Context-Based Approaches to Person-Centered Person-Centered Aphasia Therapy

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Early Morning Outline

- Introduction to person-centered treatment
- Compare and contrast person-centered treatments and more standard, evidence-based approaches
- Review of 3 key components to person-centered care
- Small group exercise, person centered measurement
- Small group feedback, person centered measurement
- Relationship between person-centered care and evidence-based practice

Person-Centered Care: Introduction

- Person-Centered Care Introduction
  - Cancer Care Ontario
  - https://www.cancercare.on.ca

Person-Centered Treatment: A History

- Florence Nightingale, "who differentiated nursing from medicine by its focus on the patient rather than the disease"
- Balint (1960)
  - Emphasis on understanding persons and their unique circumstances as a way of providing care
- Lipkin, Quill, and Napodano (1984),
  - An interview should be conducted in a way that allows the person to share his or her unique story promoting trust and confidence, clarifying symptoms and concerns, generating and testing hypotheses that may include biological and psychosocial dimensions of illness, and creating a foundation of genuine trust for an ongoing relationship

Morgan, S. & Yoder, L.H. (2012). A concept analysis of person-centered care. *Journal of Holistic Nursing, 30* (1), 6-15.

Person-Centered Treatment: A History (cont.)

- Stewart (1995)
  - Exploring the experience of the illness
  - Understanding the person as a whole
  - Agreeing to the plan for health care management, including prevention and promotion of health
  - Focusing on the doctor–patient relationship
  - Being realistic about personal limitations

Person-Centered Treatment: A History (cont.)

- Picker-Commonwealth Program for Person-Centered Care (1998)

1. Respect for persons' values, preferences, and expressed needs
2. Coordination and integration of care
3. Information, communication, and education
4. Physical comfort
5. Emotional support and alleviation of fear and anxiety;
6. Involvement of friends and family
7. Transition and continuity (Beach, Saha, & Cooper, 2006)

Person-Centered Treatment: A History (cont.)

- Mead & Bower (2002)
  1. Biopsychosocial perspective
  2. Patient as person
  3. Shared power and responsibility
  4. Therapeutic alliance
  5. Doctor as person

Person-Centered Treatment: A History (cont.)

- IOM (2001) defined PCC as "care that is respectful and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions" (p. 49)
- McCormack (2003) defined PCC as "the formation of a therapeutic narrative between professional and patient that is built on mutual trust, understanding and a sharing of collective knowledge" (p. 203)
- Suhonen, Välimäki, and Leino-Kilpi (2002) defined PCC as being comprehensive care that meets each patient's physical, psychological, and social needs

3 Components to Person-Centered Care

1. Person participation and involvement
2. The relationship between the patient and the healthcare professional
3. The context where care is delivered

Kitson, A., Marshall, A., Bassett, K., & Zetiz, K. (2012). What are the core elements of patient-centered care? A narrative review and synthesis of the literature from health policy, medicine and nursing. *Journal of Advanced Nursing, 69* (1), 4-15.

Person Participation & Involvement

- Person participating as a respected and autonomous individual
  - Respect for patient's values, preferences, and expressed needs
  - Person as a source of control
  - Person actively involved and participating
  - Autonomy
- Care plan based on person's individual needs
  - Care customized according to patient needs and values
  - Transition and continuity

Person Participation & Involvement (cont.)

- Addressing a person's physical and emotional needs
  - Physical comfort and care
  - Emotional support
  - Alleviation of anxiety

Relationship between the Person & the Health Professional

- Genuine clinician-person relationship
  - Care based on a continuous healing relationship
- Open communication of knowledge, personal expertise, and clinical expertise between the person and the professional
  - Knowledge shared and information flows freely
  - Information, communication and education
  - Feedback mechanisms to measure patient experience

Relationship between the Person & the Health Professional (cont.)

- Health professionals have appropriate skills and knowledge
  - Skill and competency
  - Attributes of the patient-centered professional
- A cohesive and cooperative team of professionals
  - Cooperation amongst clinicians is a priority
  - Differences in perceptions of role between doctors, nurses, and patients

The Context Where Care is Delivered

- System issues
  - Policy/practice continuum/language used
  - Access
  - Barriers
  - Supportive organizational environment
  - Therapeutic environment

Evidence-Based Practice: Brief Background

- The conscientious, explicit and judicious use of current best evidence, primarily from clinical trials, in making decisions about the care of individual patients in the combination with clinical expertise and the needs and wishes of patients
- Standardization of medical care though clinical guidelines, protocols or best practices

Sackett, D.L. et al. (1996). Evidence-based medicine: What it is and what it isn't. *British Medical Journal, 312*, (7023), 71-72.

Hasnain-Wynia, R. (2006). Is evidence-based medicine patient-centered and is patient-centered care evidence-based? *Health Services Research, 41* (1), 1-8.

Evidence-Based Practice: Brief Background (cont.)

- Positivistic
- Biomedical
- Disease oriented
- Gold standard is Randomized-controlled trials
  - Patient characteristics are considered a nuisance that might disturb the results of the study
  - Artificially constructed by excluding many people
- Doctor or Healthcare Professional centered

Bensing, J. (2000). Bridging the gap. The separate worlds of evidence-based medicine and patient-centered medicine. *Patient Education & Counseling, 39*, 17-25.

Evidence-Based Practice: Brief Background (cont.)

- Evidence fills the doctor or healthcare professional's agenda with knowledge that is tapped from scientific research on populations
  - Groups of people with the same clinical condition
- Goal is safer, more consistent, more cost effective care

Greenhalgh, T. et al. (2014). Evidence-based medicine: A movement in crisis? *British Medical Journal, 348*, doi: 10.1136/bmj.g3725

Compare Person-Centered/Evidence-Based Approaches

- Good
- Important
- Valuable
- Something to strive for

Contrast Person-Centered/Evidence-Based Approaches

- Standard approaches based on a population
- Person-centered approaches based on the individual
- Standard approaches are disease focused
- Person-centered approaches are strengths focused

Compare/Contrast Person-Centered/Evidence-Based Approaches

- Compare and contrast person-centered/evidence-based approaches
  - www.menti.com
  - Enter code 68 51 92

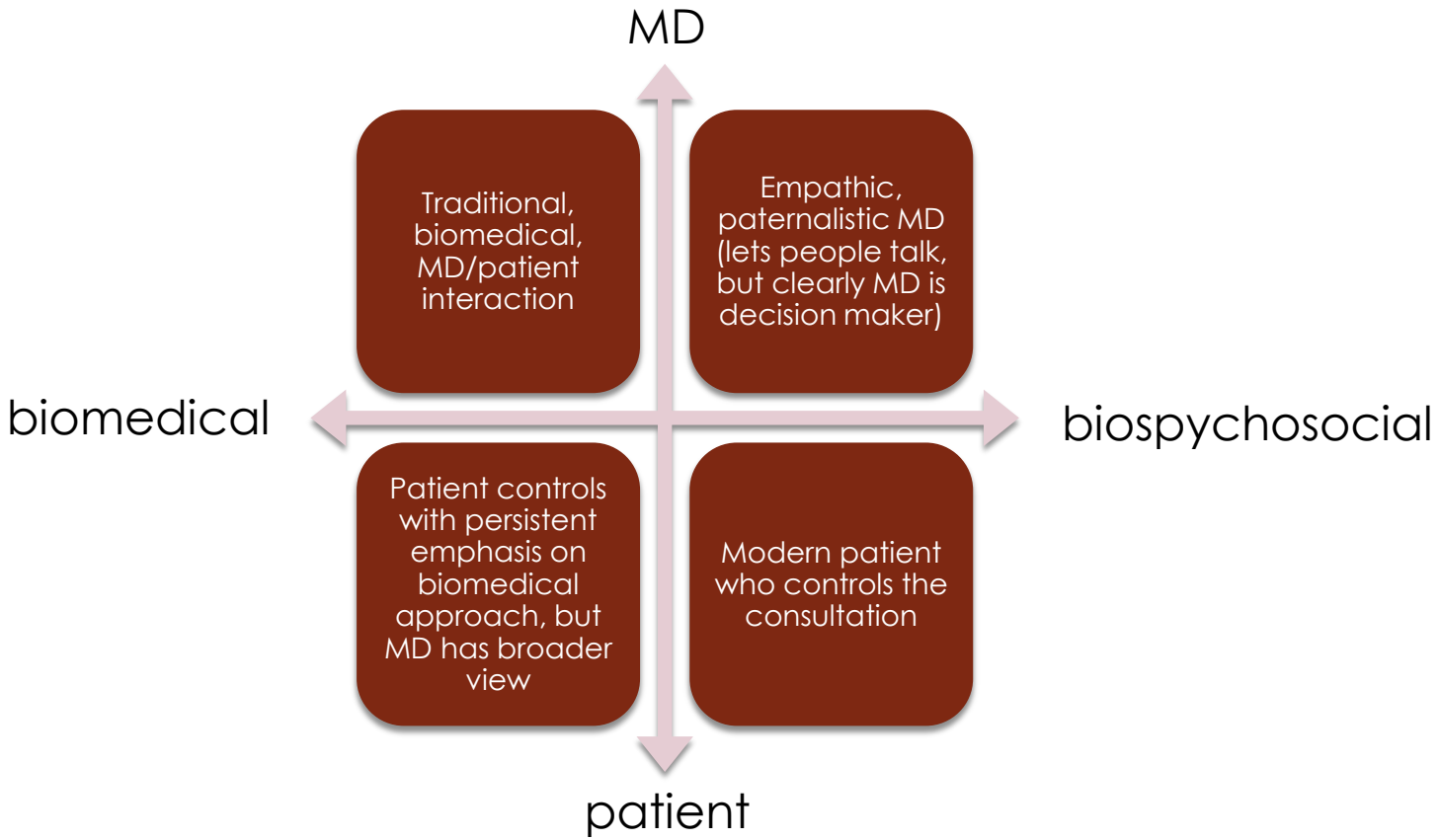
Small Group Exercise: Person Centered Measurement

- Dynamic tools to measure health outcomes from the client perspective
- Patient Reported Outcomes Measurement Information System (PROMIS®) is a system of highly reliable, precise measures of client–reported health status for physical, mental, and social well–being
- PROMIS® tools measure what clients are able to do and how they feel by asking questions
- http://www.healthmeasures.net/explore-measurement-systems/neuro-qol

Small Group Exercise: Person-Centered Measurement, Feedback

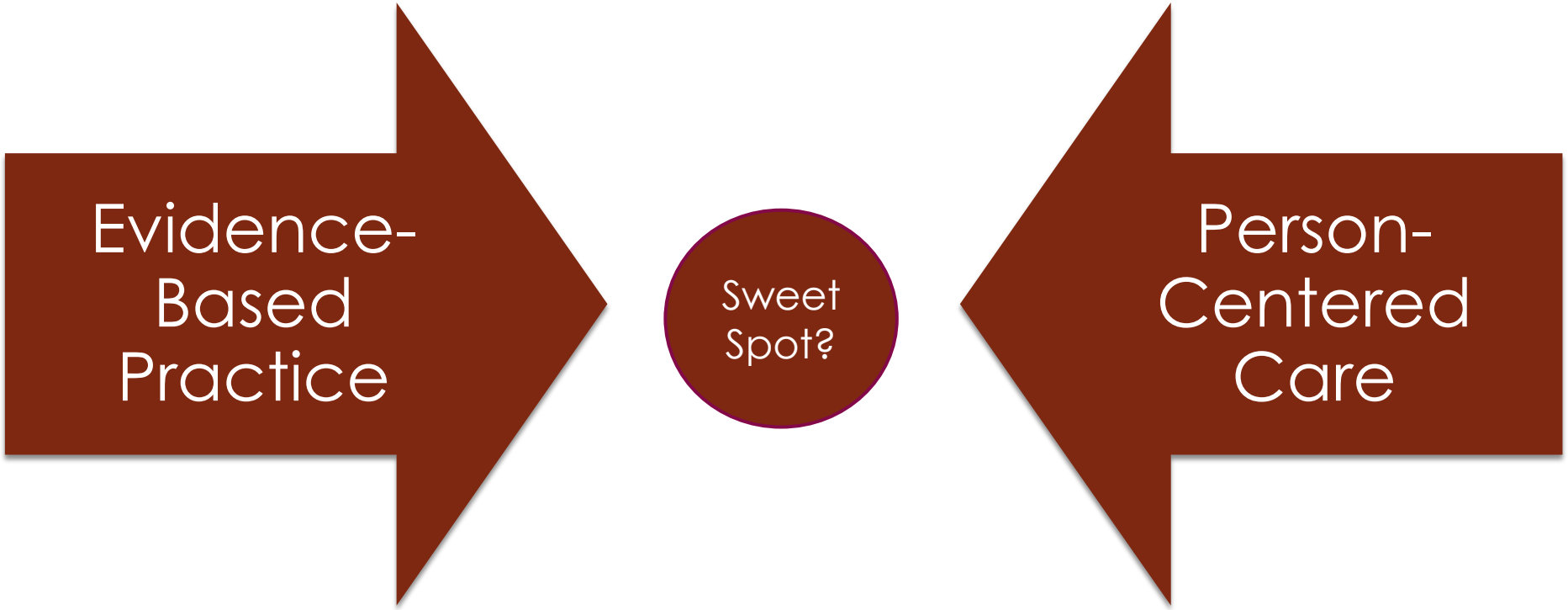
- Feedback RE: PROMIS Measures
- www.menti.com
- Enter code 68 51 92

Intersection of Evidence-Based Practice and Person-Centered Practice



Bensing, J. (2000). Bridging the gap. The separate worlds of evidence-based medicine and patient-centered medicine. *Patient Education & Counseling, 39*, 17-25.

Intersection of Evidence-Based Practice and Person-Centered Care



Late Morning Outline

- Person-centered care, Case: Wernicke's, fluent aphasia, community dwelling
- Person-centered treatment goals/goal writing
- Coaching
- Authentic communication contexts

Client-Centered Care in Aphasia: Severe Wernicke's Aphasia

- 78 year old male
- Left CVA
- Lives at home with wife
- Ambulatory
- High blood pressure but usually controlled
- Medical history otherwise unremarkable
- Severe auditory comprehension deficits
- Majority of speech is jargonous with occasional "windows" of intelligibility

Client-Centered Care in Aphasia: Severe Wernicke's Aphasia

- L!V cards completed (Haley, KL, Womack, JL, Helm-Estabrooks, N, Caignon, D, McCulloch, KL, (2010). *The Life Interest and Values Cards*. Chapel Hill, NC: University of North Carolina Department of Allied Health Sciences)
- Interacting with others
- Eating out
- Conversing with family is a key value and goal for client

	Check activities the PWA *wants to do more*. Circle any activity number where the PWA and FFM give different responses.	PWA: Order: 1 2 3 4 Date:	FFM: Relationship: Date:
1	Cleaning the House	❒ YES ❒ NO	❒ YES ❒ NO
2	Cooking	❒ YES ❒ NO	❒ YES ❒ NO
3	Washing Dishes	❒ YES ❒ NO	❒ YES ❒ NO
4	Doing Laundry	❒ YES ❒ NO	❒ YES ❒ NO
5	Taking Out the Trash	❒ YES ❒ NO	❒ YES ❒ NO
6	Indoor Plant Care	❒ YES ❒ NO	❒ YES ❒ NO
7	Pet Care	❒ YES ❒ NO	❒ YES ❒ NO
8	Home Maintenance	❒ YES ❒ NO	❒ YES ❒ NO
9	Yard Work	❒ YES ❒ NO	❒ YES ❒ NO
10	Paying Bills	❒ YES ❒ NO	❒ YES ❒ NO
11	Childcare	❒ YES ❒ NO	❒ YES ❒ NO
12	Online Shopping	❒ YES ❒ NO	❒ YES ❒ NO
13	Grocery Shopping	❒ YES ❒ NO	❒ YES ❒ NO
14	Clothes Shopping	❒ YES ❒ NO	❒ YES ❒ NO
15	Shopping at Hardware Store	❒ YES ❒ NO	❒ YES ❒ NO
16	Car Maintenance	❒ YES ❒ NO	❒ YES ❒ NO
17	Driving	❒ YES ❒ NO	❒ YES ❒ NO
18	Getting Gas	❒ YES ❒ NO	❒ YES ❒ NO
19	Public Transportation	❒ YES ❒ NO	❒ YES ❒ NO
20	Beauty/Barber Shop	❒ YES ❒ NO	❒ YES ❒ NO
21	Going to the Doctor	❒ YES ❒ NO	❒ YES ❒ NO
22	Taking Classes	❒ YES ❒ NO	❒ YES ❒ NO
23	Going to Place of Worship	❒ YES ❒ NO	❒ YES ❒ NO
24	Voting	❒ YES ❒ NO	❒ YES ❒ NO
25	Working for Pay	❒ YES ❒ NO	❒ YES ❒ NO

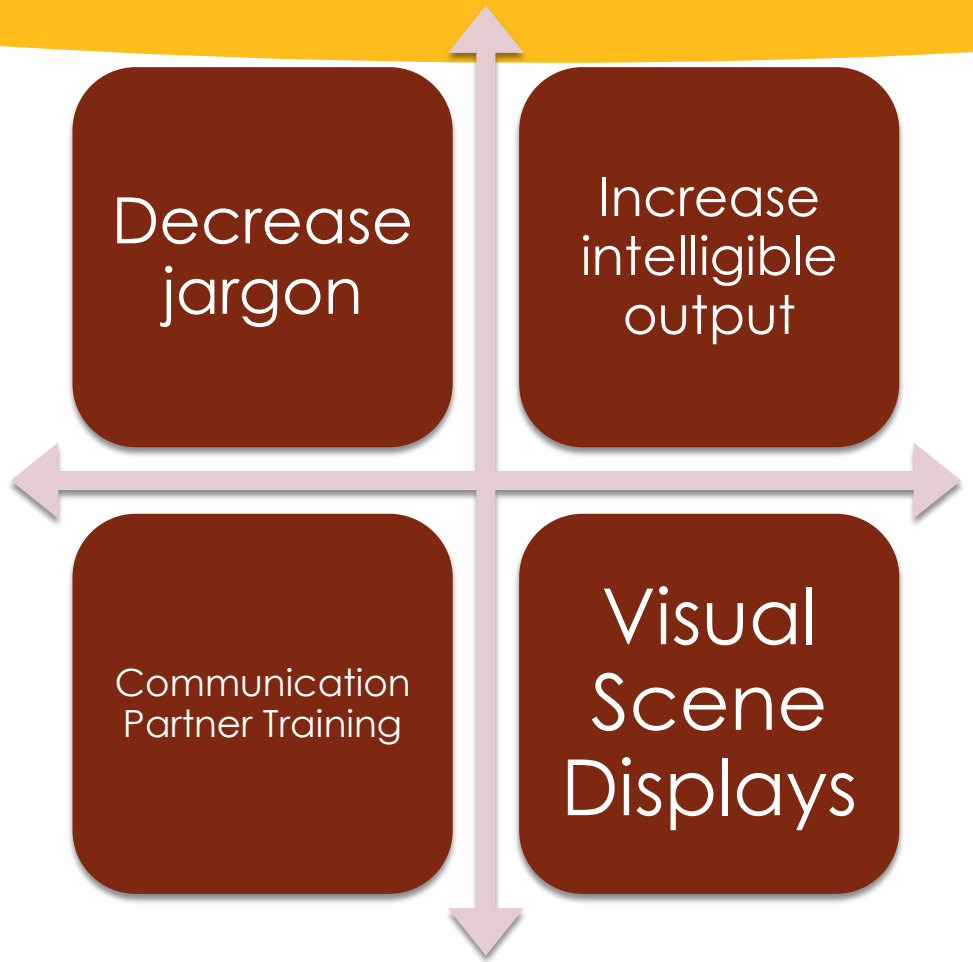
	Check activities the PWA ***wants to do more***. Circle any activity number where the PWA and FFM give different responses.	PWA: Order: 1 2 3 4 Date:	FFM: Relationship: Date:
1	Watching TV	❒ YES ❒ NO	❒ YES ❒ NO
2	Playing Video Games	❒ YES ❒ NO	❒ YES ❒ NO
3	Using a Computer	❒ YES ❒ NO	❒ YES ❒ NO
4	Bird Watching	❒ YES ❒ NO	❒ YES ❒ NO
5	Library	❒ YES ❒ NO	❒ YES ❒ NO
6	Reading	❒ YES ❒ NO	❒ YES ❒ NO
7	Sitting/Thinking	❒ YES ❒ NO	❒ YES ❒ NO
8	Resting	❒ YES ❒ NO	❒ YES ❒ NO
9	Getting a Massage	❒ YES ❒ NO	❒ YES ❒ NO
10	Photography	❒ YES ❒ NO	❒ YES ❒ NO
11	Drawing/ Painting	❒ YES ❒ NO	❒ YES ❒ NO
12	Interior Decorating	❒ YES ❒ NO	❒ YES ❒ NO
13	Flower Arranging	❒ YES ❒ NO	❒ YES ❒ NO
14	Hand Crafts	❒ YES ❒ NO	❒ YES ❒ NO
15	Scrapbooking	❒ YES ❒ NO	❒ YES ❒ NO
16	Sewing	❒ YES ❒ NO	❒ YES ❒ NO
17	Needle Crafts	❒ YES ❒ NO	❒ YES ❒ NO
18	Puzzles	❒ YES ❒ NO	❒ YES ❒ NO
19	Collecting	❒ YES ❒ NO	❒ YES ❒ NO
20	Listening to Music	❒ YES ❒ NO	❒ YES ❒ NO
21	Playing a Musical Instrument	❒ YES ❒ NO	❒ YES ❒ NO
22	Singing	❒ YES ❒ NO	❒ YES ❒ NO
23	Attending Concerts	❒ YES ❒ NO	❒ YES ❒ NO
24	Art Museum/Gallery	❒ YES ❒ NO	❒ YES ❒ NO
25	Going to the Movies	❒ YES ❒ NO	❒ YES ❒ NO

	Check activities the PWA *wants to do more*. Circle any activity number where the PWA and FFM give different responses.	PWA: Order: 1 2 3 4 Date:	FFM: Relationship: Date:
1	Yard Games	❒ YES ❒ NO	❒ YES ❒ NO
2	Ball Sports	❒ YES ❒ NO	❒ YES ❒ NO
3	Racquet Sports	❒ YES ❒ NO	❒ YES ❒ NO
4	Golfing	❒ YES ❒ NO	❒ YES ❒ NO
5	Bowling	❒ YES ❒ NO	❒ YES ❒ NO
6	Winter Sports	❒ YES ❒ NO	❒ YES ❒ NO
7	Group Exercise	❒ YES ❒ NO	❒ YES ❒ NO
8	Indoor Exercise	❒ YES ❒ NO	❒ YES ❒ NO
9	Yoga/Tai Chi	❒ YES ❒ NO	❒ YES ❒ NO
10	Cycling	❒ YES ❒ NO	❒ YES ❒ NO
11	Walking/Running	❒ YES ❒ NO	❒ YES ❒ NO
12	Swimming	❒ YES ❒ NO	❒ YES ❒ NO
13	Horseback Riding	❒ YES ❒ NO	❒ YES ❒ NO
14	Hiking	❒ YES ❒ NO	❒ YES ❒ NO
15	Camping	❒ YES ❒ NO	❒ YES ❒ NO
16	Boating	❒ YES ❒ NO	❒ YES ❒ NO
17	Fishing	❒ YES ❒ NO	❒ YES ❒ NO
18	Hunting	❒ YES ❒ NO	❒ YES ❒ NO
19	Beach	❒ YES ❒ NO	❒ YES ❒ NO
20	Traveling	❒ YES ❒ NO	❒ YES ❒ NO
21	Going on a Road Trip	❒ YES ❒ NO	❒ YES ❒ NO
22	Sightseeing	❒ YES ❒ NO	❒ YES ❒ NO
23	Going to the Mall	❒ YES ❒ NO	❒ YES ❒ NO
24	Gardening	❒ YES ❒ NO	❒ YES ❒ NO
25	Woodworking	❒ YES ❒ NO	❒ YES ❒ NO

Social Activities

	Check activities the PWA ***wants to do more***. Circle any activity number where the PWA and FFM give different responses.	PWA: Order: 1 2 3 4 Date:	FFM: Relationship: Date:
1	Volunteering	❒ YES ❒ NO	❒ YES ❒ NO
2	Watching Sports	❒ YES ❒ NO	❒ YES ❒ NO
3	Attending Parties	❒ YES ❒ NO	❒ YES ❒ NO
4	Family Gatherings	❒ YES ❒ NO	❒ YES ❒ NO
5	Entertaining at Home	❒ YES ❒ NO	❒ YES ❒ NO
6	Discussing Politics/Current Affairs	❒ YES ❒ NO	❒ YES ❒ NO
7	Attending Meetings	❒ YES ❒ NO	❒ YES ❒ NO
8	Having Coffee/Tea with Friends	❒ YES ❒ NO	❒ YES ❒ NO
9	Eating Out	❒ YES ❒ NO	❒ YES ❒ NO
10	Going to a Bar with Friends	❒ YES ❒ NO	❒ YES ❒ NO
11	Dancing	❒ YES ❒ NO	❒ YES ❒ NO
12	Picnic	❒ YES ❒ NO	❒ YES ❒ NO
13	Laughing/Joking	❒ YES ❒ NO	❒ YES ❒ NO
14	Gift Giving	❒ YES ❒ NO	❒ YES ❒ NO
15	Going to Children's Activities	❒ YES ❒ NO	❒ YES ❒ NO
16	Storytelling to Children	❒ YES ❒ NO	❒ YES ❒ NO
17	Table Games	❒ YES ❒ NO	❒ YES ❒ NO
18	Playing Cards	❒ YES ❒ NO	❒ YES ❒ NO
19	Using the Phone	❒ YES ❒ NO	❒ YES ❒ NO
20	Writing for Communication	❒ YES ❒ NO	❒ YES ❒ NO

Treatment Approach



Materials Needed

- Alphabet board
- Dry erase white board and markers
- Pictures or Conversation Starters
  - Pictures from family
  - Magazines
  - Newspaper clippings
  - Visual scenes online
  - The more relevant, the better
  - You-tube clip of something they enjoy watching

Conversational Coaching

- Client wants improved conversational outcomes, start with conversational outcomes
- **Little evidence to show benefits of bottom-up approaches generalize to conversation**

Holland, A., Hopper, T., Rewega, M. (2002). Conversational coaching: Treatment outcomes and future directions. *Aphasiology, 16*(7), 745-761.

Intervention: Conversational Coaching (Hopper, Holland & Rewega, 2002)

Overview

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.

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.

Conversational Coaching

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.

Procedures

1. Effective strategies for each partner are collaboratively identified.
2. A communication situation is created, such as viewing a short video clip. Both partners should be using their identified communication strategies to achieve a collaborative result.
3. The clinician acts as a coach to each of the two partners.

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

(M)PCA

Behavioural Guidelines: Summary

A. INTERACTION

Verbal/Vocal	• Does Partner with Aphasia share responsibility for maintaining the feel and flow of conversation (including appropriate affect)?
Non-Verbal	• Does Partner with Aphasia initiate/maintain interaction with Conversation Partner or make use of supports offered by Conversation Partner to initiate/maintain interaction? • Does Partner with Aphasia indicate communicative intent? • Is Partner with Aphasia pragmatically appropriate? • Does Partner with Aphasia ever acknowledge the frustration of the Conversation Partner or acknowledge his/her competence /skill? • Behaviours might include: appropriate eye contact, use of gesture, body posture and facial expression, use of writing or drawing in any form, use of resource material, use of verbalization/vocalization in any form.

B. TRANSACTION

Verbal/Vocal Non-Verbal	• Does Partner with Aphasia maintain exchange of information, opinions and feelings with Conversation Partner? • Does Partner with Aphasia ever initiate transaction? ◆ introducing or referring back to a previous topic? ◆ spontaneously using a compensatory technique? • Does content of transaction appear to be accurate? (depending on context and purpose of rating, rater would have more/less access to means of verification of information) • Does Partner with Aphasia use support offered by Conversation Partner for the purpose of transaction? This might include: using a gesture modelled by Conversation Partner; pointing to key-words or pictured resources, collaborating with Conversation Partner around a drawing.

Kagan et al, 2001

Supported Conversation for Aphasia: Video Example

- Video clip of client


THE CORE OF AUTHENTICITY IS THE COURAGE TO BE IMPERFECT, VULNERABLE, AND TO SET BOUNDARIES.
BRENÉ BROWN

Authentic Communication Contexts

- What does the person WANT, NEED, CAN talk about?
- Can create via observation, interview tools, life stories
- Written information
- Personal artifacts from the person
- Relevant pictures

Authentic Communication Contexts (continued)

- Decrease bottom-up processing
- Decrease specific word retrieval targets
- Decrease repetition or response to cues
- Decrease use of wh-questions
- Increase verification, rephrasing
- Increase orientation to topic
- Increase listening breaks
- Summarize successes!

Authentic Communication Contexts (continued)

- No drill
- No repetition
- Nothing without context
- Laughter, joy!
- "What are they doing? It looks like they're just talking."

- Marshall, RC (2008). Early management of Wernicke's aphasia: A context-based approach. In Chapey, R. (ed.), *Language interventions strategies in aphasia and related neurogenic communication disorders* (5th ed.), 507-529, Baltimore: Lippincott, Williams & Wilkins.

Person-Centered Treatment Goals

- The person with aphasia and his communication partner will increase the quality of communication interactions as the person with aphasia decreases jargonous output by 50% or greater during a 15 minute conversational sample.

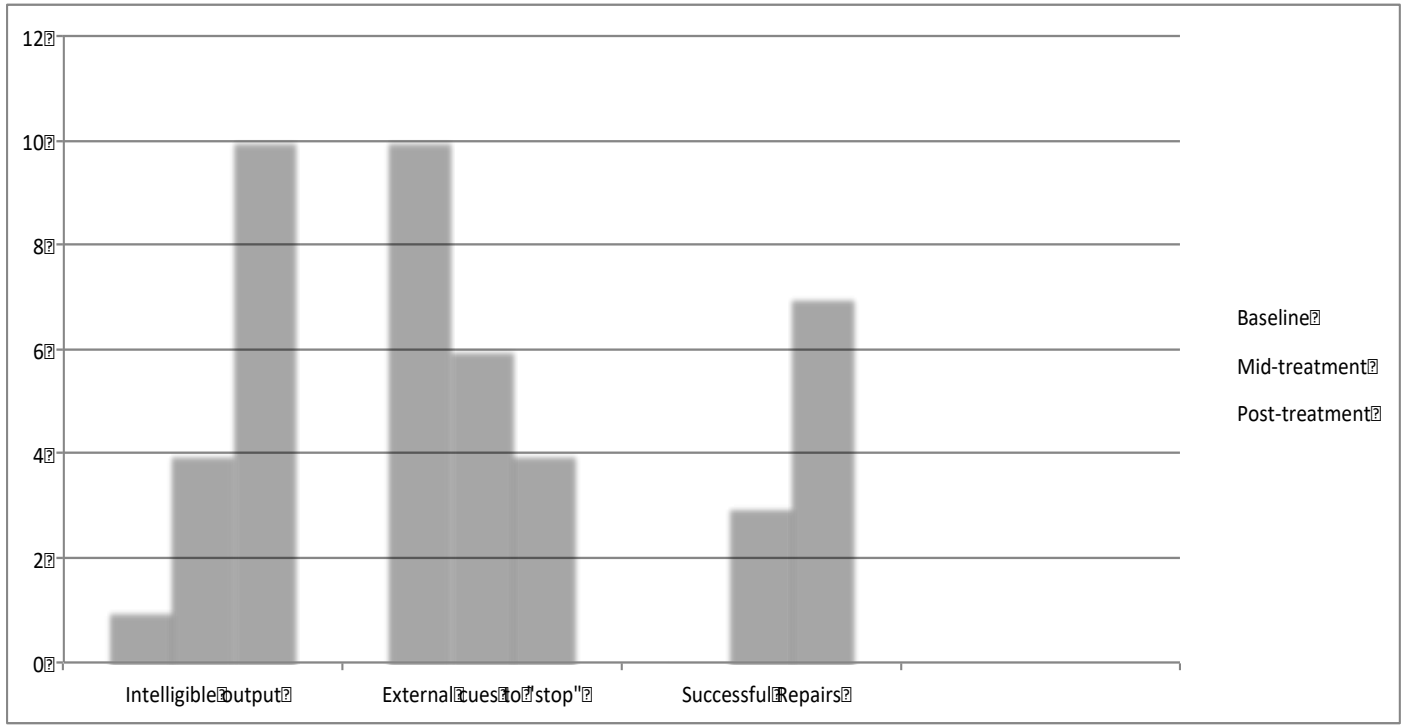
Person-Centered Treatment Goals

- The client and his communication partner will increase the quality of communicative interactions as the person with aphasia increases intelligible speech output from 0 to 7 words or phrases during a 15 minute conversational sample.

Person-Centered Treatment Goals

- The person with aphasia will increase communicative efficiency during a 15 minute conversational sample with a designated communication partner by increasing use of word-retrieval strategies such as writing, drawing, gesturing, pointing to pictures within a visual scene, and pointing to the 1st letter of an alphabet board by 50% or greater.

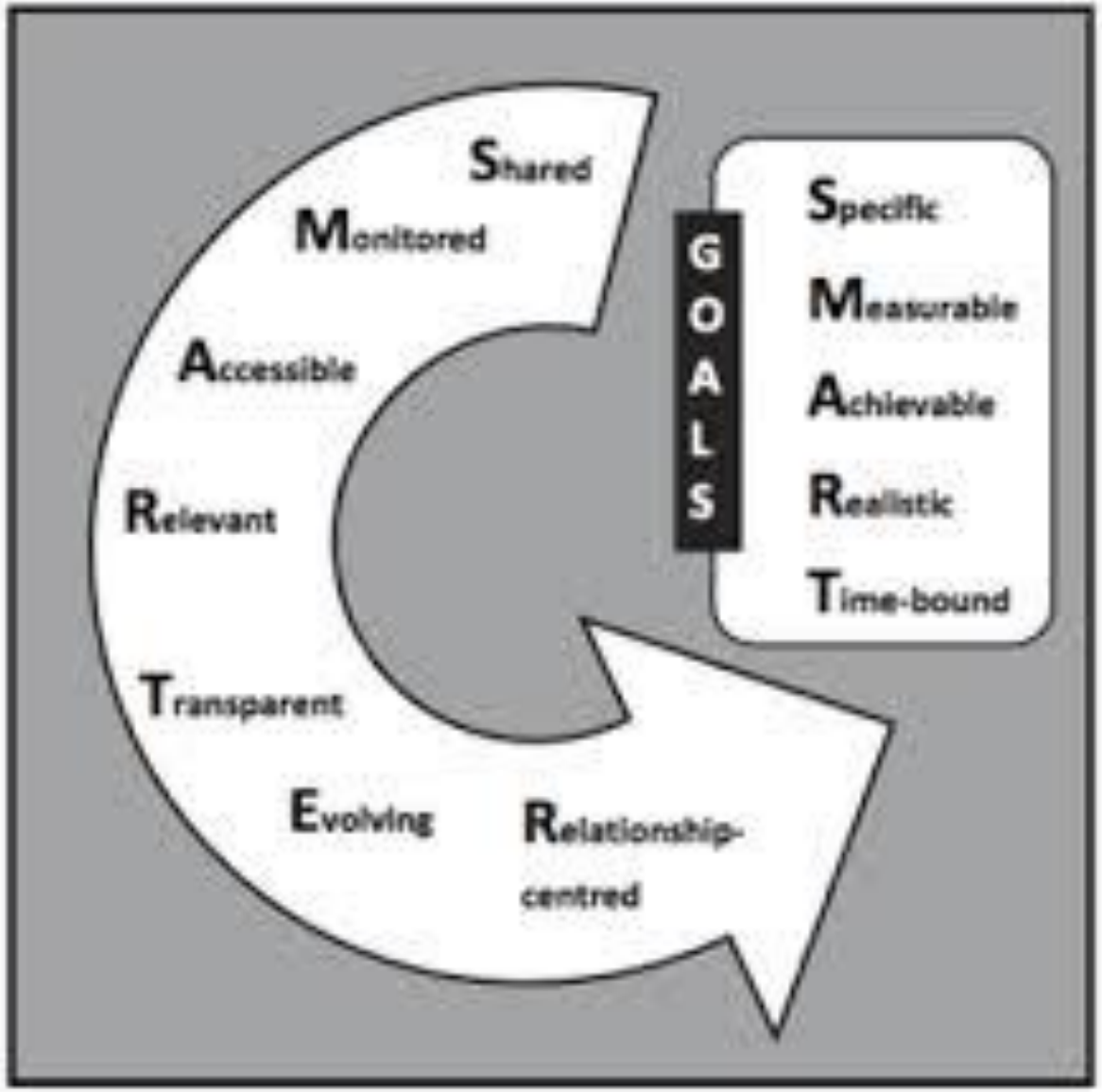
Therapy Data



Treatment Planning: SMARTER Goal-Setting for People with Aphasia

- S: Shared
- M: Monitored
- A: Accessible
- R: Relevant
- T: Transparent
- E: Evolving
- R: Relationship-centered

Hersh, D., Worrall, L., Howe, T., Sherratt, S., Davidson, B. (2012). SMARTER goal setting in aphasia rehabilitation. *Aphasiology, 26*(2), 220-233.


Shared
Monitored
Accessible
Relevant
Transparent
Evolving
Relationship-centred
GOALS
Specific
Measurable
Achievable
Realistic
Time-bound

Shared

- Shared decision making
- Understanding each other's perspective
- Having real choices and negotiation
- Coming to agreement

Monitored rather than Measured

- Monitored denotes continuous evaluation
- Regularly discussing improvement or lack of it
- Measurement of change on therapy goals does not have to be numerically based
  - Client self evaluation
  - Family evaluation
- Evidence-based but not rigid for the sake of rigidity's sake

Accessible

- Information in an aphasia friendly format
- Extra time
- Total communication approach
- Supported conversation
- Careful adaptation
- Even the word goal may be a problem
  - What do you want to work on?
  - What would you like to see improve?

Relevant

- Relevant to people's lives
- If you are my SLP, please do not ever have me do anything related to cooking or scrapbooking!

Transparent

- Lists
- Visualizations
- Metaphors
- Analogies
  - Steps
  - Ladders

Evolving

- Revise and revisit goals regularly
- Flexibility with both the acceptance process and the rehabilitation process

Relationship Centered

- Both therapists and clients bring themselves as people
- Relationship is critical

Person-Centered Care: Evidence for Coaching in Aphasia

- Coaching, "An active listening process"
- 1. Learning to live successfully with aphasia does not occur immediately, rapidly, or spontaneously following stroke. It takes time.
- 2. Aphasia is a family problem.
- 3. Given its chronicity, people do not "get over" aphasia. Rather, they learn to fit it into their lives (Holland, 2007b, p. 341)
- "Even if the life-coaching approach is not adopted wholeheartedly by the profession, the principles of positive psychology and the life goal perspective appear highly relevant to living successfully with aphasia"

Worrall, L., Brown, K., Crucie, M., Davidson, B., Hersh, D., Howe, T., Sherratt, S. (2010). The evidence for a life-coaching approach to aphasia. *Aphasiology, 24*(4), 497-514.

Early Afternoon Outline

- Person-centered care, Case: Broca's, non-fluent aphasia, long-term care community dwelling
- Person-centered treatment goals
- Person-centered care, Case: Fronto-temporal dementia/Primary Progressive Aphasia

Person-Centered Care: Broca's Aphasia, Long-Term Care Community Dwelling

- Mrs. T., 77 years old
- Broca's aphasia (chronic, s/p 5 years ago)
- Decreased, new onset interest in activities
- Does not want to leave the room
- Retired banker
- Window and no children, a few cousins visit a couple times a year
- Her functional communication consists of the use of some gestures and pointing, facial expressions, and head nods and shakes

Person-Centered Care: Broca's Aphasia, Long-Term Care Community Dwelling

- Preference for Everyday Living Inventory (PELI)
- http://www.polisherresearchinstitute.org/assessment-instruments
- Van Haitsma, K., Crespy, S., Humes, S., Elliot, A., Mihelic, M., Scott, C. et al., (2014). New toolkit to measure quality of person-centered care: Development and evaluation within nursing home communities. *The Journal of Post-Acute and Long-Term Care Medicine, 15*(9), 671-680.
- PELI review

1=Very Important

2=Somewhat Important

3=Not Very Important

4=Not Important at All

Assessment Results

- Person-centered assessment results revealed environmental barriers to independence
- A deep passion for photography
- Need for new bras

Treatment Approach

Mrs. Smith: The Facility Photographer

- Although she withdrew from activities directly, she re-engaged by photographing activities
- Mrs. Smith increased both socialization targets by at least 50% by the end of the 4-week training period.
- Staff were trained to sustain her photography by way of completing maintenance checks on the camera, and placing the location in the same place in her room every time.

Mrs. Smith Treatment Outcomes

- Staff was also trained to download photos off of the storage card intermittently, so that the resident would have adequate memory for photography.
- Staff was additionally coached regarding how to maintain written labels for toiletries and dressing, such as how to make new cues if the current ones deteriorated over time. A set of "back-up" cues was also provided in the case that the cues were to be lost immediately

Camera Tip Sheet

1: Turn on camera by pressing the yellow button on top.

2: Point the camera and look at the screen.

3: Press the red button to take a picture.

Camera Tip Sheet (continued)

4: Press the blue button to look at your picture. 

5: Press the yellow button to turn the camera off. 

Gaugler, J.E., Hobday, J.V., Savik, K. (2013).

cares

CARES® Observational Tool®

Today's Date: _____ Start Time: _____ End Time: _____ Total: _____

Person Being Observed: _____ Person Being Cared For: _____ Person Observing: _____

Describe the care being done: _____

			Score 1 if **any** bulleted item is observed. **Score 0** if **no** bulleted item is observed.
1.	_____	**Greet**	• CNA uses a greeting (hello, good morning, etc.)
2.	_____	**Introduce**	• CNA introduces himself/herself
3.	_____	**Use Name**	• CNA uses resident's name
4.	_____	**Smile/Eye**	• CNA smiles and makes eye contact for at least 2 seconds
5.	_____	**Physical Contact**	• CNA makes physical contact (shake hands, rub on back, hug, etc.)
6.	_____	**Approach**	• CNA approaches the resident from the front
7.	_____	**Eye Level**	• CNA crouches down or sits next to resident to be at eye level or below
8.	_____	**Calm**	• CNA is calm and not rushed in approach
9.	_____	**Ask/Discuss/ Assess**	• CNA asks/discusses how resident is feeling or doing
10.	_____	**15 Seconds**	• CNA speaks to resident at least a total of 15 seconds during care interaction
11.	_____	**Explain**	• CNA explains an activity/care (e.g., "I'm here to pick up your laundry.") **and/or** • CNA proposes an activity (e.g., "Let's go for a walk.")
12.	_____	**Involve in Care/ Activity**	• CNA involves resident in care appropriately (according to their abilities) **and/or** • CNA tries to involve resident in a care (instead of CNA doing the care for the resident)
13.	_____	**Resident's Life**	• CNA mentions something specific about resident's life **and/or** • CNA mentions something meaningful in resident's life, personal life story, or history
14.	_____	**Comfort**	• CNA gets resident into a more comfortable position (i.e., repositions resident) **and/or** • CNA asks if there is anything he/she can bring them or do for them
15.	_____	**Share**	• CNA shares something verbally about the resident with another team member
16.	_____	**Write**	• CNA documents/writes something about resident (chart, Post-it® Note, communication book)
	_____	**Total Score**	

Documentation Need	Documentation Statement
Prior Level of Function	Documented decline in communication, participation in group activities and independence in ADLs
Statement of Risk Related to Safety	Resident at significant risk for safety concerns due to decreased communication
Statement of Risk Related to Quality of Life	Resident at significant risk for decreased quality of life due to new onset of social isolation
Statement of Reasonable Expectation of Improvement	Multiple scientific studies support the use of supported conversation and other cueing techniques to enhance social participation and improve communication.

Ms. VanDeMark, Background Information

- 52 year old female
- Initial symptoms included memory difficulties, temporal orientation problems, difficulty learning new information
- Unable to learn new computerized documentation system during work as an SLP, forced to retire
- 3 daughters, 1 in high-school
- Lives alone
- Confusion in medical diagnosis, multiple physicians with conflicting information

Ms. VanDeMark, Background Information (cont.)

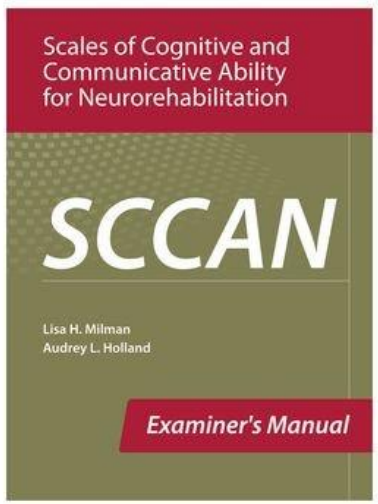
- Neuropsychological evaluation
  - Reduced information processing
  - Short-term memory impairment
  - Attention deficit disorder
  - Unspecified mild-moderate neurocognitive disorder
- Medical history
  - Migraine
  - Chronic depression and anxiety
  - Severe stress
  - Concussions x2
  - Post traumatic stress disorder
  - Bipolar disorder

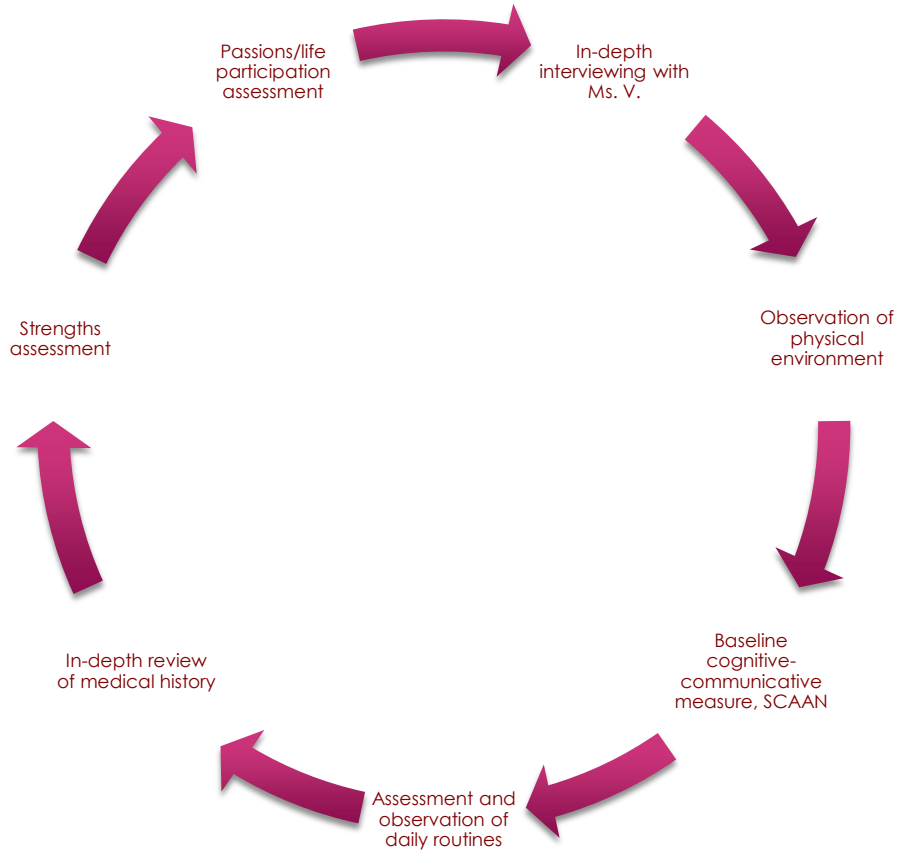
Ms. VanDeMark, Background Information (continued)

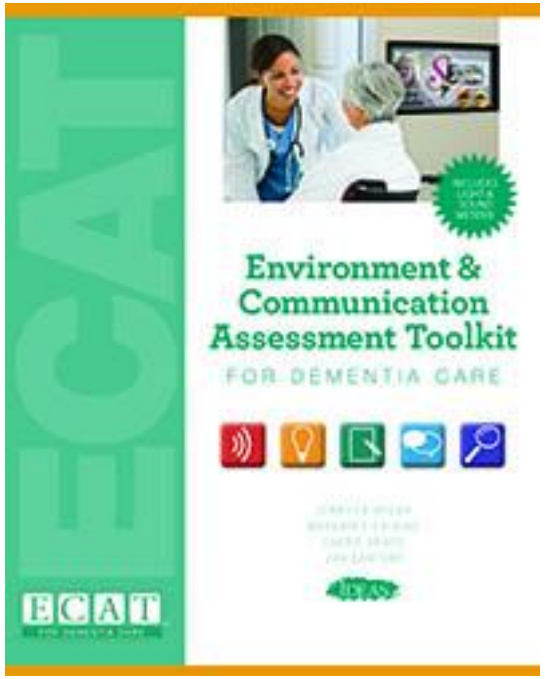
- Eventual diagnosis of frontotemporal dementia from 2 out of 3 physicians on medical team

- What is Frontotemporal Dementia?

Assessment Approach



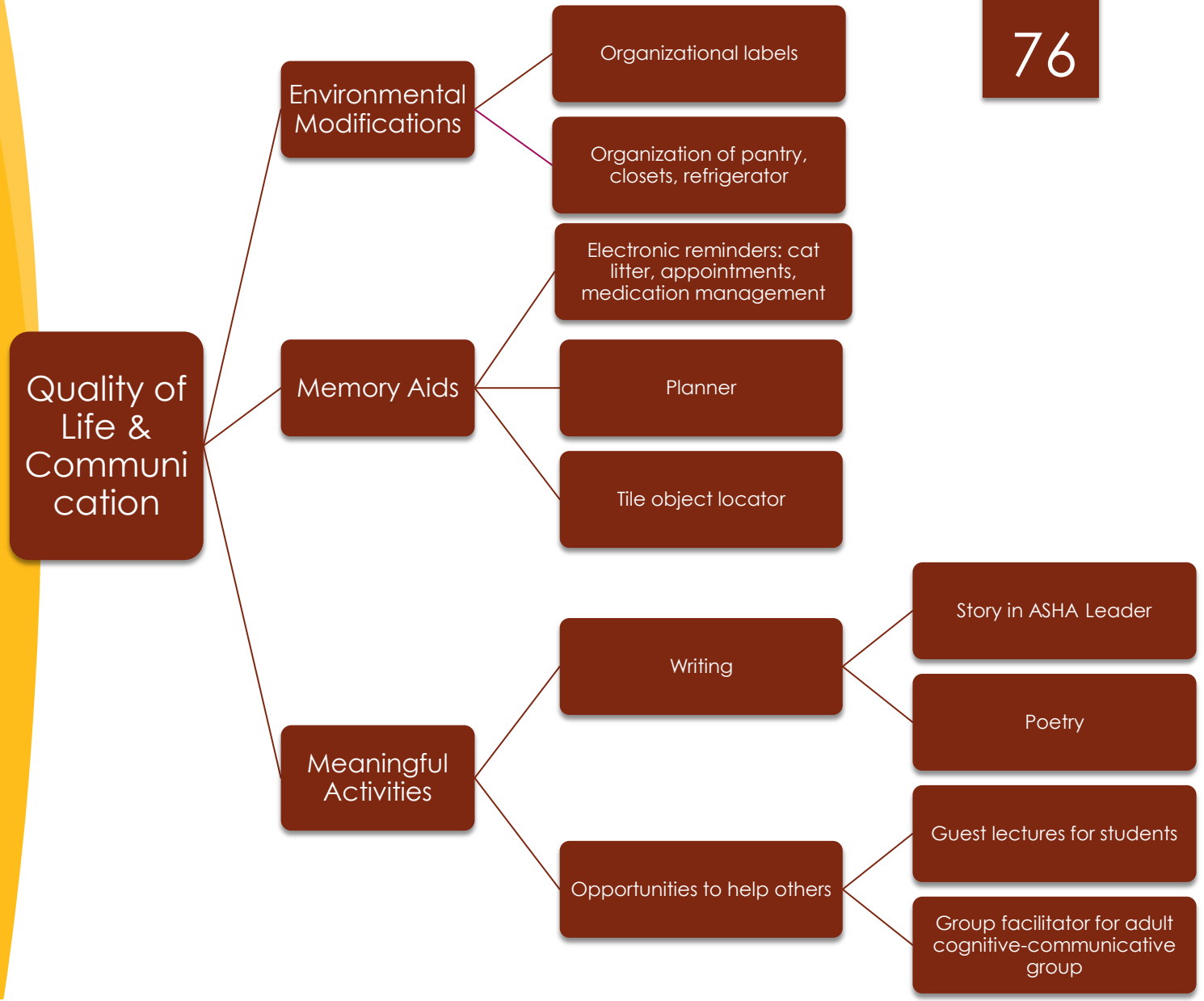




Assessment Summary

- Moderate-severe memory difficulties
- Mild-moderate word finding difficulties
- Strengths in auditory comprehension, written expression, written comprehension
- Moderate disorganization, planning difficulties in daily routines
- Moderate-disorganization in physical environment
- Passions for helping others, photography, art, poetry

Treatment Approach



Treatment Approach (continued)

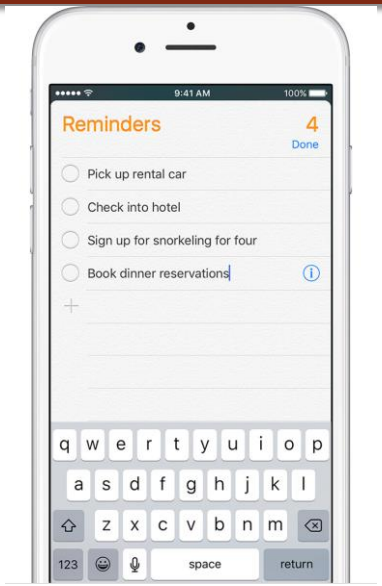
Enviroment

- Organizational labels
- Pantry
- Closets/Refrigerator

Treatment Approach (continued)

Memory Aids

- Electronic Reminders
  - Trained with SRT
    - Medications, Cat litter, To look at planner
- Planner
- Tile Object Locator



Spaced Retrieval Training

- Spaced Retrieval Training (Brush & Camp, 1998a; Hopper, Mahendra et al., 2005; Hopper et al., 2013)
  - What do you do when you hear the alarm?
  - Verbal: Look at my phone
  - Motor: Take out phone and look at it
  - Spaced Retrieval Training

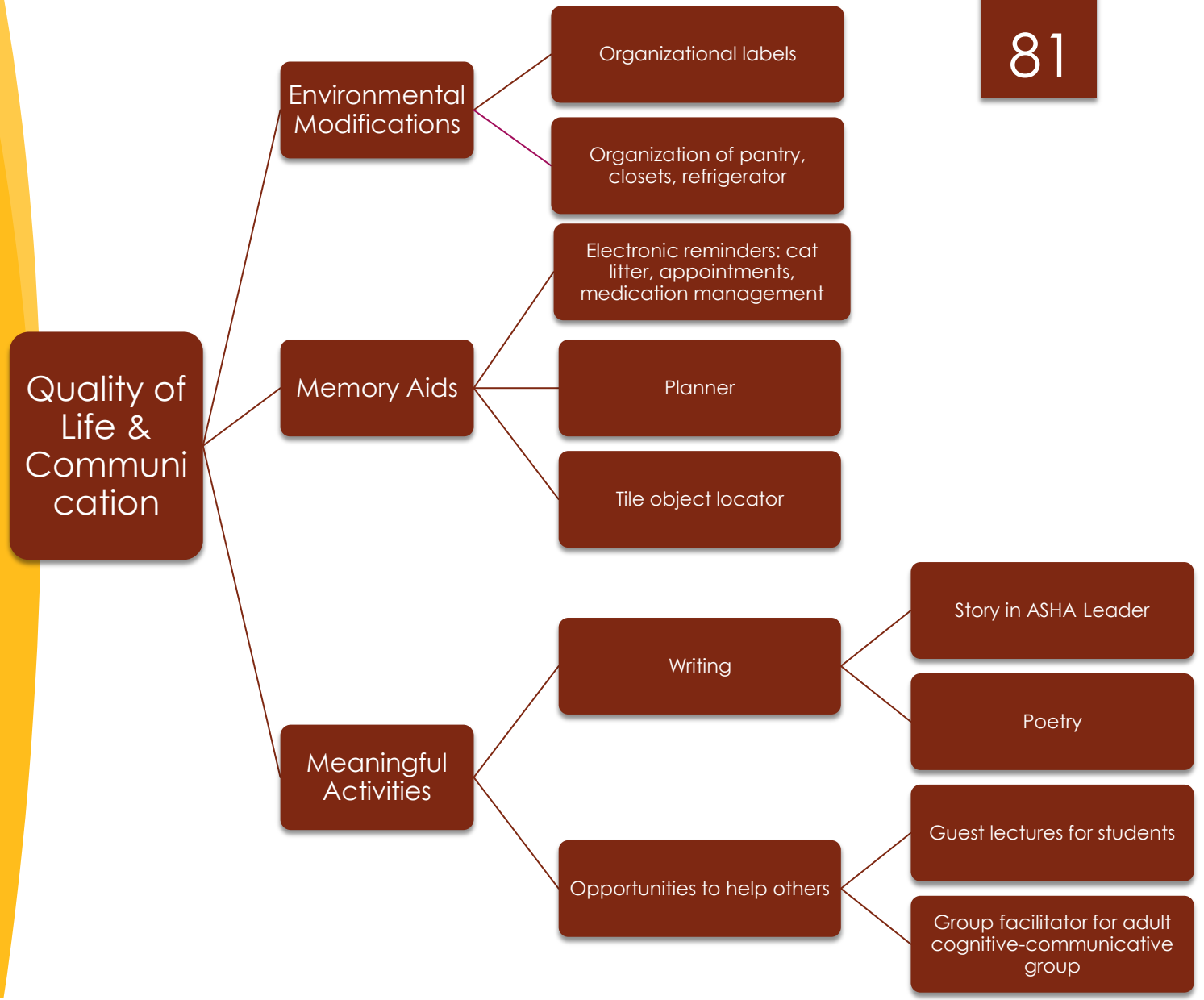
Treatment Approach (continued)

Meaningful Activities

- Poetry
- *ASHA Leader* story
- Opportunities to Help
  - Guest Lectures
  - Cognitive-Communication Group Facilitator

ASHA Leader Article

Treatment Approach, Summary



Late Afternoon Outline

- Small group exercise, barriers to the implementation of person-centered aphasia treatment
- Facilitators to implementation person-centered aphasia: Implementation science
- AphasiaAccess
- Questions/wrap-up

Barriers to the Implementation of Best Clinical Practice

- What are barriers to the implementation of best, person-centered practice in your setting?
- www.menti.com
- Enter code: 68 51 92

Why Knowledge Translation & Implementation Science?

Let's start with an example…

- Getting evidence into use?

The gap is no longer 368 years BUT…

On average, it takes 17 years for new evidence-based findings to reach clinical practice.
(Balas & Boren, 2000)

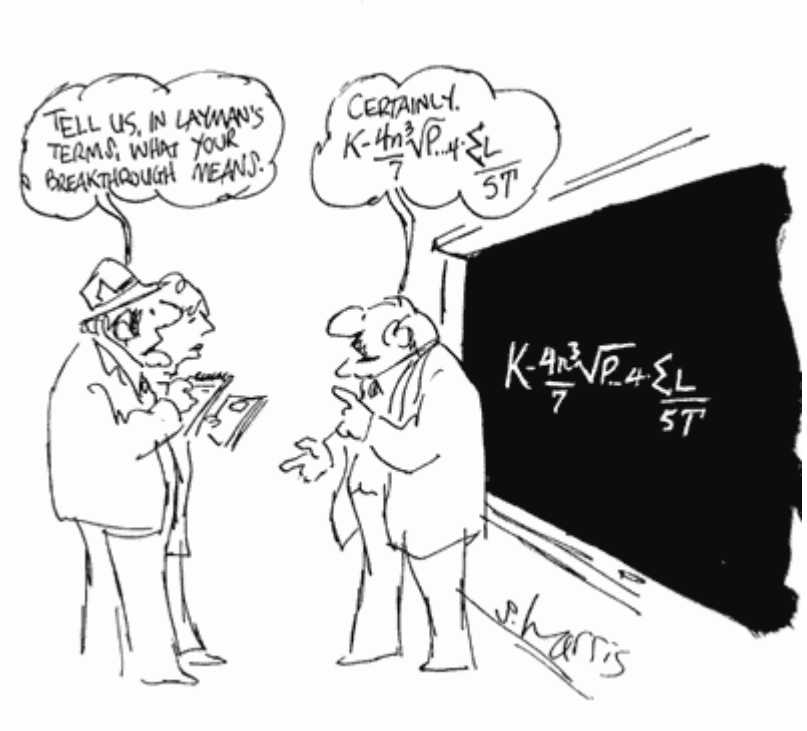
Even after 17 years, only 14% of new scientific discoveries enter day-to-day clinical practice.

(Westfall et al., 2007)

What is Knowledge Translation?

"Getting the right information, to the right people, at the right time, and in a format they can use, so as to influence decision making."

(Knowledge Translation Australia, 2016)



What is Implementation Science?

"Implementation science is the scientific study of variables and conditions that impact changes at practice, organization, and systems levels; changes that are required to promote the systematic uptake, sustainability and effective use of evidence-based programs and practices in typical service and social settings."

(Blasé & Fixsen, 2010, National Implementation Research Network)

What do we mean by “variables and conditions”?

Factors that impact changes in **practice**	Attitudes Skills & Knowledge Training & Mentorship Provision of Feedback
Factors that impact changes in **organizations** (e.g., schools, hospitals, long term care facilities)	Workplace Culture Leadership Resources Infrastructure
Factors that impact changes in **systems**	Policy Funding mechanisms

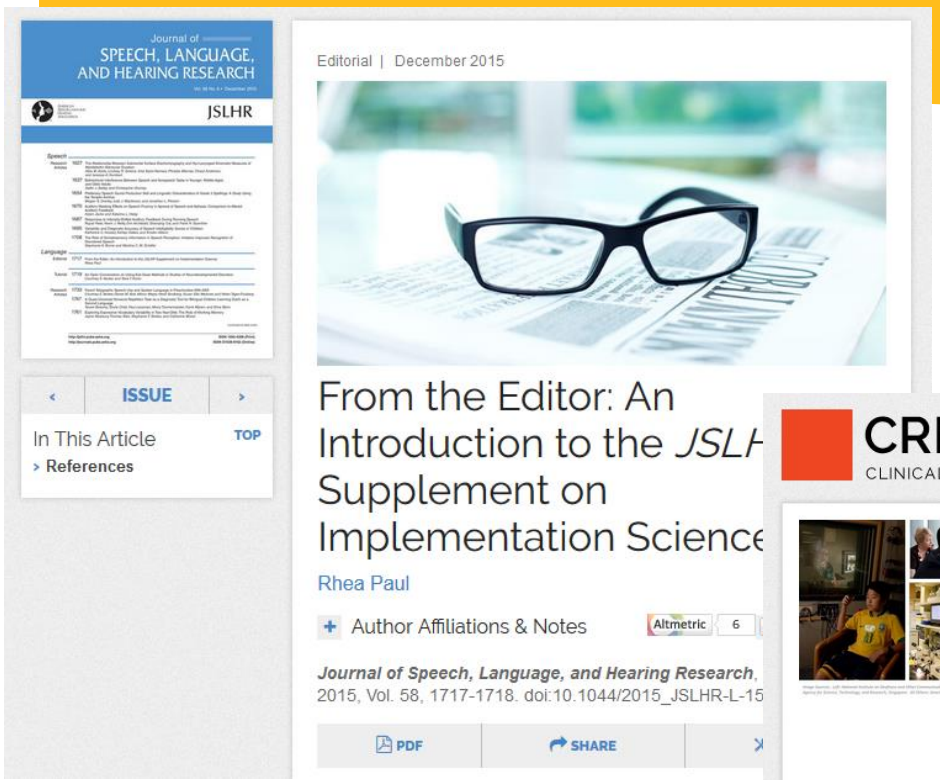
Why do practice, organization, and system factors matter?

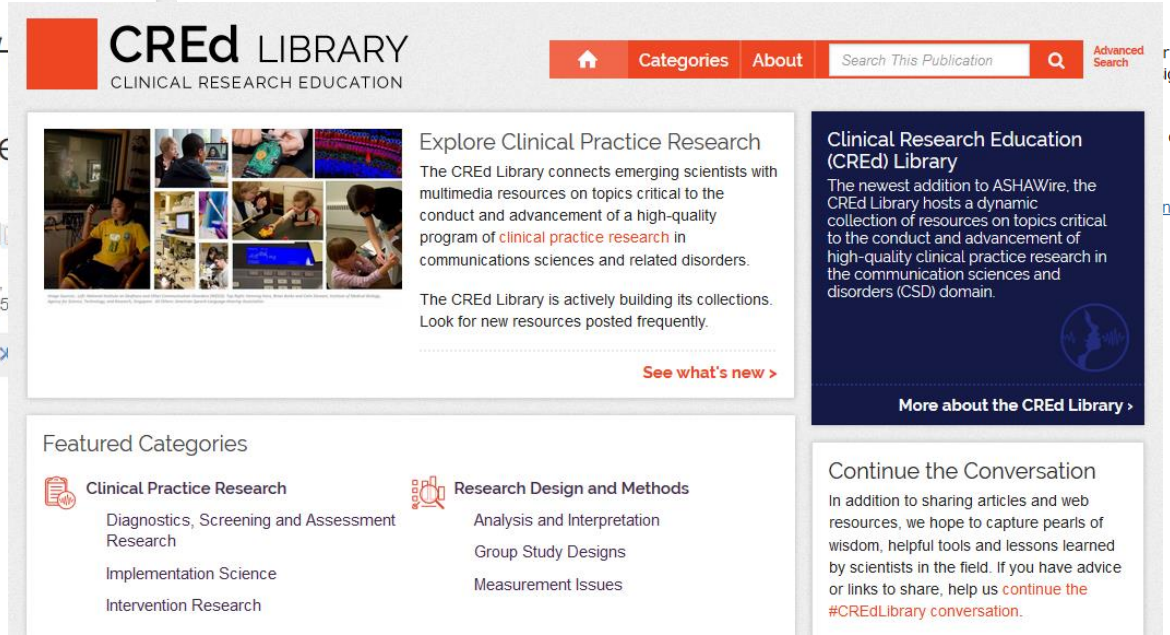
These factors have a huge influence on:

- willingness to adopt a new way of practicing
- fidelity with which a new practice is implemented
- sustainability of a new practice after implementation
- effective use of new practices in everyday settings

Why Knowledge Translation & Implementation Science?

ASHA Initiatives in KT & IS





r research programs, where to start, and what to think about in ign, measurement, fidelity, and sustainability.

discipline of human communication sciences and disorders.

n Descriptions page.

Where to Find Training Opportunities in KT & IS

- **Knowledge Translation Canada** (or KT Canada) is a network that offers webinars, workshops, institutes, and resources to support capacity building in KT. www.ktcanada.org
- **KT Connects** offers a series of monthly expert-led, beginner-level KT training webinars. http://www.msfhr.org/ktconnects
- **The National Cancer Institute (NCI) Division of Cancer Control & Population Sciences** coordinates and supports several IS training and educational activities, including a monthly webinar series, training programs, and an annual conference. https://cancercontrol.cancer.gov/IS/training-education/index.html#trainings

Funding Opportunities in KT & IS

http://www.pcori.org/funding-opportunities

http://www.ahrq.gov/funding/fund-opps/index.html

http://grants.nih.gov/grants/guide/pa-files/PAR-13-055.html

http://www.queri.research.va.gov/ciprs/training.cfm

pcori
PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE

U.S. Department of Veterans Affairs

AHRQ

Who's moving the needle?

LPAA Project Group Chapey, R., Duchan, J.F., Elman, R.J., Garcia, L.J., Kagan, A., Lyon, J., Simmons-Mackie, N., Life Participation Approach to Aphasia: A Statement of Values for the Future

Table 1 Examples of the Shift in Focus of Life Participation Approach to Aphasia

LPAA	Examples of Shift in Focus
Assessment includes determining relevant life participation needs and discovering clients' competencies	In addition to assessing language and communication deficits, clinicians are equally interested in assessing how the person with aphasia does *with support*
Treatment includes facilitating the achievement of life goals	In addition to work on improving and/or compensating for the language impairment, clinicians are prepared to work on anything in which aphasia is a barrier to life participation (even if the activity is not directly related to communication)
Intervention routinely targets environmental factors outside of the individual	In addition to working with the individual on language or compensatory functional-communication techniques, clinicians might train communication partners or work on other ways of reducing barriers to make the environment more "aphasia-friendly"
All those affected by aphasia are regarded as legitimate targets for intervention	In addition to working with the individual who has aphasia, clinicians would also work on life participation goals for family and others who are affected by the aphasia, including friends, service providers, work colleagues, etc.
Clinician roles are expanded beyond those of teacher or therapist	In addition to doing therapy, clinicians might take on the role of: • "communication partner," and give the person with aphasia the opportunity to engage in conversation about life goals, concerns about the future, barriers to life participation, etc. • "coach," "problem solver," or "support person" in relation to overcoming challenges in reengaging in a particular life activity
Outcome evaluation involves routinely documenting quality of life and life participation changes	In addition to documenting changes in language and communication, clinicians would routinely evaluate the following in partnership with clients: • life activities and how satisfying they are • social connections and how satisfying they are • emotional well-being

TABLE 2
Systematic guide to the selection and design of everyday functional situations

Key aspect of context of situation	*Role of language*	*Key aspect of language use*	*Key aspects when selecting assessment & treatment*
Field	Exchange of meaning about what is happening	Vocabulary, syntactic-semantic relations within the clause (e.g., who/what is doing what to whom, when, where, why, how) Taxonomic relations within linguistic system	Topic (e.g., familiarity, technicality) Setting
Tenor	Reflect, establish, & maintain role relationship between interactants	Mood/modality (e.g., shading meaning, politeness) Speaker role (giving/ receiving information/ goods & services)	Partner (e.g., familiarity, power/ status) Role (e.g., knower or recipient, actor)
Mode	Instantiating & binding meanings	Channel (verbal, non-verbal modality; spoken, written) Cohesion including aspects of reference	Accompanying action (e.g., while playing cards, at the shops), or constituting exchange (e.g., chat, interview)

Armstrong, E. & Ferguson, A. (2010). Language, meaning, and functional communication. *Aphasiology, 24* (4), 480-496

AphasiaAccess Resources for Education

- LPAA 101

Finding the Sweet Spot Together!