



UNIVERSITY
OF WYOMING

College of Health Sciences
Division of
Communication Disorders

2026-2027 CLINICAL PRACTICUM PROCEDURAL MANUAL

CORRI SANDOVAL, SPEECH CLINIC DIRECTOR

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Important Division Documents

DIVISION, VISION MISSION, & STRATEGIC PLAN

Vision: Our vision is to be a program of excellence with cutting edge research, exceptional teaching and learning, and state-of the art clinical programs.

Mission: Our mission is to advance the science behind practice, develop practice ready speech-language pathologists to serve the communication needs of individuals from all backgrounds.

Strategic Plan: The Division strategic plan can be found here: <https://www.uwyo.edu/comdis/strategic-plan-2023.html>.

UNIVERSITY OF WYOMING STATEMENT OF NON-DISCRIMINATION

The University will provide all applicants for admissions, employment and all University employees with equal opportunity without regard to race, gender, religion, color, national origin, disability, age, protected veteran status, sexual orientation, gender identity, genetic information, creed, ancestry, political status and belief, pregnancy, or any other applicable protected category or participation in any protected activity. The University's nondiscrimination policy applies to all matters relating to its education programs and activities including recruiting, hiring, training, compensation, benefits, promotions, demotions, transfers, and all other terms and conditions of employment. For more information, please see UW Regulation 4-1 (Equal Education and Employment Opportunity) The Division of Communication Disorders applies the University's nondiscrimination policy to persons served in the program's clinic, and also provides equal opportunity regardless of an individual's status as a parent.

WELCOME!

We are excited to welcome you to our graduate program and soon, to the ranks of certified speech-language pathologists. You will be working toward your Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP), often called the “Cs” or “ASHA certification.” This credential is awarded by the American Speech-Language-Hearing Association (ASHA), the official accrediting body for our profession. We are here to support you every step of the way!

To help you know what to expect, here is a brief overview of the ASHA certification requirements, which will also provide a helpful snapshot of the program. For successful completion of an accredited SLP graduate program, 2 major aspects are required:

- 1) **Graduate Courses** (see the Communication Disorders Graduate Student Handbook for information on academic coursework)
- 2) **Clinical Experiences**

ASHA has certain stipulations about these experiences:

- The student must have obtained a sufficient variety of supervised clinical experiences in different work settings and with different populations so that he or she can demonstrate skills across the ASHA Scope of Practice in Speech-Language Pathology. Clinical experiences (e.g., assessment, diagnosis, evaluation, screening, treatment, report writing, family/client consultation and/or counseling) should allow students to:
 - interpret, integrate, and apply core concepts and knowledge
 - demonstrate appropriate professional and clinical skills
 - develop critical thinking and decision-making skills
- Successful completion of clinical experiences, sufficient in breadth and depth, will be evaluated using a new On-Campus Student Skill Demonstration and Feedback Rubric. This rubric measures students’ progress across key skill areas each semester of Clinical Practicum. To receive satisfactory status, students must demonstrate progress consistent with expected developmental benchmarks within the following overarching areas:
 - Evaluation Skills
 - Intervention Skills
 - Professional Practice, Interaction and Personal Qualities

CLINICAL EDUCATION SPPA 5030 ~ CLINICAL PRACTICUM

Students will be introduced to clinical skills through carefully designed and closely supervised experiences in the UW Speech and Hearing Clinic, at sites supervised by UW clinical instructors and approved community-based sites. Collectively, these experiences are gained under the course SPPA 5030, Clinical Practicum. The Speech Clinic Director makes assignments in the Speech & Hearing Clinic and approved sites. In addition, students complete Alternative Clinical Experiences or simulations and will be required to purchase membership to corresponding website/programs that will be used in SPPA 5030 and possibly other courses.

Students must enroll and the specified number of semester credit hours for clinical assignments (SPPA 5030 Clinical Practicum, SPPA 5270 Educational Practicum & SPPA 5290 Medical Practicum). Details on the number of credit hours required for clinical courses as well as the sequence of clinical courses are specified in the Graduate Curriculum.

Graduate students complete four semesters of SPPA 5030 for a total of 14 credits (see the Graduate Curriculum section). The Speech Clinic Director assigns clients with consideration of client needs, supervisor availability, student educational needs, and clinic scheduling constraints. Clinical assignments are also based by regularly monitoring each graduate student's clinical experiences and clock hours to ensure exposure to clients across disorder areas (i.e., Articulation, Fluency, Voice, Language, Hearing, Swallowing, Cognition, Pragmatics, Communication Modalities), severity levels, and life span to meet each student's need for diverse clinical experiences.

SPPA 5270 EDUCATIONAL PRACTICUM & SPPA 5290 MEDICAL PRACTICUM (Externships)

The externship practicums are viewed as an *extension* of academic and clinical experiences. Clinical instruction continues in these experiences. A student's academic and clinical performance may be shared with external supervisors to enable them to best support the student's learning.

Graduate students complete two full-time externships following completion of coursework and SPPA 5030 requirements. Graduate students complete SPPA 5270 Educational Practicum for 6 semester credit hours and SPPA 5290 Medical Practicum for 6 semester credit hours (see the Graduate Curriculum section). Externships typically are 12 weeks in length; however, each externship is individualized by the Speech Clinic Director and preceptor, and Alternative Clinical Experiences (simulations) may also be required to supplement clinical experiences. Students register for one externship in the Spring and one in the Summer semester, but the beginning and ending dates do not align with semester dates. Clinical experiences across SPPA 5030 and the two externships are structured to provide students with experience in both educational and medical/clinical settings. The order of externships is arranged and determined by the student and Speech Clinic Director.

The remainder of this manual outlines the policies and procedures for the clinical portion of the graduate program. Additional information about Clinical Practicum is available in the SPPA 5030 Clinical Practicum Syllabus and online WyoCourse. This manual is intended as a resource, not something you are expected to memorize or use as your sole source of information. We encourage you to ask questions and seek supervisor guidance throughout your clinical experiences.

We are excited you chose our program and wish you success as you pursue a fulfilling career as a speech-language pathologist!

CLINIC PRACTICUM PROCEDURAL MANUAL

The Speech Clinic Director, Corri Sandoval, will determine all clinical assignments for your on-site Clinical Practicums. Client assignments for treatment are generally given at the start of each semester; diagnostic assignments are given throughout the semester. Please refer to the SPPA 5030 Clinical Practicum Syllabus for information concerning the specific timelines for written assignments, supervisory conferences, and for information on how your clinical skills will be scored. Also, please note that all forms and documents that are referred to throughout this manual can be found in the SPPA 5030 Clinical Practicum WyoCourse website.

SECTION 1: GENERAL POLICIES

1a. Clinic Attire

Clinicians must wear their UW name badge at all times when working in the clinic and with clients at other facilities (e.g., The Cooper Center). See Ms. Sandoval if you forget your badge and she will give you a temporary one. It is appropriate to remove your badge when working with a client in a public area (e.g., Turtle Rock) to protect the client's association with the clinic. Clinicians should wear appropriate professional attire (e.g., **no baseball caps, no sweatshirts or hoodies, no revealing clothing, no shirts with graphic designs or large print, no blue jeans** etc.) for all sessions, including observations. Professional dress is required at all times in the clinic. Repeated failure to adhere to the dress code will result in corrective action to include suspension and/or termination from the Division of Communication Disorders

1b. Clinic Visitors

Due to the vast amount of PHI contained within the clinic, and the need to respect the privacy of individuals receiving services, **unauthorized visitors are not allowed anywhere within the clinic premises at any time.** You may not invite your family or friends to visit you in the clinic. Authorized visitors to clinic premises include graduate student clinicians, undergraduate student observers, clinical supervisors, clients, family members/friends/caregivers bringing or brought by clients, Communication Disorders faculty and staff, UWIT workers, and individuals pre-approved for a clinic tour by either the Clinic Director or Division Director.

1c. Childcare Requests

We occasionally get requests from the parents of current clients for their clinicians or past clinicians to provide childcare outside of sessions (e.g., babysitting, respite care, etc.). This is **not allowed**. As long as a client is receiving clinical services here, no clinician is permitted to provide them with any other services. This is an ethical and professional boundary that must be maintained.

1d. Restricted Use Computers/iPads /Clinic Work rooms

- You will be given an iPad for academic and clinical use throughout your first year of graduate school. This iPad must be returned to the Division in working condition at the end of your first year.
- There are computers for student use in Sterilization and Cleaning Room (1111).
 - The (H) drive is part of the UW network. It is specific to your personal account and password. If space on your (H) drive is full, delete files and folders that are no longer needed.

- **Do not store client files or personal information on the hard drive.** All client files (e.g., SOAP notes, treatment plans, progress notes, etc.) are created, modified, and saved **only** in the electronic medical record system ClinicNote. Any other client-related files (e.g., data sheets, session recordings, etc.) must be saved on a password-protected memory stick/flash drive. The memory stick/flash drive is a confidential item and should be kept in a secure location (e.g., in the student's locker, with a supervisor.)
- Paper copies of data sheets, assessment protocols, etc. must be kept in secure locations (Grad Prep Room-1132, in your locker) or with the supervisor. Test protocols are given to your supervisor to upload to ClinicNote. After data sheets are no longer needed, place in appropriate shred container.

There are other student computers available in HS205 and elsewhere across the University for **non-clinical** work.

1e. Printing and Copying

Clinic forms, reports and treatment materials can be printed or copied on the copier or printer in the Division Copy Room (1103) or Grad Prep Room (1132). All academic and personal printing and copying is at your own expense. Printing orders that do not contain client PHI can be sent to general student computers throughout campus or can be printed on your own paper using the printers in Grad Prep Room (1132). Copying of material not containing client PHI is also available at the Student Union Copy Center. Copying or printing of any material containing client PHI must only be done on the machines in the copy room at MVMP (1103) or the Grad Prep Room (1132).

1f. Consultations with Professor

When working with new, unique, or challenging cases, students and supervisors may want input from a faculty professor. Students must first discuss and get approval to request a consultation from their supervisor. In the 5030 WyoCourse you will find a copy of the request form as well as in [Appendix 1.1](#) in this manual. This allows supervisors to have input as to what the consult will involve and the professors an opportunity to review and prepare for the meeting. Professors have the right to decline the consultation.

SECTION 2: CLINICAL DOCUMENTATION

2a. Accessing Client Electronic Medical Records

All client records and evaluation/treatment documentation is completed and stored using the electronic medical record (EMR) online platform called ClinicNote. You will be guided through setting up your ClinicNote login during orientation. Please note that ClinicNote only works when opened using the Google Chrome web browser. You can access ClinicNote on your iPad, however, the record system does not always save as it should so it is recommended you complete all documentation using a computer. Laptops are available for student use while at MVMP. Students may use a laptop without checking it out; however, laptops may not leave the MVMP building. When you are finished using a laptop, return it to a charging dock in the Sterilization & Clean Room (1111) so it is available and charged for the next student.

Once you are logged in to ClinicNote, you will be asked to complete a training. This training is mandatory and provides you with information to aid proficiency using the modules in this EMR system. In the following sections of this manual, you will read through directions for how to use the ClinicNote modules throughout the semester. Please be aware that we will discuss and practice using each module at length in class, and there are also videos for how to use each module for a variety of documentation purposes contained within the ‘ClinicNote Help’ module on your home page. You are encouraged to refer to these videos as often as you may need to as you are learning how to use this electronic medical record system. Do not forget that your supervisors are here to help also!

When Ms. Sandoval has made your client assignments, she will give you access to those clients’ records in ClinicNote. You will only have access to the clients for whom you are currently providing treatment or diagnostic services as well as clients of clinicians within your small assigned groups. Please follow these steps in order to thoroughly review your clients’ files for treatment planning purposes:

- Once you are logged in to ClinicNote, you will see a sidebar navigation menu on the left side. **Click on ‘Clients’ and go to ‘Client List’.** Click on any client’s name to enter their file. You will see several tabs across the top.
- In the first window you can scroll through their information which includes contact information.
- Choose **‘Documents’** which will open another set of tabs. Read through the most recent notes in the ‘SOAP Notes’ tab. Additional SOAP notes, treatment plans, evaluation reports and progress notes are found in the ‘Narrative Templates’ tab.
- In the ‘Uploaded Files’ tab you will find any uploaded information including referrals, other provider notes, etc.
- As needed, you will **use the ‘Client Communication’ tab to document each time you have phone or email contact** with a client or their parent/guardian/caregiver. You can also see a list of previous contact notes.

2b. Completing and Reviewing Client Treatment or Diagnostic Evaluation Forms

At the start of each semester, treatment clients seen through the University clinic will complete a ‘fresh’ set of permission forms or review previously completed forms. These are all located under ‘Fillable Forms’ in ClinicNote. A list of required forms for new and established clients is found in WyoCourses. All forms will be completed in ClinicNote except the notice of billing for level 3 clients. For each client you will follow these steps to complete appropriate forms prior to seeing the client:

Preparing Forms for the Client

1. Go to **Clients**, then select **Client List** and choose your client.
2. Click **Documents**, then select + **New Document**.
3. From the drop-down menu, select the form template you are completing.
4. Select the supervising therapist (e.g., Ms. Clark).
5. **Complete as much of the form as possible before the first session.**
6. Save the form when you have finished entering the available information.
7. Submit the forms to your assigned supervisor for review prior to the first session.

Reviewing Forms With the Client

During the first session, review the appropriate forms with the client using your iPad. Log into ClinicNote through Chrome, then select your client.

1. Go to **Clients**, then select **Client List** and choose your client.
2. Click **Documents**, then select **Fillable Forms**.
3. Select the form you will be reviewing and click **Edit** to open the form.
4. When you have finished reviewing the form, click **E-Sign** and sign your name.
5. Click **Add Signature**, then select the blank E-Sign field.
6. Have the client sign the form using the appropriate method:
 - In-person clients: Using your iPad, have the client sign in the signature box. Enter the client's name and select Client as the title. For a parent or guardian, select Parent/Guardian as the title.
 - Telepractice clients: You may give the client mouse control so they can sign using their mouse. Alternatively, the client may type their name in the signature field if they agree to use their typed name as their electronic signature. Document the method used in the Client Communication tab.
7. Submit the completed forms to your supervisor for their signature.

Uploading Client Documents

If the client has their insurance card, use your iPad to take a photo of the card. Upload the image to **Uploaded Files** in ClinicNote.

A list of the forms and a summary of each form's purpose follows:

- **Notice of Privacy Practices** (Found in Materials Room 1119)
 - This form is required by federal HIPAA law, and is printed on BLUE paper.
 - This form explains to the client how, when, and why we may use their personal health information (PHI) and their rights to request copies, amendments, and disclosures of such information.
 - A copy of this form should be offered to the client or client's representative (e.g., parent, guardian, caregiver) for them to keep.

- Additionally, a copy of the Notice of Privacy Practices can be found in a binder in the UWSHC waiting room (on the shelf next to the front desk). Clients are welcome to read this copy as they wait whenever they wish.
- **Patient Acknowledgement Receipt of Notice of Privacy Practice** (Completed on ClinicNote)
 - This form is required by federal HIPAA law.
 - The client or client's representative signs this form to indicate that they have been informed of the UWSHC's privacy practices, and that they were offered a hard copy of the NPP document to keep.
- **Treatment Agreement** (Completed on ClinicNote)
 - This form serves as the financial agreement between the UWSHC and the client/representative to pay for the services provided.
 - Complete all demographic fields and use the current **SLP Fee Schedule** to help the client determine and complete the 'sliding scale fee level' and 'semester fee' fields on the form. The client is welcome to keep a copy of the fee schedule if they wish.
 - The number of members in the client's household and the annual household net income determine the fee schedule level (level 1=full price; level 2= half price; level 3= free services).
 - If the client qualifies for levels 2 or 3 (reduced or waived fees), they must submit proof of their annual household net income (e.g., federal tax return forms, social security statements, etc.) to the Clinic Office Associate within the first two weeks of services.
 - If the client qualifies for levels 1 or 2 (meaning that a full or partial charge for services will be billed), the client must also present a copy of their insurance, Medicaid or Medicare card(s) to the Clinic Office Associate.
 - If the client qualifies for levels 1 or 2 and will be billing Medicare, notify Ms. Sandoval immediately. Medicare requires different documentation and supervision procedures.
 - Once signed by all parties, a copy will be provided to the client in the form they choose (e.g., paper copy, through patient portal, or email).
 - See WyoCourses for more information related to billing
- **Service Agreement** (Completed on ClinicNote)
 - Complete this form instead of a Treatment Agreement if your client is receiving accent modification services.
 - Follow the same procedures as for the Treatment Agreement form, except that the client does not need to present their insurance/Medicaid/Medicare card(s) to the UWSHC Office Associate. These services are not 'billable' to insurance and must always be paid for by the client.
 - Once signed by all parties, a copy will be provided to the client in the form they choose (e.g., paper copy, through patient portal, or email).
- **Permission to Evaluate or Treat** (Completed on ClinicNote)
 - This form is required by federal HIPAA law.
 - This form serves as formal permission for us to commence treatment and/or evaluation services for the semester.

- It also doubly ensures that the client is aware of our privacy and nondiscriminatory practices and informs them that services will be performed by students under appropriate supervision.
- **Client Attendance Policy** (Completed and signed on ClinicNote, paper copy provided at session)
 - The information in this form outlines the expectations for participation in services provided by the UWSHC. Please make sure the client is especially aware of the 90% attendance policy. If a client is not meeting the 90% attendance rate, we do not automatically dismiss them from services, but it is considered by the supervisor and Clinic Director (Ms. Sandoval) on a case-by-case basis, especially if there are clients with a high level of need on the waiting list.
 - Before you present it to the client, fill in the known closure dates for the UWSHC for that semester on ClinicNote and on a paper copy.
 - After they have signed on ClinicNote, provide the paper copy (they do not need to sign the paper copy).
- **Permission to Record Sessions and Take Photographs** (Completed on ClinicNote)
 - This form permits us to record sessions or to take photographs of the client.
 - For a diagnostic session for a new client, this form is typically the first to be signed, so that the recording of the session can be started immediately thereafter.
- **Permission for Activities** (Completed on ClinicNote)
 - This form gives us permission to engage with the client in a variety of activities. Note that the only applicable option on this form for telepractice clients is the one for observers.
 - If a client does not permit observers, please notify Ms. Sandoval right away.
 - There is a section labeled 'Exceptions to above' on this form. This is the place to note food allergies and any other restrictions the client may have.
- **Patient Authorization for Disclosure of Protected Health Information (PHI)** (Completed on ClinicNote)
 - If the client/representative wishes us to exchange information with an outside entity, this form is required by federal HIPAA law.
 - This form allows the UWSHC to receive information from or disclose information to another entity such as the client's school SLP or their physician.
 - You must fill out a separate form for each entity that the client wishes us to obtain information from or send information to. Please include the DOB of the client (see example in WyoCourse).
 - A copy of this signed form should accompany all disclosures sent to the entity designated on the form.
 - Each time information is sent or received, it should be noted in the contact log of the client's file in ClinicNote.
- **Telepractice Permission form** (Completed on ClinicNote)
 - This form educates the client about the benefits and risks of telepractice sessions.
 - Before presenting this form to the client, discuss with your supervisor the need for an eHelper. If it is decided that an eHelper will be beneficial during each session, write the designated person (a consistent person present each session is preferred for best outcomes) on the space provided after talking it over with the client/representative.
 - You MUST complete the phone number and address at which the client can be consistently reached during every session in case of emergency. Make sure the client knows that they

- should be available at the same phone number and located at the same address during each session. Make sure your phone is with you during the session and has the client's phone number entered in your contacts so that you can call them if needed. You should also make sure you have a secure way to access their address quickly if needed in the event of an emergency that requires you to call first responders. See the telepractice section of this manual for more information.
- **Notice of Billing (Level 3 Clients ONLY-** paper copies found in Materials Room 1119)
 - Take one of these to your diagnostic and first treatment appointment. Copies are found in the file drawer in the Materials Room 1 (1119) and on WyoCourses.
 - If the client reports they are a level 3, this informs them we will still bill insurance.
 - Take a picture once signed and upload it into ClinicNote, the client takes original form with them.
 - **Client Intention letter**
 - All clients are presented with this form about 2 weeks prior to the end of each semester.
 - This form lets us know if they wish to return for continued services the following semester.
 - Be sure to confer with your supervisor about whether or not continued services are recommended before presenting this form to your client.
 - Clinicians will review the form with clients and once they receive a response they will complete an electronic form sent by Ms. Sandoval for each client.
 - **Case History forms**
 - For diagnostic evaluation clients, there are various case history forms that each new client will complete prior to their first diagnostic session.
 - These forms are sent to the client by the Clinic Director, Ms. Sandoval, or the Clinic Office Associate when the appointment is scheduled.
 - The client will hopefully complete it and mail it back to us prior to the session, but if not, you can complete it in the format of an interview during the session.
 - More details about these forms can be found in the Diagnostic Procedures section of this manual.
 - **Evaluation Agreement (Completed on ClinicNote)**
 - This form is to be completed at the start of the diagnostic evaluation for a new client.
 - Follow the same guidelines outlined for the Treatment Agreement form above.
 - **Summary of Diagnostic Evaluation (Found on WyoCourses)**
 - This form will be completed at the end of an evaluation to outline our initial impressions and recommendations.
 - A copy will be given to the client at the end of the evaluation.
 - See the Diagnostic Procedures section of this manual for more details.

These forms are outlined in checklist format along with additional procedural instructions in the treatment and diagnostic paperwork modules in the SPPA 5030 Clinical Practicum WyoCourse website. As you are preparing for the session during which the forms will be presented to the client, be sure to refer to the appropriate checklist to ensure you are following all procedures appropriately. Remember that prior to the session, you should complete all known information on all forms before presenting them to the client to

expedite the process. Do not leave blank spaces on any of the forms (if needed, either put a dash or “N/A”).
A client/caregiver must never sign a form until all information has been filled in.

2c. Completing Clinical Service Documentation

You will use the modules in ClinicNote to document client contacts, schedule sessions, mark attendance, complete reports (i.e., Initial Notes, Evaluation Reports, Semester Treatment Plans, Midterm and Final Progress Notes), formulate and track clients’ long-term and short-term goals (LTGs and STGs), and complete SOAP/DAP notes. You will be trained on how to do all these things in class. The videos in the ‘ClinicNote Help’ module will walk you through these processes also. Refer to the videos as often as you need and remember that your supervisor is here to help!

Documenting Client Contacts:

Each time you have contact with the client or other authorized party designated on the Patient Authorization for Disclosure of Protected Health Information form via phone, text, mail, or email, you will document it in the contact log. This would include communication you have with the client outside of treatment sessions such as when you contact the client to schedule sessions or relay information, when they contact you for any reason, when you send them documents, when they send you documents, etc. To make an entry in the client’s contact log, please follow these steps:

- Go to the **Clients** then **Client List**.
- Click on the client’s name and choose **Client Communication** tab.
- Click on the **New Contact Note** button.
- Type out your note (e.g., Client’s mother called to cancel sessions next week due to a family vacation).
- Click the **Save Contact Note** button.

Scheduling Sessions:

Once you have logged in to ClinicNote, you will see an appointment calendar. All sessions scheduled in the UWSHC for that day will be displayed automatically. To schedule a new session, click the calendar icon in the upper left corner. Navigate to the desired day and time to identify an available room. Available rooms and times are shown in white.

When you find an open room at the desired day and time, double-click the blank space corresponding to that day, time, and room. The scheduling box will appear. **Do not double-click on a blue space, as this indicates that the room and time are already scheduled.**

When scheduling a session, complete the following:

1. Use the drop-down menu to select the type of session (e.g., diagnostic, in-person, or telepractice).
2. Select the room from the drop-down list.
3. Add both yourself and your supervisor as the therapists.
4. Select the client from the drop-down list.

Only your assigned clients will appear in the list. Group sessions involving multiple clients and/or clinicians may need to be scheduled by the Clinic Director or supervisor, who has access to all applicable client records and can schedule everyone within the same appointment.

5. Enter the start and end times for the session. You can either type the date and time directly into the fields or use the calendar and clock icons.

The clock icon only provides half-hour increments (8:00, 8:30, 9:00, 9:30, etc.). If your session begins at a time other than a half-hour increment (e.g., 8:15 or 10:10), type the time directly into the field.

6. If the session is a rescheduled appointment, enter “one-time make-up session” in the Description box.
7. Leave the Attendance field set to “Select.” Attendance will be completed later.

Scheduling Recurring Sessions

- For recurring sessions:
 1. Select the Weekly option.
 2. Select “Repeat every: 1 week.”
 3. Select the days of the week on which the sessions will occur.

If the sessions have the same start and end times and will take place in the same room on all selected days, you can schedule the applicable weekdays together. For example, a session scheduled from 8:30–9:00 on Tuesdays and Thursdays in Room 163 can be scheduled as one recurring appointment.

If sessions have different times or rooms depending on the weekday, schedule each weekday or room separately.

4. Select the “After” option and enter the last day of Clinical Practicum for the semester. Refer to the SPPA 5030 Clinical Practicum Syllabus for this date.

Changing a Recurring Session

If a client needs to change their schedule during the semester, double-click one of the client's scheduled appointments and select “Edit the Series.”

Marking Attendance:

You must mark attendance for each treatment or diagnostic session that has been scheduled. To mark attendance, please follow these steps:

- Double-click on the appointment in the schedule and select ‘Edit current occurrence.’
- Go to the ‘Attendance’ field and select the appropriate option from the drop-down list.
- For treatment sessions where a SOAP will be completed, click on the pencil icon if a group or the ‘+’ icon to indicate that you need to complete a SOAP note for that session.

Creating, Revising, and Finalizing Reports:

SOAP notes will be written when assigned. Data will be maintained for each of your client’s sessions using an electronic system you will discuss in clinic meetings. When you finish a diagnostic evaluation, you will write an Evaluation Report. In general, Evaluation Reports are due 5 workdays after the evaluation session. When you finish baselining for your treatment clients, you will write a Semester Treatment Plan (STP). In general, STPs are due 5 workdays after the final baselining session. Progress notes will be written as assigned. General time frames for these reports are included in the SPPA 5030 Clinical Practicum Syllabus. Your supervisor will give you a specific due date and time for each report that you are assigned to complete. Please see the ‘Explanatory Templates’ module in the SPPA 5030 Clinical Practicum WyoCourse website for detailed guidelines on the

information you need to include in each section of these reports. To complete one of the reports in ClinicNote, follow these steps:

Creating a New Report

1. Go to **Clients** and then select **Client List**.
2. Click on the client's name and select the **Documents** tab.
3. Click + **New Document** on the right side of the screen.
4. Select the appropriate report type from the drop-down menu.
5. Select your supervisor.
6. Click **Generate**.
7. At the top of the document, in the ribbon under the font size options, turn on **Track Changes**. **Track Changes should remain on until the report has been finalized by your supervisor.**
8. Click anywhere in the template where you need to enter information and complete the report.

Saving a Report to Finish Later

If you are not finished and need to return to the report later, click **Save**. The report will appear in your **To-Do list**, where you can reopen it and continue working.

Submitting and Revising Reports

When you have completed your draft:

1. Use **E-Sign Narrative Template** at the bottom of the document to add your electronic signature.
2. Click the **Submit** button and select your supervisor from the drop-down list. Click **Submit** again. The report will then appear in your supervisor's **To-Do list**. Your supervisor will review the report and may make edits or add comments indicating changes that need to be made. Select your supervisor from the drop-down list.
3. **Review your supervisor's edits and comments:** When your supervisor returns the report, it will appear in your **To-Do list**. Open the report by clicking **Edit Document**. You will then be able to view your supervisor's edits and comments.
Important: If you click **Complete** instead of **Edit Document** from your To-Do list, the item will be removed from your To-Do list, but this does **not** mean that the report has been finalized. If you accidentally select **Complete**, you can retrieve the report by going to the **Documents** tab in the **Client List** module. Find the report you need and click **Edit**.
4. **Review edits:** Any edits made by your supervisor will appear in the document and in a pane on the right side of the document, showing who made each edit. **Do not click the checkmark to accept the edits until your supervisor tells you the report is ready to be finalized.**
5. **Review comments:** Comments from your supervisor will also appear in a pane on the right side of the document. Respond to comments and make any requested changes. **Do not click the checkmark to accept the edits until your supervisor tells you the report is ready to be finalized.**
6. **Resubmit the report:** Once you have completed the requested edits and addressed the comments, click **Submit** to send the report back to your supervisor for review. If additional changes are needed, your supervisor will return the report to you and the editing and commenting process will be repeated.

7. **Final approval:** Once your supervisor determines that the report is ready to be finalized, they will approve the report and add their electronic signature. **At this point, the report becomes a permanent part of the client's file.**

Viewing the Finalized Report

1. To view the finalized report or show it to your client after your supervisor has signed it, go to the **Client List** module and select the client.
2. Select the **Narrative Template (Reports)** tab.
3. Click **View** next to the report you want to open.

Formulating and Tracking Client Long-term (LTG) and Short-Term Goals (STG):

Entering Goals into ClinicNote

Once your supervisor has approved your STP you will need to enter the LTGs and STGs into ClinicNote.

1. Select your **Client** from the list.
2. Choose the **Goals** tab.
3. Click **Add New Goal** button.
4. Add your first semester LTG in the top box by typing it in or copying and pasting from the STP.
5. Add the date you want that goal to begin in **Date Assigned**. (It must be the day of or day before your first electronic SOAP note, otherwise your goals will not show on the note.)
6. Leave the drop down as **No Parent Goal (Long Term Goal)**
7. You are not required to enter your baseline data here but you can if you like.
8. Using dropdown menu for **Discipline**, select SLP.
9. If you think you will want to use the data boxes and have ClinicNote create graphs, checkmark **Track data for this goal**. You can always delete the graphs later if you do not want to use them. If you select this you can also quickly review your most recent data entries quickly, if you do not you will only see assessment comments when you look at the summary- see below)
10. Leave the **Nickname** box **blank**.
11. Click **Save Goal**.
12. Repeat this process until all semester LTGs have been entered.
13. **To enter your STGs**, click the **Add New Goal** button again.
14. Type the STG into the top box.
15. **Select the LTG** you want this STG to fall under from the list in the “**Make this a short term goal of**” option.
16. The rest of the steps are the same. Repeat as needed until all LTGs and STGs have been entered.

As you enter qualitative and quantitative data for a client's LTGs and STGs in the SOAP notes throughout the semester, the information will automatically pull into the **Manage Client Goals** module. To review the data, open the client's active goal list and click **Manage** next to the LTG or STG you want to review. This will display a running list of the data points and associated qualitative comments entered for that goal. If you choose not to track quantitative data, only the qualitative comments will be displayed.

Completing and Archiving Client Goals

If you are completely finished with a goal for the semester and are certain it will not be targeted again, you may mark the goal as **Met** or **Not Met**.

- **Completing a Goal**

1. Go to the **Goals** tab and click **Manage** next to the goal.
2. Select **Met** or **Not Met** and enter the date.
3. Click **Save**.

At the end of the semester, after completing the client's Final Progress Note, you must mark **all semester goals** as either Met or Not Met.

- **Archiving Completed Goals**

After saving the goal status:

1. Return to the client's goal list.
2. Select the box next to each goal you want to archive.
3. Select **Move to Archive**.

Archived goals will no longer appear in the client's active goal list. This allows the next clinician to begin tracking the new set of LTGs and STGs developed for the following semester.

Important: Short-term goals (STGs) must be marked Met or Not Met and archived before the associated long-term goal (LTG) can be archived.

Completing SOAP Notes:

You will complete a SOAP note in ClinicNote when assigned. Please see the **Explanatory Templates** module in the SPPA 5030 Clinical Practicum WyoCourse website for guidance on the information that belongs in each section of the SOAP note.

After your goals have been approved by your supervisor and entered into ClinicNote, all SOAP notes should be completed using the following instructions.

Opening a SOAP Note

There are several ways to open a new SOAP note in ClinicNote. The required method is to first mark the client's attendance in the Scheduling module. See the previous section, **Marking Attendance**, for instructions. Once you have marked attendance and the SOAP note template has been generated, complete the following:

1. Under **Place of Service**, select **Independent Clinic** if the client attended the session in person at the clinic. Select **Telehealth Provided in Patient's Home** if the client attended the session via Zoom.
2. Make sure the date matches the date of the session.
3. Enter the actual start and end times of the session. If the session started late or ended early, enter the times that actually occurred.
4. Use the **SOAP Note Coding Guide**, located in the Explanatory Templates module of the SPPA 5030 Clinical Practicum WyoCourse website, to select the appropriate procedural (CPT) codes. Use the **ICD-10 Diagnosis Codes** resource to select the appropriate diagnostic (ICD-10) codes. **Only document and bill for diagnoses and services that were actually addressed during that session.**

If the client has multiple diagnoses related to the treatment provided during the session, enter the appropriate CPT code under each applicable diagnosis.

5. Enter the number of units only for the CPT codes associated with the services actually provided during that session. The **Units** field should be **1** for applicable CPT codes except 97129 and 97130, which are used for cognitive function intervention. For these codes, enter the number of 15-minute increments of therapy provided beyond the first 15 minutes. See the SOAP Note Coding Guide in WyoCourses for additional information.
6. Before beginning the SOAP note, turn on **Track Changes**. Track Changes should remain on until the note has been finalized by your supervisor.

Completing the SOAP Note

- **Goals**

The semester's LTGs and STGs that you entered into ClinicNote will automatically appear in the **Goal** section.

1. Click **Expand All** so that you can see all LTGs and STGs.
2. Uncheck the boxes for goals that were not targeted during that session. Only goals targeted during the session should appear in the Objective section.

If this is not the client's first SOAP note, the plan entered in the previous note will automatically appear in the **Previous Plan** section.

- **Subjective**

Enter your subjective comments in the **Subjective** box.

- **Objective**

In the **Objective** section, enter the quantitative data for each goal targeted during the session. Make sure the data entered matches the goal.

For percentage-based data, you can either enter the percentage directly (e.g., enter 0.75 for 75% accuracy) or enter a formula based on the number correct out of the total number of opportunities (e.g., =6/8). Be sure to include the equal sign at the beginning of the formula.

Enter qualitative comments in the box under each data point, or select **Combine Objective Comments** to enter comments for all targeted goals in one box. Check with your supervisor regarding their preference.

- **Assessment**

In the **Assessment** section, select each goal that was targeted during the session from the drop-down list and enter your assessment information for each goal.

You may also select **Combine Assessments** to enter assessment information for all targeted goals in one box. Follow your supervisor's preference for using individual or combined assessments.

- **Plan for Next Session**

In the **Plan for Next Session** section, describe what you plan to do when the same skills are targeted again. The plan does not necessarily need to describe what you will do during the very next session if you plan to target different skills during that session.

Write the plan from the perspective of what you will do as the clinician, rather than what the client will do. For example:

Do not write: "Bryce will use past tense -ed with 100% accuracy."

Instead, write: "Continue to support Bryce's use of past tense -ed by providing an increased number of models and practice opportunities."

- **Home-Based Therapy Tasks**

If you assigned a homework assignment in the previous SOAP note, it will automatically appear under **Previous Home-Based Therapy Tasks**. Describe the homework assignment you want the client to complete before the next session.

- **Additional Comments**

The **Additional Comments** box should generally be left blank. Your supervisor will provide guidance if information needs to be entered that does not fit into another section of the SOAP note.

For Medicare clients, the supervisors will use this section to document that 100% of the session was supervised. Also enter the session number so you and your supervisor can track when the 10th-visit progress report is due. The 10th-visit progress report template is available in the SPPA 5030 Clinical Practicum WyoCourse website.

- **Signing and Submitting the SOAP Note**

1. Click **Add Signature** to add your electronic signature to the note.
2. If you are not finished and need to return to the note later, click **Save**. You can return to the note from your To-Do list.
3. When you have completed the note and are ready to submit it for supervisor review, click **Submit**.
4. Select your supervisor from the list that appears.
5. Click **Submit** again.

The note will then appear in your supervisor's To-Do list for review.

- **Reviewing and Revising SOAP Notes**

- Review your supervisor's edits and comments: When your supervisor returns the SOAP note, it will appear in your **To-Do list**. Open the note by clicking **Edit**. You will then be able to view your supervisor's edits and comments.
- **Review edits:** Any edits made by your supervisor will appear in the document and in a pane on the right side of the document showing who made each edit. **Do not click the checkmark to accept the edits until your supervisor tells you the report is ready to be finalized.**
- **Review comments:** Comments from your supervisor will also appear in a pane on the right side of the document. Respond to comments and make any requested changes. **Do not click the checkmark to accept the edits until your supervisor tells you the report is ready to be finalized.**

- **Resubmit the SOAP note:** Once you have completed all requested edits and addressed the comments, click Submit. Select your supervisor from the list that appears, then click Submit again. If your supervisor requests additional changes, the note will be returned to you and the editing and commenting process will be repeated.

- **Final Approval of the SOAP Note**

Once your supervisor determines that the SOAP note is ready to be finalized, they will add their electronic signature. At this point, the SOAP note becomes a permanent part of the client's file.

Once the supervisor has signed the note, it will no longer appear in your To-Do list, and you do not need to take any further action.

- **Final Approval**

Once your supervisor determines that the SOAP note is complete, they will add their electronic signature. The note will then become a permanent part of the client's file.

Once the supervisor has signed the note, it will no longer appear in your To-Do list and you do not need to take any further action.

2d. Clinical Documentation for Albany County School District #1 (ACSD1) and MOEC Clients

These clients are middle or high school students from the Mae Olson Education Center (MOEC) and adult students through ACSD#1. Since, in these instances, we are operating as a legally bound Individual Education Plan (IEP) service provider (rather than as an at-will service provider as for all other clients), the paperwork for these clients is completed by the Speech Clinic Director. If you have an ACSD1 or MOEC client, your supervisor will advise you on following the appropriate report formats and timelines. The confidentiality form and report formats for MOEC clients can be found in the 'MOEC' module in WyoCourse. Attendance must still be marked for these clients in ClinicNote, and data will be maintained for each session using the electronic system reviewed in your clinic meetings.

- Mark attendance and choose '+' and hit save.

2e. Clinical Documentation for Medicare Clients

Clients covered under Medicare will fill out all the same treatment and evaluation paperwork as all other clients. The way we document treatment plans, SOAP notes, and progress notes is slightly different. Please see the 'Medicare' module in WyoCourse for the specific templates you will use for Medicare clients. Additional Medicare compliance guidelines are as follows:

- **Evaluation Session:**
 - Eval session counts as first session towards the 10th-visit progress note
 - Eval report will be sent to physician, but physician signature is not required
 - Eval session should include all baselining tasks if possible
- **Separate Baselining Sessions:**
 - Cannot be considered part of the evaluation because the report must be written sooner by the diagnostic clinicians; cannot be part of treatment, because treatment is not supposed to start until the plan of care (POC) has been established. SO:
 - If needed, treating clinician can schedule up to 2 additional baselining sessions as free, stand-alone appointments

- no billing for these sessions
- **no SOAP notes entered in ClinicNote for these sessions**
- these sessions do not count towards the 10-visit reporting period
- Treatment sessions and Plan of Care (POC):
 - Treatment sessions can begin once the first draft of the POC has been written
 - POC is written in lieu of an STP
 - POC must include a home program if the 90-day certification period will include winter break
 - Physician must sign the POC within 30 calendar days of the first treatment session
 - 100% of treatment sessions must be supervised
 - Regular-visit SOAP notes will be numbered 2-9 (eval session was visit #1; 10th visit is documented on the 10th visit progress report template under 'reports' and 'generate report')
 - Medicare clients will be prioritized for treatment during summer clinic
- 10th-visit progress note:
 - 10th-visit progress note is written in lieu of midterm and final progress notes
 - All scheduled sessions, including ones where the client was absent, will be included in the 10-visit reporting period
 - A separate clinical note template is used for this progress report.
 - Progress notes will be sent to physicians, but they do not need physician's signature.
- Recertification plan:
 - Will be completed every 90 calendar days after the date of the first treatment session
 - Can be completed sooner if a significant change to the current plan is needed, or if the 90-day period ends during winter break
 - Physicians must sign the Recertification plan within 30 calendar days of it being written

2f. Presenting Reports to Clients

For each client that you treat throughout the semester in the on campus clinic, you will hold at minimum two conferences: an STP conference and a Midterm Progress conference. You will present the Final Progress Report to the client via written communication only. For Evaluation Reports, you will work with your evaluation partner to present the findings to the client during an evaluation conference if they continue seeing us for treatment sessions. If not, you will present the Evaluation Report via written communication only.

STP Conference:

Once your STP has been completed, you will present it to the client or their parent/caregiver by pulling it up in ClinicNote and sharing your screen. You will verbally summarize the main points in each section by following the STP Conference Outline contained within the 'Powerpoints and Handouts from Class' module in the SPPA 5030 Clinical Practicum WyoCourse website. Once you have presented the STP to the client or their parent/caregiver, you will ask them to e-sign the report or provide verbal acceptance.

If the client or parent/caregiver wishes to modify any part of the plan, notify your supervisor immediately (she's probably listening and watching already!) so that she can join in on the discussion to collaborate on the client's desired modifications and then work with you later to follow-up on the requested modifications and to create and finalize a new version of the STP.

Once the client has verbally confirmed approval of the plan, document that the STP conference was held and that the client expressed verbal approval of the plan in the client's contact log in ClinicNote. Either your supervisor or the clinic office associate will mail/email (depending on the client's preference) a copy of the STP to the client and to all parties authorized to receive a copy through an Authorization for Disclosure form. They will document this in the client's ClinicNote contact log also.

Midterm Progress Conference:

At midterm, you will review the client's progress with your supervisor and prepare a summary of the client's progress based on the data collected to date. You are expected to use the available quantitative and qualitative data to determine whether the client is making progress toward each goal that has been addressed and whether any changes to the treatment plan may be appropriate.

- **Step 1: Review Progress With Your Supervisor**

You will prepare and orally present a summary of the client's progress to your supervisor. Your presentation should include:

- The most recent data collected for each goal that has been addressed during sessions.
- The client's overall progress toward each goal.
- An explanation for any goal on which the client has not made expected progress. **If a client has not made progress on a goal, you must be able to provide a reasonable explanation based on your clinical observations and data and describe what you plan to do differently moving forward.**
- Any recommended changes to the treatment plan, including goals that may need to be continued, modified, discontinued, or added.

Your supervisor will review this information with you and provide feedback. **You must receive your supervisor's approval before presenting the progress information to the client or family.**

- **Step 2: Present Progress to the Client/Family**

After reviewing and receiving approval from your supervisor, you will hold a progress conference with the client, parent, or caregiver. During this conference, you will verbally explain:

- The client's most recent data and progress toward the goals addressed during treatment.
- The client's overall progress and areas of improvement.
- Any areas in which the client has not made expected progress and what will be done to address those areas.
- Any recommended changes to the treatment plan, including changes to goals or intervention strategies.

Changes to goals are appropriate when supported by the data. Goals may be continued, modified, discontinued, or added based on the client's progress and current needs.

Documenting the Conference

After the progress conference, document in the client's **Contact Log** in ClinicNote that the midterm progress conference was completed.

Sending Final Progress Reports:

Final Progress Notes are completed at the end of the semester after the last treatment session. Once the report has been finalized and signed by the supervisor, you or your supervisor will send a copy to the client. They

will also send a copy of the report to any entities authorized on the Patient Authorization for Disclosure of Protected Health Information form. They will document this in the client's ClinicNote contact log.

Evaluation Report Conference:

After the Evaluation Report has been finalized and signed by you, your partner, and your supervisor, you and your partner will present the report to the client (if your clinic/class/GA schedule allows) during one of their treatment sessions if they are continuing with us for treatment. If no member of the evaluation team is available to present the report to the client during one of their sessions, then the treating clinician will present it. You will show the client the report and you and your partner will collaborate to verbally summarize each section of the report. Please work with your partner prior to the conference to decide which of you will discuss each part of the report.

- When discussing the Background Information section, please let the client know that if any of the information is incorrect, we will modify the report to correct it.
- You will devote the most time to discussing the Assessment Procedures section. When discussing this section, be sure to:
 - describe the purpose of each assessment that you completed
 - give a summary of the results
 - explain what percentile ranks and standard scores mean as you present results
- State the diagnosis
- Explain how the results from each assessment procedure support the diagnosis.
- Summarize the client's strengths and weaknesses.
- State your recommendations for treatment.

After the Evaluation Report conference, the lead/treating clinician will document in the client's ClinicNote contact log that the conference occurred. The supervisor will send a copy of the Evaluation Report to the client and to any authorized entities designated on the Patient Authorization for Disclosure of Protected Health Information form. They will document this in the client's ClinicNote contact log also.

2g. Clarification on Long Term Goals Versus Short Term Goals

Long Term Goals: must include an area of function to be improved (e.g., improve expressive language skills), an observable skill (e.g., formulating complex sentences), a condition (e.g., in an expository essay), a criterion (e.g., % accuracy or % of opportunities; **not % of the time**), and a support level (e.g., independently, with minimal support, etc.). For example: 'John will improve his expressive language skills by formulating complex sentences in expository essays with 90% accuracy and minimal support.' You are encouraged to seek guidance from your supervisor about the most appropriate way to word goal criteria for each client and skill. You should plan to meet with your supervisor to discuss client goals before you submit your first draft of the STP. Some acceptable ways to word goal criteria include:

- ___% accuracy
- ___% opportunities
- In ___ out of ___ opportunities (e.g., 3 out of 5 opportunities)
- An average rating of ___ on a scale of ___ to ___ (e.g., an average rating of 3.5 on a scale of 1 to 5)

- A specific number of units of something (e.g., 3 bottles of water per day)
- Qualitative descriptors (e.g., will self-evaluate his performance as fair, improving from a self-rating of poor)
- **Do not use ‘% of the time,’** unless you are actually using time-based units of measurement to measure the amount of time the client spent doing something (e.g., how many minutes they were attentive out of a total number of minutes)

Short Term Goals: these are the little steps that will help the client build up to performing the functional skill identified in the long term goal. Short term goals may be differentiated from the long term goal in any of the following ways:

- Level of support (e.g., the LTG is for ‘independence,’ while the STG is ‘with minimal support’)
- Context (e.g., the LTG context is: ‘embedded within a functional writing task,’ while the STG context is: ‘in isolated instructional tasks’)
- Overall skill vs. broken-down components (e.g., the LTG is to ‘write a 5-sentence paragraph,’ while the STG is to: ‘formulate a topic sentence’)
- Skill vs. prerequisite (e.g., the LTG is to ‘provide an empathetic response,’ while the STG is to ‘identify emotions based on facial expression’)
- Different ways to do something (e.g., the LTG is to ‘initiate conversation,’ while the 2 different STGs are to ‘make a comment’ and to ‘ask a question’)
- Different types of something (e.g., the LTG is to ‘tell a complete narrative,’ while the 2 different STGs are to ‘tell a story about a main event (such as a birthday party the client attended)’ and to ‘tell a story about a problem that needed to be solved’)

Short Term Goals may be written vertically (i.e., the first STG must be met before the second STG can be targeted) or horizontally (i.e., all STGs can be targeted at the same time). At minimum, they must include a skill and an accuracy and support level.

- Example of **vertical** STGs:
 - John will formulate an independent clause (i.e., a complete subject and predicate) with 90% accuracy independently.
 - John will formulate a dependent clause (i.e., an additional subject and predicate that adds a detail about when, why, etc.) to add to an independent clause with 90% accuracy independently.
- Example of **horizontal** STGs:
 - John will formulate complex sentences using the subordinating conjunction ‘whereas’ with 90% accuracy independently.
 - John will formulate complex sentences using the subordinating conjunction ‘although’ with 90% accuracy independently.
 - John will formulate complex sentences using the subordination conjunction ‘unless’ with 90% accuracy independently.

2h. Professional Writing Tips

Below is a collection of tips for clinical writing compiled from ASHA recommendations and the input from previous and current supervisors. They are not written in a hierarchical form and should be used as a checklist as you evaluate your own writing. They are in no way comprehensive for all that is possible in clinical writing.

- **Think/write CLEAR:**
C = CLEAR
L = LOGICAL
E = EVIDENCE / ENOUGH
A = ACCURATE
R = RELEVANT
- **Chronological age** is marked by using a **semi-colon** (e.g., 13;7), not a colon. In narrative format, it is acceptable to write: *Mary is a 13-year-old student* **or** *Mary is a 13 years, 7 months old student*.
- **Do not use contractions.**
- Avoid referencing yourself, but if you must, do so in 3rd person, referring to yourself as ‘the clinician’ or ‘the examiner’. **Never use personal pronouns** (e.g., “I,” “me,” etc.).
- **Do not use indirect verbs to describe the client or their actions** such as, “*was able to*,” “*appeared to*,” or “*seemed to*”. Instead, **state what you directly observed** (e.g., “John smiled” rather than, “John *appeared to be happy*” or “John wrote” instead of “John *was able to write*”).
- **Do not use verbs that cannot be observed** to describe what will be measured in client goals and objectives. For example, do not use verbs such as ‘understand,’ ‘comprehend,’ ‘recognize,’ ‘remember,’ etc. These are verbs that describe internal mental processes that you cannot observe or measure. Instead, state the verbal or nonverbal skill the client will demonstrate that gives direct evidence of their understanding, comprehension, recognition, or remembrance. For example, ‘Mr. Smith will answer questions about the anatomy and physiology of his voice production mechanism with 90% accuracy,’ is an observable skill that will tell you whether or not he understands the information. Here are some additional examples:

Do not say:	Instead say:
Lilly will comprehend an expository passage with 90% accuracy.	Lilly will summarize the main idea and key details of an expository passage with 90% accuracy.
Ms. Carson will recognize familiar household items with 90% accuracy	Ms. Carson will name or point to familiar household items with 90% accuracy.
Ted will remember decoding strategies with 90% accuracy.	Ted will describe and demonstrate decoding strategies with 90% accuracy.

- Refer to phonemes using slash marks (e.g., the /s/ sound). Refer to graphemes using brackets or apostrophes (e.g., [r] or ‘r’).
- The first time you use a **phonetic symbol** in a document; **you must include an example of it in a word**. For example: Reagan correctly produces the /ʃ/ sound (e.g., as in “*ship*”) in the initial position of words with 89% accuracy.
- **Always keep in mind the audience(s)** to whom you are writing. Make sure the document can be understood by the client/parent and is concise enough for a medical professional.
- **Define all technical terms** (e.g., ‘phonological,’ ‘grammatical morphemes,’ ‘otoscopy,’ etc.) the first time they are used in each document. If you have defined a technical term in a previous document, you must define it again. Do not burden your reader to have to go search for the other document to find out what the term means.
- **Give the full name of an assessment first, immediately followed by the acronym**. For example: Test of Problem Solving (TOPS); then refer to the acronym from that point forward. The same applies for

names of organizations, such as American Speech and Hearing Association (ASHA). The name of an assessment does not need to be underlined, only capitalized.

- **You must address all supervisor comments/suggestions for revision** in a draft. If you disagree with a suggestion, you must discuss it with the supervisor.
- Watch verb tense switching throughout document. **Keep tenses consistent within a section** of the report (e.g., the progress report is written in past tense, since the semester/sessions have been completed).
- **PROOFREAD** by reading the report aloud to hear if the language used makes sense to you **and a peer reviewer within your cohort**. You might try reading the report backwards as a way to check for spelling and punctuation errors. Allow time between the initial writing and proof-reading of the report. Make an editing checklist for problems you frequently encounter in your writing. If you struggle with the same elements consistently, your supervisor may assist you in devising a written checklist as part of an action plan.
- **Beware of your use of confusing/commonly misused terms**. For example, *effect* (a noun, as in ‘The book had a strong effect on me’) vs. *affect* (a verb, as in ‘The book affected me strongly’).
- Use the abbreviations ‘**i.e.**’ and ‘**e.g.**’ correctly.
 - ‘**i.e.**’ tells your reader that you are going to **explain or re-state a term** in other words. For example:
Gretchen produced a complete independent clause (i.e., a clause that includes a subject and predicate) to describe what was happening on each page of the storybook.
 - ‘**e.g.**’ tells your reader that you are going to give a **specific example** of something. For example:
Gretchen produced a complete independent clause (e.g., “The little kid is running to his mommy”) to describe what was happening on each page of the storybook.

2i. Using Patient Portal in ClinicNote to Exchange Forms and Reports with Clients

Supervisors will facilitate the use of this function by following these steps:

- Once the clinician has finished completing paperwork with the client during the first session, the supervisor will ask the client or client’s parent/caregiver if they would like to begin exchanging documents electronically through their own ClinicNote Patient Portal login, or if they wish to continue using email/mail.
- If the client wants to use the Patient Portal, the supervisor will go to the ‘Edit Info’ button in the client’s main file, then scroll down and select the name and email address of the person (client, parent, and/or primary caregiver) who will have the Patient Portal account. You can select to create a patient portal account for multiple individuals associated with the client.
- Once this has been done, tell the client that they should receive an email with steps to set up their password. Once they have done this, have them login and screen share so you can show them how to use the portal.
- Student clinicians only have access to view what is in the patient portal for their clients.
- Supervisors have access to add reports and forms to the patient portal.
- For treatment and evaluation forms, the clinician will still complete them (including their signature where applicable) and will email them to the supervisor for approval immediately after the first session.

- The supervisor will review them for accuracy and will sign them when approved, then will upload a pdf version to the client's 'View Forms' tab by clicking on the 'Portal' button in the client's main file.
 - The supervisor must notify the client directly that the forms have been added to their portal. The client will then download them, sign them, and upload the signed version. The supervisor must follow up with the client and/or check the portal to make sure all forms get signed and uploaded by the client.
- When reports are completed, the supervisor will upload these to the 'view patient records' tab also by clicking on the 'Portal' button in the client's main file.
- SOAP notes will NEVER be shared with the patient.
- Parents will have one login even if they have multiple kids receiving services. Forms and reports for each child will be organized separately under their login.

SECTION 3: GENERAL PROCEDURES

3a. Scheduling Sessions

Only pre-approved GA duties and class times take priority over scheduling sessions. Other than these times, you must be available to accommodate clients' scheduling preferences between 8:00am and 6:00pm Monday through Thursday. Some treatment sessions may be scheduled on Fridays with your supervisor's approval. Diagnostics will be primarily scheduled on Fridays. Clients should not be scheduled before 8:00am or after 6:00pm. You are responsible for **scheduling treatment sessions through the on-campus clinic. ACSD1 and MOEC sessions will be scheduled by the supervisor.** Please follow these steps:

- 1) Contact your supervisor to check their availability and to find out how often and how long treatment sessions for the client should be scheduled (e.g., two 30-minute sessions per week, one 45-minute session per week, etc.). Most will provide a shared scheduling form.
- 2) After obtaining your supervisor's available times, review your schedule and find the times that work for both of you, then contact the client or client's parent/guardian.
- 3) When contacting clients, provide them with information about our clinic location if they have not been seen in our new building. The clinic is in the Mountain View Medical Park, 2710 Harney, Suite 100.
- 4) Please follow these guidelines regarding when and how often you attempt to contact clients about scheduling:
 - Stick to normal business days. Do not call on weekends or holidays.
 - Do not call multiple times in one day when attempting to reach them for the first time.
 - Do not call consecutive days in a row; call every other day instead to give them time to return your call on their own.
- 5) Once you have confirmed a schedule with the client, contact your supervisor once more for final approval.
- 6) Once you have obtained supervisor approval of the agreed-upon schedule, book the sessions in ClinicNote (see instructions in Section 2c).
- 7) If your client does not respond to 3 attempts to contact them for scheduling, send them a verbal **and** written final notice. Call and speak to them or leave them a voicemail message **and** send them an email stating that it is your final attempt and that they have 2 days to respond. For example, "This is _____ from the

UW Speech and Hearing Clinic. I have been attempting to reach you about scheduling, but I have not heard back from you yet. This is my final attempt to contact you. If I do not hear back from you by 6:00 pm on _____ (tell them the weekday and date 2 days from now), then we will give your spot to another client. You are welcome to call me at _____ or email me at _____. Thanks, and have a pleasant day.”

Diagnostic evaluation sessions will be scheduled by the Clinic Director or the supervisor. Due to limited room availability Monday through Thursday, diagnostic sessions will primarily be scheduled for 2-hour time frames on Fridays. At least 2 weeks before the appointment, you will receive email notification when you have been assigned a diagnostic evaluation, which will include the day and time of the appointment, your diagnostic partner and supervisor, and a few overall details of the assignment (e.g., a voice evaluation for a 60-something year-old male complaining of persistent hoarseness). Notify the Clinic Director immediately if the appointment time conflicts with another program-approved time commitment (e.g., a pre-determined GA duty). Once planning for the appointment is underway by the diagnostic team (you, your partner, and your supervisor), any re-scheduling needs due to client request will be managed by the diagnostic team. Please notify the Clinic Director when a diagnostic evaluation has been re-scheduled.

3b. Getting Started with Treatment Clients

At the beginning of each semester, you will be assigned a caseload of at least 1, but no more than 3 client contacts (*contact* is defined as one client or one group). You will receive details about your client assignments during orientation. Follow these steps to prepare for your first couple of sessions:

- **Read the client’s most recent treatment plan, SOAP/DAP notes, and progress notes** (see instructions in Section 2a). Be sure to take note of their most recent goals and treatment approaches/procedures. You will want to discuss these with your supervisor during your planning meeting and have some idea of if you want to continue or change them. Do not print out hard copies of any of the client’s files, but take thorough notes instead.
- **Schedule a time to meet with the previous clinician** to discuss what they did, what worked/did not work, behavior management tips, established session routines, etc.
- **Schedule an initial planning conference with the supervisor.** Be prepared to present your ideas for what you want to assess during baselining, and the treatment approaches, procedures, and goals you may want to implement. Complete the chart review and upload to Typhon.
- **Book the sessions in ClinicNote** (see Section 2c) once you’ve established an agreed-upon schedule with the client and your supervisor (see Section 3a).
- **If the sessions will be telepractice, schedule them in Zoom as well.** (see Section 6e)
- **Review the list of treatment paperwork** (in the Client Treatment Paperwork module in WyoCourse) and gather/prepare all necessary forms. Using information in the client’s ClinicNote file, fill out as much of the forms as you can before the session—this will make the paperwork completion process with the client during the first session go much more smoothly and efficiently. See the description of each form’s purpose in Section 2b so that you are prepared to verbally explain each form to the client. It is recommended that you have the paperwork list with you as you present the forms to the client so that you can double-check to make sure you haven’t forgotten anything.
- Based on the potential semester goals discussed with your supervisor during the initial planning conference, **plan baseline tasks for the first 3 sessions.** During the first semester of clinical practicum,

and the first few weeks of the second semester, you are required to prepare and submit a treatment plan to your supervisor for review. The treatment plan should include your session objectives and the materials you plan to use (See WyoCourses for template). This allows your supervisor to provide feedback and ensure that your treatment planning is appropriate and accurate. Once you have demonstrated consistent accuracy in treatment planning, your supervisor may determine that you no longer need to submit treatment plans for every session. This decision will be made by your supervisor based on your demonstrated clinical skills and progress. Even after your supervisor determines that treatment plans are no longer required, you are always encouraged to send treatment plans, session objectives, materials, or other clinical questions to your supervisor when you would like additional feedback or support.

- You might not need 3 full sessions for baselining, but you will probably need at least 2. Remember to work with your supervisor to determine if or when you are to scaffold, prompt or cue during baselining tasks. Baselining should tell you what the client's current level of functioning is and what they can do independently. Once you've observed what they can do independently, it might be appropriate to then trial a few different forms/levels of support to determine what performance criteria will be attainable by the client by the end of the semester. Over-plan and bring materials for more activities than you think you will need in a session. If you run out of things to do with a client, you cannot dismiss them from the session early. It will be up to you to figure out something to fill the time with.
- **Prepare and bring data sheets with you to the session.** Your data sheet should be well-organized (charts work well) with specific places to indicate the objective being targeted, whether the client's response was correct or incorrect, and what level of support was needed to elicit a correct response. Sometimes it is helpful to also list the specific stimuli or responses that they are expected to produce (e.g., an articulation word list organized by initial, medial, and final position of words)
- **Call the client/parent/guardian the day before the first session** to remind them of their first appointment and to confirm the schedule one final time. If anyone other than the client (e.g., the parent or guardian) needs to attend the first session in order to be present for the paperwork review process, make sure they know that. If they express that they cannot be present for the first session, you must make alternate arrangements with them to review paperwork prior to the first session. Also make sure to remind them of the check in and waiting room procedures (see section 3a).
- **If it is a telepractice session, email the client the link at least 30 minutes before the session is due to start.**
- **Begin the first session by reviewing all paperwork with the client/parent/guardian.**
- Once paperwork is complete, **explain to the client/parent/guardian/caregiver that the first few sessions will be comprised of baselining activities.** Explain what that means so that they are aware that you will not be prompting or cueing, and that they should not assist, prompt or cue either unless you direct them to do so. Begin conducting your baselining activities.

3c. In-Person Sessions

- Check your treatment room, make sure it is set up appropriately for your client.
- Have equipment for observation up and ready (see **VALT instructions in WyoCourses**)
- Upon entering the room use the hand sanitizer on the table or wash your hands and encourage your client to do so as well.

3d. Telepractice Sessions

If you need technical assistance from your supervisor during your session, the supervisor will give you verbal instructions over Zoom.

To start your session, follow these steps:

1. Enter the room in plenty of time to log in and set up materials including doc camera if needed. If there are issues, you can quickly use the spare laptop to make sure you can start your session on time.

- You must bring to every session:
 - Your **cell phone**
 - **Data sheets**
 - **Treatment materials**
 - A **back-up version of treatment materials** on a flash drive or emailed to yourself in case a telepractice station fails mid-session.

2. Use hand sanitizer.

7. Open up the session in your UW licensed Zoom account through the browser.

After each session, the student clinician will follow these steps:

1. Log out of the clinic telepractice station

2. Use hand sanitizer.

4. Use disinfectant cleaner (located in the cabinet above the sink in each room) to wipe down the following surfaces:

- The **telepractice station touch screen, keyboard, and mouse**
- The **doc cam**
- The **table** you used
- The **chair** you sat in

3e. Post-Session Procedures In-Person

After each in-person session, please complete the following steps:

- ☐ Walk the client out to the waiting area or transportation pick-up location. If the client is a child, wait with them until pick-up. Ark clients usually do not need someone to wait with them, unless otherwise noted in their Ark plan of care. Consult with your supervisor for Ark clients.
- ☐ Return to the treatment room and get it ready for the next client by doing the following:
 - Remove **all** materials that you brought in with you from the room. **Treatment materials are not allowed to be left in the rooms overnight or between sessions.**
 - Put on gloves and spray and wipe down the table and chairs you were using the provided cleaning supplies in the cupboards of each room. Make sure to wipe down door handles as well.
 - Push chairs back under the tables.
 - Turn off and unplug space heaters if they were turned on during the session.
 - Close all window blinds, if opened during the session (to respect client privacy this is generally not allowed, unless the client specifically requests it)
 - Erase any markings made on the marker boards
 - Turn off the lights
 - You should leave the room a 'blank canvas' exactly how you found it

- Take all reusable toys/materials to the cleaning room and spray down with provided cleaning supplies and set on drying racks, spray basket used and set out to dry.
- ❑ Review your data and enter information into the correct format (i.e., data collection system and/or assigned SOAP note) & begin planning for the next session.
- ❑ Enter clock hours in Typhon and submit them to the supervisor weekly. You can only submit Case Logs within 7 days of the session.

Please remember that you are responsible for concluding treatment and diagnostic sessions on time. This includes cleaning and disinfecting the room. Another clinician may be scheduled for a session very soon after your session, so please be conscientious and professional with your time management. As a general rule, you should begin to review and close your session about 3 minutes before the actual ending time. If your sessions start late because the clinician before you continually ends late, please discuss this with them first. If the problem is not resolved, speak with your supervisor.

Each clinician will donate 30 minutes to one hour during the last week of each semester to clean up the clinic areas, including the clinic materials room, treatment, observation and graduate rooms. The Clinic Director will post a sign up sheet with a description of each job to be done the week before finals week. Supervisors will check on the status of this job at the final conference. All cleaning jobs must be completed before final grades will be posted.

3f. Use of Clinic Waiting Area

When you conclude a session, do NOT leave any client who is a minor unattended in the waiting area. If you have another client and cannot wait with them, either ask another clinician to assume responsibility for this client or notify your supervisor. Under no circumstances should you leave the client unattended or left with the clinic Office Associates. If your client being picked up late is continually a problem, have a respectful conversation with the client/parent/guardian/transport person about this. If it persists, talk with your supervisor. Be aware that Ark clients may or may not be left alone in the community, depending on what is stated in their Individualized Plan of Care (IPC). Contact Ark if there is not a copy of the client's IPC in the permanent file.

3g. Lock-up Procedures

All rooms within the clinic, the clinic front, side and back doors, the audiology room and all materials rooms are locked at the end of each day. This will be done by the Clinic Office Associate or a supervisor at 6:00pm. All lights and space heaters must be off, and all window blinds must be closed. Treatment materials cannot be left in the treatment rooms overnight or between sessions.

3h. Access to Clinic Rooms After Business Hours

During the weeks when clinic is in session, the front, back and side doors to the clinic will be unlocked between 8:00 am and 6:00pm. If you need to use any rooms within the clinic outside of these hours, you can use your student ID card to enter through the South side door. The door will automatically lock behind you, so make sure you bring your ID card with you if you need to leave for a moment and then return. **Do NOT** ever leave the clinic doors propped open, as there is very expensive equipment and PHI contained within.

3i. Clinic Attendance, Cancellations and Substitutes

Students are required to maintain a 90% attendance rate for scheduled sessions. Falling below this threshold without approval from the Clinic Director will result in a U for that semester. Attendance exceptions are permissible only in cases of emergencies (e.g., illness), accommodation from the disability support services office, or pre-approved program-related scheduling conflict (e.g., you are attending ASHA). If one of these 3 conditions apply, you must follow these steps:

1. Call and discuss the matter with your supervisor as soon as possible and inform Ms. Sandoval. Do not consider finding a substitute, notifying the client or canceling the session* until you have gotten your supervisor's approval of appropriate next steps. (*Note that canceling a session is always a last-resort solution.)
2. Once the supervisor agrees that finding a substitute is appropriate, you are responsible for finding the substitute clinician, planning the session, and making sure the substitute is prepared (e.g., materials, routines, instructions for tasks, data sheets, etc.). Begin by checking with members of your assigned group.
3. As soon as possible, notify the client that they will have a substitute clinician.
4. If unable to reach a supervisor in the event of an extreme emergency (e.g., a sudden and unexpected event that arises 30 minutes or less before the session is due to start), contact the clinic office associate (766-6426) and inform them of your absence. They will notify the supervisor and client as needed. If there is no time for the supervisor to arrange for a substitute and it is very short notice for the client (i.e., they are already here or on their way here), the supervisor will conduct the session. If the supervisor is unavailable to conduct the session, they will let the office associate know and the office associate will inform the client of the session cancellation.
5. If a substitute was not feasible and the session had to be canceled, attempt to re-schedule the session later in the week with supervisor consent.
6. Document cancellation and/or re-scheduling of the session in the SOAP note and the contact log.
7. If the session was re-scheduled as a make-up session, book the session in the ClinicNote scheduler.
8. If arranging for a substitute clinician was feasible, keep in mind that clinical documentation must always be done by the actual clinician who provided the services. Therefore, the substitute clinician is responsible for completing the SOAP note if it was assigned for that session. The substitute clinician will need to contact Ms. Sandoval to be short-term access in ClinicNote to that client.
9. The substitute clinician will submit clock hours for the sessions they conduct to the supervisor assigned to that client.

If a **client** contacts you and asks to cancel a session:

- Inform your supervisor immediately.
- Document the cancellation in the SOAP note and the contact log.
- Talk to your supervisor about whether you can/should offer to re-schedule the session. In most cases, we do not re-schedule sessions that are cancelled due to client request. Exceptions may apply, such as when a client has already missed many other sessions due to an extended illness.

3j. Assigning Client Homework

To facilitate carry-over and promote a sense of pride and ownership regarding speech/language activities, it is expected that clients will be regularly provided with home practice tasks. When presenting a homework assignment to a client, first give them verbal instructions on how to complete the assignment, then demonstrate the completion of one or two items and ask them to complete one or two items to ensure comprehension of instructions. The materials you send home should always include written instructions also. If the assignment is for a child or Ark client and the parent/guardian/caregiver was not present during the session, a letter to the parent/guardian/caregiver and a *written* explicit description and model of the assignments you want the client to complete, how to complete it, and when it is due will be necessary. Encouraging the client to be involved in the development of homework assignments is a great way to ensure that they will be motivated to complete the assignment. If you are unsure of what is needed for your client in this area, visit with your supervisor.

3k. Behavior Management Guidelines

The suggestions below are designed to be a general guide for how to manage behavior problems that are encountered during sessions. Consult with your supervisor for specific suggestions that may facilitate optimal behavior from your client.

Behavior management consists of shaping appropriate client behavior by differentially reinforcing desired behaviors (e.g., verbal praise, stickers, tokens, etc.). Undesired behaviors may either be simply brought to the client's attention or ignored altogether. Note that we do not condone punishing undesired behaviors.

Suggestions for successful behavior management include:

- Use the first session to find out what motivates your client (e.g., what topics/activities they are interested in, what specific communication skills they want to learn, what reading material they prefer, etc.)
- Use interesting and age appropriate materials.
- Keep things simple. Elaborate materials (e.g., complicated games, crafts, etc.) may detract from treatment objectives and be over stimulating to the client.
- Be well organized. Prepare everything, including the room/environment, before the session begins.
- Be prepared for more than you think you will need. Vary materials if necessary but do not feel compelled to use everything that you have prepared.
- Positive reinforcement of desired behaviors is more powerful in shaping behavior than pointing out your client's negative behaviors.
- Resist showing anger or losing your temper. It may frighten your client and/or make the client misbehave even further.
- Be consistent. The client must know what to expect from each task or session. A visual schedule can be very useful for some clients. Clearly explain your expectation and do not have one set of "rules" one day and another set the next session. Consistency will also help to decrease power struggles.
- Maintain a matter-of-fact attitude about accomplishing the session's tasks. **Example:** "I understand that you are feeling tired but this is our scheduled time to work, so let's get to it!"
- Offer as many choices as possible to give the client a sense of control. (e.g., "Do you want to practice the /l/ sound or the /s/ sound first today?"; if the client is playing with something distracting, ask, "where would you like to keep that until we're finished" instead of just telling them to put it away.)

- Tell them how many items they have to complete before they receive a pre-determined break or reward (chosen at the start of the session so that they know what they are working for that day).
- Keep the client's attention. Some ways to refocus a client are to whisper, touch on the shoulder or arm, or silence while looking at the client.
- When a client is demonstrating undesired behavior, remind them of the expectations and rewards and then quickly move on to the task planned.
- Follow through with the reward plan. Make sure you never run out of time before the client receives the reward. If they don't complete the task, let them know that they can try again next session.
- Keep the client's welfare paramount. This may mean keeping the client safe from harm by terminating a given task or the session entirely.
- If a client becomes physically aggressive, distance yourself and all other nearby persons from them (perhaps even leaving the room) but continue to monitor them. You absolutely cannot leave an escalated client unattended. Do not attempt to physically restrain them or stop them from destroying materials. This is extremely unsafe for you and your client. Materials can be replaced. The only situation in which it is appropriate to try to physically intervene is if the client is attempting to harm themselves or another person. Wait until your client is calm before attempting any interactions with them.

Additional strategies to use with young children:

- 1. In giving directions:** Be sure the child understands. Get to the child's level when you give a directive; both in your choice of words and physically (stoop down).
- 2. Be matter-of-fact:** Take compliance for granted (e.g., "We all sit in our chairs like this.")
- 4. Be quiet in manner and tone:** Move slowly, talk softly, be in the background as much as possible.
- 5. Let the child learn by experience:** Help him/her only when it is necessary to avoid a feeling of failure or discouragement.
- 6. Praise the type of behavior you wish to be continued on every opportunity:** It is better to emphasize the good things and let the bad drop out of sight. If you must attend to the bad behavior, attend to the behavior, not the person (e.g., "Hitting is unsafe" instead of "You are not being nice").
- 7. Be consistent:** Praise or disapproval should be given consistently for a definite behavior.
- 8. Suggest the next specific act when a child dawdles:** When a child continues with one activity for too long, say for instance, "Where is the lid to the box?" to terminate the activity.
- 9. Give the child a choice of action when feasible:** Asking, "Where would you like to put your train, here or there?" gives the child a personal interest in the situation and develops his initiative and independence.
- 10. Give the child a choice about following instruction only when a negative reply is acceptable:** Do not say, "Do you want to do X?" or "Can you do X?" unless you are prepared to accept them saying, "no." Otherwise, state the expectation without asking.
- 11. When children are in a social conflict situation, let them work through it if they can.** Step in to suggest a socially approved solution if the conflict continues for an extended period of time or if children begin to show signs of escalation. You may need to terminate the task or remove them from each others' company for a 'cool down' period.
- 13. Don't interrupt anything the child is doing without giving him a fair warning:** Prepare him/her in advance (e.g., "After 2 more minutes/turns it will be time to pick up.") Setting a timer is useful.
- 15. State what is expected instead of what is not expected:** Say, "Sit at the table with your juice, Mary." Not, "Don't walk around with you juice box, Mary."

16. Have confidence in yourself: Children feel your uncertainty and act on it. A hurried decision is better than losing a child's attention with uncertainty.

3l. Observers

Undergraduate and graduate UW students from an aligning degree or other individuals may be observing treatment and diagnostic sessions pending approval from clients/parents/guardians. These students may ask you for client information to complete assignments. Please provide it to them in a timely manner, always remembering the **minimum necessary rule**. You may only share with them the client's general communication diagnosis (e.g., vocal hyperfunction, articulation, aphasia, specific language impairment, autism spectrum disorder, etc.) and information about treatment goals, prompting, scaffolding, behavior management strategies, etc. You may **NOT** share with them information about personal or medical history (e.g., specific circumstances leading to a brain injury, complicating factors such as drug/alcohol use, etc.). Sharing such information is a HIPAA violation. If an observer asks you for information that is outside of the minimum necessary rule, let them know that it is against the clinic's Privacy Practices for you to share such information.

UW students must get an observer badge from the Clinic Office Associate and wear this in the clinic. They must also follow clinic dress code. Clients/family. Family members, friends, or caregivers of clients do not have to comply with clinic dress code.

3m. Audiological Screenings

We screen each in-person client's hearing once each semester, unless there is an exceptional reason not to (e.g., the client has a known hearing loss and is already under the care of an ENT/audiologist). For telepractice clients, you will use a questionnaire-based screening protocol (in the Oral Mech and Hearing Screening module in WyoCourse). You must obtain supervisor approval if there is a legitimate reason not to screen your client's hearing. Notify your supervisor **at least 48 hours in advance** of when the screening is scheduled so that they can be sure to be there to give you feedback. You must never conduct a hearing screening without your supervisor present.

For in-person clients, you will check out an audiometer using ClinicNote and you will move that audiometer (found in the screening room 1113) to your treatment room. Supervisors will use a hearing screening observation checklist (see the 'Screenings Feedback' form in the 'Supervisor Forms' module in WyoCourse) to document and evaluate your performance. When practicing this procedure, you are encouraged to use the 'Hearing Screening Checklist Explanations' form in the 'Diagnostic Paperwork' module in WyoCourse to ensure that you are including all the necessary components of a well-rounded screening. You and your supervisor can determine together whether you need assistance from an audiologist in exceptional situations or when OAEs are needed (e.g., your client has a cognitive impairment, is too young to give reliable behavioral responses, has challenging behaviors, etc.). Contact the audiologist in advance to schedule the screening if these conditions apply.

Follow these steps for hearing screenings:

1. Practice on several members of your cohort several times prior to conducting client screenings.
2. Read Appendices 3-1 and 3-2 (*Audiometric Screening Procedures and Guidelines for Referral and Biological Calibration of Audiometers*) at the end of this manual.

3. If you have questions about procedures or equipment, have them answered by a supervisor before you are scheduled to begin the screening. You must notify a supervisor if you notice equipment problems as you are practicing.
4. If a client has had a screening before, know the results of this prior screening.
5. Prior to screening your client, make sure equipment is turned on, warmed-up for at least 10 minutes and functioning properly; then perform a biological calibration (see [Appendix 3-2](#)). Make sure the number on the headphones matches the number on the audiometer. Do not switch headphones and audiometers, as this disrupts calibration.
6. Make sure the otoscope is adequately charged or batteries are fresh. Generally, otoscopes are kept plugged in to an outlet at their assigned station when not in use.
7. Conduct the hearing screening (see [Appendix 3-1](#)) and fill out the hearing screening protocol form as you go (in the 'Diagnostic Paperwork' module in WyoCourse).
8. Turn off all equipment and otoscopes after the screening, unless someone has signed up directly after you. Make sure headphones and otoscopes stay at their appropriate stations (as labeled numerically).
9. Place used tympanometry tips in the container at each station marked 'dirty.' Materials room staff will clean them later. Discard used otoscope tips.
10. The completed screening protocol is due to the supervisor **within 24 hours**.
11. Once you and your supervisor have signed the protocol, scan and upload the signed hearing screening protocol form in the client's ClinicNote file.
12. Hearing screenings are coded under **Hearing** in the **Evaluation** category on the Typhonclock hour form.

3n. Oral Mechanism Screenings

Perform a full oral mechanism screening on each of your in-person clients each semester (these are usually done during the same session as the hearing screening). For telepractice clients, use the modified oral mech screening form (in the DX module in WyoCourse). Notify your supervisor **at least 48 hours in advance** of when the screening is scheduled so that proper supervision is maintained. Supervisors will use an oral mechanism exam observation checklist (included in the 'Screenings Feedback' form in the 'Supervisor Forms' module in WyoCourse) to document and evaluate your performance. Use this checklist when practicing this procedure to ensure that you are including all the necessary steps. A video tutorial for oral mechanism screenings is located in the 'Demo videos' module in WyoCourse.

Follow these steps for oral mech screenings:

1. Practice on several members of your cohort several times prior to conducting client screenings.
2. Before the session, clean the table and gather all materials (e.g., unopened tongue depressor, penlight, nasal mirror, gloves, pen, alcohol wipes). Oral mechanism materials are found in room 185. Put on gloves and clean all reusable materials with alcohol wipes, then place the clean materials on a clean paper towel until they are ready to be used.
3. Put on fresh gloves and conduct the screening following the items on the Oral Mechanism Screening Protocol (in the Diagnostic Paperwork module in WyoCourse) and the checklist on the Screenings Feedback form. If at any time during the screening you touch any surfaces that hadn't been cleaned immediately prior to the session, then you must change gloves.

4. After the session, complete the Oral Mechanism Screening Protocol and turn it in to your supervisor **within 24 hours**.

Examples of acceptable descriptive terminology for specific tasks:

- *Rhythm, speed and accuracy are judged to be inadequate as indicated by _____.*
- *Results are consistent with a diagnosis of Parkinson's disease with reduced strength and coordination noted in _____.*
- *Structures are adequate but deviation noted in function of tongue on elevation which may impact speech production for sounds such as _____.*
- *Additional key markings that are acceptable:*
 - *NR = no response from client*
 - *WNA = client would not attempt*

Examples of acceptable terminology in the Summary/Recommendations section at the bottom of the protocol:

- *Structures and functions are adequate for speech production.*
- *Functions consistent with last screening on xx/xx/xxxx indicating no further regression or loss of skills.*

If needed, write a recommendation such as:

- *Follow-up screening after palate expander has been removed to assess articulation.*
- *Re-screen next semester due to lack of compliance.*

5. Once you and your supervisor have signed the protocol, scan and upload it into the client's ClinicNote file.
6. Oral mech screenings are coded under **Speech Sound Production** in the **Evaluation** section on the Typhon clock hour form.

30. Diagnostic Procedures

The Clinic Director will schedule and assign all diagnostic evaluations. A team of two clinicians typically conduct diagnostic evaluations, but you may be assigned to complete one for a client you will be seeing. Assignments will be emailed to the assigned clinicians and supervisor at least two weeks before the appointment. One clinician is designated as the 'lead clinician' and the other clinician is designated as the 'partner.' The lead clinician is responsible for all communications with the supervisor and client, and for scheduling and paperwork. Observers may also be assigned if a specific role for them to fulfill is needed (e.g., assist with data taking or transcription). It is the goal of the Clinic Director to assign every clinician as a lead and as a partner in at least one diagnostic evaluation each semester; however, there is no way to predict how many diagnostic evaluations we will have in a semester, or how many will cancel. Although it is the lead clinician's responsibility for making sure the evaluation runs smoothly, it is up to all team members to work together for a successful outcome. Typically, the clinicians will be scored separately for their roles in conducting the diagnostic session (refer to the 'Evaluation Feedback' form in the 'Supervisor Forms' module in WyoCourse). The clinicians will complete the Evaluation Report (see the eval report template in the 'Explanatory Templates' module in WyoCourse) **collaboratively**, and **one score for the report** will be given to both clinicians. It is the supervisor's discretion to adjust these scoring policies and at times, a clinician may be assigned a specific section of the report to write and be scored on separately.

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Below are the detailed steps for conducting a diagnostic evaluation:

- The lead clinician will schedule an initial planning meeting with the supervisor (the partner also attends this meeting).
- After the initial planning meeting and at least 3 days before the session, the lead clinician will turn in the Diagnostic Plan (in the 'Diagnostic Paperwork' module in WyoCourse) to the supervisor for their approval. This plan will include what procedures will be included and which clinician will carry them out. (Note that an oral mechanism and hearing screening are typically included in any in-person diagnostic session.)
- Soon after the initial planning meeting, the lead clinician will contact the client/parent to:
 - Introduce themselves and their diagnostic partner (e.g., "I'll be working with another clinician named _____ during your evaluation session.")
 - Confirm the date and time for the session. Remind them that the session will take approximately 2 hours, check in procedures, and assigned waiting area.
 - Confirm their address and preferred contact information.
 - Confirm that they received the diagnostic packet mailed/emailed out by the Clinic Director which includes:
 - Case history form
 - Self-addressed return envelope (if mailed)
 - Fee schedule
 - Campus map indicating our location (if it is an in-person session)
 - Remind them to return the case history form that was sent by the Clinic Director if they have not done so already. Let them know that it assists us in planning their session, and so it is preferable for us to receive it back by mail prior to the session.
 - Ask any follow-up questions that were brought up during the initial planning meeting.
 - Discuss having observers, if applicable.
 - Tell them you will call them once again to confirm the appointment the day before the session.
- The lead clinician will document all contact with the client in the ClinicNote contact log.
- The lead clinician will book the session in the ClinicNote scheduler.
- Both clinicians must review and practice all assessment materials and procedures thoroughly before administration. It is expected that standardized procedures will be followed, including application of basal and ceiling rules. Remember that scores are invalid if basal and ceiling rules are not followed exactly as described in the assessment's manual.
- Assigned observers, if applicable, should be informed of what their role will be during the evaluation by the lead clinician after the planning meeting.
- The lead clinician will contact the client the day before the diagnostic evaluation once more to remind them of the appointment. Remind the client/parent to bring the case history or other pertinent forms with them if they have not already mailed them to us.
- On the day of the diagnostic evaluation session, place copies of all forms and protocols in the observation room for the supervisor and observer (if applicable).
- At the start of the session, the lead clinician will complete the diagnostic paperwork (see the 'List of Diagnostic Session Forms' in the 'Diagnostic Paperwork' module in WyoCourse) with the client or parent/guardian.

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- For in-person sessions, once the paperwork has been completed parents should be encouraged to observe in the observation room and not remain in the diagnostic session unless they are needed due to separation anxiety or to be interviewed.
- As long as the client/representative signs the Permission to Record form, all evaluations should be video recorded for later review and analysis. As soon as they express permission, start the recording. (Note that although the session is being recorded, clinicians are encouraged to take on-line data during the evaluation for immediate analysis and examples to present during the oral summary at the end of the session.)
- If the case history form was not completed and returned to us beforehand, allow for sufficient time to complete it during the session in the form of an interview.
- When administering a standardized assessment, record the responses immediately and directly on the assessment protocol. (To protect the client's PHI, do not complete the heading information until it is ready to be scanned and uploaded into the client's ClinicNote file.)
- At the end of the session, the supervisor and diagnostic team will meet in a separate room (if it is an in-person session, the parent/caregiver will be sent to join the client in the treatment room) to discuss their findings and complete a Diagnostic Summary Sheet (in the 'Diagnostic Paperwork' module in WyoCourse).
- The lead clinician will return to the treatment room to give the client/parent/caregiver a verbal summary of results, findings, and recommendations. A **copy** of the Summary of Diagnostic Evaluation sheet is given to the client/parent, and it is also scanned and uploaded into the Client's file in ClinicNote.
- If the client will continue for treatment, discuss how/when scheduling treatment sessions will occur.
- If it is an in-person session, escort the client back to the clinic waiting room to complete any payment procedures (including making a copy of their insurance/Medicare/Medicaid cards) with the office associate based upon the Diagnostic Agreement form.
- Both clinicians will **collaboratively** write the Evaluation Report, unless otherwise directed by the supervisor. This report is typically due within 5 business days of the diagnostic session. Your supervisor will give you a specific due date and time at the end of the session.
- The lead clinician will submit the report to the supervisor via ClinicNote by the due date and time. They will place all data recording sheets, language sample transcripts/analyses, completed assessment protocols and corresponding assessment manuals in the supervisor's mailbox at the time that they submit the report.
- The supervisor will email the Written Product Feedback form (in the 'Supervisor Forms' module in WyoCourse) with feedback and grades to both clinicians. They will scan protocols, data sheets and language sample transcripts into the client's file in ClinicNote and will return assessment manuals to the lead clinician.
- Once finalized and signed by the clinicians and supervisor, a copy of the report is mailed by the lead clinician to the client/parent and others who are listed on the signed Authorization for Disclosure form, if applicable. Document that the report was mailed out in the client's contact log in ClinicNote.
- If the client is not returning for treatment, send a satisfaction survey letter (in the 'Client Treatment Paperwork' module in WyoCourse) with a self-addressed stamped envelope along with the copy of the report that is sent to the client.
- If the client is returning for in-person treatment, a copy of the evaluation report may be hand-delivered and discussed with them during the first treatment session instead of mailed.

General Information about Evaluation Reports:

An **evaluation report** is a systematic, written description of a client's overall communicative performance. In this report, the clinician states the assessment procedures administered and then describes the client's strengths, weaknesses, and present level of functioning. From this information, a diagnosis and recommendations are made. Consider the following tips:

- For some clients, you must evaluate all aspects of communication. For other clients, only selected aspects of communication need to be assessed. Make those sections that relate directly to the primary reason for the referral first and the most specific. Other sections can be more general.
- In some instances, you will be asked to determine whether or not a communication disorder exists (e.g., articulation, language, dysphagia, etc.). In such cases, the information you present in the diagnostic report will: a) explain the nature, cause, and extent of the disorder, and b) serve as a foundation of support for your recommendations.
- In other cases (e.g., stuttering, and aphasia) you and the client know that a disorder exists. Thus, your job is to describe the parameters of the disorder as it applies to and negatively impacts the client and to make recommendations for further treatment or maintenance.
- In virtually all cases, your diagnostic information will be used as a baseline measurement of performance against which progress in treatment will be measured.
- Clients, parents, educators, physicians, and other professionals read diagnostic reports. Thus, the report is a reflection of you, your supervisor, and the University's credibility. Therefore, accuracy of content and professionalism of wording is tremendously important.
- When writing the report, refer to the client by name. Always use a title (Mr., Mrs., and Miss) when referring to an adult client. Use the same format when referring to the parents of a child (e.g., Mrs. Smith or John's mother).
- Verify all assessment scores and be certain that all information on the assessment protocols (including name, birthdate, date of evaluation, scores, etc.) is correct. There are times when copies of the assessment protocols are requested with the report so information must be accurate.
- Reports should be written with the primary audience in mind (i.e., client and parents), but should also included professional terminology for other SLPs, physicians, etc. Technical terminology (e.g., 'phonation,' 'grammatical morphemes,' 'phonological processes,' 'executive functions,' etc.) contained within the report should be supported with explanations and/or examples.
- Sometimes a client is referred to our clinic to seek an "objective second opinion". In these instances, it is wise to make your observations more specific (by providing examples) and concrete since you are typically unable to support your findings in person.
- See the 'Evaluation Report Explanatory Template' in WyoCourse for specific guidelines and components of UWSHC's Evaluation Reports.

SECTION 4: HIPAA COMPLIANCE and CORRESPONDENCE

4a. Protection of Clinic-Related Documentation Outside of ClinicNote

- Do not include client personal health information (PHI) in any document stored outside of ClinicNote. If you must store documentation containing client PHI outside of ClinicNote for some reason approved by your supervisor, you must password protect all such documents AND store them only on a password

protected flash drive. ClinicNote and Typhon should be used for almost all exchange of documents back and forth between the clinician and the supervisor. Instances in which a document containing client PHI needs to be exchanged outside of ClinicNote (i.e., via email) should be very few.

- Graduate students should only use their personal computers, UW computers in HIPAA compliant spaces (H), or the laptops available for checkout in the Division for all client sensitive work. Never use the computers in the UW computer labs for clinic-related work.
- Use a high quality and reliable password encrypted flash drive to save clinic documents (e.g., data sheets, treatment materials) and session recordings.
- Consult the Graduate Handbook regarding HIPAA violations.

4b. Telephone confidentiality is important. You may use your personal cell phone to contact clients as long as you are in a private room where no one else not affiliated with the clinic (e.g., roommates, friends, random-passers-by, etc.) may overhear.

You may also use the telephones in the clinic front office or supervisor's offices to make calls to clients. The only other people authorized to be in these spaces are other graduate student clinicians who have been HIPAA trained, so it is okay if they are within earshot when you call.

When you call a client, properly identify yourself and your affiliation with the University of Wyoming Speech and Hearing Clinic. Leave only the *minimum necessary* information on voicemail for clients to return your call. You do not have to give them your personal cell phone number if you do not wish. In this case, instruct them to call the clinic at 307-766-6426 and leave a message for the Office Associate to relay to you containing the requested information or the best time for you to reach them.

4c. Email correspondence between a supervisor and clinician should be kept confidential by only using initials when referencing the client and disclosing only the minimum necessary information. **Again, password protection is required when sending any document containing client PHI via email or use of encryption.** All UW emails can use encryption. To do so, type WYOENCRYPT in the subject line.

4d. Mailboxes are used to exchange hard-copy documents with client's PHI between clinicians and supervisors, whenever hand-delivery is not possible or convenient. Graduate student clinician and supervisor mailboxes are in the galley behind the front desk. Clinic documents placed in student and supervisor mailboxes should always be contained within an envelope. There are many re-usable envelopes for this purpose.

4e. Outgoing Mail for clinic purposes should be placed in Heather's In Box on the counter behind the front desk. Enclose the mail you wish to send in a division envelope addressed to your client or client-approved entity (in accordance with a signed Authorization for Disclosure form). Print your last name above the UW return address. Postage will be added for you. Document in the client's contact log in ClinicNote whenever anything is mailed to the client or client-approved entity.

SECTION 5: CLINIC MATERIALS AND TECHNOLOGY

5a. Equipment or Computer Problems

If there are any issues with any clinic materials, equipment, printers or computers, please do **not** attempt to fix them yourself or call IT. Notify either Ms. Sandoval or the Clinic Office Associate so that we can contact the correct entity to come and fix the problem. Some clinic technology is maintained by an outside entity, not by UWIT.

5b. Session Recording Equipment

For telepractice sessions use the recording capability in Zoom to record your sessions. You can store your recordings on a password encrypted flash drive and delete them as soon as possible. Be extremely careful with session recordings and do not store them in any way that does not require password access.

For in-person sessions, you will use VALT for all recordings. VALT enables you to schedule recordings, view live sessions, and review your recordings. Note that VALT can only be accessed through specific IP addresses. For detailed information on how to log in, schedule, record, and view sessions, please refer to the SPPA 5030 WyoCourses module for VALT.

5c. Assessment and Treatment Materials

Clinic Materials are organized in rooms and storage closets throughout the clinic. Please see WyoCourses for a map and list of items to help direct you.

Speech/language materials, minus some games/toys and craft materials, must be checked out using Libib prior to use and checked back in when no longer needed. Prior to checking out any clinic materials, you must complete brief training during clinical practicum class. Check-outs and check-ins are done using Libib on a dedicated iPad stored in the Clean Room 1111. Each item will be checked out by using this app to scan either the barcode that came with the item, or the QR code/barcode that was added to the item. If you cannot find a barcode on an item, notify Tana Sanchez. For articulation and phonology kits that contain multiple card sets, please check out only the card set you need, not the entire kit. You must not take any treatment or assessment items without properly checking it out first, even if you are only going to use it in a session for a moment, and then ‘bring it right back.’ These items do not have a check-out time limit, but you will receive a notice from Libib about an item being due 30 days after you check it out. If you plan to continue to use the item, you will need to contact the Tana Sanchez or the Clinic Director to renew.

You must check an item back in before another clinician checks it out and uses it. When checking items back in, scan it with the iPad app first, and then place it in one of the wire baskets in Clean Room 1111. The materials room staff will check the item to make sure it has all components and is in good condition before re-shelving the item. ***Please do not re-shelve any items yourself.***

The person who has checked out an item is responsible for the item. It is not acceptable for one person to check out an item and then pass it off to another clinician without checking it back in first. An “incomplete” grade or other monetary consequences (i.e., you may have to reimburse the clinic for the dollar amount of the lost item

or purchase a replacement item) may be imposed if an item is not returned by the person recorded as having checked out the item.

The toys for young children do not need to be checked out. Simply take what you need and return it if it is a reusable item. Notify Ms. Sandoval if any supplies are running low or any items are in poor condition and need to be discarded or replaced.

5d. iPads for Treatment

The clinic owns additional iPads equipped with speech, language and AAC apps that can be used for treatment throughout the semester. These iPads can be checked out to use with clients through Libib. Keep in mind you are responsible for any damage to these iPads or missing items. The additional iPads are found in the Sterilization and Cleaning Room 1111.

5e. Flipboards, Telepractice Stations and Document Cameras

There are two portable flipboards housed in group rooms 1 and 2. These boards can be used for in-person or telepractice sessions. They have 2 functions: one acts as an electronic white board (simply touch the screen or use the electronic pen at the bottom of the board; when done, you can save your client's work on a flash drive), and the other function acts as a computer to use for Zoom sessions or other web activities.

To use the portable flipboard follow these steps:

- Plug it into the wall outlet.
- Plug the Ethernet cord into one of the internet ports on the wall with a green dot next to it.
- Once the board is plugged in, press the power button on the lower right-hand corner (when board is flipped horizontally) to turn it on.
- Follow the same steps listed for the permanent flipboard above to switch to the computer mode.
- Once you are in computer mode, this board continues to operate as a touch screen.
- This board does not have its own external keyboard. When you click on a space on the screen where you need to type something in, a touch keyboard should pop up automatically on the bottom of the screen. If it does not, complete the following steps:
 - Click the windows icon in the bottom left corner
 - Scroll down to 'Settings'
 - Select 'Devices'
 - Select 'Typing'
 - Scroll down to the item that says: "Show the touch keyboard when not in tablet mode and there's no external keyboard attached." Slide the toggle to turn this item on.
 - Click anywhere else on the screen to exit settings.
 - The touch keyboard should start working the next time you touch on a space that requires typing something in.

Telepractice stations: These utilize two screens, desktops, cameras, and document cameras. You just need to log into the laptop using your UW log in and then your Zoom account.

Document cameras: There is a ‘plug and play’ document camera in each room where you will conduct telepractice sessions. Simply plug the doc camera into your USB port and open it using your ‘camera’ app from the windows toolbar. The flipboards will have their own document cameras. To use them, follow these steps:

- Plug the orange cable into the back of the doc cam in the port with the USB icon, not the port labeled ‘install’
- Open the Hover Flex 10 desktop app on the computer
- On the doc cam, open the camera arm. This automatically turns the camera on.
- There are only a few buttons on the doc cam. Use them as labeled to turn on the light or adjust them zoom if needed. The button labeled ‘AF’ controls the auto focus.
- When done, close the arm. The camera will automatically turn off. There is no other on/of button.
- Unplug it from the orange cable and put the camera back where it is stored (on the shelf/desk to the right of the station).

If you need an additional document camera for any reason, there are extras in the material room you can check out using the same checkout system. We also have additional plug and play HUE cameras that allow you to show any document on a laptop, zoom or other. You just plug it in and choose it as the camera.

SECTION 6: TELEPRACTICE SESSIONS

6a. Rationale

We strive to ensure that each clinician gets at least one telepractice client during their first year of clinical practicum. There are several reasons for this goal:

- This is a rural state in which many clients can benefit from teletherapy who would not have access to services otherwise. By offering this service, we are having a strong positive impact on the lives of Wyomingites living with disabilities.
- Telepractice is becoming more and more ubiquitous all the time. It is not just for rural areas anymore. Many school districts and medical facilities across the country, including those in highly populated metropolitan areas, are using telepractice as a service delivery model. Chances are very high that you will be a telepractice practitioner at some point in your career.
- Telepractice experience makes you a highly marketable and desirable job candidate straight out of graduate school. It requires development of technical skills, advanced preparation and time management skills, and flexibility, all of which are fabulous skills to tout on a resume or in a job interview.
- In many cases, telepractice sessions require active and on-going involvement on the part of the parent, partner, or primary caregiver, which in turn leads to them using effective strategies and techniques to facilitate the client’s communication during everyday life. This often leads to more rapid progress and/or greater skill generalization.

6b. Eligibility

Although it might not be the ideal delivery method for everyone, all clients are eligible to receive and can benefit from telepractice services.

6c. Platform

Telepractice sessions are conducted using Zoom. You must always use your UW Telehealth Network Zoom account to conduct sessions. This account is a HIPAA compliant clinical service account. You must never use your personal Zoom account to conduct sessions. On our end, a hard-wired internet connection (via Ethernet cable) is required. Please make sure the wi-fi is turned off on the station that you are using. The client is encouraged to use a hard-wired internet connection on their end also, but they can use wireless if they wish. If they prefer to use wi-fi, make sure that they are aware that there may be poorer sound quality or more transmission lag time. They should understand that this may impede their therapeutic progress to some extent. They can participate in their sessions via a desktop, laptop, iPad, or iPhone.

6d. Wyoming Telehealth Network Enrollment

Before conducting your first telepractice session, you will need to enroll as a temporary Wyoming Telehealth Network service provider using the following link: <https://redcap.uwyo.edu/surveys/?s=LJR9FN4H77>. You will choose the option “Student” for your specialty. You can also contact wy-telehealth@uwyo.edu for additional assistance or support. Once you have submitted the enrollment form, you will receive an email with instructions for setting up your telehealth Zoom account. You must use your UW email when setting up this account in order for the account to be associated with the Wyoming Telehealth Network and for it to be appropriately HIPAA compliant; do NOT use Facebook or the Zoom button shown on WyoWeb.

6e. Setting Up and Conducting Sessions

You must set up separate meetings for each client, you cannot just send your ‘room’ information. To set up and conduct telepractice sessions once you have your Zoom account, login to Zoom at zoom.us and follow these steps.:

- Select **Schedule**
- Under the **Topic** heading, name your sessions using the client’s initials. For example: MS speech sessions. You can leave the description box blank.
- Enter the date, time, and duration of the first session.
- Click on **Recurring meeting** and set **Recurrence as Weekly and set Repeat Every as 1 week**.
- If your sessions occur at the same time each day, select the days of the week that apply.
- Select **End Date By** and then enter the last day of clinic for the semester.
- If your sessions happen at a different time (for example 12:00 on Mondays and 5:00 on Wednesdays), you will have to repeat the process for each day of the week separately.
- You must enable the **Passcode** option. In your settings, **make sure you have enabled embed passcode in link for one click join**. This will prevent any anonymous people from bombing your zoom session, but your client will not have to go through the extra step of entering a passcode separately from clicking on the meeting link.
- Turn video **On** for Host and Participant.
- For Audio, select **Telephone and Computer Audio** so that they can call in and you can hear each other over the phone if for some reason the computer audio is not working.
- Select **Clinical/Direct Service** as the Primary Purpose for Meeting.
- Click **Save**.
- To **invite your client**, go to **Meetings** in the left-hand column of your Zoom home page.

- Click on the meeting from the list that corresponds to the appropriate day and time.
- Click on **Copy Invitation** and copy just the URL and the passcode and email them to the client and the supervisor. Do this **at least** 30 minutes before the session is due to start. Please email the link with embedded passcode to the client prior to every session.
- Before starting the session, make sure you have the client's phone number and physical address handy (i.e., stored in your cell phone and/or quickly accessible in ClinicNote) so that you can call them or send emergency responders to them if needed. This is PHI, so make sure you do not leave this information anywhere where someone else will find it!
- To start the session, click **Start**.
- A box will automatically appear in which you will select **Join with Computer Audio**
- Check the tool bar at the bottom left to make sure you are unmuted, and your video is on. This allows your client to see and hear you.
- Talk to your client!
- Share materials by selecting the **Share** icon in the middle of the bottom toolbar, then selecting which computer application (ex. Document camera image) or internet tab you want them to see. You must open the applications before you can share them. Be sure to check the box labeled **share computer sound** if you want them to hear whatever it is you are sharing (e.g., a video or a game with sound effects).
- Click on your client's image if you want to see them the whole time; otherwise, the image will toggle back and forth between whoever is talking at the moment.
- If you and your client cannot hear each other for some reason, type messages to them by selecting the **chat** icon (next to the 'share' icon in the center of the toolbar). When the chat function is pulled up, it will automatically be set to 'everyone,' which means anyone in the meeting will see what you have typed.
- **If you want to type a private message or question to your supervisor**, while in the chat function you can select their name from the To list as long as they are logged in to the meeting. Your supervisor will use the chat function to send private messages to you if needed throughout the session also.
- If you want to record the session (as long as you are using your UW computer), click the **Record** icon next to the chat icon in the center of the tool bar.
- When you end the meeting by simply Xing out, a message box will automatically pop up after a few seconds asking you to select a location for saving the recording. Remember to save the recording in a secure location (e.g., on a password-encrypted flash drive) so that it is not accessible to anyone but you.

6f. Additional First-Session Discussion Points

Devote some time during the first few sessions with a brand-new telepractice client to walk them through the technical operation aspects of Zoom, and to counsel them and their eHelper/caregiver/parent about reasonable expectations. They need to understand that it is typical for it to take a few sessions to 'get in a groove,' so their patience is needed and appreciated. It will take a bit of time for them to become comfortable with the technical aspects, and for the clinician to learn and adjust to the unique pacing needed to accomplish a session due to screen sharing or sound transmission lag time. If a designated eHelper will be present during all sessions, discuss what their specific roles and responsibilities will be (e.g., repeat instructions verbatim, provide prompts, present materials, manage behaviors, give feedback or reinforcement, etc.). If you want them to provide prompting or cuing, teach them the specific prompts or cues you want them to use, and in what order. It is very helpful to type these out and send it to them so that they can reference it as often as needed throughout the session.

6g. Materials

Most treatment materials are presented to the client on PowerPoint or on online websites. You can find tutorials for how to develop a variety of games in PowerPoint. You can also present hard copy materials via the document camera. If the client needs their own copy of materials, email them to the client at least **the day before** the session. Most treatment materials are reproduceable, but most assessment materials are not (due to copyright laws). Do not send copies of assessment materials, use the document camera instead. In cases where technology does not behave as expected, always have a back-up plan. A list of some of our favorite free online resources is available in the 'Resources' module in WyoCourse.

6h. In-person Visits to the Clinic

New telepractice clients are encouraged to come to the clinic for an in-person evaluation prior to treatment, but it is not required unless required by their insurance. They can participate in their initial evaluation via telepractice. Clients receiving treatment via telepractice can request in-person sessions and will be accommodated if there is space in the clinic.

SECTION 7: GRADING & ASHA CLOCK HOURS

7a. Overview

Earning clock hours requires three major aspects: 1) clock hours are supervised by a licensed and certified SLP (at least 25% of each client's total treatment time must be supervised), 2) you record your hours and submit them for supervisor approval via Typhon, and 3) you pass your clinical practicums.

ASHA says, "Supervised practicum must include experience with client/patient populations across the life span and from culturally/linguistically diverse backgrounds. Practicum must include experience with client/patient populations with various types and severities of communication and/or related disorders, differences, and disabilities...**The [student] must demonstrate direct client/patient clinical experiences in both assessment and intervention with both children and adults from the range of disorders and differences.**" This means that we ensure you get diverse client experience while enrolled in our graduate program. To do this, we try to vary the types/ages of clients you see while you are completing clinical hours on campus and that we give you diverse off-campus experiences.

Your clock hours and clinic scores are managed in a system called Typhon. You will need to sign up for this service. We will cover how to register and use Typhon during clinic orientation and class meetings at the beginning of the semester.

7b. Clock Hour Requirements

[ASHA requires 400 clock hours minimum for the Certification of Clinical Competence.](#) This is also the *minimum* number required for graduation from our program. At least 25 of these hours must have been spent in clinical observation and at least 375 of these hours must have been spent in direct client/patient contact. 325 of those must be at the graduate level (i.e., you can claim up to 50 clock hours at the undergraduate level—submit documentation of these hours to Ms. Sandoval if they were not entered into Typhon as part of your UW undergraduate coursework). Only direct contact with the client or the client's family in assessment, management, and/or counseling can be counted toward the practicum requirement.

The Council for Clinical Certification in Audiology and Speech-Language Pathology (CFCC) defines 1 clinical practicum hour as equal to 60 minutes. When counting clinical practicum hours for purposes of ASHA certification, experiences/sessions that total less than 60 minutes (e.g., 45 minutes or 50 minutes) cannot be rounded up to count as 1 hour.

While there are no minimum hour requirements in each of the different categories, every attempt is made to have at least some direct contact time listed in each of the big 9 categories for children and/or adults in treatment and/or evaluation with appropriate supervision.

- Hours must reflect the “breadth of the life span” and demonstrate multi-cultural aspects and severity levels.
- Hours should reflect direct services in prevention, screening, evaluation, and treatment.
- “Big 9” disorder categories include:
 1. Speech Sound Production (this category includes accent modification)
 2. Fluency
 3. Voice and Resonance, including respiration and phonation
 4. Receptive and Expressive language (phonology, morphology, syntax, semantics, pragmatics, prelinguistic communication, and paralinguistic communication) in speaking, listening, reading, and writing
 5. Hearing (including impact on speech and language)
 6. Swallowing (oral, pharyngeal, esophageal, and related functions, including oral function for feeding, orofacial myology)
 7. Cognitive Aspects of Communication (attention, memory, sequencing, problem-solving, executive functioning)
 8. Social Aspects of Communication (including challenging behavior, ineffective social skills, and lack of communication opportunities)
 9. Augmentative and alternative communication modalities

All your clock hours must be logged into Typhon. You will need to submit a case log for each client contact. More information about completion of Typhon case logs is found on WyoCourses.

Take care to make sure you enter clock hours in the appropriate section (e.g., evaluation vs. treatment). **Note that baselining activities, oral mechanism exams and hearing screenings are all entered in the evaluation section.** Do not worry if you realize you have made a mistake after you have submitted your entry. Let Ms. Sandoval know, and she can fix the entry for you.

IEP/STP/Progress conferences are part of treatment or the evaluation/screening category, depending on the nature of the information contained in the report. For example, if the STP you are discussing with your client includes interpretation of standard scores obtained during baselining activities, then this could be counted in the category. Discussion of semester goals and treatment approaches would go under the ‘treatment’ category. Clinicians should strive to utilize all categories whenever possible. For example, if a client has more than one disorder, split the service time on your clock hour submission accordingly (e.g., 15 minutes in fluency and 15 minutes in articulation for a total of 30 minutes of treatment).

7c. The Supervision Process

The graduate clinician's major goal and responsibility in the clinical process is to provide quality service to their clients. This means planning effective assessments and treatment to the best of one's ability. It includes documentation, analysis and interpretation of collected data, and modifying treatment/recommendations as needed for the best possible outcome. In order to achieve this, the clinician should be an **active participant** in the supervision process. This includes critical reflection, self-evaluation of clinical skill/strengths/weaknesses and an on-going collaboration with the clinic supervisor. To be an active part of the supervision process, it is essential that the clinician openly expresses his/her thoughts, concerns, needs and ideas with their supervisor. It is best to go directly to your supervisor for clarification on expectations before consulting another supervisor, faculty member or the Clinic Director. To facilitate increased clinician independence throughout the semester, supervisor involvement should shift from a very hands-on teaching/coaching role at the beginning, to more of an as-needed collaborative role towards the end.

While you are enrolled in graduate school you will have many different supervisors who require or prefer procedures and documentation to be done in specific ways. This will differ between supervisors and may be confusing at times. Embrace these difference as a way to learn to do things many different ways, which contributes to your professional knowledge base as well as your ability to maintain flexibility as a clinician!

In your first two semesters you will have several (if not all!) supervisors that work here at the UWSHC. After that time, you will have supervisors at external placements (community placements and externships).

Please be aware that some supervisors may be more hands-on and take over parts of your session or speak to you during your session over VALT, chat in Zoom, while others will quietly observe and never enter the treatment room. These different styles are based on many factors (e.g., the client's needs/behavior, the supervisor's relationship with the client, the supervisor's clinical style, your relationship with the client, etc.). Do not make judgments about your own clinical performance based on the supervisory style (i.e., don't assume that when your supervisor enters the room during a session you are not doing a good job; this is usually not the case!); rather, watch/read/listen and implement the feedback or follow the model you are given from your supervisor. If you are unsure about how you are doing clinically, set up a time to talk to your supervisor(s).

7d. Supervision Requirements

Supervision must be provided by individuals who hold the Certificate of Clinical Competence (CCC) from ASHA and have completed continuing education in supervision practices. ASHA states that, "The amount of direct supervision must be commensurate with the student's knowledge, skills, and experience, must not be less than 25% of the student's total contact with each client/patient, and must take place periodically throughout the practicum. Supervision must be sufficient to ensure the welfare of the client/patient." This means:

- that our supervision must be in real time (not watching recordings of you after the session, though we can do that...it just does not count as direct supervision time). This may take place in the treatment room with you, via Zoom, live view through VALT, or from the observation room.
- supervisors must be available to consult with a student providing clinical services to the supervisor's client. In order to meet this ASHA requirement, we hold weekly class meetings, initial, midterm and final conferences, and are also available to meet with you individually by appointment.
- a supervisor with their CCCs must be on site 100% of the time graduate students are providing direct services.

7e. Feedback

Supervisors will provide frequent feedback about your clinical performance and may provide data or observations about your clients' performance. Feedback may include weekly verbal debriefings, comments and written feedback in ClinicNote, observations through VALT, documentation in Typhon, email, and other written or verbal communication. The format and frequency of feedback may vary by supervisor.

At UWSHC, you will receive more frequent feedback than you may receive during external placements. Weekly verbal debriefings are an important part of this process and provide an opportunity to discuss your clinical performance, client progress, questions, and areas for continued development.

Supervisors may provide comments and written feedback directly in ClinicNote, including on SOAP notes, reports, and other clinical documentation. You are responsible for reviewing and implementing feedback and responding to comments when requested.

You will be formally evaluated using the **On-Campus Student Skill Demonstration and Feedback Rubric** a minimum of two times each semester, typically at midterm and final. Feedback and documentation throughout the semester are used to support your clinical development, provide direction for continued growth, and monitor your implementation of feedback. This documentation may also be considered when faculty write letters of recommendation.

7f. Personal Goal-Setting and Self-Reflection

In order to facilitate self-directed growth and learning as much as possible, you will be encouraged to set specific goals regarding your improvement of clinical skills. Your supervisor(s) will ask you to informally submit at least one goal for yourself around midterm of first semester, and again at the beginning of second semester. These goals will not be formally graded but will help your supervisor identify which clinical skills to focus on during their observations. This will enable us to provide you with targeted and constructive feedback to support your development.

You are also strongly encouraged to engage in self-reflection after every session. This will take place informally during frequent conversations with your supervisor(s) (e.g., What went well during that session? What will you change for next time?, etc.). If needed, your supervisor may assign a more formal self-reflection assignment to be completed. You will be assigned video self-reflections each semester. This is a very useful way to critique your own skills and recognize areas for growth. This also may be used as a formal assignment as part of an action plan, if needed.

7g. Grading/Conferences *(there is more detailed information about this in your SPPA 5030 Syllabus)*

Students and supervisors will have regular conferences. This includes at minimum the initial planning conference, the mid-term conference and the final conference. Prepare for all supervisory conferences by coming with ideas, potential solutions to problems, and self-reflections/self-evaluations. Adequate preparation demonstrates responsibility and initiative by the clinician. Come to the conferences with items to discuss and be prepared to lead the discussion. Present ideas about areas upon which you would like to improve your clinical skills. Share some potential solutions to solve the problems you are encountering with your client or the overall clinic process.

You must be evaluated by all of your supervisors on your clinical skills with diagnostic and treatment procedures, documentation, professionalism, and adherence to policies, procedures, and the ASHA Code of Ethics (<https://www.asha.org/Code-of-Ethics/>). The criteria on which we evaluate you does not change and is determined by ASHA standards. Our expectations on how well you meet these criteria over time does change. That is, we expect to see you grow in proficiency in all areas as you gain more and more clinical experience throughout graduate school. Your grade in clinic each semester is satisfactory/unsatisfactory. Clinic grades are based on demonstrated progress, not just a score. To earn a satisfactory grade, you must show measurable growth in clinical skills, knowledge, and professional behaviors, moving toward the benchmarks expected for your stage in the program ([see Appendix 7-3](#)).

You will be evaluated formally at the midterm and final points of each semester by each supervisor to whom you are assigned in Typhon. This is done using the On-Campus Student Skill Demonstration and Feedback Rubric, which you can view anytime, using the same grading scale and criteria. Supervisors who only supervised you for a single diagnostic session will complete relevant ratings using the evaluation in Typhon and will finalize and submit it to you without holding a formal conference. You will have a formal conference with one assigned supervisor. During the conference, you will bring your completed Typhon self evaluation, and you and your supervisor will compare ratings, discuss your strengths and weaknesses, and will formulate goals and/or action plans as needed.

Completing a midterm evaluation is required; however, these ratings are not permanently recorded in your transcript. Only your final semester evaluation ratings are used to determine a satisfactory/unsatisfactory grade that will be recorded on your official transcript for the semester. A student who is not yet receiving a satisfactory overall score by midterm can still improve and pass by the final evaluation. Often, with focused effort and effective communication, significant progress can be made.

Your final conference will also include a checkout list completed by your supervisor. This checkout list ensures that all client documentation is completed correctly; it also ensures that you have turned in materials, completed clean-up responsibilities, and not left personal items behind before leaving campus.

7h. Clinical Growth Plans and Performance Improvement Plans:

Students are expected to demonstrate continued growth and increasing competence across the skill areas identified in the **On-Campus Student Skill Demonstration and Feedback Rubric**. When a student needs additional support or when concerns about clinical performance arise, the program may use either a **Clinical Growth Plan** or a **Performance Improvement Plan (PIP)**.

These plans serve different purposes.

Clinical Growth Plan

A **Clinical Growth Plan** is used to support intentional development in a targeted clinical skill area. It may be initiated by the student, supervisor, or collaboratively when a student would benefit from additional focus, practice, feedback, or support.

A Clinical Growth Plan is appropriate when the primary purpose is **continued development**. For example, a student may be demonstrating an expected level of performance but need to become more consistent, confident, efficient, or independent in a particular skill area.

A Clinical Growth Plan is **not required before a Performance Improvement Plan is initiated**. If a student's performance indicates that they are not meeting clinical expectations, a PIP may be initiated directly.

Performance Improvement Plan

A **Performance Improvement Plan (PIP)** is a formal plan used when a student is **not meeting expected clinical performance or competency** and must demonstrate specific improvements within an identified timeframe.

A PIP will:

- Identify the specific skill areas or competencies that are not being demonstrated at the expected level.
- Reference the applicable areas of the **On-Campus Student Skill Demonstration and Feedback Rubric**.
- Describe the specific concerns and observed examples of performance.
- Establish measurable expectations that the student must demonstrate.
- Identify strategies, supports, and resources available to help the student meet the expectations.
- Establish a timeline and specific dates for reviewing progress.
- Identify how achievement of each expectation will be measured.

The PIP will be documented in Typhon and reviewed regularly by the student and supervisor. Progress toward each expectation will be documented throughout the plan period.

A PIP may be **extended when additional time is appropriate to allow the student to demonstrate the required competencies**. An extension does not guarantee successful completion of the PIP; the student must ultimately demonstrate the competencies identified in the plan.

Failure to Meet a Performance Improvement Plan

If a student does not meet the expectations established in a PIP, the student's clinical performance may be referred for further review by a **faculty panel within the Division**. The panel may review the student's clinical performance, documentation, feedback, progress on the PIP, and other relevant information including academic engagement and progress when determining an appropriate course of action.

Following review, possible outcomes may include continuation or modification of the PIP, an extension of the plan when appropriate, or other action consistent with program policies. **Failure to demonstrate the required clinical competencies may result in an unsatisfactory (U) grade for the clinical course.**

Serious or Immediate Clinical Concerns

A PIP or Clinical Growth Plan is **not required in every situation before a student may receive an unsatisfactory (U) grade**. Certain serious or immediate concerns may warrant intervention or further review without first completing a Growth Plan or PIP.

Examples may include, but are not limited to:

- Conduct that violates the **ASHA Code of Ethics** or other applicable professional or university standards.
- Actions or omissions that place a client at risk or compromise client safety.
- Significant breaches of confidentiality or privacy.
- Falsification of clinical records, data, hours, or other required documentation.
- Serious or repeated failure to follow supervisor direction when doing so may affect client care or safety.
- Other significant professional or clinical concerns that the program determines warrant immediate action.

Depending on the nature and severity of the concern, the program may remove a student from clinical activities, initiate a formal review, require a PIP, or assign a **U** without first completing a Clinical Growth Plan or PIP.

Unsatisfactory Clinical Grade (U)

An unsatisfactory (**U**) grade may result when a student does not meet the clinical competencies and expectations required for successful completion of the clinical experience. A **U** may result following failure to meet the expectations of a Performance Improvement Plan, following faculty review of significant clinical concerns, or when serious or immediate concerns warrant an unsatisfactory grade without a prior Growth Plan or PIP.

They cannot count the clinical hours for the semester (this is an ASHA stipulation).

- 1) They must comply with a remediation plan. An initial remediation plan is determined by any or all of the following individuals:
 - Clinical supervisor assigning the failing grade
 - Clinical supervisors also assigned to the student
 - Clinic Director
 - Division Director
 - Graduate program Chair
 - Faculty or clinical supervisors with specific content knowledge regarding the client/case/disorder
- 3) They must repeat that semester of clinic.

7i. Student Complaint Process

The University of Wyoming and the Division of Communication Disorders seeks to create a positive and inclusive learning environment for students to reach their educational goals. The Division's policy is to first attempt to settle disputes through discussion with the affected parties. If this does not resolve the dispute

informally, they should then follow the appeals process found here: <https://www.uwyo.edu/comdis/student-objectives-handbooks-manuals.html>

A summary of the appeals process is shown below:

1. Discuss the Issue: First, talk directly with your instructor about the conflict. If you need support, contact the Office of the Ombuds for guidance.
2. Request a Meeting: If the issue is not resolved after talking to the instructor, request a meeting with the Division Director and/or Speech Clinic Director. If unresolved, submit a written appeal to the Division Director within the specified timeframe.
3. Initiate Dispute Process: If the dispute is still unresolved, initiate a formal dispute process.
4. Timing for Appeals: Appeals about grades must be initiated within 15 working days after grade posting. For other issues, initiate the appeal within 15 working days of the incident.
5. Prepare Written Appeal: Include details of the disputed action, its basis, and any supporting evidence.
6. Hearing: The Division Director will hold a hearing with the student and instructor(s) within 10 working days of receiving the appeal and may involve other instructors for input.
7. Decision: The Director will make a decision and inform the parties involved in writing. This decision will be recorded in the student's file.
8. Further Appeals: If dissatisfied with the Director's decision, you may appeal further. For grade-related issues, contact the College of Health Sciences; for other complaints, refer to the University Office of Academic Affairs.

For more details, visit the respective links for the College of Health Sciences student academic appeals (<https://www.uwyo.edu/hs/student-resources/index.html>) and University Office of Academic Affairs complaints (<https://www.uwyo.edu/studentcomplaint/>).

SECTION 8: CLINIC SAFETY POLICIES AND PROCEDURES

** All clinical staff and students should follow these guidelines—see the **Exposure Control Plan** on WyoCourses and hard copies are located in **Clean Room 1111, Grad Prep Room 1131 and at the front desk** for more detailed information **

See [Appendix 8-1](#) for more specific cleaning protocols

8a. Equipment

Decontamination, cleaning, disinfection, and sterilization of multiple use equipment before reuse should be carried out according to specific infection control policies and procedures (as detailed in the Exposure Control Plan).

All reusable clinical materials (e.g., games, toys, etc.) and work surfaces (e.g., table tops, arm rests on chairs, mirrors) should be cleaned and disinfected after **each** use. Clinical materials may be cleaned with an approved disinfectant (e.g., Lysol wipes) or household bleach solution (these are kept in each treatment room).

Reusable audiological equipment (e.g., tympanometry probe tips, headphones) must be cleaned/disinfected by the materials room staff following the Clinic Equipment Cleaning Protocol. Disposable items such as otoscope tips should be discarded after a single use.

8b. Hand Washing

- Wash hands immediately if they are potentially contaminated with blood or body fluids containing visible blood.
- Wash hands before and after treating patients/clients.
- Wash hands and have clients wash hands before and after snack time in sessions.
- Wash hands after removing gloves.
- Wash hands after cleaning/disinfecting room and materials.
- Follow the basic hand washing technique:
 - vigorous mechanical action whether or not a skin cleanser is used
 - use of antiseptic or ordinary soap under running water
 - rinsing for at least 20 seconds
 - thorough hand drying with a disposable paper towel to help eliminate germs
- An alternative when hand-washing is not feasible is to use an alcohol-based disinfectant gel (i.e., hand sanitizer).

8c. Gloves

A supply of gloves in all sizes is stocked in each treatment room.

- Wear gloves when touching blood or other body fluids containing visible blood.
- Wear gloves when performing **invasive** procedures on all patients/clients. This includes performing an examination of the oral speech mechanism; using a laryngeal mirror, oral endoscope, or nasoendoscope; and assisting with oral-myofunctional tasks.
- Wear gloves to clean/disinfect all equipment, unless otherwise indicated.
- Change gloves after contact with each patient/client or after touching an item (e.g., your pen) that was not disinfected immediately prior to donning the gloves.
- If a glove is torn, remove the glove and use a new glove as promptly as patient/client safety permits.
- After removing gloves, wash hands immediately.
- Discard gloves in the room before exiting.

8d. Spills

To clean and decontaminate spills and/or splashes of blood or other bodily fluids:

- Maintain a barrier between the spill and your own body. Wear a pair of gloves, and eye protection (safety glasses are located in HS 185)
- Surround spill with disinfectant (e.g., Maxicide—located in Clean Room 1111).
- Cover with paper towel.
- Saturate paper towel with disinfectant.
- Allow for contact time per disinfectant instructions.

- Paper towels can be thrown in regular waste.
- Clean surface with a freshly prepared 1:9 hydrochloride (e.g., household bleach solution).
- Notify clinic supervisor and/or Clinic Director immediately.
- In the event of a large spill or when items cannot be completely disinfected (e.g., items that are disposable such as fabric chair seat or carpet), call Environmental Health and Safety (EHS) at (766-3277) and the Physical Plant Blood Team at (766-6225).

8e. Human Blood Borne Pathogen Exposure Incident Instructions (see packet Appendix 8-2)

- 1) Rinse or wash affected surface immediately and apply first aid.
- 2) Report incident to supervisor immediately.
- 3) Report to student health to seek medical attention.
- 4) Return copy of the incident report and all relevant medical reports to the Division office
- 5) A copy of the report should be sent to the EHS office

Please see Biohazard Manual hard copy found in the Clean Room 1111, Grad Prep Room 1131 and the front desk. You can also access it in WyoCourses.

8f. Cleaning Solutions

** Gloves and protective eyewear must be worn during all cleaning/disinfecting processes unless otherwise indicated **

Disinfectants

- Disinfectant spray is located in every treatment room in the cupboards.
 - It is not necessary to wear personal protective equipment (PPE) when using this solution, however, if you are sensitive to some solutions gloves are recommended.

Sporox

- The Sporox is premixed and ready to use by the office associate in Clean Room 1111 for cleaning tympanometry tips.
- Pour two cups of Sporox liquid into the clearly marked container.
- The Sporox should be changed every **21** days. The materials room attendant will change the solution and log the date on the sheet posted near the container.
- Dispose of used Sporox into the Hearing Aid Lab or Cleaning room sinks.
- Should you have any reaction from contact with the Sporox, refer to the warnings and precautions sheet posted inside the cabinet where the container is located and notify the appropriate Clinic Director immediately.

Maxicide

- The Maxicide solution must be mixed before use. The two agents (one powder one liquid) become active once mixed.
- For cleaning endoscopes after Maxicide mixture is made, pour the designated amount into the marked tubes in Instrument Room 2 (1160) and/or cleaning area on clinic map.
- The Maxicide in the tubes and any unused solution should be discarded after 21 days into the sink. Log the date when the mixture is made on the container and place the same information on the base of the tubes with the Maxicide mixture.

- Should you have any reaction from contact with the Maxicide, refer to the warnings and precautions sheet posted directly on the container and notify the Clinic Director immediately.

8g. Universal Precautions

1. Assume all human blood, bodily fluids and unfixed tissues are contaminated with Human Immunodeficiency Viruses (HIV), hepatitis viruses including Hepatitis B Viruses (HBV), Hepatitis C Virus (HCV), and other Blood Borne pathogens. Pathogens are disease-producing microbes. These human materials are thus considered biohazardous in any workplace.
2. Any direct physical contact with human biohazardous materials is to be avoided. Maintain a barrier between yourself and the potential contaminant. Use personal protective devices such as gloves and eye protection when appropriate. Gloves should be worn during all invasive procedures, including oral peripheral examinations and otoscopic examinations. Protective glasses should be worn when grinding hearing aids.
3. Know the signs and symptoms of Hepatitis B Virus, and Human Immunodeficiency Virus infections. Report unexplained significant illnesses, rashes and fevers to your supervisor if you have handled human biohazardous materials.
4. Understand the biohazardous tasks you must do in your job classification or category as detailed to you in the Blood Borne Pathogen training.
5. Become proficient at using personal protection (e.g., gloves, masks, eye shields, etc.) *before* becoming in contact with biohazardous materials.
6. It is highly recommended that you obtain the vaccination against Hepatitis B. Notify the Clinic Director when this series has been completed.
7. Avoid needle sticks, cuts, abrasions, and splashes in work associated with human hazardous materials. Protect face and broken, irritated or abraded skin from human materials, and avoid aerosols.
8. Always use good hygiene work practices including antiseptic techniques, spill clean-up, medical waste containment and **regular, thorough hand washing** with soap and water and/or non-water hand sanitizers, especially after removing gloves or when leaving your work area.
9. Dispose of biohazardous human materials and contaminated, disposable lab ware properly. Contaminated recyclable lab equipment must be sterilized. Protect yourself, patients/clients, staff and visitors from accidental exposure.
10. Decontaminate all reusable protective gear immediately after use following specific clinic procedures.
11. Clean work areas thoroughly with disinfectant or a mixture of household bleach before leaving your work area.
12. Report all accidental exposures to the Clinic Director and seek medical follow-up. The attending healthcare professional will want to know the individual's name who was the source of the contaminate, if possible. Do NOT save specimens for HIV or HBV testing.
13. Obtain proper biosafety training and become proficient in performing all biohazardous tasks assigned to you.

** These Universal Precautions must be strictly followed by all Division supervisors, graduate clinicians, and student observers in all settings **

You will complete UW's Bloodborne Pathogens training and will sign a training form before your first client contact. This training will be completed annually.

8h. Hepatitis B Vaccine

Most off-campus sites require a Hepatitis B vaccine before initiating a practicum at that site. Since students may not know their site's requirements until it is too late to order the serum, it is strongly advised that all students obtain the Hepatitis B vaccine while on campus at some point during the first three semesters.

If students choose to receive the Hepatitis B vaccine, they will receive a series of three shots across a six-month period. The Hepatitis B series takes at least 6 months to complete, so plan accordingly or run the risk of the externship being delayed. Students may receive both vaccines at the University of Wyoming Student Health Center. Students are responsible for the cost of this vaccine.

You must provide proof of Hep B or sign a form that you have either received the vaccine or decline it at that time prior to your first client contact.

8i. Health Insurance

Graduate students enrolled in at least 4.5 credit hours of campus instruction are charged automatically each semester unless a waiver is signed. The deadline for signing the waiver will vary for each semester. Students who are on externship (enrolled in section 80) **are not** automatically enrolled for health insurance (this includes campus track students enrolled in 5270 and 5290 externships and Orals in their final semester). To obtain health insurance, you must a) petition for the optional student fee package through the graduate school, and then b) complete an enrollment form in the Student Health Insurance office. Contact the Student Health Insurance offices at 307/766-3025 for further information.

8j. Liability Insurance

The University of Wyoming provides general and professional liability coverage for clinical undergraduate observation students and graduate students in the Division of Communication Disorders for a nominal fee. Such coverage shall not apply to activities on the part of students which are not part of or are beyond the scope of the educational program.

Recently, an increasing number of externship sites have been requesting higher liability coverage than what is offered through UW. If the student wishes to complete an externship in one of these sites, this additional professional liability insurance coverage is the responsibility of the student. Verification of this additional liability insurance must be provided to the Clinic Director by submitting a photocopy of the page(s) from the insurance policy, which indicates who the coverage is with and effective dates of the policy. Students who fail to provide written verification of this additional coverage will not be allowed to start their externship at the site requesting additional coverage until verification is complete. A relatively easy and inexpensive way to obtain additional personal liability insurance is through the National Student Speech Language and Hearing Association (NSSLHA). Contact them at their web site: www.nsslha.org.

8k. Emergency Response Procedure

Client welfare and safety are paramount while clients are attending the UW Speech and Hearing Clinic. The following steps are procedures that should be followed to ensure the client safety is maintained.

If an emergency arises that is client-centered:

- Stay with the client

- Call/yell for assistance (e.g., open door and yell for help)
- Use your cell phone to call **9-1-1**
- Offer client assistance (e.g., first aid, CPR, etc.)
- Stay with client until medical assistance arrives
- After situation is resolved, report incident to clinical supervisor and coordinator
- Supervisor/director will follow-up with Risk Management and others as needed

If an emergency arises that is environmental (fire, tornado, etc.)

- Remove or assist client away from the building in case of fire
- Move client to a safe location away from windows/debris if a tornado
- Remain with the client
- Use your cell phone to call **9-1-1** to report the situation
- After the situation has resolved, report the incident to your clinical supervisor and the Clinic Director
- Return to building only after an “all clear” has been given by the authorities.

UW Alert: This is a text messaging system designed to keep students, faculty and staff informed of emergencies via cellphone and email. Please find more information here:

<https://uwyo.teamdynamix.com/TDClient/1940/Portal/KB/ArticleDet?ID=30905>

SECTION 9: EXTERNAL CLINICAL PLACEMENTS

9a. Overview

SPPA 5270/5290

The externships are viewed as an *extension* of academic and clinical experiences. Clinical instruction continues in these experiences. A student's academic and clinical performance may be shared with external supervisors to enable them to best support the student's learning.

Graduate students complete **two** full-time, **twelve-week externships** following completion of coursework and SPPA 5030 requirements. Students register for one externship in the Spring and one in the Summer semester, but the beginning and ending dates do not align with semesters. One externship is to occur in an **educational setting** (a school or early childhood program), and one is to occur in a **medical or clinical setting**. Most students will complete the educational internship first. The order of externships are arranged and determined by the student and Externship Director.

Determination of a student's preparedness for externships is subject to approval by the clinical supervisors and the faculty. This may include meeting a required number of clinic hours and/or demonstrating the knowledge and skills appropriate for the externship (e.g. successfully completion of coursework). Thesis students must complete the prospectus meeting before entering into externships.

Students will be expected to perform in a professional manner and demonstrate growth toward a life of professional service. These externships are more like work settings, although clinical guidance and supervision continues. From their practica and externships, the student needs to gain experiences covering the breadth of the lifespan across the Big 9 disorder categories. If a student is dismissed from an externship, they automatically receive a U and must enroll to repeat the externship in a future semester.

Students are expected to be able to relocate in order to complete these externships. Travel and living arrangements for the externships are the student's responsibility. A letter to financial aid for loan repayment purposes can be issued by the Division indicating the practica are full-time experiences despite their part-time credit hour status (i.e., 6 SCH).

Community Placement and Externship Supervisors may be unfamiliar with Typhon. If this is the case:

- Supervisors will be added in Typhon as needed. Students should guide their supervisors through the Typhon one-time registration process and assist in answering any questions that may arise.
- A copy of all supervisors' ASHA certification cards and, if applicable, state licenses must be given to the Clinic Director before the end of each clinical rotation. Typhon allows for these documents to be uploaded too.
- Students should include notes to supervisors in the "Comment" box regarding client initials, time supervised, etc. to ensure adequate supervision amounts are met.

9b. Process of Securing an Externship

General Information on Externships

The program will provide opportunities for two externships. In order to complete the program on time, students will need to work with our existent framework and processes described below. Our program does not allow students to "make their own" externship opportunity, as you will see below externships are complicated agreements that involve many parties and aspects beyond student-supervisor. Students are an integral part of the externship process but never to arrange their own externships.

Medical externships include hospitals, medical sites, skilled nursing facilities, outpatient therapy, and clinics (this can include in the home Part C services). For our program, medical externships are available only at established sites listed in the Externship Listings, OR in rare circumstances the Clinic Director will inquire with an additional site if the site is in the "Mountain-West region." A cooperative education agreement (i.e., contract) must be approved by the University and externship facility, and hospital /medical/clinic sites have restrictions and several layers of approval. Typically, it takes 8-12 months to execute a contract in one of these sites, and general counsel and legal consultation expenses make this a costly process. These sites in particular have been increasingly difficult to secure, and we have been turned away from sites outside the region because they simply prefer to train students who are from local programs or who are residents in the area. Bottom line: **Students should plan on completing their medical externship at one of our existent sites from the Externship Listings.**

Educational externships include schools, preschools, and early intervention programs. Our program has more than enough cooperative education agreements with educational externship sites to meet the needs of our students. We strongly encourage students to select from our existent sites, however- we will make up to 2 inquiries if a student would like to request an educational internship in a given educational site for which we do not currently hold a agreement. Consult with the Clinic Director prior to completing your Externship Request

Externship Application Process

Overview:

Students will follow the externship application process as established by the Clinic Director. SharePoint will be used to organize this process. In the spring semester, students will receive a link to SharePoint, where they can access externship listings, the Microsoft Form, and the due date for submitting requests, typically early March.

Requesting Externship Sites:

1. Review Externship Listings:

- Students should review the externship listings organized by state.

2. Submit Site Requests:

- Using the provided Microsoft Form, students will request three sites for each term: fall (SPPA 5030), spring (SPPA 5270), and summer (SPPA 5290). (Upon approval of Clinic Director the student may request one additional site not found in the externship listings.)

3. Form Submission:

- Submit the completed form by the specified due date. The Clinic Director will review each submission and begin contacting potential placements. Students must check their email regularly for updates and additional requests.

4. Fulfill Requirements:

- Students are responsible for completing all requirements according to each site's specifications. Some sites may have an interviewing process or require applications via email with a cover letter and resume. Students will be informed if they are approved to apply and provided with relevant timelines and deadlines.

5. Accept or Decline Placement:

- Once a placement offer is made, students must notify the site of their decision and complete any additional onboarding requirements. The Clinic Director will handle any necessary documentation.

Additional Information:

Each externship request and student's circumstances are unique. Timing and responses from sites may vary. Educational sites may not commit until the academic year begins, and some medical sites may conduct interviews in March or September, or not at all.

9c. Externship Guidelines

The Clinic Director will work from the student's externship requests. Students cannot pursue other opportunities independently. The Clinic Director will consult with students to evaluate their clinic needs, interests, academic and clinic skills to determine if requested sites align with these factors.

Students may encounter situations where:

1. A site is not accepting students.

2. Students have already been selected.
3. They were not matched or selected for a site.
4. Issues arise, or the site is not viable (e.g., lack of required supervision or diverse experiences).

Students should be prepared to explore alternative options to ensure timely graduation, including those not initially requested.

Regulatory Compliance:

Due to the Higher Education Act and state authorization regulations, the Division of Communication Disorders will not place students in certain states. Check the University website for eligible states: [University State Authorization](<https://www.uwyo.edu/stateauth/nc-sara.html>).

Approval and Contact:

Students must obtain approval or a "greenlight" before contacting externship sites. Unauthorized contact may result in lost opportunities. After approval, students may make initial inquiries to obtain contact information for the Clinic Director to follow up. The Clinic Director will provide further instructions and manage any electronic applications or fees.

Contract and Site Issues:

If a site's contracting terms or legal requirements are problematic, or if a secured site unexpectedly falls through, students will need to work with the Clinic Director to find alternatives.

Documentation and Costs:

Many sites require additional documentation before the externship begins, such as background checks, drug screenings, fingerprinting, or facility attire (e.g., scrubs). Students are responsible for the costs associated with these requirements.

Students should avoid contacting the Clinic Director for status updates; updates will be provided as information becomes available.

gd. Supervisor Requirements

Like the University supervisors, the externship supervisor(s) must hold the following minimum credentials:

- a) A Master's degree in Speech-Language Pathology
- b) Certificate of Clinical Competence in Speech-Language Pathology
- c) State license and/or Department of Education Endorsement (if applicable)
- d) The equivalent of a minimum of 9 months of full-time clinical experience after being awarded ASHA certification
- e) Has completed a minimum of 2 hours of professional development in clinical instruction/supervision after being awarded ASHA certification

A copy of the supervisor's current ASHA certification card and state license, if applicable, must be given to the Clinic Director within the first 6 weeks of the externship. This applies to all supervisors that participate in clinical education during the externship. The supervisor must supervise a minimum of **25%** of each client's total treatment and/or evaluations (including screenings). It is the **student's** responsibility to notify the Clinic Director if the externship supervisor is not maintaining the proper levels of supervision. Clock hours that are not properly supervised will **not** be counted in your accumulation of ASHA hours. Weekly clock hours of client contact are recorded on Typhon.

Mid-term conference calls will be held during each externship. This conference will parallel the documentation of the student's overall mid-term performance using the Typhon Performance Evaluation form. At mid-term the student must be informed of current grade (S/U) and an understanding of what is needed to improve performance. A final evaluation (Typhon) of the student's overall performance is required from the supervisor and should be returned to the Clinic Director by the end of the externship. Note that expectations after the midterm continue to increase, and students who do not perform to expectation or who are struggling should inform the Clinic Director as soon as possible so that conference calls and remediation can be discussed. Students who fail an externship do not receive any clock hours for that site, and must apply and enroll for a repeat of the externship in a subsequent semester. Additional remediation steps will be required.

ge. Student – Externship Supervisor Communication

Each student should be familiar with the externship site's policy regarding lines of communication and professional responsibilities. Site supervisors bear the ethical and professional responsibility for management of clients seen by the student. This means that the site supervisor must approve all recommendations, referrals, and discussions regarding client management before they are implemented. The Clinic Director is responsible for communicating proper supervision practices to the supervisor prior to the start of the externship and if needed, re-assigning a graduate student to another site or supervisor if supervision is not adequate.

Respect for professional lines of communication is essential to good client management and avoids placing the student and clients in the position of having to respond to competing and contradictory messages. To gain maximum benefit from this clinical training, students need to maintain open lines of communication with their supervisors. Many unnecessary days of anxiety and difficult situations can be avoided if the supervisor (and Clinic Director) are kept informed.

Treat this experience as it is your first professional job. For example, if you are going to be absent, your supervisor must be notified. Any missed days are expected to be made up. However, the student is not expected to "fill-in" for an absent certified clinician nor manage a caseload that is not commensurate with his or her clinical competency. Regardless of what has been learned previously, approach externships as opportunities to develop emerging competencies and acquire new ones.

gf. Student Expectations for Externships...Being a Student and a Professional

Although each externship site is unique and may have specific guidelines for students to follow, some *general* guidelines are meant to serve as recommendations for professional behavior in any site. Students should consult their immediate site supervisor to discuss expectations during the externship. Doing this early can avoid many unnecessary miscommunications for the student and the supervisor. If issues are not resolved, the student should notify the Clinic Director so interventions can be made.

- Only the clinical supervisor has been granted clinical privileges at their site. The site supervisor must approve all clinical services you provide.

- These extensions of your academic and clinical education are to provide you with opportunities to learn and not solely to fulfill the required clock hours for graduation. *Be an equal partner in the responsibility of your learning.*
- Treat the externship as you would a job. Demonstrate a positive work ethic. Adhere to the work hours followed by your supervisor.
- Attend the externship for the scheduled duration. Do not arrange time off for vacations or study.
- Be prepared and ready to work with clients.
- Show up on time and where and when you are expected to be someplace. Be accountable to your supervisor when you are on the job.
- Notify your supervisor and office staff **immediately** of any absence. Offer to make up any missed days if the supervisor's schedule allows.
- During any "downtime" from client care, engage in learning opportunities such as treatment planning, studying evaluations, reviewing suggested readings, practicing writing notes or evaluations and helping with miscellaneous facility needs.
- Be involved and absorbed in the site you are participating in. Do not turn down an opportunity to gain more experience because you have already obtained the required clock hours for a particular disorder category.
- Participate and share in your learning by offering to conduct an in-service or share your recent academic background with your supervisor or other related staff. Reciprocal teaching is one of the small 'perks' our program can offer to supervisors for their service.
- Maintain a professional demeanor. Dress and act professionally. Be aware of what you say in front of clients, family members and other staff members and how it may be perceived.
 - Remember that you are representing yourself, the University of Wyoming, the Division of Communication Disorders, and the particular site and supervisor with whom you are working when you are working with clients. *What impression will you leave each of them?*

9g. Supervisor Expectations for Externships

Although each externship site is unique and may have specific guidelines for students to follow, these *general* principals are meant to serve as recommendations for site supervisors about the overall clinical learning process. Students' learning will be commensurate with the opportunities provided by each particular site. The Division recommends that supervisors consult with their students early in the externship to discuss their expectations. This may avoid many unnecessary miscommunications between the student and the supervisor. If issues are not resolved, it is important that the supervisor notify the Clinic Director immediately so adjustments can be made.

- Only the clinical supervisor has been granted clinical privileges at their site. The site supervisor is expected to approve all clinical services provided by the graduate student.
- This *extension* of academic and clinical education is to provide students with opportunities to learn, gain hands-on exposure, and to fulfill the required clock hours for graduation and ASHA certification. Supervisors should assist the student by providing a well-balanced clinical experience (treatment, screenings and evaluations).
- Repeated opportunities to learn are a hallmark of any externship. Supervisors should feel confident in providing students with ample opportunities to improve knowledge and skills regardless if the student has obtained "required clock hours" for a particular disorder category.

University of Wyoming
Speech and Hearing Clinic
Division of Communication Disorders
Department 3311
1000 E. University Avenue
Laramie, WY 82071
307/766-6426

- The externship should be treated like a job. Supervisors should not require students to perform duties in their absence to “make-up” for lost productivity nor should supervisors expect students to compensate for staffing shortages by being “free labor”. Supervisors should notify their students if they are to be absent. Coverage by another certified SLP within the facility is acceptable. *If the supervisor’s schedule allows*, students should offer to make-up any missed days. Supervisors should contact the Clinic Director if attendance is a concern.
- During any “downtime” from client care, supervisors should assign students learning opportunities such as treatment planning, studying evaluations, reviewing suggested readings, practicing report and note writing and learning about the practical aspects of billing and administration of their particular facility.
- Supervisors may request that students extend their learning by having them conduct an in-service or share their academic or clinical knowledge with supervisors or other related staff.

Supervisors should submit all documentation required by the Division in a timely manner. This includes a copy of ASHA Certification cards, state license, *if applicable*, summary feedback forms emailed by Clinic Director, and mid-term and final performance evaluations on Typhon

Appendix 1.1

One-time Consultation Request with Professor

Purpose: Sometimes clinicians need to consult with one another when working with new, unique, or challenging cases. Students should first work closely with the supervisors. In some instances, students and supervisors may want input from a faculty member. This form serves as a record of that request. Professors have the right to decline the request.

Instructions:

- Complete this request with your supervisor and obtain their approval before sending it to the consulting professor.
- CC the supervisor
- Do not include client identifiers of any kind.
- Subject line: “Consultation request (confidential)”
- Cut and paste the following information into an email.
- The consultation does not include PhD faculty session observation or other- it is a onetime opportunity to structure ideas and seek outside input.
- Keep it brief. Part of this activity is for you to be concise and professional in your communication, and to highlight and organize information succinctly

Date:

Graduate Clinician:

Supervisor:

Client Description:

Describe your current intervention and specific strategies being applied:

Describe responsiveness:

What are family/client and other socio-cultural considerations:

What are your specific questions for this consultation:

APPENDIX 3-1

Audiometric Screening Procedures and Guidelines for Referral

Once every semester (usually around midterm), you will complete a hearing screening for each of your clients. For most clients, the hearing screening consists of 3 parts: otoscopy, tympanometry and pure tone screening. If your client has **a known hearing loss and wears hearing aids**, you will complete otoscopy and tympanometry only—**no pure tone screening**. For clients with a known hearing loss, you must state in the ‘Recommendations’ section of the protocol that they should continue to see their audiologist regularly for ongoing monitoring and management.

Otoscopy

Visualize the external ear (skin tags/pits, malformed pinna, absence of a pinna, absence of an ear canal), ear canal (foreign body, blood, drainage, excessive wax, tube) and TM (perforation, tube placement, redness) and note any abnormalities. If things do not look normal, or you have questions about what you are observing, have your supervisor look.

Acceptable terminology:

- *Otoscopy results are unremarkable.*
- *Otoscopy results show the ear canals to be clear.*
- *Otoscopy results show excessive cerumen (i.e., ear wax) that did not allow for a clear view of the tympanic membrane (i.e., ear drum).*

Unacceptable terminology: Otoscopy is WNL.

Tympanometry

Complete a screening tympanogram on each ear. Tympanometric width (TW) should be equal to or less than 250 daPa to pass the screening. TW is sometimes referred to as a gradient (GR). Normal range for peak pressure (daPa) is +100 to -200, for admittance (cm³) it is 0.2 to 1.8. Ear canal volume (ECV) will vary greatly, but average ECVs are .42 to .97 for children and .63 to 1.46 for adults. If you get a flat tympanogram, reposition the probe and repeat the screening or have your supervisor do it. Flat tympanograms must be interpreted in conjunction with ECV readings.

Interpretation samples:

- Flat tymp (NP, NP) with normal average ECV may suggest middle ear pathology (e.g., otitis media).
- Flat tymp with a small ECV may suggest that the ear canal is occluded with wax/debris (which would have been visualized in otoscopy) or that the immittance probe is pushed against the side of the ear canal.
- Flat tymp with large ECV suggests a patent pressure equalization tube (pe tube) or perforation of the tympanic membrane.

Acceptable terminology:

- *Tympanometry results are within normal limits.*
- *Tympanometry results indicate negative middle ear pressure with normal admittance; (or if admittance is low) reduced admittance.*
- *Tympanometry results indicate flat tympanogram with normal ECV.*

- *Tympanometry results indicate flat tympanogram with large ECV, suggesting patent PE tube, perforated tympanic membrane (depending on what otoscopy revealed or patient/parents report). Otoscopy results are unremarkable.*

Pure Tone Screening

Do not switch the headphones around with different audiometers. Each audiometer is calibrated to a specific set of headphones. Below are the procedures for children and adults.

Children

Pure tones are presented to each ear separately at **20 dB** at the frequencies of 1000 Hz, 2000 Hz, and 4000 Hz. To be considered a pass they must respond to all frequencies in both ears. For small children you may need to perform conditioned play audiometry. It is also important to vary the pure tone presentation rate to avoid the child from guessing.

Acceptable terminology: *Passed/failed the hearing screening in the both/X ear at X frequency*

Adults

Pure tones are presented to each ear separately at **25 dB** at the frequencies of 1000 Hz, 2000 Hz, and 4000 Hz.

Acceptable terminology: *Passed/failed the hearing screening in the both/X ear at X frequency*

Otoacoustic Emissions Test

If your client has challenging behaviors or a cognitive impairment and cannot complete the pure tone screening, you may perform an Otoacoustic Emissions test instead. Contact Ms. Garcia to discuss the use of Otoacoustic Emissions for your client.

Guidelines for Referral

- Red bulging TM - medical referral after consulting your supervisor
- Wax occluding ear canal, with flat tympanogram, and failing the pure tones at one or more frequency - medical referral after consulting your supervisor
- Foreign body in ear canal - medical referral after consulting your supervisor
- Tympanometric width (TW) or gradient (GR) > 200 daPa – rescreen in 3 to 5 weeks
- Flat tympanogram with normal looking ear canal and TM – rescreen in 3 to 5 weeks
- Negative middle ear pressure (beyond -200 daPa) – rescreen in 3 to 5 weeks
- Failure to respond to the pure tones at any frequency - rescreen in 3 to 5 weeks or at the discretion of your supervisor
- PE tubes: if the ECV is outside the normal range but with a flat peak (i.e., NP) and the tube is visible, the tube is likely working; if the ECV is within normal range with a normal peak and/or flat and tube is visible, the tube is likely not working.
- **If you are unsure about the recommendation, consult your supervisor!**

APPENDIX 3-2

Biological Calibration of Audiometers

1. Check power.
2. Make sure the number on the headphones matches the number on the audiometer.
3. Check cords for signs of wearing and cracking, and listen to earphones while moving and twisting cords; check for signal intermittency when wires are twisted gently.
4. Check dials and switches for looseness or misalignment.
5. Check operation of interrupter switch/bar.
6. When tones are presented, listen for audible clicks or other sounds that might cue listener, both with and without earphones.
7. With attenuator set to audible level, change frequency on frequency selector. Listen to determine the presence of different and appropriate pitches; do this for both earphones. Listen for any hum, static, distortion (sound quality).
8. Do a rough check of linearity of attenuator by making sure that intensity/loudness is consistent with attenuator settings.
9. Listen for crosstalk between earphones; can disconnect earphone that is being fed a signal; listen to opposite earphone.
10. Check own thresholds or those of another person with known HLs, using both earphones. Levels should be within ± 10 dB of known thresholds.

APPENDIX 7-3

On-Campus Student Skill Demonstration and Feedback Rubric

Skill Area	Not Yet Demonstrating	Emerging	Developing	Approaching Independence for a MS SLP Graduate Student
Assessment Skills Key Areas to Evaluate and Provide Feedback On: • Chart Review/Case Hx • Selecting Instrument/procedures • Administration of instrument/procedures • Interpreting results to develop diagnosis and recommendations ASHA Standards: -Standard IV-C -Standard IV-D -Standard V-B (1-3) CAA Standards: 3.1.1B, 3.1.2B, 3.1.3B, 3.1.6B	Skill Demonstration: Not yet able to reliably administer or interpret assessments, even with support. Supervisor Support: Provides direct modeling, scripting, and step-by-step guidance.	Skill Demonstration: Procedurally, administers assessments with guidance. Interpretation is developing but not yet consistent. Supervisor Support: Offers frequent support in tool selection and models aspects of interpretation.	Demonstration: Selects and administers assessments with minimal guidance. Begins to interpret findings more independently, though clinical reasoning may be developing. Supervisor Support: Provides occasional input, confirms conclusions, supports and refines “clinical” or diagnostic reasoning.	Skill Demonstration: Selects, administers, and interprets familiar assessments with increasing accuracy. Begins integrating findings into planning. Demonstrates initiative but often requires support with complex cases. Supervisor Support: Confirms interpretation and supports diagnostic reasoning as needed. Encourages reflection and planning. At times may provide some guidance in interpretation.
Intervention Planning Key Areas to Evaluate and Provide Feedback On: • Developing setting-appropriate goals • Intervention plans consider anatomical/physiological, developmental, and linguistic cultural correlates	Skill Demonstration: Not yet able to generate appropriate, measurable goals or therapy plans. Goals lack connection to assessment data and are not functional or client centered. Intervention plans do not reflect clinical rationale. Materials selected are unrelated to goals or client needs, or otherwise not a good match for the goals/context.	Skill Demonstration: Develops basic goals and plans with significant support. Goals may be vague, lack specificity, or show weak connection to assessment data or client priorities. Selected materials may not fully support goals or client needs. Clinical reasoning may be limited or unclear. Supervisor Support: Guides alignment of	Skill Demonstration: Creates goals and intervention plans that begin to reflect client needs and assessment data in most opportunities. Demonstrates improving clinical reasoning and some application of theory. Materials and instrumentation are generally on target but may require refinement.	Skill Demonstration: Develops client-centered, measurable goals and logical intervention plans for familiar cases. Demonstrates solid clinical reasoning and growing flexibility. Materials and instrumentation are generally appropriate and adapted to client needs. Supervisor Support: Provides consultation and confirmation of

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Skill Area	Not Yet Demonstrating	Emerging	Developing	Approaching Independence for a MS SLP Graduate Student
Selects/Develops appropriate materials and instrumentation ASHA Standards: -Standard V-B (4-5) -Standard V-B (8) CAA Standards: 3.1.3B, 3.1.6B, 3.1.4B	Supervisor Support: Provides direct modeling of goal writing and planning. Offers structured templates and examples. Actively assists in selecting or developing materials.	goals with assessment findings and functional outcomes. Supports use of SMART goal structure. Provides ongoing modeling and structured feedback for planning and material selection.	Supervisor Support: Provides targeted feedback to enhance goal clarity, data alignment, and rationale. Encourages reflection on how plans connect to clinical reasoning. Offers guidance as needed for materials or planning in more nuanced cases.	plans as needed. Encourages independent planning and offers scaffolding for complex clients, unfamiliar settings, or diverse populations. Promotes reflective adjustment of plans.
Therapy Implementation Key Areas to Evaluate and Provide Feedback On: - Implements intervention plans that involve clients/patients and relevant others in the intervention process - Data taking reflecting client performance and related to goals - Sequences tasks to meet objectives - Uses prompts and cues that match the clinical scenario - Demonstrates Behavior management skills - Modifying plans, strategies, materials, activities to meet client needs ASHA Standards: -Standard V-B (5-6, 8-10) -Standard V-B (10) CAA Standards: 3.1.3B, 3.1.6B, 3.1.4B	Skill Demonstration: Not yet able to carry out therapy tasks or use strategies effectively. Sessions may lack therapeutic intent or responsiveness to client needs or responses. Data collection is inconsistent, inaccurate, or absent. Little evidence of progress despite supervision. Supervisor Support: Provides continuous modeling and coaching. Intervenes frequently during sessions. Guides data collection directly through step-by-step modeling and feedback.	Skill Demonstration: Delivers therapy tasks with growing consistency. Begins to incorporate prompts and cues that fit the client's needs. May attempt to adapt activities, but responsiveness to client is limited. Collects data consistently, though it may not fully align with goals or be used to guide decisions. Supervisor Support: Provides real-time prompts, modeling, or brief coaching as needed. Offers structured support for integrating prompting, task sequencing, and data relevance.	Skill Demonstration: Implements therapy strategies effectively with familiar clients. Demonstrates flexibility by adjusting activities based on client response. Collects and analyzes data accurately and begins to use it to inform decisions with minimal support. Supervisor Support: Offers occasional check-ins and feedback. Encourages reflection and clinical reasoning. Intervenes rarely, allowing the clinician to lead with confidence.	Skill Demonstration: Delivers structured, responsive sessions for familiar client profiles. Independently sequences tasks, applies appropriate prompts, and adjusts strategies based on client needs and data. Demonstrates growing autonomy and adaptability across behavioral challenges. Supervisor Support: Provides consultation and brief feedback as needed. Encourages independent problem-solving while remaining available for more nuanced guidance. Supports reflection on data-driven adjustments.

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Skill Area	Not Yet Demonstrating	Emerging	Developing	Approaching Independence for a MS SLP Graduate Student
Professional Communication Key Areas to Evaluate and Provide Feedback On: - Communicates effectively, considering the needs, values, communication preferences, and cultural/linguistic background of individuals, families, caregivers, and others involved. - Demonstrates skills in oral and other forms of communication sufficient for entry into professional practice ASHA Standards: -Standard V-A & V-B (7) -Standard V-E CAA Standards: 3.1.1B, 3.1.6B, 3.1.5B	Skill Demonstration: Communication can be unclear, lacking in refinement, or misaligned with audience or context. This may cause confusion or misunderstandings. Not yet able to adjust tone or language. Supervisor Support: Provides direct modeling and scripts for verbal interactions. Reviews written work closely for tone, content, and clarity. Offers repeated feedback on professional expectations.	Skill Demonstration: Demonstrates overall clear communication skills. Needs support adjusting message, tone, or content for different audiences. Written and verbal communication may lack precision or may not fit in the setting. Supervisor Support: Provides structured feedback and guided practice. Role-plays sensitive conversations. Reviews documentation and emails for alignment with professional expectations.	Skill Demonstration: Communicates clearly and respectfully in most clinical situations. Begins to tailor communication based on audience and context. Demonstrates improving autonomy in professional conversations. Supervisor Support: Provides feedback as needed, particularly for higher-stakes interactions or written communication. Encourages reflection on tone and clarity. Reviews sensitive or complex communications when appropriate.	Skill Demonstration: Communicates clearly, respectfully, and professionally in a range of familiar clinical situations. Adjusts tone, language, and delivery based on context and individual needs. Demonstrates increasing initiative and self-awareness in managing professional interactions. Supervisor Support: Offers consultation as needed. Encourages independent drafting of communications and reflective adjustment. Reviews high-stakes or unfamiliar interactions for support and learning.
Documentation Key Areas to Evaluate and Provide Feedback On: Completing clinical documentation, including SOAP notes, progress reports, and other administrative functions, to support evaluation and treatment/intervention.	Skill Demonstration: Documentation skills are in process but often incomplete, disorganized, or clinically unclear. This may include errors in structure, content, or confidentiality. Not yet able to meet expectations for EMR use or timelines. Supervisor Support: Provides modeling,	Skill Demonstration: Documentation includes required elements but contains some errors, lacks clarity, or may not fully align with clinical goals. Developing consistency with structure, timelines, and EMR. Supervisor Support: Reviews for clarity, completeness, and relevance. Offers guided	Skill Demonstration: Documentation is accurate, timely, and generally relevant. Demonstrates growing ability to integrate clinical reasoning. Uses EMR effectively with minimal prompts. Supervisor Support: Spot-checks documentation and offers feedback on insight, tone, and precision.	Skill Demonstration: Documentation is accurate, timely, and relevant. Demonstrates solid integration of data and clinical reasoning in written work. Adjusts content to match context and purpose. Supervisor Support: Consults as needed. Encourages independent organization and insight.

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Skill Area	Not Yet Demonstrating	Emerging	Developing	Approaching Independence for a MS SLP Graduate Student
Following documentation policies (e.g., use of EMR, timelines, appropriate templates, etc.) ASHA Standards: -Standard V-B (11): -Standard V-F CAA Standards: 3.1.3B, 3.1.6B	templates, and direct feedback. Clarifies expectations for structure, format, and compliance with documentation standards.	editing and feedback to reinforce structure and expectations. Asks student to begin to self-monitor and reflect on documentation.	Encourages continued development of professional writing.	Reviews challenging or nuanced cases.
Clinical Reasoning Key Areas to Evaluate and Provide Feedback On: - Use of assessment data to identify communication and swallowing disorders. - Applying current research and evidence to clinical decision-making. - Demonstrating an understanding of research methodology and interpreting relevant research findings. - Identifying the need for referrals or collaboration with other professionals when necessary. - Modifying treatment plans as needed based on client progress and feedback. - Identifying and addressing challenges that arise during therapy sessions.	Skill Demonstration: Not yet able to apply clinical data to decision-making. Relies heavily on supervisor to interpret client needs and guide treatment. Reflection is limited. Supervisor Support: Provides real-time coaching and models decision-making. Guides interpretation of client outcomes step-by-step.	Skill Demonstration: Beginning to apply data and feedback to treatment decisions, but frequently requires back up or prompting, confirmation or other support in data tracking. Developing reflective skills. Supervisor Support: Facilitates frequent debriefs and reflective questioning. Scaffolds decisions and discusses alternatives.	Skill Demonstration: Recognizes clinical patterns and applies logical reasoning in most decisions. Begins to independently evaluate client progress and adjust plans. Reflects regularly to improve clinical outcomes. Needs support in unfamiliar and complex situations including referrals. Supervisor Support: Offers feedback and perspective on complex cases. Encourages refinement of clinical reasoning and deeper reflection.	Skill Demonstration: Uses data to inform decisions for familiar cases. Modifies treatment appropriately and identifies when to refer. Seeks clarification for unfamiliar or complex situations. Supervisor Support: Provides consultation and validation of reasoning. Encourages problem-solving.

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Skill Area	Not Yet Demonstrating	Emerging	Developing	Approaching Independence for a MS SLP Graduate Student
- Engaging in reflective thinking and self-evaluation to improve clinical skills. - Demonstrates an understanding of the effects of own actions and makes appropriate changes as needed ASHA Standards: -Standard IV-F -Standard V-B (9) -Standard V-B (12) CAA Standards: 3.1.3B, 3.1.4B, 3.1.5B				
Responsiveness to Feedback Key Areas to Evaluate and Provide Feedback On: - Demonstrates openness and responsiveness to clinical supervisions and suggestions - Implements feedback ASHA Standards: -Standard V-A CAA Standards: 3.1.1B, 3.1.6B	Skill Demonstration: Student is not yet responsive to feedback (e.g., dismisses, ignores, or inconsistently acknowledges feedback). May appear resistant or defensive. May result in minimal observable improvement despite supervisor input. Supervisor Support: Provides frequent, direct feedback. Models implementation and checks for understanding. May reframe feedback multiple times.	Skill Demonstration: Generally receptive but applies feedback inconsistently. Needs reminders to implement or generalize across settings. May need more development in self-reflection. Supervisor Support: Gives structured feedback, models changes, and encourages reflection. Provides reminders across sessions.	Skill Demonstration: Accepts and applies feedback with increasing independence. Reflects on skill demonstration and begins suggesting strategies for improvement. Supervisor Support: Encourages student-led reflection and asks the student to evaluate skill demonstration. Supports planning next steps.	Skill Demonstration: Responds positively to feedback. Adjusts skill demonstration consistently and independently. Begins initiating self-correction. Supervisor Support: Provides consultative guidance. Encourages metacognition and goal tracking.
Client-Centered Practice Key Areas to Evaluate and Provide Feedback On: Adapts evaluation and treatment procedures to meet	Skill Demonstration: May prioritize task completion over client participation. Sessions are clinician-driven, generic, or misaligned with client needs or preferences. May show	Skill Demonstration: Shows basic awareness of client needs but inconsistently integrates client preferences or feedback. Attempts engagement but may	Skill Demonstration: Demonstrates growing ability to plan and adjust sessions based on client input. Begins guiding client self-reflection and makes purposeful	Skill Demonstration: Designs sessions with the client's needs and preferences in mind. Uses meaningful materials and promotes collaboration. Responds

Communication Disorders

Skill Area	Not Yet Demonstrating	Emerging	Developing	Approaching Independence for a MS SLP Graduate Student
the needs of individuals receiving services - Guides client to self-evaluate and family/relevant others to critique performance during treatment. - Uses/develops materials appropriate and engaging to client ASHA Standards: -Standard V-B (7, 8) -Standard V-B (10) CAA Standards: 3.1.3B, 3.1.6B	limited responsiveness to client input, even with guidance from supervisor. Supervisor Support: Provides direct modeling of client-centered approaches. Gives step-by-step guidance on adapting activities and using client input. Highlights misalignment.	revert to clinician-centered choices. Supervisor Support: Cues student to recognize client perspectives and adjust materials or approach. Encourages empathy and flexibility.	adaptations to increase engagement. Supervisor Support: Provides feedback on how to align intervention with client goals. Affirms effective engagement strategies and encourages thoughtful reflection.	flexibly to changing needs. Supervisor Support: Offers consultative support. Reinforces culturally responsive, participatory care.

Expected Benchmarks by end of Fall Semester Clinic:

Goal: Establish foundational clinical behaviors and demonstrate readiness to learn through guided participation.

Skill Area	Expected Benchmark	What to Look For
Assessment Skills	Emerging	Can administer parts of assessment with support. Needs modeling. Beginning to recognize patterns. May not yet link findings to treatment.
Intervention Planning	Emerging	Needs help writing goals and structuring sessions.
Therapy Implementation	Emerging → Developing	Follows models, leads parts of sessions, needs cues to adapt.
Professional Communication	Emerging	Learning professional tone. Needs support writing notes and talking to caregivers or team members.

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Skill Area	Expected Benchmark	What to Look For
Documentation	Emerging	Needs substantial feedback on session notes. Learning SOAP structure, terminology, and relevance.
Clinical Reasoning	Emerging	Starting to connect clinical data to decisions with help. Often requires supervisor guidance to determine next clinical steps.
Responsiveness to Feedback	Emerging → Developing	Accepts feedback, needs repetition and reminders. Limited self-correction during sessions.
Client-Centered Practice	Emerging	Focused more on task completion than client experience. Needs reminders to adjust for client interests or engagement.

Key First Semester Goals:

- Build **clinical confidence and foundational routines**.
 - Demonstrate **willingness to learn** and apply feedback.
 - Begin developing **basic independence** in structured, predictable tasks.
 - Show early understanding of **client-centered care** and **professional expectations**.
-

What Should *Not* Be Expected:

- Full independence or flexible session adjustments.
- Mastery of documentation or clinical reasoning.
- Independent clinical decision-making in unfamiliar situations.

Expected Benchmarks by end of Spring Semester:

Goal: Strengthen consistency and accuracy in foundational clinical skills while building confidence and early independence in familiar routines.

Communication Disorders

Skill Area	Expected Benchmark	What to Look For
Assessment Skills	Developing	Independently administers portions of assessments. Begins to synthesize findings and connect to therapy.
Intervention Planning	Developing	Creates increasingly appropriate and measurable goals with guidance. Begins linking plans more clearly to client priorities.
Therapy Implementation	Developing	Implements therapy strategies more confidently. Begins adjusting techniques or activities in response to the client's needs but still needs support.
Professional Communication	Emerging → Developing	More confident with clinical discussions and basic written communication.
Documentation	Emerging → Developing	Documentation is generally complete and well-organized. May still require occasional guidance for clarity or alignment with clinical expectations.
Clinical Reasoning	Emerging → Developing	Beginning to use data to guide decisions. Still needs feedback to reflect accurately.
Responsiveness to Feedback	Developing	Applies feedback with more consistency. Starts reflecting independently.
Client-Centered Practice	Developing	Starts adapting sessions. Basic engagement strategies emerging.

Key Second Semester Goals:

- Improve alignment between assessment, planning, and intervention.
- Increase independence in structured clinical tasks.
- Apply feedback more consistently and begin self-correction.
- Expand professionalism in communication and documentation.

What Should *Not* Be Expected:

- Consistent independence across all clinical tasks or settings.
- Mastery of clinical reasoning, particularly in unfamiliar cases.

Communication Disorders

- Fluency in adapting therapy sessions without support.
- Fully professional documentation or communication without some revision.

Expected Benchmarks by end of Summer Semester:

Goal: Demonstrate readiness for off-campus placement by applying clinical skills more independently in structured and familiar contexts, with moderate supervisory support depending on graduate student previous experience and progression through coursework.

Skill Area	Expected Benchmark	What to Look For
Assessment Skills	Developing → Approaching Ind.	Administers most tools independently. Begins linking results to planning, still needs some support to synthesize findings accurately.
Intervention Planning	Developing → Approaching Ind.	Creates more appropriate goals/plans with support. Plans are logical, functional, and mostly client centered.
Therapy Implementation	Developing → Approaching Ind.	Implements therapy strategies more confidently. Begins adjusting techniques or activities in response to the client's needs.
Professional Communication	Developing → Approaching Ind.	Communicates clearly with most audiences. Needs support or more complex or novel situations.
Documentation	Developing → Approaching Ind.	Documents with improved relevance and clarity. Timeliness improving.
Clinical Reasoning	Developing → Approaching Ind.	Begins to recognize clinical patterns and makes basic adjustments to treatment based on client response and data.
Responsiveness to Feedback	Developing → Approaching Ind.	Seeks feedback. Applies it across contexts.
Client-Centered Practice	Developing → Approaching Ind.	Builds sessions around client interests. Growing responsiveness.

Key Final Semester Goals:

- Demonstrate **increasing flexibility** and **responsiveness** in applying therapy strategies, adjusting as needed based on client progress and feedback with moderate support moving to more independence.
- Begin integrating **more complex clinical reasoning** in assessment and therapy.

Communication Disorders

- Build on **client-centered care** by understanding the individual's goals, interests, and responses.
 - Develop **self-reflection** skills and apply **feedback more independently**.
-

What Should *Not* Be Expected:

- Full independence in **difficult or unfamiliar cases**.
 - Advanced **documentation skills** with no need for review.
 - Mastery in **complex therapy techniques** without supervision.
-

What Progress Should Look Like:

- By the second semester, students should have **expanded confidence** in implementing therapy independently, even in **familiar scenarios**. Support still needed.
- **Assessment interpretation** should improve as students start drawing connections between assessment data and interventions with **greater ease**.
- There should be **less reliance on prompts** and more demonstration of **autonomous critical thinking** in therapy sessions.

	Not Yet Demonstrated	Emerging	Developing	Approaching Independence for an MS SLP Graduate Student
Cultural Competence ASHA Standards: -Standard V-B (8) -Standard V-B (7) -Standard V-A & V-E -ASHA Code of Ethics & DEI competencies CAA Standards: 3.1.1B, 3.1.3B, 3.1.6B, 5.1 & 5.3	Skill Demonstration: Does not yet recognize how cultural or linguistic differences affect communication or service delivery. May unintentionally rely on personal bias or use inappropriate communication. Supervisor Support: Provides direct modeling and explains inclusive strategies.	Skill Demonstration: Aware of cultural and linguistic differences but needs frequent help adjusting language, materials, or behaviors. May overlook the client's perspective. Supervisor: Models culturally responsive strategies and guides student in adapting materials or approach.	Skill Demonstration: Begins adapting communication and planning to reflect client backgrounds. Seeks help appropriately. Supervisor: Provides feedback on respectful adaptation and encourages independent reflection.	Skill Demonstration: Consistently considers cultural and linguistic factors in planning and delivery. Adjusts approach with minimal support and demonstrates respect for diverse perspectives. Supervisor: Offers minimal input and supports occasional reflection or refinement.

Communication Disorders

	Not Yet Demonstrated	Emerging	Developing	Approaching Independence for an MS SLP Graduate Student
Interprofessional Collaboration ASHA Standards: - V-A -V-E CAA Standards: 3.1.5B, 3.1.6B, 3.1.4B	Skill Demonstration: Does not effectively engage with other professionals. May act without understanding team roles or shared goals. Supervisor Support: Models collaboration and explains professional roles.	Skill Demonstration: Acknowledges team roles but requires support to participate or communicate clearly. Supervisor Support: Facilitates introductions, supports initial collaboration, and coaches clear communication.	Skill Demonstration: Participates in team discussions and communicates relevant clinical information. Seeks clarification when roles or responsibilities overlap. Supervisor Support: Offers feedback on communication and encourages active involvement.	Skill Demonstration: Collaborates respectfully and shares information clearly. Integrates feedback from other professionals into care. Seeks guidance only in complex or unfamiliar situations. Supervisor Support: Consultative. Supports navigation of nuanced team dynamics.

Note: These areas reflect professional disposition and communication that may evolve more gradually and vary depending on the placement setting. While full independence may not be demonstrated in every interaction, students should show increasing initiative, respect, and adaptability across contexts.

What Progress Should Look Like

- Student independently considers cultural context in planning and adapts as needed with some supervisor input.
- Greater comfort working with diverse clients, families, and teams.
- Demonstrates flexibility and initiative in working with professionals from other fields.
- Begins applying interprofessional and culturally responsive practices with growing consistency and confidence.

Professionalism

Aligned with ASHA standards: V-A and V-E and ASHA Code of Ethics Principle I–IV

Aligned with CAA Standards: 3.1.1B, 3.1.3B, 3.1.6B, and 5.3

Communication Disorders

Skill Area	Present	Not Present
Attendance and Timeliness	- Attends all clinic obligations - Communicates promptly regarding absences or lateness. -Consistently submits work by the agreed-upon due date and rarely requests extensions.	- Frequently absent or late without valid reason. - Fails to notify supervisors or team. - Submits work late without communication.
Complies with Policies and Standards	- Follows clinic, university, and legal rules (e.g., HIPAA, FERPA). - Maintains professional appearance and hygiene.	- Fails to comply with clinic, university, or legal policies. - Demonstrates inconsistent professional appearance or hygiene.
Personal Responsibility and Accountability	-Demonstrates accountability for own actions and decisions. - Prepares for clinic duties and seeks feedback/support appropriately. - Advocates for their own learning needs while maintaining professional boundaries and respect for supervisory roles.	- Does not accept responsibility for actions. - Arrives unprepared and avoids help-seeking. - Shows minimal initiative or ownership.
Ethical Integrity	- Maintains client confidentiality. - Is honest and respectful in all interactions. - Recognizes limits of their knowledge and avoids misrepresenting their skills. - Uses good judgment when making clinical decisions.	- Breaks confidentiality. - Acts dishonestly or disrespectfully. - Misrepresents knowledge or skills. - Makes poor or unethical clinical choices.

If a student receives a **"Not Present"** rating in any skill area, **an individualized action plan must be developed** to support progress toward meeting expectations by the end of that semester.

APPENDIX 8-1

CLINIC EQUIPMENT CLEANING PROTOCOL

** Gloves and protective eyewear must be worn during all cleaning/disinfecting processes **

Disinfectants

- Oxiver TB and/or Sani-Cloths are located in each clinic treatment area.
- Sporox is premixed and ready to use in Health Sciences, Rooms 178 (Hearing Aid Lab) and 185 (Cleaning room).
- Pour two cups of Sporox liquid into the clearly marked container.
- The Sporox should be changed every **21** days. Log the date when liquid is changed on the sheet posted near the container.
- Dispose of used Sporox into the Hearing Aid Lab or Cleaning room sinks.
- Should you have any reaction from contact with Sporox, refer to the warnings and precautions sheet posted inside the cabinet where the container is located and notify the appropriate Clinic Coordinators immediately.
- Maxicide solution must be mixed before use. The two agents (one powder one liquid) become active once mixed.
- After Maxicide mixture is made, pour the designated amount into the marked tubes in the Cleaning room.
- The Maxicide in the tubes and any unused solution should be discarded after **21** days into the sink. Log the date when the mixture is made on the container and place the same information on the base of the tubes with the Maxicide mixture.

Should you have any reaction from contact with the Maxicide, refer to the warnings and precautions sheet posted directly on the container or as posted in the cleaning room and notify the Clinic Coordinators immediately.

Tympanometry and Instrument Cleaning (completed by Office Associate or Clinic Director)

Place used tympanometry tips into the plastic container labeled "dirty tips."

- Wash tympanometry probe tips in warm soapy water. (Otoscope probe tips are disposable and should be thrown away after use.)
- Take cleaned tips to the appropriate Sporox container (e.g., audiology will use the Hearing Aid Lab speech will use the Sterilization and Clean Room 1111).
- Place rinsed probe tips/instruments in container of Sporox for **6** hours to fully disinfect.
- Use tweezers OR gloved hands to remove disinfected tips/instruments from

Sporox container.

- Rinse with warm-hot water.
- Place on clean paper towel and air dry in the Hearing Aid Lab OR the Cleaning Room/
- Using the paper towel, transport cleaned tips/instruments to the proper storage container in the Hearing Aid Lab OR the Screening Room.
- Throw away used paper towel.

1. Other Materials

Any materials used in the course of treatment or assessments that are NOT disposable (toys, assessment items, flashlights, lip retractors, FM systems, etc.) must be cleaned after **each** use. Every treatment room is equipped with a solution of appropriate disinfectants and/or disinfectant wipes (Sani-Cloths) to wipe off materials. All materials should be air dried and then returned to the proper storage area. Tabletops, armchair handles, and other furniture used during a session should be wiped down with disinfectant spray and/or wipes.

APPENDIX 8-2

EXPOSURE PACKET

Exposure Control Plan and Packets are found on WyoCourses and hard copies are located **in Clean Room 1111, Grad Prep Room 1131 and at the front desk** for more detailed information.

Items included in this packet:

- Human Bloodborne Pathogens Exposure Instructions
- Bloodborne Pathogens Post Exposure Evaluation Form
- Healthcare Professional's Written Opinion Form
- Procedures for evaluating the circumstances surrounding an exposure incident
- 29 CFR 1910.1030 – OSHA's Bloodborne Pathogen Standard

UW Associated documents:

- Workers Compensation Form: <https://www.uwyo.edu/hr/employee-benefits/workers-compensation.html>
- Biosafety Incident Report Form: <https://www.uwyo.edu/safety/biological/index.html>

Human Bloodborne Pathogens Exposure Instructions and Checklist

___	1. Call 911 if an emergency. Rinse or wash affected surface immediately and apply first
___	2. Report to supervisor immediately.
___	3. Exposed worker must report to Ivins Memorial Hospital Emergency Room, or other local Urgent Care Doctor, as soon as possible. ~If a non-paid student, report to student health if open. Otherwise report to local urgent care or emergency room. ~ALL: If not in Laramie report to facility designated by your department or the nearest Emergency Room or Health Care Provider
___	4. Obtain Exposure Packet before leaving to Emergency Room
___	5. Before seeing healthcare professional fill out the following documents: ___ Bloodborne Pathogen Post Exposure Evaluation ___ Workers Compensation Form ___ Biosafety Incident Report Form ___ Sharps Injury Log Form, <i>if necessary</i>
___	6. Provide Exposure Packet information to healthcare professionals. Supervisor shall ensure that he healthcare professional is provided the following information: ___ A copy of the regulation ___ A completed copy of the Bloodborne Pathogen Post Exposure Evaluation form ___ Vaccination Status and relevant medical records of the injured worker.
___	7. Healthcare Professional completes the following form during the visit: ___ Health Care Professionals Written Opinion form ___ Healthcare Professional's Medical Release form (obtained from their office)
___	8. Submit completed paperwork to department work unit contact person.
___	9. Submit Workers Compensation form as soon as possible.
___	10. Department work unit contact person or exposed worker, contact the UW Biological Safety Specialist as soon as possible of the exposed incident. Send the following forms to biosafety@uwyo.edu ___ Bloodborne Pathogens Post Exposure Evaluation ___ Healthcare Professionals Written Opinion Form ___ Biosafety Incident Report Form ___ Sharps Injury Log Form, <i>if necessary</i>

Communication Disorders

Supervisor's Signature: _____
File with Department Work Contact Person