Campus-based assessment team members should be supportive of one another. This is based on the idea of respect and acknowledgment that all individuals bring their specialized skills to the team. Data should drive determination of all eligibility. This is often a muddy process since all group members are interpreting the available data from the focal point of their specialization. Teams will not necessarily agree on a conclusion 100 percent of the time. However, if the group respects one another and takes the time to listen to one another's perspective, the "why" behind their views, and all the data collected, they are more likely to reach agreements that are beneficial to the student being evaluated.

Campus-based assessment teams need not lose sight of the fact that they have a common goal or a shared mindset, which is determining educational need. As long as the team doesn't lose sight of this goal, they should be able to confront and overcome most obstacles that arise. Even those that arise when evaluating someone from a culturally diverse background can be overcome. Eligibility determinations are evidence- or data-based. This requires that all members of the team work as one organism toward the mutual goal. Members of the team need to communicate with one another and actively listen to each other as they determine how best to proceed. They need to exchange ideas as well as data. Teams that do not share these components will likely be parasitic in nature—a relationship in which one organism gains, while the other suffers. An example is a team in which its members are all out for themselves and have lost sight of the common goal, which is helping students regardless of their background. A team that works as a cohesive organism is more likely to ensure its decisions have taken into account cultural and language differences.

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The CLD Corner was created in an effort to provide information and respond to questions on cultural and linguistic diversity (CLD). Please follow the Communicologist *and TSHA's website in order to obtain new information provided by the CLD Committee. If you have specific questions or topics you would like for us to cover in future issues, please email publications@txsha.org.*

EBP Edge: Functional Treatment Interventions for Aphasia in the Skilled Nursing Facility

By: Danielle Connor, MS, CCC-SLP

Clinicians practicing in skilled nursing facilities (SNFs) and long-term care facilities often have a variety of patients on their caseload with varying medical diagnoses and therapeutic needs. It is within the speech-language pathologist's scope of practice to assess and develop a plan of care to address each individual's needs and goals in order to achieve the highest amount of independence possible. When it comes to aphasia, determining which evidence-based and functional therapeutic approaches will be most beneficial to the patient will be based on the type and severity level of aphasia with which they are presenting.

Evidence-based practice (EBP) is shown to produce meaningful and reproducible results in carefully controlled research studies (ASHA, *Evidence-Based Practice*, n.d.). Evidence-based practice is often a topic of education; however, applying evidence-based practices during therapy sessions requires attention and skill. Undoubtably, implementation will improve outcome results. Weaving EBP with patient-centered interventions can further enhance the patient's response, carryover, and motivation. Current types of evidence-based treatment approaches for aphasia include phonological and semantic cueing, task-specific training, constraint-induced aphasia therapy, melodic intonation therapy, semantic feature analysis, and script training to name a few.

In this article, we will briefly discuss the types and levels of aphasia that are often seen in skilled nursing facilities. Evidence-based practice and its importance for a successful outcome will be reviewed. We will go into detail on several types of evidence-based treatment approaches, delivering specific examples and relatable scenarios as well as functional goal writing.

Aphasia

According to the American Speech-Language-Hearing Association (ASHA), aphasia is an acquired neurogenic language disorder resulting from an injury to the brain—most typically, the left hemisphere (ASHA*, Aphasia Overview*, n.d.). Aphasia may involve impairment in varying degrees to four primary areas, including spoken language expression, spoken language comprehension, written expression, and reading comprehension (ASHA, *Aphasia Overview*, n.d.). In some cases, impairments may result in loss of ability to use communication as a tool for life participation (Threats & Worral, 2004). Aphasia is characterized by paraphasia, word-finding difficulties, different levels of impaired comprehension, and reading/writing problems. Overall, these impairments have a huge impact on the quality of life of our patients including their capacity to maintain relationships with others, hampering work productivity and participation in important life events.

There are many possible causes of aphasia, stroke being the most common (National Aphasia Association [NAA], n.d.). Other potential causes of aphasia include traumatic brain injury (TBI), brain tumors, brain surgery, brain infections, and progressive neurological diseases (i.e., dementia and Alzheimer's Disease) (ASHA, *Aphasia Causes*, n.d.). According to ASHA in *Aphasia Overview* (n.d.), there are a number of classification systems available to describe the various presentations of aphasia; however, the most common is based on the pattern of impaired language abilities based on the characteristics of spoken language expression and categorized as either fluent or nonfluent (Davis, 2007).

Categorizing Aphasia

A patient's symptoms may not fit perfectly into one single aphasia type description, and classification may change over time as communication improves (ASHA, *Aphasia Overview*, n.d.). For patients with fluent aphasia, the ability to produce connected speech remains, sentence structure may be relatively intact, and language comprehension varies (ASHA*, Classification of Aphasia*, n.d.). Those patients with fluent aphasia who have a good understanding of language may have conductive aphasia or anomic aphasia (ASHA*, Classification of Aphasia*, n.d.). Conductive aphasia consists of word-finding difficulties and word/phrase repetition difficulties (ASHA*, Classification of Aphasia*, n.d.). A person with conductive aphasia can typically read, write, speak, and understand spoken messages (ASHA*, Classification of Aphasia*, n.d.). With anomic aphasia, repetitions of words/phrases is intact (ASHA*, Classification of Aphasia*, n.d.). Anomic aphasia is characterized by difficulty retrieving words, especially nouns and verbs, and, according to the National Aphasia Association (NAA) in *Aphasia Definitions* (n.d.), this word-finding difficulty carries over into written expression. It is common for patients with anomic aphasia to use generic fillers or circumlocution (NAA, *Aphasia Definitions*, (n.d.).

Patients with fluent aphasia who have poor language comprehension may have Wernicke's aphasia or transcortical sensory aphasia (ASHA*, Classification of Aphasia*, n.d.). Wernicke's aphasia, a receptive aphasia, affects a patient's ability to grasp the meaning of spoken words, while the ability to produce connected speech may not be considerably affected (ASHA*, Classification of Aphasia*,

n.d.). Reading and writing are often severely impaired as well (NAA, *Aphasia Definitions*, n.d.). For patients with transcortical sensory aphasia, damage is more specific to the temporal lobe, resulting in poor auditory comprehension while leaving repetition and fluent speech relatively intact (ASHA*, Classification of Aphasia*, n.d.). Patients with transcortical sensory aphasia may repeat questions rather than answering them, presenting with echolalia (ASHA*, Classification of Aphasia*, n.d.).

With non-fluent aphasia, the ability to produce speech is limited. Speech production may be halting and effortful with impaired grammar; however, content words may be preserved (ASHA*, Classification of Aphasia*, n.d.). Language comprehension for patients with non-fluent aphasia varies (ASHA*, Classification of Aphasia*, n.d.). A patient with non-fluent aphasia who has a good understanding of language may have Broca's aphasia or transcortical motor aphasia (ASHA*, Classification of Aphasia*, n.d.). Broca's aphasia, an expressive aphasia, is characterized by difficulty producing language (spoken or written), especially repetition of words/phrases (ASHA*, Classification of Aphasia*, n.d.). According to the National Aphasia Association in *Aphasia Definitions* (n.d.), "Vocabulary access is limited and the formation of sounds by persons with Broca's aphasia is often laborious and clumsy." Patients with transcortical motor aphasia may have strong repetition skills; however, even though language comprehension is relatively intact, patients with transcortical motor aphasia often have difficulty spontaneously answering questions (NAA, *Aphasia Definitions*, n.d.).

A patient with non-fluent aphasia who has a poor understanding of language may have mixed non-fluent aphasia or global aphasia (ASHA*, Classification of Aphasia*, n.d.). Global aphasia is the most severe form of aphasia and is applied to patients who can produce few recognizable words and understand little or no spoken or written language (National Aphasia Association). They may be able to communicate using facial expressions, intonation, and gestures.

Now that we have discussed the many different types of aphasia, we want to look at which treatment approaches are going to work best for each of these patients; however, prior to delving into treatment approaches for aphasia, we must first look at our patients holistically during assessment as we develop their plan of care. A holistic assessment should consist of reviewing a patient's case history, getting to the bottom of their medical status/history, education, occupation/hobbies, and cultural and linguistic backgrounds.

A thorough oral-motor examination should be conducted to differentiate between language-based and motor-based deficits (ASHA, *Aphasia Assessment*, n.d.). Once you have an understanding of the patient's medical status, history, personal preferences, and motor abilities, you proceed to assess expressive and receptive language skills in spoken and written language across a variety of contexts. There are several standardized assessments to utilize, including the Western Aphasia Battery - Revised (WAB-R) and Boston Diagnostic Aphasia Examination (BDAE), to name a couple.

Review of the Life-Participation Approach to Aphasia

The Life-Participation Approach to Aphasia (LPAA) is a philosophy, rather than a treatment approach, that supports individuals with aphasia and others affected by it in achieving their immediate and long-term life goals (Chapey et al., 2000). LPAA empowers the individual with aphasia in decision-making and focuses on re-engaging in life, beginning with the initial assessment and intervention and continuing, after discharge, until the individual with aphasia no longer elects to have communication support (Chapey et al., 2000). Truly getting to know your patient, their goals, and the resources they will have available or need will ensure the LPAA is the core of the patient's treatment.

Are you asking your patient questions about their individual struggles? Are you allowing them to participate in determining their goals? Is the patient, or maybe their family/friends/caregiver, given the opportunity to express their preferences to the best of their abilities? We know the more involved the patient and their family is in the care-planning process, the more engaged and successful they will be in their treatment outcomes. Patients and their caregivers should play a big role in the holistic assessment and determining the plan of care as well as goals that will be meaningful to the patient

and family upon discharge. As skilled clinicians, it is our role to provide the results of assessments and work together to determine goals.

When your initial assessment is complete and you are determining treatment approaches to present to the patient, there are two methods to consider. Does this patient have room to improve and restore their impaired function? If so, a restorative treatment approach may be initiated that focuses on returning to the prior level of function. On the other hand, is the prognosis of this patient severe, possibly prohibiting the ability to return to a prior level of function? In this case, the patient may benefit from a compensatory approach to therapy in which the clinician will train techniques to the patient and their family/caregivers to compensate for these deficits as well as make environmental adaptations. In most cases, both treatment approaches often extend across domains and are relevant for all patients.

After determining an approach to therapy that is built around the patient's unique needs and circumstances, the clinician must determine the mode of treatment that will be most appropriate. Is individual, group, or concurrent treatment indicated and available as an option in your setting? Some evidence-based treatment approaches do require multiple speakers and listeners to be effective.

Review of Evidence-Based Treatment Approaches
There are several evidence-based treatment approaches available that have been shown through research and consistent positive results to improve the language function of the patients with aphasia. This list is not all-encompassing; however, this list is a great place to start when looking at evidence-based approaches as research in these areas is abundant.

We will review the following:

- Response Elaboration Training
- Verb Network Strengthening Treatment (VNeST)
- Oral Reading for Language in Aphasia (ORLA)
- Promoting Aphasics' Communicative Effectiveness (PACE)
- Constraint-Induced Aphasia Therapy (CIAT)
- Melodic Intonation Therapy
- Semantic Feature Analysis (SFA)
- Script Training
- Treatment of Wenicke's Aphasia
- Group Therapy and Partner Approaches

Response Elaboration Training (RET)
A therapeutic approach known as Response Elaboration Training (RET) is designed to allow the clinician to expand or elaborate on the initial response of the patient utilizing modeling or cueing (Kearns, 1985). RET encourages the patient to increase the content and/or utterance length in their response to improve conversational speech. RET has been shown to be effective for patients with various types of aphasia (Bunker et al., 2019), including those patients with apraxia (Wambaugh et al., 2001).

After identifying target stimuli for the session, the clinician will present a picture or drawing and ask the patient to describe the image or what action is occurring. Based upon the response of the patient, the SLP will reinforce the patient by giving an example of a full sentence or expanding on the sentence by asking questions.

Let's look at some goals that are relevant in the SNF setting:

<u>Short-Term Goal</u>

- Patient will increase utterance length to three words in 90 percent of opportunities during RET with minimal prompts from the clinician in order to participate in functional, social communication exchanges with familiar listeners.

Long-Term Goal

- Patient will use four- to five-word utterances to describe an image presented by the clinician during RET with occasional verbal and/or visual cues in order to improve ability to communicate basic wants/needs.

Verb Network Strengthening Treatment (VNeST)
The goal of Verb Network Strengthening Treatment (VNeST) is to improve the patient's word-finding abilities to produce more complete sentences (Edmonds & Babb, 2011). In this approach, the clinician presents verbs to the patient with aphasia, possibly verbally or via index card or flash card, and then prompts the patient to create sentences with the verb. With minimal supplies needed to carry out this approach, VNeST is great for the clinician working in the SNF.

For example, the clinician presents a card with a verb such as "drink." The patient will then be encouraged to create sentences with the verb independently or with assistance of the clinician by answering questions (e.g., who, what). Possible responses: "Sammy drinks water. Calvin drinks milk. I drink soda."

VNeST also can be expanded upon to include more details (e.g., where, when, why). Expanding upon the previous verb, some possible responses may be: "Sammy drinks water from the pitcher. Calvin drinks milk during dinner. I drink soda, because I like it."

By creating a network of words relating to the verb, the likelihood that the verb and related words will be produced correctly increases. VNeST will be most meaningful to the patient if the sentences are true and relatable to the patient's everyday life. VNeST has been shown to improve sentence production in patients with a variety of aphasia types. Patients with basic comprehension will be most successful; however, there can be modifications for patients who do have a comprehension impairment. "A Tutorial for Verb Network Strengthening Treatment (VNeST): Detailed Description of the Treatment Protocol with Corresponding Theoretical Rationale (Edmonds, 2014)" provides details on utilizing this approach as well as types of aphasia this treatment has been successful with. The primary goal of VNeST is extending improvement beyond the trained verb networks (Edmonds & Babb, 2011).

Examples of goals for the SNF setting:

Short-Term Goal

- Patient will complete generative naming tasks with 75-percent accuracy during VNeST activity with occasional verbal and/or visual cues in order to communicate basic wants/needs.

Long-Term Goal

- Patient will increase ability to express self during conversation with 80 percent of opportunities during VNeST and occasional verbal and/or visual cues in order to successfully participate in functional, social communication exchanges with familiar and non-familiar listeners.

Oral Reading for Language in Aphasia (ORLA)
Oral Reading for Language in Aphasia (ORLA) focuses on reading for the treatment of patients with

aphasia. Specifically, the clinician utilizes ORLA to promote reading full sentences in unison and independently (Cherney, 2015). During ORLA, the clinician will read the sentence aloud, modeling for the patient with aphasia. Next, the clinician and the patient will read the sentence together. During this phase, the clinician may point to each word being read. The sentence can be repeated multiple times. Last, the patient will read the sentence aloud and independently, if they are able.

Beginning with simple sentences, the ORLA approach allows for multiple levels of complexity depending on the patient's abilities. Sentences become more complex as treatment proceeds, eventually leading to paragraph length and beyond. ORLA focuses on connected discourse rather than single words, making it a fantastic way to incorporate life participation into your treatment (Cherney, 2010) (e.g., preparing for a speaking event at an upcoming benefit or practicing children's books to read to grandchildren).

A benefit of ORLA within the SNF setting is that a variety of texts and topics can be utilized that may already be available to your patient, including newspapers, magazines, books, and/or letters from family and friends. Additionally, ORLA can utilize digital devices to access reading content.

Statistical analysis reveals the ORLA technique may be appropriately applied to the aphasia population with positive therapeutic effects on patients with either fluent or nonfluent aphasia (Cherney et al., 1986).

Some examples of appropriate goals within the SNF setting may be:

Short-Term Goal

- Patient will increase reading comprehension for five- to six-word sentences with 100-percent accuracy with minimal verbal and/or visual cues from the clinician in order to communicate basic wants/needs.

Long-Term Goal

- Patient will increase reading comprehension for sentences and paragraphs to 90-percent accuracy with occasional verbal and/or visual cues from the clinician in order to participate in complex communication about thoughts, ideas, opinions, and/or feelings.

Promoting Aphasic's Communication Effectiveness (PACE)

The next treatment approach we will focus on is Promoting Aphasic's Communication Effectiveness (PACE). PACE is a conversational treatment approach in which any modality of communication (verbal, non-verbal, written, augmentative and alternative communication [AAC]) may be used to communicate ideas from one partner to another (Lingraphica, PACE Therapy, n.d.). The patient and clinician take equal turns in the sender/receiver roles, and this promotes conversational participation. This can be achieved with topic cards or a stack of message stimuli cards initially and then upgraded to patient/clinician choice of topic if progressing. The patient has a free choice as to the communicative mode used to convey their messages. The clinician's feedback as a receiver is based on the patient's success in conveying the message. This means the clinician should let the patient know if he/she was successful in conveying the idea successfully. If they did not effectively convey the message, the clinician would respond as if they do not know the message (even if they do). PACE can be adapted to different skill levels, making it an appropriate treatment approach for many types and severities of aphasia. Both the clinician and the patient with aphasia take an equal number of turns as the speaker and listener, encouraging a positive communication environment and resembling a game. Many patients in the SNF setting will find it a fun way to improve natural conversation.

A plan of care for PACE may have goals similar to this:

Short-Term Goal

- Patient will successfully communicate messages with three-fifths accuracy during conversation with the clinician in order to improve verbal expression.

Long-Term Goal

- Patient will successfully communicate messages utilizing chosen modalities with 90 percent of attempts in order to improve verbal expression.

Constraint-Induced Aphasia Therapy (CIAT)
Constraint-Induced Aphasia Therapy (CIAT) is an intense therapy approach based on the forced use of verbal oral language as the sole channel of communication, while any non-verbal communication (writing, gesturing, pointing) is prevented. A great correlation here is to compare CIAT with Constraint-Induced Muscle Therapy (CIMT). For patients with hemiplegia, CIMT is often a therapeutic approach utilized by physical and occupational therapy. It is based on the notion that the potential rehabilitation of the affected limb is detrimentally influenced by the compensatory use of the unaffected limb. By forcing patients to utilize the affected muscles/limb while avoiding compensating with the non-affected limb, the patient begins to improve the affected muscle/limb. For aphasia, CIAT limits the patient's response to spoken verbal production only. This sometimes includes placing screens between players to prevent them from seeing each other's cards or communicating gestures. Use of non-verbal communication is prohibited! Typically for CIAT, treatment is provided on an intensive schedule up to three hours per day for five days per week; however, in the SNF setting, CIAT would need to be adjusted as this intensity may not be an option for patients. Based on current evidence, CIAT was efficient at improving language performance with regard to naming, comprehension, repetition, written language, and oral language (Wang et. al., 2020).

Although CIAT is an intense therapeutic approach, it can be incorporated into fun games or therapeutic language exercises closely related to everyday communication and can be played in the form of a game of cards, similar to Go Fish!

The plan of care for CIAT utilization can range from single words to conversational speech. Goal examples for CIAT include:

Short-Term Goal

- Patient will complete verbal expression of single words during a structured task following a model with 80-percent accuracy using moderate verbal and visual cues.

Long-Term Goal

- Patient will verbally express a sentence length response to a question in eight of 10 opportunities given minimal cues in order to successfully participate in functional, social communication exchanges.

Melodic Intonation Therapy (MIT)
Next is a treatment approach that utilizes the musical elements of speech to improve expressive language. Melodic Intonation Therapy (MIT) emphasizes the use of rhythm and prosody to elicit verbal output. Humming, unison intoning, unison intoning with fading, and immediate repetition are all styles that can be incorporated into MIT. Patients begin by intoning (singing) simple phrases and then gradually intoning phrases of increasing syllable length. Some great samples for intoning may include singing the alphabet, "Happy Birthday," or nursery rhymes. Visual and tactile cues are given by the clinician, and phrases of social and functional importance to the individual are practiced. The

reliance the patient has on intonation is gradually decreased over time. While MIT is directed to language, some clinicians have reported success adapting it to improve slurred articulation and to reduce frequency of phonemic errors in some aphasic patients as well (Sparks & Holland, 1976). Positive results have been reported with MIT in nonfluent aphasia patients with damage to their left-brain speech processes, using the patient's intact ability to sing to promote functional language (Conklyn et. al., 2012).

Incorporating MIT into your plan of care can be very fun, especially in the SNF setting. Here are some examples of goals to utilize:

Short-Term Goal

- Patient will increase verbal language/expression during singing tasks with 80-percent accuracy with 20-percent verbal cues in order to communicate complex thoughts, ideas, opinions, and/or feelings.

Long-Term Goal

- Patient will increase verbal language/expression during singing tasks with 100-percent accuracy with 5-percent verbal cues in order to communicate complex thoughts, ideas, opinions, and/or feelings.

Semantic Feature Analysis (SFA)

Semantic Feature Analysis (SFA) is a treatment approach that focuses on the semantic information when the patient has difficulty accessing the specific word or label they want to say. SFA is utilized to enhance semantic mapping or the connection of words in the brain. This is achieved by providing verbal and visual cues of the features of a specific word and by reinforcing the process of talking about the features of that specific word. This teaches the individual to use these same strategies to self-cue and help themselves think of words in everyday life. This can be seen with a patient who has difficulty retrieving the word "stove." This patient may be prompted with questions to provide information related to the stove such as, "Where is it located?" and/or "What is it used for?" Another example is the patient who has difficulty retrieving the word "cup." This patient may be prompted with questions to provide information related to the cup such as, "What is it used for?" and/or "What does it go with?" SFA is a treatment approach thought to improve word retrieval by activating the semantic network associated with the target word, thereby raising the word's threshold for being retrieved. SFA does improve word-finding abilities in nonfluent aphasia; however, carryover into discourse is limited to trained target words (Rider et. al., 2008).

SFA is a common treatment approach that can be utilized across levels of impairment. Some goal examples for SFA include:

Short-Term Goal

- Patient will verbalize three associations of the word in the picture presented in 10 out of 10 opportunities in order to improve verbal expression of wants/needs.

Long-Term Goal

- Patient will use semantic feature analysis (SFA) to prevent communication breakdowns occurring during conversations with caregiver with 90-percent success in order to improve verbal expression of wants/needs.

Script Training
Script training is a treatment approach that consists of repeating words, phrases, and sentences embedded within a monologue or dialogue that is individualized to the person with aphasia. With script training, the clinician utilizes topics that represent typical situations for most people or specific to the patient. For the success of this treatment approach, the clinician must include the patient in the script-planning process! The goal is that, by repetition, the phrases/sentences become automatic speech that are then produced in real-life discourse. Over time and with progress, the clinician will be able to increase grammatical and semantic difficulty.

Examples of a typical script would be ordering at a restaurant (speaking to server) and planning to buy groceries (speaker to acquaintance). Script training is a treatment approach for patients with either fluent or non-fluent aphasia. The use of highly personalized and specific content is at the core of script training intervention, and it is possible that treatment effects are particularly strong for highly motivating scripts (Holland et. al., 2010). Script training can be time-consuming because it takes time and detail to create a script that is individualized to the patient and their abilities; however, it can be successfully executed in various ways, including listening to the script, repeating the target utterances, reading them aloud, producing them from memory, or performing a combination of these activities. There is evidence that script training intervention can improve accuracy, grammatical productivity, speaking rate, and articulatory fluency in script production tasks as well as in more functional conversational tasks (Goldberg et. al., 2012).

Goal examples for script training:

<u>Short-Term Goal</u>

- Patient will imitate functional vocabulary words with 90-percent accuracy in order to improve verbal expression of wants/needs.

<u>Long-Term Goal</u>

- Patient will verbally express three phrases during script training with 90-percent accuracy in order to improve verbal expression during conversation with unfamiliar listeners.

Group Therapy and Partner Approaches
Group therapy and partner approaches consist of multiple strategies utilizing listeners and other speakers with similar deficits. Evidence supports that group therapy is effective for communication outcomes. Group-based therapy offers some benefits that individual therapy does not, particularly the psychosocial and conversation-level outcomes. Group therapy is an effective clinical strategy for improving a broad array of communication impairments following stroke, including word-finding, pragmatics, and discourse skills, particularly in psychosocial and conversation-level outcomes (Layfield et. al., 2013).

Let's discuss some ideas to incorporate into group therapy sessions. First up is incorporating an ongoing language group that targets discourse-based interactions, utilizing therapy principles and strategies from SFA and CIAT but applied in a multimodal format. Second, create a higher-level language discussion and problem-solving group, targeting activity and participation-level goals. Last, incorporate communication partner training groups, targeting activity and participation-level goals.

Conversational Coaching
Conversational coaching is used to train verbal and nonverbal communication strategies to the individual with aphasia and their primary communication partner (spouse, sibling, parent, caregiver, etc.). The strategies used in conversational coaching are chosen by the patient and their primary communication partner. The strategies selected are practiced in scripted conversations with the SLP serving as a "coach" for both communication partners. This is a great approach that keeps the

patient working even when you aren't there! By involving the family and facility staff in communication strategies, the patient can continue working on their communication and have increased carryover from your sessions.

Supported Communication Intervention (SCI)
Supported Communication Intervention (SCI) is another treatment approach that relies heavily on the primary communication partner. The communication partner is taught how to support their loved one's communication by the SLP. This can include multimodal communication in which the clinician is teaching the patient and communication partner how to use multiple modes of communication. This also can include partner training in which the clinician is training communication partners to support both expressive and receptive communication for the individual. Last, SCI can include basic social interaction by promoting opportunities for social interaction.

Conclusion
We have reviewed different types of aphasia and effective evidence-based treatment approaches. Clinicians should additionally review literature of each approach to ensure proper implementation and appropriateness for each patient. As with any patient, it is important to continue to assess the patient's response to aphasia treatment and make adjustments to the plan of care accordingly. This may include upgrading goals, downgrading goals, changing treatment approaches, and changing the amount and type of cueing as the plan of care progresses.

The approaches we have reviewed today are not all inclusive. There are several more evidence-based approaches to utilize in treatment with patients with aphasia. If one approach does not work, clinicians must look at other options. By continuing to research different approaches and techniques utilized and by engaging family, friends, and facility staff, the SLP enhances the patient's ability to improve language function.

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Student Spotlight: The Pandemic as a Vehicle for Positive Change

By: Matthew Randal, BS, TSHA Graduate Student Representative, and Michelle Hsieh Pho, AuD, PhD, CCC-A Vice President of Audiology

Circumstances surrounding the ongoing pandemic have exposed limitations within the current healthcare system and have drastically changed the way many hearing healthcare professionals meet the needs of their patients. We have witnessed the effects of increased financial hardship that have prevented patients from affording recommended interventions. We have seen the Deaf or Hard-of-Hearing (D/HH) community burdened by masks and personal protective equipment (PPE) that have made communication without visual cues exceedingly difficult. We have endured the limited availability of services due to closures and reduced occupancy restrictions. And, perhaps most prevalently, there has been an unprecedented spike in anxiety and deterioration of mental health as we struggle to navigate these challenges. These stressors have made apparent the need for providers to expand their telehealth and counseling services to meet the new needs of their patients and communities.

Clinical programs in speech, language, and hearing sciences have been given the unique opportunity to prepare future hearing healthcare professionals to be exceptional telehealth providers in conjunction with the typical practicum experiences. Providers across the country adapted their services to provide limited contact or drive-through operations. Masks with clear windows were worn to reduce communication lapses. A shift toward expanded telehealth services empowered clinicians to increase the volume of their services while limiting potential COVID-19 exposure from in-person visits. Similarly, it is this flexibility and evolution of care that should be addressed in the classroom to prepare students to enter the workforce with an increased repertoire of emotional counseling and telehealth skills to address the healthcare disparities revealed by the pandemic.

The Texas Speech-Language-Hearing Association (TSHA) advocated for increased telehealth provisions to ensure high-risk patients continued to receive crucial services while limiting their potential COVID-19 exposure. The Centers for Medicare and Medicaid Services (CMS) thankfully increased Medicare coverage for numerous audiology and speech-language pathology telehealth services provided during the pandemic. TSHA continues to petition for permanent telehealthcare coverage and Medicaid billing and has requested that audiologists and speech-language pathologists (SLPs) contact their congressional members to show support for H.R. 2168. Building upon this momentum is critical for sustaining telehealth services for patients across the country.