I have always viewed a state speech-language-hearing association as being what earlier generations called a “guild.” The Oxford English Dictionary defines a guild as “a confraternity … or association formed for the mutual aid and protection of its members, or for the prosecution of some common purpose” (second edition, p. 933). When I read this definition, several expressions come to mind: “common professional purpose,” “strong sense of community,” “strength in numbers,” and “professional connection.” Each of these represents a benefit for any professional within the guild.

Our state associations draw strength from their memberships, but our leadership is what determines how that strength is manifested. Some of our state associations struggle to maintain a leadership core that is both consistent and capable at keeping those associations going. Some of us have difficulty recruiting members to positions of leadership. Across the country, there are state association members who are highly qualified and committed to moving our state associations forward. The catch, however, is that they often can be hard to find. Once they are found, many of them simply need to be asked.

I challenge each of you to take some time and answer the following four questions: (1) How has your state association benefitted you as a professional? (2) More importantly, how has being a member of your state association benefitted you? (3) Why did you become a leader in the state association? (4) How have you grown personally and professionally as a result of your service on the executive board? Our answers to these questions form the “elevator speech” that we can share when reaching out to recruit the next generation of state association leaders.

As I stated in my last message, you are not alone as the leader of your state association. Please do not hesitate to let CSAP know how it can assist you and the membership you represent.

Douglas F. Parham, PhD, CCC-SLP
CSAP President

CSAP is a related association of the American Speech-Language-Hearing Association.
**Client Safety and Telepractice**

**Introduction**

Every day, thousands of errors occur in health care systems (Institute of Medicine, 2003). Medical emergencies, falls, psychological emergencies and unsafe events can cause harm to those seeking services in health care systems. In traditional settings, personnel are available to assist in summoning help for those involved in emergency situations. Client safety requires a health care system that can respond in a timely manner to emergencies. Telepractice is a health care delivery system which must also be implemented in a manner that ensures client safety and prevents harm. Safety and quality cannot be separated, thus health care professionals must provide a culture of safety for clients served via telepractice as well as in-person (Department of Veterans Affairs, 2013).

The American Speech-Language-Hearing Association (ASHA) Code of Ethics states “Individuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally (ASHA, 2010).” The use of telepractice to provide speech-language and audiology services obligates clinicians to think about delivery of services in a setting where a clinician is not physically present.

Evidence supporting the efficacy of telepractice continues to be forthcoming (Lemaire, Boudrias & Greene, 2001; Georgeadis, Brennan & Baron, 2004; Mashima, Birkmire-Peters, Syms, Holtei, Burgess & Peters, 2003; Theodoros, Constantinescu, Russell, Ward, Wilson & Wootton, 2006; Boisvert, Hall, Andrianopoulos & Chaclas, 2012). Not only do clinicians desire ways to provide efficacious treatment, but client safety is critically important as we strive to provide speech-language and audiology services which are convenient and accessible. Emergency situations may arise in a client’s home or remote clinic during a telepractice session. A plan to manage such situations should be in place and practiced before they occur.

As an example, imagine you have just concluded a telepractice session to a remote clinic. Your client is alone in the treatment room. After disconnecting, you continue with your day. As your client rises to leave the room, he or she trips and falls. If your client is unable to call for help, he or she may lie on the floor without immediate attention until a staff member enters the room. In most cases, as long as the door to a treatment room is closed, clinic staff assumes a client is being treated by a clinician and does not enter due to privacy concerns. Falls are the second leading cause of accidental or unintentional injury deaths worldwide and the greatest number of fatal falls happen to adults over age 65 (World Health Organization, 2012). Anyone treating this population should be aware of this finding.

In another example, you may observe a client suffering a medical emergency during a telepractice session. Having a plan for summoning medical staff to assist could mean the difference between life, death or disability for your client. In a telepractice application you don’t have the ability to call for help just outside your door. Your client could be hundreds of miles away.

Or suppose you are conducting a telepractice session to a client alone in his or her home and you notice smoke and realize the house is on fire. If you are located in another town or state and call 911, you will lose valuable response time dispatching emergency services to the client’s location. Calling 911 only works in the local area from which you are calling. Additionally, you could lose time if you call local emergency personnel but don’t have the client’s address readily available.

Therefore, prior to initiating a telepractice application, safety concerns for clients should be considered. Whether in a client’s home or a remote clinic, a number of steps can be taken to prepare for emergencies, possibly eliminating unsafe conditions. These include locating emergency numbers and available persons to assist in an unsafe or emergency situation.

**Telepractice to Remote Clinical Sites**

Telepractice from clinic to remote clinic can be a safe, effective way to provide speech and language services with a few preliminary safety measures. In most cases clients are escorted to the therapy room and left alone or with an accompanying family member. Here are safety considerations to implement:

- An initial meeting with staff at both locations is important in identifying safety concerns and solutions.
- A plan should be developed at this meeting and practiced to make certain all involved staff are familiar with their role in the event of an emergency.
- If an unsafe condition is identified by a remote clinician, emergency numbers should be prominently displayed for quick access.
- A phone number for emergencies should be provided by the remote clinic which will always be answered by a staff member. In case no one is available to answer that phone, local police, fire and rescue numbers should be easily accessible for the location of the remote clinic.
- Speech-language pathology or audiology practitioners should also have the address of the remote clinic available to give to emergency personnel. Remember, calling 911 from your location in another town or state will not be beneficial to your client at a remote site. Local emergency numbers can be found at http://www.usacops.com/. Your plan should also include persons to contact in case of a medical, psychological or life-threatening situation at the remote site.
- At the conclusion of a telepractice clinic visit, never disconnect the camera until the client leaves the room and is in the presence of staff at the remote clinic.

continued on page 3
Telepractice to Client’s Home

Telepractice to a client’s home via the Internet can also carry a certain level of risk that should be given consideration and pre-planning. Safety measures to implement for telepractice to a client’s home are:

• Ask the client for the street address where the home telepractice session will be conducted. Clinicians should also ask this question at the beginning of each session. With portable devices, clients have the potential to travel to virtually any location, so it is essential that clinicians know where clients are physically located during a telepractice session in case of an emergency.

• Then, using the previously mentioned website, obtain local emergency numbers and have them readily available.

• Detailed contact information should also be obtained from the client as to who should be contacted in case of an emergency. A home phone or cell phone of family members living in the home or close by should be listed.

• Finally, a telephone contact number at the client’s home should be listed in the event of a technical disruption during the session. A disruption of Internet service may also be indicative of an emergency or other type of problem.

Conclusion

As speech-language pathologists and audiologists move into the telepractice arena, all aspects of delivering speech-language and audiology services must be considered. Although client safety may not have been considered when conducting in-person treatment in the past, it must now be considered and preparations made in case the unthinkable happens. Telepractice has many potential and exciting uses, but it is the responsibility of speech-language pathologists to make sure the safety and security of the clients is of utmost importance. Telepractice should never be referred to as “better than nothing” but when using this technology, strides should be made to provide the same high quality service and safety assured as in any in-person encounter.

Disclaimer

These contents do not represent the views of the Department of Veterans Affairs or the United States Government.

References


SHAV completed a service activity with Prince George County Toddler Fair on April 25, 2015. It was quite a success! Many thanks go to Alisha Springe, MS, CCC-SLP and Corrin Richels, PhD, who made the trek from Old Dominion University. They were kind enough to sacrifice their Saturday and brave the rain to conduct toddler screenings with me. We conducted 41 communication and 30 hearing screenings. We found 10 children in need of additional evaluation. SHAV can’t wait to do it again next year!

The emergency regulations for cerumen management (CM) officially went into effect on December 29, 2014. Prior to that date, cerumen management was not written in to the Virginia code and was not considered part of the scope of practice for audiologists. Instead, it was considered to be part of the practice of medicine. The new BASLP regulation permits “limited cerumen management” but requires audiologists to have specific training in CM. You may review the emergency regulations at the following link: https://www.dhp.virginia.gov/aud/leg/Emergency_cerumen.doc. This new regulation has caused many audiologists within our state to scramble in search of CM training that meets the guidelines outlined in the regulations. The practice limitations for audiologists, the impact upon the public, as well as the vast concerns of Virginia audiologists about the new regulations prompted the BASLP to reconvene the Ad Hoc Committee on CM on March 12, 2015, to reconsider the emergency regulations. Some changes to the regulations were suggested at that time. Replacing or even amending the emergency regulations has only happened once before in history. The recommendations of the March 2015 Ad Hoc Committee were reviewed and discussed by the BASLP at their most recent meeting on June 11, 2015. The newly proposed regulations will now go back to the State Budget and Planning Committee for review. That process could take several months. Once they return from the budget and planning committee, there will then be a period of public comment. Stay tuned to the Regulatory Town Hall and look for updates!

SHAV is eager and willing to support the audiologists within our state by sponsoring some CM trainings. Since many audiologists are not members of SHAV or ASHA, it is difficult for us to determine exactly how many audiologists within our state actually need the training. As our President Shannon Salley mentioned in her article, SHAV has been working on developing a needs assessment and exploring the possibilities of sponsoring some CM trainings in an effort to ensure that the audiologists within our state have the training that they need to practice CM. We are currently trying to get the word out and determine how many audiologists are in need of CM training. If you know any audiologists, please tell them about SHAV’S efforts on their behalf, and encourage them to contact the SHAV Office at shavoffice@shav.org for the CM survey and training information.

Provisional licensure went into effect in Virginia on December 15, 2014. This means that clinicial fellows must work under a licensed audiologist or speech-language pathologist during their provisional licensure period. Previously, this was not a requirement in Virginia. The link for the provisional license application can be found at https://www.dhp.virginia.gov/Forms/aslp/AudAppProvisional.doc.

Please note that the application process now requires verification from the supervisor, on company letterhead, indicating that the clinical fellow will be working under his/her supervision. This requirement has many new grads baffled and may put them in an awkward situation with their potential employers. Many employers are equally confused by this chicken or the egg situation because many of them stipulate that employment is contingent upon licensure.

The BASLP became the universal licensing entity in Virginia on June 30, 2014. It’s been well over a year since the new regulation was passed. However despite the VDOE’s massive educational push to HR departments throughout the state, some school districts are not aware that this regulation requires SLPs to have a BASLP issued license in hand prior to practicing in schools. Previously, school-based SLPs who were endorsed by the Department of Education could begin working in the schools while their application was in process. This is no longer the case!

The BASLP has drafted a one-time renewal fee decrease for 2016 due to a recent revenue expenditure and cash balance analysis. Now, that is indeed some happy news!

Darlene D. Robke, MS, CCC-SLP
VP for Governmental and Professional Affairs and President-Elect Speech-Language-Hearing Association of Virginia

Vermont Successfully Advocates for Change in Regulatory Authority for Speech-Language Pathologists and Audiologists

The Vermont Speech-Language-Hearing Association (VSHA) successfully collaborated with the Vermont secretary of state on a legislative bill to move speech-language pathology and audiology regulatory authority from the Agency of Education to the Office of Professional Regulation, a division under the VT Secretary of State.

Vermont Governor Shumlin recently signed Bill H.282 into law, which will go into effect September 1, 2015. The law creates a regulatory construct that is on par with other similarly licensed professionals (such as nurses, occupational therapists, physical therapists, school psychologists, etc.) and is supported by a formally appointed licensing board that ensures that standards of practice are well defined, applicants are qualified and that complaints of unprofessional conduct are investigated.

The law sets forth definitions, prohibitions and penalties, exemptions, advisors, license application, eligibility, transitional provisions and fees. It revises the existing statutes to separate out Audiologists and Hearing Aid Dispensers and Speech-Language Pathologists.

Catherine Lavigne
VSHA President
The Missouri Speech-Language-Hearing Association celebrated a big year in Legislative Affairs thanks to the Vice President, Kim Stewart, and the MSHA Legislative Committee.

To prepare for Legislative Day and learn about the legislative process, the MSHA Legislative Webinar was conducted online with 156 attendees on February 10, 2015. Presenters were Dr. Diane Golden, Ms. Jane Webb, Dr. Jayanti Ray, and Ms. Kim Stewart.

MSHA Legislative Day was held February 24, 2015, at the Missouri State Capitol in Jefferson City. There were 118 university students majoring in speech-language pathology/audiology and association members in attendance. Meetings were held throughout the day with legislators in their offices, as well as several legislators visiting and eating lunch with attendees. The MSHA attendees were also able to observe both the House and Senate sessions and take capitol tours.

MSHA sponsored two bills regarding the revision of the Speech Pathology and Audiology Practice Act. The bill sponsors were on hand during a brief meeting and during the hearing testimony given by MSHA representatives that day. The Speech Pathology and Audiology Practice Act bills have been in active mode during the past two years. Several trips were made by members to testify at House and Senate Committees before moving on through the process. The bills were passed through both Missouri legislative chambers and sent to the Governor’s office for final approval by July 14, 2015.

At the MSHA Convention the association presented the ‘Friends of MSHA Award’ to our bill sponsors Senator David Pearce and Representative Dean Dohrman. They remained steadfast with us through the two year process.

Jane Webb, MS, CCC-SLP
Past President
Missouri Speech-Language-Hearing Association
“So what is it that you do?” This is a question I often hear when I attend various events with my husband. He is a substance abuse prevention specialist, and I often accompany him at his conferences and workshops because it allows me to obtain information from a different discipline. This particular conference was more applicable to my profession though, because the focus was prevention of mental illness in infants. As a speech-language pathologist, I was keenly interested in the workshops being presented, but as I looked around the room it was clear that I was the only one present from my field. At lunch that day my husband and I happened to be seated with the Director of the Early Intervention Initiative from the newly blended Ohio Mental Health and Substance Prevention departments. The question came from her. Here was my chance to advocate for my profession: taking a deep breath, I launched into my elevator speech about the benefits of including speech-language pathologists and audiologists in this early intervention initiative.

What is an elevator speech? It is a prepared 30-second to 3 minute presentation that can be employed when one is speaking with anyone who is in the position to benefit your profession. It comes in handy when you attend an event, a conference, a convention or some other type of meeting with networking opportunities (King, 2014). It is a presentation that can best be delivered in the time it takes an elevator to travel from the first floor to the top floor of a building. It is a short description of what you do professionally, often combined with an advocacy pitch or call to action on the part of the person being addressed.

Why would one need an elevator speech? Kim Lewis writes in her recent article that there seems to be an assumption, particularly among those in the helping professions, that sales skills are unnecessary or somehow beneath what we do (ASHA Leader, 2014). On the contrary, our profession is one that is continually in need of elevator speeches so that we can market our services in a way that will make whoever we are talking to want to know more about what we do and to make sure that we are at the table when decisions are being made.

To whom would one present an elevator speech? To anyone and everyone who will listen. The more often you give your short speech the better it will become. Once you get over the initial fear of “selling” what you do, you will find that you will experience such unique reactions to what you are saying that you will easily be able to inject enthusiasm and energy into your short speech. My first presentation of an early version of my elevator speech was to my great-aunt when I was trying to convince her to see a speech-language pathologist after her first stroke. I was aware that all she knew about what I did was the “label” of speech-language pathologist. My elevator speech was to share the benefits that she would receive from working with an SLP; in other words, the skilled and caring person behind the “label”. We never know who might be able to assist us or facilitate greater awareness and utilization of our services, so having the ability to present your speech standing in line at the grocery store, sitting next to a new teacher during the first teacher’s meeting or to the school superintendent at your child’s soccer game, are all possibilities.

How does one develop an elevator speech? It is important to consider your audience. Craft a speech that is developed around the core message you want to deliver. It is important to define your intention by identifying your end goal. Your core outline includes an introduction that captures the listener’s attention; a body that sets the case and establishes credibility; a conclusion that summarizes the main points and finally a close that calls the listener to action. Do you need money to purchase new assessment materials? Do you want your parents or clients to understand the variety of services you can provide? Do you want to make a change in the legislation or rules that dictate how we provide our services? Any of these situations would be an opportunity to use an elevator speech to inform, explain and request. There are a few simple rules and guidelines to follow in the development of this presentation.

1. Tell your story – use examples from your experiences. Including examples and stories helps support your points and makes your speech memorable. A story will help illustrate your point and allows you to make your speech sound effortless, conversational and natural.

2. Use creativity when developing your presentation. Include a compelling “hook” so that the listener will be engaged and involved. The listener is probably thinking “why should I care” so give specific case examples that will draw the listener into your presentation.

3. Write it out and practice, practice, practice. Use concrete, listener-friendly language – not terminology that your listener will not comprehend. Writing and rewriting will allow you to sharpen the focus of your presentation while eliminating unnecessary words. Practice so that you are able to project your passion for what you do.

4. Focus on how, what you do or what you are asking for can benefit the person or the organization. Remember that the listener may be mentally asking “What’s in it for me (WIIFM) or for my organization?” Make sure that you are able to communicate the WIIFM efficiently and effectively.

5. End your speech with an action or next step. What do you want to happen next? Will you contact them by phone or email? Do you want them to contact you with any other questions? If you do not ask for a next step it will not happen.

While it may seem foreign to those of us in this field, developing an elevator speech is an important part of advocating for our profession. The pitch you develop can be adapted for e-mails, a casual conversation in a hallway or even expanded to a more formal presentation to legislators, superintendents or special education directors. My elevator speech with the director at lunch resulted in the inclusion of our profession on the committee for the development of guidelines for working with families of children diagnosed with Neonatal Abstinence Syndrome; the result I wanted. What change would you like to see happen in your work environment or in other professional organizations? Remember that change begins with you developing a speech that will inform and/or persuade. In closing, remember the words of Franklin D. Roosevelt in crafting your speech – Be sincere; be brief; be seated.

References and Resources


Pepperdine University website http://www.bschool.pepperdine.edu/career/content/elevatorSpeech.pdf

Small message. Big difference website http://www.sjodincommunications.com

Janice M. Wright, MA, CCC-SLP
Ohio Speech-Language-Hearing Association
Many thanks to those who supported our legislative efforts to provide some fiscal relief to those Mississippians purchasing hearing aids. Thanks to your efforts and our supportive legislators, Senate Bill 2656 passed the House and Senate and was signed by the Governor on April 14, 2015, authorizing the exemption of sales tax for hearing aids prescribed by a physician, audiologist or hearing aid specialist. Hopefully, in the next legislative session, we can revisit the issue of mandating insurance coverage and support for deaf and hard of hearing individuals in our state. Please remember this legislative agenda item when you come in contact with your area legislators.

The PowerPoint training guide regarding auditory processing disorders and the CAPD screening checklist are now posted on the MSHA website at the following location: http://www.mshausa.org/continuing-education/other-offerings/. The checklist was designed to assist speech-language pathologists with identifying children that need a referral for a CAPD evaluation.

The most recent quarterly Early Hearing Detection and Intervention in Mississippi (EHDI-MS) advisory committee meeting was held in Jackson on May 6. One important item of discussion was the upcoming go live release of the new data management system for the infant hearing screening program in Mississippi. This is designed to provide enhanced data management for all involved in newborn hearing screening throughout the state. A related data management issue that continues to surface is the timely reporting of diagnostic findings on the Audiological Diagnostic/Follow-up Report (Form 53). Current EHDI-MS policies and procedures require a return of this information within a two business day time period following the completion of the diagnostic workup. In addition, if an infant (family) is a “no show” for the second appointment and rescheduling is believed to be futile, the diagnostic center should complete form 53 and fax/mail to the EHDI Diagnostic Coordinator indicating the no show status. This important step will alert the EHDI staff to this potential lost to follow-up situation and initiate certain tracking activities. The EHDI committee is seeking your support in completing this form so together we can improve services for the children of our State. Would it benefit you to have online access to this form? If so, please let me know and I will encourage individuals at EHDI to develop online access for audiologists involved in the diagnostic process to expedite data management.

MSHA’s annual continuing education conference once again delivered an impressive array of continuing education offerings for the audiologists of our state. Conference chairs Ms. Amy Rosonet and Dr. Kim Ward are to be commended for their efforts in recruiting speakers that provided current, relevant information designed to enhance your theoretical and clinical knowledge. I encourage you to participate in next year’s conference and to suggest speakers or content that interest you. As always, if there are issues or concerns, that you would like the Audiology committee to address or if you wish to serve on this committee, please contact me at vp.audiology@mshausa.org.

C.G. Marx
Vice President of Audiology
Mississippi Speech-Language-Hearing Association
Treatment of Cognitive-Communication Disorders: Evidence to Guide Treatment Decisions

Traumatic brain injury (TBI) has received recent national and international attention. TBI is defined as a, “bump, blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain” (Centers for Diseases Control and Prevention, n.d.). Nationally, TBI is a major cause of death and disability (CDC, 2014). While causes vary slightly across age groups, the highest overall reported cause of non-fatal TBI in the United States are from falls (35%), followed by motor vehicle-related injuries (17%), and strikes or blows to the head from or against an object, such as sports injuries (17%) (CDC, 2014). Everyday, 138 people in the United States die from a TBI (CDC, n.d.). For those that survive, the consequences of a TBI can be devastating, including impairments in cognition, movement, sensation and/or emotions that impact daily function (CDC, 2014). Estimates suggest that 3.2 million–5.3 million persons in the United States are living with a TBI-related disability (CDC, 2014).

In recent years, old stereotypes about TBI have gradually begun to fade, with new attention, and most importantly, new evidence emerging. For example, researchers now warn of the long-term impacts of even mild TBI and those of repeated brain injuries (McKee & Robinson, 2014; Maroon, Winkelman, Bost, Amos, Mathyssek, & Miele, 2015). New evidence documents the risk of exposure to explosions for military personnel and their impact on the brain (McKee & Robinson, 2014). In addition, awareness and concern about concussions as a form of brain injury related to sports have increased recently (Committee on Sports-Related Concussions in Youth; Board on Children, 2014). Given their expertise in cognitive-communicative disorders, speech-language pathologists (SLPs) are increasingly called upon to contribute to understanding the impacts of TBI. Deficits in cognition, including the mental processes of thinking, knowing, remembering, judging and problem-solving, are a cardinal feature associated with TBI (Archiniegas, Held, & Wagner, 2002). Broadly defined, cognitive-communication disorders, “encompass difficulty with any aspect of communication that is affected by disruption of cognition” (ASHA, 2005a, para. 2). Once considered a clinical specialty, today it is commonplace for SLPs to offer services to individuals who have experienced a TBI, across a variety of settings. SLPs play an important role in all aspects of cognitive-communicative disorders, including identification, assessment, intervention, counseling, collaboration, case management, education, prevention, advocacy and research (ASHA, 2005a). In terms of intervention, SLPs are charged with selecting and implementing clinically, culturally and linguistically appropriate, evidence-based approaches to intervention (ASHA, 2005a, para.

These include:
- Training discrete cognitive process
- Teaching specific functional skills
- Developing compensatory strategies and support systems
- Providing caregiver training
- Providing counseling and behavioral support services

Generally speaking, cognitive-communication treatment approaches specific to TBI focus either on restoration of skills or compensation for deficits, with the overarching goal of achieving the highest level of independent function in daily living (ASHA, n.d.). Fortunately, SLPs now have many resources to support their treatment decisions in this area. The sections that follow highlight several key resources available specifically for SLPs on the topic of treatment of cognitive-communicative disorders in adults following TBI. In addition to the resources discussed below, readers are also referred to the additional resources listed in Table 2, at the end of this article. While these resources are not exhaustive, practitioners will find many helpful resources on the topic of TBI within each of the internet sites listed, in addition to those discussed below.

Evidence Maps on Treatment for TBI

Evidence maps from the National Center for Evidence-Based Practice in Communication Disorders (NCEP) are available on the topic of treatment for adults following TBI. Located at http://ncepmaps.org/atbi/tx/, NCEP maps sort the current research literature into three levels of evidence. These include external scientific evidence (practice guidelines and systematic reviews), clinical expertise/expert opinion and client/patient/caregiver perspectives. At present, there are nine treatment approaches summarized within NCEP maps on this topic (Table 1). Each of these approaches has a detailed description of the evidence landscape, including primary source links to evidence and a summary of the evidence. Of note, while the information discussed in this resource focuses on evidence maps on the treatment of adults with TBI, NCEP maps are also available for children with TBI at http://ncepmaps.org/ptbi/.

Table 1. NCEP Evidence Map Categories for the Treatment of Adults with TBI.

<table>
<thead>
<tr>
<th>Evidence Maps on Treatment for TBI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coma Stimulation</td>
</tr>
<tr>
<td>Compensatory Treatment</td>
</tr>
<tr>
<td>Computer Assisted Treatment</td>
</tr>
<tr>
<td>Drill and Practice Training</td>
</tr>
<tr>
<td>Dual-Task Training</td>
</tr>
<tr>
<td>Instructional Treatment</td>
</tr>
<tr>
<td>Metacognitive Treatment</td>
</tr>
<tr>
<td>Social Skills Training</td>
</tr>
<tr>
<td>Specific Skills/Functional Training</td>
</tr>
</tbody>
</table>

ASHA New Practice Portal on TBI

ASHA recently added a Practice Portal on the topic of TBI in adults at http://www.asha.org/Practice-Portal/ (ASHA, 2015). It includes many resources for SLPs on this topic, including an overview of basic treatment principles and a summary of several different types of treatment approaches in the area of cognitive-communication disorders for adults with TBI. An ASHA Practice Portal on the topic of TBI in children is also under development.

continued on page 9
ASHA has several policy documents in the area of TBI and cognitive-communicative disorders. Many of these are now housed within the TBI Practice Portal (see above). Primary documents in this area include: a position statement outlining the roles and responsibilities of SLPs in service provision to individuals with cognitive-communication disorders (ASHA, 2005a) and a technical report on the knowledge and skills needed of an SLP to do so (ASHA, 2005b). ASHA policy documents also include a technical report detailing rehabilitative principles in the treatment of adults and children with TBI (ASHA, 2003a) and two documents on interdisciplinary approaches to acquired brain injury and brain damage (ASHA, 1990; Joint Committee on Interprofessional Relations Between the American Speech-Language-Hearing Association and Division 40 of the American Psychological Association, 2007). ASHA policies also include a document explaining the referral and collaborative process between SLPs and neuropsychologists relative to cognitive-communication disorders (ASHA, 2003b).

Clinical Practice Guidelines

Additional evidence to support treatment decisions relative to TBI is also available from the Academy of Neurologic Communication Disorders and Sciences (ANCDS). Between 2002 and 2010, ANCDS published multiple practice guidelines and related documents detailing on the topic of cognitive-communicative disorders in TBI, including guidelines devoted to evidence-based intervention and those detailing research on specific treatment approaches and techniques, such as direction attention training, behavioral and social intervention, external aids for memory compensation and instructional techniques. These documents are available free of charge at http://www.ancds.org/evidence-based-practice-guidelines#TBI.

Conclusion

Evidence-based treatment approaches and sound clinical judgment, based on multiple points of information, is the cornerstone of intervention in the field of speech-language pathology. Now more than ever, SLPs have a variety of resources at their disposable to help guide clinical decisions in the area of cognitive-communication disorders following TBI. These include evidence maps, practice guidelines, and policy documents from ASHA, as well as many online informational sources. With these resources, SLPs can partner with individuals who have experienced a TBI and their families in reaching for the highest level of independent function and communication after an injury.

References


Jennifer A. Ostergren, PhD, CCC-SLP
California State University, Long Beach
Table 2. Additional TBI Internet Resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Center for Disease Control TBI information pages, located at <a href="http://www.cdc.gov/Traumatic-BrainInjury/">http://www.cdc.gov/Traumatic-BrainInjury/</a></td>
<td>The CDC page on TBI contains educational material, data and statistics on the topic, and resources for health care providers and the public. This resource also includes the CDC’s Heads Up Concussion Program targeting education, assessment, and return to play guidelines for concussion in sports, a recent report to Congress on the status of TBI in the United States, and a free, on-line edition of the Journal of Head Trauma devoted to recent evidence on the topic of TBI.</td>
</tr>
<tr>
<td>BrainLine.org, located at <a href="http://www.brainline.org">http://www.brainline.org</a></td>
<td>BrainLine.org is a national multimedia project offering information and resources about preventing, treating, and living with TBI. This site contains resources helpful for both individuals with TBI and their families, as well as clinicians providing services in this area.</td>
</tr>
<tr>
<td>Brain Injury Association of America (BIAA) <a href="http://www.biausa.org">http://www.biausa.org</a></td>
<td>The BIAA is a national advocacy organization. Their website contains listings of support groups and other important information for consumers on the topic of brain injury.</td>
</tr>
<tr>
<td>American Academy of Neurology (AAN), located at <a href="https://www.aan.com">https://www.aan.com</a></td>
<td>AAN is the national professional organization for neurologists. This website contains helpful systematic reviews on topics related to brain injury, including patient materials on related topics.</td>
</tr>
<tr>
<td>National Institute of Neurologic Disorders and Stroke (NINDS) TBI information page, located at <a href="http://www.ninds.nih.gov/disorders/tbi/tbi.htm">http://www.ninds.nih.gov/disorders/tbi/tbi.htm</a></td>
<td>NINDS’ page devoted to TBI offers educational information in this area, as well as details about current research being conducted on this topic and links to recent abstracts and research articles.</td>
</tr>
<tr>
<td>National Institute of Health (NIH) Toolbox, located at: <a href="http://www.nihtoolbox.org/WhatAndWhy/Cognition/Pages/default.aspx">http://www.nihtoolbox.org/WhatAndWhy/Cognition/Pages/default.aspx</a></td>
<td>This website contains resources and standardized tools for researchers interested in employing measures of cognition within treatment studies in the area of cognitive-communication.</td>
</tr>
</tbody>
</table>
2. “A range of passions rather than an unbalanced obsession with work”: What are our passions outside of work? I don’t mean sitting down to watch the favorite weekly television show. I am thinking more about hobbies or interests that truly give us meaning in our lives. What is the last thing outside of work that you really enjoyed doing?

3. “Attention to personal as well as professional development”: I received my first ASHA Award for Continuing Education (ACE) this year. Whereas the intent of this award is to recognize a commitment to continued professional education, it basically means that I spent a great deal of time sitting in conferences. I did learn valuable things that have helped me as a professional, but professional development is not the same as personal development. When was the last time you took a class just for fun?

4. “Dedication to making scholarly and practical contributions to the world”: This is the sine qua non of the academic world, but we can apply it to our discipline. This is perhaps the easiest of McKinney’s six points for us to do well. We are all committed to our discipline and the people whom we serve. If we are burned out, however, our dedication can seem more like an obligation.

5. “The quest for a personal spirituality that includes compassion and curiosity”: This one means different things to different people. I have little doubt that most of us in the professions are both compassionate and curious. Those descriptors—especially the first one—help us do what we do well. The problem is that we can be too oriented towards helping others, and neglect our own wellness.

6. “Laughter and playfulness”: When is the last time you laughed uncontrollably? Was it because of a YouTube video? Was it because of a comedy on television? Or was it during a spontaneous moment of silliness with someone whom you love? When burnout occurs, it can be difficult to have fun. What do you need to do to maintain a sense of fun outside of work?

Attention to developing just one or two of McKinney’s ideas might not make us “fired up,” but they probably can go a long way towards helping us avoid or even emerge from feelings of burnout. Which ones do you need to focus on in the coming months? I know which ones will be important for me.

Douglas F. Parham
CSAP President

This article originally appeared in the November-December 2012 issue of the Kansas Speech-Language-Hearing Association Connection. Reprinted by permission of the author.