# Diagnostic Clinic Procedures

A half- to full hour planning meeting with the supervisor takes place prior to a Rees Clinic evaluation, at a time determined by the supervisor and diagnostic team members. Each case is assigned one Lead and one Assistant clinician; each Diagnostic clinician will have training opportunities in both roles. Assistants for diagnostic cases will accrue evaluation hours according to ASHA standards. Clinicians complete a minimum of one or two onsite cases in lead and assistant roles, which may include Twin Oaks Montessori and other sites as assigned by Clinic Director and outlined in each term's SLHS 696 syllabus and Diagnostic Schedule. Additional onsite DX leads will be scheduled as dictated by the clinician's performance on their first one or two onsite cases in which they must achieve a minimal competency rating of 3.0 as defined by CALIPSO. All clinicians will conduct at least 3-4 offsite assessments under the supervision of various Speech-Language Pathologists working in the S.F. Bay Area as assigned by the Clinic Director and outlined in the SLHS 696 syllabus and DX schedule for that term. Clinicians often have opportunities to complete offsite assessments before registration in the course or during their concurrent or subsequent offsite assignments or in their first internships. Students only enroll in SLHS 696 for one term with the Clinic Director keeping track of onsite and offsite evaluations for determination of final grade, which may initially result in an Incomplete until all evaluations are completed and graded by the various supervisors.

Processes and procedures as outlined below may be modified for telepractice evaluations, and are based on a system of electronic client record keeping. Telepractice evaluations are scheduled on a two-clinician model in which both clinicians share all responsibilities of planning, administration and documentation, according to C.A.A. (our accreditation body) standards.

## Lead Responsibilities

1. Prior to a planning meeting
   a) Review client's file, research disorder, contact other professionals involved with case as appropriate and if authorization for releases are in place (e.g., SLP, teacher, doctor).
   b) Review diagnostic tests and interview procedures.
   c) Prepare a Diagnostic Plan, submitted electronically to supervisor prior to the planning meeting.

2. During a planning meeting
   a) Present Diagnostic Plan to supervisor and assistant for discussion. (These roles may differ in a shared telepractice evaluation.)
   b) Make appropriate changes to Diagnostic Plan as indicated and submit electronic revisions if the supervisor requires them.
   c) Determine duties of Assistant. (These roles may differ in a shared telepractice evaluation as there is no assistant.)
   d) Obtain test protocols from ASC if not available in Resource Room.

3. Prior to the assessment, contact the client and/or caregiver by phone and/or email to introduce yourself, answer any questions, check for allergies, motivators, etc. For telepractice evaluations, the clinicians provide *Zoom* link and other necessary adaptations to client and/or caregiver.
   a) Enter information on test protocols neatly and in ink. Use only one protocol per client, with assistant using a photocopy.
   b) Confirm required evaluation forms are available to complete if the client has not previously submitted them. This includes caregiver POA/PHI release as applicable for clients over 18.
   c) Ask the supervisor if they require a copy of the Diagnostic Plan or copies of test protocols for reference during the evaluation. If the evaluation is to be observed by students, ask instructor if the Diagnostic Plan and copies of protocols need to be available for them.
   d) Set up room for interview for in-person evaluations, and organize materials for testing.

4. During the evaluation
   a) Conduct interview.
   b) Explain evaluation procedures.
   c) Administer measures and take data during assessment.
   d) Note behavioral observations.

5. Staffing (This portion of evaluation may be changed for telepractice and/or at the discretion of supervisor for efficiency, for example if client is scheduled for immediate therapy, in which the outcome/recommendations of the evaluation are known.) While the client and possible caregiver wait in reception area, clinical impressions and recommendations are briefly discussed in preparation for the exit interview.

6. Exit Interview
   a) Discuss clinical impressions and recommendations with parent/client, allowing time for questions.
   b) In some cases of re-evaluation or DX within TX, the supervisor may choose not to have an exit interview.

7. Clean-up
   a) Collaborate with assistant regarding their data, impressions, etc.
   b) Return tests and other materials to Resource Room.
   c) Disinfect and return audiometric equipment.
   d) Check that evaluation recording is halted.
   e) Retrieve plan and protocols from Observation Room.

8. Written Documentation- Please include signature line for lead clinician, or shared clinician in the case of telepractice, in addition to supervisor.
   a) First submissions of report and letter to clients/caregivers are to be typed double spaced in Arial 11 point font with pagination at the bottom center, and are due as electronic WORD documents. **Reports should include client initials* until final approval.** Upload test protocols, language samples and other relevant assessment data to Google Drive folder for client. In addition, please provide hard copies to supervisor. The lead clinician and in the case of telepractice, both clinicians should upload their signatures as a jpeg to Google DX folder that the Clinic Director opens as soon as client's evaluation is scheduled.
   b) Letter to client/caregiver must be individualized and appropriate to their needs. (Aphasia-friendly letters should be an option if appropriate.) Typically, these are written in a natural tone, summarizing the exit interview and without jargon or reference to tests or results. Discuss the content with supervisor. Priority is to mail letters out within one week of assessment. Letters are typically one page, single-spaced, and on letterhead once finalized. Once the letter is finalized, the supervisor is responsible for ensuring that identifying information (PHI) is inserted in a HIPAA compliant manner, electronic signatures applied and that it is filed with the client's Google Drive folder for ASC to mail to client or caregiver.
   c) Write entire diagnostic report without aid of assistant, unless this is a shared telepractice evaluation, in which case in planning meeting the supervisor determines/assigns sections to clinicians, but both submit their own *General Impressions* section. They collaborate on the *Diagnostic Impressions* section. To align with FERPA regulations, for telepractice, each clinician submits their own sections as a WORD document. They submit a separate document DX Impressions, a collaborative product. Once, all sections of report are in final form, the supervisor then combines all sections and edits, the *General Impressions* submission into one section.
   d) Subsequent edits of report will be due as determined by your supervisor, and initial grade can be lowered if timelines are not met.
   e) Once report is finalized, the supervisor is responsible for ensuring that identifying information (PHI) is inserted in a HIPAA compliant manner, electronic signatures applied and that it is filed with the client's records for ASC to mail to client or caregiver. The ASC will also move contents of Rees Clinic folder, Google Drive folder to Clinic Note, our EMR system, and close out those two folders.
   f) Clinician is responsible for uploading scans of test protocols into client's electronic diagnostic file.
   g) Clinician is responsible for communicating disposition status (waiting list, ATP only, no therapy, etc.) to Clinic Director as she is responsible for tracking DX clients.

9. Please be mindful that all information from client's file and diagnostic interview/testing/exit meeting and subsequent discussions with the supervisor is confidential and should not be discussed outside of the clinic conference room or other clinical suite rooms.

10. All test manuals and protocols should remain in the Clinic at all times. Graduate Diagnostic Team Members may check-out diagnostic tools overnight with prior permission, to be returned the following morning or as approved by Clinic Director or supervisor. Clinicians must review client records in a confidential place where no one can accidentally access or view their contents. Weekend building passes are available with prior planning, and require an approval signature from a permanent staff supervisor or faculty member.

## Assistant Responsibilities

(These responsibilities may change as directed by the supervisor in the event of a "shared" telepractice evaluation.)

1. Prior to the planning meeting, review client's electronic file for participation in meeting.

2. During the evaluation, the assistant will participate in the evaluation as determined during the planning meeting and as needs arise during the evaluation session.

3. Supervisor approves contact hours according to C.A.A. standards that allow for only "active" participation in session or engagement with client for in person assessments. Other hours will simply be considered observation. For telepractice evaluations, C.A.A. allows active participation for both clinicians as "leads," resulting in supervisor approving full contact hours for both.

## Diagnostic Expectations

**(Please refer to SLHS 696 Syllabus posted on Canvas)**

- Review the available background information in a diagnostic case file and determine the purpose of the evaluation.
- Plan a complete, well-organized interview, appropriate for the problem and information available.
- Plan diagnostic testing or screening for the problem presented and for the client's age and functional level, utilizing behavioral observation, non-standardized and standardized assessment measures, and instrumental procedures with the goal of completing a non-biased assessment.
- Conduct a well-organized interview, utilizing active listening strategies, appropriate to the situation and the informant with careful attention to the needs of the client and/or the family.
- Correctly administer all diagnostic and screening procedures. This includes completing test protocols, language samples, phonological analyses, behavioral checklists, etc.
- Correctly score, analyze and interpret all evaluation procedures.
- Interpret, integrate and synthesize background information from a variety of sources, observations, assessment findings in order to formulate appropriate clinical impressions and recommendations.
- Present overall impressions and recommendations to clients and or families in a complete and organized fashion using language appropriate to the needs of the listener.
- Write a complete, accurate professional report that follows the established format and which succinctly, but completely summarizes the outcome of each evaluation.
- Write an individualized letter to the client of family summarizing the outcome and recommendations of each diagnostic evaluation in language appropriate to the reader.
- Promptly complete all written documentation associated with the diagnostic clinic and the maintenance of clinic records, including information releases as necessary to disseminate information to appropriate individuals or agencies for further referrals.
- Adhere to the ASHA and California Board of Speech-Language Pathology and Audiology Codes of Ethics with special attention to privacy regulations and appropriate referrals. The clinicians will engage in discussion of these issues in the planning meetings, staffings for each assessment, as well as during periodic DX Rounds Scheduled by Clinic Director during Fall and Spring semesters.

# Diagnostic Report Grading Rubric

**Statement of the Problem** - Abstract of the case

- Written in present tense, avoiding wordy and passive voice.
- Personal information included.
- *Statement of the Problem* clearly stated.
- Succinct, but includes most important, relevant info, including reason for assessment (e.g., family concerns, determination of treatment objectives, etc.)
- Do not include redundant information (date of evaluation, Rees Clinic, etc.) as it is in report heading.

**History**

- Written in past tense, avoiding wordy passive voice.
- Includes all pertinent information from interview, as well as that from previous evaluations (what, where, by whom, results), progress reports, IEPs, etc.
- Headings and/or paragraphs in logical sequence according to supervisory suggestions.

**(In most cases, combine *Statement of Problem* and *History* in which first sentence is in present tense with background information and that from interview written in past tense, ending in present tense sentence stating the reason for the assessment.)**

**Evaluation Results**

- Written in past tense, avoiding passive voice.
- Sub-headings used and organized by area of primary problem first. Ask supervisor about collapsing sub-headings as appropriate (Speech Parameters, Oral Mechanism and Audiometric Screenings, etc.)
- Discussion/analysis/presentation of specific communication behaviors within each domain, without an analysis of unremarkable results.
- Contains information of significance (vs. irrelevance)
- Scores represent normative data (i.e., SS & %iles most meaningful vs.less meaningful age scores.
- Areas that are WFL are described in <u>brief</u>, without inclusion of lengthy detail or examples. Do <u>not comment on unremarkable.</u>
- Analysis goes beyond reporting scores and behaviors, but includes data outside of standardized measures.
- Analysis synthesizes the communication/behaviors into an organized summary of information.
- Analysis answers the whys of the behaviors that were or were not demonstrated.
- Specific tests are cited and underlined throughout.
- Includes, as appropriate, non-verbal behavior, pragmatics, play/cognitive skills, etc.
- Reports client's response to cues, stimulability, or dynamic assessment as appropriate.

**Diagnostic Impressions**

- Written in present tense
- Restatement of client information and past remarkable history (e.g., previous treatment, special day class placement, complicating medical history/problems, etc.)
- Summary of significant findings from evaluation in functional terms as opposed to test data.
- Report any possible contributing factors.
- Should be able to stand alone, providing reader with a thumbnail synopsis of case.
- Successfully integrates and synthesizes the results with no introduction of new information, etc. You are building a logical case that leads to your *Recommendations* that includes a prognostic statement. Do not introduce new information in this section.
- Relates current findings to past reports, testing, functioning.

**Recommendations**

- Written in present tense.
- Recommendation for therapy is stated, with mention of frequency and type.
- Initial specific goals are presented in list form.
- Goals are appropriate, reasonable, and specific to the client.
- Mention of any additional assessments/referrals needed.
- Mention specific recommendation to parent/caregiver, including a Home Program as appropriate.
- Prognostic statement needs to be realistic and specific based on both positive and negative factors, as appropriate, referencing information in *Diagnostic Impressions*.

## Evaluation of Performance in Clinical Practicum Via CALIPSO

Typically, a supervisor will complete one "final" CALIPSO evaluation for each Rees Clinic evaluation for the lead clinician and in the case of telepractice, both clinicians.

**PERFORMANCE RATING SCALE**

1 **Not evident:** Skill not evident most of the time. Clinician requires direct instruction to modify behavior and is unaware of need to change. Supervisor must model behavior and implement the skill required for client to receive optimal care. Supervisor provides numerous instructions and frequent modeling (skill is present <25% of the time).

2 **Emerging:** Skill is emerging, but is inconsistent or inadequate. Clinician shows awareness of need to change behavior with supervisor input. Supervisor frequently provides instructions and support for all aspects of case management and services (skill is present 26-50% of the time).

3 **Present:** Skill is present and needs further development, refinement or consistency. Clinician is aware of need to modify behavior, but does not do this independently. Supervisor provides on-going monitoring and feedback; focuses on increasing clinician's critical thinking on how/when to improve skill (skill is present 51-75% of the time).

4 **Adequate:** Skill is developed/implemented most of the time and needs continued refinement or consistency. Clinician is aware and can modify behavior in-session, and can self-evaluate. Problem-solving is independent. Supervisor acts as a collaborator to plan and suggest possible alternatives (skill is present 76-90% of the time).

**5. Consistent:** Skill is consistent and well developed. Clinician can modify own behavior as needed and is an independent problem-solver. Clinician can maintain skills with other clients, and in other settings, when appropriate. Supervisor serves as consultant in areas where clinician has less experience; Provides guidance on ideas initiated by clinician (skill is present >90% of the time).

**Grading Scale – SLHS 696**

| Start | End | Letter |
|---|---|---|
| 4.27 | 5.00 | A |
| 3.96 | 4.26 | A- |
| 3.65 | 3.95 | B+ |
| 3.34 | 3.64 | B |
| 3.03 | 3.33 | B- |
| 2.72 | 3.02 | C+ |
| 2.41 | 2.71 | C |
| 2.10 | 2.40 | D |
| 1.00 | 2.09 | F |

## SELECTED GUIDELINES FOR PREPARING DIAGNOSTIC REPORTS AND LETTERS

**FORMAT:**

1. Only first page of Diagnostic Letter is on letterhead; subsequent pages on plain bond, but very few letters are more than one page.

2. Margins of one inch at top and bottom of page for reports and letters, but supervisor may change this for better page breaks.

3. Use pagination, bottom center.

4. Cannot have topic heading, e.g., **Receptive Language**, alone at the bottom of the page without additional text. Adjust page breaks accordingly.

5. Double space between paragraphs.

6. Cannot have signatures alone on page; adjust text accordingly. Allow four spaces between end of text to insert electronic signature on lines with names and titles (i.e., Graduate Clinician, Supervisor, Clinic Director with graduate degree, CCC-SLP following below.

7. Utilize outline form, underlining and capitalizing Roman Numerical headings (e.g., STATEMENT OF PROBLEM & HISTORY, GENERAL IMPRESSIONS, etc. but not Roman numerals). Subheadings (e.g., Phonology, Audiometric and oral Mechanism Screenings, etc.) are bolded, not in all caps and without underlining or doublespacing before typing narrative for that section.

**PUNCTUATION/STYLE:**

1. Refer to adults as Mr., Mrs., or Ms.

2. Do not include months in reporting the age of adults (over 18).

3. Write ages with a dash, not a period, e.g., 3 years, 3 months = 3-3.

4. Quotes must be exactly what the client said. Cannot say: Ms. Smith reported that “people do not understand her due to her speech.” This would have to be “people do not understand me due to my speech.”

5. Only use quotes when the statement is important or significant enough to quote. Otherwise, report the client’s information in direct form, e.g., the client said that people do not understand her. Use quotes of interview informant judiciously.

6. Avoid using the client’s name in every sentence. Use pronouns as referents after mentioning the client’s name the first time within each paragraph.

7. The first mention of any test or formal procedure must be written out in full and underlined, e.g., the Peabody Picture Vocabulary Test – Revised (PPVT-R). Subsequent references may use abbreviations, e.g., PPVT-R. Underline test name only, not parentheses.

8. Punctuation goes inside of quotation marks. “She seems to understand everything.” Italicize targets, instead of using quotation marks: He omitted the final sound in the words *house*, *book*, and *watch*.

9. Keep constructions parallel or equivalent. For example, do not say: She washes and dries her hands, plays interactive games and will attend kindergarten in the fall.

**10.** Avoid wordiness, passive voice, and *is/was able/unable.*

**11.** Use quotation marks to indicate client's verbal responses, but in referring to test items of say adjectives within client's repertoire, italicize. Never use quotation marks around italicized text.

**PUNCTUATION/STYLE:**

**1.** Commas: In a compound sentence, use a comma if there is a separate subject in the second clause. For example:

She reported that he walked early, but he was late in all other developmental areas.

vs.

She reported that he walked early but was late in all other developmental areas.
He dresses and undresses himself and takes care of his toilet needs.

vs.

He dresses and undresses himself, and he takes care of his toilet needs.
He initiated conversation and used a variety of sentence types.

vs.

He initiated conversation, and he was responsive to conversation addressed to him.

**2.** Please avoid semicolons except when separating lists of phrases in place of commas.

**3.** Use of e.g., and i.e.,: Examples are listed using e.g., which means "for example." You will see many examples of **e.g.,** used throughout this paper. The other form, i.e., means "that is" and is used to clarify or define your meaning, i.e., to specify exactly what you mean. During the next quarter, **i.e.,** fall, we will be introducing a new course.

**4. PROOFREAD** your work.

**PROFESSIONAL:**

**1.** Do not report raw scores. Report percentiles, age equivalents, ranges, etc. Example: On the Peabody Picture Vocabulary Test-Revised (PPVT-R), Form L, Nick achieved a Standard Score of 85, placing him at the 75$^{th}$ percentile, which corresponds to a high average score.

**2.** Try to include a brief statement of what a test or subtest assesses, only if the measures name does not clearly indicate its purpose.

**3.** Submit work using phonetic symbols as needed.

**4.** Refer to sample reports for professional style and content.

**5.** Depending on the measures used, often it is inappropriate to divide results into Receptive vs. Expressive

**6.** Avoid using the same word or client's name twice in a sentence.

**7.** Write succinctly, combining sentences to create complex ones without overusing, conjunction *and*, presenting information in a logical and sequential manner