Diagnostic Clinic Procedures

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

Processes and procedures as outlined below may be modified for telepractice evaluations, and are based on a system of electronic client record keeping.

Lead Responsibilities

1. Prior to a planning meeting
   a) Review client's file, research disorder, contact other professionals involved with case as appropriate and if authorization for releases are in place (e.g., speech pathologist, teacher, doctor, audiologist).
   b) Review diagnostic tests and interview procedures.
   c) Prepare a Diagnostic Plan, submitted electronically to supervisor prior to the planning meeting.
2. During a planning meeting
   a) Present Diagnostic Plan to supervisor and assistant for discussion. (These roles may differ in a shared telepractice evaluation.)
   b) Make appropriate changes to Diagnostic Plan as indicated and submit electronic revisions if the supervisor requires them.
   c) Determine duties of Assistant. (These roles may differ in a shared telepractice evaluation.)
   d) Obtain test protocols from Clinic Receptionist if not available in Resource Room.

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

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

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

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

8. Written Documentation
   a) First submissions of report and letter to clients/caregivers are to be typed double spaced in Arial 11 point font with pagination at the bottom center, and are due as electronic or hard copies as determined by Supervisor. Reports should include client initials* until final approval. Late reports will be marked down one-third grade per day according to clinic policy. Include test protocols, language samples and other relevant assessment data with report submission.
   b) Letter to client/caregiver must be individualized and appropriate to their needs. Typically, these are written in a natural tone, summarizing the exit interview and without jargon or reference to tests or results. Discuss the content with supervisor. Priority is to mail letters out within two weeks of assessment. Letters are typically one page, single-spaced, and on letterhead once finalized. Once the letter is finalized, the supervisor is responsible for ensuring that identifying information (PHI) is inserted in a HIPAA compliant manner, electronic signatures applied and that it is filed with the client's records for ASC to mail to client or caregiver.
   c) Write entire diagnostic report without aid of assistant, unless this is a shared telepractice evaluation.
   d) Subsequent edits of report will be due as determined by your supervisor, and initial grade can be lowered if timelines are not met.
   e) Once report is finalized, the supervisor is responsible for ensuring that identifying information (PHI) is inserted in a HIPAA compliant manner, electronic signatures applied and that it is filed with the client's records for ASC to mail to client or caregiver.
   f) Clinician is responsible for uploading scans of test protocols into client's electronic diagnostic file.
   g) Clinician is responsible for communicating disposition status (waiting list, ATP only, no therapy, etc.) to Clinic Director as she is responsible for tracking DX clients.

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

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

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

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

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

Diagnostic Expectations

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

Diagnostic Report Grading Rubric

Statement of the Problem - Abstract of the case
- Written in past tense & avoid wordy and passive voice.
- Personal information included
- Statement of the problem is clearly stated
- Succinct, but includes most important, relevant info, including reason for assessment (e.g. family concerns, determination of treatment objectives, etc.)

History
- Written in past tense and avoid wordy and passive voice.
- Includes all pertinent info, including previous testing (what, where, by whom, results)
- Headings and/or paragraphs in logical sequence according to supervisory suggestions

Evaluation Results
- Written in past tense and passive voice.
- Sub-headings used and organized by area of primary problem first. Ask supervisor about collapsing sub-headings as appropriate (Speech Parameters, Oral Mechanism and Audiometric Screenings, etc.)
- Discussion/analysis/presentation of specific communication behaviors within each domain
- Contains information of significance (vs. irrelevance)

- Scores presented relative to norms (i.e., SS and percentiles most meaningful); less meaningful are age scores.
- Areas that are WFL are described in brief, without inclusion of lengthy detail or examples. Do not comment on unremarkable.
- Analysis goes beyond reporting scores and behaviors.
- Analysis synthesizes the language/behaviors into an organized summary of information.
- Analysis answers the why's of the behaviors that were or were not demonstrated.
- Specific tests are cited and underlined throughout.
- Includes, as appropriate, non-verbal behavior, pragmatics, play/cognitive skills, etc.
- Reports client's response to cues, stimulability, or dynamic assessment as appropriate.

Diagnostic Impression

- Written in present tense and passive voice.
- Restatement of client information and past remarkable history (e.g., previous treatment, special day class placement, complicating medical history/problems, etc.)
- Summary of significant findings from evaluation in functional terms as opposed to test data.
- Report any possible contributing factors.
- Should be able to stand alone, providing reader with a thumbnail synopsis of case.
- Successfully integrates and synthesizes the results with no introduction of new information, etc. You are building a logical case that leads to your Recommendations and prognostic statement.
- Relates current findings to past reports, testing, functioning.

Recommendations

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

Evaluation of Performance in Clinical Practicum

PERFORMANCE RATING SCALE

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

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

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

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

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

Grading Scale – SLHS 696

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

SELECTED GUIDELINES FOR PREPARING DIAGNOSTIC REPORTS AND LETTERS

FORMAT:

1. Only page 1 of Diagnostic Letters is on letterhead; subsequent pages on plain bond.

2. Margins of 1 inch at top and bottom of page for reports and letters.

3. Use pagination, bottom center.

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

5. Cannot have signatures alone on page; adjust text accordingly.

6. Double space between paragraphs.

7. Allow 4 spaces between end of text and signature lines.

PUNCTUATION/STYLE:

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

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

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

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

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

6. Avoid using the client's name in every sentence. Use pronouns as referents after mentioning the client's name the first time.

7. The first mention of any test or formal procedure must be written out in full and underlined, e.g., the Peabody Picture Vocabulary Test – Revisited (PPVT-R). Subsequent references may use abbreviations, e.g., PPVT-R.

8. Punctuation goes inside of quotation marks. "She seems to understand everything." He omitted the final sound in the words "house," "book," and "watch."

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

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

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

PUNCTUATION/STYLE:

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

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

    vs.

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

    He dresses and undresses himself and takes care of his toilet needs.

    vs.

    He dresses and undresses himself, and he takes care of his toilet needs.

    He initiated conversation and used a variety of sentence types.

    vs.

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

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

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

15. PROOFREAD your work.

PROFESSIONAL:

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

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

3. Submit work using phonetic symbols as needed.

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

5. Avoid using the same word twice in a sentence.

6. Write succinctly presenting information in a logical and sequential manner.