



OSLA

The Ontario Association
of Speech-Language
Pathologists and Audiologists

Maximizing Speech-Language Pathologists' Capacity in Ontario's Health Care System

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Executive Summary

The Ontario government, in exercising its duty related to the delivery of a sustainable publicly funded health care system, has for some time been actively seeking innovative and strategic solutions that assure that quality, safety and efficiency are basic pillars to optimal health care for the public.

Speech-language pathologists, likewise, have been engaged in this dialogue at the grassroots level contributing to new models of care, at the organization level championing multidisciplinary solutions, and at the systems level considering policy and standards that will support the broader needs of patients/clients. The profession supports the Ministry of Health and Long-Term Care’s *Excellent Care for All Act, 2010* principles that:

- Care is organized around the person to support their health
- Quality and its continuous improvement is a critical goal across the health care system
- Quality of care is supported by the best evidence and standards of care
- Payment, policy and planning support quality and efficient use of resources

OSLA’s Proposed Revisions to Scope of Practice

The proposed changes do not abandon the concept of current practice roles for speech-language pathologists; rather, these roles are facilitated by a flexible and more system-responsive approach, by authorizing speech-language pathologists who have met the standard and regulatory requirements of the College to perform them. This allows the roles to be tailored to the patient/client and system needs. This approach is in keeping with the national and international trends and the *Regulated Health Professions Act, 1991* (RHPA) in general, which promotes flexibility, portability, ease of application and innovation at the point of care. The major changes being proposed are as follows:

1. Amendments to the speech-language pathology scope of practice statement to include ‘diagnosis’ and ‘swallowing’.

Comparison of Current and Proposed	
Scope of Practice for Speech-Language Pathologists in Ontario	
<p>Current: The practice of speech-language pathology is the assessment of speech and language functions and the treatment and prevention of speech and language dysfunctions or disorders to develop, maintain, rehabilitate or augment oral motor or communicative functions.</p>	<p>Proposed: <i>The practice of speech-language pathology is the prevention, assessment, diagnosis, and treatment of speech, language, communication, voice, and swallowing dysfunctions and/or disorders to develop, maintain, rehabilitate or augment communication or swallowing functions.</i></p>

2. Addition of the authority to perform four (4) controlled acts or components of controlled acts for all speech-language pathologists:

- a. Communicating a diagnosis identifying a *communicative or swallowing disorder* [emphasis added] as the cause of a person's symptoms.
- b. Ordering a form of energy, specifically a videofluoroscopic swallow study, for the *purpose of assessing or managing a swallowing disorder* [emphasis added].
- c. Putting an instrument, hand or finger beyond the point in the nasal passages where they normally narrow *for the purposes of assessing and managing a communication or swallowing disorder* [emphasis added].
- d. Putting an instrument, hand or finger into an artificial opening of the body *for the purpose of assessing and managing voice disorders and voice restoration, and for the purpose of suctioning a tracheostomy* [emphasis added].

3. Removal of limitations in other statutory provisions, to enable ordering of important resources and activities (by speech-language pathologists with appropriate demonstrated competence):

- a. Enabling direct referrals to specialty medicine, such as an ENT or Psychologist. This would require changes to the *Health Insurance Act*.
- b. Receiving reports of screening or diagnostic tests that:
 - Are ordered by a health care professional (other than a speech-language pathologist); and
 - Assist in the diagnosis and intervention plan to promote and maintain an individual's *communication or swallowing* health care needs.

Seeking Change

This submission is presented by the Ontario Association of Speech-Language Pathologists and Audiologists (OSLA) on behalf of the 3,077 speech-language pathologists registered with the College of Audiologists and Speech-Language Pathologists of Ontario (CASLPO) in 2014 and based on the following principles:

- Improve patient care and encourage meaningful patient engagement for enhanced patient outcomes;
- Protect the public interest and ensure the highest standards of professional conduct and patient safety;
- Maximize collective resources effectively and efficiently while protecting the public interest;
- Optimize the skills and competencies of diverse health care professionals to enhance access to high quality and safe services;
- Ensure access to high quality and safe services no matter which health profession is responsible for delivering care or treatment; and
- Ensure that all regulated health professionals work to their maximum competence and scope.

We gave careful consideration to current practice standards and guidelines, combined with entry-to-practice requirements and post graduate professional development. Methodology involved preliminary

research and consultations with subject matter experts to update the picture of evolving speech-language pathology practice. Results reinforced the need for a more accurate and flexible approach to defining scope of practice and authorized acts.

This document provides the background information, evidence, rationale, and examples to support the proposed revisions to the scope of practice for speech-language pathology. Appendices include the underlying research and jurisdictional scans that underpin and illustrate the context of practice evolution on which the proposed changes are based.

Protecting the Public – Current Practice Environment in Ontario

Speech-Language Pathology is a well-established profession whose practitioners hold a minimum entry-to-practice Master's and/or doctorate degree with extensive practical clinical training followed by a minimum 6 month mentorship period prior to independent practice. As a regulated health profession, we have high standards of practice, a rigorous quality assurance program and a code of ethics governing our practices. As in any health-care related profession, speech-language pathologists are required to study anatomy and physiology, but they also study genetics, human and language development, linguistics, psychology, acoustics and more, making them qualified to evaluate and diagnose a broad range of delays and disorders. Speech-language pathologists work in a variety of health and educational settings, including, but not limited to: hospitals, public health units and community health centre (18%), schools and preschool settings/daycares (23%), children's treatment centres (10%), community care access centres (6%), and in private practice or other settings (42%) (CASLPO, 2013).

As in Current legislation (*Audiology and Speech-Language Pathology Act, 1991; Health Insurance Act*) limits speech-language pathologists – by requiring alternative authorization or delegation by other health professions to be involved in care – from responding to the system, and performing to the full extent of their competencies.

The statutes currently limit:

- The communication by speech-language pathologists of a communication or swallowing diagnosis identified by the speech-language pathologist from an assessment of a patient/client under their care.
- The speech-language pathologist's ability to respond to patient needs and provide intervention in a timely manner.
- Effective ways of approaching patient care that address the challenge of working with finite human and financial resources.

Speech-language pathologists' education, training, and experience ensure that they are competent to perform a much greater range of activities than are included within Ontario's current scope of practice, which results in the following barriers and system strains:

- Expending unnecessary time and resources to seek out alternate authorization such as medical directives/delegations/orders. These alternatives may have been beneficial early in the

evolution of SLPs scope of practice; however when the competencies to perform the act safely and within the principles of autonomous practice exist, as they do now and have for decades, then the alternate authorizations become an unnecessary restriction on the scope of a profession as well as a burden on system resources. The current requirement for alternate authorizations compromises timely access to essential health care interventions by adding additional steps and barriers and requiring additional health professions to be involved in care at a time when health human resources are increasingly strained.

- Referring unnecessarily to another health profession (physician or other medical specialist):
 - in order to assist the patient/client in ultimately accessing a diagnosis that was in fact formulated by the speech-language pathologist.
 - to request an order or referral from the physician for the diagnostic tests requested/recommended by the speech-language pathologist.
- Being unable to perform the medical intervention, thus causing risk of harm to the patient.
- Eliminating patient/client access to service, particularly in rural, remote or under-serviced areas of Ontario.

All speech-language pathologists are educated at the entry-to-practice level to diagnose and communicate a diagnosis related to communication and swallowing disorders to their patients/clients or their personal representative. Diagnosis is a core competency of the curriculum of accredited Canadian universities conferring Master's and/or doctorate degrees in speech-language pathology. Preclusion of the qualified SLP professional to communicate the results of their assessment / diagnosis is inefficient and potentially harmful to the patient.

Instrumental swallowing assessments including videofluoroscopic swallow studies and Fiberoptic Endoscopic Evaluation of Swallowing (FEES) are within the knowledge, skills and judgement of speech-language pathologists.

Speech-language pathology has also developed expertise in the area of voice restoration following laryngectomy surgery. Clinicians have the training and expertise in post-surgical tracheoesophageal puncture (TEP) procedures to perform this act without delegation.

Quality Assurance and Health Care Benefits for the People of Ontario

The College of Audiologists and Speech-Language Pathologists of Ontario currently regulates both professions and sets the standards of practice and will continue to do so in keeping with any enhancement in scope of practice. Professional competence to perform these controlled acts will be assured by the College as part of their quality assurance program. The College currently undertakes this responsibility through a variety of processes within their quality assurance program, including compulsory self-assessment, peer assessment and continuing education requirements. Although the scopes of practice discussed in this paper are common areas of training within the Canadian Masters degree programs for SLPs, the College provides additional assurance that each individual member ensures and demonstrates that they possess the appropriate competencies, when they participate in the quality assurance program.

The proposed changes will improve public access to speech-language pathology services at a lesser cost to the system while maintaining existing quality and safety of care. For example, a patient would not have to make a physician visit to receive a communication diagnosis or to obtain a videofluoroscopic swallow assessment; instead, the speech-language pathologist would communicate the diagnosis and/or order the assessment without the additional time and cost of a physician visit. Physicians currently communicate the diagnosis and/or order a videofluoroscopic swallow assessment on the recommendation of the Speech-Language Pathologist, so the physician visit is a redundant step. The proposed changes would also enhance the productivity of other health professionals, boosting overall system performance and improving patient care.

The profession looks forward to discussing this submission with The Ministry of Health and Long-Term Care and is committed to realizing the fullest contribution of speech-language pathologists to collaborative, patient-centred, safe, quality care in Ontario.

Section 1 – Introduction

We have used the questionnaire that HPRAC utilizes when reviewing submissions from regulated health professionals as a guide to our document.

Speech-language pathologists, as regulated health care professionals in Ontario, are committed to the provision of culturally and linguistically relevant clinical services, and to the consideration of diversity in evidence-based research on human communication and swallowing. They have a necessary and widespread contribution to make to the health of Ontario’s infants, children, adolescents and adults.

The speech-language pathology (SLP) profession advocates for recognition of a scope of practice that is reflective of SLP education, competencies, and clinical practice activities.

The speech-language pathologists of Ontario aim to meet the diverse communication and swallowing needs of Ontarians in alignment with the government’s position to maximize regulated health care professionals’ scopes of practice, and the implications that this has for enriching inter-professional outcomes for the public (e.g. interdisciplinary work in a health care setting, collaborative service delivery in schools, multidisciplinary practice in early intervention settings).

The Ontario Association of Speech-Language Pathologists and Audiologists (OSLA) is pleased to present this submission, *Maximizing Speech-Language Pathologists’ Capacity in Ontario’s Health Care System*, on behalf of all registered speech-language pathologists practicing across Ontario.

In this document, OSLA provides ample and compelling evidence of the profession’s ability to realize the full scope of practice of speech-language pathologists, and to be granted authority to perform the authorized acts for which they are duly trained and qualified. The SLP’s knowledge, competence and judgment needs to be fully understood and supported in order to position this body of regulated health care professionals to better serve the public, contribute more to other health professionals in collaborative practice, and to improve health system efficiency and effectiveness.

Section 2 – Profession Information (Questions 1-8)

1. Does your current scope of practice accurately reflect your profession’s current activities, functions, roles and responsibilities?

No. The scope of practice within the *Audiology and Speech-Language Pathology Act, 1991* does not reflect current clinical practice roles or the present entry-to-practice post-graduate education. The evolution of the practice and education of speech-language pathologists over the past twenty years has resulted in an array of competencies that are regularly performed under delegation protocols or medical directives, but which are not authorized under the *Audiology and Speech-Language Pathology Act, 1991*.

More specifically with respect to the current scope of practice statement, the absence of the word “diagnose” is most notable, negatively impacting Ontarians who require the services of SLPs. Speech-language pathologists are the only regulated health care professional specifically educated and trained in the competencies necessary to assess for, formulate and communicate diagnoses for speech, language, communication, swallowing and vocal disorders.

The profession routinely formulates diagnoses in order to devise treatment plans and to communicate their diagnoses to referring practitioners and other members of the health care team. The absence of a reference to communicate this diagnosis to recipients of care in the statutory scope of practice statement has a substantial negative impact at the point of care – increasing risk of miscommunication of diagnosis, delaying treatment, complicating inter-professional interactions, and confusing patients/clients who expect a diagnosis from their assessing regulated health professionals (including speech-language pathologists).

The proposed changes aim to improve public access to speech-language pathology and related services at lesser cost while maintaining existing quality and safety of care. For example, current barriers to access such as a patient having to go to a physician to obtain a requisition for a videofluoroscopic swallow assessment would be eliminated; the speech-language pathologist would be able to order the assessment without the additional time and cost of a physician visit. Physicians currently order a videofluoroscopic swallow assessment on the recommendation of the SLP so the physician visit is a redundant step; the proposed changes will provide safe and timely access to appropriate health and diagnostic care for the patient and will enhance the productivity of other health professionals, boosting overall system performance. Current wait times in Ontario for a videofluoroscopic swallow study are 2 weeks to 6 months.

2. Name the profession for which a change in scope of practice is being sought and the professional Act that would require amendment.

Profession: Speech-Language Pathology

Act: *Audiology and Speech-Language Pathology Act, 1991*

3. Describe the change in scope of practice being sought.

See detailed description of proposed changes at Question 12. All proposed changes would be reinforced by accountability measures articulated in College standards and regulatory mechanisms related to controlled acts.

4. Name of the College/association/group making the request, or sponsoring the proposal for change, if applicable.

Ontario Association of Speech-Language Pathologists and Audiologists (OSLA)

5. Address/website/e-mail

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7. Contact person (including day telephone numbers)

Mary Cook, Executive Director

Ontario Association of Speech-Language Pathologists and Audiologists

Telephone: 416-920-3675

Email: mcook@osla.on.ca

8. List other professions, organizations or individuals who could provide relevant information applicable to the proposed change in scope of practice of your profession. Please provide contact names, addresses and contact numbers, where possible. Professional Regulatory Bodies in Ontario

College of Audiologists and Speech-Language Pathologists of Ontario
3080 Yonge St. Suite 5060, Box 71
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416-975-5347
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Ontario University Training Programs

University of Western Ontario
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Elborn College
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Tel: 519-661-4081
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earmouth@uwo.ca

Université d'Ottawa
Programme d'audiologie et d'orthophonie
École des sciences de la réadaptation
Faculté des sciences de la santé
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Université Laurentienne S-LP Program (French)
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Professional Speech-Language Pathology Associations in Canada

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1 Nicholas St., Suite 1000, Ottawa, Ontario K1N 7B7
(613) 567-9968
Email: info@sac-oac.ca

Section 3 – For Associations (Questions 9-11)

9. Names and positions of the directors and officers.

Peggy Allen, President, Speech-Language Pathologist

Lorie Grant, Vice President, Speech-Language Pathologist

Julie Herczeg, Secretary-Treasurer, Speech-Language Pathologist

10. Length of time the association has existed as a representative organization for the profession.

Incorporated in 1965, the Ontario Association of Speech-Language Pathologists and Audiologists is the voluntary, not-for-profit professional association for speech-language pathologists and audiologists in Ontario. It provides a range of services to its members, including professional support, inter- and intra-professional partnerships, dissemination of information and trends, research, access to resources, media relations, professional development, and public education. OSLA also cooperates with consumer groups and other stakeholders who depend upon the professional expertise of audiologists and speech-language pathologists. It is the advocacy organization for the two professions.

11. List name(s) of any provincial, national or international association(s) for this profession with which your association is affiliated or who have an interest in this application. Please provide contact names, addresses and contact numbers where possible.

Not applicable.

Section 4 – Legislative Changes (Questions 12-13)

12. What are the exact changes that you propose to the profession’s scope of practice (scope of practice statement, controlled acts, title protection, harm clause, regulations, exemptions or exceptions that may apply to the profession, other legislation that may apply to the profession and other relevant matters)? How are these proposed changes related to the profession and its current scope of practice?

This submission proposes a change in the speech-language pathology scope of practice statement; authority for four (4) controlled acts; and other statutory changes to remove key barriers to practice as already qualified and to more fully, expeditiously, and cost effectively meet the needs of Ontarians with communication and swallowing concerns. Changes are supported by academic and regulatory infrastructure currently found in university curriculum and in College standards. Each proposed change is reviewed in more detail below.

OSLA’s proposals:

1. Scope of practice statement

The first proposed amendment is the addition of the word “diagnose/diagnosis” and “swallowing” further clarification of current professional practice as follows:

Comparison of Current and Proposed Scope of Practice for Speech-Language Pathologists in Ontario	
<p>Current: The practice of speech-language pathology is the assessment of speech and language functions and the treatment and prevention of speech and language dysfunctions or disorders to develop, maintain, rehabilitate or augment oral motor or communicative functions.</p>	<p>Proposed: <i>The practice of speech-language pathology is the prevention, assessment, diagnosis, and treatment of speech, language, communication, voice, and swallowing dysfunctions and/or disorders to develop, maintain, rehabilitate or augment communication or swallowing functions.</i></p>

The changes reflect the current practice of speech-language pathologists and affirm the capacity of speech-language pathologists to diagnose within their scope of practice, enabling them to practice to the full extent of their individual competencies to better meet the needs of patients/clients. An evolving health system, coupled with the increasingly complex care requirements of Ontarians, requires an expanded and more accurately defined role for speech-language pathologists to ensure timely access to safe, quality care.

Within this statement, the most significant proposed change is the addition of the word 'diagnose'. The intention is to make it clear that diagnosis is an activity that should be reflected in the statutory scope of practice for speech-language pathology. It represents a core element of speech-language pathology practice, critical to serving population needs. The knowledge, skill and judgement associated with communicating a diagnosis is trained and assessed in post-graduate programs across Canada as an expected entry-to-practice competency for speech-language pathologists.

Including diagnosis in the scope of practice statement also necessitates the request (below) for the authority for speech-language pathologists to perform the controlled act of 'communicating a communication or swallowing diagnosis'. The change would bring Ontario in line with other Canadian provincial and territorial jurisdictions and selected countries reviewed for this submission, affirming 'diagnosis' as part of expected entry-to-practice and legislation.

The provision of service for swallowing disorders (dysphagia) falls within the current scope of practice of speech-language pathologists. Speech-language pathologists assess swallowing function as well as develop, implement and monitor dysphagia treatment and management programs in collaboration with the patient/client and other members of the health care team. Speech-language pathologists play a primary role in the evaluation and treatment of infants, children, and adults with swallowing and feeding disorders. This proposed change simply clarifies the current role and scope of speech-language pathology.

2. Controlled Acts

The current *Audiology and Speech-Language Pathology Act, 1991* does not authorize speech-language pathologists to perform any controlled acts.

All proposed amendments to current controlled acts already fall within the scope of what speech language pathologists are trained to do. The proposed changes would apply to speech-language pathologists with demonstrated competence, in keeping with the legislation and as regulated by the College's standards of practice, including its Standard for Professional Practice. In this way, the model is similar to many of our allied health professionals, where for example, physiotherapists, psychologists; physicians are authorized to perform controlled acts, as regulated by their College, but only if they have the competence to do so.

Addition of the authority to perform four controlled acts or components of controlled acts for all speech-language pathologists:

- a. Communicating a diagnosis identifying a *communication or swallowing disorder* [emphasis added] as the cause of a person's symptoms.
- b. Ordering a form of energy, specifically videofluoroscopic swallow study, for the *purpose of assessing or managing a communicative or swallowing disorder* [emphasis added].
- c. Putting an instrument, hand or finger beyond the point in the nasal passages where they normally narrow *for the purposes of assessing and managing a communication or swallowing disorder* [emphasis added].

- d. Putting an instrument, hand or finger into an artificial opening of the body *for the purpose of assessing and managing a communication or swallowing disorder, for example a voice disorder or voice restoration* [emphasis added].

Controlled Act #1 - Communicating to the individual or his or her personal representative a diagnosis identifying a *speech, language, communicative or swallowing disorder* [emphasis added] as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely upon the diagnosis.

Discrepant from other Canadian jurisdictions, speech-language pathologists in Ontario are not permitted to communicate a diagnosis under the current legislation despite this being a core competency of the curriculum of accredited Canadian universities conferring Master's degrees in speech-language pathology. Communication of a communication or swallowing diagnosis as assessed by a speech-language pathologist is essential for timely response to immediate patient/client needs and related imperatives, such as access to funding to cover the required services (where available). It is critical to treatment planning, and is considered requisite for fully informed consent to treatment. The process of consent is convoluted and unnecessarily complicated by including other practitioners who are not the assessing/diagnosing professional. This also compromises timely referral for other specialty services that may arise from the speech-language pathology diagnosis.

The provision of service for swallowing disorders (dysphagia) falls within the current scope of practice of speech-language pathologists. Speech-language pathologists assess swallowing function as well as develop, implement and monitor dysphagia management programs in collaboration with the patient/client and other members of the health care team. Speech-language pathologists play a primary role in the evaluation and treatment of infants, children, adults and seniors with swallowing and feeding disorders. The addition of "swallowing" simply clarifies the nature of speech-language pathologists' current scope of practice.

All speech-language pathologists are educated and trained to diagnose and communicate a diagnosis related to speech, language, communication and swallowing disorders to their patients/clients or their personal representative at the entry-to-practice level. It is a fundamental and primary aspect of the care that speech-language pathologists provide to their patients/clients. To formulate findings and not communicate these to the patient/client is counterintuitive, confusing to the patient and preventing streamlined access to care or informed decision making for treatment options.

Clients (or their families/caregivers) self-refer to a speech–language pathologist or are referred by health or education professionals. The speech–language pathologist may function as part of a larger clinical or educational team and make use of findings from other health, psychological or educational assessments. The differential diagnosis of the communication, speech or language disorder, however, is made by the speech-language pathologist. Professionals with less expertise in human communication may fail to recognize a communication disorder or may not know whether an observed communication pattern is consistent with known disease states. For example, family physicians may advise parents that

nonverbal three-year olds are merely late talkers rather than disordered learners, although research evidence indicates this is highly unlikely. Or, a home care nurse may wrongly attribute a client's slurred speech to a previous diagnosis of early Alzheimer's, thereby missing the signs of a stroke that would warrant referral to a physician. In addition, speech-language pathologists are trained to diagnose specific types of communication disorders that other medical professionals may not be aware of. For example, being able to differentially diagnose dysarthria subtypes or other motor speech disorders a person may have can assist the physician in identifying the underlying neurological disorder related to that dysarthria. Speech-language pathologists will assess and treat patients with Parkinson's, ALS, and MS in their care path. There is research that early intervention in aphasic patients dramatically improves health outcomes.

Communication disorders can be roughly classified into two types: developmental and acquired. Each of these can be further subdivided according to whether the disorder involves peripheral structures or more central neural mechanisms. The following examples of diagnostic activity (in highly abbreviated form) are drawn from these various practice areas.

Clinical Story #1: Communicating a Diagnosis – Delay in Treatment.

A mother brings her three and a half year-old son for consultation with a speech–language pathologist. She is concerned because the boy speaks infrequently, uses short sentences, and doesn't know as many words as his two year old sister. The speech-language pathologist observes the child playing and interacting with his mother and administers language tests, tests of nonverbal problem solving and a hearing screening. The speech-language pathologist notes that the boy's play is full of complex stories. His behaviour is appropriate, and he uses speech both to describe events and to ask for assistance. His speech, though limited, is intelligible and contains age appropriate sounds such as "S", "K" and "G". The data confirm the mother's impression of delayed speech and language learning, and he is diagnosed with specific language delay. The SLP cannot communicate the diagnosis to the parent, and must refer back to the family physician for the diagnosis. The child will be scheduled for language intervention sessions, with the goal of reducing the gap between language skills and other areas of development. However, the physician calls the SLP to understand what is needed in order for the treatment plan to commence. This process took 3 months to complete. Immediate treatment would have occurred if the SLP had the authority to communicate the diagnostic findings.

Clinical Story #2: Communicating a Diagnosis – Delay in Treatment and Loss of Income for the Patient

A 57 year-old woman is admitted to hospital with slurred speech following a stroke on the left side of her brain. She is primarily concerned about her slurred speech, but also mentions that she is having difficulty thinking of words and occasionally understanding what people are saying to her. The speech–language pathologist administers a battery of tests including a language assessment and an examination of the structure and function of her mouth. Following the assessment, the speech-language pathologist determines the woman has mild dysarthria and mild to moderate aphasia. The dysarthria is likely to resolve, however, the aphasia has affected the woman's word-finding, auditory comprehension, reading and writing abilities. The woman will be enrolled in a language therapy program, with the goal of

improving language function. However, the SLP is unable to communicate her diagnosis to the patient and begin immediate treatment. The findings are referred back to the family physician along with the treatment plan. This process delays treatment by four months. This delay had a significant impact on her degree of recovery given the evidence of increased effectiveness of early intervention. As well, her return to work as a business consultant was delayed and resulted in lost contracts, loss in income and overall sense of self. The emotional impact was significant, resulting in clinical depression and a breakdown in her marriage.

Clinical Story #3: - Communicating a Diagnosis – Misdiagnosis by Physician – Severe Delay in Treatment – Causes Anguish for the Parents

A three year old boy is referred to a speech-language pathologist for assessment because of parental concerns regarding the boy's communication development. The SLP conducts an assessment using both standardized and non-standardized measures. She asks the parents to complete questionnaires to gain information about the boy's daily communication patterns. She observes the child during play with peers and with his parents. The results indicate that the child has significant delays in understanding and use of language, narrow scope of interests, ritualistic behaviours and poor social language skills. The SLP reviews the finding with the parents and they ask her what she thinks is the cause of the problem. Because the SLP is not allowed to use diagnostic communication terms, the SLP is not able to communicate that her findings suggest a broader developmental issue that must be identified by another health professional. The SLP recommends that the parents see their family doctor and pursue a pediatric developmental assessment.

The family do not have a family doctor and decide to wait until the child enters school the following year in hopes that he will outgrow his communication difficulties. This choice results in a late diagnosis of ASD and the child not receiving the appropriate preschool services that require a diagnosis of Autism. This scenario might have been avoided if the SLP were able to frankly discuss with the parents that her findings indicated that the child most likely had autism and strongly encouraged them to seek confirmation of the diagnosis through pediatric developmental assessment.

Clinical Story #4: Communicating a Diagnosis – Delay in Treatment

A boy in kindergarten is referred to a Speech-Language Pathologist because he has very poor speech intelligibility. Prior to school entry he did not receive any therapeutic intervention. Because others have significant difficulty understanding what he is saying he is growing increasingly frustrated at school. The Speech-Language Pathologist does an assessment and results indicate that his language comprehension is age appropriate but his ability to accurately produce and sequence speech sounds is disordered. The SLP suspects that this child has a motor speech disorder called "Apraxia". Intensive one-to-one intervention will be required. The parents want to arrange for private therapy due to the lengthy wait list through CCAC. Because the SLP is not permitted to use diagnostic terms only the pattern of strengths and needs based on the assessment is discussed with the parents and they are directed to see the family physician to receive a formal diagnosis. Unnecessary delays are incurred getting the child referred for

intensive speech therapy because the parents have to see the family doctor for formal diagnosis before treatment can be initiated.

Controlled Act #6b - Putting an instrument, hand or finger beyond the point in the nasal passages where they normally narrow *for the purposes of assessing and managing communication and swallowing disorders.* [emphasis added]

Nasoendoscopy is an instrumental assessment of palatal, pharyngeal and laryngeal functioning for speech, voice and swallowing disorders. Fiberoptic Endoscopic Evaluation of Swallowing (FEES) and flexible transnasal nasoendoscopic examinations entail insertion of a flexible scope beyond the point in the nasal passages where they normally narrow.

Speech-language pathologists assess and treat people who are having difficulty communicating or swallowing due to a variety of causes, including disordered anatomy or physiology of the structures required for speech or swallowing. Visualization and imaging of the vocal tract, laryngeal and velopharyngeal structures is required to accurately assess and treat these disorders, and can be achieved by placing a nasoendoscopic instrument beyond the point in the nasal passages where they normally narrow whereby a high intensity light illuminates structures as they move in real time to be viewed and/or recorded by the clinician. This is an effective tool for evaluating, assessing and adjusting treatment for voice, resonance, aeromechanical, and swallowing disorders. If such an assessment identifies a physical problem that may require medical diagnosis or interventions such as surgery, the patient/client is referred on to the appropriate medical professional.

The use of endoscopy is well documented as a cost-effective objective and effective tool in the assessment of speech, voice or swallowing but its use is not yet wide spread in Ontario given the hurdles of delegation for speech-language pathologists. Speech-language pathologists acquire the knowledge and skills necessary to perform this procedure through the master's program and clinical training (Appendices C and D). The authority to perform this controlled act will reduce delays in patient care and potential complication risks associated with such delays. Furthermore, it would increase access to service, reduce wait times and reduce health care costs by eliminating the need for repeated and unnecessary consultation with the physician.

In **British Columbia, Alberta and Manitoba**, speech-language pathologists are authorized to perform this controlled act. Currently in Ontario however, these procedures are only conducted by the speech-language pathologist when delegated by another health care provider which precludes timely access and increases health care spending by involving more providers in the process and delaying intervention. This delay also placed the patient at further risk.

Clinical Story #1: FEES Assessment – Patient at Risk – Delegation Required – Delay in Assessment and Treatment

A 24 year-old client with muscular dystrophy, who is on a ventilator and has a history of a swallowing disorder, has recently experienced increased difficulty managing food or fluid by mouth. The speech-language pathologist requires an instrumental assessment to determine what, if any, changes need to

be made to his current diet (manipulating food texture and consistency is a common method for managing swallowing difficulties and avoiding aspiration) . A videofluoroscopic swallow study (VFSS) is not possible due to the inability to transfer the client to the chair for the x-ray. A Fiberoptic Endoscopic Evaluation of Swallowing (FEES) is the safest, most effective way to assess the client's risk of aspiration (material entering the lungs) with fluid intake. The FEES allows the speech-language pathologist to view the pharyngeal and laryngeal structures while the client is swallowing fluid in order to evaluate risk for aspiration and to then allow the clinician and client to make informed decisions regarding diet modifications, treatment, and prognosis. As the SLP did not receive the delegation from a physician required to perform the FEES for four (4) weeks, the patient's health deteriorated substantially due to his inability to ingest nutrition. Had the SLP been able to order the FEES immediately and perform the test, the patient's status would not have been unnecessarily compromised further and the treatment plan would have commenced sooner.

Clinical Story #2: Role of the SLP in Utilizing FEES to Treat Patient – Demonstrating Competence- Putting an Instrument Beyond the Point in the Nasal Passages.

A singer is referred to a speech-language pathologist by the Ear, Nose and Throat (ENT) surgeon with a diagnosis of vocal nodules (growths on the vocal cords). The SLP competently uses flexible nasoendoscopy and videolaryngoscopy to objectively view significant muscle tension with the larynx (voice box). During voicing there is abnormal front-back constriction within the larynx. The client is participating in voice therapy but is having significant difficulty reducing the laryngeal tension. The speech-language pathologist is able to use nasoendoscopy during treatment sessions for visual feedback during speaking to help the client reduce muscle tension. After a course of therapy, vocal quality is improved but the client is still very anxious about the presence of the nodules. The speech-language pathologist then does a follow-up nasoendoscopic video to demonstrate to the client that the nodules have resolved.

Controlled Act #6g - Putting an instrument, hand or finger into an artificial opening of the body for the purpose of assessing and managing voice disorders and voice restoration, and for the purpose of suctioning a tracheostomy [emphasis added].

Assessing and Managing Voice Disorders and Voice Restoration

Speech-language pathologists provide therapy for voice restoration following larynx surgery. In addition to the traditional voice rehabilitation methods, such as the use of esophageal voice or the use of an artificial larynx, more current trends include voice prostheses by way of trachea-esophageal puncture (TEP; an opening between the trachea or windpipe and esophagus within which a valved tube is placed).

Voice is produced by temporarily blocking the opening, either with a finger or an adjustable tracheostoma valve, so that exhaled air from the lungs can be directed from the windpipe through the prosthesis into the esophagus (where vibrations are produced) and then out through the mouth.

When a client who has had a laryngectomy has a voice prosthesis, the speech-language pathologist serves a primary role in the selection and fitting of the prosthesis, teaching in the care and use of the prosthesis, and in identifying and resolving difficulties related to sound generation. In the course of treatment it may be necessary to insert or remove a voice prosthesis for fitting, cleaning, maintenance, or training in self-management of the prosthesis. Opening of the passage may also require a catheter.

Currently in Ontario, SLPs have the above described controlled act delegated to them by health professionals authorized to perform this act; In **British Columbia, Alberta** and **Manitoba**, speech-language pathologists are authorized to perform these controlled acts without delegation.

Once again, the current situation in Ontario results in unnecessary barriers to access to treatment, increased burden on the health care system and increased expenditure of health care dollars.

Clinical Story #1: Access and Wait Time – Barrier to Timely Treatment

A client who has undergone total removal of the larynx (voice box) sees the speech–language pathologist for post-operative prosthesis fitting. The speech-language pathologist removes the semi permanent catheter, inserts a dilator into the TEP fistula, and then inserts a sizing device to determine the appropriate prosthesis length. The speech-language pathologist removes the sizing device, then prepares and inserts the prosthesis. The speech-language pathologist checks prosthesis seating. The speech-language pathologist instructs the client on voice production by blocking the opening in the neck with a gloved finger. The client then attempts to produce voice with the speech-language pathologist assisting the client to cover the opening with his finger.

The barrier to timely relevant treatment for the patient was delayed by three weeks as the SLP had to wait for delegation of the controlled act of “inserting a finger....” rather than proceeding with the above steps that he/she is trained to carry through with. This resulted in unnecessary delays in patient rehabilitation.

Clinical Story #2: Access and Wait Times – Delegation Required

A client who has undergone total laryngectomy also has arthritis and cataracts, resulting in vision and manual dexterity limitations. As a result the client cannot remove and change his own prosthesis. He therefore uses a more secure, semi-permanent (“Indwelling”) voice prosthesis, which is routinely changed twice annually by the speech–language pathologist. This involves the speech-language pathologist removing the prosthesis with forceps, opening the passageway with an expander or catheter, resizing the passageway if necessary, preparing the replacement prosthesis, inserting the prosthesis, and finally checking for prosthesis fit and function.

The barrier to timely relevant treatment for the patient was delayed as the SLP had to wait for delegation rather than proceeding with the above steps that he/she is trained to carry through with.

Tracheostomy Suctioning

Tracheostomy suctioning is a procedure used to remove airway secretions, blood, vomitus, or other foreign material from the windpipe and lower airway whereby sub-atmospheric pressure is applied through a catheter inserted into the artificial airway of the tracheostomy. Suctioning may be necessary

when the individual is unable to clear the material naturally by coughing; suctioning may become necessary to remove these accumulated secretions for the purposes of swallowing and communication. In the course of completing a swallowing assessment, for example, many times it is necessary to suction a client in order to assess for entrance of material into the airway or to clear out material before, during, or after a swallowing assessment. In order to manage a client's tracheostomy for communication purposes as well, many times it is necessary to suction the client so that they are able to produce voicing when a cap or a valve is placed on their tracheostomy.

In the hospital (acute, rehabilitation, complex continuing care), long-term care or community settings nursing or respiratory therapy staff may not be available to provide suctioning during swallowing and communication assessments which may preclude the assessment from occurring in a timely manner as the SLP does not have the authority to perform the controlled act. This creates duplication in use of health personnel when the speech-language pathologist has the necessary training and experience to conduct this procedure. Once again, the result is added costs to health care, reduced access to service, increased wait times and increased risk of complications through delayed service.

Clinical Story # 1: Delay in Treatment – Increased Risk of Complications

A client with muscular dystrophy who has had a long term tracheostomy uses a speaking valve to be able to speak with the tracheostomy in place. Prior to having the valve placed on the opening, the speech-language pathologist must suction secretions through the tracheostomy so that the client is able to breathe adequately and produce adequate voicing. This ability to immediately proceed with the treatment process is not feasible if the speech-language pathologist is required to rely on other personnel to conduct the suctioning.

Controlled Act #7 - Applying or ordering the application of screening or diagnostic tests using prescribed form of energy to *diagnose and treat a communication or swallowing disorder.* [emphasis added]

The health care field evolves with advances in technology, allowing practitioners to provide new and improved methods of diagnosis and treatment; the current scope of practice for speech-language pathologists limits those qualified professionals from providing the most up to date technological resources to the patients/clients they assess and treat for communication and swallowing concerns. Speech-language pathologists currently possess the necessary knowledge, skills and training in visualization and imaging procedures to enhance the diagnosis and treatment of communication and swallowing disorders. Sophisticated imaging techniques provide crucial information for both the differential diagnosis and clinical management of speech, voice and resonance disorders.

Speech-language pathologists have the requisite competencies in their practice areas that qualify them to order and receive reports of screening and diagnostic imaging tests that provide clinical information necessary to their clinical decision making for optimal, timely and cost effective patient/client outcome.

Speech-language pathologists working with clients who have had diagnostic tests, including, but not limited to, videofluoroscopic swallow studies (VFSS), Fiberoptic Endoscopic Evaluation of Swallowing

(FEES), MRIs, chest x-rays, CT scans, base many of their clinical decisions on the results of these tests and as such may be in the best clinical position to place an order for these examinations. This would reduce delays in patient care and potential complication risks associated with delays; would increase access to service by reducing wait-times; and reduce health care costs with the elimination of redundant consultation with the ordering physician.

Oropharyngeal Swallowing Disorders (Dysphagia)

Speech-language pathology practice includes the assessment and treatment of oropharyngeal swallowing disorders (dysphagia).

Dysphagia diagnoses are most often based on interdisciplinary assessments in which the role of the speech-language pathologist is to assess the oral and pharyngeal phases of swallowing. Such assessments include examination of the oral structures and function, evaluation of oral manipulation of food or liquids of various textures and evaluation of pharyngeal function during swallowing (often assessed in conjunction with a radiologist doing video fluoroscopic swallowing studies (VFSS), or using flexible nasoendoscopy). The role of the speech-language pathologist is to diagnose the observed swallowing disorder by identifying the specific difficulties that contribute to it. For example, motor weakness in the oral cavity, pharyngeal phase issues, or cognitive impairments that contribute to difficulty swallowing. The speech-language pathologist is able to determine the type and severity of swallowing disorder the person is experiencing, the prognosis for recovery of swallowing function, and makes recommendations for diet modifications, remediation and/or strategy interventions.

The information that the speech-language pathologist provides in these situations is essential to the health care team in improving patient outcomes, reducing risk of pneumonia and re-hospitalisation. In the stroke population, 10% of deaths within 30 days of admission to hospital can be attributed to pneumonia. One death can be averted for every 11 clients in whom stroke-related pneumonia is prevented (Katzan et al., 2011). This means that if speech-language pathologists are able to assess and diagnose swallowing disorders, and then treat it appropriately within a timely manner, these deaths can be prevented. In addition, many decisions that are made by other health care professionals regarding, for example, nutrition, method of medication administration, and even end of life care, are based on, or impacted by, the results of the swallowing assessment and the assessment/diagnosis provided by the speech-language pathologist. Ironically, the leading researcher in electromyography and videofluoroscopy studies, for swallowing disorders, Dr. Catriona Steele, is based in Ontario – a province in which speech-language pathologists are not included in the controlled act (Steele CM., et. al, 2013).

Clinical Story #1: – Ordering a Form of Energy - Delay in Diagnostic Assessment and Patient’s Health at Risk

An individual admitted to an acute care hospital following a stroke is discharged home to the care of his wife, prior to assessment and management of moderate swallowing concerns. The client is seen by a private speech-language pathologist for community based treatment; the SLP conducts a bedside swallowing evaluation and determines that a VFSS is necessary to make appropriate clinical decisions regarding diet modifications and swallowing treatment. The process of returning to the physician for an

appointment to follow through on the SLP's recommendations for ordering a VFSS is arduous for the patient and his spouse; it entails a wait time to see the physician, delay in booking , adds unnecessary costs to the process, and the patients' health is compromised in the meantime. The ordering of a VFSS took four months from delegation to performing the test.

Clinical Story #2: Communicating a Timely Diagnosis and Ability to Order a Form of Energy (VFSS) by SLP to Expedite Care Path

A six year-old child with cerebral palsy and history of recurrent aspiration pneumonia is referred to the speech-language pathologist for a swallowing assessment. The assessment reveals oral motor weakness, incoordination, and decreased range of movement. Speech is moderately slurred and there is indication of impaired cognition. In the swallowing assessment, the speech-language pathologist observes the child eating at a rapid rate, taking large bites of food, and large sips of water. Frequent coughing and throat clearing is observed throughout the assessment. The speech-language pathologist completes a videofluoroscopic swallow study (VFSS) to further assess the child's pharyngeal swallow. The VFSS reveals entrance of thin liquids into the airway and lungs; however, the risk of this is decreased when the rate of intake is controlled. The instrumental assessment also shows the child having difficulty manipulating large amounts of food in the mouth with significant residue of food in the pharynx following the swallow. The speech-language pathologist diagnoses the child with mild to moderate swallowing disorder, which is impacted by cognition, and suggests modifications to the presentation of the food provided, including providing smaller amounts at a time, cutting food into smaller pieces, providing liquids in a sippy cup, and decreasing distractions at mealtimes. Prognosis for improvement in swallowing function is poor given the diagnosis, however, with some modifications this child should be able to eat a variety of foods and textures safely. The diagnostic information in this case was helpful to the medical team in determining a possible cause of the child's pneumonia and useful to the family in providing practical advice at mealtimes.

Clinical Story #3: Ordering a Form of Energy

A client with a swallowing disorder who is eating a modified diet of puree and thickened liquids for two weeks develops clinical signs of a chest infection. The physician may order a chest x-ray to confirm a diagnosis of aspiration pneumonia. Unfortunately, there may be a delay in getting in to see the physician in order for the chest x-ray to be ordered. In this case, it would be cost effective and more time effective for the treating speech-language pathologist to order this examination. Timely access to relevant clinical information can alter patient management and reduce the risk of more serious health complications.

Shortage of Primary Care Physicians

Ontario suffers from a shortage of doctors. 1.4 million Ontarians – more than 10% of the twelve-and-over population are without family physicians.¹ There are just 1.89 doctors per 1,000 Ontarians. Ontarians have the lowest doctor-to-population ratio of any OECD country.² In many cases, especially in remote communities in Ontario, referral to a family physician may be non-existent given the Ontario statistics. In order for the patient to receive timely access to care, the Speech-Language Pathologist must have the authority to communicate the communication or swallowing diagnosis, perform the Controlled Acts outlined above, and have the ability to refer directly to the relevant specialist.

These proposed changes support the increasingly expanding roles for speech-language pathologists throughout the province facilitating an accurate, flexible and more system responsive approach for Ontarians. It fosters tailored and accurate provision of care to the patient/client and supports system needs.

13. How does current legislation (profession-specific and/or other) prevent or limit members of the profession from performing to the full extent of the proposed scope of practice?

Current legislation, such as the *Audiology and Speech-Language Pathology Act, 1991* and the *Health Insurance Act*, limits speech-language pathologists – by requiring alternative authorization or additional health professions to be involved in care – from responding to the system, and performing to the full extent of their competencies.

The statutes currently limit:

- The communication by speech-language pathologists of a speech, language, communication or swallowing diagnosis derived from a SLP assessment of a patient/client under their care.
- The profession's ability to be responsive to an evolving health system, coupled with the complex care requirements of Ontarians.
- New ways of approaching patient care that address the challenge of working with finite human and financial resources.
- The ordering of medical tests necessary for diagnosis and treatment.

Speech-language pathologists' education, knowledge, and experience make them competent to perform a much greater range of activities than are included within the current scope of practice. The options they face under the current legislative environment to deal with the limitations include:

- Referral to another health profession (physician or other medical specialist) in order to assist the patient/client in accessing a diagnosis that was formulated by the speech-language pathologist.
- Expending unnecessary time and resources to seek out alternate authorization such as medical directives/delegations/orders. These alternatives may be beneficial when they represent initial

¹ Statistics Canada (2012) CANSIM Table 105-0501, Health Indicator Profile, Annual Estimates by Age Group and Sex, Canada Provinces, Territories, Health Regions (2012 Boundaries and Peer Groups).

² Canadian Institute for Health Information (CIHI) 20122 Number of Family Medicine and Specialist Physicians by Jurisdiction, Canada 2011. Available at <http://www.cihi.ca>

evolutions of a profession's scope of practice; however when the competencies to perform the act safely and within the principles of autonomous practice exist, then the alternate authorizations become an unnecessary restriction on the scope of a profession as well as a burden on system resources. The current requirement for alternate authorizations compromises timely access to essential health care interventions by adding additional steps and barriers and by requiring additional health professions to be involved in care at a time when health human resources are increasingly strained.

- Referral to another health profession (physician or other medical specialist) to request an order or referral from the physician for the diagnostic tests requested by the speech-language pathologist; tests that would eventually be ordered by the attending physician.
- Not being able to perform the medical intervention, causing risk of harm to the patient.
- Limited or no patient/client access to services, particularly in native/indigenous communities and rural, remote or under-serviced areas of Ontario.

Despite health care system objectives for responsiveness to population needs, speech-language pathologists face a range of limitations on practice that give rise to unfortunate barriers and issues for the public and the system.

Limitations on Access and Treatment:

Speech-language pathologists contribute through a variety of roles to the health care system; they are clinicians, managers, educators, researchers, and/or consultants. Speech-language pathologists, under delegation protocols, are currently contributing to strategies related to reducing wait times, increasing access to specialty care, improving system triage for appropriate intervention, and increasing patient satisfaction through enhanced health outcomes. Advanced training and clinical practice in a variety of health, community, social care and education settings have always existed, and are promoted and supported through extended, ongoing continuing professional development.

OSLA's proposed changes will facilitate public access to the right care, at the right time and contribute significantly to the productivity of other health professionals, with whom the SLP profession collaborates across the continuum, boosting overall system performance.

The profession believes this suggested approach to matching speech-language pathology current practice and competencies to a modernized and more accurate scope of practice statement and controlled acts authorization is in the best interest of the public, health care providers and the system. It represents paramount opportunity for the speech-language pathology profession to assist government and health care employers to improve health outcomes and health system performance in serving population needs.

Limitations on treatment include:

- Needed care may be delayed – for certain acts, the speech-language pathologist cannot immediately respond to, communicate about, or act on functions involving controlled acts.

- In the absence of being authorized to communicate a communication or swallowing diagnosis, the process of obtaining informed consent for treatment for the domains assessed by the SLP is unnecessarily complicated resulting in barriers and elevated costs to treatment. The public rightfully expects a diagnosis from the regulated health care professional that has conducted their assessment, who recommends and conducts their treatment and who consults to multidisciplinary health care, academic and community teams on their behalf. Trust, belief and confidence in the skills and knowledge of the regulated health professional are important components of successful outcomes.
- In order to receive assessment and treatment, the public is required to take or repeat extra steps to see other medical specialists.
- Access to funding for treatment from third party insurers who require a diagnosis is unnecessarily delayed.

The public will benefit from receiving a communication or swallowing diagnosis from the assessing professional which will foster clarity and trust in the patient/client/ /family/professional relationship. Speech-language pathologists would also then be in a position to complete relevant forms for more timely communications and access to third party payers. The outcome for the public is increased timely access to service. The outcome for the health care system is reduced costs involved in patient access to service.

Constraints on System Performance:

Current legislation limits speech-language pathologists to fully implement their skills and training and to participate fully in inter-professional collaborative practice. This compromises system performance as follows:

- Contributes to a lack of clarity and understanding in the workplace of speech-language pathologists' roles, accountability, scope and competencies;
- Leads to underutilization of the profession and increases unnecessary burden on other health professionals.

Added delays and costs to the healthcare system are particularly felt in long-term care facilities, home care, rural/remote and other under-serviced areas – especially services for the aging population.

Challenges include:

- Lengthy processes to develop appropriate delegation protocols or medical directives, specific to individual settings;
- Problems with changing medical specialists and the need to keep directives current;
- Problems in finding appropriate delegators/authorizers in community practice (or the absence thereof, e.g. in rural and remote areas);
- Added time and costs related to daily service delivery due to:
 - Delays in communicating a diagnosis which inhibits timely consent to, and initiation of, treatment. In some cases (e.g. swallowing interventions) this can result in escalated costs due to extended hospital stay, rehospitalisation, or death.

- Unnecessary duplication of services by other practitioners that speech-language pathologists are fully trained and competent to provide.

The aforementioned unnecessary limitations are contrary to professional and systemic aims regarding accessible, responsive patient-centred interprofessional care and Ministry of Health and Long Term Care strategies for health human resources (Ministry of Health and Long-Term Care, 2005; HealthForce Ontario, 2007), Ontario's Action Plan for Health Care (2012); Aging at Home (Ministry of Health and Long-Term Care, 2007) . The limitations on speech-language pathologists practicing to their full scope of competency in the province of Ontario is discrepant from current practice in other jurisdictions (as discussed more fully in Questions 32 and 33).

Section 5 – Collaboration (Question 14)

14. Do members of your profession practice in a collaborative or team environment where a change in scope of practice and the recognition of existing or new competencies will contribute to multidisciplinary health care delivery? Please describe any consultation process that has occurred with other professions.

Speech-language pathologists work in collaborative and team practice environments in hospitals, schools, long-term care facilities, through Community Care Access Centres, family health teams, public health, rehabilitation facilities, Aphasia Centres, Children’s Treatment Centres, Long-Term Care, private practice, Pre-school Programmes, agencies such as Geneva Centre and Surrey Place for Autism, and other care settings. They consult with numerous disciplines (for example: physicians; specialty medicine such as otolaryngology, neurology, radiology, physiatry, psychiatry; psychology; neuropsychology; psychotherapy; social work; physiotherapy; occupational therapy; respiratory therapy; social work, dietary, audiology) across the continuum of the inter-professional care team.

Speech-language pathologists provide services to support instructional program at schools and education institutions; working in a highly integrated manner with general and special education teachers, literacy coaches, occupational therapists, physical therapists, psychologists, audiologists, guidance counselors, and social workers. This multidisciplinary approach is crucial to designing and implementing effective programs to support literacy (reading, writing and numeracy), language and overall progression within the Ontario educational curriculum.

Implementing the proposed changes to scope of practice statement, controlled acts, and other statutory provisions will improve interprofessional care overall, facilitating the clarity of current and evolving roles, scope and accountability of speech-language pathologists (HPRAC, 2008). This will ensure that speech-language pathologists work to their optimal levels of individual competence thus optimizing their role on multidisciplinary health care, education and community teams for maximized patient/client outcomes. As part of essential competencies presented in Dimension 3 of *Practice Competencies for Speech-Language Pathologists* prepared by the Council for Accreditation of Canadian University Programs in Audiology and Speech-Language Pathology, speech-language pathologists are committed to understanding and respecting the competencies, expertise and perspectives of the professional colleagues with whom they work.

As pointed out in *Interprofessional Care: A Blueprint for Action in Ontario* (HealthForceOntario, 2007), it is only when health professionals are able to work to the full extent of their competence within scopes of practice that they can maximize their contribution to effective collaborative and complementary working relationships with professional colleagues, allowing the public to benefit from their expertise. With a scope of practice statement that is truly reflective of current realities in speech-language pathology practice, there is significant potential to strengthen, streamline and improve interprofessional care along the spectrum of care and across the various sectors within which SLPs work.

Recognition of the highly successful approach of speech-language pathologists working in clinical practice in health, social care and education settings contributes to multidisciplinary health care delivery. For example, using instrumentation (e.g. videofluoroscopy, electromyography, nasoendoscopy, stroboscopy, endoscopy) to observe, collect data and measure parameters of communication, vocal function and swallowing, or other upper aerodigestive functions has impacted positively on otolaryngology colleagues (who then have more time to focus on surgery), and has improved access for patients to appropriate providers and treatment. Both results have implications for more timely and improved services, with associated cost savings for the system (please see other illustrations of systemic cost/benefits in Questions 17 and 34).

The specific consultative input of other professions is discussed at Question 19.

Section 6 – Public Interest (Questions 15-19)

15. Describe how the proposed changes to the scope of practice of the profession are in the public interest.

Critical strategic areas of focus of *Ontario's Action Plan for Health Care* include plans to improve access, shorten wait times, promote wellness and prevent illness, and to modernize the health infrastructure for the population of Ontario.

One in 6 Canadians has a speech, language or hearing disorder (SAC, 2014) thus the profession of speech-language pathology should be well engaged in the care of Canadians. There are key health care drivers in our country – mental health services (Mental Health Commission of Canada, 2012), care of the aging population (Canadian Institute for Health Information, 2011) and acquired brain injury (Canadian Institutes of Health Research, 2013) - where SLP services are positively impacting the health and participation of those among these demographics.

The evidence for the benefits and effectiveness of speech language therapy interventions with children is well researched and documented. There are an ever-increasing number of efficacy studies, including randomized control trials that address the effectiveness of particular speech language therapy interventions with specific populations.

The speech language pathologist assesses delay or disorder in a child's communication and institutes therapy to support the child's development. Since as high as 50% of early-identified language delays are not self-correcting (Law et al., 2000), identifying the children in need of support is critical to the effective use of resources. If speech, language and communication difficulties persist past five years of age and are not treated, problems are more likely to continue through school and into adulthood. (Johnson et al., 1999; Beitchman et al., 2008). For children with communication challenges that persist, academic and social success necessitates the continuation of early intervention into the schools.

The risks of not addressing speech language or communication difficulties in children have also been explored. Early language competency is a reliable predictor of later literacy achievement; a child who has struggled to acquire language and has had no support will also struggle to read, write and do arithmetic. Children and adolescents with an identified language impairment have poorer academic performance than children in the general population (Botting, Simkin, & Conti-Ramsden, 2006; Conti-Ramsden, Durkin, Simkin, & Knox, 2009; Whitehouse, Line, Watt, & Bishop, 2009); (Beitchman, Wilson, Brownlie, Walters, & Lancee, 1996; Young, Beitchman, Johnson, Douglas, & Atkinson, 2002; Catts, Fey, Tomblin, & Zhang, 2002; Puranik, Petscher, Al Otaiba, Catts, & Lonigan, 2008). Children with language impairments identified at the age of five are more than six times as likely as the general population to have an identified learning disability at the age of 19 (Young et al., 2002).

Traumatic Brain Injury (TBI) is the number one killer and disabler of young Canadians under the age of 40. Every year, 16,000 Ontario residents sustain traumatic brain injuries. Available research indicates that 80-100% of those with traumatic brain injuries will have some form of communication impairment (Macdonald & Wiseman-Hakes, 2010; Halpern, Darley & Brown, 1973; Sarno, 1980); this group is

comprised largely of those who have cognitive-communication deficits which are the most prevalent (Freund et al., 1994; Lalper, A et al., 1991; Sarno, MT et al.; 1986; Hagen, 1986; Hartley, 1995; Holland, 1984). As well as providing direct assessment and treatment of communication, cognitive-communication concerns, speech-language pathologists act as a resource for individuals, families, trauma or brain injury teams, and the community at large.

Given the high incidence and prevalence of cognitive-communication disorders and their potentially serious consequences—including negative impact on social, academic, and vocational success; on quality of life; and on caretakers and personal finances—appropriate preventive efforts, assessment, diagnosis, and management are critical. Speech-language pathologists are knowledgeable about normal and abnormal development, brain-behavior relationships, pathophysiology, and neuropsychological processes as related to the cognitive aspects of communication which is a well-defined and internationally accepted area of practice within the field of speech-language pathology. Ironically, the leading SLP clinician in cognitive-communication disorders, Sheila MacDonald, is based in Ontario – a province in which speech-language pathologists are not included in the controlled act (MacDonald, S. & Johnson, C.J., 2005; MacDonald, S. & Wiseman-Hakes, C,2010).

The burden of disability is cumulative with the added conditions associated with aging (Yorkston et al, 2010) and the impacts to communication and swallowing functions are not exempt. There is a marked increase in the proportion of speech-language pathologists providing services to individuals with swallowing disorders among older populations as compared to those working with children. In the U.S., 60% of SLPs work with the adult population in some capacity and almost 50% of those SLPs work with individuals with swallowing disorders (ASHA, 2011). Statistics in the United States have historically mirrored those in Canada.

In Canada, the elderly population, and its associated illnesses, is expected to double from 5 million in 2011 to 10 million in 2033. A significant number of people with stroke experience aphasia (language and communication disorder), with advancing age associated with high risk; 35% of adult patients admitted to hospital with a diagnosis of stroke in Ontario during 2004-2005 had symptoms of aphasia at the time of discharge (Dickey L, et al, 2010). Progressive neurological diseases such as Parkinson's disease, Amyotrophic Lateral Sclerosis (Lou Gehrig's disease), Multiple Sclerosis frequently affect speech intelligibility, communication and swallowing function and patients benefit from speech-language pathology intervention (Shewan, C.M., Kertesz, A., 1984).

Speech-language pathologists, practicing to the full extent of their competencies within the scope of practice, are well positioned to affect achievement of these goals. An evolving health system coupled with the complex care requirements and aging population of Ontarians, requires that speech-language pathologists be permitted to practice to their full competencies so that Ontarians may get more timely access to accurate and quality care.

16. How would this proposed change in scope of practice affect the public's access to health professions of choice?

A scope of practice that more accurately reflects speech-language pathology training and competencies would allow patients to choose to be treated by speech-language pathologists in more components along the continuum of care in more delivery venues. Patient access and convenience would be markedly improved by reducing the need for referrals to other health professionals in order to obtain a diagnosis for a disorder or condition in fact determined by the assessing speech-language pathologist or to order diagnostic tests in circumstances related to speech-language scope of practice.

Removing the current barriers implicit in the scope of practice and controlled acts afforded to speech-language pathologists will enable the public to more immediately benefit from the array of services that speech-language pathologists are qualified to provide. With an enhanced scope of practice for speech-language pathologists and their capacity expanded to readily address needed services, the public will have more timely access to services and improved continuity of care.

Patients and their families want to know immediately what is wrong from the professional who has conducted the assessment and who has the knowledge, skills and judgement to make that diagnosis. Going through a third party for the information in order to comply with the legislation's limitations is time consuming, confusing to the patient/family member, and the information can be miscommunicated by the 3rd party to the patient/family.

In summary, the proposed scope of practice reflective of speech-language pathologists' knowledge, skills and training will lead to positive impacts on patient services and timely access across the continuum of care.

17. How would the proposed change in scope of practice affect current members of the profession? Of other health professions? Of the public? Describe the effect the proposed change in scope of practice might have on:

The proposed change in scope of practice will provide positive effects for all parties involved – for the profession, other health professions and the public.

a. Practitioner availability;

Those speech-language pathologists who are working in advanced practice roles (through medical directive/delegation models) have demonstrated how the profession can offer more immediate and expansive response to population needs in primary, specialty and community care. Speech-language pathologists already possess the competence in the additional authorized acts being requested by OSLA; by redefining the scope of practice and precluding the necessity for delegation by other health care providers, speech-language pathologists would be more readily available to provide these services to Ontarians. This would reduce wait times and reduce risks to the patient's health.

Speech-language pathologists are required to be competent in interprofessional collaboration with other health care and allied health care providers, educators, mental health specialists and other

professionals. Permitting the SLP to effectively, directly communicate a communication or swallowing diagnosis, and perform other necessary medical diagnostic tasks, would provide clarity in multidisciplinary collaboration and would reduce the added task load on the physicians who are already overloaded.

With a scope of practice more in alignment with what is occurring nationally and internationally, speech-language pathologists practicing in Ontario will be better able to respond to the needs of health teams and patients/clients of our province.

b. Education and training programs, including continuing education;

Speech-Language Pathology is a well-established profession whose practitioners hold a *minimum* entry-to-practice Master's degree with extensive practical clinical training followed by a minimum 6 month supervised mentorship period prior to independent practice.

The field of speech-language pathology has a multidisciplinary knowledge base that includes a pre-requisite degree in linguistics, psychology, education and medicine. Practitioners need to integrate knowledge from each of these fields to understand how best to treat communication, cognitive-communication, voice and swallowing disorders. University programmes have specific courses on diagnostics. During post-graduate studies, speech-language pathologists receive a theoretical basis for assessment, diagnosis, treatment and practical skills that position them well to perform a number of the additional authorized acts.

Established continuing professional development programs support ongoing education needs related to speech-language pathology competencies in all areas proposed. This includes programs related to the authorized acts (e.g. understanding uses for/roles in diagnostic tests and x-rays).

c. Enhancement of quality of services;

The ability to communicate a diagnosis directly to a patient, parents, patient's family, and health care team, would improve the quality of service as well as improve the confidence between a patient and their clinician. Speech-language pathologists with additional competence in one or more of the authorized acts requested are already providing care in Ontario's health, social care and education settings working under the redundant step of medical directives/delegation.

d. Costs to patients or clients;

When patients are unable to access the right provider at the right time for the right services, they may bear personal costs due to complications (e.g. lost time from work due to extended recovery time/delayed rehabilitation; loss of employment; attendant care or child care costs; travel to other communities, direct and indirect costs related to more appointments/consultations than necessary). Further, the various health sector systems may bear additional cost in light of health/academic/social complications due to delays in accessing relevant interventions. The proposed changes for the scope of practice for speech-language pathologists will contribute to improving access to the services provided by these professionals. The potential for enhancement of access in hospitals, schools, long-term care

facilities, Community Care Access Centres, family health teams, private practice, and other care settings will also include speech-language pathologists referring patients/clients as required to other appropriate practitioners, for improved overall patient/client management and system navigation.

e. Access to services;

The ability of many professionals to provide more complex care than originally envisioned in the RHPA's scheme of 'scopes of practice' and 'controlled acts' is being driven as much by improvements in education, training and technology as it is by a need to adapt to skills shortages and recruitment and retention issues.

It is essential that Ontario's health care system (and the regulatory mechanisms that guide it) continue to evolve and adapt in order to ensure citizens receive effective, transparent, quality care from the most appropriate profession. The RHPA was conceived as a "living" document and should reflect enhanced and improved patterns of practice while fulfilling its primary purpose of public protection.

The ability to order relevant diagnostic tests would reduce unnecessary delays for patients/clients. Currently, the SLP recommends the diagnostic test or specialist consultation (e.g. videofluoroscopic swallow study or an ENT consult) and the patient/client has to make an extra visit to the physician to have the order for the test or consultation placed. Access to diagnostic procedures facilitates inter-professional collaboration by ensuring that needed information is included in discussions with physicians and other practitioners. This will facilitate an understanding of the roles of speech-language pathologists and their contribution to patient/client care in hospitals, schools, community and long-term care facilities, children's treatment centres, and family health teams.

f. Service efficiency;

The profession routinely formulates diagnoses in order to devise treatment plans and to communicate with referring practitioners and other members of the health care team. Yet, under the *Audiology and Speech-Language Pathology Act 1991*, speech-language pathologists cannot communicate these diagnoses to their patients/clients. Reluctance on the part of clinicians to provide meaningful assessment conclusions for fear of violating the RHPA may not only prevent a patient/client from understanding their disorder, it may also have a significant impact on other matters, such as the right diagnosis being communicated, timely access to services, and funding.

With speech-language pathologists' improved access to authorized acts for which they are competent, less time will be spent on creating medical directives or providing direct orders. In addition, directives are specific and, therefore, restrictive. Such directives are not transferable to another institution, which limits access, portability and flexibility of health human resources.

Expanding scopes of practice allows better use of scarce resources. This would have particular relevance in rural areas, remote communities, native/indigenous communities and home-based care with shortages of all health care professionals. Speech-language pathologists given authority to

autonomously perform a greater number of controlled acts for which they are trained and competent, would:

- free up physicians (e.g. to delegate acts)
- eliminate need for nurses to make home visits (e.g. to be available for suctioning during swallowing assessments and therapy);
- prevent aspiration for swallowing disorders, and reduce re-admission rates; and
- provide immediate communication therapy after stroke or traumatic/acquired brain injury.

There is potential to reduce the time patients spend in emergency departments when a speech-language pathologist is used to triage swallowing disorders. The SLP can order relevant tests that will ultimately be ordered by the attending physician, so that treatment can be provided as soon as possible. This timely access to care will not only improve patient outcomes, but will also reduce costs to the system.

g. Inter-professional care delivery;

Essential competencies for speech-language pathologists include communication and collaboration – to work with colleagues to plan, coordinate and evaluate patient/client services; share information with other professions; and show respect for the expertise and perspectives of other health care professionals. Speech-language pathologists play a critical role in screening and early detection of individuals at risk, for example, for autism spectrum disorder, communication delays, and cognitive-communication disorders. The ability to make referrals to the relevant professionals for collaborative diagnosis and treatment planning fosters quality services for the public.

Improved clarity of the scope and the roles for speech-language pathology will enhance collaboration and multidisciplinary care.

Further discussion of inter-professional collaboration can be found in the response to Question 14.

h. Economic issues;

The economic burden of being unable to work or tend to daily living activities while awaiting treatment is reduced when the health system and necessary clinical care paths can be more efficiently accessed. Patients/clients will appreciate the elimination of potentially redundant or unnecessary appointments that are currently required to receive orders for tests or to facilitate directives for the SLP; and/or to receive communication of a communication or swallowing diagnosis that the SLP had formulated; and to receive treatment.

When patients are unable to access the right provider at the right time for the right services, they may bear personal costs due to complications (e.g. lost time from work, costs of care from paid or unpaid caregivers), and the system may bear additional cost because of health complications due to delays.

A number of studies have demonstrated potential savings for the system and for patients/clients (Marsh et al., 2010). This includes the potential for reduced economic impact on the public with more timely access to appropriate care as illustrated in examples above.

Further discussion of economic issues can be found in Section 11.

i. Other impacts.

Health human resource shortages faced by the health care system also affect speech-language pathologists so strengthening the attraction, career opportunities and pathways for speech-language pathologists can improve and reinforce recruitment and retention. Allowing speech-language pathologists to utilize their skills and competencies to the maximum potential and to have the opportunity to further advance these skills will foster retention of speech-language pathologists within their profession and within the province of Ontario. University programmes in Ontario report that the graduating class of SLPs are relocating to other provincial or international jurisdictions where they are allowed to practice to their full level of skills, knowledge and judgement.

18. Are members of your profession in favour of this change in scope of practice? Please describe any consultation process and the response achieved.

The Ontario Association of Speech-Language Pathologists and Audiologists (OSLA) conducted extensive consultation with the 3,049 speech-language pathologists registered with the College of Audiologists and Speech Language Pathologists of Ontario (CASLPO) in 2013. This submission is presented on their behalf.

Early in the consultation process, the profession's leadership agreed that any proposed changes to the scope of practice of speech-language pathologists should be consistent with the following principles:

- Improve patient care, encourage meaningful patient engagement and facilitate better results for patients;
- Protect the public interest and ensure the highest standards of professional conduct and patient safety;
- Maximize collective resources effectively and efficiently while protecting the public interest;
- Optimize the skills and competencies of diverse health care professionals to enhance access to high quality and safe services;
- Ensure access to high quality and safe services no matter which health profession is responsible for delivering care or treatment; and
- Ensure that all regulated health professionals work to their maximum competence and capability.

The leadership consistently reaffirmed the need to distinguish between the public interest and the profession's self-interest during each of the following professional engagement activities:

- A survey was distributed to all registered speech-language pathologists in the Spring of 2013;

- Two workshops were held at the “Energized by Excellence” conference jointly sponsored by OSLA and CASLPO in October 2013;
- Regional consultation sessions were facilitated in Ottawa, the Greater Toronto Area and London in Fall of 2013; and
- Lastly, an electronic town hall meeting was convened to foster participation from professionals practicing across Ontario in November 2013.

Considerable effort has been made during the preparation of this submission to connect with all speech-language pathologists currently registered with the College, colleagues in other provincial and international jurisdictions, other professional organizations and key informants in Ontario.

19. Describe any consultative process with other professions that might be impacted by these proposed changes.

Consultation with colleagues in the other regulated health professions have provided thoughtful input as to the importance of assuring the changes actively promote collaborative care models, and do not undermine the substantial progress the government has made in this area.

Professions consulted in either or both the regulatory and association collegial relationship include:

- Ontario Medical Association (including ENT),
- Ontario Nurses Association,
- Dietitians of Canada,
- Ontario Physiotherapy Association,
- Ontario Society of Occupational Therapy,
- Ontario Psychology Association,
- Speech-Language Pathology and Audiology of Canada, and
- College of Audiologists and Speech-Language Pathologists of Ontario.

Section 7 – Risk of Harm (Questions 20-25)

20. How will the risk of harm to the patient or client be affected by the proposed change in scope of practice?

The profession does not foresee any potential for increased risk of harm to patients with the proposed changes to scope of practice and authorized acts. Speech-language pathologists are fully trained to perform the authorized acts safely and effectively, and to identify contraindications to their performance. The aim of the proposed change is to clarify the scope of practice statement, to enable speech-language pathologists to practice to the full extent of their competencies, and to capture their current range of practice activities, including communicating a communication or swallowing diagnosis. In fact, OSLA asserts that there will be a significant reduction of risk to the patient/client for the various reasons outlined throughout the body of this document.

A speech-language pathologist typically does not practice in all areas of the field. The College of Audiologists and Speech-Language Pathologists of Ontario *Code of Ethics* (Bylaw 2011-8) sets forth the fundamental principles and rules considered essential to the preservation of the highest standards of integrity and ethical conduct in the practice of speech-language pathology. The Code specifically states that speech-language pathologists “shall practice within the limits of their competence as determined by their education, training and professional experience”. They shall also “regularly participate in professional development and educational programs designed to improve quality of care”.

The profession’s misconduct regulation (Ontario Regulation 749/93) and standards of practice also establish a level of practice that ensures patient safety and prohibits speech-language pathologists from undertaking activities for which they are not competent. It is both ethically and legally incumbent upon certified speech-language pathologists to determine whether they have the knowledge and competencies necessary to perform services.

It is important to highlight that the proposed authorized acts are already part of speech-language pathology practice in a number of other jurisdictions in Canada, the United States and the United Kingdom. In all Canadian jurisdictions, speech-language pathologists must assess their competence, be in compliance with standards of practice and, where necessary for restricted or authorized acts, demonstrate to the Colleges that they have the education and requisite competencies when working in their areas of practice.

Where there may arise any potential to expose patients to risk of harm, the profession will recognize this risk and will mitigate it in a number of ways:

- The College has established a standard for professional practice that clearly outlines the professional expectations on registrants relating to the performance of controlled acts. The standard only permits registrants to perform controlled acts when assessments are done, risks are assessed and discussed with the patient, competence is assured, and professional responsibility is taken.

- This obligation is reinforced with a professional misconduct regulation that requires registrants to uphold the standard of practice of the profession and to practice within individual spheres of competence.
- The College also has a robust quality assurance program in place that requires registrants to regularly submit to practice reviews by their peers in which the kinds of practice activities they perform are assessed for potential to cause harm to patients.
- The approach taken by Colleges in other jurisdictions and in Ontario is to apply additional measures of oversight where any activity warrants it for public safety.
- Speech-language pathologists in Ontario are also required to carry malpractice insurance. Current insurance parameters satisfy the addition of the proposed controlled acts, as well as the need of other practitioners and their respective malpractice models, in the spirit of shared care.

21. What other regulated and unregulated professions are currently providing care with the competencies proposed as an expansion to your scope of practice? By what means are they performing it? (Under delegation, supervision or on their own initiative?)

Scope of practice statements have considerable overlap and are not exclusive to one profession. Physicians, podiatrists, chiropractors, dentists, optometrists, physiotherapists, and practitioners of Traditional Chinese Medicine are authorized to “communicate diagnoses”. Their authority is limited to diagnoses relevant to the provider’s scope of practice, training and skills as designated in regulations. The extended class of nurses can also communicate a diagnosis identified through methods involving: the patient’s health history, the findings of a comprehensive health examination, or the results of any laboratory tests, other tests or investigations that the member is authorized to order or perform, within their scope of practice, training and skills as designated in regulations.

Currently, Physicians, nurses, and dietitians are providing care to patients with a swallowing disorder, and psychologists with a cognitive-communication disorder.

Currently, Physicians are diagnosing a communication diagnosis to their patient. However, in many cases SLP receives referrals from physicians for the assessment and findings.

22. Specify the circumstances (if any) under which a member of the profession should be required to refer a patient/client to another health professional, both currently and in the context of the proposed change in scope of practice.

The right to communicate a communication or swallowing diagnosis and the ability to make a referral to another health care professional is not intended as a challenge to the essential role that family physicians play in overseeing patients’ care. Speech-language pathologists have no desire to undermine or usurp the role of physicians or their right to exercise discretion when making referrals.

A timely referral to the appropriate health care professional, will avoid delay in treatment. Direct referral will expand capacity and access across the system – and encourages efficiencies in the system.

Clinical Story #1 – Enabling Direct Referrals to Specialty Medicine

A speech-language pathologist assesses a school-aged child. She believes that the child speech problems relate to a hearing disorder. In order for the child to have a hearing test, the SLP must refer the child back to the family Physician, who refers to the ENT, who then refers to the Audiologist for the hearing test. Six months later, the SLP still does not have the results from the hearing test, which must go back down through the system. This puts the child at a real disadvantage in receiving timely access to health care.

Speech-language pathologists operate under a current obligation to make a referral when it is appropriate to do so, which would also apply in the context of the proposed change in scope of practice. In general, a referral should occur whenever the speech-language pathologist recognizes an abnormality or condition that would be more appropriately or effectively served by another health professional. The proposed change in scope of practice would foster timelier follow-up by precluding an unnecessary middle step of an additional physician visit to make the referral. Access to relevant and necessary referrals would be expedited and the costs of accessing referrals reduced.

23. If this proposal is in relation to a current supervisory relationship with another regulated health profession, please explain why this relationship is no longer in the public interest. Please describe the profession’s need for independence/autonomy in practice.

The speech-language pathologist operates as an autonomous, accountable primary care professional. Patients may access speech-language pathologists directly without a referral from a physician or other professional. As members of collaborative teams of health professionals, speech-language pathologists’ relationship with other professions is not one that is supervisory; rather it is complementary in nature – each bringing unique skill sets and strengths to serve common goals for patient/client care.

The proposed changes to scope of practice and authorized acts will align the profession more completely with the current and evolving practice of speech-language pathology across Canada and internationally. Such change is more in keeping with international trends toward ‘task shifting’, depicted by the World Health Organization’s 2007 *Task Shifting: Global Recommendations and Guidelines* as: “the rational redistribution of tasks among health workforce teams”. The report explains further that “task shifting can make more efficient use of existing human resources and ease bottlenecks in service delivery”. The overall aim is to free up and expand health human resources capacity across health systems.

Inter-professional relationships have in general promoted the development of the profession by enabling speech-language pathologists to engage in practice activities through the use of delegation directives. The proposed changes to scope of practice and authorized acts are intended to remove limitations associated with elements of delegation and directives where necessary (as discussed more fully in Question 13). Changing the authority mechanisms for acts supported by competency that meet College standards will not alter the act of collaboration necessary for quality patient care and system efficiencies.

To illustrate, speech-language pathologists who have already acquired additional competencies in the areas for proposed change are currently constrained, primarily in hospitals, under a medical directive/delegation in order to function at a level for which they are already competent, and could more readily contribute to interprofessional initiatives. The current approach is cause for concern for a number of reasons, including: delays for care; variation in how the directives are expressed in different settings across the province. This leads to a lack of mobility of speech-language pathologists to other areas of the system in need (e.g. to benefit patients in another hospital on the merit of their proven expertise; if the delegating physician departs, the qualified speech-language pathologist cannot continue to promote optimal patient outcomes without that delegation). The regulatory College doesn't know who is delegated and who is not delegated in Ontario.

Such barriers to practice have not optimally served the public interest or promoted streamlined access to responsive care. By contrast, the proposed changes will bring in standards, quality and mobility of this expertise to benefit the public in many institutions (now freed of the cumbersome mechanisms required in-house to recognize them) and to other sectors where this will enhance and strengthen multidisciplinary teams and promote innovation in services that are truly responsive to the public.

24. Does the proposed change in scope of practice require the creation of a new controlled act or an extension of or change to an existing controlled act? Does it require delegation or authority to perform an existing controlled act or subset of an existing controlled act?

No change is required to be made to the current list of 13 controlled acts in the *Regulated Health Professions Act*. Further, there is no requirement for an extension of or a change to an existing controlled act.

25. If the proposed change in scope of practice involves an additional controlled act being authorized to the profession, specify the circumstances (if any) under which a member of the profession should be permitted to delegate that act. In addition, please describe any consultation process that has occurred with other regulatory bodies that have authority to perform and delegate this controlled act.

A speech-language pathologist is not permitted to delegate at this time. The College's current professional misconduct rule contains an absolute prohibition on members of the profession delegating a controlled act they are authorized to perform. The current regulation defines "Delegating a controlled act" as professional misconduct (Regulation 861/93 under the *Audiology and Speech-Language Pathology Act, 1991*).

Section 8 – Competencies/Educational Requirements for Practice (Questions 26-30)

26. Are the entry-to-practise (didactic and clinical) education and training requirements of the profession sufficient to support the proposed change in scope of practice? What methods are used to determine this sufficiency? What additional qualifications might be necessary?

Yes. Certified speech-language pathologists hold a Master's and/or doctorate degree from an accredited university program. These professionals have a sound knowledge base in speech-language/literacy/cognitive-linguistic and swallowing development, as well as strong competencies in assessment, diagnosis, intervention and treatment practices and have completed a supervised professional placement and mentoring experience.

To keep abreast of changes in evidence-based practices in speech-language pathology, demonstration of continued professional development is mandated for the maintenance of speech-language pathology certification, for example, the College's Self-Assessment Tool (SAT).

27. Do members of the profession currently have the competencies to perform the proposed scope of practice? Does this extend to some or all members of the profession?

Communicating a Diagnosis

All speech-language pathologists are educated at the entry-to-practice level to diagnose and communicate a diagnosis related to communication and swallowing disorders to their patients/clients or their personal representative. Diagnosis is a core competency of the curriculum of accredited Canadian universities conferring Master's and/or doctorate degrees in speech-language pathology. It is a fundamental and important aspect of entry-to-practice speech-language pathology practice.

Ordering a Form of Energy and Putting an Instrument, Hand or Finger beyond the Point in the Nasal Passage where they Normally Narrow

Since their introduction in the early 1980s (CASLPO Practice Standards and Guidelines for Dysphagia, 2007), dysphagia services have grown to constitute a substantial portion of the speech-language pathology caseload. Recent surveys by the American Speech-Language-Hearing Association (ASHA) indicate that over 45 per cent of speech-language pathology services to adults in health care settings in the United States are devoted to the assessment or treatment of dysphagia [85]. Dysphagia also accounts for 16 per cent of all paediatric services provided by SLPs in U.S. health care settings [85]. Similar evidence has not been published for Canadians, however these figures are in line with those reported in workload measurement summaries across acute care and complex continuing care facilities in Ontario where approximately 66 per cent of clinical caseloads was devoted to dysphagia services. Instrumental swallowing assessments including videofluoroscopic swallow studies and Fiberoptic Endoscopic Evaluation of Swallowing (FEES) are current competencies. Speech-language pathologists performing swallowing assessments possess the necessary knowledge, skills, and judgement needed to perform and interpret the procedure. Each speech-language pathologist is ethically responsible for achieving the appropriate level of proficiency to provide these services competently.

Putting an Instrument, Hand or Finger into an Artificial Opening of the Body

Speech-language pathology has also developed expertise in the area of voice restoration following laryngectomy surgery. Clinicians have acquired the training and expertise in post-surgical TEP procedures to perform this act without supervision.

28. What effect will the proposed change in scope of practice have on members of your profession who are already in practice? How will they be made current with the changes, and how will their competency be assessed? What quality improvement/quality measurement programs should or will be put into place? What educational bridging programs will be necessary for current members to practise with the proposed scope of practice?

None. - All speech-language pathologists possess the knowledge, skills and judgement to diagnose and communicate a diagnosis related to communication and swallowing disorders to their patients/clients or their personal representative at the entry-to-practice. Speech-Language Pathologists are currently performing the additional controlled acts being requested with delegation.

29. How should the College ensure that members maintain competence in this area? How should the College evaluate the membership's competence in this area? What additional demands might be put on the profession?

No additional demands are required. All speech-language pathologists are educated to diagnose and communicate a diagnosis related to communication and swallowing disorders to their patients/clients or their personal representative at the entry-to-practice. It is a fundamental and important aspect of entry-to-practice.

Speech-language pathologists –possess the knowledge, skills and judgement and are already performing the other controlled acts under medical delegation. Each speech-language pathologist is ethically responsible for achieving the appropriate level of proficiency to provide these services competently.

Established continuing professional development programs support ongoing education needs related to speech-language pathology competencies in all areas proposed. This includes programs related to the authorized acts (e.g. understanding uses for/roles in diagnostic tests and x-rays).

30. Describe any obligations or agreements on trade and mobility that may be affected by the proposed change in scope of practice for the profession. What are your plans to address any trade/mobility issues?

There are no implications for trade/mobility. The proposed changes would bring Ontario in alignment with other Canadian provincial and territorial as well as selected international jurisdictions and selected countries reviewed for this submission. In fact the changes would allow Ontario to retain those trained in Ontario to fully perform their knowledge, skills, and competencies, and we would not lose that talent to other provinces. (See Appendix E).

Section 9 – Public Education (Question 31)

31. How do you propose to educate or advise the public of this change in scope of practice? Other jurisdictions?

Information packages will be developed in both electronic and paper format which will be circulated to members to share with patients/clients and professional colleagues.

Key stakeholders will be informed directly to update them on speech-language pathology roles and capabilities. This will include not only health professional associations and colleges, but also Boards of Education, hospitals, long-term care facilities, Community Care Access Centres, pre-school programmes, children's treatment centres, family health teams and any other settings where speech-language pathologists provide care.

Existing channels will be used to advise the public including the College and Association websites and other public forums. The month of May is Speech and Hearing month and would provide the Association with the opportunity to promote the changes for the public interest.

Section 10 – Other Jurisdictions (Questions 32 & 33)

32. What is the experience in other Canadian jurisdictions? Please provide copies of relevant statutes and regulations.

While Appendix E provides a more complete description of jurisdictional information, the following serves as a broad based synthesis.

Other Canadian jurisdictions vary in terms of how they approach recognizing or authorizing speech-language pathology activities that are or have been considered ‘controlled acts’ in Ontario. For example, speech-language pathology Colleges in the Maritimes have the flexibility to respond to all of the activities under consideration for authorization in this proposal. This is due to the fact that the Maritime Provinces do not have umbrella legislation for health professionals, and so there is no central list of what are considered ‘controlled acts’ in Ontario. The Maritime College regulations determine, with great flexibility, how to respond to emerging areas of expertise that are within the scope of practice for speech-language pathologists. As a result, a number of the activities of speech-language pathologists are recognized based on the need for evidence of individual knowledge and competency of a given speech-language pathologists.

In other provinces, particularly in western Canada, umbrella legislation for health professionals exists. As such, there is a central list of ‘controlled acts’ (also called reserved acts or restricted activities). Colleges in those jurisdictions are addressing these activities through application of College oversight such as requiring evidence of education for the activity, inclusion in a roster and other measures. For some activities, entry-to-practice competence may be considered sufficient to carry out the activity. In Alberta, the approach is to authorize some restricted activities for entry-to-practice while others are addressed through requiring licensed speech-language pathologists to provide evidence of advanced training approved by the Council and by registering (inclusion on the roster).

33. What is the experience in other International jurisdictions?

In the majority of American states, speech-language pathologists who acquire and maintain the necessary knowledge and skills can diagnose a range of issues, diseases and conditions. They are also permitted to communicate a diagnosis to their patients/clients. While this is regulated at a state-by-state level, guiding principles and professional requirements have been established by the American Speech-Language-Hearing Association (ASHA), which has produced an array of condition-specific policy papers identifying where/when their regulated professionals can communicate an independent diagnosis, and where they must be part of a diagnostic team or involved in interprofessional collaborations. ASHA has also published numerous guidelines on the process of diagnosis, up to and including appropriate referrals to other regulated health professionals to rule out other conditions and facilitate access to comprehensive services. Several American states incorporate these policy guidelines in their professional rules and regulations for speech-language pathologists.

Despite the differences in approaches and models, a significant majority of English-speaking jurisdictions permit speech-language pathologists to both diagnose and communicate said diagnosis to their

patients/clients. Further details on the regulatory framework for the United States, United Kingdom, Australia and New Zealand are provided in Appendix F.

Section 11 – Costs/Benefits (Question34)

34. What are the potential costs and benefits to the public and the profession in allowing this change in scope of practice? Please consider and describe the impact of any of the following economic factors:

It is estimated that nearly 20% of the population may experience communication difficulties at some point in their lives. One in 10 children has a speech and language difficulty, and it is the most common disability in childhood. Nearly 30-40% of stroke survivors have communication or swallowing complications requiring speech and language therapy. In the context of increased budgetary pressures, evidence of return on investment is critical to help guide effective spending decisions.

Helping people with speech, language, communication and swallowing problems can have a far reaching effect on health, wellbeing, educational attainment, productivity gains, and integration/reintegration into society. Economic analysis studies (Marsh et al., 2010; University of Birmingham, 2013, O'Connor et al., 2012) indicate that the net benefits of speech-language pathology can exceed the costs.

Findings published in November 2010 by the Royal College of Speech and Language Therapists (RCSLT) highlight how speech and language therapy offers significant cost savings – a net benefit to the U.K. economy of £765 million (\$1.4 billion) – to the national health system and wider government by avoiding other clinical interventions and improving life aspects. Benefits considered in the analysis include health and social care cost savings, quality of life and productivity gains; it did not include the effect on return to work. The RCSLT study looked at four of the most common conditions which are treated by speech-language therapists practicing in the U.K.: patients suffering swallowing problems following a stroke; stroke survivors having difficulty with communication; children with speech and language impairment (SLI); and children with autism. Further analysis would be required to estimate the value speech and language therapists generate across all of the populations this profession serves.

The RCSLT *Economic Evaluation of Speech and Language Therapy* study found:

- In the case of patients suffering swallowing problems following a stroke (dysphagia) the provision of speech and language therapy delivers £13.3 million (\$23.8 million) in net savings to the NHS, or a return of £2.30 (\$4.12) for every £1 (\$1.80) invested.
- For stroke survivors having difficulty with communication (aphasia), such as speech, comprehension, reading and writing, the net benefits are equivalent to £15.4 million (\$27.6 million), with a return of £1.30 (\$2.35) for every £1 (\$1.80) invested.
- For children with SLI which is encountered by 203,000 UK school children in a given year, the annual net benefit to the UK is £741.8 million (\$1.3 billion), with every £1 (\$1.80) invested generating a return of £6.43 (\$11.51) in enhanced lifetime earnings.
- For children suffering from autism, the cost savings are £9.8 million (\$17.5 million) and every £1 (\$1.80) invested generates £1.46 (\$2.61) in cost savings.

a. Direct patient benefits/costs;

Participation and inclusion in society are viewed as critical aspects of health. Communication difficulties reduce opportunities to participate at home, at school, at work, and in the community. Specifically, reduced ability to communicate disrupts links with family, loved ones, peers and caregivers, and affects ability to participate in leisure, academic and vocational pursuits. Helping parents to understand their child's language and academic problems provides relief and validation because parents often know there is something wrong but can't identify what it is.

In addition, communication difficulties impact patient's/client's ability to direct their own personal care and make an informed decision (e.g. to communicate with physicians, therapists, case managers, other supporting health professionals and the education team). Similarly, swallowing difficulties can have a negative effect on overall health and quality of life. Speech-language pathology services in the community promote client independence and caregiver coping, and in doing so, lead to improved quality of life and optimal social, academic and vocational integration.

With the improvement in scope of practice and access to additional authorized acts, speech-language pathologists will be better positioned to provide timely access to appropriate assessment and treatment for the public who choose them. With the existing barriers removed, the public should ultimately experience increased access to and benefit from speech-language services.

The public will benefit from speech-language pathologists' participating in their care planning and goals, and from receiving a diagnosis which should increase the patient/client/professional relationship and trust. Speech-language pathologists in this context would be able to provide more timely completion of forms and communications with payers to ensure that patients can access their benefits.

Patients/clients will appreciate reduced costs associated with lost time to attend additional appointments required to receive orders, directives, referrals for communication of diagnosis and accessing treatment. The economic burden that can impact on patients/clients and their informal caregivers was illustrated in Question 17(d).

The effectiveness of care means fewer complications and greater potential for patients to have improved quality of life and ability to be productive. For example, the core features of autism spectrum disorders include impairments in reciprocal social interaction. Due to the nature of autism, family members, peers and other communication partners often encounter barriers in the efforts to communicate and interact with individuals with autism spectrum disorders. The speech-language pathologist's role is critical in supporting the individual, the environment and the communication partner to maximize opportunities for interaction in order to overcome barriers that would lead to ever-decreasing opportunities and social isolation if left unmitigated.

In addition, management in the community can enable earlier discharge from hospital, and help prevent admissions to hospitals and long-term care facilities. Other cost savings are realized through promotion of client independence, caregiver coping and utilization of appropriate resources to support the patient's/client's needs.

b. Benefits and costs to the broader health care service delivery system;

The proposed changes will enhance the capacity of speech-language pathologists to contribute to multidisciplinary collaboration given the removal of some of the barriers they now face to maximizing their professional competencies in servicing the public and associated teams. Other professionals on health teams will better appreciate and understand the speech-language pathology role, scope, competencies and accountability to improve collaborative, integrated and inter-supportive work. The proposed scope of practice changes would serve to enhance public confidence that they are receiving the right care at the right time, rather than questioning the need to go to another more general professional to receive a specific diagnosis.

The RCSLT *Economic Evaluation of Speech and Language Therapy* study found that, in comparison to usual care by a non-specialized nurse, assessment and treatment of swallowing disorders by speech language pathologists is estimated to prevent 4,300 cases of chest infections requiring hospital care and 9,200 cases of chest infections requiring community care. This reduction in chest infections results in health cost savings that exceed the cost of the speech and language therapy by £13.3 million (\$23.8 million). The benefits of speech and language therapy, and in this example, a timely swallowing intervention by the SLP, go beyond the reduction in chest infections (e.g. improved quality of life, reduce re-admission to hospitals, avoidance of malnutrition and death.)

c. Benefits and costs associated with wait times;

The Canadian Institute of Child Health reported that emotional and behavioural problems and early learning difficulties have the greatest impact in lowering life quality and reducing life opportunities and achievements of Canadian children and youth. Yet, the average wait time for a child to enter therapy or service for mental health and associated language impairments is between 6 to 8 months.

In July 2010, Deloitte released *The Review of School Health Support Services*, which identified a number of trends and challenges facing the current system. Most notably:

- Overall, wait times for speech-language services are increasing: *“The total number of individuals waiting for these services in 2009/10 (4,066) is...9% higher than 2007/08 levels (3,715).”*
- There is a significant disparity in access to speech language services depending upon whether the child is in a private school system or the public school system.
- There is significant disparity in access to services across Ontario in terms of services available and wait times. The wait for services in Central East and Hamilton Niagara Haldimand Brant are well above the provincial average.

With the proposed changes in scope of practice (and future access to additional authorized acts), speech-language pathologists will be better positioned to provide timely access to appropriate assessment and treatment for the public who choose them. For example, speech-language pathologists practicing in a school environment are in a position to intervene early. It is not uncommon for a speech-language pathologist to be the first health professional to identify a communication problem, to conduct an assessment, and to initiate a treatment plan in the school and broader medical setting (where

appropriate). The end result of an early diagnosis of a speech and/or language disorder would be shorter wait times for services and the improvement of the child's learning opportunities.

Removing the requirement for referral to another health profession (such as a physician or specialist) in order to assist the patient/client in accessing a diagnosis, or to request an order or referral from the physician for the diagnostic tests requested by the speech-language pathologist, or to request an order or referral back to the speech-language pathologist in order to initiate a treatment would significantly reduce wait times between assessment and treatment.

With the existing barriers removed, the public should ultimately experience increased access to, and benefit from decreased wait times, and improved health care outcomes.

d. Workload, training and development costs;

There should be no changes to workload, training or development costs for the proposed changes to the scope of practice since speech-language pathologists already possess the knowledge, skills, judgement and training. This proposed change will simply remove some of the barriers to the SLP optimizing their existing competence. Ongoing University curriculum updates are now part of the current environment, so some of the costs are already in place. This is no different than what is currently happening if you move to a different clinical context of any health professional. Refer to letter of support from Ontario's University programme chairs. (Appendix D)

The Association's role and legislative mandate (*Act respecting the Ontario Association of Speech-Language Pathologists and Audiologists, 1965*) is to provide both professionals with the most current learnings and knowledge in the field of clinical practice.

e. Costs associated with educational and regulatory sector involvement.

The University education sector already provides courses and practicum focusing on speech, language, voice and swallowing diagnostics and how to communicate assessment findings and work with the patient and families to develop a patient centered plan of care. There are minimal regulatory changes needed to address the proposed changes to the scope of practice for speech-language pathologists. Costs associated with this would not be different from what applies now to the current scope of practice.

Section 12 – Other Information (Question 35)

35. Is there any other relevant information that HPRAC should consider when reviewing your proposal for a change in scope of practice?

Other Statutory Provisions

- **Removal of limitations in other statutory provisions**, to enable ordering of important resources and activities by speech-language pathologists and receiving diagnostic reports in order to commence treatment in a timely manner:
 1. Enabling direct referrals to specialty medicine, such as ENT and Psychology. This would require changes to the *Health Insurance Act* as well as other Acts.
 2. Receiving reports of screening or diagnostic tests that
 - Are ordered by a health care professional (other than a speech-language pathologist); and
 - Assist in the diagnosis and intervention plan to promote and maintain an individual's *communication or oral swallowing* health care needs.

Potential Future Options for Consideration

As populations are aging and living longer, profiles of need have evolved to include multiple and more complex chronic diseases. These must be addressed by a health system now struggling with shortages of health professionals. Maximizing the capacity of all health resources, especially health care practitioners, is essential. This involves a delicate balance between serving day to day needs while working to achieve systemic reform and also embracing opportunities offered through new technologies and research.

With a responsible eye to the future and the need to maximize all resources to serve patient needs and system effectiveness, it would benefit Ontario to give future consideration to affording the following additional authorized act to speech-language pathologists:

- Ordering a form of energy *for the purpose of assessing or managing a communication or swallowing disorder* [emphasis added]
 - the application of electromagnetism for magnetic resonance imaging; and
 - the application of sound waves for diagnostic ultrasound.

The opportunity to follow the development of speech-language pathologists' performance of these controlled acts under delegation and their impact on care delivery models could be important to ensuring an open and transparent process by which the scope of practice of speech-language pathologists can continue to appropriately evolve.

Further rationale on these proposed changes is provided in Appendix A.

Section 13 - Conclusions

Speech-language pathologists are significant team players in the delivery of safe, quality care to Ontarians. This submission is an opportunity to consider, within our legislative model, the best way in which the skill sets of speech-language pathologists can be optimally used to contribute to the health system and its goals. Based on evidence which has focused on the profession's current levels of skill, knowledge, training and competency, this submission seeks change. The proposed changes to the scope of practice statement and authorized acts are consistent with the research literature, the reality of the current practice environment, national and international trends, and the government's health care goals.

OSLA, on behalf of the speech-language pathology professionals of Ontario, looks forward to discussing this submission with The Ministry of Health and Long Term Care and is committed to being a willing player in all dialogues or potential options that will fully realize the contribution that speech-language pathologists can make to collaborative, patient-centred care.

Appendix A – Background Information on Speech-Language Pathology in Ontario

One in 6 Canadians has a speech, language or hearing disorder (SAC, 2014) thus the profession of speech-language pathology should be well engaged in the care of the Canadians. There are key health care drivers in our country – mental health services (Mental Health Commission of Canada, 2012), care of the aging population (Canadian Institute for Health Information, 2011) and acquired brain injury (Canadian Institutes of Health Research, 2013) – where SLP services are positively impacting the health and participation of those among this demographic.

Speech-language pathologists can help with:

- **Speech delays and disorders** including articulation, phonology and motor speech disorders.
- **Language delays and disorders**, including expression and comprehension in oral and non-verbal contexts
- **Fluency disorders**, including stuttering.
- **Voice and resonance disorders.**
- **Swallowing and feeding disorders** in adults and, children and infants.
- **Cognitive-communicative disorders** including social communication skills, reasoning, problem solving and executive functions.
- **Pre-literacy and literacy skills** including phonological awareness, decoding, reading comprehension, writing, and numeracy.
- **Communication and swallowing disorders related to other issues.** For example, hearing impairments, traumatic brain injury, dementia, developmental, intellectual or genetic disorders and neurological impairments.

Speech-Language Pathology and Children

The speech-language pathologist assesses delay or disorder in a child’s communication, both written and oral, and institutes therapy to support the child’s development. Since as high as 50% of early-identified language delays are not self-correcting (Law et al., 2000), identifying the children in need of support is critical to the effective use of resources. If speech, language and communication difficulties persist past 5 years of age and are not treated, problems are more likely to continue through school and into adulthood. (Johnson et al., 1999; Beitchman et al., 2008). For children with communication challenges that are necessarily going to continue— such as autism, or neurological disorders, such as cerebral palsy or epilepsy, or an acquired brain injury or traumatic brain injuries – school, academic and social success require early intervention. Persistent communication difficulties have been linked to an increased likelihood of incarceration, low socio-economic status, and reading, writing and numeracy disabilities.

The evidence for the benefits and effectiveness of speech language therapy interventions with children is well-documented and researched. There are an ever-increasing number of efficacy studies, including randomized control trials that address the effectiveness of particular speech language therapy interventions with specific populations.

The risks of not addressing speech, language or communication difficulties in children have also been explored. Early language competency is a reliable predictor of later literacy. A child who has struggled to acquire language and has had no support will also struggle to read and write. Children and adolescents with an identified language impairment have poorer academic performance than children in the general population (Botting, Simkin, & Conti-Ramsden, 2006; Conti-Ramsden, Durkin, Simkin, & Knox, 2009; Whitehouse, Line, Watt, & Bishop, 2009); (Beitchman, Wilson, Brownlie, Walters, & Lancee, 1995; Young, Beitchman, Johnson, Douglas, & Atkinson, 2002; Catts, Fey, Tomblin, & Zhang, 2002; Puranik, Petscher, Al Otaiba, Catts, & Lonigan, 2008).

Behaviour problems can be a reaction to frustration associated with communication problems. Research has shown that 58% of children presenting with behavioural concerns have a co-morbid, and often undetected, language disorder (Cohen, 1997).

Children with language impairments identified at the age of 5 are more than six times as likely as the general population to have an identified learning disability at the age of 19 (Young et al., 2002).

The key message of a cost-benefit analysis commissioned by the U.K.'s Royal College of Speech and Language Therapists, *The Economic Case for Speech and Language Therapy* (Matrix Evidence, December 2010) is: "Every £1 invested in enhanced Speech Language Therapy generates £6.43 through increased lifetime earnings." The report concludes that improved language facilitates access to curriculum and creates opportunity for greater academic attainment for a child. Based upon longitudinal testing of all children in the UK over ten years, education data shows that early literacy scores predict success throughout the school system until completion of formal education. While there is not causality in the data it is a reliable conclusion that students who do well early in their education show similar achievement throughout their academic career. A child with speech and language difficulties who struggles to read and write, and do math will have difficulties with most aspects of the school curriculum. The Matrix Evidence report continues:

"It is important to note that the analysis covers only the benefits generated by education (specifically increased access to curriculum). It does not capture additional benefits such as improved quality of life, social inclusion or mental health gains (pp29)."

In addition:

"The restricted ability to understand and be understood in the communicative environment can cause concern and upset, behavioural problems and impact the individual's ability to access education and employment (if needs continue into adulthood) and prevent them from fully participating in society" (pp29). "

Speech-Language Pathology and Mental Health

The association between psychiatric disorders and speech and language impairments is well established (Baker & Cantwell, 1987; Beitchman et al., 2001; Benner, Nelson, & Epstein, 2002). Additionally children with a speech and language disorder are more likely to have behavioural problems than their non-communication impaired peers. (Beitchman, Wilson, Brownlie, Walters, Inglis, et al., 1995; Brownlie et al., 2004; Conti-Ramsden & Botting, 2008; Snowling, Bishop, Stothard, Chipchase, & Kaplan, 2006).

- Attention-deficit hyperactivity disorder and anxiety disorders occur at higher rates in children and adolescents with speech and language impairments. (Beitchman et al., 2001; Cantwell & Baker, 1991; Beitchman, Nair, Clegg, Ferguson & Patel, 1986; Beitchman, Brownlie, et al, 1995).
- Juvenile delinquency and conduct problems are more likely in children, especially boys, who have poor verbal skills. (Hinshaw, 1992; Lynam & Moffitt, 1993).
- Children with language or speech problems are subject to social difficulties with social isolation continuing into adulthood. (Beitchman, Wilson, Brownlie, Walters, Inglis, et al., 1995; Conti-Ramsden & Botting, 2004; Bonica, Arnold, Fisher, Zeljo, & Yershova, 2003).

The higher rates of speech and language problems in the prison population of the United Kingdom has emphasized the social impacts and consequences of the marginalization of the speech language and communication impaired: 35% of young offenders have speaking and listening skills below Level 1 of the UK National Curriculum (age equivalent of 5 years old) (Davis. K, et al. 2004; Bryan & Furlong, 2007).

Speech-Language Pathology and the Aging Population

The burden of disability is cumulative with the added conditions associated with aging (Yorkston et al, 2010) and the impacts to speech, language and swallowing functions are not exempt. There is a marked increase in the proportion of speech-language pathologists providing services to individuals with swallowing disorders among older populations as compared to those working with children. In the U.S., 60% of SLPs work with the adult population in some capacity and almost 50% of those SLPs work with individuals with swallowing disorders (ASHA, 2011). Statistics of United States have historically mirrored that of Canada.

In Canada, the elderly population, and its associated illnesses, is expected to double from 5 million in 2011 to 10 million in 2033. To put this statistic into a monetary perspective for a single diagnostic group, the combined direct (medical) and indirect (lost earnings) costs of dementia alone totals \$33 billion per year in 2011 but by 2040, this figure will skyrocket to \$293 billion per year (Alzheimer Society Canada, 2012). Conservative estimates suggest that 15% of the senior population is affected by a swallowing disorder (Barczy et al, 2000) and greater than 42% are affected by a communication disorder (Hoffman et al, 2005). Approximately 35% of stroke patients suffer from various types of aphasia (Dickey et al., 2010; Szaflarski et al., 2013; Laska et al., 2001). Ontario's Aphasia Centres, many of which receive funding from the Aging at Home programme, have been successful in providing unprecedented speech therapy to stroke patients diagnosed with Aphasia.

Speech-Language Pathology and Traumatic Brain Injury

Traumatic Brain Injury is the number one killer and disabler of young Canadians under the age of 40. Every year, 16,000 Ontario residents sustain traumatic brain injuries. Available research indicates that 80-100% of those with traumatic brain injuries will have some form of communication impairment (Halpern, Darley & Brown, 1973; Sarno, 1980); this group is comprised largely of those who have cognitive-communication deficits (Freund et al., 1994; Hagen, 1986; Hartley, 1995; Holland, 1984) which require specific techniques (ASHA, 1987; Freund, et al., 1994; Gillis, 1996; Heilman, Safran & Geschwind, 1971; Sarno, 1980; Ylvisaker & Szekeres, 1986). Given the high incidence and prevalence of cognitive-communication disorders and their potentially serious consequences—including negative impact on

social, academic, and vocational success; on quality of life; and on caretakers and personal finances—appropriate preventive efforts, assessment, diagnosis, and management are critical. Speech-language pathologists are knowledgeable about normal and abnormal development, brain-behavior relationships, pathophysiology, and neuropsychological processes as related to the cognitive aspects of communication which is a well-defined and internationally accepted area of practice within the field of speech-language pathology. As well as providing direct assessment and treatment, speech-language pathologists act as a resource for individuals, families, trauma or brain injury teams, and the community at large.

Appendix B – Communication Disorders Listed DSM-V

COMMUNICATION DISORDERS

- 315.31 Expressive Language Disorder
- 315.32 Mixed Receptive-Expressive Language Disorder
- 315.39 Phonological Disorder
- 307.0 Stuttering
- 307.9 Communication Disorder NOS (Not otherwise specified)

OTHER DISORDERS OF INFANCY, CHILDHOOD OR ADOLESCENCE

- 313.23 Selective Mutism

Communication Disorders

The DSM-5 communication disorders include language disorder (which combines DSM-IV expressive and mixed receptive-expressive language disorders), speech sound disorder (a new name for phonological disorder), and childhood-onset fluency disorder (a new name for stuttering). Also included is social (pragmatic) communication disorder, a new condition for persistent difficulties in the social uses of verbal and nonverbal communication. Because social communication deficits are one component of autism spectrum disorder (ASD), it is important to note that social (pragmatic) communication disorder cannot be diagnosed in the presence of restricted repetitive behaviors, interests, and activities (the other component of ASD). The symptoms of some patients diagnosed with DSM-IV pervasive developmental disorder not otherwise specified may meet the DSM-5 criteria for social communication disorders.

Appendix C – Curriculum for Clinical Practice

The Canadian Association of Speech-Language Pathologists and Audiologists (now known as Speech-Language and Audiology Canada – (SAC)) developed a document of *Clinical Competency: Foundations of Clinical Practice for Audiology and Speech-Language Pathology* following a two-year period of broad consultation with clinicians and university faculty across the provinces and territories, which models current University curriculum.

While the document provides a common framework, it allows each Canadian university program to create their own curriculum, building on the unique strengths and interests of their faculty and the network of clinicians that are part of each student’s training. It also serves as the basis for the national Association SAC to conduct examinations – a voluntary process on the part of the graduating student - used to “certify” speech-language pathologists in a number of provincial and territorial jurisdictions and allow reciprocal labour mobility to other countries such as the U.S.

Speech-language pathologists have specific training in the assessment, identification and remediation of speech, language, voice and swallowing disorders.

A speech-language pathology assessment is designed to:

- Determine the extent and nature of the communication disorder.
- Conclude whether the impairment is developmental or acquired.
- Identify whether a motor speech disorder is an apraxia or a dysarthria.
- Specify the presence and severity of a receptive language disorder.
- Establish whether an expressive language disorder is complicated by a motor speech disorder.
- Distinguish the dysfluency of stuttering from the dysfluency of cluttering or aphasia.

Speech-language pathologists are competent to diagnose swallowing disorders based on a combination of coursework and clinical experience³. In the graduate program students take courses in anatomy and physiology (60 hours), principles of clinical practice (45 hours), structurally related disorders (45 hours), swallowing disorders (45 hours), and advanced principles of clinical practice (30 hours). Students also complete clinical practicum in a variety of health, social care and education settings to obtain a total of 350 hours of clinical experience. Following graduation, speech-language pathologists are also required to complete 6 months of initial registration where they are mentored by a fully certified speech-language pathologist to ensure competency.

Instrumental swallowing assessments including videofluoroscopic swallow studies and Fiberoptic Endoscopic Evaluation of Swallowing (FEES) is within the SLPs scope of competencies. Speech-language pathologists performing swallowing assessments undergo sufficient training to demonstrate the knowledge and competence needed to perform and interpret the procedure. Each speech-language pathologist is ethically responsible for achieving the appropriate level of proficiency to provide these services competently.

³ Hours for clinical coursework are based on the Masters of Health Science in Speech-Language Pathology curriculum from the University of Toronto 2012-2013.

UNIT ONE: BASIC REQUIREMENTS (AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY)

Section 1.1 ANATOMY AND PHYSIOLOGY

The audiologist and speech-language pathologist demonstrate basic knowledge of the gross anatomy and physiology of the following systems:

- i. Respiratory system (respiratory tract, chest wall, diaphragm, and abdominal wall).
- ii. Articulatory, phonatory, and resonatory systems (larynx, pharynx, mouth, and nose).
- iii. Auditory and vestibular systems (external, middle and inner ear, auditory pathways, and auditory cortex).

Section 1.2 NEUROANATOMY AND NEUROPHYSIOLOGY

The audiologist and speech-language pathologist demonstrate basic knowledge of:

- i. The structure and function of the nervous system.
- ii. Maturation and development of the nervous system.
- iii. Neurological substrates of speech, language, cognition, memory, and hearing.
- iv. Hemispheric asymmetry and specialization.
- v. Methods of investigating the nervous system.

Section 1.3 GENETICS AND HUMAN DEVELOPMENT

The audiologist and speech-language pathologist demonstrate basic understanding of:

- i. Normal human genetics and embryological development, and their relationship to congenital disorders which affect communication.
- ii. Infant, child, and adolescent development.
- iii. The aging process.

Section 1.4 COUNSELLING AND APPLIED PSYCHOLOGY

The audiologist and speech-language pathologist demonstrate basic knowledge of:

- i. The role of communication in interpersonal relations.
- ii. The psychosocial effects of communication disorders on the client and significant others.
- iii. The psychosocial effects of disease processes that may include a communication disorder (e.g., stroke, cancer, cerebral palsy), including the implications of acute versus chronic illness, stable versus progressive conditions, and congenital versus acquired conditions.
- iv. Coping mechanisms used by clients/families.
- v. Interviewing and counselling methods for clients, their caregivers, and their significant others.
- vi. Cultural factors that may affect clinical relationships, assessment, and treatment outcomes.
- vii. Learning theory and behaviour modification.

Section 1.5 PSYCHOLINGUISTICS AND LINGUISTICS

The audiologist and speech-language pathologist demonstrate basic knowledge of:

- i. Normal and abnormal communication behaviour throughout the lifespan in the following areas: phonetics and phonology, morphology and syntax, semantics, pragmatics, discourse, nonverbal communication, and sociolinguistics.
- ii. The nature and theories of second language development.
- iii. The nature and theories of reading and writing and their acquisition.
- iv. Methods of observation and analysis useful in the description of communicative behaviour in the following areas: phonetics and phonology, morphology and syntax, semantics, pragmatics, discourse, nonverbal communication, and sociolinguistics.

Section 1.6 SPEECH PERCEPTION AND ACOUSTICS

The audiologist and speech-language pathologist demonstrate basic knowledge of:

- i. The nature and theories of perceptual processes and their development with a special emphasis on speech perception.
- ii. The physics of sound.
- iii. Psychophysical methods.
- iv. Psychoacoustics.

Section 1.7 INSTRUMENTATION

The audiologist and speech-language pathologist demonstrate basic knowledge of:

- i. The instrumentation relevant to clinical practice and its operation (e.g., amplification and assistive devices, audiometers, audio and video recorders, voice and speech synthesizers and analyzers).

Section 1.8 PHARMACOLOGY AND OTHER MEDICAL INTERVENTIONS

The audiologist and speech-language pathologist demonstrate basic knowledge of:

- ii. The effects of medical intervention on auditory function and communication (e.g., medication, surgery, radiation).

Section 1.9 RESEARCH METHODOLOGY

The audiologist and speech-language pathologist demonstrate basic knowledge of:

- iii. The scientific method.
- iv. Basic statistical concepts and theories.
- v. Commonly used research designs.
- vi. How to critically evaluate research.
- vii. Systematic evaluation of the reliability and validity of assessment procedures, and of treatment efficacy

UNIT TWO: PRINCIPLES OF CLINICAL PRACTICE AND PROFESSIONAL PRACTICE ISSUES

Section 2.1 PREVENTION

The speech-language pathologist demonstrates knowledge of:

- i. Concepts and strategies for prevention of communication disorders across the age span (e.g., primary, secondary, and tertiary preventive strategies).
- ii. Risk factors (e.g., medical, social, developmental) for communication disorders.

Section 2.2 EVALUATION

The speech-language pathologist:

- i. Uses principles of assessment to generate assessment plans based on available information about the client, the presenting disorder(s), and knowledge of normal and disordered communication; modifies the plan when appropriate.
- ii. Obtains a case history that is relevant to the diagnosis and management of each individual's communication disorder.
- iii. Demonstrates knowledge of principles underlying clinical assessment including standardized and non-standardized procedures and their advantages, disadvantages, and limitations.
- iv. Demonstrates knowledge of test administration and scoring procedures.
- v. Interprets assessment data to formulate diagnostic and prognostic statements based on knowledge of normal and disordered communication, the assessment results, and knowledge of treatment efficacy.
- vi. Interprets assessment data to make recommendations based on the assessment information and available resources.
- vii. Communicates assessment information to the client and/or family when appropriate, and to the referring agency and other professionals in accordance with guidelines for maintaining client confidentiality.
- viii. Demonstrates knowledge of the roles of other health professions, when to refer clients, and how to collaborate effectively with them.

Section 2.3 CLIENT MANAGEMENT

The speech-language pathologist:

- i. Employs a conceptual framework for client management decisions that is based on accepted philosophies, approaches and/or theories, and which considers the needs of the whole client, including communication contexts and partners.
- ii. Develops a management plan based on a rationale that considers the results of the assessment, knowledge of the nature of the communication disorder, theories of learning and available resources. The management plan includes selection of a service delivery model (e.g., regular

review assessments, home/school program, individual or group therapy, consultation), and development of a specific program of intervention for optimal management of the client's communication disorder.

- iii. Formulates appropriate short-term and long-term goals; develops and implements appropriate clinical activities to meet these goals and to facilitate generalization and maintenance; evaluates progress towards goals and modifies them and the discharge criteria accordingly.
- iv. Monitors progress during treatment to obtain valid and reliable indicators of change using one or more appropriate methods (e.g., standardized tests, instrumental measures, counting behaviours, probes).
- v. Involves families, teachers, caregivers, and other appropriate people in the management process, as appropriate, keeping them informed of progress and current goals.
- vi. Provides information to family, caregivers, and team members about communication disorders in general and regarding communicating with specific clients.

Section 2.4 REPORTING

The speech-language pathologist:

- i. Produces organized, grammatical, informative and concise written assessment, treatment or progress reports meeting the standards of the employing agency and/or licensing body. Reports often include:
 - a) Case history information.
 - b) Observations about the client's behaviour and cooperation.
 - c) Description of assessment measures and rationale for their selection.
 - d) Description and interpretation of client's responses.
 - e) Diagnostic statement about the client's communication disorder(s).
 - f) Statement of the client's communication needs and motivation for improving communication.
 - g) Prognostic statement.
 - h) Recommendations.
 - i) Statement of treatment goals, methods, and progress.

Section 2.5 PROFESSIONAL BEHAVIOUR

The speech-language pathologist will demonstrate knowledge of:

- i. The roles and functions of speech-language pathology and audiology professional associations and licensing bodies, and the qualifications required for practice.

- ii. The ethical considerations (e.g., in professional codes, canons of ethics, provincial laws) which affect the delivery of services and the practice of speech-language pathology including those concerning the use of support personnel and volunteers.
- iii. Responsibilities and legal requirements regarding confidentiality of client information, including informed consent.
- iv. Effective self-evaluation and evaluation of intervention outcomes.
- v. Personal responsibilities for continuing education.
- vi. Caseload management (selection of cases, referral, scheduling).
- vii. Problem-solving and conflict resolution strategies.

UNIT THREE: DEVELOPMENTAL ARTICULATION/PHONOLOGICAL DISORDERS

Section 3.1 NATURE

The speech-language pathologist demonstrates knowledge of:

- i. Normal phonological development and theories of the acquisition of normal phonology, including the relationship between normal and disordered articulation/phonological development.
- ii. How the factors and processes associated with the development of normal phonology (e.g., linguistic, motor, perceptual, cognitive, affective, environmental) apply to clinical practice.
- iii. The different theoretical frameworks relevant to articulation/phonological delays and disorders.
- iv. The characteristics of disordered articulation/phonology.
- v. The profiles of special populations (e.g., cleft palate and other structural disorders, hearing impairment, mental handicap) with respect to phonetic and phonological acquisition.
- vi. The psychosocial, educational, and vocational impact of developmental articulation/phonological disorders.
- vii. The impact of a first language on the development of English and/or French articulation and phonological skills in children whose first language is not English or French.

Section 3.2 ASSESSMENT

The speech-language pathologist:

- i. Develops and implements an assessment plan based on background information about the client, known or suspected concomitant disorders, knowledge of normal and disordered articulation/phonological development, and principles of assessment, and modifies it when appropriate.
- ii. Uses appropriate standardized and/or non-standardized procedures for assessing phonemic awareness, articulation, and/or phonology at the sound, syllable, words, sentence, and discourse levels.
- iii. Understands issues related to obtaining a representative and diagnostically useful sample of a client's speech.

- iv. Conducts an appropriate analysis of a sample of the client's speech (e.g., structural, traditional, and/or phonological approaches) to describe the child's errors.
- v. Applies specific procedures for examination of the speech production mechanism and judges its adequacy for normal speech production.
- vi. Assesses the impact of factors in the client's environment on his/her communication needs and effectiveness.
- vii. Demonstrates knowledge of specific procedures for assessing auditory/speech perception skills and understands the issues related to an adequate assessment of speech perception ability.
- viii. Formulates a diagnostic statement about the client's articulation/phonological skills.
- ix. Formulates a prognostic statement about the client's articulation/phonological skills.

Section 3.3 INTERVENTION

The speech-language pathologist:

- i. Demonstrates knowledge of different approaches to articulation/phonological intervention, their theoretical bases, advantages, disadvantages, and limitations.
- ii. Chooses an appropriate service delivery model (e.g., periodic review, home/school program, direct individual therapy, direct group therapy, referral to a multidisciplinary program) for treatment of the client's articulation/phonological disorder.
- iii. Selects and applies an appropriate approach for treatment of the client's articulation/phonological disorder.
- iv. Formulates appropriate short-term and long-term goals for treatment of the client's articulation/phonological disorder which takes into account other linguistic, cognitive, or motor deficits.
- v. Develops and implements appropriate clinical activities for meeting treatment goals and facilitating generalization and maintenance.
- vi. Demonstrates knowledge of procedures to stimulate phoneme and syllable production.
- vii. Evaluates progress towards articulation/phonological goals and modifies the management plan and discharge criteria accordingly.

UNIT FOUR: NEUROLOGICALLY BASED SPEECH DISORDERS

Section 4.1 NATURE

The speech-language pathologist will demonstrate knowledge of:

- i. The neurological basis for normal speech production and how damage to the central and peripheral nervous systems affects speech.
- ii. Different theoretical frameworks for neurologically based speech disorders (e.g., dysarthria, apraxia).
- iii. Characteristics of the dysarthrias including their respiratory, phonatory, resonatory, articulatory, and prosodic features.
- iv. Characteristics of apraxia of speech.

- v. Etiological factors related to neurologically based speech disorders and their impact on prognosis (e.g., stable vs. degenerative conditions).
- vi. Disorders that may accompany neurologically based speech disorders (e.g., aphasia) and their impact on communication.
- vii. The impact of neurologically based speech disorders on speech intelligibility, as well as their psychosocial, educational, and vocational impact.

Section 4.2 ASSESSMENT

The speech-language pathologist:

- i. Develops and implements an assessment plan based on background information about the client, knowledge of normal and disordered speech, known or suspected concomitant disorders, and principles of assessment; modifies this plan when appropriate.
- ii. Assesses physiological support for speech production (including assessment of the respiratory, laryngeal, velopharyngeal, and oral mechanisms) using instrumental and non-instrumental procedures as appropriate, and judges the adequacy of each mechanism for speech production.
- iii. Assesses phonation, resonance, articulation, and prosody, using perceptual and acoustic measures.
- iv. Assesses speech intelligibility and identifies factors that influence it.
- v. Assesses the impact of factors in the client's environment on his/her communication needs and effectiveness.
- vi. Formulates a diagnostic statement about the client's speech disorder.
- vii. Formulates a prognostic statement about the client's speech disorder.

Section 4.3 INTERVENTION

The speech-language pathologist:

- i. Demonstrates knowledge of different approaches to the treatment of neurologically based speech disorders, their theoretical bases, advantages, disadvantages, and limitations.
- ii. Chooses appropriate service delivery model(s) (e.g., regular review assessments, home program, individual therapy, group therapy, referral to a multidisciplinary program) for treatment.
- iii. Selects and applies an appropriate approach for treatment of the client's speech disorder.
- iv. Formulates appropriate short-term and long-term goals for treatment of the client's speech disorder.
- v. Develops and implements appropriate clinical activities for meeting communication treatment goals and facilitating generalization and maintenance.

UNIT FIVE: DEVELOPMENTAL LANGUAGE DISORDERS

Section 5.1 NATURE

The speech-language pathologist demonstrates knowledge of:

- i. Normal language development and its application to clinical practice, including the relationships between normal first language acquisition, normal second language acquisition, and developmental language disorders.
- ii. Factors and processes associated with the development of normal language (e.g., motor, perceptual, cognitive, affective, environmental, and cultural).
- iii. Different theoretical frameworks relevant to developmental language disorders.
- iv. Characteristics of developmental language disorders for different age levels (including phonologic, morphosyntactic, semantic, pragmatic, discourse, and narrative abilities).
- v. The profiles of special populations at risk for developmental language disorders (e.g., children with autism, hearing impairment, Down syndrome).
- vi. The relationship between normal language development, language disorders, literacy, and learning disabilities.
- vii. The psychosocial, educational, and vocational impact of developmental language disorders.

Section 5.2 ASSESSMENT

The speech-language pathologist:

- i. Develops and implements an assessment plan based on information about the client, knowledge of normal monolingual and/or bilingual language development, known or suspected concomitant disorders, and principles of assessment; modifies this plan when appropriate.
- ii. Uses standardized and non-standardized procedures appropriately to assess language (phonology, morpho-syntax, semantics, pragmatics, discourse, narrative skills), reading and writing and metalinguistic skills.
- iii. Demonstrates ability to obtain, analyse, and interpret a language sample and an understanding of the issues in obtaining a representative and diagnostically useful sample of a child's language.
- iv. Assesses the impact of internal (e.g., cognitive, motor, perceptual) and external (e.g., environmental, cultural) factors on the client's communication needs and effectiveness.
- v. Assesses the impact of the disorder on the client's daily activities, and his/her educational, vocational, and psychosocial needs.
- vi. Formulates a diagnostic statement about the client's language skills.
- vii. Formulates a prognostic statement about the client's language skills.

Section 5.3 INTERVENTION

The speech-language pathologist:

- i. Demonstrates knowledge of different approaches to language intervention, their theoretical bases, advantages, disadvantages, and limitations.
- ii. Chooses appropriate service delivery models (e.g., regular review, home/school program, individual therapy, group therapy, referral to a multidisciplinary program, consultation/collaboration with parents, teachers and/or other professionals) for treatment of the client's language disorder.
- iii. Selects and applies an appropriate approach for treatment of the client's language disorder.

- iv. Formulates appropriate short-term and long-term goals in the areas of phonology, morpho-syntax, semantics, pragmatics, metalinguistic skills, literacy, narrative skills, and discourse.
- v. Develops and implements appropriate clinical activities for meeting specified language treatment goals and facilitating generalization and maintenance.
- vi. Evaluates progress towards language goals; modifies the management plan and discharge criteria accordingly.

UNIT SIX: ACQUIRED LANGUAGE DISORDERS

Section 6.1 NATURE

The speech-language pathologist demonstrates knowledge of:

- i. Normal changes in language function throughout the life-span, related factors and processes (e.g., motor, sensory, perceptual, cognitive, affective, cultural) and their application to clinical practice.
- ii. The neurology and neurophysiology of acquired language disorders including aphasia, cognitive communication disorders associated with dementia, head trauma, and right hemisphere pathology.
- iii. The factors associated with recovery or dissolution of language and communication.
- iv. Theoretical frameworks relevant to acquired language disorders.
- v. The clinical and functional characteristics of acquired language disorders.
- vi. The associated perceptual, motor, cognitive, and affective problems and their impact on communication.
- vii. The psychosocial, educational, and vocational impact of acquired language disorders.

Section 6.2 ASSESSMENT

The speech-language pathologist:

- i. Develops and implements an assessment plan based on background information about the client, knowledge of normal language and acquired language disorders, known or suspected concomitant disorders, and principles of assessment; modifies this plan when appropriate.
- ii. Uses appropriate standardized and/or non-standardized procedures for assessing language (phonology, orthography, morpho-syntax, semantics, pragmatics, and discourse), gestural communication, and complex cognitive functioning relating to language (e.g., aspects of memory, organizational processes, and verbal reasoning).
- iii. Assesses the impact of factors in the client's environment on his/her communication needs and effectiveness.
- iv. Assesses the impact of the language disorder on the client's daily activities, and his/her social, psychological, educational, and/or vocational needs.
- v. Formulates a diagnostic statement about the client's communication disorder.
- vi. Formulates a prognostic statement about the client's communication disorder.

Section 6.3 INTERVENTION

The speech-language pathologist:

- i. Demonstrates knowledge of different approaches to language intervention, their theoretical bases, advantages, disadvantages, and limitations.
- ii. Chooses an appropriate service delivery model (e.g., regular review assessments, home/school program, direct individual therapy, direct group therapy, referral to a multidisciplinary program) for treatment of the client's communication disorder.
- iii. Selects and applies an appropriate approach for treatment of the client's communication disorder.
- iv. Formulates appropriate short-term and long-term goals for the treatment of the client's communication disorder.
- v. Develops and implements appropriate clinical activities for meeting specified goals and facilitating generalization and maintenance.
- vi. Evaluates progress towards goals and modifies the management plan and discharge criteria accordingly.
- vii. Educates the family/caregivers and other team members about the language disorder and its impact.

UNIT SEVEN: VOICE DISORDERS

Section 7.1 NATURE

The speech-language pathologist demonstrates knowledge of:

- i. The anatomy, neuroanatomy, and physiology of the larynx and of normal voice production across the lifespan, and application of this knowledge to clinical practice.
- ii. Normative data for each dimension of voice across the lifespan (e.g., loudness, pitch, fundamental frequency, resonance, quality) and their application to clinical practice.
- iii. The differences between normal and pathological voice production.
- iv. Factors and processes which may impact on voice production (e.g., removal of larynx, hearing loss, neuromuscular involvement, musculoskeletal tension, vocal fold pathology, systemic conditions, affective states, environmental factors).
- v. The physiological basis, the perceptual and acoustical characteristics of alaryngeal speech and speech produced via esophageal means, tracheoesophageal prostheses, and/or mechanical devices.
- vi. The characteristic profiles of clients with a diagnosis of organic or nonorganic vocal pathology.
- vii. The psychosocial, educational, and vocational impact of voice disorders.

Section 7.2 ASSESSMENT

The speech-language pathologist:

- i. Develops and implements an assessment plan based on background information about the client, including any previous medical investigation, knowledge of normal language and abnormal voice production, known or suspected concomitant disorders, and principles of assessment; modifies this plan when appropriate.
- ii. Uses appropriate perceptual, physiologic, and acoustic measures for assessing voice production and for making a differential diagnosis.
- iii. Evaluates options for alaryngeal sound production when appropriate.
- iv. Assesses the impact of physical, emotional, vocational, and environmental factors that influence the client's voice production.
- v. Formulates a diagnostic statement about the normalcy of the client's voice.
- vi. Formulates a prognostic statement based on the medical diagnosis and voice assessment, referring the patient for further ENT examinations as required.

Section 7.3 INTERVENTION

The speech-language pathologist:

- i. Demonstrates knowledge of different approaches to voice intervention, and alaryngeal voice production, their theoretical bases, advantages, disadvantages, and limitations.
- ii. Chooses an appropriate service delivery model (e.g., regular review assessments, home/school program, direct individual therapy, direct group therapy, referral to a multidisciplinary program) for treatment of the client's voice disorder.
- iii. Selects and applies an appropriate approach for treatment of the client's voice disorder.
- iv. Formulates appropriate short-term and long-term goals for the treatment of the client's voice disorder.
- v. Develops and implements appropriate clinical activities for meeting specified goals and facilitating generalization and maintenance.
- vi. Evaluates progress towards goals; modifies the management plan and discharge criteria accordingly.

UNIT EIGHT: RESONANCE DISORDERS

Section 8.1 NATURE

The speech-language pathologist demonstrates knowledge of:

- i. The anatomical and neurophysiological basis of normal and abnormal velopharyngeal function (e.g., hypernasality, hyponasality, mixed nasality, and cul-de-sac resonance) and its application to clinical practice.
- ii. The perceptual characteristics of normal and abnormal resonance (hypernasality, hyponasality, cul de sac resonance) and factors influencing the perception of abnormal resonance characteristics.
- iii. Organic conditions/syndromes and nonorganic factors associated with abnormal resonance.

- iv. The articulatory, vocal, phonological, linguistic, and psychosocial factors associated with abnormal resonance.
- v. Communication profiles of subgroups of clients with resonance disorders.
- vi. The psychosocial, educational, and vocational impact of resonance disorders.
- vii. The impact of resonance disorders on other speech subsystems (e.g., respiratory, laryngeal, articulatory).

Section 8.2 ASSESSMENT

The speech-language pathologist:

- i. Develops and implements an assessment plan based on background information about the client, knowledge of normal and abnormal resonance, known or suspected concomitant disorders, and principles of assessment; modifies the plan when appropriate.
- ii. Demonstrates knowledge of specific procedures by which speech-language pathologists and other professionals assess velopharyngeal adequacy including instrumental (e.g., multiview videofluoroscopy, naso/endoscopy, aerodynamic, and acoustic measures) and perceptual means (e.g., speech production tasks).
- iii. Assesses the impact of physical, emotional, developmental, and environmental factors on the client's resonance pattern(s).
- iv. Determines the need for further consultation (e.g., genetics, otolaryngologist, multidisciplinary team).
- v. Demonstrates the ability to distinguish the following: hypernasal resonance, hyponasal resonance, mixed hyper-hyponasal resonance, and nasal air emission.
- vi. Formulates a diagnostic statement about the client's resonance disorder.
- vii. Formulates a prognostic statement about the client's resonance disorder.

Section 8.3 INTERVENTION

The speech-language pathologist:

- i. Demonstrates understanding of the roles of other professions in team care for clients with cleft palate and cranio-facial disorders. Demonstrates an understanding of the surgical, prosthetic, and nonsurgical management approaches for velopharyngeal disorder, their advantages, disadvantages, and limitations.
- ii. Chooses an appropriate service delivery model (e.g., regular review assessments, home program, individual therapy, group therapy, referral to/collaboration with other professionals) for management of the client's resonance disorder.
- iii. Formulates appropriate short-term and long-term goals for the treatment of the client's resonance disorder.
- iv. Develops and implements appropriate clinical activities for meeting specified communication goals and facilitating generalization and maintenance.
- v. Evaluates progress towards communication goals; modifies the management plan and discharge criteria accordingly.

UNIT NINE: FLUENCY DISORDERS

Section 9.1 NATURE

The speech-language pathologist demonstrates knowledge of:

- i. The characteristics of normal and abnormal disfluency across the lifespan.
- ii. The cause and predisposing factors in developmental stuttering, neurogenic stuttering, psychogenic stuttering, and in cluttering.
- iii. The psychosocial, educational, and vocational impact of fluency disorders.
- iv. Similarities and differences between developmental and acquired fluency disorders.

Section 9.2 ASSESSMENT

The speech-language pathologist:

- i. Develops and implements an assessment plan based on background information about the client, knowledge of normal and disordered fluency, known or suspected concomitant disorders and principles of assessment; modifies this plan when appropriate.
- ii. Uses appropriate standardized and/or non-standardized procedures for describing patterns and frequency or disfluencies, rate of speech, and secondary characteristics.
- iii. Understands issues related to obtaining representative and diagnostically useful samples of a client's speech.
- iv. Uses appropriate standardized and/or non-standardized procedures for measuring the client's attitudes toward disfluency and speaking situations.
- v. Assesses the impact of factors in the client's environment on his/her communication needs and effectiveness.
- vi. Assesses the psychosocial, educational, and/or vocational impact of the fluency disorder.
- vii. Formulates a diagnostic statement about the client's dysfluency.
- viii. Formulates a prognostic statement about the client's dysfluency.

Section 9.3 INTERVENTION

The speech-language pathologist:

- i. Demonstrates knowledge of different approaches to fluency intervention, their theoretical bases, their advantages, disadvantages, and limitations.
- ii. Chooses an appropriate service delivery model (e.g., parent counselling, parent training, home/school program, individual therapy, group therapy) for treatment of the client's dysfluency.
- iii. Selects and applies an appropriate approach for treatment of the client's dysfluency and for improving the client's attitudes toward speech and speaking situations.
- iv. Formulates appropriate short-term and long-term goals for treatment of the client's dysfluency.

- v. Develops and implements appropriate clinical activities for meeting specified communication goals and facilitating generalization and maintenance.
- vi. Evaluates progress towards communication goals; modifies the management plan and discharge criteria accordingly.
- vii. Refers clients to other professionals (e.g., psychology or social work) if appropriate.

UNIT TEN: AUGMENTATIVE AND ALTERNATIVE COMMUNICATION

Section 10.1 NATURE

The speech-language pathologist demonstrates knowledge of:

- i. The symbols, aids, strategies, and techniques that are components of an augmentative and alternative communication (AAC) system.
- ii. Profiles of clients who are appropriate candidates for an AAC system.
- iii. Factors associated with normal language, phonological, and literacy development and their application to AAC.
- iv. The social, pragmatic, educational, vocational, and technical impact of augmentative and alternative methods of communication, and their application for face-to-face and written communication.
- v. Handicapping conditions (e.g., cognitive, linguistic, sensory, motor, visual, and hearing) which impact on AAC use in effective and efficient oral and written communication.

Section 10.2 ASSESSMENT

The speech-language pathologist:

- i. Develops and implements an assessment plan based on background information about the client, knowledge of normal language development, current and previous communication methods and needs, client's level of language/cognition, vision, and motor skills.
- ii. Uses appropriate standardized and non-standardized procedures for assessing the communication skills of potential AAC users, including language, speech, symbol knowledge, and literacy potential.
- iii. In collaboration with other team members, ensures that there is an appropriate access method for an AAC system including consideration of eye gaze, direct selection, and scanning.
- iv. Assesses the impact of factors such as the client's behaviour, motivation, endurance, communication partners, living/school/work environment, seating, and mobility on the client's communication needs and effectiveness.
- v. Understands the role of the speech-language pathologist with respect to the other members of the AAC team.
- vi. Formulates a diagnostic statement about the client's communication disorder.
- vii. Formulates a prognostic statement about the client's communication disorder.

Section 10.3 INTERVENTION

The speech-language pathologist:

- i. Selects an appropriate AAC system/device in collaboration with the client, caregivers, and team members, taking into consideration the client's environment, skills and needs, advantages/disadvantages of high versus low tech systems, and funding sources.
- ii. Chooses an appropriate service delivery model (one-to one, facilitator training, consultation) for implementation of the AAC system.
- iii. Formulates appropriate long-term and short-term goals.
- iv. Develops and implements appropriate clinical activities for meeting specified goals which include communication partners who are able to facilitate generalization and/or maintenance of gains, and enhance the independence of the user.
- v. Evaluates progress toward achieving AAC goals; modifies the management plan and discharge criteria accordingly.

UNIT ELEVEN: HEARING DISORDERS AND RELATED SPEECH-LANGUAGE DISORDERS

Section 11.1 NATURE

The speech-language pathologist will demonstrate knowledge of:

- i. Anatomical, physiological, and environmental conditions contributing to hearing disorders.
- ii. Symptoms of hearing disorders, including associated speech, language, and voice profiles for prelingual and postlingual onset.
- iii. Different theoretical frameworks relevant to the speech and language problems of people with hearing impairments.
- iv. Incidence and prevalence of hearing impairment in specific populations.
- v. Acoustics of speech and its role in speech perception.
- vi. The psychosocial, educational, and vocational impact of hearing impairment.

Section 11.2 ASSESSMENT

The speech-language pathologist will demonstrate knowledge of:

- i. The basic processes and procedures used to assess unaided and aided hearing.
- ii. Application of audiometric information to the speech-language assessment, including recognizing the type and degree of hearing loss from an audiogram (sensorineural, conductive, mixed); procedures for basic audiometric screening; hearing aid and cochlear implant information.
- iii. The need for further investigation and referral of clients with hearing impairments.
- iv. Compensating mechanisms for hearing loss and speech-language difficulties.
- v. Modification in speech and language assessment procedures to accommodate varying degrees of hearing loss.
- vi. Prognostic factors.

Section 11.3 INTERVENTION

The speech-language pathologist will demonstrate knowledge of:

- i. Approaches to the prevention of speech and language difficulties including early identification and referral, education of, parents, teachers, and the public.
- ii. The philosophical underpinnings of sign language (e.g., American Sign Language, Langue des signes québécoise) and other communication methods used by the hearing impaired (e.g., Manually Coded English, Signed Exact English).
- iii. Approaches to habilitation and rehabilitation of speech and language (e.g., oral, manual, total, aural, visual communication), and their advantages and disadvantages.
- iv. The use, care, and maintenance of hearing aids, assistive listening devices, and amplification systems.
- v. Modifying management plans to accommodate varying degrees of hearing loss.

UNIT TWELVE: DYSPHAGIA

Section 12.1 NATURE

The speech-language pathologist:

- i. Applies knowledge of normal anatomy, physiology, and neurophysiology of the upper aerodigestive tract to clinical practice.
- ii. Applies knowledge of the factors and processes associated with dysphagia¹ to clinical practice.
- iii. Demonstrates knowledge of different theoretical frameworks related to swallowing² and/or feeding³ assessment and rehabilitation.
- iv. Demonstrates knowledge of the profiles of special populations who may present with dysphagia (developmental disorders, neurogenic disorders, surgical, etc.).
- v. Demonstrates knowledge of the social, cultural, ethical, and vocational impact of dysphagia.
- vi. Demonstrates knowledge of the relationship between the characteristics of the dysarthrias⁴ and dysphagia and the effect of apraxia⁵ on feeding and swallowing.
- vii. Demonstrates knowledge of cranial nerve functioning and of the interrelationship between the respiratory, laryngeal, pharyngeal, and oromotor systems.
- viii. Demonstrates knowledge of the risk factors associated with dysphagia and the consequences for the patient/client.

Section 12.2 ASSESSMENT

The speech-language pathologist, in conjunction/collaboration with physicians and health professionals integral to the dysphagia assessment process:

- i. Demonstrates knowledge in the identification of persons at risk for feeding and swallowing disorders including knowledge of previous and current medical history, significant medical conditions, pharmacologic effects, pulmonary/respiratory and nutritional sequelae related to

dysphagia, methods of oral-nonoral nutritional intake, and the contributions of cognitive-linguistic, or behavioural deficits to the feeding-swallowing process.

- ii. Demonstrates knowledge of methods to evaluate feeding-swallowing including physiologic sensorimotor examinations, instrumental, and non-instrumental clinical evaluations of swallowing function.
- iii. Demonstrates proficiency in the selection and administration of age and developmentally appropriate assessment/evaluation methods and procedures that are functionally relevant, culturally sensitive, ethical, and theoretically grounded.
- iv. Demonstrates knowledge in the identification of normal-abnormal anatomy and physiology of the oral, pharyngeal, laryngeal, and respiratory mechanisms related to swallowing, and of the functional skills related to safe, efficient nutritional intake.
- v. Demonstrates knowledge in the use and application of instrumental techniques for screening/diagnosis of oropharyngeal dysphagia. These techniques may include, but are not limited to videofluoroscopy⁶, fiberoptic endoscopy⁷, ultrasonography⁸, and electromyography⁹. Competency in the use of these techniques is based on demonstrated education and supervised training in instrumental operations, examination methods and procedures, appropriate selection for use in specified patient groups, advantages and limitations, interpretation of results, knowledge of risk factors, and safety procedures. Use of any instrumental technology is undertaken within the limitations/licensure of existing institutional policies or regulatory boards.
- vi. Demonstrates knowledge in the formulation of assessment reports including documentation of pertinent background information, interpretation of results, determination of capacity and safety for oral feeding, determination of presence and severity of risks associated with dysphagia, recommendation for intervention, prognostic indicators, and the need for repeated assessment or monitoring.

The speech-language pathologist makes appropriate referrals and communicates the evaluation results and recommendations.

Section 12.3 INTERVENTION

The speech-language pathologist:

- i. Demonstrates knowledge of different approaches to the management and treatment of feeding and swallowing disorders, their theoretical bases, their impact on other functions of the upper aerodigestive tract, the ethical aspects involved, and their relative value for specific cases. Included among these approaches are therapeutic and postural manoeuvres, manipulation of bolus texture/ temperature/taste/presentation variables, alternative routes to provision of nutrition/hydration, and education, training, and supervision of caregivers who participate in feeding the client.
- ii. Recommends selection of an appropriate service delivery model (referral to other professionals, selection and implementation of treatment strategies, frequency and mode of direct

- intervention, education/training and supervision of mediator caregivers for indirect treatment) for the treatment and management of the client's feeding or swallowing disorder.
- iii. Selects and recommends appropriate treatment and management approaches for the client's feeding or swallowing disorder.
 - iv. Formulates appropriate short-term and long-term treatment or management goals.
 - v. Develops and implements appropriate clinical activities for meeting and facilitating maintenance of specific treatment and management goals related to a client's feeding or swallowing disorder.
 - vi. Regularly reviews and evaluates the outcome of the interventions selected for a client's feeding or swallowing disorder, and modifies the treatment plan accordingly.

GLOSSARY

1. Dysphagia. Impairment of any stage or component in the process of swallowing.
2. Swallowing. The process of ingesting food or liquid, beginning immediately following placement of a bolus into the mouth and ending when that bolus has entered completely into the stomach.
3. Feeding. The process of transferring food or liquid from a container to the mouth for swallowing.
4. Dysarthria. Neuromuscular impairment of the resonatory, oral motor, laryngeal, and respiratory components of speech production.
5. Apraxia. The inability to voluntarily execute a learned sequence of motor actions. Motor functions may remain intact for involuntary or reflexive actions.
6. Videofluoroscopy. A videofluorographic study of oral and pharyngeal swallowing, incorporating modifications in bolus variables, patient positioning, volitional control of swallowing technique, and radiographic focus to facilitate optimum visualization of the oral-pharyngeal-laryngeal structures and their function during swallowing. This procedure is also commonly referred to as a modified barium swallow (MBS), oral-pharyngeal motility study, or videofluoroscopic swallowing study (VFSS) or examination.
7. Fiberoptic Endoscopy. Use of a fiberoptic nasopharyngolaryngoscope to assess several components of abnormal oropharyngeal swallowing included premature spillage of a bolus into the hypopharynx or laryngeal vestibule before swallowing; incomplete vocal fold adduction during coughing, breath holding and swallowing; presence of residue in the hypopharynx or laryngopharynx after swallowing; and presence of laryngo-pharyngeal sensation in response to delivery of calibrated oxygen pulses through the endoscope is sometimes included.
8. Ultrasonography. Use of an ultrasound transducer, which emits and receives sound waves at frequencies over 20 kHz, to provide real time imaging of the movement of the tongue, floor of mouth musculature, hyoid bone, palate, and epiglottis during oral preparation and transport of a food or liquid bolus from the mouth to the upper pharynx.

9. Electromyography. A procedure used to record electrical activity of a muscle or muscle group during certain behaviours such as swallowing, which provides information on the onset and offset of muscle activity, the frequency of motor neuron firing, and some indication of muscle strength.

Dear Sir or Madam:

As Chairs and Directors of the four Ontario University graduate programs of audiology and speech-language pathology we are pleased to provide our collective voices via this letter in support for OSLA's initiative to expand the scopes of practice for audiologists and speech-language pathologists in the Province of Ontario. We support, for example, a change in our scope of practice that would legally allow both professions to communicate a diagnosis to our clients/patients or to their legal guardians with respect to language, speech, and swallowing disorders.

Faculty in our professional graduate programs provide students with outstanding and highly innovative education and training in professional and research-based topics related to foundational knowledge, clinical practice and interprofessional care. Our award-winning faculty provide unique learning opportunities to our students that make them well prepared for the complex care settings in various areas of our disciplines and professions.

Current legislation limits audiologists and speech-language pathologists from responding to the needs of clients/patients in the current education and health care systems, and performing to the full extent of their competencies.

Audiologists' and speech-language pathologists' education, training and clinical experience make them competent to perform a much greater range of activities than what is currently included within the scope of practice under the Controlled Acts in the RHPA in Ontario.

More specifically, the curricula in our university graduate programs provide the knowledge, skills and judgment for audiologists or speech-language pathologists to:

- Communicate a diagnosis identifying a communicative, hearing (audiologists only) or swallowing disorder (SLPs only) as the cause of a person's symptoms.
- Order the use of additional screening procedures, for example, a videofluoroscopic swallow examination for the purpose of assessing and/or managing a swallowing disorder (SLPs only).
- Put an instrument, hand or finger beyond the nasal passages where they normally narrow for the purposes of assessing and managing a communicative or swallowing disorder (SLPs only).
- Put an instrument, hand or finger into an artificial opening of the body (stoma) for the purpose of assessing and managing voice disorders and voice restoration, and for the purpose of suctioning a tracheostomy (SLPs only).

Under the current legislative environment, unnecessary time and resources are expended seeking out alternate authorization such as medical directives, delegations and/or orders for the purposes of obtaining evaluations that could be carried out safely and appropriately by audiologists or speech-language pathologists.

Appendix D – Letter of Support from University Chairs

The proposed changes in scope would improve the efficiency of client/patient care, encourage meaningful client/patient engagement and facilitate better outcomes for clients/patients, while protecting the public interest and ensuring the highest standards of professional conduct and client/patient safety.

We provide our highest endorsement and support unequivocally the efforts of OSLA as they seek to expand the scopes of practice for audiologists and speech-language pathologists of Ontario.

Sincerely,



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Appendix E - Canadian Jurisdictional Review

Legislative Framework

The models for legislating and regulating health professions vary across Canada. Quebec, New Brunswick, Manitoba, Saskatchewan and the three territories use a model of licensure or certification for the regulation of professions, or both (Quebec and Saskatchewan). Under licensure, the legislation typically prohibits all who are not licensed from providing services that fall within the scope of practice. Under certification, there is no such prohibition in legislation; rather the legislation only prohibits others from using the title of the regulated profession. The scope of practice is limited to authorizing members of the regulated profession to provide services that fall within it. “Whereas licensure gives a legislated monopoly to members of a regulated profession, certification is limited to giving them a competitive advantage.” (Lahey & Currie, 2005)

On the other hand, Ontario, Alberta and British Columbia have taken another approach. In 1991, Ontario passed the *Regulated Health Professions Act (RHPA)*, which provides a common framework for the regulation of the province’s regulated health professions, replacing exclusive scopes of practice (i.e. scopes of practice statements are no longer protected) with a system of 13 controlled acts. This approach licenses acts rather than professions. As a result, health care services not involving a controlled act are in the public domain and may be performed by anyone, acknowledging the overlapping scopes of practice of health professions. However, no one can perform a controlled act unless the law that applies to their health profession allows them to do so. Because of overlaps in practice, more than one profession can be authorized to perform the same, or parts of the same, controlled acts. On the other hand, not all of the regulated health professions are authorized to perform controlled acts (College of Nurses of Ontario, 2004). Moreover, in accordance with a profession’s regulations, the *RHPA* allows a regulated health professional who has authority to perform a controlled act to delegate the performance of that act to another regulated health professional who does not have the authority to perform the act or to an unregulated person. (HPRAC, 2001) Fundamentally, the change was introduced to balance flexibility and protection from harm, i.e. to allow greater flexibility as to who delivers health care services and to allow patients greater choice of provider while still protecting the public from harm (Schwartz, 1989).

The *RHPA* framework was found to permit focused changes in profession-specific legislation and regulation, allowing for legislative amendments to expand professions’ scopes of practice or regulatory adjustments responding to changing needs that give definition or set limits on controlled acts authorized to a profession. For optimum flexibility, it was recommended that there be regular reviews of profession-specific Acts (HPRAC, 2001).

In 1999, Alberta adopted a similar piece of legislation, the *Health Professions Act*, to regulate its 30 self-regulated health professions. Like the Ontario legislation, the Act sets out the same requirements for governance, registration, and discipline for each profession. The Act also contains schedules for each profession outlining the profession’s practice statement and the services generally provided by the profession. The Act comes into force on a profession-by-profession basis as their regulations are approved and enacted. Under the new legislation, health professionals are not bound by exclusive scopes of practice, but by their abilities and the range of services they can provide in a safe and competent manner, subject to the standards of their regulatory college (Alberta Health and Wellness, 1999). British Columbia followed suit and adopted similar provisions in its *Health Professions Act, 2012*.

Regulated Jurisdictions

The scope of practice for the professions of speech-language and audiology are distinctly different across Canada.

Speech-language and audiology health professionals are regulated in seven provinces - **Alberta, British Columbia, Manitoba, New Brunswick, Quebec, Saskatchewan and Ontario**. The other three provinces and three territories were included in our jurisdictional analysis. However, the below results reflect the regulated provinces only.

Details on the legislative and regulatory parameters for speech-language pathologists practicing in Alberta, British Columbia, Manitoba, New Brunswick and Quebec are included here.

Summary of Controlled (or Restricted) Activities

1. Communicating a Diagnosis or Disorder

In **British Columbia**, the health professions legislation lists “reserved acts” similar to Ontario’s controlled acts. In that province, however, the reserved act is “making a diagnosis” instead of “communicating a diagnosis.”

In **Alberta**, the list of “restricted activities” is similar to Ontario’s list of controlled acts, but neither making nor communicating a diagnosis is included in the list of restricted activities in the province’s *Health Professions Act*. Alberta decided that restricting diagnosis would offer little protection over and above the other restricted activities defined in its legislation. The working group that discussed this issue stated it was not possible to develop a meaningful or useful definition of diagnosis that would apply to all health care providers. It concluded that diagnosis was implicitly included within the performance of each proposed restricted activity and, in that context, is already addressed. The group also said that if diagnosis were restricted, virtually all health care providers would have to be regulated.

Other regulated jurisdictions include **Manitoba, New Brunswick, Quebec** and **Saskatchewan**. Speech-language pathologists in each of these provinces are authorized to ‘communicate a diagnosis’.

In unregulated provinces, most, if not all professionals are members of Speech-Language and Audiology Canada (SAC) because employers require this. Although this is not a regulatory body, it is interesting to note that the described scope of practice includes diagnosis:

“Speech-language pathologists are involved in a number of different activities to promote effective communication and swallowing for the individuals they serve. These activities may include assessment of communication and swallowing disorders, which may involve: screening, identification, evaluation, and diagnosis.”

2. Inserting an Instrument, Hand or Finger

- a. Beyond the nares
- b. Into an artificial opening into the body

Speech-language pathologists who have demonstrated the requisite competencies to proficiently perform these two controlled acts are authorized to do so in **Alberta** and **Manitoba**. Those practicing in **British Columbia** are authorized to insert an instrument, hand or finger beyond the pharynx under delegation only – similar to Ontario.

3. Ordering the Application of a Form of Energy

Legislation in **Alberta** grants speech-language pathologists the authority to order the application of a form of energy. In **Manitoba**, this act is restricted to surface electromyography.

The governing legislation in Alberta is the [Health Professions Act, RSA 2000](#). Section 3(1) of Chapter H-7 defines the scope of practice for speech-language pathologists as the ability to perform one or more of the following:

- a) Assess, *diagnose*, rehabilitate and prevent communication and oral motor and pharyngeal disorders and disorders;
- b) Teach, manage and conduct research in the science and practice of speech-language pathology; and
- c) Provide restricted activities authorized by the regulations.

Restricted Activities are described in [Alberta Regulation 124/2002](#). They are as follows:

14(1) In the provision of speech-language pathology services, members registered on the speech-language pathologist general register or speech-language pathologist courtesy register may perform the following restricted activities:

- a) insert into the ear canal air under pressure;
- b) insert or remove instruments or devices beyond the point in the nasal passages where they normally narrow;
- c) insert or remove instruments, devices or fingers beyond the pharynx;
- d) insert or remove instruments or devices into an artificial opening into the body;
- e) administer oral diagnostic imaging contrast agents.

The governing legislation in British Columbia is the Health Professions Act, RSA 2008 and the [Speech and Hearing Health Professionals Regulation](#). After considerable consultation, the regulation was amended effective October 1, 2012.

Section 1 defines the scope of practice for speech-languages as follows:

“Speech-language Pathology” means the health profession in which a person provides, for the purposes of promoting and maintaining communication and nutritional health, the services of assessment, treatment, rehabilitation and prevention of

- a) Speech, language and related communication disorders and conditions; and
- b) *Vocal tract disorder, including related feeding and swallowing disorders.*

Section 5(3) describes the restricted activities that speech-language pathologists are authorized to perform in the course of practising speech-language pathology:

- a) make a diagnosis identifying, as the anatomical cause of behavioural, psychological or language-related signs or symptoms of an individual, a speech, language or related communication disorder;
- b) put an instrument or a device or finger into the external ear canal, up to the eardrum, for the purpose of tympanometry;
- c) put an instrument or a device beyond the point in the nasal passages where they normally narrow, for the purposes of assessing and managing communication and swallowing disorders;
- d) put an instrument or a device or finger beyond the pharynx, for the purposes of assessing and managing voice disorders and voice restoration;
- e) put an instrument or a device into an artificial opening in the body, for the purposes of assessing and managing voice disorders and voice restoration;
- f) put into the external ear canal, up to the eardrum and for the purpose of tympanometry, air that is under pressure;
- g) administer topically a drug that
 - i. is specified in Schedule I or Schedule II of the Drug Schedules Regulation, B.C. Reg. 9/98, and
 - ii. is an anaesthetic,

for the purposes of performing a restricted activity set out in paragraphs (c) to (e).

Manitoba's governing legislation is its [Regulated Health Professions Act, 2009](#). The [Practice of Audiology and Practice of Speech-Language Pathology Regulation 191/2013](#) was finalized and registered in December 2013.

Section 4(2) describes the scope of practice of speech-language pathology as:

- a) the assessment of speech and language functions, related to communication disorders and swallowing functions; and
- b) the treatment and prevention of speech and language dysfunctions and disorders, including vocal tract dysfunction and related swallowing dysfunctions and disorders

to develop, maintain, rehabilitate or augment oral motor, communication functions, vocal tract dysfunction, or elective modification of communications behaviours, and to enhance communication.

Reserved acts are set out in Table 2 attached to the Regulation. These include:

- Making a diagnosis of a speech, language or related communication dysfunction or disorder or a swallowing dysfunction or disorder and communicating it to an individual or his or her personal representative in circumstances in which it is reasonably foreseeable that the individual or representative will rely on the diagnosis to make a decision about the individual's health care.
- Receiving reports of screening or diagnostic tests that:
 - a. are ordered by a health care professional (other than a speech-language pathologist); and
 - b. are for the purpose of treating or diagnosing a communication or swallowing dysfunction or disorder.
- Inserting or removing an instrument or a device into the external ear canal for the purpose of
 - a. screening of hearing; or
 - b. inserting or removing a wearable hearing instrument.
- Inserting or removing an instrument or a device beyond the point in the nasal passages where they normally narrow for the purpose of assessing and managing communication and swallowing disorders.
- Inserting or removing an instrument or a device or finger beyond the pharynx for the purpose of
 - a. assessing and managing voice disorders and voice restoration; and
 - b. suctioning a tracheostomy
- Inserting or removing an instrument or a device or finger into an artificial opening in the body for the purpose of
 - a. assessing and managing voice disorders and voice restoration; and
 - b. suctioning a tracheostomy
- Topically administering a drug that is an anaesthetic for the purpose of minimizing pain or discomfort to a client when performing a procedure during assessment and management of swallowing or voice disorders.
- Applying surface electromyography for the purpose of treating swallowing disorders.

Although the list of authorized reserved acts provided to each profession is extensive, individual members will only be authorized to perform a reserved act if the following requirements are met:

- **Certificate of Practice:** A member must hold a current and valid Certificate of Practice. The performance of a reserved act will be subject to any conditions placed on his or her registration or Certificate of Practice.
- **Scope of Practice:** A member may only perform a reserved act that is within his or her respective scope of practice.
- **Competency:** A member must be competent in order to perform a reserved act and the performance of the reserved act must be safe and appropriate for the procedure being performed.

New Brunswick does not have province-specific professional practice guidelines; they follow the Canadian Association of Speech-Language Pathologists and Audiologists (now known as Speech-Language and Audiology Canada or SAC) guidelines for speech-language pathology.

Chapter C26 of Quebec’s [Professional Code](#) was updated in October 2013. The Code designates speech-language pathologists as “Reserved Professions”.

Any member of the “Professional Association of Speech-Québec” can perform the following professional activities, which are reserved in the activities that Article 37.1 of a.2 allows it to exercise:

- a) evaluate hearing impairment in order to determine the treatment plan and audiological response;
- b) adjust a hearing aid as part of an audiological procedure;
- c) make a functional assessment of a person where the assessment is required under any law;
- d) assess language disorders, speech and voice in order to determine the treatment plan and speech therapy interventions;
- e) assess a student with adjustment difficulties in the determination of an action plan under the Act on Public Education;
- f) assess a child who is not yet eligible for preschool and who shows signs of developmental delay in order to determine rehabilitation and adaptation to meet their needs.

Appendix F – International Jurisdictions

Despite the differences in approaches and models, a significant majority of English-speaking jurisdictions permit audiologists to both diagnose and communicate said diagnosis to their patients/clients. Further details on the regulatory framework for the United Kingdom, Australia and New Zealand are provided below.

Jurisdiction	Framework for Regulation	Communicating a Diagnosis (Audiologist)	Communicating a Diagnosis (Speech-Language Pathologists)
Ontario	<i>Regulated Health Professionals Act</i>	Audiologists do not have access to the controlled act of communicating a diagnosis.	SLPs do not have access to the controlled act of communicating a diagnosis.
UK	<p>According to the British Academy of Audiology “A new regulatory body is currently being created which will manage registration”</p> <p>Speech Language is regulated under the <i>Health Professions Council</i></p>	Audiologists diagnose and “counsel” clients, family members, care givers and other professionals.	The <i>National Health Service Plan</i> introduced the idea that registered staff, including SLTs, could formally broaden or add to their scope of practice. This involves taking on additional roles...that might previously have been undertaken by other professional groups.

Jurisdiction	Framework for Regulation	Communicating a Diagnosis (Audiologist)	Communicating a Diagnosis (Speech-Language Pathologists)
Australia	<p><i>Health Practitioner Regulation National Law Act</i></p> <p>Audiological Society of Australia sets training and education requirements for Audiologists.</p> <p>Speech Pathology Association of Australia sets training and education requirements for SLPs.</p>	<p>Under current scopes of practice Audiologists provide full diagnostic hearing assessment and determine the individual's need for medical and/or rehabilitative intervention. Audiologists refer individuals with identified primary ear health needs for primary care management as required. Anyone identified for ENT management is currently referred back to a primary health practitioner for an appropriate referral to an ENT.</p>	<p>SLPs determine the basis or diagnosis of the communication and/or swallowing issues or condition and projects, the possible outcomes and reports on analysis and interpretation; Provides feedback on results of interpreted speech pathology assessments to the client and/or significant others and referral sources, and discusses management [with patients and clinicians] .</p>
New Zealand	<p>Audiologists and Speech Language Pathologists are not regulated.</p>	<p><i>Identification, diagnosis and management of hearing loss or disorders of the auditory and balance system in clients of all ages...including the conduct and interpretation of otoscopic examination and safe and appropriate cerumen management, behavioural, electro-acoustic and electro-physiological tests.</i></p>	<p>In New Zealand, a speech-language pathologist may work to provide services in the area of communication and swallowing disorders including diagnosis and clarification of communication support needs.</p>

Jurisdiction	Framework for Regulation	Communicating a Diagnosis (Audiologist)	Communicating a Diagnosis (Speech-Language Pathologists)
<p>USA – ASHA</p>	<p>Audiology and Speech Language Pathology are regulated at the state level.</p>	<p>While regulation is established at the state level, the ASHA has produced a series of detailed policy papers, which are disease/condition dependent, outlining the process of how and when Audiologists can communicate a diagnosis.</p>	<p>While regulation is established at the state level, the ASHA has produced a series of detailed policy papers, which are disease/condition dependent, outlining the process of how and when Speech Language Pathologists can communicate a diagnosis.</p>
<p>Alabama</p>	<p>Alabama Board of Examiners of SLP & Audiology</p>	<p>The overriding principle is that audiologists will provide only those services for which they are adequately prepared through their academic and clinical training and their experience. The practice of audiology includes: (a) Screening, identifying, assessing, interpreting, diagnosing, preventing, and (re)habilitating peripheral and central auditory system dysfunctions [14 other roles/duties/responsibilities]</p>	<p>Speech-language pathologists will provide only those services for which they are adequately prepared through their academic and clinical training and their experience. The practice of speech-language pathology includes: Providing screening, identification, assessment, diagnosis, treatment, intervention (i.e. prevention, restoration, amelioration, compensation) and follow-up services for disorders of [5 conditions/disorders listed]</p>

Appendix F – International Jurisdictions

Jurisdiction	Framework for Regulation	Communicating a Diagnosis (Audiologist)	Communicating a Diagnosis (Speech-Language Pathologists)
Alaska	Department of Commerce, Community and Economic Development	“appraisal” and “consultation” are within the scope of practice	Scope of practice includes screening, identifying, assessing and interpreting, diagnosing, rehabilitating, and preventing [5 conditions disorders related to SLP]
Arizona	Arizona Department of Health Services, Office of Special Licensing, Speech and Hearing Advisory Committee	The nonmedical and nonsurgical application of principles, methods and procedures of measurement, testing, evaluation and prediction that are related to hearing, its disorders and related communication impairments for the purpose of nonmedical diagnosis, prevention, amelioration or modification of these disorders and conditions.	Screening, identifying, assessing, interpreting, nonmedical diagnosing and rehabilitating [3 conditions/disorders related to SLP]
Arkansas	Board of Examiners in Speech-Language Pathology and Audiology	Diagnosis is within the scope of practice. Unclear on communicating said diagnosis.	Communicating a diagnosis with patients/clients, parents, and family members is within the scope of practice.

Jurisdiction	Framework for Regulation	Communicating a Diagnosis (Audiologist)	Communicating a Diagnosis (Speech-Language Pathologists)
California	California Speech-Language Pathology and Audiology Board	Audiologists may communicate a diagnosis. They must, depending on the patient and the condition, provide a referral within a specific time frame.	Speech Language pathologists may communicate a diagnosis only for those conditions within the SLP scope of practice. SLPs “may not diagnose an auditory processing disorder or utilize the previous diagnostic label, central auditory processing disorder.”
Colorado	Colorado Professions and Occupations	Communicating a diagnosis is within the practice of audiology as defined by the Colorado Professions and Occupations articles for Audiologists.	
Connecticut	Connecticut Speech-Language-Hearing Association, licensing board, and state education agency Connecticut General Statutes Chapter 399 Speech And Language Pathologists And Audiologist	Diagnosis is not within the scope of practice	Diagnosis is within the SLP scope of practice.

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Jurisdiction	Framework for Regulation	Communicating a Diagnosis (Audiologist)	Communicating a Diagnosis (Speech-Language Pathologists)
Delaware	Board of Speech Pathologists, Audiologists, and Hearing Aid Dispensers	Defers to the ASHA standards and policy papers, which are disease/condition dependent and outline the process of how and when Audiologists can communicate a diagnosis.	Defers to the ASHA standards and policy papers, which are disease/condition dependent and outline the process of how and when Audiologists can communicate a diagnosis.
Florida	Florida Board of Speech Language Pathology & Audiology	Any audiologist who has complied with the provisions of this part may: offer, render, plan, direct, conduct, consult, or supervise services to individuals or groups of individuals who have or are suspected of having disorders of hearing, including prevention, identification, evaluation, treatment, consultation, habilitation, rehabilitation, instruction, and research.	Practice of speech-language pathology means the application of principles, methods, and procedures for the prevention, identification, evaluation, treatment, consultation, habilitation, rehabilitation, instruction, and research, relative to the development and disorders of human communication; to related oral and pharyngeal competencies;
Georgia	Georgia State Board of Examiners for Speech-Language Pathology and Audiology	Communicating a diagnosis is disease/ condition specific.	Communicating a diagnosis is disease/ condition specific.

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Jurisdiction	Framework for Regulation	Communicating a Diagnosis (Audiologist)	Communicating a Diagnosis (Speech-Language Pathologists)
Hawaii	Department of Commerce and Consumer Affairs Professional and Vocational Licensing Board of Speech Pathology and Audiology	Scope of practice does not specify	Scope of practice does not specify
Idaho	The Idaho State Speech & Hearing Services Licensure Board	Scope of practice does not specify	Scope of practice does not specify
Illinois	Illinois Department of Financial and Professional Regulation Speech Language Pathology /Audiology Act Truth in Health Care Professional Services Act	Communicating a diagnosis is disease/ condition specific.	Communicating a diagnosis is disease/ condition (and in some cases location – e.g. hospital) specific.

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Jurisdiction	Framework for Regulation	Communicating a Diagnosis (Audiologist)	Communicating a Diagnosis (Speech-Language Pathologists)
Indiana	<p>Indiana Professional Licensing Agency</p> <p>Indiana Speech-Language Pathology and Audiology Board</p>	<p>Audiologists provide assessment and diagnosis of speech, voice, hearing, auditory perception, and language impairments. There are requirements for referral for any condition/disease/technique that is outside of the audiologist scope.</p>	<p>Speech Language Therapists provide diagnosis or treatment, so long as it's related to the examination.</p>
Iowa	<p>Bureau of Professional Licensure – Speech Pathology and Audiology</p> <p>Iowa Speech-Language Hearing Association</p>	<p>Scope is limited to “non-medical evaluating”</p>	<p>Scope is limited to “non-medical evaluating”</p>
Kansas	<p>Kansas Department of Health and Environment</p> <p>Kansas Speech and Hearing Association</p>	<p>Cannot diagnose or treat conditions identified under the public health act.</p>	<p>Cannot diagnose or treat conditions identified under the public health act.</p>
Kentucky	<p>Kentucky State Board of Speech Language Pathology and Audiology</p> <p>Kentucky Speech Language Hearing Association</p>	<p>Communicating a diagnosis is within the practice of audiology as defined by the Laws and Regulations Relating To Licensure as a Speech-Language Pathologist Or Audiologist</p>	<p>Communicating a diagnosis is within the practice of Speech Language Pathology as defined by the Laws and Regulations Relating To Licensure as a Speech-Language Pathologist Or Audiologist</p>

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Jurisdiction	Framework for Regulation	Communicating a Diagnosis (Audiologist)	Communicating a Diagnosis (Speech-Language Pathologists)
Louisiana	Louisiana Board of Examiners for Speech Language Pathology and Audiology Speech-Language Pathology and Audiology Act	Yes, but cannot delegate.	Yes, but cannot delegate.
Maine	Office of Licensing and Registration Board of Speech-Language Pathology, Audiology and Hearing Aid Dealing and Fitting	Audiologists can diagnose and counsel patients and their families.	SLP may diagnose and treat; counsel patients and their families.
Maryland	Board of Audiologists, Hearing Aid Dispensers & Speech-Language Pathologists	Audiology scope of practice does not include diagnosis, but does include, “counseling, consultation, and instruction”	SLP Scope of practice does not include diagnosis, but does include, “counseling, consultation, and instruction”
Massachusetts	Board of Registration in Speech-Language Pathology and Audiology	Communicating a diagnosis is disease/ condition specific.	Communicating a diagnosis is disease/ condition specific.

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Jurisdiction	Framework for Regulation	Communicating a Diagnosis (Audiologist)	Communicating a Diagnosis (Speech-Language Pathologists)
Michigan	Bureau of Health Professions	<p>No mention of diagnosis in the scope.</p> <p>“Practice of audiology does not include the practice of medicine or osteopathic medicine and surgery or medical diagnosis or treatment”</p>	<p>No mention of diagnosis in the scope.</p> <p>“Practice of speech-language pathology does not include either of the following:</p> <p>(a) The practice of medicine or osteopathic medicine and surgery or medical diagnosis”</p>
Minnesota	Minnesota Speech-Language-Hearing Association, licensing board, and state education agency	Diagnosis of hearing disorders, but not “medical diagnosis that is commonly performed by a physician”	Diagnosis of a specific range of disorders, but not “medical diagnosis that is commonly performed by a physician”
Mississippi	Mississippi Department of Health, Office of Health Protection, Professional Licensure	No mention of diagnosis in the scope of practice.	No mention of diagnosis in the scope.
Missouri	Division of Professional Regulation	Provides diagnosis and counseling to patients, clients, students, their families and interested parties	Uses instrumental technology to diagnose and treat disorders of communication and swallowing, provides consultation and counseling and makes referrals when appropriate

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Jurisdiction	Framework for Regulation	Communicating a Diagnosis (Audiologist)	Communicating a Diagnosis (Speech-Language Pathologists)
Montana	Montana Board of Speech-Language Pathologists and Audiologists	"Practice of audiology" means nonmedical diagnosis"	"Practice of speech-language pathology" means nonmedical diagnosis"
Nebraska	Department of Health and Human Services	The practice of audiology does not include the practice of medical diagnosis, medical treatment, or surgery	The practice of speech-language pathology does not include the practice of medical diagnosis, medical treatment, or surgery
Nevada	State of Nevada Board of Examiners for Audiology and Speech Pathology	Diagnosis is not within the scope of practice: "measurement, testing, appraisal, prediction, consultation, counseling, research or treatment of hearing and hearing impairment for the purpose of modifying disorders in communication involving speech, language and hearing."	Diagnosis is not within the scope of practice: "the measurement, testing, identification, prediction, treatment or modification of, or counseling or research concerning [4 conditions/ acts]."
New Hampshire	New Hampshire Speech-Language-Hearing Association, licensing board, and state education agency	Must refer patient to physician or surgeon if medical treatment is determined to be necessary	Communicating a diagnosis is limited to "disorders of speech, articulation, fluency, voice, verbal and written language, auditory comprehension, cognition communication and swallowing disorders"
New Jersey	New Jersey Speech-Language-Hearing Association, licensing board, and state education agency	Can communicate "nonmedical diagnosis." Additional regs for specific conditions/acts.	Can communicate "nonmedical diagnosis"

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Jurisdiction	Framework for Regulation	Communicating a Diagnosis (Audiologist)	Communicating a Diagnosis (Speech-Language Pathologists)
New Mexico	New Mexico Regulation and Licensing Department Speech-Language Pathology, Audiology and Hearing Aid Dispensing Practices Act	Scope of practice includes “nonmedical diagnosis” related to hearing disorders.	Scope of practice includes “nonmedical diagnosis” related to 11 disorders/conditions.
New York	Office of the Professions, Speech Language Pathology and Audiology	Communicating a diagnosis is limited to treatment of specific disorders.	Communicating a diagnosis is limited to treatment of specific disorders.
North Carolina	North Carolina Board of Examiners for Speech and Language Pathologists and Audiologists	No mention of diagnosis in the scope of practice.	No mention of diagnosis in the scope of practice.
North Dakota	North Dakota State Board of Examiners on Audiology and Speech Language Pathology	No mention of diagnosis in the scope of practice (“evaluating, identifying, preventing, ameliorating, or modifying such disorders...”)	No mention of diagnosis in the scope of practice (“evaluation, identification, prediction, counseling, or instruction related to...”)
Ohio	The Ohio Board of Speech Language Pathology and Audiology	Limited to “audiologic diagnosis”	No mention of diagnosis in the scope of practice.
Oklahoma	Board of Examiners for Speech Language Pathology and Audiology	Scope of practice limits to: “evaluate, examine and counsel”	Scope of practice limits to: “evaluate, examine and counsel”

Jurisdiction	Framework for Regulation	Communicating a Diagnosis (Audiologist)	Communicating a Diagnosis (Speech-Language Pathologists)
Oregon	Board of Examiners for Speech-Language Pathology and Audiology	No mention of diagnosis in the scope of practice.	No mention of diagnosis in the scope of practice.
Pennsylvania	State Board of Examiners in Speech-Language and Hearing Speech-Language and Hearing Licensure Act	“preventing, identifying and diagnosis and treatment of auditory and vestibular disorders”	“providing evaluation, diagnosis and treatment services for disorders of speech, language, swallowing, cognitive and social aspects of communication.”
Rhode Island	Rules And Regulations For Licensing Speech Pathologists And Audiologists (R5-48-Spa)	No mention of diagnosis in the scope of practice.	No mention of diagnosis in the scope of practice.
South Carolina	Department of Labor, Licensing and Regulation - Board of Examiners in Speech-Language Pathology and Audiology	Diagnosing individuals with peripheral and central auditory and vestibular disorders	Diagnosing disorders of speech, language, voice, oral-pharyngeal function, and cognitive/communication skills...
South Dakota	South Dakota Board of Hearing Aid Dispensers and Audiologists	Diagnosis limited to disorders of human hearing, balance, and other neural systems;	

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Jurisdiction	Framework for Regulation	Communicating a Diagnosis (Audiologist)	Communicating a Diagnosis (Speech-Language Pathologists)
Tennessee	Board of Communications Disorders and Sciences	No mention of diagnosis in the scope of practice.	No mention of diagnosis in the scope of practice.
Texas	The State Board of Examiners for Speech-Language Pathology and Audiology,	Scope limits diagnosis to “Non-medical”	Scope limits diagnosis to “Non-medical”
Utah	Division of Occupational and Professional Licensing	Communicating a diagnosis “related to hearing, vestibular function, and the disorders of hearing...”	Communicating a diagnosis “related to the development and the disorders or disabilities of human communication, speech, voice, language, cognitive communication, or oral, pharyngeal or laryngeal sensorimotor competencies...”
Vermont	Department of Education, Educator Licensing	Diagnosing “peripheral and central auditory system dysfunctions peripheral and central auditory system dysfunctions”	Diagnosing “disorders of oral-pharyngeal function, including dysphagia and related disorders”
Virginia	Virginia Board of Audiology and Speech Language Pathology	No mention of diagnosis in the scope of practice.	No mention of diagnosis in the scope of practice.

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Jurisdiction	Framework for Regulation	Communicating a Diagnosis (Audiologist)	Communicating a Diagnosis (Speech-Language Pathologists)
Washington	Department of Health, Hearing and Speech Services	No mention of diagnosis in the scope of practice.	No mention of diagnosis in the scope of practice.
West Virginia	Board of Examiners for Speech, Language Pathology and Audiology	Communicate with patients/clients, parents, and family members about diagnosis, prognosis, and treatment plan.	Communicate with patients/clients, parents, and family members about diagnosis, prognosis, and treatment plan.
Wisconsin	Department of Regulation and Licensing	No mention of diagnosis in the scope of practice.	No mention of diagnosis in the scope of practice.
Wyoming	Board of Speech Pathology and Audiology	Diagnosis related to “peripheral and central auditory system dysfunction”	Diagnosis related to, “Development and disorders of speech, voice, language or swallowing”

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