Aphasia rehabilitation best practice statements: development, validation and implementation

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Aphasia Best Practice Statements

Australia, my home


Australia, my home

Dr Emma Power Speech Pathology, University of Sydney
Australia, my home


Univeristy of Sydney, Australia

Discipline of Speech Pathology, Faculty of Health Sciences campus University of Sydney – research and teaching position

**Interests**
(i) enhancing life participation for people with neurological cognitive-communication deficits and
(ii) knowledge translation (KT) and EBP
Who are you?

Overview

› Background to the BPS
  (i.e. some problems for aphasia rehabilitation)

› A solution:
  1. Develop a pathway with best practice recommendations
  2. Validate it
  3. Create an implementation platform
  4. Implement it

› Discussion
  1. Let’s take section 8 together....

› Summary
Background to the BPS
(i.e. some problems for aphasia rehabilitation)

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Discussion
1. Let’s take section 8 together....

Summary
The Problems - 1

› How do people with aphasia and their families experience aphasia rehabilitation?

1. They had good and bad experiences of aphasia rehabilitation
2. Their experiences of the health system after the stroke were very important to them. The journey was important.
3. There was variability in aphasia services within the continuum of care and across districts/areas –i.e. lack of equity
4. There was no “road map” or pathway for what would happen to them

(Tomkins et al., 2013; Worrall et al., 2011; Howe et al., 2012)

The Problems - 2

› Not many good SYNTHESISED TOOLS /guides for best practice (Rhode et al., 2012)

→ Best then was the Australian National Stroke Foundation (NSF) stroke guidelines
→ Implementation of CPG improves stroke care and outcomes post stroke (Hubbard et al., 2012)

› But even when quality guidelines are available, there are challenges implementing them...
To what extent are you implementing stroke best practice guidelines for clients with aphasia?

1 = Not at all
2 = Sometimes
3 = Most of the time
4 = All recommendations all the time

How do you know you are? What hinders/helps?
### National survey

- **Hadeley, Power & O’Halloran (2014)**

- **320 commenced survey → 254 eligible**
  - 7 had not seen a person with stroke recently
  - 46 (15%) had seen a person with stroke but did not use CPG

- Good representation:
  - Wide distribution by state, demographics similar to SPAA
  - Significant differences on demographics between those who did and did not use CPG (p<0.05)

### Barriers – Guideline itself

- **93/254 (32%)** reported the guideline itself was a barrier

- **Top three reasons:**
  - Recommendations were not practical (81.5%)
  - Lack of high-level evidence (50%)
  - Insufficient or poor information for practice (49%)

> “They are **not detailed enough** and effectively represent a stand alone document, rather than a package of tools to put them into clinical practice. They’re not dynamic in a web sense, but static…”

> “**Difficult to implement i.e. daily therapy for someone with aphasia** when you may have 4 people with aphasia on the caseload, new admissions daily and only 4 hours of paid time for the stroke caseload.”
### 2.3 Communication

#### Stroke CPG (National Stroke Foundation, 2010)

<table>
<thead>
<tr>
<th>Grade</th>
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<tbody>
<tr>
<td>C</td>
</tr>
<tr>
<td>GPP</td>
</tr>
</tbody>
</table>

**2.3.1 Aphasia**

- **a)** All patients should be screened for communication deficits using a screening tool that is valid and reliable.
- **b)** Those patients with suspected communication difficulties should receive formal, comprehensive assessment by a specialist clinician.
- **c)** Where a patient is found to have aphasia, the clinician should:
  - document the provisional diagnosis
  - explain and discuss the nature of the impairment with the patient, family/carers and treating team, and discuss and teach strategies or techniques which may enhance communication
  - in collaboration with the patient and family/carer, identify goals for therapy and develop and initiate a tailored intervention plan. The goals and plans should be reassessed at appropriate intervals over time.
- **d)** All written information on health, aphasia, social and community supports (such as that available from the Australian Aphasia Association or local agencies) should be available in an aphasia-friendly format.
- **e)** Alternative means of communication (such as gesture, drawing, writing, use of augmentative and alternative communication devices) should be used as appropriate.
- **f)** Interventions should be individually tailored but can include:
  - treatment of aspects of language (including phonological and semantic deficits, sentence-level processing, reading and writing) following models derived from cognitive neuropsychology
  - constraint-induced language therapy

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**NSF stroke guidelines (2010) – Note currently being updated**

Barriers – work environment

› 224/254 (88%) said work environment was a barrier

› Top three reasons:
  - Insufficient time (92%)
  - Lack of resources to carry out recommendations (81%)
  - Lack of interest / influence from others (e.g. colleagues) (58%)

"Insufficient local resources create huge barriers to complying with the guidelines, whether it’s staffing, insufficient treatment spaces etc ... if the consultant doctors are not on-board with the guidelines, it can be difficult to advocate for a person’s length of admission that allows them access to the duration and intensity of multidisciplinary input due to bed-pressure".

(The Knowledge-to-Action Framework (KTA); Graham et al., 2009)
Despite CPG, there are still evidence-practice gaps.
Evidence-to-practice gaps

Aphasia friendly information provision

Recommendation (A)

1. All stroke survivors and their families/carers should be offered information tailored to meet their needs using relevant language and communication formats (Grade A).

Results

Of the 92 hospitals with a stroke unit, 91 (99%) routinely provided information about stroke to patients, compared to 43 (51%) of the 85 hospitals without stroke units.

Aphasia friendly communication was available for all information provided to patients with stroke in 17 (10%) hospitals. ‘Some’ aphasia friendly material was available in 46% of hospitals.

Background to the BPS
(i.e. some problems for aphasia rehabilitation)

A solution:

1. Develop a pathway with best practice recommendations
2. Validate it
3. Create an implementation platform
4. Implement it

Discussion

1. Let’s take section 8 together....

Summary
A solution?

1. 2014 synthesis of evidence and expert opinion
   - What is the evidence for each step along the continuum of care (include all levels of evidence/designs and qual)?
   - Considering the evidence, what is the consensus of an expert panel about best practice along the continuum of care?
   - How can we help SLPs achieve best practice?

2. Australian Aphasia Rehabilitation Pathway
   (www.aphasiapathway.com.au) - Packaging evidence in a more clinician friendly way with more resources

The pathway

Aim of the Australian Aphasia Rehabilitation Pathway
To improve the overall journey for people living with aphasia by developing a rehabilitation pathway within a knowledge transfer framework
What is a pathway?

› A tool that **promotes organised and efficient patient care** based on the best available evidence and guidelines.

› A pathway aims to **deliver the recommended care to the right person at the right time**.

› **Other terms:**
  - Integrated care pathways
  - Clinical pathways
  - Patient journeys
  - Care maps

(Kwan et al., 2004)

How was it developed?

› **A community of practice (CoP) approach**

› **CCRE Aphasia Community of Practice:**
  - 12 investigators
  - 24 research affiliates
  - 33 doctoral students
  - 200 clinical affiliates
  - Consumer reps from AAA
  - Reps from NSF

› **Three initial face to face meetings** + emailed versions of the AARP for comment using Google documents
Aphasia Best Practice Statements

KNOWLEDGE CREATION
- Knowledge inquiry
- Knowledge Synthesis
- Tailor knowledge

ACTION CYCLE
- Identify problem/gap
- Identify, review & select knowledge
- Adapt to local context
- Assess barriers / facilitators
- Select, tailor, implement interventions
- Evaluate outcomes
- Sustain knowledge use
- Monitor knowledge use

(The Knowledge-to-Action Framework (KTA); Graham et al., 2009)

The Australian Aphasia Rehabilitation Pathway (AARP) – Version 1!
The pathway is the ‘casing’ for the statements

**Needed to:**
- Populate pathway with statements + evidence
- Validate this with a group of aphasia experts

**Aim:** To develop an expert-endorsed set of evidence-based recommendations for aphasia → **Best Practice Statements** (*Power et al., 2015*)

**Using a systematic approach** → **RAND/UCLA Appropriateness Method (RAM)** (*Fitch et al., 2001*)
Validation and BPS

Development and validation of Australian aphasia rehabilitation best practice statements using the RAND/UCLA appropriateness method

1st Step
Collation & synthesis of evidence

- Identified need for more detailed aphasia recommendations
- Identified major rehab steps with Community of Practice
- Conducted literature reviews
- Content experts assisted translating evidence into statements

Method – 2 steps

1. RECEIVING THE RIGHT REFERRALS
2. OPTIMISING INITIAL CONTACT
3. SETTING GOALS AND MEASURING OUTCOMES
4. ASSESSING
5. PROVIDING INTERVENTION
6. ENHANCING THE COMMUNICATIVE ENVIRONMENT
7. ENHANCING PERSONAL FACTORS
8. PLANNING FOR TRANSITIONS
Method – 2 steps

SECTION 6 :: ENHANCING THE COMMUNICATIVE ENVIRONMENT

<table>
<thead>
<tr>
<th>Best Practice Statement: 6. Enhancing the communicative environment</th>
<th>Reference</th>
<th>Level of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Communication partner training should be provided to improve the communicative environment provided by frequent communication partners for the person with aphasia.</td>
<td>(Simones-Mackie et al., 2018)</td>
<td>I</td>
</tr>
<tr>
<td>Rationale: Communication partner training was shown to be an effective approach for improving communication activities and/or participation of same communication partners.</td>
<td></td>
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</tr>
<tr>
<td>6.2 People with aphasia should have support material available to enable them to participate in communication.</td>
<td>(Rose et al., 2003)</td>
<td>III-2</td>
</tr>
<tr>
<td>Rationale: A preliminary study showed that aphasia friendly material (AFM) assists people with aphasia to comprehend written information (Brennan, Wormalt, &amp; McKenna, 2006; Rose et al., 2003). Recommendations for how to best format printed education material (RAM) for people with aphasia include: short, simple language; content that is relevant and interesting to the reader; an explicit font; bolding of important information; well-organized information and the use of relevant graphics that contain captions (Rose et al., 2002; Rose, Wormalt, Hickson, &amp; Hoffmann, 2012).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.3 Communicatively accessible environments should be provided for people with aphasia.</td>
<td>N/A</td>
<td>QPP</td>
</tr>
<tr>
<td>Rationale: Environmental barriers exist at the system, service and policy level and efforts to reduce these barriers are likely to improve communicative access for people with aphasia (Duchan, Jennings, Barter, &amp; Butcher, 2004; Kagan &amp; LeBlanc, 2002; Parr, Pound, &amp; Hermitt, 2006). These peer-reviewed articles describe the clinical experiences of creating communicatively accessible health care and community services for people with aphasia and other communication disabilities (Duchan et al., 2006; Kagan &amp; LeBlanc, 2002; Parr et al., 2006). It is recommended consideration be given to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Establishing an advisory group that includes multiple perspectives and expertise.</td>
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<tr>
<td>2. Involving people with aphasia at every step.</td>
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</tbody>
</table>

2nd Step
Expert validation process (RAM)

- 9 aphasia experts identified and agreed to participate
- Round 1: 74 statements were rated via email on 9 pt. scale = “appropriateness”
- Round 2: Face-to-face meeting: areas of difference discussed. BPS re-rated
- Statements with high agreement & “appropriateness” retained
Results – RAM

Round 2: Face to face meeting - Sydney

› Rated 74 statements over 8 areas of care
› ++ discussion primarily on wording of statements
› 13 statements were added through splitting existing items or adding new statements
› 7 statements were deleted leaving 83 statements
› Agreement reached for 82 of the final 83 statements

Results & Discussion – Best Practice Statements

<table>
<thead>
<tr>
<th>BPS Section</th>
<th>n =</th>
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</thead>
<tbody>
<tr>
<td>1    Receiving the right referrals</td>
<td>8</td>
</tr>
<tr>
<td>2    Optimizing initial contact</td>
<td>6</td>
</tr>
<tr>
<td>3    Setting goals and measuring outcomes</td>
<td>7</td>
</tr>
<tr>
<td>4    Assessing</td>
<td>5</td>
</tr>
<tr>
<td>5    Providing intervention</td>
<td>22</td>
</tr>
<tr>
<td>6    Enhancing the communicative environment</td>
<td>3</td>
</tr>
<tr>
<td>7    Enhancing personal factors</td>
<td>22</td>
</tr>
<tr>
<td>8    Planning for transitions and discharge</td>
<td>9</td>
</tr>
</tbody>
</table>
**Evidence Level**

- GPP (expert opinion) 38%
- Level I (Syst RVs of RCTs 28%
- Levels II-IV 14%
- Qual 20%

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**Results – Best Practice Statements**

**Best Practice Statement: 7. Enhancing personal factors - Working with people from Aboriginal and Torres Strait Islander backgrounds.**

<table>
<thead>
<tr>
<th>Reference</th>
<th>Level of Evidence</th>
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</thead>
<tbody>
<tr>
<td>(Betancourt, Cantilo, &amp; Green, 1998)</td>
<td>GPP</td>
</tr>
<tr>
<td>N/A</td>
<td>GPP</td>
</tr>
</tbody>
</table>

**Rationale:**

7.11 Speech pathologists should be trained in cross-cultural competence with particular reference to Aboriginal and Torres Strait Islander cultures.

Rationale: In order to commence the journey towards developing cultural competence and providing cultural security to Aboriginal and Torres Strait Islander clients, it is essential that speech pathologists engage with cultural competence training. Such training is known to enhance client engagement with health services and improve health outcomes. It is recommended that this training be carried out regularly.

7.12 Speech pathologists should implement local protocols that guide working with Aboriginal and Torres Strait Islander people and communities.

Rationale: General principles can underpin engagement activities and social in the development of relationships and appropriate cross-cultural communication. Such principles may include being respectful, being informed and informing others; establishing sustainable relationships; behaving ethically; being meaningful; being outcomes focussed and ensuring follow-up and feedback occur. It should be recognised that every community is unique and that great diversity exists in Aboriginal and Torres Islander society. Therefore speech pathologists should collaborate with their local Aboriginal and Torres Strait Islander communities to develop respectful local protocols.
Results – Best Practice Statements

Aphasia Rehabilitation Best Practice Statements 2014
Comprehensive supplement to the Australian Aphasia Rehabilitation Pathway

www.aphasiapathway.com.au

Four new ideas in the AARP

1. Goal setting comes before assessment -WHY?

2. Assessment is dynamic and therapeutic (WHO ICF)

3. Intervention is categorised in terms of (i) access to therapy, (ii) types of therapy and (iii) service delivery.

4. Great emphasis on personal factors → especially CALD, and Aboriginal and Torres Strait Islander populations.
For example - Goal setting comes before assessment

1. Easier to be person-centred if goals of patient and family are determined first.
2. 'SMARTER' goal setting framework (*Hersh et al, 2013*)

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Intervention is categorised into **access**

➢ **OVERALL ACCESS:**
   
   - “People with aphasia should be offered therapy to gain benefits in receptive and expressive language and communication in everyday environments”.

➢ **SPECIFICALLY MENTIONING CHRONIC STAGE:**
   
   - “People with chronic aphasia should be offered therapy to gain benefits in receptive and expressive language, and communication in everyday environments”.

➢ **TARGETTING ACUTE:**
   
   - “People with aphasia less than one month post onset could have access to intensive aphasia rehabilitation if they can tolerate it”.
**Intervention is categorised: type**

**Aphasia rehabilitation can include:**
- treatment of aspects of language following models derived from cognitive neuropsychology - word retrieval deficits, reading deficits, writing deficits
- treatment of sentence comprehension and production impairments
- discourse treatment
- augmentative and alternate communication
- constraint-induced language therapy
- gesture based therapy

**Aphasia rehabilitation should:**
- be tailored to the needs of the PWA and the nature of their communication difficulty
- address impact of aphasia on functional everyday activities, participation and QOL incl upon relationships, vocation and leisure as appropriate from post-onset and over time for those chronically affected
- address the needs of family/carers;
- include information tailored to meet the needs of PWA and family/carers;
- include communication partner training.

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**Intervention is categorised: service delivery**

› In addition to individual therapy delivered by a speech pathologist, aphasia rehabilitation may include:
- group therapy and conversation groups
- computer-based treatments
- telerehabilitation
- trained volunteers

- ? Can we do everything ourselves?
- ? Allied Health Assistants?

https://fresnostatelivewellblog.com/2015/02/05/aphasia-group/, www.constanttherapy.com
### Culturally and linguistically diverse populations (CALD)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Description</th>
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<tbody>
<tr>
<td>7.3</td>
<td>Health care providers should consider both cultural and linguistic factors of the person/family with aphasia that may have an impact on service delivery.</td>
</tr>
<tr>
<td>7.4</td>
<td>Where the speech pathologist is not proficient in a language of the person with aphasia, a trained and qualified interpreter, knowledgeable with the specific requirements for speech pathology, should be used.</td>
</tr>
<tr>
<td>7.5</td>
<td>Where a patient reports having used more than one language premorbidly, comprehensive information about the patient’s language history should be obtained.</td>
</tr>
<tr>
<td>7.6</td>
<td>Where possible, assessments should be used that are appropriate to the languages/dialects and cultural backgrounds of each client.</td>
</tr>
<tr>
<td>7.7</td>
<td>Where possible, treatment should be offered in all relevant languages and the relevant modalities.</td>
</tr>
<tr>
<td>7.8</td>
<td>Language behaviours unique to the bilingual person with aphasia such as translation, language mixing and switching should be considered in both assessment and intervention planning.</td>
</tr>
<tr>
<td>7.9</td>
<td>Speech pathologists should talk with the person with aphasia and their family about the roles the client has in the family and community.</td>
</tr>
<tr>
<td>7.10</td>
<td>Speech pathologists should explain terminology in a way that is relevant and culturally appropriate.</td>
</tr>
<tr>
<td>7.11</td>
<td>Speech pathologists should be trained in cross-cultural competence with particular reference to Aboriginal and Torres Strait Islander cultures.</td>
</tr>
<tr>
<td>7.12</td>
<td>Speech pathologists should implement local protocols that guide working with Aboriginal and Torres Strait Islander communities.</td>
</tr>
<tr>
<td>7.13</td>
<td>Speech pathologists should routinely check Aboriginal and Torres Strait Islander status in clients’ health records and with the clients themselves.</td>
</tr>
</tbody>
</table>

### Working with people from Aboriginal and Torres Strait Islander backgrounds

<table>
<thead>
<tr>
<th>Statement</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>7.14</td>
<td>Speech pathologists should offer the involvement of an Aboriginal Liaison Officer (ALO) where possible to advise on cultural issues and liaise with client and family.</td>
</tr>
<tr>
<td>7.15</td>
<td>Where the speech pathologist is not proficient in a language of the person with aphasia, a trained and qualified interpreter, knowledgeable with the specific requirements for speech pathology, should be used.</td>
</tr>
<tr>
<td>7.16</td>
<td>Speech pathologists should explain speech pathology terms in a way that is relevant and culturally appropriate to the Aboriginal and Torres Strait Islander person and their family.</td>
</tr>
<tr>
<td>7.17</td>
<td>Speech pathologists should include some varying time with Aboriginal and Torres Strait Islander clients and their family during the assessment process i.e. time talking about personal backgrounds (both therapist and client).</td>
</tr>
<tr>
<td>7.18</td>
<td>Speech pathologists should talk with the Aboriginal and Torres Strait Islander person with aphasia and their family about the roles the client has in the family and community.</td>
</tr>
<tr>
<td>7.19</td>
<td>Speech pathologists should take a holistic approach to assessment and management that is aligned to an Aboriginal and Torres Strait Islander worldview.</td>
</tr>
<tr>
<td>7.20</td>
<td>Where possible, assessments should be used that are appropriate to the languages/dialects and cultural backgrounds of each Aboriginal and Torres Strait Islander client.</td>
</tr>
<tr>
<td>7.21</td>
<td>Speech pathologists should develop an awareness of local Aboriginal health services and Aboriginal specific social services.</td>
</tr>
<tr>
<td>7.22</td>
<td>Speech pathologists should develop reflective practice skills so that they learn from each experience with an Aboriginal or Torres Strait Islander client and improve the service they provide with each new client with guidance of a mentor.</td>
</tr>
</tbody>
</table>
Implementation platform

http://www.aphasiapathway.com.au

The eight parts of the pathway
Inside the box – more detailed components

Receiving the right referrals

1. **Aphasia awareness**
   - By increasing aphasia awareness in the community, speech pathologists can help ensure early identification and management of aphasia.

2. **Aphasia screening**
   - To implement aphasia screening tools in environments, speech pathologists can help ensure that early intervention occurs.

3. **Communication training for health professionals**
   - Facilitating communication for those who work with people with aphasia, speech pathologists can provide aphasia rehabilitation in a collaborative approach.

Further into the box – best practice statements

Increasing aphasia awareness

**Best Practice Statements**

These statements about increasing awareness of aphasia have been developed by the NHMRC COPE in Aphasia Rehabilitation in accordance with the most up-to-date research and expert opinion.

1. **Community awareness of aphasia should be initiated.**
2. **In awareness campaigns, it should be established that aphasia can be an early and permanent condition of stroke.**
3. **Up-to-date clinical information should be given to people with aphasia and their family members.**

Dr Emma Power Speech Pathology, University of Sydney
Community awareness

How much is known about aphasia?

Aphasia is a largely unknown disorder to the public (Mais, 2007; Simmons-Mackie et al., 2010; Elman et al., 2000 & Code et al., 2001). A lack of public awareness of aphasia has negative economic, psychosocial, and political consequences (Elman, 2000). Surveys across multiple English-speaking countries show that while 3.25% to 16% of people have heard about aphasia, only 1.64% to 11.83% had some basic knowledge of aphasia (Mais, 2007; Simmons-Mackie et al., 2010 & Code et al., 2001). Many people hear about aphasia at work, so make sure you talk about it with your colleagues (Code et al., 2001).

More detail – background

Figure 1: “How did you hear about aphasia?” (Mais, 2007; Simmons-Mackie et al., 2010 & Code and Armstrong et al., 2001).
Aphasia Best Practice Statements

**The most useful bits - resources**

**RESOURCES:**

How can raise awareness of aphasia?

1. **Most useful bits - resources**
2. **Best practice statements**
3. **About**
4. **Contact**

**References:**


**Some pages have too much detail & no useful resources**

**Types of aphasia therapy**

Aphasia rehabilitation can include:

<table>
<thead>
<tr>
<th>Types of Therapy</th>
<th>Reference</th>
<th>Level of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment driven from cognitive neuropsychological models</td>
<td>Wang et al., 2012</td>
<td>1.0</td>
</tr>
<tr>
<td>- word retrieval deficits</td>
<td>3.2</td>
<td></td>
</tr>
<tr>
<td>- reading deficits</td>
<td>3.2</td>
<td></td>
</tr>
<tr>
<td>- writing deficits</td>
<td>3.2</td>
<td></td>
</tr>
<tr>
<td>Treatment of anxiety and depression</td>
<td>Thompson et al., 2002</td>
<td>1.0</td>
</tr>
<tr>
<td>Group therapy</td>
<td>Daley et al., 2011</td>
<td>2.0</td>
</tr>
<tr>
<td>Augmentative and alternative communication</td>
<td>Foster et al., 2002</td>
<td>2.0</td>
</tr>
<tr>
<td>Construction-based intervention</td>
<td>Zetsu et al., 2010</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Other pages have no detail and no resources...!

Aphasia Best Practice Statements

The Pathway

Strategies

- Receiving the right referrals
- Optimising initial contact
- Setting goals & measuring outcomes
- Assessing
- Providing intervention
- Enhancing the communicative environment

Enhancing personal factors

- Self-management
- Strategies
- Social supports
- Culturally and linguistically diverse (CALD) populations

References:


KNOWLEDGE CREATION

Knowledge inquiry

Knowledge Synthesis

Tools

Tailor knowledge

ACTION CYCLE

Monitor knowledge use

Select, tailor, implement interventions

Evaluate outcomes

Assess barriers / facilitators

Adapt to local context

Identify problem/gap

Identify, review & select knowledge

Sustain knowledge use

(The Knowledge-to-Action Framework (KTA); Graham et al., 2009)
Overview

› Background to the BPS
   (i.e. some problems for aphasia rehabilitation)

› A solution:
   1. Develop a pathway with best practice recommendations
   2. Validate it
   3. Create an implementation platform
   4. Implement it

› Discussion
   1. Let’s take Section 8 together....

› Summary

Discussion

› Look at the single page in front of you

› Think about your area of practice or past clinical placements – transitions may be important for many areas

› Discuss with the person next to you:
   - Do or did you do this in practice?  (How do you know?)
   - Do you think the BPS is important (& would your clients?) (rating 1 not very – 5 very)
### Planning for Transitions

<table>
<thead>
<tr>
<th>8</th>
<th>Planning for the next phase should be initiated as early as possible.</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1</td>
<td>Speech pathologists should be part of the discharge planning team and adopt an advocacy role to promote optimal care.</td>
</tr>
<tr>
<td>8.2</td>
<td>During transitions, timely, up-to-date, accurate and appropriate patient-related information should be shared with the receiving healthcare providers.</td>
</tr>
<tr>
<td>8.3</td>
<td>At the time of any transition, written information that includes current diagnosis, action plans, follow-up care, and goals should be provided to the patient, family and carers.</td>
</tr>
<tr>
<td>8.4</td>
<td>The speech pathologist, as part of an interdisciplinary team approach, should contribute information about the communication skills of the person with aphasia that may influence appropriateness of discharge.</td>
</tr>
<tr>
<td>8.5</td>
<td>Services that provide early supported discharge should ensure that the person with aphasia and their family is still carefully linked in with ongoing supports and appropriately prepared for the transition.</td>
</tr>
<tr>
<td>8.6</td>
<td>The speech pathologist should endeavor to connect the person with aphasia and their family with other people with aphasia, aphasia groups or support organisations.</td>
</tr>
<tr>
<td>8.7</td>
<td>As part of the interdisciplinary team, the speech pathologist should, for legal issues, document all observations regarding the person’s ability to understand written and verbal information and express their wishes.</td>
</tr>
<tr>
<td>8.8</td>
<td>People with aphasia and their families/carers should have access to a contact person for any queries post-discharge and know how to self-refer to appropriate speech pathology services after discharge if they feel further rehabilitation is required.</td>
</tr>
</tbody>
</table>

### Importance

1 (not at all) - 5 (very)

Do you do it?

---

**Implementation?**

![Diagram of the Knowledge-to-Action Framework](image)

(The Knowledge-to-Action Framework (KTA), Graham et al., 2009)
Our implementation study

› Shrubsole, Worrall, Power & O’Conner

Conducted a qualitative study using Theoretical domains framework (TDF) to determine barriers and enablers to guideline implementation for four recommendations

› Main four barriers were:
   - ‘environmental context and resources,’ & ‘beliefs about consequences’,
   - ‘beliefs about capabilities’ & ‘social influences’.

› SLPs working in the acute stroke setting reported more barriers to implementing aphasia recommendations than those working in inpatient rehabilitation setting

› So devise intervention for clinicians to help them.

Implementation RCT

› Pilot RCT implementation intervention for clinicians (not patients) for two recommendations:
   - Tailored aphasia friendly information
   - Collaborative goal setting

› Intervention consists of a workshop to SLPs incorporating evidence-based behaviour-change techniques such as:
   - Education (give them knowledge, skills, plus info on their compliance)
   - Persuasion (pw Aphasia persuade SLPs it is important)
   - Enablement (give them confidence in their skills)
   - Environmental restructuring (tailored, packaged resources meeting SLP needs)

› Interventions will be tailored to acute setting with clinicians help
Baseline data

“But we are already implementing the recommendations!!!”

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Site 1</th>
<th>Site 2</th>
<th>Site 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaborative Goal Setting</td>
<td>10%</td>
<td>10%</td>
<td>50%</td>
</tr>
<tr>
<td>Information provision (verbal)</td>
<td>0%</td>
<td>50%</td>
<td>90%</td>
</tr>
<tr>
<td>Information provision (written)</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

› Aim to create **behaviour change** in the acute setting
› Change works best when adherence is low (so have a good chance to improve practice)!
› Workshops occurring now!

BPS Discussion - limitations

› Comprehensive review but may not be exhaustive
› Judgments by a single panel may not reflect all opinions
› Have not returned final BPS to CoP for wider national consensus
› Internationally applicable but may require local adaptation
Overview

› Background to the BPS
  (i.e. some problems for aphasia rehabilitation)

› A solution:
  1. Develop a pathway with best practice recommendations
  2. Validate it
  3. Create an implementation platform
  4. Implement it

› Discussion
  1. Let’s take section 8 together....

› Summary

Summary

› The Best Practice Statements for aphasia rehabilitation are:
  - On the pathway website at www.aphasiapathway.com.au
  - A combination of evidence and best practice statements.
  - Embedded into the Australian Aphasia Rehabilitation Pathway.
  - AND combined with resources and tools attract speech pathologists to the website and may increase uptake of best practice statements.

› BPS critical foundation step for a national implementation effort in aphasia rehabilitation.

› Further implementation research required to evaluate the utility / impact of the BPS on practice / the journey for people with aphasia.

› For the article and references see Power et al., 2015 BMJOpen
Acknowledgements

› The CCRE in Aphasia Rehabilitation working group who developed and synthesised the initial best practice statements including Ms Emma Thomas, Professor Linda Worrall, Dr Miranda Rose, Professor Leanne Togher and Dr Emma Power. Ms Justine Robins and Ms Emma Leach who have provided administrative support for the development of the BPS.

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› Ms Kirstine Shrubsole – PhD Student in aphasia implementation science