The Aphasia Goal Pool Project: Updates and Observations

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THE FOURC MODEL

The purpose of the FOURC model is to coordinate interventions, ensure they are driven by anticipated generalization, support motivation, and help establish a collaborative partnership between the clinician and person with aphasia (Haley et al., 2019). To establish feasibility of implementation, the model was developed through partnership between researchers and clinicians working in outpatient clinics under typical productivity requirements.

As we continue to develop and test hypotheses about collaborative intervention planning, we want to consider the perspectives of speech-language pathologists who work in varied settings and likely have approached the problem with different strategies. We also seek to help clinicians share their varied perspectives with each other. To this end, we started the UNC Aphasia Goal Pool. For illustration purposes, we used the four FOURC model prongs simply to characterize the unedited goals speech-language pathologists submitted to this pool:

Focus: Communicative Participation
"The client will initiate a phone call once a week"

Prong 1: Skills and Abilities
"The client will independently identify the superordinate category and select 2 same-category members out of a field of 10 written choices for a written concrete noun with 80% accuracy across 2 consecutive sessions"

Prong 2: Intentional Strategies
"The client will utilize trained word finding strategies (SFA, circumlocution, etc.) for 2 minute description of recent event with at least 80% accuracy with min cues over 3 consecutive sessions"

Prong 3: Environmental Supports
"The caregiver will demonstrate comprehension and appropriate application of communication supports to promote participation and decision-making at home".

Prong 4: Motivation and Confidence
"In order to nurture post-stroke identity, the participant will print five photos of choice indicative of his interests"

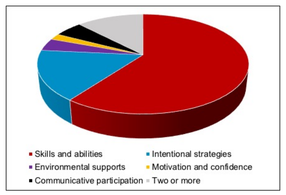
Haley KL, Cunningham, KT, Barry J, & de Riesthal M. (2019). Collaborative goals for communicative life participation in aphasia: The FOURC model. *American Journal of Speech-Language Pathology, 28 (1), 1-13. doi: 10.1044/2018_AJSLP-18- 0163*

aphasia.unc.edu

The **Aphasia Goal Pool at UNC** is a way to help speech-language pathologists share experiences and knowledge about treatment planning for aphasia across the continuum of care. Since May 2015, we have collected goals from speech-language pathologists who work in many different settings and have varied levels of experience. We share these goals and information about them in a variety of ways.

Contributors are asked to share sample goals from **their practice** or answer questions about the way they write goals. As a thank you to all who contribute, we share unedited examples from the goal pool. These examples are organized in different ways to highlight strategy, focus, and problem solving. We share **25 to 100 goal examples** with each goal pool contribution. We **do not critique or revise** the submitted goals. Instead, we work to reflect the clinical excellence that exists within the community of aphasia practitioners and to challenge and support one another to offer the best services we can to people living with aphasia.

Currently, the goal pool includes more than 1,224 goal examples submitted by speech language pathologists and graduate students in the US and world-wide. Six months ago, when we sorted 609 goals that had been shared by ASHA certified speech-language pathologists, distribution across the FOURC prongs, communicative participation, and cognition, was very uneven (*see figure*). Currently, we are working to understand more about how our community addresses environmental and psychological supports.



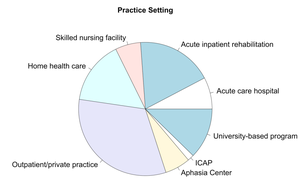
Only 4% of goals addressed environmental supports and less than 3% were about communication partner training. How do we address this aspect of our practice?

RESEARCH SURVEY

The UNC Aphasia Goal Pool is meant to be a resource for speech-language pathologists and speech-language pathology students. It is also meant to inform our intervention research.

In addition to contributing goals to our collective pool, visitors to our website are invited to participate in brief survey studies (5-10 minutes). We share some of the results on our website and in future surveys and we analyze most responses in qualitative research studies.

During the period September 1 to March 1 2019, our optional survey was about what SLPs do and do not include as written goals and how we train family and friends as communication partners. Some of those responses are reported here to invite discussion.



"Goals need to be measurable and sometimes it's difficult to quantify what I am really working on. So I quantify something close, but really work on something a bit different that doesn't lend itself to quantification. Communication is more complex."	*"I think I have been told that in home health we must at least acknowledge family/patient goal in one STG"*
"A couple of years ago the acute rehab created stock goals on one sheet for clinicians to check off. One sheet for "long-term' and one for 'short-term'…..I don't pay much attention to them and neither do the other clinicians. "	*"Goals must reflect medical necessity and the need for skilled intervention. They must include the type and level of cuing provided by the SLP that is required to meet that goal."*
"I find FIM ranges & G-code language often influence goal writing styles & expectations"	*"My goals are already written for me. I only get to select a goal. There is a choice of 120 goals"*
" I don't always write goals that consider an LPAA approach, especially if I go into the evaluation without much information from the patient regarding their family, potential caregivers, etc."	*"If something is targeted that is not included in a goal, it is typically the counseling aspect of things; however, in the last year I have grown accustomed to including this aspect of therapy in my goals so that is a changing perspective and priority in my goal writing with these patients"*

TRAINING FAMILY AS COMMUNICATION PARTNERS

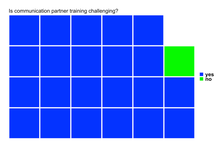
At some point I was told to only write goals for the patient. That the insurance didn't cover anything for the caregivers and so not to write it as a goal. I always provided training for family/ caregivers anyway. Just never stated it as a goal"

"In order to be reimbursed, goals have to be about the patient. So I might make a goal such as: Patient will repair communication breakdowns when attempting to express thoughts and needs with minimal assistance from the communication partner"

"Counseling is referred to as Education which is reimbursable. SLP typically does not get reimbursement for counseling. I also add goals for caregivers and other family members"

Challenges and reasons for not including as goals:

"Communication partners are not reliably present for sessions, hence it is difficult to have a consistent goal addressing them."	*"Families are invited but don't usually come in. At times I have a spouse who comes to every session and asks questions and helps with homework sometimes"*	*"I often find there is a lack of a consistent caregiver or support person with many people I work with"*
"Caregivers are often overwhelmed with meeting all of the needs of family and client, there is little energy left for something else"	*"During the sessions, the family is on board with "homework" and following strategies, but in action, they do not participate and carryover"*	*"A lot of caregivers look at me as though I am a mechanic and the patient is a broken car"*
"Oftentimes family members are not present during treatment sessions and are difficult to reach via telephone"	*"Sometimes as soon as even the second visit, the communication partner is either never present during speech therapy visits or exhibits behaviors that you did not see on the initial (honeymoon visit) such as disinterest or even resentment towards the patient."*	*"Partner and patient are sometimes "set" in their communication style and it can be hard to train a new way of communicating. Sometimes caregiver burden is already high, so they don't have the energy for communication training"*



PARTNER TRAINING METHODS

"Having the family member demonstrate/or repeat back instructions/directives taught"

"First, I observe the partner interact and make notes about what they are doing well and not; Next, I explain the strategies and educate; Finally, I have them observe me apply them."

"Use pictures of brain to teach patient and family about normal pathways for communication and disordered"

"I have communication partners document situations that are challenging in between sessions so that we can determine where the communication breakdown occurred and troubleshoot ways to avoid it from happening again"

"I typically provide verbal education with demonstration when introducing strategies. I supplement with written handouts and highlight specific strategies that are applicable to each patient/care partner"

"I think ensuring you have a handout and additional resources (e.g., online resources such as videos, cases, and additional definitions/handouts) to give communication partners is helpful as it takes the burden off the caregiver to have to remember everything you say in your session"

"I frequently set up a communication book based on information that the patient and family want. I train family and patient on its use"

'I always use video-recordings of communication partners having structured and unstructured conversation and will kindly/gently critique and compliment strategies and lack thereof. I give strategies/cueing tips based on what I have observed and what we observe together through the video"

"I have learned over the years that caregiver-PWA support needs and the expectations to participate in client-caregiver communication support training must be established on the day of evaluation or the next session. These are the sessions the caregiver is most likely attending"

"Don't forget kids, parents, and if/when appropriate, coworkers"

NEXT STEPS

Data collection for thematic analysis will continue through related brief surveys as we work to understand the practice circumstances and approaches in various settings. Over the next year, we will prioritize discussions around: a) many forms of environmental supports, including training of conversation partners that are not family or close friends; b) motivation, confidence, and other modifiable psychological factors; c) reimbursement and documentation requirements.

New initiatives:

- Supporting self-efficacy in acute inpatient rehabilitation
- International expansion
- Clinician training modules for intervention planning

"I would like to collaborate with others about goal writing. But there is no one to collaborate with in my setting"

https://www.med.unc.edu/ahs/sphs/card/resources/aphasia-goals/goal-pool/

DISCLOSURES

Financial
Salary from UNC Chapel Hill, royalties from MedBridge (Haley)
Nothing relevant to declare (Cunningham)

Nonfinancial
Author of LIV Cards, sold by the UNC Department of Allied Health Sciences, Board member of Aphasia Access (Haley)
Noting relevant to declare (Cunningham)