EASTERN MICHIGAN UNIVERSITY

DEPARTMENT OF SPECIAL EDUCATION

SPEECH HEARING CLINIC

BACKGROUND INFORMATION

The Speech and Hearing Clinic at Eastern Michigan University is an integral part of the training program for students majoring in 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 three-fold:

1) To provide supervised practical experience for students-in-training
2) To provide expert speech, language and hearing diagnostic and therapeutic services to the community.
3) **To provide a variety of clinical experiences on and/or off campus as preparation for a career in Speech-Language Pathology**

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 al] 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 a binder above the Clinical Educators inboxes and are there for your reference. The handbook is also available on the CSD 528 and 538 shared drive.

All graduate CSD majors are required to complete a minimum of two full semesters in clinical practice by enrolling in CSD 528 and 538. Prior to course enrollement, clinicians will submit evidence to their advisor that they have completed the 25 clock hours of supervised observation. COVID vaccinations are required. If you are unvaccinated due to health or other variables, you must request an accommodation via the University. Request a vaccine accommodation through the University Accommodation Portal. EMU will describe any accommodation requirements including, but not limited to, weekly testing for COVID-19 and reporting. Students must also meet the following continuation criteria of the CSD program.

A. Maintenance of a cumulative major GPA of 3.0 or better in CSD related classes.

B. Receive a grade of or better in any major academic graduate course and a B or better in the clinical practicum course (CSD 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 CSD 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: CSD 528, 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 clinic is passed.** 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. Note 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 CSD 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 **Confidentiality 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 the clinic and/or the CSD 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. 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 snow 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. Dress attire on the days that you see your client needs to be considered "business casual." Some of the dress attire, but not limited to, is not appropriate for clinic include flip flops, short dresses, tennis shoes, jogging pants, jeans, blouses/tops that reveal cleavage, shirts that are too short to cover your back when sitting or moving, and pants with holes, In addition, tight stretch revealing "yoga pants" are NOT allowed in the clinic.

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 your 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. PLEASE DISCUSS WITH YOUR CE IF YOU ARE ABLE TO ACCEPT A GIFT FROM YOUR CLIENT.

7.) All clinicians are expected to wear name tags always identifying them as graduate clinicians while in the clinic. Your name tag should be worn on your shirt collar or pocket so that it is near your face. NOT on your pants or skirt. Name tags will be issued free of charge at the beginning of each semester. Replacement tags will cost $10.00.

Clinic Schedules and Caseloads

Clinicians should expect to be assigned two to six hours per week of actual client therapy via tele-health or in-person. If your clinical assignment in CSD 538 is off site, frequency of therapy may be increased. The ratio of in-person and virtual service delivery will be driven by ASHA guidelines. To schedule based on students' 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

Work times are considered when assigning a client, however, NOT guaranteed.

FILES

General Guidelines and Office Protocol

A hardcopy (paper) file and an electronic file (Treatwrite) is maintained for each client. All reports and client files are confidential. See ASHA's Code of Ethics, their Confidentiality policy and HIPAA behavior. All hardcopy files are to be read in the student room and returned to the Clinic office by 4:00 p.m. Monday through Thursday. These files may be accessible on Friday upon request but are dependent on CE availability.

NO HARDCOPY FILE OR PORTION THEREOF MAY BE REMOVED FROM THE CLINIC EXCEPT TO DISCUSS THE CLIENT WITH A CLINICAL EDUCATOR AND OR FACULTY MEMBER IN HER/HIS OFFICE. YOU ARE ONLY PERMITTED TO ACCESS YOUR CLIENT FILE IN TREATWRITE UNLESS DIRECTED BY YOUR CE.

YOU MAY NEVER, UNDER ANY CIRCUMSTANCES, XEROX ANYTHING IN THE CLIENT'S FILE.

The Clinic office is a place of business. When entering the office, please check out your client file. Do not remain in the office. Complete your charting elsewhere; i.e., student workroom. Do not have conversations in the main office with your colleagues, or any other person in this location.

For all secretarial tasks that involve a client's paper file, see your CE.

CABINET NUMBER 12 (HOWEVER the bottom drawer of cabinet number 12 is off limits to clinicians) AND 13 ARE THE ONLY CABINETS IN THE MAIN CLINIC OFFICE THAT MAY BE USED BY CLINICIANS.

Log entries must be made in BLACK INK only every time a:

1.) Phone or email contact is made with your client,
2.) Items are added or removed from the file,
3.) 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 CARD MUST BE USED EVERY TIME A CLIENT FILE IS REMOVED FROM ITS PENDAFLEX FOLDER. 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. **FILES MUST BE RETURNED BY 4:00 MONDAY THROUGH THURSDAYS. FRIDAY DEADLINES ARE DICTATED VIA CE PRESENCE IN THE CLINIC. The file drawer is scanned at the end of the day to make sure all of the files have been returned. If your client file is taken home by mistake, your CE will call you. You will have to come back to the clinic immediately to return the file even if you are at home.**

File Forms

Client contact Log **(F-14)**. 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. Formal test protocols, audiograms, IEP's, information from referral resources, referral letters are placed in the file and logged on the yellow contact log. 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 initial. WHITE OUT IS ABSOLUTELY PROHIBITED.

Forms (**these must be signed before services are provided)

Because the majority of services are provided by students who will be observed by Clinical Educators, Faculty 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 possible audio/video recordings of all services. 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.

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, or other family member.

**Due to the combination of virtual and in person services, the client and/or guardian etc. must sign a *Tele-health Consent form (F-6)* The form states that clients/family understand that delivery of therapy via Zoom or other computer based intervention may not be, despite attempts via firewalls etc., electronically secured to protect confidentiality. However, the client/family agrees to this arrangement of therapy delivery and will not hold EMU Speech and Hearing Clinic liable for any breach of personal or medical information that became accessible during the tele-practice session/computer based intervention using the platform.

A general *Client Consent to Release Confidential/Protected* **(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 Plan*). This form must be reviewed, updated as needed and 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), when a client is discharged or per CE review. These forms are located in the office. Please ask your CE to get you a form.

ALL FORMS ARE LOCATED ON THE LEFT SIDE OF THE CLIENT FILE ARE TO BE FILED BY THE CLINICAL EDUCATOR. 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.

File Content and Sequence

All information should show a natural chronology; i.e.: case history on the bottom, medical reports next, etc. Other documentation including IEPs, referral letters, and formal protocols are filed via chronological order (most recent on the top). Please be sure that material on the right side does 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 PRECAUTIONS

The following procedures or conditions occur in the Clinic and may involve exposure to pathogens contained in the body fluids or blood. Personal Protective Equipment (PPE) procedures are to be used to avoid exposure to the pathogens. Refer to the EMU Safe Policy or your CE for mask requirements within the clinic.

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), COVID 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.

Procedure/ Condition	Personal Protective Equipment Needed					
	NSG*	SG*	UG*	FS*	PC*	OTHER
Oral Mech. Exam [3]	X					
Oral-motor exercises [1]	X					
Otoscopy with drainage	X			**		
Earmold modification	X					
Ear impressions	X					
Vomiting [2]	X			**	X	
Toileting [2]	X					
Equipment Cleaning			X			
Spill Cleanup			X		X	
Saliva Management	X					
Feeding evaluation [1]	X			X		
Videofluoroscopy [1]	X			X		
Dysphagia Evaluation [1]	X			X		
Cleaning Treatment Rooms			X		**	

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, cold symptoms, flu etc should not come to campus to prevent infection of clients and all persons in the clinic. Tele-health sessions could be scheduled per CE discretion.

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

Appropriate clinical procedures must be always observed to protect both client and clinicians. This means that disposable gloves are to be worn during all oral peripheral examinations, always with clients who demonstrate self-destructive behaviors, and all clients 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 or wipes. Alcohol wipes, disinfectant spray, tongue blades, paper bags and gloves are located at the clinician's work area.

You should make every effort to ensure that your client is safe while under your care. Review your client's file to determine if there is a red Medical Alert Notice with special procedures of which you should be aware **(see CP-8 *Medical Emergency Plan*)**. If you have a child who mouths 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 individuals, 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 or finish the virtual session five minutes before the session is finished so there is time to give some general statement of the client's progress to the appropriate family member, guardian and/or the client. 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 expectations 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.

End of the Semester Family Conferences

Family conferences are held at the end of the semester as a review of client progress. The last week of therapy will be used to conduct family conferences with family members and appropriate clients. Consult your CE regarding scheduling this conference with you, your CE, client and/or the appropriate member of the family. Your CE must observe the meeting therefore, it is imperative that you ensure that your CE is available to observe. **DO NOT start this meeting without your CE being ready to observe.**

The purpose of the 30-minute conference is to review: 1.) goals, 2.) procedures implemented to achieve the goals, 3.) semester outcomes, 4.) prognosis and 5.) recommendations. Please, keep the meeting length within the 30 minutes allotment. You will be asked to prepare a document that reflects the information you will be discussing in the meeting guideline to enhance the structure and content of your conference outline (see syllabus for due date). The conference will

be evaluated via Scoring Rubric Clinician/Client/Family Final Conferences (F-7). Your performance will be reflected via CALIPSO Clinical Performance Scale (F-13). The related items within this form are in the *Preparedness, Interaction and Personal Qualities* section (Std IV-B Uses appropriate rate, displays effective oral communication with patient, family or other professionals).

Additional family meetings

The clinician may feel a meeting is needed before the end of the semester. So, all additional meetings with the client or family member/s must be approved by your CE prior to client/family notification of the need for an additional conference.

Many times, in client/family conversations, the clinician may be asked a question regarding therapy strategy, predicted therapy outcomes etc. 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.

Homework

You should assign homework/home programs to address client semester goals. Refer to the Clinician Directed Hierarchy Chart (F-8). This is to be done only with your CE's approval. If your client receives weekly homework, please submit with other required documentation within your weekly paperwork submission. When 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 and/or a video screen that is accessible in their offices. ASHA requires that at least 25% of all client contact be directly observed by your CE.

A written summary with suggestions, questions or feedback MAY be placed in the clinician's mailbox (in person client sessions) or sent to you (email, text, chat) after in person/telehealth sessions your client's session. After reading the summary, the clinician who has questions about the comments should immediately seek an appointment with the CE. If your 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 via their paperwork inbox. If feedback is provided after a virtual session, please send your responses and comments via email or text to your CE.

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 email your CE, call/text CE and call the office. All three communications **MUST** be completed. In addition, contact your CE via their office phone number (located on the syllabus). Your CE will cancel your client or reschedule the session virtually.

2.) Clients are expected to attend all scheduled sessions. There will be no reschedules for a canceled session under any circumstances. Should a client not be able to attend a session, the CE should be contacted via email **AND** cell. Excessive absences for whatever reason will result in termination of therapy for the remainder of the term. If your session has participant/s **YOU** are responsible for contacting that clinician regarding the cancellation of the session.

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-13)** 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, CSD 528 and Clinic 2 CSD 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/remark by your CE).
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 given over the course of the semester.

Clinic 1-CSD 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. Re-evaluation and Progress Reports via Electronic Medical Record system (Treatwrite)
        ii. SOAP notes
        iii. Letters and other correspondence
        iv. Logging phone calls, contact and correspondence in client's file Complete all paperwork and correspondence in a timely manner.
6.) Communicate concisely and grammatically in all interactions with the client and family.
7.) 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

Late paperwork will be reflected on appropriate CALIPSO items.

Clinic 2 CSD 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. Evaluation and Re-evaluation preparation
        ii. Progress note 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.

Late paperwork will be reflected on appropriate CALIPSO items.

6.) ***Understand that CSD 538 clinical experience may include, but is not limited to, outside placements, group facilitation, mentoring, and/or program development (voice group, summer camps, aphasia group etc.). You are expected to fulfill your CSD 538 opportunities assigned by your CEs. These experiences provide unique and diverse clinical enhancement in the preparation of your Speech Language Pathology profession.***

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

Poor Clinical Performance

Please refer to Clinical Policies **CP-9 Notification of Failure at Midterm and CP-12 Remediation Plan for Poor Clinical Performance** regarding these issues.

GENERAL REQUIREMENTS

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

Competency Hours

Competency hours are incorporated into selected weekly clinical meeting topics. Clinicians will be required to complete a pre-test highlighting the concepts of the anticipated topic. Upon completion of the pre-test and participation in class, all hours accrued will be approved by your Clinical Educator at the end of the semester. If the pre-test is not completed in the timeline that is set by your instructor, these hours will not be credited toward your 400 clinical hours required by ASHA for graduation.

Simucase

A Simucase subscription may be required for CSD 528 and 538. Simucase may be part of your class requirement. The Simucase instructor will provide a syllabus with assigned simulations. Simucase provides a variety of diverse clinical experiences in evaluation and treatment of various disorders. The format of the program requires a pre-brief and debrief for each clinical case. In preparation for the Simucase debrief, clinicians must obtain a 90% competency score within the categorical parameters as they review the client's case history, possible referral resources, complete virtual testing and determine appropriate client goals. The Simucase instructor will provide the timeline as to the due date of simulation completion dictated by a 90%

competency score. In addition, the clinicians must meet the time requirement assigned to the case. The Simucase hours will be approved at the end of the clinical experience.

Research

Evidence-Based Research

Evidence-based practice is a crucial component of effective therapy. You are expected to research best clinical intervention strategies throughout the semester. Referenced research articles are listed in the Re-evaluation and Progress Note reports. You will be asked to submit summaries of the research (refer to your syllabus Evidence-Based Research Before & After Midterm (F-9)

Professional Issues

Article summaries discussing current professional issues (e.g. caseload numbers, efficacy of tele practice, diversity in the profession etc.) are required at some point in the semester (refer to syllabus). Grading Scale for Professional Research (F-10)

Attendance

Therapy

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 in-person session or log on 10-15 minutes before your virtual session. Therapy sessions should be held in the rooms assigned unless permission to hold sessions elsewhere has been granted. **Telehealth** sessions are facilitated via Zoom using your emich student access. In person sessions are 45- minutes which allows enough time to sanitize the table, chairs and door handles. Telehealth sessions are 50-minutes unless otherwise specified by your CE. Clinician absence should only be due to illness or other extreme circumstances. Absence due to illness for 2 or more days will require a written physician's excuse.

Clinic Class

Any clinician who is unable to attend the Clinic Meeting **must contact the instructor at least 2 hours prior** to the class meeting time. Failure to do so will result in an unexcused absence. Clinician absence should only be due to illness or other extreme circumstances. Late arrival to Clinic Meeting (over 10 minutes) will constitute being tardy.

Communication

Clinicians will communicate with their CE via email, mailbox or/and in person. 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. If a client report is not generated via Treatwite (clinic's Electronic Medical Record System) the documentation must be transferred to 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 unless approved by your CE. 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 communications should be logged in black ink on the log sheet in the client's folder.

Often clinicians will communicate with clients or client's families via proton email. Exceptions can be approved by the CE as needed. The intended email must first be approved by your CE. Upon approval, the email correspondence must be cc'd to your CE. Protonmail provides free basic accounts.

Documentation

The majority of clinic documentation is completed via Treatwrite. Refer to the Canvas file entitled Treatwrite for the log in and password.

Appropriate and professional documentation is required by law and many national accrediting agencies. The paper files of the client will include outside agency reports, authorizations, and/or formal test protocols. SOAP notes will be located within Treatwrite. When filing the required documents make sure that there are NO STAPLES in any documents **USE ONLY CLIENT INITIALS ON PAPERWORK, TEST PROTOCOLS, ETC. FOR THE PROTECTION OF THE CLIENT'S PERSONAL INFORMATION, USE THE INITIALS OF THE FULL LEGAL CLIENT'S NAME (first and last) on final documents. INITIALS REMAIN ON FINALIZED REPORTS. Formal reports ARE DISTRIBUTED VIA PROTONMAIL BY THE CE AT THE APPROPRIATE TIME IN THE SEMESTER.**

WEEKLY PAPERWORK TIMELINES ARE AS FOLLOWS.

- Monday/Wednesday clients scheduled between 8:30 and 5:00 p.m. is due at the latest by 4:00 on Thursday.
- Tuesday/Thursday clients scheduled between 8:30 a.m. and 5:00 p.m. is due at the latest by noon on Friday.

No paperwork timelines will be extended into the weekend.

If you have extenuating circumstances which prevent you from meeting these deadlines, see the appropriate CE. Please attach data sheets, test protocols, prior revisions, with weekly paperwork correspondence **VIA CANVAS UNLESS OTHER INSTRUCTIONS ARE GIVEN BY YOUR CE.**

Paperwork Requirements

**********When you are requested to revise any of the documentation below, the revision is due 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. In addition, full names are not to be used in soap notes or any other client documents. 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.

1.) *Evaluation//Re-evaluation*

The *Evaluation/Re-evaluation* and *Progress Report* *Treatwrite Evaluation/Re-evaluation Cheat sheet (F-15)* templates are found within the Treatwrite EMR system. The *Evaluation/Re-evaluation* report (beginning of semester) summarizes the assessment findings and outlines client semester goals. All pertinent information reported in the evaluation SOAP notes must be included in the Evaluation/Re-evaluation reports. *Evaluation/Re-evaluation report* must be submitted 48 hours after the last diagnostic SOAP note is approved by their CE.

2.) The *Progress Report* (end of semester)

This report includes semester goal performance and recommendations. Please refer to the Treatwrite Progress Note Cheat Sheet (F-16) for the content required for each segment of the reports. In addition, this report requires you to update client progress (number baselines and comments) via Progress Tracker on Treatwrite. Remember to include the number of sessions attended/number of sessions available and hours in the Progress Summary.

Reports are written for the families, therefore the content should be easily understood by the client/family. Use professional vocabulary, however, definitions of "speech related" terms (i.e., syntax=word order, semantic=vocabulary) can be included in performance summaries. Refer to the syllabus for the due dates.

CALIPSO rating scores will reflect the first submission. Use the Cheat sheets to ensure all initial content is included in your first submission. If the required sections are not completed, you will receive a rating of 1 on the corresponding CALIPSO item.

3.) *Plan of Assessment (F-22 and F23)*

You will be assigned a client/s and expected to review past reports and SOAP notes within the Treatwrite system. You are encouraged to obtain client permission to contact other professionals for the most recent information (SLP, Pediatrician) that may be critical as you prepare formal and informal assessment options. After review of client information and ideas for assessment baselines, you are expected to meet with your CE to discuss your client's status, plans for assessment and the days needed for the assessment. You will then submit a detailed Plan of Assessment that includes a list of areas and skills that you plan to assess. You are expected to include ALL related materials (data sheets, reading passages, word lists, virtual links, interview questions etc.) that are needed during baseline testing.

4.) *SOAP Notes*

A daily annotation of therapy must be submitted in the Treatwrite system. SOAP notes will NOT be added to the client's paper file. You MUST include length (units) of the session (1=15 minutes), type of visit (evaluation, consultation, treatment) and CPT & ICD codes that are appropriate for this clinical context. As listed on the **ICD/CPT Code Information (F-24),** SOAP notes are submitted with the corresponding data sheet (via email or Canvas for CE reference. Make sure to include the calculation of your data (math). You are encouraged to submit a corresponding SOAP note immediately following a session before your weekly paperwork deadline. The feedback in these SOAP notes may be beneficial when writing your next SOAP note. You will find CE feedback in the text box to the right corner of the Treatwrite screen. Clicking on the box of arrows will allow you to see your CE's comments.

Missed sessions, canceled sessions, and holidays require a SOAP note. These SOAP notes will reflect text within the S and P sections only. The S briefly states why the session was canceled and the P outlines the objectives for the next session. When you have completed writing the SOAP, you must click the submit button in the drop box found under documentation. If you have submitted a SOAP note before your weekly paperwork deadline, please notify your CE. An approved SOAP will be labeled as superbilled. If a SOAP needs revision, you will see a rework message. Information that is available to provide guidance in the written format of SOAP NOTES include these documents:

1.) General Guidelines (F-18)
2.) Diagnostic and Guidelines for Describing Severity Disorders(F-18a)
3.) Content changes after midterm (F-18b)
    a.) You will need to have CE approval to change the format of your SOAP note
4.) Re-evaluation (F-18c)
5.) Family Conference (F-18d)

5.) *Self-Evaluations*

The clinician is expected to complete the *Clinician Critical Reflection form* (**F-20**) which presents a series of questions for reflection of the week's sessions. Completion of one *Clinician Reflection Form* per week is expected to summarize your weekly performance. This is submitted via Canvas with weekly paperwork. 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 or guide thoughts for future changes based on prior unsuccessful sessions. The reflection should not outline your client's performance. You need to discuss anticipated changes in the therapy tasks based on your clinical observations of client behavior. The summary analyzes the reason for the

behavior and modifications in your performance to enhance client success. It is most beneficial to complete your self-evaluation BEFORE lesson plan preparation.

6.) *Lesson Plans (**F-19 & F-19a**).*
A weekly lesson plan is submitted after assessment is completed. The lesson plan reflects all anticipated therapy days of the corresponding week. Lesson plan components include: 1.) long-term goals, 2.) objectives for the session, 3.) easier and harder hierarchy steps, 4.) procedures, 5.) materials, 6.) anticipated task time and 7.) homework assignments. The lesson plan and related materials are turned in via Canvas. You MUST include ALL the materials needed for the anticipated sessions (word lists, data sheets, reading passages, Power Points). The due date of ALL lesson plan documentation depends on the time and day of your client session. If a home program is needed, you are expected to submit all the related documents to your CE BEFORE giving them to your client. Submit the home program with your weekly paperwork deadline. At least 10 minutes before your IN-PERSON session the correct and/revised copy of your lesson plan is to be placed in your CE's mailbox. Your CE will use the lesson plan as your therapy session is observed. The lesson plan will be returned to your mailbox at the conclusion of the session.

7.) *Graphs and Treatment Hierarchies* When your Re-evaluation client report is approved, you will be expected to prepare one graph per goal including baselines and teaching steps (objectives). These are **due 48 hours** (does not include weekends) **after** your Re-evaluation has been super billed by your CE.

8.) *Goal Cards* (**F-21**).
If the Treatment Hierarchies are approved by your CE when therapy sessions are progressing satisfactorily, evaluation/re-evaluation report is finalized, prior SOAP notes super billed, and graphs are finalized, then your CE may award the use of a Goal Card (an abbreviated planning format). All Goal Cards for the following week are due with the **WEEKLY PAPERWORK** deadlines stated above. You will use the same Goal Card for the rest of the semester. Goal cards are placed in your CE's mailboxes for in-person sessions.

9.) *Clinician Client Family Conference* A conference outline must be approved by your CE before the family conference. The family conference session will be evaluated via the Scoring Rubric For Clinician/Client/Family Final Conferences (F-7) Your performance will be reflected via CALIPSO Clinical Performance Scale (F-13). The related items within this form are in the *Preparedness, Interaction and Personal Qualities* section (Std IV-B Uses appropriate rate, displays effective oral communication with patient, family or other professionals).

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 but computer generated is preferred. DO NOT

BEGIN THE FAMILY CONFERENCE WITHOUT YOUR CLINICAL EDUCATOR. CSD 538's will be required to graph at least one goal for the family conference.

At the End of Each Semester

1.) Anticipated CSD 538 clinicians are required to complete a Clinical Practicum Schedule. The will be sent to you by Instructor of Record.
2.) 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.
3.) Final conferences with your CE will be scheduled the week after family conferences. Please contact your CE for a time and day that is convenient for you and your CE.
   - You must have your Progress Note finalized.
   - During the final conference with your CE, you will review your clinical performance and submit your semester clinical hours in CALIPSO.
4.) Clean out your mailbox and personal therapy materials.
5.) Remove all items from the refrigerator.
6.) Return books and materials borrowed from CE's.
7.) Return all clinic materials by the date posted by the Material Librarian.
8.) Give your CE your name tag so it can be used for the next semester.

9.) If you are not returning to the clinic for the next semester, please remove your lock from your locker. If the lock is left on the locker, a locksmith is contacted, and the clinic is charged for their services to cut off the lock.

ASHA Logs

Clinical Practicum hours may be earned in various contexts including session participation, class competencies, Simucase, in person client contact, virtual sessions, and any other situation in which your CE has deemed appropriate (awarded per ASHA guidelines). Each clinician MUST track their hours on a weekly basis. **The Clinical Hour Log sheet (F-25) should** be used for documentation of the hours. Based on the most recent ASHA guidelines, hours will be categorized into Simulation, Simucase, in-person and tele-practice. CE's may ask you to submit your hours at various times in the semester to monitor hour accumulation.

At your final conference with your CE at the end of the semester, your hours will be approved for submission. You will enter the Clinical Hour Log hours into CALIPSO. You can also request a hard copy of the hours from your **CE (ASHA Log Sheet (F-26).** 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

Materials are located in two different clinical areas 135*/Clinician Library* and 136 *Materials Room.* All resources are UPC coded (barcodes) to monitor check out and check in status. To have access to the materials, clinicians must create an account via Libib. You will register as a Patron after the Materials Librarian has entered your email (emich) into the system. The Materials Librarian will also post work hours at the beginning of the semester. She/He is in the clinic for approximately 10 hours a week. Please plan accordingly and do not expect materials to be available immediately. CE's will not always be able to check out material "at the last minute." Please see Materials Room Policy for further instructions.

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.

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 near their container unless explicitly told to share by the Materials Librarian.

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 overnight request form. The signed form is then returned to the clinician's holding shelf and placed in the plastic envelope.

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.

Materials Library

Resources found in the Materials Library need to be formally requested via Libib. Locate the item within the system and then request a hold. The material will be put on your shelf as soon as possible by the Material Librarian for a maximum of two weeks. After two weeks, the item will be taken off the shelf and returned to the Materials Library. 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. Forms for material extension will be found in the Materials Librarian mailbox. Please complete the form, obtain a signature from your CE and then place the signed form in the plastic envelope attached to your library shelf.

Clinician Library

Resources found in the Clinician Library can be checked out by the clinicians. This room is available to the clinicians Monday-Thursday 9:00 to 5:00 and Friday based on CE availability. To obtain material in this room, 1.) check out the material via Libib, 2.) locate the material in the room, 3.) sign your name and date on the library card and 4.) place the library card in the basket ON the desk. When you are done using the material, simply return the material in the laundry basket against the wall and LEAVE THE LIBRARY CARD IN THE BASKET ON THE DESK. The Material Librarian will check in the material based on the library cards in the basket. There are detailed instructions for check out and in on the wall by the laundry basket.

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 in each treatment room. Periodically, students may be requested to help clean rooms, which means 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 CSD 528, 538, 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 swallowing evaluation, or treatment. Please shut off lights and be mindful of ongoing treatment. Keep the noise level at a minimum.

Observation Rooms

The observation rooms are available to parents and 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. The lights in the observation rooms are to be left off at ALL times. 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 notices and job openings are posted on the board in the clinicians' work areas.

Fees

Due to Medicare regulations, 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 sexploitation 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).

F-1 Authorization to Treat

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) 780-3095

AUTHORIZATION

CLIENT'S NAME		BIRTHDATE	
PARENT'S GUARDIAN'S NAME		RELATIONSHIP	

PHONE NUMBERS				
PHONE	CLIENT	MOTHER	FATHER	GUARDIAN/SPOUSE
HOME				
WORK				

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

I hereby authorize the Eastern Michigan University Speech and Hearing Clinic to make customary and constructive 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 part of their training program.

_____ _____

Signature Date

EASTERN MICHIGAN UNIVERSITY
COLLEGE OF EDUCATION CLINICAL SUITE
COUNSELING CLINIC ↔ SPEECH AND HEARING CLINIC
Suite 135 Porter Building ● Ypsilanti, MI 48197 ● Phone: (734) 487-4410 ● Fax: (734) 780- 3095

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION
FOR _____

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

□ my own record □ my spouse's record date of birth _____
□ my child's record
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**
   NAME: _____
   HOME ADDRESS FOR REPORT: _____
   CITY: _____ STATE: _____ ZIP: _____

2. **SPECIFIC TYPE OF INFORMATION TO BE DISCLOSED**

	Diagnosis		Substance use Records		Academic/School Records
	Treatment Plan		Ideological Records		Employment Records
	Final Report/ Treatment Outcome		Evaluation		Court Records
	Medical Records and Reports		Psychological Records		Other (please specify below)

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:**

	One year from date signed		When requested information has been supplied
	At the end of the current academic semester		At termination of treatment
	Other (please specify)		

_____ _____
WITNESS **CLIENT/GUARDIAN SIGNATURE**

_____ _____
DATE WITNESSED **DATE SIGNED**

EASTERN MICHIGAN UNIVERSITY SPEECH AND HEARING CLINIC

Client Consent to Release Confidential/Protected Health Information

I, _____ _____
(Client Name or Authorized Legal Representative) (Date of Birth)
Authorize EMU's Speech and Hearing Clinic, to request information including confidential/protected health information, which may be helpful in providing service 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 (60) days after discontinuation of services to Client.** To revoke this Consent, I understand I must notify EMU's Speech and Hearing 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's initial)

F-4 Emergency Information

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

REFERENCE: American Speech-Language-Hearing Association. (2004). Admissions/Discharge Criteria in Speech-language Pathology. *ASHA Supplement 24,* in press.

EASTERN MICHIGAN UNIVERSITY

Speech and Hearing Clinic

135 Porter

Initial date_____

TELE-PRACTICE CONFIDENTIALITY Consent Form

I, _____ understand that delivery of therapy via Skype or other computer based intervention may not be, despite attempts via firewalls etc., electronically secured to protect my confidentiality. However, I agree to this arrangement of therapy delivery and will not hold EMU Speech and Hearing Clinic liable for any breach of personal or medical information that became accessible during my tele-practice session/computer based intervention using the platform of **Zoom**/Skype or _____.

This agreement is to be reviewed, signed or initialed every year to ensure continued awareness of the possible implications of computer-based evaluation and treatment.

_____

Client/family member/guardian

_____

Graduate Clinician and/or Clinical Educator

Dates reviewed with required initials (client/family members/guardian/Clinical Educator and/or Graduate Clinician:

Signature/s_____ Date_____

Signature/s_____ Date_____

Signature/s _____ Date_____

F-6 Tele practice Consent Form 12/19/18
Revised 03/17/20

Services module of tele-practice:

- Therapy session duration and days are dependent on client desire and clinician recommendations
- Computer based therapy is delivered in a designated room that is equipped with a one-way mirror which will be utilized by Clinical Educators and Student Graduate clinicians participating in EMU's SLP training program.
- If, at any time, there is another individual that is not a graduate student or Clinical Educator the client will be informed. A verbal consent will be given by the client and/or POA family member
- Evaluations, treatment delivery and materials may be altered to facilitate therapy within the context of tele-practice. Adaptions will not impact the validity of assessments or content of treatment resources.
- You have the right to revert to traditional face-to-face care at any time
- The state of Michigan does not have regulations in place for management of tele-practice based therapy.
- Computer based intervention is not a platform that confidentiality is guaranteed despite efforts from EMU staff.

How do tele-practice services differ from services delivered in person?

Cons

- Technology failures i.e., internet access, modem support, no audio, microphones not working, frozen computer connections and delays in sound transmission
- Inadequate computer knowledge to problem-solve during the therapy session
- Inability to therapy materials/homework home upon completion of the session
- Papers that need to be signed have to be proxies by SLP/Clinical Educator
- Delayed feedback from the computer may negatively impact the effectiveness of a given cue
- Lack of physical proximity to provide tactile cueing/support needed for speech related objectives/goals

Pros

- Provides services to individuals with transportation concerns
- May promote generalization of skills by empower clients ability to complete a task without physical assistance
- Flexibility with time and frequency of sessions
- Cost effective
- Services are not directly impacted by circumstances of winter weather

HIPPA Information:

- Protected Health Information includes:
    - Names or parts of names

  - Geographical Identifiers
  - Phone numbers
  - Email addresses
  - Medical records numbers
  - Account numbers
  - Dates directly related to an individual
  - Fax numbers
  - Social Security Numbers
  - Certificate or license numbers
  - Vehicle license plate numbers
  - Web URL's
  - Fingerprints
  - Device identifiers and serial numbers
  - Photographic Images
- Your rights with HIPPA:
  - Right to request medical records at anytime
  - Request amendments to medical records when appropriate
  - Limits to who has access to personal health information
  - Choose how healthcare providers communicate with them.
  - Right to complain about the unauthorized disclosure of Personal Information
- How EMU tele-practice is HIPPA compliant:
  - Privacy of Personal Information
    - Tele-practice will only be available to be observed by Graduate Student Clinicians, designated family members, Clinical Educators. Other individuals that do not fit this criteria will be given permission from client before the anticipated observation.
    - The therapy content of the tele-practice session may be recorded for review for teaching purposes. This includes but is not limited to:
      - Individual review
      - Class review
      - Family review
    - Video content will not be provided to any other distributors/outside resources (software companies, other universities etc.)
    - Recorded tele-practice sessions may be used for an infinite amount of time for instruction purposes even after client is discharged.
    - There will be no link to other websites when logged on to the tele-practice site.

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SCORING RUBRIC FOR CLIENT/ FAMILY FINAL CONFERENCES

INTRODUCTION: Welcome/Thank you for attending
Explain meeting purpose: Discuss/review goals Procedures Outcomes Prognosis Recommendations

GRAPHS:
Each graph represents one semester goal
Graphs are neat and easy to read
Graphs are shared with the family
Transitions between graphs are "flawless"/annotations are used effectively Explain format of graph including criteria axis, objective presentation and representation of cuing
Review aloud each goal
Give them time to look at the graph after graph structure and goal review are completed
State whether the goal was MET, NOT MET, OR PARTIALLY MET Indicate via red line which days were calculated to measure end of the semester progress
Write current level of performance on the top right of the graph
Review progress toward each goal with the graphs beginning with baseline
Describe how progress was evaluated
Procedure Examples
Use positive language
Check for clarity and understanding
Ask for client/family perception of change in functional skills

PROGNOSIS:
State Prognosis and factors that influence this prognosis

RECOMMENDATIONS:
Confirm if returning
State recommendations
Family input for changes, suggestions for additional goals
Home assignments over break
Referrals and rationale
Give graphs to family

NONVERBAL COMMUNICATION/PROFESSIONALISM
Professional appearance in dress and hygiene
Professional demeanor and posture/appropriate volume/professional vocabulary

CLINICIAN DIRECT HIERARCHY CHART

Continuum of Clinical Behaviors throughout the Intervention Process
Cues & Prompts
Maximum _____ *Minimum*
Model Target Response
Direct Imitation _____ *Delayed Imitation* _____ *None*
Feedback
*Frequent*_____ *Rare*
Linguistic Complexity
Simple _____ *Complex*

Maintain a high rate of client accuracy throughout (about 75% accuracy)

Level	Client Ability	Clinician Support to Achieve Target Success	Parents/Teachers/Outside of Therapy
Level 5 Getting There!	Able to self-monitor for errors with minimal support in uninstructed activities Client is consistently 80-100% accurate in the therapy setting	Provide very minimal or indirect cues Provide opportunities for production in unstructured activities and/or linguistically complex tasks Provide opportunities for self-monitoring in unstructured activities and outside of therapy setting	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
Level 4 Carrying it Over	Able to use target in new or exciting games, discourse 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 & generalization Provide many opportunities for production outside of therapy room	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
Level 3 Moving Along	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, than proceed with less structured activity Use of intermittent feedback is sufficient Promote self-monitoring of accuracy Increase linguistic complexity for productions	Client is able to practice Level 2 skills in specific, structured activities with parents, teachers Emerging spontaneous use of target independently outside of therapy
Level 2 A Conscious Effort	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 level 1	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

F-8 Clinician Directed Hierarchy Chart

Level 1 **Beginning a New Goal**	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 Elicits target through direct imitation Provide consistent (100%), contingent feedback Provide explicit feedback for correct production Elicit target with linguistically simple stimuli	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

F-9 Evidence-Based Practice Research Rubric

RESEARCH SUMMARY GRADING SCALE for
EVIDENCE-BASED PRACTICE BEFORE AND AFTER MID-TERM

BEFORE MID-TERM/CALIPSO #2A	AFTER MID-TERM/CALIPSO #2B
SCORE 0-1	
No research was submitted	No research submitted
If submitted only one article with brief summary	If submitted, brief summary of article/s
Resource questionable/not peer reviewed	Resource questionable/not peer reviewed
No application to current client semester goals	Application to current client semester goals
SCORE 2-3	
Two-Three Articles	One article submitted
Basic Summary	Basic Summary
Reliable Source	Reliable source
Application to client but limited future use	Basic summary provides general treatment ideas for future goal recommendations
SCORE 4 AND ABOVE	
Four or more articles	One or two additional articles submitted
Credible Source	Credible Source
Summary describes how article will influence service delivery by providing rationales of why or why not it is applicable to the client - Immediate implementation on service delivery to the client	Recommendations within the Progress Note Reflect concepts in the research article - The article is cited within the Progress Note context

REFLECTIVE OF CALIPSO ITEM:

****POSSESS THE KNKOWLEDGE TO INTEGRATE RESEARCH PRINCIPLES INTO EVIDENCE-BSED CLINICAL PRACTICE (Std III-F)

F-10 Professional Issues Research Rubric

Revised 12/22

GRADING SCALE for PROFESSIONALISM RESEARCH

PROFESSIONALISM
SCORE 0-1
No research was submitted
Summary to brief
Resource questionable/not peer reviewed
If submitted, outdated professional issue
SCORE 2-3
One article
Basic Summary
Reliable Source
Current/recent professional issue topic
SCORE 4 and ABOVE
One or two articles/different professional issues with basic summaries for each/or a detailed summary for one article (detail=how do you feel about the topic, career application, concerns for anticipated practice upon graduation)
Credible source
Professional issues/s are applicable to all treatment settings (school, hospital, SNIF etc.) --- Issue is applicable to clinician's current delivery setting

REFLECTIVE OF CALIPSO ITEM

PREPARDNESS, INTERACTION AND PERSONAL QUALITIES

Demonstrates knowledge of contemporary professional issues that affect Speech-Language Pathology (CFCC IV-G; CAA 3.1.1B)

January 2023

Created 12/22

GRADING SCALE for PREVENTION ARTICLE

PREVENTION ARTICLE
SCORE 0-1
No research was submitted
Summary to brief
Resource questionable/not peer reviewed
If submitted, outdated professional issue
SCORE 2-3
PREVENTION terminology was summarized accurately in the clinician's written review of the article
Reliable Source
Summary of the article utilized ONE reference to *PREVENTION* terminology outlined in ASHA's position statement (Primary, Secondary, Tertiary, At Risk, Incidence, Prevalence, Epidemiology or Wellness)
SCORE 4 and ABOVE
Summary of the article utilized TWO or MORE references to *PREVENTION* terminology outlined in ASHA's position statement (Primary, Secondary, Tertiary, At Risk, Incidence, Prevalence, Epidemiology or Wellness)
Credible source
PREVENTION topic relates to present client's disorder/delay
PREVENTION terminology was summarized accurately in the clinician's summary of the article

REFLECTIVE OF CALIPSO ITEM

EVALUATION SKILLS

Demonstrates current knowledge of the principles and methods of prevention and assessment, including consideration of anatomical/physiological, psychological, developmental, and linguistic and cultural correlates (CFFCC IV-D)

Professional Behaviors*

Professional Behaviors are attributes, characteristics or behaviors that are not explicitly part of the profession's core of knowledge and technical skills but are nevertheless required for success in the profession. Ten Professional Behaviors were identified through a study conducted at the Physical Therapy Program at UW-Madison. The ten abilities and definitions developed are:

Generic Ability	**Definition**
1. Critical Thinking	The ability to question logically; identify, generate and evaluate elements of logical argument; recognize and differentiate facts, appropriate or faulty inferences, and assumptions; and distinguish relevant from irrelevant information**.** The ability to appropriately utilize, analyze, and critically evaluate scientific evidence to develop a logical argument, and to identify and determine the impact of bias on the decision making process.
2. Communication	The ability to communicate effectively (i.e. verbal, non-verbal, reading, writing, and listening) for varied audiences and purposes.
3. Problem Solving	The ability to recognize and define problems, analyzes data, develop and implement solutions, and evaluate outcomes.
4. Interpersonal Skills	The ability to interact effectively with patients, families, colleagues, other health care professionals, and the community in a culturally aware manner.
5.Responsibility	The ability to be accountable for the outcomes of personal and professional actions and to follow through on commitments that encompass the profession within the scope of work, community and social responsibilities.
6.Professionalism	The ability to exhibit appropriate professional conduct and to represent the profession effectively while promoting the growth/development of the Physical Therapy profession.
7.Use of Constructive Feedback	The ability to seek out and identify quality sources of feedback, reflects on and integrates the feedback, and provides meaningful feedback to others.
8.Effective Use of Time and Resources	The ability to manage time and resources effectively to obtain the maximum possible benefit.
9.Stress Management	The ability to identify sources of stress and to develop and implement effective coping behaviors; this applies for interactions for: self, patient/clients and their families, members of the health care team and in work/life scenarios.
10. Commitment to Learning	The ability to self direct learning to include the identification of needs and sources of learning; and to continually seek and apply new knowledge, behaviors, and skills.

**Originally developed by the Physical Therapy Program, University of Wisconsin-Madison*

May, W.W., Morgan, B.J., Lemke, J.C., Karst, G.M., & Stone, H.L. (1995). Model for ability-based assessment in physical therapy education. Journal of Physical Therapy Education, 9(1), 3-6.

Updated 2010, to be published.

*****The level of educational instruction is noted below, however, this is a general guideline of professional behavior sequences

PROFESSIONAL BEHAVIORS	Beginning Level: CSD 528	Intermediate Level: CSD 538	Entry Level: Internships	Post-Entry Level: CFY and on.....
Critical Thinking - The ability to question logically; identify, generate and evaluate elements of logical argument; recognize and differentiate facts, appropriate or faulty inferences, and assumptions; and distinguish relevant from irrelevant information. The ability to appropriately utilize, analyze, and critically evaluate scientific evidence to develop a logical argument, and to identify and determine the impact of bias on the decision making process.	- Raise relevant questions - Considers all available information - Articulates ideas - Understands the scientific method - States the results of scientific literature but has not developed the consistent ability to critically appraise findings (i.e. methodology and conclusion) - Recognizes holes in knowledge base - Demonstrates acceptance of limited knowledge and experience	- Feels challenged to examine ideas - Critically analyzes the literature and applies it to patient management - Utilizes didactic knowledge, research evidence, and clinical experience to formulate new ideas - Seeks alternative ideas - Formulates alternative hypotheses - Critiques hypotheses and ideas at a level consistent with knowledge base - Acknowledge presence of contradictions	- Distinguishes relevant from irrelevant patient data - Readily formulates and critiques alternative hypotheses and ideas - Infers applicability of information across populations - Exhibit openness to contradictory ideas - Identifies appropriate measures and determines effectiveness and applied solutions efficiently - Justifies solutions selected	- Develops new knowledge through research, professional writing and/or professional presentations - Thoroughly critiques hypotheses and ideas often crossing disciplines in thought process - Weighs information value based on source and level of evidence - Identifies complex patterns of associations - Distinguishes when to think intuitively vs. analytically - Recognizes own biases and suspends judgmental thinking - Challenges others to think critically
Communication - The ability to communicate effectively (i.e. verbal, non-verbal, reading, writing, and listening) for varied audiences and purposes.	- Demonstrates understanding of the English language (verbal and written): uses correct grammar, accurate spelling and expression, legible handwriting - Recognizes impact of non-verbal communication in self and others - Recognizes the verbal and non-verbal characteristics that portray confidence - Utilizes electronic communication appropriately	- Utilizes and modifies communication (verbal, non-verbal, written and electronic) to meet the needs of different audiences - Restates, reflects and clarifies message(s) - Communicate collaboratively with both individuals and groups - Collects necessary information from all pertinent individuals in the patient/client management process - Provides effective education (verbal, non-verbal, written and electronic)	- Demonstrates the ability to maintain appropriate control of the communication exchange with individuals and groups - Presents persuasive and explanatory verbal, written or electronic messages with logical organizations and sequencing - Maintains open and constructive communication - Utilizes communication technology effectively and efficiently	- Adapts messages to address needs, expectations, and prior knowledge of the audience to maximize learning - Effectively delivers messages capable of influencing patients, the community and society - Provides education locally, regionally and/or nationally - Mediates conflict
Problem Solving – The ability to recognize and define problems, analyzes data, develop and implement solutions, and evaluate outcomes.	- Recognizes problems - States problems clearly - Describes known solutions to problems - Identifies resources needed to develop solutions - Uses technology to search for and locate resources - Identifies possible solutions and probable outcomes	- Prioritizes problems - Identifies contributors to problems - Consults with others to clarify problems - Appropriately seeks input or guidance - Prioritizes recourse (analysis and critique of recourse) - Considers consequences of possible solutions	- Independently locates, prioritizes and uses resources to solve problems - Accepts responsibility for implementing solutions - Implements solutions - Reassesses solutions - Evaluates outcomes - Modifies solutions based on the outcomes and current evidence - Evaluates generalizability of current evidence to a particular problem	- Weighs advantages and disadvantages of a solution to a problem - Participates in outcome studies - Participates in formal quality assessment in work environment - Seeks solutions to community health-related problems - Considers second the third order effects of solutions chosen

Interpersonal Skills – The ability to interact effectively with patients, families, colleagues, other health care professionals, and the community in a culturally aware manner.	- Maintains professional demeanor in all interactions - Demonstrates interest in patients as individuals - Communicates with others in a respectful and confident manner - Respects differences in personality, lifestyle and learning styles during interactions with all persons - Maintains confidentiality in all interactions - Recognizes the emotions and bias that one brings to all professional interactions	- Recognizes the non-verbal communication and emotions that others bring to professional interactions - Establishes trust - Seeks to gain input from others - Respects role of others - Accommodates differences in learning styles as appropriate	- Demonstrates active listening skills and reflects back to original concern to determine course of action - Responds effectively to unexpected situations - Demonstrates ability to build partnerships - Applies conflict management strategies when dealing with challenging interactions - Recognizes the impact of non-verbal communication and emotional responses during interactions and modifies own behaviors based on them	- Establishes mentor relationships - Recognizes the impact that non-verbal communication and the emotions of self and others have during interactions and demonstrates the ability to modify the behaviors of self and others during the interaction
Responsibility – The ability to be accountable for the outcomes of personal and professional actions and to follow through on commitments that encompass the profession within the scope of work, community and social responsibilities.	- Demonstrates punctuality - Provides a safe and secure environment for patients - Assumes responsibility for actions - Follows through on commitments - Articulates limitations and readiness to learn - Abides by all policies of academic program and clinical facility	- Displays awareness of and sensitivity to diverse populations - Completes projects without prompting - Delegates tasks as needed - Collaborates with team members, patients and families - Provides evidence-based patient care	- Educates patients as consumers of health care services - Encourages patient accountability - Directs patients to other health care professionals as needed - Acts as a patient advocate - Promotes evidence-based practice in health care settings - Accepts responsibility for implementing solutions - Demonstrates accountability for all decisions and behaviors in academic and clinical settings	- Recognizes role as a leader - Encourages and displays leadership - Facilitates program development and modification - Promotes clinical training for students and coworkers - Monitors and adapts to changes in the health care system - Promotes service to the community
Professionalism – The ability to exhibit appropriate professional conduct and to represent the profession effectively while promoting the growth/development of the Physical Therapy profession.	- Abides by all aspects of the academic program honor code and the APTA Code of Ethics - Demonstrates awareness of state licensure regulations - Projects professional image - Attends professional meetings - Demonstrates cultural/generational awareness, ethical values, respect, and continuous regard for all classmates, academic and clinical faculty/staff, patients, families, and other healthcare providers	- Identifies positive professional role models within the academic and clinical settings - Acts on moral commitment during all academic and clinical activities - Identifies when the input of classmates, co-workers and other healthcare professionals will result in optimal outcome and acts accordingly to attain such input and share decision making - Discusses societal expectations of the profession	- Demonstrates understanding of scope of practice as evidenced by treatment of patients within scope of practice, referring to other healthcare professionals as necessary - Provides patient/family centered care at all times as evidenced by provision of patient/family education, seeking patient input and informed consent for all aspects of care and maintenance of patient dignity - Seeks excellence in professional practice by participation in professional organizations and attendance at sessions or participation in activities that further education/professional development	- Actively promotes and advocates for the profession - Pursues leadership roles - Supports research - Participates in program development - Participates in education of the community - Demonstrates the ability to practice effectively in multiple settings - Acts as a clinical instructor - Advocates for the patient, the community and society

			- Utilizes evidence to guide clinical decision making and the provision of patient care, following guidelines for best practices - Discusses role of physical therapy within the healthcare system and in population health - Demonstrates leadership in collaboration with both individuals and groups	
Use of Constructive Feedback – The ability to seek out and identify quality sources of feedback, reflects on and integrates the feedback, and provides meaningful feedback to others.	- Demonstrates active listening skills - Assesses own performance - Actively seeks feedback from appropriate sources - Demonstrates receptive behavior and positive attitude toward feedback - Incorporates specific feedback into behaviors - Maintains two-way communication without defensiveness	- Critiques own performance accurately - Responds effectively to constructive feedback - Utilizes feedback when establishing professional and patient related goals - Develops and implements a plan of action in response to feedback - Provides constructive and timely feedback	- Independently engages in a continual process of self evaluation of skills, knowledge and abilities - Seeks feedback from patients/clients and peers/mentors - Readily integrates feedback provided from a variety of sources to improve skills, knowledge and abilities - Uses multiple approaches when responding to feedback - Reconciles differences with sensitivity - Modifies feedback given to patients/clients according to their learning styles	- Engages in non-judgmental, constructive problem-solving discussions - Acts as conduit for feedback between multiple sources - Seeks feedback from a variety of sources to include students/supervisees/peers/supervisors/patients - Utilizes feedback when analyzing and updating professional goals
Effective Use of Time and Resources – The ability to manage time and resources effectively to obtain the maximum possible benefit.	- Comes prepared for the day's activities/responsibilities - Identifies resource limitations (i.e. information, time, experience) - Determines when and how much help/assistance is needed - Accesses current evidence in a timely manner - Verbalizes productivity standards and identifies barriers to meeting productivity standards - Self-identifies and initiates learning opportunities during unscheduled time	- Utilizes effective methods of searching for evidence for practice decisions - Recognizes own resource contributions - Shares knowledge and collaborates with staff to utilize best current evidence - Discusses and implements strategies for meeting productivity standards - Identifies need for and seeks referrals to other disciplines	- Uses current best evidence - Collaborates with members of the team to maximize the impact of treatment available - Has the ability to set boundaries, negotiate, compromise, and set realistic expectations - Gathers data and effectively interprets and assimilates the data to determine plan of care - Utilizes community resources in discharge planning - Adjusts plans, schedule etc. as patient needs and circumstances dictate - Meets productivity standards of facility while providing quality care and completing non-productive work activities	- Advances profession by contributing to the body of knowledge (outcomes, case studies, etc) - Applies best evidence considering available resources and constraints - Organizes and prioritizes effectively - Prioritizes multiple demands and situations that arise on a given day - Mentors peers and supervisees in increasing productivity and/or effectiveness without decrement in quality of care

Stress Management – The ability to identify sources of stress and to develop and implement effective coping behaviors; this applies for interactions for: self, patient/clients and their families, members of the health care team and in work/life scenarios.	- Recognizes own stressors - Recognizes distress or problems in others - Seeks assistance as needed - Maintains professional demeanor in all situations	- Actively employs stress management techniques - Reconciles inconsistencies in the educational process - Maintains balance between professional and personal life - Accepts constructive feedback and clarifies expectations - Establishes outlets to cope with stressors	- Demonstrates appropriate affective responses in all situations - Responds calmly to urgent situations with reflection and debriefing as needed - Prioritizes multiple commitments - Reconciles inconsistencies within professional, personal and work/life environments - Demonstrates ability to defuse potential stressors with self and others	- Recognizes when problems are unsolvable - Assists others in recognizing and managing stressors - Demonstrates preventative approach to stress management - Establishes support networks for self and others - Offers solutions to the reduction of stress - Models work/life balance through health/wellness behaviors in professional and personal life
Commitment to Learning – The ability to self direct learning to include the identification of needs and sources of learning; and to continually seek and apply new knowledge, behaviors, and skills.	- Prioritizes information needs - Analyzes and subdivides large questions into components - Identifies own learning needs based on previous experiences - Welcomes and/or seeks new learning opportunities - Seeks out professional literature - Plans and presents an in-service, research or cases studies	- Researches and studies areas where own knowledge base is lacking in order to augment learning and practice - Applies new information and re-evaluates performance - Accepts that there may be more than one answer to a problem - Recognizes the need to and is able to verify solutions to problems - Reads articles critically and understands limits of application to professional practice	- Respectfully questions conventional wisdom - Formulates and re-evaluates position based on available evidence - Demonstrates confidence in sharing new knowledge with all staff levels - Modifies programs and treatments based on newly-learned skills and considerations - Consults with other health professionals and physical therapists for treatment ideas	- Acts as a mentor not only to other PT's, but to other health professionals - Utilizes mentors who have knowledge available to them - Continues to seek and review relevant literature - Works towards clinical specialty certifications - Seeks specialty training - Is committed to understanding the PT's role in the health care environment today (i.e. wellness clinics, massage therapy, holistic medicine) - Pursues participation in clinical education as an educational opportunity

CLINICAL INSTRUCTOR Evaluation of Student

Midterm: Red Ink
Final: Black Ink

Professional Behaviors

Instructions: Assess each ability based on your observation of the student's performance (highlighted areas – refer to the key sample behaviors for each ability. Mark the scale to reflect your rating. Comments and examples provide valuable information. Please sign and date the assessment.

B-Beginning Level I-Intermediate Level E-Entry Level

1. **Critical Thinking** B I E
Comments & Examples: _____

2. **Communication** B I E
Comments & Examples: _____

3. **Problem Solving** B I E
Comments & Examples: _____

4. **Interpersonal Skills** B I E
Comments & Examples: _____

5. **Responsibility** B I E
Comments & Examples: _____

6. **Professionalism** B I E
Comments & Examples: _____

7. **Use of Constructive Feedback** B I E
Comments & Examples: _____

8. **Effective Use of Time and Resources** B I E
Comments & Examples: _____

9. **Stress Management** B I E
Comments and Examples: _____

10. **Commitment to Learning** B I E
Comments and Examples: _____

Student _____ Facility _____

Clinical Instructor _____ Date _____

STUDENT

Student Self-Assessment

Midterm: Red Ink
Final: Black Ink

Professional Behaviors

Instructions: Assess each ability based on your performance (highlighted areas – refer to the key sample behaviors for each ability. Mark the scale to reflect your rating. Comments and examples provide valuable information. Please sign and date the assessment.

B-Beginning Level I-Intermediate Level E-Entry Level

1. **Critical Thinking** B D E
Comments & Examples: _____

2. **Communication** B D E
Comments & Examples: _____

3. **Problem Solving** B D E
Comments & Examples: _____

4. **Interpersonal Skills** B D E
Comments & Examples: _____

5. **Responsibility** B D E
Comments & Examples: _____

6. **Professionalism** B D E
Comments & Examples: _____

7. **Use of Constructive Feedback** B D E
Comments & Examples: _____

8. **Effective Use of Time and Resources** B D E
Comments & Examples: _____

9. **Stress Management** B D E
Comments and Examples: _____

10. **Commitment to Learning** B D E
Comments and Examples: _____

Student _____ Facility _____

Clinical Instructor _____ Date _____

11/2022 form Fall 2023 graduates and all proceeding clinicians

CALIPSO – CLINICAL PERFORMANCE SCALE – CSD 528 & 538

CLINICIAN_____ **SEMESTER**_____

CLINICAL EDUCATOR_____ **YEAR**_____

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

GRADING SCALE:

5	**Independent** Adequately and effectively implements the clinical skill/behavior. Demonstrates independent and creative problem solving.
4	**Developing Mastery** Displays minor technical problems which do not hinder the therapeutic process. Minimum amount of direction from supervisor needed to perform effectively.
3	**Present** 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	**Emerging** 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	**Early Emerging** Specific direction from supervisor does not alter unsatisfactory performance.

**********Please rate all divisions and applicable items within the categories of Evaluation, Treatment and C. Preparedness, Interaction, and Personal Qualities

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

Social Aspects Communication Modalities

1	Conducts screening and prevention procedures (CFCC V-B, 1a)	5	4	3	2	1
	A. Prepared for consultation with the audiologist and followed hearing protocol****_completed by the audiologist_					
	B. Writes accurate, appropriate, and detailed audiological evaluation summary****_completed by the audiologist_					
	C. Provides evidence of outside reading regarding prevention in the areas of communication sciences and disorders (vocal abuse, stroke prevention, hearing, health risks, child abuse, elder abuse etc.) ***_completed by CE_					
	Average:					
2	Demonstrates current knowledge of the principles and methods of prevention and assessment, including consideration of anatomical/physiological, psychological, developmental, and linguistic and cultural correlates (CFCC IV-D)	5	4	3	2	1
	A. Prompt contact with family regarding start date and time of semester clinical sessions					
	B. The initial "get to know session" reflects creativity, client interests and preliminary information that contributes to the development of Plan of Assessment					
	C. Preparedness i.e., review of hard copy chart and/or Treatwrite reports, previous SOAP notes, IEP forms, familiarity with client diagnosis based on the clinical records etc. for the initial meeting with CE (if applicable).					
	Average:					
3	Collects case history information and integrates information from clients/patients, family, caregivers, teachers, and relevant others, including other professionals (CFCC V-B, 1b)	5	4	3	2	1

	A. Writes thorough Plan of Assessment for initial evaluation sessions					
	B. Appropriate rationales that reflect understanding of client's strengths, weaknesses, family concerns and previous clinician recommendations					
	Average:					
4	Selects appropriate evaluation procedures (CFCC V-B, 1c)	5	4	3	2	1
	A. Shows evidence of thorough review of evaluation materials prior to administering formal and informal assessments					
	B. Data sheets reflect in-depth analysis of anticipated informal evaluation measures					
	C. Baselines from previous session/s are considered Average:					
5	Administers non-standardized and standardized tests correctly (CFCC V-B, 1c)	5	4	3	2	1
	A. All sections/subtests of the formal evaluation are administered according to testing guidelines which are summarized in the testing manuals.					
	B. Accurate calculation of formal assessments (knowledge of Means, Standard Deviations, Percentiles, Quotients etc.)					
	C. Informal measures reflect accurate calculations of client behavior/responses					
	D. Formal testing booklets/protocols etc. are completed (client initials, birthday calculations, clinician name, date of administration)					
	E. Protocols are completed with black pen, errors are crossed of and initialed rather than scribbled out or altered with white out.					
	Average:					
6	Adapts evaluation procedures to meet the needs of individuals receiving services (CFCC V-B, 1d)	5	4	3	2	1
	A. Demonstrates flexibility when determining appropriate assessment					
	B. Minimizes client frustration during the assessment					
	C. Sequence of assessment/organization of test materials promotes testing reliability, validity and minimizes client distraction.					
	Average:					
7	Demonstrates knowledge of communication and swallowing disorders and differences (CFCC IV-C)	5	4	3	2	1
	A. Demonstrates ability to explain profile of client strengths and weaknesses in preparation of the evaluation.					
	B. Demonstrates the knowledge and/or ability to complete/document swallowing evaluation.					
	Average:					
8	Interprets integrates, and synthesizes all information to develop diagnoses (CFCC V-B, 1e)	5	4	3	2	1
	A. Writes accurate and coherent ***Patient Data Tab*** (CPT, ICD codes, patient history, medical diagnosis)					
	B. Write an accurate and coherent description of client's ***Assessment*** (Tests Administered, Clinical Progress Tracker, and Summary)					
	C. Write an accurate and coherent ***Diagnostic Statement*** (Impressions)					
	D. Writes an accurate and coherent ***Prognostic*** statement					
	E. Develops appropriate ***Long-term Goals*** that are measurable and relevant					
	F. ***Recommendations*** (Frequency of treatment, reference to research applicable to client anticipated treatment, all signatures and dates included)					
	G. Maintains the correct tense, and pronoun use throughout the Re-eval report					
	H. Includes severity ratings of client disorder/s based on diagnostic information which may include but are not limited to: 1.) rating/severity words which may be provided in the formal testing manual, 2.) standard deviations as scores pertain to the bell curve,3.) developmental norms, and/or 4.) criterion-referenced scoring,					
	I. Sections/subtest/composite scores etc. were calculated correctly					
	J. Timely completion of the Evaluation/Re-evaluation report in Treatwrite					
	Average:					
9	Interprets, integrates, and synthesizes all information and makes appropriate recommendations for intervention (CFCC V-B, 1e)	5	4	3	2	1
	A. Collaborates with clients and families regarding goals					
	B. Demonstrates ability to select relevant goals and explain rationale/s in respect to the disorder areas					

	C. Writes goals with all components:					
	Average:					
10	Completes administrative and reporting functions necessary to support evaluation (CFCC V-B, 1f)	5	4	3	2	1
	A. Timely contact with family for initial client session					
	B. Chart documentation/consents are completed all required signatures and dates within the expected time frame					
11	Refers clients/patients for appropriate services (CFCC V-B, 1g)	5	4	3	2	1
	A. Referral to other disciplines (PT, OT, Early On, Specialty Physician, Neuropsychology, support groups etc.) if appropriate					
	Average:					

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

Speech/Sound Production Fluency Voice Language Hearing Swallowing
Cognition Social Aspects Communication Modalities

1	Develops setting-appropriate intervention plans with measurable and achievable goals that meets client/patient needs, demonstrating knowledge of the principles of intervention and including consideration of anatomical/physiological, developmental, and linguistic cultural correlates. Collaborates with client/patients and relevant others in the planning process (CFCC IV-D, V-B, 2a)	5	4	3	2	1
	A. Clearly explains results of evaluation to clients and family					
	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					
	Average:					
2	Implements treatment plans that involve clients/patients and relevant others in the intervention process (CFCC V-B, 2b)	5	4	3	2	1
	A. Writes lesson plans including behavioral objectives, hierarchies and procedures which will efficiently achieve semester goals					
	B. Includes all related materials (word lists, reading passages, home program, stimuli, PowerPoints, completed data sheets with the weeks calculations and new data sheets for upcoming session) with lesson plan submission.					
	C. Develops concise and accurate data collection tools					
	Average:					
3	Selects or develops and uses appropriate materials and instrumentation (CFCC V-B, 2c)	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					
	C. Has **all** required materials for evaluation and treatment to execute effective diagnostic and treatment sessions (digital recorder, mirror, paper, clipboard, data sheets, etc.)					
	Average:					
4	Measures and evaluates clients'/patients' performance and progress (CFCC V-B, 2d)	5	4	3	2	1
	A. Maintains accurate, concise SOAP notes					
	B. Graphs clearly illustrates baseline, objectives, the long-term, cuing levels and correspond to all schedules therapy sessions					
	C. Maintains accurate and timely EMR documentation					
	Average:					

5	Modifies intervention plans, strategies, materials, or instrumentation to meet individual client/patient needs (CFCC V-B, 2e)	5	4	3	2	1
	A. Demonstrates ability to select materials and activities appropriate to clients current level of functioning					
	B. Planning, implementation, and adaption of treatment sessions are client centered					
	Average:					
6	Completes administrative and reporting functions necessary to support intervention (CFCC V-B, 2f)	5	4	3	2	1
	A. Follows designated time frames to submit **ALL** clinical paperwork including first drafts and revisions					
	B. Proactive initiation with scheduling of client/family meetings when needed/required (home evaluations, final conferences, school visits, IEP attendance etc.)					
	C. Follows appropriate office procedures for filing, logging, phone calls, etc.					
	D. Compliance with HIPPA regulations (consents for outside collaboration, use initials on all clinical paperwork, adheres to guidelines of CE regarding email platform to use when contacting the family etc.)					
	Average:					
7	Identifies and refers patients for services as appropriate (CFCC V-B, 2g)	5	4	3	2	1
	A. Writes appropriate and specific **Recommendations** in the *Progress Report*					
	B. Establishes home assignments that are appropriate to client's level of functioning submitted prior to the intended session					
	Average:					

ADDITIONAL CLINICAL SKILLS

1	Sequences tasks to meet objectives	5	4	3	2	1
	A. Organizes and sequences activities in therapy session to maximize responses, attention, and cooperation.					
	B. Establishes time frames for therapy for therapy activities appropriate to client's level of functioning.					
	C. Write appropriate hierarchies and includes levels of cuing if appropriate for each semester goal.					
	D. Transitions between tasks are evident and "smooth"					
	Average:					
2	Provides appropriate introduction/explanation of tasks	5	4	3	2	1
	A. Uses vocabulary and language appropriate to client's level of comprehension					
	B. Clearly explains objectives and desired responses at client's level of comprehension					
	C. Appropriate rate of speech and conciseness of direction					
	Average:					
3	Uses appropriate models, prompts, or cues. Allows time for patient response.	5	4	3	2	1
	A. Uses appropriate modeling or cueing to elicit desired response					
	B. Provides appropriate reinforcement and target-specific feedback					
	C. Provides successful experiences to exceed failure experiences					
	D. Allows appropriate time for patient response					
	Average:					
4	Demonstrates effective behavior management skills					
	A. Clearly defines for client acceptable behaviors and consequences for inappropriate behavior					
	B. Maintains control of therapy situation in a firm, gentle manner					
	C. Is consistent in use of behavior management techniques					
	D. Reinforces desired behavior with appropriate timing and reinforcer					

	E. Deals appropriately with client's frustration, grief, anger etc.					
	Average:					
5	Practices diversity, equity and inclusion (CAA 3.4B)					
	A. Considers culture, disabilities, gender and race, age, disabilities, ethnicity, gender expression, gender identity, national origin, race, religion, sex, sexual orientation, and/or veterans' status in the treatment planning process status (i.e. stimulus pictures, books, vocabulary, etc.)					
	B. Considers client functional needs based on age, culture, disability, when developing treatment goals and session tasks					
	Average:					
6	Addresses culture and language in service delivery that includes cultural humility, cultural responsiveness, and cultural competence (CAA 3.4 B)					
	A. Materials are representative of client's cultures, disabilities, gender, race, age, disabilities, ethnicity, gender expression, gender identity, national origin, race, religion, sex, sexual orientation, and/or veterans' status (i.e. stimulus pictures, books, vocabulary, etc.)					
	Average:					
7	Demonstrates clinical education and supervisor skills. Demonstrates a basic understanding of and receives exposure to the supervision process. (CAA 3.1 6B)					
	A. Completes a CALIPSO rating reflecting clinician performance					
	B. Demonstrates basic knowledge of the role of clinician teaching, clinical modeling and supervision of other student/s (various supervision tools, rubrics and frameworks that represent supervisory content and theory).					
	Average:					

PREPAREDNESS, INTERACTION AND PERSONAL QUALITIES:

1	Demonstrates knowledge of basic human communication and swallowing processes. Demonstrates the ability to integrate information pertaining to normal and abnormal human development across the life span (CFCC IV-B, CAA 3.1.6B)	5	4	3	2	1
	A. Assessment of the quality and effectiveness of multi-modal communication strategies used with client's friends and family.					
	B. Considers the quality of communication with friends/ family etc.					
	Average:					
2	Demonstrates knowledge and processes used in research and integrates research principles into evidence-based clinical practice (CFCC IV-F:CAA 3.1.1B Evidence-Based Practice)	5	4	3	2	1
	A. Shows initiative and provides evidence of outside reading related to client's disorder.					
	B. Continues evidence-based research throughout the semester/adjusts clinical approaches as warranted.					
	Average:					
3	Demonstrates knowledge of contemporary professional issues that affect Speech-Language Pathology (CFCC IV-G; CAA 3.1.1B)	5	4	3	2	1
	A. Collaborates with other professionals regarding client treatment (school, IEP/Met attendance home, nursing home, group home etc.) if warranted					
	B. Completes research on a professional issue in the field					
	Average:					
4	Demonstrates knowledge of entry level and advanced certifications, licensure, and other relevant professional credentials, as well as local, state and national regulations and policies relevant to professional practice (CFCC IV-H)	5	4	3	2	1
	A. Graduate clinicians/interns are appropriately identified during the treatment process					

	B. Reflect on emerging clinical skills as it pertains to the clinical experience/knowledge/professional behaviors from graduate level instruction to entry Clinical Fellowship Year (CFY) and beyond.					
	Average:					
5	Communicates effectively, recognizing the needs, values, preferred mode of communication, and cultural/linguistic background of the individual(s) receiving services, family, caregivers, and relevant others (CFCC V-B, 3a; CAA 3.1. 1B Effective Communication Skills, CAA 3.1.6 B)	5	4	3	2	1
	A. Communicates effectively with the client					
	B. Maintains open, efficient lines of communication with the client's family					
	C. Demonstrates ability to assimilate client's ore supervisor's point of view and constructive feedback.					
	Average:					
6	Provides counseling regarding communication and swallowing disorders to clients/patients, family, caregivers, and relevant others (CFCC V-B; 3c: CAA 3.16B)	5	4	3	2	1
	A. Consistently delivers concrete and constructive feedback after session to the family when appropriate					
	B. Provides empathy and support to client/family during treatment sessions and/or family/client meetings or contact					
	Average:					
7	Manages the care of individuals receiving services to ensure an interprofessional, team-based collaborative practice (CFCC V-B, 3b; CAA 3.1.1B)	5	4	3	2	1
	A. Works effectively with other clinicians when client is involved in group sessions					
	B. Actively contributes to positive group functioning					
	C. Initiates and/or maintains communication with other professionals working with the client (classroom teacher, SLP, OT, audiology other SLP's)					
8	Demonstrates skills in oral and other forms of communication sufficient for entry into professional practice (CFCC V-A)	5	4	3	2	1
	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					
	B. Effective integration of graphs when discussing baselines, procedures, and outcome					
	C. Professional disposition during any family meeting reflects verbal organization of information presentation, professional vocabulary, eye contact and positive language					
	D. Demonstrates ability to communicate in an articulate, grammatical fashion in oral communication					
	E. Language speech rate and voice volume is always appropriate in the clinical setting (i.e., fillers/glottal fry, lisp, "like", "these ones", "did good" "perfect" "awesome" "that was wrong")					
	Average:					
9	Demonstrates skills in written communication sufficient for entry into professional practice (CFCC V-A)	5	4	3	2	1
	A. Writes concise and accurate information in the **ASSESSMENT TAB** (updated skills via Progress Tracker, client attendance, home involvement, behavior observations)					
	B. Writes a concise and accurate information in the **TREATMENT PLAN** section (status of long-term goal achievement)					

	C. Write a concise and accurate **PROCEDURES AND MATERIALS** (techniques, and materials used)					
	D. **FAMILY/STAFF APPROACH** (prognosis, home programs if family support needed)					
	E. State logical and relevant **RECOMMENDATIONS** for future (possible goals, outside resources, referrals if applicable, includes all signatures and dates.					
	F. Uses professional vocabulary in **PROGRESS REPORT** with accurate verb tense, sentence structure, spelling etc.					
	G. Timely completion of the *Progress Report* in Treatwrite					
	Average:					
10	Demonstrates knowledge of standards of ethical conduct, behaves professionally and protects the welfare (CFCC IV-E, V-B, 3d; CAA 3.1.1B-Accountability; 3.8B)	5	4	3	2	1
	A. Initiates and maintains contact with supervisor					
	B. Attends, is prepared for and participates in class meetings					
	C. Makes appropriate contacts to ensure the welfare of clients and families (Social Services, nursing facility, family/client counseling etc.)					
	Average:					
11	Demonstrates understanding of the effects of own actions and makes appropriate changes as needed (CAA 3.1B - Accountability)	5	4	3	2	1
	A. Demonstrates insight into negative consequences of own behavior and does not blame others or external factors for failures and/or difficulties					
	B. Seeks own solutions for problems					
	Average:					
12	Demonstrates professionalism (CAA 3.1.1B: Professional Duty, 3.1.6B)	5	4	3	2	1
	A. Dress attire and personal appearance is appropriate for daily responsibilities in the clinic					
	B. Prompt follow-through with CE requests					
	C. Writes self-evaluations/recorded observations/observations of other clinicians that reflect careful analysis of clinician behavior during therapy sessions					
	Average:					

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

MIDTERM	Total Pts. Achieved		/	Total # of Items	Score
A. Evaluation Skills					
B. Treatment Skills					
C.Additional Clinical Skills					
E. Preparedness, Interaction, and Personal Qualities					
Midterm Grade	<B-	B-	B+	A-	A

STRENGTHS:

WEAKNESSES

PLAN TO IMPROVE WEAKNESSES

FINAL	Total Pts. Achieved		/	Total # of Items	Score
A. Evaluation Skills					
B. Treatment Skills					
C.Additional Clinical Skills					
D. Professional Practice, Interaction and Personal Qualities					
Final Grade	<B-	B-	B+	A-	A

Comments:_____
_____
_____
_____

CLIENT CONTACT LOG

NAME		FILE NUMBER	
PARENT/GUARDIAN		HOME PHONE	
ADDRESS		CELL PHONE	
		BILLING STATUS	

DATE	CONTACT	INITIALS
	New File.	HL

F-15 Evaluation/Re-evaluation Cheat Sheet

TREATWRITE CHEAT SHEET for EVALUATION/RE- EVALUATION

To add your report as a **Re-evaluation**:
Find client name
Follow boxes to the right of client's name
Click on **Documents**
Click on **Add Report**
Click on **Re-evaluation**

A. **Patient Data tab** -complete patient data information

*Medical, educational, hobbies, interests, IEP, client/family comments

*ICD-10 codes and CPT codes

*History window- include information about medical hx, semesters received services at EMU, past speech tx in school or hospital

Begin this paragraph with: "client name, a ____ year, _____month old male/female is being seen at Eastern Michigan University Speech and Hearing Clinic via telepractice due to the COVID-19 pandemic." Include educational setting, IEP category and current services, if applicable. Include information re: family, where the client resides, prior treatment and medical history and work history if applicable.

*Medical Test Results window- include if provided

B.**Speech Services tab**

* Referral date

*Previous Service date

* Referral Source

C**. Assessment tab** (includes 6 windows)

*Tests Administered window-check off test given, then "add"*Clinical Progress Tracker window- rate numerical severity, in "comments"
add baseline data only after you determine the long-term goals

*Summary window: your findings from "O" of your SOAP and impressions from "A" of your SOAP

Summarize diagnosis and relative severity of current impairments. Begin this statement with: client's name presents with a mild receptive and moderate expressive language delay/disorder….characterized by……..(see handbook for examples).
*Speech and Language Diagnosis window -state the dx (could be more than one)

* Prognosis window -state your prognosis

This must include prognosis of further speech/language development or improvement of skills. For example, "Based on the progress or (lack of progress) noted during the previous semester the prognosis for further speech language development or improvement skills is (excellent, good, fair, guarded or poor). The prognosis statement should also include other factors such as health, age, attitude of client, family involvement, services received elsewhere, etc. (present tense).

* Limitations window- examples: mobility, cognitive functioning, aspiration precautions, dysphagia, etc. If there is not any put in n/a

F-15 Evaluation/Re-evaluation Cheat Sheet

D. **Tx Plan Data tab**
* Outcome Goals window- we don't use

* Long Term Goals window- add semester goals (can copy and paste)
The following goals have been established for (client name) this semester. Include all components of a goal (rationale, "to do" statement condition and criteria).
* Short Term Goals window-we don't use

* Procedures/Materials window-add anticipated procedures and materials

* Fill in for Tx Frequency, Tx Session Length, and Service Duration

E: Recommendation tab- add appropriate information

*Recommendation box can be N/A or name specific type of tx

*Add research citations of reading you have done related to client dx or tx

*Referring Physician box- type "Graduate Student Clinician"

*CE will add her information and dates

TREATWRITE CHEAT SHEET FOR PROGRESS NOTE

*****You MUST have a finalized Evaluation for the client in order to generate a Progress Note**

To add your report as a **Progress Note**:

Open your evaluation
Find client name (in upper left)
Follow boxes to the right of client's name
Click on **Documents**
Click on **Add Report**
Click on **Progress**

Patient data tab: No need to update unless client had a procedure/medical test during semester

Speech Services tab: Fill in total number of times seen, then below that, total number of times possible in semester

Assessment tab:

Click on **Progress Tracker**- fill in rating number, add comment
Click on **Progress**- fill in attendance and hours seen, add post tx impression

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. Writer a summary of incidents and describe behaviors. Be factual and concise. (PAST TENSE)

Treatment Plan tab:

Click on **Long Term Goals**- update progress as of current

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

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

Click on **Procedures/Materials**- explain your procedures used during semester and the materials you used

Write a paragraph about the techniques you used to teach the skills to your client. The first sentence in the paragraph should read: The following techniques were utilized in treatment: (then list the

F-16 TW Cheat Sheet Progress Note

techniques). Then, provide a general summary describing how these techniques were used in the treatment sessions. (PAST TENSE)

Write a second paragraph about the materials you used and the reinforcement strategies/schedule. Describe their effectiveness. The materials can be communicated via list form. Then, the effectiveness of these materials can be summarized in a short paragraph. (PAST TENSE)

Click on **Family/Staff Approach-** add prognosis, if home program was provided, family or caregiver assist needed to complete tasks for tx or home programming

The final paragraph of this section must include a statement of prognosis for further speech and language development of 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)

Recommendation tab: *(PRESENT TENSE)*

Add recommended minutes and times per week/should they return to therapy
Add recommendations for future testing and rationales
Add recommendations for tx areas or specific programs or apps
Be specific about the recommendations
Give suggestions for maintenance and carryover to teachers, parents and/or clients
Make referrals as needed to medical personnel or other professionals if appropriate
Include any further research citations that you have done since midterms

Referring Physician area: add ***Graduate Student Clinician***
Student's Name area: add your name
Date area: add date last seen (<u>this would be the family conference day)</u>

GUIDELINES FOR DESCRIBING THE SEVERITY OF DISORDERS

Taken from the Clinical Evaluation of Language Fundamentals – 4 (CELF – 5)

(Semel. Wiig, Secord 2003)

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

GENERAL SOAP NOTE GUIDELINES

Throughout the entire SOAP note:

- Complete sentences are not necessary
- Use medical abbreviations as much as possible
- "short and sweet" is the key for the note
- Can use charts especially for testing of articulation and subtests of diagnostic materials
- Don't be hesitant to look back at other SOAP notes for examples
- Don't worry if you get notes back to revise Writing these notes is and art that has to be learned via trial and error
- Tests are initially spelled out for the first reference, but initials are used thereafter for every SOAP note of the semester
- The PERFORMANCE CHARTING REMINDERS are necessary for interpreting your results for the SOAP notes if standard scores, developmental norms, or criterion references are not applicable to the specific data
- 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 information

Information related to each SOAP note division:

- S (Subjective)
    - Short and sweet
    - Information you need to include client feelings (illness), late/on time and the number of minutes late if their session was "cut short" because of tardiness
    - 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 information that you obtain outside the therapy room and/or on the phone.
    - NO COMPLETE SENTENCES NEEDED
- O (Objective)
    - This is for data (percentages, number correct, Standard scores, Scaled Scores) only
    - No interpretation of data is included in this section
    - It is about the data that you have gathered via formal or informal measures
    - The section includes the scores of the test and the mean ranges. Please include the mean ranges as follows:
        - (Mean (M) =100, Standard Deviation (SD=/- 15)
        - After you have included the M and SD for the first set of interpretations of the data you can simply use the acronym M or SD or SS (scaled score).
- A (Assessment)
    - This part of the note is analyzing the data/numbers for the O section
    - This is the part of the SOAP that SLP's are hired to do. Interpret the results. What does this data mean? Severity ranges? Specific delays and/or disorders etc.

- Many times, other professionals simply look at this section of the note for client information.
- This includes severity ranges based on:
  - Informal observations
    - Use the CHARTING REMINDERS/PERFORANCE LEVELS for severity ranges
  - Standardized Tests
    - Some tests have their own descriptive words i.e., CAAP, TACL, Bracken based on the SS. Check the test manual to see if the authors of the tests have determined their own descriptive terms. Usually, can find this information in the "*Interpretation of Results"* type of heading in the Table of Contents.
    - If the test does not have their own descriptive words use the descriptive words from the CELF=5 (form F-17).
  - NO COMPLETE SENTENCES NEEDED

- P (Plan)
  - Briefly list what your client will be doing the next session. Refer to example SOAP notes for the format of this section.

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A.) DIAGNOSTIC SOAP NOTE FORMAT

SOAP note

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

S: POSSIBLE STATMENTS

- Arrived on time and willingly went into the Tx room. I told him that next time duct tape
- 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**:** FORMAL EVALUATION DOCUMENTATION

.

This should be written in an impression format so you can just "cut and paste" the impression statement when your treatment plan is due. Here is an example of an impression statement: REMEMBER THE FOLLOWING (**in this example** the following impression statement does not correspond with the above information.

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-4 descriptive words outlined in your clinic handbook appendix. 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.

Receptive language skills are average based on formal testing and informal observations with expressive language abilities that are below age expectations with skills that range from 13-22 months based on results from the Westby Symbolic Play Scale Checklist. EV's current expressive vocabulary consists of 30-40 word approximations. This significant receptive and expressive language gap suggests presence of moderate-severe verbal apraxia characterized by limited syllable shape combinations including CV, CVC and CVCV.

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 old 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 months 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. Mild to moderate short-term and long-term memory deficits are also noted. Writing is WFL with the exception of consistent writing errors.

SOAP Note Examples 528 and 538

528 PHASE 1 (Before Midterm)

S: Arrived on time and prepared to begin the session. Client mentioned he was feeling tired today.

O: Intelligibly produced one sentence tongue twisters 73% (16/22) min (13%) cuing. (obj. 100% no cuing)

Produced /r/ in all positions of words within a paragraph 85% (53/62) min (5%) cuing. (obj. 80% min cuing).

Produced /s/ in all positions of words within sentences 67% (14/21) min-mod (36%) verbal cuing. (obj. 80% mod cuing).

A: Intelligible production of one sentence tongue twisters obj. not met. Mild imp. Cont. obj.

Production of /r/ in all positions of words within paragraphs obj. met. No imp, new obj

Production of /s/ in all positions of words within sentence obj. partially met. Cont. obj.

P:

Cont. obj:

One sentence tongue twisters with 100% no cuing.

/s/ in all positions/words in sentences with 80% mod cuing.

New obj.

/r/ in all positions/ words in structured conversation 80% min cuing.

F-18b SOAP Content Change throughout the semester

528 PHASE 2 (After Midterm)

S: Arrived on time and prepared to begin the session. Client mentioned he was feeling tired today.

O: Intelligibly produced one sentence tongue twisters 73% (16/22) min (13%) cuing

Produced /r/ in all positions of words within a paragraph 85% (53/62) min (5%) cuing

Produced /s/ in all positions of words within sentences 67% (14/21) min-mod verbal (36%) cuing

A: Intelligible production of one sentence tongue twisters obj. not met. Mild imp.

Production of /r/ in all positions of words within paragraphs obj. met. No imp.

Production of /s/ in all positions of words within sentence obj. partially met. Mod imp

P: Continue tongue twisters and /s/
Begin /r/ in all positions/ words in structured conversation

538 PHASE1 (Before Midterm)

F-18b SOAP Content Change throughout the semester

S: **3 Different Examples Provided**

Arrived on time and prepared to begin the session. Client mentioned he was feeling tired today.

Logged into the Zoom session on time with the help of his significant other. AB appeared in good spirits.

Logged onto telepractice on time. He reported using the rephrasing memory strategy successfully over the weekend.

O: **3 Different Examples Provided**

Produced functional 3 syllable words 10/13 (77%) min (20%) phonemic cueing

Described pictures using RET by producing 4 “wh” questions and 1 functor word 3/4 (75%) min to mod (33%) verbal and visual cueing

Utilized MIT in the production of 4 syllable sentences given visual stimulus and model by clinician with 78% (average 2.3/3) mild (15%) verbal cues.

A: **3 Different Examples Provided**

Produced 3–4-word responses to questions, obj. not met, mod. imp.

Met journal obj., goal met, WFL

Utilized abdominal breathing to produce accented fricatives, obj. not met, mild imp.

P: **3 Different Examples Provided**

Continue

Continue; begin new objective for 2-word phrases

Journal goal met and discontinued

PHASE 2 Weekly (After Midterm)

F-18b SOAP Content Change throughout the semester

S: **3 Different Examples Provided**

3/30 and 4/1 AC logged into the Zoom session with the help of his significant other. Client was motivated throughout the sessions and breaks were used to minimize frustration. On 3/30 client reported he was tired.

Sessions provided via telepractice 3/22 and 3/24/21. Client arrived on time for both sessions and was reading to begin therapy. Wife present for 1st session this week but not the second. Over the weekend his wife reported the client did feel some side effects from his vaccine.

Sessions provide 3/23 and 3/25/21. Client independently logged onto his Zoom session. Graphs illustrating performance were shown on 3/23.

O: **4 Different Examples Provided**

Repeated 2 syllable words provided by his clinician 80%, min cueing

Pain scale was administered, and the client reported that he was in no pain

Recalled 2 details from a short semi-structured conversation 100% min-mod cueing

Described pictures using RET by producing 4 wh questions and 1 functor word 75% max cueing

A: **6 Different Examples Provided**

Sentence repetition not met, sev. imp.

SFA chart, not met, mod imp.

Recall obj. met, no imp.

Produced functional nouns, mild imp.

Described pictures using RET, mod. imp.

AD breathing, mild imp

P: 6 Different Examples Provided

Continue

Continue, begin new objective for 2 word phrases

Begin assessment next week

Continue re-eval at goal level

FC 4/8

Assigned CART home program for noun pictures utilized this week

F-18c SOAP Re-evaluation at end of the semester

WHEN YOU BEGIN YOUR RE-EVALUATION SESSIONS

S: No changes

	1st SOAP	2nd SOAP	3rd SOAP
O:	Began Re-evaluation (goal-) vs. (obj) after tasks	Continued Re-evaluation	Completed Re-evaluation

A: Report if the goal was met, not met or partially met

P: Cont. re-eval | Complete re-eval | Conduct Family Conference

FAMILY CONFERENCE SOAP NOTE FORMAT

SOAP note

Client: (Use initials) Clinical Educator: (*Mrs. First, last and credentials*)
Date: Clinician: *(include your credentials*)

S: _____attended the Clinician/Client/Family Conferences

O: Discussed semester goals, procedures, outcomes, prognosis, recommendations and homework.

Results of therapy: #/# goals met: #/# goals not met: #/# goals surpassed

A: _____agreed with the recommendations. (or added……..)

P: State recommendations (as in the Treatment Outcome) with other information such as Return in Fall, Winter, Summer (year) or Discharge recommendations.

LESSON PLAN FORMAT FOR GET-TO-KNOW-YOU SESSION
******** Use client initials only

1.) Remember to include your interview questions, PowerPoint presentations and applicable links in the lesson plan with this document submitted VIA canvas
2.) Include the purpose of task
3.) Make sure to include the date REFLECTIVE OF THE ANTICIPATED SESSION and your name at the top of the lesson plan.
4.) This is an example of one session. You are expected to have planned more than one task (depending on the needs of your client).

PURPOSE	**PROCEDURES**	**MATERIALS**	**ANTICIPATED TIME FRAME FOR EACH TASK**
Examples: Put client at ease (bring pictures of yourself, show family pets) IceBreaker Interview client Interview mom Begin language sample Life participation	Examples: Life Participation (what informal testing tool will be used) Language Sample (MLU, TTR, Intelligibility) Ice Breaker (game, book, sharing pictures, pets)	Examples: Website links https://wow.boomlearning.com/deck/flip-floppin-speech-2YMntRMHTQNSK7zik Interview questions Review telepractice lists on shared drive	15 minutes

SEMESTER LESSON PLAN

Clinician: Clinical Educator:
Client: Date of the session/s:

Assessment Baseline **OR** Previous Session Performance	Long-term Goal	Objective with hier. Steps (easier to harder)	Procedure	Materials	Homework
******* Please remember to include all of your materials with your lesson plan. That includes word lists, Power Points, websites etc……and you data sheet/s for the week.					

Clinician Critical Reflection Form

Clinician: Client: Date:

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?

F-20 Clinician Critical Reflection Form

(questions adapted from Pultarak, E.G., 1993)

GOAL CARD

CLINICIAN _____CLIENT _____

SUPERVISOR _____

_____

SEMESTER GOALS

PROCEDURES, ACCURACY LEVELS AND MATERIALS

F-21 Goal Card form

PLAN OF ASSESSMENT 528/LESSON PLAN FOR DX SESSION

Primary_____
Date:_____
Client Initials:_____

PARENT/CLIENT INTERVIEW Day_____Date_____Time frame_____
Procedure: (must include the set of questions in your Plan of Assessment paperwork submission)

RECEPTIVE LANGUAGE Day_____ Date_____-Time frame_____
INFORMAL ASSESSMENTS
(i.e., auditory and reading comprehension, phonological awareness, pre-literacy skills etc.)

Procedure:_____
_____
List and attach forms to be used:_____
_____
_____
Rationale for modality being tested, the procedure, and forms used:
_____
_____
Attach developmental norms to be referenced for diagnostic interpretation (if applicable):
_____
_____
FORMAL ASSESSMENTS
Tests that used:_____

Subtests that will be used:_____

Rationale for the tests being used:_____

EXPRESSIVE LANGUAGE. Day_____ Date_____Time frame_____
INFORMAL ASSESSMENTS
(i.e., Browns stages, semantic relations, MLU, TTR, Sentence Structure and Types, rate of speech, intelligibility, narratives, pragmatics etc.)

Procedure:_____
_____
List and attach forms to be used:_____
_____
_____
Rationale for modality being tested, the procedure, and forms used:
_____
_____
Attach developmental norms to be referenced for diagnostic interpretation (if applicable):

FORMAL ASSESSMENTS:

Tests that will be used:_____

Subtests that will be used:_____

Rationale as to the tests being used: _____

ORAL MOTOR Day_____ Date_____Time frame_____

INFORMAL ASSESSMENTS

(i.e., evaluation of STRUCTURE and FUNCTION)

Procedure:_____

_____

List and attach forms to be used:_____

_____

_____

Rationale for modality being tested, the procedure, and forms used:

_____

_____

FORMAL ASSESSMENTS

Tests being used:_____

Subtest being used:_____

Rationale for test being used:_____

MOTOR SPEECH Day_____ Date_____Time frame_____

(i.e., vowel, percentage of consonants correct, syllable shapes)

INFORMAL ASSESSMENTS

Procedure:_____

_____

List and attach forms to be used:_____

_____

_____

Rationale for modality being tested, the procedure, and forms used:

_____

_____

FORMAL ASSESSMENTS

Tests being used:_____

Subtest being used:_____

Rationale for test being used:_____

ARTICULATION Day_____ Date_____Time frame_____

(possible online resources: mommyspeechtherapy.com, littlebeespeech.com apple store)

INFORMAL ASSESSMENTS

Procedure:_____

_____

List and attach forms to be used:_____
_____
_____
Rationale for modality being tested, the procedure, and forms used:
_____
_____
FORMAL ASSESSMENTS

Tests being used:_____

Subtest being used:_____

Rationale for test being used:_____

VOICE (Hegde Chap 11) Day_____ Date_____Time frame_____
(i.e., rate, pitch, prosody, loudness)
I
INFORMAL ASSESSMENTS
Procedure:_____
_____
List and attach forms to be used:_____
_____
_____
Rationale for modality being tested, the procedure, and forms used:
_____
_____

FLUENCY (Hegde Chap 10) Day_____ Date_____Time frame_____
(i.e., Repetitions, Prolongations, Interjections, Revisions, Associated Motor Behaviors)

INFORMAL ASSESSMENTS
Procedure:_____
_____
List and attach forms to be used:_____
_____
_____
Rationale for modality being tested, the procedure, and forms used:
_____
_____
FORMAL ASSESSMENTS

Tests being used:_____

Subtest being used:_____

Rationale for test being used:_____

BEHAVIOR Day_____ Date_____Time frame_____
(i.e., attention, distractibility, cooperation)

Procedure:_____
_____
List and attach forms to be used:_____
_____
_____

Rationale for modality being tested, the procedure, and forms used:
_____
_____

BASELINE ANY GOALS YOU ARE THINKING OF CONTINUING GOALS FROM PREVIOUS SEMESTERS
Day_____ Date_____Time frame_____

Procedure:_____
_____
List and attach forms to be used:_____
_____
_____
Rationale for modality being tested, the procedure, and forms used:
_____

PROTOCOLS THAT MAY BE HELPFUL IN THE HEGDE BOOK

Language

- ” Common Protocol 5: Speech-Language Sample Transcription Protocol Page: 38-41
- ” Common Protocol 6: Language Sample Analysis Protocol: Syntactic, Morphologic and Pragmatic Skills.
- ” Language Assessment Protocol 4: Task-Specific Assessment and Protocol for Grammatic Morphemes Page 285-288
- ” Language Assessment Protocol 5: Task-Specific Assessment Protocol for Conversation Skills

Oral motor examination:

- ” Common Protocol 3: Orofacial Examination and Hearing Screening Protocol
- ” Common Protocol 4: Diadochokinetic Assessment Protocol

Articulation

- Speech Sound Assessment Protocol 6: Speech Sound Stimulability Assessment Protocol. (vowel assessment).
- ” Speech Sound Assessment Protocol 7: Childhood Apraxia of Speech Assessment Protocol 2
- ” Speech Sound Protocol 2: Phonetic Inventory Analysis Protocol Page 189
- ” Speech Sound Protocol 3: Manner-Place-Voicing Protocol Page 190
- ” Speech Sound Protocol 4: Consonant Clusters Inventory Protocol Page 191-193
- ” Speech Sound Protocol 6: Speech Sound Stimulability Assessment Protocol Page 196-203

PLAN OF ASSESSMENT 538/Lesson Plan for DX sessions

Primary_____

Date:_____

Client initials:_____

***If you are assessing a client with a DX other than aphasia/stroke, please contact your CE for required format for your client

INTERVIEW/CASE HISTORY Day_____Date_____Time_____ Procedure: Must include at least 10 questions, ask about pain, swallowing and hearing status Attach Forms to be used_____ Rationale for your choice in /procedure and forms_____

_____

LIFE PARTICIPATION Day_____Date_____Time

Procedure:_____
_____ Attach Forms to be used_____

_____ Rationale for your choice in procedure and forms_____

_____

ORAL MOTOR SKILLS Day_____Date_____Time_____

Procedure_____
_____

Attach Forms to be used_____

_____

_____

Rationale for your choice in procedure and forms_____

_____

_____

QUICK APHASIA BATTERY (QAB) Day_____Date_____Time_____

Procedure: Form 1, 2 or 3 – assesses LOC, connected speech, AC word and sentence comprehension, naming, repetition, oral reading and motor speech

Forms to be used_____

_____

_____

Rationale for your choice in procedure and forms_____

_____

_____ **MOTOR SPEECH**

-If further assessment is needed

ARTICULATION Day_____Date_____Time_____

Procedure_____ Forms to be used_____

_____

Rationale for your choice in procedure and forms_____

_____

INTELLIGIBILITY Day_____Date_____Time_____

Procedure_____ Forms to be used_____

_____ Rationale for your choice in procedure and forms_____

_____ **BEHAVIOR**

Day_____Date_____Time_____

Procedure_____
_____

Forms to be used_____ Rationale for your choice in procedure and forms_____

_____ **COGNITION**

Day_____Date_____Time_____

Procedure-SLUMs may be warranted
_____
_____

Forms to be used_____

_____

Rationale for your choice in procedure and forms_____

_____

VOICE Day_____Date_____Time_____

Procedure_____
_____

Forms to be used_____

_____ Rationale for your choice in procedure and forms_____

_____ **FLUENCY**

Day_____Date_____Time_____

Procedure_____
_____

Forms to be used_____

_____

Rationale for your choice in procedure and forms_____

_____ **BASELINE ANY GOALS YOU**

ARE THINKING OF CONTINUING

Procedure_____
_____

Forms to be used_____

_____

Rationale for your choice in procedure and forms_____

_____ **ANY ADDITIONAL**

ASSESSMENTS NEEDED-further assess reading comprehension, writing, etc.

F-24 ICD and CPT Medical Codes

WHAT YOU NEED TO KNOW ABOUT ICD-10 AND CPT CODES

CPT codes report medical procedures and services such as diagnostic, laboratory, radiology, and surgical. It describes the medical services and procedures done by the physician. It aims at providing a uniform language to describe the treatment and diagnostic procedures performed to aid in the communication between doctors, patients, and insurance companies. CPT codes are maintained by the *American Medical Association* (updated annually and effective Jan 1st of the new year).

ICD-10 codes identify a diagnosis and describe a disease or medical condition. After diagnosing what is wrong with the patient, a physician will assign a diagnostic code which can be found in the ICD 10-book. It describes a medical indent condition or disease that is being treated so that all parties involved; doctor, patient, an insurer will understand better the disease which is being treated. You can have more than one ICD-10 code for a client. ICD codes are maintained by the *World Health Organization (*updated annually and effective October).

CPT

- 96105 Aphasia Testing
- 92507 Speech Treatment-ind.
- 92508 Speech Treatment-group
- 92521 Evaluation of Fluency (e.g. stuttering, cluttering)
- 92522 Evaluation of Speech Sound Production
- 92523 Evaluation of Speech Sound Production with evaluation of Language
- 96154 Early Intervention
- 97112 Development Cognitive Skills
- 92524 Behavioral and qualitative of voice and resonance
- 92526 Swallow Treatment and/or oral function feeding
- 92610 Evaluation of oral and pharyngeal swallow function

ICD-10

- F80 Specific developmental disorder of speech and language
- F80:0 Phonological Disorder
- F80:1 Expressive Language Disorder
- F80:2 Mixed receptive/language Disorder
- F80:4 Speech and Language developmental delay due to a Hearing Loss
- F80:81 Childhood onset fluency disorder
- F80:82 Social Pragmatic Communication Disorder
- F80:82 Other Developmental disorder of Speech and Language
- F82 Specific Developmental disorder of Motor Function

CLINICAL HOUR LOG SHEET

SSP= Speech Sound Production RE=Receptive and Expressive Language F=Fluency D=Dysphagia CM=Communication Modalities. SA=Social Aspects of Communication H=Hearing V=Voice

FACE TO FACE HOURS

Date	Disorder(s) areas	Dx or Tx	Age AND client initials	Hours
			Midterm Total:	

Date	Disorder(s)	Treatment	Age	Hours
			Midterm Total:	
			Finals Total:	

CLINICAL LOG SHEET

SIMULATION HOURS				
Date	**Disorder(s)**	**Competency Topic**	**Age**	**Hours**
				1
			Midterm Total:	
			Finals Total:	
			Total Hours:	

CLINICAL LOG SHEET

TELEPRACTICE HOURS				
Date	**Disorder(s)**	**DX/Tx**	**Age AND client nitials**	**Hours**
			Midterm Total:	
			Finals Total:	
			Total Hours:	

CLINICAL LOG SHEET

F-25 Clinical Hour Log

SIMUCASE HOURS				
Date	**Disorder(s)**	**DX/Tx**	**Age and initials**	**Hours/Minutes**
			Midterm Total:	
			Finals Total:	
				Total Hours:

Eastern Michigan University **F-26** Semester Log Of Clinical Practicum Clock Hours

Department of Special Education/Speech and Language Pathology Program

Name: Supervisors Name:

Student Number:_____ Supervisors ASHA Number:

Date of practicum: Practicum Site: EMU Speech and Hearing Clinic

Notes: Record only hours supervised by an ASHA certified person who holds the Certificate of Clinical Competence

Evaluation **Treatment**

Type of Assessment	**Child 0-17**			**Adult 18-65+**			**Type of Assessment**	**Child 0-17**			**Adult 18-65+**		
	F	**V**	**S**	**F**	**V**	**S**		**F**	**V**	**S**	**F**	**V**	**S**
Articulation/Speech Sound Production							Articulation/Speech Sound Production						
Fluency							Fluency						
Voice and Resonance							Voice and Resonance						
Recep./Expr. Language							Recep./Expr. language						
Hearing							Hearing						
Swallowing/ Feeding							Swallowing/ Feeding						
Cognitive aspects of comm.							Cognitive aspects of comm.						
Social aspects of comm.							Social aspects of comm.						
AAC/Communication Modalities							AAC/Communication Modalities						

Total Hours Recorded Above: _____ (F_____ V _____ S _____)

Student Signature:_____ Date:_____

Supervisor Signature: _____ Date: _____

Revised 4/12/2022

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

Clinical Policy

Subject: Materials Room
Clinician Library

Date: January 31, 2022
February 7, 2022
April 29, 2022

1.0 POLICY

Uniform procedures will be followed to ensure that materials signed out of the Speech and Hearing Clinic's *Materials Room* and *Clinician Library* by students, faculty, or staff are returned in good condition, i.e., with all parts intact and not damaged in any way.

2.0 PURPOSE

The procedure was developed to allow quick and easy access of materials for any class and to ensure an organized and effective check-out and check-in of tests, audiometers, and materials. The procedure also ensures that materials are returned in good condition and in a timely manner.

3.0 RESPONSIBILITY

The Speech and Hearing Clinical Educators, Clerical Staff, Audiologist, CSD Faculty Members, and the Materials Librarian will hold sole responsibility for following these procedures.

4.0 PROCEDURES FOR CLINICIANS (MATERIALS ROOM)

4.a Clinicians will sign the STUDENT FORM FOR CLINIC MATERIALS (attached) and give to the materials room librarian. The materials librarian will set up an account with Libib. Once this account is set-up for you, a patron status is established. The material librarian creates a patron status using your emich email.

4.b Register as a patron on the website https://www.libib.com/u/emumaterials
Clinicians are required to create their own passwords initiated by *Need Password?* Icon. To register follow these directions:

- You must use the browser Chrome
- Type in the link https://emumaterials.libib.com
- Type in your email
- Click *Need Password* (you will be creating your own password)
- Log in with your personal password
- Search the libraries that correspond to the type of materials needed (Adult Materials, Language Tests, Articulation/Phonology/Auditory Tests, Audiometers etc.)

- Locate the desired item and then click the picture
- Choose the item to *Hold*
- *Confirm checkout at Kiosk*
- Request will be sent to Materials Librarian
- Materials will be placed on your shelf in the material holding room

4.c) 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. Forms for material extension will be found in the Materials Librarian mailbox. Please complete the form, obtain a signature from your CE and then place the signed form in the plastic envelope attached to your library shelf. The form is found by the Materials Librarian mailbox under the clinician mailboxes.

4.d) A material from the Materials Room may be checked out overnight i.e., test review for an upcoming evaluation. You must get permission from a CE for overnight permission. Please complete the form, obtain a signature from your CE and then place the signed form in the plastic envelope attached to your library shelf. The form is found by the Materials Librarian under the clinician mailboxes.

5.0 PROCEDURES FOR CLINICIANS (CLINICIAN LIBRARY)

5.a Materials in the Clinician Library do not require checkout via the Materials Librarian. You are welcome to browse in the Clinician Library throughout the day. There is a limit of two persons in the library at one time.

5.b Please take the library card from the material and place in the out basket on the table with you name and date of checkout. (At this time, musical Instruments do not have a library card).

5.c To check out the material follow the same directions as above, but you will be given the choice of *checkout,* not *hold*. Click on the *checkout* label. The material librarian will then have information as to what item you have checked out.

5.d You can check out **three** items at one time.

5.e Please return the material promptly (seven days). Place the library card back in the material with the "check in" date AND place the item in the designated area in the Clinical Library. The materials librarian will "check in" the material via libib.

5.f It is very important to follow these procedures to make sure that the materials are available across semesters.

5.g You will have access to these libraries that have a prefix of CLINICIAN LIBRARY. You will not have access for self-checkout for materials in the MATERIALS ROOM. Look for the prefix Clin. Library (Clin. Lib.) as you browse the libraries within the libib.com program.

6.0 DATE TO BE REVIEWED

This policy will be reviewed annually by all Clinic Staff.

Speech and Hearing Clinic
Eastern Michigan University
STUDENT FORM FOR CLINIC MATERIALS

I, _____ agree to return materials that have been
(print name)

Signed out to me when they are due and. To return them in good condition: i.e., with all parts intact and not torn, written on or otherwise damaged.

If I do not return them in good condition, I will receive an incomplete (I) in the corresponding course until the materials are replaced.

Signature_____ E#_____ Date_____

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, 12-19-18

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 throughout the Clinician's Handbook and in Appendix A in (ASHA Code of Ethics and Confidentiality statement) and Appendix B (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 after review (see CP-9 Addendum 1). 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 student work room computers must be deleted immediately. 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.

5.0 DATE TO BE REVIEWED

This policy will be reviewed annually by all Clinic Staff.

Eastern Michigan University
Speech & Hearing Clinic
135 Porter Building
Ypsilanti, MI 48197
(734) 487-4410

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, employee 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 the 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 audio or videotapes for a client are in my possession, I assume total responsibility for the confidential retention and viewing of these tapes. I understand that the unauthorized use and/or disclosure of information from the client's record, audio or videotapes, 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

SECTION III. HEARING ASSESSMENT AND MONITORING FOR CLINIC CLIENTS

A. Annual monitoring of hearing

Each client should receive a complete audiological evaluation on an annual basis for monitoring purposes. (Note: Due to ongoing hearing and/or middle ear problems, some clients may require more frequent assessment). Hearing screening will be administered if an annual check is not due. Upon assignment of clinic clients, each student clinician should review his/her client's audiological history and meet with Dr. Lee to discuss the hearing assessment needs of his/her clients. Please review the charts prior to meeting with Dr. Lee. Be sure to review the previous audiological evaluation, as well as the previous hearing screening results. Please note any information and concerns in regards to hearing.

B. The student clinician is expected to do the following:

- Review client cases - especially the audiological history.
- Each student should have a 15-minute consultation with Dr. Lee within the first 2 weeks of clinic to provide Dr. Lee an update of the audiological needs of his/her assigned clients. Dr. Lee has 2 offices (Porter 135C6 and Porter 128B), her availability is posted outside her offices. Please see Dr. Lee during her clinic hours, all consultation is done as walk-in. Do NOT make appointment for this purpose.
- At this consultation, bring the client's current chart, and related charts that include previous audiological records, as well as hearing screening records. At this time, two additional meetings will be set up, please record those dates.

  1st: A hearing evaluation/screening appointment will be scheduled. Screening criteria will be discussed.

  2nd: A 30-minutes "final-draft" appointment will be scheduled with the clinician to either review the final draft of the audiological report (1-2 weeks after the hearing evaluation/screening appointment), or to complete a hearing screening audiogram.
- ALL hearing evaluation/screening will be administered in the sound booth. Once the hearing evaluation/screening appointment is determined, please reserve the sound booth accordingly (sign-up sheet is on the counter in front of the CE's in/out boxes).
- Inform client and/or parent/care provider of the test date and reason for the test.
- Accompany the client to the audiology appointment.
- Prior to your meeting your client for hearing screening
  - Set up the portable audiometer for testing
    - familiar with the portable audiometer (available in the sound booth)
    - perform biological check of the portable audiometer
  - Administer hearing screening, adhere to agree upon criteria
  - Put away the portable audiometer and put all furniture back to original place prior to leaving the sound booth
  - Please do not close the double door when you leave
  - Please enter your hearing screening record in Calipso (6 minutes hearing evaluation per client; put in comment session client's initials), bring your hearing screening practicum log sheet to be signed off at the "final-draft" appointment.

- For hearing evaluation:
    - Please check out your client's current chart. Assist Dr. Lee in the assessment process. A student who has taken a course in Audiology may be asked to administer the test (with supervision), screening hours may be obtained if the student perform the test, or a screening
    - Submit a draft of the audiological report (hard copy) within 24 hours in Dr. Lee's mailbox in the clinic (135D2, behind the clients' file cabinets)
    - Edit changes prior to "final-draft" appointment

C. The audiologist will be responsible for the following:

- With your input, determine the type and extent of testing necessary.
- Ensure all testing and report findings/recommendations were discussed with the clinician (if necessary with client and/or his/her family/care providers).
- Posting written report in file and notes in log.
- Providing the student clinician with explanation or description of any audiological related information pertinent to the client and his/her communicative needs.
- Provide with hearing aid evaluation and consultation if necessary

D. Ongoing consultation

If a client has a hearing loss, and/or ongoing middle ear problems, the audiologist will provide ongoing consultation and/or frequency follow-up assessments upon request. Please see the audiologist if your client has such needs and a plan for involvement can be determined in conjunction with the assigned supervisor.

SECTION IV. AUDIOLOGICAL REPORT

Purpose of the evaluation, audiometric findings, and recommendations should be included in the report. The draft will be reviewed by Dr. Lee, and returned to clinician's mailbox. During the "final draft" meeting, the clinician should bring with him/her the client's chart, and the final draft (2^{nd} draft) of the audiological report. The audiological report needs to be on a portable drive, or email it to Dr. Lee in advance (.doc/.docx format). The draft report will then be opened on Dr. Lee's computer and a final copy of the report will be printed out on University letterhead (provided by Dr. Lee).

Typically, reports are in the following format:

1. ID information: Name, date of birth, date of report
2. Background: When was the test administered, audiological history, any information in regards to hearing, and the purpose of assessment
3. Results: Otoscopy, pure-tone findings, immittance (if appropriate), speech audiometry (if appropriate), aided findings (if appropriate)
4. Recommendations
5. All reports should include signatures of Clinician and Professor
6. All reports should include the audiogram, and cc to client/guardian

Sample outline

AUDIOLOGICAL REPORT

Client:
Date of Birth:
Date of Report:

Background:
xxxxxxxxxxxxxxxxx

Results:
xxxxxxxxxxxxxxxxx

Recommendation:
xxxxxxxxxxxxxxxx

Superstar clinician, B.A. (or B.S. etc)	Lidia Lee, Ph.D., CCC-A
Graduate Clinician	Professor

encl: audiogram (date of test)
cc: name of client or legal guardian

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 red medical alert sheet and to review and update, every semester 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 In the event of a medical emergency with a student clinician or clinic staff, a clinical supervisor will be contacted to determine if emergency services should be requested.

4.5 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 the kind of assistance needed- police or ambulance

4.6 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
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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. (See **CP-10/1** Remediation Plan for Poor Clinical Performance and CP-**10/2** CALIPSO Performance Scale Remediation Items.)

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 CALIPSO 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. See **CP-12/1** Remediation Plan for Poor Clinical Performance and CP-**12/2** CALIPSO Performance Scale Remediation Items.)

5.0 DATE TO BE REVIEWED

This policy will be reviewed annually by all Clinic Staff.

REMEDIATION PLAN FOR CLINICIAN AT RISK

DATE: _____

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

RE: _____

Clinician Strengths:

Clinician Weaknesses:

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

Completion Date/Actual Performance Rating

_____	_____	_____	_____
Clinician	Clinical Educator	Faculty Advisor	Date

SUPPORT TEAM REFERRAL ☐ACCEPTED ☐DECLINED

CP-1212 Remediation Items (Example)

CALIPSO Performance Scale Remediation Items (Example)

Clinical Performance Items	Evaluation Skills #9	Treatment #3	Professionalism #6
Performance Rating Week 1	3	2.5	2.5
Performance Rating Week2	3	2.5	3
Performance Rating Week3	3.5	3	3
Performance Rating Week4	3.5	3.5	3.25
Performance Rating Week5	3.5	3.5	3.5
Performance Rating Week6	3.75	3.75	3.5
Performance Rating Week?	3.75	3.75	3.75
Performance Rating Week8	4	4	4
Performance Rating Week9	4	4	4
Performance Rating Week 10	4.25	4.25	4.25