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Are We in Our Right Mind? Infusing Holistic Thinking and Adult Learning Theory into Service Delivery for Persons with Aphasia

Presenter: Jennifer Kerr, MS, CCC-SLP

Moderated by:

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Are we in our right mind?

Infusing holistic thinking and adult learning theory into service delivery for persons with aphasia

Jennifer Kerr, MS, CCC-SLP
Clinical Assistant Professor, Missouri State University
Speechpathology.com Presentation October 2016

Learner Outcomes

- Learners will apply right-brain thinking processes and adult learning theory toward establishing patient-centered care for persons with aphasia and will:
  - Describe how to complete a critical self-evaluation regarding their current level of holistic care provided to patient with aphasia.
  - Identify at least 4 specific post-stroke wants reported by persons with aphasia and their caregivers.
  - Define the primary principles of 3 different adult learning theories.

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Inspiration…

- Patient feedback
- Jill Bolte-Taylor -
  - *"We are not in a balanced brain society; we're spending most of our time in our left hemisphere, which creates stress."* http://www.dailymotion.com/video/x5wloc_jill-bolte-taylor-phd_webcam
- Studying Adult Learning Theory
- 17 years of experience across settings
- Wave of change toward social approaches
- My own aging self….

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Laying a foundation: WHO ICF Levels

- **Impairment** – Disease, damage, injury
- **Body Function and Structure** – Loss or anomaly in anatomical, physiologic or psychological structure or function
- **Activity** (Functional Limitations) – Limitations imposed on daily life activities due to changes in body function and structure
- **Participation Restrictions** – Extent all of the above restrict engagement in meaningful life activities.

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Client Videos

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How are we approaching these wants for PWA across care settings?

1. **Upon receiving an order to evaluate a patient on "CVA/Stroke" protocol, my first thought is**
   a. What type of stroke did they have?
   b. What type of aphasia may they have?
   c. How has their life changed?
   d. Can I fit in this assessment with everything else I have going on? ;-)
2. **My department (or I) approach assessment with a great deal of flexibility versus using a uniform protocol.**
3. **I regularly implement the use of MMC tools when assessing those with aphasia.**
4. **I regularly implement the use of MMC tools when treating those with aphasia.**
5. **Following chart review and prep, I initiate an aphasia assessment with a naturalistic interaction regardless of the patient's level of severity**
6. **My assessment findings clearly describe, in equal measure, both the deficits and strengths of the PWA.**
7. **Truth be told, I feel a bit awkward directing patients to answer questions like "Are the lights on in this room?" or to follow commands like "Put the keys next to the cup then point to me."**
8. **When communicating results to professional others, I initially describe what the patient is capable of versus their type of aphasia and limitations.**
9. **As part of my information gathering, I ask the patient (or their caregiver) how the patient best learned information prior to their stroke.**
10. **I feel I do a competent job within my sphere of influence, but often feel restricted in working the patient toward achieving success with life participation activities.**

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What do patients with aphasia want?

- 2011study by Worrall and colleagues interviewed 50 participants with aphasia post-stroke.

- Goals involving specific categories were identified:
- Wanted to return to **pre-stroke life**
- Communicate **opinions**, not just basic needs
- Wanted **information** about aphasia and services
- More **speech therapy**
- Greater **autonomy, dignity** and **respect**
- Involvement in **social and work** activities
- Wanted **to help** others

  - Mostly identified areas within **"Participation"** level of WHO model.

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"What do PWA think about their health care? (Tomkins, Siyambalapitiya and Worrall, 2013)

- Interviewed 50 PWA; findings adhered to specific criteria for credibility, transferability, dependability and confirmability.
- Themes emerged toward healthcare (sampling)

Satisfaction

- Increased feelings of comfort and reduced anxiety when provided with label of "aphasia" as cause or problem
- Professionals showed concern and interest in well-being
- Health professionals encouragement and faith in patient's ability to achieve
- Health professionals and PWA had friend-like relationship versus hierarchical

Dissatisfaction

- Healthcare professional interactions with formal communication not as good as "friend" relationships
- Overuse of medical jargon.
- Information not directed to them
- Written menus difficult to use
- Not enough information provided regarding diagnosis; more would lead to better outcomes

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Why is it important we help PWA communicate what *they* want?

- "Successful patient-provider communication *correlates positively with patient safety, patient satisfaction, positive health outcomes, adherence to recommended treatment, self-management of disease and lower costs*. It is also key to addressing health disparities across populations—another important national health policy goal. " (Blackstone, S 2016)
- Patient satisfaction is linked to greater patient effort, motivation, and participation in therapy (Tomkins, et al 2013)

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A little left brain and right brain review:

- The theory of left brain versus right brain dominance has been somewhat debunked, as most people use both sides of their brains almost all of the time
- However, the 2 hemispheres do serve different functions and also, as we age, we tend to have more "balance" with integrating these functions (being logical and creative, for example)
- For our purposes, we will refer to left vs. right brain as a non-scientific ***neuroanatomical metaphor*** relating to the duality of thought processing to investigate....
  - ***Are we applying balance as SLPs to***
  - ***the Art and Science of our work?***

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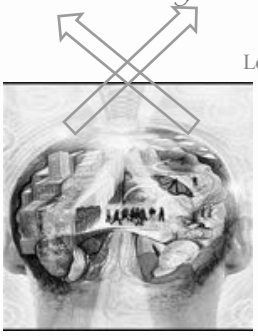
Left Brain – The Science

Logical
Sequential
Rational
Analytical
Objective
Looks at parts

Practical
Detail Oriented
Reality-Based
Safe
Rigid

Right Brain – The Art

Intuitive
Can "get it"
Presents Possibilities
Appreciative
Holistic
Takes Risks
Synthesizing
Uses Feeling
Random
Looks at Whole



Are we using one over the other? Can we meet in the middle?

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We receive an "order" and …

- Traditionally, "work the patient up" to establish diagnosis and reasonable plan of care – lends itself to a left-brained approach.
  - Follow protocols.
  - Incorporate some patient interview and try to accommodate religious and cultural preferences (check those boxes on documentation!)
  - Find out **what is wrong** and make a plan – it's a process, it's a sequence, it can be effective, BUT, it's often not very patient-friendly.
    - **-does not often reveal (or focus on) competence**

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So, do you ever ask yourself "What are we really doing?"

- Rightly so, our field places strong emphasis on EBP:
- Often, we initiate services at "body function/structure." We determine "Is there a disorder?" and we then work toward remediating "it" and/or compensating for "it."
  - This is of course our role, but it also lends itself toward mounting a strategic battle plan with an arsenal of reliable testing to capture specific data so we can label it, put a name to it, classify it.
  - Although this can be accomplished with compassion, the focus is on "It," meaning the disorder….not the individual.

The evaluation process in particular, may feel "confrontational" to the patient. (My Beautiful Broken Brain, Lotje Sodderland, 34 year old stroke survivor).

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Implementing Intervention that Matters

Let's ditch what we're doing!!!

- **What or Who determines what matters?**
  - Because we say so?
  - Because research says so?
  - Because we need to document outcomes?
  - Because insurance says so?
  - Because it's relevant to specific participation needs?
  - A combination of the above?

Not quite…

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American Heart Association Endorsed Practice Guidelines

Recommend:

- All patients be screened for depression and motor, sensory, cognitive, communication and swallowing deficits by appropriately trained clinicians using standardized and valid screening tools
- If deficits are found, all patients should be formally assessed by the appropriate clinician
- Clinician use standardized, valid assessments to evaluate stroke-related impairments and functional status and encourage participation in community and social activities
- Standardized assessment results be used to assess probability of outcome, determine level of care and develop interventions.
- Assessment findings be shared and expected outcomes discussed with patient and caregivers. (Duncan et al, Stroke 2005)

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ASHA Preferred Practice Patterns

- http://www.asha.org/policy/pp2004-00191.htm#sec1.3.20
- "Clinical Process" calls for the integration of both left and right brain thinking approaches
  - Ideally, we will use each, BUT, with which approach do we start or should we start?
  - **There is no stated preferred technique or strategy.**
  - But, we are learning some things over the last decade – if we don't focus on strengths, train partners, implement supportive communication early on - lose opportunities to reveal competence, train appropriate strategies, thus planting seeds of social isolation and failure vs. healing and possibility…

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What if at each stage of recovery, we begin with "How will this aphasia impact this person's life?" versus "What's wrong?"

- Start at Participation Level and work "backwards" toward data collection
- Start with the "end game" in mind – the "Big Picture"
  - Information you gather about the patient and their needs through interactions versus testing could lead to a more robust classification of the disorder and its direct impact.
- Ask "what does the patient want?" and ask it again as the response may vary by recovery stage and practice setting

A participation-based approach follows person-centered care principles, allows for more inclusion of right-brain thinking, integrates adult learning theory and allows patient and family to see 'what is possible' from the start.

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Infusing Adult Learning Theory into Practice as a Facilitator

- We are asking patient to learn or re-learn skills in the presence of degraded and damaged neural pathways, even still…
- Do we stop to consider how adults best learn before approaching intervention (or since, they have brain damage, do we tend to "prescribe?")
- Are we afraid to take some risks, address some feelings, be a little random and take a holistic approach in the context of disability?

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**Learning is an ACTIVE Process –
It's not just about the "student."**

- While much oneness to learn indeed lies with the student, teachers carry much responsibility for the process.
  - To be effective, teachers must have knowledge not only of the material, but of the LEARNER.
  - Must not only be competent in the technique, but be imaginative, flexible, and able to employ different methods
  - Must be able to motivate (adaptable to "student" needs)

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Learning and Service Delivery

- "Enables individuals to adapt to demands and changing circumstances" (Braungart, M, et al)
- Understanding and applying learning theories is needed to design and implement tx plans; to solve problems; to change habits; to build constructive relationships; to manage emotions and to develop effective behavior.
- Consider how the individual processes information and how we as "teachers" apply a learning philosophy.

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Learning Theory Considerations for the SLP

- How does the environment influence learning?
- Is the learner passive or active?
- What is the task of the "educator?"
- What is motivating to the learner?
- What encourages transfer of learning to new situations?

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Learning Theories

1. Behaviorist
2. Cognitive
3. Social

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Behaviorist

- What is directly observable? Learning as product of stimulus conditions and responses. Ignore what happens inside the individual and manipulate environment to promote change. Use of reinforcements.
- Teacher-centered model with "passive" learners. Who decides what is considered a "desirable" change in behavior?

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Cognitive

- Stresses the importance of the internal dynamics within the individual.
- Key to learning is how one perceives, thinks about, and remembers information
- Reinforcements are not necessary; learner's goals and expectations and motivating
- Information must be acted upon in some way

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Retrieve learned information by making it organized and meaningful:

- Gain learner's attention
- Inform learner objectives
- Stimulate recall of previous learning
- Present information
- Provide guidance to facilitate understanding
- Have learner demonstrate skill
- Give feedback
- Assess performance
- Work to enhance retention and transfer through application and varied practice

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- Considers how does learner best process information?
- "A significant benefit of the cognitive theory of health care is its encouragement of recognizing and appreciating individuality and diversity in how people learn and process experiences."
- *Comprehensive assessment is sensitive to cultural and linguistic diversity and addresses the components within the WHO framework, including body structures/functions, activities/ participation, and contextual factors.*

Part of our Preferred Practice Patterns

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Social

- Combines principles of behaviorist and cognitive theories
- Considers impact of social factors and social context within which learning and behavior occur
- Learning need not be the result of direct experience; can take note of others' behavior and subsequent consequences - "Role modeling."
- Role models = enthusiastic, professionally organized, caring, self-confident, good communicators, skilled.

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- Human mind is not just reactive – it is generative and creative (right-brain??)
- Individual engages in a transactional relationship between social environment and self
- **Self-efficacy (belief in one's ability to succeed) is key. Sense of low SE produces stress** **(ref: Tomkins "faith in patient's ability to achieve).**
- Responsibility is placed on teacher to act as exemplary role model and to choose socially healthy experiences for individuals to observe and repeat.

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Learning "blockers" vs. "facilitators"

- Ignoring considerations of learner's past
- Lack of clarity re: what is to be learned
- Inappropriate materials
- Low "readiness" to learn
- Lack of stimulation
- Lack of realistic expectations

- Organizing the learning experience
- Make it meaningful and pleasurable
- Is setting pleasing to senses?
- Recognize role of emotions
- Pacing according to learner's ability to process
- Practice new knowledge under varying conditions
- Selective reinforcement can signal that "new learning" has taken place
- Assess learning immediately as well as over time; adjust teaching as needed

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- All learning theories acknowledge the need to recognize and **relate new information (e.g., therapy) to the patient's past (e.g., self)** – **see the "WHOLE" picture.**
- So, in applying learning theory and right brain concepts, **we are applying researched principles of learning theory ("left brained science") to expand our approaches to include more holistic big picture approaches ("right brained")**

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Neuropsychology and Learning

- Learning is a function of physiological and neurological developmental changes that are ongoing and dynamic; the **brain** is now viewed as less fixed and it **changes with learning and experience – "plasticity**."
  - Greater treatment effects are seen for trained language behaviors
  - Use it and improve it
  - Complex and rich treatment environments are more likely to produce significant behavior gains

Let us not forget perhaps the most crucial:

- **Salience is important. Treatment must matter to the patient**
- **Meaningful practice strengthens learning connections, which may fade from lack of use**. ***One-shot counseling, education, explanations and insufficient practice are not effective.

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But, even if treatment is meaningful to PWA and they are motivated, important to keep in mind…

- Brain processing is different for each learner (pre-morbidly) – ***How did they learn best?***
- **Stress can interfere with or stimulate** learning – depends on individual coping, emotions, past experiences.
- **Treatment environment AND learning environment need to be robust**

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- If the patient's participation in the process and in the development of treatment goals are paramount, and the goals are relevant to their needs – ***Union of analytical approach and creativity/sensitivity is mandatory***.

Essence of blending the

of our profession.

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Left Brain / Analytical

- Chart review; integrate information to formulate initial hypothesis
- Standardized and non-standardized tests administered in sequential and methodical fashion (often "repeatable").
- Clipboard, bedside standing or sitting, taking specific data in real time
- Counseling – provide information on label, current status, prognosis
- Initiate stimulation-response hierarchy of skills/restorative treatment
- Caregivers as observers of therapy

Practice Patterns Snapshot

Right Brain / Creative and Flexible

- Chart; integrate information to formulate initial hypothesis
- Interview patient and family members – "Who is this person?" Repeatedly visit patient needs and "wants."
- Facilitate communicative interactions – what helps? What hinders? What can patient do versus not do? Implement real-life interactions.
- Limit clipboard, use supportive communication, sit at side, interact, qualitative data, use rating scales.
- Implement background music, modify lighting, aromatherapy. Or, YOU alone may need to be the comfortable setting.
- Counseling – provide information about strengths and weaknesses, graphic and written information about aphasia, talk about rehab process, prognosis
- Train communication partners early on – set stage for success
- Implement standardized testing and formal treatment once education about disorder has been initiated.

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Consistent with WHO, intervention is designed to:

- **capitalize on strengths** and address weaknesses related to underlying structures and functions that affect communication;
- **facilitate the individual's activities and participation** by assisting the person to acquire new skills and strategies;
- **modify contextual factors that serve as barriers and enhance facilitators** of successful communication and participation and provide appropriate accommodations and other supports, as well as **training** in how to use them.

Our practice patterns align nicely with principles of Adult Learning Theory mentioned earlier….

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- Practical Tools and Application

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Medical Based Services for PWA

Revisiting Tomkins Survey:

- Participants revealed satisfaction or dissatisfaction regarding both structure and relevance of therapy; whether or not it met their wants/needs.
- **Most influential factor across respondents was whether or not therapy was adjusted to suit individual expectations and needs.** (Tomkins, et al 2013).
- Same study revealed feeling of boredom, restriction and disempowerment during hospital stay

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Acute Care (Marshall and Campbell)

- Fresh and evolving strokes
- Interruptions; Noise
- Crisis Mode
- Dysphagia as priority
- Short LOS: avg. 6 days, yet post-lesional shock to nervous system resulting in decreased responsiveness to intact neurons remote from damaged area is at its greatest 2-5 days post-onset (Diaschesis).
- Multiple interventions

Best time to introduce formalized, decontextualized, and/or standardized testing??

Given above factors, is this the best time to ask, "Is my hair on fire?" or "Do you know where you are?" (…..again).

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Family Member Suggested Needs at onset of Aphasia

- What is a stroke?
- What is aphasia?
- Where can we get more information about aphasia?
- What is the best that we can expect?
- What can we do?
- What resources are available once we leave the hospital?

Avent, J, Glista, S, Wallace S., Jackson, J. Nishioka, J., & Yeip, W. (2005). Family needs about aphasia. Aphasiology, 19, 365-375. As cited in Holland, Counseling in Communication Disorders text, pg. 166.

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Facilitating Learning Success in Acute Care

- Learning "readiness" through informative counseling and establishing "culture of capability"
- Establish salience early on – Make it matter!
- Create aphasia-friendly environment : modifiable factors (Howe, Worrall and Hickson)
  - Noise
  - Speaking rate/simplified language
  - Speak to PWA directly
  - Provide resources and information

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TABLE 3
Facilitators for removing barriers

Type of facilitator	*Examples*	*Corresponding ICF environmental factor domain*
Environmental	Educate people to:	
	• Become aware of the need for aphasia-friendly environments	Attitudes
	• Alter written language to meet the needs of people with aphasia	Products and technology
	• Alter spoken language to meet the needs of people with aphasia	Support and relationships
	• Provide more time when interacting with people with aphasia	Support and relationships
Attitudinal	Educate people about the nature and impact of aphasia	Attitudes
	Challenge attitudes that are negative, patronising, and prejudiced	Attitudes
	Promote understanding of the barriers that people with aphasia face	Attitudes
Structural	Educate service providers/organisers to:	
	• Be aware of the changing needs of people with aphasia	Attitudes
	• Establish appropriate services and resources for people with aphasia	Services, systems, and policies
	• Be accountable to people with aphasia	Services, systems, and policies
	• Develop communicative access to work and education environments	Services, systems, and policies
Informational	Educate information providers to:	
	• Understand the nature and impact of aphasia	Attitudes
	• Understand that information needs of people with aphasia change over time	Attitudes
	• Provide information that is accessible	Services, systems, and policies
	• Provide information in different ways and in different languages	Services, systems, and policies

Adapted from Parr et al. (1997).

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See Handout:

Ref:
Tami Howe, Linda Worrall & Louise Hickson (2004) Review, Aphasiology, 18:11, 1015-1037, DOI: 10.1080/02687030444000499

Strength Based Intervention

- Holland speaks of **"Getting off to a good start"** with the assertion that early treatment should focus on counseling with direct intervention and that clinical encounters illustrate spontaneous **recovery "embedded into the familiar medium of conversation."**
- 1995 study by Murray and Holland found that patients who had only received 15 minutes of conversational counseling tx per day vs. those that received this plus 45 minutes of traditional stim-response treatment, actually had higher WAB AQ scores at discharge (cited in Marshall and Campbell).
- Emphasize what the PWA can "do" in the earliest phase of tx, despite the aphasia.

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- *Think about how you start a conversation with someone you have just met…*

Hi, I'm Jenn. What's your name? Nice to meet you.
…….
How are you today? Do you mind if we talk a bit?
……..
I see that you live in Springfield. I've only been here 5 years (pause….). How about you?
……..

You look pretty tan. I'm guessing you like to be outside.
……..
Oh, what a beautiful ring. How long have you been married?

- "Tell me why you're here."
- "Will a cork sink in water?"
- "Does it take longer to put on a hat than shoes?"
- "Does one pound of flour weight more than two?"
- "Is my hair on fire?"

Test batteries and drills ARE valuable, absolutely. We need them to help to aid differential diagnosis, to reveal level of breakdown, to develop goals, to track progress – but WHEN they are used could be negotiated.

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- "Show" versus talk about spontaneous recovery (less jargon, interact less formally, as a "friend").
- Observe and discuss daily changes
  - ***Example:*** ***"Wow, Mr. Evans, you were able to say "Good morning" to me today and to tell me how long you've lived in Springfield. You couldn't do that yesterday…."***
- Conversation can reveal small daily changes in a natural context, including use of alternative means.
- Plays to PWA's strengths and **SELF-EFFICACY**
- "Helps PWA and their families to mitigate the **'identify theft**' that results from communication disorders."
- "Helps the PWA enter into rehabilitation with some self-esteem and self-efficacy" (Holland, 2007)

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Acute Care Activity Suggestions

- Encourage families to track and record what the PWA expresses and understands
- Ask for some biographical information about PWA (go beyond habits, hobbies; ask about pet peeves, proudest moments)
- Complete menu forms together. Enlist a volunteer to help create aphasia-friendly menus.
- Structure conversation around biographical information to assess and track yes/no responses.
- Read Get Well cards; Write thank-yous.
- Structure command following with daily tasks (turning tv on an off, pressing call light, dialing phone, setting up and manipulating grooming)
- Watch part of tv program or video based on interests and discuss. Use family photos for discussion
- **Incorporate information counseling relating to aphasia into activities for answering questions, reading, speaking**
- Track task attention, task transitions, fatigue and frustration. Use rating scales.
- **Implement and model use of supportive materials and techniques.**

Ref: Holland, 2007

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Would your mindset change ?

- Johnson, Betty: 254; 78 yo L MCA CVA; moderate NFA; work on following multi-step pointing directions and naming objects, stating function
- Johnson, Betty: Retired HS Teacher, married over 50 years; 6 grandchildren; gardens; NFA; L MCA CVA; Motivated; great attention; Goals set for answering questions and following directions regarding aphasia and naming/identifying likes/dislikes. 78 years old, Rm 254

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Let's talk specifics regarding supportive materials…

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Visual Aids and Supports

Guidelines for text and graphics:

- **Text:**
  - Use 14 point or larger sans-serif font
  - Bold important words in larger type
  - One "box" per message with border around message box
  - Use everyday words

- **Pictures:**
  - Good quality pictures that are "adult" appropriate
  - One "meaning" per picture
  - Pictures for concepts are similarly styled
  - Use of white space
  - Consideration of potential visuo-spatial/scanning deficits

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Facilitative MMC Tools:

- Aphasia Friendly Resources

http://www.aphasiafriendly.co/free-resource-library.html

- Patient Provider Communication

http://www.patientprovidercommunication.org/communication_tools.htm

- Accessible Information Guidelines

https://www.stroke.org.uk/sites/default/files/Accessible%20Information%20Guidelines.pdf(1).pdf

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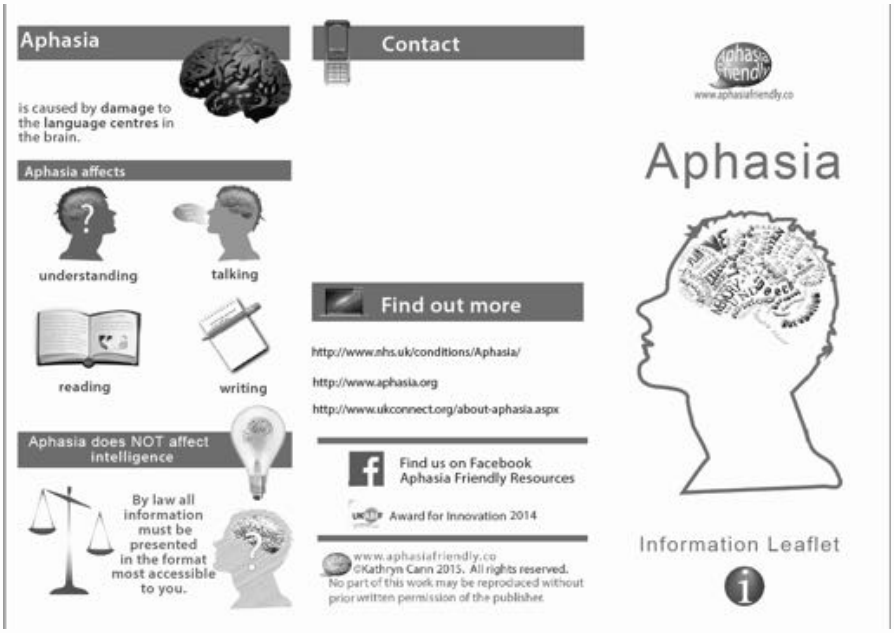

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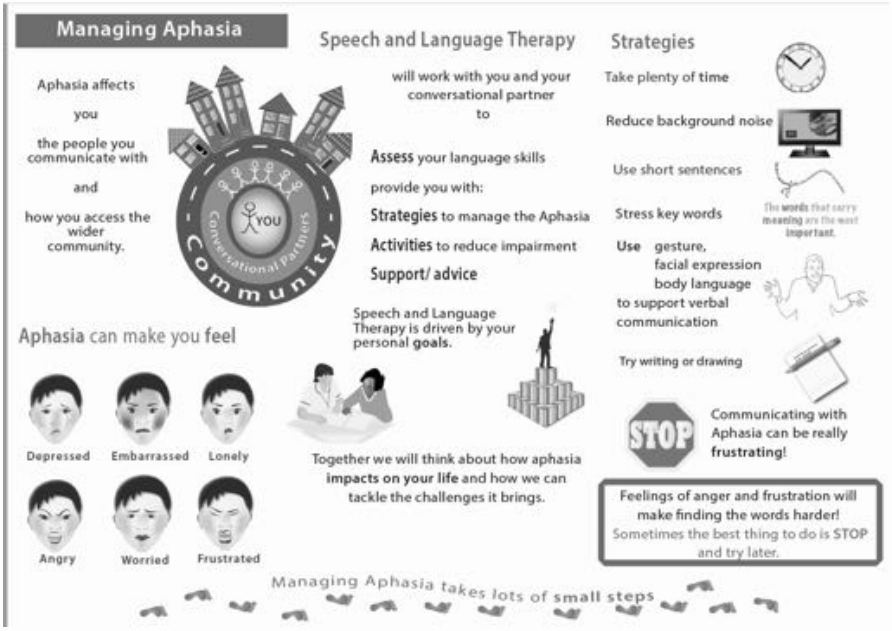

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Aphasia Access Videos and News

- **Aphasia Access**
  http://www.aphasiaaccess.org/educational-videos (in addition to being helpful for patients and families; can be used in in-services to other providers).
- **American Stroke Association Stroke Connection Magazine**
  http://www.strokeassociation.org/STROKEORG/StrokeConnectionMagazine/InStroke-Connection-Magazine_UCM_308575_SubHomePage.jsp
- **National Stroke Association StrokeSmart® Magazine**
  http://support.stroke.org/site/PageServer?pagename=strokesmartsignup&gclid=CjwKEAjwuo--BRDDws3x65LL7h8SJABEDuFR8Wwu4W6ZdsOBhRhqTITbs3OUYAVW3JHrHYYJBVuS7RoCijfw_wcB

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Inpatient to Outpatient Rehab

- Laying the foundation (Holland):
  - Need to explore family and patient expectations regarding therapy (i.e., "rehabilitation magic").
  - Help learn the routine (i.e., solve the rehabilitation mystery").

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Family Member Suggested Needs at onset of SLP Tx

(Avent, et al as cited in Holland counseling text)

- What is the purpose of testing and of treatment?
- Can we watch or participate?
- How can we improve interactions?
- How can we help?
- What other things should we be aware of?
- Is there someone we can talk to who has gone through this?

Avent, J, Glista, S, Wallace S., Jackson, J. Nishioka, J., & Yeip, W. (2005). Family needs about aphasia. Aphasiology, 19, 365-375. As cited in Holland, Counseling in Communication Disorders text, pg. 172.

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Important Issues

- PWA and family are new to aphasia and to rehab process, which is *SWIFT!*
- Often, perception is that rehab is the "end game."
- Need to communicate that it is the "first significant step in living successfully after stroke." It is not magic. It is not the final step. (Holland, 2007)
- Provide explicit information regarding therapy and rehabilitation (schedule, staffing, meals, routine, meetings). Reference sections from the HOPE Guide and redesign to be more PWA friendly. https://www.stroke.org/sites/default/files/resources/NSA-Hope-Guide.pdf

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Involving Family in Tx

- **Supportive techniques** *should* have been role-modeled in acute care**
- **Train family** is specific methods; too often, this does not happen until chronic/outpatient phase
- **Revisit education** about aphasia; show videos; provide written information. Establish written communication system to facilitate dialogue.
- See **"family as expert."** Incorporate the knowledge they have about their loved one into treatment tasks to increase salience and showcase capability.

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For the PWA

- Time for full assessment battery? Perhaps just sections?
  - Balance with single tests that are likely to reveal greater areas of competence, particularly for those severely impaired – NEPT, MCSTA, non-standardized drawing protocol, reminiscence subjects/rating scales.
- Emphasize the need to attach meaningfulness to what we are doing – otherwise, will impede learning. Incorporate patient interests in both drill based and naturalistic therapy.
- Conduct a patient-centered assessment with conversational interviews – What does the patient want to participate in? (Hinkley, Yones, and Wong)
- Assess readiness to learn – wakefulness, pain, depression, anxiety? The role of exercise and activity – better to have SLP tx pre or post PT/OT?
- Assess learning environment – is it deprived of visually pleasant stimulation, aromas, sound? Balance with not allowing it to be too distracting.
- Timing and structure of therapy delivery
- Talk about treatment and how to work toward making learning permanent
- Provide information regarding the therapy you are recommending. See aphasia therapy guide: http://www.aphasia.org/aphasia-resources/aphasia-therapy-guide/?gclid=CjwKEAjwuo--BRDDws3x65LL7h8SJABEDuFRwExVj8E4Ede-ABORTu2Jf2h4LROIzsEmp8ucN1hXFRoC9YDw_wcB

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Goals and Feedback

Goals and Objectives:

Consider using LPAA Goal Attainment Scales versus traditional % correct goals

- +2 Most Favorable Outcome
- +1 More than Expected Outcome
- 0 Expected Outcome
- -1 Less than expected outcome
- -2 Least Favorable Outcome

(Moganstein and Smith, 2007)

Feedback – Be a Coach!

- "I think that sounded better than your first try, what do you think?"
- "Great, you seem to understand. Are you confident?"
- "Actually, let's try it again. I don't think your family will make sense out of it."
- "It can't hurt to try it once more. How about it?"

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Outpatient and Beyond

- Family Member Information Needs *after* Discharge from Tx (Holland)
  - What alternative therapies or activities are available?
  - Whom can we call when we have questions?
  - What else can help at home?
  - Where can we get travel information?
  - Is job training available?
  - What support services are available?
  - What resources are available for long-range planning?

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Outpatient and Beyond

- 6 months is about when when folks would like additional info re: aphasia (Rose, Worrall, Hickson, and Hoffmann)
- Revisit LPAA in meaningful way – explore options for functional goal attainment.
- Caregivers active in therapy process – feedback and praise for both
- Communication group therapy
- Online support groups http://strokeconnection.strokeassociation.org/Everyday-Survival/
- Opportunities for advocacy and teaching others –SPEAK TO GROUPS, IN CLASSES, Toastmasters https://www.toastmasters.org/About/Who-We-Are
- Learn something new
- Set up for success following discharge – online groups, meet up groups, university clinics

"Fit the disability In" versus "getting over it." (Holland, 2007)

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Final Thoughts

- Remember, it's not about neglecting or omitting evidenced-based intervention
- It's about adding and enhancing our approach toward a more patient-centered focus
- Collaborate vs. Prescribe
- See the BIG PICTURE, TAKE a RISK, See Patient an Family as LEARNERS.
- Approach with STRENGTH in Mind

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Small changes toward creating "culture of capability"

- **Upon receiving an order to evaluate a patient on "CVA/Stroke" protocol, my first thought will be**
  - How has their life changed?
- **Approach assessment with a great deal of flexibility**
- **Implement the use of MMC tools**
- **Naturalistic interaction regardless of the patient's level of severity**
- **Describe, in equal measure, both the deficits and strengths of the PWA.**
- **Describe what the patient is capable of**
- **Ask how the patient best learned information prior to their stroke.**
- **Work the patient toward achieving success with life participation activities.**

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Thank you!

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