BACKGROUND INFORMATION

The Speech and Hearing Clinic at Eastern Michigan University is an integral part of the training program for students majoring in the area of Speech-Language Pathology. The graduate program is accredited by the Council on Academic Accreditation (CAA) of the American Speech-Language-Hearing Association (ASHA). The professional services offered by the Clinic are accredited by the Council for Professional Services Accreditation (CPSA) of the American Speech-Language-Hearing Association (ASHA).

The clinicians supplying diagnostic and therapy services are all students who are successfully completing courses in the evaluation and remediation of speech and language disorders. The goals of the program are two-fold:

1) To provide supervised practical experience for students-in-training, and
2) To provide expert speech, language and hearing diagnostic and therapeutic services to the community.

The mission of the Speech and Hearing Clinic is to create an exemplary educational environment to facilitate the acquisition of knowledge and skills and to encourage the intellectual curiosity and creativity of its students. Students will be prepared as professionals who deliver habilitative/rehabilitative services to persons with communicative impairments.

The Speech and Hearing Clinic strives to provide quality services to clients from the University and community with:

• A caring and considerate attitude to foster a sense of worth in clients and families
• Ethical and open communication with clients, families, the community and each other
• Respect for the dignity of the individual.

University faculty and staff participate in all evaluations as part of a student-faculty team. University staff also supervises all therapy, both by approving therapy plans prior to use and by observing students implementing the approved plans. Any question regarding either an evaluation or therapy technique should be directed to the Clinical Educator. All audiological services are provided by a certified audiologist. The Clinic offers a full range of diagnostic and therapeutic services as required for students-in-training.
POLICIES

Coursework and Grade Requirements per Department/Clinical Policy

Clinical procedures/policies and forms are located in 2 sources: 1) binder above the Clinical Educators inboxes and 2) handbook. You are responsible for knowing the contents of all the procedures/policies and forms.

All graduate SLI majors are required to complete a minimum of two full semesters in clinical practice by enrolling in SPSI 528 and 538. Students will submit evidence that they have completed the 25 clock hours of supervised observation of individuals with communication disorders prior to beginning their clinical practicum. These observation hours must be uploaded and approved by your advisor before the start of the SPSI 528 and/or 538 semester. Negative TB tests must also be uploaded into the Immunizations category in CALIPSO. The negative TB test MUST be valid throughout the entire semester of 528 and 538. Negative TB tests expire in a year so a new negative TB test may be needed when enrolled in 538. Students must also meet the following continuation criteria of the SLI program.

A. Maintenance of a cumulative major GPA of 3.0 or better (SPSI and SPHI courses).

B. Receive a grade of or better in any major academic graduate course and a B or better in the clinical practicum course (SPSI 528 and 538) Courses in which a lower grade is achieved (i.e., less than a B- in an academic course or less than a B in SPSI 528 and 538) must be repeated. ONLY ONE FAILED COURSE MAY BE REPEATED including undergraduate deficiency courses, graduate academic courses or graduate practicum. This means that a student may receive below a B in an academic source and retake it OR receive below a B in a clinic course and retake it). Once a student has failed a second course (or for the second time as the retake), he/she may not continue in the program. Failure in any course will prevent a student from enrolling in clinical practicum courses: SPSI528, 538, 687, 688, or 698. The failed course must be repeated at the next opportunity.

During the semester in which a course is repeated a student may enroll in only two additional courses within the program in consultation with the academic advisor. Students may not exceed 25 credit hours before passing clinic. For purposes of financial aid, the student is responsible for choosing electives outside of the program to complete the required academic load for financial aid. Not that 4 credit hours (for fall, winter and summer) are considered full time for graduate student; however, students should check their financial aid package.

C. Complete any Incompletes (I) within one year of issuance of the I. Note that a grade of Incomplete is given in a course when a student has completed at least fifty percent of the course requirements with a grade of B or better.
D. Demonstration of behaviors that indicate reasonable aptitude, maturity, stability, skill and understanding as judged necessary for predicted success as a Speech-Language Pathologist are expected in all program requirements. Qualitative judgments will be made by the SLI Faculty and staff.

E. Students on academic probation WILL NOT be allowed to enroll in major courses until the probation is lifted and their overall GPA is 3.00 or better.

Professional Demeanor

Students are expected to conduct themselves in a professional manner in accordance with the ASHA Code of Ethics, the Confidentiality statement and Scope of Practice (See CP-3 and www.asha.org/policy) at all times in the clinic. Demonstration of unprofessional conduct will result in a meeting with you, the Clinical Educators, and your advisor to discuss your behavior and develop a remediation plan. Failure to improve your behavior will result in dismissal from clinic and/or the SLI program. The following guidelines are suggested:

1.) The language used in the clinic should not include inappropriate slang, profanity or inappropriate topics of conversation. The clinic is a professional place of business. Loud boisterous behavior is not acceptable.

2.) Discussion of clients should occur in the CASE Analysis Room or Clinical Educator or faculty offices ONLY. Avoid discussion of clients in the waiting areas, the front office, therapy rooms, observation rooms and hallways. Clients should not be discussed outside of the clinic in any public places. Remember that all therapy rooms have remote observation, so your behavior and conversation can be monitored at any time.

3.) You will be expected to dress in a manner appropriate for a professional clinic, “business casual.” While a range of styles is acceptable, dress that is appropriate for class and campus may not be for the clinic. Remember that your dress provides your clients first impression of you for clients, families and other professionals. Clinical educators reserve the right to determine appropriate clinical dress. Coats or boots are not to be worn or carried into the therapy room. Please hang your coats into room’s 135C-15 or 135-C 19. Since many people have allergies, perfume or aftershave should be avoided.

4.) Clinical Educators will be addressed in the clinic by Ms., Mr. or Dr. and their last name. You may decide what form of address you would prefer to be called by your client/s and families. Assume that adult clients and adult family members of client are addressed as Mr. or Ms. unless they inform you otherwise.

5.) At NO time should a clinician eat, drink, or chew gum in the observation rooms, waiting room or therapy rooms. The EMU campus has been designated a “smoke-free environment” by the University.
6.) Students are allowed to accept nominal gifts from families and clients not to exceed $25.00.

7.) All clinicians are expected to wear nametags identifying them as a student clinicians at all times while in the clinic. Your nametag should be worn on your shirt collar or pocket so that is near you face. NOT on you pants or skirt. Nametags will be issued free of charge at the beginning of each semester. Replacement tags will cost $1.00.

Clinic Schedules and Caseloads

Clinicians should expect to be assigned to two to four hours per week of actual client contact therapy. In order to schedule based on student needs and clients preferences, clinicians are expected to clear a time in one of the options listed below:

- Mondays through Thursdays from 8:30-11:30
- Mondays through Thursdays from 1:00-5:00

Files

Files are maintained for each client. All reports and client files are confidential. See ASHA’s Code of Ethics, their Confidentiality policy and HIPPA behavior. All files are to be read in the student room and returned to the Clinic office by 4:30 p.m. Monday through Thursday and 4 p.m. on Fridays.

NO FILE OR PORTION THERE OF MAY BE REMOVED FROM THE CLINIC EXCEPT TO DISCUSS THE CLIENT WITH A CLINICAL EDUCATOR AND/OR FACULTY MEMBER IN HER/HIS OFFICE.

YOU MAY NEVER, UNDER ANY CIRCUMSTANCES, XEROX ANYTHING IN OUR CLIENT’S FILE.

One copy of the Treatment Plan and Treatment Outcome will be provided at the end of the semester. SOAP notes will not be provided. Immediate family members (guardians, spouses, and parents) must FILL IN AND SIGN A RELEASE FROM to receive records. It is the responsibility of the clinician to check the file at the beginning of the semester to make sure that all forms are accurate, complete and have not expired.

Forms (The first three must be signed before services are provided)

Because the majority of services are provided by students who will be observed by program staff and other students, the Client or the person legally responsible for a client MUST read and sign an Authorization Form. (F-1) acknowledging acceptance of student-provided services and audio and recorded observation of all services.
The Consent for Release of Confidential Information form (F-2) must also be completed (by the student clinician, if necessary) and signed by the client or person legally responsible or the client. In addition, the witness signature must be completed. A witness can be the CE, graduate clinician, Patient Care Representative (PCR/clinical secretary), or other family member.

A general Client Consent to Release Confidential/Protected Health Information (F-3) form may be completed and signed by the client or the person legally responsible for the client, to allow communication between the clinician and family members or other professionals involved with the client. This is not required but needed if the graduate clinician would like to collaborate with other professionals (classroom teacher, SLP).

A red Emergency Information form (F-4) is completed in consultation with the client or family members and contains emergency contact information, allergies to food, medicine, etc., medications (time and dosage), medical history and specific protocols, as needed, for seizure disorders, fall risks, dysphagia risks, etc. (See CP-8 Medical Emergency Policy). This form must be reviewed, updated as needed an initialed/dated by the client or family member each semester.

A Continuation and Discharge Criteria form (F-5) must be completed when a client has been on the caseload for two years (6 semesters) or when a client is discharged. These forms are located in the office. Please ask the PCR or CE to get you a form.

Clinic Office Protocol

The Clinic office is a place of business. When entering the office, please check out your client file and chart in it elsewhere; i.e., student workroom. Do not have conversations in the main office with your colleagues, the PCR or the office assistants.

For all “secretarial” related tasks, use the “work basket” next to the PCR’s work station. These tasks may include but are not limited to new log sheets. When a file is placed in the work basket please document on the OFFICE OUTGUIDE that the document was given to the PCR.

CABINET NUMBER 12 AND 13 ARE THE ONLY CABINETS IN THE MAIN CLINIC OFFICE THAT MAY BE USED BY CLINICIANS.

Log Entries

Log entries must be made in INK each and every time a phone or email contacts made with your client, when items are added or removed from the file, and if any action is taken in conjunction with your client. Never use liquid paper or correction tape to correct errors. Draw a line through, initial your error and write the correct information. Remember to initial the right column on the final line of the entry.

Signing Out Files

ON OFFICE OUTGUIDE CAD MUST BE USED EVERY TIME A CLIENT FILE IS REMOVED FROM ITS PENDAFLEX FOLDER. (“OUT” cards are stored in the student work room area.) To sign out a file, write your name, the client’s initials, and the date and place the card in the penda flex folder. Never remove the penda flex folder from the file drawer. Be sure to
work with your files in the student work areas, not in the Clinic office. To return the file, place the file back in the penda flex folder with the most current file in front, remove the “OUT” card and return the “OUT” card to the student work room. FLES MUST BE RETURNED BY 4:30 on MONDAY THROUGH THURSDAYS AND BY 4:00 ON FRIDAYS.

Filing Information

ALL FORMS ARE LOCATED ON THE LEFT SIDE OF THE CLIENT FILE ARE TO BE FILED BY THE CLINCAL EDUCATOR OR THE PCR ONLY. If forms require revision clinicians must take the file to the CE form removal. These include contact logs, the Consent for Release, Client Consent to Release Confidential/Protected Health Information forms, and the Authorization Form. Emergency Information forms are always filed on TOP of the contact log on the left side of the client file.

SOAP notes, Treatment Plans with corresponding protocols, Treatment Outcomes, with semester stimuli (ORLA-MIT sentences, functional word lists etc.) are filed on the right side of the client file by the student clinician. All information should show a natural chronology; i.e.: case history on the bottom, medical reports next, etc. Please be sure that material on the right side do not cover the file tab or folder crease (to protect them from damage then the file is closed).

REMOVE ALL STAPLES AND PAPERCLIPS BEFORE FILING MATERIALS.

Place any papers to be shredded in the “Please Shred” box on top of cabinet #12. DO NOT USE THE PAPER SHREDDER. The water cooler and photocopier are the only items that can be used in Room 135D-4. Please review guidelines above the copier when you copy any documents.

Universal Precaution, Health and Accident

The following procedures or conditions occur in the Clinic and may involve exposer to pathogens contained in the body fluids or blood. Personal Protective Equipment (PPE) procedures are to be used to avoid exposure to the pathogens.

Universal precautions are used in the EMU Speech and Hearing Clinic to eliminate contact with body fluids, secretions and blood. The following fluids are to be treated as if they are known to contain Hepatitis, Human Immunodeficiency Virus (HIV) or other pathogens:

- Saliva
- Blood

It is not expected that clinician will come into contact with other fluids such as semen, vaginal secretions, cerebrospinal fluid, pericardial fluid, etc. in the Clinic; however, all fluids are to be treated as if they are infectious.
<table>
<thead>
<tr>
<th>Procedure/ Condition</th>
<th>Personal Protective Equipment Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Mech. Exam ¹</td>
<td>NSG* X</td>
</tr>
<tr>
<td>Oral-motor exercises ¹</td>
<td>X</td>
</tr>
<tr>
<td>Otoscopy with drainage</td>
<td>X</td>
</tr>
<tr>
<td>Earmold modification</td>
<td>X</td>
</tr>
<tr>
<td>Ear impressions</td>
<td>X</td>
</tr>
<tr>
<td>Vomiting ²</td>
<td>X</td>
</tr>
<tr>
<td>Toileting ²</td>
<td>X</td>
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<tr>
<td>Equipment Cleaning</td>
<td>X</td>
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<tr>
<td>Spill Cleanup</td>
<td>X</td>
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<tr>
<td>Saliva Management</td>
<td>X</td>
</tr>
<tr>
<td>Feeding evaluation ¹</td>
<td>X</td>
</tr>
<tr>
<td>Videofluoroscopy ¹</td>
<td>X</td>
</tr>
<tr>
<td>Dysphagia Evaluation ¹</td>
<td>X</td>
</tr>
<tr>
<td>Cleaning Treatment Rooms</td>
<td>X</td>
</tr>
</tbody>
</table>

# Procedures vary depending on the setting and population served. Health care settings with clients/patients diagnosed with TB, Hepatitis, HIV, Meningitis, etc. will have specific procedures utilized by all staff.

* Code to abbreviations: *
  - NSG: Nonsterile Gloves
  - SG: Sterile Gloves
  - UG: Utility Gloves
  - FS: Face Shield
  - PC: Protective Clothing

** Optional
1- Procedure not performed in the EMU Clinic.
2- Housekeeping is to be notified IMMEDIATELY when a clean up is needed, the room shall be closed until clean up is completed.
3- All oral motor supplies are placed in a paper bag and disposed of in the waste basket in the Clinicians’ Workroom after use.
Work Practice Controls

To minimize exposure to pathogens all Clinic personnel will do the following:

- Wash hands* prior to wearing gloves and as soon as possible after removing gloves.
- Hand sanitizer is in every room-use as needed.
- Wash hands* prior to each session and after each session.
- Clean all surfaces exposed to fluids with disinfectant spray.
- Equipment and therapy material that become contaminated shall be cleaned immediately with disinfectants.
- Clinicians with open lesion or weeping dermatitis on his/her hands will wear gloves during treatment sessions and when handling all clinical materials. If the lesions cannot be covered the clinician will not conduct treatment.
- Clinicians with a fever or server illness will cancel sessions to prevent infection of clients.

*Hands and wrists shall be thoroughly lathered and scrubbed for at least 15 seconds and time must be taken to clean between fingers and under fingernails. Dry hands and wrist completely with a clean towel.

Appropriate clinical procedures must be observed at all times to protect both client and clinicians. This means that disposable gloves are to be worn during all oral peripheral examinations, at all time with clients who demonstrate self-destructive behaviors, and any client known to be carrying communicable viruses. When gloves are needed, the clinician must also take a paper bag into the therapy room and place the used gloves in the bag. The bag shall be disposed of in the trash bin in the Student Workroom. At NO TIME shall the bags be placed in the wastebaskets in the therapy rooms. When a client drools on tables or therapy materials or places materials in the mouth, the materials should be disinfected with disinfectant spray. Alcohol wipes, disinfectant spray, tongue blades, paper bags and gloves are located at the clinician’s work area.

You should make every effort to insure that your client is safe while under your care. Review your client’s file to determine if there is a read Medical Alert Notice with special procedures of which you should be aware (see CP-8 Medical Emergency Plan). IF you have a child who mouth toys, be sure that toys with small pieces are NOT used in therapy. IF you have a child who runs and jumps, be careful to prevent falls and bruises. Geriatric clients may need your assistance as they open clinic doors or navigate clinic hallways. All accidents or injuries to either clients’ or clinicians must be reported to your Clinical Educator immediately and logged in the client file.

Hearing Evaluation (see CP-7 Hearing Assessment and Monitoring for Clinic Clients).

Hearing evaluation will be scheduled during normal therapy hours so clinicians can accompany their clients to the evaluation. At the beginning of each semester clinicians are expected to
review recommendations and then consult with the audiologist, as appropriate, to schedule hearing evaluations for their clients and to write audiological reports.

**Agency Liaison**

Many of the children enrolled in the Clinic are involved in some type of school program. Therefore, IEP meetings are scheduled once each year by the school district. The Clinical Educator will encourage the clinicians to initiate contact with the school SLP, special education case manager, or classroom teacher. When the clinician and/or Clinical Educator are invited to attend an IEP the clinician is encouraged to participate. As a reminder, assigned consent forms must be filed before initiating any external contacts. Additionally, if the child is receiving speech and language services in a school program, the student clinician should contact the school SLP to coordinate therapy goals and procedures.

Adult clients may be involved in educational and/or rehabilitation programs in addition to the services received in the Clinic. The clinician should initiate and maintain communication with other professionals involved with the client.

When it is necessary to contact another agency, either in person or by phone, the Clinical Educator MUST be consulted prior to the contact. All agency contacts must be logged in the client's file.

Home evaluation may be warranted. They are recommended on an “as needed” basis as determined by the clinician and Clinical Educator.

**Family-Centered Evaluation and Treatment**

While the primary goal of the Speech and Hearing Clinic is to provide high quality clinical practicum experience for students in the SLI program, the Clinic also seeks to provide treatment that is family-centered. All services will be provided with the following values:

1.) The client is embedded in a family system that is a constant more powerful than the episodic contact maintained by the Clinic staff.
2.) The family provides the context for further growth and development of communication.
3.) Each family is different and has a right to determine their individualized priorities and goals.
4.) Services will be provided to foster a family’s independence, competence and worth.
5.) Goals will be developed in collaboration with families based on their perceived needs and priorities.
6.) A family’s right to define their membership and relations will be respected by clinic staff. Thus the family will determine who will represent them in the treatment of the family member.
7.) The University affirms the participatory rights of all individual, regardless of gender, race, color, religion, and creed, national or ethnic origin. The University also complies with the Americans with Disabilities Act.
Informal Verbal Feedback

It is suggested that a clinician leave the therapy room five minutes before the session is over so there is time to give some general statement of the client’s progress to be appropriate family member or guardian. Complaints concerning the client’s general behavior should never be made, nor should it be suggested that disciplinary action be taken outside of the Clinic for misbehavior during therapy. A serious problem should immediately be reported to your CE who will recommend appropriate steps. Any discussion with a family member that includes more than a general statement of client progress or homework assignment should NOT take place in the waiting room. Such discussions should be planned in advance and conducted in an office or empty therapy room.

Informal verbal feedback can often allow a shy or confused or angry parent to become receptive to professional advice and feel free to ask questions in “lay” terms. A reminder of what the child can do may provide clues to more realistic expectation for the over-protective or rejecting parent.

Guidelines for approaching parents:

1. Be brief—one or two positive examples are enough. Never complain about the child’s behavior-management is YOUR problem.
2. Be specific—don’t say “John did well today,” say “John said his whole name today.” Be genuine in your enthusiasm but don’t make predictions or overwhelm the parent. Explain why each achievement is important.
3. If the child is present, don’t compete with him/her for the parent’s attention or ask him/her to “perform” to prove your success. If homework is to be assigned, allocate time during a treatment session to explain to the family member or parent how it is to be carried out.
4. Be willing to listen—the parent knows the child best and may begin the communication you need for success.

Summary of Goals and End of the Semester Family Conferences

All conferences with family members must be approved by your CE prior to the contact. Formal conferences or meetings to discuss progress, diagnosis, educational or treatment plans or prognosis should be scheduled with your CE. Use your own discretion when answering a family’s or client’s questions.

Answer the question if you think you have the knowledge and expertise to answer it appropriately and accurately. If you have any doubts, tell the family you would like to speak to your CE before you answer. The last week of therapy each semester will be used to conduct family conferences with family members and appropriate clients (see F-6 and F-7). Consult your CE regarding scheduling one of your sessions during the last week with you, your CE and the
appropriate member of the family. Your CE must observe the meeting therefore, it is imperative that you ensure that our CE is available to observe. **DO NOT** start these meetings without your CE present.

**Homework**

You should assign homework/home program to address client semester goals. Refer to the *Clinician Directed Hierarchy Chart* (F-9). This is to be done only with your CE’s approval. If homework is assigned make sure you discuss the following with the client and/or family:

1.) The exact procedures to be employed by them, the responses they will accept and the type of reinforcement to be used.
2.) The suggested maximum length of the activity which should be well within the ability of the client.
3.) The number of times per week the client is expected to practice.
4.) When correction should and should not take place.

**Observation of Therapy**

Adult family members may observe therapy sessions as often as they wish to facilitate an understanding of the procedures being used. Such observation will also help in understanding the purpose of homework assignments. **CHILDREN ARE NOT ALLOWED IN THE OBSERVATION ROOMS. CE’S can approve and make exceptions to this policy.**

Students will be observed regularly by their CE through one-way mirrors in the observation areas or through recorded session review (see F-10). ASHA requires that at least 25% of all client contact be directly observed by your CE.

After each observation, a written summary with suggestions, questions or feedback may be placed in the clinician’s mailbox. After reading the summary, the clinician who has questions should immediately seek and appointment with the CE. If you CE has asked you a question, you are EXPECTED to respond on the reverse side of the sheet or in person. The written summary should be returned to your CE after your review.

**Absences**

1.) Graduate clinicians are required to complete a specific number of clinical hours, it is essential that absences be kept to a minimum. If you are not able to provide therapy secondary to illness, hospitalization, or other unforeseen circumstances, etc. it is imperative to contact your CE via their office phone number (located on the syllabus). In addition, the clinic needs to be contacted via phone (487-4410) so your client can be cancelled.

2.) Clients are expected to attend all scheduled sessions. Should a client not be able to attend a session, the Clinic should be contacted (487-4410). Excessive absences for whatever reason will result in termination of therapy for the remainder of the term.
CLINICAL PERFORMANCE

The following section is intended as a guide to understanding the performance levels expected of clinicians as they move through the practicum experience. The CALIPSO Clinical Performance Scale (F-11) will be used for mid-term and final grades. This evaluation procedure will be used by the clinician and the CE to evaluate student clinicians' performance, and to determine, in part, the final grade for clinician practicum. Clinic 1, SPSI 528 and Clinic 2 SPSI 538, will be evaluated on a scale of 1 to 5 on this instrument.

Clinicians are also evaluated on the following:

1.) Compliance with policies and procedures listed in the Handbook
2.) CE’s observation of therapy sessions (may be accompanied by a narrative evaluation/remarks by your CE, see Handbook.
3.) Paperwork submitted by you for each client
4.) Interaction with supervisors, peers, and families
5.) Any presentations that are assigned in clinic meetings
6.) Participation in clinic meetings
7.) Unannounced quizzes over the assigned readings which may be give over the course of the semester.

Clinic 1-SPSI 528

By the end of the semester, clinicians will be expected to:

1.) Answer any question concerning developmental norms in the following areas:
   a. Cognition
   b. Language
   c. Motor
   d. Socio-emotional
2.) Explain how each client deviates from any or all norms.
3.) Establish semester goals appropriate to each client.
4.) Demonstrate behavior management techniques appropriate to the client’s age and impairment that will:
   a. Facilitate the achievement of therapeutic goals
   b. Develop and maintain positive client attitudes toward the therapeutic process.
5.) Communicate effectively through:
   a. Professional writing
      i. Treatment Plan preparation
      ii. Treatment Outcome preparation
      iii. SOAP notes
      iv. Letters and other correspondence
      v. Logging phone calls, contact and correspondence in client’s folder
6.) Complete all paperwork and correspondence in a timely manner.
NOTE: If paperwork or paperwork revisions are incomplete, unacceptable or late more than three times during a semester (with any client), a failing grade of B- or lower will be assigned by the supervising CE. A meeting will then be held with the CE, Academic Advisor and student to formulate a Remediation Plan for Poor Clinical Performance (see CP-12).

7.) Communicate concisely and grammatically in all interactions with the client and family.
8.) Professionally present themselves during:
   a. Personal and telephone communication with families of client’s to explain home assignments
   b. Personal and telephone communication with involved agencies or other professionals to coordinate programming
   c. Communication with families and clients at the final conference scheduled the last week of clinic

Clinic 2-SPSI 538

By the end of the semester, clinicians will be expected to:

1.) Answer any question concerning the possible etiology, prognosis or techniques appropriate to the disorder exhibited by individual clients
2.) Organize short-term objectives that effectively progress to achieve long term goals.
3.) Organize individual therapeutic sessions that utilize appropriate procedures and materials and thus ensure adequate therapeutic progress.
4.) Communicate effectively in oral and written communication:
   a. Professional writing
      i. Treatment Plan preparation
      ii. Treatment Outcome preparation
      iii. SOAP notes
      iv. Letters and other correspondence
      v. Logging phone calls, contact and correspondence in client’s folder
5.) Complete all paperwork and correspondence in a timely manner.

NOTE: If paperwork or paperwork revisions are incomplete, unacceptable or late more than three times during a semester (with any client), a failing grade of B- or lower will be assigned by the supervising CE. A meeting will then be held with the CE, Academic Advisor and student to formulate a Remediation Plan for Poor Clinical Performance (see CP-12).

6.) Communicate concisely and grammatically in all interactions with the client and family.
7.) Present information at and IEPC or similar program planning meeting.
General Requirements

All clinicians are responsible for the information transmitted in both lectures and readings from all classes taken prior to a clinician's assignment and from Clinic Meetings. In addition, CE will require outside reading pertinent to individual clients.

Attendance

Therapy sessions should always begin promptly continuing through the prescribed time for that client, unless other specific arrangements have been approved by your CE. You are expected to be in the clinic at least 30 minutes prior to your session. Therapy session should be held in the rooms assigned unless permission to hold sessions elsewhere has been granted. Any clinician who is unable to keep his/her appointment and/or to attend the Clinic Meeting must call the Clinic at least 2 hours prior to his/her scheduled therapy or Clinic Meeting. Failure to do so will result in an unexcused absence. Clinician absence should only be due to illness or other extreme circumstance. Absence due to illness for 2 or more days will require a written physician’s excuse. Late arrival to Clinic Meeting (over 10 minutes) will constitute being tardy.

Three (3) tardies will be counted as one (1) unexcused absence. Three unexcused absences will lead to client reassignment, your dismissal from clinical practicum and a failing grade for the semester. If a clinician accrues over 3 unexcused absences, this will lead to client reassignment and a failing grade.

Individual arrangements between clinician and families may be made if your client is scheduled for and 8:30. These arrangements MUST be cleared with your CE FIRST. Otherwise, only the PCR, on the CE’s advice, may cancel a client. Upon client’s absence, the clinician will observe therapy at these times and submit a written report of the observation to their CE. (F-12) with a corresponding SOAP note that states the client was absent and circumstances if given by client/family. The SOAP note should include a S with stating the absence and a reason if given, an O and A with no content and a P that states the objectives for therapy upon client return. (Usually this P content was used in the previous SOAP note).

Communication

Clinicians will communicate with their CE via email and/or clinician mailbox. Mailboxes are available in the student work area. Each clinician should look for his/her name at the beginning of the semester. To facilitate communication with the CE, clinicians are expected to respond promptly to CE questions or requests for a meeting or other information.

Clinicians will not distribute letters or reports regarding their client without the approval of the CE and the signed release by an authorized part. Any communication which has been approved must be typed on EMU letterhead and a copy placed in the client file. A clinician’s personal telephone number should not be given to clients or families of clients. Phone calls, emails or any other type of communication with clients or families is not acceptable outside of the clinic unless your CE has approved that communication. ALL communication, written or verbal, with outside agencies and individuals should be authorized by the client or family FIRST. These communication should be logged in black ink on the log sheet in the client’s folder.
Often clinicians will communicate with client or client’s family via email. The intended email must first be approved by your CE. Upon approval, the email correspondence must be sent with your CE cc’s. The complete email correspondence needs to be printed, filed and logged.

**Documentation**

Appropriate and professional documentation is required by law and many national accrediting agencies. The following documentation is required in this clinic. There are to be NO STAPLES in any document that is filed. **USE ONLY CLIENT INITIALS ON PAPERWORK, TEST PROTOCOLS, ETC. FULL LEGAL CLIENT NAMES (first, middle and last) ARE WRITTEN ONLY ON THE COMPLETE TREATMENT PLAN AND TREATMENT OUTCOME WHEN IT IS PRINTED ON STUDENT REPORT PAPER.**

**WEEKLY PAPERWORK:**

- **Monday/Wednesday** clients scheduled between 8:30 and 2:00 p.m. is due at the latest by 4:00 on Wednesday.
- **Monday/Wednesday** clients at 3:00 p.m. or 4:00 p.m. is due by 11:30 a.m. on Thursday.

- **Tuesday/Thursday** clients scheduled between 8:30 a.m. and 2:00 p.m. is due at the latest by 4:00 p.m.
- **Tuesday/Thursday** clients scheduled between 3:00 p.m. or 4:00 p.m. is due by 11:30 a.m. on Friday.

If you have extenuating circumstances of group assignment or group assignment on Thursday which prevent you from meeting these deadlines, see the appropriate CE. Please attach data sheets, test protocols, prior revisions, with weekly paperwork correspondence.

1.) **Client contact Log** (F-13). The client log sheet is a yellow sheet located on the left-hand side of each folder. Every telephone call, document mailed or received, or clinic paperwork filed is logged on this sheet. Each time a SOAP note is filed or removed it is also recorded on the log sheet. Be sure to date and initial each entry on the sheet. **Entries should be made in black ink.** Errors are to have a line drawn through them with the corrected information written next to the error and initialed.

2.) **Client Status Review and Plan of Assessment (POA)** (F-14, and F-15). During the first week, after you have completed a Chart Review and Client Information Sheet, you are expected to meet with your CE to discuss your client’s status, plans for assessment, and days needed to complete the evaluation. The assessment days can range from 1-3 days for 528 and 1-2 days for 538. You will then submit a detailed list of areas and skills that you plan to assess in the Plan of Assessment column on the Client Status Review form. All evaluation data should be written on the POA in the appropriate section.

3.) **SOAP Note** a daily annotation of therapy must be maintained in each client file in the SOAP note format (F-16, F-17, and F-18). SOAP notes must be submitted to your CE with your weekly lesson plans. However, you are encouraged to submit a corresponding SOAP note immediately following a session before the weekly paperwork deadline. The
feedback in these SOAP notes may be beneficial when writing your next SOAP note. These notes must be typed with the clients’ initials, clinician and CE’s names, date of session and title SOAP note. Missed sessions, cancelled sessions, and holidays require a SOAP note and the S + P portion of the SOAP note needs to be addressed.

After approval by your CE, these notes should be filed immediately in each client’s file in chronological order by date. It is the clinicians’ responsibility to file all SOAP notes and to log the filing on the log sheet in the client’s folder. All SOAP notes should be typed and placed in the file by the midterm conference and the final conference of each semester. See (F-19 and F-20) for Guidelines for Describing the Severity of disorders and the format to report the ASHA QCL Scale and the ALA.

4.) **Self-Evaluations** The clinician is expected to complete the Clinician Self Evaluation Check Sheet (F-21) and write a narrative of his/her therapy with each client each week. This is then submitted with SOAP notes and lesson plans. Self-evaluation reports should deal strictly with the success or failure of a particular lesson. The self-evaluation reports should NOT be descriptive in nature but instead should attempt to answer the question: “why”, “when” and “how.” It is perhaps most important to analyze when a particular session was successful or unsuccessful. The knowledge learned from such analysis should allow additional sessions to be equally successful. The Clinician Critical Reflection (F-22) form is only to be used after midterm given permission from you CE.

5.) **Lesson Plans (F-23)** for format. Lesson plans are to be written for each week after assessment is completed for each client until such time as your CE indicates otherwise.

At least 10 minutes before each session the correct and/or revised copy of you lesson plan is to be placed in your CE’s mailbox. **NOT IN A FOLDER.** Your CE will use the lesson plan as your therapy session is observed.

6.) **Graphs and Treatment Hierarchies** When your Treatment Plan is approved, you will be expected to prepare one graph per goal including baselines and teaching steps (objectives). Include possible homework assignments for each level of the hierarchy. These are due 48 hours after your Treatment Plan has been signed by your CE.

7.) **Goal Cards** (F-24). If the Treatment Hierarchies are approved by your CE and if your therapy sessions are progressing satisfactorily your CE may approve the use of Goal Cards, an abbreviated planning format. All lesson plans or Goal Cards for the following week are due with the WEEKLY PAPERWORK deadlines stated above. Lesson plans will be reviewed/corrected by your CE and returned to you. Check your CE’s out basket Monday morning for your lesson plan.

8.) Refer to **Observation Reports** (F-25 or F-12) for formats and conditions of each type of observation report. These are to be completed in detail for any required observation and placed in your CE’s IN box for checking.

9.) **Treatment Plans** (F-26, F-27 and F-28). Treatment Plans for each client must be submitted to the CE 48 hours after the last diagnostic SOAP note is approved by their CE (see CE for form and ICD-10 codes).
All pertinent information is reported in the evaluation SOAP notes must be included in the Treatment Plan reports.

All narrative Treatment Plan drafts should be submitted to your CE typed double-spaced. The adult Treatment Plan template should be submitted to your CE written legibly, printed neatly with black ink. Submit all previous drafts, test protocols and all applicable data sheets with the first draft and all revisions. If the Treatment Plan has not been approved by Friday of midterm week (see syllabus for date), the student will receive all ones on the CALIPSO form pertaining to the Treatment Plan.

If at any time during the semester your CE has concerns regarding clinical performance the clinician has the right to a remediation plan. Please see (CP-12).

When the CE approves the Treatment Plan, the student clinician inserts all identifying information including the client’s full legal name and the client’s name or applicable pronoun throughout the report and testing protocols. Protocols are filed in the back of the Treatment Plan.

Two final copies of the Treatment Plan will be printed on “Student Report” paper and should be single-spaced. These are to be signed by the clinician and given to you CE for their signature. After the CE signs, one copy is filed in the client’s file and the other given to the client and family during the Summary of Goals meeting.

11.) Summary of Goals after the Treatment Plan have been approved, you will complete two copies of the Summary of Goals on plain, white paper (F-29) for the format. This is a one-sided page summary which states the goals for your client for the semester. A SOG outline must be approved by your CE before the SOG meeting (See Canvas for samples of SOG outlines). You must put the SOG scoring rubric (F-8) in your CE’s box BEFORE the intended meeting.

During the SOG meeting you will review with the client or family and obtain signatures. Upon Client/family agreement the clinician and CE will sign. The SOG review should include baselines for each goal and a brief description of procedures to be used to achieve each goal DO NOT BEGIN TO REVIEW THE SOG WITHOUT YOUR CLINICAL EDUCATOR. One copy is given to the family and the other filed.

12.) Treatment Outcomes Clinicians will write a Treatment Outcome (F-30), a summary of your treatment for each client for a given semester. Refer to the syllabus for the due date. All drafts should be submitted to your CE typed double-spaced. Please submit previous drafts with each revision. Final copies will be printed on paper labeled “Student Report” and should be single-spaced. The original and one copy of the typed final report must be submitted, approved and signed by your CE prior to your Final Conference upon approval with signature. One copy of the Treatment Outcome is to be filed and the other copy is given to your CE to be mailed at a later date.

13.) Clinician Client Family Conference A conference outline must be approved by your CE before the family conference meeting (F-6 and F-8). In addition each semester goal is to be graphed on a single piece of paper, i.e., 4 goals = 4 graphs. They can be hand-drawn or computer generated. DO NOT BEGIN THE FAMILY CONFERENCE WITHOUT YOUR CLINICAL
EDUCATOR. Please make sure the final conference rubric is your CE’s mailbox prior to the meeting.

When you are requested to revise any of the above documentation, the revision is due in your CE’s mailbox within 48 hours of the time you receive the request for revisions.

Due to HIPPA, it is not appropriate for a clinician to maintain a copy of any client paperwork for personal files. All drafts and copies are to be put in the shred box. Delete all client documents from workroom computers before you leave each day and check printers to ensure documents are taken. This includes drafts of treatment plan, outcome, SOAP notes, or any other documents containing client information.

At the End of Each Semester

1.) In the materials holding room) so they can be scheduled in the time slots they prefer. Be certain they give 2 days and 2 time preferences. If they are not returning complete a preference sheet stating this plan. If they are “taking a break” for the semester/s a blue preference sheet is needed with anticipated semester return and anticipated time availability. When completed, place in the labeled folder that is located in the clinician work area.

2.) Anticipated 528 and 538 clinicians are required to complete a Clinical Practicum Schedule.

3.) Clinic class meetings will be scheduled on a semester to semester basis. Please make yourself available Monday through Thursday 8:30-5:00 until client and class meetings have been determined and communicated.

4.) Final conferences with your CE will be scheduled the week of final exams. Please sign up for times outside their doors.
   • You must have Treatment Outcomes approved and signed and all SOAPS typed and filed PRIOR to the conference.
   • Bring your client’s file, one ASHA log sheet and a completed Generic Abilities form to the conference.
   • CE will announce due date for your clinical Performance Scale self-evaluation.

5.) Clean out your mailbox, materials shelf and locker if you are completing SPSI 538.

6.) Remove all items from the refrigerator.

7.) Return books and materials borrowed from CE’s.

8.) Return all clinic materials by the date posted by the Material Librarian.

9.) Delete all client related documents on your computer, memory stick, etc. and empty the Trash Bin on your computer. Bring your computer to your final conference so your CE can witness your deleted files mandated by HIPPA. If you do not bring your computer, then your final conference will be re-scheduled.

ASHA Logs

One ASHA (semester) log will be completed at your final evaluation conference with your CE. She will review your hours and appropriate placement on the logs. You will enter the ASHA Log hour on CALIPSO at your final conference. This proof of supervised practicum will be necessary for ASHA application. The program will make every effort to see that you obtain the necessary
experiences to meet the clinical practicum clock hour requirements. It is **YOUR** responsibility to monitor your progress, however, and to notify your advisor if you are short of hours in particular categories.

**THERAPY MATERIALS**

**Availability**

Each student is encouraged to prepare and use personal materials for therapy. However, the Clinic maintains a large supply of various types of therapy materials for student use. These materials have a dual purpose. First, they should be considered by the clinician as samples of items which may be effective with various types of clients. Second, they should be evaluated by the clinician for overall effectiveness with an eye toward future professional purchase on a limited budget. **YOU WILL BE EXPECTED TO VARY THE MATERIALS YOU USE WEEKLY.** Exceptions to this must be approved by your CE.

**Procedures for Use**

All materials are requested by completing a materials request form. Request forms need to be completed in full and placed in the materials librarian’s IN box according to dates/times posted each semester. The Materials Librarian will place requested materials on the shelf labeled with the clinician’s name in the material holding room. After use, all materials, including tests, are to be returned to this shelf. The Clinic is not responsible for personal therapy materials you may store on your shelf. Please place your personal materials in a small container on your shelf with your name clearly marked on the container. Therapy materials not belonging to the clinic which are left on the holding room floor or not in the clinician’s container for a period of one week will be offered to other clinicians.

Students are never to be in the Speech and Hearing material room without permission or to take or return any materials to that room. Should a clinician wish to survey the materials which are available, he/she should make every effort to do this during the Materials Librarian scheduled work hours. If this is not possible you may ask a CE to open the materials room for you.

Whenever such items as the Webber Articulation cards are requested, they must be kept together as a unit. Should a clinician desire to use only a portion of a kit or card file, for instance, the entire kit or file must be taken into the therapy room and the entire kit returned to the holding room. At no time should any parts of kits be observed anywhere except in close proximity to their container.

Materials are **ONLY** to be used by the clinician requesting them. Not following material procedures/guidelines may result in the termination of the privilege of using Clinic materials. Students who have been denied the use of Clinic materials may petition for reinstatement of the privilege at the end of one month.

Materials can be checked out over-night. The clinician must have any CE sign the materials request form. The signed form is then returned to the clinician’s holding shelf.
One week each term will be designated “NO Materials Week”. This means that the only therapy aids available to the clinician are those already in each room (mirror, dry-erase board, etc.) and any materials a clinician may choose to purchase or make. Any clinician who believes that a clinic material is essential to the treatment of his/her client will be given the opportunity to defend that position by his/her CE.

**Maintenance of Therapy Rooms and Work Areas**

All students are expected to help maintain the therapy rooms. This means that furniture is expected to be returned to its proper place, dry-erase boards are to be erased, and all waste paper is to be picked up from the floor. If you complete an activity or project that litters the floor, you are expected to vacuum after your session. A hand-held vacuum is available if needed. Please ask a CE or office for assistance. At no time should a clinician leave equipment or materials in the therapy room or clinic hallways after a therapy session is concluded. Clients should be involved in the therapy room cleanup.

**Clinicians are expected to clean the table(s) with antibacterial cleaner found on the tray table by the treatment rooms.** Periodically, students may be requested to help clean room, which mean washing boards, tables and mirrors. The student work areas are provided for the benefit of all Speech Language Pathology majors. They are intended as work and study rooms. Meetings and conferences may be held in any conference room in the Clinical Suite. Students enrolled in SPSI 528, 538, 543 have priority for use of the work areas. The Eastern Michigan University Chapter of the National Student Speech-Language-Hearing Association purchased a refrigerator for storage of snacks for clinic clients and oral-motor supplies. Snacks or supplies must be labeled with clinician/client names and date that they were put in the refrigerator.

There are lockers available in the Case Analysis Room. See our CE if you wish to use a locker for the semester.

It is of the utmost importance that the rooms be maintained in a sanitary manner. **FOOD AND DRINK ARE ALLOWED ONLY IN CLINICAL SUITE CONFERENCE ROOMS** unless you are providing snacks or using food and drink for oral motor and dysphasia evaluation, or treatment. Please shut off lights and be mindful of ongoing treatment. Keeping the noise level at a minimum.

**Observation Rooms**

The observation rooms are available to SLI majors from selected classes, families of clients and student clinicians. Other persons wishing to observe must consult the appropriate CE. Conversation among students is prohibited in the observation rooms. Please enter and leave the rooms quietly and close the door behind you. The lights in the observation rooms are to be left off at ALL times. If the door is open clients may see through the observation room into the hallway. Everything you hear and see in therapy is CONFIDENTIAL and not to be discussed outside of the clinic.
Bulletin Boards

The bulletin boards in the hall outside the clinic classroom and in the main hallway outside of the entrance to the Clinical Suite are the main information centers of the SLI Area. All schedules, notices, messages, and announcements related to the academic program are regularly posted on these bulletin boards. Clinic cancellations are posted on the bulletin board of the Clinic office. Other clinic notices and job openings are posted on the board in the clinicians’ work areas. It is essential that each clinician check every day for any pertinent announcements.

Fees

Due to Medicare changes, the clinic is unable to charge a fee for EMU clinical speech/language services. However, the clinic does welcome donations that are tax deductible. If a family is interested in a donation, please contact your CE.

Title IX Compliance at Eastern Michigan University

Title IX of the Education Amendments of 1972 prohibits discrimination on the basis of sex under any education program or activity receiving federal financial aid. Sexual assault and sexual harassment is a form of sex discrimination prohibited by Title IX.

Eastern Michigan University is committed to providing a learning, living and working environment free from discrimination. Any gender based discrimination, including sexual misconduct which includes but is not limited to, sexual assault, sexual harassment, stalking, relationship violence and sexual exploitation committed by EMU students, staff or faculty will not be tolerated. This applies to academic, education, athletic, residential and other University operated programs. Eastern Michigan University encourages individuals who believe they have been sexually harassed, assaulted or subjected to sexual misconduct by an EMU student or employee to seek assistance.

While compliance with the law is everyone’s responsibility at EMU, the person designated to handle inquires of sex discrimination is the Title IX Coordinator (see emich.edu website for the individual’s name).
CLINICAL POLICIES AND PROCEDURES MOST APPLICABLE TO STUDENT CLINICIANS

(for other clinical related policies please reference the *Policy and Procedure Manual* above the CE’s mailboxes'you are also responsible for their content).
EASTERN MICHIGAN UNIVERSITY  
Speech and Hearing Clinic  
Suite 135, Porter Building  
Ypsilanti, MI 48197  
(734) 487-4410

Clinical Policy

Subject: Medical Emergency Plan    Date: 09/12/99    Revised: 12/2/03, 11/15/16

1.0 POLICY

All staff and students in the Speech and Hearing Clinic will know and will follow established procedures in the event of a medical emergency.

2.0 PURPOSE

This policy is established to provide clear guidelines for staff and students to follow in the event of a medical emergency.

3.0 RESPONSIBILITY

The Clinic Speech-Language Pathology staff, Audiologist, students and the office staff.

4.0 PROCEDURES

4.1 The Clinical Educator and student clinician will review each of their client files to determine if there is a need or a Red Medical Alert Sheet (AMAS). If a AMAS is appropriate, it should be reviewed and updated every semester to determine the appropriate procedure, specified on the form, in case of an emergency.

4.2 All Clinical Educators will be apprised of the nature of the medical alert and the procedures to be followed in the event of a medical emergency.

4.3 In the event of a medical emergency with a clinic client the student clinician is to notify the family member and the clinical supervisor immediately. The family member and/or the Clinical Educator will determine whether emergency services should be requested.
4.4 Emergency services will be contacted by calling 1222 and providing the following information:

4.5.1 the location of the emergency- The Clinical Suites on the first floor of the Porter College of Education Building, Suite 135

4.5.2 kind of assistance needed- police or ambulance

4.5 If emergency services are called, a clinic staff member will proceed to the first floor entrance of the Porter Building to help direct emergency personnel to the Clinic.

5.0 DATE TO BE REVIEWED
This policy will be reviewed annually by all Clinic Staff.
EASTERN MICHIGAN UNIVERSITY
Speech and Hearing Clinic
Suite 135, Porter Building
Ypsilanti, MI 48197
(734) 487-4410

Clinical Policy

Subject: Confidentiality Date: 3-26-07
Revised: 12-19-07, 4-17-08, 12-2-11, 12-2-16

1.0 POLICY

All staff and students in the Speech & Hearing Clinic will know and follow established procedures regarding confidentiality of clients and clinical records. These are stated in the ASHA Code of Ethics and Confidentiality statement and HIPAA Behavior.

2.0 PURPOSE

This policy is established to provide clear guidelines for staff and students to follow regarding the protection of client's privacy.

3.0 RESPONSIBILITY

The Clinic Speech-Language Pathology staff, Audiologist, students and office staff.

4.0 PROCEDURES

4.1 All SPSI 528 and 538 clinicians will sign a Confidentiality Agreement at the first Clinic Orientation meeting. This signed Agreement will be kept in each clinician's file in the Speech & Hearing Clinic.

4.2 Files are maintained for each client and are confidential. All files are stored in a locked filing cabinet in the Clinic office.

4.3 Only students officially assigned to a clinic client, may check out files from the Clinic office.
4.4 To check out a file, fill in an orange checkout card, located in the wire basket in the student work area, with the date, your name and client's initials. Place the checkout card in the pendaflex in place of the file.

4.5 All files are to be read in the student work areas within the clinic and returned promptly. Do not leave a file unattended. All files MUST be returned to the client's pendaflex by 4:30 p.m. Monday through Thursday and by 4:00 p.m. on Fridays. The orange checkout card must then be put back in the wire basket in the student work area. Be certain to return the file to the appropriate pendaflex and maintain the chronological order (File 1 in back, most recent in front).

4.6 No file or portion thereof may be removed from the Clinic except to discuss the client with a faculty member in her/his office. You must receive one of the clinical educators' permission to do this.

4.7 You may never, under any circumstances, take a client file out of the building.

4.8 You may never, under any circumstances, Xerox anything in your client's file. Any client document must be given to your supervisor to be shredded. All client documents typed on the computer in the student work room computers must be deleted immediately. All client documents on personal computers must be deleted in the presence of your CE during the final student conference.

4.9 If you receive a document from another setting (hospital, school system, etc.) you must log and file it immediately.

4.10 You are to use only the client's initials on SOAP notes; these will then be filed with initials only.

4.11 Treatment Plan and Treatment Outcome report drafts are to be written with client initials only and without the file number. The client's full (including middle) name and file number will be added only when the report is approved by your supervisor to be printed on Student: Report paper.

4.12 All DVD's of clients' sessions are confidential and are the property of EMU's Speech & Hearing Clinic. They may not be viewed by anyone other than the clinician and must be returned to the Clinical Educator with your completed observation form.

4.13 See Addendum for all related forms.

5.0 DATE TO BE REVIEWED
This policy will be reviewed annually by all Clinic Staff.
Confidentiality Agreement

All EMU Speech & Hearing Clinic client information whether contained in a client’s Clinic record, or in any other medium, including audio, videotapes, or any computer system is strictly confidential. Disclosing, accessing, or permitting access to confidential client information without proper authorization is a violation of EMU Speech & Hearing Clinic policy, state laws and Federal laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and unauthorized disclosures may result in disciplinary action. In addition, disclosing, accessing, or permitting access to confidential Protected Health Information (PHI) without proper authorization may also subject the violator to civil and/or criminal penalties for violation of state laws and HIPAA. Billing and financial management information is also to be held in strict confidence and is not to be disclosed without written authorization by the client.

I certify that as a practicum student, staff, volunteer, or faculty member of the EMU Speech & Hearing Clinic, I understand the statements above and am aware of the confidential nature of the client’s PHI. I understand and agree that in the performance of my duties at EMU Speech & Hearing Clinic, I am obligated to respect client privacy and to protect client PHI from unauthorized use and/or disclosure. This includes only accessing client’s PHI on a need to know basis related to treatment, payment, and health care operations, or training. I understand that when the recordings for a client are in my possession, I assume total responsibility for the confidential retention and viewing of the CD’s. I understand that the unauthorized use and/or disclosure of information from the client's recordings or audio, or from any computer system may result in disciplinary action up to and including dismissal, in accord with the policy outlined in the EMU Speech & Hearing Clinic Policy and Procedures Manual, and may further subject me to civil and criminal penalties under HIPAA.

I acknowledge that I may have access to confidential client information. By signing this statement, I agree to follow the guidelines below, and as further detailed in the EMU Speech & Hearing Clinic Policy and Procedures Manual. The identity of clients, or information that would reveal the identity of clients, cannot be revealed without the specific permission of the client. The only exceptions to this are cases in which the client may be dangerous to themselves or others and in cases of child abuse. In such situations, there may be legal requirements that responsible agencies be informed. There are also certain legal proceedings in which case notes and other records can be ordered to be released by the courts. Clinicians must familiarize themselves with, and adhere to, confidentiality procedures of the Clinic and the laws of the State. Case material discussed in class must be prepared in such a way that client confidentiality is maintained.

______________________________
Name (print)

______________________________
Position in Clinic

______________________________
Signature

______________________________
Date
EASTERN MICHIGAN UNIVERSITY
Speech and Hearing Clinic
Suite 135, Porter Building
Ypsilanti, MI 48197
(734) 487-4410

Clinical Policy

Subject: Notification of Failure at Midterm
Date: 12/06/04
Revised: 8/04/05, 12/19/07, 4/17/08, 12/8/11, 12/6/16

1.0 POLICY

Uniform procedures will be followed to assist clinicians in SPSI 528 or 538 who have or will receive a failing grade at midterm.

2.0 EXPECTED OUTCOMES

Notification will allow the clinician to collaborate with the Clinical Educator, the Instructor of Record and the academic advisor in identification of strengths and weaknesses, as well as, to develop an Action Plan with proposed performance ratings and dates of completion.

3.0 RESPONSIBILITY

The Clinic Speech-Language Pathology staff and clinicians.

4.0 PROCEDURES

4.1 If the Treatment Plan has not been approved, signed and filed by the date listed in the syllabus, a score of 1 will be assigned to the CALIPSIO performance scale on Treatment Plan items.

4.2 If the clinician receives a failing grade at midterm as pertained items are calculated on the Treatment Plan, the clinician and Clinical Educator(s) will collaborate in identifying strengths and weaknesses via a Remediation Plan with the development of a Plan of Action.
4.3 Refer to the Remediation Plan policy for details.

5.0 DATE TO BE REVIEWED
   This policy will be reviewed annually by all Clinic Staff.
EASTERN MICHIGAN UNIVERSITY
Speech and Hearing Clinic
Suite 135, Porter Building
Ypsilanti, MI 48197
(734) 487-4410

Clinical Policy

Subject: Remediation Plan for Poor Clinical Performance   Date: 12/17/04
Revised: 12/19/07,
4/17/08, 12/5/11, 12/6/16

1.0 POLICY

Uniform procedures will be followed to assist clinicians who are performance poorly in SPSI 528 or 538 prior to midterm.

2.0 EXPECTED OUTCOME

Completion of a Remediation Plan will allow the clinician and Clinical Educator(s) to identify problems and develop a Plan of Action with dates of completion and expected performance ratings to facilitate an improvement in clinical skills.

3.0 RESPONSIBILITY

The Clinic Speech-Language Pathology staff and clinician.

4.0 PROCEDURES

4.1 The clinician will be informed by the Clinical Educator(s), faculty advisor, or the Instructor of Record that a Remediation Plan is needed.

4.2 The clinician will complete a draft of the Remediation Plan containing identification of strengths and weaknesses in his/her clinical skills.

4.3 The Clinical Educator(s), faculty advisor, the Instructor of Record and any other faculty member that the clinician chooses (the SLI Support Team) will meet to review and finalize the clinicians draft of his/her Remediation Plan.
4.4. Upon approval of the Remediation Plan, a Plan of Action with dates of completion and proposed performance ratings will be developed and this form will be copied and given to the clinician, the Instructor of Record and the clinician's faculty advisor. The Clinical Educator will retain the original.

4.5. It is the clinician's responsibility to meet with the Clinical Educator(s) on an ongoing basis throughout the semester to discuss progress toward or accomplishment of each item on the Plan of Action as well as the performance rating(s) numerical values assigned by the Clinical Educator(s).

4.6. If needed, the SLI Support Team may ask to meet with the clinician periodically to discuss the remediation plan and the clinician's progress regarding the Plan of Action.

4.7. Failure to maintain the Remediation Plan related to completion dates and performance ratings could result in a failing grade in SPSI 528 or 538.

4.8. Completion of the Remediation Plan does not guarantee a passing grade in SPSI 528 or 538.

4.9. See Addendum for related forms.

5.0 DATE TO BE REVIEWED
This policy will be reviewed annually by all Clinic Staff.
REMEDIATION PLAN FOR POOR CLINICAL PERFORMANCE

DATE: __ __ __ __ __

TO: ______________________, CCC-SLP, Instructor of Record and Dr. ______________________, Advisor

FROM: ______________________, SPSI 528/538 Clinician

Clinician Strengths:

Clinician Weaknesses:

Plan of Action/Person Responsible/Due Date/Proposed Performance Rating

Completion Date/Actual Performance Rating

Clinician ______________________  Date __ __ __

Clinical Educator ______________________  Date __ __ __
### CALIPSO Performance Scale Remediation Items (Example)

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CLINICAL FORMS AND PROTOCOLS/TEMPLATES
EASTERN MICHIGAN UNIVERSITY
COLLEGE OF EDUCATION CLINICAL SUITE
SPEECH AND HEARING CLINIC

Suite 135 Porter Building • Ypsilanti, MI 48197 • Phone: (734) 487-4410 • Fax: (734) 487-0028

AUTHORIZATION

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PHONE NUMBERS

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<td>HOME</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>WORK</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
</tbody>
</table>

PERSON TO BE CONTACTED IN CASE OF EMERGENCY (IF NOT LISTED ABOVE)

<table>
<thead>
<tr>
<th>NAME</th>
<th>RELATIONSHIP</th>
<th>PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I hereby authorize the Eastern Michigan University Speech and Hearing Clinic to make customary instructional use, exercising due discretion, for education, scientific and professional purposes, and in the public interest of information, photographs, sound recordings, video recordings, and other records and materials pertaining to, and in consideration of, my enrollment, examination, instruction, and scientific participation, or that of my minor child, , or that of , for whom I am legally responsible, in the Speech and Hearing Clinic. I understand that the services in the clinic are rendered by students as a part of their training program.

______________________________  _______________________
signature                        Date

Please note: We do not accept or bill Medicare, Medicaid, nor any other insurance.
CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

FOR ___________________________, hereby authorize the College of Education Clinical Suite at Eastern Michigan University to exchange/release information in:

- [ ] my own record
- [ ] my spouse's record
- [ ] my child's record
- [ ] date of birth

[ ] to the individual or organization listed below, and only under the conditions specified.

1. THE REPORTS WILL BE SENT TO YOU: COMPLETE THE INFORMATION BELOW.

<table>
<thead>
<tr>
<th>NAME</th>
<th>STREET</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
</tr>
</thead>
</table>

2. SPECIFIC TYPE OF INFORMATION TO BE DISCLOSED

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Substance use Records</th>
<th>Academic/School Records</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Plan</td>
<td>Ideological Records</td>
<td>Employment Records</td>
</tr>
<tr>
<td>Final Report/Treatment Outcome</td>
<td>Evaluation</td>
<td>Court Records</td>
</tr>
<tr>
<td>Medical Records and Reports</td>
<td>Psychological Records</td>
<td>Other (please specify below)</td>
</tr>
</tbody>
</table>

3. THE PURPOSE AND NEED FOR SUCH DISCLOSURE

- [ ] Assessment and treatment planning
- [ ] Court Ordered
- [ ] Coordination of treatment
- [ ] Other

4. I UNDERSTAND THAT THIS CONSENT CAN BE REVOKED BY ME AT ANY TIME, IN WRITING.

UNLESS I CHOOSE TO EXERCISE MY RIGHT OF REVOCATION AT AN EARLIER DATE, THIS CONSENT EXPIRES:

<table>
<thead>
<tr>
<th>One year from date signed</th>
<th>When requested information has been supplied</th>
</tr>
</thead>
<tbody>
<tr>
<td>At the end of the current academic semester</td>
<td>At termination of treatment</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
</tr>
</tbody>
</table>

WITNESS

DATE WITNESSED

/ I My child attend(s) the: [ ] COUNSELING CLINIC [ ] READING CLINIC [ ] SPEECH AND HEARING

CLIENT/GUARDIAN SIGNATURE

DATE SIGNED

SUMMER 2010 consent for release.doc
EASTERN MICHIGAN UNIVERSITY
SPEECH AND HEARING CLINIC

Client Consent to Release Confidential/Protected Health Information

I, ____________________________________________________________________________ (Date of Birth)
Client Name or Authorized Legal Representative) authorize EMU's Speech and Hearing Clinic, to request information,
including confidential/protected health information, which may be helpful in
providing services to Client and to exchange, use, and disclose such
information with the agencies and persons listed below for continuation of
care and Client's care management.

1. ____________________________________________________________________________
2. ____________________________________________________________________________
3. ____________________________________________________________________________
4. ____________________________________________________________________________

I further consent to the release of confidential/protected health information and
materials to qualified professional personnel in furtherance of clinical services
provided on Client's behalf, or any other person(s) named above, as deemed
necessary by EMU's Speech and Hearing Clinic, in its sole discretion. By signing
this Consent, I hereby permit the free exchange of information between those
agencies or individuals that are bound by contract.

I understand that my signing this Consent is voluntary and that I may revoke this
Consent at any time, except to the extent that action has been taken in reliance
upon it and that in any event, this Consent shall expire sixty (60) days after
discontinuation of services to Client. To revoke this Consent, I understand I
must notify EMU's Speech and Hearing Clinic in writing.

This Consent has been fully read by (or to) me. I am voluntarily signing it; I
certify that I understand its contents, and I understand that I am entitled to a
copy of it.

__________________________________________________________________________
Client/Authorized Legal Representative Signature Date

__________________________________________________________________________
Witness Signature Date

Authorized Legal Representative Documentation provided.
_____(witness' initial)
EMERGENCY INFORMATION

Date ______

Client Name ___________________________ Date of Birth ______

Address __________________________________________

Phone # ________________________________

Emergency Contact(s)

(name) (relationship) (phone #)

or

(name) (relationship) (phone #)

PHYSICIANS:
Family-
Other-

ALLERGIC TO

MEDICATIONS: (name, reason, dosage/time)

MEDICAL HISTORY:
CONTINUATION AND DISCHARGE CRITERIA FOR SPEECH, LANGUAGE AND HEARING THERAPY CLIENTS

CLIENT: __________________________ FILE NUMBER: ___________________

CONTINUATION CRITERIA
☐ Ongoing measurable progress in treatment continues to be significant.
☐ There is good to excellent prognosis for further improvement with continued treatment.
☐ The client is willing to continue in treatment.
☐ The family, where applicable, is supportive of and invested in the therapeutic process.

DISCHARGE CRITERIA
☐ The disorder is now within normal limits or consistent with premorbid status or client has attained the desired level of enhanced communication skills. (FU1)
☐ Long-term speech and language goals and objectives have been met. (FU1)
☐ Skills no longer adversely affect the client’s educational, social, emotional, vocational performance or health status. (FU1)
☐ Unwilling to participate in treatment; treatment attendance has been inconsistent or poor and efforts to address these factors have not been successful. (FU1)
☐ The client has made minimal or no measurable progress over a period of two or more semesters. During this time, program modifications and varied approaches have been attempted unsuccessfully. A second opinion may be obtained. Prognosis is fair or lower. Reevaluation should be considered at a later date to determine whether status has changed or new treatment options have become available. (FU 1 or 3)
☐ Parent/guardian or age of majority client requests that speech-language service be discontinued. And/or requests continuation of services with another provider. (FU 1 or 2)
☐ Unable to tolerate treatment due to a serious medical, psychological, or other condition. (FU1)
☐ Demonstrates behavior that interferes with improvement or participation in treatment (noncompliance, malingering, etc.), providing that efforts to address the interfering behavior have been documented and unsuccessful. (FU1)

FOLLOW UP
☐ 1. FOLLOW UP if client/family requests.
☐ 2. Information given regarding other service providers ________________________
☐ 3. Referral (call or letter) made to: ________________________________

Clinician __________________________ Date ___________ Clinical Supervisor __________________________ Date ___________

Outline for Clinician/Client/Family Conferences

To construct Graphs-
- Review each treatment SOAP note and list dates/stimulus conditions/%/cueing per goal.
- Review the data to decide the clearest, easiest way to convey it on a graph. Use color coding for cueing level, goal level, etc. to communicate information visually.

- Write semester goal at top of each graph.
- Be sure to incorporate SCT concepts into graph. Use color to communicate goal and cueing level.

- Perpendicular (Y) axis – usually % or frequency-
   - Horizontal (X) axis – usually daily or weekly dates – TIME FORWARD → list every possible session date.
     a. Graph baseline phase/assessment
     b. Graph daily/weekly objectives
     c. Graph last 3 consecutive sessions/reevaluation
     *May include a key to explain stimulus condition, modeling, cueing, etc.

I. Three objectives of a conference:
   - to provide information
   - to obtain information – This is where LISTENING comes in.
   - to share information

II. Two way conference
   - all involved feel comfortable – this starts with the clinician
   - all involved are active participants
   - LISTEN vs. talk
   - give frequent opportunities for questions from client, family
     - if you don’t know the answer, ask the CI:

(Use the following bolded items as a guideline to write your Conference outline)

III. Purpose:
   - Welcome them
   - State the purpose of the meeting which is to discuss/review goals, procedures, outcomes, prognosis and recommendations.

IV. Review treatment goals, procedures and progress in the following order:
   - Place each graph in front of the client and family member(s).
   - Review aloud each goal. State goal in lay language, if needed.
   - Give them time to look at each graph.
   - State whether goal was/not achieved or surpassed and current performance level, i.e.: stimulus condition and accuracy level and write this at the top of the graph.
   - Review progress toward each goal with the graph
   - Describe how you evaluated progress
   - Be careful to use positive language when discussing progress or other behaviors
Prognosis
- State prognosis for further improvement or development in ____________.
- State factors contributing to this prognosis

VI. Discuss further treatment and recommendations for next semester:
- Confirm if will be returning- i.e. Have you returned the Client Preference Sheet to the Clinic Coordinator?
- Recommendations should be brief and clearly stated in behavioral terms
- Ask family/client for reaction to your recommendations, would they like to make any changes to goals? Would they like to suggest any additional goals?
  Do they have any other suggestions or comments?

-Suggestions regarding home assignments, carry-over activities. Homework packets should be reviewed at the last treatment session instead of in the conference, secondary to time limitations.
-Referrals to outside professionals? Rationale.

Be sure that the client and/or family member(s) take the graphs home.

SAMPLI:
SOAP Note

S: _______ attended Clinician/Client/Family Conference.

O: Discussed semester goals, procedures, outcomes, prognosis, recommendations and homework.
  Results of therapy: #/# goals achieved; #/# not achieved; #/# surpassed.

A: __________ agreed with recommendations. (or “added…”)

P: State recommendations. i.e. Return in semester/year.
Scoring Rubric for Clinician/Client/Family Conferences

Welcome/Thank for attending

Explain purpose: Discuss/review goals    Procedures    Outcomes    Prognosis    Recommendations

Graphs
Each graph provided for client and family members
Review aloud each goal
Give them time to look at graphs
State whether each goal was/not achieved or surpassed and current performance level and
Write at top of each graph
Review progress toward each goal with the graphs beginning with baseline
Describe how progress was evaluated       Procedure examples
Use of positive language
Check for clarity and understanding
Ask for client/family perception of change in functional skills

Prognosis
State prognosis and factors

Recommendations
Confirm if returning       Blue Preference sheet to clinic coordinator?
State recommendations
Family input for changes, suggestions for additional goals
Home assignments for the break
Referrals and rationale
Graphs go home

Nonverbal communication
Eye contact with and attention to client?       Family Member?
Professional demeanor and posture
Appropriate volume
Seating Arrangement
Placement of items to review


Scoring Rubric for Clinician/Client/Summary of Goal (SOG) Conference

Welcome/Thank for attending/Purpose of the Meeting:
Explain: Baseline measures (formal or informal evaluation results)
Semester goals
Rationale for selected goals
Treatment procedures to obtain semester goals

Explanations of procedures

If graphs have been approved by your CE include in conference:
Graphs are used during the discussion
Each graph visible for client and family members
Integration of graphs when discussing baseline and procedures
Check for clarity and understanding
Clarification of cueing concept and how it is used to supplement therapy
Explanation of cueing and performance levels (Can use the Charting Reminders card)
Continuous check for clarity and understanding

Nonverbal and Verbal Presentation

Use of positive language
Eye contact with and attention to client?
Professional demeanor and posture
Professional vocabulary
Verbal organization in presentation
Copy of SOG for the client and/or family during the discussion
<table>
<thead>
<tr>
<th>Level</th>
<th>Client Ability</th>
<th>Clinician Support to Achieve Target Success</th>
<th>Parents/Teachers/Outside of Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 5</td>
<td>Getting There!</td>
<td>Able to self-monitor for errors with minimal support in un instructed activities Client is consistently 80-100% accurate in the therapy setting</td>
<td>Client is able to self-monitor most of the time outside therapy Parents/teachers report client is generally accurate in most circumstances Provide Level 4-Level 5 activities</td>
</tr>
<tr>
<td>Level 4</td>
<td>Carrying it Over</td>
<td>Able to use target in new or exciting games, discuss with some support Able to self-monitor for errors with moderate support in structured or familiar activities Target is consistently accurate in structured activities Target is inconsistent in unstructured activities Provide occasional/minimal cues Generally not necessary to provide a model of the target Provide opportunities for production in increasingly distracting, less structured activities in therapy Use increasingly complex linguistic stimuli Provide opportunities for client to self-evaluate accuracy Reinforce evidence of self-monitoring &amp; generalization Provide many opportunities for production outside of therapy room</td>
<td>Client is able to produce target consistently in structured activities outside of therapy, 10-20 minutes Client is able to self-monitor for specified periods of time outside of therapy Parents/teachers may comment that target is spontaneously produced more frequently Provide Level 3 activities for home/school</td>
</tr>
<tr>
<td>Level 3</td>
<td>Moving Along</td>
<td>Aware of target goal in structured speech/language activity May need more cues initially in session; fewer cues towards end of session May need review of previously acquired steps initially in session Provide minimal-moderate cues Use of delayed imitation may be needed initially; fewer models needed later in session May initiate activity with drill review, then proceed with less structured activity Use of intermittent feedback is sufficient Promote self-monitoring of accuracy Increase linguistic complexity for productions</td>
<td>Client is able to practice Level 2 skills in specific, structured activities with parents, teachers Emerging spontaneous use of target in structured settings (therapy, homework) Generally does not produce target independently outside of therapy</td>
</tr>
<tr>
<td>Level 2</td>
<td>A Conscious Effort</td>
<td>Able to produce target with conscious effort Needs frequent cues to maintain accuracy Needs consistent models to maintain accuracy Can be accurate with slightly more complex stimuli Provide moderate level of cues Use prompts frequently, but not consistently Use both direct imitation and delayed imitation Provide ample, explicit feedback Elicit target with simple stimuli; slightly more complex than in level 1</td>
<td>Support client in identifying new target to parent/teacher Send home materials that promote awareness of new target May practice Level 1 skills for short periods of time</td>
</tr>
<tr>
<td>Level 1</td>
<td>Beginning a New Goal</td>
<td>Generally unaware of target Requires maximum, explicit cues to produce new target accurately Produces target correctly only in direct imitation Accurate with only very simple stimuli Demonstrate/explain new target Provide maximum auditory/visual/tactile cues Provide models of target consistently Elicit target through direct imitation Provide consistent (100%), contingent feedback Provide explicit feedback for correct production Elicit target with linguistically simple stimuli</td>
<td>Clinician will discuss new target, approach to therapy Discuss initial steps to achieve long-term goal May send home products from activities to stimulate awareness of target</td>
</tr>
</tbody>
</table>
SELF-EVALUATION OF RECORDED SESSION

Clinician          Client          Supervisor          Date

Please watch this CD and evaluate your strengths and weaknesses within the session. This review is not about your client but about your performance. Return the CD with your review to your supervisor. This will take the place of your self-evaluation this week.

As you review the CD of your session, write about the following:

1. Describe the instructions you give before you being to work on each objective. Does your client understand the instructions? How do you know? Do you give the client enough time/too much time to respond? Provide two examples of your objective instruction.

2. How did you prepare for the session? What changes did you make compared to the previous sessions.

3. Describe how you adapt your communication style to the client

4. Describe how you maintain on-task behavior. Are your activities and material motivating? Functional?

5. Is time used efficiently? How many responses does the client make during each task?

6. Are the tasks appropriate for the client's skill level? Describe teaching techniques you're using. Describe effectiveness or ineffectiveness or your modeling and/or cueing. Provide an example of your teaching techniques.

7. Reinforcement-
   Are the reinforcers motivating the client?
   When and how are you reinforcing target behavior?
   What is the frequency and do you modify it as necessary?
   What do you do when the client is not successful or what do you do when the client makes an error?

8. Feedback-
   When and how are you giving feedback? How does your client respond to your feedback? Do you give a brief summary of performance after each activity? At the end of the session? Provide one or two examples of your feedback.

9. After watching the CD, how did you enhance your current strengths? What do you need to continue to improve upon? How are you going to accomplish these needed improvements?

10. After watching the CD, what would I do differently?
CALIPSO – CLINICAL PERFORMANCE SCALE – SPSI 528 & 538

CLINICIAN ____________________________ SEMESTER ____________

CLINICAL EDUCATOR ____________________________ YEAR ____________

Client age (circle)    Infant 0-2    Young child 3-5    Child 6-17    Adult 18-64    Older adult 65+

GRADING SCALE:

5  Exceeds Performance Expectations. Adequately and effectively implements the clinical skill/behavior. Demonstrates independent and creative problem solving.

4  Meets Performance Expectations. Displays minor technical problems which do not hinder the therapeutic process. Minimum amount of direction from supervisor needed to perform effectively.

3  Moderately Acceptable Performance. Inconsistently demonstrates clinical behavior/skill. Exhibits awareness of the need to monitor and adjust and make changes. Modifications are generally effective. Moderate amount of direction from supervisor needed to perform effectively.

2  Needs Improvement in Performance. 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.

1  Unacceptable Performance. Specific direction from supervisor does not alter unsatisfactory performance.

EVALUATION SKILLS: Disorder(s) (circle all that apply):

Articulation   Fluency   Voice   Language   Hearing   Swallowing

Cognition   Social Aspects   Communication Modalities

1  Conducts screening and prevention procedures (Std III-D, Std IV-G, 1a)  5  4  3  2  1

   A. Prepared for consultation with the audiologist and followed hearing protocol

   B. Writes accurate, appropriate, and detailed audiological evaluation summary

   Average:

2  Collects case history information and integrates information from clients/patients and/or relevant others (Std IV-G, 1b)  5  4  3  2  1

   A. Complete and accurate case history review based on Chart Review form categories

   B. Preparedness for the initial CE meeting

   C. Depth in the analysis of recorded review prior to POA

   Average:

Revision 8/21/2018
<table>
<thead>
<tr>
<th></th>
<th>Selects appropriate evaluation instruments/procedures (Std IV-G, 1c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>A. Writes appropriate, detailed Plan of Assessment for initial evaluation sessions</td>
</tr>
<tr>
<td></td>
<td>B. Demonstrates ability to explain profile of client strengths and weaknesses in preparation for evaluation to CE</td>
</tr>
<tr>
<td></td>
<td><strong>Average:</strong></td>
</tr>
<tr>
<td>4</td>
<td>Administers and scores diagnostic tests correctly (Std IV-G, 1c)</td>
</tr>
<tr>
<td></td>
<td>A. Shows evidence of thorough review of evaluation materials when administering formal or informal materials to clients</td>
</tr>
<tr>
<td></td>
<td>B. Accurate calculations of formal and informal assessment measures</td>
</tr>
<tr>
<td></td>
<td><strong>Average:</strong></td>
</tr>
<tr>
<td>5</td>
<td>Adapts evaluation procedures to meet client/patient needs (Std IV-G, 1d)</td>
</tr>
<tr>
<td></td>
<td>A. Demonstrates flexibility when determining appropriate assessment</td>
</tr>
<tr>
<td></td>
<td>B. Minimizes client frustration during the assessment</td>
</tr>
<tr>
<td></td>
<td>C. Sequence of assessment/organization of test materials promotes testing reliability, validity and minimizes client distraction</td>
</tr>
<tr>
<td></td>
<td><strong>Average:</strong></td>
</tr>
<tr>
<td>6</td>
<td>Possesses knowledge of etiologies and characteristics for each communication and swallowing disorder (Std III-C)</td>
</tr>
<tr>
<td></td>
<td>A. Demonstrates appropriate understanding of client's developmental/skill level in speech, language and cognitive domains</td>
</tr>
<tr>
<td></td>
<td>B. Demonstrates ability to complete/document swallowing evaluation</td>
</tr>
<tr>
<td></td>
<td><strong>Average:</strong></td>
</tr>
<tr>
<td>7</td>
<td>Interprets, integrates, and synthesizes test results, history, and other behavioral observations to develop diagnoses (Std IV-G, 1e)</td>
</tr>
<tr>
<td></td>
<td>A. Writes accurate and coherent Statement of the Problem</td>
</tr>
<tr>
<td></td>
<td>B. Write an accurate and coherent description of client's Present Level of Performance in the TP</td>
</tr>
<tr>
<td></td>
<td>C. Writes an accurate and coherent Impression statement in the TP</td>
</tr>
<tr>
<td></td>
<td>D. Develops Evaluation Procedures that are measurable and relevant in the TP</td>
</tr>
<tr>
<td></td>
<td>E. Maintains the correct tense, and pronoun use throughout the TP</td>
</tr>
<tr>
<td></td>
<td><strong>Average:</strong></td>
</tr>
<tr>
<td>8</td>
<td>Makes appropriate recommendations for intervention (Std IV-G, 1e)</td>
</tr>
<tr>
<td></td>
<td>A. Collaborates with clients and families regarding goals</td>
</tr>
<tr>
<td></td>
<td>B. Demonstrates ability to select relevant goals and explain rationale in respect to disorder areas</td>
</tr>
<tr>
<td></td>
<td>C. Writes appropriate Semester Goals</td>
</tr>
<tr>
<td></td>
<td><strong>Average:</strong></td>
</tr>
<tr>
<td>9</td>
<td>Completes administrative functions and documentation necessary to support evaluation for license and initial phone call (Std IV-G, 1f)</td>
</tr>
<tr>
<td></td>
<td>A. Follows appropriate office procedures for initial semester phone calls including details of semester days/times and clarification of the client/family license plate number</td>
</tr>
<tr>
<td></td>
<td><strong>Average:</strong></td>
</tr>
</tbody>
</table>
### B. Chart documentation/consents
- Completed all required signatures and dates within the expected time frame

<table>
<thead>
<tr>
<th>Average:</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

| 10 | Refers clients/patients for appropriate services (Std IV-G, 1g) | 5 | 4 | 3 | 2 | 1 |

| Average: |  |  |  |  |  |

### A. Referral to other disciplines (PT, OT, Early On, Neuropsychology, etc.) if appropriate

| Average: |  |  |  |  |  |

### TREATMENT SKILLS: Disorder(s) (circle all that apply):

<table>
<thead>
<tr>
<th>Articulation</th>
<th>Fluency</th>
<th>Voice</th>
<th>Language</th>
<th>Hearing</th>
<th>Swallowing</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Cognition</th>
<th>Social Aspects</th>
<th>Communication Modalities</th>
</tr>
</thead>
</table>

### 1 Develops appropriate treatment plans with measurable and achievable goals
- Collaborates with clients/patients and relevant others in the planning process (Std IV-G, 2a)

| Average: | 5 | 4 | 3 | 2 | 1 |

| A. Clearly explains results of evaluation to clients and families |
| B. Collaborates with clients and families regarding goals |
| C. Clearly explains semester goals and procedures to be used to achieve those goals to clients, families and/or other professionals |
| D. Effective integration of graphs when discussing baselines and procedures |

### 2 Implements treatment plans (Std IV-G, 2b)

| Average: | 5 | 4 | 3 | 2 | 1 |

| A. Writes lesson plans including behavioral objectives, hierarchies and procedures which will efficiently achieve semester goals |
| B. Submits all related materials with the lesson plan |
| C. Develops concise and accurate data collection tools |
| D. Demonstrates ability to explain clients strength/weaknesses throughout the semester |

### 3 Selects and uses appropriate material/instrumentation (Std IV-G, 2c)

| Average: | 5 | 4 | 3 | 2 | 1 |

| A. Uses materials and activities appropriately to elicit desired behaviors |
| B. Utilizes a variety of materials/activities to maximize learning and fosters generalization |

### 4 Sequences tasks to meet objectives

| Average: | 5 | 4 | 3 | 2 | 1 |

<p>| A. Organizes and sequences activities in therapy session to maximize responses, attention and cooperation |
| B. Establishes time frames for therapy activities appropriate to client’s level of functioning |
| C. Writes appropriate hierarchies and includes levels of cuing if appropriate for each semester goal |</p>
<table>
<thead>
<tr>
<th>5</th>
<th>Provides appropriate introduction/explanation of tasks</th>
<th>5 4 3 2 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Uses vocabulary and language appropriate to client’s level of comprehension</td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>Clearly explains objective and desired responses at client’s level of comprehension</td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td>Appropriate rate of speech and conciseness of direction</td>
<td></td>
</tr>
</tbody>
</table>

Average: 

<table>
<thead>
<tr>
<th>6</th>
<th>Measures and evaluates clients’/patients’ performance and progress (Std IV-G, 2d)</th>
<th>5 4 3 2 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Maintains accurate, concise SOAP notes</td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>Graphs clearly illustrates baseline, objectives, the long-term goal, cueing levels and correspond to all sch. therapy sessions</td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td>Maintains accurate and timely EMR documentation</td>
<td></td>
</tr>
</tbody>
</table>

Average: 

<table>
<thead>
<tr>
<th>7</th>
<th>Uses appropriate models, prompts or cues. Allows time for patient response</th>
<th>5 4 3 2 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Uses appropriate modeling or cueing to elicit desired response</td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>Provides appropriate reinforcement and target-specific feedback</td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td>Provides for successful experiences to exceed failure experiences</td>
<td></td>
</tr>
<tr>
<td>D.</td>
<td>Allows appropriate time for patient response</td>
<td></td>
</tr>
</tbody>
</table>

Average: 

<table>
<thead>
<tr>
<th>8</th>
<th>Modifies treatment plans, strategies, materials, or instrumentation to meet individual client/patient needs (Std IV-G, 2e)</th>
<th>5 4 3 2 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Demonstrates ability to select materials and activities appropriate to client’s current level of functioning</td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>Planning, implementation and adaption of treatment sessions are client-centered</td>
<td></td>
</tr>
</tbody>
</table>

Average: 

<table>
<thead>
<tr>
<th>9</th>
<th>Completes administrative functions and documentation necessary to support treatment (Std IV-G, 2f)</th>
<th>5 4 3 2 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Follows designated time frames for submission of ALL clinical paperwork including first drafts and revisions</td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>Proactive initiation with scheduling of client/family meetings when needed/required (home evaluations, SOG, final conferences, school visits, IEP attendance etc.)</td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td>Follows appropriate office procedures for filing, logging, phone calls, etc.</td>
<td></td>
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<tr>
<td>D.</td>
<td>Compliance with HIPPA regulations</td>
<td></td>
</tr>
</tbody>
</table>

Average: 

<table>
<thead>
<tr>
<th>10</th>
<th>Identifies and refers patients/clients for services as appropriate (Std IV-G, 2g)</th>
<th>5 4 3 2 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Writes appropriate and specific Recommendations in the TO</td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>Establishes home assignments that are appropriate to client’s level of functioning/ submitted prior to intended session</td>
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</tbody>
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Average:
## PREPAREDNESS, INTERACTION AND PERSONAL QUALITIES:

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<tbody>
<tr>
<td>1</td>
<td>Possesses foundation for basic human communication and swallowing processes (Std III-B)</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
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<tr>
<td></td>
<td>A. Assessment of the quality and effectiveness of multi-modal communication strategies used with client’s friends and family.</td>
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<td></td>
<td>B. Considers the quality of communication with friends/family, etc</td>
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<td><strong>Average:</strong></td>
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<tr>
<td>2</td>
<td>Possesses the knowledge to integrate research principles into evidence-based clinical practice (Std III-F)</td>
<td>5</td>
<td>4</td>
<td>3</td>
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<tr>
<td></td>
<td>A. Shows initiative and provides evidence of outside reading related to client’s disorder</td>
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<td></td>
<td>B. Continues evidence-based research throughout the semester</td>
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<td></td>
<td>C. Utilizes research information to adjust clinical approaches</td>
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<td><strong>Average:</strong></td>
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<tr>
<td>3</td>
<td>Possesses the knowledge of contemporary professional issues and advocacy (Std III-G)</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
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<tr>
<td></td>
<td>A. Completes research on a professional issue in the field</td>
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<td></td>
<td>B. Discussed research findings with CE</td>
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<td></td>
<td>C. Advocates for client in other environments (school, home, nursing home agency if warranted)</td>
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<td><strong>Average:</strong></td>
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<tr>
<td>4</td>
<td>Communicates effectively, recognizing the needs, values, preferred mode of communication, and cultural/linguistics background of the patient, family, caregiver, and relevant others (Std IV-G, 3a)</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
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<tr>
<td></td>
<td>A. Communicates effectively with the client</td>
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<tr>
<td></td>
<td>B. Maintains open, efficient lines of communication with client’s family</td>
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<td></td>
<td>C. Demonstrates ability to assimilate client’s or supervisor’s point of view and constructive feedback.</td>
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<tr>
<td>5</td>
<td>Establishes rapport and shows sensitivity to the needs of the patient</td>
<td>5</td>
<td>4</td>
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<td></td>
<td>A. Clearly defines for client acceptable behaviors and consequences for inappropriate behavior</td>
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<td></td>
<td>B. Maintains control of therapy situation in firm, gentle manner</td>
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<td></td>
<td>C. Is consistent in use of behavior management techniques</td>
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<td></td>
<td>D. Reinforces desired behavior with appropriate timing and reinforcer</td>
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<td></td>
<td>E. Deals appropriately with client’s frustration, grief, anger, etc</td>
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<td></td>
<td><strong>Average:</strong></td>
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<tr>
<td>6</td>
<td>Uses appropriate rate, pitch and volume when interacting with patients or others</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
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<tr>
<td></td>
<td>A. Demonstrates ability to communicate in an articulate, grammatical fashion in writing and verbal exchanges</td>
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<td></td>
<td>B. Language/ speech rate and voice volume is appropriate in the clinical setting at all times (i.e. fillers/ glottal fry, lisp, “like”)</td>
<td></td>
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<td></td>
<td>Provides counseling and supportive guidance regarding communication and swallowing disorders to patients, family, caregivers and relevant others (Std IV-G, 3c)</td>
<td>Average:</td>
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<td></td>
<td>A. Consistently delivers concrete and constructive informal verbal feedback after sessions to the family when appropriate.</td>
<td>5 4 3 2 1</td>
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<tr>
<td>7</td>
<td>Collaborates with other professionals in case management (Std IV-G, 3b)</td>
<td>Average:</td>
<td></td>
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<tr>
<td></td>
<td>A. Works effectively with other clinicians when client is involved in group sessions</td>
<td>5 4 3 2 1</td>
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<td></td>
<td>B. Actively contributes to positive group functioning</td>
<td>5 4 3 2 1</td>
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<td></td>
<td>C. Maintains communication with other professionals working with the client (classroom teachers, other SLP’s, OT, audiology)</td>
<td>5 4 3 2 1</td>
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<tr>
<td>8</td>
<td>Displays effective oral communication with patient, family, or other professionals (Std IV-B)</td>
<td>Average:</td>
<td></td>
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<tr>
<td></td>
<td>A. Clearly explains semester goals, procedures used to achieve those goals and recommendations to clients, families and/or other professionals at the end of the semester.</td>
<td>5 4 3 2 1</td>
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<td></td>
<td>B. Effective integration of graphs when discussing baselines, procedures, and outcome</td>
<td>5 4 3 2 1</td>
<td></td>
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<td></td>
<td>C. Professional disposition during any family meetings reflects verbal organization of information presentations, professional vocabulary, eye contact and positive language</td>
<td>5 4 3 2 1</td>
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<tr>
<td>9</td>
<td>Displays effective written communication for all professional correspondence (Std IV-B)</td>
<td>Average:</td>
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<tr>
<td></td>
<td>A. Writes concise and accurate Results of Treatment section in the TO</td>
<td>5 4 3 2 1</td>
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<tr>
<td></td>
<td>B. Writes a concise and accurate Clinical Impressions section in the TO</td>
<td>5 4 3 2 1</td>
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<td></td>
<td>C. Writes a concise and accurate Technique in the TO</td>
<td>5 4 3 2 1</td>
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<td></td>
<td>D. Uses professional vocabulary in written paperwork in the TO</td>
<td>5 4 3 2 1</td>
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<tr>
<td>10</td>
<td>Adheres to the ASHA Code of Ethics and conducts him/herself in a professional, ethical manner (Std III-E, IV-G, 3d)</td>
<td>Average:</td>
<td></td>
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<tr>
<td></td>
<td>A. Demonstrates insight into negative consequences of own behavior and does not blame others or external factors for failures and/or difficulties.</td>
<td>5 4 3 2 1</td>
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<td></td>
<td>B. Initiates and maintains contact with supervisor</td>
<td>5 4 3 2 1</td>
<td></td>
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<tr>
<td></td>
<td>C. Attends, is prepared for and participates in class meetings</td>
<td>5 4 3 2 1</td>
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<tr>
<td>11</td>
<td>Assumes a professional level of responsibility and initiative in completing all requirements</td>
<td>Average:</td>
<td></td>
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<tr>
<td></td>
<td>A. Writes self-evaluations/ recorded reviews that reflect careful analysis of clinician behavior during therapy sessions</td>
<td>5 4 3 2 1</td>
<td></td>
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<tr>
<td></td>
<td>B. Seeks own solutions for problems</td>
<td>5 4 3 2 1</td>
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<tr>
<td>C. Thoroughly summarize procedures and techniques when observing another clinician</td>
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<tr>
<td>13</td>
<td>Demonstrates openness and responsiveness to clinical supervision and suggestions</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>A. Able to apply suggestions and techniques provided by supervisor in therapy</td>
<td></td>
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<td></td>
<td>B. Prompt follow through with CE requests</td>
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<td></td>
<td>Average:</td>
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<tr>
<td>14</td>
<td>Personal appearance is professional and appropriate for the clinical setting</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>A. Dress attire and personal appearance is appropriate for daily responsibilities in the clinic</td>
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<td></td>
<td>Average:</td>
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</tr>
<tr>
<td>15</td>
<td>Displays organization and preparedness for all clinical sessions</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>A. Transitions between tasks are “flawless”</td>
<td></td>
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<tr>
<td></td>
<td>B. Has all required materials to execute effective diagnostic and treatment sessions (digital recorder, mirror, paper, clipboard, data sheets, etc.)</td>
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<td></td>
<td>Average:</td>
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**Midterm**

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<tr>
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<th>/</th>
<th>Total # items</th>
<th>=</th>
<th>Score</th>
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<tbody>
<tr>
<td>A. Evaluation Skills</td>
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<tr>
<td>B. Treatment Skills</td>
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<tr>
<td>C. Preparedness, Interaction, and Personal Qualities</td>
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<td>Total:</td>
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**Midterm Grade:**

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<tr>
<td>&lt;B-</td>
<td>B-</td>
<td>B+</td>
<td>A-</td>
<td>A</td>
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</table>
Strengths/Weaknesses:

Recommendations for improving weakness:

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<tr>
<th>Final Grade:</th>
<th>&lt;B-</th>
<th>B-</th>
<th>B+</th>
<th>A-</th>
<th>A</th>
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</table>

<table>
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<tr>
<th>Final</th>
<th>Total Pts Achieved</th>
<th>/</th>
<th>Total # Items</th>
<th>=</th>
<th>Score</th>
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<td>A. Evaluation Skills</td>
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<tr>
<td>B. Treatment Skills</td>
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<td></td>
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<tr>
<td>C. Preparedness, Interaction, and Personal Qualities</td>
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<td>Total:</td>
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Comments:

________________________________________________________________________
F-12 Observation of a Clinical Session

Observation of Clinical Session

Name __________________________  Date __________________________

Client Name ______________________  Disorder ______________________

Clinician Name ____________________  Number of times you have observed this client __________________________

Please use the back of this page if necessary. 😊

1. What were the objectives of this session?

2. How did the clinician explain the tasks? How was it effective? or ineffective?

3. What materials did the clinician employ? Did they stimulate responses and maintain interest?

4. What methods, techniques, procedures did the clinician employ?


6. How many responses were elicited? Was this # sufficient? Why? (Pick one task to collect data)

7. How does the clinician reinforce and give feedback?

8. How do you evaluate what the clinician did? Were the objectives accomplished?

9. What did you learn from observing this session?
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<thead>
<tr>
<th>NAME</th>
<th>FILE NUMBER</th>
</tr>
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<tbody>
<tr>
<td>PARENT/GUARDIAN</td>
<td>HOME PHONE</td>
</tr>
<tr>
<td>ADDRESS</td>
<td>CELL PHONE</td>
</tr>
<tr>
<td>BILLING STATUS</td>
<td>CONTACT</td>
</tr>
<tr>
<td>DATE</td>
<td>NPRLS</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE</th>
<th>CONTACT</th>
<th>NPRLS</th>
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</table>
Client Information Sheet
Pediatric Form

Name ___________________________ Nickname: ___________________________

Address ___________________________

Date of Birth ____________ C.A. ____________

Phone ___________________________

Family Members including siblings and their ages ___________________________

Any additional family members that live in the home with relationship to client ___________________________

Grade/Teacher/School ___________________________

Date of Initial Dx / Source of Dx (School Psychologist/Neuropsychologist etc.) ___________________________

MET and IEPT Yes or No ___________________________

IF yes most current dates ___________________________

Service eligibility within the school ___________________________

Speech and Language Goals from current IEP ___________________________

Impression Statement from prior Treatment Plan ___________________________

Other existing conditions (ADHD, LD, ADD etc) ___________________________

Cur. Medications ___________________________

Developmental Hx-Preg/birth ___________________________

Sp/Lang Dev. ___________________________

Motor Dev. ___________________________

Cognition ___________________________

Current Interests/Activities School ___________________________

Extra-Curricular ___________________________

Interests ___________________________

Peer Relationships ___________________________

Supplemental services and frequency for other services within the school (PT, OT, SW etc) ___________________________
<table>
<thead>
<tr>
<th>Articulation/Phonology</th>
<th>Motor Speech/Oral Mechanism</th>
<th>Gestures</th>
<th>Written</th>
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**Expressive Language**

**verbal**
<table>
<thead>
<tr>
<th>Voice/Fluency</th>
<th>Hearing</th>
<th>Behavior</th>
<th>Cognition (If applicable)</th>
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</table>
## F-15 Client Information Sheet

### Adult Client Information Sheet

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Age</th>
<th>New or Continuing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Birthplace</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Phone</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Significant Other</th>
<th>Language</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Phone</th>
<th>Occupational History</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Family Members</th>
<th>Leisure</th>
</tr>
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<tbody>
<tr>
<td></td>
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</table>

### Date of Onset/DX

<table>
<thead>
<tr>
<th>Physicia(n(s)</th>
<th></th>
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<tbody>
<tr>
<td></td>
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### Rehab Course

<table>
<thead>
<tr>
<th>Other relevant medical history/DX/Surgery</th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
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</table>

### PREMORBID | NOW

<table>
<thead>
<tr>
<th>Mobility</th>
<th>Vision</th>
<th>Hearing</th>
<th>Dentition</th>
<th>Diet</th>
<th>Higher Level ADLS (reading, writing, shopping, bills, etc)</th>
<th>Hand Dominance</th>
<th>Computer Use</th>
<th>Driving</th>
</tr>
</thead>
<tbody>
<tr>
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### Previous Treatment

<table>
<thead>
<tr>
<th>Other</th>
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<table>
<thead>
<tr>
<th>Other</th>
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</table>

<table>
<thead>
<tr>
<th>Other</th>
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<tr>
<td></td>
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</tbody>
</table>
Throughout the entire SOAP note:
- Complete sentences are not necessary
- Use abbrev as much as possible
- “Short and Sweet” is the key for the note
- Can use charts especially for articulation results
- Don’t be hesitant to look back at other notes for examples
- Don’t worry if you get notes back to revise. Writing these notes is an art that has to be learned via trial and error.
- No bold face should be used on the note
- Tests are initially spelled out for the first reference but initials are used thereafter for every soap note of the semester.
- Your performance charting reminders are necessary for interpreting your results for the soap notes if standard scores, developmental norms, or criterion references are not available.
- Don’t have to mention the clients name throughout the note. That information is a given since the note is about their performance only.
- Bullet points are an effective way to record results and it makes the information easier to scan to find specific info.

S-Subjective
- Short and sweet.
- Information you need to include-client feels, late or on time-if late how many minutes
- This section includes any information that you obtained via mom or other professionals working with your client. Can directly quote parents if needed. This is the information that you obtain outside the therapy room. Includes information also obtained on the phone.
- NO COMPLETE SENTENCES NEEDED!!

O-Objective
- This is for data (numbers) only.
- No interpretation of data is included in this section.
- This is the information that can be collected as an observer, meaning it is about gathering the data.
- This section includes the scores of the test (standard, criterion, developmental) of the tests and the mean ranges. Please include the mean ranges as follows:
  - (Mean (M)=100. Standard Deviation (SD) +/-15)
- Then after you have written out the words the first time you can report it this way: $M = 100$, $SD = +/- 100$ for the remainder of the soaps for the semester.
- Initially write out the standard score this way: Standard Score (SS) = 85 (whatever you child’s SS is). Then you can use SS throughout all soaps for the semester.

- **NO COMPLETE SENTENCES NEEDED**

**A—Assessment**

- This part of the note is analyzing the data/numbers from the O section.
- This is the part that we get paid for.
- Many times other professionals will only read this section of the note.
- This gives information based on what all the numbers mean/how do you interpret your results.
- Includes severity ranges including WNL, mild, moderate and severe (these descriptions can pertain to standard scores or informal assessment percentages). If aphasic, state type of aphasia with combinations of severity.
- Some tests include their own descriptive words ie., CAAP, TACL, Bracken based on the SS. Need to check and see if your test has its own Descriptive Words.
- If a test doesn’t have its own descriptive words use the descriptive words from the CELF-5.
- Deviations from the mean are used in this section in addition to the descriptive words. Example of how to write a summary statement.
  - (Given SS) *Receptive, Expressive, Semantic etc* skills were within one standard deviation below the mean indicating “borderline” skills.
  - (without SS) Three to four year old receptive skills were WNL.

- **NO COMPLETE SENTENCES NEEDED**

**P—Plan**

- Briefly list what you will be doing the next session. This should reflect changes based on today’s S, O and A information.

- **NO COMPLETE SENTENCES NEEDED**
SOAP note

Client: (Use initials)  Clinical Educator:
Clinician:  Date:

S: POSSIBLE STATEMENTS

- Arrived on time and willingly went into the Tx room.
- Cooperative and focused
- Mom reported S.S. did not sleep well secondary to cold
- Cancelled due to illness, family emergency, weather etc
- 20 minutes late
- Mtg with classroom teacher scheduled for 1/23/12 at 2:00 at Bryant Elementary
- Interviews that you conduct with the family or client are reported in the O section of the SOAP. Direct quotes from the conversation with parents(s), physicians(s), other SLP, OT, PT, Nursing, etc. can be included.

NOTICE

1.) Client name not mentioned because this information is implied.
2.) Specific information was given about the date and time of the school meeting.
3.) Short phrases were used, omitting the “little words” (the, he, she etc.)
4.) Past tense used in S, O and A

O: POSSIBLE STATEMENTS FOR FORMAL EVALUATION DOCUMENTATION

- (Began, Continued or Completed) the Test of Language Development-I-3 (TOLD-I-3). Results of the subtests are as follows: (Mean (M)=10, Standard Deviation (SD)=+/-3):
  Sentence Combining (evaluates-----------------------------)-SS 6 =>1SD below M
  Picture Vocabulary=(measures________________)-SS 11 <1SD above the M

NOTICE

1.) The statement needs to begin with one of the words in parenthesis. This states the progression of the test administration when given across more than one session.
2.) The test name was written out in its entirety since it was the first time the assessment was documented. From that point on, the test abbreviation can be used. This also applies to abbreviations for Standard Score and Mean. Be sure to check the test manual for means and standard deviations for that particular test.
3.) The relationship to the M is stated with the SS and is part of the O section of the SOAP.
4.) You may also want to include a brief description in parentheses as to what that subtest evaluates in lay terms. You can refer to the test manual for this information. This information can then be used in the Treatment Plan.
POSSIBLE STATEMENTS FOR INFORMAL EVALUATION DOCUMENTATION

- Correctly read Dolch sight words at 1st, 2nd, and 3rd grade level 122/127 (96%)
  - Level 1-39/40 (98%)
  - Level 2-45/46 (98%)
  - Level 3-38/41 (93%)

- Informally assessed receptive language via guidelines from Shipley and McAfee (2009):
  - Pointed to objects 4 array when given function (cup, ball, brush, fork, toothbrush, blocks, book, bowl) 10/10
  - Pointed to 7/13 (64%) colors when named (red, blue, green, not yellow or black).

NOTICE
1.) When accuracy/trial percentage numbers are obvious (10/10) versus (7/13) the percentage does not have to be documented on the SOAP.
2.) The source of the developmental guidelines is included. Be careful - some of the sources in Shipley and McAfee are not from their research. Check the author of the developmental sources carefully.

A: You are responsible for generating a clinical impression statement. The severity description in this section may be found in the test manual. If the manual has descriptive words then you need to use those in your assessment section of the SOAP. If the manual does not include descriptive words then you must use the CELF-5 Descriptive Words. The information in this section needs to be reported in an impression statement. You are to integrate the diagnostic information and generate a speech and language diagnosis including severities, baselines and normative data.

P: PLAN—What will you do in the next session based on what you saw in this session? Brief statements i.e., Continue informal assessment of 4-5 y.o. receptive and expressive language skills including 2-3 part commands, color recognition.

SAMPLE IMPRESSION STATEMENTS

Developmental receptive-expressive language deficit/delay
Articulation deficits/delay

Sample 1:
Mary Smith a 4 yr. 5 month year old male/female presents with a mild-moderate receptive and expressive language delay. Mild receptive language delays are characterized by inconsistent comprehension of 1-step commands, poor recognition of body parts, and the inability to distinguish rhyme in structured language tasks. Expressive language skills reflect a reduced MLU with the absence of bound morphemes including plurals and past tense in addition to incorrect pronoun use. Phoneme inventory is age-appropriate with normal structure and function of oral motor skills.

Sample 2: John Smith a 7 year old male presents with a mild-moderate articulation deficit characterized by poor intelligibility and inconsistent stimability for errand phonemes.
Mastered phonemes that are consistently produced include early developing bilabials (p, b,) and lingua-alveolar/palatal sounds (t, d, k, and g).

**Cognitive-Communicative secondary to neurogenic etiologies:**

**Sample 1:**
Jim is 2 yrs. 4 month post CVA, LMCA and presents with severe verbal apraxia and Broca’s aphasia characterized by a mild life participation deficit, moderate verbal comprehension deficits, moderate to severe reading comprehension deficits and severe impairments of verbal expression and repetition. His strengths include cognitive skills and writing mechanics.

**Sample 2:**
Client presents one year and five months post stroke with mild high-level language deficits, characterized by mild anomia, severe problem-solving and reasoning skills and severe auditory processing and retention for complex tasks. Mode to moderate short-term and long-term memory deficits are also noted. Writing is WFL with the exception of consistent writing errors.
SOAP Note

Client: (Use initials)                          Clinical Educator:
Clinician:                                      Date:

S: Arrived on time, brought his sight word flipbook from prior semester. Mother stated (initials) is working on 2nd grade level books at school. Motivated and cooperative.

O: Produced initial (or l) /s/ monosyllabic word when shown a picture 8/13 (61%) with mod (50%) cue (obj: 70% with no cue).

Highlighted characters and setting given a 50-75 word 2nd grade passage as (initials) read aloud a story 30/31 (97%) with min (12%) verbal cuing (obj. 90% no cue).

Note: If homework assigned for the 1st time, explain task(s).
Example:

Sent book home for practice after review with mother in session. Requested that she
1.) Listen to each production and mark √ =accurate or x=/th/ substitution.
2.) Not give verbal or nonverbal feedback re: accuracy

When homework assignment returned explain task(s) and the client’s performance/accuracy.
Example:

Homework assignment returned-named 1 /s/ pictures @ home 4x since last session. Mother reported accuracies of 6/10, 7/10, 8/10 and 8/10.

1.) The statement in the O simply consists of your objective re-stated
Note:
1.) The statement in the O simply consists of your objective re-stated in past tense without the rationale, without the rationale.
2.) Remember to put the intended accuracy target in ( ), include cues, models, as appropriate.
3.) If there was not a specific accuracy and cue level targeted then simply write (baseline established).

A: 1.) The 3 components of a treatment A include (in this order):
-achieved/not achieved/partially achieved (partially =one part of the criteria was not met including cue or criteria).
rating performance. i.e. mild, moderate, severe (remember informal evaluation and treatment objectives use the rating ranges on the Charting Reminders). Be sure to weigh amount of cueing needed with % accuracy achieved to choose the correct rating word. state if the objective was/new obj or continue obj (continue=the criteria components will not change for the next session.

2.) The A section of performance should follow the order of the objectives in the O P:
The following information should be included in the P based on report of a.) new obj or b.) continue objective written in the A.

Information needed within a new objective report includes: stimulus condition, to do statement, intended criterion and stimulus materials. Continue objective includes re-statement of the objective:
- Continue ORLA at 4-5 word level
- Continue /s/ initial position at sentence level
- Continue syllable shapes of CVCV using visual stimulus (Kaufman)

Notice:
1.) This should be the planning of your next lesson. This is the most important part. If you really think carefully regarding this section of the SOAP note your lesson plan for the next week should be easy to write. Many times especially at the beginning of the semester this section is not given proper time and consideration. If the content in this section is analyzed and considered then your lesson plan becomes easier.

WHEN YOU BEGIN YOUR RE-EVALUATION SESSIONS:

1st SOAP 2nd SOAP 3rd SOAP
"O" - Began re-evaluation. Continued... Completed...
(goal- ) vs. (obj) after tasks " " "
"A" - report goal met/not met/surpassed " " "
"P" - Cont. re-eval Complete re-eval Conduct Fam Conf.
GUIDELINES FOR DESCRIBING THE SEVERITY OF DISORDERS

Taken from the Clinical Evaluation of Language Fundamentals-4 (CELF-5) (Semel, Wiig, Secord 2003)

<table>
<thead>
<tr>
<th>Core Language Score</th>
<th>Classification</th>
<th>Relationship to Mean and Index Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>115 and above</td>
<td>Above average</td>
<td>+1 SD and above</td>
</tr>
<tr>
<td>86-114</td>
<td>Average</td>
<td>Within +1 or -1 SD</td>
</tr>
<tr>
<td>78 to 85</td>
<td>Marginal Borderline/Mild</td>
<td>Within -1 to -1.5 SD</td>
</tr>
<tr>
<td>71 to 77</td>
<td>Low Range/Moderate</td>
<td>Within -1.5 to -2 SD</td>
</tr>
<tr>
<td>70 and below</td>
<td>Very Low Range/Severe</td>
<td>-2 SD and below</td>
</tr>
</tbody>
</table>

GUIDELINES FOR REPORTING ASHA QCL SCALE

0: Administered the Quality of Communication Life Scale (ASI IA, 2004). Read A loud to client or completed I in minutes; mood today S Shown printed scale 1 to no, 5 high; yes-overall mean score was . General quality of life with aphasia rated # word. (Then list items from scale that received a score of 3 or lower.)

A: WF L/Mild/Moderate/Severe impairment in quality of communication life skills. (Based on % calculated re: overall score- i.e. mean score divided by 5).
### GUARDLINES FOR REPORTING ASSESSMENT FOR LIVING WITH APHASIA (ALA)

O: Began (or Administered – if completed in one session) Assessment for Living with Aphasia (ALA). Chose responses shown a Rating Scale Card of 0 – “most negative response” to 4 – “most positive response” with .5 divisions.

<table>
<thead>
<tr>
<th>Aphasia Domain</th>
<th>#/20 points</th>
<th># - average score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talking</td>
<td>#</td>
<td></td>
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<tr>
<td>Understanding</td>
<td>#</td>
<td></td>
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<tr>
<td>Reading</td>
<td>#</td>
<td></td>
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<tr>
<td>Writing</td>
<td>#</td>
<td></td>
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<tr>
<td>Communication</td>
<td>#</td>
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</table>

<table>
<thead>
<tr>
<th>Participation Domain</th>
<th>#/68 pts</th>
<th>#</th>
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<tbody>
<tr>
<td></td>
<td># of places in a week</td>
<td>#</td>
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<tr>
<td></td>
<td># of days in a week</td>
<td>#</td>
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<tr>
<td></td>
<td># of people talk to</td>
<td>#</td>
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</table>

<table>
<thead>
<tr>
<th>Environment Domain</th>
<th>#/16 pts</th>
<th>#</th>
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</thead>
<tbody>
<tr>
<td></td>
<td># of strategies used-</td>
<td>#</td>
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<tr>
<td></td>
<td>&quot; used by ___</td>
<td>#</td>
</tr>
</tbody>
</table>

| Personal Domain      | #/44 pt | # |
| Wall Question        | #/4 pts | # |
| TOTAL                | #/152   | # |

A: Perceived aphasia as ____________; talking most impaired, etc.
Participation in daily life was ______________ impacted by aphasia.
Perceived physical, social and attitudinal environment as mildly ___ impacting life with aphasia.
Perceived autonomy, self-esteem and confidence as __________ impacted by aphasia.
Perceived _____________ disruption of life due to aphasia.
Overall impact of aphasia on life was ________.
The ability to evaluate your own clinical skills is a significant component in the development of your clinical competence. In order for you to function independently you must be able to assess your own performance. On the continuum of supervision, self-supervision can be regarded as a final stage. Use the following form to assist you in the self-evaluation process. Do a self-evaluation form weekly and a way's write a narrative on the reverse of the form. When you are required to write self-evaluations it helps you to clearly evaluate your therapy sessions. When you become more mature with the self-evaluation process your supervisor may permit you to use just the check list.

**CLINICAN SELF EVALUATION CHECK SHEET**

Clinician ____________________________ Date ____________________________
Client ____________________________ Supervisor ____________________________

<table>
<thead>
<tr>
<th>1. Unacceptable performance.</th>
<th>Specific direction from supervisor does not alter unsatisfactory performance.</th>
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</thead>
<tbody>
<tr>
<td>2. Needs Improvement in Performance.</td>
<td>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.</td>
</tr>
<tr>
<td>3. Moderately Acceptable Performance.</td>
<td>Inconsistently demonstrates clinical behavior/skill. Exhibits awareness of the need to monitor and adjust and make changes. Modifications are generally effective. Moderate amount of direction from supervisor needed to perform effectively.</td>
</tr>
<tr>
<td>4. Meets Performance Expectations.</td>
<td>Displays minor technical problems which do not hinder the therapeutic process. Minimum amount of direction from supervisor needed to perform effectively.</td>
</tr>
</tbody>
</table>

**NOTE:** SPSI 528 STUDENTS ARE RATED 1 THROUGH 4, SPSI 538 STUDENTS ARE RATED 1 THROUGH 5

**Treatment**

1. Did I effectively explain the objective of the task to my client? 5 4 3 2 1
2. Did I clearly explain the desired response to my client? 5 4 3 2 1
3. Did I give my client sufficient time to respond? 5 4 3 2 1
4. Did I provide a model for the target behavior when necessary? 5 4 3 2 1
5. Did I cue when appropriate? 5 4 3 2 1
6. Did I accurately discriminate my client’s errors from the target behavior? 5 4 3 2 1
7. Did I appropriately reinforce correct responses? 5 4 3 2 1
8. Was my feedback consistent, concrete and concise? 5 4 3 2 1
9. Did I encourage my client to self-evaluate? 5 4 3 2 1
10. Did I get maximum responses from my client? 5 4 3 2 1
11. Were my materials and/or activities effective in eliciting the responses I wanted? 5 4 3 2 1
12. Was I able to maintain appropriate pace towards the completion of the session’s objectives? 5 4 3 2 1
13. Was I able to record data during the session? 5 4 3 2 1
14. Was my transition from activity to activity smooth? 5 4 3 2 1
15. Did I use pronouns such as you/your which fosters client independence within the session? 5 4 3 2 1
16. Did I minimize the shuffling of extra papers during the session?

**Professionalism**

17. Was the therapy room arranged in such a way to facilitate optimal therapy, (attention, cooperation, and responding)? 5 4 3 2 1
18. Was the therapy room arranged in such a way to facilitate optimal observation by Supervisor, family members or others? 5 4 3 2 1
19. Did I provide feedback to the client and/or family concerning the results of the session? 5 4 3 2 1
Clinician Critical Reflection Form

1.) What were the essential strengths of the session?

2.) What factors contributed to success in the session?

3.) What were the essential weaknesses of the session?

4.) What factors contributed to the weaknesses of the session?

5.) What unanticipated clinician learning outcomes resulted from the session?

6.) Can you think of any other way you might have taught the objectives in the session?

(questions adapted from Pultorak, E.G., 1993)
<table>
<thead>
<tr>
<th>Client</th>
<th>Educational/Behavioral Objective</th>
<th>Task 1</th>
<th>Task 2</th>
<th>Task 3</th>
<th>Procedure</th>
<th>Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Where will you start?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Distance from start</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Performance Assessment Baseline</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Date</td>
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**LESSON PLAN**

Please include the following with your lesson plan:

- Homework
  - Word lists, reading passages, etc.
  - Printed key words if applicable/adults
  - Data sheets
- Lesson Plan
  - F23 Lesson Plan

Client:

Educational/Behavioral Objective:

Assessment Baseline:

Date:

Materials:

Procedure:

Performance:

Task 1:

Task 2:

Task 3:

Start:

Distance from start:

Where will you start?
# GOAL CARD

<table>
<thead>
<tr>
<th>CLINICIAN</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SUPERVISOR</td>
<td></td>
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</tbody>
</table>

## SEMESTER GOALS

- [ ]
- [ ]
- [ ]

## PROCEDURES, ACCURACY LEVELS AND MATERIALS

- [ ]
- [ ]
- [ ]
Please use another piece of paper to give yourself enough room to respond to each item.

Facilitator ____________________________ Date ______________

1. Describe how the clinician adapts her communication style to the client(s).

2. Are the tasks appropriate for the clients' skill levels?
   Describe teaching techniques used.
   Describe modeling and/or cueing.

3. When and how is feedback given?
   How do the clients respond to feedback?

4. What does the clinician do verbally and nonverbally to ensure that all group members are engaged?

5. How can you increase or decrease the level of the information that's provided?

6. How can you apply what you observed today?
TREATMENT PLAN

Client: (first, middle, last) Date of Report: (1st complete draft due date)
File #: Clinician: ,B.S. or B.A. (as applicable)
Age: (year; months) Clinical Educator:
Gender:
ICD-10-CM: diagnosis #/term

(Example words: statements are given in italics.)

Statement of Problem (includes diagnosis and severity level if applicable)

Begin this paragraph with: “client name, a __ year, _ month old male female, is being seen at the Eastern Michigan University Speech and Hearing Clinic for his her _ semester of therapy”. Use the diagnosis stated in the IMPRESSION section of the prior TP (discuss with supervisor). Include educational setting, IEP category and current services, if applicable. Include information re: family, where the client resides, prior treatment and medical history, work history, if applicable.

PRESENT LEVEL OF PERFORMANCE (present tense)

Receptive Language (present tense)

Begin this section with: Informal/formal assessment completed on date’s using the name of test write/underline complete name then give abbreviation in ( ). or assessment scale or procedure write author name and date of publication in ( ). reveals that client’s name receptive language abilities (or specific skill assessed) are developing at age level or use severity rating words. If standard or scaled scores (SS) from standardized tests are presented, be sure to state the mean score and standard deviation for the test, then interpret the score based on the standard deviation from the mean score. Include specific examples of form, content, use you have formally or informally documented.

This section includes auditory and reading comprehension.
Reading comprehension includes areas such as: pre-literacy skills, phonological awareness, reading comprehension, functional reading and if appropriate, grade level reading skills.

(Please include page numbers on the bottom middle pages starting on page two.)
Expressive Language

See above for the narrative outline of reporting the SS and severity ratings.

A 50 to 100 utterance language sample should be used in addition to any formal or informal assessment you complete. When reporting results of a language sample present the following information (for children):

1. number of utterances in the sample
2. Mean Length of Utterance
3. TTR
4. description of semantics
5. description of grammar-morphemes and syntax
6. pragmatics-conversation initiation/maintenance, turn-taking, etc.

For school age children or adults-1st paragraph: report in same order as Receptive Lang. section. Rate overall impairment.
Describe spontaneous speech, conversation baseline
Naming, Repetition, Oral reading
2nd paragraph: Writing-hand preference, mechanics, signature, words, sentences, functional material

Cognition-if applicable

Articulation/Phonology

You may begin this section with: Based on informal/formal assessment using the name of test or assessment scale or procedure, client's name articulation abilities are developing at age level or use SS and rating words, for adults-describe abilities. Include a thorough analysis of articulation errors (substitutions, omissions, distortions) or phonological rules you have observed. Present in chart form. Include information, if applicable about speech rate and/or intelligibility in single words versus connected speech. For adults-include verbal praxis, intelligibility.

Oral Mechanism Examination/Observations
At a minimum descriptions of the following should be included in this section:

1. facial symmetry at rest
2. oral structure on visual examination (mandible, teeth, lips, tongue, hard palate, soft palate/velum)
3. oral function/movement (mandible, lips, tongue, soft palate/velum)-include oral apraxia, as necessary
4. diadochokinesis

Voice/Fluency
Always include a description of voice and fluency, even if these are normal.

Hearing Evaluation
See Audiological Report dated _________.

Behavior Observation
All descriptions of behavior should be accompanied by concrete examples you have experienced or observed. Avoid overly negative terms or subjective terms such as nice, well-mannered, pretty, well-behaved, handsome. Describe attention, motivation, cooperation, and willingness to accompany you to therapy.

**IMPRESSIONS** (present tense)

Summarize diagnosis and relative severity of current communication impairments. Present the information in the same order as the report. Begin this statement with: *client’s name presents with a mild receptive and moderate expressive language delay...characterized by....*

**SEMESTER GOALS** (future tense)

The following goals have been established for *client name* this semester:
(List goals in the same order as the body of the Ix. Plan. Each goal must be stated behaviorally and include the following components:)

1) rationale/specific behavior to be changed
2) performance or “do” statement
3) condition
4) criteria/iron

**SPECIFIC PLACEMENT** (future tense)

___ will attend # individual and/or group (discuss with supervisor) therapy sessions per week.

**EVALUATION** (future tense)

*Progress toward goal one will be evaluated by:*
1.
2.

*Progress toward goal two will be evaluated by:*
1.
2.

If using the same evaluation procedure(s) for all goals, just state it once. You may elect to measure progress via test administration, a language sample or by averaging performance over the last 3 sessions. Research reveals that if a skill is demonstrated over 3 sessions, the skill is (probably) acquired. In some cases, a longer re-evaluation period is warranted.

Clinician’s Name, B.S. or B.A.
Graduate Clinician

Clinical Educator’s Name, Degree
Clinical Educator
1. All drafts must be type written, double-spaced, 12 font
2. Final drafts must be single spaced and on “student report” paper. Be certain that there are at least 5 lines of typing on the last page.
3. Each revision submitted to supervisors must include all of your previous drafts.
5. Headings and subheadings should look **EXACTLY** like this sample.
COGNITIVE COMMUNICATION TREATMENT PLAN

Client: ___________________________ File #: ___________________________ Age: ___ Birthdate: __________

Onset: ____________________________ ICD-10-CM: ___________________________ Semester: F/W/S __________

Medical Diagnosis/History: __________________________

________________________________________

________________________________________

Educational History: __________________________

Vocational History: __________________________

Social History: __________________________

Hobbies and Personal Interests: __________________________

________________________________________

________________________________________

Significant other/caregiver perceived strengths/challenges/strategies: __________________________

________________________________________

________________________________________

Evaluation Dates: __________________________

Tests Administered: __________________________

________________________________________

________________________________________

Life Participation: __________________________

________________________________________

________________________________________
Pain Assessment: Acute _____ Chronic _____

Severity: ___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

Location: ___ head, ___ neck, ___ shoulder, (___ left, ___ right, ___ both), ___ upper back, ___ lower back, ___ chest, ___ abdomen, ___ leg, (___ left, ___ right, ___ both); ___ knee (___ left, ___ right, ___ both); ___ foot (___ left, ___ right, ___ both); ___ other.

Based on the findings of the pain assessment, the client states that the

___ Present pain control is inadequate and will follow up with the physician to discuss options;

___ Present pain control is adequate and there is no need for intervention by the physician;

___ Pain is long standing; client can live with it and does not want to discuss it further with physician.

AUDITORY COMPREHENSION

Client perceived strengths/challenges/strategies: ____________________________________________

____________________________________________________________________________________

Words: ______________________________________________________________________________

____________________________________________________________________________________

Sentence: ____________________________________________________________________________

____________________________________________________________________________________

Complex Material: _____________________________________________________________________

____________________________________________________________________________________

HEARING

WFL: ____________ Uses aids:  ○ Both  ○ Right  ○ Left

VISUAL PERCEPTION (TBI):

Colors and Searching: _________________________________________________________________

Matching Letters: _____________________________________________________________________

Recognizing Shapes: ___________________________________________________________________

READING COMPREHENSION

Client perceived strengths/challenges strategies: ____________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Visual Status:  ○ glasses  ○ neglect/inattention  ○ hemianopsia

Sentences: __________________________________________________________________________

Paragraphs: __________________________________________________________________________
VERBAL EXPRESSION
Client perceived Strengths/Challenges/Strategies: 

Confrontation Naming: 
Responsive Naming: 
Word fluency: 
Word definitions: 
Discourse analysis (for TBI): 
Produce narrative (for RHS): 
To picture: 

MOTOR SPEECH EVALUATION  o Dysarthria  o Apraxia  o Both
Client perceived Strengths/Challenges/Strategies: 

Oral Mechanism: 

Feature Description:
  o Verbal motor sequencing 
  o Grouping/struggling to initiate/make adjustments 
  o Imprecise movement/articulation 
  o Slow, writhing, twisting movements 
  o Jerking Movements 

Voice/Fluency: 
WRITING: ○ Right ○ Left ○ Preferred ○ Cursive ○ Print

Client perceived strengths/challenges strategies:

Mechanics:

Name:

Address:

Copy Forms/Words/Sentences:

Single Words:

Sentences:

Picture Description/Narrative:

Functional Task:

COGNITION

Client perceived strengths/challenges strategies:

Affect:

Orientation:

Insight/Self awareness:

Attention/Concentration:

Speed of information processing (auditory and/or visual):

Short Term Memory:

Recent Memory:

Long Term Memory:
Prospective Memory: ________________________________

Executive Function/Multitasking: ____________________________

Dynamic Awareness: ________________________________

Verbal Reasoning: ________________________________

Non Verbal Problem Solving: ________________________________

Computational Skills: ________________________________

Pragmatics: ________________________________

COMMUNICATION SKILLS:

Receptive Emotional Prosody (RHS): ________________________________

Expressive Linguistic Prosody (RHS): ________________________________

HIGH LEVEL LANGUAGE SKILLS:

Idioms: ________________________________

Proverbs: ________________________________

Verbal Absurdities: ________________________________

Verbal Fluency: ________________________________

IF APPLICABLE:

Aphasia Quotient: ________________________________

Language Quotient: ________________________________

Cortical Quotient: ________________________________

Behavior: ________________________________

DYSPHAGIA: ________________________________
EASTERN MICHIGAN UNIVERSITY
Department of Special Education
Speech and Hearing Clinic

IMPRESSIONS:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

PROGNOSIS:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

RECOMMENDATIONS: _____ Individual @ _____ Minutes _____ group @ ____________ minutes

GOALS:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Evaluation Procedures:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

_________________________ ________________________ ________________________
Graduate Clinician Date Clinical Educator Date

Revised 1/18
EASTERN MICHIGAN UNIVERSITY
Department of Special Education
Speech and Hearing Clinic

APHASIA TREATMENT PLAN

Client: ____________________________ File #: ____________________________ Age: ______ Birthdate: ____________

Onset: ____________________________ ICD-10-CM: ____________________________ Semester: F/W/S ____________

Medical Diagnosis/History: __________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Educational History: _________________________________________________________________

Vocational History: _________________________________________________________________

Social History: _________________________________________________________________

Hobbies and Personal Interests: _______________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Significant other/caregiver perceived strengths/challenges/strategies: ____________________________

________________________________________________________________________________

________________________________________________________________________________

Evaluation Dates: _________________________________________________________________

Tests Administered: _________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Hearing: ________________________________________________________________

Life Participation: _________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________
Pain Assessment: Acute ____ Chronic  ____

Severity: _0_ _1_ _2_ _3_ _4_ _5_ _6_ _7_ _8_ _9_ _10

Location: ___ head, ___ neck, ___ shoulder,(___left, ___right, ___both), ___ upper back, ___ lower back, ___ chest, ___ abdomen, ___ leg,(___left, ___right, ___both); ___knee(___left, ___right, ___both); ___foot(___left, ___right, ___both); ___ other:

Based on the findings of the pain assessment, the client states that the
___ Present pain control is inadequate and will follow up with the physician to discuss options;
___ Present pain control is adequate and there is no need for intervention by the physician;
___ Pain is long standing; client can live with it and does not want to discuss it further with physician.

AUDITORY COMPREHENSION

Client perceived strengths/Challenges/Strategies:

__________________________________________________________________________

Yes/No Questions:

__________________________________________________________________________

Object/Picture Recognition: __________ Right/Left Discrimination:

Body Part Recognition:

Sequential Commands:

Complex Material:

READING COMPREHENSION

Client perceived strengths/challenges strategies:

__________________________________________________________________________

Visual Status: o glasses ___ neglect/inattention ___ hemianopsia

Own Name: __________________________ Matching shapes/letters: __________________________

Single Words:

Sentences:

Paragraphs:

Functional Material:

_}
VERBAL EXPRESSION

Client perceived strengths/challenges strategies:


Automatic Speech:

Repetition:

Confrontation Naming:

Responsive Naming:

Sentence Completion:

Picture Description:

Conversational Speech:

Communication Strategies used by client: ○ Gestures ○ Writing ○ Communication Book ○

MOTOR SPEECH EVALUATION ○ Dysarthria ○ Apraxia ○ Both

Oral Mechanism:

Feature Description:

○ Verbal motor sequencing

○ Groping/struggling to initiate/make adjustments

○ Imprecise movement/articulation

○ Slow, writing, twisting movements

○ Jerking Movement

Voice/Fluency:

Intelligibility:
WRITING:

- Right  
- Left  
- Preferred  
- Cursive  
- Print

Client perceived strengths/challenges strategies:

Mechanics:

Name:

Address:

Copy Forms/Words/Sentences:

Single Words:

Sentences:

Functional Task:

COGNITION

Client perceived strengths/challenges strategies:

Affect/Pragmatics:

Attention/Concentration:

Memory/Orientation:

Multitasking/Executive Function:

Verbal/Non-Verbal Problem Solving:

Insight/Awareness:

Dysphagia:

Diet:

Aphasia Quotient:

Language Quotient:
Coritcal Quotient:

IMPRESSIONS


Prognosis:


RECOMMENDATIONS: _____ Individual @ _____ Minutes  _____group @ _______ minutes

GOALS:


Evaluation Procedures:


Graduate Clinician  Date  Clinical Educator  Date

Revised 2/23/18
SUMMARY OF GOALS

Client: first. middle and last
Clinician:

Age: year:month
Semester:

SEMESTER GOALS

The following semester goals have been established with you or for your child (pick one):

1.

2.

3.

4.

5.

Parent/Spouse Guardian (pick one)  
Client  
(any client that can sign their name)

Supervisor's name. degree  
Clinical Educator

Clinician's name. B.S. or B.A  
Graduate Clinici

*This document should be no more than one page in length and printed on plain paper.

*Goals should be single spaced, with double spacing between them.
*Signature line(s) should be as long as the typed name beneath.
TREATMENT OUTCOME

Client: first. middle, last  
Date of Report: (last date of clinic)  
File No.:  
Time Period Covered: (1st-last date seen*)  
Age:(year: month)  
Attendance: #/# sessions (total hours)  
*incl. I am cont. group  
Also calculate treatment hrs and group hrs  
Clinician: B.S. or B.A. (if applicable)  
Clinical Educator:

RESULTS OF THERAPY (present tense)

Write one result for each goal in the same order as you wrote them in the Treatment Plan. Restate the goal in the result.

For example, "The goal to improve articulation by producing /k/ in the initial position of words with a model with 90%" was met /not met/partially met. "Sally produces /k/ in the....averaged over the last 3 sessions."

Re: ORLA. MIT. Phoneme ↔ Grapheme goals-Write "See attachment for targets."

(OPTIONAL) If needed, give an overall general summary statement of progress emphasizing the area(s) of achievement. This paragraph is useful when results of therapy (above) do not accurately reflect progress in therapy. You may list dates absent or tardy and minutes missed if you feel that this has affected progress. You may also report on tests administered after the Treatment Plan was completed. Medical changes, events, procedures may also be reported here. Your CP will help you decide if this paragraph is necessary.

THERAPY TECHNIQUES (past tense)

Write a paragraph about the techniques you used to teach the skills to your client. List the techniques in a logical order in the first sentence. Explain the techniques as they relate to the goals in the same order in the remainder of the paragraph. If you used a Life Participation Approach to Aphasia and supplied the client with a wallet and/or visor card, "What is Aphasia" packet, subscription to Stroke Connection magazine, etc., include that information here as well.

Write a second paragraph about the materials you used and the reinforcement strategies/schedule. Describe their effectiveness.
CLINICAL IMPRESSIONS

Write a paragraph about home involvement. What types of assignments/suggestions were given to clients/parents? Was home involvement successful? How did it affect change? (past tense)

Write a paragraph about behavioral observations. Summarize any changes in behavior from the beginning of the semester. Stress the positive. If detail on negative behavior is needed, do not be punitive. Write a summary of incidents and describe behaviors. Be factual and concise. (past tense)

The final paragraph of this section must include a statement of prognosis for further speech and language development or improvement in skills. For example, “Based on the progress (or lack of progress) obtained during this semester the prognosis for further speech and language development or improvement in skills is (excellent, good, fair, guarded, poor). The prognostic statement should also include other factors, such as health, age, attitude of client, family involvement, services received elsewhere, etc. (present tense)

RECOMMENDATIONS (present tense)

Be specific about recommendations:
Should client continue to receive speech-language pathology services?
If so, should sessions be individual? Group?
If not, provide rationale and procedures for follow-up.
If so, list goal areas for the next clinician and suggestions for further evaluation.

Give suggestions for maintenance and carryover to teachers, parents and/or clients.

Make referrals as needed to medical personnel and other professionals.

______________________  ________________________
Clinician’s Name, B.S. or B.A.  Clinical Educator’s Name, Degree
Graduate Clinician  Clinical Educator

All drafts must be typed, double-spaced, in 12 font
1. Final drafts must be single spaced and on “student report” paper
2. Each revision submitted to supervisors must include all your previous drafts
3. Number each page after the first at the bottom center of each page
4. Headings and subheadings should look **EXACTLY** like this sample.
SCOPE OF PRACTICE IN SPEECH-LANGUAGE PATHOLOGY

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

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Scope of Practice in Speech-Language Pathology

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 DeRuitter (chair), Michael Campbell, Craig Coleman, Charlotte Green, Diane Kendall, Judith Montgomery, Bernard Rousseau, Nancy Swigert, Sandra Gillam (board liaison), and Lemmietta McNelly (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 section of the document on May 9, 2016 (Motion 07-2016).

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- References
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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,

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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
Scope of Practice in Speech-Language Pathology

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

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Scope of Practice in Speech-Language Pathology

- 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

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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

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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

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SLPs are involved in prevention and wellness activities that are geared toward reducing the incidence of new disorders 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 multitiereed 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.
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- **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, communication, 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;
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- 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., IDEA [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

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- 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

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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);

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- 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.

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- 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;

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- 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.

REFERENCES


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RESOURCES


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