

Issues in Ethics: Essential Information for Speech-Language Pathologists

PDH Academy Course #2101
5 CE HOURS



ASHA CE
APPROVED PROVIDER

PDH Academy

Introductory Level

.5 ASHA CEUs

Course Abstract

The topic of ethics in the field of speech-language pathology is a pervasive and sometimes challenging one, applicable to all professionals, practice settings, and types of clients. This course provides a brief review of ethics in general and the American Speech-Language-Hearing Association (ASHA) Code of Ethics (2016) specifically. Ethical issues and applicable principles specific to health care, private practice, and school-based services, in addition to several areas of practice are discussed. The course culminates with case studies depicting potential ethical violations.

NOTE: Links provided within the course material are for informational purposes only. No endorsement of processes or products is intended or implied.

Learning Objectives

By the end of this course, learners will be able to:

- Identify key concepts, principles, and strategies pertaining to ethics and ethical decision-making
- Delineate elements of the American Speech-Language-Hearing Association (ASHA) Code of Ethics (2016)
- Recall ethical issues relevant to specific work settings and current areas of practice

Topic Outline

I. Introduction; Legal, Moral, and Ethical Standards; Ethical Decision-Making (15 minutes)

II. Professional Associations and Regulatory Boards (10 minutes)

III. The National Practitioner Data Bank (15 minutes)

IV. The American Speech-Language-Hearing Association (ASHA) Code of Ethics (2016) (15 minutes)

Why Did ASHA Revise the Code of Ethics?; What Changed?

- V. Ethical Issues in Areas of Practice (180 minutes)
Health Care and Private Practice; Research; School-Based Speech-Language Pathology Practice; Telepractice; Supervision; Utilization of Speech-Language Pathology Assistants; Interprofessional Practice
- VI. Ethical Scenarios; Conclusion (45 minutes)
Billing and Reimbursement; Confidentiality; Supervision; Telepractice
- VII. References and Exam (20 minutes)

Delivery Method

Correspondence/internet self-study with interactivity, including a provider-graded final exam. *To earn continuing education credit for this course, you must achieve a passing score of 80% on the final exam.*

Accessibility and/or Special Needs Concerns?

Contact customer service by phone at (888) 564-9098 or email at support@pdhacademy.com.

Course Author Bio and Disclosure

Theresa H. Rodgers, MA, CCC-SLP, ASHA Fellow, Licensed SLP, EdS (LD), is a speech-language pathology and special education consultant in the metro Baton Rouge area. She is the former CAO for St. John the Baptist Parish government, and a former special education supervisor and speech-language services coordinator for the Ascension Parish School System. Theresa was the 2017 Chair of the ASHA Board of Ethics, served six terms on the Louisiana licensure board including three years as Chair, co-authored a Code of Ethics for SLP Assistants, and has been instrumental in the revision of Louisiana's practice act and Rules and Regulations. She is a former President of the National Council of State Boards of Examiners for Speech-Language Pathology and Audiology for which she has provided Training for Board Members for more than a decade and delivered several invited presentations.

Theresa was the 2020 ASHA President and was previously a member of ASHA's Board of Directors from 2012-2014, serving as Vice President for Government Relations and Public Policy. She was a member of ASHA's SLP Advisory Council, the Continuing Education Board, and a former member and chair of the Council for Clinical Certification. Theresa is a former President of the Council for State Speech-Language-Hearing Association Presidents (CSAP) and the Louisiana Speech-Language-Hearing Association. She has been an invited presenter for numerous state association conferences in addition to the Federation of Associations of Regulatory Boards (FARB), CSAP, and several ASHA conferences. She has also presented internationally on the topic of ethical use of social media. In addition to earning bachelor's and master's degrees in speech-language pathology from Louisiana State University, Theresa holds an Education Specialist's degree in Learning Disabilities.

DISCLOSURES: Financial – Theresa H. Rodgers received a stipend as the author of this course. Nonfinancial – Theresa H. Rodgers served as both a member and chair of the ASHA Board of Ethics, and six terms on the Louisiana Board of Examiners for Speech-Language Pathology and Audiology.

Introduction

With the exception of evidence-based practice, there is probably no other issue in the field of speech-language pathology that transcends all professionals, practice settings, and types of clients, aside from the topic of ethics. Ethical principles, codes of ethics, and ethical decision-making processes are pervasive to our work.

Speech-language pathology is regarded as a “helping” profession, one which has rigorous standards and, fortunately, does not attract unscrupulous, underhanded individuals. Consider that there were 164,772 ASHA-certified speech-language pathologists at the end of 2016 (ASHA, 2017). Compare that number to actions of the American Speech-Language-Hearing (ASHA) Association’s Board of Ethics in 2016. There were 103 new complaints opened, 79 Board of Ethics hearings conducted, and 53 final decisions rendered relative to audiologists, speech-language pathologists, and applicants for certification (Bupp & Robinson, 2017). One can conclude, then, that the number of speech-language pathologists in violation of the American Speech-Language-Hearing Association’s (ASHA) Code of Ethics is relatively low.

Nonetheless, Noma Anderson and Shelly Chabon (2007) affirmed that “Ethical dilemmas are a common and difficult part of the practice of speech-language pathology and audiology.” With increased emphasis on legal and ethical standards, health care reform, technological advances, and the complexity of practice, never has training and education in the area of ethics been more important.

Legal, Moral, and Ethical Standards

Legal (criminal law, civil law, administrative law), ethical, and moral standards establish principles or rules for behavior, and all three are interrelated.

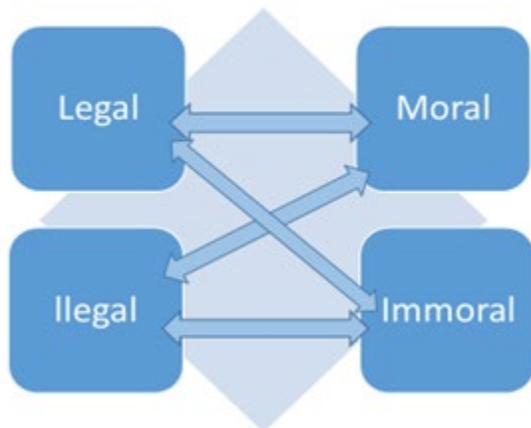
Legal standards dictate what we must do. Whether originating from constitutional, statutory (state), case, or administrative law, legal provisions establish an orderly society and protect the health, safety and welfare of citizens.

Ethics is the branch of philosophy which involves the study of our actions, values and the rules of conduct by which we live (Scott, 1998 in *Ethics for Real: Case Studies Applying the ASHA Code of Ethics*, Davidson, 2008).

Moral values are largely developed within our family and community, consisting of individual beliefs regarding what is right and what is wrong. These values are, for the most part, widely shared and accommodate diversity. While influenced by society, moral values involve personal principles that guide behavior. As stated by Horner (2003), “moral values guide our reasoning, our judgments, and our actions that have in mind the *good of everyone* in our community” (pg. 264).

J. Michael Slocum, Esquire, delineates various relationships between ethics or morals and the law (depicted in graphic below). Is the action legal and moral? This is a non-controversial relationship; one in which professionals should engage in all situations with all clients. Consider how an action could be illegal and moral. Following Hurricane Katrina in 2005, food and water were not available for several days for many affected by the storm. There were families with no mechanism for obtaining these basic necessities, including for young children and the elderly. Glass doors on stores were shattered and food supplies taken without payment in order to meet urgent needs. Certainly this action was not legal, but given the circumstances, could be considered moral. Also, consider how an action might be viewed as legal and immoral. An example of this is abortion – legal provided there is compliance with prevailing laws and regulations, but an act which may be considered by an individual to be immoral based on their values. Lastly, Mr. Slocum delineates a relationship between actions which are illegal and immoral. Most would agree that murder is an example of this categorization of the relationship of the law and ethics.

Ethics and the Law



J. Michael Slocum, Esquire – *Ethics, Law and Regulatory Affairs: Comparisons and Contrasts*

One could argue that a well-established moral foundation is essential in the ethical practice of speech-language pathology. While the terms are sometimes used interchangeably and are interconnected, moral values should not be equated with ethical standards or principles. Consider the Four Principles of biomedical ethics by Beauchamp and Childress, which are widely-regarded as a standard theoretical framework:

- Autonomy – The individual's right to make his or her own decisions; freedom of action and choice.
- Beneficence – Duty to do good for others; acting in the best interest of the individual.
- Non-maleficence – Duty to cause no harm; preventing harm.

- Justice – Fairness; duty to treat all fairly and equally.

Alcroft, in a 2012 blog post, remarked “The values inherent in the principles clearly resonate with our moral norms, and their practical use in ethical decision making is immediately apparent. As a theoretical framework, the four principles remain as useful today as when they were published over 30 years ago.”

Ethical Decision-Making

Possessing a strong moral code and being knowledgeable about legal and ethical standards are not sufficient. The challenge is application of ethical principles in daily professional practice. Further, does the individual practitioner recognize the existence of an ethical dilemma, or a situation in which the speech-language pathologist (SLP) must choose between seemingly unfavorable actions that will affect the well-being of a client? Because professionals may face choices with zero-risk options, it is critical that SLPs are well-versed, not only in applicable laws, regulations, and codes of ethics, but in ethical decision-making processes.

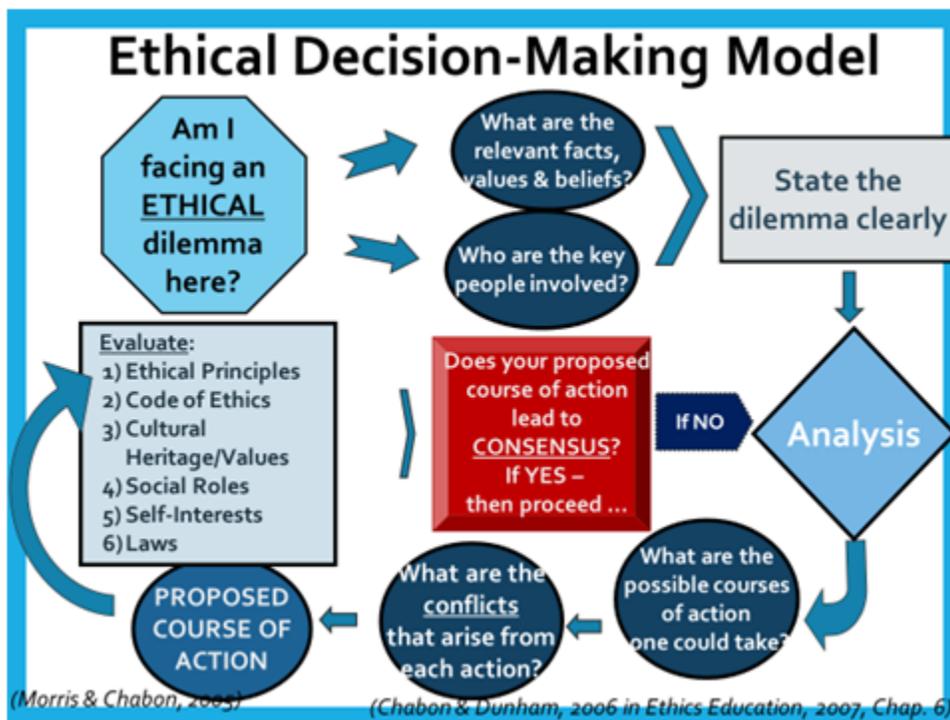
Kitchener developed a critical evaluation model based on the Four Principles which illustrates the role of “virtues” in making decisions. Autonomy, justice, beneficence, non-maleficence, and fidelity (to standards of practice, loyalty to commitments), comprise the underpinnings of ethical guidelines. However, there can be issues in the application of these principles. Consider the freedom of the client to make his or her own decisions. The principle of autonomy presupposes that independence is good; but there may be challenges when a patient chooses not to have an intensive intervention which may seem to be warranted given the diagnosis and conditions, or when the client cannot provide informed consent for various reasons. In applying the principle of beneficence, who determines what is in the best interest of the client? Are practitioners applying the principle of non-maleficence if treatment with thickened liquids is delayed for the patient with dysphagia when there are safety issues?

Ethical decision-making models, including the practical sequential model described by Forester-Miller and Davis (2016), commonly contain the following steps:

1. Identify the problem or dilemma and be aware of the different perspectives that may be used to identify the problem.
2. Identify the potential issues involved considering autonomy, beneficence, non-maleficence, and justice.
3. Review the relevant ethical guidelines. Does one or more exist?
4. Consult with others in analyzing the decision-making strategies and reasoning employed.
5. Consider various possible and probable courses of action.
6. Delineate the consequences of the various actions.
7. Decide upon (what appears to be) the best course of action.

The Consensus Model for ethical decision-making is frequently applied in the field of speech-language pathology. Chabon and Morris developed a process which

incorporates several of the factors identified above, and ensures that the influence of culture and diverse values are considered in deriving appropriate resolution of the issue. In considering the Consensus Model, it is important to be cognizant of the fact that consensus “is not 100% unanimity, nor is it a compromise” (Chabon and Morris, 2004). The first consideration relative to this model is answering the question, “Am I facing an ethical dilemma?” If personal and professional integrity are being challenged, the answer will likely be “yes.” The SLP must determine the relevant facts and identify the key people involved. Based on that information, the dilemma must be stated clearly followed by analysis of possible courses of action (which may be obligatory, impermissible, or permissible) and the conflicts that may arise from each of those courses of action. Next a proposed course of action is determined along with evaluation of the following factors: ethical principles, code of ethics, cultural heritage/values, social roles, self-interests, and applicable laws. Lastly, the practitioner must decide if the proposed course of action leads to consensus. If the answer is affirmative, the practitioner may proceed. Otherwise, the deliberation should be repeated beginning with analysis of possible courses of action and the conflicts that may arise, with subsequent procedures in the process implemented until consensus is reached.



Chabon and Morris, 2005

An important element included in the Consensus Model is the inclusion of culture as a consideration. Many decision-making models omit this component from the process (Oliveira, 2007). Values, beliefs, how information is processed and interpreted, as well as preferences manifested in behavior may frequently be associated with and influenced by culture. Studies have shown that culture dictates how problem-solving occurs because of the influence on how people “think, communicate, and behave” (pg. 15, Oliveira, 2007). Cultural competence, then, is essential in order to understand

underlying assumptions, and recognize cultural differences and their potential effects on the ethical dilemma at hand.

Documentation lapses, employer demands, use and supervision of support personnel, clinical fellowship mentoring/student supervision, reimbursement for services, client abandonment, business competition, impaired practitioners, and affirmative disclosures (of past criminal or professional disciplinary action) have been the most frequently recurring themes to ethics inquiries and/or complaints each year (Bupp, 2012). The American Speech-Language-Hearing Association (ASHA) receives more than 3000 such inquiries annually. Speech-language pathologists can avoid ethical difficulties by discussing potential ethical issues before they become problematic, by knowing and understanding the ASHA Code of Ethics as well as other applicable laws (e.g., licensure laws), regulations and policies, by utilizing evidence-based practices, and by being well-versed in the application of ethical decision-making models such as those depicted in this section.

Professional Associations and Regulatory Boards

The path to certification by the American Speech-Language-Hearing Association (ASHA) encompasses a rigorous journey – years of university coursework and practicum experience followed by a national examination and a thirty-six week Clinical Fellowship. The focus of the university student, as well as the faculty members training the student, is ensuring the requirements for ASHA certification are met. When the graduate degree is in hand and the CCC-SLP (Certificate of Clinical Competence in Speech-Language Pathology) is within view, it is not altogether surprising that state licensure is sometimes an afterthought, and not always well-understood. The role of ASHA as a professional association and the role of the state licensure board should be clarified relative to regulation of the profession and required adherence to codes of ethics.

Speech-language pathology licensure laws¹ exist in all fifty states and the District of Columbia. These statutes regulate the practice of the profession in the respective jurisdictions including the requirements for licensure, scope of practice, exemptions, board structure and function, administrative provisions, and grounds for and types of disciplinary action. The rules and regulations further implement the enabling statute and will typically include a Code of Ethics. Unless a specific exemption is included in the licensure law, all SLPs in the state must hold a license in order to practice. Note that it is not uncommon for the school-based setting² to be exempt; however, if an SLP who works in the schools holds a license, the individual must comply with all mandates of the practice act and rules and regulations including the Code of Ethics.

ASHA represents speech-language pathologists, audiologists, speech, language and hearing scientists, speech-language pathology and audiology support personnel, and students. The ASHA Code of Ethics (2016) is applicable to an individual who holds the CCC and/or is a member of ASHA, or is an applicant for certification, or for certification and membership. These individuals then are subject to the jurisdiction of the Board of Ethics (BOE). ASHA members who are providing clinical services must hold the appropriate CCC.

Given the licensure law in each state, many ASHA members, then, are subject to the jurisdiction of both the state licensure board and the ASHA BOE. However, that jurisdiction is separate and independent as are varying Codes of Ethics/Professional Conduct Standards/Codes of Conduct for each entity. The content of a state licensure board's Code of Ethics may closely mirror the ASHA Code of Ethics, or may be quite different in scope. The complaint and adjudication process of a state regulatory body is specified by the enabling statute and Administrative Procedure Act, and include a

¹ Colorado was the last state to obtain licensure for speech-language pathology (2012). Four additional states, Michigan, New Hampshire, South Dakota, and Vermont, have separate practice acts for audiology and speech-language pathology.

² A growing trend: more than twenty states now require licensure (in addition to or in lieu of a credential from the Department of Education) for speech-language pathologists to work in the schools. This is sometimes referred to as "universal licensure".

description of the investigative and subpoena powers of the licensing board or designee. It is important to note that the ASHA BOE does not have investigatory nor subpoena power, and the complaint materials are critical to the adjudication process.

Could the same complaint be submitted to both the ASHA BOE and a state licensure board and receive a different outcome? Violation of a state practice act and/or rules and regulations inclusive of the Code of Ethics will likely also be a violation of the ASHA Code of Ethics, but this is not automatically nor necessarily the case. Each case is conducted as a separate matter based on the available evidence. A violation of the ASHA Code of Ethics may not be a violation of a state licensure board's Code of Ethics for a variety of reasons. For example, the state licensure board may not have subject matter jurisdiction in that the issue was not adequately delineated within their Code of Ethics. Conversely, a complaint submitted to ASHA Ethics (with little evidence) may not have resulted in an ethical violation following a BOE adjudication, but may result in significant disciplinary action under the jurisdiction of the state regulatory body because of documents discovered during the investigative phase and sworn testimony provided during a hearing.

It is also important to remember that state bodies are typically empowered to mete out a more extensive range of disciplinary sanctions based on their enabling statute. The ASHA BOE may issue a reprimand which is private and is communicated only to the person in violation of the Code of Ethics and the complainant. All other sanctions which can be imposed by the BOE are public: censure, suspension, revocation of certification and/or membership. Additionally, the BOE can withhold membership and/or certification for a specified period of time and this is also a public/published sanction. ASHA BOE decisions resulting in public sanctions are shared with licensing bodies. It should be noted that a 2017 ASHA Bylaws amendment reflects the addition of an ethics examination and/or continuing education hours as potential sanctions for consideration by the BOE.



Rodgers, T. & Waguespack, G. (2016)

Sanctions* – Licensure Boards

- Reprimand (Public)
- Probationary status (e.g., limit practice to areas prescribed by the board; completion of professional education approved by the board until satisfactory skill level achieved, etc.)
- Fine (for each violation)
- Require restitution to a consumer who suffered damages as a result of the conduct
- Suspension
- Revocation
- Other discipline (e.g., Examination on Law and Rules [including Code of Ethics])

Restitution of costs and expenses associated with disciplinary proceedings may also be allowed.

* *Varies from state-to-state as delineated in each Practice Act.*

Rodgers, T. & Waguespack, G. (2016)

Licensure Boards - Considerations in Imposing Sanctions

- Board powers (enabling statute); Federal requirements
- Self-report vs. consumer complaint
- Severity of offense
- Extenuating circumstances
- First or repeated offense for same violation
- Repeat offender for various violations
- Consistency with previous board actions - precedents
- Degree of harm to the consumer

Rodgers, T. & Waguespack, G. (2016). Board member training: Ethical decision-making. Preconference workshop presented at the annual conference of the National Council of State Boards of Examiners for Speech-Language Pathology and Audiology, Santa Fe, NM.

Rodgers, T. & Waguespack, G. (2016)

The National Practitioner Data Bank

Title IV of Public Law 99-660 sought to improve health care quality by creating a data bank for the reporting of medical malpractice payments and other adverse actions for physicians, dentists, and other health care providers, thereby restricting the ability of these professionals to relocate to various states without discovery of these actions. The adverse actions included clinical privileges, certain licensure actions, professional society membership actions, exclusions from participation in Medicare, Medicaid, and other federal health care programs, as well as Drug Enforcement Administration (DEA) controlled-substance registration actions and exclusions. While the original version of the data bank as established by the Health Care Quality Improvement Act of 1986 was intended as a disciplinary clearinghouse for physicians and dentists, speech-language pathologists and other health care professionals were included in the data bank on rare occasions – mainly as the result of malpractice judgments, including settlements. The National Practitioner Data Bank (NPDB) opened in September 1990.

And then along came the HIPDB – the Healthcare Integrity and Protection Data Bank! The legislation creating the HIPDB was originally known as the Kennedy - Kasselbaum Bill, after the two highly-respected senators who sought to protect the public, improve the quality of patient care, and deter fraud and abuse in the health care system through passage of Section 1128E of the Social Security Act, inclusive of the addition of 221(a) of the Health Insurance Portability and Accountability Act of 1996. While a data clearinghouse for final adverse actions had been in existence for some time for physicians and dentists, Public Law 104-191 now mandated reporting for more than fifty professions inclusive of all individuals required to hold licensure or certification in a state in order to provide health care. Speech-language pathologists were included in the mandate. The HIPDB opened in October 1999, requiring the reporting of all final adverse actions by federal and state government agencies (e.g., state licensing boards), Medicare and Medicaid exclusions, health-care related criminal convictions and civil judgments. These adverse actions include reprimands, censures, probations, limitations on scope of practice, suspensions, revocations, voluntary surrenders (of license), and certain other actions.

A third law, Section 1921 of the Social Security Act, which governs operation of the NPDB, cannot be excluded from this discussion. This law expanded protection from unfit health care practitioners to individuals participating in Medicare and state health care programs, and improved the anti-fraud components of the programs. Therefore, data collected and disclosed as the result of Section 1921 includes negative actions or findings for all health care practitioners by peer review organizations and private accreditation organizations, state licensure and certification actions against entities, providers, and suppliers, and final adverse actions taken by certain state agencies including state law enforcement entities, state Medicaid fraud units, and state health program agencies. Health-care related criminal and civil judgments in state court were included. These reports and reports on medical malpractice payments were made available to hospitals, licensing boards, and other health care organizations for the purpose of making decisions about employment, credentialing, and licensing.

The Health Resources and Services Administration, or HRSA, through the federal rule-making process, was authorized within Section 6403 of the Affordable Care Act of 2010 to merge the NPDB and HIPDB in order to avoid the duplicative data reporting and access functions of the two data bases and to improve efficiency at the federal level by streamlining operations. The Final Rule was published in the April 5, 2013 *Federal Register* with the NPDB and the HIPDB merging effective May 6, 2013 into one data bank: the National Practitioner Data Bank (NPDB).

Can an individual SLP query the Data Bank? The answer is both “yes” and “no.” An individual may perform a self-query at any time for a fee, which is currently \$4.00, to determine the malpractice payment, judgments, convictions, and/or adverse licensure action information contained in the NPDB about the individual. It should be noted that respondents do receive a copy of any data sent to the NPDB by licensing boards at the time of the individual’s adverse action report. Individuals may not perform NPDB queries other than a self-query. NPDB information about individual practitioners is not available to the general public.

There are entities which can query the NPDB, including hospitals which are required by law to do so under the following circumstances:

- When a speech-language pathologist (physician, dentist, or health care practitioner) applies for clinical privileges at a hospital or for a position on the hospital’s medical staff
- When a practitioner applies for temporary privileges
- When a practitioner requests to add or expand existing privileges

Additionally, hospitals must query the NPDB every two years on all speech-language pathologists, physicians, dentists, and other health care practitioners who are on the medical staff or who hold clinical privileges. Licensure boards (e.g., when processing speech-language pathologists’ applications) and authorized health care organizations are examples of other entities which can also query the NPDB. The fee may be for a one-time, individual query (\$2.00 per practitioner name) or continuous query (monitoring of all reports on a practitioner for a twelve-month period). Agencies such as the U.S. Comptroller, state Medicaid Fraud Control Units, agencies administering Federal and state health care programs, and other health plans, may only query NPDB reports submitted under Section 1921.

Following are the data relative to SLPs reported to the National Practitioner Data Bank as well as the Health Care Integrity and Protection Data Bank prior to the merger, and the most common reasons for reporting. Numbers for audiologists are also provided.

Data: National Practitioner Data Bank

The fifteen most frequently-reported reasons or bases for actions for speech-language pathologists:

**National Practitioner Data Bank (NPDB)
Reasons for Adverse Action Reports (AARs) for SLPs
(as of December 31, 2011 – pre-merger)**

Major 15 Reasons for AARs	Speech-Language Pathologists
Unprofessional Conduct	50
Violation of Federal or State Statutes, Regulations or Rules	104
Criminal Conviction	35
Failure to Comply with Continuing Education or Competency Requirements	112
Practicing without a Valid License	97
Negligence	17
License Action by Federal, State, or Local Licensing Authority	18
Incompetence	10
Submitting False Claims	4
Practicing with an Expired License	69
Fraud (Unspecified)	17
Misrepresentation of Credentials	14
Improper or Inadequate Supervision or Delegation	35
Improper or Abusive Billing Practices	18
Other (Not Classified)	64

Number of reports* by practitioner type:

Report Type	Audiologists	SLPs	Total
Clinical Privileges/Panel Membership Action	1	2	3
Government Administrative Action	5	7	12
Health Plan Action	8	2	10
Judgment or Conviction	13	66	79
Malpractice Payment	56	20	76
State Licensure Actions	295	1476	1771
Total NPDB Reports	378	1573	1951

**Data is as of December 2016 – post-merger*

Data: Health Care Integrity and Protection Data Bank

The fifteen most frequently-reported reasons or bases for actions for speech-language pathologists:

Healthcare Integrity and Protection Data Bank (HIPDB) Reasons for Adverse Action Reports (AARs) for SLPs (as of December 31, 2011 – pre-merger)

Major 15 Reasons for AARs	Speech-Language Pathologists
Unprofessional Conduct	50
License Action by Federal, State, or Local Licensing Authority	23
Violation of Federal/State Statutes, Regulations or Rules	105
Practicing without a Valid License	98
Failure to Comply with Continuing Education or Competency Requirements	112
Negligence	17
Program-Related Conviction	16

Incompetence	10
Practicing with an Expired License	69
Criminal Convictions	35
Misrepresentation of Credentials	14
Improper or Abusive Billing Practices	18
Improper or Inadequate Supervision or Delegation	35
Failure to Meet Licensing Board Reporting Requirements	44
Other (Not Classified)	63

Number of reports* by practitioner type:

Total of 1216 Reports for Audiologists and SLPs

- 265 reports for audiologists
- 951 reports for speech-language pathologists

SLP Practitioners with Reports

- One Report – 554
- Two Reports – 142
- Three Reports – 23
- Four Reports – 5
- Five Reports – 5
- Total – 729

Audiology Practitioners with Reports

- One Report – 140
- Two Reports – 40
- Three Reports – 4
- Four Reports – 3
- Five Reports – 3
- Total – 190

****Data is as of December 31, 2011 – pre-merger***

ASHA Code of Ethics (2016)

Why Did ASHA Revise the Code of Ethics?

First issued as a component of the 1930 association bylaws followed by formalization as an independent document in 1952, the ASHA Code of Ethics has been modified and adapted as the professions and society have changed. Article VIII of the ASHA Bylaws charges the Board of Ethics (BOE) with the task of formulating, publishing, and from time to time, amending a Code of Ethics (hereinafter referred to as the Code). The Code is revised approximately every five years through careful analysis of the current Code, stakeholder input, and the addition of new and expanded areas based on adjudications within the five-year period. Consideration is also given to current codes of conduct from relevant professional associations and organizations. This task is largely the responsibility of the BOE Ethics Education Subcommittee which submits a draft of the revised Code of Ethics to the BOE for discussion, and ultimately, approval to send to the Board of Directors. This Cardinal document of the American Speech-Language-Hearing Association was approved by the Board of Directors in October of 2015.

What Changed?

Effective March 1, 2016, the Code was implemented with a new Terminology section, a revised Preamble, edited wording of Principles III and IV, and fifteen new rules. There are also edits to additional rules which serve to clarify, update, and strengthen the language in the rules. The organizational structure of the Code is a constant. Principles of Ethics form the underlying philosophical basis for the Code, while Rules of Ethics are specific statements of minimally acceptable as well as unacceptable professional conduct.

As stated in the Preamble, “The Code is designed to provide guidance to members, applicants, and certified individuals as they make professional decisions. Because the Code is not intended to address specific situations and is not inclusive of all possible ethical dilemmas, professionals are expected to follow the written provisions and to uphold the spirit and purpose of the Code,” (ASHA, 2016, pg. 2). It is critical that professionals not only be well-versed in the content of the Code, but are able to apply the Principles and Rules of Ethics in the daily practice of speech-language pathology.

The Terminology section defines certain concepts and terms contained within the Code. Terms range from those that have a legal basis such as the plea of “nolo contendere” (meaning “no contest”) to differentiation of “shall” vs. “may” (“Shall denotes no discretion; may denotes an allowance for discretion,” [ASHA, 2016, pg. 4]). Diminished decision-making ability, negligence, publicly sanctioned, and self-report are also included in the Terminology section along with the mailing address for ASHA Standards and Ethics, required for self-reporting.

The underlying philosophical basis for the Code is found within the four Principles of Ethics. Principles I and II are identical to the prior version of the ASHA Code of Ethics. Principle III and Principle IV have been edited, but still relate to one’s responsibility to the public (III) and responsibility for professional relationships (IV).

Principle I

- Responsibility to persons served professionally and to research participants

Principle II

- Responsibility for one's professional competence

Principle III

- Responsibility to the public

Principle IV

- Responsibility for professional relationships

If the Code is to define minimally acceptable as well as unacceptable statements of conduct, and guide our decision-making as professionals, the Rules of Ethics must, then, reflect currency of practice. As mentioned previously, while there are fifteen new rules³, there are also additional edits to existing rules resulting in clarity and strengthened language. Some of the major themes within the Rules of Ethics include the following (inclusive of new, edited, and unedited Rules):

- Administrative/Supervisory Roles – Principle of Ethics II, Rules F and G (New Rules): These new Rules address practice environment issues including unrealistic productivity demands and being asked to provide services outside of one's scope of training and/or competency.
- Conflict of Interest – Principle of Ethics III, Rule B
- Disclosures – Principle of Ethics III, Rule G (New Rule); Principle IV, Rules F and Q (New Rules): Principle III, Rule G strengthens the requirements for processes related to research, presentations, or writing. Principle IV, Rules F and Q provide specific stipulations for individuals applying for ASHA certification and/or membership or reinstatement (Rule F) and those making or responding to ethics complaints or offering testimony and/or evidence relative to a complaint (Rule Q).
- Impaired Practitioner – Principle of Ethics I, Rule R; Principle of Ethics I, Rule S (New Rule): The new Rule recognizes that a practitioner who is impaired may not be able or willing to withdraw from practice and/or seek professional assistance.
- Informed Consent – Principle of Ethics I, Rule H and Principle of Ethics I, Rule I

³ Thirteen of fifteen of the new Rules are delineated within the thematic delineation of Rules. Principle of Ethics I, Rule M and Principle of Ethics II, Rule B are the other two new Rules of Ethics.

- Intra- and Interprofessional Collaboration – Principle I, Rule B; Principle IV, Rule A (New Rule)
- Patient/Client Abandonment – Principle of Ethics I, Rule T
- Reporting Members of Other Professions – Principle of Ethics IV, Rule N (New Rule): This new rule becomes applicable when the care of those we serve is compromised.
- Research Conduct – Principle of Ethics I, Rule J (New Rule); Principle of Ethics II, Rule C (New Rule); Principle IV, Rule R (New Rule)
- Self-Reporting – Principle of Ethics IV, Rule S and Rule T (New Rules): Requires reporting of convictions or pleas of “nolo contendere” for felonies and certain misdemeanors, public sanctioning by or denial of a license/credential by a professional regulatory body or association.
- Supervision – Principle of Ethics I, Rules D, E, F, G; Principle of Ethics IV, Rule I: The responsibility for the welfare of those being served remains with the certified speech-language pathologist. It should be noted that there are several *Issues in Ethics Statements* housed on the ASHA web site which address various supervisory roles and considerations.
- Use of Technology – Principle I, Rules K, N; Principle II, Rules G (New Rule), H: New language addresses the increased use of technology and telepractice including best practice, treating within scope of practice and competency.

ASHA has a long-standing history of delineation of ethical standards for conduct by professionals. Faced with ethical dilemmas, with at times limited options for resolution, it is imperative that SLPs are both knowledgeable about and skilled in the application of the 2016 Code of Ethics. ASHA, through revision of the Code, continues to provide certified individuals and/or members a document which is relevant, current, and comprehensive.

Ethical Issues in Areas of Practice

The practice parameters and factors that influence ethical decision-making in various work settings can be complex. The changing landscape in the world of speech-language pathology dictates that there cannot be a rote solution to any particular issue, as new situations are continually encountered and may include a variety of environmental constraints for consideration. This section seeks to provide relevant, essential information that can help professional behavior as challenges in the workplace and in certain areas of practice are encountered.

Health Care and Private Practice

One of the "...nation's larger investor-owned skilled nursing, senior living and rehabilitation services providers, with more than 500 skilled nursing facilities in thirty-four states," (News in Brief, ASHA, 2017c, p.12) was ordered to pay \$53.6 million in Medicare fraud claims. *Note: the claims involve Medicaid, Tricare, and Medicare.* The claims are for actions taken by acquired companies (and their personnel), some of which occurred before the companies were acquired by the larger rehabilitation company. While the dollar amount of the fraud settlement is rather shocking, complaints about various aspects of practice in certain health care settings are, unfortunately, no surprise. In this whistleblower case, the Department of Justice's allegations include: billing for more therapy (minutes) than patients received, billing for therapy that was not medically necessary, billing for outpatient therapy services that were not medically necessary or were unskilled, and "upcoding" or assigning patients to a skilled therapy category higher than necessary in order to increase reimbursement (p.12).

In 2016, another company, the "...largest rehabilitation therapy provider in the nation," agreed to pay \$125 million to settle false claim allegations for rehabilitation services in skilled nursing facilities. The allegations in this Medicare fraud case were not dissimilar to those cited above: submitted claims for therapy despite therapists' discharge recommendations, inflated reimbursement by misreporting evaluation time as therapy time, estimated or rounded minutes on claims rather than accurately reporting therapy minutes, "ramped" claims (i.e., boosted the amount of reported therapy during assessment reference periods but provided significantly less therapy to the same patients outside the reference period), reported provision of skilled therapy to patients unable to benefit (e.g., patient asleep, patient transitioned to palliative care), placed patients in the highest reimbursement level rather than individually evaluating patient to determine needed level of care, and other allegations (News in Brief, ASHA, 2016b).

This is not to imply that service delivery in health care and private practice is in some way "more unethical" than practice in other settings although it has been stated that "...ethical issues in healthcare are common," (Larson, 2013). There are countless companies, facilities, and professionals that advocate for ethics and integrity in the delivery of health care services. However, when profit rather than patient-centered care is driving decision-making, SLPs may face ethical quandaries with limited options for resolution. As in other practice settings, it is imperative that the SLP be well-versed in

regulatory requirements and ethical standards including Principle I, Rule M, Principle III, Rules E and F, and Principle IV, Rule B of ASHA's Code:

- Principle I, Rule M: Individuals who hold the Certificate of Clinical Competence shall use independent and evidence-based clinical judgment, keeping paramount the best interests of those being served.
- Principle III, Rule E: Individuals in administrative or supervisory roles shall not require or permit their professional staff to provide services or conduct research activities that exceed the staff member's certification status, competence, education, training, and experience.
- Principle III, Rule F: Individuals in administrative or supervisory roles shall not require or permit their professional staff to provide services or conduct clinical activities that compromise the staff member's independent and objective professional judgment.
- Principle IV, Rule B: Individuals shall exercise independent professional judgment in recommending and providing professional services when an administrative mandate, referral source, or prescription prevents keeping the welfare of persons served paramount.

The results of ASHA's 2019 SLP Healthcare Survey revealed variance in administrative pressure depending on facility type. 68% of the survey respondents indicated they had not felt pressured by an administrator or supervisor to participate in clinically inappropriate activities (listed below) in the last twelve months, which is fairly consistent with 2017 (69%) and 2015 (62%). SLPs working in a Skilled Nursing Facility (SNF) were the most likely group to feel coerced to engage in four out of five of the activities.

- Pressure to provide inappropriate frequency or intensity of services – 14% overall; Range of 8% in outpatient clinics or offices to 23% in SNFs.
- Pressure to delay discharge or to discharge early – 14%; Range of 6% in outpatient clinics or offices to 35% in SNFs.
- Pressure to provide evaluation and treatment that was not clinically appropriate – 12%; Range of 6% in outpatient clinics or offices and home health to 25% in SNFs.
- Pressure to provide services for which the SLP had inadequate training and/or experience – 8%; Range of 6% in SNFs and rehabilitation hospitals to 11% in outpatient clinics or offices.
- Pressure to alter documentation for reimbursement – 4%; Range of 1% in pediatric hospitals to 6% in SNFs.

As evidenced by the multi-million dollar settlements and allegations delineated in the fraud cases described earlier, coding, billing and reimbursement are common areas of ethical inquiry, and potentially ethical (and legal) challenges. Even when there are unintentional coding errors, mistakes on billing claims submitted for reimbursement to the payer can result in allegations of fraud or abuse. The terminology section of the ASHA Code of Ethics defines fraud as “any act, expression, omission, or concealment- the intent of which is either actual or constructive-calculated to deceive others to their

disadvantage.” It is imperative that SLPs thoroughly understand Current Procedural Terminology (CPT®) and ICD-10 (International Classification of Diseases, 10th Revision) codes, Medicare, Medicaid, and other third party payer guidelines, as well as facility policies and procedures relative to billing and reimbursement.

Documentation in health care is a critical area and is directly related to provision of essential clinical information (diagnostic, treatment, and progress or outcome data) and communication with payers and reimbursement. Documentation of services must be aligned with billing records and meet payer standards as well as those of applicable federal and state agencies and the employer. “If it’s not documented, it didn’t happen,” is a common expression regarding speech-language pathology paperwork. Signed, dated documentation which contains clinician credentials is required. Vague, inconsistent, and missing documentation can result in denials by payers. As described in ASHA’s Practice Portal on Documentation in Health Care, at a minimum, the SLP’s record-keeping must address the following:

- Is the service medically necessary? Medicare stipulates that services which are not medically necessary are not covered. (Note that many payers adopt Medicare documentation guidelines.)
- Does the service require the knowledge and skills of an SLP? If the specific expertise of the health care professional is not warranted, then the service is not reimbursable because it is not considered to be a skilled service. Additionally, if the documentation does not reflect the special knowledge and skills of the SLP, the service may be deemed unskilled even though it was a skilled service.
- Are goals and treatment functionally relevant?
- How does the service add value to the patient’s overall health?

ASHA’s Practice Portal on Documentation in Health Care also highlights Medicare guidance in describing reasonable and necessary services in Local Coverage Determination as “safe and effective, not experimental or investigational... appropriate in accordance with standards of medical practice... ordered and furnished by qualified personnel,” (CMS, 2014r-b). The Centers for Medicare and Medicaid Services (CMS) stipulates “...the services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a therapist...” (CMS, 2014r-c).

A common ethical dilemma, particularly in some SNF settings, relates to situations created by productivity demands of 80% - 90% (and sometimes higher) issued by the facility or rehabilitation contractor. SNFs are reimbursed for speech-language services (and other therapies and services) under Medicare Part A which governs inpatient services and hospital stays, and Medicare Part B which applies to medical or outpatient services, including rehabilitation. Part A pays the facility a daily rate which encompasses all services.

Significant productivity demands are placed on SLPs. If 90% of the SLP’s time must be spent in reimbursable activities (i.e., direct patient contact for medically necessary,

skilled services), when does the SLP engage in other necessary tasks such as documentation of treatment (per Medicare guidelines), planning, consultation with the health care team, education of family members, transitioning from one patient to another? In a 2014 *ASHA Leader* article (Cutter and Polovoy), it was calculated that a productivity requirement of 90% for an eight-hour day leaves only 48 minutes for all of the non-billable activities and a productivity level of 85% leaves only 72 minutes. Point-of-service documentation can be a remedy, but practitioners report this is sometimes not possible if the patient's cognitive level, for example, does not allow for involvement of the patient in a discussion of accomplishment of goals and progression with the Plan of Care (POC), or, for example, if an electronic health records system does not facilitate portability. SLPs have resorted to working "off-the-clock" or clocking out in order to accomplish many of these tasks, but this can lead to violation of labor laws.

It should be noted that in 2014, ASHA, in collaboration with the American Occupational Therapy Association (AOTA) and the American Physical Therapy Association (APTA) developed the "Consensus Statement on Productivity and Revenue Conflicts in Health Care Settings" to address concerns about administrative pressures for productivity and other issues related to independent clinical judgment. It asserts, "Clinicians are ethically obligated to deliver services that they believe are medically necessary and in the patient's/client's best interest, based upon their independent clinical reasoning and judgment as well as objective data." Unacceptable practices are delineated, as is information about evaluation and treatment, documentation, upholding clinical integrity, and taking action if there is a problem.

Practitioners should keep in mind that the medical or health record is a legal document. Any change to the record must be dated and initialed by the original documenter. Should there be evidence of an improper alteration, it is the ethical obligation of the SLP to report such instances. While reporting procedures are usually delineated, the SLP should also consider the applicability of a rule added during the revision of the ASHA Code of Ethics (2016). Principle IV, Rule N states: "Individuals shall report members of other professions who they know have violated standards of care to the appropriate professional licensing authority or board, other professional regulatory body, or professional association when such violation compromises the welfare of persons served and/or research participants."

SLPs should be knowledgeable about and able to apply the following Rules from the ASHA Code, which are also pertinent to documentation and reimbursement issues:

- Principle I, Rule J: Individuals shall accurately represent the intended purpose of a service, product, or research endeavor and shall abide by established guidelines for clinical practice and the responsible conduct of research.
- Principle I, Rule K: Individuals who hold the Certificate of Clinical Competence shall evaluate the effectiveness of services provided, technology employed, and products dispensed, and they shall provide services or dispense products only when benefit can reasonably be expected.

- Principle I, Rule Q: Individuals shall maintain timely records and accurately record and bill for services provided and products dispensed and shall not misrepresent services provided, products dispensed, or research and scholarly activities conducted.
- Principle III, Rule C: Individuals shall not misrepresent research and scholarly activities, diagnostic information, services provided, results of services provided, products dispensed, or the effects of products dispensed.
- Principle III, Rule D: Individuals shall not defraud through intent, ignorance, or negligence or engage in any scheme to defraud in connection with obtaining payment, reimbursement, or grants and contracts for services provided, research conducted, or products dispensed.
- Principle IV, Rule E: Individuals shall not engage in dishonesty, negligence, fraud, deceit, or misrepresentation.

Dysphagia is a common treatment area in many health care facilities, and practitioners should be particularly aware of ethical issues in this area of clinical practice. These patients may present with complex profiles including co-morbid conditions. The principles of bioethics including autonomy, beneficence, non-maleficence, and justice guide the SLP's ethical reasoning in providing services to these individuals. While the patient may be vulnerable and we desire to "do no harm," patient autonomy cannot be discarded. A central factor is the patient's decision-making capacity and ability to provide informed consent. When recommending treatment intervention for dysphagia including diet consistency, need for tube feeding, etc., there may be a conflict between the SLP, the patient, and the legal healthcare decision-maker, even when there is clearly an advance directive such as a Durable Power of Attorney for Healthcare. Wigginton (2016) identified that ideally a patient should have a Living Will and a Power of Attorney (for health care) document. Casper (2014) noted that "patient education and counseling support provided by the SLP while delivering dysphagia services should be thoroughly and clearly documented without conveying judgment about the choices made by the patient" (p. 62).

The implementation of evidence-based practice becomes even more difficult when a patient chooses not to follow a recommended dietary regimen. Kaizer, Spiridigliozzi, and Hunt in 2012 (as cited in Horner, Modayil, Chapman, & Dinh, 2016) reported that up to 40% of patients do not follow recommendations for dietary restrictions. In these situations, some SLPs and/or institutions may request that the patient sign a waiver or document releasing the practitioner and/or institution from liability. The document affirms that the patient has received education about risks and benefits (alternatives should also be discussed), "excuses" the practitioner/institution from harm, and documents refusal of the recommended dietary regimen. The patient or surrogate must not be coerced into agreeing to the waiver. Courts may find such waivers unenforceable as a matter of public policy in holding health professionals responsible for the care provided. It has been argued that the "risk of care" cannot be shifted to "...the less knowledgeable and more vulnerable individual: the patient," (p. 465, Horner, et al, 2016).

Ethical issues in private practice should also be noted. When a private practitioner recruits clients for their private practice from his or her primary place of employment, a conflict of interest may exist. Principle of Ethics III, Rule B of the ASHA Code of Ethics (2016) states “Individuals shall avoid engaging in conflicts of interest whereby personal, financial, or other considerations have the potential to influence or compromise professional judgment and objectivity.” There have been complaints filed with the ASHA BOE involving a “...real, perceived, or potential conflict of interest,” (ASHA, 2017a). For example, an SLP who is employed by a public school system nine months of the year and provides private therapy to students from the same school system during the summer months must be cautious in how those referrals for services during the summer are obtained. They must be of the parent’s own volition, and this is not uncommon in the case of parents who want speech-language services to continue during the summer months (in the absence of the child qualifying for Extended School Year Services or services beyond the regular school year). The parents may desire continued improvement in their child’s speech-language skills during the summer and want to avoid any regression in progress. Further, the parents will likely seek out a provider in their community rather than drive a significant distance for the same service. It is important that the SLP inform the school superintendent, director of special education, and speech-language services coordinator (if applicable) of the intent to provide services to students from the school system during the summer. Informed consent (Principle of Ethics I, Rule H) for the private services is another critical issue. The parents must be informed that they will have to pay for the services provided privately and the services offered/provided during the summer months cannot in any way supplant the free, appropriate public education (FAPE) to which students are entitled during the school year.

As stated in *Issues in Ethics: Obtaining Clients for Private Practice from Primary Place of Employment* (2017a), in a similar situation the BOE said “...preservation of the best interests of the persons served is of paramount concern, pursuant to Principle I,” and “...affirmed the principle that once people are timely and fully informed of the choices available to them, they have the right to choose whether and from whom they wish to obtain professional services for their communication problems.” (One should always check for state-level restrictions and requirements in these circumstances. For example, in Louisiana, this type of situation could be a violation of the Louisiana Code of Governmental Ethics [which applies to public school employees who are by definition considered to be a public servant] in that an individual is not allowed to utilize a position to provide himself or herself with anything of economic value.)

Contractual agreements for the provision of services in schools by private practitioners are a fairly common arrangement. Students with disabilities must be provided with mandated services as delineated in the Individualized Education Program (IEP). Private practice owners provide an invaluable service when a school system experiences personnel shortages and the needs of students cannot be met through school system employees. That being said, ethical issues can arise when the SLP views implementation of the contract as an extension of private practice operations at a school site rather than the provision of services in accordance with education laws and

district requirements. It is imperative that the SLP has expertise in federal/state laws and regulations as well as local guidelines regarding required policies, processes and procedures affecting all facets of the school environment including procedural safeguards, evaluation and re-evaluation timelines and mandates, IEP processes, progress report requirements, record-keeping systems (electronic or otherwise), Medicaid billing requirements (if applicable), disciplinary standards and school-based programs (such as PBIS or Positive Behavioral Interventions and Supports), etc. There have been complaints of alleged violations in these circumstances reported to the ASHA BOE. While the alleged violations may range from breach of confidentiality to misrepresentation of services rendered and numerous other areas, the practitioner should be mindful of Principle IV, Rule R, a new rule added to the (2016) ASHA Code: “Individuals shall comply with local, state, and federal laws and regulations applicable to professional practice, research ethics, and the responsible conduct of research.”

Research

SLPs as well as scientists in the area of speech-language pathology strive to conduct research and scholarly activities in an appropriate manner. Research studies are frequently complex; and the design, process, procedures, data analysis, and dissemination of findings must all be implemented in a careful, deliberate manner, particularly when the research involves human subjects. The ethical conduct of research is a critical consideration and component for all involved in these endeavors. It is especially vital for the 598 SLPs whose primary employment function as of 2019 was research (ASHA, 2020), as well as for those predominantly engaged in another aspect of the profession but who also engage in research efforts, including researcher-clinician collaborations.

The National Research Act was signed into law July 12, 1974 and created the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. The identification of “basic ethical principles that should underlie the conduct of biomedical and behavioral research involving human subjects and to develop guidelines which should be followed to assure such research is conducted in accordance with those principles” was one of the Commission’s charges (Fed. Reg., pg. 23192). The Commission’s work resulted in the *Belmont Report*, which, to this day, is viewed by many as the cardinal document guiding the conduct of research with human subjects. It is still an essential, albeit historical, document for Institutional Review Boards, or IRBs, which must ensure that federal regulations (Protection of Human Subjects, 2009), inclusive of ethical principles, are applied.

The *Belmont Report* identified three comprehensive ethical principles relevant to research with human subjects, and noted that other principles may also be applicable. While not identical to Beauchamp and Childress’ Four Principles of biomedical ethics discussed earlier, there are obvious similarities. The fact that “individuals should be treated as autonomous agents” and that “persons with diminished autonomy are entitled to protection” are the two moral requirements involved in Respect for Persons, the first ethical principle described in the *Belmont Report* (Fed. Reg., pg. 23193). *Note: other sources may refer to this as the principle of autonomy.* The autonomous person is

capable of deliberation and choice, and the researcher must respect the individual's right to make judgments based on fully disclosed information. The ability to make research participation decisions may be diminished in other individuals due to mental disability, a health condition, or some set of circumstances restricting the individual's freedom (e.g., prison). These individuals may need extensive protection.

Beneficence, an ethical principle found in much of the ethics literature, is the second basic principle discussed in the *Belmont Report*. While semantically one may think of an act of kindness as demonstrating beneficence, in the field of research (and the practice of speech-language pathology), beneficence is an obligation that exceeds the personal characteristic of kindness. Two general rules of which to be mindful are "(1) do not harm," which is the long-held Hippocratic precept, and "(2) maximize possible benefits and minimize possible harms," (Fed. Reg., pg. 23914). Although more readily associated with medical research, an ethical quandary exists when research for the purpose of learning what may be harmful involves risk to patients. Relative to speech-language pathology, an individual in a clinical trial may not experience improvement in their condition by participating in the research. Hopefully new knowledge would be gained through the study resulting in future benefits. Ultimately, research must "be terminated if harm becomes evident," (Carter & Lubinsky, 2016a, pg. 44).

An historical background relevant to Justice, the third ethical principle delineated in the *Belmont Report*, helps the investigator to conceptualize its relevance. In previous centuries, the poor who were wards in some capacity were involuntary research subjects. Likewise, minority groups who are vulnerable for reasons such as confinement – for example, prisoners in Nazi concentration camps as well as the Tuskegee syphilis study – became unwilling research participants because they were "available" at a given point in history, and were manipulated rather than being selected for a purpose directly related to a research study (Carter & Lubinsky, 2016a). (It should be noted that the Nuremberg Code, which resulted from the 1947 Nazi War Crimes Tribunal, is recognized as the first code of research ethics. The Nuremberg Code became a prototype for codes of ethics. [Fed. Reg., 23192])

Although not specifically mentioned in the *Belmont Report*, non-maleficence relates to the principle of beneficence discussed above. Patients or research participants should be protected from harm and unnecessary risk. Carter and Lubinsky (2016a) also identified the principle of utility relative to rehabilitation research ethics. Are risks disproportionate to that which can be gained through the research study? Which projects contribute most to patient care? The latter question is particularly applicable in the development of research agendas and funding priorities.

The *Belmont Report* emphasizes the application of ethical principles by requiring informed consent, risks benefits assessment, and selection of subjects. Relative to informed consent, sufficient information must be disclosed which generally includes: the research procedure(s) (including duration of subject's participation), purpose(s), risks and anticipated benefits, alternative procedures, extent to which confidentiality of records identifying the subject is to be maintained, statement offering the individual the

opportunity to ask questions and withdraw at any time. How participants are selected, person(s) responsible for the research, and other parameters are additional considerations for stipulation. “The manner and context in which information is conveyed is as important as the information itself.” (pg. 23195) Appropriate rate of speech, organization of details, and allowing time for questions, all contribute to “informed” consent. If the potential for risks is rather serious, there is an even greater obligation to ensure the information is completely understood. While the assent of capable children is desired, utilization of a legally authorized representative to provide informed consent may be necessary in the case of minor children, individuals with diminished capacity, etc. If not freely given, informed consent has not been obtained. Avoidance of conflicts of interest must also be considered. Inducements, undue influence, and coercion are prohibited. Consent is valid only when there is “voluntariness” as stated in the *Belmont Report*.

The last two applications of research ethics described in the *Belmont Report* can be summarized as follows:

- Systematic, nonbiased assessment of risk should be determined to the extent possible through thorough review and analysis of information in employing methods for ascertaining risk.
- “Fair procedures and outcomes” including application of the principle of justice must be utilized in the selection of research subjects (Fed. Reg., pg. 23916).

The U. S. Department of Health and Human Services established the Office of Human Research Protection because of the potential for misconduct and resulting negative consequences. The Office of Human Research Protection (OHRP) functions under the statutory authority of United States Code (USC) Chapter 42 – Public Health and Welfare. In addition to providing a significant amount of information including policy and guidance in the area of research ethics, the OHRP also investigates ethical misconduct allegations.

Although the rights and welfare of research participants, as well as public statements about research results, were addressed in earlier versions of ASHA’s Code, the 2003 revision in particular sought to address “informed consent, confidentiality, humane treatment of animals, and appropriate maintenance of research data” (Mustain, 2003). The current Code (2016) also incorporates aspects of ethical research conduct not found in the 2010r or previous versions. In examining topics for revision, then-ASHA Ethics Director Heather Bupp, Esq., stated, “The high-profile issues that garnered the most debate were those related to... informed consent and diminished decision-making ability,” (Bupp, 2016).

The importance of ethical research practice is evident given the multitude of pertinent rules in the current Code. While there are additional principles and rules of ethics which may be applicable (e.g., Principle III, Rule B – Conflict of Interest, Principle IV, Rule E – Dishonesty,...Misrepresentation), the following specifically reference research activities and conduct.

Principle of Ethics I: Individuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally or who are participants in research and scholarly activities, and they shall treat animals involved in research in a humane manner.

- Rule A: Individuals shall provide all clinical services and scientific activities competently.
- Rule C: Individuals shall not discriminate in the delivery of professional services or in the conduct of research and scholarly activities on the basis of race, ethnicity, sex, gender identity/gender expression, sexual orientation, age, religion, national origin, disability, culture, language, or dialect.
- Rule D: Individuals shall not misrepresent the credentials of aides, assistants, technicians, support personnel, students, research interns, Clinical Fellows, or any others under their supervision, and they shall inform those they serve professionally of the name, role, and professional credentials of persons providing services.
- Rule I: Individuals shall enroll and include persons as participants in research or teaching demonstrations only if participation is voluntary, without coercion, and with informed consent.
- Rule J: Individuals shall accurately represent the intended purpose of a service, product, or research endeavor and shall abide by established guidelines for clinical practice and the responsible conduct of research.
- Rule O: Individuals shall protect the confidentiality and security of records of professional services provided, research and scholarly activities conducted, and products dispensed. Access to these records shall be allowed only when doing so is necessary to protect the welfare of the person or of the community, is legally authorized, or is otherwise required by law.
- Rule P: Individuals shall protect the confidentiality of any professional or personal information about persons served professionally or participants involved in research and scholarly activities and may disclose confidential information only when doing so is necessary to protect the welfare of the person or of the community, is legally authorized, or is otherwise required by law.
- Rule Q: Individuals shall maintain timely records and accurately record and bill for services provided and products dispensed and shall not misrepresent services provided, products dispensed, or research and scholarly activities conducted.

Principle of Ethics II:

- Rule C: Individuals who engage in research shall comply with all institutional, state, and federal regulations that address any aspects of research, including those that involve human participants and animals.
- Rule F: Individuals in administrative or supervisory roles shall not require or permit their professional staff to provide services or conduct research activities that exceed the staff member's certification status, competence, education, training, and experience.

- Rule H: Individuals shall ensure that all technology and instrumentation used to provide services or to conduct research and scholarly activities are in proper working order and are properly calibrated.

Principle of Ethics III:

- Rule C: Individuals shall not misrepresent research and scholarly activities, diagnostic information, services provided, results of services provided, products dispensed, or the effects of products dispensed.
- Rule D: Individuals shall not defraud through intent, ignorance, or negligence or engage in any scheme to defraud in connection with obtaining payment, reimbursement, or grants and contracts for services provided, research conducted, or products dispensed.
- Rule E: Individuals' statements to the public shall provide accurate and complete information about the nature and management of communication disorders, about the professions, about professional services, about products for sale, and about research and scholarly activities.
- Rule F: Individuals' statements to the public shall adhere to prevailing professional norms and shall not contain misrepresentations when advertising, announcing, and promoting their professional services and products and when reporting research results.

Principle of Ethics IV:

- Rule C: Individuals' statements to colleagues about professional services, research results, and products shall adhere to prevailing professional standards and shall contain no misrepresentations.
- Rule H: Individuals shall not engage in sexual activities with individuals (other than a spouse or other individual with whom a prior consensual relationship exists) over whom they exercise professional authority or power, including persons receiving services, assistants, students, or research participants.
- Rule K: Individuals shall reference the source when using other persons' ideas, research, presentations, results, or products in written, oral, or any other media presentation or summary. To do otherwise constitutes plagiarism.
- Rule N: Individuals shall report members of other professions who they know have violated standards of care to the appropriate professional licensing authority or board, other professional regulatory body, or professional association when such violation compromises the welfare of persons served and/or research participants.
- Rule R: Individuals shall comply with local, state, and federal laws and regulations applicable to professional practice, research ethics, and the responsible conduct of research.

School-Based Speech-Language Pathology Practice

More than half, specifically 51.3%, of the 179,409 SLPs certified by ASHA who are also ASHA members, are employed in schools (ASHA 2019 Member & Affiliate Profile).

There are additional practitioners who choose not to be affiliated with ASHA for various reasons, including the fact that the state department of education and/or school district

may not require the Certificate of Clinical Competence (CCC) credential, but who also work in schools. School-based practice is by far the predominant location for delivery of speech-language pathology services.

SLPs in the school setting fulfill an essential role in determining student eligibility for services, designing appropriate intervention plans as a member of the Individualized Education Program (IEP) team, and implementing various service delivery models in collaboration with others to meet the needs of children. The school-based SLP is an integral member of the faculty working to achieve school, district, and state performance standards which reflect students' mastery of English language arts (reading and writing), mathematics, science and social studies skills, and successful outcomes such as graduation from high school with the knowledge and skills needed for college, careers, and life. The complexity of functioning as a school-based SLP can present various challenges requiring proper decision-making and application of ethical principles in delivering effective services. Common issues are discussed in this section.

Expertise in the Individuals with Disabilities Education Improvement Act (IDEA), the state regulations and guidelines for implementing IDEA, and local district policies (e.g., Special Education Policies and Procedures Handbook [for the Local Educational Authority]) governing identification and programming for students with disabilities is an important foundation. For students suspected of having a disability (including speech or language impairment), a comprehensive evaluation conducted by a multidisciplinary team is required. All evaluations must meet compliance standards and be conducted in a timely manner (as defined in regulations/policy). Service provision for children with disabilities is then governed by the IEP which must be reviewed on at least an annual basis. A multitude of standards, regulations, and policies delineate these processes.

Proper training and utilization of resources are essential to avoid not only compliance issues, workplace conflict, and potential due process hearings, but also to ensure ethical practice. As stated in Principle of Ethics IV, Rule R of the ASHA Code (2016): "Individuals shall comply with local, state, and federal laws and regulations applicable to professional practice, research ethics, and the responsible conduct of research." Additionally, Principle of Ethics II, Rule D indicates, "Individuals shall enhance and refine their professional competence and expertise through engagement in lifelong learning applicable to their professional activities and skills."

Lack of record-keeping and inaccurate documentation of services have led to the filing of ethics complaints by school system practitioners, administrators, and parents, and have resulted in adjudications by ASHA's BOE. Concerns may relate to content (questionable or no data collection) as well as the lack of provision of progress reports which are required by IDEA ("such as through the use of quarterly or other periodic reports concurrent with the issuance of report cards") to provide parents information regarding progress toward achieving IEP goals. Lack of consistent documentation of services places the SLP and school district in a position whereby implementation of the services agreed upon and guaranteed in the IEP cannot be demonstrated. Additionally, lack of systematic data collection and daily recording of therapy sessions has led to

situations in which services were falsely recorded as if the sessions occurred on a weekend, school holidays, or days children were absent. One of the significant factors in these cases is that there is a pattern of misrepresentative paperwork, rather than a mistake that occurred on rare occasions.

There are several Rules of Ethics that apply in these types of situations. “Individuals shall maintain timely records and accurately record and bill for services provided and products dispensed and shall not misrepresent services provided, products dispensed, or research and scholarly activities conducted,” is the ethical standard contained in Principle of Ethics I, Rule Q of the ASHA Code. Principle of Ethics III, Rule C requires that individuals “shall not misrepresent research and scholarly activities, diagnostic information, services provided, results of services provided, products dispensed, or the effects of products dispensed.” “Individuals’ statements to colleagues about professional services, research results, and products shall adhere to prevailing professional standards and shall contain no misrepresentations,” is indicated in Principle IV, Rule C. Depending on the unique aspects of the situation, there may also be a violation of all or part(s) of Principle IV, Rule E, “Individuals shall not engage in dishonesty, negligence, fraud, deceit, or misrepresentation.”

Almost all states participate in Medicaid billing for speech-language pathology services provided in the schools for Medicaid-eligible children. The services are billed with the individual SLP’s National Provider Identifier (NPI), which is an identification number issued by the Centers for Medicare and Medicaid Services (CMS), or the school district’s identifier. Reimbursement is provided to the school district, and the monies may be returned to the service(s) or program that generated the revenue, or may become part of the district’s general fund. Some districts utilize a third-party agency to complete Medicaid billing, but many school systems require that SLPs systematically complete coding and billing documents which may be electronic. In all instances, there is a direct link between Medicaid billing, the IEP (prescribed services), and documentation of services (dates, duration). When practitioners do not employ effective record-keeping structures or fail to timely and accurately utilize their school district’s on-line data systems for documentation of services and submission of Medicaid claims, Medicaid fraud, even when unintended, may occur. In addition to the Rules of Ethics cited above, Principle of Ethics II, Rule D applies, “Individuals shall not defraud through intent, ignorance, or negligence or engage in any scheme to defraud in connection with obtaining payment, reimbursement, or grants and contracts for services provided, research conducted, or products dispensed.”

Medicaid is a federal-state partnership and each state’s requirements, including provider qualifications, are delineated in the state Medicaid Plan. When a speech-language pathologist does not qualify as a provider due to lack of appropriate credentials (ASHA Certificate of Clinical Competence, state licensure, etc.) or fulfillment of master’s level degree requirements in speech-language pathology, Medicaid billing may still occur for that individual’s services “under the direction of” a qualified provider. Unfortunately, guidance from CMS and most state Medicaid agencies regarding specific requirements for supervision of Medicaid services remains unclear. CMS has clarified

that the qualified SLP assumes ultimate responsibility and that the client/student must be observed at least once, services prescribed, and ongoing service needs periodically evaluated. It is not unusual for school systems to “pressure” ASHA-certified SLPs to “sign off” on Medicaid billing when the sessions have not been supervised in any way. For the SLP to agree to “sign off” without supervising or verifying the occurrence of sessions being submitted for reimbursement is clearly unethical.

Rules of Ethics were added to the revised (2016) ASHA Code to address the type of administrative or supervisory pressures described above. There have also been reported instances of eligibility disputes (e.g., pressure to qualify students for services because of parent advocacy efforts, or to not qualify students due to high caseloads), undue influence outside of IEP meetings over frequency of services, and disagreement over dismissal decisions (e.g., adolescents not being provided with needed speech-language services, insistence on dismissals when caseload numbers are high rather than basing decisions on data and individual needs of students, or compelling the SLP to retain a student on the caseload when the data indicate otherwise). These rules include the following:

- Principle of Ethics II, Rule E: Individuals in administrative or supervisory roles shall not require or permit their professional staff to provide services or conduct research activities that exceed the staff member’s certification status, competence, education, training, and experience.
- Principle of Ethics II, Rule F: Individuals in administrative or supervisory roles shall not require or permit their professional staff to provide services or conduct clinical activities that compromise the staff member’s independent and objective professional judgment.

Also, the rule now delineated in Principle of Ethics IV, Rule B was expanded and strengthened to address these issues: Individuals shall exercise independent professional judgment in recommending and providing professional services when an administrative mandate, referral source, or prescription prevents keeping the welfare of persons served paramount. It is critical to provide information, including discussing ASHA’s Code of Ethics, to supervisors, as a method for preventing/resolving some of these issues. That being said, ASHA’s BOE does not have jurisdiction when the supervisory authority is not an ASHA-certified SLP or audiologist or an ASHA member.

Based on National Center for Education Statistics data through fall 2017, there were 4,952,708 million English-Language Learning (ELL) students enrolled in public schools in the U.S. Assessing and treating children from culturally and linguistically diverse populations including ELL students has sometimes presented challenges in the schools. Differentiating a speech-language disorder from communication difficulties due to learning English as a second language is incumbent upon the SLP and requires adherence to IDEA (§ 300.304) as well as practice standards. Utilization of appropriate assessment and evaluation instruments (particularly avoiding tests which may contain biases) is essential, as is knowledge about the linguistic differences of a child’s language and the developmental characteristics in learning English as a second

language. Arias and Friberg (2016), in reporting the results of their study, stated that "...it would appear that SLPs within schools are attempting to use a combination of measures in order to gain a more detailed account of the student's overall language abilities in the first language and English," (pg. 9). They reported an increase in the number of SLPs utilizing formal and informal measures to obtain accurate information. The ethical considerations for serving culturally and linguistically diverse populations are numerous and are discussed in detail in ASHA's *Issues in Ethics: Cultural and Linguistic Competence* (2017).

A student population with significant medical acuity is evident in the schools. Provision of FAPE (free and appropriate education) is mandated by IDEA as are school health services as specified on the IEP. Dysphagia management in the schools, then, may be an essential component in ensuring student safety, FAPE, and implementation of mandated related services. While SLPs should never engage in any aspect of practice that exceeds their education, training, and experience (ASHA Code of Ethics Principle II, Rule A), it is important for practitioners to recognize their role as an integral member of the team in establishing and implementing school-based swallowing and feeding protocols. ASHA's 2020 Schools Survey indicates that 10% of school-based speech-language pathologists regularly serve children with dysphagia. Is it acceptable/ethical for a school system to stipulate that SLPs in that district do not engage in dysphagia management? It may be ethical if a qualified SLP is not on staff, but may not be acceptable if the service is needed and cannot be managed through referral and/or interprofessional collaboration (Principle I, Rule B). The 2017 article "Make It Happen: School Based Swallowing and Feeding" (Homer and Faust) published in *Perspectives of the ASHA Special Interest Groups* is one of the recommended sources for guidance on dysphagia management in the schools.

Are school-based SLPs engaging in unethical practice if missed sessions are not made up? In ASHA's 2020 Schools Survey, 62.7% of respondents reported having to make up a session any time one is missed for any reason. Contrasting with the majority, 31.9% percent indicated missed sessions do not have to be made up. While IDEA regulations do not address this specific issue, the U.S. Department of Education's Office of Special Education Programs (OSEP) reaffirmed in 2016 (reaffirmation of 2007 guidance letter) that missed sessions must be examined on a case-by-case basis. If interruption of services affects performance and progress to the extent that FAPE has been denied, the session must be made up. School systems do not correctly address the issue by establishing district-level policy requiring that all sessions must be made up or setting a threshold of missed sessions warranting these services. It is an individual decision, based on the needs of the student and the provision of a Free and Appropriate Public Education consistent with the child's IEP.

The ethical requirement (ASHA Code Principle IV, Rule R) to "comply with local, state, and federal laws and regulations applicable to professional practice" has already been emphasized relative to school-based practice. The mandates regarding peer-reviewed research and research-based instruction (including in the delivery of Early Intervening Services) in IDEA must be considered in light of this directive. The law specifically

requires that each student's IEP must include "a statement of the special education and related services and supplementary aids and services, based on peer-reviewed research to the extent practicable, to be provided to the child, or on behalf of the child" (34 C.F.R § 300.320 (a) (4)). Additionally, the Every Student Succeeds Act, or PL 115-95 which replaces the No Child Left Behind Act, requires development of innovative, evidence-based approaches to help struggling learners. Title II, Section 2244 of the law consistently refers to "evidence-based" assessment tools, literacy instruction and strategies, and evidence-based professional learning. The school-based SLP, then, in developing and implementing IEPs and Multi-Tiered Systems of Support (MTSS/Early Intervening), must be aware of and be able to apply peer-reviewed research and evidence-based practice (EBP). Evaluation of treatment outcomes by school-based SLPs is required in data-driven decision making for MTSS, evaluations, and assessment of student progress. Principle I, Rule J of the ASHA Code of Ethics is also applicable to implementation of EBP: "Individuals shall accurately represent the intended purpose of a service, product, or research endeavor and shall abide by established guidelines for clinical practice and the responsible conduct of research."

The dilemma is: are school-based SLPs accessing and implementing research-based practices? A study by Hoffman, et al (2013) revealed the need for formal training in evidence-based practice, although informal training was frequently reported by the school-based SLPs. Reading of zero to four articles in an ASHA peer-reviewed journal during the 2010-11 school year was reported by 71% of the entire survey sample (pg. 272). However, Hoffman, in a 2014 Clinical Forum Prologue, emphasized that the EBP focus does not have to be externalized; rather, clinician expertise and expert opinion, "...hundreds of incremental choices about targets, materials, reinforcement, contingent responses, and explicitness of feedback that practitioners make every day impact intervention," (pg. 89). Hoffman maintained that, "The time has come to look inward, to explore and weigh our own knowledge, preferences and practices," (pg 90). "Therapy is only as good as the clinician who is delivering it. Intervention only happens through clinicians," (pg. 91).

As a final topic for ethical consideration, previously discussed in the context of private practice, school-based practitioners should be aware of the potential ethical violations created by also serving students in a part-time private practice situation. It is not uncommon for parents to seek the continuation of services during the summer months or request additional speech-language therapy after the school day. The SLP who is primarily employed by the school district must take certain precautions to ensure there is not a real or perceived conflict of interest (ASHA Code, Principle III, Rule B) and that the welfare of persons served professionally is held paramount (ASHA Code, Principle I). The school-based SLP considering after-school or summer therapy clients must notify the school district of their intent, and discuss guidelines and any restrictions (local district and/or state governmental ethics code) that exist. Privately provided services by the school SLP may not supplant those that the student with a disability needs and is entitled to under IDEA. That is, the school SLP may not offer to provide additional services after school in lieu of recommending appropriate services (goals, frequency and duration of services, etc.) on the IEP, or qualifying an eligible student for Extended

School Year Services. The parents must be fully informed of their rights under IDEA including services recommended by and available in the school setting.

Telepractice

(Author’s Note: The COVID-19 public health emergency forced a rapid pivot to use of alternative service delivery methods during the pandemic. Telepractice became prevalent in almost all practice settings. The ethical and practice considerations discussed in this section are those most pertinent when there is not a declared federal public health emergency.)

While the term “telemedicine” typically refers to remote diagnostic and treatment services delivered by physicians or nurses via telecommunications technology, and “telehealth” applies to the broader context of clinical (diagnostic, intervention) and non-clinical (e.g., medical information and literature for patients, health administration, etc.) services provided at a distance, ASHA has adopted the term “telepractice.” As indicated within ASHA’s Practice Portal on Telepractice, it is defined as “the application of telecommunications technology to the delivery of speech-language pathology and audiology professional services at a distance by linking clinician to client/patient or clinician to clinician for assessment, intervention, and/or consultation.”

Professional and ethical responsibilities interweave through all areas and methodologies in the practice of speech-language pathology. Utilization of telepractice as a service delivery mechanism is no exception. What a novice may not recognize is that there are unique knowledge and skill parameters that must be mastered, in addition to more traditional aspects of practice, in order to be competent in the use of telepractice for the provision of services. Principle II, Rule A of the ASHA Code states, “Individuals who hold the Certificate of Clinical Competence shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their certification status, education, training, and experience.”

Additional Rules in the ASHA Code which are applicable to telepractice include provisions for competent performance of clinical services, informed consent, evaluation of services including technology employed, confidentiality, provision of telepractice consistent with professional standards and federal and state regulations, use of technology and instrumentation consistent with professional guidelines and in proper working order, and compliance with local, state, and federal laws and regulations.

- Principle I, Rule A: Individuals shall provide all clinical services and scientific activities competently.
- Principle I, Rule H: Individuals shall obtain informed consent from the persons they serve about the nature and possible risks and effects of services provided, technology employed, and products dispensed. This obligation also includes informing persons served about possible effects of not engaging in treatment or not following clinical recommendations. If diminished decision-making ability of persons served is suspected, individuals should seek appropriate authorization

for services, such as authorization from a spouse, other family member, or legally authorized/appointed representative.

- Principle I, Rule K: Individuals who hold the Certificate of Clinical Competence shall evaluate the effectiveness of services provided, technology employed, and products dispensed, and they shall provide services or dispense products only when benefit can reasonably be expected.
- Principle I, Rule N: Individuals who hold the Certificate of Clinical Competence shall not provide clinical services solely by correspondence, but may provide services via telepractice consistent with professional standards and state and federal regulations.
- Principle I, Rule O: Individuals shall protect the confidentiality and security of records of professional services provided, research and scholarly activities conducted, and products dispensed. Access to these records shall be allowed only when doing so is necessary to protect the welfare of the person or of the community, is legally authorized, or is otherwise required by law.
- Principle I, Rule P: Individuals shall protect the confidentiality of any professional or personal information about persons served professionally or participants involved in research and scholarly activities and may disclose confidential information only when doing so is necessary to protect the welfare of the person or of the community, is legally authorized, or is otherwise required by law.
- Principle II, Rule G: Individuals shall make use of technology and instrumentation consistent with accepted professional guidelines in their areas of practice. When such technology is not available, an appropriate referral may be made.
- Principle II, Rule H: Individuals shall ensure that all technology and instrumentation used to provide services or to conduct research and scholarly activities are in proper working order and are properly calibrated.
- Principle IV, Rule R: Individuals shall comply with local, state, and federal laws and regulations applicable to professional practice, research ethics, and the responsible conduct of research.

Is telepractice appropriate for all patients/clients? Telepractice has been successfully utilized with numerous clinical disorder populations. Given that the quality of the service should be equivalent to that provided face-to-face, the unique needs of the individual must be analyzed to determine candidacy. ASHA's Practice Portal delineates the following categories for consideration: physical and sensory characteristics; cognitive, behavioral, and/or motivational characteristics; communication characteristics; and the client's support resources. For example, insufficient manual dexterity for operation of a keyboard or a mouse can be a factor. The ability of the client and/or caregiver to follow directions, cultural/linguistic variables, and access to an interpreter are also examples of critical considerations.

Regulatory constraints can be barriers to the provision of services delivered via telepractice. Licensure is mandatory in all fifty states and the District of Columbia. Practice across state lines requires credentialing in multiple states. With the exception of Louisiana's statutory and 2016 regulatory regulations establishing the telepractice registration credential for out-of-state practitioners (whose out-of-state license is

unrestricted, does not require supervision, is in good standing in the state in which the provider is located, and is comparable to a Louisiana license [qualifications]), all other states with the exception of Florida require that the speech-language pathologist be licensed in the state in which the SLP is located as well as the state in which the patient/client is located. The SLP must also abide by the practice act and regulations, including ethical codes, for every state in which the individual holds licensure. If telepractice services are being delivered to schools, State Departments of Education may require an additional credential issued by their agency. (Similar to Louisiana, Florida established Out-of-State Telehealth Provider Registration effective July 1, 2019, for out-of-state health practitioners licensed outside of Florida.)

There are organizations such as the Federation of State Medical Boards which seek to remove barriers to telehealth services by advocating for licensure portability. The *Interstate Medical Licensure Compact*, which went live April 6, 2017, expedites licensure for physicians to practice in multiple states. As of February 2021, there are more than twenty-five member states, with additional states having introduced legislation to join the compact. The National Council of State Boards of Nursing has a compact allowing registered and licensed practical/vocational nurses to work in multiple states under one license. The enhanced Nurses Licensure Compact went into effect January 19, 2018 when the majority of states adopted it, and thirty-four state legislatures have done so as of February 2021. There is pending legislation in additional states.

The ASHA Board of Directors in 2016 passed a resolution (BOD 23-2016) approving the development and implementation of an interstate licensing compact for audiologists and SLPs. In 2017, ASHA as well as the National Council of State Boards of Examiners for Speech-Language Pathology and Audiology (NCSB) appointed committees to address development of an Interstate Compact for licensure of audiologists and SLPs. As of February 2021, the Audiology and Speech-Language Pathology Interstate Compact (ASLP-IC) has been adopted in six states (Louisiana, North Carolina, Oklahoma, Utah, West Virginia, Wyoming) with legislation pending in fourteen other states. Ten states is the threshold for the ASLP-IC to become operational. Similarly, the Federation of State Boards of Physical Therapy worked with the Council of State Governments, National Center for Interstate Compacts, and the PT Compact now has twenty member states as of early 2021.

Until there is a more universal standard and process for obtaining speech-language pathology licensure, it is critical that SLPs are well-versed on telepractice standards, including ethical provisions, in each state in which licensure is held. As of the fall of 2019, twenty-eight states had regulations specific to telepractice in speech-language pathology while five jurisdictions (California, the District of Columbia, Massachusetts, Minnesota, South Carolina) have developed telepractice policy documents. Examination of some of the regulations gives impetus to the importance of knowing the provisions and limitations for delivery of telepractice services for each of the applicable jurisdictions. For example, Texas' Speech-Language Pathologists and Audiologists Administrative Rules, Section 111.212. Requirements for the Use of Telehealth by

Speech-Language Pathologists (effective October 1, 2016; amended May 1, 2018; amended August 1, 2020) specify:

- “(a) The requirements of this section apply to the use of telehealth by speech-language pathologists.
- (b) A provider shall comply with the commission's Code of Ethics and Scope of Practice requirements when providing telehealth services.
- (c) The scope, nature, and quality of services provided via telehealth are the same as that provided during in-person sessions by the provider.
- (d) The quality of electronic transmissions shall be equally appropriate for the provision of telehealth services as if those services were provided in person.
- (e) A provider shall only utilize technology that the provider is competent to use as part of the provider’s telehealth services.
- (f) Equipment used for telehealth services at the clinician site shall be maintained in appropriate operational status to provide appropriate quality of services.
- (g) Equipment used at the client/patient site at which the client or consultant is present shall be in appropriate working condition and deemed appropriate by the provider.
- (h) The initial contact between a licensed speech-language pathologist and client may be at the same physical location or through telehealth/telepractice, as determined appropriate by the licensed speech-language pathologist.
- (i) A provider shall consider relevant factors including the client’s behavioral, physical, and cognitive abilities in determining the appropriateness of providing services via telehealth/telepractice.
- (j) A provider shall be aware of the client’s or consultant’s level of comfort with the technology being used as part of the telehealth services. The provider shall adjust the provider’s practice to maximize the client’s or consultant’s level of comfort.
- (k) When a provider collaborates with a consultant from another state in which the telepractice services are delivered, the consultant in the state in which the client receives services shall be the primary care provider for the client.
- (l) As pertaining to liability and malpractice issues, a provider shall be held to the same standards of practice as if the telehealth services were provided in person.
- (m) A provider shall be sensitive to cultural and linguistic variables that affect the identification, assessment, treatment, and management of the clients.
- (n) Upon request, a provider shall submit to the department data which evaluates effectiveness of services provided via telehealth including, but not limited to, outcome measures.
- (o) Telehealth providers shall comply with all laws, rules, and regulations governing the maintenance of client records, including client confidentiality requirements, regardless of the state where the records of any client within this state are maintained.
- (p) Notification of telehealth services shall be provided to the client, the guardian, the caregiver, and the multi-disciplinary team, if appropriate. The notification

shall include, but not be limited to: the right to refuse telehealth services, options for service delivery, and instructions on filing and resolving complaints.”

The Board of Speech-Language Pathology & Audiology in Kentucky requires that candidacy for telepractice be determined in person: “Section 2. Client Requirements. A practitioner-patient relationship shall not commence via telehealth. An initial, in-person meeting for the practitioner and patient who prospectively utilize telehealth shall occur. A licensed health care practitioner may represent the licensee at the initial, in-person meeting.” To the author’s knowledge, this is the only speech-language pathology jurisdiction with this type of requirement.

Recent (2017) legislation has resulted in re-evaluation of initial in-person meeting regulations such as the rule previously specified in Section 111.212 (h) of the Texas Speech-Language Pathologists and Audiologists Administrative Rules. That rule, which has since been revised, stated: The initial contact between a licensed speech-language pathologist and client **shall be at the same physical location** to assess the client’s candidacy for telehealth, including behavioral, physical, and cognitive abilities to participate in services provided via telecommunications prior to the client receiving telehealth services. The 2017 legislation prohibited Texas medical and allied health regulatory boards from imposing higher standards of care for telehealth practitioners than for in-person practitioners, and the initial in-person meeting mandate was removed. (It should be noted that prior to passage of the legislation, Teladoc was in a six-year anti-trust lawsuit with the Texas Medical Board over telemedicine requirements.)

Protection of client/patient confidentiality and knowledge of privacy and security laws and regulations are essential components in the delivery of telepractice services. In addition to state licensure laws and regulations and the ASHA Code of Ethics, mandates are contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) including requirements for protection of individuals’ protected health information (whether electronic, on paper, or oral), national standards for the security of electronic protected health information (PHI), and the breach notification rule which requires covered entities and business associates to provide notification following a breach of PHI (Houston, 2014). Elementary and secondary schools are generally exempt from HIPAA, but are governed by the Family Educational Rights and Privacy Act (FERPA) in addition to confidentiality mandates contained in the Individuals with Disabilities Education Act. If the school (district) electronically transmits claims to a health plan such as Medicaid, the school is a HIPAA covered entity and must then comply with HIPAA rules. The Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009 is the most recent federal law regarding privacy/security mandates and increased civil penalties for various categories of violations. Sessions delivered through telepractice means must be secure; thus, password protection, secure firewalls and appropriately encrypted web platforms or videoconferencing software as well as anti-virus software must be utilized. SLPs are responsible for protecting data and the security of the room in which clinical services are provided (clinician and client).

Some additional practice considerations warrant description:

- Sufficient bandwidth to conduct telepractice services is key.
- Informed consent must be obtained including the right of the client to refuse services delivered via telepractice and to make complaints about privacy and security.
- Permission should be obtained prior to recording sessions or allowing individuals to observe.
- Facilitators who may be paraprofessionals or speech-language pathology assistants should be incorporated into sessions as needed following appropriate training including role delineation.
- Materials and activities which are easily depicted over video/audio should be planned and implemented.
- The ever-evolving world of technology as well as advances in practice applications, legislation, regulation, and policy, all contribute to the need for continual review of the literature and professional development to address various telepractice topics.
- The welfare of the client/patient must always be paramount.

One of the most notable changes during the COVID-19 public health emergency was the relaxation by the Office of Civil Rights for the U.S. Department of Health and Human Services (HHS) of HIPAA enforcement standards for telehealth remote communications. The guidance issued by HHS stated: “A covered health care provider that wants to use audio or video communication technology to provide telehealth to patients during the COVID-19 nationwide public health emergency can use any non-public facing remote communication product that is available to communicate with patients. OCR is exercising its enforcement discretion to not impose penalties for noncompliance with the HIPAA Rules in connection with the good faith provision of telehealth using such non-public facing audio or video communication products during the COVID-19 nationwide public health emergency. This exercise of discretion applies to telehealth provided for any reason, regardless of whether the telehealth service is related to the diagnosis and treatment of health conditions related to COVID-19.” Providers were encouraged to enable available encryption and privacy modes and to notify patients/clients of potential privacy risks. Public facing video communication applications (such as Facebook Live, TikTok, Twitch) were not allowed by HHS during the public health emergency.

Supervision

For many years there has been a general assumption that an SLP who is competent to provide services to clients is also competent in the provision of supervision, whether the supervision is for students in university training programs, clinical fellows, support personnel, or for other SLPs in the workplace. The contrast in the depth of formal training in clinical disorders and training in the area of supervision is glaring. While supervision has long been recognized as a critical area of practice, the need to address formalized training as a requirement for supervisors is a rather new concept. Further,

lack of training is a significant factor when considering ethical issues in implementation of supervision. Three important documents were the result of a widely-recognized need to address the overarching issue of training for SLP supervisors.

The Council of Academic Programs in Communication Sciences and Disorders (CAPCSD) published a White Paper: *Preparation of Speech Language Pathology Clinical Educators* in 2013. Key issues included: review of the current evidence in communication sciences and disorders relative to preparation of supervisors; identification of knowledge and skills associated with levels of development for clinical supervisors; state requirements for supervisory training; related professions' regulations and preparation programs for clinical educators; and recommendations for achieving "...accessible and appropriate preparation in the supervisory process," (pg. 3).

Also published in 2013, *Knowledge, Skills and Training Consideration for Individuals Serving as Supervisors* (Final Report, ASHA Ad Hoc Committee on Supervision) delineated necessary training parameters for effective supervision of five groups: students in university programs or off-campus settings; audiology students in the final externship; clinical fellows; support personnel; and professionals re-entering the workforce or changing primary clinical focus. The general assumptions and operating principles identified in the document are fundamental to the provision of clinical supervision. As stated on page four:

- "A body of literature exists describing necessary knowledge and skills required for effective supervision.
- In all instances, the supervisor should possess the clinical skills necessary to guide the supervisee in the correct course of evaluation or treatment to achieve positive outcomes.
- Those engaged in clinical supervision should possess a dedication to lifelong learning specific to clinical education, which is evidenced by participating in relevant continuing education programs.
- Individuals engaging in supervision should adhere to and model principles of ethical practice in accordance with the ASHA Code of Ethics."

In *A Plan for Developing Resources and Training Opportunities in Clinical Supervision* (Final Report, ASHA Ad Hoc Committee on Supervision Training), a detailed approach is provided for creating resources and instituting training in clinical supervision incorporating the competencies identified in the previously discussed ASHA report document. This ad hoc committee also developed content for ASHA's Practice Portal, stipulated quality indicators for identifying supervision experts, and recommended a two-phase transition plan over a six-year period.

Not only have speech-language pathology organizations studied and published these significant reports, but the addition of a certification standard change requiring a minimum level of professional experience and formal supervision training was approved by ASHA's Council for Clinical Certification (CFCC). The CFCC described their

rationale at the time the requirement was being considered (*Certification Matters: The CFCC's Official Newsletter, 2016*):

“In order to meet growing concerns over the quality of student supervision and accountability of Clinical Fellow mentorship, the proposed updates... will require certified speech-language pathologists (SLPs) to be actively certified for a minimum of 9 months prior to supervising student clinicians or mentoring clinical fellows. Additionally, supervisors and mentors will be required to take continuing education hours in supervision.”

The 2020 Standards and Implementation Procedures for the Certificate of Clinical Competence in Speech-Language Pathology include the following mandates relative to supervision:

“Standard V-E

Supervision of students must be provided by a clinical educator who holds ASHA certification in the appropriate profession and who, after earning the CCC-A or CCC-SLP, has completed (1) a minimum of 9 months of full-time clinical experience, and (2) a minimum of 2 hours of professional development in clinical instruction/supervision.

The amount of direct supervision must be commensurate with the student's knowledge, skills, and experience; must not be less than 25% of the student's total contact with each client/patient; and must take place periodically throughout the practicum. Supervision must be sufficient to ensure the welfare of the individual receiving services.

Implementation: Beginning January 1, 2020, clinical educators and clinicians who are involved in the preparation of student clinicians, and who provide guided observation and supervision of clinical practicum hours, must (a) hold the CCC-A or CCC-SLP and have completed a minimum of 9 months of full-time, post-certification (or its part-time equivalent) clinical experience, and (b) [must complete 2 hours of professional development/continuing education](#) in clinical instruction/supervision. The professional development/continuing education must be completed after being awarded ASHA certification and prior to the supervision of a student. Direct supervision must be in real time. A clinical educator must be available and on site to consult with a student who is providing clinical services to the clinical educator's client. Supervision of clinical practicum is intended to provide guidance and feedback and to facilitate the student's acquisition of essential clinical skills.

In the case of CS, asynchronous supervision must include debriefing activities that are commensurate with a minimum of 25% of the clock hours earned for each simulated individual receiving services.”

“Standard VII-B: Clinical Fellowship Mentorship

The Clinical Fellow must receive ongoing mentoring and formal evaluations by the CF mentor. Mentorship must be provided by a clinician who holds the CCC-SLP and who, after earning the CCC-SLP, has completed (1) a minimum of 9 months of full-time clinical experience, and (2) a minimum of 2 hours of professional development/continuing education in clinical instruction/supervision.

Implementation: Effective January 1, 2020, CF mentors for ASHA certification [must complete 2 hours of professional development/continuing education](#) in clinical instruction/supervision after being awarded the CCC-SLP and prior to [mentoring the Clinical Fellow](#).”

Prior to implementation of ASHA’s 2020 standards, several state licensure boards had already adopted, as a component of their Rules and Regulations, mandates for professional experience minimums (e.g., two years of professional experience) and/or mandated supervisory training (e.g., 1 continuing education unit in supervision, 6 hours of supervision training prior to supervising temporary license holders or SLP Assistants, 10 clock hours of training in the supervision of assistants) as a requirement for supervising licensees or support personnel in the respective states. There is also an expectation, as stated in the ASHA Code, that all services will be delivered competently (Principle I, Rule A) and that “Individuals who hold the Certificate of Clinical Competence shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their certification status, education, training, and experience,” (Principle II, Rule B).

While lack of training and experience can contribute to ethical issues in supervision, there are other factors including personality conflicts, generational differences, cultural and linguistic differences, workplace demands, productivity quotas, inaccurate or insufficient documentation practices, time constraints, and lack of familiarity with organizational and regulatory mandates, among others. Even failure to timely pay the annual fee for ASHA certification, to comply with ASHA certification maintenance standards, or to meet state licensure renewal requirements inclusive of fee payment and submission of continuing education information, can result in an ethics violation in that the individual is not credentialed to provide supervision. If the SLP continues to supervise in these instances, there is a violation of ASHA’s Code of Ethics, specifically Principle III, Rule A (“Individuals shall not misrepresent their credentials, competence, education, training, experience, and scholarly contributions.”) as well as other potential violations. The need to “repeat” the clinical fellowship experience because the mentor did not possess the CCC-SLP during the entire thirty-six week timeframe has occurred and is an unfortunate situation for the Clinical Fellow (CF). In the case of lapsed licenses, the individual is violating state statute in practicing illegally if supervision and other speech-language pathology services are continued.

While the vast majority of postgraduate professional experiences are successful, these can be challenging when the mentor/supervisor is unduly influenced by personal interests, business practices, monetary gain, and caseload issues. For example, the mentor may assign excessive duties to the CF so that there is more time for activities

the mentor/supervisor enjoys. CFs may be directed to engage in independent practice and to falsify components of the Clinical Fellowship Skills Inventory. There have also been instances in which the CF mentor withholds paperwork until the CF agrees to certain conditions (e.g., continued employment). Depending on the specifics of the situation, this could be a violation of Principle III, Rule B (“Individuals shall avoid engaging in conflicts of interest whereby personal, financial, or other considerations have the potential to influence or compromise professional judgment and objectivity,”) and Principle IV, Rule G (“Individuals shall not engage in any form of harassment, power abuse, or sexual harassment.”).

Lack of appropriate supervision of SLP Assistants is a concern, including for state licensure boards that regulate support personnel. Consider the case of the SLP in a state requiring a minimum of three hours of direct and two hours of indirect supervision weekly for SLP Assistants. It is surprising when an explicit mandate such as this is violated because the SLP claims to not be familiar with the regulation. The question of supervision appropriate for each task and consideration of client outcomes is even more complex. Principle of Ethics I, Rule E (“Individuals who hold the Certificate of Clinical Competence may delegate tasks related to the provision of clinical services to aides, assistants, technicians, support personnel, or any other persons only if those persons are adequately prepared,”) and Rule F (“Individuals who hold the Certificate of Clinical Competence shall not delegate tasks that require the unique skills, knowledge, judgment, or credentials that are within the scope of their profession to aides, assistants, technicians, support personnel, or any nonprofessionals over whom they have supervisory authority,”) are particularly applicable. How the supervisor determines tasks to be delegated, the various conference and communication arrangements, and how the assistant’s credentials are represented to clients and in the workplace (Principle I, Rule D) are additional concerns.

The following sections of the ASHA Code of Ethics apply to supervision of student clinicians, whether on-site in university clinics or in an off-campus practicum or externship.

- Principle I: Individuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally or who are participants in research and scholarly activities, and they shall treat animals involved in research in a humane manner.
- Principle I, Rule A: Individuals shall provide all clinical services and scientific activities competently.
- Principle I, Rule D: Individuals shall not misrepresent the credentials of aides, assistants, technicians, support personnel, students, research interns, Clinical Fellows, or any others under their supervision, and they shall inform those they serve professionally of the name, role, and professional credentials of persons providing services.
- Principle I, Rule G: Individuals who hold the Certificate of Clinical Competence may delegate to students tasks related to the provision of clinical services that require the unique skills, knowledge, and judgment that are within the scope of

practice of their profession only if those students are adequately prepared and are appropriately supervised. The responsibility for the welfare of those being served remains with the certified individual.

- Principle II, Rule A: Individuals who hold the Certificate of Clinical Competence shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their certification status, education, training, and experience.
- Principle II, Rule D: Individuals shall enhance and refine their professional competence and expertise through engagement in lifelong learning applicable to their professional activities and skills.
- Principle IV, Rule G: Individuals shall not engage in any form of harassment, power abuse, or sexual harassment.
- Principle IV, Rule H: Individuals shall not engage in sexual activities with individuals (other than a spouse or other individual with whom a prior consensual relationship exists) over whom they exercise professional authority or power, including persons receiving services, assistants, students, or research participants.
- Principle IV, Rule L: Individuals shall not discriminate in their relationships with colleagues, assistants, students, support personnel, and members of other professions and disciplines on the basis of race, ethnicity, sex, gender identity/gender expression, sexual orientation, age, religion, national origin, disability, culture, language, dialect, or socioeconomic status.

As with SLP Assistants, the supervisor of student clinicians must inform the client or client's family about the qualifications of the student and the supervisory relationship. Documentation of supervision must be on-going and in accordance with university, workplace, and certification and/or licensure requirements. Additionally, the supervisor or clinical educator should be properly trained, and may only supervise areas of clinical practice for which the clinical educator possesses requisite knowledge and skills.

ASHA's Code provides a framework for ethical behavior across supervisory settings. The supervisor is ethically and legally responsible for the actions of supervisees. In all situations, supervisors "shall honor their responsibility to hold paramount the welfare of persons they serve professionally," (Principle of Ethics I).

Utilization of Speech-Language Pathology Assistants

There are no circumstances in which the fully credentialed SLP does not retain the ethical and legal responsibility for services provided by an SLP Assistant (SLPA) or other support personnel. It is critical, then, that an SLP engaged in supervision of support personnel not only have training and at least a minimum level of professional experience (e.g., two years), but the SLP must be knowledgeable about specific parameters in the utilization of these individuals. These areas include requirements established by ASHA as well as state mandates governing scope of practice, credentialing, supervision, continuing education, and ethical considerations applicable to all aspects of support personnel practice. These support personnel may be SLPAs,

aides, paraprofessionals, and technicians. Discussion in this section will focus predominantly on utilization of assistants.

The ASHA Model Bill for State Licensure of Audiologists, Speech-Language Pathologists, and Audiology and Speech-Language Pathology Assistants was revised in 2012 to add language regarding licensure of assistants. As stated on page one of the current iteration, “The model bill is an example of licensure legislation that holds consumer protection paramount and is based on current licensure practices and existing ASHA policies. The model bill is presented as a prototype for state regulation of audiologists, speech-language pathologists, and audiology and speech-language pathology assistants. It is designed as an example to be modified to reflect individual state’s needs.”

ASHA’s assistants’ certification program was launched in the fall of 2020. The credential for SLPAs, designated by C-SLPA, includes three education options (which must be completed at an accredited institution): a minimum 2-year SLPA program degree; bachelor’s degree in communication sciences and disorders; or college degree, plus specified coursework (i.e., introductory course in communication disorders, phonetics, speech sound disorders, language development, language disorders, anatomy and physiology of speech and hearing mechanisms), and completion of ASHA’s online education modules or equivalent. Individuals applying to be an ASHA-certified SLPA must also complete a 1-hour course in each of the following: ethics, universal safety precautions, and patient confidentiality. One hundred hours of clinical fieldwork under the supervision of an ASHA-certified SLP and passage of the national Assistants Certification Exam are required to achieve the C-SLPA.

Applicants and C-SLPAs must abide by ASHA’s Assistants Code of Conduct (2020) and are subject to ASHA Board of Ethics jurisdiction. The Code of Conduct contains three principles of conduct: (1) responsibility to persons served professionally, (2) responsibility to the public, (3) responsibility for professional relationships. As stated in the Preamble to the Code, it “was created to guide certified assistants in their clinical practice” and “is intended to ensure the welfare of the consumer and to protect the reputation and integrity of the professions.” There is no question that assistants may not practice independently and must be supervised by “appropriately-credentialed ...speech-language pathologists consistent with state licensing laws and/or with ASHA’s Code of Ethics.”

There are provisions in at least thirty-three states for registration, licensure or certification of SLPAs who possess a college degree or equivalent training. There are additional states that regulate support personnel in some form but may do so through governance of the SLP supervisor rather than credentialing the assistant or aide. Eleven states require a minimum of a bachelor’s degree for SLPA licensure or registration, while most states will credential individuals with an associate degree. There are other educational requirement variations including a high school diploma coupled with on-the-job training by the supervising SLP. For comparison purposes, the end of this section

contains a chart compiled by the National Council of State Boards of Examiners for Speech-Language Pathology and Audiology which depicts educational requirements in states requiring an associate's degree or higher for the SLPA regulatory board credential.

Given the range of mandates established across the country, and the fact that tasks are to be assigned by the supervising SLP based on the education, training, and repertoire of the assistant, it is fundamental that the supervisor have knowledge of the assistant's background inclusive of the degree, courses completed, and practicum and/or fieldwork experiences. This information must be carefully weighed against individual client needs in the delegation of activities appropriate for implementation by the SLPA. Principle I of the ASHA Code requires, "Individuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally or who are participants in research and scholarly activities, and they shall treat animals involved in research in a humane manner." Also relevant to consideration of task delegation are:

- Principle I, Rule A: Individuals shall provide all clinical services and scientific activities competently.
- Principle I, Rule E: Individuals who hold the Certificate of Clinical Competence may delegate tasks related to provision of clinical services to aides, assistants, technicians, support personnel, or any other persons only if those persons are adequately prepared and are appropriately supervised. The responsibility for the welfare of those being served remains with the certified individual.
- Principle I, Rule F: Individuals who hold the Certificate of Clinical Competence shall not delegate tasks that require the unique skills, knowledge, judgment, or credentials that are within the scope of their profession to aides, assistants, technicians, support personnel, or any nonprofessionals over whom they have supervisory responsibility.

ASHA as an organization began discussing support personnel in the 1960's, and various documents and position statements on the training, use, and supervision of assistants, particularly for speech-language pathology, have been published over the years. In 2013, the ASHA Speech-Language Pathology Assistant Scope of Practice ad hoc committee's work was approved by the Board of Directors and can be found in the landmark document *Speech-Language Pathology Assistant Scope of Practice*. "Given that standards, licensure, and practice issues vary from state-to-state, this document delineates ASHA's policy for the use of SLPAs," (pg. 1) and provides guidance for the ASHA-certified SLP as well as the SLPA. The document was updated in 2019 to reflect the current ASHA Code of Ethics and includes sections delineating SLPA qualifications, responsibilities within and outside the SLPA scope of practice, practice settings, ethical considerations, liability, the role of the supervisor, and guidelines for supervision.

Responsibilities within and outside the speech-language pathology assistant's scope of practice as stated in ASHA's *Speech-Language Pathology Assistant Scope of Practice* document are as follows:

“Provided that the training, supervision, and planning are appropriate, tasks in the following areas of focus may be delegated to an SLPA.

“Service Delivery

- a. Self-identify as SLPAs to families, students, patients, clients, staff, and others. This may be done verbally, in writing, and/or with titles on name badges.
- b. Exhibit compliance with The Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA) regulations, reimbursement requirements, and SLPAs' responsibilities.
- c. Assist the SLP with speech, language, and hearing screenings **without** clinical interpretation.
- d. Assist the SLP during assessment of students, patients, and clients exclusive of administration and/or interpretation.
- e. Assist the SLP with bilingual translation during screening and assessment activities exclusive of interpretation; refer to *Issues in Ethics: Cultural and Linguistic Competence* (ASHA 2017).
- f. Follow documented treatment plans or protocols developed by the supervising SLP.
- g. Provide guidance and treatment via telepractice to students, patients, and clients who are selected by the supervising SLP as appropriate for this service delivery model.
- h. Document student, patient, and client performance (e.g., tallying data for the SLP to use; preparing charts, records, and graphs) and report this information to the supervising SLP.
- i. Program and provide instruction in the use of augmentative and alternative communication devices.
- j. Demonstrate or share information with patients, families, and staff regarding feeding strategies developed and directed by the SLP.
- k. Serve as interpreter for patients/clients/students and families who do not speak English.
- l. Provide services under SLP supervision in another language for individuals who do not speak English and English-language learners.

“Administrative Support

- a. Assist with clerical duties, such as preparing materials and scheduling activities, as directed by the SLP.
- b. Perform checks and maintenance of equipment.
- c. Assist with departmental operations (scheduling, recordkeeping, safety/maintenance of supplies and equipment).

“Prevention and Advocacy

- a. Present primary prevention information to individuals and groups known to be at risk for communication disorders and other appropriate groups; promote early identification and early intervention activities.
- b. Advocate for individuals and families through community awareness, health literacy, education, and training programs to promote and facilitate access to

- full participation in communication, including the elimination of societal, cultural, and linguistic barriers.
- c. Provide information to emergency response agencies for individuals who have communication and/or swallowing disorders.
 - d. Advocate at the local, state, and national levels for improved public policies affecting access to services and research funding.
 - e. Support the supervising SLP in research projects, in-service training, public relations programs, and marketing programs.
 - f. Participate actively in professional organizations.” (pg. 4-5)

The document reiterates that no task should be performed by an SLPA without the approval of the supervising SLP:

“The SLPA should NOT engage in the following:

- a. represent himself or herself as an SLP;
- b. perform standardized or nonstandardized diagnostic tests, formal or informal evaluations, or swallowing screenings/checklists;
- c. perform procedures that require a high level of clinical acumen and technical skill (e.g., vocal tract prosthesis shaping or fitting, vocal tract imaging and oral pharyngeal swallow therapy with bolus material);
- d. tabulate or interpret results and observations of feeding and swallowing evaluations performed by SLPs;
- e. participate in formal parent conferences, case conferences, or any interdisciplinary team without the presence of the supervising SLP or other designated SLP;
- f. provide interpretative information to the student/patient/client, family, or others regarding the patient/client status or service;
- g. write, develop, or modify a student's, patient's, or client's treatment plan in any way;
- h. assist with students, patients, or clients without following the individualized treatment plan prepared by the certified SLP and/or without access to supervision;
- i. sign any formal documents (e.g., treatment plans, reimbursement forms, or reports; the SLPA **should** sign or initial informal treatment notes for review and co-sign with the supervising SLP as requested);
- j. select students, patients, or clients for service;
- k. discharge a student, patient, or client from services;
- l. make referrals for additional service;
- m. disclose clinical or confidential information either orally or in writing to anyone other than the supervising SLP (the SLPA must comply with current HIPPA and FERPA guidelines) unless mandated by law;
- n. develop or determine the swallowing strategies or precautions for patients, family, or staff;
- o. treat medically fragile students/patients/clients independently;
- p. design or select augmentative and alternative communication systems or devices.” (pg. 5-6)

While performance of a clinical activity may seem appropriate given an individual SLPA's competence, the action may be a violation of state rules and regulations. Thus, it is also crucial that the supervising SLP be well-versed in the state's regulations and practice act components relative to assistants. There is definitely overlap between the various states in the duties allowed as well as those prohibited. However, the expression coined by the late Charles Diggs, J.D., an ASHA staff member, is quite applicable: "When you've seen one state, you've seen one state." Practitioners place themselves in ethical, legal, and professional peril in the absence of expertise in state mandates pertaining to the utilization of SLPAs.

For example, the Texas rules and regulations, one of the most recently revised state regulatory documents (August 2020), address the duties which are within and outside of an assistant's scope of practice. The Texas Administrative Code in Subchapter F. Section 111.52. Assistant in Speech-Language Pathology License—Practice and Duties of Assistants (*45 TexReg 5172*) cites:

- “(c) Duties that a supervisor may assign to an assistant, who has received appropriate training, include the following:
- (1) conduct or participate in speech, language, and/or hearing screening;
 - (2) implement the treatment program or the Individual Education Program (IEP) designed by the supervisor;
 - (3) provide carry-over activities which are the therapeutically designed transfer of a newly acquired communication ability to other contexts and situations;
 - (4) collect data;
 - (5) administer routine tests if the test developer does not specify a graduate degreed examiner and the supervisor has determined the assistant is competent to perform the test;
 - (6) maintain clinical records;
 - (7) prepare clinical materials;
 - (8) participate with the licensed supervisors' research projects, staff development, public relations programs, or similar activities as designated and supervised by the supervisor; and
 - (9) may write lesson plans based on the therapy program developed by the supervisor. The lesson plans shall be reviewed and approved by the supervisor.
- “(d) The assistant shall not:
- (1) work with any cases that are not assigned to the supervisor's caseload;
 - (2) conduct evaluations;
 - (3) interpret results of routine tests;
 - (4) interpret observations or data into diagnostic statements, clinical management strategies, or procedures;

- (5) represent speech-language pathology at staff meetings or at an Admission, Review and Dismissal (ARD) meeting, except as specified in this section;
- (6) attend staffing meeting or ARD without the supervisor being present except as specified in this section;
- (7) design or alter a treatment program or Individual Education Program (IEP);
- (8) determine case selection;
- (9) present written or oral reports of client information, except as provided by this section;
- (10) refer a client to other professionals or other agencies;
- (11) use any title which connotes the competency of a licensed speech-language pathologist;
- (12) practice as an assistant without a current Supervisory Responsibility Statement on file with the department;
- (13) perform invasive procedures;
- (13) screen or diagnose clients for feeding and swallowing disorders;
- (14) use a checklist or tabulated results of feeding or swallowing evaluations;
- (15) demonstrate swallowing strategies or precautions to clients, family, or staff;
- (16) provide client or family counseling;
- (17) sign any formal document relating to the reimbursement for or the provision of speech-language pathology services without the supervisor's signature; or
- (18) use "SLP-A" or "STA" as indicators for their credentials. Licensees shall use "Assistant SLP" or "SLP Assistant" to shorten their professional title.

“(e) An assistant may represent special education and speech pathology at the Admission, Review, and Dismissal (ARD) meetings with the following stipulations:

- (1) The assistant shall have written documentation of approval from the supervisor.
- (2) The assistant shall have three years of experience as an assistant in the school setting.
- (3) The assistant may attend, with written approval of the supervisor, a student's annual review (ARD) meeting if the meeting involves a student for whom the assistant provides services. If an assistant attends a meeting as provided by this rule, the supervisor is not required to attend the meeting. A supervisor must attend an ARD meeting if the purpose of the meeting is to develop a student's initial Individual Education Program (IEP) or if the meeting is to consider the student's dismissal, unless the supervisor has submitted the supervisor's recommendation in writing on or before the date of the meeting.

- (4) The assistant shall present IEP goals and objectives that have been developed by the supervisor and reviewed with the parent by the supervisor.
- (5) The assistant shall discontinue participation in the ARD meeting and shall contact the supervisor when questions or changes arise regarding the IEP document.

“(f) In any professional context the assistant must indicate the assistant’s status as a speech-language pathology assistant.”

Supervision as a broader topic has been discussed in an earlier section; however, it is important to note here that not only must minimum mandated levels of direct and indirect supervision be implemented, but the supervision must be appropriate given the setting’s context, specific tasks assigned, and the demonstrated skill level of the SLPA. How supervision will be scheduled should be discussed with the assistant and administration. It is important that the SLP’s workload be adjusted so that proper supervision can be delivered and refined as needed. Supervision should not be scheduled within the same timeframe weekly, but delivered so that a range of all clients have been supervised directly over time. While this flexibility may not be possible on a weekly basis in certain circumstances, the model protects the client, the assistant, and the supervisor. Indirect supervision activities such as review of documentation of services, review of video or audio recordings, etc., can be easier to schedule and are also essential in the utilization of SLPAs. Telesupervision (via webcam) in states which allow it, ensuring that HIPAA and FERPA protections are not violated, has been remarkably successful and facilitates the provision of appropriate supervision in large geographical and/or rural areas.

While ASHA only has jurisdiction over its members and/or certified individuals, it is still imperative that the supervising SLP review the ASHA Code of Ethics with assistants. For example, it is important for both supervisors and SLPAs to know that it is unethical to represent the assistant generically as a “speech-language therapist”. Principle I, Rule D stipulates, “Individuals shall not misrepresent the credentials of aides, assistants, technicians, support personnel, students, research interns, Clinical Fellows, or any others under their supervision, and they shall inform those they serve professionally of the name, role, and professional credentials of persons providing services.” While the SLPA who is not ASHA-certified is not under ASHA BOE jurisdiction, they may be under the jurisdiction of the state licensure board rules and regulations, including ethical provisions and support personnel regulations, which may provide grounds for disciplinary action and sanctions. The Louisiana Board of Examiners for Speech-Language Pathology and Audiology, for example, includes in its rules and regulations a Code of Ethics for professionals as well as a specific Code of Ethics for SLP Assistants.

In addition to already-cited Principles and Rules of Ethics from the ASHA Code of Ethics, the following are also pertinent in the utilization of SLPAs:

- Principle I, Rule C: Individuals shall not discriminate in the delivery of professional services or in the conduct of research and scholarly activities on the basis of race, ethnicity, sex, gender identity/gender expression, sexual orientation, age, religion, national origin, disability, culture, language, or dialect.
- Principle II, Rule E: Individuals in administrative or supervisory roles shall not require nor permit their professional staff to provide services or conduct research activities that exceed the staff member’s certification status, competence, education, training, and experience.
- Principle of Ethics IV: Individuals shall uphold the dignity and autonomy of the professions, maintain collaborative and harmonious interprofessional and intraprofessional relationships, and accept the professions' self-imposed standards.
- Principle IV, Rule I: Individuals shall not knowingly allow anyone under their supervision to engage in any practice that violates the Code of Ethics.
- Principle IV, Rule R: Individuals shall comply with local, state, and federal laws and regulations applicable to professional practice, research ethics, and the responsible conduct of research.

STATES THAT CREDENTIAL SUPPORT PERSONNEL*

STATE	LICENSURE OR REGISTRATION	MINIMUM EDUCATIONAL REQUIREMENTS	SLP/AUD/ BOTH
Alabama	Registration	Bachelor’s Degree	Both
Alaska	Registration	Associate from approved program or Bachelor’s Degree	SLP
Arizona	Licensure	Completion of 60 credit hour or approved training program	SLP
Arkansas	Registration	Bachelor’s or SLPA Training Program Culminating in Associate Degree	SLP
California	Registration	Associate from SLPA Program or Bachelor’s Degree in SLP or Comm. Disorders	SLP
District of Columbia	Registration	SLPA – Bachelor’s in SLP or Associate’s Degree from SLPA Technical Training Program Aud. Asst. – 2 years of college with minimum of 48 semester hours, Associate Degree, or Technical School Cert. Program in Health Care	Both
Florida	Certification	SLPA - Bachelor’s Degree Aud. Asst. – High School Diploma or Equivalent	Both
Georgia	Registration	SLP Aide – High School Diploma or Equivalent	Both

		Aud. Asst. - Associate Degree or 2 years of College Education or Completion of Technical School Cert. Program in Health Care	
Idaho	Licensure	Bachelor's Degree – Aides; Associate Degree – Assistants	SLP
Illinois	Licensure	Associate or Bachelor's Degree	SLP
Indiana	Registration	Associate Degree – Speech Associate Bachelor's Degree - Speech Assistant	SLP
Kentucky	Licensure	Bachelor's Degree	SLP
Louisiana	Licensure	Bachelor's Degree	SLP
Maine	Registration	Associate Degree	SLP
Maryland	Licensure	Associate or Bachelor's Degree	SLP
Massachusetts	Certification	Associate Degree from Approved Program or Bachelor's Degree	Both
Missouri	Registration	Bachelor's Degree	SLP
Montana	Registration	Bachelor's Degree/enrolled in grad program- SLP Aide/Assistant I; Bachelor's Degree – SLP Aide/Assistant II	SLP
Nebraska	Registration	Associate or Bachelor's Degree or Equivalent	Both
New Hampshire	Certification	Associate Degree (or higher)	SLP
New Mexico	Licensure (Temporary)	Bachelor's Degree + Enrollment in Grad Program (or completion of grad hours if not enrolled in master's program; Title = Apprentice in Speech-Language)	SLP
North Carolina	Registration	Associate or Bachelor's Degree	SLP
North Dakota	Licensure	Bachelor's Degree	SLP
Oklahoma	Licensure	Associate Degree (or equivalent) – SLP Assistant	Both

		High School Diploma or Equivalent – Audiology Assistant	
Oregon	Licensure	30 semester or 45 quarter hours of general education credit + 30 semester or 45 quarter hours of technical credit related to communication disorders	SLP
Rhode Island	Registration	Bachelor’s Degree + 18 grad. hours – SLP Aide	SLP
South Carolina	Licensure	Bachelor’s Degree	SLP
South Dakota	Licensure	Associate or Bachelor’s Degree	SLP
Tennessee	Registration	60 Semester Hours (gen. ed. + knowledge & skills for SLPA)	SLP
Texas	Licensure	Bachelor’s Degree – SLP Assistant High School Diploma + 20 Hour CAOHC Course/Exam – Aud. Assistant	Both
Washington	Certification	Associate or Bachelor’s Degree	SLP
West Virginia	Registration	Associate or Bachelor’s Degree	Both
Wyoming	Certification	Associate or Bachelor’s Degree	SLP

* The term support personnel as used here refers to individuals having a minimum of an associate degree or equivalent. There are other states that regulate assistants and/or aides which require university coursework, but do not mandate a minimum of an associate degree. Additionally, there are states that regulate the practice (duties allowed, prohibited duties, supervision, etc.) but do not credential the assistant. It should be noted that there are states which have support personnel provisions for individuals with a high school diploma or GED who may be referred to as aides or assistants.

Interprofessional Practice

Interprofessional Education (IPE) and Interprofessional Practice (IPP) involve concepts which have existed for many years, but have more recently become prominent in the field of speech-language pathology. SLPs have worked side-by-side with professionals of many disciplines in education as well as health care settings. However, interprofessional education and interprofessional practice, respectively, extend beyond cooperative models of education such as shared learning, and beyond multidisciplinary treatment or service provision.

The definitions established by the World Health Organization (WHO) are widely recognized and have been adapted by ASHA. Interprofessional education exists when “...two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes.” Similarly, the World Health Organization

identifies interprofessional practice (also known as interprofessional collaborative practice) as occurring when "...multiple health workers from different professional backgrounds provide comprehensive health services by working with patients, their families, caregivers, and communities to deliver the highest quality of care across settings."

Why the impetus for IPE and IPP by SLPs? ASHA convened the Changing Health Care Landscape Summit in October of 2012 which identified an urgent need to reframe the professions given "...changing needs in both the health care and educational settings," (pg. 4, *Final Report: Reframing the Professions of Speech-Language Pathology and Audiology*). Implementation of the Patient Protection and Affordable Care Act (ACA), and replacement of fee-for-service with bundled payments, value-based purchasing, and outcomes-driven reimbursement systems, are major factors driving consideration of changing service delivery models including interprofessional practice, to promote increased efficiency and accountability, positive outcomes and patient/client-centered care.

Originally published in 2011 and updated in 2016, an expert group of health care professionals developed *Core Competencies for Interprofessional Collaborative Practice* which categorizes necessary individual-level knowledge and skills. The panel included representatives from the American Association of Colleges of Nursing, American Association of Colleges of Osteopathic Medicine, American Association of Colleges of Pharmacy, American Association of Medical Colleges, and the Association of Schools of Public Health. Nine additional organizations were involved in the 2016 update. ASHA is recognized as one of the twelve supporting associations of the original document and formally joined the Interprofessional Education Collaborative (IPEC) in 2017. While discipline-specific practices and procedures will always exist, the core competencies provide an essential resource and are applicable across health care professions.

There are four core domains, with Competency 1, Values/Ethics for Interprofessional Practice, essential to any discussion of ethics. "Work with individuals of other professions to maintain a climate of mutual respect and shared values," is the stated competency and is the only one of the four that did not change in the 2016 document. Because interprofessional practice involves multiple, critical parameters which are synergistic, it is also important to recognize the other three competencies:

- Competency 2 - Roles/Responsibilities: Use the knowledge of one's own role and those of other professions to appropriately assess and address the health care needs of patients and to promote and advance the health of populations.
- Competency 3 – Interprofessional Communication: Communicate with patients, families, communities, and professionals in health and other fields in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health and the prevention and treatment of disease.

- Competency 4 – Teams and Teamwork: Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, deliver, and evaluate patient/population-centered care and population health programs and policies that are safe, timely, efficient, effective, and equitable.

The prevalence of interprofessional practice was quantified in ASHA’s 2016 Interprofessional Practice Survey. Eighty-four percent of SLPs in health care and ninety-one percent of SLPs working in schools indicated engagement in interprofessional collaborative practice as defined by the WHO. Interestingly, only thirty percent (29.9%) of SLPs in health care, and twenty-nine percent (28.8%) of those whose primary work setting is schools, had any formal education or training in IPP. Nonetheless, the majority felt prepared to effectively participate on IPP teams.

Response	SLPs in Health Care	SLPs in Schools
Very prepared	43.7	43.2
Somewhat prepared	47.4	49.1
Not very prepared	6.6	6.6
Not at all prepared	2.3	1.0

How then does the individual develop competency and improve performance of the array of needed skills for interprofessional practice? The survey results as well as anecdotal analysis of training programs demonstrate that interprofessional education is an emerging area in the field of speech-language pathology. Various successful models have been implemented throughout the country, several of which incorporate simulated cases and infusion of IPE throughout already-existing coursework. It should be noted that the 2017 Council on Academic Accreditation (CAA) Standards for Accreditation of Graduate Education Programs in Audiology and Speech-Language Pathology include IPE/IPP language including “Understand how to work on interprofessional teams to maintain a climate of mutual respect and shared values,” and “Communicate – with patients, families, communities, interprofessional team colleagues, and other professionals caring for individuals – in a responsive and responsible manner that supports a team approach to maximize care outcomes,” under Standard 3.1 Professional Practice Competencies.

The 2016 revisions to the ASHA Code of Ethics reflect currency of practice, and intra- and interprofessional collaboration is one of the major themes. Principle IV, Rule A was added as a result: “Individuals shall work collaboratively, when appropriate, with members of one’s own profession and/or members of other professions to deliver the highest quality of care.” Additionally, Principle I, Rule B was expanded to include interprofessional collaboration: “Individuals shall use every resource, including referral and/or interprofessional collaboration when appropriate, to ensure that quality service is provided.”

How does an SLP develop values/ethics in interprofessional practice? In addition to preservice interprofessional education and continuing education activities

focusing on IPP, self-reflection, analysis and goal delineation can be effective mechanisms. Focus on the Subcompetencies (listed below) within the Values/Ethics domain of the Core Competencies for Interprofessional Collaborative Practice. One can begin with identifying a subcompetency, for example, “VE2. Respect the dignity and privacy of patients while maintaining confidentiality in the delivery of team-based care,” already demonstrated with such proficiency that it may be considered a strength for the practitioner. Perhaps even more important is the process of identifying one or more of the subcompetencies which may be a relative weakness for the SLP, and targeting the area as a goal for improvement. For example, a relative weakness related to VE4. (“Respect the unique cultures, values, roles/responsibilities, and expertise of other health professions and the impact these factors can have on health outcomes,”) could be addressed through professional development including self-study of the organizational structure, roles and responsibilities across health professions at the SLP’s work site, and cultural diversity training.

Given that the ASHA Code requires that “Individuals shall provide all clinical services ...competently,” (Principle I, Rule A) and “Individuals shall honor their responsibility to achieve and maintain the highest level of professional competence and performance,” (Principle of Ethics II), it is incumbent upon entry-level as well as veteran SLPs to develop competencies associated with interprofessional practice. As stated by the IPEC panel (pg. 7), “...requires the continuous development of interprofessional competency by health professions students and students in other professional fields as part of the learning process, so that they enter the workforce ready for collaborative practice.” In addition to building the foundation for interprofessional competency, a lifelong learning trajectory for experienced SLPs must also be accomplished.

EXCERPT: Core Competencies for Interprofessional Collaborative Practice (2016)

Values/Ethics - Work with individuals of other professions to maintain a climate of mutual respect and shared values.

Subcompetencies:

VE1. Place interests of patients and populations at center of interprofessional health care delivery and population health programs and policies, with the goal of promoting health and health equity across the life span.

VE2. Respect the dignity and privacy of patients while maintaining confidentiality in the delivery of team-based care.

VE3. Embrace the cultural diversity and individual differences that characterize patients, populations, and the health team.

VE4. Respect the unique cultures, values, roles/ responsibilities, and expertise of

other health professions and the impact these factors can have on health outcomes.

VE5. Work in cooperation with those who receive care, those who provide care, and others who contribute to or support the delivery of prevention and health services and programs.

VE6. Develop a trusting relationship with patients, families, and other team members (CIHC, 2010).

VE7. Demonstrate high standards of ethical conduct and quality of care in contributions to team-based care.

VE8. Manage ethical dilemmas specific to interprofessional patient/population centered care situations.

VE9. Act with honesty and integrity in relationships with patients, families, communities, and other team members.

VE10. Maintain competence in one's own profession appropriate to scope of practice.

Ethical Scenarios

Each of the following scenarios represents a potential violation of the ASHA Code of Ethics or a dilemma with which you may be confronted. As you analyze the scenario, determine if any violations have occurred and, if so, which principles and/or rules have been violated. Since the practice of the profession is regulated by virtue of state law and regulations, individuals should also identify those rules and regulations (including ethical provisions) as well as applicable statutory provisions (e.g., unprofessional conduct) that may have been violated. While not included in the scenario discussion, formulating a possible course of action for prevention or resolution utilizing one of the ethical decision-making models is recommended.

Billing and Reimbursement

A speech-language pathologist works for a private practice which provides occupational therapy, physical therapy, and speech-language pathology services. The SLP has numerous clients who are seen at the clinic, at day care facilities, and in homes. Her schedule is rather challenging in that she must closely adhere to it or sessions will be missed due to her tendency to spend extra time visiting with families, and the fact that she scheduled her sessions with a minimum of time between appointments (so she can finish work by mid-afternoon). Additionally, she frequently accommodates parents' needs, even when a change in appointment times is requested at the last minute. The speech-language pathologist is highly regarded for her knowledge and skills in providing therapy to the pediatric population. She is personable, easily establishes rapport, and is popular with clients and families.

The SLP, who does not excel at time management, struggles with record-keeping including documentation of services. Because of the number of assigned clients and her desire to not work until late afternoon, there is no time built in to the schedule for paperwork with the exception of Friday afternoons. Unfortunately, the SLP, who does not like paperwork, spends much of the time on Friday afternoons researching therapy techniques and preparing materials for the following week.

An audit is conducted by a third-party payer and significant issues are identified. Services have been billed by the SLP for numerous dates for which there is no documentation including some dates which do not match the SLP's schedule. There is billing for more than the approved number of sessions for some clients and there is a pattern of inaccurate coding for speech-language evaluations. The private practice owner (who is also an SLP) attempts to reconcile some of the billing records with the SLP through calendar entries, parent interviews, and diagnostic reports, but still has to repay thousands to the insurance company.

The owner of the private practice determines that an internal audit of the SLP's documentation and billing is needed. The owner reviews all records for the previous quarter and discovers more of the same – improper coding, incorrect billing dates, inconsistent, inaccurate and missing documentation. She discovers that the SLP has billed for too many sessions for some clients and for an insufficient number of sessions

for others. When there are some records of therapy sessions, the files are not always consistent with the clients' needs, contain numerous abbreviations, and are rarely signed as per policy. The owner feels she has no choice but to terminate the SLP's employment with the private practice and begins to plan for hiring of new staff and caseload reassignment.

What are the ethical issues described in this scenario?

Discussion:

Abusive billing practices seem to be the norm for this speech-language pathologist working for a private practice entity. While she does not appear to be engaged in an intentional scheme to obtain higher rates of reimbursement than are warranted, her negligence regarding proper record-keeping and billing has a similar effect. Principle III, Rule D of the ASHA Code of Ethics (2016) states, "Individuals shall not defraud through intent, ignorance, or negligence or engage in any scheme to defraud in connection with obtaining payment, reimbursement, or grants and contracts for services provided, research conducted, or products dispensed." Additionally, Principle IV, Rule E compels that, "Individuals shall not engage in dishonesty, negligence, fraud, deceit, or misrepresentation." The missing and inaccurate documentation as well as improper billing codes reflect a misrepresentation of services and negligence in record-keeping and billing which regrettably result in billing fraud.

Given the scenario content, it is obvious that two additional Rules of Ethics have been violated. Principle I, Rule Q requires that "Individuals shall maintain timely records and accurately record and bill for services provided and products dispensed and shall not misrepresent services provided, products dispensed, or research and scholarly activities conducted." Principle III, Rule C stipulates, "Individuals shall not misrepresent research and scholarly activities, diagnostic information, services provided, results of services provided, products dispensed, or the effects of products dispensed." The speech-language pathology provider is responsible for keeping detailed records which would typically include the name of the client, dates, duration of services including times, description of services provided, and outcome(s).

While the SLP seems attentive to treatment research and preparation of therapy materials (in lieu of completing paperwork), there is insufficient evidence that the SLP appropriately evaluates the effectiveness of services. In the absence of service documentation and data, how can the SLP assess accomplishment of therapy goals and related parameters such as a need to modify the treatment protocol? Principle I, Rule K states, "Individuals who hold the Certificate of Clinical Competence shall evaluate the effectiveness of services provided, technology employed, and products dispensed, and they shall provide services or dispense products only when benefit can reasonably be expected."

The obligations of the private practice owner given the depicted situation should also be considered. Whether the owner delivers clinical services or functions strictly as an

administrator, there is an obligation to ensure that employees practice in an ethical manner. Knowledge of successful business practices including supervision of employees as well as office operations is imperative in avoiding instances of billing fraud such as that described in the scenario. While the scenario depicted the practitioner as knowledgeable and highly regarded for her therapy skills with children, supervision of the provision and documentation of services was needed on a regular basis. As a private practice owner, there should be some level of oversight for even the most seasoned professionals. Otherwise, the ethical and legal ramifications as well as the negative effects on the individual's business can be significant.

Confidentiality

A speech-language pathologist in a rehab facility decides to prepare for an initial therapy session by reviewing health records, including speech-language information, while she eats lunch. The records are predominantly electronic, but she is able to print out a few necessary pages for temporary use. The SLP receives an emergency phone call and inadvertently leaves the health records on the table in the facility's conference room where she was having lunch. While usually accompanied there by staff, visitors and family members do have access to this conference room. The file folder with the health record pages is discovered by the adult daughter of one of the facility's patients who promptly returns the file to a nurse that she knows. The individual who returned the file folder saw the patient's name and the name of the facility on the records, and just a few other details included on the first page in the folder. She did not read any of the other content.

What are the ethical issues described in this scenario?

Discussion:

This scenario depicts how important it is to follow all applicable laws, regulations, policies, and procedures, including those of the facility, in ensuring patient privacy and confidentiality are protected. HIPAA, the Health Insurance Portability and Accountability Act, has been violated and the breach would need to be analyzed to determine the level to which PHI, or Personal Health Information, has been compromised. Risk assessment factors include identification of the person to whom disclosure was made, the nature and extent of the breach/harm (financial and reputational), and whether PHI was actually acquired or viewed. The facility's efforts to exhibit compliance with HIPAA would be taken into consideration should a complaint be filed.

Two Rules of Ethics, specifically O and P under Principle I of the ASHA Code of Ethics, have, technically, also been violated. Principle of Ethics I, Rule O states, "Individuals shall protect the confidentiality and security of records of professional services provided, research and scholarly activities conducted, and products dispensed. Access to these records shall be allowed only when doing so is necessary to protect the welfare of the person or of the community, is legally authorized, or is otherwise required by law." Principle of Ethics I, Rule P mandates, "Individuals shall protect the confidentiality of any professional or personal information about persons served professionally or

participants involved in research and scholarly activities and may disclose confidential information only when doing so is necessary to protect the welfare of the person or of the community, is legally authorized, or is otherwise required by law.”

The confidentiality and security of components of the patient’s health record were not protected even though the action was not deliberate. The name of the patient and other details were “disclosed” when the visitor examined the file in order to discern what had been left in the facility’s conference room. While these violations may seem rather minor, patients, families, facilities, organizations, and government entities view patient privacy and confidentiality as a serious matter. The speech-language pathologist’s “responsibility to hold paramount the welfare of persons they serve professionally” is not being upheld.

Supervision

A speech-language pathologist who is excited about her newly-acquired Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP obtained following first year of employment in a school system) volunteers to supervise/mentor Clinical Fellows (CF) for her employer, a public school system. Despite the newly certified SLP’s lack of supervision training, at the beginning of the school year she is assigned as the Clinical Fellowship mentor for an SLP who obtained her Master’s degree in May. The two of them meet and seem to instantly have great rapport. Typical of a brand-new professional in a first employment experience, the CF has numerous questions about service delivery, evaluations, IEPs, and policies and procedures required by the school system. She also asks the CF mentor about scheduling the required 18 hours of direct observation as well as the 18 hours of indirect observation, and when she will be rated on the Clinical Fellowship Skills Inventory. The CF mentor assures the CF that everything will be all right, and an observation schedule will be drafted as soon as the CF Mentor finalizes the schedule for all of the students on her caseload. The CF Mentor states that Fridays will likely be the best day for observations.

The first segment of the Clinical Fellowship experience, including the required hours of direct and indirect observation, is completed, and a conference is held to discuss the Clinical Fellowship Skills Inventory ratings. The CF notes at the conference that, although the mentor did observe some therapy, this seemed to be rather limited with much more of the direct observation spent watching screening and evaluation activities, activities in which the CF engages on Fridays. The CF attempts to identify areas for which she feels additional help would be beneficial, and also requests the observation schedule for the remainder of the 36-week Clinical Fellowship experience. The mentor abruptly ends the conference telling the CF that students were recently added to the mentor’s caseload and she is very busy. The mentor assures the CF that it will all work out.

The mentor rarely answers the CF’s email messages, but does implement appropriate observation activities during the second segment of the CF. The conference at which ratings are to be discussed does not last much longer than five minutes, with the CF being instructed to sign the form and review the ratings when she has time. The CF

mentor is rarely seen for the last segment of the CF experience. During the last week of the school year, the CF is told to sign the forms and enter the CF experience information into her online application even though the mentor only “had enough time to” deliver 4 of the required 12 hours of observation. The mentor states that the CF is doing well, all ratings are a “3” (exceeds expectations), the required number of hours are recorded, and that the CF has everything needed to apply for ASHA CCC’s.

Uneasy about the situation, the CF calls an experienced SLP who is a friend of the family. Among other discoveries, the CF finds out that she should have verified via the ASHA website whether the CF mentor maintained her CCC’s during the entire CF experience. Upon investigating, the CF discovers that the mentor did not pay the required fee for the new calendar year until April 15 and, therefore, did not hold the CCC for a significant portion of the school year.

What are the ethical issues described in this scenario?

Discussion:

For CCC-SLP applicants who apply under the 2020 certification standards and earn hours toward the completion of their CF on or after January 1, 2020, the CF mentor has both a professional experience and a professional development requirement. After being awarded the CCC-SLP, the CF mentor must have at least nine months of full-time experience as a speech-language pathologist. The individual must also have completed two hours of professional development in the area of supervision after being awarded the CCCs. It should be noted that several state licensure boards mandate provisions similar to one or both of these requirements in order to qualify for supervisory duties. These vary from state-to-state and it is imperative that an individual determine such regulations governing their state license.

In the scenario above, the new CCC-SLP did not have experience beyond the CF nor any training in the area of supervision. Obviously, the mentor could have benefitted from supervisory training, particularly activities concentrating on supervision of Clinical Fellows. Principle II of the ASHA Code of Ethics (2016) states, “Individuals shall honor their responsibility to achieve and maintain the highest level of professional competence and performance,” while Principle II, Rule A dictates, “Individuals who hold the Certificate of Clinical Competence shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their certification status, education, training, and experience.” Further, Principle II, Rule D stipulates, “Individuals shall enhance and refine their professional competence and expertise through engagement in lifelong learning applicable to their professional activities and skills.”

The mentor was not honoring her “responsibility to hold paramount the welfare of persons they serve professionally” (Principle I) nor was she providing “all clinical services and scientific activities competently” (Principle I, Rule A). There was no specific indication in the scenario that the Clinical Fellow was performing tasks which

exceeded her abilities. It was only stated that the CF wanted to discuss areas for which she thought additional help would be beneficial. Otherwise, there could have been a violation of Principle II, Rule E, “Individuals in administrative or supervisory roles shall not require or permit their professional staff to provide services or conduct research activities that exceed the staff member’s certification status, competence, education, training, and experience.” One could argue that the CF mentor did not do a thorough job of ensuring this Rule of Ethics was upheld in that she delivered less than the required level of supervision, focused on screening and assessment activities during at least the first CF segment (because it was easier for her to observe on Fridays), and would not discuss the CF’s concerns about service delivery.

Principle III, Rule A, “Individuals shall not misrepresent their credentials, competence, education, training, experience, or scholarly contributions,” was violated by the CF Mentor in not maintaining her Certificate of Clinical Competence for the duration of the Clinical Fellowship experience and misrepresenting herself as having the appropriate credentials. She also violated Principle III, Rule C, “Individuals shall not misrepresent research and scholarly activities, diagnostic information, services provided, results of services provided, products dispensed, or the effects of products dispensed,” by indicating that the required supervision had been provided during the last segment of the CF. The non-compliance with ASHA standards as well as the dishonesty and misrepresentation demonstrated by the act of falsifying the Clinical Fellowship Skills Inventory is also a violation of Principle IV, “Individuals shall uphold the dignity and autonomy of the professions, maintain collaborative and harmonious interprofessional and intraprofessional relationships, and accept the professions’ self-imposed standards,” and Principle IV, Rule E, “Individuals shall not engage in dishonesty, negligence, fraud, deceit, or misrepresentation.” One could contend that Principle IV, Rule D was also violated: “Individuals shall not engage in any form of conduct that adversely reflects on the professions or on the individual’s fitness to serve persons professionally.”

Once the CF applies for ASHA certification and/or membership, the individual is then under the jurisdiction of the ASHA BOE. Should it become known that an individual falsified documents utilized in the application process, the individual could be found in violation of Principle IV, Rule F, “Applicants for certification or membership, and individuals making disclosures, shall not knowingly make false statements and shall complete all application and disclosure materials honestly and without omission.”

Telepractice

A speech-language pathologist has been hearing about telepractice services and decides she would like to engage in this form of service delivery. She leaves employment at a private practice intending to read some of the literature and obtain continuing education in the area; however, she does not get around to researching telepractice information or engaging in professional development on the topic. The speech-language pathologist soon realizes that she needs income and begins to deliver services from her home utilizing her already-existing equipment and a non-encrypted, Voice over Internet Protocol (VoIP) software system that was loaded on the computer

when purchased. The services are provided only to in-state pediatric clients. The speech-language pathologist really likes the convenience of providing telepractice services from her home but is somewhat frustrated with the lack of attentiveness of the children. She is challenged by the inconsistency of her home wireless network including failed connections and lack of operational speed. Within three months, she loses a telepractice contract with a school system due to complaints about the lack of reliability of the SLP's connectivity and other issues.

What are the ethical issues described in this scenario?

Discussion:

This speech-language pathologist's competency to provide services via telepractice is an issue. Principle II, Rule A of the ASHA Code of Ethics (2016) states, "Individuals who hold the Certificate of Clinical Competence shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their certification status, education, training, and experience." Most state licensure boards have similar requirements regarding the need for licensees to deliver services competently and to possess appropriate education, training, and experience in order to engage in an area of practice. The speech-language pathologist in this scenario did not acquire education or training in the area of telepractice before engaging in this method of service delivery.

The evaluation of technology to be utilized by the practitioner as well as the client is crucial in the delivery of telepractice services. It is unknown whether there was a discussion about the school system's or other clients' hardware, available bandwidth and other technology parameters. Sufficient network connection speed and bandwidth would be needed so that video and audio quality, connectivity, and screen sharing are not affected. The SLP utilized the technology that already existed in her home without taking these considerations into account. The scenario described the SLP as frustrated by the inattentiveness of the children. This could have been due to lack of communication and coordination with the school system, lack of training of a facilitator in order to focus student behavior and attention, and/or the connectivity disruptions. There are several Rules in the ASHA Code of Ethics that are applicable to this discussion including requirements to evaluate the effectiveness of services provided and technology employed (Principle I, Rule K), and utilization of technology and instrumentation consistent with accepted professional guidelines in areas of practice (Principle II, Rule G).

Lastly, there is the issue of confidentiality, privacy, and security of client information. FERPA, or the Family Educational Rights and Privacy Act, is applicable in the provision of services to the children in the school system, as are HIPAA (Health Insurance Portability and Accountability Act) and the HITECH (Health Information Technology for Economic and Clinical Health) Act if there is, for example, Medicaid billing or other electronic transmission of health information. Principle IV, Rule R of the ASHA Code of Ethics mandates that "Individuals shall comply with local, state, and federal laws and

regulations applicable to professional practice, research ethics, and the responsible conduct of research.” The SLP in this scenario is not using an encrypted web platform and is potentially violating Principle I, Rules and O and P of the ASHA Code of Ethics in that the exchanges with clients cannot be assumed to be confidential or secure.

Conclusion

Consider the term “willful blindness,” a mechanism for maintaining lack of awareness of facts, and its application to evasion of ethical challenges. Margaret Heffernan, author of *Willful Blindness: Why We Ignore the Obvious at Our Peril* (2011), states “We could have known and should have known, but we feel better for not having known something that instead we strove not to see.” Lack of conscious acknowledgement does not result in lack of culpability or responsibility. She maintains, “Our blindness grows out of the small, daily decisions that we make, which embed us more snugly inside our affirming thoughts and values. And what’s most frightening about this process is that as we see less and less, we feel more comfort and greater certainty. We think we see more – even as the landscape shrinks.” It’s a paradox: willful blindness makes us feel safe even though it can put us in danger.

The parallels to the importance of recognition and resolution of ethical challenges should be apparent to us. Given the speech-language pathologist’s knowledge and skills, including the essential information provided in this course, the practitioner should be well-grounded **and willing** to engage in decision-making strategies involving systematic analysis of relevant facts, key people, possible courses of action and potential conflicts, along with evaluation of critical factors including ethical principles, codes of ethics, applicable laws, cultural values, self-interests, and societal roles (Chabon & Morris, 2004). Speech-language pathologists will continually encounter circumstances requiring ethical choices. We have an obligation to abide by the ASHA Code of Ethics as well as applicable laws and regulations. Our professional conduct must result in the provision of high-quality services, holding paramount the welfare of those we serve.

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Conclusion

Chabon, S. & Morris, J. (2004). A consensus model for making ethical decisions in a less-than-ideal world. *The ASHA Leader*, 9(3), 18-19.
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Issues in Ethics: Essential Information for Speech-Language Pathologists
5 CE HOURS

FINAL EXAM

1. _____ are largely developed within our family and community, consisting of individual beliefs regarding what is right and what is wrong.
 - a. Conduct rules
 - b. Ethical philosophies
 - c. Legal standards
 - d. Moral values

2. Per the Four Principles of biomedical ethics by Beauchamp and Childress, "_____" is defined as "Duty to cause no harm; preventing harm."
 - a. Autonomy
 - b. Beneficence
 - c. Non-maleficence
 - d. Justice

3. Per the Four Principles of biomedical ethics by Beauchamp and Childress, "_____" is defined as "The individual's right to make his or her own decisions; freedom of action and choice."
 - a. Autonomy
 - b. Beneficence
 - c. Non-maleficence
 - d. Justice

4. Which of the following is NOT one of the seven steps commonly contained within ethical decision-making models?
 - a. Consult with others in analyzing the decision-making strategies and reasoning employed
 - b. Eliminate the different perspectives that may be used to identify the problem
 - c. Identify the potential issues involved considering autonomy, beneficence, non-maleficence, and justice
 - d. Review the relevant ethical guidelines. Does one or more exist?

5. The _____ which opened in October 1999, required the reporting of all final adverse actions by federal and state government agencies (e.g., state licensing boards), Medicare and Medicaid exclusions, health-care related criminal convictions and civil judgments. These adverse actions include reprimands, censures, probations, limitations on scope of practice, suspensions, revocations, voluntary surrenders (of license), and certain other actions.

- a. Health Care Quality Improvement Bureau (HCQIB)
- b. Health Resources and Services Administration (HRSA)
- c. Healthcare Integrity and Protection Data Bank (HIPDB)
- d. National Practitioner Data Bank (NPDB)

6. The underlying philosophical basis for the ASHA Code of Ethics is found within the four Principles of Ethics. Principles I and II _____.

- a. Are identical to the prior version of the Code
- b. Have been edited, but still relate to one's responsibility to the public (I) and responsibility for professional relationships (II)
- c. Have been eliminated
- d. Have been renumbered, and are now Principles III and IV

7. Which of the following is NOT among the major themes contained with the ASHA Code of Ethics' Rules?

- a. Disclosures
- b. Impaired Practitioner
- c. Sanctions
- d. Use of Technology

8. Per ASHA's 2019 SLP Healthcare Survey, _____ of respondents experienced pressure to provide inappropriate frequency or intensity of services.

- a. 6%
- b. 10%
- c. 14%
- d. 20%

9. When a private practitioner recruits clients for their private practice from his or her primary place of employment, a conflict of interest may exist. To mitigate this concern, an SLP who is employed by a public school system nine months of the year and provides private therapy to students from the same school system during the summer months should _____.

- a. Inform the parents that they will have to pay for the services provided privately and the services offered/provided during the summer months cannot in any way supplant the free, appropriate public education (FAPE) to which students are entitled during the school year
- b. Inform the school superintendent, director of special education, and speech-language services coordinator (if applicable) of the intent to provide services to students from the school system during the summer
- c. Make certain all referrals are of the parent's own volition
- d. All of the above

10. The second basic principle discussed in the *Belmont Report*, _____ is an obligation that exceeds the personal characteristic of kindness. Two general rules of which to be mindful of are “(1) do not harm,” which is the long-held Hippocratic precept, and “(2) maximize possible benefits and minimize possible harms.”

- a. Beneficence
- b. Justice
- c. Respect for Persons
- d. Utility

11. Lack of record-keeping and inaccurate documentation of services have led to the filing of ethics complaints by school system practitioners, administrators, and parents, and have resulted in adjudications by ASHA’s BOE. One of the significant factors in these cases is _____.

- a. A mistake that occurred on rare occasions
- b. A pattern of misrepresentative paperwork
- c. Paperwork that consistently adheres to prevailing professional standards
- d. Paperwork that consistently contains no misrepresentations

12. Are school-based SLPs engaging in unethical practice if missed sessions are not made up? While IDEA regulations do not address this specific issue, the U.S. Department of Education’s Office of Special Education Programs (OSEP) reaffirmed in 2016 that _____.

- a. All missed sessions must be made up
- b. Missed sessions under a district-mandated threshold do not need to be made up
- c. Missed sessions must be examined on a case-by-case basis
- d. School systems should set district-level policy addressing this issue

13. The ASHA Board of Directors in 2016 passed a resolution (BOD 23-2016) approving _____.

- a. A universal standard and process for obtaining speech-language pathology licensure
- b. An interstate licensing compact for audiologists and SLPs
- c. Regulations specific to telepractice in speech-language pathology in eighteen states
- d. The development and implementation of an interstate licensing compact for audiologists and SLPs

14. Protection of client/patient confidentiality and knowledge of privacy and security laws and regulations are essential components in the delivery of telepractice services.

In addition to state licensure laws and regulations and the ASHA Code of Ethics, mandates are contained in _____.

- a. The Education Statistics Data Center's Final Report (2014)
- b. The Health Insurance Portability and Accountability Act (HIPAA) of 1996
- c. The Interstate Medical Licensure Compact of 2017
- d. The National Council of State Boards of Examiners for Speech-Language Pathology and Audiology (NCSB) referendum of 2012

15. Three important documents were the result of a widely-recognized need to address the overarching issue of training for SLP supervisors. Which of the following is NOT among them?

- a. ASHA's *Issues in Ethics: Perspectives of the ASHA Special Interest Groups*
- b. The ASHA Ad Hoc Committee on Supervision Training Final Report: *A Plan for Developing Resources and Training Opportunities in Clinical Supervision*
- c. The ASHA Ad Hoc Committee on Supervision's Final Report: *Knowledge, Skills and Training Consideration for Individuals Serving as Supervisors*
- d. The Council of Academic Programs in Communication Sciences and Disorders (CAPCSD)'s White Paper: *Preparation of Speech Language Pathology Clinical Educators*

16. Multiple sections of the ASHA Code of Ethics apply to supervision of student clinicians. For example, _____ states that "Individuals shall not misrepresent the credentials of aides, assistants, technicians, support personnel, students, research interns, Clinical Fellows, or any others under their supervision, and they shall inform those they serve professionally of the name, role, and professional credentials of persons providing services."

- a. Principle I, Rule D
- b. Principle II, Rule A
- c. Principle IV, Rule G
- d. Principle IV, Rule L

17. Per ASHA's *Speech-Language Pathology Assistant Scope of Practice* document, which of the following tasks may NOT be delegated to a speech-language pathology assistant?

- a. Assist with departmental operations (scheduling, recordkeeping, safety/maintenance of supplies and equipment)
- b. Discharge a student, patient, or client from services
- c. Document student, patient, and client performance (e.g., tallying data for the SLP to use; preparing charts, records, and graphs) and report this information to the supervising SLP
- d. Serve as interpreter for patients/clients/students and families who do not speak English

18. Multiple sections of the ASHA Code of Ethics apply to the utilization of speech-language pathology assistants. For example, _____ states that “Individuals shall not knowingly allow anyone under their supervision to engage in any practice that violates the Code of Ethics.”

- a. Principle I, Rule C
- b. Principle II, Rule E
- c. Principle IV, Rule I
- d. Principle IV, Rule R

19. Originally published in 2011 and updated in 2016, an expert group of health care professionals developed *Core Competencies for Interprofessional Collaborative Practice* which categorizes necessary individual-level knowledge and skills. There are four core domains, with _____, Values/Ethics for Interprofessional Practice, essential to any discussion of ethics.

- a. Competency 1
- b. Competency 2
- c. Competency 3
- d. Competency 4

20. The prevalence of interprofessional practice was quantified in ASHA's 2016 Interprofessional Practice Survey. _____ of SLPs in health care and _____ of SLPs working in schools indicated engagement in interprofessional collaborative practice as defined by the World Health Organization (WHO).

- a. 27%, 14%
- b. 42%, 56%
- c. 63%, 59%
- d. 84%, 91%

COURSE EVALUATION

Learner Name: _____

Course Name: _____ Date: _____

	Disagree				Agree	
Orientation was thorough and clear	1	2	3	4	5	
Instructional personnel disclosures were readily available and clearly stated	1	2	3	4	5	
Learning objectives were clearly stated	1	2	3	4	5	
Completion requirements were clearly stated	1	2	3	4	5	
Content was well-organized	1	2	3	4	5	
Content was informative	1	2	3	4	5	
Content reflected stated learning objectives	1	2	3	4	5	
Exam assessed stated learning objectives	1	2	3	4	5	
Exam was graded promptly	1	2	3	4	5	
Satisfied with learning experience	1	2	3	4	5	
Satisfied with customer service (if applicable)	1	2	3	4	5	n/a

What suggestions do you have to improve this program, if any?

What educational needs do you currently have?

What other courses or topics are of interest to you?
