

This poster reports on the activities to date of the Stroke and Aphasia Canada team including results of a Canadian Institutes of Health Research (CIHR) Knowledge Translation (KT) planning grant (grant #290592, 2013).

The 2010 Canadian Stroke Strategy guidelines incorporated recommendations for most physical interventions but had limited reference to aphasia management across the continuum of care. Addressing this gap was considered an important goal because stroke patients with aphasia have longer lengths of stay, higher costs of care, lower rates of returning home and less favorable outcomes overall (Ellis, Simpson, Bonilha, Mauldin & Simpson, 2012). In addition, aphasia is included in the ten top stroke research priorities (Pollock, St. George, Fenton & Firkens, 2012), and a large Canadian study identified aphasia as having the largest negative impact on quality of life after stroke (Lam & Wodchis, 2010). In 2011, a team of stroke and aphasia thought leaders assembled to address the need for developing comprehensive best practice guidelines (BPG) for stroke and aphasia in Canada and implementing a knowledge mobilization strategy to influence actual stroke practice. Key focus areas included 1) building reciprocity so that stroke researchers, clinicians and policy makers know about aphasia and understand the broad 'implications' of aphasia intervention; 2) approaching and disseminating research by speech-language pathologists (SLP's) in a way that makes sense to the stroke community; 3) evaluating existing evidence in relation to best practice guidelines (BPGs); and 4) identifying gaps in evidence. The KT grant referred to above was used to move this agenda forward.

As a first step, the team reviewed existing research inventories, international BPG sources and levels of evidence in order to identify gaps in evidence and priorities for knowledge translation. In order to ensure that issues addressed are ones that matter to key stakeholders, focus groups were conducted with people with aphasia (PWA) and family members, and Canadian SLPs were surveyed regarding their management of people with aphasia.

In total, two focus groups were held with persons with mild to moderate aphasia ($N = 8$) and one focus group was held with family members of persons with aphasia ($N = 8$). Overall observations and key themes included:

- Health care system – related to health human resources, program access and eligibility, patient safety, transitions between care settings, financial considerations, specialized aphasia services, and family support;
- Stroke and aphasia knowledge and expertise – related to health care providers knowledge about aphasia and its impact, diagnosis and proper acute care, patient safety, mental health issues, family support, emergency services and financial and legal considerations;
- Therapy
 - What was helpful – related to testing and diagnosis, acute care, family advocates, rehabilitation, tools and techniques, transition to home, family support, and the Aphasia Institute
 - What was not helpful – related to approach to care and therapy and financial considerations
 - What wished was different – related to communication training, receipt and timing of rehabilitation, transitions and end of life care planning, media representation, and independence.

The survey was distributed by the Canadian Association of Speech-Language Pathologists and Audiologists (CASLPA) to Canadian SLP's directly involved with aphasia. The response rate was 73.7% (140 respondents). The purpose was to examine SLP awareness of aphasia literature and BPG, strategies used to support people with aphasia, actual interventions implemented, and barriers/enablers to implementing BPG related to aphasia. Priority items identified that would enable consistent use of evidence-based practices when supporting PWA and their family members included time, training and education, interdisciplinary approach, resources, support from management, physicians, and health care team, technology, funding for resources, and services and system improvements. 54% of SLPs indicated that BPG's are used to inform their practice.

Based on data gathered from stakeholders, along with a discussion of the gaps and misalignments between existing best practices guidelines, current research, and expert opinion, the team met and developed a preliminary set of nine BPG's for stroke and aphasia. In the Spring of 2013 these BPG's were incorporated

into the Canadian Stroke Best Practice Recommendations (<http://www.strokebestpractices.ca>). A description of the nine BPG's will be made available.

As the final step of the CIHR KT planning grant, over 40 thought leaders in both stroke and aphasia from across Canada attended a half day workshop in October 2013, to give input on priorities for a knowledge mobilization strategy related to the nine new stroke and aphasia guidelines. Participants included researchers, policy-makers, clinical experts and a person with aphasia. The group assessed all nine new aphasia best practice guidelines and explained what each one means from a practical perspective; identified existing evidence from three sources (research, practice and lived experience); and identified barriers and enablers to implementation. Then, each participant independently indicated how ready each best practice guideline was to mobilize and voted on the ones they believed would have the most impact on the health care system; the greatest impact on people with aphasia; and would be easiest to implement. Via this carefully planned process, the group rated BPG#7 – “Treatment to improve functional communication should include Supported Conversation techniques for potential communication partners of the person with aphasia,” as highly ready for mobilization. Other top priorities included the importance of focus on training for stroke providers/teams and the needs of families.

Based on the process to date, the team has applied for a larger KT operating grant to further this agenda including concrete plans to implement targeted BPGs in two acute care settings in Canada.