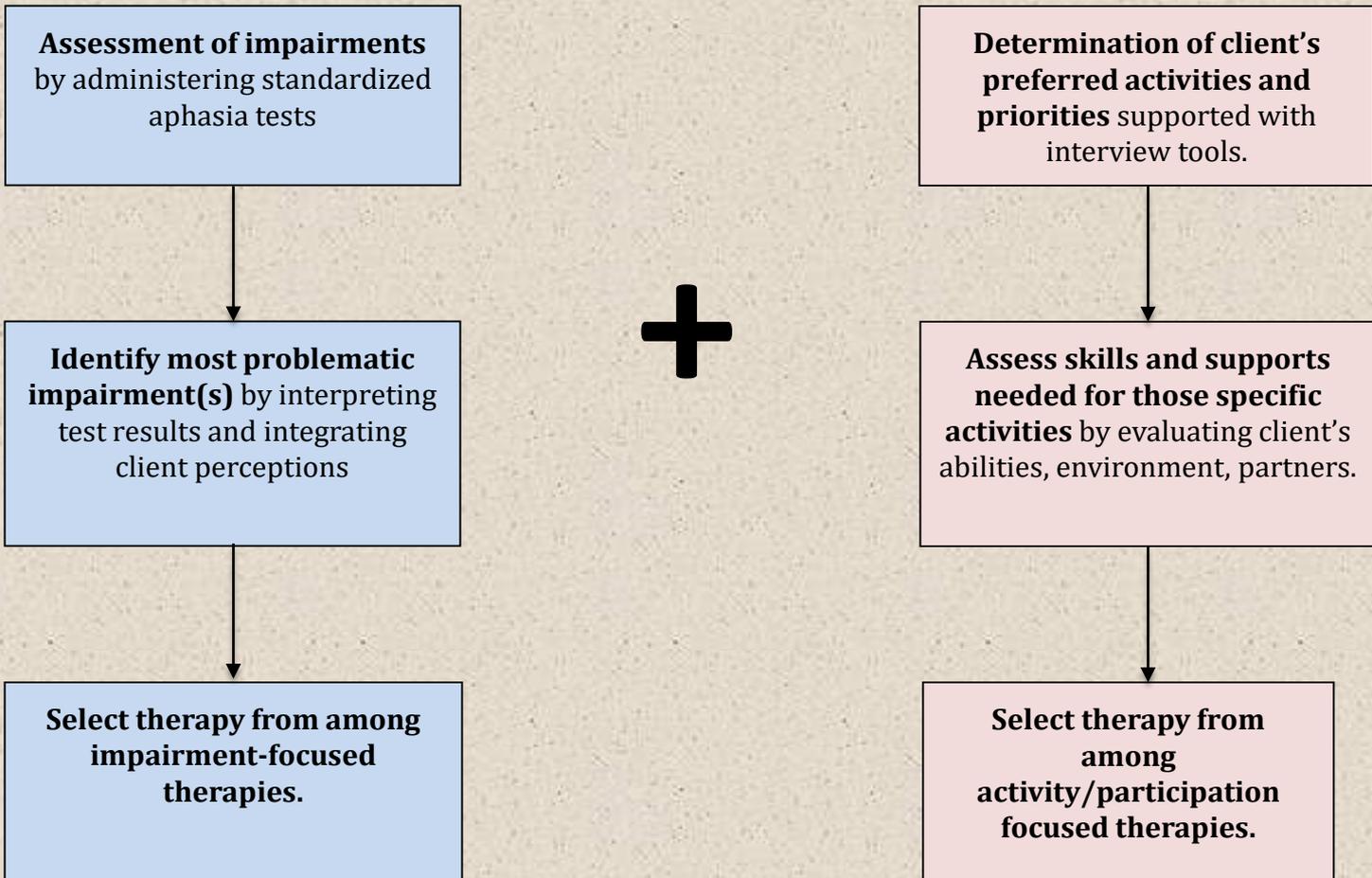# 4. Matching Goals with Evidence-Based Treatments

A Survey of Techniques with Case Examples

Barrows Speech Symposium, 2019

A typical model for selecting treatment

Assessment of impairments by administering standardized aphasia tests

↓

Identify most problematic impairment(s) by interpreting test results and integrating client perceptions

↓

Select therapy from among impairment-focused therapies.

Assessment	Scores/Observations	Assessment	Score
Western Aphasia Battery	Aphasia Quotient = 68 Information Content = 5/10 Fluency = 6/10	Ravens Colored Progressive Matrices	33/36
Comprehension: Yes/No Questions	60/60	Object Recognition subtest of RBMT – immediate and delayed	15/15
Comprehension: Auditory Word Recognition	60/60	Face Recognition subtest of RBMT – immediate and delayed	10/10
Comprehension: Following sequential commands	80/80	WCST	6 categories learned
Repetition	82/100		
Object Naming	21/100		
Word fluency	5/20		
Sentence completion	10/10		
Responsive speech	8/10		
Boston Naming Test	15/60		

An *additive model* to selecting therapy

Assessment of impairments by administering standardized aphasia tests

↓

Identify most problematic impairment(s) by interpreting test results and integrating client perceptions

↓

Select therapy from among impairment-focused therapies.

+

Determination of client's preferred activities and priorities supported with interview tools.

↓

Assess skills and supports needed for those specific activities by evaluating client's abilities, environment, partners.

↓

Select therapy from among activity/participation focused therapies.

15 min

Problem: word-finding

Practice "skill" of word-finding across exemplars

15 min

Problem: Using word-finding skills in daily activities (e.g., conversation)

Practice use of skill in conversation

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- Acquired Apraxia of Speech
- Aphasia
- Autism Spectrum Disorder
- Bilingual Service Delivery
- Caseload/Workload
- Childhood Apraxia of Speech
- Childhood Fluency Disorders
- Classroom Acoustics
- Collaborating With Interpreters, Transliterators, and Translators
- Cultural Competence
- Dementia
- Documentation in Health Care
- Intellectual Disability
- Late Language Emergence
- Pediatric Dysphagia
- Social Communication Disorders
- Speech-Language Pathology Assistants
- Speech Sound Disorders: Articulation and Phonology
- Spoken Language Disorders
- Telepractice
- Traumatic Brain Injury in Adults

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From ASHA's Practice Portal

Impairment-focused	Participation-focused
Computer-Based Therapy targeting various language modalities	Multi-Modal Therapy including: • Augmentative and Alternative Communication • Visual Action Therapy (VAT) • Promoting Aphasics' Communication Effectiveness (PACE) • Oral Reading for Language in Aphasia (ORLA)
Constraint-Induced Language Therapy	Conversation Partner Training** including: • Conversational Coaching • Supported Communication Intervention • Social and Life Participation Effectiveness
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Syntax Therapy including: • Therapy of Underlying Forms* • Verb Network Strengthening Therapy* • Chaining • Sentence Production Program for Aphasia	Script Training
Word-Finding Therapy including: • Word Retrieval Cueing Strategies (Semantic and Cueing Verbs)* • Gestural Facilitation of Naming • Response Elaboration Training • Semantic Feature Analysis	
Writing Therapy	

15 min

Problem: word-finding

Practice "skill" of word-finding across exemplars

↓

Word cueing
Gestural facilitation
RET
Semantic feature

15 min

Problem: Using word-finding skills in daily activities (e.g., conversation)
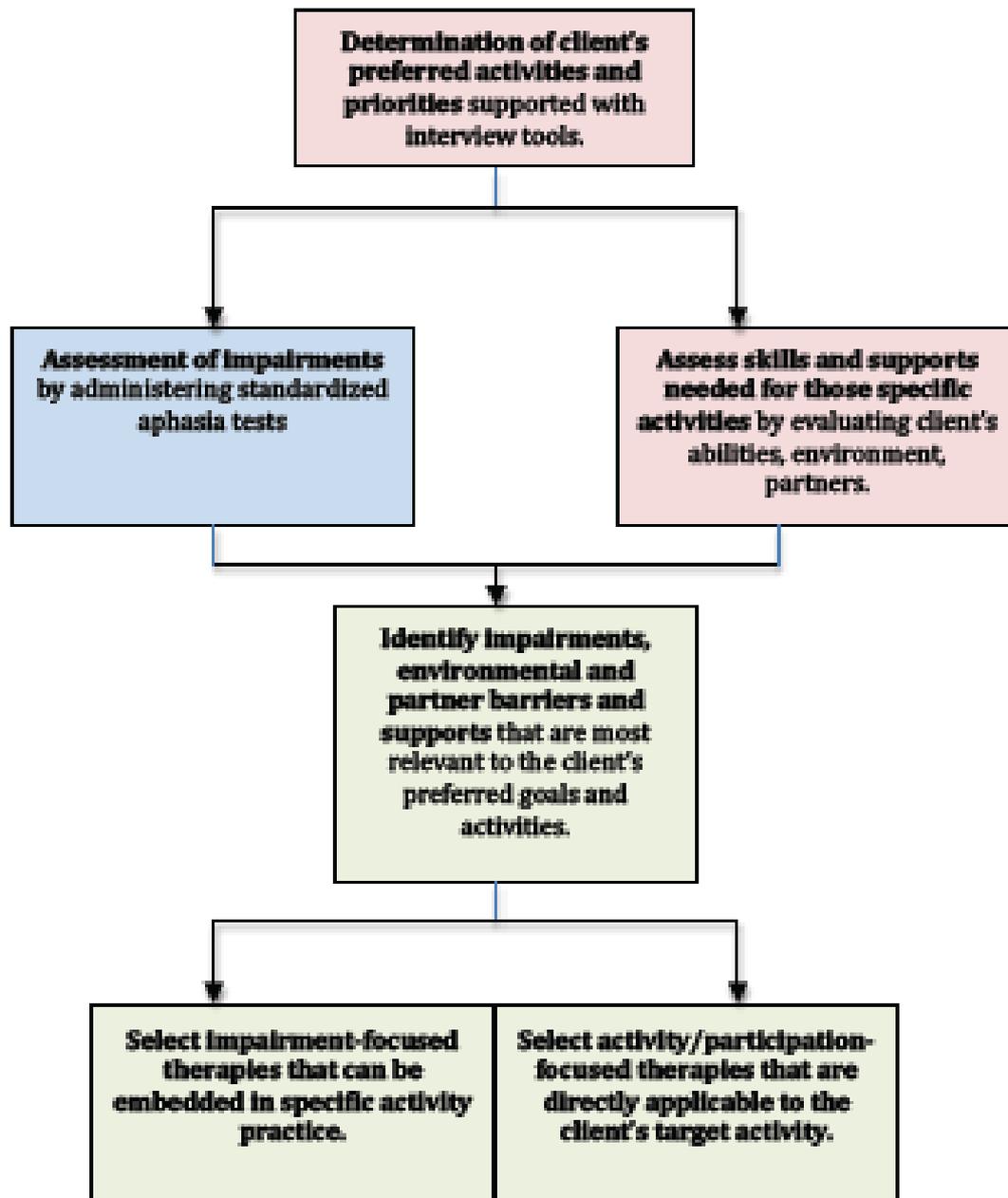
Practice use of skill in conversation

↓

PACE
Conversational coaching
Script training

An additive model

- Allocate some of our time to an impairment-focused therapy

- Allocate the rest of the therapy to an activity/participation-focused therapy, like practicing conversation

- We believe that we are working on the impairment (word-finding) and its generalization or transfer to a target task

```
┌─────────────────────────────┐
│  Determination of client's  │
│  preferred activities and   │
│  priorities supported with  │
│  interview tools.           │
└─────────────────────────────┘
```

```
┌──────────────────────────────┐          ┌──────────────────────────────┐
│  Assessment of impairments   │          │  Assess skills and supports  │
│  by administering standardized│         │  needed for those specific   │
│  aphasia tests               │          │  activities by evaluating     │
│                              │          │  client's abilities,          │
│                              │          │  environment, partners.       │
└──────────────────────────────┘          └──────────────────────────────┘
```

```
┌──────────────────────────────┐
│  Identify impairments,        │
│  environmental and            │
│  partner barriers and         │
│  supports that are most       │
│  relevant to the client's     │
│  preferred goals and          │
│  activities.                  │
└──────────────────────────────┘
```

```
┌──────────────────────────────┬──────────────────────────────┐
│  Select impairment-focused   │  Select activity/participation-│
│  therapies that can be       │  focused therapies that are    │
│  embedded in specific activity│  directly applicable to the   │
│  practice.                   │  client's target activity.    │
└──────────────────────────────┴──────────────────────────────┘
```

Example 1

- Client's priority activity is talking about travel with friends and visitors

- Sample goal: "Client will maintain conversation about selected personal topic for xx minutes using communication supports"

- "with trained/untrained partners"

Compare:

"Client will name travel words with xx% accuracy"

OR

"Client will correctly label travel photos with XX% accuracy"

Example 1

- Client's priority activity is talking about travel with friends and visitors
- Sample goal: "Client will maintain conversation about selected personal topic for xx minutes using communication supports"
- "with trained/untrained partners"

Stroke and Aphasia Quality of Life Scale:

"Did you…do your hobbies less often than you would like?

Now, instead of searching for treatments for **word-finding** (impairment)

…we are searching for treatments that practice ***telling a story*** (activity/participation)

Impairment-focused	Participation-focused
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Writing Therapy	

Response Elaboration Training: Evidence Support

RET is a type of "loose training" which works to improve lexical retrieval and the number of content words produced by an individual with aphasia (Conley & Coelho, 2003). This treatment method focuses on initiation of responses and conversation through the use of forward chaining, or elaboration of the client's responses by the clinician. Kearns (1985) has demonstrated that RET is an effective intervention program for improving verbal production in conversation and for generalization of improved skills across types of aphasia.

Response Elaboration Training: Evidence Support

RET has been found to have positive generalization of responses and stimuli, as well as positive acquisition on the behalf of patients with aphasia (Wambaugh, Martinez, & Alegre, 2001). Conley and Coelho (2003) found that a combination of RET with semantic feature analysis (a more instructive type of lexical retrieval treatment) aided response elaboration as well as word retrieval. Since the participants did not have restrictions to their use of language, it was found that creative utterances facilitated word retrieval through patient-initiated carrier phrases. The result of this combination of treatment methods was found to promote more effective generalization of learned skills.

RET Steps	Clinician's stimulus	Patient's response	Clinician feedback
1. Elicit initial verbal response to picture	Line drawing of simple event (man with a broom) "Tell me what's happening in this picture."	"Man…sweeping"	
2. Reinforce, model, and shape initial response			"Great. The man is sweeping
3. Wh- cue to elicit elaboration of initial response	"Why is he sweeping?"	"Wife…mad!"	
4. Reinforce, model, and shape the two patient responses combined			"Way to go! The man is sweeping the floor because his wife is mad."

1) Second model and request repetition	"Try and say the whole thing after me. Say 'The man is sweeping the floor because his wife is mad.'"	"Man…sweeping…wife…mad."	"Good job!"
2) After reinforcement, elicit delayed initiation of the combined response.	"Now, try to say it one more time."	"The man…sweeping because his wife…mad."	

Promoting Aphasics' Communicative Effectiveness (PACE) (Davis & Wilcox, 1985; Davis, 2005, 2007)

Overview: A conversational treatment in which any modality can be used to communicate ideas from one partner to the other. The client and clinician take equal turns in the sender and receiver roles, and this promotes conversational participation.

Candidacy: Procedures can be adapted to specific linguistic impairments, thus people with a variety of types and severities of aphasia can benefit from this treatment.

Goals and Expected Outcomes: Use appropriate communication modalities (speaking, writing, drawing, gesturing, communication notebook or other AAC strategies) to effectively participate as sender and receiver.

The 4 principles and procedures of PACE - 1

1. The clinician and patient exchange new information.

2. The clinician and patient participate equally as senders and receivers of messages.

1. Instead of having a picture of an object or event (called the message) in simultaneous view of the clinician and patient, a stack of message stimuli is placed face down to keep messages from the view of a message receiver. A client selects a card and attempts to convey the message on the card.

2. The clinician and client simply alternate in drawing a card and sending messages.

The 4 principles and procedures of PACE - 2

3. The patient has a free choice as to the communicative modes used to convey a message.

4. The clinician's feedback as a receiver is based on the patient's success in conveying the message.

3. The patient is left to choose the mode that is used for any message. The patient has a free choice as to the communicative modes used to convey a message.

4. Our feedback should let the client know if he or she got the idea across.

PACE: Goals and measures

- Frequency of successfully communicated message
- Number of attempts prior to success/% of attempts with x number of attempts or fewer
- Improved efficiency measured by total time required for each attempt (averaged); can be reported as % faster
- Frequency/% of attempts using a particular strategy

PACE rating scale

5 – message conveyed at first attempt

4 – message conveyed after general feedback from the clinician

3 – message conveyed after specific feedback from the clinician

2 – message partially conveyed

1 – message not conveyed

0 – no attempt to convey message

Davis, G. (1980). A critical look at PACE therapy. In Brookshire, R. (ed), *Clinical Aphasiology Conference Proceedings.* Minneapolis: BRK Publishers.

Edelman, G. (1987). *P.A.C.E.: Promoting Aphasics' Communicative Effectiveness.* Oxon, UK: Winslow Press.

Conversational Coaching: Overview

Conversational coaching is a method for training the individual with aphasia to use effective communication strategies – such as gesture, drawing, or writing – similar to PACE. However, in conversational coaching the training also includes the primary communication partner, such as a spouse or other family member. The clinician serves in the role of coach to both parties.

Effective communication strategies for both the person with aphasia and the primary communication partner are targeted. The clinician acts as a communication strategy coach for both partners (with and without aphasia). The primary communication partner plays an equal role in improving conversation.

(Holland, Hopper & Rewega, 2002)

Conversational Coaching: Candidacy

- **Candidacy**: Effective for a variety of types and severities of aphasia. Best outcome will be achieved when there is a primary communication partner who is willing and able to learn and maintain communication strategies.

- **Goals & Expected Outcomes**: The desired outcome is the implementation of effective communication strategies in conversation by both the person with aphasia and the primary communication partner.

Conversational Coaching: Steps 1-2

Step 1. Determine a hierarchical list of strategies for each partner. This should be based on the needs of the person with aphasia and what will work within that dyad.

Examples of strategies could include: drawing or writing to aid expression; drawing or writing to aid comprehension; longer pauses; slower speech rate; learning a gesture to request more time

Step 2. The clinician presents a short narrative or story to one member of the dyad while the other is out of the room. This could be a short video clip (e.g., *America's Funniest Videos*)

Conversational Coaching: Steps 3-4

Step 3. The other partner comes into the room. The first partner explains the clip or story to the second partner using the targeted strategies.

> The clinician should direct each member to their strategies as needed, or coach one member or the other on more effective ways to achieve success while they are engaged in this transaction. Positive feedback should also be provided.

Step 4. This can be repeated as needed to master strategy use and practice in a variety of contexts.

Supported Conversation for Aphasia™ (SCA)

www.aphasia.ca

Supported conversation for adults with aphasia based on the idea that reduced ability and opportunity to engage in conversation affects the way that adults with aphasia are perceived. The less opportunity there is to engage in genuine conversation the less opportunity there is to reveal competence.

(*Kagan et al., 1995)*

Supported Conversation for Adults with Aphasia (SCA™): Two principles

Acknowledge Competence

Techniques to help PWA **feel competent**

Reveal Competence

Techniques to **give** and **receive accurate information** from PWA

Example 2

Barrows Speech Symposium, 2019

From the

PALPA

(Kay, Lesser &

Coltheart, 1992)

Spoken Word-Picture Matching = 100%
Written Word-Picture Matching = 85%
Written picture naming = 0
 Spoken picture naming = 72%
CADL-2) = 17%

(Holland, 1999)

Determine client's preferred activities and priorities
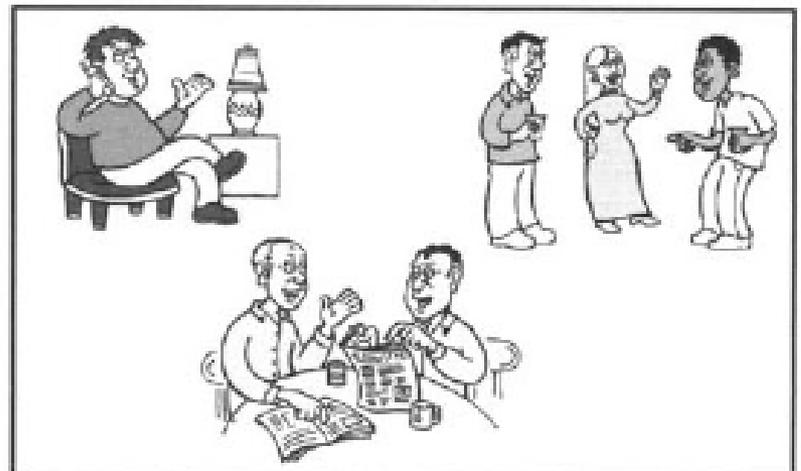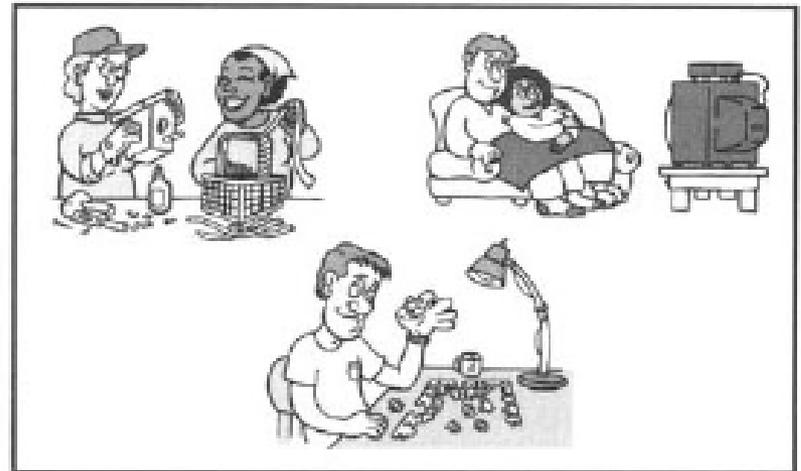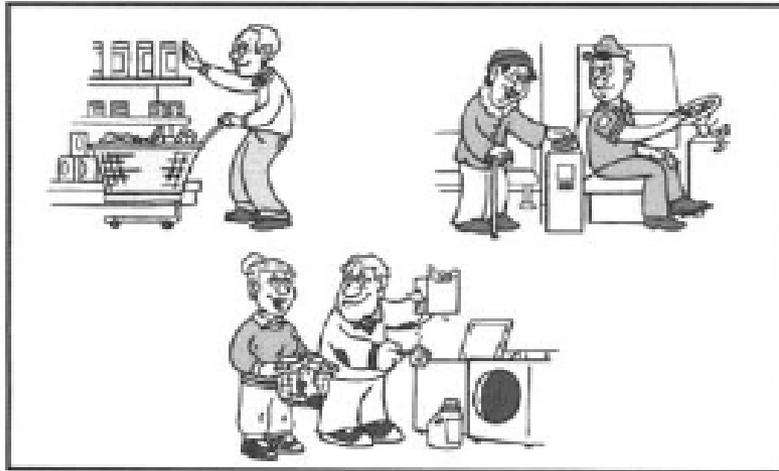
Example Activity Goals:

1. Order supplies for farm
2. Order at restaurant
3. Have dinner conversation with wife

Impairment-focused	Participation-focused
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Writing Therapy ←	

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Example: Catalog ordering

Clinician	Client Response	Cueing/Comments
1. Thank you for calling. May I help you?		
2. What is the number above the name on the back of the catalog?		
3. What is your home phone number starting with the area code?		
4. What is your last name and the spelling, please?		
5. What is your first name and the spelling?		

Catalog-ordering - potential measurements

- Response latency – time to respond
- Accuracy – communicative effectiveness
  - Scoring system (adapted from CADL-2)
    - 2 = fully communicative response
    - 1 = some errors
    - 0 = completely inaccurate/ineffective
- Total time/total duration of task

Semantic feature analysis

Semantic Feature Analysis (SFA) builds on the interconnections of semantic features and knowledge, and provides an elaborated network of cues that can strengthen association with the targeted items. SFA has been shown to be successful in patients with aphasia who have a semantic impairment. This could be patients with fluent-type aphasias, but some patients with nonfluent-type aphasias also benefit.
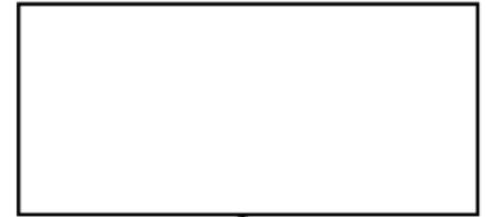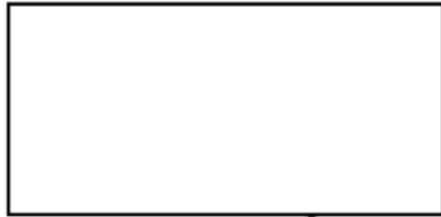
(Boyle & Coelho, 1995; Boyle, 2004)

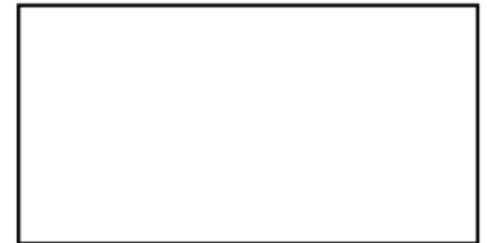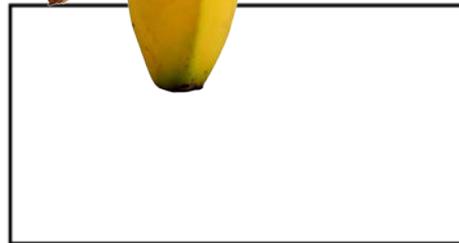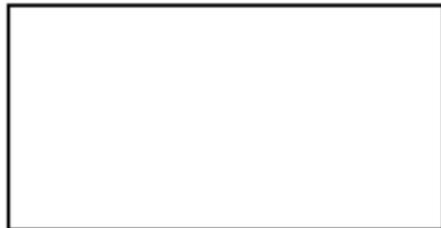| SFA Steps	Clinician's stimulus	Patient's response	Clinician feedback
1) Elicit initial verbal response to picture	Picture of target item is presented. "Can you name this item?"	Patient either successfully or unsuccessfully names target.	Positive feedback for correct production.
2) Elicit and complete semantic feature chart.	"What group [or category] is this in?" "What do you use it for?" etc.	Clinician writes patient's responses in appropriate boxes. More than one response can be entered into each box.	

GROUP

USE

ACTION

PROPERTIES

ASSOCIATION

1) Provide model for items that are not produced.		Patient is unable to come up with the use of the target.	"You can use it to eat with." Clinician writes "eat" in appropriate box.
2) Elicit production of target.	After all the boxes are completed, ask the patient to name the target picture.	Patient names target.	"Great! Let's try the next one."
3)		Patient cannot name target.	Clinician provides target and asks patient to repeat target word.

Script training

Script training is reminiscent of "dialogue training" in foreign language learning. A specific dialogue or script is trained. This is based on theoretical and conceptual models in which scripts run automatically as part of how we respond to particular contexts. A script can be a prayer, an explanation about the client's stroke and aphasia, a description about a special interest – but in all cases it should be something that will be very important to the person with aphasia, and something that can be used across a variety of social contexts or occasions. Script training is effective and has been associated with transfer and generalization of phrases learned within a particular script to other contexts.

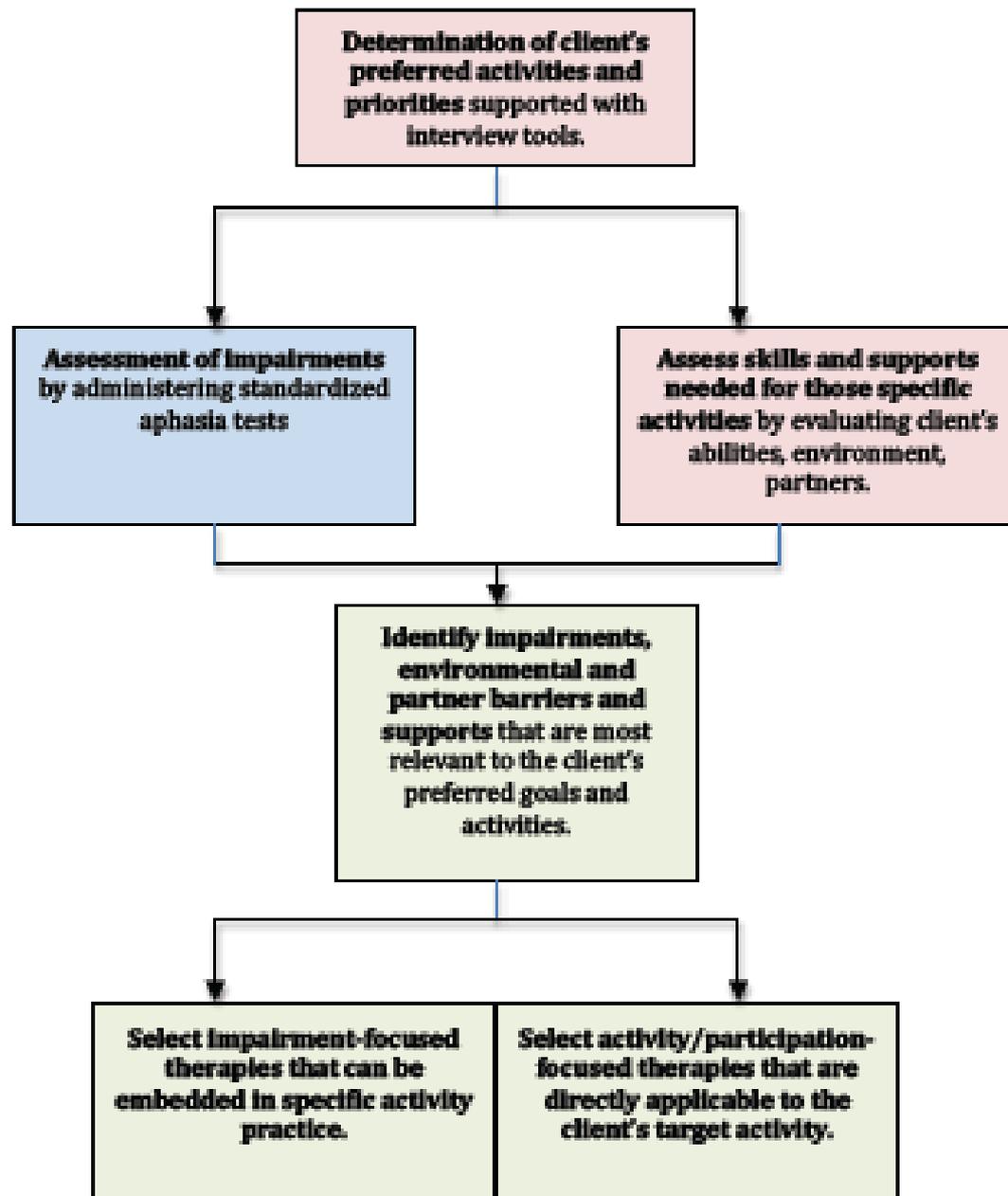|	
Step 1. Select topic and draft target script.	The client selects the topic for the script, with collaboration from the clinician. The clinician and client work collaboratively to produce target script.
Step 2. Begin training – phrase repetition, choral reading with clinician, independent training.	Client practices first phrase. When client can produce phrase accurately 20 consecutive times, add next phrase. Continue.
Step 3. Client practices independently for at least 15 minutes per day.	Client can be given audiotapes or other assists for independent practice.
Step 4. Practice using script in appropriate social situations.	These should be facilitated initially by the clinician.

TABLE 1. Script themes in monologues.

Script theme	No. of monologues
Stories from life	19
Story of my stroke	12
Introducing me to others	3
Prestroke story	3
Retelling an impersonal story or event	1
Prayers, testimonials, speeches, and lectures	6
Outside interests	2
Making plans	1
Total	28

TABLE 2. Script themes in dialogues.

Script theme	PWA-R	PWA-I	Total
Conversations with family	4	11	15
Seeking or providing information			13
About strangers		3	
About family	1		
From salespeople	2	3	
Asking/answering questions	2	2	
Outside interests	6	4	10
Ordering in a restaurant	7	1	8
Phoning	5	3	8
Conversations with others	3	4	7
Stories from life			5
Present life	1	2	
Prestroke		1	
Retelling an impersonal story or event		1	
Work talk		4	4
Making plans	1	1	2
Total	32	40	72

Note. PWA-R = person with aphasia as the respondent of the dialogue; PWA-I = person with aphasia as the initiator of the dialogue.

Determination of client's preferred activities and priorities supported with interview tools.

Assessment of impairments by administering standardized aphasia tests

Assess skills and supports needed for those specific activities by evaluating client's abilities, environment, partners.

Identify impairments, environmental and partner barriers and supports that are most relevant to the client's preferred goals and activities.

Select impairment-focused therapies that can be embedded in specific activity practice.

Select activity/participation-focused therapies that are directly applicable to the client's target activity.

4. The Client's Future, Part 1

What Families Really Need to Know

What do family members need or want from rehabilitation?

- Seven categories of family members' goals
- Interviews of 48 families

Howe, T., Davidson, B., Worrall, L., Hersh, D., Ferguson, A., Sherratt, S., & Gilbert, J. (2012). 'You needed to rehab … families as well': family members' own goals for aphasia rehabilitation. International Journal of Language & Communication Disorders, no-no. doi: 10.1111/j.1460-6984.2012.00159.x

Family members should be included in rehabilitation

- Also one of the 10 international best practices for aphasia rehabilitation (www.aphasiaunited.org)
- Family members want to know how to:
  – Best help the person with aphasia
  – How to cope, during and after therapy ends

How can we do this?

- Provide structure at the beginning
  - E.g., "here's how we'll be working together"
- Meet cultural needs
- Active Listening
  - Listen carefully to what families need
- Education
  - Understanding the disorder
- Skills training
  - Specific communication skill/strategy use
- Support for community integration

Clinical Situation	Potential Communication Partners to be Trained	Goals and Approach
Limited Contact Time (1-2 visits), Individual Sessions	Person who will spend most time with the person with aphasia (family member, caregiver, nurse)	- Provide information about the nature of aphasia and importance of communication - Identify and practice one strategy that will be most effective for that person with aphasia - Provide information about local and national resources for aphasia
Minimum of 5 visits (or more), Individual Sessions	Members of primary social circle (caregivers in living situation, family members)	All of the above, and add: More in-depth partner training, such as Conversational Coaching, Supported Conversation for Aphasia, SPPARC
Group Programs (1-2 day training workshops)	Primary communication partners (family members, friends)	- Information about aphasia - Examples of strategies - Counseling, discussion groups, support groups - Positive experiences doing enjoyable leisure activities

Hinckley, Douglas, Goff & Nakano, 2013.

Family members want to be provided with hope and positivity

- Hope is
  - An inner state
  - An active cognitive process in which current state and future goals are analyzed
  - Can be an outcome-linked process
- Outcomes of hope
  - Improved perseverance
  - Improved coping
  - Increased participation in life

A clinical framework for hope

(Bright et al, 2013)

- Everyone experiences hope differently
- Hope is not something you "give" to someone
- It's important to ask and understand what will give each person hope
- Specific interventions that facilitate hope include
  - Listening to a client's "hope story" – "What would help you look to the future with positivity?"
  - Exploring future selves
  - Storying alternative futures (Hinckley, 2008)
- Hopeful language (Hopper & Edey, 2007).

Family members want to maintain their role with the person with aphasia

- Consider these examples
  - Training the caregiver to provide certain kinds of therapeutic cues?
  - Asking the caregiver to complete homework or workbook type sheets?
  - Planning times for effective conversation?

Family members need information

Example:

http://aphasiacorner.com/aphasia-simulations/

Family members need support and to take care of themselves

– Facilitate participation in caregiver support groups

– Consider national resources, such as:

  - National Stroke Association
  - American Stroke Association
  - AARP
  - Well Spouse Foundation
  - National Caregiving Alliance

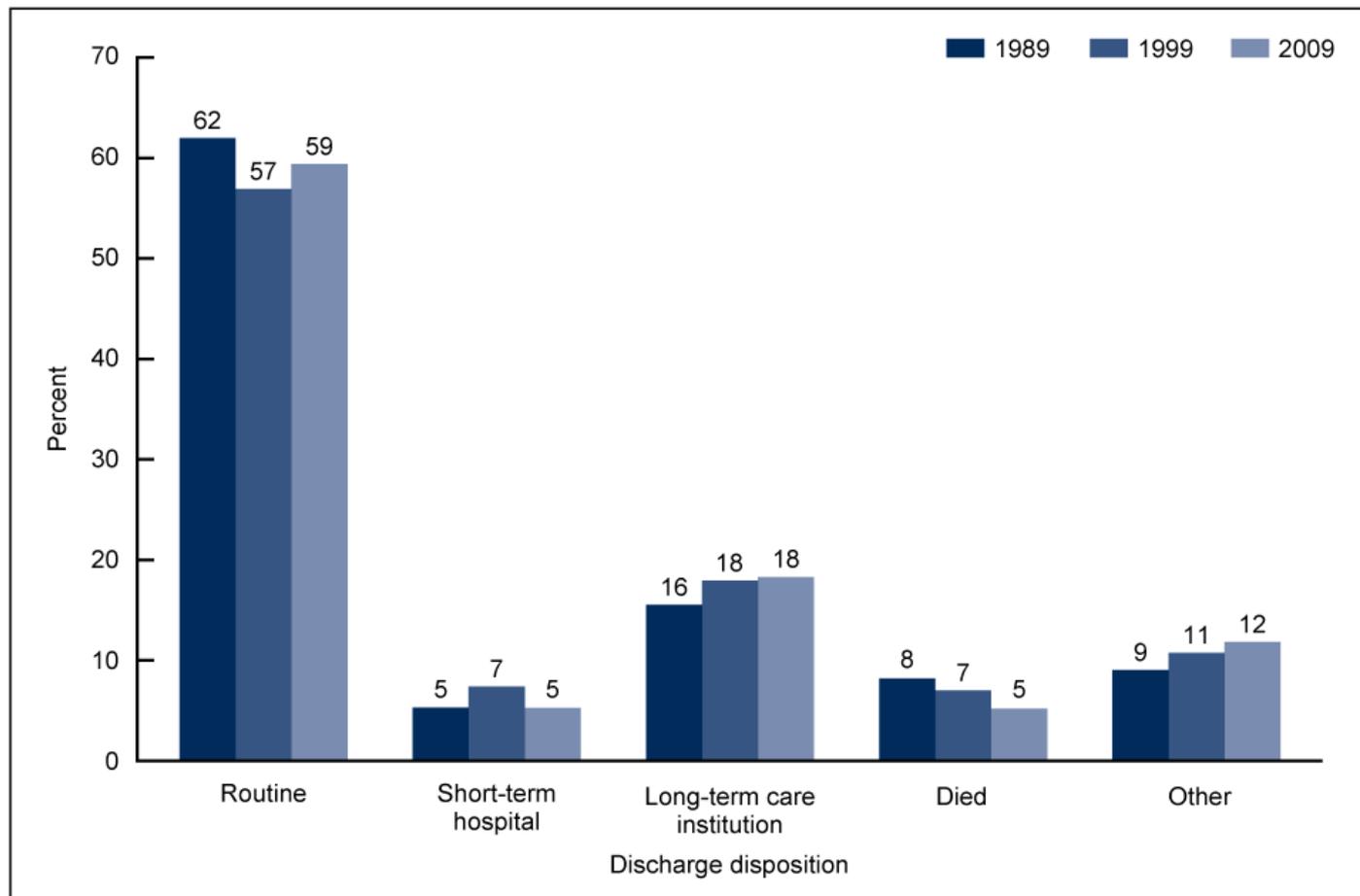Cell phone
Airplane
Vacuum cleaner
Facebook
Email
Digital camera

5. The Client's Future, Part 2

A Day in Your Client's Life

What happens to people living with traumatic aphasia (stroke or TBI)?

Figure 4. Discharge disposition of stroke patients: United States, 1989, 1999, and 2009

SOURCE: CDC/NCHS, National Hospital Discharge Survey, 1989, 1999, and 2009

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Of the ~60% who go home:

- Most will spend most of their time, after therapy discharge, watching TV.
- Most will only go out of the home 1-2x weekly
- Most will visit with someone outside the immediate caregiver 1x/week
- Most will lose their friends
- Many will experience depression and other health risks or concerns due to social isolation

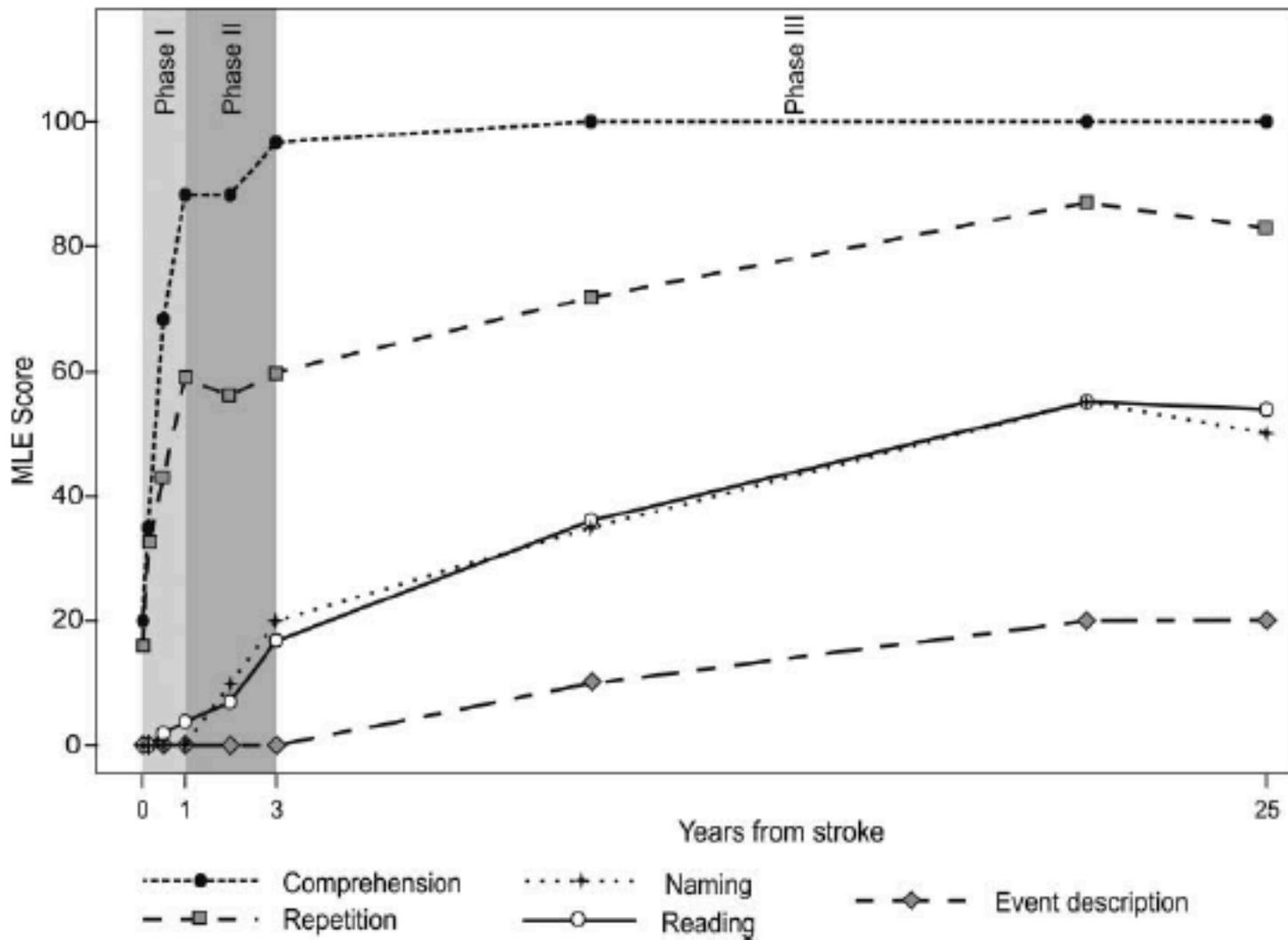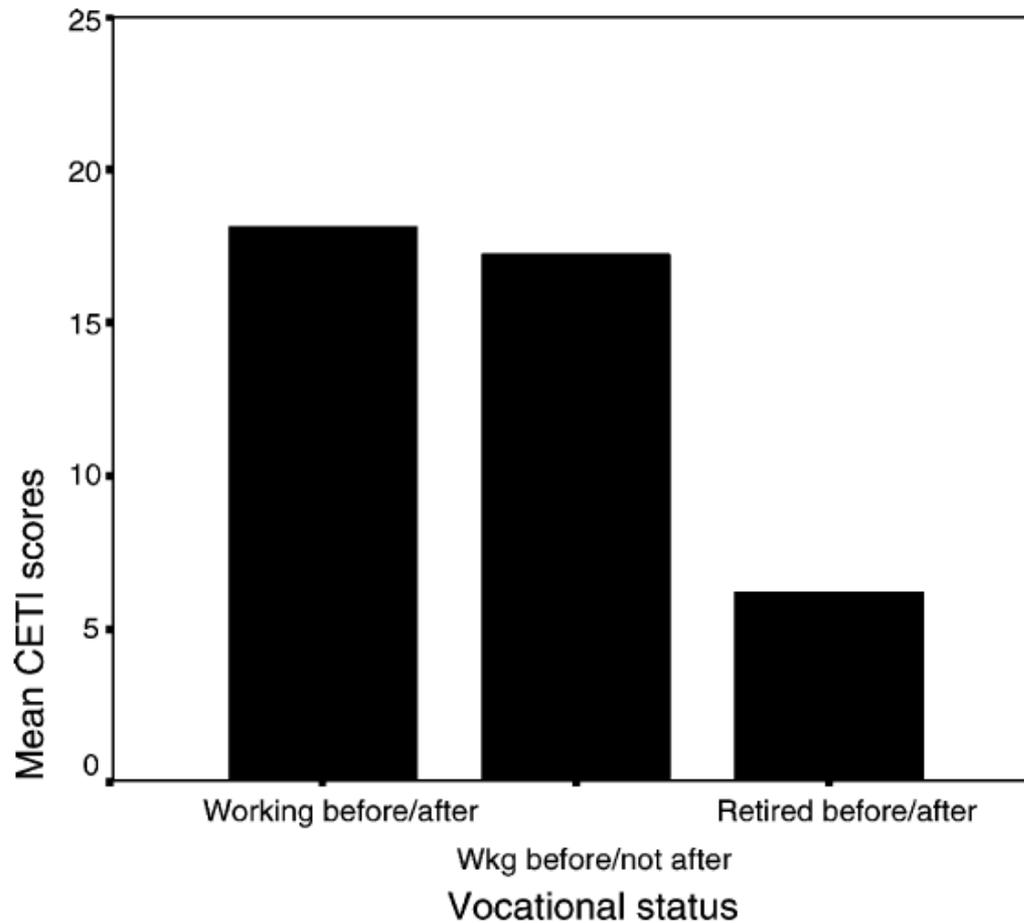(Hinckley & Holland, 2015)
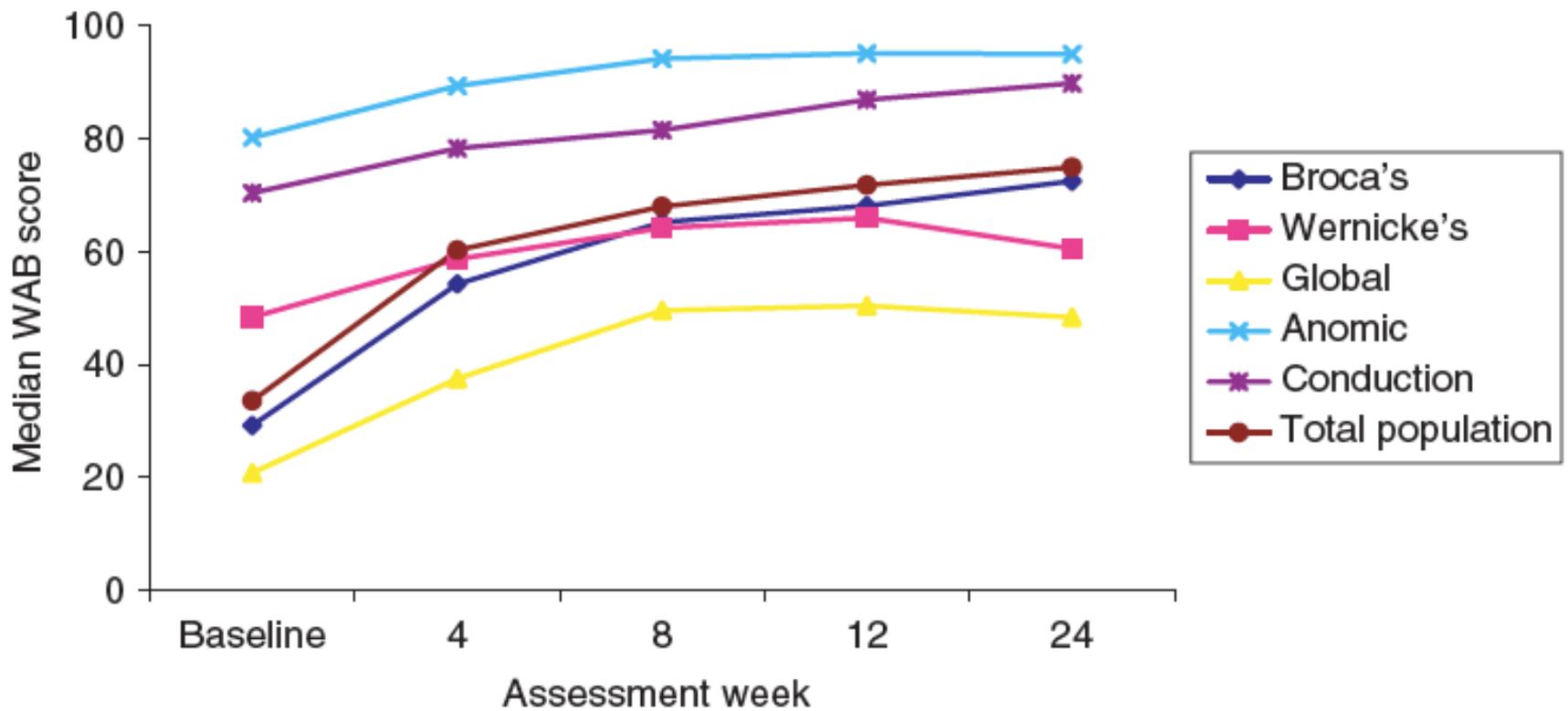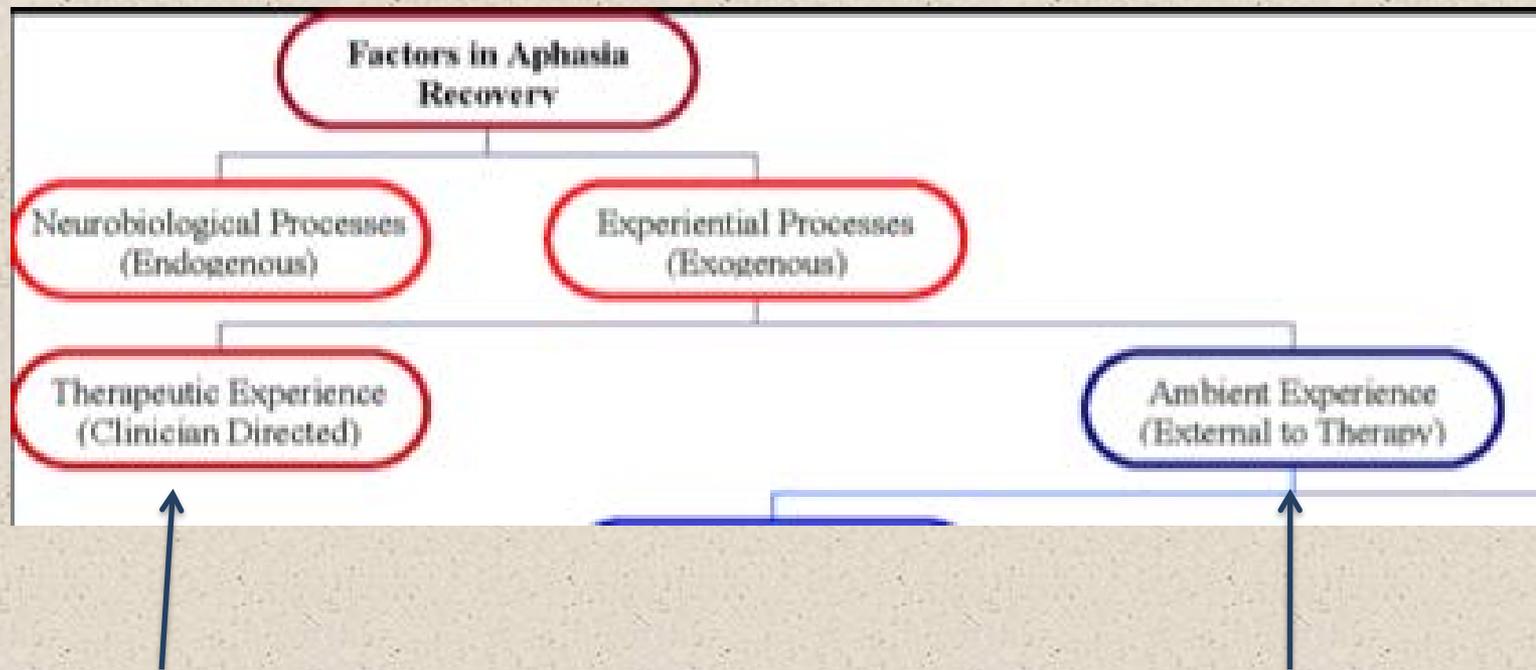
Bakheit et al, 2007; p. 946

Figure 2. Time course of recovery of language function over 25 years. MLE indicates Milan Language Examination

Smania et al, 2010

Change on CETI scores 3 years after therapy discharge

Fig. 1. *CETI* change scores for the respondents based on vocational status at follow-up.

What accounts for long-term change?

(McClung, Gonzalez-Rothi, & Nadeau, 2010)

Kleim & Jones, 2008 (JSLHR)

Table 1. Principles of experience-dependent plasticity.

Principle	Description
1. Use It or Lose It	Failure to drive specific brain functions can lead to functional degradation.
2. Use It and Improve It	Training that drives a specific brain function can lead to an enhancement of that function.
3. Specificity	The nature of the training experience dictates the nature of the plasticity.
4. Repetition Matters	Induction of plasticity requires sufficient repetition.
5. Intensity Matters	Induction of plasticity requires sufficient training intensity.
6. Time Matters	Different forms of plasticity occur at different times during training.
7. Salience Matters	The training experience must be sufficiently salient to induce plasticity.
8. Age Matters	Training-induced plasticity occurs more readily in younger brains.
9. Transference	Plasticity in response to one training experience can enhance the acquisition of similar behaviors.
10. Interference	Plasticity in response to one experience can interfere with the acquisition of other behaviors.

Improvements can continue over many years.

- For those with traumatic aphasia, ***continued improvement*** is to be expected if the person ***stays active and socially connected***.

- For those with degenerative conditions, ***maintenance*** of ability for longer than anticipated is to be expected if the person ***stays active and socially connected***.

What does this mean – in acute care? - 1

- All patients with stroke should receive a formal screening for possible language and cognitive impairments

- Best efforts should be made to educate the family. Provide written materials that can be referred to later.

- Best efforts should be made to train other health care staff, including nurses, nursing assistants, doctors, other therapists, social workers, on how to communicate with people with aphasia.

What does this mean – in acute care? - 2

- If you are in a position to provide short-term therapy in acute care:
  - Be sure to assess reading and writing skills; our patients are being asked to sign forms of all kinds!
  - One of the best things you can do for aphasia in the acute care setting is to help the patient understand what is going on and how to manage.
    - Besides asking for the toilet or using the call button, consider
      - Understanding medications
      - Understanding the stroke
      - "Mediating" or coaching other staff to communicate with patient
      - Making sure the patient and family understand that they have a diagnosis called "aphasia" – so they can find other resources in their future.

What does this mean – in inpatient/outpatient rehab? - 1

- Ask "what is this person going to be able to do after therapy discharge?"
  - Make sure the answer is a specific activity, not just a generality like "name words better"
  - Order their own food? Request preferred activities/games?
- Ask the patient how they spent their time before. Work collaboratively to identify at least one activity that you can work towards in therapy.

What does this mean – in inpatient/outpatient rehab? - 2

- Remember the best practice guideline: "No one with aphasia should be discharged without a means to communicate"

- Spending your therapy time, especially when limited, on the communication skills needed for one specific activity will be better spent than trying to target an entire language "domain" (e.g., "word-finding", "spelling", etc.) (Hinckley & Carr, 2005)

What does this mean – in SNFs? - 1

- Focus on one (or more) activities that the person will actually do on a daily basis after therapy.
  - Ordering alternative food items?
  - Requesting puzzles or particular activities that can not be accessed independently?
  - Use therapy time to help create a pasttime that the person will be able to continue to do after therapy (perhaps as functional maintenance?)
    - Labeling family photos in album, following an audiobook, keeping scrapbook of interesting magazine articles

What can you do during therapy to improve the "ambient experience" after therapy?

- Focus in on future social interactions.
  - Use therapy time to make connections between patients that can be maintained after therapy ends
  - Emphasize and prioritize family training (e.g., communication coaching) to improve family communication after therapy ends
  - Connect your patient to others who are living with similar challenges

Reducing social isolation and increasing social interaction...

- ...reduces the risk of depression

- ...helps your therapy generalize and the results of your therapy be used!

- ....improves the general health and wellness of the individual

- ...improves the sense of self-efficacy and confidence of the individual, so that they continue **to try**.

A person-centered approach

- ***Explicitly incorporate*** the priorities and preferences of our clients into each step of the clinical process
- ***Resist the urge*** to let other factors determine our therapeutic actions

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