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# Outcome assessment in aphasia: a survey

Nina Simmons-Mackie[a,*], Travis T. Threats[b], Aura Kagan[c]

[a]*Department of Communication Sciences and Disorders, Southeastern Louisiana University, 59020 Highway 433, Slidell, LA 70460, USA*
[b]*Department of Communication Sciences and Disorders, Saint Louis University, St. Louis, MO, USA*
[c]*Aphasia Institute (incorporating the Pat Arato Aphasia Centre), The University of Toronto, Toronto, Canada*

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**Abstract**

There has been a marked increase in attention to the measurement of ''outcomes'' after speech-language intervention for adult aphasia. Consumers, speech-language pathologists (SLPs), and funding sources desire evidence of therapy outcomes that improve communication and enhance the quality of life for people with aphasia. While many assessment tools are available to measure outcomes after aphasia therapy, there is little information regarding the use of these tools in everyday practice by SLPs. Therefore, the current investigation was undertaken to identify and describe the practices of SLPs relative to outcome assessment in aphasia. An online survey of outcome assessment practices was distributed. Results revealed that 85% of the 94 respondents reportedly perform outcome assessment. A majority of respondents reported barriers to assessment such as time and funding limitations. Considerable variability existed in the types of assessments and the actual tools reported. The impact of the results on clinical practice is discussed.

**Learning outcomes:** As a result of this activity the reader will be able to (1) define outcome assessment in aphasia, (2) describe patterns of outcome assessment in aphasia as reported by survey respondents, and (3) describe a conceptual framework for situating outcome assessment in aphasia.


*Keywords:* Outcome; Aphasia; Assessment; WHO ICF; Survey

Speech-language pathologists (SLPs) are trained to conduct therapy to improve the communication of individuals with aphasia. Inherent in the delivery of these therapy services is the assumption that service providers should provide evidence of outcomes.

* Corresponding author. Tel.: +1-985-645-9898; fax: +1-985-549-5030.
*E-mail address:* nmackie@selu.edu (N. Simmons-Mackie).

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In fact, accreditation organizations, funding agencies and government policy makers often mandate the documentation of intervention outcomes (Hicks, 1998). But what is an ''outcome''? An outcome is defined ''... simply as the result of an intervention'' (Frattali, 1998, p. 8), as ''any consequence of health care'' (Donabedian, 1982, p. 356) or as the ''success of particular actions in health care'' (Byng, Van Der Gaag, & Parr, 1998, p. 559). However, these simple definitions belie the complexity and multidimensionality of clinical outcomes measurement (Frattali, 1998; Hesketh & Sage, 1999). What rehabilitation professionals measure in outcomes assessment, as well as when or how outcomes are measured, depends on a range of variables such as the philosophical and experiential orientation of the person doing the assessment, the intended audience, the time and resources available, and the specific purpose of the assessment.

Worrall and Egan (2001) make a distinction among outcome measurements used at an individual level, at a service level and at a population level. Most clinicians are familiar with outcome measures at the individual level that measure changes or outcomes related to a specific client. Service level measures might provide information on the success of a particular service or facility in achieving particular outcomes. Population measures provide information on broad outcomes across a population such as individuals with traumatic brain injury or voice disorders. In addition, Frattali (1998, p. 9) suggests that outcomes can be ''clinically derived, functional, administrative, financial, social or client-defined.'' For example, outcome assessment targeting the individual client might measure specific aspects of language such as word finding or sentence formulation (clinically derived outcome), functional changes in the ability to perform activities of daily living (functional outcomes), return to work or engagement in recreational activities (social participation outcomes), improvements in the perceived quality of life (client-defined), or the ''cost'' or amount of therapy associated with a specific improvement (financial) (Baum, Swigert, & Gallagher, 1997; Frattali, 1998).

Additionally, outcome assessment has been discussed in relation to research into aphasia intervention and in terms of evidence-based clinical practice guidelines (Golper et al., 2001). For example, the terms efficacy, effectiveness and efficiency have been defined as they refer to therapy outcomes in research studies (Golper et al., 2001; Robey, 2001). Treatment *efficacy* refers to the demonstration of the extent that a therapy is beneficial for a population under ideal conditions (e.g., controlled, research conditions). *Effectiveness* refers to the degree to which a therapy is beneficial under real-world conditions. The term treatment *efficiency* is used to refer to the demonstration of what treatment or treatment package works ''best'' or involves the least components or time. Thus, clinical outcome assessment of individual clients is distinguished from research into outcomes for the purpose of demonstrating efficacy, effectiveness or efficiency of interventions.

There are many tools and methods available for assessing and documenting outcomes in aphasia (see examples in Holland, 1998 and Holland & Thompson, 1998). For example, in assessing individual clients, clinicians might use traditional formal tests or informal tests designed to measure aspects of language or cognitive processing, functional assessment tools, discourse analysis, quality of life scales, social participation indices, ratings of communicative effectiveness, or well-being indices. To determine the