Data Collection

videoconference link, while in another location the silent SLP oriented the participant in front of the computer and assisted with the headset microphone. The

a clinician satisfaction survey comparing assessments conducted in each modality. However, despite these limitations the strength of results are enhanced by the thorough description of methods, procedures, and videoconferencing protocol making the study easier to reduplicate. Randomizing and blinding SLP's reduced the potential for subjective and examiner bias, as did test-retest effects by simultaneous scoring of responses. Finally, high levels of inter- and intrarater reliability and internal validity add to the strength of results obtained.

Overall, results of the Hill et al. (2009) study indicate

First, patient candidacy for telerehabilitation needs to be further explored to determine what adjustments can be made to improve the accuracy of assessment. For instance, the accuracy of results and patient satisfaction in patients with TBI may improve by having a clinician present during assessment to redirect their attention and assist them in staying on task. Alternative methods to increase the accuracy results obtained when administering conversational, naming, and paraphasia subtests to patients with severe aphasia should also be considered. Likewise, altering the administration and format of questionnaires would be beneficial to compensate for any deficits in comprehension patients may have, and may increase accuracy of responses.

Refinements in videoconferencing protocol should be further examined to determine the optimal bandwidth, ways to decrease intermittent disruptions in audio and video footage, and ensuring clinicians are properly trained in the use and troubleshooting of all equipment. For future research, it is critical for authors to include a detailed outline of protocols used to conduct remote assessments, in order to increase the ability to replicate their study and provide evidence for using this method of evaluation. Finally, clinicians must ensure patient confidentiality is maintained in online settings, as was done by Theordoros et al. (2008) and Hill et al. (2009).

All studies highlight the need for future research to include more participants, those with global or profound aphasia, as well as those with severe concomitant motor speech deficits, to increase the power and ability to generalize results. It may be useful to investigate the effects of concomitant cognitive deficits on assessment using telerehabilitation as well (Hill et al., 2009).

To increase the external validity of studies, it would be beneficial for researchers to utilize multiple subject designs whenever possible. It would also be useful for researchers to include a detailed outline of their methods and procedures to increase the ability to replicate their study, and give evidence for or against the remote assessment of language skills of patients post-stroke.

Conclusion and Clinical Implications

Overall, there is persuasive evidence to support the use and accuracy of administering the BDAE-3, BNT, and SRP to patients post-stroke using telerehabilitation. Due to the novelty of this modality of evaluation in speech language pathology, clinicians are cautioned to carefully assess patient candidacy before conducting remote testing. Based on the evidence presented, assessment of patients with profound or global aphasia, as well as severe concomitant motor speech or cognitive deficits,