Evidence-based rehabilitation for aphasia post stroke: Concrete plans to address the knowledge to action gap in Canada

Speech Language Pathologist Survey Report

Report Written by:
Sheila Cook and Katie Mairs, InFacilitation

June 3, 2013
<table>
<thead>
<tr>
<th>Table of Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>3</td>
</tr>
<tr>
<td>Section A: Demographics</td>
<td>6</td>
</tr>
<tr>
<td>Section B: Background</td>
<td>10</td>
</tr>
<tr>
<td>Section C: Best Practice Guidelines</td>
<td>12</td>
</tr>
<tr>
<td>Section D: Interventions</td>
<td>30</td>
</tr>
<tr>
<td>Section E: Enablers and Barriers</td>
<td>37</td>
</tr>
<tr>
<td>Section F: Comments</td>
<td>52</td>
</tr>
<tr>
<td>Appendix I: Communication to SLP</td>
<td>55</td>
</tr>
</tbody>
</table>
Executive Summary

The Aphasia Institute is partnering with a research team from across Canada to address an important knowledge to action gap. Although there is an abundance of research literature on aphasia, it has not been successfully translated into aphasia best practices or used effectively to help people with aphasia improve their communication skills, health outcomes and quality of life. The team recently received a Planning Grant from the Canadian Institutes for Health Research (CIHR) to complete some foundational work that will lead to a proposal for a larger project. The objectives of this grant entitled, “Evidence-based rehabilitation for aphasia post stroke: Concrete plans to address the knowledge to action gap in Canada” are to:

• To build an inter-professional team of clinician leaders, researchers, knowledge users and stakeholders with a shared goal of improving stroke care for people with aphasia;
• To conduct focus groups for individuals with aphasia and their family members to gather input on practice gaps based on their lived experience. Survey a subgroup of Canadian speech language pathologists to gather pilot data on current practices and what tools and techniques facilitate the integration of evidence into practice; and,
• To convene two knowledge exchange meetings and stakeholder engagement opportunities that will position the team to apply for a Knowledge Translation Operating Grant by:
  o Identifying gaps in the translation of aphasia rehabilitation evidence into practice
  o Developing plans and strategies to address these knowledge translation (KT) gaps
  o Forming and strengthening partnerships to support the implementation and evaluation of these strategies

The purpose of the SLP survey was to learn more about:
• Awareness of aphasia literature;
• Strategies being used by SLPs to support people with aphasia; and,
• Barriers and enablers to implementing stroke best practices related to aphasia.

The initial plan for the development of the SLP Survey was to use questions from two Australian surveys (1. Rose, M., Ferguson, A., Power, E., Togher, L. & Worrall, I. [In Submission]. Aphasia rehabilitation in Australia: Current practices and challenges. International Journal of Speech-Language Pathology. 2. Hadely, K., Power, E., O’Halloran, R. [In Preparation]. A national survey to identify speech language pathologist perceived barriers and facilitators to the implementation of stroke clinical practice guidelines in Australia.) However, it was determined that while some of the questions aligned with the objectives of the grant, others did not. As a result, a different plan of action was subsequently taken – Sheila Cook reviewed CSPBG and created a summary related to aphasia, a small team including Sheila, Aura, Nina, and Guylaine developed the survey questions, the survey was beta-tested, refined, and shortened, and Ada created the survey using Survey Monkey. Where possible the same questions and rating scales were used so the Canadian data could be compared to the Australian.

All Canadian SLPs with past or current experience working with persons with aphasia, SLP managers and professional practice leaders who supervise/support Canadian SLPs with past or current experience working with persons with aphasia were invited to complete the survey. The survey and a communication describing the purpose of the survey were emailed to Canadian Association of Speech-Language Pathologists and Audiologists (CASLPA) members. There are
approximately 190 of 4000 Canadian SLPs who indicated on their registration forms that they work in aphasia.

The survey took approximately 25 minutes to complete. The overall response rate of the survey was 73.7% (140 respondents). Most participants were aged 22-34 years, a speech language pathologist, had zero to five years of practice and experience with the stroke population, work in Ontario, work in large urban communities, and work in acute care – medicine.

The most common roles relative to services for people with aphasia included assess communication difficulties, provide aphasia therapy, provide aphasia education to persons with aphasia, provide aphasia education to family/friends of persons with aphasia, and consult with team members regarding aphasia. Most participants reported spending 0-10% of their time working on language or communication with people. Of patients with aphasia, 75-100% of participants indicated that these patients had stroke as the etiology.

Best-practice guidelines:

• 54% of participants agreed that they use the “Canadian Stroke Strategy – Canadian Best Practice Recommendations for Stroke Care, 2010” to inform their practice;
• 59% of participants indicated that they typically assess stroke patients for communication/speech 24-48 hours after admission or referral;
• 42% of participants indicated that they typically begin therapy for stroke patients for communication/speech 1-3 days after admission or referral;
• Participants indicated that aphasia therapy services are more commonly delivered either one-on-one SLP with patients and family member present or one-on-one SLP with patient only;
• SLPs tend to deliver aphasia therapy to people with aphasia in their facility or program during the week;
• People with aphasia participate in communication practice with family/volunteer every day of the week;
• Participants indicated that health care providers at their program/facility are occasionally taught methods of supporting or facilitating the communication of people with aphasia;
• Participants indicated that family members are taught methods of supporting or facilitating the communication of their family member with aphasia very frequently;
• Participants indicated that they very frequently provide opportunities for patients to communicate their feelings about communication challenges;
• Participants indicated that they very frequently describe aphasia to their patients;
• Participants indicated that periodic assessments for communication/speech are conducted for persons with severe and moderate stroke frequently;
• Participants indicated that discharge plans for a patient with aphasia very frequently include follow-up plans;
• Participants indicated that for patients with aphasia, assessments are performed very frequently to identify ability to interact socially, perform activities of daily living and communicate effectively in the community (e.g. shopping, banking); and,
• Participants indicated that they frequently spend time working with families of people with aphasia.
Interventions:

- For patients with dementia, participants indicated that the interventions in their program:
  - very frequently include deficit specific semantic therapy;
  - frequently include deficit specific phonological therapy;
  - occasionally include syntax training;
  - frequently include treatment of reading and writing;
  - frequently include other language specific therapy;
  - are less likely to include constraint induced aphasia therapy;
  - very frequently include functional communication activities of daily living;
  - very frequently include multimodality or total communication training;
  - occasionally include participation oriented intervention; and
  - very frequently include counseling.

- For family members of people with aphasia, participants indicated that the interventions in their program:
  - very frequently include caregiver education and communication partner training and frequently include emotional support;
  - Participants indicated very frequently doing education about the term aphasia with persons with aphasia, family of persons with aphasia, and other health care providers;
  - occasionally using education about the term aphasia with friends of persons with aphasia and community members/groups;
  - Participants indicated very frequently doing education about the causes of aphasia with persons with aphasia and family of person with aphasia;
  - occasionally using education about the causes of aphasia with other health care providers; and
  - rarely using education about the causes of aphasia with community members/group;
  - Participants indicated very frequently doing education about recovery in aphasia with persons with aphasia and family of person with aphasia;
  - occasionally doing education about recovery in aphasia with other health care providers; and
  - rarely doing education about recovery in aphasia with community members/groups.

Enablers and barriers:

- The most common enabler and barrier to accessing evidence was conference attendance and the availability of evidence-based summaries that include practice strategies respectively;
- The most common enabler and barrier to accessing support and resources related to aphasia was the availability of communication tools and availability of community-based aphasia services respectively;
- The most common enabler and barrier to team processes was functional communication intervention strategies and workload respectively;
- The most common enabler and barrier to evidence-based education was online opportunities (e.g., courses, e-Learning, webinars, CoPs) and training in aphasia communication techniques for community-based care respectively;
- Participants did not have opinions on whether the following are enablers or barriers to accessing evidence: usefulness of Canadian Stroke BPG, availability of BPG specifically for aphasia, availability of Canadian Stroke BPG, physician support of BPG, and information about how other organizations implement BPG.

Overall, it is anticipated that the results of the survey will be used to help inform the team's recommendations, as well as future grant proposals.
Section A: Demographics

Age:

Role:

Other:
  - ACC Specialist
Years of Practice and Working with Stroke Population:

Province or Territory Where You Work:
The Community/Communities You Work in is/are:

![Bar chart showing the distribution of communities worked in.](chart1.png)

Facility and Program You Currently Work in:

![Bar chart showing the distribution of facilities and programs.](chart2.png)
Other:
Public Health
• Public Health Clinic

Hospital
• Hospital based outpatient service, •NOT• a day hospital

Community
• Community - AAC program
• Work in community - home visits
• contracted service to community services - nursing homes nad client homes
• Community - Client's Own Home
• community-home
• Community- advocacy for communication accessibility, dignity in healthcare
• Community - private practice
• Community based home care
• supportive living sites
• Community - Adult Rehab Clinic

Acute Care
• Acute - Critical Care
• Acute - critical care, Acute - Emergency
• Acute - Heart & Vascular Surgery

Consultation
• Provide consultations only to long-term care
• Also provide consultations to community groups, long-term care facilities, occasional home visits

Education
• University Aphasia Program focused on educating healthcare students
• Education
• Schools, classes K through grade 6

Private Practice
• private practice
• private SLP clinic
• Private practice - community

Other
• Rehabilitation: Brain Injury
• Laryngectomee and tracheostomy
• Our hospital doesn’t have a stroke unit.
• We are formally called a rehab unit but it is not unusual to receive patients in a sub-acute stage - sometimes they are not ready for a full course of treatment
Section B: Background

Question 1 - What is your role relative to services for people with aphasia

<table>
<thead>
<tr>
<th>Role</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide aphasia therapy</td>
<td>120%</td>
</tr>
<tr>
<td>Provide aphasia education to family/friends of persons with aphasia</td>
<td>80%</td>
</tr>
<tr>
<td>Assess swallowing difficulties</td>
<td>30%</td>
</tr>
<tr>
<td>Consult with team members re: aphasia</td>
<td>20%</td>
</tr>
<tr>
<td>Direct clients to further medical and rehab. management</td>
<td>0%</td>
</tr>
<tr>
<td>Manage/gap/analyze SLPs</td>
<td>0%</td>
</tr>
</tbody>
</table>

Other: Education
- Provide aphasia education to healthcare students.
- Clinical educator for students working with clients with aphasia
- Train staff regarding communication strategies; dysphagia management
- Train caregivers in ways to support communication
- Direct clients to further medical and rehab. management

Augmentative and Alternate Communication Strategies

Other
- Acute care only at tertiary care level hospital
- Private Practice
- Supervise conversation group (run by CDA and volunteers)
- I work in home care and many of these questions I cannot answer
- Research
- I work in several programs in the hospital but I will respond re: outpatient rehab, as the needs here need to be highlighted

None
- Currently none
- No role, as I work in schools
Question 2 - What proportion of your time involves working on language or communication for people with aphasia?

Question 3 - What proportion of your patients with aphasia have stroke as the etiology?
Section C: Best Practice Guidelines

Question 4 - Use BPG to Inform Practice

I use the “Canadian Stroke Strategy – Canadian Best Practice Recommendations for Stroke Care, 2010” to inform my practice.

Comments:

<table>
<thead>
<tr>
<th>Theme</th>
<th># Comments</th>
<th>Representative Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Challenges applying</td>
<td>12</td>
<td>“To inform my practice - yes, but can these recommendations always be practically applied? - no.”</td>
</tr>
<tr>
<td>• Practicality</td>
<td></td>
<td>“In private practice. These address aspects of care not directly relevant to my practice setting.”</td>
</tr>
<tr>
<td>• Relevance</td>
<td></td>
<td>“However my facility does not support its full application.”</td>
</tr>
<tr>
<td>• Not supported</td>
<td></td>
<td>“Not specific enough for Aphasia but focuses solely on mobility issues (and a small section on swallowing).”</td>
</tr>
<tr>
<td>• Limitations due to setting (e.g. home care)</td>
<td></td>
<td>“However, the facility I work in does not follow them therefore pts with aphasia receive only 2 -3 session (very rarely 3) of therapy/day, none if they are not in stroke rehab.”</td>
</tr>
<tr>
<td>• Time limitations to read</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Resource constraints (staffing)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Not aware of BPG | 8 | “Have not heard of it or seen it.”  
“I do follow guidelines regarding best practice research, however I have not come across that specific document.” |
|---|---|---|
| Career Path | 2 | “Was not available when I worked with patients.”  
“I am a recent graduate so I’m sure this document was a part of my education however, I have not referred to it directly.” |
| Other resources that guide practice | 5 | “In working with the stroke team the lead physician encourages all staff members to follow and monitor for updates.”  
“Standard of care follow CASLPA.”  
“TBSST” (The Toronto Bedside Swallowing Screening Test©)  
“And the evidence based review of stroke rehabilitation.”  
“I also draw on my years of clinical experience in rehab and private practice settings.” |
Question 5 - Assessment

How soon after admission or referral do you typically assess stroke patients for communication/speech?

Relevant Best Practices (This information was not provided in the survey)

**Best Practice Recommendation 4.2**
Prevention and Management of Complications Following Acute Stroke
All patients admitted to hospital with acute stroke should be assessed by rehabilitation professionals as soon as possible after admission.

**Best Practice Recommendation 5.1**
Initial Stroke Rehabilitation Assessment
Rationale: Speech–language pathologists assess swallowing difficulties and provide swallowing therapy and compensatory techniques. The speech–language pathologist is also able to assess the degree of difficulty with communication and initiate appropriate therapy.
All persons with acute stroke should be assessed to determine the severity of stroke and early rehabilitation needs.

i. All patients admitted to hospital with acute stroke should have an initial assessment by rehabilitation professionals as soon as possible after admission preferably within the first 24 to 48 hours.

iii. All patients with acute stroke with any residual stroke-related impairments who are not admitted to hospital should undergo a comprehensive outpatient assessment(s) for functional impairment, which includes a cognitive evaluation, screening for depression, screening for fitness to drive, as well as functional assessments for potential rehabilitation treatment preferably within 2 weeks.
Question 6 - Initiate Therapy

How soon after admission or referral do you typically begin therapy for stroke patients for communication/speech?

Relevant Best Practices (This information was not provided in the survey)

Best Practice Recommendation 5.3
Delivery of Inpatient Stroke Rehabilitation

*All patients* with stroke should begin rehabilitation therapy within an active and complex stimulating environment as early as possible once medical stability is reached.

Timely access to specialized, interprofessional stroke rehabilitation services, regardless of geographic location of patients’ home community.
Question 7 - Therapy Services

How are aphasia therapy services delivered? Select all that apply.

<table>
<thead>
<tr>
<th>Theme</th>
<th># Comments</th>
<th>Representative Quotes</th>
</tr>
</thead>
</table>
| Caregiver Education and Training             | 111        | “Home program with family assistance.”  
“Training for family/caregivers re: supported conversation for aphasia.”  
“Family members providing therapy, where appropriate.” |
| Groups                                        | 1111       | “I want to try communication groups in long term care.”  
“Therapy Assistants run groups for clients; SLP educate/consult with client family members as needed.”  
“Communication groups are held if/when possible but not since spring 2012 due to MRSA and VRE outbreaks.” |
<table>
<thead>
<tr>
<th>Other</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>“We do not provide therapy in the traditional sense; but meet as a group to educate students and participate in activities in the community.”</td>
<td></td>
</tr>
<tr>
<td>“SLP trains family members; SLP trains staff &amp; volunteers in communication strategies.”</td>
<td></td>
</tr>
<tr>
<td>“I am the only SLP in a primary care hospital so I can only see so many patients and it is rare that the patient stays long enough or is alert enough for therapy.”</td>
<td></td>
</tr>
<tr>
<td>“Speech and Hearing Assistant providing therapy under SLP guidance.”</td>
<td></td>
</tr>
<tr>
<td>“Students, assistants.”</td>
<td></td>
</tr>
<tr>
<td>“I provide AAC consultation, not therapy.”</td>
<td></td>
</tr>
</tbody>
</table>
Question 8 - Rehabilitation Intensity: Hours

How many hours a week do people with aphasia receive speech-language therapy in your facility or program?

![Bar chart showing hours of therapy per week]

Relevant Best Practices (This information was not provided in the survey)

**Best Practice Recommendation 5.3**
**Delivery of Inpatient Stroke Rehabilitation**

i. Patients should receive the intensity and duration of clinically relevant therapy defined in their individualized rehabilitation plan and appropriate to their needs and tolerance levels

ii. Stroke patients should receive, through an individualized treatment plan, a minimum of three hours of direct task-specific therapy by the interprofessional stroke team for a minimum of five days per week
Question 9 - Rehabilitation Intensity: Days

What days of the week do SLPs deliver aphasia therapy to people with aphasia in your facility or program? Select all that apply.

![Bar chart showing the days of the week and the percentage of SLPs delivering therapy. Monday: 113, Tuesday: 113, Wednesday: 116, Thursday: 114, Friday: 106, Saturday: 9, Sunday: 3.]

Relevant Best Practices (This information was not provided in the survey)

5.2.2 For all settings (hospital, clinic, community) where stroke rehabilitation is provided
Post–acute stroke care should be delivered by a variety of treatment disciplines, experienced in providing post-stroke care, to ensure consistency and reduce the risk of complications.
Timely access to specialized inpatient stroke rehabilitation services.

- An adequate number of geographically defined stroke units with critical mass of trained staff; interprofessional team care during the rehabilitation period following stroke.
- Stroke rehabilitation units adequately staffed with clinicians with expertise in stroke rehabilitation.
- Resources to enable patient access to appropriate type and intensity of rehabilitation professionals throughout their stay (including weekends when required).
Question 10 - Rehabilitation Intensity: Practice

What days of the week do people with aphasia participate in communication practice (e.g. “homework” exercises, tools provided by SLP) with family/volunteer? Select all that apply.

Relevant Best Practices (This information was not provided in the survey)

Best Practice Recommendation 5.3
Delivery of Inpatient Stroke Rehabilitation
iii. The team should promote the practice of skills gained in therapy into the patient’s daily routine in a consistent manner
Question 11 – Provision of Educational Resources

You or your organization provide educational resources (e.g. stroke, aphasia, chronic disease management, transitions, etc.) that are:

Relevant Best Practices (This information was not provided in the survey)

**Best Practice Recommendation 2.1**  
**Lifestyle and Risk Factor Management**  
Educational resources, that are culturally and ethnically appropriate, are available in multiple languages and that address the needs of patients with aphasia.
Question 12 - HCP Trained in Aphasia Communication Strategies

Health care providers in your program/facility are taught methods of supporting or facilitating the communication of people with aphasia?

Relevant Best Practices (This information was not provided in the survey)

NO specific BPG found

Best Practice Recommendation 5.3
Delivery of Inpatient Stroke Rehabilitation

• A critical mass of trained healthcare providers functioning as a coordinated interprofessional team during the rehabilitation period following stroke.
• Adequate clinician resources to provide the recommended intensity of individualized therapies for stroke patients.
Question 13 - Families Taught Aphasia Communication Strategies

Family members are taught methods of supporting or facilitating the communication of their family member with aphasia?

Relevant Best Practices (This information was not provided in the survey)

**Best Practice Recommendation 6.2**

*Patient and Family Education*

…..Patient and family education should include information sharing, teaching patients self-management skills, and training of caregivers.

i. Educational content should be specific to the phase of care or recovery and appropriate to the readiness and needs of the stroke survivor, family, and caregiver. The scope of the educational content should cover all aspects of stroke care and recovery.

iv. Family and caregiver education should include training in personal care techniques, communication strategies, physical handling techniques other daily living activity goals and preferences, how to access community services and resources, problem-solving techniques, health system navigation, and self-management
Question 14 - Opportunities to Communicate Feelings

You provide opportunities for your patients to communicate their feelings about communication challenges.

Relevant Best Practices (This information was not provided in the survey)

NO specific BPG found
Best Practice Recommendation 6.2
Patient and Family Education
iii. Patient education should promote self-efficacy through mastering self-management skills, including action planning, modeling behaviors and problem-solving strategies, reinterpreting symptoms, and social persuasion through group support and guidance for individual efforts
a. Key topics in self-management training should include exercise, symptom management techniques, risk factor management, secondary stroke prevention, nutrition, fatigue and sleep management, use of medications, managing emotions of fear, anger and depression, cognitive and memory changes, training in communication with health professionals and others, and health-related problem-solving and decision making.
Question 15 - Describe Aphasia

You describe aphasia to your patients.

Relevant Best Practices (This information was not provided in the survey)

NO BPG found
Question 16 - Periodic Assessments

For persons with severe or moderate stroke periodic assessments for communication/speech are conducted.

Relevant Best Practices (This information was not provided in the survey)

Best Practice Recommendation 6.4
Discharge Planning

v. The rehabilitation needs of survivors of a severe or moderate stroke should be reassessed weekly for the first month, and then at intervals as indicated by their health status
Question 17 - Discharge Planning

When you discharge a patient with aphasia, do discharge plans include follow-up plans?

Relevant Best Practices (This information was not provided in the survey)

Best Practice Recommendation 6.1
Supporting Patients, Families and Caregivers Through Transitions

Patients, families, and caregivers should be prepared for their transitions between care environments by being provided with information, education, training, emotional support, and community services specific to the transition they are undergoing.

iii. Support should include:
   a) written discharge instructions from care providers that identify action plans, follow-up care, and goals, provided to the patient, family, and primary care giver

Best Practice Recommendation 6.4
Discharge Planning

Discharge planning should be initiated as soon as possible after the patient is admitted to hospital (emergency department or inpatient care).

iii. Information about discharge issues and possible needs of patients following discharge should be provided to patients and caregivers soon after admission

iv. Discharge planning activities should include patient, family and team meetings, discharge and transition care plans, a pre-discharge needs assessment, caregiver training, post discharge follow-up plan, and review of patient and family psychosocial needs
Question 18 - Assess Interaction & Communication Skills

For patients with aphasia, assessments are performed to identify ability to interact socially, perform activities of daily living and communicate effectively in the community (e.g. shopping, banking).

Relevant Best Practices (This information was not provided in the survey)

Best Practice Recommendation 5.6
Outpatient and Community-Based Stroke Rehabilitation
i. Early supported discharge should be considered for patients discharged to the community
ii. People who have difficulty in activities of daily living, including self-care, productivity and leisure, should receive occupational therapy or interprofessional interventions targeting activities of daily living
iii. Patients who are identified as high risk for falls in the community should have a comprehensive set of interventions implemented, such as an individually prescribed exercise program, in order to prevent or reduce the number and severity of falls
iv. People with difficulties in mobility should be offered an exercise program specific to those difficulties and monitored throughout the program
v. Patients with aphasia should be taught supportive conversation techniques
Question 19 - Family Support

You spend time working with families of people with aphasia.

Relevant Best Practices (This information was not provided in the survey)

**Best Practice Recommendation 5.3**
**Delivery of Inpatient Stroke Rehabilitation**
Stroke rehabilitation support initiatives for caregivers.

**Best Practice Recommendation 6.2**
**Patient and Family Education**
Stroke survivor, family and caregiver education is an integral part of stroke care that must be addressed at all stages across the continuum and at all transition points of stroke care for both adult and pediatric patients. Patient and family education should include information sharing, teaching patients self-management skills, and training of caregivers.  
i. Educational content should be specific to the phase of care or recovery and appropriate to the readiness and needs of the stroke survivor, family, and caregiver. The scope of the educational content should cover all aspects of stroke care and recovery.
**Section D: Interventions**

**Question 20 - For patients with aphasia, in my program, interventions include:**

Other:
- Does Not Apply
  - Does not apply to me at all - maybe I shouldn't fill out this survey...?
- Education/Communication
  - Education to staff and family and volunteers about aphasia, and SCA techniques
  - Little 'therapy' all AAC and communication support development and implementation
  - Conversation groups
- Other settings:
  - Work in home care
  - Provision of AAC system
  - Depends on client's needs
  - Outpatient Constraint Induced Aphasia Therapy Group to be piloted in near future
  - I work in an acute care setting
Question 21 - For family members of people with aphasia, in my program interventions include:

Other:

Family Need/Availability
- This is not usually provided unless sought out by the family or person with aphasia, due to the context in which we provide service (people with aphasia have been living with chronic aphasia for 1-25 years)
- Depends on family availability
- Depends on availability of family

Other program interventions:
- Occasionally homework exercises with patient
- Training on use of AAC system
- Device/technology training
- Some family members see the social worker for emotional support as well.
Question 22 - Please indicate how frequently you use these philosophical models or frameworks for people with aphasia.
Question 23 - Do you do education about the TERM “aphasia” with ......?

Other health care providers:
Students & Volunteers
  • Health care students (PT, OT, SLP, Audi, Medicine, Nursing, Dental, Pharmacy, Nutrition, +) - Very Frequently
  • Hospital volunteers
Family
  • Education of family depends on availability (population = inpt Rehab)
Other
  • depends on interest
  • healthcare team here in a rehab context is already quite education about aphasia.
Question 24 - Do you do education about the CAUSES of aphasia?

Other health care providers:

Students & Volunteers
- Health care students (PT, OT, SLP, Audi, Medicine, Nursing, Dental, Pharmacy, Nutrition, +) - Very Frequently
- hospital volunteers

Other
- depends on interest
Question 25 - Do you do education about RECOVERY in aphasia?
Question 26 - When providing education about aphasia which of the following do you use? Select all that apply.

Other:
- Just recently got an iPad for our output program so I intend on using this for future education.
- Invite previous patients and/or their family to provide feedback if they so wish/agree.
- My education is provided one to one (or few with family present). It is presented verbally with any supports that the client needs (printed words, diagrams, etc.)
Section E: Enablers and Barriers

Question 27 - ACCESS TO EVIDENCE: Currently, which of the following are enablers and which are barriers to the therapy you provide to people with aphasia? (BPG = Best Practice Guidelines)

Comments:

Usability/Relatability

- Access to evidence is not a barrier. The barrier is being able to apply it. Our programs are not designed to allow for anything remotely approaching best practice.
- The evidence based guidelines are helpful but I feel the conclusions drawn by Teassell et. al did not delineate well enough between intensive Tx and non-intensive. We already know aphasia therapy works with the right dose. We now need to know who needs which type of Tx.
- Most literature is non-specific and rarely replicable in clinical setting - little exists re: specific treatments and for which patients they would work.
- Almost none of my clients fit research inclusion criteria (they all have multiple severe conditions and usually ESL). And our model is mostly consultative, so, while read best practice guidelines, I find they seldom apply.
Funding
- Funding for continuing ed has been cut back at our hospital. I would like there to be more lit reviews/syntheses and evidence-based summaries including practice strategies. I find Ontario North Network helpful to attend Aphasia Interest Group at a distance.
- I understand from my own reading that at least 8 hours a week for at least 12 weeks is required for there to be any chance of improvement as measured by ASHA FIM. This is not funded. I am left with encouraging clients and families who can afford apps to use them, and wishing them good luck.

Support
- Difficulties are due mainly to the fact that there is lack of support from the organization and clinician should search and find information on its own. also application of such information is rarely supported by the organization

Time Constraints
- One of the major barriers is not lack of the materials, but lack of time to read/implement the ideas.

Other:
- The BPG need to address the practice setting - e.g. OP, community care etc.
- Information and resources on the Aphasia Institute website are helpful.
- Ontario aphasia centres interest group
- I don't find that much of this information finds its way to me - I have to go out and find it.
Question 28 - ACCESS TO SUPPORT AND RESOURCES RELATED TO APHASIA: Currently, which of the following are enablers and which are barriers in determining what you actually work on in therapy with people with aphasia.

Comments:

Barriers

• Management supports use of BPG but I have limited access to this information and no time to read it when I can get it. I'd love to improve our service delivery.

• Funding for SLP time & test/treatment resources is absent or severely lacking.

• Difficult to rate as not sure if you mean an actual 'barrier' to my work today or seen as an overall barrier or enabler irrespective of what is currently happening in our area. E.g., adequate SLP resources overall would be an enabler but this is not currently happening so I have rated this as a barrier to my practice today.

• Resistance of physicians and staff to learn more about aphasia - they often don't see the need for it mostly because they do not realize that their understanding of aphasia is very limited and often inaccurate.

• Inadequate availability of treatment time. No access to technology (computers, iPads) to allow patients to practice independently.

• Resource limitations in general being the biggest barrier
• York-Durham Aphasia Centre ++useful, but many of my patients can't travel to closest groups in Whitby and Peterborough. Also, I understand that there is no longer a PSW who can assist a person with the bathroom while attending the group and some pt's have found this a barrier. Very little communication therapy available from Central East Community Care Access Centre.

Enablers
• Private practice give me flexibility to pursue these professional development interests.
• My favorite aphasia outcome measures are the coast and carer coast, available free. More accessible and user friendly than the ALA. Access to adult aac clinic is an enabler for me

Other
• It is difficult for me to comment on links between the hospital and community services since I am the sole provider of both hospital and community based services in my region.
**Question 29 - TEAM PROCESSES:** Currently, which of the following are enablers and which are barriers in determining what you actually work on in therapy with people with aphasia.

![bar chart showing enablers and barriers]

**Comments:**

**Funding**
- Funding for SLP time & equipment resources are severely lacking.

**Workload/Resources**
- Workload is a huge barrier because often, dysphagia assessments take higher priority over aphasia assessments and therapy in the hospital setting.
- Supportive patient care manager on our complex continuing care unit who is funding nursing to attend SLP training sessions in communication impairments and strategies. I do write discharge notes with suggestions for communication but I suspect they are not followed up with as nursing home staff do not have training and CCAC SLP communication resources are minimal.

**Language**
- Lack of good tools in French.
Other

- I was somewhat confused by the format of this question and didn't know how to answer. Many of these items are things I would love to integrate more in my practice but currently do not. For example, I would like to do more community-based and functional assessments and intervention strategies but find there are barrier to doing this (caseload demands and a large rural region mean that I cannot see the clients as often and for as long as I would like to) - some services not available in our community

- Work in home care setting.

- We are a consult based program with few staff to manage a large zone in facility and assisted living. Another barrier is other professionals being aware of our program in order to refer to us.

- Not enough community programs, and long waitlists for those that do exist.
Question 30 - EVIDENCE-BASED EDUCATION: Currently, which of the following are enablers and which are barriers in determining what you actually work on in therapy with people with aphasia.

Comments:

Funding
- On-line information is available but usually tied into a fee to access which makes it a barrier. It would be nice to have a specific website to go for therapy techniques when starting out in stroke rehab

Support
- Lack of organizational support for above in acute care hospital and in community, especially community care access services.

Training
- I took the Aphasia Institute (AI) "Train the Trainer" course, and have used the materials to train staff, families and volunteers - very useful. AI pictographic resources were donated to our hospital by Central East Stroke Network - very useful. I find "speechpathology.com" a very inexpensive continuing ed resource.
- Training in adult AAC- low and high tech- enabler for me
- Time for PD is limited.
- We've had difficulty getting enough people to run education for family.

Other
- I own a private practice which specializes in stroke care. We just completed a telehealth project which we hope to present at the Canadian Stroke Network Conference.
Question 31 - List 5 priority items that would ENABLE you to consistently use evidence-based practices when supporting persons with aphasia and their family members. Consider access to evidence, support & resources, team processes and evidence-based education.

NOTE: This section organized the comments into high-level themes. A content analysis is recommended to identify sub-themes and specific recommendations.

Time

- Increased time to dedicate to adult communication disorders;
- More time to read the evidence in the workplace
- Time to read, gather them 2. Time to implement them
- More time or more staff to carry out programs and education sessions
- More time for continuing education
- Greater availability of SLP related research and literature
- Increased time to allow for interdisciplinary therapeutic interventions
- Increased time available - currently unable to address all of the areas of connecting with family members, communities and education for other health care disciplines and no work time allocated for ongoing education simply due to the high demands for the service.
- Understanding of management that we need to spend more time SEEING patients and less time WRITING REPORTS and doing data entry about patients
- Access to more time to actually DO assessment and intervention
- More time to read about the evidence-based practices
- Time to organize education groups for pwa and family members
- Time to read literature
- More time to stay up to date with bgps, journal articles etc.
- Decreased workload in order to increase time to find and read evidence Better resources and accessibility to materials for family education
- Increase in outpatient hours for the number of referrals Easier access to research More linkage with research SLP's and clinicians for aphasia research More time!
- Time to review material and implement
- Having enough time to determine what items we need (e.g. More aphasia friendly materials or more groups etc.) and figuring out a way to build while maintaining our caseloads
- Receive referrals for screening of all possible candidates for therapy
- Be awarded more time/ week : 2 days for intensive stroke rehab + referrals from geriatric rehab, ccc and acute are really low
- Need time to read the information
- More time/smaller caseload. pre-made programs/materials.
- time to read the evidence and attend workshops
- More time allotted to inpatient communication services.
- Access to SLP. In acute care settings, swallowing takes priority and therefore there is less time to appropriately plan and deliver aphasia tx sessions.
- Time to review articles. Time to discuss articles. Increase in community supports (more and reduce waitlist). Time for family and friends to attend therapy sessions. Time for family and friends to attend education sessions.
Training/Education

- Training re evidence-based programs;
- With More SLPs to discuss evidence-based practices with Professional Development days at work that focus solely on discussing up-to-date EVP
- Increased access to continuing education specifically related to aphasia - even through telehealth so as to limit some of the travel costs
- More time/ resources willingness of physicians to learn more about aphasia better access to high intensity therapy programs availability of communication assistants availability of volunteers
- Time to review evidence Access the time of team members to educate them Opportunity to demonstrate the effect of BPG to team members Prepared material to present to team members More SLP resources (FTE)
- More education TIME to attend conferences
- More opportunities to teach other health-care professionals about aphasia
- Time access to standardized testing material education of staff members access to journal articles time for continuing education
- Reading and discussing journal articles with peers
- Strong practice guidelines for across the continuum supported by stroke networks Better education of physicians, esp. neurosurgeons, re: benefits of aphasia intervention
- National outcome measure for SLP in Canada (like ASHA NOMS in USA) to provide better support for intervention Better public awareness of aphasia
- Time for evidence-based education time for looking at evidence
- Need frequent ongoing educational opportunities to highlight EBP
- Continuing Education; Educational Resources; Therapy Materials; Access to Support; Interdisciplinary Team
- Easily accessible articles (e.g. available in one publication or on one website) 3. physician education re: importance of aphasia education, assessment and treatment
- Better preparation in university
- Access to training EBP
- Resources to attend workshops more time to read the literature more frequent access to friends / family more regular access to functional settings more time to carry out interdisciplinary meetings with patients and family
- Review of literature removing studies with inadequate amounts of treatment to determine Tx strategies which were helpful rather than debating whether aphasia therapy is beneficial or not.
- Being an inpt therapist I usually don't complete IADL assessments. A tool to guide evaluation of same would be beneficial.
- Development of extensive speech/language restorative software (i.e., similar to bungalow) available in iPad rather than desktop to provide more intensity.
- I attended a train-the-trainer session by Aphasia Institute a few years ago. I found it helpful. Similar programs offered in other geographic locations would be beneficial.
- Our grad students having access to recent best practice guidelines as they provide most of our direct care
• More access to learning opportunities for functional activities (both online and classroom)
• More time to participate in education (online, courses, seminars) **note I find my patients (in-patient rehab) vary so much in terms of their deficits, specific functional needs, etc. that it can be very hard to put research into practice.
• Access to education. Organization/Government does not support continuing educations; therefore SLPs are expected to gain CEE outside work hours, when most webinars, conferences, etc. actually occur.
• Ability to provide direct training to staff re: aphasia and how to facilitate communication through general day-day interactions. Again our load is often too high and there time is not there to do so.
• Ongoing professional review/journal groups, resources for community education & continuity of care,
• Greater communication between professionals working with pwa (knowledge exchange) greater emphasis on researching community aphasia centres ease of access to information (journals etc.) attending conferences mandatory training
• Training in aphasia communication techniques for inter-disciplinary team.
• Time to participate in professional development opportunities.
• Access to Journal Articles - could this not be arranged through CASLPA. Regardless of area of service, SLPs are required to be familiar with evidence-based practice standards, yet we have no access to the majority of journals that would allow us to do so.
• Increased training opportunities in therapy for functional communication skills - locally (such opportunities tend to be centered more in provinces such as ON)
• Increased resources (print, etc.) re: therapy approaches, particularly functional communication skills)
• Access to reviews/summaries/meta-analyses of current BPG
• Up-to-date materials - many materials in clinics are out-of-date and often no longer comply with BPG. Wording is not familiar to patients/families and no longer reflects linguistic norms.
• Ability to increase frequency of intervention Training of entire team in supported conversation Access to technology to allow for further independent and supported practice of therapy goals Improved French language therapy resources Sufficient time/support to develop more communication groups
• Support to educate physicians and team members re: prognostics for aphasia therapy
• Better and more succinct summaries (with empirical research links) to highlight evidence-based practices by different practice settings (e.g., acute, community, individual, group, etc.).
• More support/resources for individual and group settings --> education for SLPs in order to lobby for effective treatment.
• More support and education regarding Constraint-Induced Language Therapy for SLPs and families/caregivers.
• A focus on functional skill training to support the life participation model
• Guidelines/support as to the amount of time/costs for SLPs and CDAs to run various treatment models (e.g., cost-benefit data)
• Provide more on-line training resources for SLP's b/o significant time limitations.
• Public awareness of aphasia.
• Time and funding for education and training in evidence-based practices - time designated
(decreased caseload demands) to provide more frequent therapy - support and funding for aphasia-support groups for patients and their families

Technology

- Increased electronic access to journals related to the field
- Increased participation from other healthcare disciplines when offering education sessions on Aphasia and communication support.
- New literature provided to SLPs by email list from college or stroke program
- Have an office, computer, phone, space for therapy instead of using momentarily free spaces and having to wait for a free computer
- More support from regional and international association to advocate for profession
- On-line opportunities such as Community of practice
- Access to a website that I don't have to register with - that includes free downloadable practical Patient handouts and assessment & treatment protocols - that are not restricted by copyright
- Ready to go, free, reproducible multidisciplinary tools such as multidisc assessment templates, goal setting templates, discharge plan templates & a comprehensive stroke passport for patients/families - that is nonpdf'd so it can be custom tailored to each patient.
- Access to free, easy to register to, weekly web-based stroke rounds with "typical patient" case scenarios/case presentations (a lot of times they present really unusual cases) that include handouts of the presentations and copies of the actual clinical tools, forms, protocols and patient education handouts and activities that they used with that patient
- Quick and easy access to prepared resources for patients and families/supporters - more education opportunities -workshops, webinars, etc. - which include videos demonstrating techniques such as supported conversation - greater community support for clients with chronic Aphasia
- Access to online journal databases through health authority
- Local access to courses/workshops (most available courses require travel + $$)
- More education opportunities offered and supported by agency
- Access to support staff or technology to add to Tx intensity provided.
- More access to technology (e.g., iPads, etc.)
- Access to online resources that are easy to locate, offer evidence to support techniques and are categorized by disorder.
- Increased access to webcasts/webinars (more of these, and more dissemination of knowledge through these modalities).

Team Approach

- A more integrated team approach
- More SLPs to be on a workplace team
- Greater opportunity to practice communication in functional settings (homes, communities, etc.)
- Increased opportunities to work in a multi-disciplinary setting to support communication for example during an OT functional (such as kitchen) assessment.
- Interaction with regional stroke program opportunities -interdisciplinary meetings for
treatment planning - community programs for patients practicing strategies

• Team support - some team members are resistant to new ideas

• Being able to put evidence into practice with the support of the SLP team, the inter-discipline team and management Collaboration with outside providers to determine what our patients get and when the best timing is More time to plan and work around communication in the community and/or activities of daily living

• A community based program that I could refer my patients to after they are discharged

• Regular, mandatory interdisciplinary team meetings - that include the FAMILY throughout the patient's stay, not just at discharge

• More involvement in discharge planning

• Opportunities for co-therapy with other disciplines.

• Health care providers to be given opportunity to participate in aphasia programming (often difficulty for sites to release staffing)

• More involvement in activities outside of therapy - e.g., make other therapies and meal times time for communication therapy as well

• Increased community-based SLPs to support transition from acute-care or rehab to home environment.

• Strong links between hospital and community services

• Information about how other organizations implement BPG

• Interdisciplinary team approach to goal setting and intervention

Resources

• Availability of resources/facility set-up (e.g., practicing skills in functional context vs. limitations of facility)

• Resources access to evidence-based education consistency of family members attending with clients

• Need resources so we can implement EBP guidelines

• Mostly availability of resources, but also availability of other places to refer patients to, since I work in an acute care setting, and frequently my patients are not well or stable enough to begin therapy and other medical needs/issues are taking precedence over speech/language issues.

• Info on EBPs readily available in easy to use/read formats. Resources made available. Volunteers, family members, and other staff made available to do practice with patients.

• Available workshops outlining EBP and aphasia assessment/treatment

• SLP Resources - acute care resources for aphasia are 'swallowed' by dysphagia

• Technician support for treatment and practice partners

• Collection of functional activities as a resource to treatment

• Aphasia sensitive material regarding cause and consequence, recovery and plan

• Knowing where to look for this EBP in aphasia therapy

• Support in accessing resources and therapy materials for our patients

• Access to resources that made community-based/functional goals more efficient to implement (e.g., banks of common goals and "tasks" that could be given to clients and family members to complete as homework)

• Access to meta-analyses of the different assessment and treatment options available and
researched for people with Aphasia.

• Access to aphasia friendly materials availability of assistant or someone to provide daily practice education of family members, care workers for better understanding of aphasia community support - not enough clients with similar background to start an aphasia group
• More current and relevant resources for aphasia.
• Access to evidence - perhaps a practice lead to guide us to most up to date info
• Access to aphasia friendly resources as timesavers
• Access to current resources Access to evidence-based education Access to support
• Awareness of community resources Improved team processes
• Better access to functional assessment tools
• Easier access to journals better accessibility to professional peers telehealth opportunities
• Easier access to aphasia friendly pre made material better access to group programs
• Access to clinically relevant research that is functional in its approach
• More direct 1on1 tx time with the SLP (as opposed to tx provided by support staff or many facilities’ current push toward group therapy
• Adequate SLP resources.
• Access to more SLP staff Access to CDA support Access to Admin support CE Access to appropriate resources/environments
• Better access to outpatient services and consistent follow up
• More resources for staff, family education; development of aphasia friendly resources, etc.
• Access to information on how to translate use of aphasia strategies to all staff on the unit. e.g. Communication mentorship
• Provide more practical and more easily accessible tools such as apps in conjunction with evidence-based support for this in order to gain organizational buy-in to purchase IPADS & other mobile devices.
• Resources to update materials
• Need access to information so we can look it up
• Solid research-based guidelines that are "do-able".
• More community-based resources. The argument of hospital managers/administrators is that if pt's do not have nursing or physical needs, then they don't need to be in the hospital. I see their point. Unfortunately, communication intervention is not available outside the hospital. 3. Access to evidence: literature reviews about the most efficient & efficacious assessment and therapy interventions; how to best use the time we have with the pt.

Management and Other Support

• Need management support to make changes to support programming to implement change & increase therapy time/services - add more staff
• Have others buy in to the importance of speech therapy 5) have buy in from family members on why they are key players
• Support from physicians regarding stroke rehabilitation would be helpful.
• Management support re: caseload
• Receive support from the interdisciplinary team
• I am concerned that in Ontario there is minimal support for people with aphasia in the acute care setting.
• support from CCAC wrt to number of visits allowed to make to clients with aphasia more evidence based education more functional assessment tools
• FTE to support achieving best practice guidelines for treatment intensity
• 5. Facilitate creations of organizational proposals for financial support for SLP time & equipment resources to facilitate programming, e.g. Proposal templates, sharing of ideas across organizations, educating stakeholders & decision-makers in community care access centres & government.
• More community-based affordable options for continuing therapy, etc.
• Awareness of other disciplines on the health-care team (nursing, OT, PT, doctors) about the value of communication intervention. These disciplines also often tend to see physical needs, seating issues, etc. as more important.
• Awareness by managers and hospital administrators of the value of communication intervention. This intervention is a low priority compared to nursing and physiotherapy intervention. Rehab stays are determined by nursing and physio needs; pt's communication needs are rarely considered when determining rehab stays or even candidacy for rehab.

**Funding**

• Funding
• More education money to attend conferences
• Government funding/resources to move forward with macro-level practices (e.g., educating community groups and social supports) 5. Increased access to online journals (I pay for access because it's my own priority, but I know many who do not share that priority).
• Access to funds for educational opportunities re: aphasia
• Provincial funding for stroke communication at least on par with physiotherapy & occupational therapy. E.g. Our FTE for stroke team SLP is only 0.5, which only enables swallowing interventions but not communication whereas for PT & OT they are 1.0 each.
• Increased funding for SLP coverage so that dysphagia assessments do not trump aphasia assessment and therapy.
• Access to and availability of evidence summaries Lack of funding for human resources (SLPs, assistants, volunteers) Lack of funding for physical resources and lack of space Lack of community based SLP service (only have acute care service with hospital based outpatients services to refer to) Lack of time to provide best practice service (large caseload to prioritize)
• Increased funding for staffing - thus more time to address communication in acute care (my main setting).

**Services**

• In-services / discussion from leaders
• BPG needs to address different service areas including home care which can be short-term and restricted in # of visits and long term access to SLP services. - number of visits permitted by the system is the greatest factor in determining what service can be provided Clients with aphasia spend the greater part of their life in the community or in nursing homes. - BPG should address more than communicating basic needs ( activities of daily
• Regular schedule of in servicing to Nursing and Allied Health staff. Regular schedule of SLP service development meetings
• Integrated services between in and outpatient programs
• More community based aphasia centers. More adult AAC clinics
• ACCESS TO WIFI for persons with aphasia living in nursing homes. ACCESS TO COMPUTERS/IPADS FOR persons with aphasia to use for self-practice EN鼓舞URES FAMILY INTERACTIONS WITH residents
• More professional development and ongoing training to stay up to date, more time allocated to this population (i.e. need for more S-LP's)
• Wide identification and dissemination of Best Practices. Best practices specific to treatment setting and acuity. Creative integration of SLP goals into other discipline's therapy.

Staffing
• Increase SLP staffing. Increase support staff. Education time off. Access to IT programs. Increase community resources.
• Adequate staffing; respect for professional expertise of SLPs; team support for promotion of communication opportunities for patients in all aspects of care; better understanding by physicians of communication impairments and treatments; intelligent management.
• SLP staffing has been adjusted over the years to accommodate dysphagia needs and not communication; SLP staffing needs to reflect that communication intervention is valued.
• We are currently short staffed with positions being frozen due to budget cuts. Therefore we are really limited in resources.

Other
• An attitude shift in management that puts more emphasis on quality and less emphasis on making excel spreadsheets look pretty in terms of "number of admits" and "number of discharges"
• Better access to the evidence (hospital does not have access to Medline)
• More evidence validating French tests and therapy material
• More support in French
• Decreased workload. More FTE. More Communication Disorder Technicians
• Having a designated stroke unit would enable opportunity to use evidence-based practices; not so much access to evidence but paucity of evidence in the field - access to new, updated materials - interdisciplinary goal setting (participation level) - link to research partners to help with translation of research to practice - link to research partners to help organize therapy into "mini research studies" that could lead to outcomes that are easier to interpret and replicate and can add to evidence informed practice.
• Improved workload relief to allow for time to review evidence. Improved access and availability for evidence-based practice. More frequent aphasia therapy technique education/training (e.g. more seminars, courses, conferences). Better ready-to-use therapy materials.
• More institutional priority put on communication (rather than swallowing!).
• More concrete, culturally sensitive/multilingual tool, summarizing and updating the most up to date research on intervention techniques.
• Manageable caseload that permits high priority patients to receive intensive treatment
Section F: Comments

Services

• Adults with communication and swallowing disorders are underserved throughout the province of BC in all areas - acute, community, long-term care.
• In the GTA (Greater Toronto Area), referrals for community access care services for stroke are most often denied or have significant wait times; community group support in other languages are lacking and government funding for aphasia is not as high a priority compared with swallowing interventions.
• Adult S-LP services in the province are underfunded and as a result it is difficult to provide optimal treatment to these populations. Our staff have been innovative and do the best that they can within the constraints of current staffing.
• It all sounds great and this is all so important, but the issues are complex. There are too many patients to see and too few SLPS. Moreover, I think that some of the treatment we give is not all that effective, in part because we just don’t have time to do it properly. When I look at Gabby Gifford’s and her amazing recovery following a gunshot wound, I wonder how many facilities in Canada would have just discharged her instead of taking the time to do the painstaking work needed to help her reach her maximum potential. Americans may do treatment too much at times and billing is a huge issue south of the border, but do we give people enough chances? And do we put enough thought into said chances? I think the answers are sometimes yes and sometimes no.
• Having a large geographical region to cover and a high demand for service makes meeting the best practices very difficult despite great intentions and efforts to do so on the part of employer and staff.
• More resources are badly needed as the number of patients with aphasia seems to be increasing. Incentives for physicians and nurses to seek training in communication strategies with people with aphasia would be most helpful. Education on aphasia should be a mandatory part of medical and nursing study program.

Time Constraints

• I find there isn't enough time to do therapy with my aphasia patients and that the dysphagia patients take up all of my time. I can only evaluate 2 per morning and even then the reports aren't quite finished. On top of that there are tracheotomy patients as well as the aphasia and dysarthria patients, to name a few. Unfortunately, therapy has to go on the back burner so that I can complete all of my evaluations.

Evidence, best practice guidelines

• We seem to be falling farther and farther behind an evidence-based practice ideal....
• There is a lot of evidence that can guide best practice in stroke care. I am surprised with the lack of interest or regard for this evidence.
• Adult AAC evidence says to offer it a.s.a.p., but waitlists are more than one year! Also SLPs and other professionals think of AAC as a last resort- should be first resort- but clinics have been halved.
• I have found that rather than programs and services that are solidly built around the current evidence, programs and services are endorsed and promoted that fit the hospital/Local Health Integration Networks funding models. It would be beneficial for CASLPA to
develop a Best Practice Guideline/Recommendations that could be disseminated to healthcare professionals and SLPs in order to advocate for appropriate services (not just settle for what is available/currently funded).

Other

• Thank you for offering this survey. I look forward to reading about the results, and how we can best move forward as clinicians.
• This is a worthwhile project. I look forward to the results.
• We need more research into what works and what does not, a good summary of all of that readily available and regularly updated and above all available and publicized with neurologists and other MDs to increase their awareness of rehab effectiveness as well. More in the community services for chronic aphasia/stroke patients with evidence that even then rehab. works.
Appendix: Communication

Subject:
Evidence-based rehabilitation for aphasia post-stroke: Make an important contribution to knowledge translation research in just 20 - 25 minutes – Please complete our survey!

Body:
The Aphasia Institute is partnering with a research team from across Canada to address an important knowledge to action gap. Although there is an abundance of research literature on aphasia, it has not been successfully translated into aphasia best practices or used effectively to help people with aphasia improve their communication skills, health outcomes and quality of life. The team recently received a Planning Grant from the Canadian Institutes for Health Research (CIHR) to complete some foundational work that will lead to a proposal for a larger project.

Who is invited to complete the survey?
All Canadian SLPs with past or current experience working with persons with aphasia; SLP managers and professional practice leaders who supervise/support Canadian SLPs with past or current experience working with persons with aphasia.

What's the purpose?
A key component of this phase of the project is to learn more about:

- Awareness of aphasia literature.
- Strategies being used by SLPs to support people with aphasia.
- Barriers and enablers to implementing stroke best practices related to aphasia.

When is it due? May 14, 2013

Link: https://www.surveymonkey.com/s/SACSLPsurvey
Please dedicate 20 - 25 minutes to complete the on-line questionnaire. Your responses will be carefully reviewed by the research team at 2 workshops and will inform the team's recommendations, as well as future grant proposals. The team will provide updates as the project unfolds. Many thanks.

Our goal is to have a strong SLP and Aphasia presence in Montreal October 17-19. Share your great work in:
- Prevention (Primary and Secondary) & Acute Treatment of Stroke
- Rehabilitation
- Basic Biomedical
- Health Systems
- Ongoing Clinical Trials
Deadline for abstracts is May 3. www.strokecongress.ca