Outcomes Measures in Philippine Speech-Language Pathology Service Delivery

Speech-Language Pathology remains a developing discipline in the Philippines. A majority of the locally relevant studies have focused on language or the nature of communication/swallowing disorders.[1,2] Studies related in particular to autism have largely addressed the lived experience of persons with autism and/or their families or the cost and availability of care.[3-8] The study of Chan et al.[9] will hopefully move forward efforts at outcome measures in this domain, sorely needed to support the development of both policy and practice.

The use of a Goal Attainment Scale (GAS) to measure change in the patient as a function of intervention was promoted almost two decades ago in the discipline of speech pathology for use in both clinical and research settings.[10] The GAS measures change along a 5-point continuum from +2 being maximal expected change to -2 being performance "much less than expected."[11] The study of Chan et al.[9] created "standardized descriptions for each increment" of a Goal Attainment Scale for each of 25 parameters of speech and/or language. These standardized descriptions varied in only one aspect of performance (usually percent of accuracy, with -2 being 0-20% accuracy and +2 being 81-100% accuracy), consistent with an effort to create equal intervals between the points in the continuum.

Schlosser describes an alternative to describing each increment, which while admittedly possibly reducing the GAS to an ordinal scale and thus most likely requiring the use of non-parametric statistics in any quantitative analysis, is more contextually valid and relevant to the individual patient.[10] In keeping with the original GAS described by Kiresuk, Smith, and Cardillo, Schlosser indicates that, after deciding on a timeframe for working on a goal consistent with evidence-based practice, the following increments be utilized:[10,13]

+2	Best expected outcome (or much more than expected outcome)
+1	More than expected outcome
0	Expected outcome (or the goal the therapy team and patient together set out to achieve within the set timeframe)
-1	Less than expected outcome (possibly no change from baseline)
-2	Worst expected outcome (possibly regression from baseline)

The above system for developing individualized Goal Attainment Scales has been used in various health disciplines including occupational therapy, physical therapy, speech-language pathology, geriatrics, early intervention and mental health.[10,11] The outcome can be based on a subdomain of function (e.g., use of verbs, within the domain of speech pathology), but it can also be defined in terms of activity limitations and participation restrictions specified by the International Classification of Functioning, Disability and Health (ICF).[12] Goal setting by a team rather than by a single clinician, and rating of performance of the target by a clinician who was not part of the goal-setting nor of actual provision of intervention increases validity of judgements.[10] As ensured by Chan et al., the clinicians need several hours of training in the use of GAS to develop reliability. [9] In addition to creating increments that vary along only one parameter, it is important that increments truly form a continuum, with no gaps or overlaps between points.[10,11]

Kirusek et al. developed a formula for computing T-scores that allows comparison across varying goals.[13] Future outcome measures using the above GAS pattern would allow monitoring the progress made by a single patient, across several patients in a clinic, or by entire clinical programs, without sacrificing the individual differences between and among goals. This is valuable for both clinical and research purposes.

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