REPORT OF THE
DEPARTMENT OF HEALTH PROFESSIONS
BOARD OF HEALTH PROFESSIONS

STUDY ON THE NEED TO REGULATE SPEECH-LANGUAGE PATHOLOGY ASSISTANTS

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 6

COMMONWEALTH OF VIRGINIA
RICHMOND
2000

COMMONWEALTH of VIRGINIA

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October 21, 1999

TO: The Honorable James S. Gilmore, III
Governor of the Commonwealth of Virginia

The Members of the General Assembly of Virginia

It is our privilege to present this report which constitutes the response of the Board of Health Professions to the request contained in Senate Joint Resolution 492 of the 1999 Session of the General Assembly.

The report provides the findings of the board from its Study of the Necessity of Regulating the Practice of Speech-Language Assistants. Approximately 120 hours of staff time and $1,600 in costs for meetings, a public hearing, library research, printing and mailing were expended in the process of conducting this study. The final report is available to the public on the website for the Department of Health Professions at http://www.dhp.state.va.us/.

The Board acknowledges the work of the Regulatory Research Committee and the staff who conducted the research and prepared the final report.

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VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS

VIRGINIA BOARD OF HEALTH PROFESSIONS

STUDY ON THE NEED TO REGULATE SPEECH-LANGUAGE PATHOLOGY ASSISTANTS PURSUANT TO SJR492 (1999)

September 21, 1999

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VIRGINIA BOARD OF HEALTH PROFESSIONS
DEPARTMENT OF HEALTH PROFESSIONS

Study on the Need to Regulate Speech-Language Pathology Assistants Pursuant to SJR 492 (1999)

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Acknowledgements

The members of the Board of Health Professions gratefully acknowledge the work of the staff of the Department of Medical Assistance Services and Department of Education for providing information and assisting the Board in its deliberations.

Final Recommendations of the Board of Health Professions

The Board has made the unprecedented decision to take no position regarding the need to regulate speech-language pathology assistants.

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EXECUTIVE SUMMARY

Background

Senate Joint Resolution 492(1999), patroned by Senator Jane H. Woods, directed the Board of Health Professions to evaluate the need to regulate speech-language pathology assistants and, with the aid of the Department of Medical Assistance Services, to determine the potential fiscal impact of regulating them.

Methodology

The sunrise review methodology detailed in the Board of Health Professions *Policies and Procedures for Evaluation of the Need to Regulate Health Occupations and Professions (1998)* was employed in this study. It must be noted that successful application of these methods is rooted in the following.

- The Board's ability to accurately determine the risk of harm to the public posed by the unregulated group.
- Its full understanding of the educational and training requirements for competent practice of the profession or occupation.
- Clear understanding of the level of autonomy of the practitioners of the profession or occupation.
- Comprehension of the actual scope of practice of the profession or occupation.
- An assessment of the economic impact of regulating the profession or occupation based upon economic variables which speak to costs at the level of the individual practitioner.
- Finally, its evaluation of alternatives to state regulation.

The Board undertook the following efforts to address these issues.

- It conducted a policy literature review that described what speech-language pathologists and their assistants are known to do, the established guidelines for supervision, information about the types and prevalence of communication disorders, and information about the education programs for assistive personnel in the United States.
- A survey of licensed speech-language pathologists was conducted by the Board to obtain first-hand information concerning the use of unlicensed assistants in Virginia. The survey sought to determine the prevalence of their employment to include information on the types of practices involved (i.e., public, private, or both), the geographic locations, the supervisory relationships, their specific duties, and the age group of the clients they serve.

- As part of its literature review, the Board also reviewed similar information from the Board of Audiology and Speech-Language Pathology's survey of all its licensees last year. Further, the Board sought to review the results of a Department of Education survey concerning school systems' use of paraprofessionals; however, the results were unavailable in time for the Board's report.
- Current relevant federal and state laws and regulations were examined.
- Disciplinary information was obtained from states regulating speech-language pathology assistive personnel.
- Relevant, available malpractice insurance coverage information was obtained as was court case history for malpractice of assistive speech-language pathology assistants
- Fiscal impact analysis was attempted but information from the Department of Medical Assistance Services regarding reimbursement for the activities of speech-language assistive personnel revealed that specific Medicare or Medicaid billing information on individual speech-language pathologists or their assistants does not exist in Virginia. This coupled with the fact that the Board does not know how many assistants are working in Virginia makes fiscal impact analysis unfeasible.
- Finally, the Board solicited and received public comment in writing and through a public hearing.

Results and Conclusions

Based upon information obtained, the occupation, referred to as "speech-language pathology assistant," itself, appears to lack standard definition. Although assistants are regulated in a number of other states under the direction of speech-language pathologists, there are no national private credentialing standards (as is routinely the case for groups seeking regulation) to define entry level competencies and no professionally validated job analyses to help define exactly what they do.

There is insufficient information concerning the number of practitioners and their actual duties in Virginia practice settings (including the schools). Currently, there are no education programs in Virginia, and although such programs exist in some other states, there are no accreditation standards. The American Speech-Hearing-Language Association is considering development of such standards; however, the Board was informed by the Speech-Hearing-Language Association of Virginia that they are at least two years in the offing.

Disciplinary information from other states licensing speech-language pathology assistants indicates that problems have been minimal to nonexistent. There are no known malpractice cases or liability insurance claims made as a result of the work of speech-language pathology assistants in Virginia or the nation.

Regarding financial information, according to the Department of Medical Assistance Services information, there is no available financial information relative to billing for the services of speech-language pathologists or their assistants tied to individual providers. Thus, a valid fiscal impact analysis was not possible.

National and state professional association ethical standards for speech-language pathologists exist to guide members in supervising unlicensed assistants. In Virginia, the Board of Audiology and Speech-Language Pathology also has regulations which speak directly to the supervision and use of assistive personnel by its licensees.

Malpractice insurance coverage is available to assistive personnel if they so choose. Those not privately certified by the American Speech-Hearing-Language Association may obtain coverage from their primary carrier which ranges from $1 million per event/$3 aggregate to $2 million per event/$5 million aggregate for premiums with range from $62 to $97 per year.

From public comment it was learned that the impetus for the study was a request from the Speech-Language-Hearing Association of Virginia (SHAV). They contend that regulating assistants may better protect the public, foster the development of assistants as a profession and aid their own professional development as supervisors, assist community colleges in justifying educational programs for assistants, and enable school systems to bill Medicaid for reimbursement for speech-language service provided by assistants. No speech-language pathology assistants, themselves, presented any information to the Board.

In their deliberations, the Board members held that they did not have adequate, objective insight into who (and how many) are doing what to whom and at what level of competency in Virginia. Further, they had no knowledge of any specific harm occurring in Virginia. With no empirical basis to render a rational decision, they chose to take *no position* on the issue of the need to regulate speech-language pathology assistants at this time.

VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS
VIRGINIA BOARD OF HEALTH PROFESSIONS

STUDY ON THE NEED TO REGULATE SPEECH-LANGUAGE PATHOLOGY ASSISTANTS PURSUANT TO SJR 492 (1999)

This study was conducted pursuant to Senate Joint Resolution 492 of the 1999 Session of the General Assembly (see Appendix 1) patroned by Senator Jane H. Woods to determine whether speech-language pathology assistive personnel should be regulated in Virginia. With the assistance of the Department of Medical Assistance Services, the Board attempted to evaluate the potential fiscal impact on the Commonwealth that such regulation may engender.

To govern the evaluation, the Board followed its formal criteria and policies referenced in its publication *Policies and Procedures for Evaluation of the Need to Regulate Health Occupations and Professions, 1998.* Among other things, these criteria assess the degree of risk from unregulated practice, the costs and benefits of the various levels of regulation, and the advantages and disadvantages of the various alternatives to regulation that might protect the public. By adopting these criteria and application policies, the Board has endorsed a consistent standard by which to judge the need to regulate any health profession. The aim of this standard is to lead decision-makers to consider the least governmental restriction possible that is consistent with the public's protection. This standard is in keeping with regulatory principles established in Virginia law and is accepted in the national community of regulators. These criteria and application policies are detailed in Appendix 2.

The general scope of the study was to review the competencies and standards of practice for speech-language pathology assistants in the Commonwealth and other jurisdictions to the degree that they exist. Generally, following the *Policies and Procedures*, this work attempted to answer these key questions:

- ***What is the potential risk for harm to the consumer?***
- ***What specialized skills and training do speech-language pathology assistants possess?***
- ***To what degree is independent judgment required in their practices?***
- ***Is their scope of practice distinguishable from other regulated occupations or professions?***

- ***What would be the economic impact to the public if this group were regulated?***
- ***Are there alternatives other than state regulation of this occupation which would adequately protect the public?***
- ***Finally, if the Board determines that this occupation requires state regulation, what is the least restrictive level that is consistent with the public's protection?***

In its attempt to answer these questions, the Board of Health professions undertook the following steps:

- A policy literature review was conducted which relates to trends in the practice of speech-language pathology with special emphasis on the oversight, both public and private, of speech-language pathology assistive personnel.
- Current relevant federal and states' laws and regulations are examined.
- Disciplinary information was obtained from states regulating speech-language pathology assistive personnel.
- A survey of licensed speech-language pathologists was conducted to obtain first-hand information concerning the use of unlicensed assistive personnel in Virginia. The survey sought to determine the prevalence of their employment to include information on the types of practices involved (i.e., public/private/both), the geographic locations, the supervisory relationships, the age groups of clients they serve, and their specific duties.
- Available relevant malpractice insurance coverage information was obtained.
- A review of court cases has been conducted to determine if unlicensed assistive personnel have been involved in malpractice.
- Information was obtained from the Department of Medical Assistance Services regarding reimbursement for the activities of speech-language assistive personnel. However, it must be noted that specific Medicare or Medicaid billing information on individual speech-language pathologists or their assistants does not exist in Virginia

POLICY LITERATURE

A review of the speech-language pathology literature reveals countless articles and books that focus on the more technical, clinical areas of speech-language pathology. Such technical content is beyond the scope of the current study and will not be addressed except to describe the types of communicative disorders often confronted by speech-language pathologists and their staff and the interventions they use. The review will be restricted to the policy issues that are directly germane to the Criteria:

- scope of practice issues relating to assistive personnel,
- the types and prevalence of communicative disorders,
- the role of speech-language assistive personnel and the supervisory responsibilities of speech-language pathologists; and
- assistants' educational program availability.

Discussion of the literature describing the impact on the practice of speech-language pathology posed by the recent changes in federal laws and regulations will be detailed with the description of these provisions.

Scope of Practice, or What Speech-Language Pathologists (and Assistants) Do

To provide insight into the types of duties that speech-language pathologists and their assistants perform, a description from the American Speech-Language Hearing Association and their guidelines for the use of assistive personnel is provided. To better understand what is being done in Virginia, information from recent Virginia surveys is presented.

Description

On their website entitled, *Frequently Asked Questions About the Professions*, the American Speech-Language-Hearing Association (ASHA), describes speech-language pathologists as:

> . . . help[ing] those who stutter to increase their fluency; help people who have had strokes or experienced brain trauma to regain lost language and speech; help children and adolescents who have language disorders to understand and give directions, ask and answer questions, convey ideas, improve the language skills that lead to better academic performance; counsel individuals and families to understand and deal with speech and language disorders.
>
> (Ref. ASHA, 1998, April 30)

The scopes of practice and definitions of what it means to be a speech language pathologist are provided for in state laws and regulations. The specific Virginia statutes and regulations and those for other states which regulate speech-language pathology assistive personnel are detailed later in this report under "Relevant State and Federal Laws and Regulations."

Guidelines

Not only do public laws and regulations exist to some degree for speech-language pathologists in their use of assistive personnel for a number of states, but private professional association ethical guidelines have also been developed to guide ASHA and SHAV members. ASHA's 1995 document, *Guidelines for the Training, Credentialing, Use and Supervision of Speech-Language Pathology Assistants,* essentially indicates tasks that may be performed by assistants under the supervision of a speech-language pathologist, if state law or regulation do not preclude it. The guidelines specify the conditions under which the tasks may be delegated as well as which tasks may **not** be performed by assistive personnel (i.e., they may not perform standardized or nonstandized diagnostic tests, formal or informal evaluations, or interpret test results). The Speech, Language and Hearing Association of Virginia (SHAV) (1996) developed similar guidelines. Complete copies of both position statements are included in Appendix 3.

SHAV's guidelines are divided into five sections. The first provides definitions of key words such as *speech-pathology assistants, speech-pathology aides, supervisory personnel, direct and indirect supervision, credentialing,* etc. The second section details a recommended curriculum for credentialing speech-language assistants. The third section provides recommended scopes of responsibilities for speech-language assistants and speech-language aides, respectively. The fourth section addresses ethical considerations. Finally, the fifth section provides for overall supervisory guidelines, including the credentials of the supervisory personnel, the exclusive responsibilities of the supervisor, the minimum supervision requirements of the supervisor, and that the responsibility for the individualized treatment plan is the supervisor's.

Surveys

As indicated above, speech-language pathologists' use of assistants (and in a number of states, the assistants, themselves) are guided in their practice by statute, regulation, and ethical guidelines. However, to determine whether the need exists in Virginia to regulate speech-language pathology assistants themselves is predicated on knowledge of what they are actually doing in Virginia. In an attempt to ascertain how speech-language pathology assistive personnel are actually being used *in Virginia* and in what types of situations, it was initially anticipated that such information could be gleaned from three sources of data: a survey of schools by the Department of Education conducted this year, a survey of speech-language pathologists licensed by the Board of Audiology and Speech-Language Pathology licensees conducted by the Board of Health Professions this year, and the Board of Audiology and Speech-Language Pathology's survey of its audiologists and speech-language pathologists conducted last year.

Department of Education's Survey

The Department of Education conducted a survey of the school systems in Virginia to determine how their employees who are defined as "assistive personnel" (across disciplinary areas) were being used. Because the surveys were due back in early June, it was anticipated that the results would be available for review by the Board at its meeting in September. Unfortunately, by mid-September the results were not fully analyzed by the Department of Education, and thus could not be considered by the Board of Health Professions.

Board of Health Professions Survey

The Board of Health Professions' *Survey of Unlicensed Assistive Personnel Duties* was designed to determine how many speech-language pathologists are aided by assistive personnel in Virginia and under what circumstances. Information on the following factors was sought:

- type of work setting (public, private, or both);
- geographic location;
- whether the assistive personnel are supervised and by whom,
- types of duties delegated to assistive personnel; and finally,
- the age groups receiving services from assistive personnel(0-2 years, 3-5 years, 6-12 years, 12-18 years, 19-55 years, and 56+).

It should be noted that the categories of duties for assistive personnel used in Question 7A were derived directly from the those included repeatedly in the practice acts for assistants and aides duties across states which regulate assistants. The terms used to describe duties in these statutes are not further defined in the survey instructions. Because of the broad nature of the practice of speech-language pathology and because of the seminal nature of this survey, inclusion of staff proscribed definitions was thought to be premature.

Unlike the Board of Audiology and Speech-Language Pathology's survey described below, only speech-language pathologists licensed in Virginia were surveyed. The surveys were sent to 1,929 licensees with United States addresses and were due back by August 13, 1999.
At the June 8, 1999 BHP Regulatory Research Committee meeting when the Committee was determining how the survey should be conducted,

representatives from SHAV expressed concern that licensees may be somewhat reluctant to disclose the duties that they delegate to assistants for fear of incriminating themselves. At the time it was noted that the problem with not identifying responders is that follow-up questioning is not possible. It was felt that the more serious problem would be failing to obtain responses so it was determined that anonymity would be assured respondents.

A copy of the survey and a detailed report of the results are in Appendix 4. The chief findings were as follows:

- The response rate was relatively small 34.9% (i.e., 673 licensees). For surveys of this type, a good response rate typically approaches 60%.
- Although the response rate was low, responses came from each region of the Commonwealth.
- The majority of participants responding to the Question #2 regarding practice type (n=557) indicated that they practiced in a public setting (n=370 or 73%), with the remainder practicing in private (8% or n=39) or both public and private settings (19% n=96);
- Of the 673 participants, **54 (8.1%)** indicated that assistive personnel were employed where they practiced. This group of 54 reported **184 assistants** were being utilized. The number of assistants working in any one practice setting ranged from 1 to 45, with the arithmetic mean being 2.2, the median 2, and the mode 1.
- Of the 54 responders, the majority (33 or 61%) indicated that they practiced in public settings.
- Of the 54 responders who reported that assistive personnel were used, **33** (provided any detail as to the actual types of duties performed by these staff members. All 33 indicated that assistants "implement therapy procedures," and the majority (25) indicated that they "conduct screenings."

Board of Audiology and Speech-Language Pathology Survey

Finally, as indicated in SJR 492(1999), a similar survey was conducted by the Board of Audiology and Speech-Language Pathology in 1998, entitled *Unlicensed Assistant/Aides and the Dispensing of Hearing Aids Survey*. Similar results to the Board of Health Professions survey were obtained. The 1998 survey was designed to glean demographic and opinion data on a wide variety of topics related to audiology as well as speech-language pathology (e.g., continuing education, dispensing of hearing aides, the use of assistive personnel).

111 audiologists, 127 reported using assistive personnel and provided a listing of duties describing their primary duties and responsibilities. The 1998 survey and its results are in Appendix 5.

Types and Prevalence of Communication Disorders

The U. S. Bureau of Labor Statistics (1997) has projected that growth in the professions of speech-language pathology and audiology will outpace the growth in jobs, overall. They attribute this to a rapidly growing and aging population and higher survival rates for premature infants and trauma victims who subsequently need special interventions. If current trends in health care and education continue, the Bureau posits that there will continue to be an increased emphasis on early detection and prevention of communication disorders.

Federally mandated changes (to be described elsewhere) in the requirement to identify children with communication disorders should increase enrollment in these programs and the attendant demand for speech-language pathology services.

Further, on July 1, 1995, the top ten states in the United States with populations ages 65 and above were: California, Florida, New York, Texas, Pennsylvania, Ohio, Illinois, Michigan, New Jersey, and North Carolina. These same states are projected to maintain similar rankings into the year 2015. Over the same time frame, Virginia is projected to rank between twelfth or thirteenth among states (U.S. Census Bureau, 1997a & b). Because the incidence of strokes is greatest among the senior segment of the population, absent a significant reduction in the risks associated with cardiovascular disease, the need for speech-language pathology services in this area is expected to continue for this segment of the population as well.

The term "communication disorders" as used in this report mean delays or disorders of speech or language which typically fall into three categories: voice, speech, and language. Examples of prevalent disorders which involve diagnosis and treatment by speech-language pathologists will be detailed briefly.

The National Institute on Deafness and Other Communication Disorders (NIDCD) (1999, August(a)), has estimated that more than 46 million people in the United States suffer from some form of disordered communication. Between six and eight million suffer from some form of language impairment or disorder. Over 15 million suffer from fluency disorders such as stuttering, and over 7.5 million have problems in using their voice. The National Information Center for Children and Youth with Disabilities (1997), estimates that over one million students in public school special education programs in the1994-1995 school year, alone, were categorized as having speech or language impairment.

NIDCD (1999, August(a)) has developed a information concerning prevalent voice, speech, and language disorders on its website designed to educate the general public about the existence, etiology, and treatment methods used to deal with the disorders. Topics include aphasia, communication in autism, disorders of vocal abuse and misuse, dysphagia, Landau-Kleffner Syndrome, laryngeal papillomatoses, spasmodic dysphonia, stuttering, traumatic brain injury, velocardiofacial syndrome, and vocal cord paralysis. Those involving remediation by speech-language pathologists will be detailed with NIDCD's information to provide insight into the types of conditions and patients and clients encountered. To further inform the reader, NIDCD has a glossary of health terms provided on another website: http://www.nih.gov/nidcd/health/glossary./glos1.htm (NIDCD, 1999, August (b)).

Aphasia affects the expression and/or understanding of speech. It usually occurs with sudden onset as a result of stroke or head injury but may develop more gradually as with brain tumors, and it may co-occur with other speech disorders resulting from brain damage. Approximately 80,000 persons in the United States acquire aphasia each year. The majority in their middle to late years.

Although in some incidences, a patient will recover totally without treatment, for the majority of cases, language recovery is less complete and typically occurs over a two-year period. For such cases, speech-language therapy is often beneficial. The aim of such therapy in aphasic patients is to foster the patient's use of his remaining abilities and to teach alternative methods of communication (NICDC, 1999, August (c)).

Communication in Autism. Autism is a brain disorder mostly detected in early childhood and often affects verbal and nonverbal communication. The extent and type of communication problems vary depending upon the social and intellectual development of the individual. Some patients have rich vocabularies but most have difficulty in using language effectively. Many have problems with word and sentence meaning, intonation, and rhythm. For those who can speak, they often say things that have no meaning to the listener.

The level and type of dysfunction may vary greatly from individual to individual, and no one treatment method works for all autistics. The most successful intervention occurs early during the preschool years with intensive individually tailored speech-language therapy (NICDC, 1999, August (d)).

Vocal Abuse and Misuse. Anyone from infants to seniors may develop a disoder related to vocal abuse. Laryngitis, vocal nodules, vocal polyps, and contact ulcers are the most common disorders of this type. Typically, the speech-language pathologist evaluates pitch, loudness, voice quality, and voice techniques (e.g., breathing patterns during speech). Most vocal abuse disorders are reversible with appropriate voice therapy, often involving teaching techniques to provide proper breath support and eliminating forceful voicing.

Children tend to be difficult to treat. They often find it difficult to evaluate their own speech and, thereby, change vocalizing behaviors (NIDCD, 1999, August (e)).

Dysphagia, or difficulty swallowing properly, is often the result of strokes or other nervous system abnormality or accompanying disorders that weaken or damage attendant muscles and/or nerves. Common antecedents include head injury; cerebral palsy; Parkinson's Disease; cleft palate; and cancer of the head, neck, and esophagus. Some patients have difficulty only with liquids while others may be completely unable to swallow (NIDCD, 1999, August (f)).

Dysphagia occurs when any aspect of swallowing is affected. Weak tongue or cheek muscles may cause a patient to allow food that is too large for swallowing to enter the throat and block air. Other patients may not be able to start the swallowing reflex on their own or have weak throat muscles which impede proper movement of the bolus completely into the stomach. Bits of food or portions of liquids can fall or be pulled into the trachea (i.e., windpipe) and may result in aspiration pneumonia or other respiratory infections.

Appropriate intervention primarily includes proper testing to determine which parts of the swallowing apparatus are affected. Fiberoptic laryngoscopy, video fluroscopy, and ultrasound may be employed. If surgery cannot correct the problem, a speech-language pathologist is usually brought in on the case to teach the patient new ways to eat and drink and/or swallow. For example, the person may need to learn to turn his head to one side or to look only straight ahead when swallowing. Some patients who have difficulty drinking may have to have their liquids thickened. Some may have to learn to avoid extremely hot or extremely cold food and drink. Further information on issues related to diagnosis and treatment of swallowing disorders and prevention of aspiration pneumonia in stroke patients may be found in two papers by the Agency for Health Care Policy and Research (1999, March (a) (b)).

Spasmodic Dysphonia is a voice disorder due to involuntary movement of the larynx musculature. Individuals with this disorder may have occasional difficulty speaking a word or two or may not be able to speak effectively at all. The voice often has a strained or strangled quality. The cause of this disorder is unknown; however, it frequently co-occurs with other disorders involving involuntary movement such as tremors, tardive dyskinesia, blepharospasm, and oromandibular dystonia. The diagnosis of the disorder often involves a team approach with the assistance of a speech-language pathologist. Voice therapy has reduced some symptoms, particularly in milder cases (NIDCD, 1999, August (g)).

Stuttering, also referred to as stammering, is a speech disorder in which the normal flow of speech is disrupted by repetitions or prolongations of word or syllables or by the inability to start a word. Stuttering affects individuals of all ages but occurs most frequently between age 2 and 6 years. Boys are three times more likely than girls to stutter. Most children outgrow the disorder, with estimates of less than one percent of adults affected.

Stuttering is normally diagnosed by a speech-language pathologist. The diagnosis is based on family and patient history and a complete evaluation of speech and language abilities. Interventions range from educating parents about restructuring the child's speaking environment to the use of electronic devices to help an individual control fluency (NIDCD, 1999, August (h)).

Traumatic Brain Injury and Communicative Disorders

Traumatic Brain Injury is forceful, sudden damage to the brain. Males between the ages of 15 and 24 have been at the highest risk because of violent crimes and highway accidents. However, young children and people over 75 years are also highly susceptible to head injury due to falls and physical abuse.

Approximately 200,000 people in the United States die from traumatic brain injuries, and additional 500,000 are hospitalized, and about 50,000 have mild to moderate problems which impair their independence, while another 200,000 are institutionalized or require other forms of close supervision.

The speech of a traumatic brain injury victim may be difficult or impossible to understand if the areas of the brain controlling the articulatory musculature are damaged – resulting in a condition known as dysarthria. In some instances the articulatory muscles are unaffected, but an individual may still experience apraxia – a condition in which the patient has difficulty saying words consistently. Also, as described earlier, brain injury can also lead to dysphagia.

Once a person with brain injury has become stabilized, a rehabilitation team is brought in which typically includes a speech-language pathologist. The speech-language therapist interventions include exercises to stimulate speech understanding, and if there are speech production and swallowing problems, to provide oral-motor exercises. The therapy may be provided while in the hospital, through home health agencies, and outpatient facilities (NIDCD, 1999, August (i)).

Velocardiofacial Syndrome is a genetic disorder associated with missing portions of chromosome 22. Thirty different features are associated with the disorder. However, the most common features include cleft palate, heart defects, facial abnormality, minor learning problems, and speech and feeding problems. Cleft palate is the fourth most common birth defect, affecting one in 700 births. Velocardiofacial syndrome (cleft palate and at least one other feature) occurs in approximately 5 to 8 percent of children with cleft palate. In the United States, there are approximately 130,000 individuals with the syndrome (NIDCD, 1999, August (j)).

Vocal Cord Paralysis involves one or both vocal cords not properly opening or closing. The range of symptoms can be mild to fatal. Neurological disorders such as stroke, Parkinsons Disease, and multiple sclerosis as well as trauma to the brain and neck trauma, and lung or thyroid cancer all may result in vocal cord paralysis. Vocal cord paralysis varies in its effects due to whether one or both cords is paralyzed and whether the cord(s) is open or closed. If open, the risk of aspiration pneumonia is increased. If one is closed, there may be discomfort from vocal straining as well as a horseness and loss of pitch or volume. In rare some instances in which both cords are closed, the individual suffers difficulty in breathing.

Voice therapy is effective in many cases. Voice therapy is designed to strengthen vocal cords and improve breath control. In some instances the affected individual must be relearn how to speak In instances in which a tracheotomy is required to allow breathing, the speech-language pathologist teaches the patient how to care for the breathing tube properly as well as learn how to use the voice in another way (NIDCD, 1999, August (k)).

Education Programs for Assistive Personnel

Currently, there are no accredited educational programs for speech-language pathology assistive personnel in Virginia. Two year speech-language pathology assistant programs offering a two year degree include the following as of this writing (ASHA, 1999, August 16):

Arizona:	Scottsdale Community College
California:	Evergreen Valley College
Idaho:	Idaho State University
Illinois:	Lake Land College
Massachusetts:	Salem State College
	North Shore Community College
Maine:	Kennybeck Valley Technical College
Michigan:	Baker College of Muskegon
North Carolina:	Caldwell Community and Technical Institute (Hudson)
	Cape Fear Community College (Wilmington)
	Fayetteville Technical Community College (Fayetteville)
	Southwestern Community College (Sylvia)
New Hampshire:	New Hampshire Community Technical College

Colleges that are *developing or considering developing* speech-language pathology assistant programs as of June 1999 are:

Arizona:	Arizona Western College
	Northland Pioneer College
California:	California State University
	Evergreen College
	Evergreen Valley working with San Jose State
	Irvine Valley College
	Long Beach City College
	Orange Coast College
	Pasadena City College
	Saddleback Valley College
	Santa Ana College
Connecticut:	Manchester Community Technical College
Florida:	Nova Southeastern University
Georgia:	Emanuel College
Iowa:	Covenant Medical College
	University of Northern Iowa
Illinois:	College of DuPage
	Elmhurst College
	Lakeland College
	Parkland College
	Provena - UMC
	Sauk Valley Community College
	South Suburban College
Indiana:	Indiana University

Kansas:	Wichita State University
	Fort Scott Community College
Louisiana:	Delgado Community College
Massachusetts:	Springfield Community College
Michigan:	Northern Michigan University
Minnesota:	Riverland Community College
Missouri:	Penn Valley Community College
New York:	College of St. Rose
	Iona College
	Marymount Manhatten College
	Rockland Community College
	Suffolk County Community College
North Carolina:	Forysyth Technical Community College (Winston-Salem)
	North Carolina Community College System (Raleigh)
	Southwestern Community College (Sylva)
	University of North Carolina (community college program for communication assistants)
Ohio:	Kettering College of Medical Arts
Pennsylvania:	Keystone College
	Westmoreland Community College
Texas:	Hardin-Simons University
	Palo Alto College
Virginia:	Mountain Empire Community College
	Thomas Nelson Community College
Washington:	Edmonds Community College
	Shoreline Community College
	University of Washington
Wisconsin:	Concordia College
	Northeast Wisconsin Technical College

In Virginia, two community colleges are conducting or have conducted feasibility studies for such programs. For example, Mountain Empire Community College in the southwest part of the state commissioned such a study conducted from January to March of this year (Darnell, 1999). Information was gleaned from local potential employment sources, and question topics ranged from their assessment of the need for assistants in the community to the types of support the education program could expect from survey responders. Based upon the responses from four local school systems and 13 area speech and hearing service agencies and upon growing competition for students from community colleges in other states, the study's consultant concluded that a program in this area of Virginia should be developed as quickly as possible.

As of the writing of this report, although several programs have been developed and numerous others are under consideration in several states, no formalized certification policies for credentialing such programs have been finalized by ASHA or any other entity. ASHA has developed a committee dedicated to developing consistent criteria for program evaluation and accreditation. Based upon public comment received at the August 24, 1999 public hearing (see Appendix 8) and verification from ASHA, it is anticipated that the work on this project will not reach fruition for at least two years.

RELEVANT STATE AND FEDERAL LAWS AND REGULATION

The following will describe how the practice of speech-language pathology is defined in Virginia and in other states, with a focus on of how the states, including Virginia, address the use of speech-language assistive personnel.

Federal regulatory issues will be discussed next by examining the implications of the *Individuals with Disabilities Education Act* (1997) and new Medicare policy which shifts reimbursements for nursing home patients' care from an actual cost basis to one based on a per diem formula. This policy also has placed a joint cap of $1,500 for reimbursement of speech-language pathology and physical therapy services for outpatients, regardless of their rehabilitative status.

Relevant Virginia Statutes and Regulations

Board of Audiology and Speech Language Pathology

Section 54.1-2600 of the *Code of Virginia* legally sets forth the definition of what constitutes the practice of speech-language pathology and who may engage in that practice.

> "Practice of speech-language pathology" means the practice of facilitating development and maintenance of human communication through programs of screening, identifying, assessing and interpreting, diagnosing, habilitating and rehabilitating speech-language disorders, including but not limited to:
> 1. Providing alternative communication systems and instruction and training in the use thereof;
> 2. Providing aural habilitation, rehabilitation and counseling services to hearing-impaired individuals and their families;
> 3. Enhancing speech-language proficiency and communication effectiveness; and
> 4. Providing audiologic screening.
>
> Any person offering services to the public under any descriptive name or title which would

indicate that professional speech-language pathology services are being offered shall be deemed to be practicing speech-language pathology.

"Speech-language pathologist" means any person who engages in the practice of speech-language pathology.

Section 54.1-2603 requires a valid license for this practice; however, exemptions to licensure are found in §54.1-2601 of the *Code* in that the law does not:

1. Prevent any person from engaging, individually or through his employees, in activities for which he is licensed or from using appropriate descriptive words, phrases or titles to refer to his services;

2. Prevent any person employed by a federal, state, county or municipal agency, or an educational institution as a speech or hearing specialist or therapist from performing the regular duties of his office or position;

3. Prevent any student, intern or trainee in audiology or speech-language pathology, pursuing a course of study at an accredited university or college, or working in a recognized training center, under the direct supervision of a licensed or certified audiologist or speech-language pathologist, from performing services constituting a part of his supervised course of study;

4. Prevent a licensed audiologist or speech-language pathologist from employing or using the services of unlicensed persons as necessary to assist him in his practice.

The Board of Audiology and Speech-Language Pathology's regulations allow two routes to licensure:

(1) the applicant must hold a valid, current Certificate of Clinical Competence (CCC) in speech-language pathology from the American Speech-Language-Hearing Association (ASHA) and has passed the qualifying examination or held employment in the practice of speech-language pathology for one of the past three years or two of the last consecutive five years,

OR

(2) the applicant must hold a master's or doctoral degree from a program accredited by ASHA and have passed a Board approved qualifying examination within the last three years or been actively engaged in the practice of the profession during the 24 months immediately preceding application.

(*Reference: 18 VAC 30-20-170*)

Although Virginia does not regulate individual speech-language pathology assistants, themselves, it must be noted that ***supervision*** of unlicensed assistive personnel is addressed through the Board of Audiology and Speech Language Pathology's general regulations. Section 18 VAC 30-20-10 of the regulations provide that:

" Supervision" means that the audiologist or speech-language pathologist is responsible for

the entire service being rendered or activity being performed, is available for consultation, and is providing regular monitoring of clinical activities and competencies of the person being supervised.

Further, § 18 VAC 30-20-240 specifically details supervisory responsibilities for unlicensed assistants in that Subsections A.1 and B. provide:

A licensed audiologist and speech-language pathologist shall provide supervision to unlicensed assistants shall be held fully responsible for their performance and activities and shall ensure that they perform only those activities which do not constitute the practice of audiology or speech-language pathology and which are commensurate with their level of training.

The identity of the unlicensed assistant shall be disclosed to the client prior to treatment and shall be made apart of the client's file.

Also, Subsections 8 and 15 of § 18 VAC 30-20-280 describe those activities of the supervisor which constitute unprofessional conduct for which the Board may take disciplinary action:

Failure to supervise persons who assist them in the practice of speech-language pathology and audiology as well as failure to disclose the use and identity of unlicensed assistants;

Aiding and abetting unlicensed activity.

Department of Education

For over twenty years, local school divisions (and other public agencies) have been required to provide free and appropriate educational services in the least restrictive environment to children with disabilities aged 2 to 21 years. To meet these and other demands (e.g., gifted children and foreign language speakers), the teaching profession has evolved a system of certifications and licensure in specialized areas. The Virginia Department of Education provides for such specialized licensure of their own speech-language pathologists.

The following relevant terms are defined in Department of Education regulations:

§8 VAC 20-80-10 Definitions:

"Children with disabilities" means those children evaluated, in accordance with this chapter, as having autism, deaf-blindness, a developmental delay, a hearing impairment which may include deafness, mental retardation, multiple disabilities, an orthopedic impairment, other health impairment, a serious emotional disturbance, a severe or profound disability, a specific learning disability, a speech or language impairment, a traumatic brain injury, or a visual impairment which may include blindness, who because of these impairments, needs special education and related services.

"Speech or language impairment" means a communication disorder, such as stuttering, impaired articulation, a language impairment, or voice impairment, which adversely affects a child's educational performance.

"Speech-language pathology" includes:

1. Identification of children with speech or language disorders;

2. Diagnosis and appraisal of specific speech or language disorders;

3. Referral for medical or other professional attention necessary for the habilitation of speech or language disorders;

4. Provisions of speech and language services for the habilitation or prevention of communicative disorders; and

5. Counseling and guidance of parents, children, and teachers regarding speech and language disorders.

Section 8 VAC 20-21-450, entitled "Special education speech-language disorders preK-12" provides:

A. The Virginia Department of Education has received approval from the Office of Special Education Programs for an extension to the year 2005 for full implementation of the master's degree requirement for licensure of speech-language pathologists. Individuals with a baccalaureate degree in speech-language pathology may be licensed provisionally to provide speech-language services until 1999. The following requirements must be met within the three-year period of the provisional licensure:

1. Obtain a passing score on the professional teacher's assessment;

2. Complete course work in professional studies;

3. Successfully complete 6 graduate hours of course work in the areas of articulation/phonology;

4. Be admitted to a graduate program in speech-language pathology.

B. The program in special education speech-language disorders preK-12 will ensure that the candidate has demonstrated the following competencies:

1. Understanding of the knowledge, skills, and processes of communication, oral and written, as defined in the Virginia Standards of Learning and how these are interrelated in forming a sound foundation for the understanding of speech and language acquisition.

2. Understanding the knowledge, skills, and processes of:
a. Normal development and the use of speech, voice, hearing, and language; and
b. Basic sciences (biology and physics) and the basic communication sciences (acoustics, physiological processes of speech, hearing and linguistics).

3. Understanding of current principles, procedures, techniques, and instruments in:
a. The evaluation of speech, language, voice, and hearing;
b. Psycho-educational assessments; and
c. Research design.

4. Understanding of the knowledge, skills, and processes of:
a. Various types of disorders of speech, language, voice and hearing classifications, causes and manifestations; and
b. Relationships among speech, language, voice and hearing problems, especially multiple disabling conditions.

5. Understanding of the knowledge, skills, and processes of the principles of remedial procedures and instrumentation in the habilitation, prevention and rehabilitation of disorders of articulation, language, fluency, voice, resonance, and hearing.

6. Understanding of the knowledge, skills, and processes of the evaluation and treatment of disorders of the oral and pharyngeal mechanisms as they relate to communication, including but not limited to dysphasia.

7. A level of knowledge and skill in the use of alternative communicative devices, modes of communication and appliances that facilitate communication.

8. Understanding of the knowledge, skills, and processes of service delivery and instruction,including:
a. Organization and administration of public school programs to provide services for persons with speech-language disorders; and
b. Services available from related fields for those with communication disorders.

9. Understanding of the knowledge, skills, and processes for educating special populations,including:
a. Historical perspective;
b. Characteristics of learners: developmental and cognitive;
c. Medical aspects;
d. Linguistic/multicultural aspects;
e. Family aspects; and
f. Program evaluation.

10. Understanding of the knowledge, skills, and processes involved in the legal aspects associated with students with disabilities, including:
a. Legislative and judicial mandates related to special education;
b. Legal decisions related to persons with disabilities;
c. Advocacy and self-determination;
d. Guardianship;
f. Behavior management; and
g. Disciplinary practices, policies and procedures, and alternative placements/programs in schools.

11. The ability to understand and manage behavior, including:
a. Behavior support systems;
b. Individual planning; and
c. Research in current practice.

12. Understanding of the current knowledge and scope of the profession and sensitivity to issues of diversity.

13. Completion of 375 clock hours of direct client contact, of which 100 must be in a supervised educational setting and a minimum of 200 clock hours must be in speech-language pathology. These clinical clock hours will be distributed in each of the following areas: diagnosis, management of language disorders, management of voice disorders, management of articulation disorders, management of fluency disorders, and audiology.

C. Endorsement requirements. The candidate must have:

1. An earned master's degree in speech-language pathology from an accredited institution; or
2. A current license in speech pathology issued by the Virginia Board of Examiners for Audiology and Speech Pathology.

Other Virginia Statutes and Regulations

Other Virginia statutes and regulations relating to speech-language pathology, the current use of speech-language pathologists, and their reimbursement by the Commonwealth include Section 32.1-326.3 of the *Code of Virginia*, as well as others to be detailed as follows.

Section 32.1-326.3 of the *Code of Virginia* references the Department of Medical Assistance Services working in cooperation with the Department of Education to examine and revise, as necessary, the regulations relating to the funding and components of special education services. The section details coordination of the services delivered by school divisions as special education health services providers participating in the Medicaid program. This statute requires that the Director of the Department of Medical Assistance Services or his designee and the Superintendent of Public Instruction or his designee to develop and execute a memorandum of agreement relating to special education health services. The memorandum serves to summarize the school division's responsibilities relative to the federal Individuals with Disabilities Education Act (IDEA) (to be discussed in more detail in the next section). A copy of the most recent memorandum of agreement was not available at the writing of this report.

Numerous references in Department of Medical Assistance Services regulations are made to speech-language pathology services, including the requirement for licensure by the Board of Audiology and Speech-Language Pathology, and other qualifications for Medicaid reimbursement when patients are in a variety of treatment settings including acute care, long-term care, nursing facilities, and school settings. The following provide a sampling.

Regulation Section	Relating to Treatment Setting/Patient Need
12 VAC 30-130-10	Outpatient rehabilitative services

12 VAC 30-130-120	Long-stay acute care hospital services requiring a services by a speech-language pathologist licensed by the Board of Audiology & Speech Language Pathology
12 VAC 30-130-210	Speech-language pathology services are denoted as "specialized services" that are to be provided by nursing facilties.
12 VAC 30-130-40	Provides for services for individuals with speech. . . and language disorders provided by or under the supervision of a speech pathologist in a wide variety of settings hospital outpatient service, nursing facility service, home health service, rehabilitation agency; by a school division employing a qualified speech-language pathologist. . . or when otherwise included as an authorized service by a cost provider who provides rehabilitation services. Effective September 1, 1990, Virginia Medicaid stopped making reimbursement to providers of speech-language pathology services for Medicaid recipients residing in long-term care facilities. Reimbursement for these services is now included as a component of the nursing facility's operating cost. Speech-language pathology services are those furnished a patient when the following conditions are met: they are specifically related to an active written treatment plan designed and personally signed and dated by a physician after needed consultation with a speech-language pathologist licensed by the Board of Audiology and Speech-Language Pathology (unless exempted from licensure requirement by federal law, IDEA'97.

12 VAC 30-130-530	Hospice services to include speech-language pathology rehabilitation services (licensure by the Board of Audiology and Speech-Language Pathology specifically required)

Section 22.1-213 of the *Code* involves definitions used by the Department of Education in remediation of children with disabilities. *Speech pathology* is included in the definition of "related services" which include transportation. developmental, corrective and other supportive services that are required to assist a disabled child to benefit from special education.

A description of the Department of Medical Assistance Services' regulations and policies on speech-language pathology services will be further discussed under the Fiscal Information section of this report.

Table 1., "State' Regulation of Speech-Language Pathology Support Personnel," on page 24, shows how states codes describe assistive personnel and how they are regulated. It should be noted that the categories are based upon how respective states' laws employ the terms *licensure* and *regulation*, not as the Board of Health Professions's *Policies and Procedures* defines them (see Appendix 1). To assist the reader in determining the level of regulation actually involved in each case, he should reference the *Policies and Procedures'* definitions when reviewing the information in Table 1 and the actual code and regulation cites provided in Appendix 6.

Across the states that regulate speech-language pathology assistants in some form, there exists a wide variety of educational background requirements and supervisory relationships. Also titling of the occupation ranges from "assistants" to "aides" to "support personnel."

Disciplinary Information from Other States

Disciplinary information from states indicate that they *license* speech-language pathology assistive personnel (see Table 1 on page 24) was solicited through interviews and freedom of information requests . The following are the results obtained at the writing of this draft:

Connecticut (support personnel) - Although statute allows for licensure of assistive personnel, none are regulated currently.

Florida (assistants) - Over 800 are currently licensed; precise disciplinary data not available at this time. They are overhauling their computer system. However, the Robert Taylor (850/487-9652) with the Agency for Health Care Administration indicated that he believed that **extremely few** complaints or closed cases existed because the normal target of investigations is with the speech-language pathologist.

Kentucky (assistants) - Currently, there are 103 "interim" speech-language pathology assistants. Interim assistants are classified as such during their first year of work. After their first year, they may be recommended for full licensure and permitted to work without direct supervision in some instances. There are 104 active, permanent speech-language pathology assistants. **In the past 16 years, there has been no disciplinary cases involving assistants.**

Louisiana (assistants) – They license 144 speech-language pathology assistants and have 78 provisionally licensed assistants. The provisional status is conferred with 100 clinical practicum hours and a bachelors degree in speech-language pathology. They have three years to obtain 125 of on-the-job training to apply for full licensure as an assistant which requires 225 hours of OJT with a bachelors. There have been **no disciplinary cases** for either category of speech-language pathology assistant.

Ohio (aides) - Currently, there are approximately 70 speech-language pathology aides licensed. Amy Rozanecki, Investigator with the Board reported that there are no disciplinary cases which involve speech-language pathology aides. She indicated that what usually happens is that non-licensed aides are found working and the supervisor is usually disciplined for it. In the past two years, they have had only one of these cases, and it involved an audiology aide. To her knowledge, there have **never been any cases** involving speech-pathology aides

Oklahoma (assistants) - They have five licensed speech assistants and two applicants. Debbie Tiehen, Secretary for the Board of Examiners for Speech-Language Pathology and Audiology, said that the state's attorney general's office reports **no complaints filed** with the board regarding speech assistants.

South Carolina (assistants) - Six assistants currently hold a license. One assistant's license has expired since December of 1997 when they began regulating this group. There have been **no disciplinary cases**.

Texas (assistants) - As of July 15, 1999, 821 speech-language assistants were licensed. They have had **10 complaints, since 1996.** No nature or disposition data were available as of the date of this draft.

Utah (aides) – Office staff indicated that speech-language pathology aides fall under the title of "health care assistant." Requirements for these assistants include graduation from an accredited high school or GED, and registration as a "health care assistant." Health care assistants can be in acute care, birthing centers, or abortion clinics. The licensing **bureau does not track disciplinary information specifically on speech-language pathology aides.**

Malpractice Insurance Information

SJR 492 (1999) requires an analysis of the potential fiscal impact that regulating speech-language pathology assistants would cause. To that end, information concerning malpractice premiums, coverage, and claims data was sought from the presumed primary carrier in Virginia through the American Speech-Language-Hearing Association, Al Wohlers Insurance.

Annual premiums for speech-language pathologists who are not privately certified by ASHA apply to assistive personnel as follows. For coverage of $1 million per event and $3million aggregate, the premium is $62 per year. For coverage of $1 million per event and $5 million aggregate, the premium is $84. For $2million per event and $5 million aggregate coverage, the premium is $97. Graduate students are covered for $1 million per event and $3 million aggregate with a $35 premium.

Initial results (as of August 8, 1999) of the Board's Survey of Unlicensed Assistive Personnel Duties, described in detail elsewhere in the report, indicates that fewer than 130 individuals are practicing as assistive personnel in Virginia. There are 1,930 speech language pathologists licensed in Virginia, with 1,526 reporting in-state addresses.

As of late July 1999, no malpractice claims had been paid for the practice of assistive personnel.

Review of Court Case History for Malpractice by Assistive Personnel

A review of Virginia Circuit, Virginia Supreme, Federal Circuit, and Federal Supreme Court case history revealed no cases that cite malpractice by speech-language pathology assistive personnel.

TABLE 1. STATES' REGULATION OF SPEECH-LANGUAGE PATHOLOGY SUPPORT PERSONNEL

LICENSURE (10)

Connecticut (support personnel)	Ohio (aides)
Florida (assistants)	Oklahoma (assistants)
Kentucky (assistants)	South Carolina (assistants)
Louisiana (assistants)	Texas (assistants)
Missouri (assistants and aides)(beginning 1999)*	Utah (aides) *

CERTIFICATION (0)

None

REGISTRATION (16)

Alabama (assistants)	Mississippi (aides)
Arkansas (assistants and aides)	Montana (aides)
California (aides)	Nebraska (communication assistants)
Delaware (aides)	North Carolina (assistants)
Georgia (aides)	Rhode Island (aides)
Indiana (aides)	Tennessee (assistants)
Iowa (assistants)	West Virginia (assistants)
Maine (assistants and aides)	Wyoming (aides)

OTHER FORMS OF REGULATION (4)

Maryland (assistants) Board has authority to regulate assistants (regulations being developed)
New Hampshire (assistants) regulated via supervisors
New Mexico (apprentices) regulated via supervisors
Wisconsin (assistants) monitored via supervisors

NO STATUTORY REGULATION (21)

Alaska	Nevada
Arizona	New Jersey
Colorado	New York
District of Columbia	North Dakota
Hawaii	Oregon
Idaho	Pennsylvania
Indiana	South Dakota
Illinois	Vermont
Massachusetts	Virginia
Michigan	Washington
Minnesota	

*Reported as licensure in American Speech-Language Hearing Association (1999, June) *State regulation of audiology and speech-language personnel: State policy team.*

Relevant Federal Statutes and Regulations

IDEA'97

The *Individuals with Disabilities Education Act Amendments of 1997(IDEA'97)* provides for eligible children with disabilities to have available to them special education and *related services* (such as speech-language pathology services) designed to address their unique educational needs. *IDEA'97*s categories of disabilities addressed by the schools include: autism, deaf-blindness, deafness, hearing impairment, mental retardation, multiple disabilities, orthopedic impairment, other health impairment such as limited strength or alertness, serious emotional disturbance, specific learning disability, visual impairment, including blindness, traumatic brain injury, and speech or language impairment (IDEA'97; National Information Center for Children and Youth with Disabilities, 1999).

As defined in IDEA'97, speech-language pathology services include:

> (i) Identification of children with speech or language impairments;
> (ii) Diagnosis and appraisal of specific speech or language impairments;
> (iii) Referral for medical or other professional attention necessary for the habilitation of speech or language impairments;
> (iv) Provision of speech and language services for the habilitation or prevention of communicative impairments; and
> (v) Counseling and guidance of parents, children, and teachers regarding speech and language impairments.

According to IDEA'97, *speech or language impairment* "means a communication disorder, such as stuttering, impaired articulation, a language-impairment, or a voice impairment, that adversely affects a child's educational performance" (ref. P. L. 105-17 §300.7(11)).

IDEA'97 represents the fifth set of amendments to the *Education for All Handicapped Children Act* (P. L. 94-142) of 1975 which became the core of federal funding for special education and which mandated a free appropriate education for all children with disabilities.

Amendments in 1986 (P. L. 99-457) mandated services for preschoolers and established a program (known as Part H--Infants and Toddlers with Disabilities) to aid states in developing comprehensive, multidisciplinary, and statewide systems of early intervention services for infants. Amendments in 1990 (P. L. 101-476) renamed the law Individuals with Disabilities Education Act and expanded the discretionary programs, mandated transition services, and added traumatic brain injury and autism to the list of categories of disabilities in children and youth which made them eligible for special education and related services. In 1992 (P. L. 102-119), the amendments primarily addressed infant and toddler interventions.

The issues of greatest relevance to the current study addressed through IDEA'97 (signed into law on June 4, 1997) relate to professional standards and the use and training of paraprofessionals and to criteria for evaluation of the students.

Under prior versions of IDEA, each state must ensure that personnel were appropriately trained, establish and maintain personnel standards, specify steps it intended to take to retrain or hire personnel to meet state standards when its current personnel did not meet the highest state standards for a specific profession. In addition to these requirements, IDEA'97 added two provisions:

- States may use paraprofessionals and assistants to assist in providing "related services" when appropriately trained and under appropriate supervision.
- Where there are shortages of adequately trained personnel, states may adopt a policy to allow hiring the most qualified available. Such persons hired who are making satisfactory progress toward completing applicable course work, have three years to complete the courses to meet the State standards (ref. IDEA'97).

In evaluating the specific needs of the children, IDEA '97 now requires that children aged 3 through 9 with suspected developmental delays (as defined by the state), to include communicative development, be evaluated -- previously the age range was 3 to 5. Parental participation in the evaluation is to be greater than in the past, informed parental consent must be obtained for re-evaluations (to determine if a disability still exists). The evaluations, which are conducted by teams, must not now only gather relevant information about the child as it relates to education but relevant overall functional and developmental information. (National Information Center for Children and Youth with Disabilities, 1999).

Thus, IDEA'97 increases the responsibility for schools to evaluate children to include developmental (not only instructional) capabilities and needs and to do so over a larger age range (i.e., age 3 to 9) and allow for schools (under certain provisions) to use paraprofessionals under the supervision of professionals to assist in the evaluation and remediation of children with disabilities.

$1,500 Cap

Portions of the Balanced Budget Act of 1997 (BBA) were designed to limit the growth in Medicare costs for outpatient rehabilitation. Section 4541 (c) expands the concept of a spending cap to all rehabilitation outpatient settings, except hospitals. Such a cap has been in place for physical therapists and occupational therapists who billed Medicare as independent practitioners. The resulting statute that ultimately affects speech-language pathology services directly is Public Law 105-33 and its interpretation by the Health Care Financing Administration (HCFA). HCFA has deemed that the $1,500 cap referenced for physical therapy services also applies to speech-language pathology services. Thus, the *total* allowable payment for either physical therapy, speech-language services, *or both* is capped at $1,500, while another rehabilitative service, occupational therapy, has its own $1,500 cap.

According to ASHA (1999), this view is significantly different from the interpretation in 1972 that added speech pathology as a rehabilitation benefit. ASHA reports:

> The Health Care Financing Administration (HCFA) interpreted the legislative rehabilitation agency amendment that added "speech pathology services" as a rehabilitation benefit, even though there is a separate definition in the statute (Section 1861(ll) of the Social Security Act) for speech-language pathology services.
>
> . . . In 1972, outpatient speech-language pathology services were incorporated within the only reference to Medicare-certified rehabilitation agencies that was found in the outpatient physical therapy section (Section 1861(p)) of the Medicare statute.

ASHA cites specific concerns related to the $1,500 cap on outpatient rehabilitation services for Medicare patients. A chief concern noted is that senior citizens in long-term care facilities who have speech rehabilitative needs beyond those covered by the $,1500 limit having to seek services through hospitals, rather than where they reside or in less expensive settings such as rehabilitation agencies, independent practitioners and comprehensive outpatient rehabilitation facilities.

They cite further concern over the potential need for patients and their families to ration the $1,500 between two, now competing, but often jointly needed types of care.

In addition to the cap, effective January 1 of this year (the same date that the $1500 caps went into effect), all outpatient rehabilitation services no longer were reimbursed based upon cost but upon a resource-based relative value formula tied to the Medicare Fee Schedule for physicians. ASHA contends that this move alone would reduce expenditures for speech-language services and obviate the need for the $1,500 joint cap, given that speech-language pathology services only account for 9 percent of Medicare's outpatient rehabilitation expenditures, and the history of fraud has been negligible compared with other rehabilitation services (ASHA, 1999)

Based upon concerns raised by ASHA and consumer groups, several legislative proposals are being considered at the writing of this draft.

FISCAL IMPACT

Reliable information pertaining to how regulation of assistive personnel may fiscally impact Virginia has been the most difficult to obtain. Discussion on this topic at this point is purely speculative.

Information on cost to the state, itself, is particularly problematic. Because the billing system used by the Department of Medical Assistance Services does not track individual therapists (only rehabilitation providers), they cannot reasonably parse out cost data relative to speech-language pathology services provided by individuals. See Appendix 7 for a detailed description of the current policies and response from staff to the inquiry for information on reimbursement policies relative to speech-language pathology. It should be noted that reimbursement for services is only allowed if the services are provided by someone licensed (or certified) in Virginia; currently, assistive personnel's activities cannot be reimbursed. Other third-party payors have not responded to a request for reimbursement information at the writing of this draft.

In terms of cost to employers, information on the salaries of licensed speech-language pathologists in Virginia and in the nation is readily available, but such data on assistive personnel are nonexistent currently.

Based upon the data obtained from other states and literature search sources, their numbers appear to be small relative to speech-language pathologists, and there is no known organizational body representing assistants/aides, themselves. Further, the results of the Board of Audiology and Speech-Language Pathology's survey last year, and initial results of the Board of Health Professions' survey this year appear to indicate that there are less than 200 speech-language pathology assistants or aides currently in Virginia. With such small numbers, without an educational program in Virginia, the likelihood that assistive personnel will increase substantially in the immediate future is small, and given that no reliable information is available to extrapolate from nationally or on a state level, cogent financial analysis cannot be provided at this time.

PUBLIC COMMENT

Public comment was solicited in writing and during a public hearing held on August 24, 1999. A summary of the comment is included as Appendix 8. The majority of comment from members of SHAV and their consultant from the national association was in favor of regulating assistants through registration in a manner similar to the system in North Carolina.

POLICY OPTIONS CONSIDERED AND FINAL RECOMMENDATION

When attempting to employ the Criteria as called for in the *Policies and Procedures*, the Board became stymied due the inability to apply the Criteria to the available evidence as is normally the case. The methologies recommended in the *Policies and Procedures* were designed to review petitions for state regulation from the professions seeking regulation, themselves. In such instances, the group has been well organized, with accredited educational programs, national entry examinations, at least anecdotal evidence of harm which might be attributable to lack of regulation, and other indications of professional cohesiveness.

In this situation, no speech-language pathology assistant nor any representative of assistants presented information regarding any of the Criteria. However, SHAV, the state association of speech-language pathologists, as well as their consultants indicated that they are seeking the regulation of assistants for the following reasons:

- to better protect the public,
- to foster development of the assistants as a profession and of their own profession in a more supervisory role,
- to enable community colleges to justify speech-language pathology assistant educational programs, and
- to enable school systems to bill for Medicaid reimbursement for speech-language services pursuant to IDEA'97.

Currently, services provided by Department of Education licensees who are not also licensed by the Board of Audiology and Speech-Language Pathology are not reimbursed. It should be noted that although regulations are being developed by the Board of Audiology and Speech-Language Pathology to provide for reciprocal licensure for Department of Education licensees, this reciprocal license is predicated upon practice only being allowed in the schools. SHAV members speculated at the September 15, 1999 meeting of the Board that Virginia's Medicaid payors would be unwilling to reimburse those with only a reciprocal license with the Board of Audiology and Speech-Language Pathology licensure by the Board of Audiology and Speech-Language Pathology).

Against the above backdrop and upon consideration that :

- no national credentialing standards exist for assistants; no professional job analyses were available on assistants to help formally define their duties and needed competencies.
- no current educational programs exist in Virginia, and although they do in other states, accreditation standards have yet been developed for such programs; such standards are at least two years away from finalization by ASHA.
- Little in the way of reliable information on the actual number and actual duties of assistants practicing in Virginia exists. We can only rely on Board of Health Professions and Board of Audiology and Speech-Language Pathology survey findings which are anonymous and allow no follow-up with responders. The results of the Department of Educations' survey of its own use of assistive personnel was unavailable at the writing of the report.

the Regulatory Research Committee determined, with the full Board concurring, that it had insufficient information to apply to Criteria. They rejected the policy options presented at the September 15, 1999 meetings (see Appendix 9), and they took the unprecedented stance of taking no position because of lack of sufficient information to make a decision.

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Appendix 1

SENATE JOINT RESOLUTION NO. 492 (1999)

Requesting the Board of Health Professions, with the assistance of the Department of Medical Assistance Services, to study the necessity of regulating the practice of speech-language pathology assistants.

Agreed to by the Senate, February 4, 1999
Agreed to by the House of Delegates, February 15, 1999

WHEREAS, speech-language pathology assistants are employed in the public schools, rehabilitation facilities, and hospitals; and

WHEREAS, 21 percent of licensed speech-language pathologists and audiologists in the Commonwealth who responded to the May 14, 1998, survey conducted by the Board of Audiology and Speech-Language Pathology indicated that they use unlicensed assistants and aides to conduct screenings, treat patients, and repair hearing aids; and

WHEREAS, 72 percent of licensees responding to the Board of Audiology and Speech-Language Pathology survey on May 14, 1998, believe that assistants and aides should be licensed due to liability concerns, to ensure the continuation of quality services, and to protect such assistants and aides from exploitation by employers; and

WHEREAS, according to a 1995 national survey by the American Speech-Language-Hearing Association, communication assistants and aides are being used to perform speech-language screenings in the public schools; and

WHEREAS, several states now require formal credentialing for speech-language-hearing assistants; and

WHEREAS, formal training programs and credentialing requirements for speech-language-hearing assistants are being established by the American Speech-Language-Hearing Association; and

WHEREAS, there are presently no state standards for the qualifications or competency of speech-language pathology assistants and aides; and

WHEREAS, in the Commonwealth, there is presently no regulation of speech-language pathology assistants and aides, while physical therapy assistants and occupational therapy assistants are regulated; and

WHEREAS, speech-language pathology assistants conduct speech-language screenings, follow documented treatment plans or protocols, document patient-client progress, assist during assessments, prepare materials, perform clerical duties, schedule activities, prepare charts and records, perform checks and maintenance of equipment, and participate in research projects, in-service training, and public relations programs under the direction and supervision of qualified speech pathologists; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Board of Health Professions, with the assistance of the Department of Medical Assistance Services, be requested to study the necessity of regulating the practice of speech-language pathology assistants. In conducting the study, the Board shall determine the fiscal impact of any such regulation, including the benefits in receiving additional Medicaid reimbursement.

All agencies of the Commonwealth shall provide assistance to the Board of Health Professions, upon request.

The Board of Health Professions shall complete its work in time to submit its findings and recommendations to the Governor and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Appendix 2
VIRGINIA BOARD OF HEALTH PROFESSIONS
CRITERIA FOR EVALUATING THE NEED FOR REGULATION

Initially Adopted October, 1991
Readopted February, 1998

Criterion One: Risk for Harm to the Consumer
The unregulated practice of the health occupation will harm or endanger the public health, safety or welfare. The harm is recognizable and not remote or dependent on tenuous argument. The harm results from: (a) practices inherent in the occupation, (b) characteristics of the clients served, (c) the setting or supervisory arrangements for the delivery of health services, or (d) from any combination of these factors.

Criterion Two: Specialized Skills and Training
The practice of the health occupation requires specialized education and training, and the public needs to have benefits by assurance of initial and continuing occupational competence.

Criterion Three: Autonomous Practice
The functions and responsibilities of the practitioner require independent judgment and the members of the occupational group practice autonomously.

Criterion Four: Scope of Practice
The scope of practice is distinguishable from other licensed, certified and registered occupations, in spite of possible overlapping of professional duties, methods of examination, instrumentation, or therapeutic modalities.

Criterion Five: Economic Impact
The economic costs to the public of regulating the occupational group are justified. These costs result from restriction of the supply of practitioner, and the cost of operation of regulatory boards and agencies.

Criterion Six: Alternatives to Regulation There are no alternatives to State regulation of the occupation which adequately protect the public. Inspections and injunctions, disclosure requirements, and the strengthening of consumer protection laws and regulations are examples of methods of addressing the risk for public harm that do not require regulation of the occupation or profession.

Criterion Seven: Least Restrictive Regulation
When it is determined that the State regulation of the occupation or profession is necessary, the least restrictive level of occupational regulation consistent with public protection will be recommended to the Governor, the General Assembly and the Director of the Department of Health Professions.

Licensure. Licensure confers a monopoly upon a specific profession whose practice is well defined. It is the most restrictive level of occupational regulation. It generally involves the delineation in statute of a scope of practice which is reserved to a select group based upon their possession of unique, identifiable, minimal competencies for safe practice. In this sense, state licensure typically endows a particular occupation or profession with a monopoly in a specified scope of practice.

RISK: High potential, attributable to the nature of the practice.
SKILL & TRAINING: Highly specialized accredited post-secondary education required; clinical proficiency is certified by an accredited body.
AUTONOMY: Practices independently with a high degree of autonomy; little or no direct supervision.
SCOPE OF PRACTICE: Definable in enforceable legal terms.
COST: High
APPLICATION OF THE CRITERIA: When applying for licensure, the profession must demonstrate that Criteria 1 - 6 are met.

Statutory Certification. Certification by the state is also known as "title protection." No scope of practice is reserved to a particular group, but only those individuals who meet certification standards (defined in terms of education and minimum competencies which can be measured) may title or call themselves by the protected title.

RISK: Moderate potential, attributable to the nature of the practice, client vulnerability, or practice setting and level of supervision.
SKILL & TRAINING: Specialized; can be differentiated from ordinary work. Candidate must complete education or experience requirements that are certified by a recognized accrediting body.
AUTONOMY: Variable; some independent decision-making; majority of practice actions directed or supervised by others.
SCOPE OF PRACTICE: Definable, but not stipulated in law.
COST: Variable, depending upon level of restriction of supply of practitioners.
APPLICATION OF CRITERIA: When applying for statutory certification, a group must satisfy Criterion 1, 2, 4, 5, and 6.

Registration. Registration requires only that an individual file his name, location, and possibly background information with the State. No entry standard is typically established for a registration program.

RISK: Low potential, but consumers need to know that redress is possible.
SKILL & TRAINING: Variable, but can be differentiated for ordinary work and labor.
AUTONOMY: Variable.
APPLICATION OF CRITERIA: <u>When applying for registration, Criteria 1, 4, 5, and 6 must be met</u>.

Appendix 3

American Speech-Language-Hearing Association (1995)
Training, Credentialing, use, and Supervision of Support Personnel in Speech-Language Pathology

Speech, Language and Hearing Association of Virginia (1996)
Guidelines for the Training, Credentialing, Use and Supervision of Speech-Language Pathology Assistants in the Commonwealth of Virginia

Appendix 4
VIRGINIA BOARD OF HEALTH PROFESSIONS
VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS
JULY 1999
SURVEY OF UNLICENSED ASSISTIVE PERSONNEL DUTIES

Senate Joint Resolution 492 from the 1999 Session of the General Assembly requires the Virginia Board of Health Professions and the Department of Medical Assistance Services to study the need to regulate speech-language pathology assistive personnel. To do this appropriately, we first need to determine what Virginia's assistive personnel are doing in public and private settings across the state. The best source of this information is primary information obtained from those actually employing or supervising such personnel.

This brief survey (on the following pages) is being sent to all of Virginia's licensed Speech-Language Pathologists. While certain demographic information is asked for, please be assured that your response is <u>absolutely anonymous.</u> All results will be reported to the Board in the aggregate.

Please complete the survey and return it by <u>August 13, 1999</u> to:

Elizabeth Carter, Ph.D.
Virginia Board of Health Professions
6606 W. Broad Street, Fourth Floor
Richmond, VA 23230-1717

or if you prefer by fax to: (804) 662-7098

Thank you for your participation in this important study. If you have any questions, please call Dr. Carter at (804) 662-7013 or e-mail her at eac1@dhp.state.va.us.

VIRGINIA BOARD OF HEALTH PROFESSIONS
VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS
JULY 1999
SURVEY OF UNLICENSED ASSISTIVE PERSONNEL DUTIES

1. Do you practice in Virginia? _____ yes no _____

If you answered "yes" to Question #1, please complete the remainder of the survey. If you answered "no," stop here and please return the survey.

2. Would you describe your practice(s) as:
_____public, _____private _____ both?

3. In which Virginia county or city do you practice? (A)_______________
If you practice in more than one location please indicate all the locations:
(B)_________________(C)_______________(D)__________________

4. Are any unlicensed speech-language pathology assistive personnel employed in your practice? _____ yes _____no

If you answered "yes" to Question #4, please continue. If you answered "no," please stop here and return the survey.

5. How many unlicensed speech-language pathology assistive personnel are employed in your practice? _________

6. Do you personally supervise unlicensed speech-language pathology assistants/aides?
___ yes ___ no

7A. If you answered "yes" to Question #6, check all of the following categories which describe the duties allowed the assistants/aides:
(1) _____ conduct screenings
(2) _____ perform further diagnostic tests
(3) _____ interpret test results
(4) _____ assist in planning therapy procedures
(5) _____ modify therapy procedures plans
(6) _____ implement therapy procedures
(7) _____ function without direct (on-site) supervision
(8) _____ provide consultation to the patient regarding care
(9) _____ provide professional training of other staff
(10) ____ provide program review for individual habilitation plans or other forms of care planning of person(s) served
(11) ____ other (specify)____
____

(OVER)

7B. If you do not personally supervise the assistant(s)/aide(s) please ask their supervisor(s) to complete question 7A and indicate their profession(s) (if any)here
(1)_________________, (2) _______________, (3)_____________.

If there are more than three supervisors, please attach a sheet and continue the list.

If no one supervises the assistant(s)/aide(s), please check here (99)________.

8. Please indicate the percentage of clients or persons served, by age, in your practice that unlicensed assistive personnel serve.

_____ % 0-2 years of age
_____ % 3-5 years of age
_____ % 6-12 year of age
_____ % 13-18 year of age
_____ % 19–55 year of age
_____ % 56+ years of age

The Virginia Board of Health Professions appreciates your assistance in this study. A report on the results will be available later this fall. If you would like a copy, please contact the Board office at (804) 662-7013.

RESULTS OF THE VIRGINIA BOARD OF HEALTH PROFESSIONS SURVEY OF VIRGINIA LICENSED SPEECH-LANGUAGE PATHOLOGISTS

QUESTION 1. DO YOU PRACTICE IN VIRGINIA?

116 (17%) "NO" OR DID NOT ANSWER
558 (83%) "YES"
673 (100%) TOTAL RESPONSES

QUESTION 2. WOULD YOU DESCRIBE YOUR PRACTICE AS:

370 (75%) "PUBLIC"
39 (8%) "PRIVATE"
96 (19%) "BOTH"
505 (100%) TOTAL RESPONSES

QUESTION 3. IN WHICH CITY OR COUNTY DO YOU PRACTICE – (NUMBER OF LOCATIONS)

551 (100%) AT LEAST ONE
142 (26%) AT LEAST TWO
56 (10%) AT LEAST THREE
2 (0.36%)AT LEAST FOUR

NOTE: Responses came from each area of the state. Because the intent of the current survey was to gather information on practice locations for unlicensed assistive personnel, details of the cities and counties of all of the practices reported by respondents will be made available only upon request to the Board office. However, as indicated in Question 4.below, 54 respondents indicated that assistive personnel were employed in their practices. Details of their practice areas/locations are as follows:

Geographic Area	Area Total	City/County/Town (total)
Eastern	**n = 7**	Chesapeake (2)
		Franklin City (1)
		Hampton (1)
		Norfolk (2)
		Portsmouth (1)
Central	**n = 10**	Danville (2)
		Dinwiddie (1)
		Henrico (1)
		Richmond City (6)

Northern	**n = 20**	Alexandria (2) Annandale (1) Arlington (2) Fairfax City (8) Fairfax County (1) Loudoun County (1) Manassas (1) Prince William (2) Spotsylvania (2)
Western	**n = 8**	Amherst (1) Augusta City (1) Augusta County (3) Bedford (1) Charlottesville (2)
Southwest	**n = 8**	Henry (1) Roanoke City (1) Roanoke County (6)
N/A	**n = 1**	

QUESTION 4. ARE UNLICENSED SPEECH-LANGUAGE PATHOLOGY ASSISTANTS EMPLOYED IN YOUR PRACTICE?

Of 558 valid respondents (i.e., practicing in Virginia), only 54 (9.7%) respondents answered "yes."

QUESTION 5. HOW MANY UNLICENSED SPEECH-LANGUAGE PATHOLOGY ASSISTANTS ARE EMPLOYED IN YOUR PRACTICE?

The above 54 respondents reported a total of 184 individuals employed as assistants. The range of assistants employed *per practice* was 1 to 45, with a median of 2, arithmetic mean of 2.2, and mode (i.e., most frequent number reported) of 1.

QUESTION 6. DO YOU PERSONALLY SUPERVISE UNLICENSED SPEECH-LANGUAGE PATHOLOGY ASSISTANTS?

Of the 54 valid responders, 33 (63%) indicated that they do, 16(30%) do not, and 4 (7%) did not answer the question.

QUESTION 7A. AND 7B. CHECK ALL OF THE FOLLOWING CATEGORIES WHICH DESCRIBE THE DUTIES ALLOWED ASSISTANTS/AIDES? IF YOU DO NOT PERSONALLY SUPERVISE THE ASSISTANT/AIDE, PLEASE ASK THEIR SUPERVISOR(S) TO COMPLETE 7A. AND INDICATE THEIR PROFESSION (IF ANY)

NOTE: This question was divided according to cases in which speech-language pathologists are the supervisor and when other professionals supervise. For the 33 who could have validly responded to Question #6, only 30 did.

CATEGORIES OF DUTIES	SLP SUPERVISED	OTHER
(1) Conduct screenings	18	7
(2) Perform further diagnostic tests	5	3
(3) Interpret test results	5	3
(4) Assist in planning therapy procedures	6	3
(5) Modify therapy procedures	4	3
(6) Implement therapy procedures	30	3
(7) Function without direct (on-site) supv.	4	5
(8) Prov. consultation to patient re: care	2	4
(9) Prov. prof. training of other staff	2	0
(10) Prov. prg. review for indiv. hab. plans or other forms of care planning of persons served	2	0
(11) Other	17	9

Item 11. "Other" was answered by 16 valid respondents (i.e., those with assistants in their practices). This was an open ended question, so a listing of the actual answers will be provided for accuracy's sake:

- simple basic treatment, oral motor ex. clerical
- clerical
- programs aac devices according to slps direction
- develop home programs, picture boards, exercise, etc.
- assist in adm tasks, billing, forms, supplies
- clerical, clean-up, crafts, watch tx problems pt
- paperwork (i.e., printing screening results)

- assist therapist with group activities only
- clerical support, assist slp's groups
- score diagnostic tests
- prep materials used in treatment as directed
- prep of devices & therapy materials
- teach parents implement home carryover prog.
- matl. prep. for tx. sess. data coll., sched., paperwk.
- clerical help (copying, etc.)
- all other duties performed by on staff slp's

In answer to 7.B., "other professions" supervising include: another speech-language pathologist (6), occupational therapist (2), clinical counselor (1), rehabilitation CAN (?)(1), "aide supervisor" (1), occupational therapist (2). Three indicated that the assistants received "no supervision."

One of those indicating "no supervision" reported being in the Tidewater area, in a "public" setting, with two employees doing all of the duties of "1-8" above and for "11" they were writing IEPs largely for elementary school (75%) and high school (24%) aged clients. The second indicating "no supervision" reported practicing in the Southwestern area in both public and private settings with three employees; no specific duties or age groups of clients were reported. Finally, the third indicating "no supervision" also reported practicing in the Southwestern area but in a private setting, only. One assistant was indicated as preparing materials, scoring tests, filing and copying. No age data was available on clients served.

QUESTION 8. PLEASE ANSWER THE PERCENTAGE OF CLIENTS OR PERSONS SERVED, BY AGE, IN YOUR PRACTICE THAT UNLICENSED ASSISTIVE PERSONNEL SERVE.

NOTE: Only 12 responders answered this question. With such a small number of responses, the results are being reported as how many practices serve a particular age group by using unlicensed assistants at all:

Age Group (in years)	Total Serving
0-2	6
3-5	12
6-12	12
13-18	7
19-55	11
56+	12

Appendix 5

RESULTS
OF
UNLICENSED ASSISTANT/AIDES
AND THE DISPENSING OF HEARING AIDS
SURVEY

May 14, 1998:

Board of Audiology and Speech-Language Pathology
Department of Health Professions
6606 West Broad Street
Richmond, Virginia 23230

1. Are you an audiologist __18%__ ? Are you an speech-language pathologist? __77%__

   Both? __4%__

2. Employed all over VA. __1%__ , South West VA. __16%__ , West VA. __9%__ ,

   North VA. __20%__ , Central VA. __17%__ , East VA. __17%__ ,

   Outside VA. __5%__ , Not employed __5%__ .

3. Do you work in a public-school setting __29%__ and/or private

   setting __61%__ , and/or federal setting __8%__ ?

4. Do you use unlicensed assistants/aides? __21%__ Yes __65%__ No

   If yes, what are their primary duties and responsibilities?

   - preparing material
   - maintaining records
   - treating patients
   - read to the children
   - conduct screenings

- maintain files
- patient transport
- prepping patients
- repair hearing aids
- conduct screenings

If you do not use assistants, why not?

- Not available
- Do not have the need for one
- Not appropriately trained
- Do not have the funds.
- No approval from my supervisor.
- Requires time to train them.
- Not beneficial to patients or audiologist.
- School system will not hire them.
- County will not hire them.
- Medicare does not recognize reimbursement for aides.

5. Do you think that an assistant/aide is a paraprofessional and should be licensed by this board?

__72%__ Yes __20%__ No

If yes, why?

- Working with speech, language, and swallowing deficits should be regulated due to the tremendous liability issues.
- Licensure would improve the quality of services.
- An assistant could handle the more routine aspects of job duties; their duties should be limited so as not to compromise the integrity of the audiologist's position and scope of practice.
- If there is to be any client contact, particularly for services which SLP charges fees, safeguards need to be in place to protect the public. Also need to protect aide/asst. from exploitation by employers who care only for profit.
- Assistants/aides usually work under less supervision than CFY fellows. They have a more direct association to patients and/or their amplification systems.
- Consistent standards.

- I believe there should be a standard for competence, established by the Board, to ensure qualified paraprofessionals are turned out. Their exam should not be an inane joke, like the hearing aid licensing test...please raise the standards.
- To continue our quality standards.
- So if anyone has complaints, you may track them.
- Have been able to see benefits in OT and PT fields.

If no, why not?

- They should not be a recognized professional.
- This paraprofessional will work under a licensed speech pathologist.
- The aid should be under the supervision of the primary professional who is licensed. The assistant/aide is the responsibility of the professional
- Communication problems are too complex for assistant and agencies would cut costs by giving them too much authority and responsibility as I have seen in RPS.
- Our aides assist two audiologist and is not responsible for any testing.
- I believe services should not be delivered by anyone who has less then a Masters Degree.
- Do not think licensure is necessary if training, qualifications & supervision plans & protocols are followed.
- They would take jobs away from licensed, masters educated therapists.
- No existing job description delineating uniform boundaries or responsibilities.
- Lowers standard of being licensed.

6. What do you think are the minimum qualifications for an assistant/aide? (Please check all that may apply)

______35%__ Associate's Degree
______49%__ Bachelor's Degree
______50%__ A practicum/internship
______52%__ At least one year of training under the supervision of a licensee
______21%__ Other:

- Specific training-leading to passing competencies to perform duties.
- I believe we should consider the qualifications required of other professional organizations & require more considering our min. requirement will soon be the AuD.

- Courses/training in Speech Pathology (training in the treatment of speech, language, & cognitive-linguistic disorders. A type of standard comprehensive exam to evaluate knowledge of basic treatment approaches & sp/lang. disorders.
- Apprenticeships for regular education students who want some special ed. exposure.
- Formal training of hearing aids.
- Passing a "hands on" and written test at end of training.
- Continuous direct supervision by a qualified licensed professional.
- Preferably graduate level assistant program.
- Practicum training in each type of setting with all types and all ages of disorders.
- Passing score on licensing exam.

7. If you are an audiologist, do you dispense hearing aids? ___**61%**___ Yes ___**23%**___ No

   If yes, Do you hold a license with the Board of Hearing Aid Specialists? ___**64%**___

8. If you are an audiologist, do you think that you should be able to dispense hearing aids under your audiology license? ___**68%**___ Yes ___**8%**___ No

   If no, why not:

   - To many audiology graduates are not adequately trained in hearing aid specialist and no test is suggested.
   - Audiologists do not have adequate training and adequate regulations to dispense/ no consumer protection.
   - Did not learn enough in audiology courses to do well with hearing aids
   - Many audiology programs do not have a strong enough hearing aid curriculum
   - The hearing aid license is important since not all audiologists dispense hearing aids. If they are out of practice, refreshers should be taken.
   - Audiologists who went to school more than, say, 10 years ago <u>may</u> not have been sufficiently trained.

9. Do you think that the clinical fellow should be licensed?
   ___**42%**___ Yes ___**22%**___ No

   If yes, why?

- Clinical Fellows have had many hours of hands on observation by a licensee. They are still under supervision and being checked by the supervisor. Many Fellows have had more experience than new dispenses due to the completion of accredited coursework and understand of hearing aids. Any education a dispenser has an audiologist fellow has the same if not more. If they can pass the same tests they should be licensed.
- Quality control.
- To make sure they have fulfilled educational guidelines.
- Because the clinical fellow is practicing audiology and not always under direct supervision.
- Because the clinical fellow has received training in disorders and diagnosis. They have also received training under a licensed therapist.
- They already had the professional course work.
- To ensure that individuals meet professional competencies.
- They have completed their academic education, passed their CCC's exam, are under (presumably) supervision & should have clinical skills.
- To have some minimal levels of expertise.
- They have completed 6 years of school and have demonstrated competence by passing the ASHA exam and their own ASHA approved school boards.
- It's good business.

If no, why not?

- A CFY is part of the training to be an audiologist.
- I think a CFY should have a temporary license of some kind to distinguish the he <u>is</u> not <u>fully</u> licensed.
- Licensed when qualified. Upon completion of all requirements and when certified by ASHA.
- It would preclude initiating the fellowship immediately after graduation for a lot of people for financial reasons.
- I feel that the clinical fellowship year represents the final step on the road to "licensure". It is a year for one to gain experience in the field, while still having limited supervision. The CFY is an invaluable experience and should continue to be the final step to licensure.
- They may not get as close of supervision their first year out of school if they were already licensed.
- They practice under supervision of CCC-SLP & are recognized by both Medicare & ASHA as Speech-Language Pathologists-they apply

for licensure after CFY is completed, as the CFY is the final phase of their training.

- Not fully certified by ASHA-should be equal requirements-Temp. License only pending CFY year completion.
- During the CFY, a person is learning & assimilating info. so that eventually he can be licensed.
- Working under supervision of a licensed professional.

10. Would continuing education as a condition for license renewal be a financial burden?
<u>45%</u> Yes <u>40%</u> No

If yes, why?

- Not all employers cover CE costs, and some require the use of vacation days off without pay to attend seminars.
- We are well educated professions. We should decide on our own. I have loans to be off for 6 years of an excellent education.
- Courses and associated travel are expensive. Rehab companies are providing lower costs for continued education due to changes in payment.
- As a public school speech therapist, I can verify that workshop fees are often paid out of the employees pocket. These fees do add up and can become financially burdensome.
- Health care organizations and private companies are the worst (they should be the best) in providing money or time off or encouraging classes. School therapists may have time, but no money. Why do school speech therapists get so much lower pay than Ots or Pts? We are required to have more education and credentials.
- Registration/tuition fees are always substantial; if quality courses require travel, a few CEU's can cost $500-$1000. If several CEU's/credit hours are required, cost is prohibited.
- My company gives us an "allowance" but there is often travel expenses, hotel, etc. I try to go to anything "local" that I can, but I live in a rural area, so I am limited somewhat.
- Not everyone's employer will pay for this and it is already costly for state license and ASHA certification.
- If you are unemployed, it is a financial burden.
- Because I work for a state agency and do not always have the opportunity to go to conferences yearly.

If no, why not?

- It should be a part of your working & life expenses to remain current in your field.
- It's vital to keep up with technology regardless of cost.
- Most CEU opportunities aren't that expensive.
- I feel this should be a requirement in order to maintain professional standards
- Continuing education is important to maintain/increase knowledge in current areas & new techniques.
- It is crucial that we, as professionals consistently strive to further our knowledge and participate in conferences, etc.
- In most work setting, continuing ed. required anyway & you may be reimbursed of a certain amount.
- I am required to have 10 CEU's in my state; necessary to stay on top of the profession.
- Small cost factor considering professional "payback" of cont. ed. in general.
- Cont. Ed. is a professional obligation. # of required CEU's should be kept reasonable though.

THE BOARD OF AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY APPRECIATES YOUR PARTICIPATION IN THIS

TOPIC	Total # of responses
Respondents	607
Are you an audiologist	111
Are you an speech-language pathologist	470
Are you an audiologist and speech-language pathologist	26
Employed all over Virginia	7
Employed in southwest Virginia	95
Employed in west Virginia	54
Employed in north Virginia	121
Employed in central Virginia	106
Employed in east Virginia	104
Employed outside of Virginia	33
Not employed	33
Employed in the public school setting	173
Employed in the private setting	372
Employed in the federal setting	50
Yes- I do use unlicensed assistants/aides	127
No- I do not use unlicensed assistants/aides	396
Yes- Assist./aides is a paraprofessional and should be licensed by ALSP Board.	436
No- Assistants/aides should not be licensed by the ASLP Board.	122
Assoc. Degree for qualifications for an assistant/aide	210
Bach. Degree for qualifications for an assistant/aide	295
A practicum/internship for qualifications for an assistant/aide	305
At least one year of training under the supervision of a licensee	315
Other	127
Yes- I am a Audiologist that dispenses hearing aids	83
No- As a Audiologist I do not dispense hearing aids	32
Yes- I have a license with the Board of Hearing Aid Specialist	88
No- I do not have a license with the Board of Hearing Aid Specialist	8
Yes- I think I should be able to dispense hearing aids based on my Aud. License	93
No- I do not think I should be able to dispense hearing aids based on my Aud. License	11
Yes- A clinical fellow should be licensed	256
No- A clinical fellow should not be licensed	133
Yes- Continuing education as license requirement will be a financial burden	271
No- Continuing education as license requirement would not be a financial burden	242

Appendix 6

RELEVANT PORTIONS OF LICENSING STATES' STATUTES AND REGULATIONS GOVERNING THE PRACTICE OF SPEECH-LANGUAGE PATHOLOGY ASSISTIVE PERSONNEL

Connecticut (support personnel) NOTE: There is nothing in known statute or regulation which defines "support personnel."

Statute

§ 20-408. Definitions.
*As used in this chapter, unless the context otherwise requires: (1) "The practice of **speech pathology** " means the application of principles, methods and procedures for the measurement, testing, diagnosis, prediction, counseling or instruction relating to the development and disorders of speech, voice or language for the purpose of diagnosing, preventing, treating, ameliorating or modifying such disorders and conditions in individuals or groups of individuals. (2) **"Licensed speech pathologist"** means a person licensed under this chapter to practice speech pathology.*

§ 20-411. Qualifications for license.
Waiver of written examination. (a) Except as provided in subsection (b) no person shall be licensed under this chapter until he has successfully passed a written examination, the subject and scope of which shall be determined by the commissioner. Application for such examination shall be on forms prescribed and furnished by the department and accompanied by satisfactory proof that he: (1) Is of good professional character; (2) possesses a master's or doctorate degree in speech pathology or audiology from a program accredited, at the time of the applicant's graduation, by the educational standards board of the American Speech Language-Hearing Association or such successor organization as may be approved by the department, or has completed an integrated educational program which, at the time of the applicant's completion, satisfied the educational requirements of said organization for the award of a certificate of clinical competence; (3) has had a minimum of thirty-six weeks and one thousand eighty hours of full-time or a minimum of forty-eight weeks and one thousand four hundred forty hours of part-time professional employment in speech pathology or audiology under the supervision of a licensed or certified speech pathologist or audiologist. Such employment shall follow the completion of the educational requirements of subdivision (2). Full-time employment means a minimum of thirty hours a week and part-time employment means a minimum of fifteen hours a week. (b) The commissioner may waive the written examination for any person who (1) is licensed as a speech pathologist or audiologist in another state and such state has licensing requirements at least equivalent to the requirements in this state; or (2) holds a certificate from a national professional organization, approved by the commissioner, in speech pathology or audiology.

Florida (assistants)
Statute
§468.1125 Definitions.

(4) ***"Certified speech-language pathology assistant" means a person who is certified under this part to perform speech pathology services under the direct supervision of a speech pathologist.***

(7)(a) ***"Practice of speech-language pathology"*** *means the application of principles, methods, and procedures for the prevention, identification, evaluation, treatment, consultation, habilitation,rehabilitation, instruction, and research, relative to the development and disorders of human communication; to related oral and pharyngeal competencies; and to behavior related to disorders of human communication. "Disorders" are defined to include any and all conditions, whether of organic or nonorganic origin, that impede the normal process of human communication, including, but not limited to, disorders and related disorders of speech, phonology, articulation, fluency, voice, accent, verbal and written language and related nonoral/nonverbal forms of language, cognitive communication, auditory and visual processing, memory and comprehension, interactive communication, mastication, deglutition, and other oral, pharyngeal, and laryngeal sensorimotor competencies.*

(b) Any speech-language pathologist who has complied with the provisions of this part may:

1. Offer, render, plan, direct, conduct, and supervise services to individuals or groups of individuals who have or are suspected of having disorders of human communication, including identification, evaluation, treatment, consultation, habilitation, rehabilitation, amelioration, instruction, and research.

2. Determine the need for personal alternatives or augmentative systems, and recommend and train for the utilization of such systems.

3. Perform a hearing screening, limited to a pass/fail determination, for the purpose of initial *identification of communication disorders.*

(9) ***"Direct supervision"*** *means responsible supervision and control by a licensed speech-language pathologist who shall assume legal liability for the services rendered by any certified speech-language pathology assistant under the licensee's supervision, or responsible supervisionand control by a licensed audiologist who shall assume legal liability for the services rendered by any certified audiology assistant under the licensee's supervision. Direct supervision shall require the physical presence of the licensed speech-language pathologist for consultation and direction of the actions of the certified speech-language pathology assistant, or the physical presence of the licensed audiologist for consultation and direction of the actions of the certified audiology assistant, unless the assistant is acting under protocols established by the board. The board shall establish rules further defining direct supervision of a certified speech-language pathology assistant or a certified audiology assistant.*

468.1215 Speech-language pathology assistant and audiology assistant; certification.—

(1) A person desiring to be certified as a speech-language pathology assistant or audiology assistant shall apply to the department.

(2) The department shall issue a certificate as a speech-language pathology assistant or as an audiology assistant to each applicant who the board certifies has:

(a) Completed the application form and remitted the required fees, including a nonrefundable application fee.

(b) Completed at least 24 semester hours of coursework as approved by the board at an institution accredited by an accrediting agency recognized by the Commission on Recognition of Postsecondary Accreditation.

(3) The board, by rule, shall establish minimum education and on-the-job training and supervision requirements for certification as a speech-language pathology assistant or audiology assistant.

(4) The provisions of this section shall not apply to any student, intern, or trainee performing speech-language pathology or audiology services while completing the supervised clinical clock hours as required in s. 468.1155.

Regulation
(summary only available)

Licensure Requirements

Speech-Language Pathology/Audiology Assistant. Twenty-four (semester) hours of course work earned at an accredited college or university, a supervisory/activity plan, and one hour HIV/AIDS [training].

Kentucky (assistants)

Statute

§ 334A.020. Definitions.

"The practice of speech pathology" means the application of principles, methods and procedures for the measruement, testing, audiometric screening, identification, appraisal, determination of prognosis, evaluation, consultation, remediation, counseling, instruction and research related to the development and disorders of speech, voice, verbal and written language, cognition/communication, or oral and pharyngeal sensorimotor competencies for the purpose of designing and implementing programs for the amelioration of these disorders and conditions. Any representation to the public by title or description of services, methods or procedures for the evaluation, counseling, remediation consultation, measurement, testing, audiometric screening, identification, appraisal, determination of prognosis, instruction and research of persons suffering or suspected of suffering from conditions or disorders affecting speech, voice, verbal and written language, cognition/communication, or oral and pharyngeal sensori-motor competencies shall be considered to be the practice of speech-language pathology.

"Speech-language pathology assistant" means one who assists in the practice of speech-language pathology only under the supervision and direction of an appropriately qualified supervisor and only within the public school system in the commonwealth. Any speech pathology services provided without appropriate supervision, or outside the public school system shall be deemed to be the unlicensed practice of speech pathology and shall subject the offending party to penalties established pursuant to KRS 334A.990.

"Assisting in the practice of speech pathology" means the provision of certain specific components of a speech or language service program provided by a speech-language pathology assistant under the supervision and direction of an appropriately qualified supervisor.

(a) If the training, supervision, documentation, and planning are appropriate, the following tasks may be delegated to a speech-language pathology assistant:

!. Conduct speech-language and hearing screenings without interpretation following specified screening protocols developed by speech-language pathologist and audiologist, separately;

2. Follow documented treatment plans or protocols as prescribed by the supervisor;

3. Document student progress toward meeting established objectives as stated in the treatment plan;

4. Provide direct treatment assistance to identified students under the supervision of the supervisor;

5. Assist with clerical and other related duties as directed by the supervisor;

6. Report to the supervisor about the treatment plan based on a student's performance;

7. Schedule activities, prepare charts, records, graphs, or otherwise display data. This does not include report generation;

8. Perform simple checks and maintenance of equipment;

9. Participate with the supervisor in research projects, inservice training, and public relations programs;

10. Assist in the development and maintenance of an appropriate schedule for service delivery; and

11. Assist in implementing collaborative activities with other professionals; and

12. Assist in implementing test for diagnostic evaluations and progress monitoring;

(b) The following activities shall be outside the scope of practice of the speech-language pathology assistant:

Performing any activity which violates the code of ethics promulgated by the board by administrative regulation;

1. Interpreting test results, or performing diagnostic evaluations without supervision;

2. Participating in parent conferences, case conferences, or any interdisciplinary team without *consultation with, or in the presence of the supervisor;*

3. Conducting client or family counseling without the recommendation, guidance, and approval of the supervisor;

4. Writing, developing, or modifying a student's individualized treatment plan in any way without the recommendation, guidance, and approval of the supervisor;

5. Treating students without following the individualized treatment plan in any way without the recommendation, guidance, and approval of the supervisor;

6. Signing any documents without the co-signature of the supervisor;

7. Selecting or discharging students;

8. Disclosing clinical or confidential information either orally or in writing to anyone not designated by the supervisor;

9. Making referrals for additional services;

10. Representing themselves as something other than a speech-language pathology assistant.

(10) "Supervisor" means a person who holds a Kentucky license as a speech-language pathologist or who holds Education Professional Standards Board certification as a teacherof exceptional children in the areas of speech and communication disorders as established by administrative regulation.

334A.033. License for speech-language pathology assistant – Requirements for licensure.

(1) The board may issue a license to practice as a speech-language pathology assistant under the following conditions:

(a) The practice shall be limited to the public schools and shall be under the supervision of an appropriately qualified supervisor;

(b) The requirements for supervision shall be set forth in administrative regulations promulgated by the board;

(c) An individual shall not supervise or be listed as a supervisor for more than two (2) speech-language pathology assistants; and

(d) The supervisor shall delegate to the assistant the appropriate tasks pursuant to KRS 334A.020 and the supervisor and assistant shall work together to provide the appropriate services to all assigned pupils. The maximum number of pupils served by each speech-language pathology assistant shall not exceed the direct service caseload of the speech-language pathologist as established in KRS 334A.190.

(2) To be eligible for licensure by the board as a speech-language pathology assistant, the applicant shall meet the following requirements:

(a) A baccalaureate degree in the area of speech-language pathology as defined by administrative regulations;

(b) Completion of postgraduate professional experience deemed appropriate by the board by administrative regulation; and

(c) List on the application the name of the appropriately qualified supervisor who has agreed to provide supervision as set forth by the board by administrative regulation.

Regulations

RELATES TO: KRS 334A.035(2), 1994 Ky. Acts ch. 32, sec. 4

STATUTORY AUTHORITY: KRS 334A.080

NECESSITY, FUNCTION, AND CONFORMITY: 1994 Ky. Acts ch. 32, sec. 4 establishes the guidelines for licensure as a speech-language pathology assistant. KRS 334A.035(2) requires an applicant for licensure as a speech-language pathology assistant to complete postgraduate professional experience in order to become licensed. This administrative regulation establishes the requirements for interim licensure.

Section 1. Education. (1) In order to receive an interim license to become a speech-language pathology assistant, the applicant shall possess a baccalaureate degree in speech-language pathology.

(2) A baccalaureate degree in speech-language pathology shall be a baccalaureate degree from a regionally accredited institution in communication sciences or disorders or its equivalent.

(3) In order to be considered as equivalent, the applicant shall have obtained a baccalaureate degree and a minimum of twenty-seven (27) hours in the core areas of communication sciences or disorders including the following:

(a) Anatomy and physiology;

(b) Phonetics and speech science;

(c) Speech and language development;

(e) Communication disorders in children;

(f) Audiology;

(g) Aural rehabilitation; and

(h) Intervention for children with communication disorders.

Section 2. Supervision. (1) The interim licensee shall function under the supervision of an appropriate supervisor during the period of interim licensure.

(2) It shall be the responsibility of the supervisor to design and provide a supervision system that protects pupil welfare and maintains the highest possible standards of quality speech-language pathology services.

(3) Additional supervision may be required, based on the experience of the speech-language pathology assistant, the pupils served, and the physical or geographic proximity to the supervisor.

(4) As the supervisory responsibility of the supervisor increases, the direct service responsibilities of the supervisor shall decrease.

(5) Treatment for the pupils served remains the responsibility of the supervisor. Therefore, the level of supervision required is considered the minimum level necessary for the supervisor to retain direct contact with the pupils.

(6) Each speech-language pathology assistant shall be required to receive no less than three (3) hours per full-time week of documented direct supervision. Supervision shall be adjusted proportionally for less than full-time employment. This ensures that the supervisor will have direct contact time with the speech-language pathology assistant as well as with the pupil.

(7) Direct supervision means on-site, in-view observation and guidance as a clinical activity is performed.

(8) Supervision shall provide information about the quality of the speech-language pathology assistant's performance with assigned tasks and verify that clinical activity is limited to tasks specified in the speech-language pathology assistant's scope of responsibilities.

(9) Information obtained during direct supervision may include data relative to:

(a) Accuracy in implementation of screening, diagnostic, and treatment procedures;

(b) Agreement between the assistant and the supervisor on correct or incorrect judgment of target behavior;

(c) Accuracy in recording data; and

(d) Ability to interact effectively with the pupil.

(10) Indirect supervision shall be required no less than three (3) hours per full-time week. Supervision shall be adjusted proportionally for less than full-time employment. Indirect supervision may include:

(a) Demonstration;

(b) Record review;

(c) Review and evaluation of audio or videotaped sessions; or

(d) Supervisory conferences that may be conducted by telephone.

(11) A minimum total of six (6) hours of direct and indirect supervision per full-time week shall be required for each speech-language pathology assistant and shall be documented. Additional direct and indirect supervision may be necessary depending on the experience of the assistant and the needs of the pupil.

(12) A speech-language pathology assistant shall not at any time provide direct services when a supervising speech-language pathologist cannot be reached by personal contact, phone, pager, or some other immediate means.

(13) If for any reason (i.e., maternity leave, illness, change of jobs) the supervisor is no longer available to provide the level of supervision stipulated, the speech-language pathology assistant may not provide service until a fully qualified speech-language pathologist has been designated as the speech-language pathology assistant's supervisor.

(14) Although more than one (1) supervisor may provide supervision of a speech-language pathology assistant, a supervisor shall not be listed as the supervisor of record for more than two (2) speech-language pathology assistants. When multiple supervisors are used, one (1) shall be designated as the supervisor of record.

(15) The maximum number of pupils served by the speech-language pathology assistant shall not exceed the caseload established for a speech-language pathologist by administrative regulation.

Section 3. Postgraduate Professional Experience. (1) The applicant shall obtain the equivalent of not less than nine (9) months of full-time professional experience with full-time employment defined as a minimum of thirty (30) clock hours of work a week. This requirement also may be fulfilled by part-time employment as follows:

(a) Work of fifteen (15) through nineteen (19) hours per week over eighteen (18) months;

(b) Work of twenty (20) through twenty-four (24) hours per week over fifteen (15) months; or

(c) Work of twenty-five (25) through twenty-nine (29) hours per week over twelve (12) months.

(2) In the event that part-time employment is used to fulfill a part of the postgraduate professional experience, 100 percent of the minimum hours of the part-time work per week requirement must be spent in direct professional experience.

(3) The postgraduate professional experience shall be completed within a maximum period of thirty-six (36) consecutive months.

Section 4. Evaluation and Recommendation. Within thirty (30) days after completion of the postgraduate professional experience, the applicant and his supervisor shall submit a written report to the board verifying the successful completion of postgraduate professional experience.

Section 5. Examination for Licensure as a Speech-language Pathology Assistant. (1) During the period of interim licensure, an applicant for licensure shall submit to an examination composed of the Praxis Series, Professional Assessments for Beginning Teachers, specialty area test in speech-language pathology and administered by the Educational Testing Service (ETS).

(2) The passing score on the examination for licensure as a speech-language pathology assistant shall be 480.

(3) If an applicant fails the examination, the applicant may, with payment of the required fee, be rescheduled to take the examination at its next regularly scheduled date.

Section 6. Licensure as a Speech-language Pathology Assistant. Upon successful completion of each requirement set forth in this administrative regulation, completion of the required application, and payment of the required fee, the holder of an interim license shall be eligible to be licensed as a speech-language pathology assistant and shall immediately apply for licensure. (21 Ky.R. 146; Am. 913; eff. 8-17-94.)

RELATES TO: 1994 Ky. Acts ch. 32, sec. 4

STATUTORY AUTHORITY: KRS 334A.080

NECESSITY, FUNCTION, AND CONFORMITY: 1994 Ky. Acts, ch. 32, sec. 4 establishes the requirements for licensure as a speech-language pathology assistant. One (1) of the requirements is that the speech-language pathology assistant may only practice under supervision. This administrative regulation establishes the supervisory requirements.

Section 1. The supervision requirements specified in these guidelines are minimum requirements.

(1) It shall be the responsibility of the supervisor to design and provide a supervision system that protects pupil welfare and maintains the highest possible standards of quality speech-language pathology services.

(2) Additional supervision may be required, based on the experience of the speech-language pathology assistant, the pupils served, and the physical or geographic proximity to the supervisor.

(3) As the supervisory responsibility of the supervisor increases, the direct service responsibilities of the supervisor shall decrease.

Section 2. Treatment for the pupils served remains the responsibility of the supervisor. Therefore, the level of supervision required is considered the minimum level necessary for the supervisor to retain direct contact with the pupils.

Section 3. Each speech-language pathology assistant shall be required to receive no less than two (2) hours per full-time week of documented direct supervision. This ensures that the supervisor will have direct contact time with the speech-language pathology assistant as well as with the pupil.

(1) Direct supervision means on-site, in-view observation and guidance as a clinical activity is performed.

(2) Supervision shall provide information about the quality of the speech-language pathology assistant's performance with assigned tasks and verify that clinical activity is limited to tasks specified in the speech-language pathology assistant's scope of responsibilities.

(3) Information obtained during direct supervision may include data relative to:

(a) Accuracy in implementation of screening, diagnostic, and treatment procedures;

(b) Agreement between the assistant and the supervisor on judgment of target behavior;

(c) Accuracy in recording data; and

(d) Ability to interact effectively with the pupil.

Section 4. Indirect supervision shall be required no less than two (2) hours per full-time week and may include:

(1) Demonstration;

(2) Record review;

(3) Review and evaluation of audio or videotaped sessions; or

(4) Supervisory conferences that may be conducted by telephone.

Section 5. A minimum total of four (4) hours of direct and indirect supervision per full-time week shall be required for each speech-language pathology assistant and shall be documented. Additional direct and indirect supervision may be necessary depending on the experience of the assistant and the needs of the pupil.

Section 6. A speech-language pathology assistant shall not at any time provide direct services when a supervising speech-language pathologist cannot be reached by personal contact, phone, pager, or some other immediate means.

Section 7. If for any reason (i.e., maternity leave, illness, change of jobs) the supervisor is no longer available to provide the level of supervision stipulated, the speech-language pathology assistant may not provide service until a fully qualified speech-language pathologist has been designated as the speech-language pathology assistant's supervisor.

Section 8. Although more than one (1) supervisor may provide supervision of a speech-language pathology assistant, a supervisor shall not be listed as the supervisor of record for more than two (2) speech-language pathology assistants. When multiple supervisors are used, one (1) shall be designated as the supervisor of record.

Section 9. The maximum number of pupils served by the speech-language pathology assistant shall not exceed the caseload established for a speech-language pathologist by administrative regulation. (21 Ky.R. 147; Am. 914; eff. 8-17-94.)

Louisiana (assistants) UNAVAILABLE AT WRITING

Missouri (aides/assistants)

NOTE: (This state's regulation of speech-language pathology assistants/aides was was reclassified as registration upon review of the current statutes as published on the state's website.)

Statutes

§345.015 Definitions.

(9) "Practice of speech-language pathology"

(a) Provides screening, identification, assessment, diagnosis, treatment, intervention, including but not limited to, prevention, restoration, amelioration and compensation, and follow-up services for disorders of:

a. Speech: articulation, fluency, voice, including aspiration, phonation, and esonance;

b. Language, involving the parameters of phonology, morphology, syntax, semantics and pragmatics; and including disorders of receptive and expressive communication in oral, written, graphic and manual modalities;

c. Oral, pharyngeal, cervical esophageal and related functions, such as, dysphasia, including disorders of swallowing and oral functions for feeding; orofacial myofunctional disorders;

d. Cognitive aspects of communication, including communication disability and other functional disabilities associated with cognitive impairment;

e. Social aspects of communication, including challenging behavior; ineffecive social skills, lack of communication opportunities;

(b) Provides consultation and counseling and makes referrals when appropriate;

(c) Trains and supports family members and other communication partners of individuals with speech, voice, language, communication and swallowing disabilities:

(d) Develops and establishes effective augmentative and alternative communication techniques and strategies, including selecting, prescribing and dispensing of augmentative aids and devices; and the training of individuals, their families and other communication partners in their use;

(e) Selects, fits and establishes effective use of appropriate prosthetic/adaptive devices for speaking and swallowing, such as tracheoesophageal valves, electrolarynges, speaking valves;

(f) Uses instrumental technology to diagnose and treat disorders of communication and swallowing, such as videoflurosocpy, nasendoscopy, ultrasonography and stroboscopy;

(g) Provides aural rehabilitative and related counseling services to individuals with hearing loss and to their families;

(h) Collaborates in the assessment of central auditory processing disorders in cases in which there is evidence of speech, language or other cognitive communication disorders; provides intervention for individuals with central auditory processing disorders;

(i) Conducts pure-tone air conduction hearing screening and screening tympanometry for the

purpose of the initial identification or referral;Enhances speech and language proficiency and communication effectiveness, including but not limited to, accent reduction, collaboration with teachers of English as a second language and improvement of voice, performance and singing;
(k) Trains and supervises support personnel;
(l) Develops and manages academic and clinical programs in communication sciences and disorders;
(m) Conducts, disseminates and applies research in communication sciences and disorders;
(n) Measures outcomes of treatment and conducts continuous evaluation of the effectiveness of practices and programs to improve and maintain quality of services;

"Speech-language pathology aide," a person who is registered as a speech-language aide by the board, who does not act independently but works under the direction and supervision of a licensed speech-language pathologist. Such person assists the speech-language pathologist with activities which require an understanding of speech-language pathology but does not require formal training in the relevant academics. *To be eligible for registration by the board, each applicant shall submit a registration fee, be of good moral and character; and*

(a) Be at least eighteen years of age;
(b) Furnish evidence of the person's education qualifications which shall be at a minimum:
a. Certification of graduation from an accredited high school or its equivalent; and
b. On the job training.
c. Be employed in a setting in which direct and indirect supervision is provided on a regular and systematic basis by a licensed speech-language pathologist. However, the aide shall not administer or interpret hearing screening or diagnostic tests, fit or dispense hearing instruments, make ear impressions, make diagnostic statements, determine case selection, present written reports to anyone other than the supervisor without the signature of the supervisor, make referrals to other professionals or agencies, use a title other than speech-language pathology aide or clinical audiology aide, develop or modify treatment plans, discharge clients from treatment or terminate treatment, disclose clinical

Ohio (aides)

Statute

§4732.072. the board of speech-language pathology and audiology shall establish by rule pursuant to Chapter 119 of the Code the qualifications for persons seeking licensure as a speech-language pathology aide or audiology aide. The qualifications shall be less than the standards for licensure as a speech-language pathologist or audiologist. An aide shall not act independently and shall work under the direction and supervision of a speech-language pathologist or audiologist licensed by the board. An aide shall not dispense hearing aids. An applicant shall not begin employment until the license has been approved.

Regulation

§4753-7-01. Licensure of aides; Requirement for plan.

(A) A license for a speech-language pathology aide or an audiology aide shall be issued only to a person working under a specific plan filed with the application and approved by the board.

A **"speech-language pathology aide"** is a person who performs duties related to the practice of speech-language pathology services under the direction and supervision of an actively licensed speech-language pathologist and who has an approved plan on file with the board. . .

(B) The specific plan shall be filled with the application for board approval and the statement of the plan shall include, but need not be limited to:

(1) The location (name and address) where the aide will work;

(2) A description of the activities to be performed by the aide;

(3) A description of the training the aide has or is to receive in the performance of his/her duties.

(4) A description of the direct supervision that the aide will receive in the performance of his/her duties.

Any experience obtained while acting as a speech-language pathology aide or audiology aide shall not be creditable toward the supervised clinical experience required in (C) of section 4753.06 of the Revised Code or the required professional experience required in division (D) of section 4753.06 of the Revised Code. The qualifications for obtaining licensure as an aide shall be graduation from an accredited high school or its equivalent.

(C) The purpose of aides is to support licensed staff in specified, non-technical aspects of testing and recordkeeping of person(s) served.

The aide shall not:

(1) perform diagnostic testing;
(2) interpret any test result;
(3) initiate, modify, plan or develop therapy procedures;
(4) implement therapy procedures;
(5) function without direct supervision;
(6) act for the licensed person at treatment team meetings or in any matter related to direct care of person (s) served which requires judgment or decision-making;
(7) provide consultation on any matter regarding care of person(s) served;
(8) provide professional training of other staff;
(9) provide program review for individualized habilitation plans or other forms of care planning of person(s) served;
(10) supervise or manage occupational hearing conservation programs;
(11) perform any duties not prescribed in the approved license application nor work for any other speech-language pathologist or audiologist who is not specified as the supervisor on the approved license application; and
(12) perform any duties without proper training.

(D) The licensed speech-language pathologist or audiologist who sins the application for the aide shall supervise that particular aide. The aide may provide services only under the supervision of the speech-language pathology or audiology supervisor of record for that applicant. If more than one supervisor is to be involved with the aide, a plan shall be submitted by each supervisor.

(E) An aide shall be clearly identified as an aide by a badge worn during all contact with person(s) served.

§4753-7-02 . Supervision requirements; aides.

Supervision of an aide shall be provided by a person who is actively licensed as a speech-language pathologist or audiologist . . ., or the equivalent as determined by the board. The supervisor shall be able to provide direct and immediate supervision to the aide. **"Direct supervision of an aide"** shall be defined as that given by a supervisor who is either present in the room in which the clinical services are being given, or, who is immediately available to provide assistance to the aide within that particular contact with person(s) served. A licensed speech-language pathologist or audiologist may supervise no more than two aides concurrently unless specifically authorized by the board. The board shall consider the public welfare in determining authorization for supervision of additional aides.

The supervisor of an aide shall make all decisions relating to the diagnosis, treatment, management and future disposition of the person(s) served and shall have the responsibility for the health, safety and welfare of the person(s) served by the aide.

Oklahoma (assistants) UNAVAILABLE AT WRITING

South Carolina (assistants)

Statute

§115-3. Speech-Language Pathology Assistants.

To be licensed as a Speech-Language Pathology Assistant an applicant must:

. . . present evidence of a bachelor's degree in Speech-Language Pathology. A bachelor's degree in Speech-Language Pathology must include as a minimum the following core curriculum of 36 hours and not less than 100 clock hours of clinical practicum.

(A) Specialized Preparation: 36 Semester Hours

(1) Directed Teaching in Speech Correction (6 Semester Hours)

100 hours of supervised clinical practicum in not less than two different sites.

(2) Basic Area

Anatomy, physiology, mechanics, and function of the ear and vocal mechanism

Phonetics

Semantics

Speech and Voice Science

Psychology of Speech

Experimental Phonetics

(3) Speech Pathology and/or Correction Courses (12 Semester Hours)

Stuttering

Articulation

Voice Disorders

Cleft Palate

Aphasia

Cerebral Palsy

Psychogenic Speech Disorders

Pathological Speech Disorders

(4) Audiology (3 Semester Hours)

Testing of Hearing

Introduction of Audiology

Auditory Training

Speech Reading

Speech for the Deaf or Hard of Hearing

(5) Psychology(6 Semester Hours)
Human Growth and Development
Psychology of Adjustment or
Abnormal Psychology

(6) Basic Course in Public Speaking (3 Semester Hours)

(B) General Guidelines

(1) No speech-language pathology assistant may begin working in direct contact with clients/patients without the board's written approval of the supervisory agreement and on the job training plan.

(2) Only a speech-language pathologist with an active license in good standing may supervise speech-language assistants.

(3) A speech-language pathologist may supervise no more than two fill-time or three part-time speech language pathology assistants. Full time is defined as 40 work hours per week. . .

(C) On-the-Job Training

At a minimum, on-the-job(OJT) must include step-by-step instruction of each and every service or task the speech-language pathology assistant is to perform and continuous visual observation by the supervising speech-language pathologist of the speech-language pathology assistant's performance of each service or task until the supervising speech-language pathologist establishes the speech-language pathologist assistant's competence.

Texas (assistants) UNAVAILABLE AT WRITING

Utah (aides) UNAVAILABLE AT WRITING

Appendix 7

August 11, 1999 Response from Department of Medical Assistance Services

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

DENNIS G. SMITH
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
804/225-4512 (Fax)
800/343-0634 (TDD)

August 11, 1999

AUG 13 1999
RECEIVED
BOARD OF HEALTH PROFE...

Dr. Elizabeth A. Carter
Deputy Executive Director
Board of Health Professions
6606 West Broad Street, Fourth Floor
Richmond, Virginia 23230-1717

Dear Dr. Carter:

This letter is in response to your letter dated 8/4/99 in which you requested information as to how Virginia Medicaid reimburses for the provision of speech language pathology services. It is my understanding this information is needed for a study the Department of Health Professions is performing to assess the need for regulation of Speech Pathology Assistants.

The Department of Medical Assistance Services (DMAS) billing system is designed for Virginia Medicaid to reimburse enrolled *rehabilitation providers* not *individual therapists* for the provision of therapy services. The qualifications of the individual therapist who provided the therapy treatment does not drive the reimbursement rate. Reimbursement is based on the number of therapy visits performed (see attached definition of a visit, Medicaid Rehabilitation Manual, Chapter IV, page 17). The reimbursement for provision of all rehabilitation therapies (physical therapy [PT], occupational therapy [OT], and speech language pathology [SLP]) include the following provider types: intensive rehabilitation inpatient hospitals, outpatient rehabilitation agencies, outpatient rehabilitation departments located in acute care hospitals, and school divisions who are enrolled with Medicaid for the provision of rehabilitation therapy services under the special education Individualized Education Program (IEP).

The intensive rehabilitation providers have an established per diem (based on end of year cost reports) for the intensive rehabilitation stay, and rehabilitation therapy services are included in the per diem rate paid to the provider. For each of the outpatient rehabilitation provider types, an established rate is determined per therapy service (PT/OT/SLP) per visit based on each providers yearly cost settled report. The outpatient rehabilitation providers *bill based on the number of visits* provided by each rehabilitation therapy discipline.

Although reimbursement rates for rehabilitation therapies are not based on the credentials/qualifications of the therapist providing the services, DMAS does have specific requirements for who is qualified to provide PT/OT/SLP services (see enclosed information, Medicaid Rehabilitation Manual, Chapter IV, pages 8-12, and "Rehabilitation Therapist's Qualifications In Order To Receive Medicaid Reimbursement"). These requirements are mandated by federal and state regulations and must be put into practice in order for the provider to receive Medicaid reimbursement. DMAS determines provider compliance by performing utilization review of the rehabilitation providers recipient's medical records (see enclosed information, Medicaid Rehabilitation Manual, Chapter VI, page 7-8).

In summary, DMAS criteria for reimbursement for the provision of rehabilitation services require that rehabilitation therapies be provided by licensed professional therapists but the reimbursement rate is driven by the number of visits not by the credentials/qualifications of the therapist providing the services. I hope this information provides the clarification needed for your report. If I can be of any further assistance in this matter please do not hesitate to contact me at (804) 786-8085.

Sincerely,

Barbara R. Seymour

Barbara R. Seymour BSW, URA, SR.
Utilization Analyst Sr.
Quality and Utilization Management
Division of Program Operations

Enclosures

TERMINATION OF INTENSIVE REHABILITATION CARE

Intensive rehabilitation care is to be considered for termination when further progress toward the established rehabilitation goal is unlikely or it is appropriate to assume progress can be achieved in a less intensive setting (nursing facility, outpatient settings, etc.). Specifically, if no further progress is observed, discharge would be appropriate.

SECTION III: OUTPATIENT PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH-LANGUAGE PATHOLOGY SERVICES

ADMISSION CRITERIA

To be eligible for general outpatient rehabilitative services, the patient must require at least one of the following services: physical therapy, occupational therapy, and speech-language pathology services. A physician must prescribe these services.

ADMISSION CERTIFICATION AND REQUEST FOR EXTENSION

Physical therapy, occupational therapy, and speech-language pathology services provided in outpatient settings of acute and rehabilitation hospitals, by rehabilitation agencies, and school divisions shall be limited to twenty-four (24) visits per rehabilitative discipline annually. Limits are specific per discipline and recipient, regardless of the number of providers rendering services. "Annually" is defined as July 1 through June 30 for each recipient. The provider must maintain documentation to justify the need for services. Preauthorization by DMAS is required before payment will be made for any visits over 24 per year.

The receipt of an authorization from DMAS does not guarantee reimbursement. DMAS reimbursement is contingent upon the continued Medicaid eligibility of the recipient, and is subject to all DMAS utilization review activities.

NOTE: A visit is defined as the treatment session that a rehabilitation therapist or other health worker is with a client to provide covered services prescribed by a physician. Visits are not defined in measurements or increments of time. The furnishing of any services by a particular health worker on a particular day or a particular time of day constitutes a visit. For example, if both a physical therapist and an occupational therapist furnish services on the same day, this constitutes two visits - one each of physical therapy and occupational therapy. If a therapist furnishes several services during a visit, this constitutes only one visit. However, if a therapist provides two distinctly separate therapy sessions in the same day (e.g., a morning session and an afternoon session), this would constitute two visits.

Combined visits by more than one therapist cannot be billed as separate visits if the goal(s) of the therapists is the same for that visit (e.g., two therapists are required to perform a single procedure). The overall goal(s) of the sessions determines how the visit can be billed.

Improvement of Function - Occupational therapy designed to improve function must be based on an expectation that the therapy will result in a significant practical improvement in a patient's level of functioning within a reasonable period of time. Where a valid expectation of improvement exists at the time the occupational therapy program is instituted, the services would be recognized even though the expectation may not be realized. However, this would apply only up to the time at which it would have been reasonable to conclude that the patient is not going to improve.

Physical Therapy

Physical therapy services are those services furnished a patient that meet all of the following conditions:

- The services must be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a licensed physical therapist.
- The services must be of a level of complexity and sophistication or the condition of the patient must be of a nature that the services can only be performed by a licensed physical therapist or a licensed physical therapy assistant under the direct supervision of a licensed physical therapist.
- The services must be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis.
- The services must be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

Note: Physical therapy that can be performed by supportive personnel is considered routine in nature by DMAS and will not be considered rehabilitation services and does not meet the criteria for reimbursement as physical therapy services.

The more common physical therapy modalities and procedures are illustrated below. These applications are appropriate for intensive rehabilitation services.

Gait Training

Gait evaluation and training furnished to a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality requires the skills of a licensed physical therapist and constitutes physical therapy, provided that it can reasonably be expected to significantly improve the patient's ability to walk.

Examples of services that do not constitute rehabilitation physical therapy are:

- Repetitious exercises to improve gait, maintain strength, endurance, and assistive walking (such as provided in support for feeble or unstable patients)
- Activities appropriately provided by supportive personnel (e.g., aides or nursing personnel)
- Activities that do not require the skills of a licensed physical therapist or licensed physical therapist assistant

Range of Motion

Range of motion exercises constitute physical therapy only when they are part of the active treatment of a specified diagnosis that has resulted in a loss or restriction of mobility as evidenced by physical therapy notes showing the degree of motion lost and the degree to be restored. Only a licensed physical therapist may perform range of motion tests, and, therefore, such tests constitute physical therapy. Range of motion exercises, whether because of their nature or the condition of the patient, which may be performed safely and effectively only by a licensed physical therapist or under the direct supervision of a therapist, will, therefore be considered rehabilitation therapy.

Generally, range of motion exercises not related to the restoration of a specific loss of function can ordinarily be provided safely by supportive personnel, such as aides or nursing personnel, and do not require the skills of a licensed physical therapist or licensed physical therapy assistant. Usually, passive exercises to maintain range of motion in paralyzed extremities can be carried out by aides or nursing personnel and will not be considered rehabilitation care.

Temporary Loss of Function

Generally, physical therapy is not required to improve or restore function where a patient suffers a temporary loss or reduction of function (e.g., temporary weakness which may follow prolonged bed rest following major abdominal surgery) that could reasonably be expected to spontaneously improve as the patient gradually resumes normal activities. Physical therapy for temporary loss of function will not be covered.

Ultrasound, Shortwave, and Microwave Diathermy Treatments

These modalities must always be performed by or under the direct supervision of a licensed physical therapist and, therefore, constitute covered physical therapy.

Therapeutic Exercises

Therapeutic exercises performed by or under the direct supervision of a licensed physical therapist due to either the type of exercise employed or the condition of the patient constitute covered physical therapy.

Hot Pack, Hydrocollator, Infrared Treatments, and Whirlpool Baths

Heat treatments of this type and whirlpool baths do not ordinarily require the skills of a licensed physical therapist. However, in a particular case, the skills, knowledge, and judgment of a licensed physical therapist might be required in giving such treatments or baths (e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, or other complications).

<u>Occupational Therapy</u>

Occupational therapy services are those services furnished a patient that meet all of the following conditions:

- The services must be directly and specifically related to an active written treatment plan designed by the physician after any needed consultation with a registered/certified occupational therapist.

- The services must be of a level of complexity and sophistication or the condition of the patient must be of a nature that the services can only be performed by a registered/certified occupational therapist or a certified occupational therapy assistant under the direct supervision of a registered/certified qualified occupational therapist.

- The services must be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonably and generally predictable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis.

- The services must be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practices; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

Only a registered and certified occupational therapist has the knowledge, training, and experience required to evaluate and, as necessary, reevaluate a patient's level of function; determine whether an occupational therapy program could reasonably be expected to improve, restore, or compensate for lost function; and, where appropriate, recommend to the physician a plan of treatment. However, while the skills of a registered and certified occupational therapist are required to evaluate the patient's level of function and develop a plan of treatment, the implementation of the plan may be carried out by a certified occupational therapy assistant functioning under the direct supervision of a registered and certified occupational therapist.

Occupational therapy may involve some or all of the following procedures:

- The evaluation and reevaluation, as required, to assess a patient's level of function by administering diagnostic and prognostic tests

- The selection and teaching of task-oriented therapeutic activities designed to restore physical function (e.g., use of woodworking activities on an inclined table to restore shoulder, elbow, and wrist range of motion lost as a result of burns)

- The planning, implementing, and supervising of an individualized therapeutic activity program as part of an overall active treatment program (e.g., the use of sewing activities that require following a pattern to reduce the confusion and improve or restore reality orientation cognitive functioning in a neurologically impaired patient)

- The planning and implementing of therapeutic tasks and activities to restore sensory-integrative function (e.g., providing motor and tactile activities to increase sensory input and improve response for a stroke patient with functional loss resulting in a distorted body image)

- The teaching of compensatory techniques to improve the level of independence in the activities of daily living (e.g., teaching a patient who has lost the use of an arm how to pare potatoes and chop vegetables with one hand, teaching an upper extremity amputee how to functionally utilize a prosthesis, or teaching a stroke patient new techniques to enable him or her to perform feeding, dressing, and other activities as independently as possible).

- Vocational or prevocational assessment and prevocational training.

<u>Speech-Language Pathology Services</u>

Speech-language pathology services are those services furnished a patient that meet all of the following conditions:

- The services must be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a certified/licensed speech-language pathologist.

- The services must be of a level of complexity and sophistication or the condition of the patient must be of a nature that the services can only be performed by a certified/licensed speech-language pathologist.

- The services must be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis.

- The services must be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

Speech-language pathology services include the following procedures:

- Assistance to the physician in evaluating patients to determine the type of speech or language disorder and the appropriate corrective therapy, such as an assessment by a speech pathologist of a patient with aphasia following a recent stroke to determine the need for speech-language pathology services.

- Providing rehabilitative services for speech and language disorders.

Reimbursement for speech-language pathology services is limited to those services related to a medical diagnosis, such as stroke or post-laryngectomy. Long-term speech-language pathology services, such as may be requested for a recipient with a speech impediment, are not covered.

<u>Cognitive Rehabilitation</u>

Cognitive rehabilitation services are those services furnished a patient that meet all of the following conditions:

- The services must be directly and specifically related to an active written treatment plan designed by the physician after any needed consultation with a qualified cognitive rehabilitation therapist.

- The services must be of a level of complexity and sophistication or the condition of the patient must be of a nature that the services can only be

REHABILITATION THERAPISTS' QUALIFICATIONS IN ORDER TO RECEIVE MEDICAID REIMBURSEMENT

PHYSICAL THERAPY SERVICES MUST BE PROVIDED BY:

1. A physical therapist licensed (LPT) by the Virginia Board of Medicine; *or*

2. A graduate (trainee) of a physical therapy program, approved by the American Medical Association *and* the American Physical Therapy Association who is engaged in clinical experience under the direct supervision of a licensed physical therapist as described above; *or*

3. A physical therapy assistant (LPTA) licensed by the Virginia Board of Medicine and directly supervised by a licensed physical therapist as described above.

OCCUPATIONAL THERAPY SERVICES MUST BE PROVIDED BY:

1. An occupational therapist registered and certified (OTR) by the National Board for Certification in Occupational Therapy and certified by the Virginia Board of Medicine; *or*

2. A graduate of an occupational therapy program approved by the American Medical Association *or* the American Occupational Therapy Association who is engaged in clinical experience under the direct supervision of a registered and certified occupational therapist as described above; *or*

3. An occupational therapy assistant certified (COTA) by the National Board for Certification in Occupational Therapy and directly supervised by a registered and certified occupational therapist as described above.

SPEECH-LANGUAGE PATHOLOGY SERVICES MUST BE PROVIDED BY:

1. A Master's level prepared speech-language pathologist (SLP) licensed by the Virginia Department of Health Professions, Board of Audiology and Speech-Language Pathology; *or*
2. An individual who meets one of the following:
    (a) has a Certificate of Clinical Competence (CCC) from American Speech and Hearing Association (ASHA); *or*
    (b) has completed the Masters level academic program and is acquiring supervised work experience to qualify for the ASHA certification *or* the Virginia Board of Audiology and Speech-Language Pathology licensure. This individual is in the Clinical Fellowship Year (CFY), typically a nine month supervision. They must be under the direct supervision of a CCC/SLP.

SECTION III: UTILIZATION REVIEW FOR OUTPATIENT PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH-LANGUAGE PATHOLOGY SERVICES

AUTHORIZATION FOR SERVICES

Physical therapy, occupational therapy, and speech-language pathology services provided in outpatient settings shall include authorization for a given number of treatments within a specific time period and allow for the authorization of extended services based on individual need. The provider must maintain documentation to justify the need for the services. Up to 24 visits each may be made by physical therapy, occupational therapy, and speech-language pathology service providers as ordered annually without authorization from DMAS.

The outpatient rehabilitative services provider shall request from DMAS authorization for treatments deemed necessary by a physician beyond the service limits by using the Preauthorization Request form (DMAS-351). Payment shall not be made for any additional services unless the extended provision of services has been authorized by DMAS. Unless authorized by DMAS, periods of care beyond those allowed shall not be approved for payment.

DOCUMENTATION REQUIREMENTS: OUTPATIENT PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH-LANGUAGE PATHOLOGY SERVICES

For each patient in need of outpatient physical therapy, occupational therapy, or speech-language pathology services, there must be a written plan of care established and periodically reviewed by a physician. **Services not specifically documented in the recipient's record as having been rendered will be deemed not to have been rendered, and any inappropriate payment may be recovered by DMAS.**

The medical record must contain sufficient information to identify the patient clearly, to justify the diagnosis(es) and treatment, and to document the results accurately. All medical records must contain documented evidence of identification data and consent forms; a medical history; a report of physical examinations, if any; the assessment of the needs of the patient, an appropriate plan of care, the care and services provided; observations and progress notes; reports of treatment and clinical findings; and a discharge summary including the final diagnosis(es) and prognosis.

The medical record must include the following information:

1. A physician's order prior to the initiation of any service (i.e., evaluation, or evaluation and treatment). The physician's order for continued treatment must include the following components: discipline, modality/treatment. frequency, and duration. All orders must be signed and fully dated by the physician. A separate physician's order is not required when the physician signs and fully dates a plan of care which includes all the components of the physician's order. The physician's order must be renewed every 60 calendar days. A physician's recertification statement of the continued need for services is also required every 60 calendar days.

The recertification statements and physician's orders must be maintained in the recipient's file and a copy sent to DMAS only when requesting preauthorization of services (using the DMAS-351 form).

2. Provide an accurate and complete chronological picture of the patient's clinical course and treatments. If appropriate, the summary of treatment rendered and results achieved during previous periods of rehabilitative services must be included.

3. An assessment/evaluation by the therapist(s) involved, including diagnosis(es), current findings, current functional deficits, clinical signs and symptoms, and needs indicating the rationale for therapeutic interventions.

4. A plan of care specifically designed for the patient by the physician after any needed consultation with the therapist(s) prior to the implementation of services. The initial plan of care may be prepared and signed by the therapist and then sent to the physician for signature. The plan of care must subsequently be reviewed by the therapist and the physician every 60 calendar days. Revisions are goal-determined. Both the initial plan of care and the plan reviewed every 60 calendar days must be signed by the physician within 21 days of the implementation of the plan of care.

   The plan of care must include patient-oriented, measurable goals (long- and short-term) which describe the anticipated level of functional improvement together with time frames for improvement and/or goal achievement. Therapeutic interventions to be addressed by the therapist must be included: Also included are those interventions to be carried out by the family or other caregivers under the direction of the therapist.

5. Verification of services must be given. Documentation per visit must include the modality/treatment rendered in accordance with the plan of care; the frequency (date the service was given); the patient response to therapy relative to established goals, changes in functional status; the recommendations for continued treatment relative to specific goals; and the identification of who provided the care (full name and title). Flow sheets or checklists/treatment logs may serve as data collection methods to document each individual visit.

6. Any changes in the patient's condition must be documented as they occur, as well as any modification in the plan of care necessary as a result of the changed patient condition.

7. The extent to which the patient/responsible party is aware of the diagnosis and prognosis must be documented.

8. Discharge planning must be an integral part of the treatment plan which is developed at the time treatment is initiated. The plan shall identify the anticipated improvement in functional status and the probable discharge outcomes. The patient, unless unable to do so, or the responsible party shall participate in the plan. Changes in the discharge plan shall be entered into the record as the changes occur.

Appendix 8

Summary of Public Comment

SUMMARY OF ORAL PUBLIC COMMENT
RECEIVED AT THE PUBLIC HEARING HELD ON AUGUST 24, 1999

COMMENTER	COMMENT
Ann Christensen **Vice President** **Speech-Language-Hearing Association of Virginia (SHAV)**	Cited awareness that speech-language pathology assistants were being utilized in Virginia without any official oversight or regulations. Cited a growing need for consistency in the practice of assistants and that, two years ago, their association developed guidelines for training credentials in the use of assistants which were based on the American Speech-Hearing-Language Association's guidelines. The guidelines are not mandatory. Contended that the current statutory and regulatory references to speech-language pathology assistants are not sufficient to guarantee client safety. Referenced written comment in which the association has prepared responses to the Criteria. Focused on harm to consumer. Noted wide range of direct and indirect services to clients, managing clinical equipment and materials, administrative and clerical tasks. Noted that SHAV guidelines require that these duties be supervised directly or indirectly. Cited an example of an assistant administering a treatment plan for a patient with dysphasia (swallowing disorder) and not recognizing the symptoms of aspiration and continuing to feed the patient -- exposing the patient to a life threatening aspiration pneumonia or choking. Cited a second example in which an assistant administered a treatment plan to a client with a significant fluency (stuttering) disorder and failing to recognize the gradual development of a more serious problem. As a result appropriate therapeutic adjustments are not made nor are referrals to other health care professionals (e.g., psychologist) Noted that there are no data that indicate any cases of actual harm in Virginia, to date. The American Speech-Language Hearing Association keeps data for the state confidential, and, consequently, the data for other states, if any, is unavailable. They called various boards throughout the country and asked for disciplinary information to be presented by a later speaker. Noted that border states (Maryland, North Carolina, West Virginia) do regulate speech-language pathology assistants. Expressed concern that persons unqualified in those states would migrate to Virginia because of proximity. Noted that there is no way to determine who is functioning as a speech-language assistant in Virginia or what they might be doing in this capacity. Noted that shortages of speech-language pathologists may make it likely that employers will seek assistants as a way to meet demand for speech, language, and cognitive services.

Ann Christensen **Vice President** **Speech-Language-Hearing Association of Virginia (SHAV) (cont'd)**	Expressed concern over the potential for fraud because the public is not generally knowledgeable about the role of speech-language pathologists and assistants and the difference between them and because of concern over fraudulent billing when assistants act independently. Urged that a specific policy of supervision be established in the regulations that tie assistants to licensed speech-language pathologists for providing services and billing for services. Referenced written materials provided and expressed that the regulations developed in North Carolina constitute a "good model" for Virginia to review. In North Carolina, they have statewide training and credential for assistants, connection between licensees and assistants, supervisory ratios, and speech-language assistants registered under a specific speech-language pathologist, very specific lists of authorized tasks allowed assistants. Contended that the North Carolina regulations protect the public by establishing supervisory relationship parameters and preventing the use of assistants in an inexpensive way to replace the most qualified provider as required by IDEA and their code of ethics. **In response to committee questions:** In North Carolina, the assistants are registered with the state through their supervising speech-language pathologist. The North Carolina Speech-Language Hearing Association obtained a grant from the American Speech-Language Hearing Association to develop the state's minimum competency test for registration. The first administration was in June 1999 in conjunction with community colleges. Requirements for the registration applicants are detailed in the association's written comments. Among other requisites is a bachelor's degree with certain core coursework and clinical practicum. As a follow-up to the issue of no record of harm to date, Ms. Christensen opined that the dearth of disciplinary data in Virginia existed because no state entity regulates assistants here. She noted that the employers of the assistants might be hearing complaints and that ASHA has obtained information from other states such as Texas, North Carolina, and Maryland. The chief issue in those states was that the assistants were not staying within their scope of practice -- particularly they are treating dysphasia patients. It was noted by Board members and staff that the Audiology and Speech-Language Pathology board's report last year reported 127 persons were reported as functioning as assistants in Virginia. Further BHP's survey indicated that 182 individuals were reported by responders to be under this job title -- most of which are employed in public settings (presumably schools). Staff cautioned that there is no valid way to confirm these numbers because of the difficulty in getting someone to say that they are using an employee illegally. Board member, Ms. Elizabeth Marshall who is herself a speech-language pathologist indicated that the data from North Carolina are muddy because registration occurs through the speech-language pathology licensee registering his assistants. The assistants are not registered as individual professionals. In response to a question about whether an individual can operate without being registered in North Carolina through exemptions, Ms. Christensen answered that one could.

Ann Christensen **Vice President** **Speech-Language-Hearing Association of Virginia (SHAV) (cont'd)**	Ms. Christensen reiterated her concern that someone could practice without being affiliated with a speech-language pathologist in Virginia. Noted that she was on the ASHA consensus panel that developed the guidelines for the use, training, credentialing and supervision of speech-language pathologists nationally. She has worked with 36 states as supervisor of clinical operations (physical therapy, occupational therapy, speech, and respiratory therapy). Indicated that her expertise is outside of Virginia. Reported that she contacted licensure boards in other states and asked them their "gut level" opinion about how things were working. She indicated that her sense was that many more people are working as assistants than say that they are working. They wear "different hats"-- rehab aides, rehab associates, techs." She notes that "support personnel" is a big "lump term." Noted concerns that states who entered into regulating assistants without sufficient forethought regretted it. She noted that the problems, when there are problems, is that the schools are not working with the medical groups to have an arrangement so that data is shared on problems that the school system is having. She advocates for some sort of depository of shared information between the State Education Association and the regulatory bodies for medicine and allied health. **In response to follow up questions:** Mr. Cannon asked how reimbursement issues are handled by the education departments in other states that are similar to Virginia. Ms. McNamara's response was that it depends upon the bill-paying intermediary for the Health Care Finance Administration (HCFA). The Medicaid reimbursement issues depend upon how the intermediary interprets HCFA's regulations -- in some states aides' work is reimbursed in others not. She did not wish to personally respond to how the issues are handled in Virginia. She noted other speakers were present who could more effectively speak to the issue. Ms. Cebuhar asked about how nursing home care would be affected. Ms. McNamara responded that it would not as long as you have fully ethical speech-language pathologists supervising. However, her concern was that some "fall through the cracks" -- that even supervising speech-language pathologists may not follow national guidelines in the absence of state regulation to enforce it. Also on the issue of reimbursement, Ms. McNamara indicated that for decades in many states that that physical therapy assistants, occupational therapy assistants have biled at two-third the rate of the licensed supervisor. They would not be doing any decision-making or evaluation, but the supervisor would delegate certain activities to them that would be necessary in the treatment plan. They were supervised to minimize the risk to the patient. However, she noted concerns in the schools and in some settings where strict ethical guidelines are not followed that patients are not protected. Ms. McNamara also provided written materials concerning the training programs in the U.S. and about the ones that are contemplating beginning based upon whether the assistants become regulated by the states. She noted that Iowa and Michigan had training programs

	without state regulation.
Sally Joan McNamara, National health care consultant, Rehabilitation consultant, Member of SHAV and ASHA	Ms. McNamara confirmed that there are no programs currently in Virginia, but indicated that some places are prepared to begin. She also noted that the programs that she knew about that exist elsewhere are based on the national guidelines for the training and credentialing of the assistant -- chiefly at the community college level such as is the case for certified occupational therapy assistants. She noted that there are many bachelor's level speech pathologists who have not been able to get into graduate school and had other obligations but would like to become registered speech assistants and work towards their speech-language pathology licensure while working. In response to Dr. Carter's question about where ASHA is in developing national accreditation standards for the programs, Ms. McNamara indicated that it is a "work-in-progress." Ms. McNamara indicated that it would be another year before the standards would be finalized. Ms. Marshall indicated that there is some concern over the financial risk of the accreditation program for service and training programs. When asked by Ms. Cebuhar about the Iowa programs, Ms. McNamara indicated that the community college model of training and then on-the-job training with the supervisor is favored but Iowa has not finalized their position. She indicated that they are anticipating two levels of registration --- Assistant I and Assistant II. For Assistant I, the applicant has to have a high school diploma and be 21 years of age, have three semester hours in audiology or speech-language pathology. Fifteen hours of instruction or 75 hours of tightly supervised practicum. Twenty percent direct supervision (line of sight). For Assistant II, 15 clock hours of practicum in specific tasks and local training equivalent to an associates degree. Ten percent direct supervision is required, as is approval by one board member. Each supervisor would only have three assistants unless a state regulating board would determine it to be inappropriate.
Sarah Peters Liaison SHAV State Special Education Advisory Committee	Urged the Board to look at regulations as a positive thing. Made a personal reference to her daughter who is a physical therapy assistant being urged to go on and become a physical therapist. She indicated that this career ladder aspect serves as one of the benefits of legitimizing the speech-language pathology assistant. She also noted that she teaches as an adjunct professor at J. Sargeant Reynolds for the COTA program. The training programs for COTA's and OTL's are very different with diverse levels of training. She stressed the importance of supervision of COTA's and PTA's and SLPA's. She noted that supervision was not as important in the former two groups because they have training programs.
Rita Purcell Robertson: President of the Speech, Hearing, Language Association of Virginia (SHAV)	She indicated that they appreciated the Board's participation in the study. Posits that the regulation of assistants is an important issue. She noted their concern about the potential for harm to consumers She also cited concern about the interpretation of what is legal. She reported that the association had asked for clarification from the Board of Audiology and Speech-Language Pathology which it received this week. She stated that according to her understanding of the interpretation, assistants may do administrative tasks but not discretionary tasks. Within a practice, the license holder determines how the assistant is used. She held that the regulations are too broad regarding the discretion afforded the licensee when supervising the assistant.

Rita Purcell Robertson cont'd	She cited concerns that profit motive will prevail and that lesser qualified persons will be hired over masters degree licensees. She noted the $1,500 Medicare cap for physical therapy and speech therapy services for a patient. She reported that many of her colleagues have said they are being fired or being told to be on call for 40 hours a week without 40 hour a week compensation. She cited concern over those in nursing homes not knowing the qualifications of staff. She also reported that there are seven speech-language pathology programs in Virginia, five that provide a masters degree (University of Virginia, Radford University, Old Dominion University, Hampton University, and James Madison University). The only program that provides a doctorate is the University of Virginia. There are two other programs that are undergraduate only -- Longwood College and Norfolk State University. She was the former program coordinator at Longwood. They examined the feasibility of providing a program for assistants. She posited that the aim of most health related an undergraduate program is tha t they are designed to be "pre-professional." Their focus was on introducing the students to providing service. This necessitated that the students be given a broad introduction to different disorders, but they are not qualified to deliver the services in these areas only with undergraduate level education and training. She stated that many programs in the state provide very few clinical hours. Within the four year program at Longwood, students obtained 40 observation hours and 60 therapy hours. They attempted to shift the focus into a more pragmatic, therapy-oriented focus. They approached Southside Community College about developing a program to provide speech-language pathology assistants certification or an associates degree. They indicated that they could use distance media to provide classes for both programs. She reported that Gary Pillow and Christina Clark were working in other geographic areas of the state to set up similar programs. Ms. Clark worked with local community colleges and laid out an entire curriculum, but the community colleges did not determine that there was sufficient need for the program to actually provide it. She noted, that unlike Iowa, where a training program exists without state certification, registration or licensure, in Virginia's schools have turned them down. She contended that in order for the programs to begin in cooperation between the Virginia the Department of Education and state regulators will be needed first. Some advance time will be required to afford academia the planning and implementation time needed. In response to Dr. Carter's question about the lack of national accreditation standards for any asssistant program, Ms. Robertson indicated that the current bachelor's programs are not accredited either -- only the master's degree programs. In response to Ms. Marshall's question about enrollment in the bachelor's programs, Ms. Robertson indicated that 60 students were in Longwood with approximately 20 seniors, 20 juniors and 20 underclassmen. At Norfolk State, it was estimated that they had 60 students total as well. Mr. York questioned the audience about the types of complaints that are received, regardless of who receives them. Ms. McNamara responded that the majority that are known are about people operating without a current license or certification. Many of these are found to be cases in which the respondent did not know that his or her supervisor did not register him or her adequately. The remaining types of complaints center around swallowing disorders -- especially aspiration pneumonia.

Sara Jones McNamara **Ann Christensen** **Rita Purcell Robertson** **(identified earlier)** **responding to follow-up questions**	When asked by Dr. Carter if she was aware of any complaints that tie into the unregulated person not recognizing secondary symptoms, Ms. McNamara replied that because of the perspective payment Medicare system, staff in nursing homes have to do more with less. A team of physical therapists, occupational therapists, speech-language pathologists, nurses and so forth conducts an initial observation on the patient. There is little in depth profession specific evaluation going on. Even though she is a speech-language pathologist, she may be the one to note that the patient has a bed sore -- noting its location and estimated circumference -- certainly not specified in the normal scope of practice for speech-language pathologists. She stated that her concern was that they have to do more with less with more risk involved. When asked by Ms. Cebuhar who is ultimately in charge, Ms. McNamara indicated that the director of rehabilitation would assume final responsibility for the team; however, each licensee could be viewed as separately responsible by their regulating boards. Discussion about ASHA's National Code of Ethics indicated that the speech-language pathologist must be adequately trained before doing anything or not do it at all. Another example Ms. McNamara cited was nasoendoscopic procedures that they now do with fiberoptic endoscopes. It is involved in cleaning out the ears and viewing swallowing up close. Ms. Cebuhar questioned whether it would be likely that an assistant would be trained to do nasoendoscopic procedures. Ms. Marshall indicated that not all of the licensed speech-language pathologists have been qualified to do some of the specialized tests. Ms. Cebuhar stated that assistants would never be in a position and/or a training situation to do this function, but they are in a position to do other high risk activities, feeding and positioning. Ms. Christensen indicated that improper positioning of a muscular dystrophied child can be devastating to the respiratory system. Ms. McNamara indicated that she had concern about individuals who had been working in a facility under a neurologists or otolaryngologist or another type of physician then got some training as speech-language pathology assistants. Such individuals may have established a level of comfort working with the staff at the facility and may overstep skill level boundaries as a result of the false security. Ms. Cebuhar reminded the committee of the report of the Board's Criteria study from 1998 where emergency medical technicians ere shown to be on intensive care units pushing IV's. Ms. Cebuhar indicated that she did not feel that the committee had a firm grasp of the threat assistants posed given that they are likely to be highly supervised. Ms Cebuhar asked if nursing facilities are having difficulty getting basic staffing, why should assistants be licensed? Ms. McNamara indicated that she believed there is sufficient rehabilitation personnel available. Ms. Cebuhar asked whether access to qualified personnel was the issue. Ms. McNamara indicated that it may be an issue in rural areas but that others should address the question. Ms. Cebuhar asked if the speech-language pathologist licensee understands where the risk is in their scope of practice duties and that high risk duties should not be delegated to assistants. Ms. McNamara referenced the ASHA code of ethics but indicated that the strength

Sara Jones McNamara **Ann Christensen** **Rita Purcell Robertson** **(identified earlier)** **responding to follow-up questions** **(continued)**	of enforcement lies with the regulatory body of the respective state. She cited how strong enforcement was in North Carolina and that, consequently, most licensees regularly refer to statute, regulation, and their Code of Ethics. However, in other states Ms. McNamara indicated that she believed fewer than two percent of licensees were similarly attuned to their legal and ethical responsibilities. Ms. Cebuhar summarized Ms. McNamara's comments by saying that effective adherence to the Code equates to regulatory intervention or threats from ASHA. Ms. McNamara indicated that ASHA's guidelines are minimal requirements. Dr. Carter's asked whether supervisors other than speech-language pathologists were using speech-language pathology assistants without some input from a licensed speech-language pathologist. Ms. McNamara indicated that she was not aware of any cases and that the speech-language pathologist at the facility should object to it and stop it. However, she did not rule out the possibility that it could happen Ms. Cebuhar asked Ms. McNamara about her experiences with home health and temporary agency paraprofessional personnel. Ms. McNamara indicated that she had been Vice-President of Operations for Mariner Health – a conglomerate in New England and Texas, Michigan and Ohio. She indicated that concern had been expressed in some parts of the country relating to the lack of continuity of nursing care sometimes experienced when temporary employees are brought it. Legally, there have been no problems, but style and philosophy may differ. However, relating to speech-language care, she was not aware of a problem. Ms. Cebuhar noted one of the results of the Board of Audiology and Speech-Language Pathology's survey from last year indicated that the respondent thought that licensing, registering, or certifying assistive personnel would assure quality of services. She asked for clarification as to how. Ms. McNamara indicated that pressures in health care are forcing the speech-language pathologist to take on more of a supervisory/managerial role and do less hand-on, one-to-one therapy. She cited an example of previously being able to see a dysphagia patient at each meal individually. Now, the patients are seen in groups with assistants or rehabilitation techs. She preferred the use of speech-language pathology assistants or rehabilitation techs to certified nurse aides with no speech-language training. She urged the importance of training people how to feed. There are high turnover rates. Dr. Carter indicated that she was confused and asked how regulating speech-language pathology assistants change how economics drive the use of personnel in nursing homes? If they are using C N A 's now, what would make them use speech-language pathologists and assistants? Ms. McNamara indicated that in small facilities, nothing would likely change, but in larger facilities the quality of what the aides would be doing would be much higher than someone simply hired off the street and told "you're a nursing assistant." Ms. Robertson reiterated the importance of not giving the patient aspiration pneumonia. Ms. Robertson indicated that the companies need to be educated to the safety value of using appropriately trained people. Ms. Marshall asked Ms. McNamara whether she was aware of any impact that having regulated assistants has had on third-party reimbursement. She was unaware of anything. She did note that she did not think there was a financial incentive to the facility to use unlicensed personnel. She reported that in the past 12 years some facilities submitted claims to the Health Care Finance Administration (HCFA) intermediary party at two-thirds of the rate but also billed for aides or techs (in some states) at a much lower rate. Ms. Marshall asked if Ms. McNamara was aware of any job displacement. She was unaware of it happening in speech-language

Sara Jones McNamara **Ann Christensen** **Rita Purcell Robertson** **(identified earlier)** **responding to follow-up questions**	pathology but was aware that it was happening in physical therapy. Ms. McNamara noted the trend toward companies cutting back all staff. She noted 50% cuts in pay. She noted a problem in Alabama in which assistants were being asked by a corporate entity to have their own case loads because state licensure regulations allowed it. Ms. McNamara wanted to state for the record that she has been in many situations that have operated very smoothly using ASHA guidelines in the absence of state regulation. She noted those situations were in states where licensees never hesitated to allege violations of the statutes or regulations. She indicated that Virginia's licensees tend not to make complaints against one another. Dr. Carter asked whether a request to regulate aides would follow. Ms. McNamara indicated that some states do have a two-tiered system, with aides below assistants. The aides are usually C N A 's but are considered among C N A's to be a little higher than the regular floor C N A, they are paid five to seven cents an hour more, and this helps to reduce turnover. Mr. York summarized that the expectation is if we regulate them at the proper level with the right standards all of these people would upgrade and do a better job. Ms. McNamara replied that some would upgrade—certainly at the assistant level – but it may not make much difference at the C N A level unless they chose to do the two-year program and work toward becoming an assistant.

SUMMARY OF WRITTEN COMMENT
Deadline for Inclusion - September 1, 1999

COMMENTER	COMMENTS
Ann Christensen **Speech-Language Hearing Association of Virginia (SHAV)**	Provided SHAV's written response to the Criteria regarding the need to CERTIFY speech-language pathology assistants in Virginia.
Sally Jones McNamara **Healthcare Consultant to SHAV**	Provided curriculum vitae detailing 30 years of experience in health care administration, business management, personnel management as well as licenses and certifications in speech-language pathology and education. Also provided her own research from other states' experiences in regulating assistants. Finally, she provided an updated listing from the American Speech-Language Hearing Association (ASHA) of self-identified two year programs currently (August 16, 1999) in existence. It should be noted that there is no endorsement of the programs by ASHA; ASHA had not yet reviewed or evaluated the programs. Finally, a listing of colleges identifying themselves as developing or considering developing speech-language pathology assistant programs as of June 1999. Again, this list supplied by ASHA does not indicate that ASHA has reviewed the potential programs nor endorses them.
Linda A. Meyer, Ph.D. CCC/ SLP **Member, SHAV**	Advocates for regulating assistants. Has used assistants and indicates awareness of the risks inherent in various settings in which speech-language pathology services are offered. In response to there being no known complaints from citizens, she contends that Virginia should be proactive so that the state could guide the development of the increasing use of assistants. Cites concerns over potential for misuse of assistants in a rapidly changing healthcare environment. Cites concern that three border states (North Carolina, Maryland, and Tennessee) do regulate assistants and that Virginia may serve as an area where less qualified persons come to work. Notes awareness of two colleges in Virginia that are ready to provide training to assistants. Indicates that she would welcome having a pool of qualified persons knowledgeable about practice and professional ethics.

Sara Elizabeth Runyan	Main concern she registers centers on the speech-language pathologist having the "complete responsibility" for the actions of the assistant. Contends that "supervision" is not adequately defined. Indicates that there should be a clear chain of responsibility which is supervisory/ managerial/responsible and the assistant being responsible for duties assigned by the speech-language pathologist. However, the speech-language pathologist rarely hires the assistant. Contends that the definition for supervisory responsibility should be expanded to all issues related to the preparation of the speech-language pathologist to supervise and prepare the assistant and not assign duties to the assistant who has not been adequately trained.
Carol C. Dudding **Speech-Language Pathologist**	Reports being a speech-language pathologist for 12 years in a variety of settings. Reports currently being a supervisor and instructor at the University of Virginia. Advocates further study of the issue of regulating assistants and some form of regulation be evolved.
Gayle Daly, MS, CCC, SLP	Expresses concern about the lack of regulation and training of assistants in Virginia. Advocates regulation, including training requirements, as a means to protect the public and professionals. Contends that an Associates degree is the appropriate level of education. Cites concern over major companies employing assistance with an eye toward the bottom line, with the supervising speech-language pathologist not having complete control over what the assistant is assigned to do.

Appendix 9

Initial Policy Options for Study Recommendation

Policy Options

For the Committee's reference, a copy of the *Policies and Procedures for the Evaluation of the Need to Regulate Health Occupations and Professions* (the *Policies*) is provided. The *Policies* delineates the guiding philosophy and evaluation standards to be employed. A broad range of policy options is available for the Committee's consideration. The listing is not exhaustive, but is provided as a framework for initial deliberaticns.

Statutory Certification Should be Mandated to Restrict the Use of the Title "Speech-Language Pathology Assistant" to Those Adequately Trained

Statutory certification merely protects the profession's title. No scope of practice is reserved to the group. However, legal use of the title "speech-language pathology assistant" would be conferred only those individuals who meet the state's certification standards, defined in terms of education and minimum competencies. Required statutory certification is the appropriate option if the Committee can argue the following:

- There is a moderate potential risk to the public that is attributable to the nature of practice, client vulnerability, or practice setting and level of supervision.
- The level of skill and training required to practice safely can be differentiated from ordinary work. The candidate must have successfully completed education and/or experience requirements that are certified by a recognized accrediting body.
- There is some independence in practice, but the majority or practice actions are directed or supervised by others.
- The scope of practice is definable, but not enforceable in legal terms.
- The following Criterion 1 (risk of harm), 2 (specialized skill & training), 4 (scope of practice), 5 (economic impact), and 6 (alternatives) must be met.

The cost of regulating with statutory certification is variable depending upon how restricted the supply of practitioners is. As mentioned previously it is known that over 180 persons practice throughout the state in varying capacities (mostly conducting screenings and implementing treatment plans) as assistants/aides. Although the regulations governing audiology and speech-language pathology call for the licensed speech-language pathology to assure that the person to whom duties are delegated has an appropriate level of education and training, there is currently no nationally recognized private credentialing for assistants or aides nor for their educational programs.

Registration Should be Required of Those Calling Themselves Speech-Language Pathology Trainers

Registration requires only that an individual file his name, location, and perhaps some background information. No entry standards are typically established. Registration is the appropriate level of regulation if the Committee believes following:

- There is a low potential for risk but consumers need to know that some state redress is possible.
- Skill and training can be variable but differentiated from ordinary work and labor.
- Autonomy is variable.
- Criterion 1, 4, 5, and 6 must be met.

When compared with the cost of the other forms of state professional regulation, registration is low. However, removal from the registry is the strongest disciplinary mechanism available to address problems.

No Change in the Status Quo is Needed

If the Committee does not believe Criteria 1, 4, 5, and 6 are met, then regulation of speech-language pathology assistants, per se, would not be necessary. However, if some statutory protection is sought, the Committee may wish to explore the development of criminally enforceable provisions for disclosure of the qualifications by the individual providing acting as a speech-language pathology assistants or of strengthening of general consumer protection laws.

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