Department of Communicative Disorders
Student Handbook

Section II
Speech-Language Pathology
Clinic Manual

Revised May
2017

The University of Alabama is an Equal Opportunity Institution.

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Note to Students

Questions regarding any portion of this manual should be discussed with the Department Chair, Clinic Director, or your Clinical Supervisor.

Each graduate student should be familiar with the manual contents and is expected to abide by the policies and procedures therein.

Disclaimer: Every effort was made to provide you, as a student in this department, with the most up-to-date general information. There are times, however, that changes may occur. You will be notified of changes through various means, such as email, in clinic meetings, notices in your student mailbox, or during staffing with your clinical supervisor. It is your responsibility as a student to request clarification if you are uncertain about changes that may have occurred.

SPEECH-LANGUAGE PATHOLOGY CLINICAL PROGRAM

Program Credentials

The Department of Communicative Disorders is accredited by the Council on Academic Accreditation (CAA) of the American Speech-Language-Hearing Association (ASHA). Professionals practicing in the field are certified by ASHA and state licensed. Students enrolled in the graduate program must meet the academic and clinical competencies specified by CAA in order to be certified by ASHA after graduation. Academic and clinical competencies required by CAA are specified on the Knowledge and Skills Assessment Form (KASA). Required competencies span a spectrum of disorders across the life span. Each student will be given a copy of the KASA form when entering the graduate program.

Clinic Director, Internship Coordinator, and Clinical Supervisors

The Clinic Director is responsible for the operation and supervision of in-house clinic and approves all off-campus practicum placements. The Clinic Director collaborates with faculty to create and initiate research opportunities within the Speech and Hearing Center. The Clinic Director ensures the clinic is following appropriate policies and procedures as detailed in this manual.

The Internship Coordinator is responsible for assignment of off-campus clinical practicums and serves as the liaison between the Speech and Hearing Center and off-campus practicum sites.

Clinical supervisors are responsible for mentoring students during the clinical education process. Clinical supervisors will meet with student clinicians periodically during the semester. They work closely with student clinicians to plan and implement clinical practices and evaluate student competency.

Speech and Hearing Center Overview

The University of Alabama is an equal opportunity institution. The Speech and Hearing Center as part of The Department of Communicative Disorders strives to provide quality services to individuals with speech, language, or hearing disorders in the Tuscaloosa community and surrounding counties. Clients of all ages and from diverse backgrounds are served through The Speech and Hearing Center and have a variety of speech,

language, or hearing problems. Since The Speech and Hearing Center is a clinical training program, services are provided by students enrolled in one of the clinical practicum courses under the supervision of state licensed and nationally certified clinical supervisors.

There are a variety of ways for clients to receive services at The Speech and Hearing Center. Since the center is open to the public, self-referral, referral from a physician, or referral from another community agency is common. In addition to these referrals, children ranging from three years to five years of age are served at the center through the Preschool Speech and Language Program. Although this program is housed at The Speech and Hearing Center, it is made possible through cooperative agreements between The Speech and Hearing Center and the Tuscaloosa County School System and the Tuscaloosa City School System.

Additional clinical experience is available to students at a variety of off-campus practicum sites in Tuscaloosa, Birmingham, and the surrounding area. Students will be assigned on-campus clinical practicum before being placed at off-campus sites.

Student Mailboxes

Each student enrolled in clinical practicum will be assigned a mailbox outside the Student Workroom/Computer Lab. Announcements and messages will put in the box as needed. Students should check their boxes regularly. The box should also be used to keep client files when the student is away from the workroom.

Vaccinations and CPR Training Requirements

CPR training will be completed in the Fall (prior to clinic beginning) at The Speech and Hearing Center. The cost of training will be paid by the student and is required for all students. Any student who does not attend training offered by the department must arrange training at his/her expense. TB testing, drug screenings, vaccinations and background checks are required for many off-campus clinic placements. Students are required to register with certifiedbackgroundcheck.com and submit proof and/or documentation of all requirements listed and are responsible for any fees associated with their account. Additionally, vaccinations, tests and screenings will be done at the student’s expense.

HIPAA

The security and privacy of clinical records is protected by professional ethics (American Speech-Language-Hearing Association) and federal legislation (Health Insurance Portability and Accountability Act). The Speech and Hearing Center is bound by ethics and law to adhere to HIPAA Policies and Practices as prescribed by The University of Alabama HIPAA Compliance Committee. (HIPAA, Appendix III)

All members of The Speech and Hearing Center workforce must comply with HIPAA Policies and Practices.

- Students enrolled in clinical practicum/courses are part of The Speech and Hearing Center workforce.
- The obligation to protect the confidentiality and security of clinical records begins with enrollment in clinical courses and is on-going (i.e., does not end with completion of clinical coursework or graduation).

Clinical practicum students will complete HIPAA training prior to engaging in delivery of clinical services. Documentation of training will be kept by The Speech and Hearing Center HIPAA Privacy and Security Officer.

HIPAA Policies and Practices apply to all paper and electronic clinical records, including photographs, video and audio recordings, and verbal and telephone conversations.

Important Points:

- Clinical data/records cannot be stored on a personal electronic device, such as a laptop, flash drive, or smart phone. Students cannot email clinical records to themselves.
- The Permanent Client File or its contents can never be taken from The Speech and Hearing Center. This policy applies to paper and electronic records or copies of records.
- The Working File can be taken from The Speech and Hearing Center. The clinician should access the information in the file only in a secure and private setting. The clinician must understand and accept that the Working File and its content are the responsibility of the clinician. Unauthorized or inappropriate disclosure of the information contained in the file is a violation of HIPAA Policies and Practices. The clinician is responsible for protecting that information and will be accountable if a breach occurs. Sanctions are enforced for all breaches of privacy and security, even if the violation was unintentional or out of the control of the clinician. Precautions for protecting the records include but are not limited to:
    - Never leave a Working File unattended in your car.

    - Never leave a Working File unattended in your home. If you are not working on the file, store it in a secure and private location.
    - Never access the content of the file around other people, such as roommates, or in a public venue, such as a restaurant.
- Violations of HIPAA Policies and Practices will be reported to The Speech and Hearing Center Privacy and Security Officer, Clinic Director, and Department Chair.
- Students who violate HIPAA Policies and Practices will be subject to sanctions.
    - The sanction imposed will be based on the severity of the breach. Mitigating factors as well as whether the breach was a first or repeat offense will be considered.
    - Neither The University of Alabama nor The Speech and Hearing Center can protect the student from legal charges filed through the court system on behalf of a client should such an action occur.
- If a student is accused of a HIPAA violation, a meeting will be scheduled to address the accusation. The HIPAA Privacy and Security Officer, Clinic Director, and Department Chair will attend the meeting with the student. Other Speech and Hearing Center personnel, such as a clinical supervisor, might be present as well.
    - The accusation and concerns will be presented. The student will be given the opportunity to provide an explanation/defense.
    - If it is determined that the student is guilty of a HIPAA violation, the HIPAA Officer, Clinic Director, and Department Chair will determine the appropriate sanctions.
    - The purpose of the meeting and outcome will be documented. A copy will be placed in the Student's Departmental File.

<u>HIPAA Sanctions</u>

Each violation will present unique circumstances. Sanctions will be determined on a case-by-case basis. General guidelines will be applied when determining sanctions. The severity of the offence is determined by considering intent and potential harm to the client and/or Speech and Hearing Center.

- Serious offense involves poor judgment on the part of the clinician; however no harm was done to the client or the reputation of The Speech and Hearing Center. No serious legal implications are anticipated as a result of the act. There was a breach of policies and practices, but protected information was not disclosed to an outside/inappropriate source. Examples include:
    - Client File is taken from The Speech and Hearing Center.
    - Working Files are left in the student's car.

- Critical offense involves not only poor judgment on the part of the clinician but harm or potential harm could occur to the client or the reputation of The Speech and Hearing Center. Confidential information is disclosed as a result of this action. Legal vulnerability is a concern. Examples include:
    - A Working File is left in a restaurant.
    - A Working File is stolen from the student's car.
- Fatal offense occurs when the violation was committed for personal profit or with malicious intent causing harm to both the client and Speech and Hearing Center. Legal implications are serious. Examples include:
    - Disclosing information about a client to someone without-a-need to know for the purpose of gossip.
    - Disclosing information about a client to someone without a need-to-know causing damage to the client's reputation, embarrassment, or personal anxiety.
    - Disclosing information about a client to an attorney, media, estranged spouse, etc.
    - Disclosing information for personal profit; selling information.
    - Disclosure of information damages the reputation of The Speech and Hearing Center or results in legal vulnerability.

Typical sanctions would include:

- Both a first offense and a serious offense typically require disciplinary sanctions but do not threaten the student's opportunity to complete the program in the expected number of semesters. HIPAA re-training, loss of clock hour credit, and a letter of reprimand are examples of possible sanctions.
- A second serious offense warrants a grade of "F" or "fail" in the clinical course. This sanction also applies to a critical offense. The student will remain in-house one extra semester for clinic rather than be placed at an off-campus site. The student will have to extend the completion date of the graduate program by one semester.
- A fatal offense, third serious offense, or second critical offense warrants dismissal from The Department of Communicative Disorders for a graduate student.

CD Student Computer Accounts

The privacy and security of clinical records are protected by the Health Insurance Portability and Accountability Act (HIPAA, Appendix III). To protect the security of clinical documents generated in this clinic, none of the computers in the Student Computer Lab allow documents to be saved on the computer hard drive. All of your work, clinic or class, will be saved to a share drive account that is designated for your use and is password protected. **Never** save clinic documents on a flash drive or other portable device.

Each CD student enrolled in clinical practicum will be assigned a cdstudent account. This account will be used while you are in school. It will be deactivated when you graduate. You can access your account only on a computer in the CD Student Computer Lab. Your account will have an assigned password. You can use this password or reset it to a password you choose.

Student:	Jane Doe
Account/User Name:	cdstudent55
Password:	aewpcch

Follow these instructions to access your account:

- *ctrl+alt+delete* to log-on
- go to *share* \\ *asfa.asnet*
    - click on CD
    - click on *GTA*
    - click on your account number
- enter your password; it is case sensitive, for example eiFgHY
- use this account to generate and save all of your clinic documents

Once you are into your account, you can reset your password:

- ctrl+alt+delete
- click on Change Password
- follow the prompts to reset password

To access clinic and student forms:

- log onto you share account
- click on My Computer
- select *'share' asfs* drive
- scroll down and click on *Speech and Hearing Center*
- you will see a file for Student Forms and a file for Clinic Forms

- to save from this location to your student account
    - click on *File* and *Save as*
    - name the file and click on save

ALWAYS LOG-OFF WHEN YOU ARE FINISHED. IT IS A HIPAA VIOLATION TO LEAVE YOUR ACCOUNT OPEN TO OTHER USERS.

Note: Because these computers are in "deep freeze" mode and will only save to the share drive, you cannot save anything you download from the internet. What you download will automatically delete if the computer is not used for 15 minutes.

Dress Code

Students are expected to follow The Speech and Hearing Center Dress Code for clinic. This includes a CD polo shirt with the department logo with dress pants, khakis, nice, dark dress jeans, or skirts of appropriate length. Students are expected to wear the dress code at all times when the student is in clinic. Students are expected to follow the dress code required at off-campus sites. Refer to Dress Code, Appendix I, for detailed dress code requirements.

Safety/Emergency Management

The safety of clients is an important concern. In the event of an emergency, the student is responsible for the safety of his/her client. See Appendix II for detailed instructions on emergency management procedures. Should the alarm system go off, the student must evacuate the building and not return until given permission to do so by emergency personnel. If the student is with a client, the student must escort the client out of the building.

Observation of Clinic

Access to therapy rooms and observation rooms is limited to clinical staff members and students in the Communicative Disorders program. Parents, spouses, or caregivers who wish to observe treatment must check with the clinical supervisor and request permission before entering the treatment area.

Observation Policy

The security and privacy of clinical records is protected by professional ethics (American Speech-Language-Hearing Association) and federal legislation (Health Insurance Portability and Accountability Act). The Speech and Hearing Center is bound by ethics and law to adhere to HIPAA Policies and Practices as prescribed by the University of Alabama HIPAA Compliance Committee.

- The Speech and Hearing Center is a training program for students majoring in Communicative Disorders. Observation of clinical services by students is part of the teaching-learning process and is a component of the operations of the Speech and Hearing Center.
- Students who engage in observation of services will be HIPAA trained.
- Students will sign an Acknowledgement of Training Form.
- Sanctions for violation for HIPAA Policies and Practices are described in the HIPAA Student Sanctions Policy.

Non-CD student observers must be approved by the Clinic Director.

- Observers will be HIPAA trained and will sign the Observation Policy and Sign-In Log at each visit.
- A copy of the Log will be kept in The Speech and Hearing Center Office.
- Observers will wear a Speech and Hearing Center name tag while in the building.
- Observers will sign and adhere to the SHC Observation Dress Code (casual business attire).
- Failure to abide by observation policies will result in termination of observation opportunities.

Parent/caregiver observation must be approved by the clinical supervisor who is responsible for the client. The clinical supervisor must be present when the parent is in the observation area.

- The Observation of Clinical Services Policy will be provided in writing to the parent/caregiver at the beginning of each semester the client is enrolled in treatment.
- Clinical Supervisor or Student Clinician will review Observation of Clinical Services Policies with the parent.
- Parent/caregiver will sign the policy form. A copy will be kept in the client file.
- Failure to abide by observation policies will result in termination of observation opportunities.
- Breach of Observation Policies will be reported to the Clinic Director and

Speech and Hearing Center HIPAA Privacy Officer.

Volunteers

Volunteer opportunities at The Speech and Hearing Center are limited to UA students who are majoring in Communicative Disorders. Students who are interested should complete a volunteer application. The application can be downloaded off the department's website or picked up from The Speech and Hearing Center's front office. An application form must be submitted for each semester the student is interested in volunteering. Volunteer assignments will be made based on clinic needs and availability.

Volunteer Policy

Volunteers are part of The Speech and Hearing Center workforce and must comply with all policies and procedures regarding the privacy and security of protected health information. The security and privacy of clinical records is protected by professional ethics (American Speech-Language-Hearing Association) and federal legislation (Health Insurance Portability and Accountability Act). The Speech and Hearing Center is bound by ethics and law to adhere to HIPAA Policies and Practices as prescribed by the University of Alabama HIPAA Compliance Committee.

- Individuals who volunteer at The Speech and Hearing Center will be HIPAA trained and will sign the Volunteer Policy and Sign-In and -Out Log at each visit.
- Volunteer services must be approved by the Clinic Director.
- Volunteers must report to The Speech and Hearing Center front office when entering the facility.
- Volunteers will wear a Speech and Hearing Center Volunteer badge while in the building.
- Volunteers will sign and adhere to the SHC Volunteer Dress Code (casual business attire).
- Volunteers will have access to The Speech and Hearing Center work areas as needed to conduct volunteer activity. All other access will be restricted.
- Failure to abide by volunteer policies will result in termination of volunteer status.

Resource Rooms and Materials

Often universities require students to purchase their own therapy materials. At The University of Alabama, most materials and equipment necessary for clinic, or the items necessary to make materials, are provided by The Speech and Hearing Center. In turn, the students are expected to take care of the materials, return them to the designated place of storage, and keep the resource rooms neat and organized.

Students doing practicum at The UA Speech and Hearing Center will be assigned to clean-up teams periodically to keep the clinic areas in good order. Students who abuse this privilege will not be allowed continued use of these resources.

Most therapy materials, such as toys, pictures, and cards are kept in the Resource Room which is accessible from Hallway B-2. Diagnostic tests and materials are kept in the Diagnostic Closet in the Supervisor Workroom (Room 106). These items must be checked-out when taken from the Closet. They should be checked-in when returned. Since many students use these materials, they should not be checked-out and kept for an unnecessarily long period of time or far in advance. Some materials and equipment are kept in the supervisors' offices. A student should never take items from a supervisor's office without permission.

Students should remove materials from the therapy room as soon as the session is complete. The materials should be cleaned according to the infection control policy and returned to the Resource Room.

Diagnostic Materials

Diagnostic materials are stored in the Diagnostic Closet on the pediatric therapy wing. Assessments may be checked out using the Check-Out Log located on the bookshelf. Enter only one assessment per line, date, and sign your name. When checking out an assessment, you must check-out the entire assessment kit; you are not allowed to take test manuals without checking out the complete assessment.

All assessment manipulatives must be thoroughly cleaned according to Center's infection control policy before being returned to the Diagnostic Closet. When returning the assessment, sign-your name in the check-in space and return the assessment to its designated place. If items are missing or there is a decreased supply of protocols, please make a note on the white board located in the Diagnostic Closet. You are responsible for missing items and/or a missing assessment if you are the last person to check out the test and did not note what was missing on the board.

Assessments must be reviewed and scored in the Supervisor Workroom located next to the Diagnostic Closet. All assessments must be returned to the Diagnostic Closet by the end of the workday. If there is a need to take an assessment out of the designated work area, you must obtain approval from a clinical supervisor. Assessments should never be taken from The Speech and Hearing Center.

Many of these items are expensive. A diagnostic test for example can cost several

hundred dollars. The Speech and Hearing Center reserves the right to bill a student's University account for items that are not returned or are damaged.

Equipment

The Speech and Hearing Center provides equipment for student use. Students are expected to follow policy with regard to each piece of equipment.

- Portable audiometers used for hearing screening can be checked out for use at off-campus practicum sites as long as the date does not conflict with any scheduled Speech and Hearing Center projects.
- OAE (otoacoustic emissions) equipment **cannot** be checked out by students.
- NSSLHA provides a copy machine for student use. Students should use the machine only for school work.
- A large laminator is located in the Supervisor Workroom. Materials to be laminated should be clipped, labeled, and placed in the Graduate Assistant's Laminating Inbox located in the Supervisor Workroom. Materials will be laminated and returned to the Laminating Outbox within 48 hours. If the materials are needed sooner than 48 hours, see your clinical supervisor.
- A small laminator is located in the student copier room. This laminator is for small project use, and a student may use this laminator independently.
- Video equipment can be used only as directed by your clinical supervisor.
    - Confidentiality and security of video recordings are protected under HIPAA regulations. (HIPAA, Appendix III).
    - Recordings can be uploaded to the students computer account on the share drive.
    - Recordings cannot be uploaded, emailed, or copied to any other device, folder, or account.
    - Recorders can be checked out 1 hour prior to use and must returned the same day with all content deleted.
    - Students who mishandle recorders can have their student account billed for replacement cost.

Infection Control

The goal in establishing an infection control program is to prevent the spread of germs between client and clinician and to prevent the spread of germs environmentally via materials and equipment. Therapy and evaluation materials should be cleaned after use. Infection control supplies are kept in the diagnostic room and each treatment room and can be replenished from extra supplies that are stored in the cabinets in the Supervisor Workroom. Infection control is regulated by OSHA (Occupational Safety

and Health Administration). Anyone involved in clinic must follow infection control policies. See Appendix II.

Clinical Experience

Step 1: Pre-Professional Observations

Each student majoring in Speech-Language Pathology is required to complete 25 clock hours of observation of appropriate clinical activities prior to enrollment in the first practicum course. Some observations will be completed via video tape while other observations will be of live sessions.

Undergraduate students typically gain this experience while enrolled in CD 277: Pre-professional Laboratory Experience. During this course the student completes a minimum of 25 hours of observation of diagnostic and/or intervention activities with individuals representing a variety of age groups and types of speech, language, and hearing problems.

Students will complete the Observation Hour Form as a log of the observations completed. These hours will be verified by the instructor at the end of the course. The student must turn in the form to the course instructor before a grade will be posted. The student should keep a copy of the form for his/her records.

Students who enter the program from another university must provide written documentation of observation hours before receiving any clinical assignments. Students who have not completed 25 hours of observation must do so before participating in clinical practicum.

Step 2: In-House Clinical Practicum

In-house clinical practicum is available to both undergraduate and graduate students. Students typically complete a minimum of 1 in-house clinical practicum before being assigned to a public school placement or other off-campus facility. The majority of students complete at least 2 in-house placements. Undergraduate students participate in in-house clinical practicum through enrollment in CD 377 and CD 378. Graduate students participate in in-house practicum through enrollment in CD 517.

At The Speech and Hearing Center, clients range from infants to geriatrics with a wide variety of speech, language, and hearing problems often complicated by additional problems such as cognitive, behavioral, and social challenges. Clients from diverse multicultural backgrounds are common.

Step 3: Off-Campus Clinical Practicum

Undergraduate students are not assigned to off-campus practicum.

All graduate students are expected to complete practicum at sites outside The Speech and Hearing Center once they have demonstrated acceptable clinical progress. A variety of settings are available. Ideally, students will complete at least one pediatric placement (i.e. public school) and one adult placement (i.e. skilled nursing facility, rehabilitation or hospital). The student's preference for a particular site will be accommodated when possible as long as it is compatible with the knowledge and skill requirements that are appropriate for the student at that point in the clinical training process.

Decisions regarding off-campus clinical practicum placement will be made on a student-by-student basis by the Internship Coordinator with input from the Clinical Supervisors and Academic Faculty and approval from the Clinic Director and Department Chair. Students must abide by the terms for placement agreed upon by the site and The Speech and Hearing Center.

Some travel by the student may be required to provide adequate hours and experiences (cost associated with all off-campus travel will be incurred by the student). Off-Campus Clinical Practicum sites considered to be in-area include the following counties: Bibb, Fayette, Green, Hale, Jefferson, Pickens, Tuscaloosa and Walker.

Only students in good standing are assigned to off-campus clinical practicum. Good standing is defined as professional conduct, academic performance and clinical performance. Students with a remediation plan are not eligible for off-campus placement until the terms of the remediation plan are met. Students under review for misconduct will not be assigned to an off-campus placement, or might be pulled from the site. In the event that a student is on Academic Probation or demonstrates questionable academic misconduct (i.e. poor class attendance), the student may be required to complete the 5th semester practicum locally. Students who are not performing to the standards and expectations outlined prior to the placement (see Appendix VIII: Expectations for the Student Intern at an Off-Campus Site) will be required to complete a remediation plan. If a practicum experience is delayed or not completed due to review of good standing, the student will complete a rotation the following semester and graduation will be delayed one semester.

For information regarding the out-of-area clinical practicum requirements refer to Appendix VII: Guidelines for Requesting Out-of-Area Sites for Clinical Training.

Time Commitment for Clinical Experience

Graduate students must be enrolled in clinical practicum each semester they are enrolled in the graduate program. They must complete a minimum of 25 observation hours and 375 clock hours of clinical practice prior to graduation. The Clinic Director and Clinical Supervisor determine the number of days and hours a student attends his or her practicum. Students must make arrangements to be available as required for practicum assignments. Students who have jobs or are involved in activities outside the department must be prepared to schedule those time commitments around clinic assignments. Students must recognize that personal decisions (pregnancy, job changes, moves, getting married, etc.) may impact or delay graduation timelines.

The Internship Coordinator arranges all off-campus practicum experiences. Students are to report for off-campus practicum on the days and dates delineated at the beginning of the practicum period, unless the site supervisor requests that the student not attend. Under no circumstances, should a student ask the off-campus site supervisor for days off or to leave early. The Clinical Supervisor, Internship Coordinator and Clinic Director must approve any changes in the student's practicum schedule.

Graduate students should expect the following time commitment (e.g. total time for direct therapy services and other case management duties) in their clinical practicum experiences as outlined below:

	1st Semester	**2nd Semester**	**3rd Semester**	**4th Semester**	**5th Semester**
Site	• Speech and Hearing Center	• Speech and Hearing Center • Pediatric Site • Adult Site	• Speech and Hearing Center • Pediatric Site • Adult Site	• Pediatric Site • Adult Site	• Pediatric Site • Adult Site
Full-Time In-house	5-10	10-15	10-15	---	----
Full-Time Off-campus	---	10-15	15-20	15-20	40
Part-Time In-house /Off-campus	---	8 hours off-campus/ up to 7 hours in	8 hours off-campus/ up to 7 hours in	---	---
Full-Time Off-campus with GA	__	10-15	15-20	15-20	32
Full-Time Off-campus with Thesis	---	10-15	10-15 *(in-house 3rd for data collection and analysis)*	15	32
Full-Time Off-campus with GA and Thesis	__	10-15	15	15	24

**Students who travel outside the Tuscaloosa area will be allotted travel time in the 3rd and 4th semesters. *Data collection/analysis for a thesis typically occurs in the 3rd semester but can happen in others. This will be adjusted accordingly.*

Graduate students completing their final 40-hour per week clinical practicum experience should understand that there is no vacation period from this placement. Students are expected to attend their site 5 days per week, all day (i.e. 40-hour work week). Spring Break may be observed at the discretion of the off-campus clinical supervisor.

Attendance Policy

Absenteeism from practicum is acceptable only in case of an emergency or when pre-approved by the student's clinical supervisor.

- The clinic director and clinical supervisor must approve and excuse any non-emergency absences by the student.
- In the event of an emergency absence, the student should contact the clinical supervisor as soon as possible. In-house clinicians should also contact the office staff.
- There may be instances when the student will be expected to make-up a missed session or find a substitute clinician.

Supervision of Clinical Practicum

Student clinicians are assigned a clinical supervisor for each semester of practicum. All clinical supervisors hold CCC-SLP (Certificate of Clinical Competence, Speech-Language Pathology, ASHA) and an Alabama State License. The responsibility of the supervisor is two-fold: (1) to meet the diagnostic and intervention needs of the client and (2) to meet the learning needs of the student clinician. The clinical supervisor serves as a teacher and mentor to his/her student clinicians while ensuring that all clients receive appropriate services.

The clinical supervisor will assign cases, assist the student in planning and execution of services, and evaluate the student's performance. The supervisor will use a clinical performance evaluation form to rate the student's performance, document progress, and identify strengths and weaknesses. Individual sessions will be observed and written or verbal feedback provided to the student. The clinical supervisor will have a mid-term and end-of-term conference with the student to evaluate and discuss the student's strengths and weaknesses and to establish goals for continued

development of competencies.

The student is expected to meet with the clinical supervisor regularly during the semester to discuss lesson plans and monitor client progress. The student is expected to meet all deadlines for submission of lesson plans, reports, and other paperwork required for clinic. The clinical supervisor will expect the student to plan thoroughly and be well prepared and prompt for each clinical session and meeting.

Professional and Ethical Conduct

Clinical practicum is a significant responsibility for the student clinician. At all times, the best interest of the client must be placed above all other considerations. Students must abide by the Code of Ethics adopted by the American-Speech-Language-Hearing Association (ASHA). The privacy and security of protected health information, or client records, must be respected at all times as required by the Health Information Portability and Accountability Act (HIPAA). See the ASHA Code of Ethics at www.asha.org and HIPAA Policies, Appendix III. Since clinical practicum is a course, The University of Alabama Code of Conduct and policies regarding academic misconduct apply to practicum students. See The University of Alabama web page to review these regulations, www.ua.edu .

A violation of the Code of Conduct, Code of Ethics, or HIPAA policies is considered an egregious event and is subject to disciplinary action, which could include dismissal from the program. Written documentation of any incidents of misconduct will be placed in the student's permanent record.

Professional conduct is expected at all times. Examples of the professional behavior include:

- being well prepared for each clinical session and meeting with the clinical supervisor
- adhering to the SHC dress code
- beginning and ending clinical sessions on time
- following rules for use of clinical materials
- meeting timelines for paper work
- being respectful of others

Grades and Remediation

At the undergraduate level, grades for clinical practicum are assigned based on a 4-point grading system using the +/- system required by The University of

Alabama.

Graduate clinical practicum is graded Pass/Fail/Incomplete.

A remediation plan may be put in place following a clinical practicum mid-term evaluation, final evaluation or diagnostic evaluation or at any time when a student's clinical performance is not in good standing. A remediation plan is developed for any student who receives an "F" or "I" grade in clinic.

The remediation plan will be developed by a remediation committee and will include:

- A description of the problem(s) or area(s) of concern
- Plan/process for remediation
- Explanation of how outcome/success will be measured/determined
- Timeline for completion will be specified in the remediation plan

The remediation committee will include the department chair, at least one clinical supervisor, and the clinic director.

If the student successfully meets the terms of the remediation plan within the timeline specified, the student proceeds with graduate study as normal. If the student does not successfully complete the remediation process, a second remediation plan may be developed. A maximum of 2 remediation plans may be implemented for a student during their graduate program. If after a second remediation plan, the deficits in performance are not successfully resolved as determined by the remediation committee, the student will be dismissed from the graduate program.

A student who earns an "F" or Fail grade in clinic is not awarded the clinical clock hours earned that semester. A student who earns an "F" or Fail grade in clinic will be required to complete an additional semester of clinical work.

A student who earns an "F" or Fail grade in clinic may be at risk for academic probation. See Probation in the Academic Section of this manual.

Evaluation of Clinical Performance

Clinical supervisors will observe treatment (therapy) a minimum of 25% of the student's contact time and each diagnostic session a minimum of 50% of the time. Observation is not the only method used in determining competency. The student will also be evaluated on quality of written work, professionalism, as well as other

pertinent indicators of professional development.

Clinical supervisors will consider a variety of factors when evaluating clinical performance. Some of these factors are objective while others are of a more subjective nature. Although evaluation forms will be used as the primary tool for evaluating clinic, the clinical supervisor's subjective opinion of student performance will be considered when determining the student's grade.

Students will be given verbal and written feedback periodically during the semester as an evaluation of performance. The student is expected to review this feedback and discuss it with the clinical supervisor if he/she has any questions or requires additional help. The student is also expected to incorporate the feedback when planning and executing future clinical sessions.

The clinical supervisor will have a mid-term and end-of-term conference with each student to discuss overall clinical progress and, if needed, concerns. Electronic performance evaluations will be completed in Calipso, a web-based application that manages clinical education, by the clinical supervisor and serve as a reference point for these conferences. The clinical supervisor is responsible for informing the student during these meetings if there are concerns about the student's competencies. Again, the student is expected to incorporate the feedback provided by the clinical supervisor in future clinical sessions/experiences. Additionally, if the clinical supervisor has concerns regarding non-academic traits (Appendix IV) exhibited by the students, which could adversely affect success in the field of speech-language pathology, they will be addressed in the midterm and/or end of term meeting.

With each semester of experience, the student clinician should become increasingly independent, improve in his/her ability to solve problems and make decisions, and apply critical thinking skills to the clinical process in an increasingly sophisticated manner. Clinical success involves a range of abilities including (1) integration of academic knowledge into the planning and execution of clinical service (2) application of evidence-based clinical procedures and strategies (3) the ability to establish an appropriate and successful relationship with clients and their families (4) the professional persona necessary for counseling and multidisciplinary case management and (5) the organizational skills necessary for accountability and effective time management. The successful clinician therefore must be able to combine academic knowledge, clinical expertise, and appropriate personal/professional traits.

Non-Academic Expectations

Speech-language pathology is a dynamic and rigorous field of study. The expectations for students planning to pursue speech-language pathology as a profession are high. The ability to communicate is critical to quality of life. When working with individuals whose communication skills are compromised, the clinician must be a model of communication skills and clinical effectiveness. See Appendix IV for a detailed description of Non-Academic traits.

It is possible for a student to be in good standing academically, but not possess the non-academic traits or abilities that are the underpinning of clinical effectiveness. These traits and abilities are important to the student's standing in the program and will be considered during the admission process and duration of the graduate program.

Once admitted to the graduate program the KASA form, which is linked with Calipso, will be used as the primary instrument to document competency during the course of clinical training. However, it must be understood that evaluation of non-academic traits will involve a degree of subjectivity.
When concerns arise regarding the non-academic traits that provide the foundation for clinical success, the student will be brought up for non- academic review by a remediation committee. When appropriate, a remediation plan will be presented to the student with a timeline required for demonstration of an acceptable level of improvement.

Demonstration of non-academic expectations is necessary to be considered for off-campus clinical practicum experiences (see Appendix IV: Non-Academic Expectations).

Disability Accommodations

The University of Alabama is an equal opportunity institution. The Department of Communicative Disorders welcomes applications to the graduate program from students with disabilities and from diverse backgrounds. For students with disabilities accommodations where needed and appropriate will be provided. Students in need of accommodations must register with the University of Alabama Office of Disability Services (133-B Martha Parham E Hall; 348-4285; TDD 348-3081). If the accommodations requested are (1) incompatible with acquisition of core competencies required for certification (KASA) or (2) become intrusive to the clinical process to the point that the client's interests cannot be placed above all other

considerations, a review of the student's status by a remediation committee will take place. The student will be advised according to the outcome of that review. See Non-Academic Expectations, Appendix IV.

The Clinical Process

During the course of the graduate program each student will gain a variety of experiences by working with clients of all ages with varied diagnoses. Each student will complete a clinical internship each semester, a minimum of 5 in-house diagnostics and participate in one semester of audiology lab. These activities will be assigned by the clinic director.

Although the specific procedures applied to clinical practice will vary depending on the age and specific needs of the client, the general framework is constant.

The clinical process:

1. The client is seen for an initial diagnostic session.
2. If the results of the diagnostic indicate intervention is warranted, an intervention/treatment program is planned and implemented.
3. Intervention continues until adequate progress is made to dismiss the client from services, or other considerations indicate that the client should be discharged.
4. Referral for additional services is made, if appropriate.

Client Files

Client records are maintained in two forms

- Permanent Client File
- Working File

Permanent Client File

The Permanent Client File houses records that document diagnosis, treatment, and management from the client's initial visit to the Speech and Hearing until discharge.

- Permanent client files are kept in The Speech and Hearing Center office in accordance with HIPAA Privacy and Security Policies.
- Client files contain long-term permanent records, such as HIPAA forms, diagnostic and treatment notes, treatment plans, as well as demographic information.
- Client files can be checked out by student clinicians and clinical supervisors but

must be returned to the Speech and Hearing Center Office by the end of the working day.

- Client files can never be taken from The Speech and Hearing Center
- Information contained in the client file is confidential. (HIPAA, Appendix III)
- All permanent client files should be organized in the following way:

Left Side (from bottom to top)

1. Initial intake form
2. Physician or Medicaid referral (if appropriate)
3. Signed permission form for video recording, etc. (if appropriate)
4. Signed and dated release forms to send and receive reports regarding client management
5. Signed HIPAA Acknowledgement form
6. Completed Permission to Contact form
7. Application for Hardship Discount (if appropriate)
8. Signed Insurance Verification/Private Pay form (if appropriate)
9. Copy of client's (or parent's) insurance card and driver's license (if appropriate)
10. Account Set-up Sheet
11. File Access Summary Sheet

Right Side (from bottom to top)

1. Case History form
2. Hearing Screen form*
3. Oral Periph form
4. Initial evaluation test protocols
5. Evaluation with signature and credentials of the person performing the evaluation AND the supervising speech pathologist (if different from the person performing the evaluation)
6. Pre-testing protocols (if testing was necessary and was completed to establish plan of care and results were reported in plan of care)
7. Plan of Care/Treatment Plan(s)
8. Daily Treatment Notes
9. Post-testing protocols (if testing was necessary and findings were included in the summary of progress report)
10. Summary of Progress Reports
11. Repeat 6-10, until either a re-evaluation is completed, or a Discharge Summary is completed.
12. Re-evaluation report and test protocol (if appropriate)
13. Discharge Summary (if appropriate). Should be the last entry for all clients.

*A hearing screening should be completed each semester on pediatric clients, and annually on adult clients. All hearing screening forms should be included in client's file.

* All pre and post-testing should be completed on ***original*** test protocols—copies of test protocols should not be included in the files and test protocols should include responses from only one testing session.

Working File

The working file provides a place for the clinician to keep information pertinent to the client for the duration of the semester. It is also the folder that will be turned in each week to the clinical supervisor for review of lesson plans, treatment notes, and plan of care.

The working file will included the following:

- Attendance Calendar
- File Review Worksheet
- Plan of Care
- Pre/Post Testing Forms
- Summary Report
- Daily Treatment Notes
- Weekly Lesson Plans
- Therapy Response Sheets
- Related paperwork or treatment worksheets

Note: *Forms for clinic are available on the Speech and Hearing Center share drive.*

Working File folders will be provided by the Speech and Hearing Center at the beginning of the semester for each client receiving services during the semester. The file is a six section folder with clasps for each section.

Working File Organization

- Clasp 1: The University of Alabama Speech and Hearing Center Attendance Calendar
- Clasp 2: The University of Alabama Speech and Hearing Center File Review
- Clasp 3: Plan of Care on top followed by pre-testing form(s); Summary of Progress Report followed by post-testing form(s)
- Clasp 4: Progress Notes with most current on top
- Clasp 5: Weekly Lesson Plans with most current on top

- Clasp 6: Therapy Response Sheet or method used to collect data

The working file can be taken from The Speech and Hearing Center to be worked on in the privacy of the student's home. The student is legally responsible for the file once it leaves the Speech and Hearing Center. The student is accountable for the privacy and security of the file and its contents. (HIPAA, Student Sanctions, Appendix III) The file and its contents should be kept together.

Files should

- Be transported inside a book bag or similar cover so that they are not visible
- Be viewed only in a private location where others cannot view them
- Never be left unattended where others might have access to them
- Never be left unattended in a car
- Never open in a public place, such as Starbucks
- Be returned promptly to The Speech and Hearing Center, not left at home

Hearing Screenings

A hearing screening is required for clients receiving speech-language diagnostic and intervention services. It is the student clinician's responsibility to be certain that hearing screenings are completed on schedule. A Hearing Screening Form should be filled out for each screening the client receives. All Hearing Screening Forms should be included in the client's permanent file.

Policy

Hearing screenings are required for clients receiving speech-language diagnostic and intervention services.

Protocol

- Option 1: pure tone screening and tympanometry
- Option 2: otoacoustic emissions and tympanometry

Frequency of screening

- Diagnostics: hearing will be screened at the time of the initial diagnostic session
- Intervention:
    - Infants and children: hearing will be screened each semester
    - Adults: hearing will be screened annually
- Documentation: hearing screening form will be completed at the time of each procedure and be included in client's permanent file.

Follow-up criteria

- Testing through the audiology clinic will be scheduled immediately for any client who does not pass hearing screening or who could not be tested.
- Client/parent/caregiver will be informed if client does not pass
- Medical referral will be made as needed

Procedures

Pure tone screening: Screen 1000, 2000, 4000 Hz at 20 dB in each ear

- Pass criteria: client responds to each test tone in both ears
- Fail: client fails to respond to one or more tones
- Could not test: client cannot be conditioned to the task or responses were judged to be unreliable

Otoacoustic emissions will be completed in each ear

- Pass criteria: as indicated in the end of test pop-up message
- Refer/fail: As indicated in the end of test pop-up message
- Could not test: client will not tolerate probe placement; too much noise to complete the test

Tympanometry will be completed in each ear

- Pass: well defined peak between 0 and -250 mmH20, Type A tympanogram
- Fail: flat; Type B tympanogram
- Retest: negative pressure greater than -250 mmH20, Type C tympanogram; repeat tympanometry in 2-4 weeks; if negative pressure persists, schedule client with audiology

Procedures are selected based on developmental level of the client. Students must demonstrate proficiency in pure tone screening, otoacoustic emissions screening, and tympanometry.

Intervention/Therapy Procedures

Clients enrolled in treatment/therapy will have a permanent clinic file and a working file. See the Client File section of this manual for detailed description of each file. Both files contain protected health information. The student is responsible for the privacy and security of these files. (HIPAA, Appendix III) The treatment/therapy process usually involves the following steps:

- During the first days of the semester, clinic meetings will be held to prepare students for the upcoming semester. Attendance is required.

- Students will submit a copy of their semester schedule at the beginning of

each semester.

- The student will be assigned a clinical supervisor who will assign the student's case load for that semester. Students with a busy class and work schedule must allow adequate time for clinical assignments.

- Student clinicians will meet with the clinical supervisor to receive their client list.

- The student will review the client files and complete The UA Speech and Hearing Center File Review form. A meeting with the clinical supervisor should be scheduled as soon as possible to plan the treatment program for that semester.

- Client files can be checked out from The Speech and Hearing Center office. The file must remain in the building and must be returned by 4:00 p.m. the same day it was checked out.

- The activities that take place during the first week of therapy usually include the activities below.
    - Collection of baseline data
    - Pre-testing

- Semester objectives are due to the clinical supervisor by the end of the first week of therapy. Use the Plan of Care (POC) template.

- Student clinicians are responsible for keeping an accurate record of client attendance. Use The UA Speech and Hearing Center Clinic Attendance Calendar.

- Student clinicians should check with their clinical supervisors to discuss billing procedures to be completed at the end of each session. See *Billing* portion of this manual for specific instructions.

- All pediatric clients should have their hearing checked each semester. The results should be recorded on a Hearing Screening form and placed in the client's file.

- Lesson plans are written weekly by the student clinician and are due on Friday for the upcoming week. Two copies should be attached to the Working File and placed in the supervisor's mailbox in The Speech and Hearing Center Office. Previous therapy plans with all data and progress logs should be included. The supervisor will review the plan, make suggestions, and return it to the student prior to the next clinical session.

- Students are expected to meet regularly with their clinical supervisors to discuss therapy plans, problems, and performance. Students should be prepared for a mid-term conference as well as additional meetings at the request of the supervisor.

- Post-testing, if indicated, will be completed during the final week of therapy. The student and clinical supervisor will meet to discuss the tests to be used.

- During the last therapy session the student clinician and clinical supervisor have a formal conference with the client or client's parents. The student clinician will review the semester's objectives and the client's performance in each area. Student clinicians should not make recommendations that have not been discussed with and approved by the clinical supervisor.

- A Summary Report on each client is due to the clinical supervisor by last clinic session or as otherwise scheduled by the clinical supervisor.

- A Discharge Summary Report on each client not returning to the Speech and Hearing Center for services is due to the clinical supervisor by the last clinic session or as otherwise scheduled by the clinical supervisor.

- The student will meet with the clinical supervisor for the end of term conference to discuss the student's final performance evaluation and grading for the semester.

Note: *No pre and post-testing on clients should be conducted unless deemed necessary by the clinical supervisor for the development of a treatment plan or to determine progress made; no testing should be conducted for student-training purposes only or for a class assignment.*

<u>Paperwork Required for Therapy</u>

All forms required for therapy and diagnostics can be found on The Speech and Hearing Center share drive. Most forms may also be found next to the student mailboxes in Hall B-2.

File Access Summary Sheet

The file access summary sheet provides a place for the clinician, clinical supervisor, and office staff to document interactions with the client and activities related to client management. Any actions with or regarding the client must be documented. Accurate and complete documentation is essential for maintaining the highest quality clinical records and is required by HIPAA as a log of disclosure of protected health information.

- Entries should be in chronological order and should be made immediately following contact with the client or activity related to case management.
- Form remains in client's Permanent File at all times.
- Documentation of cancellation/no show do not need to be documented on this form but should be documented on daily progress notes and attendance calendar.
- Standard entries for returning clients include: POC established and reviewed with client/parent; POC faxed to PCP for signature; conference held to discuss progress; client attended therapy (term, year), recommendations for next session; client scheduled for evaluation; client dismissed from treatment; client no-show for treatment; report mailed/faxed; called to request referral; referral received.
- Standard entries when completing a diagnostic on a new client: called to request referral; referral received; intake paperwork mailed; evaluation scheduled; diagnostic completed on…; results and recommendations reviewed with client/parent; report mailed to client/parent; recommended….; client to contact us for treatment; client added to treatment waitlist; client enrolled for treatment; POC established and faxed to referring physician for signature.

UA Speech and Hearing Center File Review

This form is to be completed for planning, pretesting, and intervention. It is the student clinician's responsibility to review the client's Permanent File and complete this form prior to meeting with the clinical supervisor. It is kept in the Working File.

UA Speech and Hearing Center Attendance Calendar

A record of each client's attendance is recorded using the calendar. It is kept in the Working File.

Plan of Care (POC)

At the beginning of the semester, the student clinician will meet with the clinical supervisor to discuss the appropriate intervention program for each individual client. The student will then write a plan of care which must be approved by the clinical supervisor. It is kept in the Working File and transferred to the Permanent File at the end of the Semester. The POC form can be found on The Speech and Hearing Center share drive.

Instructions for Completing a POC

When do I write a POC?

- A plan of care or POC must be written following a client's initial evaluation if treatment is going to be provided at The Speech and Hearing Center. Treatment for a new client **cannot** begin until a POC is established.
- A POC must also be written at the beginning of each semester for all returning clients.

When is POC Due?

- POC's for new clients are due no later than 24 hours following the initial diagnostic.
- POC's for returning clients are due by the end of the first week of treatment.

When treatment is not recommended following an evaluation or the client is being recommended for treatment elsewhere, a POC is not written.

In some instances, a client may be seen for an evaluation, but waitlisted for treatment. POC is not immediately written for a client who is put on a waitlist for treatment. POC is not written until the client officially starts treatment. POC for waitlisted client must be written within one week of the day the client officially starts treatment.

For BCBS insurance and Medicaid clients, all POC must be faxed to the referring physician for signature *as soon as possible*.

When do I use this form?

The POC form is used for all clients (i.e., self-pay/private, BCBS, Medicaid, contract), including city and county school clients.

Who completes the POC form?

- POCs are written for new clients immediately (i.e., within 24hours) following the initial diagnostic by the individual who completed the diagnostic.
- POCs are written for returning clients by the treating clinician.
- The supervising SLP's signature goes on the first/top signature blank.

Do I have to send the POC form to anyone once it's completed?

- Yes. All BCBS insurance and Medicaid clients must have the POC certified. A POC is certified when the referring physician signs it. POC for BCBS insurance and Medicaid clients should be faxed to the referring physician ***as soon as possible***.
- All BCBS insurance and Medicaid clients who do not have a signed POC within 30 calendar days of the initial evaluation date or the first day of treatment for returning clients should be discharged from treatment.
- POCs for private pay or city/county clients do not need to be faxed to anyone for signature.

Note: Make sure the ***Acknowledgement of Health Information Practices*** *form is signed and in the client's file, before faxing any information. The form must be updated every 3 years*.

Once I complete the POC what additional documentation must I complete?

It is required that the POC be discussed with the client (parent). For new clients, treatment objectives and recommendations to be included on the POC should be discussed when giving the client (parent) feedback following the evaluation. On the file Access Summary Sheet, document that the POC was discussed with the client, indicate the date, and initial the entry.

For clients who are returning for treatment, the POC should be discussed with the client (parent) at the start of treatment. Again, document that the POC was discussed with the client (parent), indicate the date, and initial the entry.

How do I fill out the POC?

Use the following information to complete the form. When in doubt, ask—don't guess! **ALL** fields **must** be completed.

Today's date: Enter the date the initial draft is written. Do NOT change this date in following drafts. This date should be same as the initial diagnostic date for new

clients who will be starting treatment at our clinic, or the date of the initial treatment session for returning clients.

Note: This date should be the same as the signature date.

File No.: Enter client's account (file) number from the Permanent File.

Initial certification: check this box if this is the client's first POC; this will apply to all new clients.

Recertification for Services: Check this box for each POC written following the expiration of the initial POC.

Example: Client started therapy in fall 2010, so I wrote a POC and checked Initial Certification for Services. I recommended services to be continued in the spring. In the spring, I write a new POC and check recertification.

Note: A POC for a BCBS or Medicaid client may not extend past 90 calendar days. Once 90 calendar days is up, the current POC has expired (i.e., treatment should not continue) and a new POC must be written and recertified even if it is before the last day of clinic for the semester.

Re-evaluation: Check *re-evaluation* if the POC is being written following a full re-evaluation; this is different from pre- and post-testing which is a part of treatment. Re-evaluations may be done at any time following a significant change in functioning or to determine if the client is ready for discharge. A new POC following a re-evaluation is required if significant changes to the treatment plan are being made as a result of the re-evaluation. If no significant changes are being made to the POC as a result of the evaluation, results can be reported in the daily treatment notes and the current POC may be continued.

Client's name: enter full name

ID#: Enter the client's Medicaid number; you will find this on the initial Medicaid referral form; if client is private pay or BCBS then you do not enter anything. Draw a line or write N/A.

Start of Care (SOC) date**:** Enter the date services began at this center. This date remains the same on all subsequent POCs. This date, in most cases, would be the date of the initial diagnostic.

Plan Dates: For all clients, except BCBS insurance and Medicaid clients, enter the day of the initial evaluation (for new clients) or the date treatment started (for returning clients) and the last day of clinic for the current semester. For BCBS and Medicaid clients enter the date of the initial diagnostic (for new clients) or the

date of the first day of treatment (for returning clients) and the date of 90 calendar days from this date. ***Plan dates for BCBS and Medicaid clients may <u>not</u> extend past 90 calendar days.***

<u>Primary Diagnosis</u>: Primary diagnosis should be the speech-language diagnosis; in some cases the speech-diagnosis may be the same as the medical diagnosis. Enter the diagnosis and the ICD-10 diagnosis code.

<u>Secondary Diagnosis</u>: The secondary diagnosis should be the medical diagnosis that supports or is related to the primary diagnosis. Secondary diagnoses must be documented in the client's medical record (i.e., you cannot use a diagnosis code unless the doctor or another qualified professional has officially stated that the client has the diagnosis being considering [e.g., autism]). Enter the diagnosis and the ICD-10 diagnosis code.

<u>Date of Onset</u>: Put the date the secondary diagnosis (medical) was made or put the date the parent reports the problems starting or put the date of the referral to our clinic. If the exact date is not known enter 01 for the day (i.e., 5-01-11).

<u>Treatment frequency and duration</u>: Put how many days a week (frequency) and for how long (duration) the client will be seen to reach the goals that have been established. For example, 3 x week for 6 weeks. Duration should reflect the number of weeks of treatment that will be provided once treatment is initiated to the last day of clinic for the semester or expiration of the POC.

<u>Payer Source</u>: Enter City Contract, County Contract, Medicaid, Private (UA students, flat fee programs, and uninsured), BCBS, or No Charge.

<u>Current Status</u>: Describe the client's ***current*** status. For an initial certification, this most likely will be a summary of the results from the initial evaluation, observations, and parent reports. Be specific to the problem(s) being targeted. If it's a recertification, then use information from the previous semester's summary of progress and informal testing/baseline measures conduced at the beginning of the current semester (i.e., the initial session). Writings should reflect a change in status from the initial current status (i.e., diagnostic) if continued therapy is recommended. Otherwise, recertification is not justified.

<u>Long-Term Functional Goal(s)</u>**:** General statement highlighting ***overall*** goal of treatment. When appropriate, long-term goals should include a functional outcome.

Examples:

- "The client will demonstrate appropriate verbal and nonverbal language

skills needed for all functional environments and routines."

- "The client will improve expressive language abilities to communicate basic needs and wants in natural settings."
- "During conversational exchanges, the client will demonstrate improved voice production characterized by increased loudness and decreased breathiness."

Short-term Goals: Short-term goals are the goals that the client should achieve by the end of the semester or during the certification period. Each short-term goal should be evaluated at the end of the specified time period (i.e., at the end of the certification period). A new objective should then be written at the point in which the objective was met or at the beginning of a new certification period. Examples*:*

- "By the end of the semester, the client will demonstrate the use of easy onset technique with no more than two visual cues."
- "By the end of the semester, the client will increase the spontaneous use of one-word requests during interactions with the clinician on the playground to at least 10x in a 1-hour session."

****All clients must have at least one short term goal that addresses client/caregiver education.**

All short-term goals in the POC should include the following parts:

- *Time Period*: This refers to the time which the objective is expected to be met.
    - *Examples*:
        - "by the end of the week"
        - "by the end of the semester"
        - "across two consecutive therapy sessions"
        - "by the end of the certification period"
- *Who*: "the client"
- *What Behavior:* This must specify the overt behavior to be changed with a verb that describes some observable behavior; i.e., specific observable action word.
    - Examples:
        - "will spontaneously use 5 one-word requests"
        - "will correctly produce the /s/ in the final position of words in structured sentences"
        - "will successfully use easy onset technique on target words at the sentence level"

        - "will correctly identify factors contributing to proper vocal hygiene"
- *What Conditions*: This must specify all antecedent events which include the following: who the client is interacting with, where the interaction occurs, the material involved, and the verbal as well as nonverbal stimuli.
    - *Examples*:
        - "in response to the clinician's verbal model of the vowel sounds /a,u,o/ in the therapy room:
        - "during natural interactions with a peer on the playground"
        - "while engaging in short conversational exchange with an unknown participant in the therapy room,"
        - "while asking questions of an attendant in the library"
        - "when presented with picture choices in the therapy environment"
        - "while engaged in role-play situations with peers within the group therapy session"
- *Criterion*: This must specify the degree of proficiency or rate of behavior, and will indicate when the objective is met.
    - *Examples*:
        - "9/10 times"
        - "80% accuracy"
        - 4 out of 5 trials
        - With less than 3 instances of intelligibility

(Examples adapted from Florida State University's Speech and Hearing Center Website)

<u>Treatment Methods/Procedures:</u> State the specific approaches and techniques to be used to facilitate mastery of goals. Do not just state: "articulation therapy" or "language therapy".

Examples:

- *Stimulus response treatment*
- *Oral motor tasks to increase kinesthetic awareness of articulatory placement*
- *Multisensory (tactile, auditory, and visual) cueing for/to….*
- *Therapeutic drill*
- *Cycles Approach*
- *Focused stimulation*
- *Pivotal response training*
- *Joint action routine*
- *Enhanced milieu teaching*
- *Pecs*
- *Descriptive talk*
- *Compensatory training*
- *Caregiver education/home program*

Treatment Rationale**:** Clearly state why you have selected the goals and the treatment procedures/techniques listed. Include developmental norms when appropriate and indicate degree of delay in months for the areas you are targeting. Reference sources that support the use of specific techniques or the inclusion of certain goals—this shows that you are using evidence based practices**.**

Rehabilitation Potential/Prognosis**:** Rate the client's rehab potential as good, fair, or poor. Base this on both positive and negative factors. When determining a client's prognosis, avoid subjective factors such as motivation and attitude. Prognostic indicators include but are not limited to: age, medical history, diagnosis, co-existing conditions, stimulability, support system/family involvement, and previous performance in treatment.

Signatures**:** The POC must have signatures from the supervising SLP, graduate clinician, and referring physician, if appropriate. Supervisor and clinician signatures should be dated the same as "today's date". The supervising SLP's signature should always be first.

Weekly Lesson Plans

Each week, the student will write a lesson plan for each client for the coming week. When writing a lesson plan, the student should refer to feedback from the clinical supervisor, the approved plan of care and daily treatment notes.

- Written weekly by the student clinician
- Due on Friday for the upcoming week
- Should be attached to the Working File and placed in the supervisor's mailbox in The Speech and Hearing Center Office. Previous therapy plans with all data and progress logs should be included.
- Supervisor will review the plan, make suggestions, and return it to the student prior to the next clinical session
- When turning in the Working File for review by your clinical supervisor, you will need two copies of the lesson plan. Place one under the clasp and leave the second copy inside that section for the supervisor to keep.

Daily Treatment Notes

Daily treatment notes must be kept on all clients regardless of payer source. All notes must be hand-written or typed in SOAP note format (The clinical supervisor will inform the student as to whether notes will be written or typed). The Daily

Treatment Notes form consists of 2 pages. Page 1 is divided into 2 sections: (1) identifying information and (2) narrative space. Once the narrative section of Page 1 is full, use Page 2 for all subsequent entries. Do not use multiple copies of Page 1. All treatment note forms must be double-sided and all portions intentionally left blank should be striked and initialed.

Daily treatment notes are considered to be a legal document. Write all notes in black ink. Sign your name after each note. Have your supervisor sign each entry. Write the month, date, and year each entry is completed (e.g., 5/2/11, not 5/2). If you make an error, put one line through the mistake and initial it. Do not use white-out. All notes will become a part of the client's permanent file. The Treatment Note template is on the share drive. See The Speech and Hearing Center share drive for an explanation and examples of SOAP notes.

Therapy Response Sheet

The Therapy Response Sheet is used to track data during a treatment session. It provides a record of correct and incorrect responses with notes at the end. It is kept in the Working File.

Summary of Progress Report

At the end of each semester, the student clinician will write a summary progress report for each client. The template for this report is on the share drive. The report summarizes the client's progress from the start date of treatment to the end date. The Summary of Progress Report is kept in the Permanent File. An explanation of each section of the report is as follows:

STATUS AT THE BEGINNING OF THE SEMESTER
Narrative description of patient (age, sex); what happened; complicating or other pertinent issues; referred by; seen at The Speech and Hearing Center since…; Special issues addressed this semester, if any; description of client's level at start of semester; include enough information to rationalize your choice of goals/objectives/tests; include diagnostic test information if you did it early in semester.

The information you choose to include here should at justify your choice of treatment targets for the semester.

DIAGNOSTIC INFORMATION (Omit this section if it is not applicable)

Include this section if you obtained supplementary information on a change in your client. For example, you are seeing your client for a developmental language disorder, but after starting treatment you realized that something else might be going on, you suspect apraxia. So, you decide to give an apraxia battery. Include this new diagnostic information in this section. If you do not have this information, then do not include this section. You also may include new diagnostic information received on your client after the start of treatment. For example, your patient has a significant decline in function—you refer your client to the neurologist to be assessed. The neurologist orders a CT scan; results of the scan are requested by you; include the results relative to the client's change in this section.

When writing this section, tell why you did the additional testing or referred the client for additional testing, what test was used, briefly tell about the test itself, what the results were, the score means in terms of norms or diagnosis, and interpret the findings in terms of functional behaviors.

Example: In response to Mrs. Smith's persistent motor difficulties, the clinician administered the Limb and Oral Apraxia Subtest of the Apraxia Battery for Adults (ABA) on October 21, 2010. The client scored 22/ 50 for limb apraxia and 22/50 for oral apraxia. According to test norms, these scores indicate the presence of moderate-severe limb and oral apraxia. The results suggest that Mrs. Smith has significant difficulty making voluntary movements with her arms and her speech articulators.

Example: Prompted by the client's persistent reading difficulties, the clinician administered a nonstandardized behavioral reading assessment to John in November, 2010. Since coming to The Speech and Hearing Center, he has experienced significant difficulties in decoding words. Despite maximal prompting this semester, he has had great difficulty matching phonemes to graphemes and vice versa. The purpose of this assessment was to analyze John's reading difficulties in order to determine the most appropriate treatment strategies. His score were as follows… These test results indicate/suggest….

TREATMENT PLAN

Treatment this semester focused on the following long-term goal(s):

Example:

1. The client will use appropriate memory strategies to schedule and recall weekly activities and appointments.

Treatment this semester focused on the following short-term goals: (report baseline status and progress for each goal) Example:

Example:
1. When given maximum cues, the client will use meaningful gestures (e.g., pointing, showing relative size or shape) in conjunction with speech to express an idea in 80% of conversational opportunities.

Baseline: The client successfully used gestures on 30% of opportunities with moderate cues.

Progress: The client used gestures on 60% of opportunities with minimal cues. Objective discontinued at this criterion level. John could not respond to maximal cueing (e.g., model-imitation) in this area due to his limb apraxia.
GOAL PARTIALLY MET

2. (include next goal)

3. (include next goal)

PROGRESS SUMMARY

Do not include any new information in this section. Provide a brief summary of what was emphasized, how it was worked on, how successful it was, what methods were especially successful. Include a general statement of progress and further needs. This section should be the "synopsis" of the report. A person should be able to read this section and the recommendation sections and get a good sense of how the client did in treatment this semester.

Example: The client was highly motivated and made considerable progress communicating more effectively in social conversations this semester. Out of the 5 treatment objectives, she met 3, partially met 1, and failed to meet 1. She has become a more active participant in conversations by initiating topics and formulating questions independently. She also attempts to use a greater variety of strategies to resolve communication breakdowns than she did at the beginning of treatment. However, she continues to need clinician support in the form of augmented input (i.e., speech paired with gestures) to improve her

comprehension. She benefits from having goals and objectives reviewed briefly with her prior to any treatment activity. Client's sister and son participated in treatment sessions this semester and learned to use augmented input and the Written Choice Communication Strategy to improve their communicative interactions with the client.

RECOMMENDATIONS
List recommendations and be as specific as possible. Include recommendations regarding goals, if appropriate.

Example:

1. It is recommended that Mr. Smith continue to receive individual and group speech-language services once a week at The Speech & Hearing Center for the Spring semester, 2011.
2. It is recommended that treatment continue to relate to Mr. Smith's current interests (e.g., family, sports, and fishing).
3. It is recommended that Mr. Smith's AAC communication book be expanded to include descriptions of family members and a chronological timeline of Mr. Smith's life.
4. It is recommended that Mr. Smith begin communication trials with a transparent symbol-based system and that future treatment goals include assessment of this strategy.

In closing, include a prognosis statement predicting progress for the next semester. Base this on your best judgment in consultation with your supervisor. Use terms such as excellent, good, fair.

Example:
Given the client's family support, his motivation to improve, the relatively recent onset of his impairments, and continued individuals and group speech therapy, his prognosis for improved communication effectiveness is good.

(Examples adapted from Florida State University's Speech and Hearing Center Website)

Discharge Summary

A discharge summary report must be completed at the time a client is discharged from treatment regardless of the reason for discharge. If the client is discharged at the end of the semester treatment period, a Discharge Summary Report is

completed in addition to the Summary of Progress Report. The discharge summary report should include the client's status at the beginning of clinical management, not status at the beginning of the current semester. The discharge summary template is on the share drive. It is kept in the Permanent File.

Diagnostics

Requirements

As a part of the graduate curriculum, all graduate students are required to complete a "diagnostic practicum". The "practicum" consists of completing:

- One observation of a diagnostic session
- A minimum of five in-house diagnostics
- The Assessments Instrument List

These requirements are fulfilled over the course of the 5 semester graduate program. During the first semester, each graduate student is given a diagnostic folder that contains:

- Assessment Instruments List
- Example of the Diagnostic Session Observation form
- Example of the Diagnostic Plan Worksheet
- In-house Diagnostic Tracking form
- Diagnostic Checklist

The Diagnostic Folder should be used to keep documents showing completion of the diagnostic requirements. During the student's last semester of graduate school, this folder will be turned in for review. The Diagnostic Checklist will be completed based on the contents of the student's diagnostic folder.

Process for Completing Diagnostic Requirements

Before conducting diagnostics, graduate students must complete one diagnostic observation and be enrolled in CD 529: Diagnostics. (The diagnostic observation will typically be completed within the diagnostics course.)

Diagnostic Teams:

All graduate students will be assigned to a "diagnostic team," which is led by a clinical supervisor. If you are completing an in-house clinic rotation, your current clinical supervisor is your diagnostic team leader. If you are off-campus, you will be assigned to a diagnostic team. Off-campus students are expected to communicate their schedules

to their diagnostic team clinical supervisor so that diagnostic assignments can be made. It is our goal to fulfill diagnostic requirements for graduation by the end of the fourth semester. Please see the table below, outlining a projection for when diagnostics should be completed. *This is subject to change due to Clinic needs or Clinic Director discretion*

1st semester	2nd semester	3rd semester	4th semester	5th semester
Observation (in diag. class) + 1 (toward the end of the semester)	1-2	1-2	1-(voice eval in class)	0

Earning Credit for Diagnostics:

In order to earn credit for each diagnostic (i.e., to count as 1 of the 5 required), satisfactory marks on the Diagnostic Session Observation form must be earned and all timelines must be met. Supervisors should also complete the Diagnostic Practicum in Calipso after each diagnostic.

Tracking Diagnostics (two ways):

1. A Diagnostic Tracking Card for each student will be housed in the Clinic Director's office. Once a diagnostic has been completed with satisfactory marks, the student will notify the Clinic Director's graduate assistant via email. The graduate assistant will log the diagnostic onto the student's Diagnostic Tracking Card. This will allow the Clinic Director to monitor where students are in the diagnostic process.

2. Additionally, students will have the clinical supervisor sign-off on the In-house Diagnostic Tracking form, once satisfactory marks have been obtained. (Supervisors will NOT sign-off on diagnostics with un-satisfactory marks.) This form will stand as your record of diagnostics completed and will be kept in your diagnostic folder and reviewed prior to graduation.

The Diagnostic Process:

When completing an in-house diagnostic, the student, with support from the clinical supervisor, is responsible for:

- Preparation
- Conducting the initial interview

- Completion of the testing
- Counseling the client/family regarding the test results
- Writing a comprehensive diagnostic report
- Making recommendations
- Meeting deadlines

When a Diagnostic CANNOT Count:

It is the responsibility of the student to notify the Clinic Director if an assigned diagnostic is not being counted toward the minimum requirements. The Clinic Director and Diagnostic Team Leader will work together so that another diagnostic may be assigned to the student.

Assessment Instruments List:

Students are required to administer a minimum number of assessment instruments in various areas of the field. Assessment instruments used should be tracked using the Assessment Instruments List form. This form can be found on the Speech and Hearing Center share drive. Minimum requirements for each area are listed on the form. Both in-house and off-campus supervisors sign-off on this form. Assessments used for pre and post-testing, initial diagnostics, and re-evaluations may be counted. This form should be kept in the student's diagnostic folder, along with the student's Diagnostic Tracking form and Diagnostic Session Observation forms, and will be reviewed during the student's last semester prior to graduation.

***It is ultimately the responsibility of the student in seeing that the diagnostic requirements for graduation are fulfilled.**

Diagnostic Procedures

Referrals

Evaluations are available to any child or adult with a communication disorder. Referrals are accepted from any source, including physicians, interested individuals, and community agencies. It is the responsibility of the client or family member to contact the Primary Care Physician for a referral for diagnostic evaluations or treatment if needed. Referrals may be faxed to the Center prior to the scheduled diagnostic or brought by the client or family member on the day of the evaluation. Diagnostic evaluations and

treatment can be conducted without physician referral; however, insurance or Medicaid claims cannot be filed without an appropriate physician referral. The client is expected to pay for services privately if physician referral is not provided.

Process for Scheduling Diagnostics

The clinic receptionist is the initial contact person for any person interested in receiving a speech/language evaluation and/or treatment. Diagnostic appointments will be scheduled by the clinic receptionist.

During the initial contact, the clinic receptionist will:

- Explain service fees
- Complete the appropriate intake form
- Schedule the diagnostic with the appropriate clinical supervisor
- Request physician referral, if appropriate (i.e., Medicaid/BCBS)
- Note on the intake form any information that indicates that the graduate student and/or supervising SLP should contact the client prior to the evaluation
- Let the client know:
    - An evaluation can take up to 2 hours
    - If a physician referral is not received prior to the evaluation then they will be charged and responsible for the total cost of the diagnostic (i.e., $93.00) prior to services being rendered
    - They need to arrive 15 minutes prior to their appointment to complete paperwork
- Enter appointment in the Diagnostic Outlook Calendar.
- Make a permanent client file
- Document on the File Access Summary sheet (tracking form) that the client was scheduled for a diagnostic; initial the entry
- Fill-out a white client contact card and include in client file

Note: If the client is between the ages of 3 and 5, the parents are to be informed about the city/county school program. If they choose to pursue school services, their information should be taken on an intake form and given to the city or county preschool contact person at The UA Speech and Hearing Center.

Recently Evaluated Clients

NOTE: It is important for the clinic receptionist to document any previous assessments on the intake form.

Clients who have recently been evaluated by an outside facility may not need evaluating and may need to be scheduled for treatment only.

- The supervising SLP should contact all clients who have recently had an evaluation prior to their scheduled diagnostic at UA to determine the appropriateness of conducting another evaluation.
- If it is determined an additional evaluation is not needed, the supervising SLP should cancel the diagnostic, document events on the tracking form in the client's file, and complete the white client card indicating treatment only is warranted.
- The white client card then should be turned in to the Clinic Director. The Clinic Director will assign the client to a supervising SLP based on availability.
- If no current availability exists, then the client will be added to a waitlist and the clinic file is stored in the front office.

Diagnostic Process

Step 1: The Diagnostic Team Leader (Clinical Supervisor) will notify the graduate student when a diagnostic has been assigned. After the student has been notified, he or she must meet with the clinical supervisor a minimum of 48 hours before the evaluation.

Step 2: During the initial meeting, the case should be reviewed and any additional information needed should be determined.

Step 3: If additional information is needed prior to the evaluation, the student should contact the client. Reasons the client might need to be contacted prior to an evaluation include:

- Request records from previous evaluations or treatment
- Request medical records (e.g., neuroimaging report, surgical procedure)
- Request a physician referral
- Clarify and/or review information on intake form
- Explain directions to clinic
- Explain fees for services, and/or
- Confirm the appointment

Following contact with the client, the graduate student should document the call, the purpose of call and the outcome of call on the File Access Summary Sheet.

Example:

9/12/10: Called to confirm appointment for 9/18/10. Mother said child was just seen by school system and she is no longer interested in evaluation. Cancellation was given to clinic secretary and supervisor-KW

OR

9/12/10: Called to confirm appointment for 9/18/10 and ask parent to bring previous evaluation reports from other agencies-KW.

Step 4: Following the initial meeting, the student should complete the Diagnostic Evaluation Plan Worksheet and set up a second meeting with the supervisor. •

During the 2nd meeting, the supervisor reviews the diagnostic plan and makes suggestions/modifications.

NOTE: Students doing diagnostics should get experience giving a variety of tests. The clinical supervisor and student should take into consideration what tests he or she has already given and when appropriate, use alternative tests, so that the student gets practice giving different tests. The supervisor should not recommend a test or tell the student what test to give before the student has reviewed different tests and made suggestions of his or her own.

Step 5: Student completes diagnostic and the Supervisor observes and completes Diagnostic Observation Form and Diagnostic Practicum in Calipso.

NOTE: The diagnostic should not be started until all paperwork has been completed and insurance has been verified.

Step 6: Following completion of the diagnostic the student and supervisor

- Provide feedback to the client (parent)
- Complete a billing slip
- Document activities on tracking form

Tracking Form Example:

9/18/10: Client seen for evaluation; results of testing and recommendations reviewed; client scheduled to start treatment 10/2/10@ 3:00p.m. Client will receive tx 2 x week, one hr per session. POC faxed to PCP -KW

Step 7: Once the diagnostic is completed, the supervising SLP should complete the white client contact card with outcomes of the diagnostic (i.e., recommend treatment,

waitlist, no treatment warranted, etc.). The completed white card with recommendations should be given to the Clinic Director for all cases where treatment is not scheduled to begin immediately.

Note: It is the responsibility of the graduate student to make sure all necessary forms (e.g., HIPPA forms, release forms, case history form, etc.) are completed and in the client's file for the front office staff to put in order. It is recommended that the forms be reviewed during the interview session to ensure all fields are complete and that the client (parent) doesn't have any questions.

Completing a Diagnostic Report

Deadlines

- Once the diagnostic is complete, the student has a maximum of 10 working days to finalize the report, or credit for completing the diagnostic may be withheld.
- Supervisor may request reports to be completed prior to 10 working days due to special circumstances.
- First draft of the diagnostic report is due no later than 48 hours from completion of the evaluation.
- Supervisor will edit the report and return it to the student for corrections. The supervisor should indicate the date and time the report was returned.
- Revisions are due are within 48 hours of receiving the edited version.
- In addition to writing the diagnostic report, the student completing the diagnostic is required to write the initial Plan of Care if treatment is being recommended at our Center without delay. The initial draft of the POC must be written and submitted to the supervisor within 24 hours of the diagnostic.

General Instruction for Diagnostic Report Writing

Each report is written using the Diagnostic Report template saved on the Speech and Hearing Center share drive.

When the first draft of the report is complete, attach it to the Permanent Client File and turn it in to the clinical supervisor.

First Draft

1. Complete first draft using the standard template.
    - Print the first draft on regular computer paper. It must be double spaced.
    - Attach it to the outside of the Permanent Client File with all other appropriate

records from the diagnostic.
- Put the file in your supervisor's box in the main office unless instructed differently by your supervisor

2. Your clinical supervisor will:
   - Make corrections and return the file and report to your box, or
   - Put the file and report in your box with a note that it was too poorly written to correct. In this case, you must start over. Ask for help with the first draft if needed to avoid this situation.

Final draft

1. When final corrections have been made by your supervisor, make the changes on your version.
   - Print 2 original copies.
   - Print the first page on Department of Communicative Disorders letter head stationary. Print subsequent pages on matching paper.
   - Attach both copies of the report to the outside of the Permanent Client file.
   - Put the file in your supervisor's box

2. The final draft will be returned to you if there are any errors. Proof your work carefully.

<u>Dissemination of Diagnostic Reports</u>

Before sending any diagnostic reports to persons or agencies other than the client or the client's parent, make sure the Acknowledgement of Notice of Health Information Practices is signed, or other release forms if necessary, and is in the client's file. If the report is being sent for any reason other than treatment, payment, or operations of The Speech and Hearing Center, an additional release form must be signed. (See HIPAA, Appendix III)

- Diagnostic reports for all clients are mailed to the client/parent by the front office staff once the report is finalized.
- If a client is seen only for a diagnostic (i.e., treatment is not being recommended or the client is being referred elsewhere) and was a physician-initiated referral, an additional copy of the diagnostic report is faxed to the referring physician no more than 15 working days from the test date.

<u>Dissemination of Plan of Care</u>

If the client is a private health insurance or Medicaid client and treatment is being

recommended at our clinic without delay, the clinician must complete a POC in addition to the diagnostic report.

- POC must be certified, or signed by the referring physician, within 30 calendar days.
- POC should be written and faxed to the referring physician as soon as possible.
- Diagnostic report does not have to be sent in this case; only the POC, which contains a brief summary of the evaluation results.

If treatment is not being recommended immediately following the diagnostic or the client is being referred elsewhere for services, then a POC is not written. Instead the diagnostic report serves as the POC and may be sent to the referring physician for his or her records.

Note: Documentation on the File Access Summary sheet must be made indicating that the test results and recommendations were discussed with family or client and when and where any reports/results were sent.

Guidelines for Completing Re-evaluations

Re-evaluations may be completed any time a clinical supervisor deems that it is necessary. If a re-evaluation is necessary, specific reasons that support the need for a re-evaluation must be documented in the client's file.

When possible, re-evaluations should be scheduled to correspond with either the beginning of a clinic term or the end of the clinic term.

Re-evaluations should not be scheduled for the beginning of the following semester if you suspect the client will "test-out" and be ready to discharge from therapy. Testing should be done at the end of the current semester.

If any significant changes to the treatment plan are made as a result of the re-evaluation, then a new POC must be written even if the current POC has not expired. If changes are not considered to be significant then the results of the re-evaluation can be documented in the clinician's treatment notes and treatment can continue under the current POC.

A full diagnostic report should be written for all re-evaluations. If the client is being discharged based on the results of the re-evaluation, then a discharge summary should also be completed.

Re-evaluations differ from informal and formal pretesting and post-testing completed

during or as a part of treatment. Guidelines for completing a re-evaluation are the same as those for completing an initial diagnostic.

CPT Code 92506 should be used for Re-evaluations.

When possible, re-evaluations should be scheduled outside regular treatment sessions.

See the share drive for examples of Diagnostic Report Outlines.

Report Writing

Each report is written using a standard report template saved on the Speech and Hearing Center share drive.

- Rough drafts are typed on the computer and double spaced.
- Use sample reports as a reference for identifying information, capitalization of major headings, and signatures.
- Complete all identifying information.
- Use past tense.
- Include your supervisor's title in the signature section.
- Use phonetic symbols and slashes correctly. (/z/, /m/, /θ/)
- Numbers, with the exception of ages, dates, and data, and test scores, must be spelled out. For example, "John's receptive vocabulary fell one and one-half years below his chronological age." "Harry was able to count from one to seven." The Arizona Articulation Proficiency Scale revealed a score of 72 percent.
- Vary wording. For example do not use terms such as, "judged to be", "revealed", "reported", "within normal limits", etc. several times in succession. Do not use the client's name more than necessary. Read the report aloud to yourself to evaluate wording, clarity, and smoothness.
- Underline test names. Capitalize test names. For example, Goldman-Fristoe Test of Articulation, (GFTA).
- If a test is mentioned more than once, the abbreviation can be used as long as it was referenced earlier in the report. For example, Goldman- Fristoe Test of Articulation, (GFTA).
- Discuss tests in terms of specific skills they measure. For example, the Peabody Picture Vocabulary Test, a measure of receptive vocabulary, indicated …..". "….. based on the Carrow Elicited Language Inventory, which measures syntactic skills."

- Proofread the report. The rough draft should be your best effort.

First and Final Draft Expectations

Written reports are the clinical practicum equivalent of a written exam. The need for on-going extensive editing as the student moves through the program is an indication that remediation might be warranted.

- The rough draft is a written summary of the student's knowledge and understanding of the clinical experience just as an exam is an example of the student's academic knowledge.
- The rough draft is also an example of the student's professionalism.
- The rough draft should be an example of the student's best effort.
- The rough draft should require minimum correction.
    - If a rough draft is so poorly written that the clinical supervisor feels it cannot be corrected, it will be returned to the student to be rewritten. It should be re-submitted to the clinical supervisor within 48 hours.
    - This is equivalent to failing an exam. It indicates that the student did not understand the clinical process and lacked the professional motivation required to remediate the problem.
- The final draft will become part of the client's permanent record.
    - The final draft is a reflection of both the clinical supervisor's and the student's clinical competence.
    - The final draft is a legal document.

End of Semester Reminders

1. Clean out student box and locker. Return all materials to the appropriate places.
2. Schedule end-of-term conference with your supervisor to go over your Performance Evaluation in Calipso. Print and keep a copy of your final performance evaluation.
3. Look for announcements regarding any type of required meetings (e.g., off campus meeting, clinic clean-up)
4. Make sure that you have logged all clinic hours in Calipso and that those have been approved by your clinical supervisor.
5. Turn in both working files and client files to your clinical supervisor with reports to

be mailed attached to the front of the client files. Two original copies of Summary of Progress Reports should be printed—one for file, one for mailing.

6. Update File Access Summary Sheet in permanent client file
7. Update your KASA in Calispo.
8. Have your supervisor sign-off on the Assessment Instruments List where appropriate.

Note: All paperwork must be completed and approved by the clinical supervisor before a grade for clinic is awarded**.**

Clinic Clock Hours

STUDENTS SHOULD ALWAYS AND INDEFINITELY KEEP A COPY OF CLOCK HOUR FORMS.

The student should indefinitely retain a copy of clinic hour forms. Documentation of clinical experiences is required for certification, licensure, and completion of the master's degree. Semester forms and the final Summary form will be kept in the student's Departmental File.

By the end of the graduate program the student must earn a minimum of 400 clinic clock hours.

- 25 hours of observation are required
- 325 hours must be completed at the graduate level
- No more than 75 undergraduate hours can count toward the 400 total hours

The Do's and Don'ts of Counting/Recording Clinic Hours

- Only record the time you spent directly providing treatment or testing.
- Calculate hours as follows: .25=15 minute session, .50=30 minute session, .75=45 minute session, and 1.0=1 hour session.
- Do NOT record time in group therapy per client (e.g., you have 3 clients in a group for 30 minutes. You record .5 on your hour form. Not 1.5).
- If you are co-treating, you ONLY count the time YOU were providing active and direct treatment. Do NOT count the entire time you were "in the room".
- Pre and post-testing should be counted under Evaluation hours and not treatment hours.
- Do NOT count screening hours under Evaluation. Record them under screenings on the clock hour forms.

- Before submitting your hour forms to your supervisor for signature, make sure each row and column is totaled.

Billing

Policy

The UA Speech and Hearing Center is a fee-for-service clinic. All clients are expected to pay for speech-language evaluation and treatment services. These services are provided by or under the direct supervision of certified and licensed speech-language pathologists. HIPAA Policies and Practices are followed during the billing process.

Blue Cross Blue Shield (BCBS) insurance may be billed for evaluation and treatment services if the client has a doctor referral for the services being requested. All clients wishing to file services on their insurance are responsible for obtaining a physician referral prior to the first appointment. If a client arrives for an evaluation or treatment without a physician referral they will be charged and required to pay the full fee for the service, at the time of service. Clients who wish to file services with BCBS should check with their health care provider prior to their appointment to determine if the services being sought are covered. Not all BCBS policies cover our services.

Medicaid claims may also be billed for evaluation and treatment services. All Medicaid clients must have a Medicaid referral form (EPSDT) from the primary care physician on file in this Center prior to services being provided. If a referral form is not provided prior to the service being rendered, no service will be provided unless the client is able to pay the full fee for the service at the time of the service. Medicaid referrals can be faxed to us by the client's physician or brought by the client on the day of the scheduled service.

Clients who are uninsured, have an insurance provider not accepted by our clinic, whose BCBS policy does not cover our services, or whose allowed insurance

visitations have expired, are classified as private-pay clients. All private-pay clients are billed for services based on the Center's established standard fee schedule.

Time-of-Service discounts are available for private pay clients. Time-of-Service fees are due in-full at the time services are provided. If the client does not pay the full amount for that day's services, the Time-of-Service fee schedule is voided and standard fees will be billed to the client's account. Time-of-Service discounts are not available for flat program fees or evaluations.

Private pay clients demonstrating an inability to pay for services in-full will be eligible to apply for discounted treatment based on a sliding-fee scale (i.e., hardship discount). A hardship discount is based upon household income and size and is updated every year using federal poverty guidelines. A completed application including any required documentation of the household income must be on file and approved before a discount will be granted. Once a discounted rate is approved, the client is expected to pay the entire amount of the discounted rate due for each day's services. Hardship discounts based on the sliding-fee scale are not available for evaluations.

Group treatment services with flat program fees are not filed for reimbursement through BCBS or Medicaid. All clients choosing to participate in a group program are responsible for paying for the program in-full. If a client is unable to pay for the program in-full, a hardship discount rate based on the sliding-fee scale may be offered.

Insurance is not filed for individual and/or group services provided to adults with neurogenic-based speech-language disorders, UA students, or adult fluency clients. These populations are billed a flat-rate for evaluations and a flat rate for treatment per semester or per session.

All treatment services (i.e. individual and group) offered in the summer are flat-fees and are not filed for reimbursement through BCBS or Medicaid. Hardship discounts are available for those who qualify.

Evaluations conducted during the summer will be filed for reimbursement through BCBS or Medicaid given the client has an appropriate referral for testing to be conducted.

Services may be paid for by check, cash, or credit card.

Billing Slips

A billing slip must be completed for each scheduled session for which payment is being collected. A billing slip must be completed EACH session for the following client types:

- UA Students
- BCBS Insurance clients
- Medicaid clients
- Self-pay/private-pay clients
- City contract clients
- County contract clients

For clients receiving a flat-fee service, complete a billing slip on their *first day of treatment only.* Do NOT complete a billing slip each visit.

Instructions for Completing a Billing Slip

Before your client arrives complete the top portion of the billing slip. Do NOT wait until your treatment session is over to get a billing slip from the front office.

For *service provider,* enter your supervisor's name; not your name.

Under Responsible Party, mark the payer source. If the client is receiving a flat-fee service, check the box and then specify the program.

Do NOT mark anything else until after you provide the service. Do NOT circle a CPT code until you have provided that particular service.

If the client does not show or cancels treatment you still MUST turn in a billing slip. Fill out the top portions and then check the *no show* or *cancelled* box.

When your treatment session is over, circle both an ICD-10 Diagnosis and a procedure code (i.e., CPT). Circle these before you leave the treatment room. Do NOT guess what codes to circle; ask your supervisor if you have any doubts-Do NOT ask the front office staff.

Do NOT write anything in the amount due or amount paid spaces.

For all City Contract and County Contract clients, you must indicate the length of the treatment session on the billing slip (i.e, 30, 45, or 60 minutes).

When you walk the client out of therapy, direct the client (parent) to the window to check-out; give the client (parent) the billing slip at the window and thank them for coming. Do NOT give the parent the billing slip in the hall or in the waiting room. Do NOT give the billing slip directly to the front office staff.

All clients who check in after 4:00 p.m. must pay prior to services being rendered. If you have a client that comes after 4:00p.m., go ahead and complete the billing slip once they arrive and have the client (parent) see the front office staff prior to you taking the client back for treatment.

If you make an error on the billing slip, draw one line through the error, initial it, and then make your correction. Never use "White Out" on a billing slip. If multiple errors are made, void the billing slip. Do NOT tear it up, throw it away, or shred it. Void the billing slip and turn it in with the corrected billing slip.

Sample billing slip and CPT and ICD codes are saved on the Speech and Hearing Center share drive.

Summary

The goal of clinical training is to provide each graduate student with the academic coursework, exposure to research and related professional activities, and the clinical experience necessary to enter the workforce as a professional in the field of speech-language pathology. Once students have graduated, they must be prepared to be critical thinkers and life-long learners. Continuing education is not only a requirement to obtain and maintain certification and licensure but is necessary to meet the challenges of a dynamic profession. Students who graduate are considered "CF Ready", (Clinical Fellowship Year Ready). From this point on, new professionals will

grow and mature as they become seasoned and experienced clinicians, always learning and pursuing excellence.