



SAN DIEGO STATE
UNIVERSITY

*Surviving Clinic
in the
“Real World”*

Speech-Language Manual for Off-Campus Clinic

SLHS 627

2012-2013

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I. Introduction

You are about to enter “the real world” for your first experience of being a speech-language pathologist in an off-campus setting. This is your chance to explore different environments and to determine areas that you are particularly interested in (not to mention getting those all-important ASHA hours done!). The goal for your off-campus placements is to be able to “do the job” by the end of your experience. You should look on this as a job and be prepared to accept this responsibility as you would if you were being paid.

II. SLHS 627 Requirements

Clinician Requirements

A. Students placed in off-campus settings must agree to conform to the administrative policies, standards and practices of the field experience site and to the ethical and legal standards of the profession. This includes getting TB tests and Hepatitis B vaccinations and obtaining CPR certification if required by your placement. For most hospital placements, you also will be required to complete a background check and drug testing.

B. You should plan on accruing a minimum of 100 hours in your off-campus setting. These hours may be treatment or diagnostic. You should be aware of the number and type of hours you need as you begin your off-campus experience. Your supervisor should have a method for keeping track of your hours as you accrue them in your placement; however, if s/he doesn't, one is provided for you (forms are in the student workroom). Note your hours daily. Not only will this help you keep an accurate account of your hours but also it's good practice for when you begin keeping billing and attendance data as a licensed and certified SLP.

C. Off-campus practicum is **a job** and you are expected to conform to the dress code of your placement. For hospitals and clinics, this usually means hose or socks and closed-toed shoes, covered shoulders and no midriffs showing. Hospitals may also require that your fingernails be natural, unpainted and less than ¼ inch long. Off-campus dress requirements tend to be more formal than on-campus. If you don't know the expected dress for your placement, ask your supervisor.

D. Attendance: Most off-campus placements are open to some negotiation in terms of scheduled days off for doctor's appointments, etc. Do not ask for time off because you have to study for a test. Also, do not wait until just before you need a day off to ask! Remember that (except for community colleges) your placements will not have things like spring break or holidays, so expect that they will want you there on those days. The placements have the right to ask you to make-up any days missed.

E. ASHA requires a minimum of 25% supervision. Your supervisor must be on-site while you are seeing clients. Your off-campus supervisors are aware of these requirements as

they are reminded of them when they agree to supervise you. However, if you feel that you are not getting adequate supervision, discuss it with your supervisor or contact the Speech-Language Clinic Director. You must be supervised by an ASHA certified speech-language pathologist. All of the current off-campus supervisors have ASHA certification.

F. The State of California requires that only hours that are supervised by a licensed SLP may count towards the required clock hours for licensure. However, there are two exceptions to this rule: 1) public schools; and, 2) federal employees. If you are placed at Navy, the V.A. or Camp Pendleton, your supervisor may not be licensed but you may still count those hours towards licensure. The same is true for hours accrued in the public school setting for your credential.

Off-Campus Supervisor Requirements

A. Each off-campus site has entered into an affiliation agreement with SDSU. These agreements specify that the site will assign a qualified staff member to provide supervision, will provide students with “pertinent and meaningful” experiences and will complete periodic evaluations of your performance. Additionally, the agreement specifies that students will be oriented “to the field experience site administrative policies, standards and practices.” Please be sure that you receive this orientation! You need to know what is expected of you in your placement.

B. As stated previously, each off-campus placement is aware of ASHA and licensure supervision requirements and will assign supervisors appropriately. Occasionally, your regular supervisor may be absent and another staff member may supervise. If you aren’t sure of your supervisor’s ASHA or licensure status: ASK! You may not count hours that are supervised by a non-certified or non-licensed SLP. Sometimes, off-campus supervisors forget and assign students to an SLP who is in his/her Clinical Fellowship Year.

University Requirements

A. The affiliation agreements state that the University will be responsible for assuring that students are eligible for field experience, that placement will be based on an application review and personal interview process, that students will have the appropriate vaccinations, TB tests, background check/drug testing and CPR training, and that students will be provided information on Standard Precautionary Practices.

B. The Speech-Language Clinic Director and/or off-campus clinical coordinator will maintain communication with your off-campus supervisor. If there are any concerns regarding performance in that setting, you may be asked to schedule an appointment to discuss possible remedies.

III. Off-Campus Sites

The School of Speech, Language and Hearing Sciences maintains affiliations with every type of setting where speech-language pathology services are provided. They include:

A. Outpatient Clinics (ex. Sharp/Rees-Stealy, Kaiser Permanente): These tend to be freestanding speech and language clinics and/or may be associated with health maintenance organizations (HMOs). The types of clients seen at these clinics tend to cover a broad range of ages and disorders.

B. Community Colleges (ex. Educational Cultural Complex, Mesa) are supported by local, state and federal funding. Services are usually provided through Disabled Students Services and include diagnostic, educational and consultative services for students and college staff. Additionally, special programs for acquired brain injury and high tech centers service students of all ages.

C. Private Practices provide diagnostic and intervention services in a variety of settings including professional offices, skilled nursing centers and private schools. They are supported by private payments for service, payments from medical insurance and funding from state and federal programs.

D. Acute care hospitals provide speech, language, cognitive and dysphagia services to patients who have recent and/or sudden onset of illness (ex. CVA, laryngectomy) or who have recurrent disorders requiring frequent hospitalizations (complications from diabetes, respiratory or cardiac disorders). Currently, patients tend to be seen for short periods prior to their being transferred to facilities or areas of the hospital requiring a lower level of care. These areas are sometimes called transitional care units, transitional living centers or step-down units. The majority of SLP services provided in acute care hospitals involve swallowing evaluation and treatment.

E. Rehabilitation centers are usually associated with a hospital (ex. Sharp Rehab, Scripps Rehab, etc.) and patients are usually followed by SLPs from the acute care portion of the hospitalization through the step-down unit and then to rehab. However, funding for “acute” rehab has been limited by many HMOs and other third-party payers (see next section on reimbursement issues). SLPs in rehabilitation settings function as part of a team with families, physicians, P.T., O.T., nursing and other allied health professionals. Patients qualifying for rehab fall under rules set by the Centers for Medicare and Medicaid (CMS), which mandates three hours of therapy per day (a.k.a. “the Three Hour Rule”). As a result, most patients receive one hour of P.T., O.T. and speech-language therapy per day.

F. Skilled nursing facilities (SNF) provide long-term care for the chronically ill and/or patients who are unable to care for themselves in more independent settings. Skilled nursing facilities also provide rehabilitation services under contract with HMOs and other third-party payers. SLPs are also part of multi-disciplinary teams in the SNF setting.

IV. Reimbursement Issues

A major part of your off-campus experience will include becoming aware of how speech-language pathologists are reimbursed for what we do. Funding for diagnostic and intervention services is always changing due to changes in health care, the economy and laws affecting eligibility for services. In order to know how to get reimbursement (e.g., how to get your patients the services they need), clinicians should be aware of the various funding sources and generally, how each one works.

A. Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO) are the fastest growing funding source for health care. However, services tend to be limited to a specific number of visits per year or condition, or to a specific money amount (called capitated plans). Also, some plans specifically omit speech-language and hearing services unless the disorder is acquired. For example, services for a child with a developmental language disorder would not be covered but services for a stroke would. If services are covered, the SLP usually must obtain prior authorization and provide a specified number of sessions within a limited time frame. For example, the authorization may specify 12 one-hour visits within 60 days.

B. Medicare is the national healthcare plan for persons over the age of 65 or adults who have been totally disabled for longer than two years and who were previously employed. There are two parts to Medicare. Part A covers hospitalization and Part B covers outpatient services, some medications and durable medical equipment. Medicare guidelines are set by CMS and fiscal intermediaries (Blue Cross, Aetna) process claims under contract to CMS. Claims are usually reviewed by nurses, not SLPs. As a result, it is extremely important that clinicians are aware of guidelines for Medicare documentation since your work may be reviewed by someone who is not as familiar with our work. (covered in Section V).

C. Medi-Cal is California's version/interpretation of the national Medicaid program. This program covers persons who would not otherwise have access to medical care. This includes adults with financially and/or medically-qualifying conditions, and mothers and their children. Depending on the site, services are either pre-authorized with a treatment authorization request (TAR) or patients can use their Medi-Cal card to obtain services.

D. Regional Center for Developmental Disabilities is a California program that uses Department of Developmental Services funds and local tax dollars to fund services for children and adults with developmental disabilities. Qualifying diagnoses include mental retardation, cerebral palsy, autism, epilepsy and conditions that result in developmental delay (ex. Down syndrome). The Regional Center is also the lead agency for California Early Start, which is California's interpretation of the Individuals with Disabilities Education Act (IDEA) for children under the age of three. Prior to the age of three, Regional Center may fund speech and language evaluations, individual or group therapy and/or infant programs. After the age of 3, children must have eligible diagnoses to continue to receive services. However, Regional Center does not provide speech and language therapy for children over the age of 3 since the schools should be providing those services. Regional Center does provide speech and language consultation,

medical/dental care, educational and vocational planning and respite services. It is also the funding agency of last resort for augmentative communication devices.

E. California Children's Services (CCS) is another California interpretation of a federal program to provide medical and therapeutic services to children with qualifying diagnoses, which includes cerebral palsy, orthopedic issues and hearing loss. CCS does not cover speech therapy except for children under the age of 3 with hearing loss and children with cleft palates. There are some exceptions since CCS administers Medi-Cal funds for qualifying children. For example, CCS may pay for an augmentative communication device for children with cerebral palsy. They may also pay for rehabilitation for a child under the age of 18 who has a traumatic brain injury.

V. Documentation

A former instructor once said, "We're not paid for the therapy we do. We're paid for the documentation we provide about the therapy we do." What she meant was this: If you're not able to document what you do in therapy, it doesn't matter that you're doing the best therapy ever. No one is going to know about it." If your documentation isn't appropriate, you will not be paid for your services. Therefore, pay attention to your off-campus supervisor when s/he orients you to the site's paperwork and documentation procedures. Here are some principles and procedures that will be universal to the various types of sites and funding sources for services:

A. Evaluations: Evaluations off-campus are very different from on-campus. You will not have the same amount of time to review, assess and document your evaluation results. Therefore, talk to your supervisor about the format used for evaluations in your site and develop your own plan for quickly evaluating your patient. Some things to remember:

1. Evaluations results must specify type and level of functional impairment.
2. The write-up of your evaluation must be concise.
3. Your evaluation documentation should list functional goals (i.e., Patient will comprehend 2 or 3 units yes/no questions related to daily needs with 80% accuracy. NOT: Patient will demonstrate improved comprehension.).

B. Daily chart notes might be reviewed by physicians and nurses who determine if therapy is appropriate and warrants continuation. It is extremely important that the notes document and quantify progress and relate to improved functional skills. Depending on your placement, notes may be narrative or may be written in a SOAP format. They must be done daily and co-signed by your supervisor. In general, daily chart notes must be short, objective descriptions of progress.

C. Progress reports can be written every week for inpatient rehabilitation patients or once a month for patients being seen on an outpatient basis. See the appendix for examples of progress report formats. These reports summarize progress made during the treatment authorization period and, based on progress, justify continued treatment with goals to be

reached during the next week or month. Since your daily chart notes will quantify your patients' performance, using these notes to document progress will make writing your monthly progress reports easier.

See Appendix 1 for more information regarding documentation.

D. Abbreviations: Many medical professionals use abbreviations as short-hand to make their writing easier. However, if you don't know the abbreviations, you will have no idea what they're writing! Follow the link to download a list of common abbreviations used in medical settings.

<http://www.asha.org/uploadedFiles/slp/healthcare/Medicalabbreviations.pdf>

It is recommended that you print the list and keep it with you at your site to quickly interpret information in your patients' charts.

There is also a list of abbreviations that cannot be used in a medical setting. See Appendix 2 for that list.

VI. Emphasis on Function and Functional Skills

No matter where you are placed, your supervisor will talk to you about writing functional goals related to functional skills. This is because third-party payers will not fund services unless we are able to document that our intervention actually resulted in our patients being able to more successfully communicate in their environment. ASHA has developed the Functional Assessment of Communication Skills for Adults (ASHA FACS), which leads to measurable outcome data. See the appendix for an outline of the theoretical framework and areas assessed. Many of the field experience sites use the Functional Independence Measure (FIM), which is a national data set used in rehabilitation settings to document level of function at admission and at discharge. A copy of the speech-language items is included in the appendix.

Functional skills and goals relates to treatment of speech and language disorders in children also. Third-party payers use the same criteria for reimbursement whether you are serving children or adults. However, functional activities for children would be related to peer interactions, play-based skills and educational success.

VII. Communication in the Professional Setting

A. Team Communication: The emphasis in rehabilitation (whether in acute rehab, SNFs, or other multidisciplinary team settings) is on setting cooperative goals that incorporate a number of individual discipline's goals. For example, the team may set a goal that the patient will be able to sequence the activities required to get from the bed to the wheelchair. The goal would mean greater independence for the patient (functional goal) and each discipline would be expected to work towards its success. From a speech perspective, this goal could mean that the SLP would work on verbal and written sequencing skills specific to wheelchair transfers and more general sequencing skills.

Most placements that use a team-based approach schedule times to meet as a team, usually called team rounds. During rounds, each discipline reports on the current level of the patient and discusses problems that may be interfering with progress. During rounds, discharge planning is also discussed.

Due to the fact that team members work so closely together, you frequently find that other disciplines comment on issues that are generally considered part of speech and language's scope of practice. Other team members' observations can be very helpful but it is easy at these times to become defensive or intimidated. Don't be. You will learn a lot by listening to the other disciplines.

B. Communication with Families: Patient care conferences are scheduled while the patient is in rehab. The frequency of the conferences can vary from once a week to once a month. Usually, the team, the physician, patient and family are all in attendance. The SLP reports current level of function and goals related to the patient's speech, language and swallowing skills. During patient care conferences, practice the following skills:

1. Do not use professional jargon. Families are under stress and may have difficulty processing the information you are providing. The use of jargon just makes it more difficult for them to understand and increases the opportunities for miscommunication.

2. Use examples to emphasize or demonstrate points.

3. Talk to the families and patients. Even if the patient doesn't understand you, s/he deserves the respect of being talked to and not treated as if they're not in the room.

C. Communicating with other professionals: In most settings, you will have the opportunity to communicate with a variety of professionals including physicians, nurses, other therapists, educators, etc. The one thing that everyone has in common is that **they are busy!** Therefore, keep communications brief and to the point. Do not be offended if people seem brusque. Please note the following during your interactions at your site:

1. If someone asks you something and you don't know the answer, say so. It is much easier to say, "I don't know, but I'll find out," than it is to give a wrong answer and have to "fix it" later.

2. Remember to stay within your scope of practice. You may not work unsupervised and you may not perform services that you were not trained to do. If you feel uncomfortable with any activities or requests for service, tell your supervisor. Some personnel at your placement may not be aware of your training status.

3. You may not take verbal or telephone orders from physicians. Only licensed SLPs can do this. If a physician or nurse wants to give you an order, tell them that you are not licensed and refer them to your supervisor.

VII. Medical Records

A. Confidentiality: See the section on HIPAA. Basically, you must maintain the same confidentiality regarding your patients in off-campus settings as you maintained on-campus. This refers to any written information as well as any verbal communications with anyone not directly involved in the patient's care. This also means that as much as you would like to, you cannot discuss the "interesting case" you saw at the hospital with family, friends, significant others, etc.

B. In most medical settings, the patient chart is used by every discipline providing services to the patient. Many sites are using electronic medical records but some still use paper-based charting. Either way, you should become familiar with the organization of the chart and know where to look for information. It is very helpful to read physician, nursing and other therapists' notes to gather background information on your patient and to monitor progress. Some information that you might need from the medical chart would be:

1. Physician orders: you cannot treat the patient without the order, so check first!
2. Physician notes: usually contain something called a "History and Physical" that contains information about the patient's history and current medical issues. Also look for daily notes, which may include information about the medical intervention plan.
3. Nurses notes: includes information about current medical status, how well and how much the patient is eating, orientation and simple communication skills.
4. Radiology reports: may tell you where the CVA or tumor is located (per CT or MRI scan) or where the aspiration is (per chest x-ray).
5. Interdisciplinary notes: contains evaluations and daily notes from therapists and allied health professionals. You may need information about participation in other treatments, progress in therapy, etc.
6. Social Work/discharge planning: contains information about where the patient may go after discharge, what level of independence they will need to achieve, who the caregivers may be and what resources are available to the patient. This information will help you plan training and discharge goals.

IX. Health Insurance Portability and Accountability Act (HIPAA)

HIPAA is a federal law, enacted in 1996 and implemented in phases beginning in October 2002. Its purpose is to protect health insurance coverage for workers and their families when they change or lose jobs. As part of this law, there were several rules that were implemented that directly affect everyone working in healthcare settings. For students, the most important is the Privacy Rule. The components of the Rule that you must know and follow are:

1. A patient's consent must be obtained to use and disclose protected health information (PHI), including any information that identifies the patient (name, address and social security number, etc.).
2. PHI cannot be disclosed in any communication that is computer-to-computer (as in billing information), person-to-person, faxed or written, without prior consent for that specific transaction.
3. The patient has the right to inspect and correct their medical records and obtain a disclosure history (i.e., find out who the hospital has sent their information to).

You will all get an orientation to your placement's HIPAA compliance policies and procedures. Be aware that there are huge fines and prison time associated with violating HIPAA regulations!

Follow these links to read more about HIPAA

<http://www.asha.org/practice/reimbursement/hipaa/>

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html>

X. Universal Precautions and Infection Control

Review the information regarding general guidelines for infection control http://www.who.int/csr/resources/publications/EPR_AM2_E7.pdf provided by the World Health Organization. When you are off-campus, the rules are basically the same: when you may come in contact with bodily fluids, take the appropriate level of precaution to avoid catching or transmitting an infection. Generally, that means wearing gloves if you're doing a swallowing evaluation or oral-motor exam. However, in hospitals and other healthcare settings, you are much more likely to come in contact with persons who have known infections. These patients will usually have some kind of notice posted in their medical chart or in their room saying that extra precautions are required. Ethically, you cannot refuse to treat someone based on the fact that they have an infection. If you may be pregnant or somehow at other risk, you can decline to treat a patient with a known infection as long as there is someone else available to treat.

Appendix 1 Overview of Documentation for Medicare Outpatient Therapy Services

Documentation continues to play a critical role in evaluating the need for Medicare outpatient therapy services. Remember that documentation is usually reviewed by Medicare contract nurses, rather than speech-language pathologists (SLPs). In maintaining and submitting documentation, a SLP should not assume that the reviewer will understand why the service requires the skill of a SLP and should include additional information that may be needed by the reviewer.

When in doubt, contact the Medicare contractor and request that they provide educational models or in-service staff training on documentation. You should consider coordinating this with your state speech-language-hearing association to make the invitation more attractive to the contractor and provide access to more of your colleagues.

The Centers for Medicare and Medicaid Services (CMS) has outlined its minimal documentation requirements in the [CMS Benefit Policy Manual Publication 100-02, Chapter 15, Section 220.3 \(PDF format\)](#).

Changes in the Benefit Policy Manual may also cause changes in the contractor's Local Coverage Determinations, and SLPs should monitor their Medicare contractor's web site for additional updates. All therapy notes must be signed by the qualified professional and include the profession credentials. When a student is assisting in the provision of services, the student may write the documentation, but it is the signature of the SLP that is required to ensure that a qualified professional is providing the service.

Required Documentation

When submitting documentation to the contractor, CMS expects that the following information be provided, unless otherwise specified by the contractor:

1. **Evaluation and Certified Plan of Care**, including initial evaluation and reevaluation relevant to the episode being reviewed. An evaluation must include:
 - a diagnosis and description of the specific problem being evaluated and or treated;
 - objective measures, preferably a standardized patient assessment instrument or outcomes measurement tool related to current functional status;
 - clinician's clinical judgment or subjective impressions of the patient's condition; and
 - determination of the need for treatment.
2. **Certification.**
 - ensure that the patient is under the care of a physician
3. **Progress Reports** (when treatment exceeds 10 treatment days or 30 calendar treatment days/one month, whichever is less). The clinician must complete a

progress report at least once during each interval of treatment. The progress note should include:

- date of the beginning of the treatment interval;
- date the report was written;
- signature of the qualified professional;
- objective reports of the patient's progress;
- objective measurements of changes in status relative to current goals;
- plans for continuing treatment; and
- changes to long and short term treatment goals.

CMS provided the following example of a speech-language pathology progress note:

Example

The Plan states diagnosis is 787.2- Dysphagia secondary to other late effects of CVA. Patient is on a restricted diet and wants to drink thick liquids. Therapy is planned 3X week, 45 minute sessions for 6 weeks.

Long term goal is to consume a mechanical soft diet with thin liquids without complications such as aspiration pneumonia.

Short Term

Goal 1: Patient will improve rate of laryngeal elevation/timing of closure by using the super-supraglottic swallow on saliva swallows without cues on 90% of trials.

Goal 2: Patient will compensate for reduced laryngeal elevation by controlling bolus size to ½ teaspoon without cues 100%.

The Progress Report for 1/3/06 to 1/29/06 states:

1. Improved to 80% of trials;
2. Achieved.

Comments: Highly motivated; spouse assists with practicing, compliant with current restrictions.

New Goal: "5. Patient will implement above strategies to swallow a sip of water without coughing for 5 consecutive trials.

Mary Johns, CCC-SLP, 1/29/06."

Note the provider is billing 92526 three times a week, consistent with the plan; progress is noted; skilled treatment is noted.

4. Treatment Encounter Notes (may also serve as progress report when required information is included in the notes). The purpose of the encounter note is not to

document medical necessity, but to create a record of all encounters and skilled intervention.

- documentation is required for every treatment day, and every therapy service;
- the encounter note must record the name of the treatment, intervention or activity provided;
- total treatment time; and
- signature of the professional furnishing the services.

If a treatment is added or changed between the progress note intervals, the change must be recorded and justified in the medical record. Frequent professional judgments resulting in upgrades to the patient's activity show skilled treatment. Objective measurements showing improvement are very helpful.

If there is no improvement, explain the setbacks, illness, new conditions or social circumstances that are impeding progress and why it is believed that progress is still attainable. Activities that are repetitive or routine, or easy enough to explain to an aide or caretaker could be questioned by the reviewer.

5. Exception to Therapy Caps. The records must justify services over the cap. A separate justification statement may be included either as a separate document or within the other documents if the provider/supplier wishes to assure the contractor understands their reasoning for the use of the KX modifier.

CMS states that objective evidence consists of standardized patient assessment instruments, outcomes measurement tools or measurable assessments of functional outcomes. The agency also states that the use of objective measures at the beginning of treatment, during and/or after treatment is recommended to quantify progress and support justification for continued treatment. While such tools are not required, CMS does state that they will enhance the justification for the need of therapy.

ASHA's National Outcomes Measurement System (NOMS) was used by the CMS to help determine the range of SLP diagnoses for the Medicare therapy cap exceptions process.

Speech-language pathologists are encouraged to participate in outcomes reporting and benchmarking by becoming as NOMS-certified user. [Visit ASHA's NOMS page for more information.](#)

ASHA also has other [information that could assist in your documentation efforts.](#)

For additional information, contact ASHA's Health Care Economic and Advocacy Team at reimbursement@asha.org.

Appendix 2 Official “Do Not Use” List

Do Not Use	<i>Potential Problem</i>	Use Instead
U, u (unit)	Mistaken for “0” (zero), the number “4” (four) or “cc”	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily)	Mistaken for each other	Write "daily"
Q.O.D., QOD, q.o.d, qod (every other day)	Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "every other day"
Trailing zero (X.0 mg)*	Decimal point is missed	Write X mg Write 0.X mg
Lack of leading zero (.X mg)		
MS	Can mean morphine sulfate or magnesium sulfate	Write "morphine sulfate"
M ₂ SO ₄ and MgSO ₄	Confused for one another	Write "magnesium sulfate"

1 Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

***Exception:** A “trailing zero” may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.