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EIU Speech-Language Hearing Clinic
Policies and Procedures for Clinical Practicum
Updated Fall 2023

A. BEGINNING OF SEMESTER INFORMATION

1. CLINICIAN INFORMATION

Clearly print your name (**last name first**), E-number, local address, **EIU** email address, and telephone numbers; **and** your permanent address (including zip code), telephone number, and parent(s) names on the card. ***Please inform the Front Office if this information changes during the semester.*** This is our primary means of contacting you.

2. COMMUNICATION

a. Clinicians will also enroll in Remind. You will receive an email invitation from Felicia. Please sign up for that ASAP after receiving the invite.

b. All departmental and university communication will use Panthermail. Students preferring to use an outside email service as a primary method of electronic communication are responsible for activating the auto-forward feature on their EIU email account and for keeping that address updated if they change internet service providers. EIU and the CDS Department will not follow up on "undeliverable mail." Email accounts are listed in the online directory and members of the EIU community are responsible for checking their account in a consistent and timely fashion.

3. CLINICAL ASSIGNMENTS

a. The first day of clinic is the second week of class. The last day of clinic is the last day of classes.

b. Assignments have been made but are subject to change, so check your mailbox, email, and the schedule **daily** to be sure you are aware of any changes.

c. Your registration for CDS 4900, 5900 will be completed by the Clinic Director. Rosters will be switched by the 10th day.

d. Review the client(s)' files and make an appointment to see your supervisor this week.

e. Call clients/guardians prior to first day of therapy to confirm days and time.

f. Review your supervisor's syllabus for information regarding expectations for initial conferences.

g. Unless otherwise noted on the clinic schedule, all sessions are 45 minutes long. Therapy rooms must be vacated promptly at the end of your session. There are only 15 minutes between sessions. Therapy sessions are expected to start on time. If necessary, vacate your therapy room prior to meeting with parents.

B. CLINICIAN RESPONSIBILITIES

1. Call client prior to first therapy session. See **phone call checklist** for details.

2. ATTENDANCE/DISPOSITION SHEETS

a. **Check** the client attendance/disposition sheet (in the binder at the Front Desk); verify with the client or guardian that all information including the name, address, etc. are correct on the form. **Do not use the address/phone numbers from previous reports.**

b. **Verify** the client's attendance every day by writing in the date and initialing the attendance grid. Please use a pen.

c. When writing reports, letters, etc. regarding the client, refer to the attendance log for the most current address/phone information.

d. At the end of the semester, have your clinical supervisor complete their sections, sign and date this form and **return it to the binder in the front office.**

3. CLINICAL CLOCK HOURS

a. Clinical hours are calculated by actual minutes (45 minutes = 45 minutes; not an hour). You may round to the nearest 5 minutes (22 minutes = 20 minutes; 23 minutes = 25 minutes).

b. We expect you to accumulate 18 to 21 hours for clients in the Clinic that come 2 times per week.

c. If you feel that you will have difficulty accumulating the required number of hours, discuss the

situation with your supervisor and then see the Clinic Director as necessary.

d. **Make sure you keep track of treatment and assessment hours throughout the semester.**

e. **5900** – hours are tracked through Calipso- track daily or weekly and submit to supervisor for approval at end of semester.

f. **4900** – need to keep track of your own hours. You will receive an hours log at the end of the semester that you will record your hours and supervisors will be required to sign.

4. **CHANGES IN SCHEDULED TIMES, ROOMS, CLINICIANS AND/OR SUPERVISORS**

Changes must be reported in writing to the Clinic GA and to the Technology GA, who will make the changes on the Master Schedule and the ISR video recording system. This may only happen after you verify the change with your supervisor and Clinic Director. Please do not change the Master Schedule. The Clinic Director will notify you of changes via email.

5. **VIDEO RECORDINGS**

a. All therapy sessions will be recorded. Sessions are scheduled ahead of time by the Tech GA and will be recorded using the ISR Intelligent Stream Recording system.

b. To maintain confidentiality, the monitors are to be left off when no one is watching.

c. The Tech GA needs to be notified in advance of all make-up session so that the session can be scheduled to be recorded.

d. Notify the tech GA if there are any issues with the ISR system.

e. Should you need to use an additional video camera, cameras are available for checkout from the Clinic Director's office.

6. **CLINICIANS' ROOM**

This is your working space. The refrigerator, microwave, toaster, etc. are for your use. We will trust you to keep it clean and neat.

7. **MAILBOXES**

You have a mailbox in the Clinicians' Room which is to be used for professional correspondence between you, your fellow clinicians, and supervisors. It is your responsibility to check your mailbox on a regular basis. Do not use mailboxes to store therapy materials, books, etc. Supervisor mailboxes are located on the wall outside their office doors. All correspondence concerning clients should be placed in the provided folders and the folders turned so the name of the client is not visible.

8. **CLINIC AFTER HOURS (Sunday – Thursday from 5:00-8:00)**

All CDS students welcome to work in the Clinic from 5:00-8:00pm while GAs are on duty. Only students enrolled in the CDS Graduate Program may remain after hours (after 8:00) but must enter the building before the outside doors are locked. The last person to leave is responsible for closing doors and turning out lights.

9. **NAME TAGS**

Wear your name tag whenever you are seeing clients or parents for therapy, diagnostics, and conferences.

10. **CONCERNS ABOUT CLINIC**

If you are concerned about anything related to your clinic assignment, first, you should discuss the situation with your supervisor. However, if you believe that you cannot discuss the situation with your supervisor, you should discuss it with the Clinic Director. Our experience is that the best results are achieved if you make us aware of problems sooner rather than later.

11. **STUDENT COMPLAINT PROCESS**

A concern should initially be communicated to the supervisor/instructor. If that presents a problem for the person with the complaint, the concern should be addressed with the Clinic Director or Department Chair, as appropriate. Complaints not resolved with the Clinic Director can be forwarded to the Department Chair. Complaints not resolved within the department can be submitted to the Dean of the College of Sciences, followed by the Vice President for Academic Affairs. Complaints not addressed within the University to the satisfaction of the student, may be submitted to the Council on Academic Accreditation of the American Speech-Language-Hearing Association.

C. CONFIDENTIALITY: ONBASE AND CLIENT FILES

1. CLIENT FILES

a. Client files can be accessed using the On-Base Records System which is installed on your computers, as well as the computers in the clinicians' room. **Students should not access paper files from the front office unless an On-Base file is not available.** appropriate information is maintained in client files.

b. Paper files may be checked out from the front office by using an orange "check out card." The check out card should be placed in the file cabinet when you remove the client's file and removed when you return the file. If you need help, ask office staff for assistance. Files may not be taken from this floor of this building. Client files checked out from the Front Office must be returned before the office closes each day. **If you have a file checked out and cannot get it returned before the office closes, you must give to the GA on duty to store in their locked offices overnight. GAs must return the files to the front office first thing in the morning of the following day.** Missing files will be reported to the clinician and supervisor.

c. Under no circumstances, should you copy anything from a client's file without permission of your supervisor or the Clinic Director.

d. ***Do not add new documents to a client file. Turn documents into the office for scanning. Office staff will add the documents to the client's file.***

2. CONFIDENTIALITY concerning our clients is paramount!

a. **Read, sign and return the Statement of Confidentiality.**

b. Avoid speaking about your clients outside of the professional setting or casually in the hallways of the Clinic. Confidentiality must also be maintained within conversations. Do not discuss your clients by name with anyone such as your parents, friends, secretaries, or teachers. Discussions of a client are confined to other clinicians, clinical supervisor and the Clinical Director.

c. Under no circumstances should any saved, electronic material about a client from the OnBase system leave the building.

d. **De-identification of client information is imperative in electronic communication** and is a requirement of HIPAA. De-identification does not only apply to client, but also their relatives, employers or household members. Electronic communication **should not contain** any of the following information:

- Names
- Geographic area smaller than state (e.g. city, street number)
- Telephone or fax numbers
- email addresses

This policy not only applies to emails, but also applies to attachments in emails. Although sending client documents through email should rarely be necessary, there may be occasions when SharePoint is not working. In a case such as this, please do not include first and last names of clients on the documents. Please use the least amount of identifying information as possible. For example, use the word "client" or if absolutely necessary, initials may be used. (See above for other guidelines regarding de-identification).

g. Clinic documents such as therapy plans, ITP and reports contain confidential information and should be saved only on our secure server, SharePoint. If you would like to save a copy of a clinic document on your personal computer, you should not include any identifying information on the document. Identifying information can be added when saving your final copy/draft to SharePoint.

h. Delete and/or shred all rough drafts of reports, letters, therapy plans, etc. that contain any personally identifiable information about a client.

i. The video system and OnBase will be accessed through the CDS WIFI LAPTOPS located in the Tech GA's office. Please wear headphones when viewing sessions.

3. SOCIAL MEDIA

a. Client privacy measures taken on social networking sites and other online media should be the same as those taken in any public forum. Faculty, staff, and students should never publicly make comments about the treatment of a specific client, especially online. Even acknowledging the care of a client is an unacceptable disclosure of PHI. The Health Insurance Portability and Accountability Act (HIPAA)

regulations apply to comments made on social and online media and violators are subject to the same federal prosecution as with other HIPAA violations. Discussions regarding specific clients, research subjects, and volunteers should be avoided, even if all identifying information is excluded. It is always possible that someone could recognize the individual to whom you are referring based upon the context.

b. Under no circumstances should photos of patients or research subjects be displayed. Interactions with clients or caregivers within these sites are strongly discouraged.

c. Do not give treatment advice using social media. Direct individuals with inquiries about services to an appropriate hospital or clinic website or phone number. Negative comments on social networking sites can jeopardize internship sites for you and future students and have a negative impact on potential employers. It can also adversely influence relations with peers and faculty.

d. Be mindful about what you post on social media.
e. Clinicians are not allowed to "friend" or "follow" clients or clients' family members on social media.

D. PROFESSIONAL CONDUCT

1. CODE OF ETHICS

Review the ASHA Code of Ethics. Ensure that your conduct adheres to these ethical guidelines. Violations of the Code will be reflected in your grade and, depending on the seriousness of the violation, may be grounds for dismissal from clinic.

2. NEGLIGENCE OF PROFESSIONAL RESPONSIBILITY

Negligence is considered very serious in its implication. Missing appointments with supervisors, unexcused absences for clinical sessions, not following MC procedures and tardiness in paperwork are examples of negligence and may result in lowering of your clinic grade or could be considered grounds for dismissal from 3900/4900/5900/5910/5920. Dismissal from clinic may be appealed to the Clinic Director and the Department Chairperson.

3. CLINIC ATTIRE

a. When conducting therapy, clinicians are expected to adhere to the following:
- No wet hair or messy buns (it should not look like you just rolled out of bed)
- No spaghetti straps or shorts
- No short skirts or dresses – should be just above the knee or minimally to the end of your fingertips when your hands are at your side
- No denim! Pants should not look like jeans.
- No yoga pants or workout clothes
- If you were leggings or tight pants, a long tunic or shirt should be worn over the leggings (minimally covering your bottom)
- No casual flip flops or athletic tennis shoes.
- No lip or tongue piercings. If you have a nose piercing it must be small and not distracting to the client.
- Cover any large or obvious tattoos.
- No strong fragrances or perfumes
- Wear name tags
- Do not use cups, hats, etc., in therapy which have profanity or logos for alcoholic beverages, tobacco, etc.

b. Name tags must be worn when conducting clinical activities (therapy, testing, etc.) Name tags should be worn above the waist.

c. Faculty who observe a clinician dressed inappropriately may send the student home to change. If there is not time to change, the clinician may be required to wear a lab coat from the Front Office.

4. DRUG FREE CAMPUS

a. Although Illinois has legalized recreational cannabis as of January 1, 2020, federal law prohibits use and possession on EIU's campus. The Student Conduct Code and University Internal Governing Policies therefore prohibit such acts and the institution can, and will, impose disciplinary sanctions or action for violations.

b. Violations of this prohibition by students may result in the application of sanctions, including:

1. possible required participation in an approved substance use disorder assessment, intervention, treatment, rehabilitation and/or recovery program; and
2. disciplinary action up to and including expulsion from the University under applicable Board of Trustees regulations and the Student Conduct Code.

Questions by students concerning this policy should be addressed to the Director of Health and Counseling Services.

5. **NETIQUETTE FOR ELECTRONIC COMMUNICATION**

a. Use formal modes of address unless you are absolutely certain that informality is acceptable to the receiver.
b. Use appropriate and professional language in your communications. Use correct spelling, capitalization, punctuation, grammar, and avoid using internet abbreviations (i.e. : brb, lol, etc).
c. Keep email short and to the point. If meeting on the phone or in person would be more effective, indicate this. Email should be used for simple communication, not to solve problems.
d. Unless professor is out of the office, email will be checked M-F during business hours. Please allow 24 hours for a response. If email is received after 12:00 p.m. on Friday expect a response Monday afternoon.
e. Remember that email is about communication with other people. When you compose a message, read it over before sending it and ask yourself what your reaction would be if you received it. Take care with sarcasm and humor so that you are not misinterpreted.

6. **UNLICENSED PRACTICE**

Student clinicians shall provide therapy only when enrolled in clinical practicum with an assigned clinical supervisor. Any CDS student determined to be providing services within the scope of practice for speech-language pathology or audiology that are not directly related to the academic or clinical training program shall be considered to be engaging in unlicensed practice and may be referred to the Illinois Department of Financial and Professional Regulation for possible disciplinary action.

7. **NONDISCRIMINATION/EQUITABLE TREATMENT**

Students, faculty, staff, and persons served in the program's clinic are treated in a nondiscriminatory manner – that is without regard to race, color, religion, sex, national or ethnic origin, disability, age, sexual orientation, genetic information, citizenship, or status as a covered veteran.

8. **ESSENTIAL FUNCTIONS**

Essential functions, as distinguished from academic standards, refer to those cognitive, physical and behavioral abilities that are necessary for satisfactory completion of all aspects of curriculum and clinical practicum, and the development of professional attributes required to meet ASHA standards. Essential functions will be monitored throughout clinical practicum. Should there be a concern(s) identified by instructors or supervisors, the student will be notified and the concern(s) will be discussed. If the concern(s) is not remediated a clinician may be pulled from their clinical practicum experience/not scheduled for a clinical experience the next semester.

E. CLINICIAN/CLIENT ABSENCES AND FIELD TRIPS

Attending clinical sessions and conferences is important for accruing clinical hours necessary for graduation as well as continuity of clinical education and assessment of student clinician learning. Clinicians should make attendance a priority and miss therapy sessions when it is absolutely necessary for excused absences.

1. **CLINICIAN/CLIENT ABSENCES**

a. When a client calls and cancels, the Front Office will notify you via the Remind App. The clinician is also responsible to let their shadow know that therapy has been cancelled.
b. If the clinician cancels, inform the supervisor and ask the Front Office to call the client and shadow. It is best to call the front office so they can receive notification of your absence immediately. 581-2712

c. If you must cancel an early morning session (8:00 or 9:00), **you** should call the client and shadow to ensure that they do not come to the Clinic unnecessarily.

d. **Sick leave** – if you miss more than 2 of your client's sessions due to an illness, a note from a doctor is required. Please provide a copy to your supervisor and Clinic Director.

e. **Bereavement leave** – clinicians are encouraged to miss as little therapy as possible due to bereavement of direct family members. Only extenuating circumstances or special permission from the Clinic Director may the clinician miss more than 2 sessions. Please notify the front office, supervisor, and Clinic Director if you will be taking bereavement leave. Documentation should be sent to the Clinic Director.

d. The clinician schedules make-up sessions with prior approval of the supervisor and Clinic Director. Please check the master schedule to be sure rooms are available for the make-up session. Your faculty supervisor or another faculty member must be in the building when make-up sessions are in progress. Once approved, please let Tech GA know so the session can be recorded

e. Clinicians are expected to attend clinic as scheduled. Any schedule changes or cancellations (not due to illness or emergency) by the clinician require the supervisor's prior approval. Supervisors or the Clinic Director may request documentation of the reason for an absence. All sessions cancelled by the clinician shall be made up if possible. Therapy cannot be cancelled as a matter of clinician convenience (e.g. to extend weekends, leave early for break, vacation). Any unexcused absences by the clinician shall be viewed as grounds for dismissal from clinic. If a clinician establishes a record or pattern of absences of concern to the supervisor, the supervisor may involve the Clinic Director in determining whether the clinician will be allowed to continue in clinical practicum for the remainder of the term. Clinicians who are dismissed must wait until the next term 4900/5900/ 5910/5920 is offered to re-enroll. Students may appeal dismissal decisions to the Clinic Director and Chairperson.

g. Client Attendance: When Clinic sessions are canceled or clients arrive late, both student clinicians and clients lose valuable learning opportunities. Clients are expected to attend scheduled appointments and to notify the Clinic Office (217-581-2712) as soon as possible when an absence is unavoidable. Although makeup sessions are not guaranteed, clients who contact the Clinic to cancel appointments may have an opportunity to make up missed sessions pending the schedules of the clinician and the supervisor and room availability.

Regular attendance is expected. The clinician will wait 10 minutes after a scheduled session time before calling to remind of an appointment. The clinician will then wait an additional 10 minutes for the client to arrive. After this 20 minute time period has elapsed, the clinician will consider the treatment session cancelled. If caregivers leave the building during a session, they need to return in time to assume responsibility for their child immediately at the conclusion of the session.

If two consecutive sessions are missed without notification, if more than four sessions are missed in any one semester with or without notification, or if a client is regularly 15 or more minutes late for scheduled sessions, services will be terminated. The client discharged due to the attendance policy will have the opportunity to reinitiate clinical services when requirements of the attendance policy can be met.

The EIU Clinic will cancel sessions if University classes are cancelled or the campus is closed. The Clinic will follow the University's schedule if late starts or early dismissals occur. Announcements concerning changes in University schedules are made on television and radio and posted on the University's website. Since weather conditions are variable, individuals are encouraged to use their best judgment in determining if they can keep scheduled appointments. Clients will not be penalized for missing sessions due to weather.

During the 6-week summer session, clients will not be scheduled whose caregivers anticipate the client will miss more than two individual therapy sessions for vacation, camps, and other activities.

**** See attendance policy addendum for specific policies related to COVID-19 absences**

2. **TRIPS**

Trips and sessions outside of the building require written permission from the parent or guardian. Permission slips are available in the Front Office and should be placed in the file tray in the Front Office after it is signed.

F. REPORTS AND THERAPY PLANS

1. THERAPY PLAN

a. Evidence based practice involves using the best available clinical literature along with our clinical intuition and client preferences to guide our assessment and treatment decisions. Students will be expected to find literature which: a) defines the client's problem(s), b) guides assessment for the client's problem(s), and c) guides the treatment process. Examples of clinical literature include textbooks, professional journals, and internet sources. Students should not limit searches to any one source. Students are expected to have obtained and read relevant research relating to their client's disorder(s) prior to the initial conference with their supervisor.

b. All report formats and forms are available in the D2L Clinic Course. See the attached memo for formatting instructions and examples. All documents must be done in Word.

c. Refer to the attached Final Report template when writing your report. Check with your supervisor to see to what extent they want you to adhere to this format.

G. MATERIAL CENTER AND EQUIPMENT

1. BATTERIES

The Clinic will provide batteries for Clinic owned equipment. Clinicians are responsible for providing consumable therapy materials (construction paper, glue, paints, etc.), batteries for personally owned equipment, and toys/games/ books/etc. desired for therapy beyond those available in the MC and Clinic toy cabinets.

2. iPads & Video Cameras

The Clinic has iPads available for checkout and several video cameras. iPads are located in the technology cabinet in the Clinic Director's office. iPads must be signed out on the technology cabinet door AND in the MC. There is a weekly reserve list that can be used if you need to reserve an iPad or video camera for a regular time each week. Clinicians should **always check the reserve list before checking out an iPad** to make sure it is not needed during the time you will have it.

3. MATERIALS CENTER (MC)

a. The Materials Center (Room 2309) has equipment, toys and materials available for student use.

b. The MC will be open Monday-Thursday 8:00am-8:00pm, Fridays from 8:00am-4:30pm, and Sunday 5:00pm-8:00pm.

c. The Clinic GA is in charge of the MC. If you notice we are running low on supplies or test forms in the Materials Center or if you have suggestions or complaints, please inform the Clinic GA.

d. When no one is assigned to work the MC, clinicians are responsible for checking items in and out of the MC.

e. Follow the check in/check out procedures which are posted in the MC. **Under no circumstances do you:**

- **Take something from the MC without checking it out, even if it is for only a few minutes.**
- **Shelve an item without checking it back into the MC computer inventory system (Inform the GA if an item will not check into the system).**

If you do not follow MC procedures, your supervisor will be notified and it will be result in lower ratings in the professional section of the clinical evaluation form.

4. EQUIPMENT

If you find a piece of equipment that is not working appropriately, please bring it to the attention of the Tech GA **ASAP**. If you plan to use an auditory trainer, digital camera or the video camera, check that it is charged. **No equipment should be left in the hallway after hours.**

5. FACILITIES

a. Nothing gets taped to a wall, door or mailboxes. Post notices on the bulletin board. Notices need to be cleared with the Clinic Director or NSSLHA sponsor.

b. The faculty lounge is off limits to students except for scheduled events such as class, meetings, etc.

c. The sensory room is not scheduled as part of the clinic schedule. It can be accessed as needed for clients. Equipment should not be taken to other rooms for use. Clients should be taken to this room

as needed. Non-clients or unsupervised clients (without their clinicians) should not use the sensory room.

d. In the video room, for confidentiality purposes, observation is limited to relatives/guardians or other authorized persons (e.g. student observers). TVs should be turned off when no one is observing. Observers should not be tuning in other therapy rooms.

e. You are expected to pick up after yourself. Cups, wrappers, etc. should be placed in the appropriate receptacle. **If you remove furniture or equipment from your therapy room or take out an electrical cover, replace it at the end of your session.** Avoid cluttering the hallway. Do not place items directly across from each other in the hall.

h. Accidents happen. If something is spilled on the carpet or if a client soils themselves, leave a note on the Sanitation room door describing what was spilled, etc. and the location. If a client has a toileting accident during a session, the clinician should notify the caregiver and the caregiver is responsible for changing the client. If the caregiver is not present, the therapy session is discontinued until a caregiver can address the issue.

6. **VIDEO VIEWING GUIDELINES IN THE VIDEO ROOM**

a. Please turn off the monitor if no one is watching.

b. Do **NOT** change the channels on the TVs for any reason. It is the clinician's responsibility to notify parents that they are not to change the channels as well. If a parent needs to view a different room (e.g. the sensory room), they need to get up and move to the appropriate viewing station.

c. Please wear headphones when observing.

d. Use an adapter at the end of the splitter to receive sound in both ears.

e. Please talk softly. It is difficult for supervisors to hear subtle differences in speech even with headphones.

f. During busy times to alleviate congestion, it would be helpful if there were only one person per viewing station besides the supervisor.

g. If there are problems with the equipment, please inform one of the staff.

H. HEALTH AND SAFETY

1. **HEALTH AND SAFETY**

Because you will be working closely with people, please take precautions for health and safety using universal precautions when appropriate. Tissues, latex gloves, tongue depressors and disinfectant wipes are located on the shelf in each clinic room.

a. **Use latex gloves** when performing oral exams or during any invasive procedure of the oral cavity.

b. **Wash your hands** before and after working with clients. Hand washing is considered one of the best ways to prevent the spread of disease. In addition, avoid touching your hands to your mouth, eyes or nose when working with your clients.

c. **Each clinician is responsible to disinfect all equipment and toys** used in therapy. Use the disinfectant located in the sanitation room. Spray the item to be cleaned with the disinfectant. Wipe clean. Rinse. Dry. Return the item to its original location in the Materials Center. Do not store wet items in the Materials Center. If you are unable to wash the item immediately after therapy, place in the bin in the sanitation room and return to clean the item as soon as possible.

- Use the disinfectant wipes located in therapy room to wipe tables, desks, etc. after each therapy session. Notify front office, the Clinic Director or faculty member on master coverage for bigger cleanup jobs.
- There is a sanitation protocol listed on certain items which you are allowed to check out from the MC. A list of items which may be sanitized and re-used are listed in the MC, Sensory Room cabinet and in the Sanitation Room. Please check this list before dedicating an item to a client or throwing it away after using it. (e.g., materials from the MOST).
- If your client has come to therapy ill, please make sure to sanitize the table, all toys, doorknobs, etc. This includes wiping down toys, books, furniture they may have been playing with in the waiting room after your session.

d. **Stay home if you are ill**, being considerate to your client and to your colleagues at the Clinic. You should strive to re-schedule the session.

e. Keep the client's welfare in mind. Keep young children away from the elevator and stairway. Consult with parents before allowing children to have a snack. If necessary, assist elderly clients to and from

the room.

f. **Sensory Room:**
   1. If you are going into the ball pit please remove shoes first.
   2. Please use hand sanitizer BEFORE using the sensory tubs, MC Play-Doh, and going into the ball pit. Sensory tub will have various items in it this semester for your use (water beads, beans, water, etc.). If the sensory room needs attention, please let the Clinic GA know (needs more beans, water beads need changed out, etc.).
   3. We will have a "Yuck Bucket" in the sensory room for you to put items in that may have been mouthed during your session. If your child is a chronic oral explorer of toys from the MC, I would suggest you use something like this during your session in your own treatment rooms so that you can keep it separate from other items and sanitize it properly prior to returning it to the MC.
   4. Items in the sensory room need checked out. There is a checkout form in the Sensory room on the Window Sill.

****Refer to sanitation guidelines posted in sensory room and sanitation room.**

2. **IMMUNIZATIONS**

a. As students enrolled in the EIU Communication and Sciences Disorders Program are entering a healthcare or educational profession, there are certain public health requirements to which our program expects students to adhere. All immunizations recommended by the Center for Disease Control (CDC) and the State of Illinois for adults must be up to date when a student begins the clinical portion of the CDS Program. People who are not correctly immunized pose a significant public health risk to their clients, co-workers and themselves.

b. Seasonal flu shots are being required by many external clinical sites and will not accept student clinicians who have not had this immunization. Flu shots are available in the fall of each year and can be obtained through the EIU Student Health Service, the Illinois Department of Public Health, your personal physician's office, local pharmacies, and other flu shot clinics in the area.

c. Students in clinical practicum are required to get flu shots. If, for some reason, a student chooses not to receive the flu shot, they will be required to sign a declination form. If immunizations and TB tests are not up to date, the CDS Department cannot guarantee that students will be accepted at medical and /or educational clinical sites. This could impact a student's timely progression through the program, prevent a student from participating in a variety of clinical experiences and ultimately prevent a student from graduating.

d. In accordance with University policy and CDC recommendations, students enrolled in the Communication Disorders and Sciences Program as an undergraduate or graduate student are required to provide proof of immunization for tetanus, diphtheria and pertussis and proof of immunity to rubeola (red measles), mumps, rubella (German or three day measles), varicella (chickenpox) and Hepatitis B.

e. Students must also include proof of freedom from active tuberculosis. Those needing a yearly retest need only be present on the final two dates. Those who have never had a TB test or if more than 1 year has passed since their last testing require the two-step. Those who have been tested in the past year only need the one step. Anyone who has previously test positive for TB must undergo a yearly TB symptoms screening scheduled with the EIU Health Service.

f. Students who do not meet these requirements will not be permitted to enroll in CDS 3900, 4900, 5900, 5910, 5920, 5970, 5980 and will not be able to complete the requirements for the degree. Any exceptions will have to be reviewed by the medical director at EIU for recommendations and approval.

g. TB tests **must be completed and returned to the Clinic GA.** The cost is $20 per injection. Individuals requiring the 2-step test must be present on all four dates.

3. **EMERGENCY EVACUATION PROCEDURES**

Emergency evacuation maps are posted in every room in the Clinic. You are responsible for reviewing the map and knowing the appropriate exit route. The Emergency Evacuation Procedures are also attached.

I. DIAGNOSTICS

1. **DIAGNOSTICS**

a. Diagnostic evaluations will be held on Friday beginning at 10:00AM (unless otherwise specified) and 1:00 PM in Rooms 2610 and 2702.

b. Teams of three graduate students have been assigned to diagnostics. It is the responsibility of the students to inquire about clients scheduled and arrange to meet with the faculty supervisor. Please make the initial contact with your diagnostic supervisor at least 10 days in advance of the scheduled diagnostic. Check the schedule in the Clinicians' Room.

c. A syllabus for CDS 5910 is posted in D2L in the CDS Practicum Supplemental Materials.

J. SPEECH AND HEARING SCREENING

1. COLLEGE SCREENINGS

a. All EIU students in teacher preparation programs must have a speech and hearing screening. Graduate clinicians enrolled in audiology practicum will be scheduled to do the testing in the Clinic.

CDS 4900
Clinical Practicum Syllabus
2022

I. Course Description: (0-2.5-1; 1 Credit hour) Supervised work with persons with a communication disorder. Supervised clinical therapy experience and clinical instruction related to treatment of speech-language- hearing disorders: Students will conduct speech-language-hearing therapy sessions and communicate effectively with the client, family, and other professionals as needed. Students will use evidence-based literature to guide clinical decision making and will develop clinical writing skills. Students will evaluate and discuss intervention strategies, data collection, and factors that influence client progress.

II. Course Objectives

- To gain an understanding of the diagnostic process through administration of formal and informal assessment procedures.
- To gain an understanding of the therapeutic process through developing and implementing a treatment plan, collecting data and assessing progress.
- To develop written communication skills through writing reports, lesson plans and progress notes.
- To develop interpersonal communication skills in parent/client conferences and interaction with other professionals.

IV. Course Assignments

- Writing reports
- Writing lesson plans
- Writing progress reports
- Participating in weekly conferences with clinical supervisor
- Conducting therapy
- Researching assessment/treatment techniques
- Performing weekly self-evaluations

V. Course Outline

- Orientation to Clinic: Policies and Procedures, Code of Ethics & ethical conduct, Confidentiality, etc.
- Review of records
- Initial conference: Discussion of background information; cultural or linguistic considerations; diagnosis; EBP; initial plan for client; and /or priorities for treatment.
- Formal and informal assessments
- Interpretation of assessment results
- Treatment Plan
- Lesson plans
- Treatment implementation
- Data collection
- Progress notes
- Final report

VI. Attendance

Clinicians are expected to attend clinic as scheduled. Any schedule changes or cancellations (not due to illness or emergency) by the clinician require the supervisor's prior approval. Supervisors or the Clinic Director may request documentation of the reason for an absence. All sessions cancelled by the clinician shall be made-up if possible. Therapy cannot be cancelled as a matter of clinician convenience (e.g. to extend weekends, leave early for break, vacation). Any unexcused absences by the clinician shall be

viewed as grounds for dismissal from clinic. If a clinician establishes a record or pattern of absences of concern to the supervisor, the supervisor may involve the Clinic Director in determining whether the clinician will be allowed to continue in clinical practicum for the remainder of the term. Clinicians who are dismissed must wait until the next term 5900 is offered to re-enroll. Students may appeal dismissal decisions to the Clinic Director and Chairperson

Sick leave – If a clinician misses more than 2 of your client's sessions due to an illness, a note from a doctor is required. Please provide a copy to your supervisor and Clinic Director.

Bereavement leave – Clinicians are encouraged to miss as little therapy as possible due to bereavement of direct family members. Only extenuating circumstances or special permission from the Clinic Director may the clinician miss more than 2 sessions. Please notify the front office, supervisor, and Clinic Director if you will be taking bereavement leave. Documentation should be sent to the Clinic Director.

VII. Grading Policy and Evaluation Procedures

Grades will be determined based on clinical performance at midterm and final. Undergraduate clinicians will be rated on clinical skills using the following scale:

Rating Scale

1 **Emerging**
2 **Developing**
3 **Established**

Clinical Performance:
Ratings will be assigned based on each clinician's performance in the areas of evaluation, intervention, professional practice, interaction, personal qualities and writing. Refer to the Clinical Performance Evaluation for specific rating items.

Grades will be assigned as outlined in the rating scale below.

Grading Scale

1.86-3.0	Credit
1.85 and below	No Credit

VIII. Clinical Hours

It is the responsibility of the clinician to keep track of their clinical hours. Clinical hours will be tracked by assessment and intervention hours throughout the semester. Clinicians will enter hours in Calipso weekly and will submit to supervisor for approval at the end of the semester.

XI. Essential Functions

Essential Functions for clinical practicum are skills, attributes, and abilities necessary for the profession of speech-language-pathology. These functions will be monitored through classroom and clinical performance in order to ensure students possess and maintain essential professional attributes to participate in all aspects of the CDS graduate program. Failure to meet essential functions could prohibit students from completing the graduate program, specifically participation in clinical practicum and internships. Clinical supervisors will monitor essential functions over the course of the semester. Student clinicians will receive feedback on essential functions throughout the semester as needed. Any concerns with essential functions will be reviewed with student clinician at midterm and final.

IX. Instructor Contact Information/Office Hours

Instructor contact information/office hours are located on or outside each supervisor's door. It is the clinician's responsibility to schedule diagnostic conferences with the supervisor during posted office hours

by appointment two weeks in advance of the diagnostic practicum.

X. Students with disabilities

Reasonable accommodations are available to any student with a covered disability. Students with a disability must provide documentation to the Office of Disability Services (581-6583) at Eastern Illinois University. Once documentation is completed, the Office of Disability Services will contact the supervisor to assist with developing reasonable accommodations for this class. Eligible students should contact the Office of Disability Services within the first two weeks of class.

XI. Student Success Center

Students who are having difficulty achieving their academic goals are encouraged to contact the Student Success Center (www.eiu.edu/~success) for assistance with time management, test taking, note taking, avoiding procrastination, setting goals, and other skills to support academic achievement. The Student Success Center provides individualized consultations. To make an appointment, call 217-581-6696 or go to 9th Street Hall, Room 1302.

XII. Evacuation Procedures

Please refer to the fire and emergency evacuation procedures posted near each therapy door.

XIII. Academic Integrity

Students are expected to maintain principles of academic integrity. Violations will be reported to the Office of Judicial Affairs.

XIV. Netiquette for Electronic Communication

- Use formal modes of address unless you are absolutely certain that informality is acceptable to the receiver
- Use appropriate and professional language in your communications. Use correct spelling, capitalization, punctuation, grammar, and avoid using internet abbreviations (i.e. : brb, lol, etc)
- Keep email short and to the point. If meeting on the phone or in person would be more effective, indicate this. Email should be used for simple communication, not to solve problems.
- Unless professor is out of the office, email will be checked M-F during business hours. Please allow 24 hours for a response. If email is received after 12:00 p.m. on Friday expect a response Monday afternoon.
- Remember that email is about communication with other people. When you compose a message, read it over before sending it and ask yourself what your reaction would be if you received it. Take care with sarcasm and humor so that you are not misinterpreted.

XV. Texts

Roth, F.P., & Worthington, C.K. (2016). *Treatment resource manual for speech-language pathology* (5nd ed.). New York: Singular.

Shipley, K.G., & McAfee, J.G. (2016). *Assessment in speech-language pathology: A resource manual* (5nd ed.). San Diego: Singular.

CDS 5900
Clinical Practicum Syllabus

I. Course Description: (0-2.5-1; 1 Credit hour) Supervised work with persons with a communication disorder. Supervised clinical therapy experience and clinical instruction related to treatment of speech-language- hearing disorders: Students will conduct speech-language-hearing therapy sessions and communicate effectively with the client, family, and other professionals as needed. Students will use evidence-based literature to guide clinical decision making and will develop clinical writing skills. Students will evaluate and discuss intervention strategies, data collection, and factors that influence client progress.

II. Course Objectives

- To gain an understanding of the diagnostic process through administration of formal and informal assessment procedures.
- To gain an understanding of the therapeutic process through developing and implementing a treatment plan, collecting data and assessing progress.
- To develop written communication skills through writing reports, lesson plans and progress notes.
- To develop interpersonal communication skills in parent/client conferences and interaction with other professionals.

III. Departmental Learning Objectives

As part of the ASHA standards, learning objectives were developed for all CDS courses and clinical practicum. Students will be evaluated in the following areas for CDS 5900 at the end of the semester. The following rating scale is used when supervisors evaluate student clinicians.

Rating Scale

1 **Emerging**
2 **Developing**
3 **Established**

Departmental Learning Objectives

- The student demonstrates knowledge and skills necessary for assessment of phonological/articulation disorders.
- The student demonstrates knowledge and skills related to the prevention and intervention of phonological/articulation disorders.
- The student demonstrates knowledge and skills necessary for assessment of oral and written developmental language disorders.
- The student demonstrates knowledge and skills related to the prevention and intervention of oral and written developmental language disorders.
- The student demonstrates knowledge and skills necessary for assessment of fluency disorders.
- The student demonstrates knowledge and skills related to the prevention and intervention of fluency disorders.
- The student demonstrates knowledge and skills necessary for assessment of voice and resonance disorders.
- The student demonstrates knowledge and skills related to the prevention and intervention of voice and resonance disorders.
- The student demonstrates knowledge and skills necessary for assessment of oral and written acquired language disorders.
- The student demonstrates knowledge and skills related to the prevention and intervention of acquired oral

and written language disorders.

- The student demonstrates knowledge and skills necessary for assessment of swallowing disorders.
- The student demonstrates knowledge and skills related to the prevention and intervention of swallowing disorders
- The student demonstrates knowledge and skills necessary for assessment of cognitive communication disorders.
- The student demonstrates knowledge and skills related to the prevention and intervention of cognitive communication disorders.
- The student demonstrates knowledge and skills necessary for assessment of social aspects of communication.
- The student demonstrates knowledge and skills related to the prevention and intervention of social aspects that effect communication.
- The student demonstrates knowledge and skills necessary for assessment of alternative and augmentative communication modalities.
- The student demonstrates knowledge and skills related to intervention with alternative and augmentative communication modalities.
- The student composes professionally written documents.
- The student engages in professional oral communication and interaction.
- The student evidences independent learning strategies, critical thinking, and problem solving skills.
- The student can collect and interpret case history information.
- The student can design, select, administer, and interpret formal and informal evaluation tools.
- When conducting an evaluation, the student demonstrates flexibility and makes appropriate modifications to meet client needs.
- The student compiles evaluation information to generate appropriate diagnosis, recommendations, and referrals.
- The student completes administrative tasks relevant to evaluation and intervention.
- The student collaborates with client/relevant others/other professionals to design and implement intervention plans.
- The student writes measurable intervention goals.
- The student selects and utilizes case appropriate materials during intervention.
- The student utilizes instructional techniques (modeling, cueing, feedback, strategies) during intervention.
- The student measures client progress and generates appropriate therapy modifications.
- The student counsels clients, family members and relevant others regarding communication disorders.
- The student interacts in a professional and ethical manner.
- The student is sensitive to cultural backgrounds when interacting with client and relevant others.
- The student demonstrates effective use of technology as appropriate.

Departmental Learning Objective Evaluation

CDS 5900	Written Documentation	Clinical Conferences	Interaction with Clients and others	Data Collection and Analysis	Evidence Based Practice	Self-Analysis
The student demonstrates knowledge and skills related for assessment of phonological/articulation disorders.	X	X	X	X	X	X
The student demonstrates knowledge and skills related to the prevention and intervention of phonological/articulation disorders.	X	X	X	X	X	X
The student demonstrates knowledge and skills necessary for assessment of oral and written developmental language disorders.	X	X	X	X	X	X
The student demonstrates knowledge and skills related to the prevention and intervention of oral and written developmental language disorders.	X	X	X	X	X	X
The student demonstrates knowledge and skills necessary for assessment of fluency disorders.	X	X	X	X	X	X
The student demonstrates knowledge and skills related to the prevention and intervention of fluency disorders.	X	X	X	X	X	X
The student demonstrates knowledge and skills necessary for assessment of voice and resonance disorders.	X	X	X	X	X	X
The student demonstrates knowledge and skills related to the prevention and intervention of voice and resonance disorders.	X	X	X	X	X	X
The student demonstrates knowledge and skills necessary for assessment of oral and written acquired language disorders.	X	X	X	X	X	X
The student demonstrates knowledge and skills related to the prevention and intervention of oral and written acquired language disorders.	X	X	X	X	X	X
The student demonstrates knowledge and skills necessary for assessment of swallowing disorders.	X	X	X	X	X	X
The student demonstrates knowledge and skills related to the prevention and intervention of swallowing disorders.	X	X	X	X	X	X
The student demonstrates knowledge and skills necessary for assessment of cognitive communication disorders.	X	X	X	X	X	X
The student demonstrates knowledge and skills related to the prevention and intervention of cognitive communication disorders.	X	X	X	X	X	X
The student demonstrates knowledge and skills necessary for assessment of social aspects of communication.	X	X	X	X	X	X
The student demonstrates knowledge and skills related to the prevention and intervention of social aspects that effect communication.	X	X	X	X	X	X

Clinicians will be rated on the above departmental learning objectives based on their performance in the following six areas:

- Written documentation
- Clinical conferences
- Interaction with client and others
- Data collection and analysis
- Evidence based practice
- Self-analysis

IV. Course Assignments

- Writing reports
- Writing lesson plans
- Writing progress reports
- Participating in weekly conferences with clinical supervisor
- Conducting therapy
- Researching assessment/treatment techniques
- Performing weekly self-evaluations

V. Course Outline

- Orientation to Clinic: Policies and Procedures, Code of Ethics & ethical conduct, Confidentiality, etc.
- Review of records
- Initial conference: Discussion of background information; cultural or linguistic considerations; diagnosis; EBP; initial plan for client; and /or priorities for treatment.
- Formal and informal assessments
- Interpretation of assessment results
- Treatment Plan
- Lesson plans
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VI. Attendance

Clinicians are expected to attend clinic as scheduled. Any schedule changes or cancellations (not due to illness or emergency) by the clinician require the supervisor's prior approval. Supervisors or the Clinic Director may request documentation of the reason for an absence. All sessions cancelled by the clinician shall be made-up if possible. Therapy cannot be cancelled as a matter of clinician convenience (e.g. to extend weekends, leave early for break, vacation). Any unexcused absences by the clinician shall be viewed as grounds for dismissal from clinic. If a clinician establishes a record or pattern of absences of concern to the supervisor, the supervisor may involve the Clinic Director in determining whether the clinician will be allowed to continue in clinical practicum for the remainder of the term. Clinicians who are dismissed must wait until the next term 5900 is offered to re-enroll. Students may appeal dismissal decisions to the Clinic Director and Chairperson

Sick leave – If a clinician misses more than 2 of your client's sessions due to an illness, a note from a doctor is required. Please provide a copy to your supervisor and Clinic Director.

Bereavement leave – Clinicians are encouraged to miss as little therapy as possible due to bereavement of direct family members. Only extenuating circumstances or special permission from the Clinic Director may the clinician miss more than 2 sessions. Please notify the front office, supervisor, and Clinic Director if you will be taking bereavement leave. Documentation should be sent to the Clinic Director.

VII. Grading Policy and Evaluation Procedures

Grades will be determined based on clinical performance (80%), midterm critical analysis (10%), and final oral presentation (10%).

Clinical Performance:
Ratings will be assigned based on each clinician's performance in the areas of evaluation, intervention, professional practice, interaction, personal qualities and writing. Refer to the Clinical Performance Evaluation for specific rating items in Calipso.

Midterm Critical Analysis:
Clinician will complete a midterm critical analysis during midterm week, **October 11th at 5:15**. The midterm will be in written format, reflect critical thinking and vary from case to case. Use the "Rational and Insights in Clinical Decision Making" document to help prepare for the midterm.

Final Oral Presentation:
Clinician will complete a 15 minute oral case presentation (10 minutes prepared presentation, 5 minutes for questions). Clinician will be randomly assigned to present to a CDS faculty member. Clinician will be rated on knowledge of the case, critical thinking, ability to describe or defend clinical decisions, and oral presentation skills. Final oral presentations, **November 29 from 11:00-1:00.**

Grades will be assigned as outlined in the rating scale:

Grading Scale

2.40-3.0	A
1.86-2.39	B
1.0-1.85	C

VIII. Essential Functions

Essential Functions for clinical practicum are skills, attributes, and abilities necessary for the profession of speech-language-pathology. These functions will be monitored through classroom and clinical performance in order to ensure students possess and maintain essential professional attributes to participate in all aspects of the CDS graduate program. Failure to meet essential functions could prohibit students from completing the graduate program, specifically participation in clinical practicum and internships. Clinical supervisors will monitor essential functions over the course of the semester. Student clinicians will receive feedback on essential functions throughout the semester as needed. Any concerns with essential functions will be reviewed with student clinician at midterm and final.

IX. Clinical Hours

It is the responsibility of the clinician to keep track of their clinical hours. Clinical hours will be tracked by assessment and intervention hours throughout the semester. Clinicians will enter hours in Calipso weekly and will submit to supervisor for approval at the end of the semester.

X. Instructor Contact Information/Office Hours

Instructor Contact Information/Office hours are located on or outside each supervisor's door. It is the clinician's responsibility to schedule diagnostic conferences with the supervisor during posted office hours by appointment two weeks in advance of the diagnostic practicum.

XI. Students with disabilities

Reasonable accommodations are available to any student with a covered disability. Students with a disability must provide documentation to the Office of Disability Services (581-6583) at Eastern Illinois University. Once documentation is completed, the Office of Disability Services will contact the supervisor to assist with developing reasonable accommodations for this class. Eligible students should contact the Office of Disability Services within the first two weeks of class.

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- Keep email short and to the point. If meeting on the phone or in person would be more effective, indicate this. Email should be used for simple communication, not to solve problems.
- Unless professor is out of the office, email will be checked M-F during business hours. Please allow 24 hours for a response. If email is received after 12:00 p.m. on Friday expect a response Monday afternoon.
- Remember that email is about communication with other people. When you compose a message, read it over before sending it and ask yourself what your reaction would be if you received it. Take care with sarcasm and humor so that you are not misinterpreted.

XVI. Texts

Roth, F.P., & Worthington, C.K. (2016). *Treatment resource manual for speech-language pathology* (5nd ed.). New York: Singular.

Shipley, K.G., & McAfee, J.G. (2016). *Assessment in speech-language pathology: A resource manual* (5nd ed.). San Diego: Singular.

VII. Grading Policy and Evaluation Procedures

Grades will be determined based on clinical performance (80%), midterm critical analysis (10%), and final oral presentation (10%).

Clinical Performance:
Ratings will be assigned based on each clinician's performance in the areas of evaluation, intervention, professional practice, interaction, personal qualities and writing. Refer to the Clinical Performance Evaluation for specific rating items in Calipso.

Midterm Critical Analysis:
Clinician will complete a midterm critical analysis during midterm week, **October 11th at 5:15**. The midterm will be in written format, reflect critical thinking and vary from case to case. Use the "Rational and Insights in Clinical Decision Making" document to help prepare for the midterm.

Final Oral Presentation:
Clinician will complete a 15 minute oral case presentation (10 minutes prepared presentation, 5 minutes for questions). Clinician will be randomly assigned to present to a CDS faculty member. Clinician will be rated on knowledge of the case, critical thinking, ability to describe or defend clinical decisions, and oral presentation skills. Final oral presentations, **November 29 from 11:00-1:00.**

Grades will be assigned as outlined in the rating scale:

Grading Scale

2.40-3.0	A
1.86-2.39	B
1.0-1.85	C

VIII. Essential Functions

Essential Functions for clinical practicum are skills, attributes, and abilities necessary for the profession of speech-language-pathology. These functions will be monitored through classroom and clinical performance in order to ensure students possess and maintain essential professional attributes to participate in all aspects of the CDS graduate program. Failure to meet essential functions could prohibit students from completing the graduate program, specifically participation in clinical practicum and internships. Clinical supervisors will monitor essential functions over the course of the semester. Student clinicians will receive feedback on essential functions throughout the semester as needed. Any concerns with essential functions will be reviewed with student clinician at midterm and final.

IX. Clinical Hours

It is the responsibility of the clinician to keep track of their clinical hours. Clinical hours will be tracked by assessment and intervention hours throughout the semester. Clinicians will enter hours in Calipso weekly and will submit to supervisor for approval at the end of the semester.

X. Instructor Contact Information/Office Hours

Instructor Contact Information/Office hours are located on or outside each supervisor's door. It is the clinician's responsibility to schedule diagnostic conferences with the supervisor during posted office hours by appointment two weeks in advance of the diagnostic practicum.

XI. Students with disabilities

Reasonable accommodations are available to any student with a covered disability. Students with a disability must provide documentation to the Office of Disability Services (581-6583) at Eastern Illinois University. Once documentation is completed, the Office of Disability Services will contact the supervisor to assist with developing reasonable accommodations for this class. Eligible students should contact the Office of Disability Services within the first two weeks of class.

CDS 5910 – Syllabus
Diagnostic Practicum Syllabus-1 semester hour

See assigned clinical supervisor for contact information and office hours.

I. Course Description: Supervised diagnostic evaluations with a variety of speech-language-hearing disorders.

II. Course Objective:
To improve clinical diagnostic skills through review of case history, selection and administration of informal and formal assessments, and development of appropriate recommendations for clients with regards to speech-language disorders. A student's performance in diagnostic practicum is evaluated in an array of categories. This syllabus lists many behaviors which are important to successful diagnostic assessment, management and the development of professional attitudes. Evaluation will include, but not be limited to, observation of these criteria.

III. Departmental Learning Objective:
As part of the new ASHA standards, learning objectives were developed for all CDS courses and clinical practicum. Students will be evaluated in the following areas for CDS 5900 at the end of the semester. The following rating scale is used when supervisors evaluate student clinicians.

A. Rating Scale:

1 **Unacceptable Performance:** Specific direction from supervisor does not alter unsatisfactory performance. Clinician is unaware and/or unresponsive of need to change.

2 **Needs Improvement in Performance/Maximum Support:** The clinical skill/behavior is beginning to emerge. Efforts to modify may result in varying degrees of success. Maximum amount of direction from supervisor needed to perform effectively. Student shows awareness of need to change behavior with supervisor input.

3 **Moderately Acceptable Performance/ Moderate Support:** Inconsistently demonstrates clinical behavior/skill. Student is aware of need to modify behavior, but does not do this independently. Supervisor provides moderate amount of support focusing on increasing student's critical thinking on how/when to improve skill.

4 **Meets Performance Expectations/Minimal Support:** Skill is developed/implemented most of the time and needs continued refinement or consistency. Student is aware and can modify behavior in-session, and can self-evaluate. Problem solving is emerging. Supervisor provides minimal amount of support and acts as a collaborator to plan and suggest possible alternatives.

5 **Independently Meets Performance Expectations:** Skill is consistent and well developed. Student can modify own behavior as needed and is an independent problem-solver. Supervisor serves as a consultant in the areas where student has less experience/ Provides guidance on ideas initiated by student.

C. Learning Objectives:

1. The student demonstrates knowledge and skills necessary for assessment of articulation/phonological disorders.
2. The student demonstrates knowledge and skills necessary for assessment of oral and written developmental language disorders.
3. The student demonstrates knowledge and skills necessary for assessment of fluency disorders.
4. The student demonstrates knowledge and skills necessary for assessment of voice and resonance disorders.
5. The student demonstrates knowledge and skills necessary for assessment of oral and written acquired language disorders.
6. The student demonstrates knowledge and skills necessary for assessment of swallowing disorders.
7. The student demonstrates knowledge and skills necessary for assessment of cognitive communication disorders.
8. The student demonstrates knowledge and skills necessary for assessment of social aspects of communication.

9. The student demonstrates knowledge and skills necessary for assessment of alternative and augmentative communication modalities.
10. The student composes professionally written documents.
11. The student engages in professional oral communication and interaction.
12. The student evidences independent learning strategies, critical thinking, and problem solving skills.
13. The student can collect and interpret case history information.
14. The student can design, select, administer, and interpret formal and informal evaluation tools.
15. When conducting an evaluation, the student demonstrates flexibility and makes appropriate modifications to meet client needs.
16. The student compiles evaluation information to generate appropriate diagnosis, recommendations, and referrals.
17. The student completes administrative tasks relevant to evaluation and intervention.
18. The student counsels clients, family members and relevant others regarding communication disorders.
19. The student demonstrates effective use of technology as appropriate.

CDS 5910	**Written Documentation**	**Clinical Conferences**	**Interaction with Clients and others**	**Data Collection and Analysis**	**Evidence Based Practice**	**Self-Analysis**
The student demonstrates knowledge and skills related for assessment of phonological/articulation disorders.	X	X	X	X	X	X
The student demonstrates knowledge and skills necessary for assessment of oral and written developmental language disorders.	X	X	X	X	X	X
The student demonstrates knowledge and skills necessary for assessment of fluency disorders.	X	X	X	X	X	X
The student demonstrates knowledge and skills necessary for assessment of voice and resonance disorders.	X	X	X	X	X	X
The student demonstrates knowledge and skills necessary for assessment of acquired oral and written language disorders	X	X	X	X	X	X
The student demonstrates knowledge and skills for assessment of swallowing disorders	X	X	X	X	X	X
The student demonstrates knowledge and skills related to assessment of cognitive communication disorders	X	X	X	X	X	X
The student demonstrates knowledge and skills related to assessment of social aspects of communication.	X	X	X	X	X	X
The student demonstrates knowledge and skills necessary for assessment of alternative and augmentative communication modalities	X	X	X	X	X	X
The student composes professionally written documents.	X			X	X	
The student engages in professional oral communication and interaction.		X	X			X
The student evidences independent learning strategies, critical thinking, and problem solving skills.	X	X	X	X	X	X
The student can collect and interpret case history information.	X	X	X	X	X	
The student can design, select, administer, and interpret formal and informal evaluation tools.	X	X	X	X	X	X
When conducting an evaluation, the student demonstrates flexibility and makes appropriate modifications to meet client needs.			X	X		X
The student compiles evaluation information to generate appropriate diagnosis, recommendations, and referrals.	X	X	X	X	X	
The student completes administrative tasks relevant to evaluation and intervention.	X	X		X		
The student counsels clients, family members and relevant others regarding		X	X			X

D. Assignments and Departmental Learning Objective Evaluation:

Clinicians will be rated on the above departmental learning objectives based on their performance in the following areas:

1. Written documentation
2. Clinical conferences
3. Interaction with client and others
4. Data collection and analysis
5. Evidence based practice
6. Self-analysis
7. Weekly therapy plans
8. Progress notes
9. Client reports

IV. Evaluation/Grades

Evaluations for diagnostics will be completed using the diagnostic evaluation form. Skills will be rated as 3 – established, 2 – developing, 1 – emerging.

Grading Scale

2.4-3.00	A
1.86-2.39	B
1.0-1.85	C

Text:

Shipley, K.G. & McAfee, J.G. (2016) Assessment in Speech-Language Pathology: A Resource Manual. 6th Ed. San Diego, CA: Singular Publishing Group, Inc.

V. Course Outline

A. Planning/management skills:

1. Promptly schedules and attends meetings with the diagnostic supervisor.
2. Uses client history and diagnostic information to develop assessment tools to be used
3. Demonstrates independence in reviewing class notes and current information available in journals and textbooks which relate to the disorder and/or applicable behavior management techniques
4. Prepares a logical progression of testing procedures in an organized format that includes assigned duties for each clinician
5. Demonstrates knowledge of testing instruments to discuss rationale for the development of testing protocol to be used
6. Considers linguistic or cultural differences

B. Interpersonal skills:

1. Uses appropriate verbal and non-verbal communication techniques with client, family, and other professionals
2. Informs parents and/or client of the purpose of assessment techniques
3. Summarizes and informs parents and/or client of results and recommendations
4. Demonstrates sensitivity to the parent/guardian of the client
5. Provides communication strategies for parents/guardian/client to use at home

C. Professional skills:

1. Demonstrates independence in the ability to gather all pertinent information
2. Reviews case history information, informal and formal testing procedures and readily discusses the preliminary diagnostic protocol
3. Makes appropriate decisions concerning dress and personal appearance when involved in professional activities
4. Meets all deadlines in a timely manner and engages in ethical conduct.
5. Maintains a positive attitude and is able to keep concerns from interfering with clinical responsibilities
6. Informs the supervisor verbally and in writing if changes occur in the schedule or in the diagnostic plan
7. Shows initiative and independence in handling the case by reporting status to the supervisor, initiating discussion and problem solving
8. Demonstrates sensitivity to the client's needs and adjusts accordingly.

D. Diagnostic skills:

1. Determines communication deficits and related behaviors to be assessed
2. Selects appropriate formal and informal assessment instruments/techniques
3. Demonstrates proficiency in administration of assessment instruments/techniques
4. Demonstrates accuracy in interpretation of assessment instruments/techniques and determines appropriate recommendations
5. Uses clinical observation skills to support formal testing and identify factors that influence the outcome of assessments
6. Demonstrates flexibility by modifying procedures, testing environment and adjusting to the need of the client
7. Pursues appropriate questioning to obtain relevant information

E. Record Keeping and Report Writing:

1. Submits all written work by the scheduled due dates in a acceptable format which is accurate, comprehensive, and free from typographical, grammatical and content errors
2. Submits draft reports and letters, double-spaced, as an example of best effort
3. Submits the final copy of the diagnostic reports and letters in a timely manner, within 10 days of the diagnostic evaluation, unless otherwise specified by the diagnostic supervisor
4. Demonstrates the ability to meet deadlines with report and letter revisions
5. Implements a recording system to accurately document informal test results, baselines, etc.

VI. Attendance:

Attendance is a university requirement and regulations outlined in the 2003-2004 undergraduate catalog will apply to this practicum. Clinicians must notify the supervisor in advance of anticipated absences.

VII. Information for Students with Disabilities:

Reasonable accommodations are available to any student with a covered disability. Eligible students should contact the Office of Disability Services within the first two weeks of class.

VIII. Student Success Center

Students who are having difficulty achieving their academic goals are encouraged to contact the Student Success Center (www.eiu.edu/~success) for assistance with time management, test taking, note taking, avoiding procrastination, setting goals, and other skills to support academic achievement. The Student Success Center provides individualized consultations. To make an appointment, call 217-581-6696 or go to 9th Street Hall, Room 1302.

IX. Evacuation Procedures:

Please refer to the fire and emergency evacuation procedures posted near each therapy door.

X. Academic Integrity:

Students are expected to maintain principles of academic integrity. Violations will be reported to the Office of Judicial Affairs.

XI. Netiquette for Electronic Communication:

- Use formal modes of address unless you are absolutely certain that informality is acceptable to the receiver
- Use appropriate and professional language in your communications. Use correct spelling, capitalization, punctuation, grammar, and avoid using internet abbreviations (i.e. : brb, lol, etc)
- Keep email short and to the point. If meeting on the phone or in person would be more effective, indicate this. Email should be used for simple communication, not to solve problems.
- Unless professor is out of the office, email will be checked M-F during business hours. Please allow 24 hours for a response. If email is received after 12:00 p.m. on Friday expect a response Monday afternoon.
- Remember that email is about communication with other people. When you compose a message, read it over before sending it and ask yourself what your reaction would be if you received it. Take care with sarcasm and humor so that you are not misinterpreted.

XII. Evidence Based Practice:

Evidence based practice involves using the best available clinical literature along with our clinical intuition and client preferences to guide our assessment and treatment decisions. Students will be expected to find literature which: a) defines the client's problem(s), b) guides assessment for the client's problem(s), and c) guides the treatment process. Examples of clinical literature include textbooks, professional journals, and internet sources. Students should not limit searches to any one source. Students are expected to have obtained and read relevant research relating to their client's disorder(s) prior to the initial conference with their supervisor.

COURSE SYLLABUS
CDS 5920
Fall 2023
CDS 5920 Diversity and the SLP
Multicultural Clinical Experience
Human Services Building

Instructors: Rebecca Throneburg
Ann Dralle

Course Objectives

Addressing culture and language that includes cultural humility, cultural responsiveness, and cultural competence in service delivery. Student clinicians review case history to identify and acknowledge client's cultural and linguistic background.

The clinician's understanding of client's culture is taught by EIU clinical supervisors, through assigned readings, collaboration with interdisciplinary professionals, and the client's and families at the MICO Care Center in Jamacia. The student is asked to use this knowledge in choosing appropriate assessments, therapy goals, determining most appropriate vocabulary, materials, and activities to utilize during teletherapy sessions.

Cultural humility is developed through guided self-evaluations of the student's approach to multicultural service delivery, through assigned readings, and developed through student's interactions with both professionals and clients.

Students are given the opportunities to identify and acknowledge the impact cultural and linguistic variables of the individual served may have on delivery of effective care.

Students are given the opportunity to recognize and discuss that effective care may be negatively impacted if cultural and linguistic variables of the client are not carefully considered. Students will reflect on and discuss how ineffective care could occur if cultural factors are not a foundation to the plan of care including misdiagnosis, inappropriate diagnosis and treatment targets, methods, and materials. If cultural considerations are not given the proper attention, relationships, including both the client-clinician therapeutic relationship, and the collaborative interdisciplinary relationships with other professionals, could be reduced.

Description of how students are given the opportunities to identify and acknowledge the interaction of cultural and linguistic variables between the caregivers and the individual served.

When clients have caregivers, clinical instructors help clinicians understand that the caregiver perspective and priorities may be different from the client's as well as from the clinician's. The impact of a disability on spouses, the parents of young children, parents of older children or adults, or on children of adults with acquired disabilities is considered and discussed. Family expectations within diverse cultures are discussed in supervisory conferences and through interactions with families during therapy sessions. Students and faculty may also communicate with families via email in addition to live interactions during sessions.

Students are provided opportunities to identify and acknowledge the social determinants of health and environmental factors for individuals served.

Supervisors lead discussions in clinical conferences which encourage reflection about potential barriers the client may experience related to access to quality education, healthcare, and economic stability and/ or different health threats dependent on geographical regions (E.g., the dengue endemic located in Africa, the Americas, South and South-east Asia, and the Western Pacific region). The social determinants of health and environmental factors are considered throughout service delivery and when providing recommendations to client and family (e.g., daily carryover activities, long term goals for educational setting, referrals to other agencies). These are also topics of reflection and discussion in Professional Issues when students are in full-time internships in a wide variety of locations throughout the state and country.

In the graduate level course titled CDS 5920 Diversity for the Speech-Language Pathologist, as well as in the required undergraduate courses Sign Language (CDS 3300), and Aural Rehabilitation (4350), students are given opportunities to identify the impact multiple languages and cultures may have on people and on their own therapeutic interactions. Students must develop a deeper level of understanding, of respect, and of empathy, regarding the differences (and likenesses) often found in diverse cultural identities (e.g., the autistic culture, Deaf culture, and multicultural service delivery in diverse geographical locations via teletherapy).

Describe how students are given opportunities to 1) recognize that cultural and linguistic diversity exists among various groups as well as within seemingly homogenous groups, and 2) foster the acquisition and knowledge regarding the acknowledgement and understanding of linguistic diversity in an individual's priorities and needs to support and develop a positive client-clinician relationship.

Students are given opportunities to recognize that cultural and linguistic diversity exists among various groups, and within those same groups. Students are encouraged to acknowledge and comprehend how cultural diversity impacts the therapeutic relationship between the client and clinician through direct teaching and modeling by the clinical supervisors. Students are taught how to take into consideration different perspectives other than their own in order to create positive therapeutic outcomes which are based upon individual client preferences and needs.

Course Structure-This portion of the course includes weekly meetings with supervisors and weekly teletherapy sessions with clients residing in or near Kingston, Jamaica in affiliation with the Ms. Brittney Aiken, M.A., CCC-SLP, at the Mico University College CARE Centre Child Assessment and Research in Education. Assigned readings, online quizzes, written assignments, and clinical analysis and discussions. Each week the student will provide teletherapy to their assigned client with 100% supervision provided by the clinical supervisor assigned to them. Readings, self-reflections, quizzes will cover assigned reading material and topics covered during clinical discussions from meetings and or from therapy sessions.

Practicum Performance Rating Scale-CDS students are rated on the development of their professional knowledge and skills. Faculty members will utilize the Practicum Performance Rating Scale at the end of the 6-week multicultural experience. These ratings are different from course grades! Course grades will be calculated by averaging all the scores/components of this course. Please note the areas rated in this course (see handout of rating scale and areas rated). Students will be rated as Emerging, Developing, or Established and are expected to demonstrate **developing levels** of competency in each area.

Rating scale	Grading scale
1-Emerging	**A 2.4-30**
2-Developing	**B 1.86-2.39**
3-Established	**C 1.0-1.85**

Text- Reading materials will be shared with students. Portions of the text below will be utilized.

Hyter, Y. D. and Salas-Provance, M.B. (2023). Culturally responsive practices in speech, language, and hearing sciences. Pural Publishing.

Professional Behavior Students are expected to exhibit professional behavior and demonstrate essential functions. This includes such items as attendance, maintaining confidentiality, arriving promptly for class and scheduled appointments, communicating with clinician and supervisor and being dependable when asked to complete a task. Please reference Essential Functions in D2L in CDS Practicum Supplemental Materials.

Information for students with disabilities/learning differences- If you are a student with a documented disability/learning differences and need accommodations to fully participate in this class, please contact the Office of Student Disability Services (OSDS). All accommodations must be approved through OSDS. Please stop by Ninth Street Hall, Room 2006, or call 217-581-6583 .

CDS 5920 – Syllabus
Diagnostic Practicum Syllabus-1 semester hour

See assigned clinical supervisor for contact information and office hours.

I. Course Description: Supervised diagnostic evaluations with a variety of speech-language-hearing disorders.

II. Course Objective:
To improve clinical diagnostic skills through review of case history, selection and administration of informal and formal assessments, and development of appropriate recommendations for clients with regards to auditory processing and speech-language disorders. A student's performance in diagnostic practicum is evaluated in an array of categories. This syllabus lists many behaviors which are important to successful diagnostic assessment, management, and the development of professional attitudes. Evaluation will include, but not be limited to, observation of these criteria.

III. Departmental Learning Objective:
As part of the new ASHA standards, learning objectives were developed for all CDS courses and clinical practicum. Students will be evaluated in the following areas for CDS 5920 at the end of the semester. The following rating scale is used when supervisors evaluate student clinicians.

A. Rating Scale:

1 **Unacceptable Performance:** Specific direction from supervisor does not alter unsatisfactory performance. Clinician is unaware and/or unresponsive of need to change.

2 **Needs Improvement in Performance/Maximum Support:** The clinical skill/behavior is beginning to emerge. Efforts to modify may result in varying degrees of success. Maximum amount of direction from supervisor needed to perform effectively. Student shows awareness of need to change behavior with supervisor input.

3 **Moderately Acceptable Performance/ Moderate Support:** Inconsistently demonstrates clinical behavior/skill. Student is aware of need to modify behavior, but does not do this independently. Supervisor provides moderate amount of support focusing on increasing student's critical thinking on how/when to improve skill.

4 **Meets Performance Expectations/Minimal Support:** Skill is developed/implemented most of the time and needs continued refinement or consistency. Student is aware and can modify behavior in-session, and can self-evaluate. Problem solving is emerging. Supervisor provides minimal amount of support and acts as a collaborator to plan and suggest possible alternatives.

5 **Independently Meets Performance Expectations:** Skill is consistent and well developed. Student can modify own behavior as needed and is an independent problem-solver. Supervisor serves as a consultant in the areas where student has less experience/ Provides guidance on ideas initiated by student.

C. Learning Objectives:

1. The student demonstrates knowledge and skills necessary for assessment of auditory processing disorders.
2. The student demonstrates knowledge and skills necessary for assessment of hearing impairments.
3. The student demonstrates knowledge and skills necessary for assessment of articulation/phonological disorders.
4. The student demonstrates knowledge and skills necessary for assessment of oral and written developmental language disorders.
5. The student demonstrates knowledge and skills necessary for assessment of fluency disorders.
6. The student demonstrates knowledge and skills necessary for assessment of voice and resonance disorders.
7. The student demonstrates knowledge and skills necessary for assessment of oral and written acquired language disorders.
8. The student demonstrates knowledge and skills necessary for assessment of swallowing disorders.

9. The student demonstrates knowledge and skills necessary for assessment of cognitive communication disorders.
10. The student demonstrates knowledge and skills necessary for assessment of social aspects of communication.
11. The student demonstrates knowledge and skills necessary for assessment of alternative and augmentative communication modalities.
12. The student composes professionally written documents.
13. The student engages in professional oral communication and interaction.
14. The student evidences independent learning strategies, critical thinking, and problem solving skills.
15. The student can collect and interpret case history information.
16. The student can design, select, administer, and interpret formal and informal evaluation tools.
17. When conducting an evaluation, the student demonstrates flexibility and makes appropriate modifications to meet client needs.
18. The student compiles evaluation information to generate appropriate diagnosis, recommendations, and referrals.
19. The student completes administrative tasks relevant to evaluation and intervention.
20. The student counsels clients, family members and relevant others regarding communication disorders.
21. The student demonstrates effective use of technology as appropriate.

D. Assignments and Departmental Learning Objective Evaluation:

Clinicians will be rated on the above departmental learning objectives based on their performance in the following areas:

1. Written documentation
2. Clinical conferences
3. Interaction with client and others
4. Data collection and analysis
5. Evidence based practice
6. Self-analysis
7. Weekly therapy plans
8. Progress notes
9. Client reports

IV. Evaluation/Grades

Evaluations for diagnostics will be completed using the diagnostic evaluation form. Skills will be rated as 3 – established, 2 – developing, 1 – emerging.

Grading Scale

2.4-3.00	A
1.86-2.39	B
1.0-1.85	C

Text:

Richard, G. (2017). *The Source for Processing Disorders 2nd ed.* Austin Tx: Pro Ed Inc.

Shipley, K.G. & McAfee, J.G. (2016) Assessment in Speech-Language Pathology: A Resource Manual. 6th Ed. San Diego, CA: Singular Publishing Group, Inc.

CDS 5920	Written Documentation	Clinical Conferences	Interaction with Clients and others	Data Collection and Analysis	Evidence Based Practice	Self-Analysis
The student demonstrates knowledge and skills necessary for assessment of auditory processing disorders.	X	X	X	X	X	X
The student demonstrates knowledge and skills necessary for assessment of hearing impairments.	X	X	X	X	X	X
The student demonstrates knowledge and skills related for assessment of phonological/articulation disorders.	X	X	X	X	X	X
The student demonstrates knowledge and skills necessary for assessment of oral and written developmental language disorders.	X	X	X	X	X	X
The student demonstrates knowledge and skills necessary for assessment of fluency disorders.	X	X	X	X	X	X
The student demonstrates knowledge and skills necessary for assessment of voice and resonance disorders.	X	X	X	X	X	X
The student demonstrates knowledge and skills necessary for assessment of acquired oral and written language disorders	X	X	X	X	X	X
The student demonstrates knowledge and skills for assessment of swallowing disorders	X	X	X	X	X	X
The student demonstrates knowledge and skills related to assessment of cognitive communication disorders	X	X	X	X	X	X
The student demonstrates knowledge and skills related to assessment of social aspects of communication.	X	X	X	X	X	X
The student demonstrates knowledge and skills necessary for assessment of alternative and augmentative communication modalities	X	X	X	X	X	X
The student composes professionally written documents.	X			X	X	
The student engages in professional oral communication and interaction.		X	X			X
The student evidences independent learning strategies, critical thinking, and problem solving skills.	X	X	X	X	X	X
The student can collect and interpret case history information.	X	X	X	X	X	
The student can design, select, administer, and interpret formal and informal evaluation tools.	X	X	X	X	X	X
When conducting an evaluation, the student demonstrates flexibility and makes appropriate modifications to meet client needs.			X	X		X
The student compiles evaluation information to generate appropriate diagnosis, recommendations, and referrals.	X	X	X	X	X	
The student completes administrative tasks relevant to evaluation and intervention.	X	X		X		
The student counsels clients, family members, and relevant others regarding communication disorders.		X	X			X

V. Course Outline

A. Planning/management skills:

1. Promptly schedules and attends meetings with the diagnostic supervisor.
2. Uses client history and diagnostic information to develop assessment tools to be used
3. Demonstrates independence in reviewing class notes and current information available in journals and textbooks which relate to the disorder and/or applicable behavior management techniques
4. Prepares a logical progression of testing procedures in an organized format that includes assigned duties for each clinician
5. Demonstrates knowledge of testing instruments to discuss rationale for the development of testing protocol to be used
6. Considers linguistic or cultural differences

B. Interpersonal skills:

1. Uses appropriate verbal and non-verbal communication techniques with client, family, and other professionals
2. Informs parents and/or client of the purpose of assessment techniques
3. Summarizes and informs parents and/or client of results and recommendations
4. Demonstrates sensitivity to the parent/guardian of the client
5. Provides communication strategies for parents/guardian/client to use at home

C. Professional skills:

1. Demonstrates independence in the ability to gather all pertinent information
2. Reviews case history information, informal and formal testing procedures and readily discusses the preliminary diagnostic protocol
3. Makes appropriate decisions concerning dress and personal appearance when involved in professional activities
4. Meets all deadlines in a timely manner and engages in ethical conduct.
5. Maintains a positive attitude and is able to keep concerns from interfering with clinical responsibilities
6. Informs the supervisor verbally and in writing if changes occur in the schedule or in the diagnostic plan
7. Shows initiative and independence in handling the case by reporting status to the supervisor, initiating discussion and problem solving
8. Demonstrates sensitivity to the client's needs and adjusts accordingly.

D. Diagnostic skills:

1. Determines communication deficits and related behaviors to be assessed
2. Selects appropriate formal and informal assessment instruments/techniques
3. Demonstrates proficiency in administration of assessment instruments/techniques
4. Demonstrates accuracy in interpretation of assessment instruments/techniques and determines appropriate recommendations
5. Uses clinical observation skills to support formal testing and identify factors that influence the outcome of assessments
6. Demonstrates flexibility by modifying procedures, testing environment and adjusting to the need of the client
7. Pursues appropriate questioning to obtain relevant information

E. Record Keeping and Report Writing:

1. Submits all written work by the scheduled due dates in a acceptable format which is accurate, comprehensive, and free from typographical, grammatical and content errors
2. Submits draft reports and letters, double-spaced, as an example of best effort
3. Submits the final copy of the diagnostic reports and letters in a timely manner, within

10 days of the diagnostic evaluation, unless otherwise specified by the diagnostic supervisor
4. Demonstrates the ability to meet deadlines with report and letter revisions
5. Implements a recording system to accurately document informal test results, baselines, etc.

VI. Attendance:

Attendance is a university requirement and regulations outlined in the 2003-2004 undergraduate catalog will apply to this practicum. Clinicians must notify the supervisor in advance of anticipated absences.

VII. Information for Students with Disabilities:

Reasonable accommodations are available to any student with a covered disability. Eligible students should contact the Office of Disability Services within the first two weeks of class.

VIII. Student Success Center

Students who are having difficulty achieving their academic goals are encouraged to contact the Student Success Center (www.eiu.edu/~success) for assistance with time management, test taking, note taking, avoiding procrastination, setting goals, and other skills to support academic achievement. The Student Success Center provides individualized consultations. To make an appointment, call 217-581-6696 or go to 9th Street Hall, Room 1302.

IX. Evacuation Procedures:

Please refer to the fire and emergency evacuation procedures posted near each therapy door.

X. Academic Integrity:

Students are expected to maintain principles of academic integrity. Violations will be reported to the Office of Judicial Affairs.

XI. Netiquette for Electronic Communication:

- Use formal modes of address unless you are absolutely certain that informality is acceptable to the receiver
- Use appropriate and professional language in your communications. Use correct spelling, capitalization, punctuation, grammar, and avoid using internet abbreviations (i.e. : brb, lol, etc)
- Keep email short and to the point. If meeting on the phone or in person would be more effective, indicate this. Email should be used for simple communication, not to solve problems.
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- Remember that email is about communication with other people. When you compose a message, read it over before sending it and ask yourself what your reaction would be if you received it. Take care with sarcasm and humor so that you are not misinterpreted.

XII. Evidence Based Practice:

Evidence based practice involves using the best available clinical literature along with our clinical intuition and client preferences to guide our assessment and treatment decisions. Students will be expected to find literature which: a) defines the client's problem(s), b) guides assessment for the client's problem(s), and c) guides the treatment process. Examples of clinical literature include textbooks, professional journals, and internet sources. Students should not limit searches to any one source. Students are expected to have obtained and read relevant research relating to their client's disorder(s) prior to the initial conference with their supervisor.

ESSENTIAL FUNCTIONS FOR
EASTERN ILLINOIS UNIVERSITY
COMMUNICATION DISORDERS AND SCIENCES
UPDATED 5/25/23

The accredited program in speech-language pathology of the Department of Communication Disorders and Sciences (CDS) at Eastern Illinois University adheres to the standards set by the American Speech-Language-Hearing Association (ASHA). Faculty in the CDS Department have a responsibility for the welfare of clients evaluated, treated, or otherwise affected by students enrolled in the CDS program. Thus it is important that persons admitted, retained, and graduated possess the intelligence, integrity, compassion, humanitarian concern, and physical and emotional capacity necessary to practice speech-language pathology.

In order to fulfill this responsibility, the Department has established academic standards and minimum essential requirements to participate in the clinical program and graduate. When requested, the University will provide reasonable accommodations to otherwise qualified students with properly documented disabilities who meet the minimum CDS requirements. Admission and retention decisions are based not only on satisfactory prior and ongoing academic achievement but also on non-academic factors that serve to ensure that the candidate can meet the essential functions of the clinical program required for graduation.

Essential functions, as distinguished from academic standards, refer to those cognitive, physical, and behavioral abilities that are necessary for satisfactory completion of all aspects of the curriculum, and the development of professional attributes required by the faculty of all students at graduation. Failure to meet minimal executive functions may result in remediation and/or dismissal from the program.

A. COMMUNICATION ABILITIES

A student must possess adequate communication skills to:

1. Communicate proficiently in both oral and written English language.
2. Provide accurate models of speech and language in Standard American English.
3. Communicate professionally and intelligibly with patients, colleagues, other health care professionals, and community or professional groups.
4. Read and write sufficiently to meet curricular and clinical demands.
5. Perceive and demonstrate appropriate non-verbal communication for culture and context, and the ability to modify communication style to meet the communication needs of clients, caregivers, and other persons served.
6. Recognize and adjust when a client and/or client's family does or does not understand one's written and verbal directions.
7. Communicate professionally, effectively, and legibly on patient documentation, reports, and scholarly papers required as a part of course work and professional practice.
8. Convey information accurately with relevance and cultural sensitivity.

B. INTELLECTUAL/COGNITIVE

A student must possess adequate intellectual and cognitive skills to:

1. Comprehend, retain, integrate, synthesize, infer, evaluate and apply written and verbal information sufficient to meet curricular and clinical demands.
2. Identify significant findings from history, evaluation, and data to formulate a diagnosis and develop a treatment plan.
3. Solve problems, reason, and think flexibly to make sound clinical judgments and modifications in patient assessment and intervention.
4. Self-evaluate, identify, and communicate the limits of one's own knowledge and skill to an appropriate professional level and be able to identify and utilize resources in order to increase knowledge.
5. Utilize detailed written and verbal instruction in order to make unique and dependent decisions.

C. BEHAVIORAL/SOCIAL

A student must possess adequate behavioral and social attributes to:

1. Display mature, empathetic, effective, and collaborative professional relationships by exhibiting compassion, integrity, and concern for others.
2. Recognize and show respect for individuals of different ability, race, ethnicity, sex, gender, identity/gender expression, sexual orientation, age, religion, national origin, culture, language, or dialect.
3. Conduct oneself in an ethical and legal manner, upholding the ASHA Code of Ethics and university and federal privacy policies.
4. Maintain physical health and hygiene, mental health and self-care in order not to jeopardize the health and safety of self and others in the academic and clinical setting.
5. Adapt to changing and demanding environments (including maintaining both professional demeanor and emotional health).
6. Manage the use of time effectively to meet deadlines and complete professional and technical tasks within realistic time constraints.
7. Accept appropriate suggestions and constructive criticism and respond by modification of behaviors.
8. Demonstrate initiative to seek support, solve problems, and complete tasks.
9. Attend all professional obligations (i.e., class, clinical sessions and clinical conferences) and demonstrate engagement and participation.
10. Dress appropriately and professionally for the setting.

D. MOTOR ABILITIES

A student must possess adequate motor skills to:

1. Sustain the necessary physical activity level in required classroom and clinical activities.
2. Respond quickly to provide a safe environment for clients in emergency situations including fire, choking, etc.
3. Access transportation to clinical and academic placements.
4. Participate in classroom and clinical activities for the defined workday.
5. Efficiently manipulate the testing and treatment environment and materials without violation of testing protocol and with best therapeutic practice.
6. Manipulate patient-utilized equipment (e.g., durable medical equipment to include AAC devices, hearing aids, etc.) in a safe manner.
7. Access technology for clinical management (i.e., billing, charting, therapy programs, etc.).

E. SENSORY/OBSERVATIONAL

A student must possess adequate aided/unaided sensory abilities of vision, hearing, touch, smell, and proprioception to:

1. Identify and discriminate normal and disordered communication in:
    a. Speech sound production, including articulation, motor planning and execution, phonology, accent modification (e.g., visualize, identify, and discriminate typical and atypical anatomic structures and functions and imaging).
    b. Fluency.
    c. Voice and resonance, including respiration and phonation.
    d. Receptive and expressive language, including phonology, morphology, syntax, semantics, pragmatics (language use and social aspects of communication), prelinguistic communication, paralinguistic communication (e.g., gestures, signs, body language), and literacy in speaking, listening, reading, and writing.
    e. Hearing, including the impact on speech and language.
    f. Swallowing/feeding, including structure and function of orofacial myology and oral, pharyngeal, laryngeal, pulmonary, esophageal, gastrointestinal, and related functions across the life span.
    g. Cognitive aspects of communication, including attention, memory, sequencing, problem solving, and executive functioning.
    h. Social aspects of communication, including challenging behavior, ineffective social skills, and lack of communication opportunities.
    i. Augmentative and alternative communication modalities.
2. Accurately monitor equipment displays and controls used for assessment and treatment of patients.
3. Discriminate text, numbers, tables, and graphs associated with diagnostic instruments and tests.

Eastern Illinois University
Communication Disorders & Sciences
Acknowledgement of Essential Functions

_____ hereby acknowledge that I have received the Essential Functions from the department of Communication Disorders and Sciences at Eastern Illinois University and understand that abilities outlined are necessary to practice as a speech-language pathologist. I understand that the communication, intellectual/cognitive, behavioral/social, motor, and sensory/observational abilities are required for admission/retention in the graduate program and for participation in clinical practicum and internships. I understand that faculty will monitor compliance with Essential Functions throughout my graduate program and that if I am unable to meet the Essential Functions, my participation in clinical practicum may be terminated.

_____
Student Name (print)

_____
Signature of Student

_____
Date

EASTERN ILLINOIS UNIVERSITY
DEPARTMENT OF COMMUNICATIONS DISORDERS AND SCIENCES
CLINICAL HOURS RECORD *(revised 7/14)*

NAME:_____ GRAD_____ UG_____ SEMESTER/YEAR:_____

Evaluation and Treatment of Children (ages 0 - 14 yrs., 11 mos.)

CLIENT NAME OR OFF CAMPUS SITE	EVAL CH-ARTIC/PHONO	EVAL CH-FLUENCY	EVAL CH-VOICE & RESON	EVAL CH-LANG	EVAL CH-SWALLOWG	EVAL CH - COGNITIVE	EVAL CH - SOCIAL	EVAL CH-COMM MOD	EVAL CH-COUNSEL-ING	SUPERVISORS' SIGNATURE & PRINTED NAME & ASHA number (if off-campus)

CLIENT NAME OR OFF CAMPUS SITE	TRMT CH-ARTIC/PHONO	TRMT CH-FLUENCY	TRMT CH-VOICE & RESON	TRMT CH-LANG	TRMT CH-SWALLOWG	TRMT CH - COGNITIVE	TRMT CH - SOCIAL	TRMT CH-COMM MOD	TRMT CH-COUNSEL-ING	SUPERVISORS' SIGNATURE & PRINTED NAME & ASHA number (if off-campus)

Site:
C = EIU S-L-H Clinic
I = Internship/Name of site
J = Jefferson
CS = Carl Sandburg
K = Kansas
CMS = Charleston Middle School
CHS = Charleston High School
CAOS = Carle Auditory Oral School Champaign
G = Group/Disorder at EIU Clinic

Evaluation and Treatment Hours: List hours in the column appropriate for the experience (evaluation of child speech in the EVAL CH- ARTIC/ PHONO). If the work was both speech and language, divide the hours accordingly. Clinical hours are calculated by actual minutes (1 hour, 50 minutes = 1:50 minutes). You may round to the nearest 5 minutes (22 = 20 minutes, 23 = 25 minutes). For group therapy, internship and other outside practicums, you may lump all hours together and not list clients by name.

CONTINUED ON BACK

Evaluation and Treatment of Adults (15 yrs. +)

CLIENT NAME OR OFF CAMPUS SITE	EVAL A-ARTIC/PHONO	EVAL A-FLUENCY	EVAL A-VOICE & RESON	EVAL A-LANG	EVAL A-SWALLOWG	EVAL A - COGNITIVE	EVAL A - SOCIAL	EVAL A-COMM MOD	EVAL A-COUNSEL-ING	SUPERVISORS' SIGNATURE & PRINTED NAME & ASHA number (if off-campus)

CLIENT NAME OR OFF CAMPUS SITE	TRMT A-ARTIC/PHONO	TRMT A-FLUENCY	TRMT A-VOICE & RESON	TRMT A-LANG	TRMT A-SWALLOWG	TRMT A - COGNITIVE	TRMT A - SOCIAL	TRMT A-COMM MOD	TRMT A-COUNSEL-ING	SUPERVISORS' SIGNATURE & PRINTED NAME & ASHA number (if off-campus)

Audiology Evaluation and Treatment

CLIENT NAME OR OFF CAMPUS SITE	EVAL CH - SCREENING	EVAL CH-AUDITORY	TRMT CH - DEVICES	TRMT CH-COMMUNICATION	EVAL ADULT - SCREENING	EVAL ADULT - AUDITORY	TRMT ADULT - DEVICES	TRMT ADULT - COMMUNICATION	SUPERVISORS' SIGNATURE & PRINTED NAME & ASHA number (if off-campus)

NAME: _____

YEAR	2022									
SEMESTER	Fall									
UNDERGRAD/GRA	Undergrad									
SITE TYPE (EIU/EX	EIU	EIU								
LOG NUMBER	1	2	3	4	5	6	7	8	9	10

ASSESSMENT HOURS

	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Total Adult	Total Child	Grand Total
Articulation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Fluency	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Voice & Resonance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Languge	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Swallowing	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cognitive Aspects	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Social Aspects	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Comm. Modalities	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hearing	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

INTERVENTION HOURS

	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Total Adult	Total Child	Grand Total
Articulation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Fluency	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Voice & Resonance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Languge	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Swallowing	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cognitive Aspects	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Social Aspects	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Comm. Modalities	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hearing	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

CLINICAL EDUCATION ASSESSMENT HOURS

	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Total Adult	Total Child	Grand Total
Articulation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Fluency	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Voice & Resonance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Languge	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Swallowing	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cognitive Aspects	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Social Aspects	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Comm. Modalities	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hearing	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

LOG NUMBER	1		2		3		4		5		6		7		8		9		10				
CLINICAL EDUCATION INTERVENTION HOURS																					Total Adult	Total Child	Grand Total
	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child			
Articulation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Fluency	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Voice & Resonance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Languge	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Swallowing	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cognitive Aspects	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Social Aspects	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Comm. Modalities	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hearing	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

OBSERVATION HOURS																					Total Adult	Total Child	Grand Total
	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child			
Articulation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Fluency	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Voice & Resonance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Languge	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Swallowing	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cognitive Aspects	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Social Aspects	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Comm. Modalities	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hearing	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Total Direct Hours (Countable)

	Adult	Child	
Assessment	0	0	
Intervention	0	0	
Total Countable Hours	0	0	0

Total Clinical Education Hours

CE Assessment	0	0	
CE Intervention	0	0	
Total Clinical hours	0	0	0

Total Observation Hours

Total Observation hours	25	
Total Practicum Hours		0

Trina Becker, Clinic Director

12/?/2022

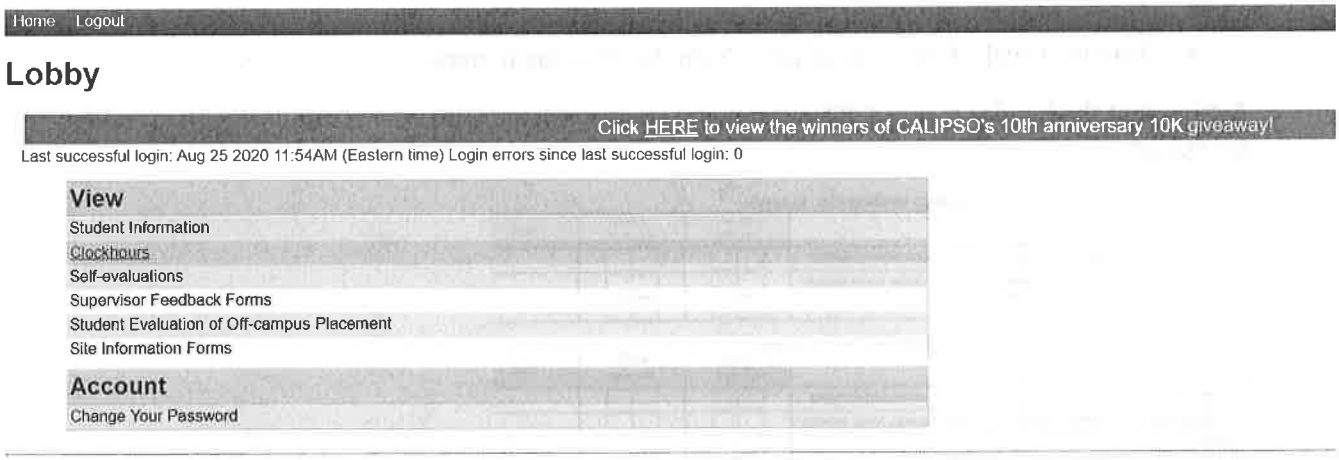
Date

Documenting Clockhours on Calipso

Step 1: Clocking your hours

*Enter hours every week, submit at the end of the semester

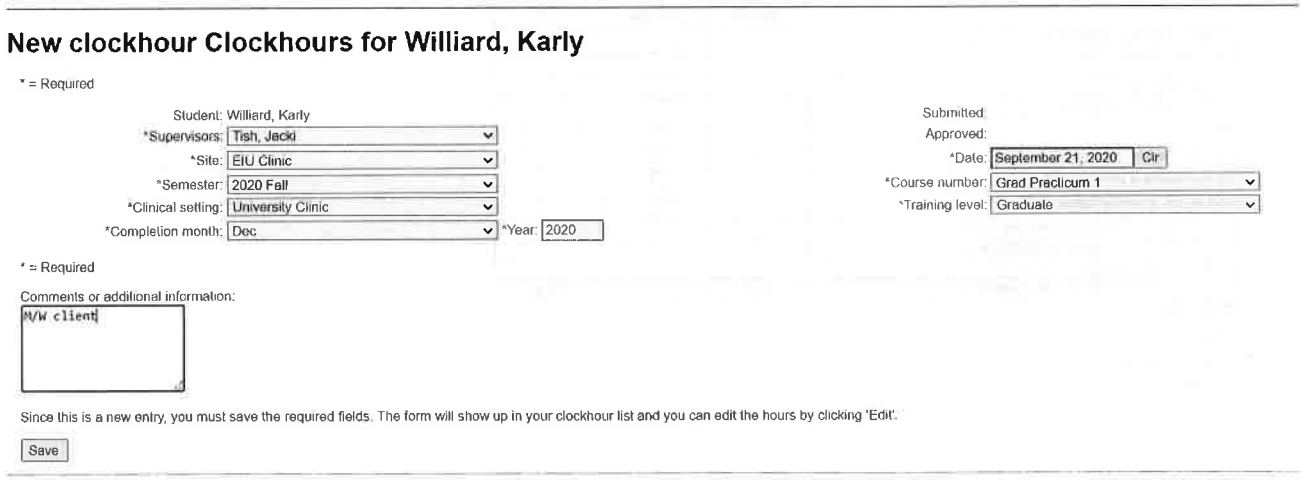
1. Click "Clockhours" on the home page



2. Click the "Daily Clockhours" tab at the top of the screen

3. Click "add new daily clockhour" if this is your first time entering clockhours for your clinical placement

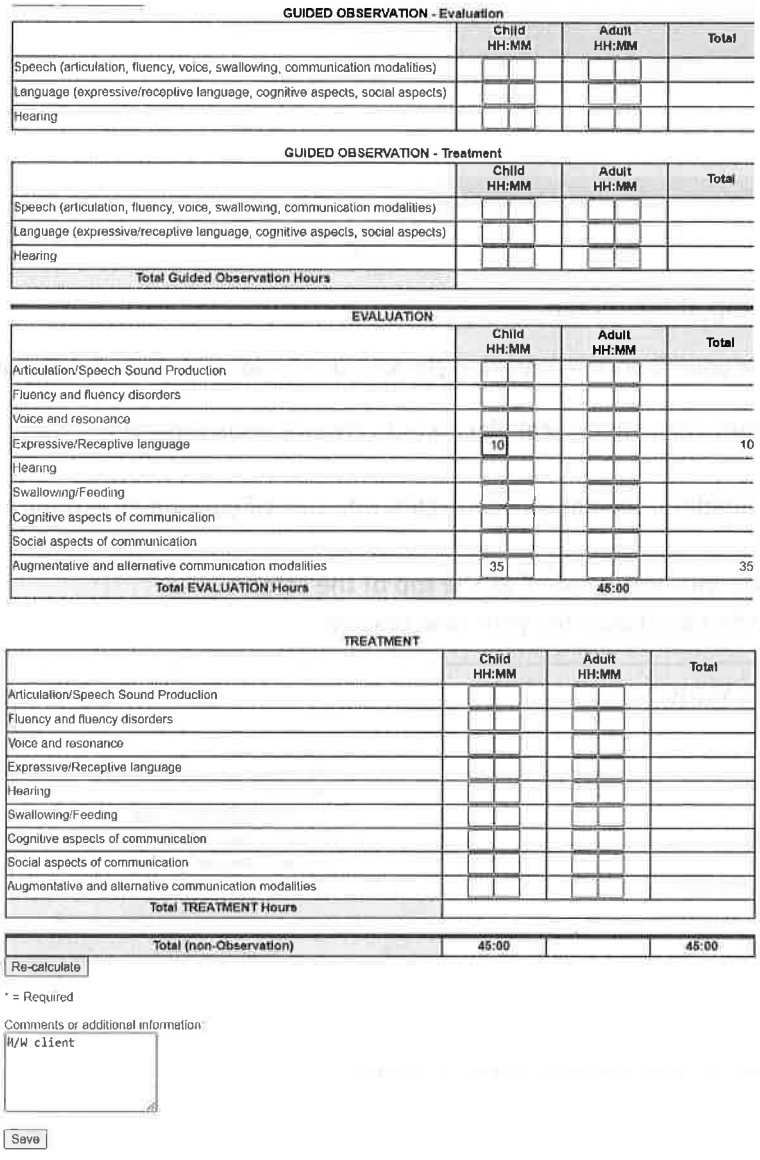
- If you've already entered clockhours for your clinical placement…choose your supervisor from the dropdown menu
    - Instead of filling out the header information again, click into one of your past sessions as if you are going to edit it
    - Then click "New clockhour with this header" at the top of the screen
    - Change the date & fill in the clockhours for your new session



4. Fill in the clockhour form with the required information and hit "Save"

- Clinical Setting: for clients in the EIU clinic this will be "University Clinic"
- Completion Month: when you will stop seeing the client
    - E.g. for Fall 2020 semester this would be December 2020
- Date: fill in the session date
- Course Number: See attachment for course numbers
- Training Level: choose "Graduate" from the dropdown menu

5. Now that the header is saved, fill in the hours you completed with your client during the session and hit "Save"



GUIDED OBSERVATION - Evaluation

	Child HH:MM	Adult HH:MM	Total
Speech (articulation, fluency, voice, swallowing, communication modalities)			
Language (expressive/receptive language, cognitive aspects, social aspects)			
Hearing			

GUIDED OBSERVATION - Treatment

	Child HH:MM	Adult HH:MM	Total
Speech (articulation, fluency, voice, swallowing, communication modalities)			
Language (expressive/receptive language, cognitive aspects, social aspects)			
Hearing			
Total Guided Observation Hours			

EVALUATION

	Child HH:MM	Adult HH:MM	Total
Articulation/Speech Sound Production			
Fluency and fluency disorders			
Voice and resonance			
Expressive/Receptive language	10		10
Hearing			
Swallowing/Feeding			
Cognitive aspects of communication			
Social aspects of communication			
Augmentative and alternative communication modalities	35		35
Total EVALUATION Hours	45:00		

TREATMENT

	Child HH:MM	Adult HH:MM	Total
Articulation/Speech Sound Production			
Fluency and fluency disorders			
Voice and resonance			
Expressive/Receptive language			
Hearing			
Swallowing/Feeding			
Cognitive aspects of communication			
Social aspects of communication			
Augmentative and alternative communication modalities			
Total TREATMENT Hours			

Total (non-Observation)	45:00		45:00

Re-calculate

* = Required

Comments or additional information

H/W client

Save

- Make sure to clock your hours under the right sections!
    - Type of hours
        - Observation-Evaluation
        - Observation-Treatment
        - Evaluation
        - Treatment
    - Client Age
        - Child
        - Adult
- If you worked on multiple areas throughout the session, split the time according to how long you spent targeting each area
    - If you have questions about how to classify your hours talk to your supervisor
- Once you submit this, it should say "Clockhour saved" at the top of the screen

Step 2: Submit your hours for approval

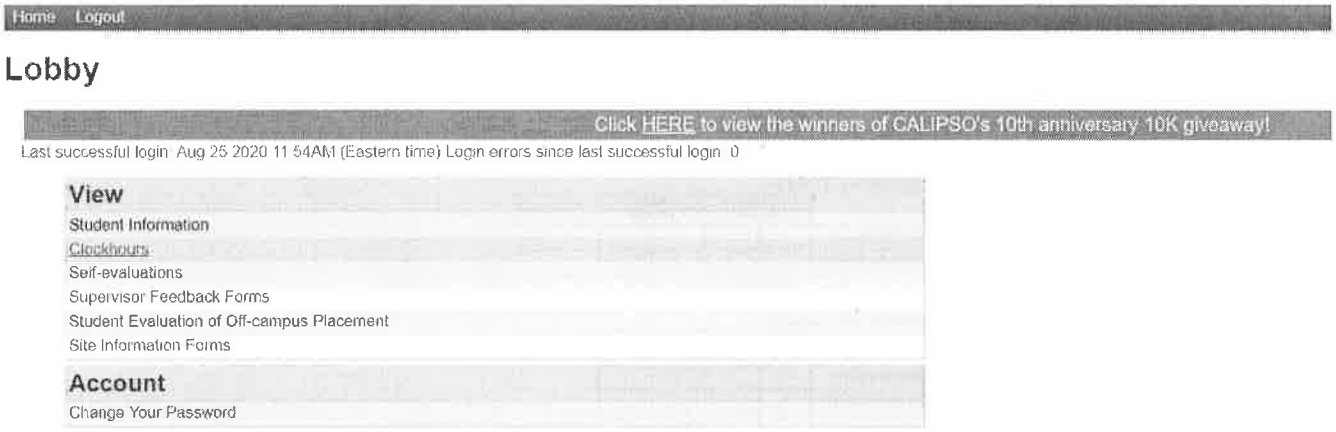
1. Click "Clockhours" on the homescreen
2. Click "Daily Clockhours" tab on the top of the screen
3. Choose your supervisor/placement from the dropdown menu and click "Show"
4. Select the sessions you would like to submit approval and click "Submit selected clockhours for Supervisor approval"
    - **IMPORTANT** – Be sure to verify the hours are documented correctly before you hit submit (if they are wrong, your supervisor cannot edit these hours and you will have to enter them again)
5. To check if your supervisor has approved your hours, go to the "Clockhours list" tab at the top of the screen

Documenting Clockhours on Calipso

Step 1: Clocking your hours

*Enter hours every week, submit at the end of the semester

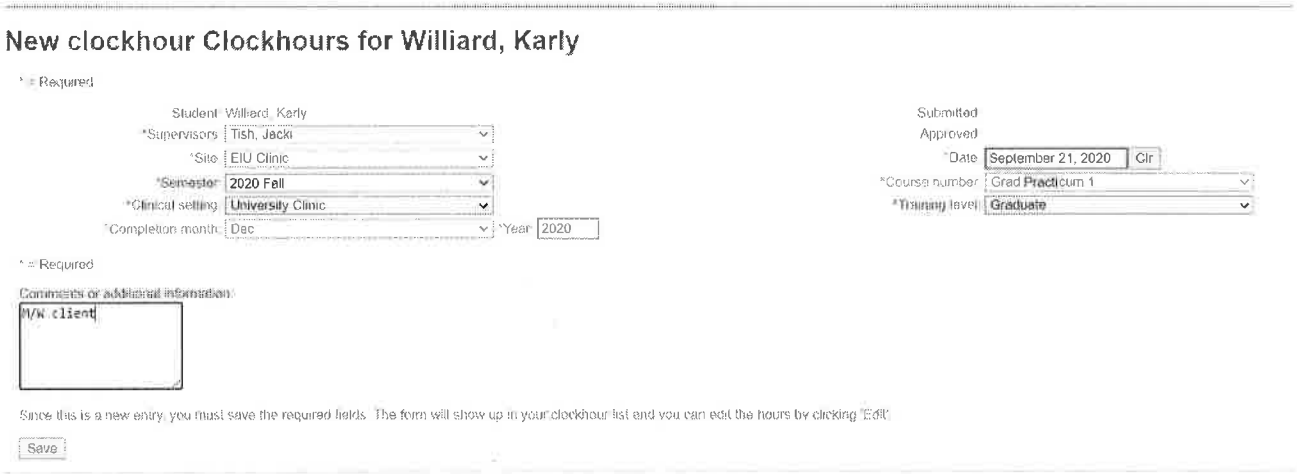
1. Click "Clockhours" on the home page



2. Click the "Daily Clockhours" tab at the top of the screen

3. Click "add new daily clockhour" if this is your first time entering clockhours for your clinical placement

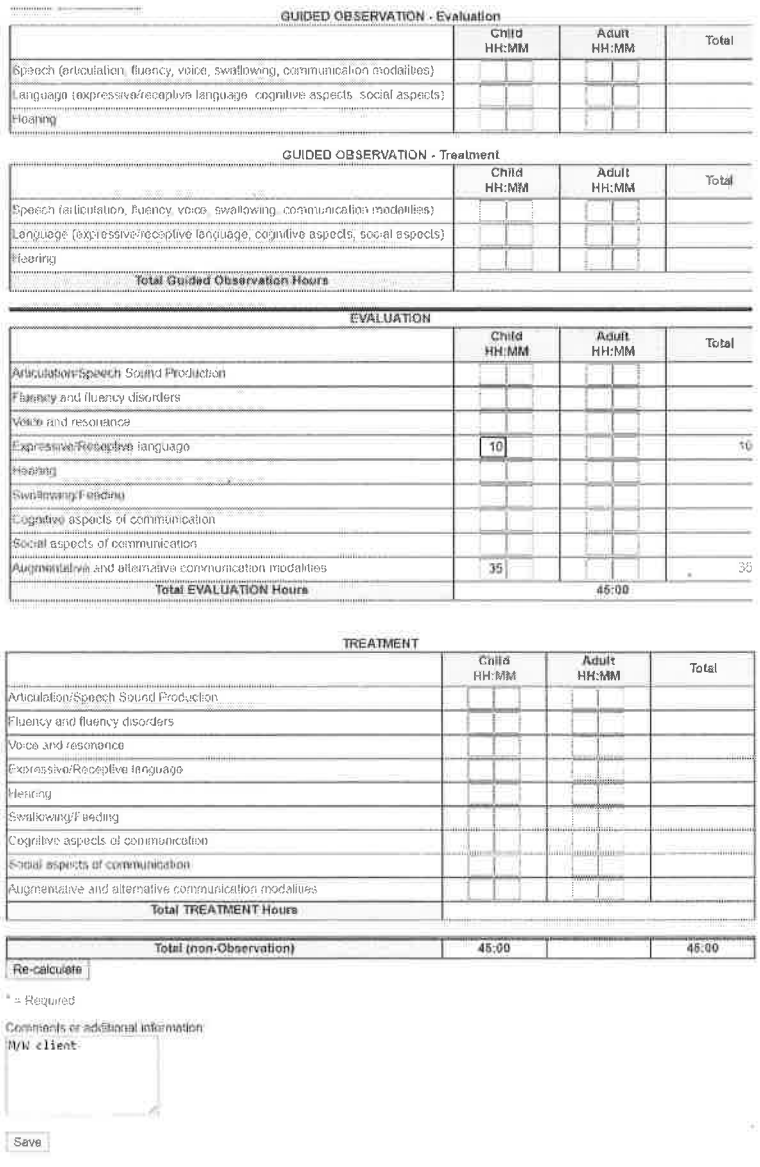
- If you've already entered clockhours for your clinical placement…choose your supervisor from the dropdown menu
    - Instead of filling out the header information again, click into one of your past sessions as if you are going to edit it
    - Then click "New clockhour with this header" at the top of the screen
    - Change the date & fill in the clockhours for your new session



4. Fill in the clockhour form with the required information and hit "Save"

- Clinical Setting: for clients in the EIU clinic this will be "University Clinic"
- Completion Month: when you will stop seeing the client
    - E.g. for Fall 2020 semester this would be December 2020
- Date: fill in the session date
- Course Number: See attachment for course numbers
- Training Level: choose "Graduate" from the dropdown menu

5. Now that the header is saved, fill in the hours you completed with your client during the session and hit "Save"



GUIDED OBSERVATION - Evaluation

	Child HH:MM	Adult HH:MM	Total
Speech (articulation, fluency, voice, swallowing, communication modalities)			
Language (expressive/receptive language, cognitive aspects, social aspects)			
Hearing			

GUIDED OBSERVATION - Treatment

	Child HH:MM	Adult HH:MM	Total
Speech (articulation, fluency, voice, swallowing, communication modalities)			
Language (expressive/receptive language, cognitive aspects, social aspects)			
Hearing			
Total Guided Observation Hours			

EVALUATION

	Child HH:MM	Adult HH:MM	Total
Articulation/Speech Sound Production			
Fluency and fluency disorders			
Voice and resonance			
Expressive/Receptive language	10		10
Hearing			
Swallowing/Feeding			
Cognitive aspects of communication			
Social aspects of communication			
Augmentative and alternative communication modalities	35		35
Total EVALUATION Hours	45:00		

TREATMENT

	Child HH:MM	Adult HH:MM	Total
Articulation/Speech Sound Production			
Fluency and fluency disorders			
Voice and resonance			
Expressive/Receptive language			
Hearing			
Swallowing/Feeding			
Cognitive aspects of communication			
Social aspects of communication			
Augmentative and alternative communication modalities			
Total TREATMENT Hours			

Total (non-Observation)	45:00		45:00

Re-calculate

* = Required

Comments or additional information

M/W client

Save

- Make sure to clock your hours under the right sections!
    - Type of hours
        - Observation-Evaluation
        - Observation-Treatment
        - Evaluation
        - Treatment
    - Client Age
        - Child
        - Adult
- If you worked on multiple areas throughout the session, split the time according to how long you spent targeting each area
    - If you have questions about how to classify your hours talk to your supervisor
- Once you submit this, it should say "Clockhour saved" at the top of the screen

Step 2: Submit your hours for approval

1. Click "Clockhours" on the homescreen
2. Click "Daily Clockhours" tab on the top of the screen
3. Choose your supervisor/placement from the dropdown menu and click "Show"
4. Select the sessions you would like to submit approval and click "Submit selected clockhours for Supervisor approval"
    - **IMPORTANT** – Be sure to verify the hours are documented correctly before you hit submit (if they are wrong, your supervisor cannot edit these hours and you will have to enter them again)
5. To check if your supervisor has approved your hours, go to the "Clockhours list" tab at the top of the screen

Section 2: Rules and Regulations

- Scope of Practice
- ASHA Code of Ethics
- Universal Precautions - Infection control and prevention
- Mandated Reporting
- Fired and Emergency Procedures
- Confidentiality and HIPPA

ASHA
American
Speech-Language-Hearing
Association

SCOPE OF PRACTICE IN SPEECH-LANGUAGE PATHOLOGY

AD HOC COMMITTEE ON THE SCOPE OF PRACTICE IN SPEECH-LANGUAGE PATHOLOGY

Reference this material as: American Speech-Language-Hearing Association. (2016). Scope of Practice in Speech-Language Pathology [Scope of Practice]. Available from www.asha.org/policy/.

ABOUT THIS DOCUMENT

This scope of practice document is an official policy of the American Speech-Language-Hearing Association (ASHA) defining the breadth of practice within the profession of speech-language pathology. This document was developed by the ASHA Ad Hoc Committee on the Scope of Practice in Speech- Language Pathology. Committee members were Mark DeRuiter (chair), Michael Campbell, Craig Coleman, Charlette Green, Diane Kendall, Judith Montgomery, Bernard Rousseau, Nancy Swigert, Sandra Gillam (board liaison), and Lemmietta McNeilly (ex officio). This document was approved by the ASHA Board of Directors on February 4, 2016 (BOD 01-2016). The BOD approved a revision in the prevention of hearing section of the document on May 9, 2016 (Motion 07-2016).

TABLE OF CONTENTS

INTRODUCTION

The *Scope of Practice in Speech-Language Pathology* of the American Speech-Language-Hearing Association (ASHA) includes the following: a statement of purpose, definitions of *speech-language pathologist* and *speech-language pathology*, a framework for speech-language pathology practice, a description of the domains of speech-language pathology service delivery, delineation of speech-language pathology service delivery areas, domains of professional practice, references, and resources.

The *speech-language pathologist* (*SLP*) is defined as the professional who engages in professional practice in the areas of communication and swallowing across the life span. *Communication* and *swallowing* are broad terms encompassing many facets of function. *Communication* includes speech production and fluency, language, cognition, voice, resonance,

and hearing. *Swallowing* includes all aspects of swallowing, including related feeding behaviors. Throughout this document, the terms *communication* and *swallowing* are used to reflect all areas. This document is a guide for SLPs across all clinical and educational settings to promote best practice. The term *individuals* is used throughout the document to refer to students, clients, and patients who are served by the SLP.

As part of the review process for updating the *Scope of Practice in Speech-Language Pathology*, the committee revised the previous scope of practice document to reflect recent advances in knowledge and research in the discipline. One of the biggest changes to the document includes the delineation of practice areas in the context of eight domains of speech-language pathology service delivery: collaboration; counseling; prevention and wellness; screening; assessment; treatment; modalities, technology, and instrumentation; and population and systems. In addition, five domains of professional practice are delineated: advocacy and outreach, supervision, education, research and administration/leadership.

Service delivery areas include all aspects of communication and swallowing and related areas that impact communication and swallowing: speech production, fluency, language, cognition, voice, resonance, feeding, swallowing, and hearing. The practice of speech-language pathology continually evolves. SLPs play critical roles in health literacy; screening, diagnosis, and treatment of autism spectrum disorder; and use of the *International Classification of Functioning, Disability and Health* (ICF; World Health Organization [WHO], 2014) to develop functional goals and collaborative practice. As technology and science advance, the areas of assessment and intervention related to communication and swallowing disorders grow accordingly. Clinicians should stay current with advances in speech-language pathology practice by regularly reviewing the research literature, consulting the Practice Management section of the ASHA website, including the Practice Portal, and regularly participating in continuing education to supplement advances in the profession and information in the scope of practice.

STATEMENT OF PURPOSE

The purpose of the *Scope of Practice in Speech-Language Pathology* is to

1. delineate areas of professional practice;
2. inform others (e.g., health care providers, educators, consumers, payers, regulators, and the general public) about professional roles and responsibilities of qualified providers;
3. support SLPs in the provision of high-quality, evidence-based services to individuals with communication, feeding, and/or swallowing concerns;

4. support SLPs in the conduct and dissemination of research; and
5. guide the educational preparation and professional development of SLPs to provide safe and effective services.

The scope of practice outlines the breadth of professional services offered within the profession of speech-language pathology. Levels of education, experience, skill, and proficiency in each practice area identified within this scope will vary among providers. An SLP typically does not practice in all areas of clinical service delivery across the life cycle. As the ASHA Code of Ethics specifies, professionals may practice only in areas in which they are competent, based on their education, training, and experience.

This scope of practice document describes evolving areas of practice. These include interdisciplinary work in both health care and educational settings, collaborative service delivery wherever appropriate, and telehealth/telepractice that are effective for the general public.

Speech-language pathology is a dynamic profession, and the overlapping of scopes of practice is a reality in rapidly changing health care, education, and other environments. Hence, SLPs in various settings work collaboratively with other school or health care professionals to make sound decisions for the benefit of individuals with communication and swallowing disorders. This *interprofessional collaborative practice* is defined as "members or students of two or more professions associated with health or social care, engaged in learning with, from and about each other" (Craddock, O'Halloran, Borthwick, & McPherson, 2006, p. 237. Similarly, "interprofessional education provides an ability to share skills and knowledge between professions and allows for a better understanding, shared values, and respect for the roles of other healthcare professionals" (Bridges et al., 2011, para. 5).

This scope of practice does not supersede existing state licensure laws or affect the interpretation or implementation of such laws. However, it may serve as a model for the development or modification of licensure laws. Finally, in addition to this scope of practice document, other ASHA professional resources outline practice areas and address issues related to public protection (e.g., A guide to disability rights law and the Practice Portal). The highest standards of integrity and ethical conduct are held paramount in this profession.

DEFINITIONS OF SPEECH-LANGUAGE PATHOLOGIST AND SPEECH-LANGUAGE PATHOLOGY

Speech-language pathologists, as defined by ASHA, are professionals who hold the ASHA Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP), which requires a master's, doctoral, or other recognized postbaccalaureate degree. ASHA-certified SLPs complete a supervised postgraduate professional experience and pass a national examination as described in the ASHA certification standards, (2014). Demonstration of continued professional development is mandated for the maintenance of the CCC-SLP. SLPs hold other required credentials where applicable (e.g., state licensure, teaching certification, specialty certification).

Each practitioner evaluates his or her own experiences with preservice education, practice, mentorship and supervision, and continuing professional development. As a whole, these experiences define the scope of competence for each individual. The SLP should engage in only those aspects of the profession that are within her or his professional competence.

SLPs are autonomous professionals who are the primary care providers of speech-language pathology services. Speech-language pathology services are not prescribed or supervised by another professional. Additional requirements may dictate that speech-language pathology services are prescribed and required to meet specific eligibility criteria in certain work settings, or as required by certain payers. SLPs use professional judgment to determine if additional requirements are indicated. Individuals with communication and/or swallowing disorders benefit from services that include collaboration by SLPs with other professionals.

The profession of speech-language pathology contains a broad area of speech-language pathology practice that includes both speech-language pathology service delivery and professional practice domains. These domains are defined in subsequent sections of this document and are represented schematically in **Figure 1**.

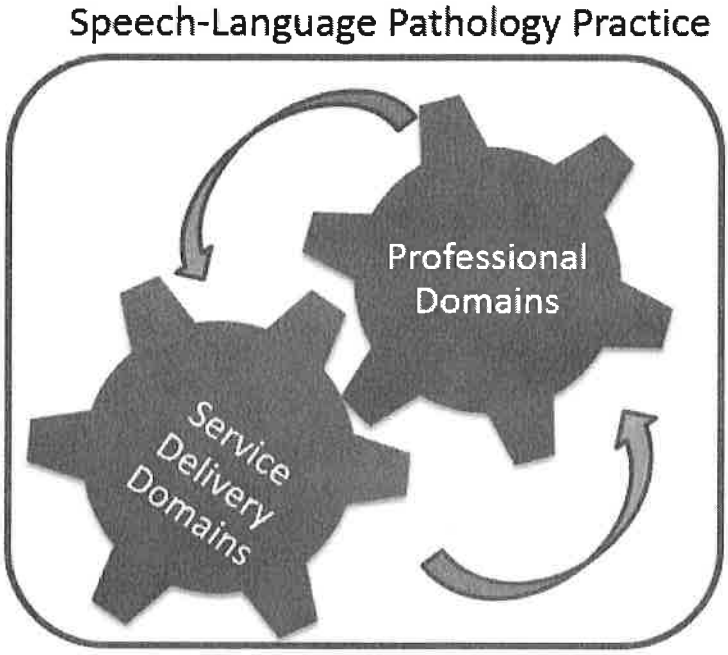


Figure 1. Schematic representation of speech-language pathology practice, including both service delivery and professional domains.

FRAMEWORK FOR SPEECH-LANGUAGE PATHOLOGY PRACTICE

The overall objective of speech-language pathology services is to optimize individuals' abilities to communicate and to swallow, thereby improving quality of life. As the population of the United States continues to become increasingly diverse, SLPs are committed to the provision of culturally and linguistically appropriate services and to the consideration of diversity in scientific investigations of human communication and swallowing.

An important characteristic of the practice of speech-language pathology is that, to the extent possible, decisions are based on best available evidence. ASHA defines evidence-based practice in speech-language pathology as an approach in which current, high-quality research evidence is integrated with practitioner expertise, along with the client's values and preferences (ASHA, 2005). A high-quality basic and applied research base in communication sciences and disorders and related disciplines is essential to providing evidence-based practice and high-quality services. Increased national and international interchange of professional knowledge, information, and education in communication sciences and disorders is a means to strengthen

research collaboration and improve services. ASHA has provided a resource for evidence-based research via the Practice Portal.

The scope of practice in speech-language pathology comprises five domains of professional practice and eight domains of service delivery.

Professional practice domains:

- advocacy and outreach
- supervision
- education
- administration/leadership
- research

Service delivery domains

- Collaboration
- Counseling
- Prevention and Wellness
- Screening
- Assessment
- Treatment
- Modalities, Technology, and Instrumentation
- Population and Systems

SLPs provide services to individuals with a wide variety of speech, language, and swallowing differences and disorders within the above-mentioned domains that range in function from completely intact to completely compromised. The diagnostic categories in the speech-language pathology scope of practice are consistent with relevant diagnostic categories under the WHO's (2014) *ICF*, the American Psychiatric Association's (2013) *Diagnostic and Statistical Manual of Mental Disorders*, the categories of disability under the Individuals with Disabilities Education Act of 2004 (see also U.S. Department of Education, 2004), and those defined by two semiautonomous bodies of ASHA: the Council on Academic Accreditation in Audiology and Speech-Language Pathology and the Council for Clinical Certification in Audiology and Speech-Language Pathology.

The domains of speech-language pathology service delivery complement the *ICF*, the WHO's multipurpose health classification system (WHO, 2014). The classification system provides a

standard language and framework for the description of functioning and health. The ICF framework is useful in describing the breadth of the role of the SLP in the prevention, assessment, and habilitation/rehabilitation of communication and swallowing disorders and the enhancement and scientific investigation of those functions. The framework consists of two components: health conditions and contextual factors.

HEALTH CONDITIONS

Body Functions and Structures: These involve the anatomy and physiology of the human body. Relevant examples in speech-language pathology include craniofacial anomaly, vocal fold paralysis, cerebral palsy, stuttering, and language impairment.

Activity and Participation: *Activity* refers to the execution of a task or action. Participation is the involvement in a life situation. Relevant examples in speech-language pathology include difficulties with swallowing safely for independent feeding, participating actively in class, understanding a medical prescription, and accessing the general education curriculum.

CONTEXTUAL FACTORS

Environmental Factors: These make up the physical, social, and attitudinal environments in which people live and conduct their lives. Relevant examples in speech-language pathology include the role of the communication partner in augmentative and alternative communication (AAC), the influence of classroom acoustics on communication, and the impact of institutional dining environments on individuals' ability to safely maintain nutrition and hydration.

Personal Factors: These are the internal influences on an individual's functioning and disability and are not part of the health condition. Personal factors may include, but are not limited to, age, gender, ethnicity, educational level, social background, and profession. Relevant examples in speech-language pathology might include an individual's background or culture, if one or both influence his or her reaction to communication or swallowing.

The framework in speech-language pathology encompasses these health conditions and contextual factors across individuals and populations. **Figure 2** illustrates the interaction of the various components of the ICF. The health condition component is expressed on a continuum of functioning. On one end of the continuum is intact functioning; at the opposite end of the continuum is completely compromised function. The contextual factors interact with each other and with the health conditions and may serve as facilitators or barriers to functioning. SLPs

influence contextual factors through education and advocacy efforts at local, state, and national levels.

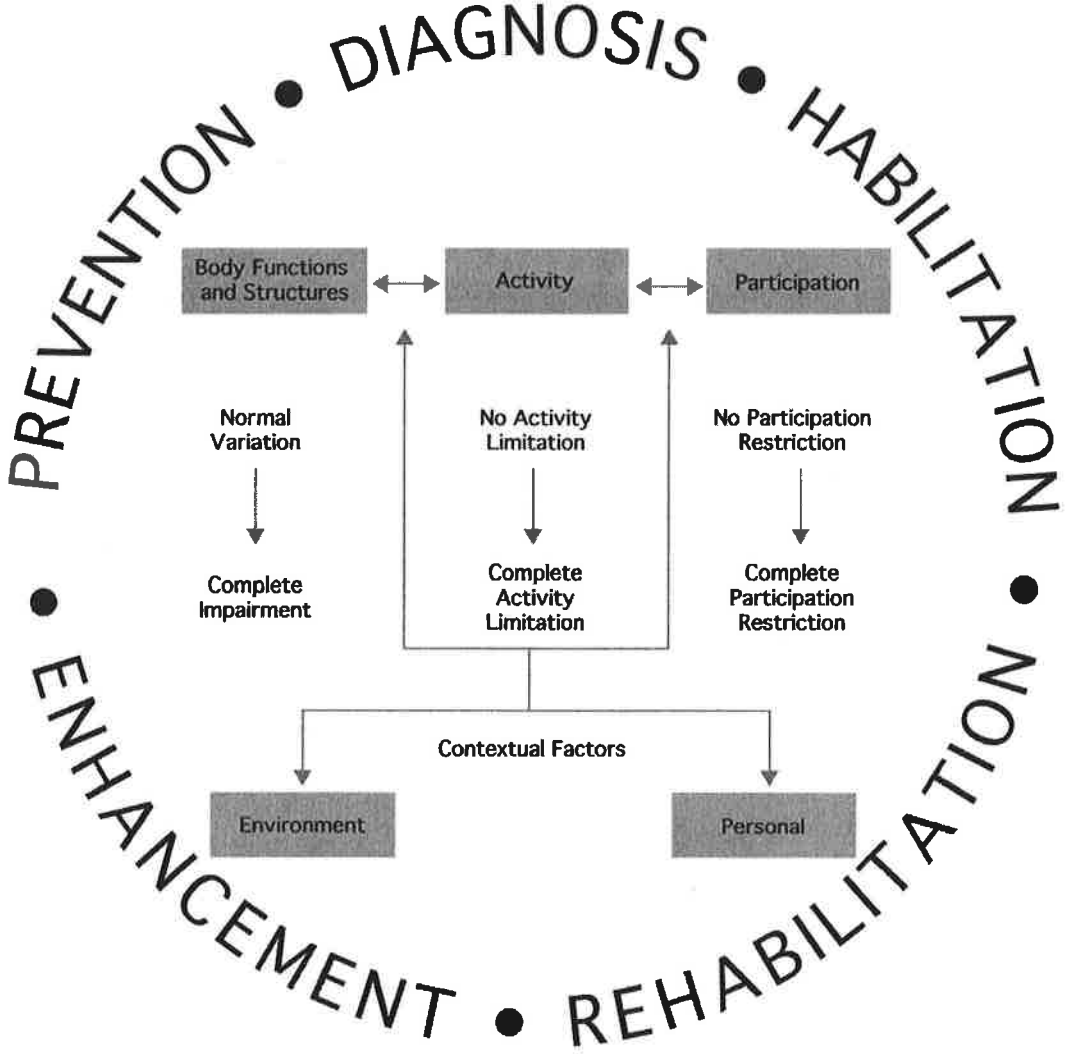


Figure 2. Interaction of the various components of the ICF model. This model applies to individuals or groups.

DOMAINS OF SPEECH-LANGUAGE PATHOLOGY SERVICE DELIVERY

The eight domains of speech-language pathology service delivery are collaboration; counseling; prevention and wellness; screening; assessment; treatment; modalities, technology, and instrumentation; and population and systems.

COLLABORATION

SLPs share responsibility with other professionals for creating a collaborative culture. Collaboration requires joint communication and shared decision making among all members of the team, including the individual and family, to accomplish improved service delivery and functional outcomes for the individuals served. When discussing specific roles of team members, professionals are ethically and legally obligated to determine whether they have the knowledge and skills necessary to perform such services. Collaboration occurs across all speech-language pathology practice domains.

As our global society is becoming more connected, integrated, and interdependent, SLPs have access to a variety of resources, information technology, diverse perspectives and influences (see, e.g., Lipinsky, Lombardo, Dominy, & Feeney, 1997). Increased national and international interchange of professional knowledge, information, and education in communication sciences and disorders is a means to strengthen research collaboration and improve services. SLPs

- educate stakeholders regarding interprofessional education (IPE) and interprofessional practice (IPP) (ASHA, 2014) principles and competencies;
- partner with other professions/organizations to enhance the value of speech-language pathology services;
- share responsibilities to achieve functional outcomes;
- consult with other professionals to meet the needs of individuals with communication and swallowing disorders;
- serve as case managers, service delivery coordinators, members of collaborative and patient care conference teams; and
- serve on early intervention and school pre-referral and intervention teams to assist with the development and implementation of individualized family service plans (IFSPs) and individualized education programs (IEPs).

COUNSELING

SLPs counsel by providing education, guidance, and support. Individuals, their families and their caregivers are counseled regarding acceptance, adaptation, and decision making about communication, feeding and swallowing, and related disorders. The role of the SLP in the counseling process includes interactions related to emotional reactions, thoughts, feelings, and behaviors that result from living with the communication disorder, feeding and swallowing disorder, or related disorders.

SLPs engage in the following activities in counseling persons with communication and feeding and swallowing disorders and their families:

- empower the individual and family to make informed decisions related to communication or feeding and swallowing issues.
- educate the individual, family, and related community members about communication or feeding and swallowing disorders.
- provide support and/or peer-to-peer groups for individuals with disorders and their families.
- provide individuals and families with skills that enable them to become self-advocates.
- discuss, evaluate, and address negative emotions and thoughts related to communication or feeding and swallowing disorders.
- refer individuals with disorders to other professionals when counseling needs fall outside of those related to (a) communication and (b) feeding and swallowing.

PREVENTION AND WELLNESS

SLPs are involved in prevention and wellness activities that are geared toward reducing the incidence of a new disorder or disease, identifying disorders at an early stage, and decreasing the severity or impact of a disability associated with an existing disorder or disease. Involvement is directed toward individuals who are vulnerable or at risk for limited participation in communication, hearing, feeding and swallowing, and related abilities. Activities are directed toward enhancing or improving general well-being and quality of life. Education efforts focus on identifying and increasing awareness of risk behaviors that lead to communication disorders and feeding and swallowing problems. SLPs promote programs to increase public awareness, which are aimed at positively changing behaviors or attitudes.

Effective prevention programs are often community based and enable the SLP to help reduce the incidence of spoken and written communication and swallowing disorders as a public health and public education concern.

Examples of prevention and wellness programs include, but are not limited to, the following:

- **Language impairment:** Educate parents, teachers and other school-based professionals about the clinical markers of language impairment and the ways in which these impairments can impact a student's reading and writing skills to facilitate early referral for evaluation and assessment services.

- **Language-based literacy disorders:** Educate parents, school personnel, and health care providers about the SLP's role in addressing the semantic, syntactic, morphological, and phonological aspects of literacy disorders across the lifespan.
- **Feeding:** Educate parents of infants at risk for feeding problems about techniques to minimize long-term feeding challenges.
- **Stroke prevention:** Educate individuals about risk factors associated with stroke
- **Serve on teams:** Participate on multitiered systems of support (MTSS)/response to intervention (RTI) teams to help students successfully communicate within academic, classroom, and social settings.
- **Fluency:** Educate parents about risk factors associated with early stuttering.
- **Early childhood:** Encourage parents to participate in early screening and to collaborate with physicians, educators, child care providers, and others to recognize warning signs of developmental disorders during routine wellness checks and to promote healthy communication development practices.
- **Prenatal care:** Educate parents to decrease the incidence of speech, hearing, feeding and swallowing, and related disorders due to problems during pregnancy.
- **Genetic counseling:** Refer individuals to appropriate professionals and professional services if there is a concern or need for genetic counseling.
- **Environmental change:** Modify environments to decrease the risk of occurrence (e.g., decrease noise exposure).
- **Vocal hygiene:** Target prevention of voice disorders (e.g., encourage activities that minimize phonotrauma and the development of benign vocal fold pathology and that curb the use of smoking and smokeless tobacco products).
- **Hearing:** Educate individuals about risk factors associated with noise-induced hearing loss and preventive measures that may help to decrease the risk.
- **Concussion/traumatic brain injury awareness:** Educate parents of children involved in contact sports about the risk of concussion.
- **Accent/dialect modification:** Address sound pronunciation, stress, rhythm, and intonation of speech to enhance effective communication.
- **Transgender (TG) and transsexual (TS) voice and communication:** Educate and treat individuals about appropriate verbal, nonverbal, and voice characteristics (feminization or masculinization) that are congruent with their targeted gender identity.
- **Business communication:** Educate individuals about the importance of effective business communication, including oral, written, and interpersonal communication.

- **Swallowing:** Educate individuals who are at risk for aspiration about oral hygiene techniques.

SCREENING

SLPs are experts at screening individuals for possible communication, hearing, and/or feeding and swallowing disorders. SLPs have the knowledge of—and skills to treat—these disorders; they can design and implement effective screening programs and make appropriate referrals. These screenings facilitate referral for appropriate follow-up in a timely and cost-effective manner. SLPs

- select and use appropriate screening instrumentation;
- develop screening procedures and tools based on existing evidence;
- coordinate and conduct screening programs in a wide variety of educational, community, and health care settings;
- participate in public school MTSS/RTI team meetings to review data and recommend interventions to satisfy federal and state requirements (e.g., Individuals with Disabilities Education Improvement Act of 2004 [IDEIA] and Section 504 of the Rehabilitation Act of 1973);
- review and analyze records (e.g., educational, medical);
- review, analyze, and make appropriate referrals based on results of screenings;
- consult with others about the results of screenings conducted by other professionals; and
- utilize data to inform decisions about the health of populations.

ASSESSMENT

Speech-language pathologists have expertise in the differential diagnosis of disorders of communication and swallowing. Communication, speech, language, and swallowing disorders can occur developmentally, as part of a medical condition, or in isolation, without an apparent underlying medical condition. Competent SLPs can diagnose communication and swallowing disorders but do not differentially diagnose medical conditions. The assessment process utilizes the ICF framework, which includes evaluation of body function, structure, activity and participation, within the context of environmental and personal factors. The assessment process can include, but is not limited to, culturally and linguistically appropriate behavioral observation and standardized and/or criterion-referenced tools; use of instrumentation; review of records, case history, and prior test results; and interview of the individual and/or family to guide decision making. The assessment process can be carried out in collaboration with other professionals. SLPs

- administer standardized and/or criterion-referenced tools to compare individuals with their peers;
- review medical records to determine relevant health, medical, and pharmacological information;
- interview individuals and/or family to obtain case history to determine specific concerns;
- utilize culturally and linguistically appropriate assessment protocols;
- engage in behavioral observation to determine the individual's skills in a naturalistic setting/context;
- diagnose communication and swallowing disorders;
- use endoscopy, videofluoroscopy, and other instrumentation to assess aspects of voice, resonance, velopharyngeal function and swallowing;
- document assessment and trial results for selecting AAC interventions and technology, including speech-generating devices (SGDs);
- participate in meetings adhering to required federal and state laws and regulations (e.g., IDEIA [2004] and Section 504 of the Rehabilitation Act of 1973).
- document assessment results, including discharge planning;
- formulate impressions to develop a plan of treatment and recommendations; and
- discuss eligibility and criteria for dismissal from early intervention and school-based services.

TREATMENT

Speech-language services are designed to optimize individuals' ability to communicate and swallow, thereby improving quality of life. SLPs develop and implement treatment to address the presenting symptoms or concerns of a communication or swallowing problem or related functional issue. Treatment establishes a new skill or ability or remediates or restores an impaired skill or ability. The ultimate goal of therapy is to improve an individual's functional outcomes. To this end, SLPs

- design, implement, and document delivery of service in accordance with best available practice appropriate to the practice setting;
- provide culturally and linguistically appropriate services;
- integrate the highest quality available research evidence with practitioner expertise and individual preferences and values in establishing treatment goals;
- utilize treatment data to guide decisions and determine effectiveness of services;
- integrate academic materials and goals into treatment;

- deliver the appropriate frequency and intensity of treatment utilizing best available practice;
- engage in treatment activities that are within the scope of the professional's competence;
- utilize AAC performance data to guide clinical decisions and determine the effectiveness of treatment; and
- collaborate with other professionals in the delivery of services.

MODALITIES, TECHNOLOGY, AND INSTRUMENTATION

SLPs use advanced instrumentation and technologies in the evaluation, management, and care of individuals with communication, feeding and swallowing, and related disorders. SLPs are also involved in the research and development of emerging technologies and apply their knowledge in the use of advanced instrumentation and technologies to enhance the quality of the services provided. Some examples of services that SLPs offer in this domain include, but are not limited to, the use of

- the full range of AAC technologies to help individuals who have impaired ability to communicate verbally on a consistent basis–AAC devices make it possible for many individuals to successfully communicate within their environment and community;
- endoscopy, videofluoroscopy, fiber-optic evaluation of swallowing (voice, velopharyngeal function, swallowing) and other instrumentation to assess aspects of voice, resonance, and swallowing;
- telehealth/telepractice to provide individuals with access to services or to provide access to a specialist;
- ultrasound and other biofeedback systems for individuals with speech sound production, voice, or swallowing disorders; and
- other modalities (e.g., American Sign Language), where appropriate.

POPULATION AND SYSTEMS

In addition to direct care responsibilities, SLPs have a role in (a) managing populations to improve overall health and education, (b) improving the experience of the individuals served, and, in some circumstances, (c) reducing the cost of care. SLPs also have a role in improving the efficiency and effectiveness of service delivery. SLPs serve in roles designed to meet the demands and expectations of a changing work environment. SLPs

- use plain language to facilitate clear communication for improved health and educationally relevant outcomes;

- collaborate with other professionals about improving communication with individuals who have communication challenges;
- improve the experience of care by analyzing and improving communication environments;
- reduce the cost of care by designing and implementing case management strategies that focus on function and by helping individuals reach their goals through a combination of direct intervention, supervision of and collaboration with other service providers, and engagement of the individual and family in self-management strategies;
- serve in roles designed to meet the demands and expectations of a changing work environment;
- contribute to the management of specific populations by enhancing communication between professionals and individuals served;
- coach families and early intervention providers about strategies and supports for facilitating prelinguistic and linguistic communication skills of infants and toddlers; and
- support and collaborate with classroom teachers to implement strategies for supporting student access to the curriculum.

SPEECH-LANGUAGE PATHOLOGY SERVICE DELIVERY AREAS

This list of practice areas and the bulleted examples are not comprehensive. Current areas of practice, such as literacy, have continued to evolve, whereas other new areas of practice are emerging. Please refer to the ASHA Practice Portal for a more extensive list of practice areas.

1. **Fluency**
   - Stuttering
   - Cluttering
2. **Speech Production**
   - Motor planning and execution
   - Articulation
   - Phonological
3. **Language**—Spoken and written language (listening, processing, speaking, reading, writing, pragmatics)
   - Phonology
   - Morphology
   - Syntax
   - Semantics
   - Pragmatics (language use and social aspects of communication)

- Prelinguistic communication (e.g., joint attention, intentionality, communicative signaling)
- Paralinguistic communication (e.g., gestures, signs, body language)
- Literacy (reading, writing, spelling)

4. **Cognition**
   - Attention
   - Memory
   - Problem solving
   - Executive functioning
5. **Voice**
   - Phonation quality
   - Pitch
   - Loudness
   - Alaryngeal voice
6. **Resonance**
   - Hypernasality
   - Hyponasality
   - Cul-de-sac resonance
   - Forward focus
7. **Feeding and Swallowing**
   - Oral phase
   - Pharyngeal phase
   - Esophageal phase
   - Atypical eating (e.g., food selectivity/refusal, negative physiologic response)
8. **Auditory Habilitation/Rehabilitation**
   - Speech, language, communication, and listening skills impacted by hearing loss, deafness
   - Auditory processing

Potential etiologies of communication and swallowing disorders include

- neonatal problems (e.g., prematurity, low birth weight, substance exposure);
- developmental disabilities (e.g., specific language impairment, autism spectrum disorder, dyslexia, learning disabilities, attention-deficit disorder, intellectual disabilities, unspecified neurodevelopmental disorders);

- disorders of aerodigestive tract function (e.g., irritable larynx, chronic cough, abnormal respiratory patterns or airway protection, paradoxical vocal fold motion, tracheostomy);
- oral anomalies (e.g., cleft lip/palate, dental malocclusion, macroglossia, oral motor dysfunction);
- respiratory patterns and compromise (e.g., bronchopulmonary dysplasia, chronic obstructive pulmonary disease);
- pharyngeal anomalies (e.g., upper airway obstruction, velopharyngeal insufficiency/incompetence);
- laryngeal anomalies (e.g., vocal fold pathology, tracheal stenosis);
- neurological disease/dysfunction (e.g., traumatic brain injury, cerebral palsy, cerebrovascular accident, dementia, Parkinson's disease, and amyotrophic lateral sclerosis);
- psychiatric disorder (e.g., psychosis, schizophrenia);
- genetic disorders (e.g., Down syndrome, fragile X syndrome, Rett syndrome, velocardiofacial syndrome); and
- Orofacial myofunctional disorders (e.g., habitual open-mouth posture/nasal breathing, orofacial habits, tethered oral tissues, chewing and chewing muscles, lips and tongue resting position).

This list of etiologies is not comprehensive.

Elective services include

- Transgender communication (e.g., voice, verbal and nonverbal communication);
- Preventive vocal hygiene;
- Business communication;
- Accent/dialect modification; and
- Professional voice use.

This list of elective services is not comprehensive.

DOMAINS OF PROFESSIONAL PRACTICE

This section delineates the domains of professional practice—that is, a set of skills and knowledge that goes beyond clinical practice. The domains of professional practice include advocacy and outreach, supervision, education, research, and administration and leadership.

ADVOCACY AND OUTREACH

SLPs advocate for the discipline and for individuals through a variety of mechanisms, including community awareness, prevention activities, health literacy, academic literacy, education, political action, and training programs. Advocacy promotes and facilitates access to communication, including the reduction of societal, cultural, and linguistic barriers. SLPs perform a variety of activities, including the following:

- Advise regulatory and legislative agencies about the continuum of care. Examples of service delivery options across the continuum of care include telehealth/telepractice, the use of technology, the use of support personnel, and practicing at the top of the license.
- Engage decision makers at the local, state, and national levels for improved administrative and governmental policies affecting access to services and funding for communication and swallowing issues.
- Advocate at the local, state, and national levels for funding for services, education, and research.
- Participate in associations and organizations to advance the speech-language pathology profession.
- Promote and market professional services.
- Help to recruit and retain SLPs with diverse backgrounds and interests.
- Collaborate on advocacy objectives with other professionals/colleagues regarding mutual goals.
- Serve as expert witnesses, when appropriate.
- Educate consumers about communication disorders and speech-language pathology services.
- Advocate for fair and equitable services for all individuals, especially the most vulnerable.
- Inform state education agencies and local school districts about the various roles and responsibilities of school-based SLPs, including direct service, IEP development, Medicaid billing, planning and delivery of assessment and therapy, consultation with other team members, and attendance at required meetings.

SUPERVISION

Supervision is a distinct area of practice; is the responsibility of SLPs; and crosses clinical, administrative, and technical spheres. SLPs are responsible for supervising Clinical Fellows, graduate externs, trainees, speech-language pathology assistants, and other personnel (e.g., clerical, technical, and other administrative support staff). SLPs may also supervise colleagues

and peers. SLPs acknowledge that supervision is integral in the delivery of communication and swallowing services and advances the discipline. Supervision involves education, mentorship, encouragement, counseling, and support across all supervisory roles. SLPs

- possess service delivery and professional practice skills necessary to guide the supervisee;
- apply the art and science of supervision to all stakeholders (i.e., those supervising and being supervised), recognizing that supervision contributes to efficiency in the workplace;
- seek advanced knowledge in the practice of effective supervision;
- establish supervisory relationships that are collegial in nature;
- support supervisees as they learn to handle emotional reactions that may affect the therapeutic process; and
- establish a supervisory relationship that promotes growth and independence while providing support and guidance.

EDUCATION

SLPs serve as educators, teaching students in academic institutions and teaching professionals through continuing education in professional development formats. This more formal teaching is in addition to the education that SLPs provide to individuals, families, caregivers, decision makers, and policy makers, which is described in other domains. SLPs

- serve as faculty at institutions of higher education, teaching courses at the undergraduate, graduate, and postgraduate levels;
- mentor students who are completing academic programs at all levels;
- provide academic training to students in related disciplines and students who are training to become speech-language pathology assistants; and
- provide continuing professional education to SLPs and to professionals in related disciplines.

RESEARCH

SLPs conduct and participate in basic and applied/translational research related to cognition, verbal and nonverbal communication, pragmatics, literacy (reading, writing and spelling), and feeding and swallowing. This research may be undertaken as a facility-specific effort or may be coordinated across multiple settings. SLPs engage in activities to ensure compliance with Institutional Review Boards and international laws pertaining to research. SLPs also collaborate with other researchers and may pursue research funding through grants.

ADMINISTRATION AND LEADERSHIP

SLPs administer programs in education, higher education, schools, health care, private practice, and other settings. In this capacity, they are responsible for making administrative decisions related to fiscal and personnel management; leadership; program design; program growth and innovation; professional development; compliance with laws and regulations; and cooperation with outside agencies in education and healthcare. Their administrative roles are not limited to speech-language pathology, as they may administer programs across departments and at different levels within an institution. In addition, SLPs promote effective and manageable workloads in school settings, provide appropriate services under IDEIA (2004), and engage in program design and development.

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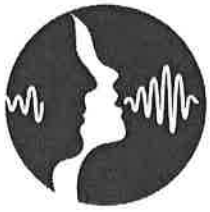


ASHA
American
Speech-Language-Hearing
Association

CODE OF ETHICS

Reference this material as: American Speech-Language-Hearing Association. (2023). Code of Ethics [Ethics]. Available from www.asha.org/policy/.

PREAMBLE

The American Speech-Language-Hearing Association (ASHA; hereafter, also known as "the Association") has been committed to a framework of common principles and standards of practice since ASHA's inception in 1925. This commitment was formalized in 1952 as the Association's first Code of Ethics. This code has been modified and adapted to reflect the current state of practice and to address evolving issues within the professions.

The ASHA Code of Ethics reflects professional values and expectations for scientific and clinical practice. It is based on principles of duty, accountability, fairness, and responsibility and is intended to ensure the welfare of the consumer and to protect the reputation and integrity of the professions. The Code of Ethics is a framework and a guide for professionals in support of day-to-day decision making related to professional conduct.

The Code of Ethics is obligatory and disciplinary as well as aspirational and descriptive in that it defines the professional's role. It is an integral educational resource regarding ethical principles and standards that are expected of audiologists, speech-language pathologists, and speech, language, and hearing scientists.

The preservation of the highest standards of integrity and ethical principles is vital to the responsible discharge of obligations by audiologists, speech-language pathologists, and speech, language, and hearing scientists who serve as clinicians, educators, mentors, researchers, supervisors, and administrators. This Code of Ethics sets forth the fundamental principles and rules considered essential to this purpose and is applicable to the following individuals:

- a member of ASHA holding the Certificate of Clinical Competence
- a member of ASHA not holding the Certificate of Clinical Competence
- a nonmember of ASHA holding the Certificate of Clinical Competence
- an applicant for ASHA certification or for ASHA membership and certification

ASHA members who provide clinical services must hold the Certificate of Clinical Competence and must abide by the Code of Ethics. By holding ASHA certification and/or membership, or through application for such, all individuals are subject to the jurisdiction of the ASHA Board of Ethics for ethics complaint adjudication.

The fundamentals of ethical conduct are described by Principles of Ethics and by Rules of Ethics. The four Principles of Ethics form the underlying philosophical basis for the Code of Ethics and are reflected in the following areas: (I) responsibility to persons served professionally and to

research participants; (II) responsibility for one's professional competence; (III) responsibility to the public; and (IV) responsibility for professional relationships. Individuals shall honor and abide by these Principles as affirmative obligations under all conditions of applicable professional activity. Rules of Ethics are specific statements of minimally acceptable as well as unacceptable professional conduct.

The Code of Ethics is designed to provide guidance to members, certified individuals, and applicants as they make professional decisions. Because the Code of Ethics is not intended to address specific situations and is not inclusive of all possible ethical dilemmas, professionals are expected to follow its written provisions and to uphold its spirit and purpose. Adherence to the Code of Ethics and its enforcement results in respect for the professions and positive outcomes for those who benefit from the work of audiologists, speech-language pathologists, and speech, language, and hearing scientists.

PRINCIPLE OF ETHICS I

Individuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally or who are participants in research and scholarly activities.

RULES OF ETHICS

A. Individuals shall provide all clinical services and scientific activities competently.
B. Individuals shall use every resource, including referral and/or interprofessional collaboration when appropriate, to ensure that quality service is provided.
C. Individuals shall not discriminate in the delivery of professional services or in the conduct of research and scholarly activities on the basis of age; citizenship; disability; ethnicity; gender; gender expression; gender identity; genetic information; national origin, including culture, language, dialect, and accent; race; religion; sex; sexual orientation; or veteran status.
D. Individuals shall not misrepresent the credentials of aides, assistants, technicians, students, research assistants, Clinical Fellows, or any others under their supervision, and they shall inform those they serve professionally of the name, role, and professional credentials of persons providing services.
E. Individuals who hold the Certificate of Clinical Competence may delegate tasks related to the provision of clinical services to aides, assistants, technicians, or any other persons only if those persons are adequately prepared and are appropriately supervised. The

responsibility for the welfare of those being served remains with the certified audiologist or speech-language pathologist.

F. Individuals who hold the Certificate of Clinical Competence shall not delegate tasks that require the unique skills, knowledge, judgment, or credentials that are within the scope of their profession to aides, assistants, technicians, or any nonprofessionals over whom they have supervisory responsibility.

G. Individuals who hold the Certificate of Clinical Competence may delegate to students tasks related to the provision of clinical services that require the unique skills, knowledge, and judgment that are within the scope of practice of their profession only if those students are adequately prepared and are appropriately supervised. The responsibility for the welfare of those being served remains with the certified audiologist or speech-language pathologist.

H. Individuals shall obtain informed consent from the persons they serve about the nature and possible risks and effects of services provided, technology employed, and products dispensed. This obligation also includes informing persons served about possible effects of not engaging in treatment or not following clinical recommendations. If diminished decision-making ability of persons served is suspected, individuals should seek appropriate authorization for services, such as authorization from a legally authorized/appointed representative.

I. Individuals shall enroll and include persons as participants in research or teaching demonstrations/simulations only if participation is voluntary, without coercion, and with informed consent.

J. Individuals shall accurately represent the intended purpose of a service, product, or research endeavor and shall abide by established guidelines for clinical practice and the responsible conduct of research, including humane treatment of animals involved in research.

K. Individuals who hold the Certificate of Clinical Competence shall evaluate the effectiveness of services provided, technology employed, and products dispensed, and they shall provide services or dispense products only when benefit can reasonably be expected.

L. Individuals who hold the Certificate of Clinical Competence shall use independent and evidence-based clinical judgment, keeping paramount the best interests of those being served.

M. Individuals may make a reasonable statement of prognosis, but they shall not guarantee—directly or by implication—the results of any treatment or procedure.

N. Individuals who hold the Certificate of Clinical Competence may provide services via telepractice consistent with professional standards and state and federal regulations, but they shall not provide clinical services solely by written communication.

O. Individuals shall protect the confidentiality and security of records of professional services provided, research and scholarly activities conducted, and products dispensed. Access to these records shall be allowed only when doing so is legally authorized or required by law.

P. Individuals shall protect the confidentiality of information about persons served professionally or participants involved in research and scholarly activities. Disclosure of confidential information shall be allowed only when doing so is legally authorized or required by law.

Q. Individuals shall maintain timely records; shall accurately record and bill for services provided and products dispensed; and shall not misrepresent services provided, products dispensed, or research and scholarly activities conducted.

R. Individuals shall not allow personal hardships, psychosocial distress, substance use/misuse, or physical or mental health conditions to interfere with their duty to provide professional services with reasonable skill and safety. Individuals whose professional practice is adversely affected by any of the above-listed factors should seek professional assistance regarding whether their professional responsibilities should be limited or suspended.

S. Individuals who have knowledge that a colleague is unable to provide professional services with reasonable skill and safety shall report this information to the appropriate authority, internally if such a mechanism exists and, when appropriate, externally to the applicable professional licensing authority or board, other professional regulatory body, or professional association.

T. Individuals shall give reasonable notice to ensure continuity of care and shall provide information about alternatives for care in the event that they can no longer provide professional services.

PRINCIPLE OF ETHICS II

Individuals shall honor their responsibility to achieve and maintain the highest level of professional competence and performance.

RULES OF ETHICS

A. Individuals who hold the Certificate of Clinical Competence shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their certification status, education, training, and experience.

B. ASHA members who do not hold the Certificate of Clinical Competence may not engage in the provision of clinical services; however, individuals who are in the certification application process may provide clinical services consistent with current local and state laws and regulations and with ASHA certification requirements.

C. Individuals shall enhance and refine their professional competence and expertise through engagement in lifelong learning applicable to their professional activities and skills.

D. Individuals who engage in research shall comply with all institutional, state, and federal regulations that address any aspects of research.

E. Individuals in administrative or supervisory roles shall not require or permit their professional staff to provide services or conduct research activities that exceed the staff member's certification status, competence, education, training, and experience.

F. Individuals in administrative or supervisory roles shall not require or permit their professional staff to provide services or conduct clinical activities that compromise the staff member's independent and objective professional judgment.

G. Individuals shall use technology and instrumentation consistent with accepted professional guidelines in their areas of practice. When such technology is warranted but not available, an appropriate referral should be made.

H. Individuals shall ensure that all technology and instrumentation used to provide services or to conduct research and scholarly activities are in proper working order and are properly calibrated.

PRINCIPLE OF ETHICS III

In their professional role, individuals shall act with honesty and integrity when engaging with the public and shall provide accurate information involving any aspect of the professions.

RULES OF ETHICS

A. Individuals shall not misrepresent their credentials, competence, education, training, experience, or scholarly contributions.

B. Individuals shall avoid engaging in conflicts of interest whereby a personal, professional, financial, or other interest or relationship could influence their objectivity, competence, or effectiveness in performing professional responsibilities. If such conflicts of interest cannot be avoided, proper disclosure and management is required.

C. Individuals shall not misrepresent diagnostic information, services provided, results of services provided, products dispensed, effects of products dispensed, or research and scholarly activities.

D. Individuals shall not defraud, scheme to defraud, or engage in any illegal or negligent conduct related to obtaining payment or reimbursement for services, products, research, or grants.

E. Individuals' statements to the public shall provide accurate information regarding the professions, professional services and products, and research and scholarly activities.

F. Individuals' statements to the public shall adhere to prevailing professional standards and shall not contain misrepresentations when advertising, announcing, or promoting their professional services, products, or research.

G. Individuals shall not knowingly make false financial or nonfinancial statements and shall complete all materials honestly and without omission.

PRINCIPLE OF ETHICS IV

Individuals shall uphold the dignity and autonomy of the professions, maintain collaborative and harmonious interprofessional and intraprofessional relationships, and accept the professions' self-imposed standards.

RULES OF ETHICS

A. Individuals shall work collaboratively with members of their own profession and/or members of other professions, when appropriate, to deliver the highest quality of care.

B. Individuals shall exercise independent professional judgment in recommending and providing professional services when an administrative directive, referral source, or prescription prevents them from keeping the welfare of persons served paramount.
C. Individuals' statements to colleagues about professional services, products, or research results shall adhere to prevailing professional standards and shall contain no misrepresentations.
D. Individuals shall not engage in any form of conduct that adversely reflects on the professions or on the individual's fitness to serve persons professionally.
E. Individuals shall not engage in dishonesty, negligence, deceit, or misrepresentation.
F. Individuals who mentor Clinical Fellows, act as a preceptor to audiology externs, or supervise undergraduate or graduate students, assistants, or other staff shall provide appropriate supervision and shall comply—fully and in a timely manner—with all ASHA certification and supervisory requirements.
G. Applicants for certification or membership, and individuals making disclosures, shall not make false statements and shall complete all application and disclosure materials honestly and without omission.
H. Individuals shall not engage in any form of harassment or power abuse.
I. Individuals shall not engage in sexual activities with persons over whom they exercise professional authority or power, including persons receiving services, other than those with whom an ongoing consensual relationship existed prior to the date on which the professional relationship began.
J. Individuals shall not knowingly allow anyone under their supervision to engage in any practice that violates the Code of Ethics.
K. Individuals shall assign credit only to those who have contributed to a publication, presentation, process, or product. Credit shall be assigned in proportion to the contribution and only with the contributor's consent.
L. Individuals shall reference the source when using other persons' ideas, research, presentations, results, or products in written, oral, or any other media presentation or summary. To do otherwise constitutes plagiarism.
M. Individuals shall not discriminate in their relationships with colleagues, members of other professions, or individuals under their supervision on the basis of age; citizenship; disability; ethnicity; gender; gender expression; gender identity; genetic information; national origin, including culture, language, dialect, and accent; race; religion; sex; sexual orientation; socioeconomic status; or veteran status.

N. Individuals with evidence that the Code of Ethics may have been violated have the responsibility to either work collaboratively to resolve the situation where possible or to inform the Board of Ethics through its established procedures.

O. Individuals shall report members of other professions who they know have violated standards of care to the appropriate professional licensing authority or board, other professional regulatory body, or professional association when such violation compromises the welfare of persons served and/or research participants.

P. Individuals shall not file or encourage others to file complaints that disregard or ignore facts that would disprove the allegation; the Code of Ethics shall not be used for personal reprisal, as a means of addressing personal animosity, or as a vehicle for retaliation.

Q. Individuals making and responding to complaints shall comply fully with the policies of the Board of Ethics in its consideration, adjudication, and resolution of complaints of alleged violations of the Code of Ethics.

R. Individuals involved in ethics complaints shall not knowingly make false statements of fact or withhold relevant facts necessary to fairly adjudicate the complaints.

S. Individuals shall comply with local, state, and federal laws and regulations applicable to professional practice and to the responsible conduct of research.

T. Individuals who have been convicted of, been found guilty of, or entered a plea of guilty or nolo contendere to (1) any misdemeanor involving dishonesty, physical harm—or the threat of physical harm—to the person or property of another or (2) any felony shall self-report by notifying the ASHA Ethics Office in writing within 60 days of the conviction, plea, or finding of guilt. Individuals shall also provide a copy of the conviction, plea, or nolo contendere record with their self-report notification, and any other court documents as reasonably requested by the ASHA Ethics Office.

U. Individuals who have (1) been publicly disciplined or denied a license or a professional credential by any professional association, professional licensing authority or board, or other professional regulatory body; or (2) voluntarily relinquished or surrendered their license, certification, or registration with any such body while under investigation for alleged unprofessional or improper conduct shall self-report by notifying the ASHA Ethics Office in writing within 60 days of the final action or disposition. Individuals shall also provide a copy of the final action, sanction, or disposition—with their self-report notification—to the ASHA Ethics Office.

TERMINOLOGY

The purpose of the following Terminology section is to provide additional clarification for terms not defined within the Principles of Ethics and Rules of Ethics sections.

ASHA Ethics Office

The ASHA Ethics Office assists the Board of Ethics with the confidential administration and processing of self-reports from and ethics complaints against individuals (as defined below). All complaints and self-reports should be sent to this office. The mailing address for the ASHA Ethics Office is American Speech-Language-Hearing Association, attn: Ethics Office, 2200 Research Blvd., #309, Rockville, MD 20850. The email address is ethics@asha.org.

advertising

Any form of communication with the public regarding services, therapies, research, products, or publications.

diminished decision-making ability

The inability to comprehend, retain, or apply information necessary to determine a reasonable course of action.

individuals

Within the Code of Ethics, this term refers to ASHA members and/or certificate holders and applicants for ASHA certification.

informed consent

An agreement by persons served, those with legal authority for persons served, or research participants that constitutes authorization of a proposed course of action after the communication of adequate information regarding expected outcomes and potential risks. Such an agreement may be verbal or written, as required by applicable law or policy.

may vs. shall

May denotes an allowance for discretion; *shall* denotes something that is required.

misrepresentation

Any statement by words or other conduct that, under the circumstances, amounts to an assertion that is false, erroneous, or misleading (i.e., not in accordance with the facts).

negligence

Failing to exercise a standard of care toward others that a reasonable or prudent person would use in the circumstances, or taking actions that a reasonable person would not.

nolo contendere

A plea made by a defendant stating that they will not contest a criminal charge.

plagiarism

Representation of another person's idea, research, presentation, result, or product as one's own through irresponsible citation, attribution, or paraphrasing.

publicly disciplined

A formal disciplinary action of public record.

reasonable or reasonably

Being supported or justified by fact or circumstance and being in accordance with reason, fairness, duty, or prudence.

self-report

A professional obligation of self-disclosure that requires (a) notifying the ASHA Ethics Office in writing and (b) sending a copy of the required documentation to the ASHA Ethics Office (see definition of "written" below).

shall vs. may

Shall denotes something that is required; *may* denotes an allowance for discretion.

telepractice

Application of telecommunications technology to the delivery of audiology and speech-language pathology professional services at a distance by linking clinician to client/patient/student or by linking clinician to clinician for assessment, intervention, consultation, or supervision. The quality of the service should be equivalent to that of in-person service. For more information, see Telepractice on the ASHA Practice Portal.

written

Encompasses both electronic and hard-copy writings or communications.

1

Infection Control Basics

All information from this PowerPoint is from the Centers for Disease Control and Prevention.

In the future, please check this link for up-to-date information: https://www.cdc.gov/infectioncontrol/basics/index.html

2

Types of Precautions

Standard Precautions for All Patient Care

Transmission-Based Precautions

3

Standard Precautions for All Patient Care

4

Perform Hand Hygiene!

- Wash hands with soap and water or use an alcohol-based hand sanitizer before and after patent contact and after contact with the immediate patient care environment!
- Hand hygiene will be audited!
- https://www.cdc.gov/handhygiene/index.html
- https://www.cdc.gov/handhygiene/training/interactiveEducation/

5

Hand Hygiene

- Perform hand hygiene – in the following clinical situations:
- IV.A.3.a. Before having direct contact with patients [illegible] *Category IB*
- IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. [illegible] *Category IA*
- IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). [illegible] *Category IB*
- IV.A.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. *Category II*
- IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. [illegible] *Category II*
- IV.A.3.f. After removing gloves. [illegible] *Category IB*
- IV.A.4. Wash hands with non-antimicrobial soap and water or with antimicrobial soap and water if contact with spores (e.g., *C difficile* or *Bacillus anthracis*) is likely to have occurred. The physical action of washing and rinsing hands under such circumstances is recommended because alcohols, chlorhexidine, iodophors, and other antiseptic agents have poor activity against spores. [illegible] *Category IA*
- IV.A.5. Do not wear artificial fingernails or extenders if duties include direct contact with patients at high risk for infection and associated adverse outcomes (e.g., those in ICUs or operating rooms). [illegible] *Category IA*
- IV.A.5.a. Develop an organizational policy on the wearing of non-natural nails by healthcare personnel who have direct contact with patients outside of the groups specified above. [illegible] *Category II*

6

Personal Protective Equipment (PPE)

- Observe the following principles of use:
- IV.B.1.a. Wear PPE, as described in IV.B.2-4, when the nature of the anticipated patient interaction indicates that contact with blood or body fluids may occur. Category IB/IC
- IV.B.1.b. Prevent contamination of clothing and skin during the process of removing PPE (see figure). Category II
- IV.B.1.c. Before leaving the patient's room or cubicle, remove and discard PPE. Category IB/IC
- Gloves – protect hands and allow efficient removal of organisms from hands
- Gowns and Aprons – protect skin and clothing
- Face masks – protect mucous membranes of mouth and nose
- Respirators – prevent inhalation of infectious material
- Goggles – protect eyes
- Face shields – mucous membranes of face, mouth, nose and eyes 5

7

PPE: Gloves

- IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin (e.g., of a patient incontinent of stool or urine) could occur. Category IB/IC
- IV.B.2.b. Wear gloves with fit and durability appropriate to the task. Category IB
- IV.B.2.b.i. Wear disposable medical examination gloves for providing direct patient care.
- IV.B.2.b.ii. Wear disposable medical examination gloves or reusable utility gloves for cleaning the environment or medical equipment.
- IV.B.2.c. Remove gloves after contact with a patient and/or the surrounding environment (including medical equipment) using proper technique to prevent hand contamination (see figure). Do not wear the same pair of gloves for the care of more than one patient. Do not wash gloves for the purpose of reuse since this practice has been associated with transmission of pathogens. Category IB
- IV.B.2.d. Change gloves during patient care if the hands will move from a contaminated body-site (e.g., perineal area) to a clean body-site (e.g., face). Category II

8

PPE: Gowns

- IV.B.3.a. Wear a gown, that is appropriate to the task, to protect skin and prevent soiling or contamination of clothing during procedures and patient-care activities when contact with blood, body fluids, secretions, or excretions is anticipated. Category IB/IC
- IV.B.3.a.i. Wear a gown for direct patient contact if the patient has uncontained secretions or excretions. Category IB/IC
- IV.B.3.a.ii. Remove gown and perform hand hygiene before leaving the patient's environment. Category IB/IC
- IV.B.3.b. Do not reuse gowns, even for repeated contacts with the same patient. Category II
- IV.B.3.c. Routine donning of gowns upon entrance into a high risk unit (e.g., ICU, NICU, HSCT unit) is not indicated. Category IB

9

PPE: Mouth, Nose, Eye Protection

- IV.B.4.a. Use PPE to protect the mucous membranes of the eyes, nose and mouth during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions and excretions. Select masks, goggles, face shields, and combinations of each according to the need anticipated by the task performed. Category IB/IB
- IV.B.5. During aerosol-generating procedures (e.g., bronchoscopy, suctioning of the respiratory tract [if not using in-line suction catheters], endotracheal intubation) in patients who are not suspected of being infected with an agent for which respiratory protection is otherwise recommended (e.g., *M. tuberculosis*, SARS or hemorrhagic fever viruses), wear one of the following: a face shield that fully covers the front and sides of the face, a mask with attached shield, or a mask and goggles (in addition to gloves and gown).[95, 96, 113, 126, 93, 94, 134] Category IB

10

Respiratory Hygiene/Cough Etiquette

- IV.E.1. Educate healthcare personnel on the importance of source control measures to contain respiratory secretions to prevent droplet and fomite transmission of respiratory pathogens, especially during seasonal outbreaks of viral respiratory tract infections (e.g., influenza, RSV, adenovirus, parainfluenza virus) in communities. Category IB
- IV.E.2. Implement the following measures to contain respiratory secretions in patients and accompanying individuals who have signs and symptoms of a respiratory infection, beginning at the point of initial encounter in a healthcare setting (e.g., triage, reception and waiting areas in emergency departments, outpatient clinics and physician offices).
- IV.E.2.a. Post signs at entrances and in strategic places (e.g., elevators, cafeterias) within ambulatory and inpatient settings with instructions to patients and other persons with symptoms of a respiratory infection to cover their mouths/noses when coughing or sneezing, use and dispose of tissues, and perform hand hygiene after hands have been in contact with respiratory secretions. Category II
- IV.E.2.b. Provide tissues and no-touch receptacles (e.g., foot-pedal-operated lid or open, plastic-lined waste basket) for disposal of tissues. Category II
- IV.E.2.c. Provide resources and instructions for performing hand hygiene in or near waiting areas in ambulatory and inpatient settings; provide conveniently-located dispensers of alcohol-based hand rubs and, where sinks are available, supplies for handwashing. Category IB
- IV.E.2.d. During periods of increased prevalence of respiratory infections in the community (e.g., as indicated by increased school absenteeism, increased number of patients seeking care for a respiratory infection), offer masks to coughing patients and other symptomatic persons (e.g., persons who accompany ill patients) upon entry into the facility or medical office and encourage them to maintain special separation, ideally a distance of at least 3 feet, from others in common waiting areas. Category IB

11

Patient Placement

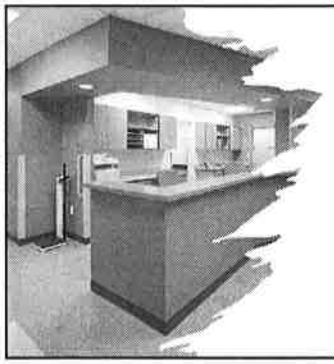
- IV.D.1. Include the potential for transmission of infectious agents in patient-placement decisions. Place patients who pose a risk for transmission to others (e.g., uncontained secretions, excretions or wound drainage; infants with suspected viral respiratory or gastrointestinal infections) in a single-patient room when available. Category IB
- IV.D.2. Determine patient placement based on the following principles: Category II
- Route(s) of transmission of the known or suspected infectious agent
- Risk factors for transmission in the infected patient
- Risk factors for adverse outcomes resulting from an HAI in other patients in the area or room being considered for patient-placement
- Availability of single-patient rooms
- Patient options for room-sharing (e.g., cohorting patients with the same infection)

12

Patient-Care Equipment and Instruments/Devices

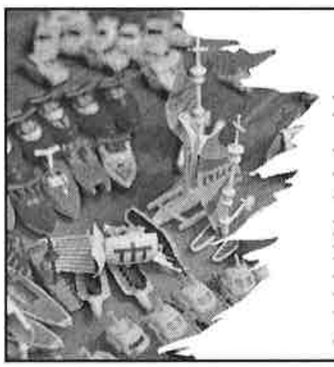
- **IV.E.1.** Establish policies and procedures for containing, transporting, and handling patient-care equipment and instruments/devices that may be contaminated with blood or body fluids.[18, 770, 975] *Category IB/IIB*
- **IV.E.2.** Remove organic material from critical and semi-critical instrument/devices, using recommended cleaning agents before high level disinfection and sterilization to enable effective disinfection and sterilization processes.[836, 991, 992] *Category IA*
- **IV.E.3.** Wear PPE (e.g., gloves, gown), according to the level of anticipated contamination, when handling patient-care equipment and instruments/devices that is visibly soiled or may have been in contact with blood or body fluids.[18, 770, 975] *Category IB/IIB*

13



Care of the Environment

14



Textiles and Laundry

15

Transmission-Based Precautions

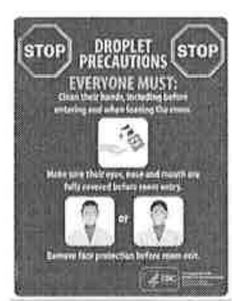
16

Contact Precautions

17

Droplet Precautions

- **Use Droplet Precautions for patients known or suspected to be infected with [illegible] that are generated by [illegible] or talking.**
- **Source control** [illegible]
- **Ensure appropriate patient placement** [illegible] settings, make decisions regarding patient placement on a case by case basis considering [illegible] risks to other patients in the room and available alternatives. In ambulatory settings, place patients who require Droplet Precautions in an exam room or cubicle as soon as possible and instruct patients to follow Respiratory Hygiene/Cough Etiquette recommendations.
- **Use personal protective equipment (PPE) appropriately.** Don mask and face [illegible] into the [illegible] or patient space.
- **Limit transport and movement of patients** outside of the room to medically [illegible]. If transport or movement outside of the room is [illegible] patient to wear a [illegible] and follow Respiratory Hygiene/Cough Etiquette.



18

Airborne Precautions

- Use Airborne Precautions for patients known or suspected to be infected with pathogens transmitted by the airborne route (e.g., tuberculosis, measles, chickenpox, disseminated herpes zoster).
- Source control: put a mask on the patient.
- Ensure appropriate patient placement in an airborne infection isolation room (AIIR) constructed according to the Guideline for Isolation Precautions. In settings where Airborne Precautions cannot be implemented due to limited engineering resources, instruct the patient and practice the patient in a private room with the door closed to reduce the likelihood of airborne transmission until the patient is either transferred to a facility with an AIIR or returned home.
- Restrict susceptible healthcare personnel from entering the room of patients known or suspected to have measles, chickenpox, disseminated zoster, or smallpox if other immune healthcare personnel are available.
- Use personal protective equipment (PPE) appropriately, including a fit-tested NIOSH-approved N95 or higher-level respirator for healthcare personnel.
- Limit transport and movement of patients outside of the room to medically necessary purposes. If transport or movement outside an AIIR is necessary, instruct patients to wear a surgical mask, if possible, and observe respiratory hygiene/cough measures. Healthcare personnel transporting patients who are on Airborne Precautions do not need to wear masks or respirator during transport if the patient is wearing a mask and infectious skin lesions are covered.
- Immunize susceptible persons as soon as possible following unprotected contact with vaccine-preventable infections (e.g., measles, varicella or smallpox).

19

Donning (Putting On) PPE

20

Doffing (Taking Off) PPE

21

Fire and Emergency Evacuation Procedures

In Case of Fire:

- Activate fire alarm
  - Located at each stairway entrance to first floor
  - Or, call 911 from nearest phone and report fire at Human Services Building on EIU campus on south 7th Street
- Fire extinguishers are located in white boxes in the north main hallway near stairwell and in the east and west hallways

Exiting the building

- Persons in classroom and clinic rooms - exit stairway in the north main hallway and proceed straight out the doors to outside of the building
- Student clinicians – escort clients from building
- Persons in waiting room, seminar room, clinician's room, and offices – exit down the stairway at the south end of the building

Building Layout

Exiting for Persons with Disabilities

- Exiting for persons with disabilities should be conducted by the Fire Department Ambulance Service
- Do not attempt to move persons with disabilities without prior training or medical equipment
- During a fire alarm, persons with disabilities should move to a stairway in the building for protection-Emergency Personnel from the Fire Dept. will respond to remove the person from the building. An intercom is located at the top of each stairway.

Emergency Assembly Point (EAP)

- The EAP is the band practice field across 7th Street to the east of the Human Services Building
- All evacuees should gather at EAP upon leaving the building
- Clinicians - help clients find family members or companions at EAP
- Alternative EAP is the quad (grassy area) on the west side of the Human Services Center toward Taylor Hall if the EAP is inaccessible

Severe Weather/Tornado Procedures

- Move to inside hallways or interior offices without windows.
- Sit on the floor and cover your head with your arms until danger has subsided.
  - The basement of Human Services Building is not accessible.

Medical Emergency

- Call 911 from nearest phone to report a medical emergency.
- Address: Human Services Center, 2nd Floor, South 7th Street on EIU Campus

Dealing with Violent Behavior

- If a person is believed to have a firearm, leave the building
- Move yourself to safety, then call security
- If you feel uncomfortable, notify the University Police to deal with the violent person

Responding to Potential Crisis Situations

- Observation – be aware throughout the day that violent behavior could occur
- Escape – plan escape route before events require escape
- Notification – notify Human Resources if you feel uncomfortable or UPD if there is potential for violence
- Documentation – aids in handling the stress and confirming that you were correct in pursuing the problem
- If needed, Shelter-In-Place, which requires building occupants to barricade themselves in their rooms

Shelter-In-Place

- Proceed to nearest available room where you can take shelter
- During a drill, once you are there:
  - Lock the door
  - Shut curtains/blinds covering windows
  - Sit/crouch in areas that are out of sight from doors and windows

Shelter-In-Place

- In a real emergency, do the same as you would in a drill, as well as:
  - Take roll call, including the names of any visitors
  - Turn off the lights and remain quiet
  - Do not open the door for anyone
  - Follow the instructions of Building Coordinators

How to know when drill/emergency is over:

- Drill: You will be notified by the Building Coordinator
- Emergency:
  - Faculty/staff will be contacted by phone or e-mail
  - Maintenance staff, campus safety, or other personnel will unlock door to room you are in to notify you that emergency has passed

Emergency Response Phone Numbers

- Chemical Spills: call Work Control
  - 581-7068
- Fire: call Charleston Fire Department
  - 911
- Police
  - 911
- Hospital: Sara Bush Lincoln Emergency Room
  - 345-2525

MANDATED REPORTING

WHAT IS DCFS?

- DCFS is the Illinois Department of Child and Family Services
  - DCFS has the primary responsibility of protecting children through the investigation of suspected abuse or neglect by parents and other caregivers in a position of trust or authority over the child.
- Most professionals in education, health care, law enforcement and social work are required by law to report suspected neglect or abuse. These individuals are called mandated reporters

WHO IS A MANDATED REPORTER?

- A person who, because of his or her profession, is legally required to **report** any suspicion of child abuse or neglect to the relevant authorities. These laws are in place to prevent children from being abused and to end any possible abuse or neglect at the earliest possible stage.

WHAT IS ABUSE?

- one whose parent or immediate family member, or any other person responsible for the child person responsible for the child's welfare or any welfare, or any individual residing in the same home as the child, or a paramour of the child's parent:
  - "any injury, by other than accidental means, which causes death, disfigurement, impairment of physical or emotional health, or loss of impairment of any bodily function"
    - Common injuries include bruises, human bites, bone fractures or burn
  - "creates a substantial risk of physical injury"
  - "acts of torture"
- This also includes sexual abuse

WHAT IS NEGLECT?

- "any child who is not receiving the proper or necessary nourishment or medically indicated treatment or other care necessary for child's wellbeing, including adequate food clothing and shelter including adequate food, clothing and shelter shelter, or who is abandoned"
  - This also includes when an adults provides inadequate supervision of a child
- "the child's environment creates a likelihood of harm to the child's health, physical well-being, or welfare" AND "the likely harm to the child is the result of a blatant disregard of parent or caretaker responsibilities"

WHAT ARE YOU REQUIRED TO DO AS A MANDATED REPORTER?

- You are required to "immediately report or cause a report to be made to DCFS" of suspected child abuse or neglect
- Willful failure to report suspected incidents of child abuse or neglect is a misdemeanor
- State law protects the identity of all mandated reporters, and you are given immunity from legal liability as a result of reports you make in good faith
  - However, you may have to testify regarding any incident you report if the case becomes the subject of legal or judicial action

GUIDELINES FOR CALLING THE CHILD ABUSE HOTLINE

- Mandated reporters "are REQUIRED to report suspected child abuse/neglect immediately when they have "reasonable cause to believe" that a child known to them in this professional capacity may be an abused or neglected child"
- As a undergraduate/graduate clinician, you SHOULD NOT call DCFS
  - If you suspect child abuse or neglect, you should contact your clinical supervisor first so they are aware of the situation.
- DCFS Hotline: 1-800-25-**ABUSE** (252-2873)

WHERE CAN I FIND ADDITIONAL INFORMATION?

- For additional information about the Act, its requirements, or the Department of Children & Family Services, you may use the following link:

https://www.illinois.gov/dcfs/Pages/default.aspx

HIPPA Training

What is HIPPA?

- HIPPA stands for "Health Insurance Portability and Accountability Act of 1996"
  - This law gave the U.S. Department of Health and Human Services (DHHS) the authority to regulate the privacy and security of patient information
- HIPPA requires providers and others who maintain health information to implement security measures to guard the integrity, confidentiality, and availability of patient information

What is PHI?

- PHI stands for "Protected Health Information"
- HIPPA defines "health information" as "any information, whether oral or recorded, in any form or medium that (A) is created or received by a healthcare provided, employer, school, or university that (B) relates to past, present, or future physical or mental health or condition of an individual , the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual"
  - Requires individually identifiable health information to be protected

What does HIPPA have to do with me?

- As a staff member or student clinician:
  - You must not use or disclose PHI except as our Privacy Policies and Procedures permit or require.
  - You must make reasonable efforts to limit access to and use of PHI to the minimum necessary to perform duties
- As a Health Care Provider:
  - We may use and disclose PHI without the individual's permission, for our:
    - own treatment activities
    - own payment activities
    - own health care operations

Authorization

- The clinic must have written authorization from the individual (or their representative) before we may use or disclose the individual's protected health information for any purpose, except as set forth by law.
- We may not rely on authorization we know has been revoked or expired.
- An individual may revoke an authorization at any time.
- Authorization does not affect actions we may have undertaken in reliance on the authorization before we learned of its revocation.

What could happen if I don't protect a client's information?

- Violating HIPPA can result in civil penalties such as civil money penalties (fines), and criminal penalties, such as fines and a federal prison sentence
- The law does not require that you know that what you did was a crime- only that you knowingly, as opposed to accidently, did what you did.
  - Ignorance of the law is no excuse
- Maximum criminal penalty if you violate HIPPA:
  10 years in prison and $250,000 fine →

How do you avoid these legal hassles?

- Use your common sense
  - If it is personal information about your client or their family, it is confidential
    - This includes all medical records, demographic information, clinic documentation, etc.
  - "Deidentify your client" when speaking to others or sending electronic communication
- Observe the "Need-to-Know" rule
  - You should only be discussing client information with people that "need to know"
    - This includes your supervisor, shadows, office personnel, etc.

Take action when you suspect a breach in HIPPA policies

- HIPPA requires reporting any and all suspected or actual breaches of confidentiality
- The first person you should report a breach to is your immediate supervisor.
  - If they are unavailable, report to the Clinic Director or Department Chair
- You should not report to the Department of Health and Human Services (DHHS) without making every effort to report to our department first

Section 3: Clinic Documentation

- 5900 Documentation
  - ICF Framework Worksheet
  - Initial Treatment Plan
  - Therapy Plan/SOAP
  - Final Semester Report
- 5910/5920
  - Diagnostic Expectations and Timelines
  - Diagnostic Plan
  - Diagnostic Report Outline
- Saving/Printing Documents
- SOAP Note Resources
- ASHA NOMs

ICF Worksheet: Person-Centered Functional Goals

Client:

Health Condition:

	Body Functions and Structures			*Activities and Participation*			*Environmental and Personal Factors*		
Background/Case Hx.									
Previous Assessment									
Recommended Assessment									
What else do you need to know?									
Do you have the information you need to plan? Area you want a goal? Need a compensatory strategy or put on hold?	***Aud Comp***	***Oral Exp***	***Written Exp***	***EF/Cog***	***Speech***	***Social***	***Behavior***	***Sensory***	***Reading Comp***
	Yes or No	Yes or No	Yes or No	Yes or No	Yes or No	Yes or No	Yes or No	Yes or No	Yes or No
	☐ goal ☐ comp ☐hold	☐ goal ☐ comp ☐hold	☐ goal ☐ comp ☐hold	☐ goal ☐ comp ☐hold	☐ goal ☐ comp ☐hold	☐ goal ☐ comp ☐hold	☐ goal ☐ comp ☐hold	☐ goal ☐ comp ☐hold	☐ goal ☐ comp ☐hold
Clinical Reasoning	*What impariments most affect function in the current setting ot at discharge, based on clinician assessment & individual report/case hx.?*			*What activities are most important to the individual in the current setting or discharge setting?*			*What personal/environmental characteristics help or hinder participation in activities or situations in the current or discharge setting?*		
Goal Areas									

Eastern Illinois University Communication Disorders and Sciences Human Services Bldg., 2nd Floor	Speech-Language-Hearing Clinic 600 Lincoln Ave. Charleston, IL 61920	Phone: 217-581-2712 Fax: 217-581-7105
Clinician:	**Initial Treatment Plan** Semester:	
Client: DOB:	Type of Service/Schedule:	

Functional Outcome Goal:	**NOMS Rating:**

Semester Goals

1.
2.
3.

Functional Outcome Goal:	**NOMS Rating:**

Semester Goals

1.
2.
3.

Functional Outcome Goal:	**NOMS Rating:**

Semester Goals

1.
2.
3.

EBP and Key Teaching Strategies:

WEEKLY THERAPY PLAN
EIU Speech-Language Hearing Clinic

Client:
Clinician:

Date:	
OBJECTIVES: **Include: Do, Condition, Criteria**	**METHODS:** **Include: RACK - Reinforcement, Activity, Cuing, Key Teaching Strategy(s)**

Progress Notes

S:

O:

A:

P:

CONFIDENTIAL CONFIDENTIAL

Final Semester Report

Name: **Date:**
DOB: **Clinician:**
Age:
Parents: Supervisor:
Address: **Diagnosis:**
Phone:

Background Information

Semester Goals and Progress

Behavioral Observations

Clinical Impressions

Recommendations

Final Semester Report

Name:
DOB:
Age:
Parents:
Address:

Phone:

Date:
Clinician:
Supervisor:

Diagnosis:

Background Information

Information in this section may include:

- Referral source
- A statement of problem/complaint
- Relevant case history including developmental, medical, social, family, educational histories
- Length and description of previous speech-language pathology services

Semester Goals and Progress

List goals and for each goal include:

- Objective data regarding the client's performance
- Description of therapy techniques or qualifying statements as appropriate.

Examination Information

May include:

- Information from the Initial Semester Report
- End of semester testing information

Behavioral Observations

May include observations regarding: cooperativeness, motivation, orientation, attention, physical impairments, effective/ineffective behavior modification techniques, etc.

Clinical Impressions

May include:

- Statement of disorder
- Severity of disorder
- Statement of whether communication/swallowing function is within normal limits

Recommendations

May include:
- Type of service needed
- Goals
- Referral for other consultations

Clinician Name
Student Clinician

Supervisor Name & credentials
Clinical Supervisor

Note: This template is intended to provide a basic outline for clinical reports. Your supervisor may have different instructions for report writing.

Memo

Printing Documents

Anything that needs printed in the front office (reports, letters, etc.) needs to be uploaded to Felicia's Sharepoint folder. When you are ready to print something, tell Felicia and she will email you a link to the folder. Please save all documents as follows:

- **Final Semester Reports**:
  - Clientslastname.firstinitial.FSR
  - (example: **Becker.T.FSR**)
  - (example for clients that attend group and individual sessions: **Becker.T.FSR-GRP** or **Becker.T.FSR-IND**
- **Diagnostic Reports:**
  - Clientslastname.firstinitial.DxRpt
  - (example: **Becker.T.DxRpt**
- **Diagnostic Cover Letter:**
  - Clientslastname.firstinitial.CoverLtr
  - (example: **Becker.T.CoverLtr**)

Expectations & Timelines for Diagnostics

Sharing diagnostics duties

Three graduate clinicians are assigned to a diagnostic and are considered the "diagnostic team." All 3 clinicians are responsible for components of the entire diagnostic process; however, some of the duties are divided among the three clinicians. The duties should be delineated as follows:

- All 3 clinicians are responsible for reviewing case history, coming up with interview questions, planning for the diagnostic, administering or actively observing assessments, and interpreting test results. Each clinician should be prepared/is expected to actively participate in all discussions regarding planning.
- All 3 clinicians are to collaboratively write the background section of the report, behavioral observations, clinical impressions, and recommendations.
- Division of duties: Administering, scoring and writing up test results
    - Each assessment will have a lead administrator, secondary administrator and observer. This should be delineated in the diagnostic plan. All 3 clinicians will need to be familiar with the assessment.
    - Lead administrator will administer the test during the dx and record on an original test form. Lead administrator will then score assessment and write up the test results.
    - The secondary administrator will simultaneously record responses on a COPY of the test form, compare those results to what lead administrator had, and double check the scoring of the original test form. Secondary administrator is to initial the top of the test form once it has been checked and necessary corrections completed.
    - Observer will be responsible for taking notes about client performance during the administration of the assessment. Observer can triple check scoring, if team decides that is necessary. Observer is responsible for proof reading the test write up on the report and will use the track changes function on Microsoft Word so that supervisor is aware that this has been completed.
    - All clinicians are expected to be able to discuss performance, scoring, and interpretation of each assessment utilized during the diagnostic regardless of their role in the process.

Initial Planning Meeting (minimally 2 weeks before the diagnostic)

- ☐ Summary of case history, reports, other submitted documents
- ☐ List of questions for parents/guardian/spouse and other professionals
- ☐ Diagnostic question: Consider possible diagnoses we can consider based on background information
- ☐ Tentative/rough diagnostic plan (what areas might we need to assess)
- ☐ Other _____

Second Planning Meeting

- ☐ Review information gathered from phone call(s) with family and other professionals
- ☐ Diagnostic question: Consider possible diagnoses we can consider based on background information
- ☐ Diagnostic plan
    - List specific areas that need to be assessed
    - List of formal assessments and rationale for why you want to administer each of the assessments
    - List of informal assessment(s), how the informal assessment(s) will be administered
    - Order of assessments
    - **Next to each assessment list the following:**
        - **Which grad student is responsible for administering and writing up the results**

- **Which grad student will also score to double check that scoring is accurate**
- **Which grad student will proof read the work**

☐ Other _____

Final Planning Meeting

☐ Final summary of diagnostic question
☐ Final diagnostic plan
☐ Order of assessments and who will be administering the assessments
☐ Other _____

Post-Diagnostic Meeting

☐ Analysis meeting to discuss:
  - Results/Scores
  - Interpretation and analysis of results (be prepared to discuss)
  - Diagnostic conclusion with formal/informal results (be prepared to discuss)

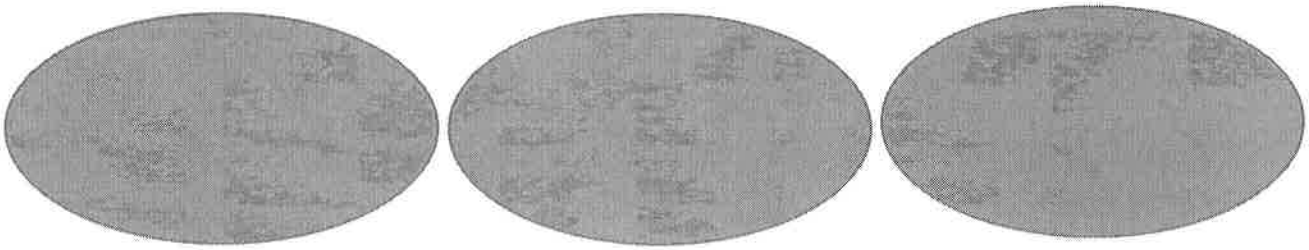
☐ First draft of diagnostic report is due _____
☐ First draft of diagnostic report should include
  - Background (include not only case history but also info learned day of dx)
  - Test descriptions and results
  - Interpretation of test results and clinical impressions
  - Goals
  - Recommendations

☐ Second draft of diagnostic report is due within _____days of supervisor feedback and should include:
  - Interpretation of test results and clinical impressions
  - Goals
  - Recommendations

☐ Subsequent drafts should be submitted in a timely manner after receiving supervisor feedback

Diagnostic Plan Worksheet

Based on referral, case history, other reports and interview: **DX QUESTION/HYPOHESIS**



Assessment Instrument (standardized, checklist, observation)	Rule In/Rule Out which of your possible dx (rationale)	Specific skills assessed	Time

CONFIDENTIAL **CONFIDENTIAL**

Diagnostic Report

Name:
DOB:
Age:
Parents:
Address:
Phone:

Date:
Clinician:
Supervisor:

Background Information

Referral and Complaint

Birth/Developmental History

Medical History

Speech and Language History

Educational History

Assessment

Behavioral Observations

Clinical Impressions

Recommendations

_____
Student name

_____
Faculty name

_____
Student name

References

Preparing Progress Notes
SOAP Notes

Fahy

Progress Reports

- Once therapy is initiated
  - MUST DOCUMENT!
  - Ongoing, frequent, regular basis
- Two types of progress reports
  - Daily
  - Periodic

Purposes of Daily Progress Notes

1. Allow you to monitor Tx plan, in order to make any necessary changes ASAP
2. Provide daily "snapshot" to other professionals also working w/client
3. Foster continuity of care, in the event that YOU are absent from work, but the CLIENT comes for Tx!

SOAP acronym:

- Subjective (S)
  - Complaints as phrased by patient
  - Your personal opinion re: relevant client behavior or status
- Objective (O)
  - Events which occurred in session
  - Data taken in session for each targeted behavior/skill
  - Types of assistance/instruction/prompting used
  - Result of that assistance/instruction/prompting
- Assessment (A)
  - Professional interpretations, conclusions
  - Diagnosis/severity/functional implications
- Plan (P)
  - Treatment plan, recommendations

Very Important SOAP Concepts!!

- If you don't write it, it didn't happen.
  - These are LEGAL documents!!
  - These are STAND-ALONE documents!!
- Write a snap-shot of the client's performance that day.
  - Tell what they CAN do, and what they CAN'T do.
  - Give the big picture, and the supporting details.
- You can write about the same things in all 4 sections, but you will write in a different style.
  - Subjective v. objective
  - Evidence for X v. making the Dx of X

Style of Writing to Use in SOAPs:

- Use sentence fragments & abbreviations appropriate to your work environment
- Each of the 4 sections requires you to use a different "voice" of writing
  - S:
    Undocumentable claims
  - O:
    Documentable evidence; exactly what happened, how well, how poorly, with what help, or was it independently, with percentages or data, at what level of difficulty, in what context
  - A:
    given the above evidence, what is your conclusion? Summary sentences; trends; comparison to previous performance
  - P:
    Recommendations; bullet-pointed short list of what to do next

SUBJECTIVE (S:)

- How the client presents
  - Affect
  - Behavior
- Quotes from the client
  - Reported history
  - Complaints, emotions, attitudes, goals
  - Response to treatment, reaction to therapy
- Your *subjective* impressions

S: Examples

- S: "He's in a mood today. Wants to go home." (Client's caregiver.)
- S: "num num num" (Client's spontaneous verbalizations during snack time.)
- S: "His teacher said he hit someone today." (Client's mother.)
- S: Client appeared distracted, inattentive, less focused today.
- S: "I see the mooning man in the orchard."

OBJECTIVE (O:)

- Objective observations of what occurred in therapy:
  - Test results
  - Data
  - Any other measurable information
- Reporting of conditions, cues, criteria
  - Under what circumstances
  - With how much and what type of cueing
  - Type of materials used
  - Degree of success, independence, performance

O: Example, Child Language

- O: Therapy cont'd this date w/focus on language processing. Client able to verbally label household items and state functions with 82% accy (was 74%), given minimal cues. Able to sort items into like categories w/82% accy (was 71%), given min prompts. After items were sorted, client spontaneously named category x2 (previously unable).

O: Example, Adult Voice, Artic

- O: Therapy cont'd today w/focus on voice and artic. Initiated client education re: vocal hygiene techniques; provided client w/list of 3 rec's (frequent hydration, minimize yelling, seek smoking cessation counseling). Provided extensive discussion & counseling; client verbalized good understanding of rec's and expressed desire, intent to follow through. Resumed work on /s/ in isolation. Client achieved 82% accy w/max cues for appropriate lingual placement and tension.

O: Example, Child, Pragmatics

- O: Therapy cont'd this date w/focus on social skills. During play-based activity using farm and animals, client requested items appropriately 75% of opportunities (was 70%). Client able to provide a response to play-mates questions 70% of time (was 62%). Turn-taking skills demonstrated 65% of time, given frequent verbal prompts. Observed initiation of relevant topics x3 this date (previously unable). Eye contact during conversation was minimal. Client tolerated shared personal space for 2 min. (ave) before moving to far corner of play area. Vocal intensity this session was WFL 60% of time; remaining utterances were inappropriately loud (yelling). Client's attention to task increased to 5 minutes (previously 3 min).Client responded positively to 3 verbal reminders to listen, work, no yelling.

O: Example, Adult Stroke

- O: Orders rec'd this date for S/L eval for this 42 yom w/Dx of L CVA, onset 8/27/04, w/ S/P R hemi. Chart review indicates decreased verbalization, inability to follow MD's directions. Pt. Seen x2 this date for initial eval of rec/exp communication and motor speech via BDAE and other informal measures. Observe min R facial droop. Articulation in conversation is generally intelligible; cues to decrease rate helpful. Auditory comprehension breaks down at complex multi-sentence level; reading comprehension not yet assessed. Written expression evidences disorganization and word omissions at sentence level; verbal expression characterized by frequent verbal paraphasias, w/minimal awareness. See full report to follow.

ASSESSMENT (A:)

- Your conclusions, based on *subjective* observations and *objective* findings:
  - Diagnosis or problem list
  - Degree of severity
  - Functional impact
- Trends in overall status
  - Progress, or lack thereof
  - How this relates to overall treatment goals

A: Example, Child ASD

- A: Client continues to present with impaired pragmatic skills consistent with diagnosis of ASD w/Asperger's tendencies; observe cont'd trend of improvement in shared space, attention, and conversation. Potential for increased social skills in structured groups remains good.

A: Example, Child Lang; Artic

- A: Cont'd progress w/verbal reasoning / processing skills; emerging naming/categorization skills observed.
- A: Emerging ability to generalize /s/ to untrained words; stimulable for /sh/. Continues to require frequent confirmation from conversational partner given moderately impaired speech intelligibility.

A: Example, Adult Dysarthria

- A: Client presents w/mild dysarthria; likely UMN; speech intelligibility mildly decreased and responds well to compensatory strats. Also presents w/mod aphasia, likely Wernicke's. Functional communication impaired in all contexts, w/all listeners, given error patterns, limited awareness, and inabilty to self-correct. Rehab potential good, given age, family support, motivation.

PLAN (P:)

- Your immediate recommendations:
  - Frequency and duration of treatment
  - Long and short term goals
  - Treatment methods or approaches
- Long term plans:
  - For discharge
  - For client/patient/family education
  - For additional testing
  - Referrals to other services

P: Example

P: Cont. Tx x2/week focusing on social skills via use of interactive toys to promote joint attention and conversation.

P: Cont ST x2/week to focus on stated goals (see full report).

P: Cont ST bid x5/week rec'd after DC from acute to inpatient.

P: Cont ST for language processing; use visual cues, structure, feedback.

P: Example

- P: Rec the following:
  - 1. ST x5/week
  - 2. Complete initial testing
  - 3. Initiate OM ex's, compensatory intelligibility strategies, training.
  - 4. Initiate aphasia Tx, to increase reliability conveying daily needs in immediate environment.
  - 5. OT consult for dressing.

Treatment Outcomes

Why Outcome Measures?

- To demonstrate treatment efficacy to our students, consumers, third party payers, legislators, and administrators
- To assist in the decision making process to continue or discontinue services
- To support writing functional treatment plans
- To improve the quality of services
- To assist in determining when alternative forms of service delivery may be appropriate
- Standard operating procedure

Why ASHA NOMS?

- Specific to communication disorders
- Applies to a comprehensive range of communication and swallowing disorders
- Applies to Pre-K through adult
- Measures functional communication and swallowing abilities
- User friendly
- Familiarizes our students with functional outcome measures now required in most settings
- Most applicable to our setting

ASHA's National Outcomes Measurement System

- Nationally, the NOMS is used to measure and evaluate a client's functional communication status over time
- Three categories:
  - Pre-K
  - K-12
  - Adults

The NOMS Functional Communication Measures (FCMs)

- Series of 7 point rating scales in various clinical areas (e.g. articulation, pragmatics, spoken language production) which:
  - Describe functional abilities over time
  - Are based on Informal clinical observations of client's communication over time
- FCMs not intended to describe all aspects of a client's communication abilities
- Only those FCMs that relate to the client's treatment plan are scored

Pre-K Measures

- Articulation/Intelligibility
- Cognitive Orientation
- Pragmatics
- Spoken Language Comprehension
- Spoken Language Production
- Swallowing

Special Terms used in the FCMs for Pre-K

- Each level of FCM contains references to the intensity and frequency of the cueing and use of compensatory strategies that are required to assist the patient in becoming functional and independent in various communication situations and activities

Frequency of Cueing

- Consistent- 80-100% of the time
- Usually- 50-79% of the time
- Occasionally- 20-49% of the time
- Rarely- Less than 20% of the time

Intensity of Cueing

- **Maximal**- Multiple cues that are obvious to nonclinicians. Any combination of auditory, visual, tactile, pictorial, or written cues
- **Moderate**- Combination of cueing types, some of which may be intrusive
- **Minimal**- Subtle and only one type of cueing

Case Scenario Pre-K – Articulation/Intelligibility

- Alex is not difficult to understand. People know Alex and even those who do not know him very well can understand what he says. Sometimes people notice that his speech is different than the speech of other children his age

Case Scenario Pre-K - Pragmatics

- At her new daycare center, Jan answered some questions and responded a few times to requests from her new teacher. When Jan's father picked her up, he was not surprised to hear that Jan did not carry on conversations with her teacher or the other children, and indicated that it had also happened early on at her old daycare center. He indicated that Jan usually carries on conversations with her family and friends in the neighborhood but does not do so with people she doesn't know very well.

Case Scenario Pre-K – Spoken Language Comprehension

- During story time, Nancy is not able to understand most of the conversation. However, when the teacher stands in front of her, provides a lot of repetition, and refocuses Nancy's attention, she is able to answer simple questions about pictures in a book.

Adult Measures

- Motor Speech
- Voice
- Fluency
- Swallowing
- Spoken Language Comprehension
- Spoken Language Expression
- Writing
- Reading
- Attention
- Memory
- Pragmatics

Special Terms used in the FCMs for Adult

- Each level of FCM contains references to the intensity and frequency of the cueing and use of compensatory strategies that are required to assist the patient in becoming functional and independent in various communication situations and activities

Frequency of Cueing

- Consistent- 80-100% of the time
- Usually- 50-79% of the time
- Occasionally- 20-49% of the time
- Rarely- Less than 20% of the time

Intensity of Cueing

- **Maximal**- Multiple cues that are obvious to nonclinicians. Any combination of auditory, visual, tactile, pictorial, or written cues
- **Moderate**- Combination of cueing types, some of which may be intrusive
- **Minimal**- Subtle and only one type of cueing

Case Scenario Adult- Memory

- In order for Mr. Orrosco to successfully dress, the nurse must always point out the pictures of clothing taped to his dresser in order for him to find his clothing. He is able to recall the names of family members only when he is specifically directed to look at pictures and names of his family which are posted on his bulletin board.

Case Scenario Adult -Voice

- Dr. Ripken has intermittent hoarseness, pitch breaks, and occasional aphonia which is at times noticeable to both her patients and colleagues. Her family reports that she is sometimes difficult to hear in the evenings after seeing patients, and has had to drop out of the church choir

K-12 Measures

- Fluency
- Intelligibility
- Pragmatics
- Speech Sound Production
- Spoken Language Comprehension
- Spoken Language Production
- Voice

Special Terms Used in the FCMs for K-12

- FCMs contain references to the frequency of responses as well as to the communication demand and the amount of support the student requires to be a functional and independent communicator.
- When scoring FCMs you will be asked to rate clients based on the following terms:
  - Frequency
  - Support
  - Intensity of support
  - Demand

Frequency

- Consistent- 80-100% of the time
- Usually- 50-79% of the time
- Occasionally- 20-49% of the time
- Rarely- Less than 20% of the time

- Example: (Intelligibility)
  - Connected speech rarely understood (level 2)
  - Connected speech occasionally understood (level 3)
  - Connected speech consistently understood (level 5)

Support

- The structure, classroom modifications or accommodations, that are required to assist the student in becoming a functional and independent communicator in a variety of situations
- Support includes but is not limited to the following:
  - Allowing additional processing time
  - Rereading information
  - Providing repetition
  - Using semantic definitions
  - Probing questions

Intensity of Support

- **Maximum** – Multiple cues/classroom modifications that are obvious to nonclinicians.
- **Minimal** – Only one type of cueing/classroom modification that is subtle and nonintrusive
- Support will vary from student to student and will be dependent upon the teacher's expectations and the educational/communicative demands of the classroom

Demand

- Demand is the educational, social, or extracurricular activity in which the student is engaged and varies according to the student's chronological age
- FCMs that refer to demand
  - Verbal
  - Comprehension
  - Vocal
  - Pragmatic

Case Scenario K-12 – Spoken Language Production

- Jerry is in second grade. When talking to his friends in the lunchroom, his sentences are generally like his friends', but are sometimes shorter, and he uses simpler vocabulary to label objects. When the class talks about a field trip, his sentences hardly ever sound like his classmates'. In these types of discussions, his teacher always has to help him by asking very easy questions.

Case Scenario K-12 – Speech Sound Production

- Ryan's classmates sometimes notice that he doesn't say his /l/ correctly during science club activities. Ryan always hears his own errors. When Ryan produces a word incorrectly, he can sometimes say it again without any help. When participating in discussions in reading class, he can say the sound correctly when he has a card on his desk with "L" written on it.

Case Scenario K-12 - Fluency

- Paul is a fifth grader who has a severe stuttering problem. His disfluencies are intense and of long duration accompanied by secondary characteristics that occur continuously. Paul is unintelligible most of the time. Typically, he becomes so frustrated that he just gives up talking and writes down what he wants to say. He doesn't have any close friends among his classmates and avoids his church youth group as well as other extracurricular activities.

Guidelines for Scoring FCMs

- Select FCMs based on client's goals
- Use CA as referent in determining abilities.
- Carefully review the descriptions of all 7 levels for each FCM category
- Determine the level that best reflects the majority of the client's communication and/or swallowing abilities
- Consider the amount of support, the complexity of the information, and the environment in which the client is able to communicate

Functional Outcomes Rating
Revised 1/25/2012

Client Name: DOB:

Clinician/Supervisor: Term:

FCM	**Initial Rating** **Date:** _____	**Final Rating** **Date:** _____
Pre-K		
Artic/Intelligibility	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Cognitive Orientation	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Pragmatics	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Spoken Language Comp.	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Spoken Lang. Production	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Swallowing	1 2 3 4 5 6 7	1 2 3 4 5 6 7
K-12		
Composition	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Emergent Literacy	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Fluency	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Intelligibility	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Pragmatics	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Reading Comprehension	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Speech Sound Production	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Spoken Language Comp.	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Spoken Lang. Production	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Voice	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Word Recognition	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Writing Accuracy	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Adult		
Alaryngeal Communication	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Attention	1 2 3 4 5 6 7	1 2 3 4 5 6 7
AAC	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Fluency	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Memory	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Motor Speech	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Pragmatics	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Problem Solving	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Reading	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Spoken Language Comp.	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Spoken Language Express.	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Swallowing	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Voice	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Voice Following Tach.	1 2 3 4 5 6 7	1 2 3 4 5 6 7
Writing	1 2 3 4 5 6 7	1 2 3 4 5 6 7

Comments: _____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Supervisor Initials: _____ _____

Section 4: Evaluation

- 5900 Written Midterm – instructions, guideline for preparation, rubric
- 5900 Oral Final – instructions and rubric
- Evaluation form – 5900 and 5910/5920
- Formative Assessment – Calipso Form

5900 Midterm Student Handout

- Format: Clinicians will receive 3 questions to answer for EACH client. Clinicians should bring laptop. Midterm will be administered through D2L. Answers should be around a paragraph long.
- Questions:
    - Questions will come from the following categories: 1.) Diagnosis and Communication Deficits 2.) Goals and Rationale 3.) Methods and Research/EBP 4.) Interprofessional Communication
    - Questions will be chosen by your supervisor, specific to your case.
    - Questions will assess your ability to describe important concepts and provide rationale for clinical decisions regarding your client (e.g. diagnosis, deficits) and your client's treatment (goals, methodology, EBP).
    - Your answers should be specific to your client.
    - Use the "Giving Rationale and Insights in Essential Clinical Decision Making" document to help you prepare. (attached)
- Handout:
    - You will be allowed to bring a one page handout on each client to the midterm.
    - Handout is to be one-sided and typed using 10 pt or greater font.
    - You can include anything you want on the handout.
    - Handout will be turned in with the midterm.
- Each supervisor will grade your midterm using a 3 point rating scale (rubric attached)
- Students must achieve a passing score on Overall Average Score. If passing score is not achieved, students will be required to rewrite the response or demonstrate proficient understanding of the topic orally.
- Written midterm performance will be considered in clinic grade.

GIVING RATIONALE AND INSIGHTS IN ESSENTIAL CLINICAL DECISION MAKING

The following should be used to help you understand background/diagnosis of your client, prepare for initial conference with supervisor, guide your clinical decisions, and understand the rationale for those decisions. This handout should also be used as a self-check throughout the semester as well as to help prepare you for the clinical practicum midterm and oral final presentation.

1. **IDENTIFYING AND DESCRIBING DEFICITS**
    a. What is the client's given diagnosis?
    b. What are differential features of this diagnosis?
    c. What does this client's version of that diagnosis look like?
    d. How severe is my client's version of that diagnosis?
    e. Can I describe my client's presentation of his diagnosis?
    f. Do I 'get' why someone diagnosed my client with this?
    g. What if I don't agree with that diagnosis?
    h. Are there other potential communication diagnoses (if not already identified)?
        i. How might I confirm/refute that?
        ii. What are differential features of this potential diagnosis?
        iii. What kinds of assessment tools or procedures would I have to use, in order to capture that kind of information or data?
        iv. Can I administer those tests? What kind of data will I obtain?
        v. Do I need interviews, questionnaires, play-based, narrative, standardized tests, or what?
    i. Do I have enough diagnostic information to draw conclusions?
    j. What are my client's comorbid diagnoses?
        i. Are they related to his primary diagnosis, or are these separate but often-affiliated problems?
        ii. Do I need to also worry about these problems?
        iii. How so? What other professionals are involved, and why?
    k. Does my client have behavior problems? If yes, do I understand WHY my client has behavioral problems/coping problems/regulating problems/insight problems?
    l. Do I have a hypothesis about prognosis? What is likely to change/not change with treatment? What is the expected rate of change? What factors are most likely to impact progress?

2. **DIGGING INTO THE CASE- INDEPENDENT RESEARCH**
    a. Do I have any class notes, books, resource materials that would apply to this situation?
    b. Is my EBP fairly current, and have I at least looked through course material to see if there are any additional, relevant resources that would apply to this case?
    c. Have I done any kind of search for EBP to support my efforts – did I use the first thing I found or did I find a variety of options and consider what is best for my client and why? Can I describe the amount and type of evidence available on the topic?
    d. Did I speak to client to understand his priorities? Did I speak to family members, teachers, etc to understand their insights on impact of deficit and priorities?
    e. Has there been past treatment? Do I understand what kind of treatment has been provided in the past? What has changed over how much time? What factors might have been influencing past treatment progress?

3. **TREATMENT GOALS**
    a. Why am I doing these goals? What are they for?
    b. Do I have any evidence to support the use of goals such as these, for this client?
    c. What are the client's underlying problems, and how do they impact functional communication, or academic performance, or social interactions, or vocational ability?
    d. Do I have a hierarchy of tasks? Am I starting at the appropriate level – what can he do now, what are the next steps?

4. **TREATMENT METHODS**
    a. What actual methods do I use to do this kind of therapy? Where is my EBP?
    b. Is what I'm doing an actual method/skilled therapy, or am I just doing something that my grandmother or my neighbor could do?
        i. Is there a cueing hierarchy, or a particular methodological approach, for this kind of therapy? Or do I need to generate a cueing hierarchy myself?
        ii. What kinds of cues, prompts, scaffolding, elicitations, etc., do I use, and WHY?
        iii. Is the client responsive to these methods? What if he isn't, then what?-
            1. Is the goal/task too difficult?
            2. Are there other treatment techniques/cuing that might work better?
            3. What else could be affecting progress? Motivation, attention, etc?
        iv. What am I taking data on?
        v. Do I know how to take data on this? Does my data reflect the client's independent skills and/or skills with cueing and support?

5. **COMMUNICATING AND EXPLAINING TO COLLEAGUES, FAMILY, CLIENT**
    a. To other SLPs, Medical or Educational Professionals
        i. What are the main, essential pieces of information that I must tell about?
        ii. How do I make sure that I explain necessary, relevant information to my colleagues, so that they will understand this client?
        iii. Can I explain ideas and information specifically, precisely, and accurately?
        iv. If I develop a handout or written summary, does it tell the reader something more than just a 'laundry list' of general/vague ideas?
    b. To Family/Client or other non-professionals
        i. Can I describe the client's deficits and the functional impact of those deficits in layman's terms without jargon?
        ii. Can I explain and answer questions about the diagnosis or prognosis in a way that makes sense to the client?
        iii. Can I describe treatment approaches and progress in layman's terms without jargon?

Midterm Evaluation Rubric

Student _____ Client initials:_____

Supervisor _____

Areas	Content	Critical Thinking	Writing	Average
Question 1				
Question 2				
Question 3				

Overall Average Score _____

Scoring Categories:

Content: Student presents accurate, relevant, and important content. Student demonstrates an understanding of theory and constructs.

Critical Thinking: Student answers questions by offering insight, analysis, rationale and evidence in an organized, focused manner.

Writing: Writing is fluent, clear, logical, concise and well-organized. Student uses terminology and style appropriate for the audience. Writing is free of distraction of gross mechanical and grammatical errors.

Scoring Criteria:
Answers to each question will be rated using a 3 point scale.

1 = Written response demonstrates EMERGING understanding of topic
2 = Written response demonstrates DEVELOPING understanding of topic
3 = Written response demonstrates ESTABLISHED understanding of topic

Grading Scale:
Students must achieve a passing score on Overall Average Score. If passing score is not achieved, students will be required to rewrite the response or demonstrate proficient understanding of the topic orally.

1.86 – 3.0 = Pass
1.0 – 1.85 = Fail

CDS 5900 Oral Final Presentation Student Instructions

Student clinicians will complete an oral final presentation for each section of 5900. Students will be required to create a one page handout and orally present the following information regarding their client to a faculty member other than their supervisor:

- Client diagnosis and deficit areas: Clinician should state client's treatment diagnosis/diagnoses and provide a description about the client's specific profile within that diagnosis, focusing on the primary deficit areas and how it affects approach to therapy (i.e. How it impacts clinical decision making and intervention plan). If client has multiple diagnoses, clinician should include all in the discussion, but focus on the primary diagnosis.
- Rationale for therapy goals: Clinician should discuss what the client is working on and why those goals were chosen to be the focus of this semester. Clinician should provide a logically sequenced narrative, including thought process in how goals were determined.
- Treatment techniques: Clinician should briefly describe methods for each goal area, including: techniques used to teach target skills, cuing hierarchy, and feedback methods. Activities used may be mentioned, but focus should be primarily on specific treatment methods.
- Clinician should include evidence-based practice references on handout. These do not need to be discussed during the presentation, but clinician should be prepared to answer questions about their resources.

Students will have 10 minutes to discuss their case. Clinicians should provide a copy of their handout to the supervisors the day of the oral final. Clinicians can reference their one page handout throughout the presentation, but should not read directly from their handout. Notecards are not allowed. Students should exhibit professionalism and talk freely and comfortably about their case, refraining from scripting and memorizing the entire presentation.

Faculty will have 5 minutes to ask follow up questions. A five point rating scale will be used to rate the student across content, critical thinking and oral fluency. The ratings will be averaged to determine the total grade. The grade for the oral final presentation will make up 10% of the student's total grade for CDS 5900.

5900 Oral Final Evaluation Rubric

Student: _____

Client initials/Supervisor:_____

Faculty: _____ _____

Areas	Content (relevance & accuracy)	Critical Thinking (makes connections, rationale & defense)	Oral Fluency	Average
Client diagnosis and deficit areas				
Treatment goals and rationale				
Treatment techniques/ Methodology				

Overall Average Score _____

Scoring Categories:

Content:	Student presents accurate, relevant, and important content.
Critical Thinking:	Student offers insight, analysis, rationale, connections and evidence.
Oral Fluency:	Oral expression is fluent, clear, logical, concise and organized. Student speaks comfortably about case.

Scoring Criteria:

Answers to each question will be rated using a 3 point scale.

1 = Oral response demonstrates EMERGING understanding of topic
2 = Oral response demonstrates DEVELOPING understanding of topic
3 = Oral response demonstrates ESTABLISHED understanding of topic

Grading Scale:

Students must achieve a passing score on Overall Average Score. If passing score is not achieved, students will be required to complete additional assignment(s)

1.86 – 3.0 = Pass
1.0 – 1.85 = Fail

CDS 5910/5920
Diagnostic Evaluation Form

Clinician:		**Supervisor:**	
Semester:		**Client Initials:**	

Rating Scale		**Grading Scale**	
3	Established	A	2.4-3.0
2	Developing	B	1.86-2.39
1	Emerging	C	1.0-1.85

Clinical Skills		**Final**
Diagnostic Planning		
1	Prepares for supervisory conferences utilizing available resources (e.g., client file and diagnostic portfolio, etc.)	
2	Reviews file to collect case history information to generate appropriate case history questions, integrating information from clients/patients, family, caregivers, teachers, and relevant others, including other professionals	
3	Selects or develops appropriate formal and informal assessments with consideration for client's cultural variables and individual needs	
4	Designs appropriate assessment plans with logically sequenced procedures and activities	
Administration & Scoring		
5	Administers, scores, and interprets standardized tests/results accurately	
6	Administers and analyzes informal assessments	
7	Demonstrates effective behavior management skills and motivates client	
8	Adapts and modifies assessment procedures to meet client/patient needs	
9	Communicates preliminary results to client/family members and others as needed	
Written Report		
10	Completes comprehensive background documentation	
11	Reports and explains assessment results accurately including relevant details and examples	
12	Documents related aspects of behavior (e.g., developmental skills, physical concomitants, interpersonal,	
13	Develops appropriate and thorough clinical impressions and recommendations specific to client	
14	Appropriately summarizes relevant information to present written content in logically sequenced, organized manner	
15	Uses appropriate grammar, syntax, format, spelling, and professional terminology in reports	1
	Average Rating of Clinical Skills	**1.00**

Clinical Foundations		**Final**
1	Demonstrates initiative (actively participates, generates ideas, seeks collaboration and resources)	
2	Demonstrates analysis (interprets, integrates, synthesizes, engages in self evaluation)	
3	Demonstrates critical thinking for decision making (integrates EBP, clinical judgement, recommendations, diagnosis, problem solving)	
4	Demonstrates ability to monitor and display flexibility (engages in self evaluation, aware of bias, makes adjustments, anticipates needs, implements feedback)	
5	Demonstrates professionalism (adheres to code of ethics; receptive to feedback; prepared and organized; maintains appropriate physical appearance; adheres to timelines, has good attendance and is punctual; demonstrates empathy, enthusiasm, and passion for client)	
6	Collaborates effectively with colleagues and other professionals throughout the diagnostic process	1
	Average Rating of Clinical Foundations	**1.00**

Total Rating (average of clinical skills and clinical foundations total ratings)	**1.00**
	C

ATTENTION SUPERVISORS

Upon completion of 5910 grade, submit student information and rating here: [redacted]

Strengths & Weaknesses/Comments:

Essential Functions:

CDS 4900/5900
Midterm/Final Evaluation Form

Clinician:	**Supervisor:**
Semester:	**Client Initials:**

Rating Scale		**Grading Scale**	
3	Established	A	2.4-3.0
2	Developing	B	1.86-2.39
1	Emerging	C	1.0-1.85

	Clinical Skills (Ratings correspond with formative assessment items on Calipso rating scale)	**Midterm**	**Final**
1	Collects case history information and integrates information from clients/patients, family, caregivers, teachers, and relevant others, including other professionals (CFCC V-B, 1b)		
2	Selects appropriate evaluation procedures (CFCC V-B, 1c)		
3	Administers non-standardized and standardized tests correctly (CFCC V-B, 1c)		
4	Develops setting-appropriate intervention plans with measurable and achievable goals (CFCC IV-D, V-B, 2a)		
5	Selects or develops and uses appropriate materials and instrumentation (CFCC V-B, 2c)		
6	Provides appropriate introduction/explanation of tasks		
7	Uses appropriate models, prompts or cues. Allows time for patient response.		
8	Demonstrates effective behavior management skills and motivates client		
9	Measures and evaluates client/patient performance and progress (CFCC V-B, 2d)		
10	Modifies intervention plans, strategies, materials, or instrumentation to meet individual client/patient needs (CFCC V-B, 2e) (Int #5)		
11	Includes complete and accurate details in therapy plans and SOAP notes		
12	Appropriately summarizes and organizes relevent information in reports		
13	Generates appropriate clinical impressions and recommendations specific to client in reports		
14	Uses appropriate grammar, format and spelling in weekly documentation and reports		
15	Finds and implements appropriate EBP to guide clinical decisions		
16	Demonstrates skills in oral communication sufficient for entry into professional practice (CFCC V-A)	1.00	1.00
	Average Rating of Clinical Skills	1.00	1.00

	Clinical Foundations	**Midterm**	**Final**
1	Demonstrates initiative (actively participates, generates ideas, seeks collaboration and resources)		
2	Demonstrates analysis (interprets, integrates, synthesizes, engages in self evaluation)		
3	Demonstrates critical thinking for decision making (integrates EBP, clinical judgement, recommendations, diagnosis, problem solving)		
4	Demonstrates ability to monitor and display flexibility (engages in self evaluation, aware of bias, makes adjustments, anticipates needs, implements feedback)		
5	Demonstrates professionalism (adheres to code of ethics; receptive to feedback; prepared and organized; maintains appropriate physical appearance; adheres to timelines, has good attendance and is punctual; demonstrates empathy, enthusiasm; effective collaboration; and passion for client)	1.00	1.00
	Average Rating of Clinical Foundations	1.00	1.00
	Total Rating (average of clinical skills and clinical foundations total ratings)	1.00	1.00
		C	C

Strengths & Weaknesses/Comments:

Essential Functions:

Eastern Illinois University
CALIPSO
Performance Evaluation
Printed for
Becker, Trina Marie

Performance Evaluation

Evaluation saved. You can now enter the scores.

Supervisor:

*Student:

*Site: EIU Clinic

*Evaluation Type: Final

*Semester:

*Course number:

*Patient population (check all that apply):

- [ ] Young Child (0-5)
- [x] Child (6-17)
- [ ] Adult (18-64)
- [ ] Older adult (65+)

* **Severity of Disorders (check all that apply):**

- [ ] Within Normal Limits
- [ ] Mild
- [ ] Moderate
- [ ] Severe

Interprofessional (or collaborative) practice (IPP) includes (check all that apply): [?]

- [ ] Audiologist
- [ ] Dentist
- [ ] Dietitian
- [ ] Family Member
- [ ] Interpreter
- [ ] Music/Creative Arts Therapist
- [ ] Nurse/Nurse Practitioner

Cultural and Linguistic Variables (check all that apply when the variables for the client/patient differ from that of the student): [?]

- [ ] Age
- [ ] Bilingual/Multilingual
- [ ] d/Deaf and Hard of Hearing
- [x] Disability
- [ ] Ethnicity
- [ ] Gender Expression

- [ ] Occupational Therapist
- [ ] Pharmacist
- [ ] Physical Therapist
- [ ] Physician
- [ ] Physician Assistant
- [ ] Psychologist/School Psychologist
- [ ] Recreational Therapist
- [ ] Respiratory Therapist
- [ ] Social Worker
- [ ] Special Educator
- [ ] Teacher (classroom, ESL, resource, etc.)
- [ ] Vocational Rehabilitation Counselor
- [ ] Other
- [ ] Gender Identity
- [ ] National Origin
- [ ] Non-Verbal Language
- [ ] Race
- [ ] Religion
- [ ] Sex
- [ ] Sexual orientation
- [ ] Verbal Language
- [ ] Veteran Status
- [ ] Other

Save

PERFORMANCE RATING SCALE
Click to see Rating Scale

Please refer to the Performance Rating Scale for grading criteria. Use a score between 1 and 5, in 0.25 increments (1.25, 1.5 etc.)

1 - Unacceptable Performance
2 - Needs Improvement in Performance/Maximum Support
3 - Moderately Acceptable Performance/ Moderate Support
4 - Meets Performance Expectations/Minimal Support
5 - Exceeds Performance Expectations/Independent

* If n/a, please leave space blank

Evaluation	Speech Sound Production [?]	Fluency [?]	Voice [?]	Language [?]	Hearing [?]	Swallowing [?]	Cognition [?]	Social Aspects [?]	AAC [?]
	Refer to Performance Rating Scale above and place number corresponding to skill level in every observed box.								
1. Conducts screening and prevention procedures, including prevention activities (CFCC V-B, 1a)									
2. Demonstrates current knowledge of the principles and methods of prevention and assessment, including consideration of anatomical/physiological, psychological, developmental, and linguistic and cultural correlates (CFCC IV-D)									
3. Collects case history information and integrates information from clients/patients, family, caregivers, teachers, and relevant others, including other professionals (CFCC V-B, 1b)									
4. Selects appropriate evaluation procedures (CFCC V-B, 1c) [?]									
5. Administers non-standardized and standardized tests correctly (CFCC V-B, 1c) [?]									

6. Adapts evaluation procedures to meet the needs of individuals receiving services (CFCC V-B, 1d)									
7. Demonstrates knowledge of communication and swallowing disorders and differences (CFCC IV-C) [?]									
8. Interprets, integrates, and synthesizes all information to develop diagnoses (CFCC V-B, 1e)									
9. Interprets, integrates, and synthesizes all information to make appropriate recommendations for intervention (CFCC V-B, 1e)									
10. Completes administrative and reporting functions necessary to support evaluation (CFCC V-B, 1f)									
11. Refers clients/patients for appropriate services (CFCC V-B, 1g) [?]									
Score totals:	0	0	0	0	0	0	0	0	0
Total number of items scored: 0 Total number of points: 0 Section Average: 0									

Save

Intervention	Speech Sound Production [?]	Fluency [?]	Voice [?]	Language [?]	Hearing [?]	Swallowing [?]	Cognition [?]	Social Aspects [?]	AAC [?]
	Refer to Performance Rating Scale above and place number corresponding to skill level in every observed box.								
1. Develops setting-appropriate intervention plans with measurable and achievable goals that meets client/patient needs, demonstrating knowledge of the principles of intervention and including consideration of anatomical/physiological, developmental, and linguistic cultural correlates. Collaborates with clients/patients and relevant others in the planning process (CFCC IV-D, V-B, 2a)									
2. Implements intervention plans that involve clients/patients and relevant others in the intervention process (CFCC V-B, 2b)									
3. Selects or develops and uses appropriate materials and instrumentation (CFCC V-B, 2c)									
4. Measures and evaluates clients'/patients' performance and progress (CFCC V-B, 2d)									
5. Modifies intervention plans, strategies, materials, or instrumentation to meet individual client/patient needs (CFCC V-B, 2e)									
6. Completes administrative and reporting functions necessary to support intervention (CFCC V-B, 2f)									
7. Identifies and refers patients for services as appropriate (CFCC V-B, 2g) [?]									
Score totals:	0	0	0	0	0	0	0	0	0

Total number of items scored: 0 Total number of points: 0 Section Average: 0

Save

Additional Clinical Skills	Score
1. Sequences tasks to meet objectives	
2. Provides appropriate introduction/explanation of tasks	
3. Uses appropriate models, prompts or cues. Allows time for patient response.	
4. Demonstrates effective behavior management skills	
5. Practices diversity, equity and inclusion (CAA 3.4B)	
6. Addresses culture and language in service delivery that includes cultural humility, cultural responsiveness, and cultural competence (CAA 3.4B)	
7. Demonstrates clinical education and supervision skills. Demonstrates a basic understanding of and receives exposure to the supervision process. (CAA 3.1.6B) [?]	
Total number of items scored: 0 Total number of points: 0 Section Average: 0	

Save

Professional Practice, Interaction and Personal Qualities	Score
1. Demonstrates knowledge of basic human communication and swallowing processes. Demonstrates the ability to integrate information pertaining to normal and abnormal human development across the life span (CFCC IV-B; CAA 3.1.6B) [?]	
2. Demonstrates knowledge of processes used in research and integrates research principles into evidence-based clinical practice (CFCC IV-F; CAA 3.1.1B Evidenced-Based Practice) [?]	
3. Demonstrates knowledge of contemporary professional issues that affect Speech-Language Pathology (CFCC IV-G; CAA 3.1.1B) [?]	
4. Demonstrates knowledge of entry level and advanced certifications, licensure, and other relevant professional credentials, as well as local, state, and national regulations and policies relevant to professional practice (CFCC IV-H)	
5. Communicates effectively, recognizing the needs, values, preferred mode of communication, and cultural/linguistic background of the individual(s) receiving services, family, caregivers, and relevant others (CFCC V-B, 3a; CAA 3.1.1B Effective Communication Skills, CAA 3.1.6B) [?]	
6. Provides counseling regarding communication and swallowing disorders to clients/patients, family, caregivers, and relevant others (CFCC V-B, 3c; CAA 3.1.6B) [?]	
7. Manages the care of individuals receiving services to ensure an interprofessional, team-based collaborative practice (CFCC V-B, 3b; CAA 3.1.1B) [?]	
8. Demonstrates skills in oral and other forms of communication sufficient for entry into professional practice (CFCC V-A) [?]	
9. Demonstrates skills in written communication sufficient for entry into professional practice (CFCC V-A) [?]	
10. Demonstrates knowledge of standards of ethical conduct, behaves professionally and protects client welfare (CFCC IV-E, V-B, 3d; CAA 3.1.1B-Accountability; 3.8B) [?]	

11. Demonstrates an understanding of the effects of own actions and makes appropriate changes as needed (CAA 3.1.1B - Accountability)	
12. Demonstrates professionalism (CAA 3.1.1B - Professional Duty, 3.1.6B) [?]	
Total number of items scored: 0 Total number of points: 0 Section Average: 0	

Save

Met All	Not Met All	(N/A) All	Met/Not Met
○	○	◉	1. Demonstrates openness and responsiveness to clinical supervision and suggestions
○	○	◉	2. Personal appearance is professional and appropriate for the clinical setting
○	○	◉	3. Displays organization and preparedness for all clinical sessions
○	○	◉	4. Practices the principles of universal precautions to prevent the spread of infectious and contagious diseases (CAA 3.8B)
○	○	◉	5. Differentiates service delivery models based on practice sites (e.g., hospital, school, private practice) (CAA 3.1.1B - Accountability)
○	○	◉	6. Explains healthcare landscape and how to facilitate access to services in the healthcare sector (CAA 3.1.1B - Accountability)
○	○	◉	7. Explains educational landscape and how to facilitate access to services in the educational sector (CAA 3.1.1B - Accountability)
○	○	◉	8. Identifies and acknowledges the impact of both implicit and explicit bias in clinical service delivery and actively explores individual biases and how they relate to clinical services (CAA 3.4B)
○	○	◉	9. Identifies and acknowledges the impact of how their own set of cultural and linguistic variables affects clients/patients/students' care (CAA 3.4B) [?]
○	○	◉	10. Identifies and acknowledges the impact cultural and linguistic variables of the individual served may have on delivery of effective care (CAA 3.4B) [?]
○	○	◉	11. Identifies and acknowledges the interaction of cultural and linguistic variables between caregivers and the individual served (CAA 3.4B) [?]
○	○	◉	12. Identifies and acknowledges the social determinants of health and environmental factors for individuals served and how these determinants relate to clinical services (CAA 3.4B) [?]
○	○	◉	13. Identifies and acknowledges the impact of multiple languages. Explores approaches to address bilingual/multilingual individuals requiring services, including understanding the difference in cultural perspectives of being d/Deaf and acknowledge Deaf cultural identities. (CAA 3.4B)
○	○	◉	14. Recognizes that cultural and linguistic diversity exists among various groups (including d/Deaf and hard of hearing individuals) and fosters the acquisition and use of all languages (verbal and nonverbal), in accordance with individual priorities and needs (CAA 3.4B)
○	○	◉	15. Engages in self-assessment to improve effectiveness in the delivery of clinical services (CAA 3.1.6B)

Save

Strengths:

Improvements since last evaluation if applicable:

Opportunities for growth:

Recommendations for continued growth:

Considering the student's knowledge and experience obtained thus far in the program, is the student meeting your expectations? Is the student performing above expectations, meeting expectations or performing below expectations?:

Do you recommend an intervention or action plan for this student? If yes, what skills should be supported and what specific recommendations do you have for the intervention or action plan?:

Total points (all sections included): 0 Adjustment: 0.0
divided by total number of items 0
Evaluation score: 0
Letter grade unsatisfactory performance

By entering the student's name, I verify that this evaluation has been reviewed and discussed with the student prior to final submission.

Student name: Date reviewed:

I verify that this evaluation is being submitted by the assigned clinical educator/supervisor and that I have mentored/educated the above-named student.

*Clinical educator/supervisor name: *Date completed:

☐ Final submission (if this box is checked, no more changes will be allowed!)

Save

Standards referenced herein are those contained in the Membership and Certification Handbook of the American Speech-Language-Hearing Association. Readers are directed to the ASHA Web site to access the standards in their entirety: CFCC Standards | CAA Standards

Section 5: Technology

- Department Laptops
  - OnBase Instructions
  - CDS Video System
- PantherShare Instructions (SharePoint)
- CDS technology for clinic and checkout procedures

CDS TECHNOLOGY

OFFICE NUMBER: 2204

NEW CHANGES TO CDS WIFI

- There will no longer be CDS WIFI
- 10 CDS laptops are available for checkout
  - For CDS Video and OnBase access
- Therefore, you will no longer be able to access CDS video from personal laptop

HOW DO I CHECK OUT A CDS LAPTOP?

- Come to RM 2204 (Tech GA office)
- CDS laptops will be in cabinets for checkout
- Scan the QR code on top of laptop (similar to MC)
- Restart laptop before leaving

- I will post a sign-up sheet on my door for everyone to choose a time to login to a CDS laptop to make sure you have access
  - I will have written proof, so I know who comes in and gets checked
  - BRING personal laptop!!

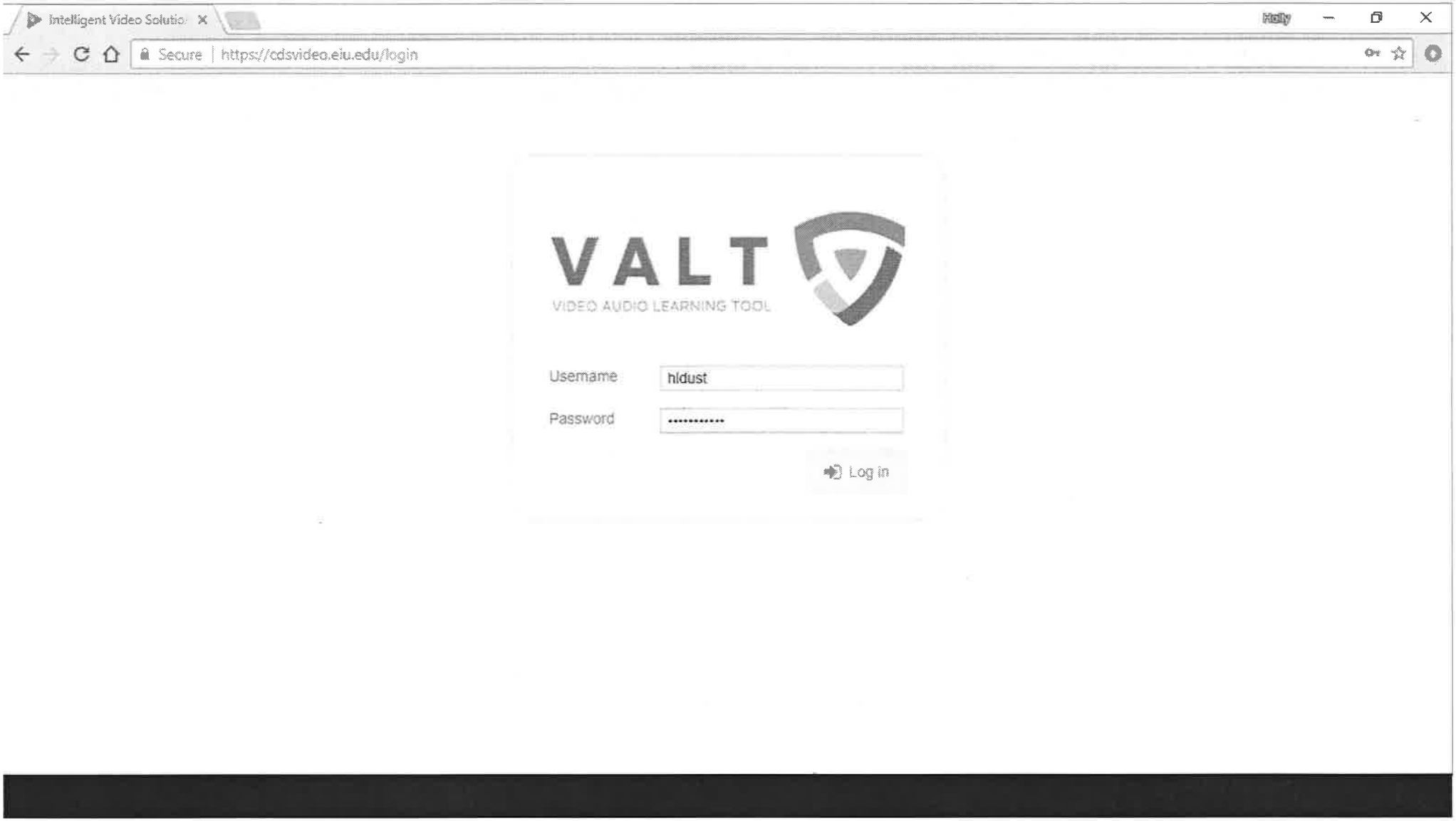
HOW TO USE NEW CDS LAPTOPS

VERY IMPORTANT, PLEASE REMEMBER!!!

- Always follow instructions inside laptop to prevent any issues!
  - NEVER shutdown CDS laptops; this allow for updates
  - You will RESTART after checkout AND before returning
  - Make sure laptop is connected to EIUCDS wifi
  - When logging in use 'other user' and normal EIU login

USING CDS VIDEO

- The video system is used to view previous therapy sessions and diagnostics
- Use google chrome to access cdsvideo.eiu.edu OR use bookmarks tab on CDS laptop
- Logging in:
  - Your EIU Username & Password
  - Click Login


Intelligent Video Solutio
Holly
Secure
https://cdsvideo.eiu.edu/login
VALT
VIDEO AUDIO LEARNING TOOL
Username
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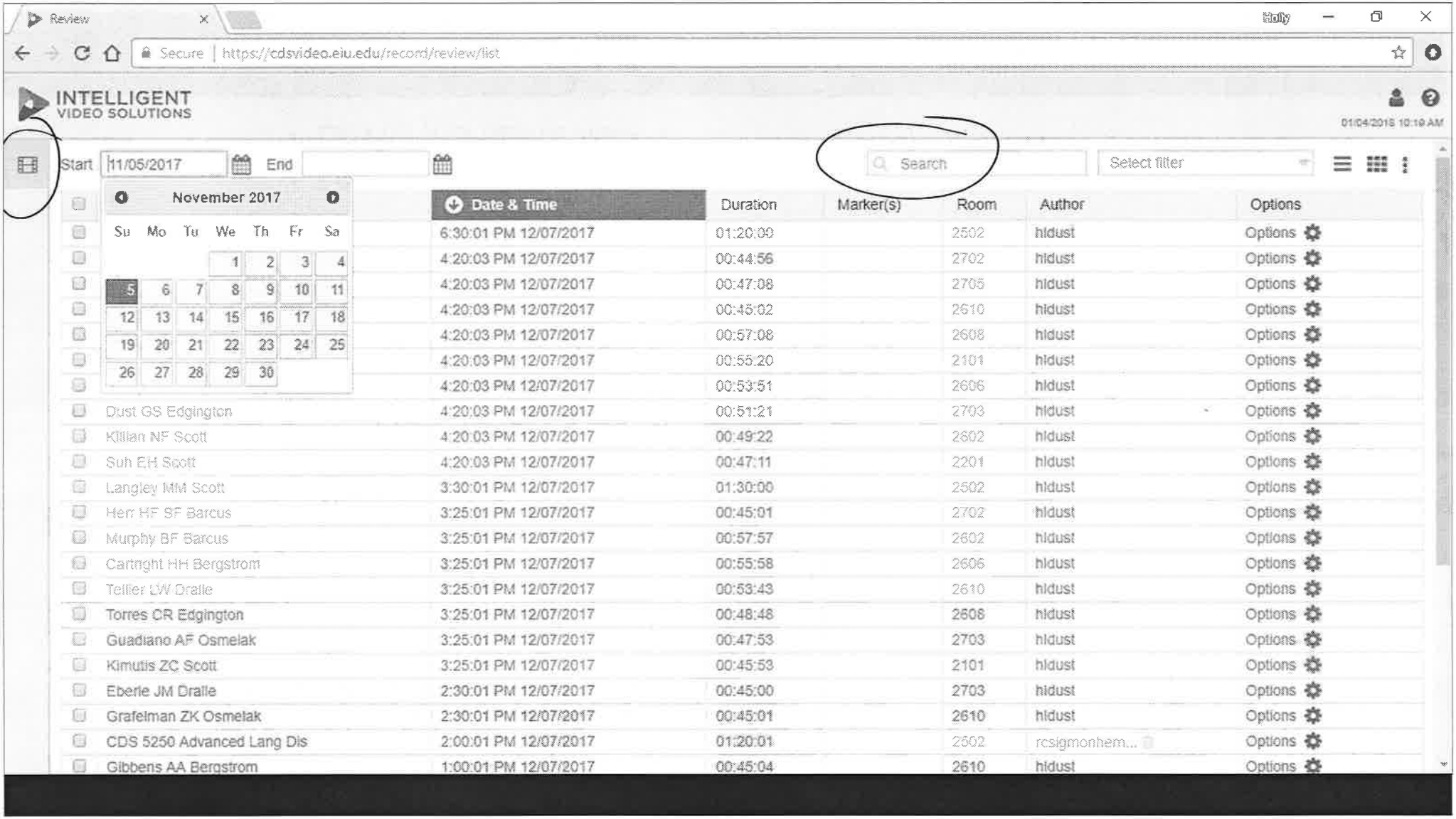
Password
Log in

VIDEO SYSTEM DIRECTIONS

- To search a session
  - Click "review"
  - Enter search criteria
    - Therapy session
      - Clinicians Last Name, Client Initials, Supervisor's Last Name
      - Armstrong CA Watson
    - Diagnostic
      - Supervisor's Last Name, Client Initials, Dx
      - Watson CA Dx
  - Select "search"
  - Click on your desired video


Review
Holly
Secure | https://cdsvideo.eiu.edu/record/review/list
INTELLIGENT
VIDEO SOLUTIONS
01/04/2018 10:19 AM
Start 11/05/2017
End
Search
Select filter
November 2017
Su Mo Tu We Th Fr Sa
1 2 3 4
5 6 7 8 9 10 11
12 13 14 15 16 17 18
19 20 21 22 23 24 25
26 27 28 29 30
Date & Time
Duration
Marker(s)
Room
Author
Options
6:30:01 PM 12/07/2017 01:20:09 2502 hldust Options
4:20:03 PM 12/07/2017 00:44:56 2702 hldust Options
4:20:03 PM 12/07/2017 00:47:08 2705 hldust Options
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4:20:03 PM 12/07/2017 00:55:20 2101 hldust Options
4:20:03 PM 12/07/2017 00:53:51 2606 hldust Options
Dust GS Edgington 4:20:03 PM 12/07/2017 00:51:21 2703 hldust Options
Killian NF Scott 4:20:03 PM 12/07/2017 00:49:22 2602 hldust Options
Suh EH Scott 4:20:03 PM 12/07/2017 00:47:11 2201 hldust Options
Langley MM Scott 3:30:01 PM 12/07/2017 01:30:00 2502 hldust Options
Herr HF SF Barcus 3:25:01 PM 12/07/2017 00:45:01 2702 hldust Options
Murphy BF Barcus 3:25:01 PM 12/07/2017 00:57:57 2602 hldust Options
Cartright HH Bergstrom 3:25:01 PM 12/07/2017 00:55:58 2606 hldust Options
Tellier LW Dralle 3:25:01 PM 12/07/2017 00:53:43 2610 hldust Options
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Eberle JM Dralle 2:30:01 PM 12/07/2017 00:45:00 2703 hldust Options
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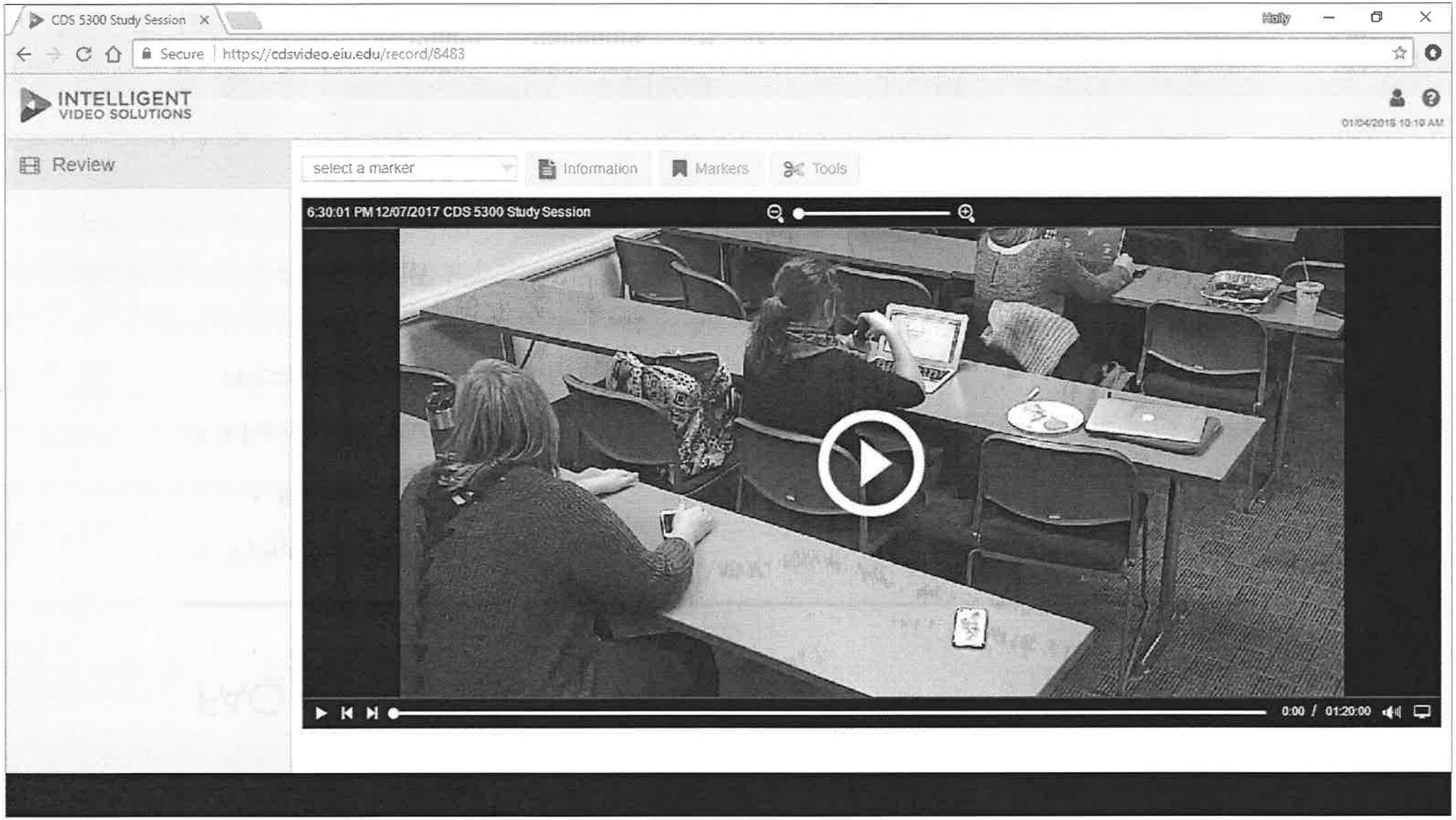
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FAQ CDS VIDEO

- Why can't I login?
  - Restart your computer
- I have a therapy session scheduled outside of my regular time and I need it recorded. What do I do?
  - Email CDS Technology at least 24 hours in advanced of the makeup session including your name, supervisor name, client initials, time, and room number
    - If is less than 24 hours in advanced recording cannot be guaranteed

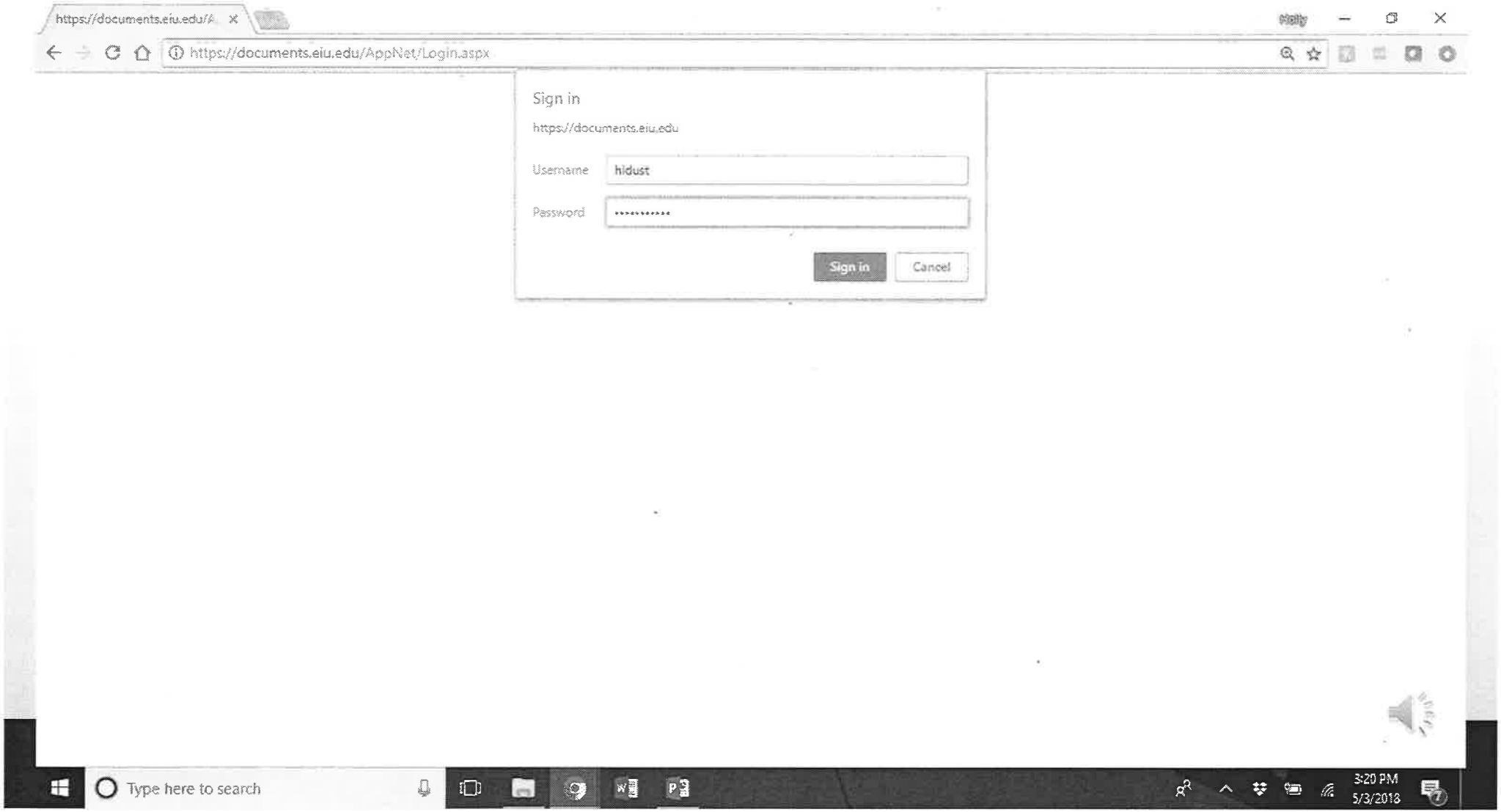
ADDITIONAL CDS VIDEO INFO

- It is **YOUR** responsibility to check in with me regarding diagnostic recordings
  - Come by my office to triple check together room number, times, etc.
  - IF I AM NOT INFORMED OF **AT LEAST 24 hours before your diagnostic**
    - This is **VERY IMPORTANT** for us CHANGES, THE RECORDING WILL BE INCORRECT AND/OR NON-EXISTENT

- **ASSUME THE TECH GA HAS NOT BEEN TOLD OF CHANGES!**

HOW TO ACCESS ONBASE

- Use CDS laptop
  - Use google chrome and click on OnBase bookmark tab
- Logging in:
  - Your EIU Username and Password
  - Click Login
  - IMPORTANT: **Log off OnBase before closing internet**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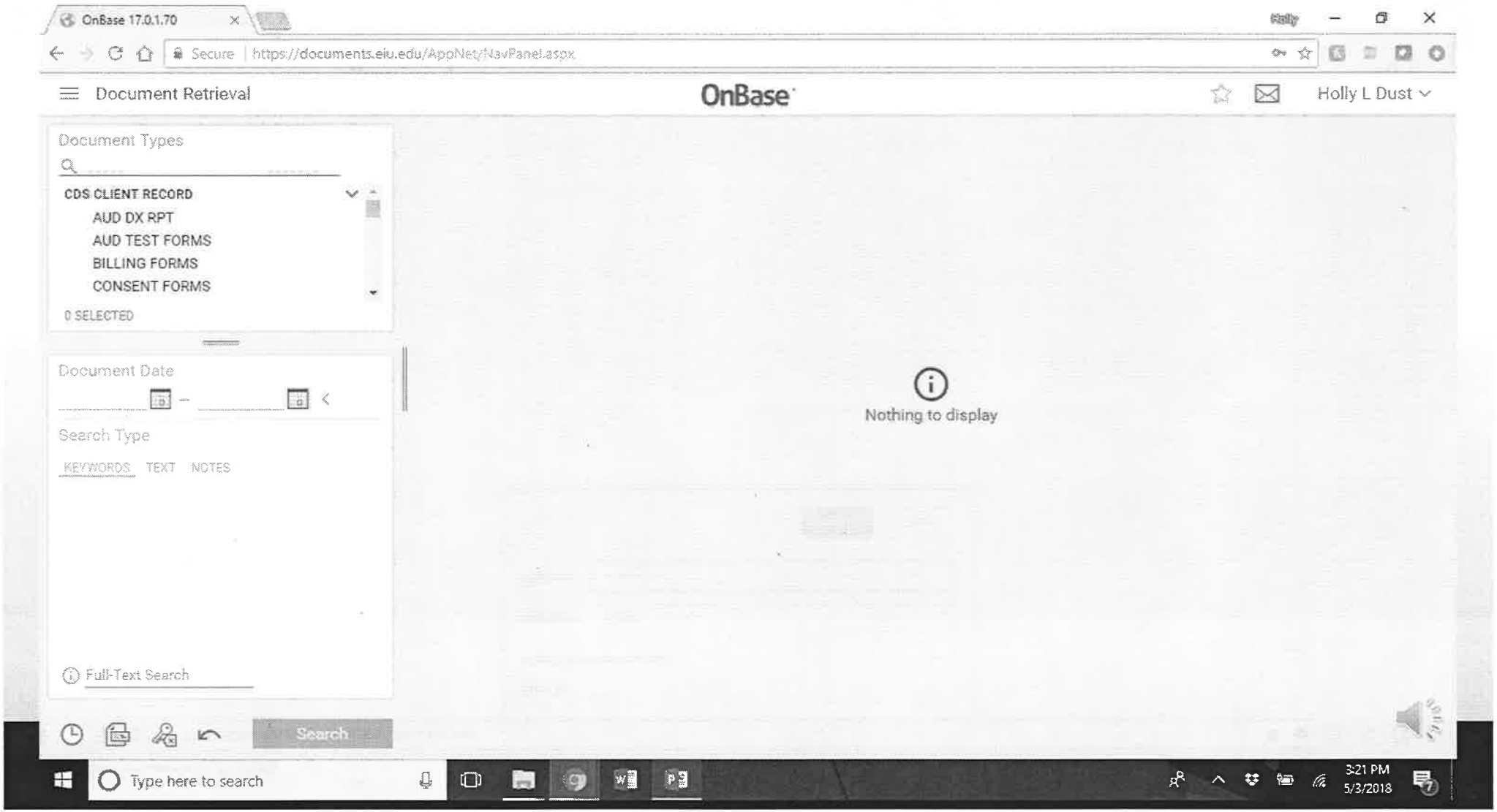
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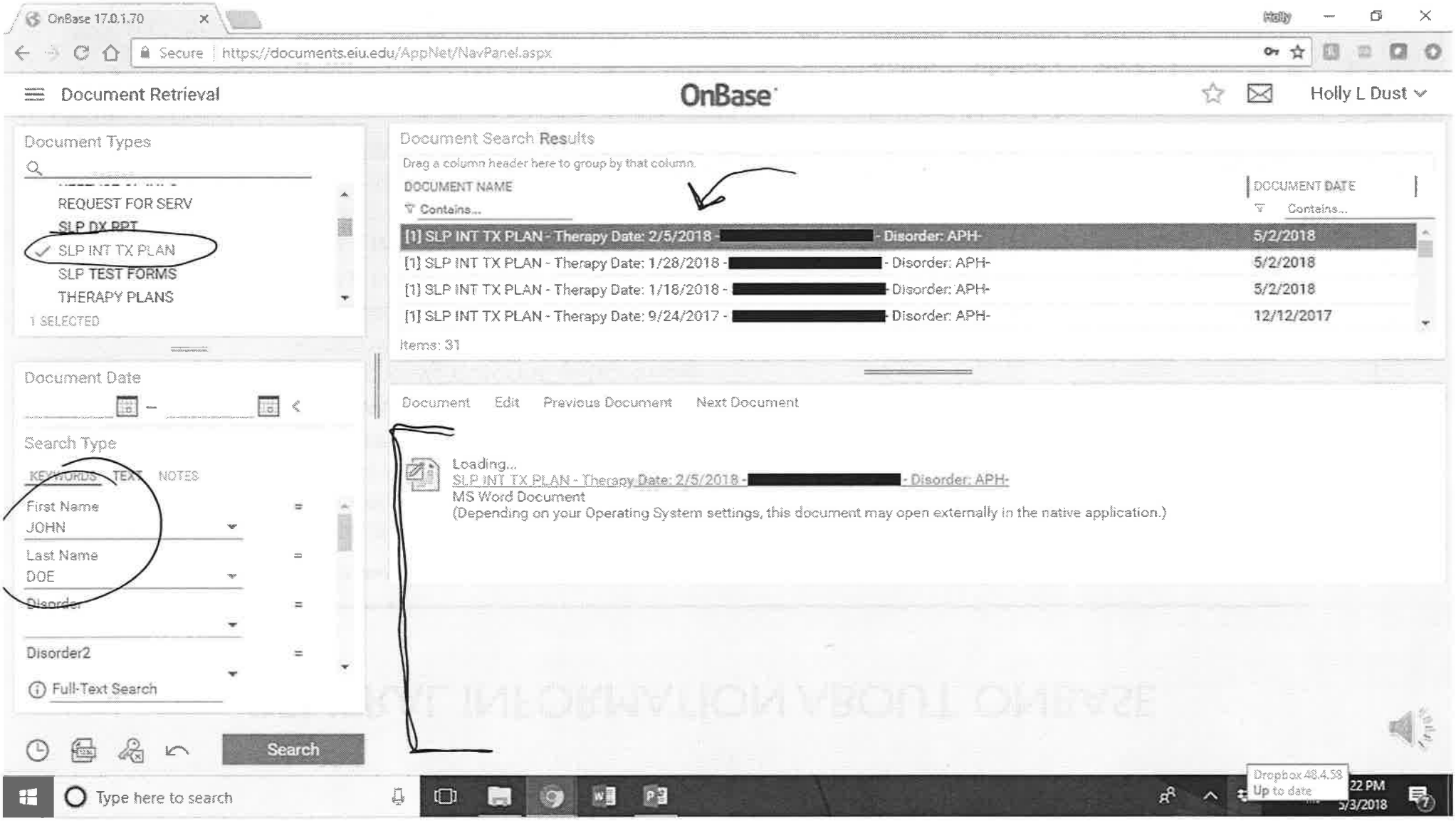
GENERAL INFORMATION ABOUT ONBASE

- OnBase is used to access client's files
- Commonly used documents:
  - CORRESPOND-CDS: letters sent to client
  - DISPO FORMS: Disposition sheet – used to record client's attendance and current identifying information
  - EXT RPT: reports/testing we have received from anywhere else
  - **FINAL SEMESTER REPORT (FSR):** Written reports from the end of each semester
  - FUNCTIONAL OUTCOME: aka NOMS ratings
  - PRE-DX INFO FORM: filled out by parent before diagnostic evaluation
  - REQUEST FOR SERV: Request for services – filled out at the beginning of each semester
  - **SLP DX RPT:** Written diagnostic report
  - **SLP INT TX PLAN**: Initial therapy plan
  - SLP TEST FORMS: Any tests given to the client at EIU Clinic.
    - Only the scoring page is in OnBase. To see the entire test, you must check out the client's paper file in the front office.
  - **THERAPY PLANS/TX PLAN PROG NOTES**: therapy plans and SOAP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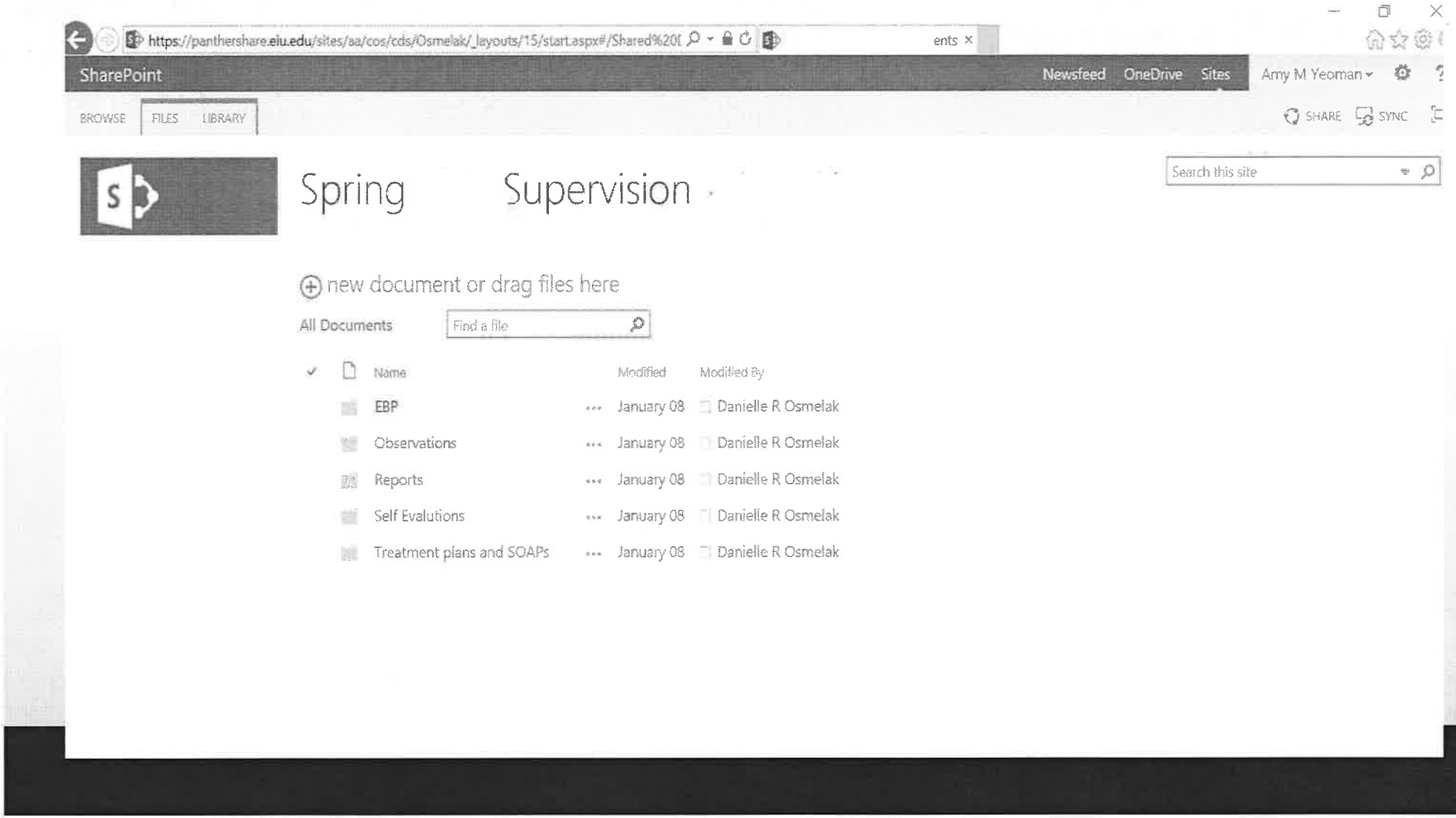
PANTHERSHARE/SHAREPOINT

- PantherShare is used for the **current semester** therapy plans, reports (ITP, FSR), EBP, etc.
- Your supervisor will email you the link for the shared file
  - **Save this link as a favorite for future use**
- Login
  - Username: EIU ID
  - Password: EIU password
- **DO NOT USE ANY IDENTIFYING INFORMATION ON HERE!!!**
  - The client will…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Danielle R Osmelak
Observations
January 08
Danielle R Osmelak
Reports
January 08
Danielle R Osmelak
Self Evalutions
January 08
Danielle R Osmelak
Treatment plans and SOAPs
January 08
Danielle R Osmelak

CLINIC TECHNOLOGY

- Tech GA Office
  - 10 CDS laptops
  - 14 iPads
  - Mini projector – can project laptop screen on wall for videos, use for therapy activities (e.g., fly swatter game, ceiling scavenger hunt), etc.
  - 3 camcorders
  - 3 new GoPros
- Bergstrom, Ramrattan, and Dralle each have a flip cam in their office to use if you are one of their clinicians

CHECKOUT/RESERVE PROCEDURE

*NOT INCLUDING CDS LAPTOPS

- Checkout – when you PHYSICALLY take something out of the tech cabinet
- Reserve – when you know in advance and want to RESERVE it for a certain date/time
- To check something back in – simply erase your name from the board

- YOU MUST CHECK OUT ALL TECHNOLOGY – NO MATTER WHAT!!!

HELP!

- I am not a tech professional!!!
- I will often need professional back-up, but you should always come to me first!

- Jong Kim – works in IT and can often help us out since he is familiar with our department
- Go to Gregg Technology Center for technology-related problems (e.g., computer won't turn on, documents won't save)
- Email support@eiu.edu for EIU-related problems (e.g., Net ID, EIU password)

- **If there is a computer problem, RESTART your computer before coming to me. It will be the first thing I ask you.**

FAQ'S

- My camcorder/flip cam isn't working.
  - Is it charged?
  - Is the memory card full?
- My session is not on CDS Video.
  - Did you inform Tech GA of room or time changes?
- Can I check out an iPad/camcorder/flip cam?
  - Did you sign the RESERVE list?
  - Does someone else already have it reserved?
  - Is it charged?
- I need a flashdrive, can I use yours?
  - No, this has important information on it that cannot be shared

FAQ'S

- I need technology help, but you're not at the clinic, what do I do?
  - Email CDS technology and I will get back to you as soon as I can
- I need technology help and you're in your office but not on GA hours. What do I do?
  - Email CDS technology and I will get back to you as soon as I can
- I need technology help and you're in your office on GA hours. What do I do?
  - Come on in! I will do my best to help you out
- I emailed CDS Technology yesterday, why haven't you answered?
  - Email is only checked during GA hours which can fluctuate each week. Additionally, the tech GA has other responsibilities outside of technology.
- Why is there a clipboard outside your office?
  - Watch the clipboard for when is a good time to ask for help!

USEFUL TIPS FROM PREVIOUS TECH GA & IT

- Do not use your iPad to take notes
- Majority of your computer problems will be solved by restarting it
  - Mac users should restart their laptop at least 2-3 times a week to avoid issues
- Avoid Google Docs
  - EIU gives you access to Word, use it!
- Always reduce the number of tabs open/programs running
- Delete unneeded files
- Storage should be less than 80%

TOP 4 POINTS

1. Follow instructions for new CDS laptops (inside laptop) NEVER SHUTDOWN
2. Restart your personal laptop 2-3 times a week
3. All communication should be done through CDS technology email
    1. No text messages please ☺
4. Give the tech GA no less than a 24 hours notice of a recording needed

QUESTIONS??

Section 6: Cultural Responsiveness

- Document from ASHA on cultural responsiveness (retrieved from website)
- Cultural competence check in: cultural competence practice
- Cultural competence checklist
- Articles

Cultural Responsiveness

Overview

Cultural responsiveness involves understanding and appropriately including and responding to the combination of cultural variables and the full range of dimensions of diversity that an individual brings to interactions. Cultural responsiveness requires valuing diversity, seeking to further cultural knowledge, and working toward the creation of community spaces and workspaces where diversity is valued (Hopf et al., 2021).

Cultural competence is a dynamic and complex process requiring ongoing self-assessment, continuous cultural education, openness to others' values and beliefs, and willingness to share one's own values and beliefs. This is a process that evolves over time. It begins with understanding one's own culture, continues through reciprocal interactions with individuals from various cultures, and extends through one's own lifelong learning.

Cultural humility refers to the understanding that one must begin with a personal examination of one's own beliefs and cultural identities to better understand the beliefs and cultural identities of others. Cultural humility is a lifelong process of self-reflection (Tervalon & Murray-Garcia, 1998).

Cultural responsiveness, cultural competence, and cultural humility are all dynamic, complex, and lifelong processes. The terms are not mutually exclusive and have sometimes been used interchangeably. For purposes of this page, the term "cultural responsiveness" will be used.

Clinical approaches—such as interview style, assessment tools, and therapeutic techniques—that are appropriate for one individual may not be appropriate for another. It is important to recognize that the unique influence of an individual's cultural and linguistic background may change over time and according to circumstance (e.g., interactions in the workplace, with authority figures, within a social context). Such changes may require adjustments in clinical approaches.

Cultural responsiveness in service delivery impacts a provider's ability to

- respond to demographic diversity;
- understand and respond to social determinants of health and health disparities as they impact different populations;
- improve the quality of services and health outcomes; and
- meet legislative, regulatory, and accreditation mandates.

For further information and access to additional ASHA resources, please see Cultural Competence Check-Ins and Social Determinants of Health.

Key Issues

Roles and Responsibilities

ASHA requires that audiologists and speech-language pathologists (SLPs) practice in a manner that considers the impact of cultural variables as well as language exposure and acquisition on the individual and their family. Audiologists and SLPs provide services to diverse populations. Professional and clinical competence requires that audiologists and SLPs practice in a manner that considers each individual's cultural and linguistic characteristics and unique values so that these professionals can provide the most effective assessment and intervention services (ASHA, 2004, 2006). ASHA-certified practitioners have met academic and professional standards that include knowledge of cultural variables and how they may influence communication and service delivery. See ASHA's *Audiology Certification Standards* and *Speech-Language Pathology Certification Standards*. Clinicians are responsible for providing culturally responsive and clinically competent services during all clinical interactions. Responsiveness to the cultural and linguistic differences that affect identification, assessment, treatment, and management includes the following actions:

- Engaging in an internal self-assessment to consider the influence of one's own biases and beliefs and their potential impact on service delivery
- Identifying and acknowledging limitations in education, training, and knowledge as well as seeking additional resources and education to develop cultural responsiveness (e.g., continuing education, networking with community members)
- Seeking funding for and engaging in ongoing professional development related to cultural responsiveness
- Demonstrating respect for each individual's ability, age, culture, dialect, disability, ethnicity, gender, gender identity or expression, language, national/regional origin, race, religion, sex, sexual orientation, socioeconomic status, and veteran status
- Integrating each individual's traditions, customs, values, and beliefs into service delivery
- Recognizing that assimilation and acculturation impact communication patterns during identification, assessment, treatment, and management of a disorder and/or difference
- Assessing and treating each person as an individual and responding to their unique needs, as opposed to anticipating cultural variables based on assumptions
- Identifying appropriate intervention and assessment strategies and materials that do not (a) violate the individual's unique values and/or (b) create a chasm between the clinician, the individual, their community, and their support systems (e.g., family members)
- Assessing health literacy to support appropriate communication with individuals and their support systems so that information presented during assessment/treatment/counseling is provided in a health literate format
- Demonstrating cultural humility and sensitivity to be respectful of individuals' cultural values when providing clinical services
- Referring to and/or consulting with other service providers with appropriate cultural and linguistic proficiency, including using

- a **cultural informant**—a member of, or someone familiar with, a given culture (Spradley & McCurdy, 1972) who can supply relevant information about that culture to a third-party member (e.g., a clinician);
- a **cultural broker**—an individual who acts as a bridge between diverse families and schools (Jezewski & Sotnik, 2001; Torres et al., 2015) or one who advocates for a given culture to a third-party member (e.g., a clinician); or
- an **interpreter** and/or a **translator**, where appropriate (see ASHA's Practice Portal page on Collaborating With Interpreters, Transliterators, and Translators for further information)

- Upholding ethical responsibilities during the provision of clinically appropriate services

Clinicians have a responsibility to advocate for consumers, families, and communities at risk for or presenting with communication and related disorders and/or differences. Advocacy specific to cultural responsiveness includes

- collaborating with professionals across disciplines and with local and national organizations to gain knowledge of, develop, and disseminate educational, health, and medical information pertinent to specific communities;
- gaining knowledge and education of high-risk factors (e.g., hypertension, heart disease, diabetes, fetal alcohol syndrome) in specific populations and the incidence and prevalence of these risk factors that can result in greater likelihood for communication and related disorders and/or differences;
- providing education regarding prevention strategies for speech, language, cognitive, hearing, balance, voice, and feeding/swallowing disorders in specific populations;
- providing appropriate and culturally relevant consumer information and marketing materials/tools for outreach, service provision, and education, with consideration of the health literacy, values, and preferences of communities; and
- identifying and educating communities regarding the impact of state and federal legislation on service delivery.

Ethical Considerations

Cultural and linguistic responsiveness is as important to the provision of services as are scientific, technical, and clinical knowledge and skills. The ASHA Code of Ethics (ASHA, 2023) contains the fundamentals of ethical conduct, which are described by Principles of Ethics and by Rules of Ethics. **Principles of Ethics** form the underlying philosophical basis for the Code of Ethics, whereas **Rules of Ethics** are specific statements of minimally acceptable as well as unacceptable professional conduct. The following provisions in the Code of Ethics establish the responsibilities of the practitioner to provide culturally and linguistically competent services and research and to avoid discrimination in professional relationships:

- Individuals shall provide all clinical services and scientific activities competently (Principle I, Rule A).
- Individuals shall use every resource, including referral and/or interprofessional collaboration when appropriate, to ensure that quality service is provided (Principle I, Rule B).
- Individuals shall not discriminate in the delivery of professional services or in the conduct of research and scholarly activities on the basis of age; citizenship; disability; ethnicity; gender; gender expression; gender identity; genetic information; national origin, including culture, language, dialect, and accent; race; religion; sex; sexual orientation; or veteran status (Principle I, Rule C).
- Individuals who hold the Certificate of Clinical Competence shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their certification status, education, training, and experience (Principle II, Rule A).
- Individuals shall not discriminate in their relationships with colleagues, assistants, students, support personnel, and members of other professions and disciplines on the basis of age; citizenship; disability; ethnicity; gender; gender expression; gender identity; genetic information; national origin, including culture, language, dialect, and accent; race; religion; sex; sexual orientation; socioeconomic status; or veteran status (Principle IV, Rule M).

Principles of Ethics and Rules of Ethics are not intended to serve as justification for the denial of services or as the basis for discrimination in the delivery of professional services or the conduct of research and scholarly activities. Rather, "individuals shall enhance and refine their professional competence and expertise through engagement in lifelong learning applicable to their professional activities and skills" (Principle II, Rule C). Assessment and treatment should not vary in quality based on factors such as ethnicity, age, or socioeconomic status. Discrimination in any professional arena and against any individual, whether subtle or overt, ultimately dishonors the professions and harms all those within the practice.

Clinicians have an obligation to seek the information and expertise required to provide culturally responsive services and are asked to carefully consider the basis for determining their need to refer and/or deny services. ASHA's Office of Multicultural Affairs can provide assistance and resources in making this determination and in identifying resources to continually enhance cultural responsiveness. The Board of Ethics' *Issues in Ethics Statement: Cultural and Linguistic Competence* (ASHA, 2017) is designed to provide guidance to members, applicants, and certified individuals as they make these types of professional decisions.

If you are concerned about the appropriate interpretation and application of the Code of Ethics, staff members from ASHA's Ethics team (ethics@asha.org) can provide further information and direction.

Developing Cultural Responsiveness

Developing cultural responsiveness is an ongoing process. It involves self-awareness and cultural humility, and it may require audiologists and SLPs to recognize what they do not know about the languages and cultures of the individuals, families, and communities they serve. As a result, they may seek culture-specific knowledge and experience in these areas. Per Kohnert (2008), the culturally responsive clinician has the ability to

- simultaneously appreciate cultural patterns and individual variation;
- engage in cultural self-scrutiny to assess cultural biases and improve self-awareness;
- utilize evidence-based practice to include client/patient/family characteristics, clinician expertise, and empirical evidence in clinical decisions; and
- understand the communication contexts and needs of clients/patients and their families by considering communication disorders within a social context.

Culturally responsive clinicians also identify bias and/or determine appropriateness of materials in assessment and treatment materials and practices. Additionally, culturally responsive clinicians recognize the role of **social justice** (fairness for all people, including the equitable distribution of resources in a society) by advocating for, promoting, and providing quality care and education for all individuals (Horton, 2021, Unger et al., 2021).

Developing cultural responsiveness includes

- self-assessment, including a review of the clinician's personal history, values, beliefs, and implicit and explicit biases;
- an understanding of how these factors might influence perceptions of communication abilities and patterns;
- an understanding of how personal perceptions might influence interactions and service delivery to a variety of individuals; and
- transitioning understanding into actions that support an unbiased, culturally appropriate, and relevant clinical environment.

As cultural responsiveness has a relationship with cultural competence, the work of Cross (2012) is relevant to the present discussion. Cross's (2012) continuum of cultural competence includes the following stages:

Cultural destructiveness—This stage includes policies, practices, and attitudes that are detrimental to cultures and individuals within those cultures.

Cultural incapacity—At this stage, agencies and individuals do not have the ability to assist those in need.

Cultural blindness—At this stage, the prevailing belief is that color or culture makes no difference or does not exist.

Cultural pre-competence—At this stage, cultural differences are accepted and respected. This includes ongoing self-assessment of cultural bias.

Advanced cultural competence—At this stage, the individual and/or agency holds culture in high esteem and works to contribute to knowledge regarding culturally competent practice.

Self-assessment may reveal where a clinician is along the continuum of cultural competence (see ASHA's Cultural Competence Assessment tool). The steps to developing cultural responsiveness are as follows:

- Learning about an individual's culture(s), language, experience, history, alternative sources of care, and power differentials.
- Developing a dynamic definition of what constitutes culture that allows for possible change, or redefinition, as all participants grow.
- Demonstrating respect for individual cultural backgrounds by integrating personal preferences and cultural practices into assessment and treatment, including recognizing the influence of culture on linguistic variations, which may result in variations in communication patterns due to context, communication intent, and communication partner.
- Recognizing that power in the clinical situation is reciprocal and that individuals receiving services are supported, are encouraged, and have the capacity to make choices and changes in their lives and to participate in service delivery as appropriate for their culture and personal preferences.
- Identifying cultural variables that are both explicit (e.g., external symbols, food, and language) and implicit (e.g., religious practices and beliefs, spiritual beliefs, educational values, age and gender roles, child-rearing practices, and fears and perceptions).
- Developing an **ethnogenetic** viewpoint that recognizes that groups, cultures, and the individuals within them are fluid and complex in their identities and relationships.
- Moving away from **ethnocentrism**, the belief that one's way of life and view of the world are inherently superior to others' and are more desirable.
- Moving away from **essentialism**, which defines groups as "essentially" different, with characteristics "natural" to a group (Fuller, 2002). Essentialism does not consider variation within a culture and can lead health care professionals to stereotype their patients. Health care professionals may incorrectly focus practice on beliefs about groups instead of individuals as a result.

Cultural Dimensions

Individuals within all cultures vary based on differences, preferences, values, and experiences. Culture is learned, not inherited. Hofstede (2011) identifies cultural dimensions that are globally applicable and are reflected in all aspects of life, including

- family life,
- child-rearing practices,
- education,
- employment, and

- health care practices.

Hofstede (2011) also identifies the following as the broadest and most encompassing dimensions of cultural variability:

- **Individualism-collectivism**—how individuals are integrated into groups
- **Power distance**—how human inequality and/or the power of one group over another is interpreted
- **Masculinity-femininity**—emotional roles as divided between genders
- **Uncertainty avoidance**—society's stress level in the event of an unforeseeable future
- **Long- and short-term orientation**—whether people's efforts are focused on the past, present, or future
- **Indulgence versus restraint**—instant versus delayed gratification and the control of desire

Please see Examples of Cultural Dimensions for definitions and explanations of the terms above.

Bearing in mind that these cultural dimensions are applied broadly to each country and that individuals may demonstrate individual differences within their country's culture, Hofstede (2011) developed a Country Comparison tool. This tool displays a graphic visualization of each country's dimensions in numerical terms, as well as a display of two or more countries' dimensions for comparison.

Additional dimensions include

- cultural value orientations (e.g., time orientation),
- verbal communication (e.g., turn-taking expectations, amount of talking allowed among conversational partners),
- nonverbal communication (e.g., eye contact, personal space use), and
- relational communication norms (e.g., greeting rituals, conversational expectations for various types of individuals).

Cultural dimensions occur along a continuum, and an individual may demonstrate behavior that falls anywhere along that continuum. A wide variety of factors may influence how cultural dimensions are manifested by each individual, including

- individual differences;
- individual circumstances;
- **assimilation**—the process of someone in a new environment totally embracing the host culture (Riquelme, 2013); and
- **acculturation**—the integration of the host culture with the native culture to varying degrees (Riquelme, 2013).

Implications of Cultural Dimensions

Cultural dimensions influence verbal and nonverbal behaviors in communicative interactions. They affect how individuals convey trust or distrust and what they interpret as friendly, unfriendly, interested, or bored behaviors. For example, friendliness is conveyed by

- listening without interrupting the speaker in a **high power distance** culture;
- using formal and specific language in a strong **uncertainty avoidance** culture;
- verbally disclosing information in an **individualistic** culture; and
- using an assertive style of communication in a highly **masculine** culture.

Please see Examples of Cultural Dimensions and the Cultural Dimensions section for definitions and explanations of the terms above. Failure to recognize these variations in interactions can result in crucial miscommunications. For example, professionals educated in a particular setting (e.g., U.S. schools) may value low power distance and may attempt to treat students, clients/patients, and families as equals, encouraging them to participate in the development of therapeutic goals and objectives. However, people from high power distance cultures may question the competence of a professional who attempts to include them in the development of interventions (Hwa-Froelich & Westby, 2003). This discrepancy may negatively impact communication.

An audiologist or SLP whose cultural beliefs are consistent with independence and active experimentation may face conflicts with families whose cultural beliefs support dependence and compliance if there is a lack of awareness of these cultural differences (Hyter & Salas-Provance, 2021).

Research suggests that when clients/patients view themselves as similar to their health care providers in terms of cultural and linguistic background, the health care provider–patient relationship is strengthened. Patient-centered communication is one factor noted to affect perceived personal similarity (Street et al., 2008).

The impact of cultural dimensions should be considered within the environment and within clinical interactions. Clinicians are encouraged to be mindful of **intersectionality**—the way in which systems of inequality that are based on discrimination due to cultural dimensions meet to create unique dynamics and the reality that each system has the potential to reinforce other systems. This concept further emphasizes the importance of developing rapport with an individual to determine the various social influences that may impact treatment outcomes. Please see Crenshaw (1989), a seminal work on intersectionality, for further information.

Cultural Responsiveness Versus Stereotyping

Cultural responsiveness requires audiologists and SLPs to consider how values and norms are uniquely shaped. Even when individuals share similar cultural backgrounds, their values are shaped by their own experiences and interpretations of these experiences. Stereotyping uses preconceptions of a particular population and may result in inappropriate behaviors, clinical judgments, and decisions.

For example, cultural responsiveness in dysphagia services includes the identification of the individual's personal food history and preferences. Stereotyping in dysphagia services could lead to recommendations based solely on the food preferences most often associated with the individual's cultural background.

Difference Versus Disorder

Cultural responsiveness requires clinicians to distinguish a communication **difference** from a communication **disorder**. A clinically competent clinician will gain sufficient knowledge of an individual's cultural and linguistic background to avoid making an assumption that a communication pattern(s) constitutes a disorder when the pattern(s) may in fact be reflecting cultural and linguistic variation.

Distinguishing between communication differences and communication disorders involves the ability to

- recognize that cultural dimensions and individual variation may influence eye-gaze behavior; facial expressions; body language; rules of social interaction; child-rearing practices; perceptions of mental health, physical health, illness, and disability; and patterns of superior and subordinate roles in relation to status by age, gender or gender identity, and class (Lau, 2006; Murry et al., 2011);
- review cultural and linguistic variables and factors that may influence communication to determine if the communication patterns of an individual may be related to their cultural background (Penn et al., 2017);
- determine if the communication pattern is related to the individual's linguistic background (see Bilingual Service Delivery);
- understand that differences may be related to the amounts and types of different exposure to and development of new cultural communication patterns;
- recognize that assimilation and level of acculturation may influence individual communication patterns and behaviors;
- identify a disorder as a breakdown in communication that is sufficient to negatively influence the effective use of symbols and message processing in the language used by the speaker;
- identify a communication difference as a variation of a symbol system used by a group of individuals that reflects and is determined by shared regional, social, or cultural/ethnic factors;
- recognize that a regional, social, or cultural/ethnic variation of a communication system is rule based and should not be considered a disorder of speech or language (e.g., an accent or a dialect does not reflect an articulation disorder; Hamilton et al., 2018); and
- incorporate the cognitive learning styles of individuals and avoid the expectation of mainstream methods for problem solving and communication (Davis & Stanford, 2020).

Although clinicians work to avoid misidentifying language/dialect differences as disorders, research has demonstrated that children from minoritized backgrounds who may speak nonmainstream English dialects are less likely to receive needed services than similar

White peers (Morgan et al., 2015, 2016). Rather than a strictly **dialect versus disorder** framework, Oetting et al. (2016) recommend that clinicians use a **disorder within dialect** framework to keep the conversation about the nature and prevalence of childhood language disorders across dialects at the forefront when considering screening, assessment, and treatment planning and when providing education about the services clinicians provide.

Terminology

Clinicians consider their use of person-first or identity-first terminology (e.g., "person with autism" vs. "autistic person") and remain aware that terminology used to describe individuals may vary based on individual identity and preference. When there is a preference for either person-first or identity-first language, that preference should be honored. When in doubt clinicians may ask the individual to whom they are referring.

Similarly, clinicians should be aware of appropriate pronoun use. Using an individual's correct personal pronouns shows respect to the individual and creates an inclusive environment. Please see Supporting and Working With Transgender and Gender-Diverse People for further information.

Response to Intervention and Dynamic Assessment

Early intervention services are used to determine which children have intrinsic learning problems that cannot be attributed to lack of experience with the tasks. Response to intervention and dynamic assessment are early intervention processes that help decrease unnecessary referrals for special education services for children who can benefit from modified instructional techniques. These approaches may also differentiate an underlying disability from a difference because they are highly focused on intended outcomes, individual needs, and data resulting from reliable screening measures (Hosp, n.d.).

Cultural Responsiveness in Clinical Service Delivery

Clinically competent service providers recognize and address the cultural and linguistic variables that affect service delivery while individualizing assessment and treatment strategies. This individualization ensures that the audiologist or SLP does not make overgeneralizations regarding a person's cultural or linguistic background. When providing services, audiologists and SLPs consider

- if the environment setup is inviting;
- if the environment is accessible;
- the need to modify scheduling and appointment times due to cultural and individual values that may influence availability;
- the appropriateness and cultural sensitivity of materials used during assessment and intervention activities; and
- individual perceptions of assessment, possible diagnosis, and intervention strategies.

The National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care (Office of Minority Health, n.d.) provide a framework for all health care organizations to best serve the nation's increasingly diverse communities.

Clinical Topics Practice Portal pages include additional information regarding the potential impact of culture as it relates to specific clinical topics.

The Assessment Process

When conducting assessments, audiologists and SLPs consider the individual's level of acculturation and assimilation within the mainstream culture. In addition, practitioners determine how familiar and comfortable the individual is with social, interpersonal, academic, and testing practices, as familiarity with testing procedures may influence performance during the assessment process. An evaluation may have to be completed over multiple sessions if there is a need to assess an individual in more than one language, collaborate with an interpreter, utilize alternate assessment formats, and find and/or establish norms for a given population. See ASHA's Practice Portal pages on Bilingual Service Delivery and Collaborating With Interpreters, Transliterators, and Translators as well as ASHA's page on Dynamic Assessment for more information.

Gathering a Case History

Case histories include information about the individual's communication characteristics as they compare to others from the same community. Whenever possible, case histories are collected using open-ended questions rather than asking respondents to select from options that may not be appropriate for them. Clinicians do not make assumptions about individuals or their families based on general cultural, ethnic, or racial information. The case history process is used to gather specific knowledge of the diverse views represented.

Ethnographic interviewing encourages the interviewee to provide information that they feel is relevant rather than to respond to clinician-presented questions. This style of interviewing can provide insight into individual perceptions, views, desires, and expectations. Strategies for ethnographic interviewing include

- using open-ended questions rather than "yes" or "no" questions;
- restating what has been said by repeating the exact words rather than paraphrasing or interpreting;
- summarizing statements and providing the opportunity for correction in case of misinterpretation;
- avoiding multiple questions posed in rapid succession and/or multipart questions;
- avoiding leading questions that tend to direct the person to a specific response; and
- avoiding using "why" questions because such questions may sound judgmental and may increase defensiveness (Westby et al., 2003).

Assessment Tools

Under most conditions, the use of standardized tests alone is not a comprehensive approach to determine whether an individual has a communication disorder. Test scores

are invalid for the test taker who is not reflected in the normative group for the test's standardization sample, even if the test is administered as instructed. In these cases, standardized tests cannot be used to determine the presence or absence of a communication disorder. However, these tests can provide valuable descriptive information about the individual's abilities and limitations in the language of the test (e.g., a test administered in English will assess an individual's ability in English).

Formal test environments and assessment tools may be unfamiliar to individuals who have not had exposure to the mainstream educational context and to the culture of testing that includes both nonverbal and verbal components. Nonverbal aspects of the testing culture include

- perception of time;
- how one is expected to learn;
- how one is expected to respond to the examiner, regardless of gender, culture, age, and/or socioeconomic background;
- attitudes toward display of abilities;
- attitudes toward guessing, using the process of elimination, storytelling, or conversing with an unfamiliar individual;
- test abstraction (e.g., naming protocols that require providing already shared information or situations in which the individual is required to assume a "make-believe" attitude in order to engage in an expected manner); and
- nonlinguistic aspects of pragmatics (DeJarnette et al., 2015).

Verbal aspects of the testing culture include

- form of language,
- functions of language,
- content of language,
- organization of language, and
- pragmatic rules of social interaction.

Accommodations and Modifications

For the purpose of this page, an **accommodation** of an assessment process refers to an adjustment or change to the environment or mode of response in order to (a) facilitate access and interaction and (b) remove barriers to participation without changing what the test measures. For the purpose of this page, a **modification** refers to a change in material, content, or acceptable response. Accommodations and modifications may be necessary to gain useful information about the individual's abilities and limitations. However, some changes may invalidate a standardized score. Selected examples of accommodations and modifications include

- rewording and providing additional test instructions other than those allowed when presenting trial items;

- providing additional cues or repeating stimuli that may not be permitted on test or task items;
- allowing extra time for responses on timed subtests;
- skipping items that are inappropriate for the individual (e.g., items with which the individual has had no experience);
- asking the individual for an explanation of correct or incorrect responses (when not standard procedure); and
- using alternate scoring rubrics.

It is important to note that there can never be one-to-one translation for test items. Languages vary across many factors, including order of acquisition of vocabulary, morphology, and syntactic structures. Well-developed standardized tests are difficult to find for individuals who use a language other than or in addition to spoken English. See ASHA's Practice Portal page on Bilingual Service Delivery for more information.

It is the clinician's responsibility to document all accommodations and modifications made during the assessment process in all reporting.

Considerations for Audiologic Assessment

Some audiologists may rely on physiological measures in an attempt to circumvent the influence of language factors on assessment outcomes. However, all components of the audiologic evaluation, including speech audiometry, should be completed if possible. It is important to note that

- speech reception threshold testing is intended to measure the threshold for hearing intelligible speech and is not intended to measure vocabulary, familiarity, or intelligence;
- responses may reflect the phonemic inventory of the language(s) spoken (see Phonemic Inventories and Cultural and Linguistic Information Across Languages);
- a lack of familiarity with test items and/or the testing process may compromise speech scores; and
- speech testing materials are language specific. It is not appropriate to simply translate and then use a test that has been developed and normed in a specific language. Compromised performance may be due to language background rather than hearing and/or processing disorders.

Treatment

Treatment should be initiated with an understanding of the environmental and language context of the individual and their family, and every effort should be made to minimize or remove physical, cultural, linguistic, and institutional barriers to intervention. Culturally relevant stimuli and experiences are to be included in intervention programs as appropriate. Audiologists and SLPs consider the nature of family and caregiver involvement during intervention. Selected considerations that may influence (a) individual expectations of the clinician and (b) the therapeutic process include

- the individual consistently deferring to the audiologist/SLP as the expert,
- cultural differences that influence the nature and level of the individual's participation based on the perceptions of their role,
- therapy techniques that promote behavior patterns inconsistent with family values, and
- how language and communication patterns are taught and influenced by the individual's culture and values.

Factors considered when selecting appropriate audiologic intervention include the impact of cultural influence on the

- acceptance of hearing loss as a disability,
- perceived value of medical intervention,
- cultural and social significance attached to hearing loss,
- role of gender as it relates to treatment options,
- language of treatment, and
- listening environment or hearing health of the individual.

Counseling

Culturally diverse views of disorders and disabilities are considered when providing counseling because cultural variations affect beliefs about the causes of a disorder as well as how the person with a disorder should be treated. Cultural views may also influence individual goals as well as the caregiver's goals for the person with the disorder or disability.

Each family unit has a system in which each member affects all other members (Bronfenbrenner, 1979). Relationships are built and maintained through communication and may be significantly impacted by a communication disorder. When counseling individuals and families, it is important to recognize the unique relationships of a family system, including how a family member's disorder affects relationships among the members as well as the functioning of the family system.

Cultural dimensions that influence counseling include

- the effect of the disability on life participation in culturally relevant contexts;
- the need for and/or acceptance of special treatment or education;
- acceptance of the use of technology for treatment;
- recognition that the family and/or the mainstream may judge some practices to be harmful;
- cultural values that conflict with mainstream values in terms of independence, individualism–collectivism, power distance, avoiding uncertainty, masculinity–femininity, hedonism, time orientation, indulgence, and restraint; and
- the individual's and the family's views of the role that each member plays—or should play—in the family.

Some cultures may have remedies or practices that mainstream professionals do not understand or embrace—and that they may even view as harmful. Professionals must discern whether cultural beliefs and practices are truly cultural variations or are harmful to the individual. Culturally sensitive counseling can provide information as well as alternative safe treatments (Westby, 2007).

In addition, religious or spiritual beliefs and practices may take precedence before educational or medical recommendations can be considered or accepted. If these beliefs or practices are misunderstood or unknown to professionals, they may interfere with or undermine educational and medical interventions (Fadiman, 2012; Shannon & Tatum, 2002; Swihart et al., 2021).

Please see ASHA's Practice Portal page on Counseling For Professional Service Delivery for further information.

Public Policy

A number of laws and regulations have implications for the culturally responsive provision of audiology and speech-language pathology services. Implications for practice relate, for example, to the implementation of standardized procedures, access to and participation in services, language proficiency, mandated accommodations to facilitate participation by individuals with disabilities, access to federal funding, availability of interpreters, classroom inclusion, disproportionate representation by race and ethnicity of children with disabilities, reducing health care disparities, and privacy.

Americans With Disabilities Act (ADA)

The ADA is intended to protect persons with disabilities and to guarantee them access to and participation in society. The statute is specifically directed at employment, public accommodations, public services (i.e., services delivered by state and local governments), transportation, and telecommunication. To be protected by the ADA, one must have a **disability**, which is defined by the ADA as a physical or mental impairment that substantially limits one or more major life activities; have a history or record of such an impairment; or be perceived by others as having such an impairment.

Equal Educational Opportunities Act

The Equal Educational Opportunities Act of 1974 states, "All children enrolled in public schools are entitled to equal educational opportunity without regard to race, color, sex, or national origin."

Executive Order No. 13166

Executive Order No. 13166 (2000) requires federal agencies to examine the services they provide, identify any need for services to those with limited English proficiency, and develop and implement a system to provide those services so that persons with limited English proficiency can have meaningful access to them. See the U.S. Department of Health and Human Services' *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient*

Persons [PDF]. This is applicable to health care providers who receive federal funds (e.g., via Medicare, Medicaid, or the State Children's Health Insurance Program).

Family Educational Rights and Privacy Act (FERPA)

FERPA (34 CFR Part 99) protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education. FERPA gives parents certain rights with respect to their children's education records. These rights transfer to the student when they reach the age of 18 years or attend a school beyond the high school level. Materials are to be provided in a manner that is culturally and linguistically accessible so that individuals can understand their rights. See FERPA Regulations.

Health Insurance Portability and Accountability Act (HIPAA)

Title II of HIPAA, known as the **Administrative Simplification (AS) provisions,** requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers. This act gives individuals aged 12–18 years the right to privacy. The provider must have a signed disclosure from the affected person before giving out any information on provided health care to anyone else, including the patient's parents. The AS provisions also address the security and privacy of health data. Materials are to be provided in a manner that is culturally and linguistically accessible so that individuals can understand their rights.

Individuals With Disabilities Education Act (IDEA)

The IDEA 2006 Regulations made significant steps toward addressing problems with inappropriate identification and disproportionate representations of children with disabilities by race and ethnicity. A provision of the IDEA requires states to review ethnicity data in addition to race data to determine the presence of disproportionality. **Disproportionality** refers to the overrepresentation or underrepresentation of a particular demographic group in a special education program relative to the number in the overall student population (National Education Association, 2007). If significant disproportionality is determined, the state is required to review and revise policies, procedures, and practices, and the local education agency is required to reserve the maximum amount of funds under Section 613(f) of the statute to provide early intervening services to children in the local education agency, "particularly, but not exclusively" to those in groups that were significantly overidentified. These regulations clearly define steps that states must take to address the problem of disproportionality in special education. See IDEA Part B: Culturally and Linguistically Diverse Students.

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act — also known as the Affordable Care Act (ACA)—addresses the expansion of health care coverage to populations that may not have been served in the past, explicitly linking health literacy to patient protection and then offering funds/grants for programs to increase cultural responsiveness. The ACA (2010) uses specific language regarding patient–provider communication—including provisions to

communicate health and health care information clearly, promote prevention, ensure equity and cultural competence, and deliver high-quality care.

Title VI of the Civil Rights Act

Title VI of the Civil Rights Act of 1964 (1989) prohibits discrimination in any federally funded program on the basis of race, color, or national origin. This includes any public or private facility, such as a hospital, clinic, nursing home, public school, university, or Head Start program that receives federal financial assistance, such as grants, training, use of equipment, and other assistance. According to the Office of Civil Rights, all providers who work for any agency funded by the U.S. Department of Health and Human Services are required to provide language access services to patients who do not speak English.

State Laws and Regulations

Differences in state regulations are reflected in a number of requirements (see ASHA's State-by-State webpage for further information).

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ABOUT ASHA

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 228,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology assistants; and students.

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CULTURAL COMPETENCE CHECK-IN: CULTURALLY RESPONSIVE PRACTICE

This tool was developed to heighten your awareness of how you view the influence of culture and language on service delivery. NOTE: There is no answer key; however, you should regularly review and reflect upon areas that you rated a 3 or even a 2.

Ratings: 1 : Things that I always do 2 : Things that I sometimes do 3 : Things that I rarely do

___ I recognize that narrative styles and pragmatic behaviors vary across and within cultures.

___ I proactively learn about behaviors and customs that are prevalent for my clients/patients/students.

___ I understand that some individuals may have different reading levels in English and/or in additional language(s).

___ I provide clients/patients/students with take-home resources that are written in their preferred languages.

___ I seek assistance from trained interpreters, bilingual coworkers, and those in related professions who can help interpret, as needed.

___ I have trained my interpreters using clearly defined roles and responsibilities to assist me in providing services to linguistically diverse populations.

___ I ask questions about language developmental history for all language(s) used.

___ I ask clients/patients/students' family members and friends about the ability to use English and additional language(s).

___ I ask clients/patients/students' family members and friends about the exposure to English and additional language(s).

___ I seek out information on how my clients/patients/students' language(s) may influence their English.

___ I listen for and am familiar with American English dialects and their influence on syntax and semantics.

___ I understand that code switching most often reflects typical and skilled use of more than one dialect and language.

___ I share my pronouns, and I ask my clients/patients/students to specify their pronouns.

___ I ask my clients/patients/students their name to use in sessions and their name to use for insurance purposes/paperwork.

___ I ask when it's acceptable for me to use the names provided to me, in an attempt to respect the privacy of my clients/patients/students.

___ I consider bias in assessment tools and materials (e.g., language batteries, articulation assessments, Pb word lists, spondee word lists) and make modifications, as appropriate.

___ I include the clients/patients/students and their caregivers as partners in determining outcomes for treatment.

___ I consider decisions to seek alternative treatments from a holistic practitioner in developing treatment plans.

___ I consider my clients/patients/students' beliefs in both traditional and alternative medicines when I make referrals.

___ I consider the cultural and linguistic background of current and potential clients/patients/students when I select treatment materials (e.g., assessment, pictures, books/workbooks, flashcards, videos, music, food).

I consider cultural norms and preferences when planning:

- ___ Appointments
- ___ Community outings
- ___ Holiday celebrations
- ___ Meals and snacks
- ___ Services in the home
- ___ Homework and recommendations for caregivers

I allow for alternative methods of sharing experiences and communication, such as:

- ___ Storytelling
- ___ Use of props to support the oral tradition that is prevalent in some cultures

I allow for alternatives to written communication, which may be preferred, such as:

- ___ Communicating verbally
- ___ Modeling the recommendations
- ___ Using video/audio clips
- ___ Using technology, such as texting, apps, and so forth

When communicating with individuals whose native language is not English, I use:

- ___ Trained interpreters/translators
- ___ Keywords or signs in their language
- ___ Visual aids
- ___ Gestures/physical prompts

___ I am aware that health care disparities and over- and under-identification create barriers to clinical services for individuals across diverse backgrounds.

___ I am familiar with specific disorders/diseases that have higher incidence in individuals across diverse backgrounds that may have implications for speech, language, and hearing.

* Although several sources were consulted in the development of this checklist, the following document inspired its design: Goode, T. D. (2002). Promoting cultural and linguistic competence self-assessment checklist for personnel providing services and supports in early intervention and childhood settings (Rev. ed.). National Center for Cultural Competence, Georgetown University Center for Child and Human Development, University Center for Excellence in Developmental Disabilities Education, Research & Service.

REFERENCE THIS MATERIAL AS FOLLOWS:

American Speech-Language-Hearing Association. (2021). Cultural competence check-in: Culturally responsive practice. https://www.asha.org/siteassets/uploadedfiles/multicultural/culturally-responsive-practice-checklist.pdf.

CULTURAL COMPETENCE CHECK-IN: SELF-REFLECTION

This tool was developed to heighten your awareness of how you view the influence of cultural and linguistic factors. NOTE: There is no answer key; however, you should regularly review and reflect upon areas that you rated as 3, 4, or 5.

Ratings: 1 : Strongly Agree 2 : Agree 3 : Unsure 4 : Disagree 5 : Strongly Disagree

___ I am aware of and acknowledge the influence of others' cultural backgrounds.

___ I am aware of my beliefs and value systems and do not impose them on others.

___ I believe that it is acceptable to use a language other than spoken English in the United States.

___ I accept all levels of acculturation into the dominant culture.

___ I am inclusive of individuals who are LGBTQIA+ *(the common abbreviation for Lesbian, Gay, Bisexual, Pansexual, Transgender, Genderqueer, Queer, Intersex, Agender, Asexual, and Ally community).*

___ I know how to use pronouns that reflect all genders–binary and non-binary.

___ I know that not all genders align with sex assigned at birth.

___ I take responsibility for my comments or behavior that may result in a negative impact on others.

___ I recognize that not all groups experience equal degrees of privilege and/or marginalization.

___ I am driven to respond to others' insensitive comments or behaviors.

___ I do not knowingly participate in insensitive comments or behaviors.

___ I am aware that the roles of family members may differ within or across culture or families.

___ I recognize family members and other designees as decision makers for services and support.

___ I am inclusive of all family structures (e.g., divorced parents; same-gender parents; grandparents as caretakers; non-binary family members, close friends, and loved ones).

___ I understand the difference between a communication disorder and a communication difference.

___ I understand that views of the aging process may influence the decision to seek intervention.

___ I understand that there are several American English dialects.

___ I recognize that all English speakers use at least one dialect of English.

I understand that the use of a foreign accent or limited English skill is not a reflection of:

___ Reduced intellectual capacity

___ The ability to communicate clearly and effectively

I understand how culture can affect child-rearing practices such as the following:

___ Discipline

___ Dressing

___ Toileting

___ Feeding

___ Self-help skills

___ Expectations for the future

___ Communication

I understand the impact of culture on:

___ Access to health care systems

___ Education

___ Family roles

___ Religion/faith-based practices

___ Gender roles

___ Alternative medicine

___ Customs, practices, or traditions

___ Perception of time

___ Use of AAC

___ Views on wellness

___ Views on (dis)ability

___ The value of Western medical treatment

___ Employment

I understand how cultural norms may influence social communication in many ways, including:

___ Eye contact

___ Interpersonal space

___ Use of gestures

___ Comfort with silence

___ Turn-taking

___ Topics of conversation

___ Asking and responding to questions

___ Greetings

___ Interruptions

___ Use of humor

___ Decision-making roles

___ Directness

___ Play, including the value of play

*Although several sources were consulted in the development of this checklist, the following document inspired its design: Goode, T. D. (2002). Promoting cultural and linguistic competence self-assessment checklist for personnel providing services and supports in early intervention and childhood settings (Rev. ed.). National Center for Cultural Competence, Georgetown University Center for Child and Human Development, University Center for Excellence in Developmental Disabilities Education, Research & Service.

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ASHA

PERSPECTIVES

SIG 14

Research Article

Perspectives Relating to Multicultural Training With Speech-Language Pathologists

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ABSTRACT

Purpose: The goal of this project was to assess whether speech-language pathologists (SLPs) feel adequately prepared and comfortable interacting with multicultural clients. To determine whether an SLP feels prepared to interact with, to assess, to teach, or to treat a multicultural client, a 25-question survey was developed and administered.
Method: The survey included questions pertaining to the SLPs' experiences with other cultures, both professional and personal, if the SLP speaks more than one language, and if the SLP has received any formal training on how to interact with multicultural clients. The survey was sent out via e-mail to 814 licensed SLPs practicing in preschool, elementary, and secondary school settings in Mississippi and Alabama. A total of 38 surveys were returned, and 36 complete responses were obtained.
Results: Preliminary results indicated that many SLPs received minimal multicultural training and felt prepared to work with multicultural clients based on personal and professional experiences; however, they also believed that they could benefit from additional formal multicultural training.
Conclusions: Surveyed SLPs do not report receiving adequate training for serving multicultural clients. Many reported that they would benefit from additional formal training in multiculturalism to better serve clients. Further research is indicated to determine the effectiveness of graduate-level training in multiculturalism.

As the landscape of the field changes, speech-language pathologists (SLPs) find themselves working with clients from different cultures. In the 1990s, racial and ethnic minorities accounted for 80% of the population growth in the nation (Roseberry-McKibbin et al., 2005). While the population growth has slowed in light of the COVID-19 global pandemic, the racial profiles of the more recent generations have never been more diverse (Frey, 2021). Such diversity increases the likelihood that an SLP will have a client from another culture on his or her caseload. It is imperative that an SLP understands that cultural differences may influence how clients and families interact with providers of rehabilitative services (American Speech-Language-Hearing Association [ASHA], 2017).

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Culture

Porter and Samovar (1993) defined culture as

> "the deposit of knowledge, experience, beliefs, values, attitudes, meanings, hierarchies, religion, notions of time, roles, spatial relations, concepts of the universe, and material objects and possessions acquired by a group of people in the course of generations through individual and group striving." (p. 11)

This inclusive definition of culture continues to be relevant to how we understand culture today; however, Merriam-Webster (n.d.) defines culture as "the customs, arts, social institutions and achievements of a particular nation, people or other social group." This current definition expands what is assumed or formerly thought of culture as an origination from a geographical group to

include those bound by social entities. No matter where the cultural identity originates, it is important for each of us to acknowledge these identities within each other. The recognition of cultural identity is valuable in a profession centralized on human connection. It is important to note that culture is not always visible or audible, and we must seek to understand how our clients define their cultural identities (Ginsberg & Mayfield-Clarke, 2021). SLPs need to shift focus and begin to recognize that one's culture is not the only one with which people may associate themselves. Not only may a client identify with a different culture, but many people also move from one culture to another and identify with elements of multiple cultures (Damico & Hamayan, 1991).

A person's culture pervades every aspect of his or her life, from food and family structure to language and education (Anderson, 1991). Cultural identity is a very important aspect of peoples' lives. SLPs should thoroughly research the various cultures of their clients in order to best serve their multicultural clients. The goal is not to be competent in every culture, rather, maintain cultural humility, which could greatly impact the services provided to multicultural clients. Such research helps SLPs to better understand how familial and cultural values affect best practice service delivery to multicultural clients.

Cultural Humility and Cultural Competence

The desire to truly know, to understand, and to learn about other cultures is sometimes even more important than conducting research on multicultural topics. Cultural competence encompasses behaviors, attitudes, and skills that are integral parts of cross-cultural communication (Alizadeh & Chavan, 2016). Verdon et al. (2015) identified six "Principles of Culturally Competent Practice" (PCCP). Of these, "Knowledge of language and culture" was included. Putting in the additional time and effort to learn produces a respect for other cultures, which, in turn, produces a respect for multicultural clients and their families (Anderson, 1991). Additionally, the work of Cross et al. (1989) demonstrated a continuum spanning from "cultural destructiveness" to "cultural proficiency." This model is important, because it demonstrates the positive and negative contributions that cultural understanding, or the lack there of, can have in professional and human connection. Historically, cultural competence and cultural humility have been used interchangeably; however, in 1998, these terms began to be distinguished and defined as separate entities (Tervalon & Murray-Garcia, 1998). Cultural competence terminology generally prevails within the professional education area. More recently, the literature shows a shift from achieving cultural competence to a lifelong perspective of cultural humility. When discussing the shift beyond cultural competence, Ginsberg and Mayfield-Clarke (2021) state that cultural humility is dynamic and a way of thinking as opposed to a skill that can be measured for accuracy. Cultural humility is defined as a lifelong commitment to understanding and discovering culture in ourselves and others; cultural humility catapults us to self-examine our thoughts and biases toward certain cultural attributes (Yeager & Baer-Wu, 2013). It is difficult to determine when or how one can be culturally competent; however, a provider can adopt a perspective of cultural humility within their service provision. Cultural competence leads to the dismantling of cultural stereotypes and assumptions that often occur when working with people who come from different cultural backgrounds (Battle, 2012).

Conducting research and familiarizing oneself of stigmas associated with different treatment delivery services furthers the concept of cultural competence. Ignorance, as it relates to a client's social, linguistic, and cultural norms perpetuates common stereotypes, and researchers can help to dissipate them. SLPs can only effectively and efficiently treat their clients if they do so within the contexts of family and culture (Anderson, 1991).

Cultural Perspectives on SLP Services

An individual's view of speech, language, cognitive, and swallowing disorders is often rooted in religious and cultural beliefs. In many cultures, there are stigmas associated with having a communication disorder (Bebout & Arthur, 1992). Because of such stigmas, patients or caregivers often omit pertinent information during the initial assessment, because they are embarrassed, or because they do not recognize the importance of discussing a communication issue (Bebout & Arthur, 1992). Since the initial assessment and treatment processes depend heavily on communication with the patient or caregivers, the more information the SLP is provided related to issues or cultural beliefs, the more he or she can be proactive in regard to any difficulties that may arise during treatment (Bebout & Arthur, 1992; Martin & Nakayama, 2001). Research can be as simple as interacting with people who come from different cultures; the more interactions one has with other cultures, the greater is his or her cultural sensitivity (Anderson, 1991).

Multilingualism and SLP Services

Cultural considerations also apply to clients who speak multiple languages. With the increase in racial and ethnic minorities, the number of multilingual students has also increased. It was reported in Table S1601 of the Census Bureau's 2019 American Community Survey that more than 67 million people age 5 years and older speak a language other than English at home. Over 12 million of multilingual people are between the ages of 5 and

17 years, which are considered to be school age in the United States. With a multilingual population of this size, it is imperative that monolingual SLPs begin to explore the best practices in assessment and treatment of the multilingual community. It is not appropriate for SLPs to administer assessment tools that were normed and standardized on English-speaking individuals to multilingual or limited English-speaking student and to use those results to determine whether a disorder is present (Every Student Succeeds Act, U.S. Government Publishing Office, 2015). Such tests, administered by SLPs who are only proficient in one language to students who are culturally or linguistically diverse, are unfair and biased, as these standardized assessments generally are not normed on populations that are representative of their cultures. Limited English Proficient (LEP) test scores likely will be lower than those of typical English-speaking students, and their test results will not reflect their actual speech and language capabilities (Adler, 1990). Because of this bias, coupled with the ever-increasing number of clients who speak multiple languages, SLPs should make every effort to locate translators or interpreters who are familiar with assessment practices in the student's own language or dialect, if the student does not appear to speak with native-like proficiency.

Many SLPs have reported that it can be difficult to find a translator or interpreter (Gibson, 2019). If there are no available professionals who speak the client's language, the client's teachers or peers can help with translations. In extreme cases, a client's immediate relatives can translate during an assessment, provided they can remain neutral (Wyatt, 2012). Administering an assessment in the client's primary language allows the client to feel more comfortable and to focus better when answering questions, which can help to level the playing field when it comes to the administration of culturally biased standardized tests.

Many SLPs say that they are uncomfortable working with clients who speak another language (Gibson, 2019). However, simply having the knowledge of another language does not necessarily equate to cultural competence. SLPs must consider that the whole picture of learning a language, which in addition to the syntax, pragmatics, and semantics, also includes cultural components (Roseberry-McKibbin et al., 2005). Having formal multicultural training for all SLPs in graduate school and continuing education, especially for those who frequently work with such populations, is invaluable for the assessment and treatment of culturally different individuals.

When reviewing the research, it is evident that multiculturalism training is important to meet the standards of practice set forth by ASHA; however, it is unclear what areas of multiculturalism are lacking. Research needs to be collected from SLPs to determine their perspectives, competencies, and comfort level serving clients of multicultural backgrounds. Our survey study was developed to address the need for perspectives and training of SLPs on multiculturalism. The following research questions were investigated.

1. How are SLPs receiving multiculturalism training?
2. Do SLPs feel prepared and comfortable serving client who are culturally and linguistically diverse?

It is hypothesized that SLPs will report showing some progression toward growth in the area of multiculturalism; however, it is also hypothesized that much of that training will be at the determination of the SLP individually and not at the programmatic level within graduate schools.

Method

The purpose of this study was to assess whether SLPs feel adequately prepared and comfortable interacting with multicultural clients. The authors utilized a mixed-methods research design, and a survey of 25 questions was developed to assess SLPs' experiences pertaining to multicultural clients. The survey was approved by the university's institutional review board (IRB 19–470). The survey was distributed to 814 school-based SLPs and yielded a completion rate of 4% (38/814). This completion rate is small and could likely be attributed to the type of survey. This survey included a variety of open-ended questions, which can lead to survey abandonment because of the effort for participation. The other possibility is the method of survey distribution. Some do not check their e-mail regularly or have filters that send e-mails to a junk folder limiting access to the survey.

Selection of Participants

Participants were chosen via a search on ASHA's website. The search had filters applied for licensing, areas of expertise, work settings, and states. Participants were licensed CCC-SLPs with expertise working in one of three areas. These areas included the following: pre-elementary schools (preschools), elementary schools, or secondary schools. Participants practiced in the states of Mississippi and Alabama. The researchers reside in both of these states and elected to investigate this specific to those two states. The search yielded results based on information that members of ASHA provided for their personal profiles.

Survey Creation

The survey was created by the co-investigators and is an original tool. The investigators utilized their literature

review (Adler, 1990; Anderson, 1991; ASHA, 2017; Battle, 2012; Bebout & Arthur, 1992; Damico & Hamayan, 1991; Martin & Nakayama, 2001; Porter & Samovar, 1993; Roseberry-McKibbin et al., 2005; Wyatt, 2012; Yeager & Baer-Wu, 2013), information from ASHA, and their knowledge and expertise to determine what areas should be included on the survey. The survey comprised 25 questions that addressed years of experience, interactions with multicultural clients, understanding of SLPs' role serving cultural clients, and their perspectives on education and training of SLPs serving multicultural clients. The investigators chose to create an original tool to most accurately answer the questions that were presented in the initial creation of the project.

Presentation of Survey

The survey was sent via e-mail using the results from the search on the ASHA website. An announcement stating the goal of the study and information about the survey was sent in the body of the e-mail in addition to an anonymous survey link. Participants were asked to complete the survey within 1 week of receiving the link. A total of 814 surveys were e-mailed: 403 to SLPs in Alabama and 411 to SLPs in Mississippi.

There was no randomization, and all respondents were presented with the same message and survey in the same order. Once the participant gave consent to participate, five questions were presented on each page totaling six presented pages. No smart questioning or question logic was utilized to guide respondents through the survey, and the only forced response question was the consent on page 1. The participants had a back button and were able to change their answers to any question throughout the survey until submit on page 6 was selected.

Survey Questions

Survey questions covered a broad range of information pertaining to how long the SLPs had been practicing, their personal and professional experiences with other cultures, if the SLPs spoke more than one language, and if the SLPs had received any formal multicultural training on how to interact with multicultural clients. Survey questions can be found in the Appendix.

Data Collection and Coding

Data were collected and analyzed using Qualtrics software provided by the university. This software was password protected and utilized by the authors only. Any digital extractions of the data were password protected and shared via a two-factor authentication e-mail platform. The investigators used the collection and analysis tool to draw descriptive data represented in the Results section below. Because the respondent number was manageable, coding was completed by two of the investigators utilizing subjective analysis. No coding software was utilized. This is easily reproducible by having any research-trained person review the data related to the open-ended questions. The investigators for this research are trained using CITI Human Subjects Research Training provided by the university.

Results

Thirty-eight surveys were received, and 36 of the respondents provided complete responses. Each of the 38 respondents gave consent prior to starting the survey. Results from each question is reported for the total number that completed that question. Some results will reflect 36 respondents because of the incomplete responses. For the 38 SLPs who completed the survey, 14 had between 1–5 and 21–25 years of experience for an average of 4.75 years of experience. In the Appendix, Table 1 gives details of all respondents and the reported years of experience. As indicated, all respondents were from Mississippi and Alabama. The populations of these two states vary by 2 million people—Alabama reporting a population of over 4.9 million and Mississippi reporting 2.9 million in 2022 (Population World Review, 2022a, 2022b). Racial composition varies as well. Mississippi racial demographics show 58.41% White, 37.72% Black, 0.99% Asian, 0.48% Native American, and 1.35% two or more races. Alabama demographics show 68.09% White, 26.64% Black or African American, 1.36% Asian, 0.52% Native American, and 1.89% two or more races. With regard to gender, both Alabama and Mississippi report 51.5% female and 48.5% male. Both states also report 83% of the population identify with Christian faith, 2% with a non-Christian religion, and 14% do not affiliate with any religion (Population World Review, 2022a, 2022b). While each state varies in different areas, it is clear that there is diversity in each state. When you compare this to the data from the SLP profession, the service provider demographics do not reflect the demographics served.

Table 1. Respondent years of experience as speech-language pathologist (SLP).

Years of experience	*n*	%
1–5	7	18.4
6–10	4	10.6
11–15	6	15.7
16–20	4	10.6
21–25	7	18.4
26–30	6	15.7
31–35	0	0
More than 35	4	10.6

Of the 38 participants, 52% had received some form of multicultural training. This training was reportedly received in many of the following settings: graduate school, continuing education units, conferences, undergraduate programs, ASHA conventions, professional development opportunities, and school systems. Many participants also said that they have had personal experiences working and interacting with people from different cultures. Sixty-eight percent said that they have personal experiences from living or studying abroad and travel experiences, from family members and friends, from church, from educational groups, and from growing up in rural areas. When asked about professional experiences, however, an overwhelming 84% reported that they have had such experiences. Professional experiences stemmed from using an interpreter for different languages, from working with multicultural clients throughout their careers, from working with multicultural colleagues, and from adapting articulation tests to reflect accent differences.

When questioned about whether they felt adequately prepared to interact with multicultural clients, 68% answered "Yes," whereas 32% answered "No." SLPs who said "Yes" cited reasons such as the following: interacting with friends and co-workers from other cultures, graduate studies, and conferences. Four SLPs who answered "Yes" said that they would only feel prepared if they were able to have an interpreter in the session, or only if the client was a bilingual English speaker. Those who answered "No" gave reasons such as the following: limited resources for assessing multilingual clients, lack of experience working with multicultural clients, or a lack of knowledge regarding languages other than English. Despite 64% already feeling adequately prepared, 84% of participants felt as though they would benefit from multicultural training because it was not covered in their graduate studies, because they would be more prepared to work in an ever-changing society, and because there is always more to learn. Sixteen percent said that they would not benefit from multicultural training because they would not have an opportunity to utilize it in their school systems, because they felt they had enough knowledge from previous training opportunities, or because they did not allow cultural differences to dictate what they do in sessions.

When asked about multicultural clients currently enrolled in their caseloads, 86% of participants said that they feel comfortable working with them. These SLPs were comfortable because of established relationships with students and their families, because they have many years of experience, and because they enjoy learning about other cultures and conducting research on their own. Only 14% indicated otherwise. The reasons given included a lack of training and experience with multicultural clients and language barriers that make it difficult to communicate, especially with parents who speak limited English.

SLPs responded to several components regarding multiculturalism, and the core numerical data are represented in Table 2. As it relates to pragmatic cues and behaviors, 53% of participants indicated that they think they understand the social cues provided by their multicultural clients. These participants said that they have really gotten to know their clients, to observe what their clients say and the gestures they use, and to communicate with parents to find out what may be culturally offensive to them. The 47% of participants who said that they do not understand the social cues of their multicultural clients reported that this was due to a lack of training, due to the vast number of different cultures, and due to the fact that they feel someone cannot truly understand another culture without years of experience or total immersion.

When asked if they mirror the behaviors of their multicultural clients' cultures that would be considered appropriate, 65% of SLPs surveyed reported that they do this. Reasons given as to why included the following: to help put their clients at ease, to establish rapport and help introduce their own culture's behaviors to the client so the client can take that knowledge, and to apply it to situations with peers. Of the 35% of SLPs surveyed who did not mirror their multicultural clients' behaviors, they said it was because their clients do not expect them to do so, or because they are unaware of what behaviors they should mirror. Some felt that there was no need for them to mirror the behaviors of multicultural clients.

When asked how their multicultural clients' cultures view communication disorders (speech, language, and hearing), over half of the respondents (51%) said that they were unaware of these views. Even more respondents (53%) said that they were unaware of how their multicultural clients' cultures normally addressed communication disorders.

When asked if they were aware, survey respondents were asked about how their multicultural clients' cultures view interacting with female versus male professionals, as it may impact how a client or a caregiver may interact with the SLP. Only 47% of SLPs surveyed shared that

Table 2. Areas of cultural consideration and practices.

Competency questions	Yes	No
Understand social cues	53%	47%
Mirrored behaviors	65%	35%
Knowledge of views of CD	49%	51%
Student perspectives gender	47%	53%
Client culture research	33%	67%
Adult interaction	64%	36%
Client culture questions	28%	72%
SLP shared culture	46%	54%
Multilingual SLPs	17%	83%

Note. CD = communication disorders; SLP = speech-language pathologist.

they were aware of their students' perspectives. The remaining 53% said that they did not know how their clients' cultures may view male versus female professionals.

Participants were asked if they had conducted any research into their multicultural clients' cultures to ensure the use of best practices. Thirty-three percent reported that they had conducted such research, and an overwhelming 67% reported that they had conducted no research related to their multicultural clients' cultures.

With culturally diverse views on female and male professionals, it follows that such cultures may also have different expectations regarding how children are expected to interact with adults. A majority of participants (64%) reported that they are aware of how their multicultural clients are expected to interact with adults, and only 36% reported otherwise.

There are many ways to conduct research into other cultures, one of those being to simply ask multicultural clients to share about their cultures. Only 28% of the SLPs surveyed reported asking their multicultural clients to share such information with peers or teachers, leaving 72% who did not ask their multicultural clients to share. On the other hand, 46% of SLPs surveyed reported that they have encouraged their clients to ask about U.S. culture or have shared their culture with their clients.

Gathering information about a client's home life provides invaluable insight into who the students are and how they do things. When asked if they had gathered such information about their multicultural clients, 59% of participants indicated that they have done so.

A client's home life can also play a role as it relates to participation in their original culture's traditions. Forty-nine percent of SLPs surveyed reported not knowing if their clients participate in original cultural traditions. Forty-six percent reported that their clients do participate in such traditions, and the remaining 5% stated that their clients do not participate in their original culture's traditions.

When asked how long their multicultural clients have been immersed in U.S. culture, some SLPs reported that their clients had only been immersed for a few months, and others reported up to 9 years of immersion. One SLP indicated that she worked with first generation multicultural students.

One component of multiculturalism is the use of multiple languages. Age of exposure and frequency of use shape multilingual proficiency (Owens, 2020). Because SLPs work with clients from a variety of cultures, they also tend to work with clients who speak a variety of languages. When asked if they feel that they have an adequate understanding of second-language acquisition, 33% said yes, 44% said no, and 22% said that their clients only speak one language. For the SLPs whose clients do speak more than one language, 42% indicated that they were familiar with communication patterns of their clients' other language(s), and 36% said that they were not familiar with these patterns.

Seventy-two percent of SLPs surveyed reported that their multicultural clients use their first language in the home environment. The language reported most frequently for home use was Spanish. Traditional Chinese, Russian, Vietnamese, Korean, Japanese, Hungarian, Mandarin, and Thai were other languages reportedly spoken at home. Only 6% of SLPs surveyed reported that their clients do not speak their first language at home.

Multiple languages can also lead to language barriers, especially during parental interviews or sessions with clients. Interpreters can be brought in to help overcome such language barriers, and 58% of participants said that they are comfortable contacting an interpreter, if necessary. Only 6% said that they would not be comfortable doing so, whereas 36% said that they have not had to use an interpreter.

While it is common for clients to speak multiple languages, SLPs often speak many languages, as well. Seventeen percent of SLPs surveyed said that they speak another language. Most have a basic or conversational knowledge of French, Spanish, or American Sign Language (ASL). One SLP indicated that she is fluent and literate in her second language; however, 83% of the SLPs surveyed said that they do not speak another language.

One important aspect to sessions is communicating information to the caregiver or parent about the progress of the client, or the plan for sessions. An overwhelming 81% of SLPs surveyed reported that they adequately convey information to clients and to family members, with only 19% indicating that they are unable to do so.

Discussion

Conclusions can be drawn from the data collected from this survey. It is evident that SLPs are currently treating students in the schools with multicultural backgrounds. This is congruent with the data that Frey (2021) reported of the U.S. population being more diverse than ever before. The results imply that many SLPs did not receive adequate multicultural training experiences during their matriculation through graduate school. One potential way to do this is to lead by example in higher education. Ginsberg and Mayfield-Clarke (2021) recommend that higher education should employ cultural humility not only in how we direct students to work with clients but also in how students are treated within the institution. Through this demonstration, it will be evident that the cultural humility that is taught can also be applied. (Ginsberg & Mayfield-Clarke, 2021).

The Council of Academic Accreditation (CAA, 2022) does not currently have a requirement for a dedicated graduate course on multiculturalism; however, the 2023 revisions to Standard 3.4b greatly expands the requirements of diversity, equity, and inclusion within

graduate programs. Some of these revisions include identification of implicit bias, acknowledgment of interaction of cultural and linguistic variables in communication, as well as the impact of multilingualism. The majority of respondents (84%) reported they would benefit from additional formal multicultural training. This poses the question as to whether or not more guidance regarding curriculum requirements for multiculturalism should be developed. On the basis of the revisions released, it seems evident that the CAA has identified DEI and multiculturalism as areas that need greater coverage and expansion within graduate programs.

When the survey data analysis was completed, the authors determined that only 24% of the participants received formal multicultural training while attending a graduate school program. Participants who acknowledged having received extensive training in multicultural language issues said that they had attended classes in graduate school, or while attending continuing education presentations during their professional careers. Some participants reported that they are prepared to work with multicultural clients based on personal and professional experiences.

Multicultural training varied significantly among the most recent SLP graduates. According to ASHA, coursework focused solely on multicultural and multilingual issues is not provided by all Communication Sciences and Disorders (CSD) programs (ASHA, 2020). As a result, the author determined that participants who indicated they had little, or no, formal multicultural training attended graduate programs that did not provide a multicultural class.

Although 18 participants received no formal multicultural training while attending graduate school, five of those 18 reported that they drew on personal experiences when interacting with multicultural clients. The other 13 participants gained experience by working professionally with other cultural groups, with multilingual clients, and with interpreters. While those five participants utilized knowledge gained through personal experiences, it is unlikely they were able to apply best practices to serve their clients, and the families of those clients probably were unfamiliar with the speech/language goals and objectives taught to their children during class sessions. This research explored preparedness and comfort level when working with multicultural clients, but a limitation is that it did not capture the data regarding SLP's self-efficacy. Self-efficacy goes beyond comfort or preparedness and determines whether SLPs are competent in creating change in a client's communication (Santhanam & Parveen, 2018). A staggering 68% of respondents reported feeling comfortable serving multicultural clients; however, many of the same respondents reported minimal use of evidenced-based practices in serving their culturally and linguistically diverse clients. Further research should go beyond measuring perceptions of comfort and look at self-efficacy and its correlation with the knowledge and use of evidence-based practice. Participants who had no professional experience teaching multicultural clients reported that they had difficulties when interacting with multicultural clients for the first time, such as having to adapt articulation tests when scoring to account for cultural differences. These difficulties reported by respondents demonstrate the idea that cultural competence is rarely obtained. Fostering a perspective of cultural humility in our programs and workplaces is the bridge needed to support growth in this area.

Six participants believed that they would not benefit from formal multicultural training. Some disclosed that they did not have an opportunity to use such training due to a lack of diversity in their school systems. An overwhelming majority of participants said that they wanted to expand their multicultural knowledge, to benefit from additional training, and most importantly, to support the needs of their multicultural clients. Although most of the survey respondents believed that they were adequately trained to teach multicultural clients, they also reported that additional training (both for themselves and for their clients) would be beneficial. It is evident from these data that SLPs are seeking more information regarding multiculturalism and our profession. These results lead us to an ongoing research idea that looks at student perspectives and the practices in place for teaching multiculturalism at the graduate level.

As mentioned previously, if SLPs are proactive when identifying learning obstacles, their class sessions are more productive (Bebout & Arthur, 1992; Martin & Nakayama, 2001). It appears that SLPs in Mississippi and Alabama want to learn more about other cultures, so they can be proactive during class sessions and to better serve their clients. Multicultural training of graduate students should include instruction related to cultural pragmatic differences, publications related to communication disorders and treatments of culturally different individuals, collaborations with other professionals, and responsiveness to cultural traditions as they relate to home life.

This survey research identifies other areas regarding multiculturalism that SLPs should consider when treating their clients. Cultural perspectives regarding methods of treatment and gender of service providers can be different from culture to culture (Bebout & Arthur, 1992; Martin & Nakayama, 2001). Many respondents were unclear on their client's cultural perspectives regarding speech-language and other medical treatments. Many also did not know their client's cultural perspective on female service providers. These are aspects of a culture that are important to know as one proceeds with services in schools or any other facility.

As stated previously, multicultural training of SLP graduate students should include as much instruction related to cultural differences as possible, specifically, as it relates to cultural pragmatic differences, collaboration

with other professionals such as translators, and fostering an attitude of cultural humility.

Obviously, it is quite challenging to know how to best serve multicultural clients without a requisite understanding of their languages or cultures. If CSD programs implement multicultural instruction into their curricula, SLPs who graduate from the field of Speech-Language Pathology will serve their clients more efficiently, and they will feel more comfortable with all aspects of assessment and class instruction.

These data were gathered from SLPs who currently practice in the states of Mississippi and Alabama, so it is unknown if survey results will vary from state to state. Other limitations would be that despite the large number of SLPs in the two states, only 38 responded making the sample rather small. This small response makes it challenging to generalize the information gleaned from these results. Additionally, this research addressed surface-level concerns regarding preparedness and comfort, but further research could address the idea of SLP self-efficacy and the need for dynamic clinical decision making through the use of evidence-based practice when serving culturally and linguistically diverse clients.

As we look forward at other areas of research that can address the gap in how we instruct regarding multiculturalism, it seems that gathering specific information regarding implementation of multiculturalism in the graduate curriculum would be vital. Another component of this is to consider student's/future SLP's perspectives related to their knowledge and needs surrounding their graduate training in multiculturalism. Programmatically, we can begin to foster conversations around cultural humility and lifelong learning as it relates to serving clients with multicultural backgrounds. Additionally, we can reflect and assess our current practices in higher education to ensure that not only are we educating in alignment with the standards but also that we are demonstrating cultural humility within classrooms and clinics.

Data Availability Statement

All data obtained and/or analyzed are available from the authors upon reasonable request.

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Appendix (p. 1 of 2)

Survey

1. How many years of clinical experience do you have?
    a. 1–5 years
    b. 6–10 years
    c. 11–15 years
    d. 16–20 years
    e. 21–25 years
    f. 26–30 years
    g. 31–35 years
    h. More than 35 years of experience
2. Have you received any formal multicultural training?
    a. If yes, when and where?
3. Have you had any personal experiences with cultures different from your own for an extensive time period?
    a. If yes, what were those experiences?
4. Have you had any professional experiences with cultures different from your own?
    a. If yes, what were your professional experiences?
5. Do you feel adequately prepared to interact with clients from other cultures?
    a. If yes, why?
    b. If no, why not?
6. Do you feel you might benefit from formal multicultural training?
    a. If yes, why?
    b. If no, why not?
7. Do you feel comfortable working with any multicultural clients who are enrolled in your caseload?
    a. If yes, why?
    b. If no, why not?
8. Do you think you understand most of the social cues and behaviors of your multicultural clients?
    a. If yes, why?
    b. If no, why not?

Appendix (p. 2 of 2)

Survey

9. Do you mirror behaviors of your multicultural clients' cultures that you consider appropriate (e.g., by using different customs and/or forms of greeting with them)?
    a. If yes, why?
    b. If no, why not?
10. Do you know how your multicultural clients' cultures view speech, language, and hearing disorders? Please elaborate on your response.
11. Do you know how your multicultural clients' cultures normally treat speech, language, and hearing disorders (e.g., do they rely on a clinician's help or use nontraditional methods such as homeopathic remedies)?
12. Are you aware of how your multicultural clients' families or cultures view female professionals vs. male professionals (e.g., how the clients' families/caregivers may interact with a female professional vs. a male professional)?
13. Have you conducted any research into your multicultural clients' cultures to ensure the use of best practices to serve them? If yes, what have you learned?
14. Are you aware of how your multicultural clients' cultures expect children to interact with adults (e.g., some cultures expect children to be seen, not heard)?
15. Have you asked your multicultural clients to share information about their cultures to their peers/teachers? If yes, what did you ask?
16. Have you encouraged your multicultural clients to ask questions about your culture or shared your culture with your multicultural clients? If yes, how did you encourage them?
17. Have you gathered information (via interview, etc.) regarding your multicultural clients' home lives? If yes, what have you learned?
18. Do your clients or their families still participate in their original culture's traditions? If yes, how do they do so?
19. On average, how many years has your client been immersed in U.S. culture?
20. As a speech-language pathologist working with clients who speak more than one language, do you feel that you have an adequate understanding of the process of second language acquisition?
21. If your client speaks another language, are you familiar with the communication patterns of that language?
22. Do your multicultural clients tend to use their first languages at home?
    a. If yes, what languages do they speak?
23. Do you feel comfortable bringing in an interpreter for sessions or assessments, if needed?
24. Do you speak another language?
    a. If yes, what language and at what level of fluency (poor, fair, good, excellent)?
25. Are you able to adequately convey information related to treatment plans/outcomes to your clients and their family members?

Section 7: Telepractice

- Overview and best practices
- Resources
- Instructions for how to use Zoom

Telepractice: An Overview and Best Practices

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Abstract

Telepractice is the use of telecommunications technology to deliver speech therapy and audiology services to a client who is in a different physical location than the practitioner. This article presents a general overview of telepractice, including terminology and definitions; ethical considerations; privacy and security; reimbursement policy and trends; considerations for client selection; and telepractice resources. It was written to provide foundational information about telepractice for practitioners who are engaged with alternative and augmentative communication (AAC).

Technological advances and evolving health care policy have significantly impacted speech-language pathology and audiology over the past decade. Increased interest in telepractice is a natural progression of this evolution. Defined broadly, telepractice is the use of telecommunications technology to deliver speech therapy and audiology services to a client who is in a different physical location than the practitioner (American Speech-Language-Hearing Association, 2013b). While telepractice has been used to deliver speech-language pathology and audiology services for decades, a significant increase in its use is the result of expansion of the Internet and the increases in computing capacity (Houston, Fleming, Brown, Weinberg, & Nafe, 2014).

This article presents an overview of telepractice, including key terminology and definitions; examines current telepractice evidence; outlines important regulatory and ethical guidelines; discusses reimbursement policy and trends; identifies practice considerations; and outlines key telepractice resources.

Definitions and Terminology

"Tele" terminology is nascent and evolving. Rehabilitation professions and organizations have adopted different terms to describe the same construct: remote service delivery. The American Speech-Language-Hearing Association (ASHA) defines telepractice as "the application of telecommunications technology to the delivery of speech language pathology and audiology professional services at a distance by linking clinician to client or clinician to clinician for assessment, intervention, and/or consultation" (ASHA, 2013b, para. 1). Additional terms used to describe this remote service delivery model and endorsed by ASHA include teleaudiology, telespeech, and speech teletherapy (ASHA, 2013b).

Other organizations have introduced telepractice terminology. The Tele-AAC Working Group of the 2012 ISAAC Research Symposium introduced the term "tele-AAC" to refer to "a unique cross-disciplinary clinical service delivery model that requires expertise in both telepractice and augmentative and alternative communication (AAC) systems" (Anderson et al., 2012, p. 80). The American Physical Therapy Association (APTA) and the American Occupational Therapy Association (AOTA) officially promote the term 'telehealth' within their respective professions (AOTA, 2013; APTA, 2012). The American Telemedicine Association (ATA), an organization comprised of many professional disciplines and institutional and industry partners, tends to employ 'telemedicine' and 'telehealth' as expansive, umbrella terms. The more specialized term *telerehabilitation* refers to habilitation and rehabilitation services (ATA, 2010a), including telepractice, telespeech, and teleaudiology. The variability of terminology between (and even within) professions requires practitioners to utilize multiple search terms to locate evidence and resources associated with telepractice.

Telepractice Evidence-base

A significant body of research to support the use of telepractice for the delivery of speech therapy, audiology, and AAC services is available when searching with the key terms mentioned above.

Telespeech

Telepractice research for speech-language pathology (i.e., telespeech) currently encompasses the assessment and treatment of articulation disorders (Crutchley, Dudley, & Campbell, 2010; Waite, Cahill, Theodoros, Busuttin, & Russell, 2006); language and cognitive disorders (Brennan, Georgeadis, Baron, & Barker, 2004; Waite, Theodoros, Russell, & Cahill, 2010); aphasia (Hall, Boisvert, & Steele, 2013); autism (Boisvert, Lang, Andrianopoulos, & Boscardin, 2010; Parmanto, Pulantara, Schutte, Saptono, & McCue, 2013); dysarthria (Hill et al., 2006); fluency disorders (Carey, O'Brian, Onslow, Packman, & Menzies, 2012; Lewis, Packman, Onslow, Simpson, & Jones, 2008); dysphagia (Coyle, 2012; Perlman & Witthawaskul, 2002); resonance disorders (Golding-Kushner, 2013); and voice disorders (Burgess et al., 1999; Halpern et al., 2012; Mashima et al., 2003; Theodoros et al., 2006; Tindall, Huebner, Stemple, & Kleinert, 2008; Towey, 2012b). A preponderance of the peer-reviewed articles published to date demonstrate that the clinical results gained via telespeech are comparable, and in some cases superior, to those of comparable treatment that is delivered in-person. It should be noted, however, that some authors selectively employ a "hybrid" approach to telepractice (i.e., a combination of in-person and telepractice sessions) when the clinician's judgment dictates such is required for a specific patient.

Teleaudiology

Proof of concept for teleaudiology now exists for pediatric hearing screenings (Krumm, Huffman, Dick, & Klich, 2007; Krumm, Ribera, & Schmiedge, 2005; Lancaster, Krumm, Ribera, & Klich, 2008); pure tone audiometry (Krumm, Ribera, & Klich, 2007); speech in noise testing (Ribera, 2005); hearing aid fitting (Campos & Ferrari, 2012); cochlear implant fitting (Wasowski et al., 2010); aural rehabilitation (Polovoy, 2009); and video-otoscopy (Burgess et al., 1999; Eikelboom, Atlas, Mbao, & Gallop, 2002; Heneghan, Sclafani, Stern, & Ginsburg, 1999; Sullivan, 1997). Vento and Krumm (2013) observed that while telehealth services can be delivered by either asynchronous (i.e., "store and forward") or synchronous (i.e., in "real time") methods, teleaudiology services are best administered via a hybrid model that incorporates both asynchronous and synchronous technologies. Most teleaudiology procedures can be deployed in a synchronous manner. An exception to this is tympanometry, since current tympanometers are not easily connected to computers to accomplish remote computing.

Tele-AAC

The interest in the use of telepractice to deliver clinical AAC services at a distance (Tele-AAC) is growing, with the opportunity to provide clinical AAC services to underserved

populations in the United States and worldwide. Going forward, the Tele-AAC Working Group of the 2012 ISAAC Research Symposium articulated numerous research needs and recommendations, many of which could apply to telespeech in general. The following are selected recommendations that are the most unique to Tele-AAC delivery:

- "As identified by the person who uses Augmentative and Alternative Communication (PWUACC), Tele-AAC should address the needs of the PWUACC's circle of communication partners" (Anderson et al., 2012, p. 80).
- "The Working Group recommends that it is important to identify and characterize the unique opportunities and constraints of Tele-AAC in all aspects of service delivery. These include, but are not limited to: needs assessments, implementation planning; device/system procurement; set-up and training; quality assurance; client progress monitoring; and follow-up service delivery" (Anderson et al., 2012, p. 81).
- "The Working Group recommends that institutions of higher education and professional organizations provide training in Tele-AAC service provision" (Anderson et al., 2012, p. 81).
- "The Working Group recommends that research and development in Tele-AAC involve and value the input of PWUACC. Research and development are needed to create valid measures across Tele-AAC practices (i.e., assessment, implementation and consultation); determine the communication competence levels achieved by Tele-AAC users; discern stakeholders' perceptions of Tele-AAC services (e.g., acceptability and viability); maximize Tele-AAC's capacity to engage multiple team members in AAC assessment and ongoing service; identify the limitations and barriers of Tele-AAC provision; and develop potential solutions" (Anderson et al., 2012, p. 81).

Environments

As stated on the ASHA Telepractice portal, "Telepractice venues include schools, medical centers, rehabilitation hospitals, community health centers, outpatient clinics, universities, clients'/patients' homes, residential health care facilities, childcare centers, and corporate settings" (ASHA, 2013a, para. 4). An initial impetus for interest in the telepractice delivery model was that it enabled healthcare providers to serve clients and their families in "exceptional settings." These may include remote and/or rural locations; difficult to access settings (e.g., correctional institutions); extreme environments (e.g., ships, spacecraft); and school districts that suffer from qualified staff shortages (Crutchley & Campbell, 2010). Most recently, Grogan-Johnson (2014) described an effective school-based telepractice service delivery model conducted in conjunction with Kent State University. This project development was guided by the results of a structured needs assessment (i.e., included in Appendix A of the cited reference).

Telepractice is increasingly viewed as a service delivery option with even wider applicability. Vento and Krumm (2013) wrote that "most audiologists believe that teleaudiology is useful for those individuals who live in rural communities where hearing health-care services are lacking or absent" (p. 126). Noting that Ciccia, Whitford, Krumm, and McNeal (2011) successfully deployed teleaudiology for individuals in inner city clinics, Vento and Krumm (2013) concluded: "...we need to expand our current notion and definition of teleaudiology" (p. 126).

It is a misconception that telepractice must be conducted at a distance; an example follows as to why telepractice might be deployed locally. In many Pittsburgh, Pennsylvania neighborhoods, decades old duplex homes were constructed with steep front steps leading to home entrances and precipitously sloped driveways with absent or unconnected garages. Residents of all ages and health status find themselves experiencing difficulty safely negotiating this architecture in ice and snow—a source of high appointment cancellation rates even for

those who live in very close proximity to their practitioner's office. Telepractice can seamlessly transcend such barriers.

Telepractice can also allow parents at work or at home to view their child's school therapy session and to communicate with members of their child's interdisciplinary team. For consumers of Tele-AAC, telepractice has the capacity to simultaneously link a provider of technical support to the client and clinician, avoiding multiple meetings and service delays.

Telepractice is also well suited to an increasingly mobile U.S. population. A client can continue to receive speech therapy while on vacation or on work-related travel—as long as the client's clinician holds the required out-of-state license. Telepractice can also accommodate clinician travel; when a private and secure Internet connection is available, a telepractitioner with the required out-of-state license can conduct therapy sessions while he or she is out of town.

If power sources and Internet connectivity prevail, telepractice can be used to avoid uninterrupted clinical service after natural disasters. Following Hurricane Sandy, travel in many parts of New Jersey was difficult, and gasoline was scarce. Telepractitioner Karen Golding-Kushner, whose own neighborhood experienced power losses for 2 weeks in October 2013, was able to temporarily relocate to a hotel with electrical power and largely maintain the continuity of her full-time telepractice-based private practice (K. Golding-Kushner, personal communication, December 23, 2013).

In addition to providing more convenient access to services, data are emerging that telepractice affords the opportunity to provide savings in travel time and expenses for both the client and practitioner (Tindall & Huebner, 2009; Towey, 2012b).

Telepractice also affords the opportunity to serve clients and their families in authentic, naturalistic environments (e.g., in school, at home, in the community, and in the workplace). Towey (2012a) described the use of high definition audio and video to engage clients in web-based interactive activities and called for "a speech therapy upgrade for the 21st century that harnesses the power of authentic, web-based content" (p. 73). He and his colleagues at Waldo County General Hospital, Belfast, ME, construct telespeech activities wherein "both therapists and clients manipulate the materials and interact online in real time. The web-based technology engenders highly personalized and engaging activities, such that clients' interactions with these high interest tasks often continue well beyond the therapy sessions" (Towey, 2012a, p. 73).

Current and future telepractice technologies will likely dramatically change features of the clinical practice environments for speech-language pathology. Williams (2013) described impactful "near emerging technologies" such as mobile and tablet computing; "serious games" (designed for an educational or clinical purpose, in contrast to "social games"); simulation learning experiences; and gesture-based computing (including digital puppets). She further identified "far developing technologies" such as augmented reality head mounted displays (e.g., Google's Project Glass); immersive virtual reality cave automatic environments (CAVEs) that possess features of the Star Trek Holodeck environments in which objects and people are simulated in an enclosed room via projected holographic images, perhaps with corresponding smells; and the therapeutic use of socially interactive robots. Williams (2013) anticipates dramatic changes in the future conduct of speech therapy, writing that "the new generation of educational technology provides both opportunities and challenges for the SLP [speech-language pathologist] profession. While learning these new skills may be daunting to some, the promise they offer patients with communication disorders makes it worth the effort" (Williams, 2013, p. 29).

Regulation

Licensure

The use of telepractice improves access to care, specialists, and subspecialists (Clawson et al., 2008); however, state licensure policy does not engender interstate licensure portability or reciprocity. Presently, with few exceptions (i.e., federally based practice settings), a practitioner is required to be licensed in both the state where he/she is physically located and in the state where the client is physically located when engaging in interstate practice (ASHA, 2013b; Cason & Brannon, 2011). When engaged in interstate practice, "location of service" is defined by the client's physical location; adherence to the scope of practice where services are rendered is required (Cason & Brannon, 2011).

The challenges associated with holding multiple state licenses are not new (e.g., practitioners working as traveling therapists or in multiple states due to proximity to state borders); however telepractice amplifies these challenges as technology is not bound by borders. Acquiring and maintaining multiple state licenses can be time consuming and costly; therefore a model to facilitate state licensure portability is needed (Brannon, Cohn, & Cason, 2012; Cohn, Brannon, & Cason, 2011).

Grassroots initiatives and national efforts reflect the interest and need for a licensure portability solution (ATA, 2012a, 2013a). In addition to providing a model regulation (ASHA 2012), which includes telepractice, ASHA has worked cooperatively with the American Telemedicine Association and other stakeholders to identify a licensure portability solution (ASHA, 2013b). Several models of licensure portability exist (e.g., compacts/mutual recognition, expedited license, limited license, national license, federal pre-emption; Cohn et al., 2011). ASHA endorses a limited license model (ASHA 2012). Currently, federal legislation for a national license model (ATA 2012a, 2013a) and a mutual recognition/compact model (Federation of State Boards of Physical Therapy, 2011; Federation of State Medical Boards, 2013) are garnering support among healthcare professions; however, the best mechanism to achieve full licensure portability for the rehabilitation professions remains undecided.

State Law

Due to the variability of state laws and regulations, licensure requirements, practice act language, and telepractice policy, it is incumbent upon practitioners to ascertain and abide by all state requirements when engaging in the use of telepractice (ASHA, 2013a, b; Cason & Brannon, 2011). Many states affirm ASHA's position and recognize telepractice as within a practitioner's existing scope of practice; however, some states have restrictive policies regarding the use of telepractice. For example, Delaware presently does not permit the use of telecommunications as the sole means of service delivery (ASHA, 2013a).

In addition to understanding state law, regulation, and/or policy for telepractice, practitioners must also determine if there are additional requirements per state law for the practice setting. For example, some states require practitioners working in school-based settings to obtain a teacher certification in addition to state licensure (ASHA, 2013b). It is the responsibility of the practitioner to ascertain and abide by all federal and state laws governing practice.

Federal Legislation

Federal laws governing in-person practice also apply to telepractice; these include the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Family Educational Rights and Privacy Act of 1974 (FERPA), and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH; ASHA, 2013b). Both HIPAA and FERPA provide protection of personal information; FERPA aligns with educational settings/practice models. The HITECH Act expands upon the protections of HIPAA by addressing privacy and security concerns

specific to electronic transmission of health information and imposes civil penalties for violations (Cohn & Watzlaf, 2011).

Practitioners must ensure the privacy and security of clients' protected health information (PHI) at all times. Use of passwords, encryption, virtual private networks (VPN), firewalls, and software configured for healthcare purposes mitigates risks associated with electronic transmission of health information, including service delivery via telepractice. Consultation with an information technology expert; development of privacy and security protocols, including breach notification policy; and a comprehensive risk analysis is recommended (ASHA, 2013b; Cohn & Watzlaf, 2011; Watzlaf, Moeini, & Firouzan, 2010).

Full compliance with federal laws requires maintaining the privacy and security of clients' PHI through electronic means as well as implementation of environmental safeguards. All written/printed materials with client information should be maintained in a secure area. During therapeutic encounters, persons present at both locations must be identified and measures taken to avoid non-authorized persons from entering the physical space or overhearing the therapeutic encounter. All electronic and environmental safeguards used to assure privacy and security of PHI should be documented.

Tele-ethics

The ASHA Practice Portal on Telepractice (ASHA, 2013b) succinctly states the ethical obligations of practitioners who engage in telepractice:

> The use of telepractice does not remove any existing responsibilities in delivering services, including adherence to the Code of Ethics, Scope of Practice in Audiology and Scope of Practice in Speech-Language Pathology, state and federal laws (e.g., licensure, HIPAA), and ASHA policy...(para. 3) There are no inherent limits to where telepractice can be implemented, as long as the services comply with national, state, institutional, and professional regulations and policies. (ASHA, 2013, para. 4)

The practitioner's paramount ethical responsibility is to uphold the welfare of the client. Cohn (2012) provided examples of best ethical practices for telepractice:

- **Competence/duty of care:** Practitioners should have knowledge of telepractice techniques, technologies, and research. Ensuring the safety of the client is paramount. The practicioner should ascertain the client's physical location and emergency phone numbers in advance of commencing the therapy session and have an emergency plan in place.
- **Equivalence of services:** The results of telepractice services should be equivalent or superior to in-person services.
- **Privacy of information:** Information transmitted during the therapy session (e.g., audio-visual), as well as communication with the client before or after a session (e.g., via phone, e-mail, or fax) must remain private, as per HIPAA. The security of the server within which clinical information is stored must also be protected "at rest," (i.e., when it is not being used).
- **Privacy of place:** The privacy of others in the home must be maintained. The practitioner should maintain control or supervision of the cameras.
- **Informed consent:** The client should agree to engage in telepractice; be informed of other service delivery options; be informed of and accepting of the limits of privacy and security using telepractice; and be informed of and accepting of the presence and qualifications of practitioners and assistants.

- **Equity of access:** Telepractice potentially reduces the inequities in access to service. In contrast, telepractice should not be used to enable a practitioner to discriminate (e.g., on the basis of gender/gender identity/sexual orientation, race or ethnicity, age, religion, country of origin or disability) by avoiding in-person therapy.
- **Licensure/Credentials:** The practitioner should not practice across state lines without holding the appropriate state licenses and credentials, or outside of the United States without the appropriate credentials.
- **Appropriate tele-supervision:** Students and support personnel who engage in telepractice must be appropriately trained and supervised. Their presence and identity should be revealed to the client before the session begins. (Consult the ASHA Telepractice Portal for additional details.)
- **Tele-research:** Clients should be informed of potential research conducted within telepractice and provide informed consent before the research begins.

Cohn (2012) also suggested that a client who receives speech-language pathology or audiology services via telepractice has the right to expect that the practitioner will minimize conflicts of interest in any relationships with equipment vendors; will not hold hidden any expected charges for telepractice; and will not charge fees that are higher than in-person services without providing prior notification.

The need to carry malpractice insurance that explicitly covers telepractice was initially addressed by Denton (2003). It is wise to carry appropriate levels of insurance from a solvent carrier and to secure written agreement that coverage will be supplied in a particular state or region. Such coverage is protective of the client as well as the practitioner, and is therefore responsive to the ethical obligation to hold the interests of the client paramount.

Reimbursement

Reimbursement for services provided via telepractice includes state mandated coverage by private insurance (21 states; ATA, 2013b); state Medicaid and Medicaid-funded programs, variable by state (Centers for Medicare and Medicaid Services [CMS], n.d.a); Department of Defense and Veterans Health Administration telehealth programs (U.S. Department of Veterans Affairs, 2013), and contractual/private pay with organizations and individuals. Currently, CMS does not recognize rehabilitation professionals, including SLPs and audiologists, as telehealth providers for Medicare reimbursement (CMS, 2012).

The Patient Protection and Affordable Care Act (2010) created opportunities for enhanced reimbursement of services provided by rehabilitation professionals via telepractice (ATA, 2010b; Cason, 2012). Bundled payment models and incentives for improving service delivery and care coordination have accelerated adoption of innovative service delivery models, including telepractice. The Center for Medicare and Medicaid Innovation (CMI), established by the Patient Protection and Affordable Care Act, may lead to expanded reimbursement of telepractice by funding initiatives that accelerate the development and testing of new payment and service delivery models, including telepractice; speed the adoption of best practices; and incentivize coordinated, high quality, efficient service delivery (CMS, n.d.b).

The American Telemedicine Association, with support and cooperation from ASHA, submitted proposals to the Center for Medicare and Medicaid Innovation to promote research that would demonstrate the value of telepractice as a means to serve students in school-based settings where SLP shortages exist (ATA, 2011). Seizing opportunities afforded by the Patient Protection and Affordable Care Act to integrate telepractice in the delivery of speech, language, audiology, and AAC services and becoming recognized on the CMS Medicare telehealth provider list (CMS, 2012) are critical next steps for the profession.

Preparing for Telepractice

While policy and reimbursement are progressing at the national and state levels, practitioners can take practical steps now to integrate telepractice into their existing speech, audiology, and AAC services. Key actions include conducting a needs assessment for organizational, environmental, and practitioner readiness; developing a business plan; selecting the appropriate technology, diagnostic, and therapy materials for the intended services; and developing policies and procedures to minimize risk and assure ethical practice using telepractice technologies.

Needs Assessment

After determining if the use of telepractice is permissible within the state where the client is located (i.e., "location of service") and reimbursable, a needs assessment is the next step to developing telepractice programming. A needs assessment enables an organization to systematically evaluate the programmatic and/or service needs of a population or community and identify gaps between available programs/services and client needs. Focus groups, surveys, interviews, and review of existing data (organizational records including financial reports and service utilization) are common approaches to conducting a needs assessment. Data including patient satisfaction; care coordination; service utilization, including no show rates; travel/distance to services; and available resources can be used to determine if telepractice would enhance current programming and improve access and quality of care.

Organizational/Environmental Assessment

Organizational buy-in cannot be underestimated and success of a telepractice program is contingent upon buy-in of both organizational stakeholders (i.e., administration, practitioners, information and technology (IT) support, and administrative and billing personnel) and external stakeholders (i.e., clients, community partners, referral sources, reimbursement entities). Identifying "telepractice champions" within the organization who understand telepractice and its potential benefits for the client is critical; a combination of administrative telepractice champions and practitioner telepractice champions is ideal. Assuring use of telepractice will be accepted by clients and referring entities is also vital.

To gain stakeholder buy-in, educational efforts explaining telepractice, existing evidence, proposed utilization of telepractice, and pilot programming may be needed. Additionally, outside consultants/telehealth experts may be valuable to provide advice and garner support.

Practitioner Readiness

Practitioners are the critical link between organizations and clients. It is vital for practitioners to be competent and comfortable implementing a telepractice service delivery model. Telepractice is not a good fit for all practitioners, just as it is not a good fit for all clients. Practitioners must possess knowledge and skills related to technology used to deliver services via telepractice, including measures to maintain privacy and security of PHI. Additionally, practitioners must be able to appropriately select clients who will benefit from a telepractice service delivery model and consider modifications and adaptations needed to accommodate the client's physical and/or cognitive limitations and cultural/linguistic needs. In some cases, support personnel are indicated, and it is the responsibility of the practitioner to train and utilize support personnel appropriately when delivering services via telepractice (ASHA, 2013b). An understanding of how the environment and therapeutic process, including communication style, impacts services and the ability to select appropriate diagnostic and therapeutic materials are also critical skills.

Technology Selection

Telepractice technology can be classified as synchronous (live, real-time interaction) or asynchronous (recorded/store-forward). The technology selected should reflect the telepractice application. Videoconferencing, a synchronous technology application, is most commonly utilized in the delivery of telepractice. While many practitioners and clients may utilize videoconferencing

in their daily lives, there are a number of important considerations when using videoconferencing for the delivery of speech therapy, audiology, and AAC services. Equipment selection should include consideration of hardware, software, peripheral devices, and connectivity needed to meet the therapeutic needs of the client. Hardware options for telepractice may include a desktop computer, mobile device (i.e., laptop, electronic tablet, smartphone), or specialized system (i.e., tele-audiology station; GlobalMed, 2013); web camera (internal or external); and high-speed connection. An array of camera options (e.g., pan-tilt-zoom, multipoint, high definition), microphone and audio accessories, and peripheral devices (i.e., video-otoscope, document camera, audiometer, sound level meter) are available.

Connection speed and Internet bandwidth affect videoconferencing quality; adequate bandwidth, a minimum of 384 Kbps (Kilobits per second), and technical support is recommended to ensure that technical issues do not impact the quality of services delivered via telepractice (ASHA, 2013b). There are many software options for videoconferencing; some are developed specifically for telehealth purposes. A risk analysis for HIPAA compliance is recommended when vetting videoconferencing software (Cohn & Watzlaf, 2011; Watzlaf et al., 2010).

Client Selection

Clinical reasoning guides appropriate selection of clients who will benefit from a telepractice service delivery model. Important considerations for client candidacy include the ability to participate in and benefit from services provided via telepractice. Physical, cognitive, sensory (e.g., auditory, visual), and/or communication impairments may negatively affect the client's ability to participate in services provided via telepractice (ASHA, 2013b). The client selection process should consider these limitations, potential modifications necessary to maximize participation, the nature of the interventions to be provided, and the support available to the client to determine if the use of telepractice is appropriate. Given the variability of clients and their contexts, therapeutic needs, and available supports (family members, facilitators), determination of candidacy for telepractice should be based on clinical reasoning and made on a case-by-case basis.

ASHA

For well over a decade, ASHA has recognized the value of remote service delivery and has dedicated resources and efforts to stimulate best practices in telepractice. The newly released Telepractice Practice Portal represents a comprehensive reference for ASHA members and the public (ASHA, 2013b). The Portal includes an educational video about telepractice; definitions; information about key issues for telepractice (i.e., roles and responsibilities, licensure and teacher certification, international considerations), reimbursement (i.e., private health insurance, Medicare, Medicaid, self-pay); client selection, environmental considerations, practice areas (i.e., audiology, speech-language pathology, modification of assessment and treatment techniques and materials, school setting considerations), telepractice technology (i.e., videoconferencing equipment, connectivity), facilitators in telepractice for audiology and speech-language pathology, state and federal laws and legislation (privacy and security), enlisting stakeholder support, and resources, organizations, and references.

In 2010, ASHA accepted a grassroots proposal to establish a Special Interest Division (now Special Interest Group [SIG]) on Telepractice (SIG 18). SIG 18 strives to enhance telepractice across professions and settings via ongoing continuing education and online dialogue among SIG 18 affiliates. SIG 18 also collaborates with other ASHA SIGs, as evidenced in the genesis of this article.

The American Telemedicine Association

The American Telemedicine Association (ATA) is the leading international resource and advocacy group for the adoption of telecommunications and information technology to improve health care services (ATA, 2012b). ATA actively educates and engages legislators, reimbursement entities, and the public to shape policy and perception around telehealth. ATA member benefits

include access to live and recorded telehealth information and training resources; networking and interprofessional discussion via special interest groups on the ATA's social networking site, The Hub; and conference registration discounts. ATA hosts two conferences each year, an international meeting recognized as the largest in the world dedicated to telemedicine and telehealth and a smaller conference each fall. ATA special interest groups (i.e., Telerehabilitation, Pediatrics, Business and Finance, Home Telehealth, Remote Monitoring, etc.) provide opportunities for professionals to connect around common interests. The Telerehabilitation Special Interest Group (TR SIG) of the ATA "is comprised of practitioners in health and education, and technology specialists who are engaged in applying educational services, and to support independent living" (ATA, 2010a, p. 4). In 2010, the ATA TR SIG produced the oft-cited telerehabilitation standard and guideline document, A Blueprint for Telerehabilitation Guidelines (ATA, 2010a). This document provides administrative, clinical, technical, and ethical principles to guide the delivery of services using telecommunication technologies. Telepractice providers can access this and other resources on ATA's website; most ATA resources are publicly accessible and support ATA's mission to educate stakeholders, develop policies and standards, and serve as a clearinghouse for information (ATA, 2012b).

Telehealth Resource Centers/Networks

The Office for the Advancement of Telehealth (OAT), funded by the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA), promotes and supports the use of telehealth technologies for the delivery of health care services and health education/information. OAT funds two national telehealth resource centers focused on technology assessment and telehealth policy, and 12 regional telehealth resource centers (Telehealth Resource Centers, 2013). The Telehealth Resource Centers provide expertise and practical support for telehealth program development. Online resources include archived telehealth-related webinars, topical modules (program development and operations, reimbursement, legal and regulatory, marketing, and practitioner training), and links to the 12 regional and two national resource centers, which house additional resources on their respective websites.

Many states have designated telehealth networks; these networks may be leveraged to support telepractice programming by capitalizing on existing infrastructure. While affordable desktop and mobile technologies can support many telepractice applications, telehealth networks and facilities are equipped with high-end commercial telecommunication technologies. These technologies provide higher resolution and lower latency (period of delay between video/voice or live video transmission) and may be a better solution for some services performed by SLPs and audiologists. Additionally, peripheral devices (i.e., video-otoscope, document camera, audiometer, sound level meter) may also be indicated for some services. A search using popular search engines yields information and links to states' telehealth network websites. These websites also contain telehealth resources and information that may be beneficial to practitioners interested in integrating telepractice into their existing services.

Conclusion

Telepractice, the use of telecommunications technology to deliver speech therapy and audiology services to a client who is in a different physical location than the practitioner, is a rapidly expanding service delivery model that is poised to provide great value to the users of AAC. Telepractitioners should be cognizant of the ethical considerations; hold the appropriate state licenses; uphold privacy, security, and client safety; engage in appropriate client selection; and become competent users of the technology. Professionals who engage in telepractice should remain watchful for changes in technology, policy, and reimbursement as this service delivery model continues to develop.

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Resource	Location	Description
Boom cards	Boomlearning.com	Boom cards are great for children of all ages up to adults. There are various free and paid boom cards that are available in the "boom store" or on teachers pay teachers. You can also make your own boom card decks. This site allows you to create a classroom and "assign" decks to each student so that they can practice and use the boom cards at home. You are able to view their submissions and see how they scored on each card. These can be modified to fit the needs of any client, any skill, and any age. Boom cards are engaging, motivating, fun, quick, and easy to use for online therapy and for parents at home.
Online silly picture scenes	UltimateSLP.com	This website has a free 2 week trial and then a paid subscription option. This website offers a variety of speech, language, and social online activities. These activities are perfect to share on your screen over a video session. There are activities for children and adults. There are also lots of game options that allow you to target multiple targets at the same time or within the same game. The silly picture scenes have 20 objects that do not belong that all contain the target sound. You click on each item when you find it, then practice saying the word aloud.
Online interactive game boards	UltimateSLP.com	This website has a free 2 week trial and then a paid subscription option. This website offers a variety of speech, language, and social online activities. These activities are perfect to share on your screen over a video session. There are activities for children and adults. There are also lots of game options that allow you to target multiple targets at the same time or within the same game. There are various board game designs to choose from. Each game allows you to pick your player icon. Multiple players can play at a time, so this is great for group sessions. Each player takes a turn by clicking the spinner on the screen. Prior to playing the game there is a list of speech, language, and social targets to choose from. The SLP will select the target skills and each skill will be targeted on a card. After each turn the student will click on a card to complete the prompt or question.
Social scene pictures	UltimateSLP.com	This website has a free 2 week trial and then a paid subscription option. This website offers a variety of speech, language, and social online activities. These activities are perfect to share on your screen over a video session. There are activities for children and adults. There are also lots of game options that allow you to target multiple targets at the same time or within the same game. There are 100 picture scenes that are real photos not cartoons or line drawings. This is a great material to work on story generation, social skills, inferencing, pragmatics, question generation, SVO sentences, etc.

Online clicker/counter	https://scorecounter.com/click-counter/	This is an online clicker/counter that is motivating for children to use or look at during therapy. You can customize the color and font of the clicker. There are also options to set a timer which would be a good option for "5-min therapy" or for different games.
Speaking of Speech	https://www.speakingofspeech.com/	Speaking of Speech is a website that contains a wide variety of free materials specifically for speech therapists. By clicking on the "Materials" tab, you will be provided numerous resources covering multiple different areas including articulation, fluency, language, etc. There are even forms created specifically for organizational purposes. Because this website includes a vast majority of options, numerous goals could be targeted via teletherapy while utilizing these materials. All the clinician needs to do is choose the desired activity and download it to their computer. After doing so, during teletherapy, the clinician will be able to share their screen with their client to complete the task.
Storyline Online	https://www.storylineonline.net/	Storyline Online is a program of the SAG-AFTRA Foundation, a nonprofit organization that relies solely on gifts, grants, and donations to fund this resource. This website would be especially useful for clients who would benefit from narrative based intervention as this resource provides multiple different children's books ranging from 5-15 minutes long. The books are presented in a video format with an individual narrating while displaying creatively produced illustrations. This resource can be used during teletherapy by selecting a story appropriate for your client's current level of functioning. After choosing the book, share your screen with the client so that he/she is able to listen and enjoy the story as well. Examples of goals that may be targeted using this resource include sequencing, answering WH questions, and building vocabulary knowledge.
Teachers Pay Teachers	https://www.teacherspayteachers.com/?gclid=CjwKCAjw1v_0BRAkEiwALFkj5u29Xb_bUGZEQhxLD4MehuKGoGuFIRenSkY-pBgdWQGdaPa9YY6UOhoCHPcQAvD_BwE	Teachers Pay Teachers is an online marketplace where you can buy and sell a variety of materials. This website would be useful for teletherapy as clinicians can easily search for items specifically created to target certain skills. Although some items cost money, many resources are free and are great to use with children. Additionally, Teachers Pay Teachers allows you to search for materials by grade and categories, making your hunt for online resources simple. This could be used for all clients as there is something on there for everyone. In regard to my client this semester, I was able to utilize this website by finding stories containing idioms.
Global Allied Health Games for Telepractice	http://www.globalalliedhealth.org/games/initial-b-word-search1.shtml	This website offers a variety of games and activities which were designed to target a variety of speech, language, and executive function goals. Clinicians are able to easily select a tab (e.g., articulation, categorization, language, memory, problem solving, social skills) corresponding with their client's goals which will then lead them to multiple games that each target a specific skill.

Tactus Therapy Apps	https://tactustherapy.com/	Provides both purchased version and lite (free) version of apps created for individuals with various aphasias. Specific areas targeted by various apps include: comprehension, naming, reading, writing, advanced versions of the previous four, conversation, apraxia, dysphagia, categories, numbers, questions, spaced retrieval, speech flipbooks, AAC.
Code Combat game	https://codecombat.com/home	This game teaches different coding languages as the player worls his/her way through challneges and gains items. The computer follows the typed plan exactly and runs tests so the client can see exactly where the error occurs and has to fix it to move on. The game functions as a highly motivating way to promote strategic planning and task monitoring.
Science News for Kids	https://www.sciencenewsforstudents.org/	Provides a variety of recent news articles with interesting topics within earth, humans, life, physics, space, technology, chemistry, math, and social science categories. Articles are written at 9-14 year old reading levels and topics can be tailored to clients' interests.
UCLA PEERS Videos	https://www.semel.ucla.edu/peers/resources/role-play-videos	Online library of social skill role-play videos that provide examples of good and bad pragmatic skills related to conversation, entering a conversation, ending a conversation, use of humor, electronic communication, sportsmanship, get togethers, handling arguments, handling teasingm handling rumors and gossip, and dating etiquette. Videos are short and typically ask questions at the beginning and the end. Characters in the videos are young adults role-playing the scenarios. Characters display many obvious nonverbal signals in most videos.
Online deduction puzzles	https://logic.puzzlebaron.com/	This website can be used by sharing the puzzle you want the client to complete and then having him/her share their screen while completing the puzzle so the appropriate cues can be given while completing the puzzle. Deduction puzzles can be utilized to address verbal reasoning skills and this website provides a way for the client to complete the puzzle using an online format.
Social inferencing, YouTube and Zoom	https://www.youtube.com/	YouTube can easily be used for telepractice since the clinician can share their screen with the client and target social inferencing/prediction skills by watching the video clip and pausing the clip and talking about the clip with the client.
Scategetories online	https://scattergoriesonline.net/new-game-create.xhtml	Using the website, the clinician can share the game link with the client and play scategories together in real time. This can easily be used over telepractice because the client can share their screen with the clinician, so the clinician can provide appropriate cues to the client as they are completing the word deduction task. Scategories can be used to target word deduction skills by providing two stipulations (e.g., specific category and letter) to use to generate an appropriate word.
WALC books online	http://affiliatedrehab.com/ipad/files/walc_1_aphasia_therapy.pdf http://affiliatedrehab.com/ipad/files/walc_2.pdf http://affiliatedrehab.com/ipad/files/walc_3.pdf http://affiliatedrehab.com/ipad/files/walc_5.pdf	Using Google drive, the clinician can share worksheets from one of the workbooks to the shared drive and both the client and the clinician can be on the document at the same time to target any of the skills in the WALC books. The WALC books

	http://affiliatedrehab.com/ipad/files/walc_6.pdf http://affiliatedrehab.com/ipad/files/walc_8-Word_Finding.pdf http://affiliatedrehab.com/ipad/files/walc_9.pdf	provide process specific therapy tasks (e.g., WALC 9 has activities for various verbal and visual reasoning tasks) that can be used to develop target skills in deficit. The tasks can be modified by increasing or decreasing the complexity of the task to meet client specific needs.
Naming/Barrier game	https://www.teacherspayteachers.com/Product/Easter-Barrier-Game-562758	Naming verbs will help promote use of verbs in everyday conversation while also diversifying the types of words used by the client. Barrier games are also a great clinical activity that can also be used within the teletherapy format. To "spice" up the activity of naming the naming activity can be switched to a more barrier game type format. Either the clinician or the client can be blocked from seeing the visual cue and must describe the visual cue to their conversational partner.
Semantic feature awareness	https://wow.boomlearning.com/deck/semantic-feature-analysis-sfa-boom-cards-for-aphasia-therapy-g8hEFtwqPyw4ZJbtj https://www.teacherspayteachers.com/Product/I-Spot-Picture-Search-3626957	Semantic Feature Analysis is a therapy method that focuses on nouns. It aims to help clients accurately describe something they are trying to name by focusing on categorical, functional, action, location, associative, and property details. Boom cards are a great teletherapy tool that is easy to use and interactive for the client. These cards allow the client to work on feature targets. SFA works specifically on nouns. This resource helps individuals with: - aphasia - traumatic brain injury (TBI) - stroke survivors. Similarly, the spot the picture search can also be used to target semantic features. The clinician and client can be shown the whole picture collage and allowed to pick one item and describe its semantic features.
VNeST, TPT	https://www.teacherspayteachers.com/Product/Distance-Learning-Boom-Cards-VNeST-Speech-Therapy-for-Adults-with-Aphasia-5396082	Verb Network Strengthening Treatment is a great therapy approach that can be used to target verbs and the use of verbs within 3-word phrases. VNeSt also can target the use of WH questions. These boom cards for VNeST allows for the structure of VNeST to be still used within the modality of teletherapy. These boom cards include the verbs sing, teach, fly, play, and send. Each verb has 3 trials and 3 recalls ensuring retention. All verbs include visual cues as well. VNeST is an evidence-based therapy technique that focuses on verbs. It aims to improve word-finding in order to produce sentences.
SVO sentences & Wh- questions	https://www.teacherspayteachers.com/Product/Aphasia-therapy-SVO-sentences-and-wh-questions-BOOM-Cards-5460450	This set of boom cards allows you to interactively create SVO sentences that are applicable to everyday life. This is ideal for clients who are working on expanding utterances or adding descriptive elements to their sentence. It allows for client lead productions. It also can be used to target WH questions by allowing the client to lead with WH questions why would choose or allowing them to create their own WH questions.
Video calling a friend/peer/family	Zoom, skype, google, FaceTime	Promoting socialization and also including a diverse number of conversational partners is a great element to add to teletherapy. Video calling & adding additional callers can be easily implemented into whatever program is used for teletherapy. This activity is also a great way to target generalization of any potential goal for your client.

Fun Brain - Book Access	https://www.funbrain.com/books	Fun Brain not only has many games but also has free access to books. Other ways the book can be used is for reading fluency and cluttering by having him read the passage out loud.
Mad Libs	http://www.madlibs.com	Mad-Libs offers a website with interactive stories, printable stories, and an app that can be used on other devices. The student is giving a part of speech then is asked to generate a word within that part of speech. Those words are then put into a story and then they can read the silly story they have created. The clinician chooses to use the app or the website and share their screen with the client. The clinician can then go through the parts of speech with the client then ask him to fill in the blanks to create a story. This will target different types of vocabulary and give the client reminders of the different parts of speech that can be included in stories to make them more descriptive.
Vocabulary - Homophones	https://www.vocabulary.co.il/homophones/middle-school/6th-8th-homophone-definitions/	This site is free to access and has games for all ages in relation to multiple meaning words. They also have other vocabulary building games such as root words, prefixes, spelling games, and word play games. In order to use this with your client you would have to click for the student and share your screen.
Fix Your Grammar & Summaries	http://www.wordgametime.com/grade/7th-grade	The Word Game Time site has many free resources that mirror grade level expectations. These videos and activities can be used as introductions and education to various writing styles that are required at the 7th grade level. During teletherapy the clinician and client use the share screen feature and talk through all the components that need to be added into summary prior to actually writing. After that the client can share their screen for Microsoft word and the clinician can monitor their writing and help stop, notice, and fix errors as are they are occurring.
A Workbook for Aphasia	http://csuspeechandhearingclinic.weebly.com/uploads/2/3/4/0/23404518/exit_project_workbook_complete_draft_2.pdf	It contains over 100 pages of activities to target word categorization, naming tasks, multiple meaning words, sentence completion, answering wh- questions, describing pictures, and sentence generation tasks for individuals with aphasia. Additionally, the workbook contains tasks to increase functional communication and living such as writing a check, labeling envelopes, or completing intake forms at a doctor's office. This workbook is applicable to telepractice because it may be shared with the client during a therapy session or used as at-home practice after a teletherapy session.
Aphasia Bundle	https://www.teacherspayteachers.com/Product/Growing-BUNDLE-of-EBP-Activities-for-Treating-Aphasia-in-Adult-Speech-Therapy-5107403	This bundle of treatment activities for aphasia is low-cost and is downloaded as as 40-page zip file. The activities in the bundle contain modified VNeST activities, Melodic Intonation Therapy, Semantic Feature Analysis, Phonological Component Analysis, communication cards, and prompts from the Sentence Production Program for Aphasia. The program is easy to access and contains realistic pictures and relevant sentence prompts. This resource may be used in telepractice by allowing the client to download and print a personal copy or by having the clinician share the file through the screenshare setting on Zoom.

iBooks	https://pubs.asha.org/doi/10.1044/2018_JSLHR-L-17-0277 https://www.apple.com/ibooks-author/	Results from the study indicated that participants were able to independently use the workbooks and showed gains in language abilities. Based on the methods in the study, the iBooks software may be used to create customized home programs through teletherapy for individuals with aphasia. Audio recordings or the text-to-speech function may be used on each page to reduce the need for reading comprehension of words or phrases. Pictures, videos, and prompts may be inserted to each page for the participants to use. Additionally, cueing hierarchies may be inserted so that the client can request a semantic or phonemic cue as needed. Video clips and pictures may be taken by the clinician or downloaded from websites such as google or pexels.
Constant Therapy Apps	https://thelearningcorp.com/constant-therapy/for-clinicians/how-to-videos/	Constant Therapy through the Learning Corp. is a program designed for patients who have experienced Traumatic Brain Injuries, Aphasia, Dementia, or other neurological conditions. The program can be customized for each patient and provides feedback for each client. The program is structured so that clinicians create an account for their clients with customized exercises to fit each client's needs. The application automatically adjusts based on the client's performance and calculates reports so that the clinician can monitor progress. An animated "clinician" provides the client with instructions to eliminate difficulties with reading comprehension. The exercises are divided into the categories of auditory and visual memory, auditory comprehension, speech intelligibility, reading comprehension, attention, problem solving, verbal expression, and visuospatial processing.
CVC segmenting word cards	https://www.teacherspayteachers.com/Product/CVC-Word-Work-Cards-Stamp-Spell-Segment-Blend-Color-Blank-Versions-3946373	This free resource of 80 CVC words can be used in telepractice to target segmenting, as well as other phonological awareness skills. The author of this resource created different versions of the material so it can be used to segment CVC words with the letters visible, without the letters visible, or to use play dough to smash each box when segmenting.
Vooks	https://www.vooks.com/	This resource is used to provide virtual books that are in video format that are kid friendly. Vooks is applicable to teletherapy because these are virtual books that can easily be shared with clients. The Vooks website has wide range of books to choose from, which means clinicians can target different goals depending on the vooks they select.

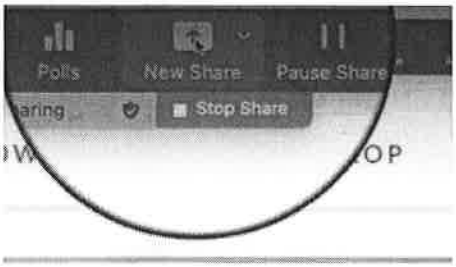
Syllable blending cards	https://www.teacherspayteachers.com/Product/Blending-Syllables-Picture-Based-Activity-Phonological-Awareness-FREEBIE-1808178	This resource contains 30 words with 2-5 syllables. It is typically used by printing out the cards, presenting several cards at a time, and having the clinician read one word segmented at a time and have the client point to the correct picture. However, this material can be adapted for teletherapy. There are 5 pages of 6 cards per page. If the clinician wants to target syllable blending, the clinician can share one page on the computer, read the segmented syllables of the words, and then ask the client to blend those sounds together and find the picture on the screen. This resource could also be used to target counting/segmenting the syllables in words. To do this, the clinician could read the word out loud and ask the client to segment the syllables by clapping out the syllables or by counting how many times their chin lowers. Although this resource was designed to target syllable blending, these picture cards could likely be used to target other goals (e.g., language goals, semantics, etc).
Sight Word Bingo resource	https://www.abcya.com/games/dolch_sight_word_bingo	This website (www.abcya.com) provides many different games for different levels (pre-k through 6th grade+). This website even allows you to search for games by common core state standards and grade level. The level of the specific game I chose (sight word bingo) is a first-grade level under the word games category. I found this website listed on a recommended telepractice resource page from http://www.sdslha.org/. The specific game I selected can be used to play a fun interactive game and target speech-language goals. In this game, there is a character at the top of the screen that reads the words out loud. The client would be expected to listen to the word and find it on the screen.
TheraSimplicity	http://www.therasimplicity.com	Therasimplicity is a site that allows for SLP to create materials for use either on paper or online. EIU is partnered with Therasimplicity allowing us free access to the services it provides. Resources that are created can then be shared with client either online through teletherapy or in a face to face session. These can be sent to the client to complete prior to a therapy session or completed during a teletherapy session through screening sharing capabilities.
Newsela	https://newsela.com/	Newsela is a site that provides access to news articles, writing prompts, and quizzes. The articles provided can be modified to make the grade level. This site provides a lot of reading materials that can be used for a variety of different teletherapy activities. Newsela can be used for telepractice through sending the information to the client prior to the session, or through sharing your screen with the client and reviewing the information together.
Google Drive	www.googledrive.com	Google Drive is something that is used quite frequently but can especially be used for teletherapy. Documents can be uploaded to the Google drive, and both the client and clinician can view the materials in real time. Google drive is easy to use, and with so many things switching to online, more individuals have access to google drives and google accounts.

Mancala	https://mancala.playdrift.com/	Mancala is two player game and has several benefits for therapy use. This website allows for two players to play at a time, while a Zoom call is running on the side. This game can be used to work on either language or social stills. This is appropriate for teletherapy based is can be played online with the client, and it could be used as a reward or for therapy purposes.
America's Funniest Home Videos	https://www.afv.com/	AFV's website has a section that includes several different videos. That were previously shown on the show. These videos can be displayed through the clinician's screen and played for the client. These videos can be used for a variety of different activities within the session. Either to practice different social skills, or as a award at the end of an activity. Videos can also be sent home for the client to practice with before or after a teletherapy session.
Online Venn Diagram Maker	https://www.canva.com/graphs/venn-diagrams/	This is an online platform that allows you to make and customize any version of a Venn diagram that the user wants. This could be used in telepractice because it can be shared on the screen so both the client and the clinician can see it.
Think Before You Speak Flowchart	https://www.teacherspayteachers.com/Product/Think-Before-You-Speak-Flowchart-5231476	This is a free flowchart on Teachers Pay Teachers made to help individuals with autism think before speaking. While this specific flowchart was possibly made for someone younger, it would be easy to customize to make it more applicable to my client. This could be used during online sessions by putting it up on the screen after the client makes a comment that was not necessary during a conversation and making him walk through the flow chart to where it says that no, the comment would not be appropriate to say during that conversation. Making this flow chart together with the client and explaining the importance of this type of thinking could help encourage the client to use this process to think.
Role Play Videos	https://www.semel.ucla.edu/peers/resources/role-play-videos	This is a list of role play videos that can be used to help the client practice identifying appropriate versus inappropriate conversational skills. It can be used during therapy by sharing the screen and talking about what aspects of the video are appropriate or inappropriate. These videos can also be used as inspiration for the client and clinician's own role play activities over video chat.
Role Play Worksheets	https://www.eslprintables.com/speaking_worksheets/role_plays/Role_play_cards_517216/	This resource provides me with an array of role play scenarios that can be used during therapy. Role play scenarios can be used over teletherapy to target familiar goals for the client such as not interrupting, topic maintenance, and active listening. Continuing to use role play as a means of targeting conversation skills provides structure to sessions that the client may need, especially if sessions would be switching to online. Role playing allows the client to narrow his focus more and to practice "pretending" to be socially appropriate in hopes that these skills slowly become more natural.

Topic Maintenance Visuals	https://www.teacherspayteachers.com/Product/Topic-Maintenance-Bullseye-1264067	Using visuals to help with topic maintenance is just as imperative as in teletharpy as it would be in therapy in person. During therapy in person with this client, the use of interactive visuals were beneficial to the client's awareness of the skills being targeted. This bullseye can be shared on screen and both the clinician and client can put a dot on where in the bullseye the client's comments were in the conversation and then share with each other. After, the clinician will discuss why the client was or was not correct in where he identified he was during the conversation. This visual especially helps when using the term "are you in the zone?" and can be used as a visual to show him where "in the zone" is, how far it is acceptable to be out of the zone, and where it starts to become inappropriate to make certain topics during conversation.
How to initiate a conversation	https://www.youtube.com/watch?v=Qy-sNx4dPhE	This video outlines general steps about how to effectively initiate a conversation in terms of body language and verbal content. The video then follows with a subsequent demonstration within a classroom setting.
How to ask good questions in	https://www.youtube.com/watch?v=1dO0dO__w	This video introduces the different types of questions and proposes strategies
Social Story: Job Interview	http://weraspies.weebly.com/uploads/6/8/5/9/685	This social story outlines the process of a job interview in terms of what the client
Social Story: Business Meeting	http://weraspies.weebly.com/uploads/6/8/5/9/685	This social story outlines typical expectations during a business meeting.
Social Story: DMV	http://weraspies.weebly.com/uploads/6/8/5/9/685	This social story outlines the general process of going to the DMV.
Texting Stories	ifaketextmessage.com	Texting stories is fan application that can be downloaded on a phone or tablet. It allows the user to create different texting examples. If clients have the app, they could create their own to share. ifaketextmessage.com is similar; however, it is free, and no download is needed. Also, it would allow for the client to "respond" when they have screen control during Zoom meetings. Both can provide functional in interactive experiences as well as promote discussion.
Say it/Filter it Sheet	https://www.teacherspayteachers.com/Browse/Search:say%20it%20or%20think%20it%20filter	While just a simple visual it can generate thoughts and starting point for discussion. It's not complicated and could easily be recreated on a document.
AWW - online whiteboard	https://awwapp.com/	No account is needed to access many of the features of this online whiteboard. It is similar to the Zoom whiteboard as you can draw, add text and save as a document. The AWW whiteboard has a few more features as you can add sticky notes to it and there is a lot more space. With extra space nothing has to be erased. There are different sharing options that can allow others to collaborate and edit or just view. It also allows for PowerPoints and PDFs to be displayed.

Basic Zoom Operations

1. **Share screen**- this allows the client to view your screen. https://youtu.be/C4sptqFb0Bk Red tab shares your screen, red tab stops sharing your screen. **Tip:** Silence notifications or they will make a sound during your session when you are sharing your screen.



- **Audio**- make sure all materials that you plan to use which require audio can be heard by both you and the client. Practice to make sure with a friend beforehand! Share your audio in the Advanced tab. https://www.youtube.com/watch?v=ugda61PyFIo
    - Share Audio. **Join Audio** or **Unmute** / **Mute** : This allows you to connect to the meeting's audio, then once connected, mute or unmute your microphone.
    - Audio controls (click ^ next to **Mute/Unmute**): The audio controls allow you to change the microphone and speaker that Zoom is currently using on your computer, leave computer audio, and access the full audio options in the Zoom settings.

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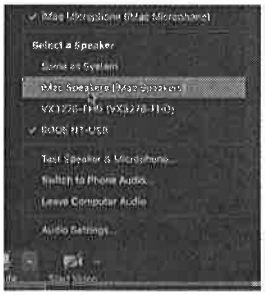


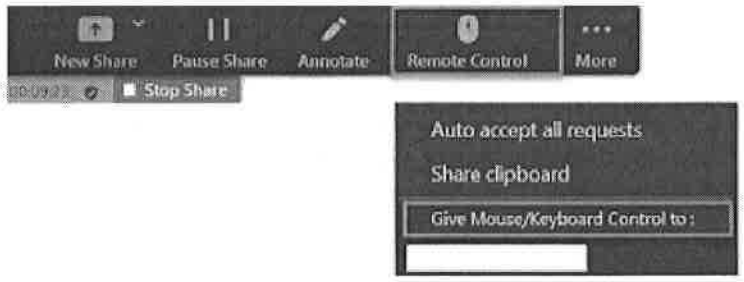
2. Allow **remote control to your client-** this allows the client to control the screen. Step-by-Step directions are below.

a. While screen sharing, you can give remote control to another participant who is in the meeting.

b. While screen sharing, click **Remote Control** and select the participant you want to give control to.
The participant will be notified they can control your screen and can click anywhere on the shared screen to start control.

c. To regain control, click anywhere on your screen. The other user can still restart remote control by clicking on their screen.

d. You can also click **Remote Control** again and select **Stop Remote Control** to regain control and not allow the other participant to start remote control again.



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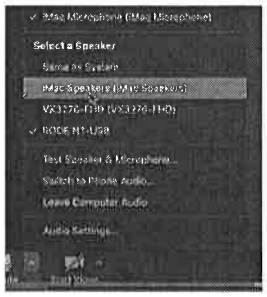

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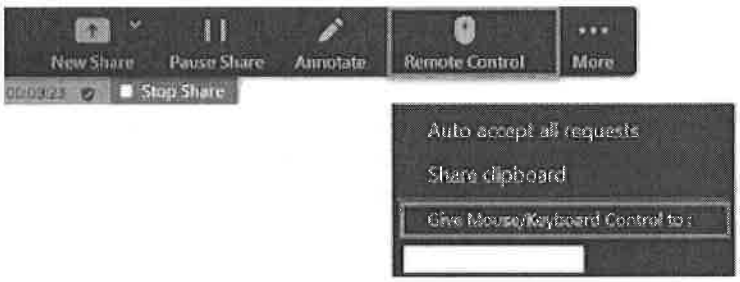
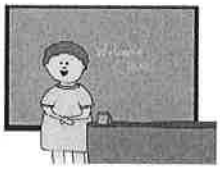


Section 8: Supervision

- Supervision PowerPoint
- Self-Evaluation Examples

Supervision



By PresenterMedia.com

Supervision Defined
(Anderson, 1988, p. 12)

- "Process that consists of a variety of patterns, the appropriateness of which depends on the needs, competencies, expectations and philosophies of the supervisor and the supervisee and the specifics of the situation (tasks, client, setting, and other variables)."
- "The goals of the supervisory process are the professional growth and development of the supervisee and the supervisor, which it is assumed will result ultimately in optimal services to clients"

Working Definition
(ASHA, 1985)

- "
- "Central premise of supervision is that effective clinical teaching involves, in a fundamental way, the self-analysis, self-evaluation and problem-solving skills on the part of the individual being supervised."

Clinical Teaching

- The interaction between supervisor/supervisee in any setting which furthers the development of clinical skills of students or practicing clinicians as related to changes in client behavior.
- Traditionally - observation and conferences.

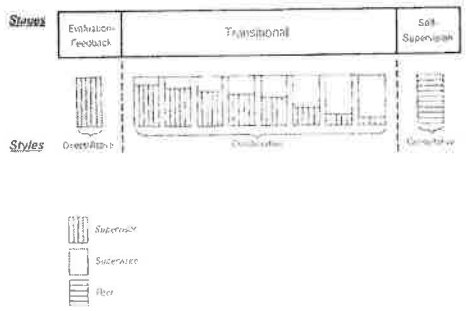
Direct/Indirect

- Direct supervisory behaviors:
  - telling, giving opinions and suggestions, directing, criticizing, suggesting change, and evaluating.
  - Can be **defense-inducing**
- Indirect supervisory behaviors:
  - accepting, clarifying questions, praising behavior, asking for opinions and suggestions, involvement in problem solving, accepting ideas and discussing feelings.
  - **Support-inducing**

Continuum of Supervision

- Supervision exists on a continuum
- There are styles of interaction appropriate to each stage
- Framework and structure for SR and SE to discuss philosophies, behaviors, etc.

Continuum of Supervision



Stages of the Continuum

- Evaluation-Feedback
- Transitional
- Self-Supervision

Stages

- Based on assumption that needs and expectations change
- Continuum mandates a change over time in amount and type of involvement
- None of the stages should be seen as time-bound
- Some may never reach the self-supervision stage, others may begin beyond the evaluation-feedback stage

Evaluation Feedback Stage

SUPERVISOR HAS A DOMINANT ROLE

- What type of supervisee is seen in this stage:
  - Beginning supervisee
  - Marginal supervisee
  - Supervisee who is working with a new disorder category, new setting, new supervisor

SR uses Direct-*Active* Style

- SR - controlling, superior position, assumes responsibility
- SE - dependence; minimal participation
- Compares with high direct-low indirect (Blumberg) and high task/low relationship (Hersey & B)

Transitional Stage

SUPERVISOR HAS A COLLABORATIVE ROLE

- What type of supervisee is seen here?
  - Someone who is learning to analyze the clinical sessions and her/his own behavior
  - Can suggest/make changes based on their own analysis
- Supervisee is an active participant
- Supervisee and Supervisor engage in joint problem solving
- Supervisor encourages and supports the supervisee in the management of the clinical process
- Supervisee is moving toward independence
  - Moving in competence, knowledge and skill

Self-Supervision Stage

SUPERVISOR HAS A CONSULTATIVE ROLE

- What type of supervisee is seen here?
  - person who is beginning to function independently but acts within boundaries of expertise
  - can analyze sessions and clinical behavior
- Supervisor views the supervisee as an independent problem solver
- Relationship becomes more of a peer interaction

Supervisees Responsible for Outcome of Conference!!

- **Supervisees should prepare for conference!!!**
  - Supervisee needs to analyze their own performance and be prepared to discuss their what they did well and what they need help with
  - Come with list of questions
  - Come with suggestions for change

Supervisees Should be Prepared

- If supervisee comes unprepared to the session, supervisor will assume more dominant role.
  - Supervisee may leave conference and still have questions
  - May not get the opportunity to express own ideas
- If supervisee prepared with agenda they will more likely…
  - Take an active role
  - Leave conference satisfied with all questions answered

Supervisee Professional Growth

- Important for supervisees to embrace idea of personal and professional growth
- Clinical training – Conferences tend to be client focused
- Part of supervisee's role is to recognize need and ask for guidance for professional growth
  - Know strengths and weaknesses …communicate to supervisor about what you feel you need to improve on
  - Ask questions about how to address things with other types of clients…big picture!

Weekly Self-Evaluation
CDS 4900/5900

Date: **Clinician/Client:** **Supervisor:**

1. What did **you** do well this week in therapy?

2. What could **you** change for next week?

3. Comments on supervisory style. Am I providing you with appropriate feedback? What would you like more help with?

One question you want to discuss in our weekly meeting.

Rate yourself on a scale of 1-5 (with 5 as the highest) on the following questions.

a. **I knew the rationale for steps taken this week _____**
b. **I provided feedback/reinforcement for my client this week _____**
c. **I was comfortable in my session this week _____**
d. **I was prepared and organized this week _____**
e. **I was productive in my sessions this week _____**

Self-Evaluation
CDS 4900/5900

Date: **Clinician/Client:** **Supervisor:**

1. What did **you** do well during your therapy?

2. What did your client do well today?

3. Which activity and/or strategy did you feel was the most successful? Why?

4. Which activity and/or strategy did you feel was the least successful? Why?

5. What did your client really struggle with today?

6. What do **you** need to change/modify for the next session?

7. What questions do you have for me? What would you like help on to improve your clinical performance? Would you like more specific feedback on anything in particular?

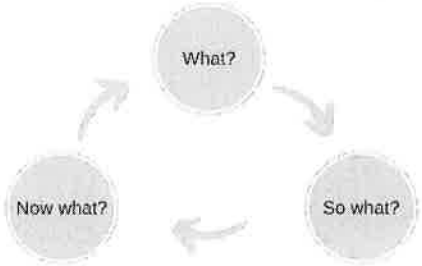
Rate yourself on a scale of 1-5 (with 5 as the highest) on the following questions.

a. I felt my overall performance during this therapy session was a ____
b. I felt my client's overall performance during this therapy session was a ____
c. I was comfortable in my session _____
d. I knew the rationale for strategies I used in therapy _____
e. I provided appropriate and specific feedback/reinforcement for my client _____
f. I was prepared and organized _____
g. I was productive in my session _____

Self-Evaluation
CDS 5900

Date: **Clinician/Client:** **Supervisor**:

Self-reflection is a critical part of being a lifelong learner. There are several models of self-reflection. Driscoll's What Model is one example that you can see below.



https://libguides.cam.ac.uk/reflectivepracticetoolkit/models

What?
Choose a video clip of approximately 2-4 minutes. Please note the time so that we can review it together as needed.

Comment on the following:

1. **The client's behavior** (e.g., what was the client doing; were there positive/negative reactions?):

2. **The client's performance** (e.g., accuracy of the response):

3. **Your input:** (e.g., how is what you are saying/doing affecting the client?):

So What?

4. What did you learn from this video clip?

Now What?

5. Write something that you will change or continue based on the video clip or session in general?

6. Write something that you are curious learning more about as it relates to your client.

7. Any questions for me? Is there anything I can do to help you better?

Developing Clinical Self-Evaluation Skills Through Guided Practice: An Introduction
General Information re: Self Reflections
Revised Fall 2022

Research has found that student clinicians benefit from the direct teaching of self-evaluator/self-reflection skills (Hulsman & van der Vloodt, 2015). Effective observation is a skill that develops over time spent in clinical practice, and with direct teaching from your supervisors. Through our guided self-analysis you will become better able to identify and interpret clinical observations (about yourselves and your clients) through detailed and insightful clinical reflections. Students report they get much more out of their weekly self-evaluations by re-watching sessions and by having access to guided teaching. To make these assignments meaningful to you, I would encourage you to rewatch your sessions-even just portions of your sessions, to increase the accuracy and depth of your self-analysis and client observations.

***We will discuss your observations and self-analysis each week.** If there is a particular interaction, observation/behavior, etc. which you would like to watch together and discuss, please make a note of exact time of the interaction.

Self-Evaluation Part 1 or Part 2 Forms* will be due on **Fridays by 5:00 pm** during **Clinic Weeks 4-12 only.**

Weeks 4-8- you will use the Self-Evaluation Form (Part 1) The questions in Part 1 were designed to increase your ability to engage in objective self-analysis. They offer guidance/ suggestions about *what* to be looking for and thinking about during your self-reflections.

Weeks 9-12- you will use the Advanced Self-Evaluation Form (Part 2) which were designed to increase your abilities to analyze your client's clinical behavior AND your own clinical behaviors. You will be evaluating the needs of your client, as well as thinking about how you are integrating theories and concepts from the classroom into your clinical practice.

Please complete **only 1** Self-Reflection Form **per week** and omit any questions which may not apply directly to your specific client/situation.

*The Forms differ because your level of observational skills will have grown from now until the end of the semester in response to your weekly guided practice.

Reference

Hulsman, R., and van der Vloodt J. (2015). *Self-evaluation and peer-feedback of medical students' communication skills using a web-based video annotation system. Exploring content and specificity,* Patient Education and Counseling, Volume 98, Issue 3, 2015, Pages 356-363,ISSN 0738-3991, https://doi.org/10.1016/j.pec.2014.11.007.