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

NATALIE F. DOUGLAS, PH.D., CCC-SLP
ASSISTANT PROFESSOR
CENTRAL MICHIGAN UNIVERSITY
NATALIE.DOUGLAS@CMICH.EDU
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

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
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

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


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

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

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 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

Traditional, biomedical, MD/patient interaction

Empathic, paternalistic MD (lets people talk, but clearly MD is decision maker)

Patient controls with persistent emphasis on biomedical approach, but MD has broader view

Modern patient who controls the consultation

Intersection of Evidence-Based Practice and Person-Centered Care

Evidence-Based Practice

Person-Centered Care

Sweet Spot?
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


- Interacting with others
- Eating out
- Conversing with family is a key value and goal for client
<table>
<thead>
<tr>
<th></th>
<th>PWA:</th>
<th>FFM:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Cleaning the House</td>
<td>YES</td>
</tr>
<tr>
<td>2</td>
<td>Cooking</td>
<td>YES</td>
</tr>
<tr>
<td>3</td>
<td>Washing Dishes</td>
<td>YES</td>
</tr>
<tr>
<td>4</td>
<td>Doing Laundry</td>
<td>YES</td>
</tr>
<tr>
<td>5</td>
<td>Taking Out the Trash</td>
<td>YES</td>
</tr>
<tr>
<td>6</td>
<td>Indoor Plant Care</td>
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</tr>
<tr>
<td>7</td>
<td>Pet Care</td>
<td>YES</td>
</tr>
<tr>
<td>8</td>
<td>Home Maintenance</td>
<td>YES</td>
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<td>9</td>
<td>Yard Work</td>
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<td>10</td>
<td>Paying Bills</td>
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<td>Childcare</td>
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<td>12</td>
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<td>Clothes Shopping</td>
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<td>16</td>
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<td>17</td>
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<td>18</td>
<td>Getting Gas</td>
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<td>19</td>
<td>Public Transportation</td>
<td>YES</td>
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<tr>
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<td>22</td>
<td>Taking Classes</td>
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<td>24</td>
<td>Voting</td>
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<td>25</td>
<td>Working for Pay</td>
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<td>Activity</td>
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<td>FFM:</td>
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<tr>
<td>------------------------------</td>
<td>------</td>
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<td>Watching TV</td>
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<td>☐ YES ☐ NO</td>
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<td>Art Museum/Gallery</td>
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<tr>
<td>Activity</td>
<td>PWA: Order</td>
<td>FFM: Relationship</td>
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<td>---------------------</td>
<td>------------</td>
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<tr>
<td>Yard Games</td>
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<td>Ball Sports</td>
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<td>Racquet Sports</td>
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<td>Golfing</td>
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<td>Bowling</td>
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<td>Winter Sports</td>
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<td>Group Exercise</td>
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<td>Indoor Exercise</td>
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<td>Yoga/Tai Chi</td>
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<td>Cycling</td>
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<td>Walking/Running</td>
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<td>Swimming</td>
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<tr>
<td>Horseback Riding</td>
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<td>Hiking</td>
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<td>Camping</td>
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<td>Boating</td>
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<td>Fishing</td>
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<td>Hunting</td>
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<td>Beach</td>
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<td>Traveling</td>
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<td>Going on a Road Trip</td>
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<td>Sightseeing</td>
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<td>Going to the Mall</td>
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<td>Gardening</td>
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<td>Woodworking</td>
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</tr>
<tr>
<td></td>
<td>Social Activities</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Check activities the PWA wants to do more. Circle any activity number where the PWA and FFM give different responses.</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Volunteering</td>
<td>PWA: Order: 1 2 3 4</td>
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<tr>
<td>2</td>
<td>Watching Sports</td>
<td>YES</td>
</tr>
<tr>
<td>3</td>
<td>Attending Parties</td>
<td>YES</td>
</tr>
<tr>
<td>4</td>
<td>Family Gatherings</td>
<td>YES</td>
</tr>
<tr>
<td>5</td>
<td>Entertaining at Home</td>
<td>YES</td>
</tr>
<tr>
<td>6</td>
<td>Discussing Politics/Current Affairs</td>
<td>YES</td>
</tr>
<tr>
<td>7</td>
<td>Attending Meetings</td>
<td>YES</td>
</tr>
<tr>
<td>8</td>
<td>Having Coffee/Tea with Friends</td>
<td>YES</td>
</tr>
<tr>
<td>9</td>
<td>Eating Out</td>
<td>YES</td>
</tr>
<tr>
<td>10</td>
<td>Going to a Bar with Friends</td>
<td>YES</td>
</tr>
<tr>
<td>11</td>
<td>Dancing</td>
<td>YES</td>
</tr>
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<td>12</td>
<td>Picnic</td>
<td>YES</td>
</tr>
<tr>
<td>13</td>
<td>Laughing/Joking</td>
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<tr>
<td>14</td>
<td>Gift Giving</td>
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<td>15</td>
<td>Going to Children's Activities</td>
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<td>16</td>
<td>Storytelling to Children</td>
<td>YES</td>
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<td>17</td>
<td>Table Games</td>
<td>YES</td>
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<tr>
<td>18</td>
<td>Playing Cards</td>
<td>YES</td>
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<tr>
<td>19</td>
<td>Using the Phone</td>
<td>YES</td>
</tr>
<tr>
<td>20</td>
<td>Writing for Communication</td>
<td>YES</td>
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</tbody>
</table>
Treatment Approach

Decrease jargon

Increase intelligible output

Communication Partner Training

Visual Scene Displays
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
Client wants improved conversational outcomes, start with conversational outcomes

Little evidence to show benefits of bottom-up approaches generalize to conversation

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 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

<table>
<thead>
<tr>
<th>Verbal/Vocal</th>
<th>Does Partner with Aphasia share responsibility for maintaining the feel and flow of conversation (including appropriate affect)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Verbal</td>
<td>Does Partner with Aphasia initiate/maintain interaction with Conversation Partner or make use of supports offered by Conversation Partner to initiate/maintain interaction?</td>
</tr>
<tr>
<td></td>
<td>Does Partner with Aphasia indicate communicative intent?</td>
</tr>
<tr>
<td></td>
<td>Is Partner with Aphasia pragmatically appropriate?</td>
</tr>
<tr>
<td></td>
<td>Does Partner with Aphasia ever acknowledge the frustration of the Conversation Partner or acknowledge his/her competence/skill?</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>

## B. TRANSACTION

<table>
<thead>
<tr>
<th>Verbal/Vocal Non-Verbal</th>
<th>Does Partner with Aphasia maintain exchange of information, opinions and feelings with Conversation Partner?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Does Partner with Aphasia ever initiate transaction?</td>
</tr>
<tr>
<td></td>
<td>* introducing or referring back to a previous topic?</td>
</tr>
<tr>
<td></td>
<td>* spontaneously using a compensatory technique?</td>
</tr>
<tr>
<td></td>
<td>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)</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>
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.”

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.
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

Intelligible output | External cues to "stop" | Successful Repairs
---|---|---
Baseline | Mid-treatment | Post-treatment
Treatment Planning: SMARTER Goal-Setting for People with Aphasia

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

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”

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
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)
- 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

Quality of Life and Communication

Meaningful Activities

Photography

Opportunities to converse
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.
<table>
<thead>
<tr>
<th>Documentation Need</th>
<th>Documentation Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Level of Function</td>
<td>Documented decline in communication, participation in group activities and independence in ADLs</td>
</tr>
<tr>
<td>Statement of Risk Related to Safety</td>
<td>Resident at significant risk for safety concerns due to decreased communication</td>
</tr>
<tr>
<td>Statement of Risk Related to Quality of Life</td>
<td>Resident at significant risk for decreased quality of life due to new onset of social isolation</td>
</tr>
<tr>
<td>Statement of Reasonable Expectation of Improvement</td>
<td>Multiple scientific studies support the use of supported conversation and other cueing techniques to enhance social participation and improve communication.</td>
</tr>
</tbody>
</table>
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
Eventual diagnosis of frontotemporal dementia from 2 out of 3 physicians on medical team

What is Frontotemporal Dementia?
Assessment Approach

- In-depth interviewing with Ms. V.
- Observation of physical environment
- Baseline cognitive communicative measure, SCAAN
- Assessment and observation of daily routines
- In-depth review of medical history
- Strengths assessment
- Passion/life participation assessment
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

Quality of Life & Communication

Environmental Modifications
- Organizational labels
- Organization of pantry, closets, refrigerator
- Electronic reminders: cat litter, appointments, medication management

Memory Aids
- Planner
- Tile object locator

Meaningful Activities
- Writing
- Opportunities to help others

Opportunities to help others
- Story in ASHA Leader
- Poetry
- Guest lectures for students
- Group facilitator for adult cognitive-communicative group

Approach
Treatment Approach (continued)

Environment

Organizational labels

Pantry

Closets/Refrigerator
Treatment Approach (continued)

Memory Aids

- Electronic Reminders
- Planner
- Tile Object Locator

Trained with SRT

Medications, Cat litter, To look at planner

[Diagram of electronic reminders and planner with an image of a planner and a 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

Quality of Life & Communication

Environmental Modifications
- Organizational labels
- Organization of pantry, closets, refrigerator
- Electronic reminders: cat litter, appointments, medication management

Memory Aids
- Planner
- Tile object locator

Meaningful Activities
- Writing
- Opportunities to help others

Opportunities
- Story in ASHA Leader
- Poetry
- Guest lectures for students
- Group facilitator for adult cognitive-communicative group
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?

Research  GAP  Clinical Practice
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)
“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)
“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
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?

Research → Optimal clinical outcomes → Clinical Practice
ASHA Initiatives in KT & IS

From the Editor: An Introduction to the JSLHR Supplement on Implementation Science

Rhea Paul

Editorial | December 2015

ASHFoundation Implementation Science Summit: Integrating Research Into Practice in Communication Sciences and Disorders

Held in Carlsbad, California in March 2016, the ASHFoundation Implementation Science Summit launched a transformative program about the science of integrating research into practice. Expert speakers from several disciplines covered topics ranging from conceptual and methodological issues to implementation models and research funding, with interactive group discussion throughout. The audience represented the professional, doctoral students, clinicians, and ASHFoundation and ASHA leadership.

Summit Highlights

Big Picture Thinking

Presentations included speakers from disciplines ranging from medicine to public health, epidemiology to social work, education to psychology. Participants had the opportunity to explore conceptually how types of implementation research fit together with implications for communication sciences and disorders.

CREd LIBRARY

CLINICAL RESEARCH EDUCATION

Explore Clinical Practice Research

The CREd Library connects emerging scientists with existing resources on topics critical to the conduct and advancement of a high-quality program of clinical practice research in communication sciences and related disorders.

The CREd Library is actively building its collections. Look for new resources posted frequently.

Featured Categories

Clinical Practice Research
Diagnosis, Screening and Assessment Research
Implementation Science
Intervention Research

Research Design and Methods
Analysis and Interpretation
Group Study Designs
Measurement Issues

Clinical Research Education (CREd) Library

The newest addition to ASHA is the CREd Library, an objective collection of resources on topics critical to the conduct and advancement of high-quality clinical practice research in the communication sciences and disorders (2016).
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](http://www.ktcanada.org)

- **KT Connects** offers a series of monthly expert-led, beginner-level KT training webinars. [http://www.msfhr.org/ktconnects](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](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://www.queri.research.va.gov/ciprs/training.cfm
Who’s moving the needle?
Table 1 Examples of the Shift in Focus of Life Participation Approach to Aphasia

<table>
<thead>
<tr>
<th>LPAA</th>
<th>Examples of Shift in Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment includes determining relevant life participation needs and discovering clients’ competencies</td>
<td>In addition to assessing language and communication deficits, clinicians are equally interested in assessing how the person with aphasia does with support</td>
</tr>
<tr>
<td>Treatment includes facilitating the achievement of life goals</td>
<td>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)</td>
</tr>
<tr>
<td>Intervention routinely targets environmental factors outside of the individual</td>
<td>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”</td>
</tr>
<tr>
<td>All those affected by aphasia are regarded as legitimate targets for intervention</td>
<td>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.</td>
</tr>
<tr>
<td>Clinician roles are expanded beyond those of teacher or therapist</td>
<td>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</td>
</tr>
<tr>
<td>Outcome evaluation involves routinely documenting quality of life and life participation changes</td>
<td>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</td>
</tr>
</tbody>
</table>
### Table 2
Systematic guide to the selection and design of everyday functional situations

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

AphasiaAccess Resources for Education

- LPAA 101
Finding the Sweet Spot Together!

Evidence-Based Practice

Person-Centered Care

Sweet Spot?