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What Life Care Planners Need to Know About the Professional Discipline of Speech-Language Pathology

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Abstract

Speech-Language Pathologists'(SLPS) professional responsibilities include prevention, assessment, diagnosis, and treatment of communication disorders with individuals ranging in age from infancy through geriatrics. Professional practice environments include different research, education and health care settings with varying roles and client populations. Speech language pathologists evaluate and/or treat individuals with cognitive-communication disorders, social communication disorders, speech sound disorders, receptive/expressive/pragmatic language disorders, swallowing impairments, as well as hearing and voice disorders. Speech language pathologists provide communication intervention, working as part of a collaborative, transdisciplinary team in medical and educational settings, including counseling and education to family and caregivers. Many SLPs engage in evidence-based research to provide new assessment and treatment methods as well as training and educating future SLPs.

History and Development of Speech-Language Pathology

Lubinski and Hudson (2017) outlined the history and development of speech-language pathology beginning in the early 1900s, when there were enough self-proclaimed speech correctionists in the United States to form special interest groups. One group comprised of speech correctionists were originally schoolteachers. Like their fellow teachers, they attended meetings of the National Education Association (NEA) and formed a subgroup that was affiliated with the NEA. The group was led by Walter Babcock Swift, an academic at Western Reserve University in Cleveland. This public school group, which called itself the National Society for the Study and Correction of Speech Disorders, began around 1918 and continued under the leadership of Swift until 1939.

A second special interest group, the one that eventually became the American Speech-Language-Hearing Association (after several name changes), was organized by physicians, scholars, and public school administrators who belonged to the National Association of Teachers of Speech. This group formed in 1925, seven years after Swift's group of public school clinicians. It was comprised of approximately 25 members who had been attending and presenting papers at specialized panels of their parent organization.

This group called itself the American Academy of Speech Correction (AASC). The membership was affiliated with university training programs, including departments of speech communication, speech correction programs, psychology and English departments. There were 25 charter members with thirteen from academic training programs, one graduate student, three physicians, two otolaryngologists, and one psychiatrist. Nine founders were affiliated with public or private school speech programs.

The 25 charter members of AASC were committed to keeping their organization small and selective. They aimed to maintain high educational standards in their newly formed discipline, setting the minimal criteria for membership to those with master's degrees or publications records. This disallowed those whom they considered quacks and most of the public school clinicians from Swift's organization, though they did not know of its existence at the time.

The master's degree required by AASC did not have to be in the field of speech correction. Indeed, they could not require a specialty degree in speech-language pathology since there were few graduate programs specializing in speech correction at that time. The leading graduate program, established in 1914, at the University of Wisconsin was well-represented with 20% of the attendees at the early AASC meetings.

Lubinski and Hudson (2017) list the following milestones in the history of speech-language pathology and audiology in the United States in their text book publication titled Professional Issues in Speech-Language Pathology.

- 1870-1914 Period of progressive movement in the United States, one that promoted values that provided a context for development of the helping professions.
- 1914 Establishment of the first graduate-level program in speech pathology organized by Smiley Blanton at the University of Wisconsin.
- 1918 Walter Babcock Swift organized public school clinicians in the Northeast. Their group affiliated with the National Education Association (NEA), was called the National Society for the Study and Correction of Speech Disorders.
- 1922 First commercial audiometer made available.
- 1925 Formation of the American Academy of Speech Correction
- 1926-1927 Formation and approval of the constitution of the American Academy of Speech Correction, including bylaws.
- 1930 American Academy of Speech Correction created an associate level of membership, allowing

practitioners to become members.
- 1934 American Society for the Study of Disorders of Speech renamed the American Speech Correction Association
- 1945 Establishment of audiology as a profession, following World War II.
- 1947 American Speech Correction Association renamed the American Speech and Hearing Association.
- 1952 Two sets of membership requirements were created by American Speech and Hearing Association, one for speech pathology and one for audiology.
- 1952 ASHA separated its membership and credentialing requirements—one could become a member but not be certified as a clinician.
- 1965 Certificate of Clinical Competence was established for both speech pathologists and audiologists.
- 1968 Master's level degree was required to practice in hospitals and agencies.
- 1969 State of Florida began a movement for state certification of professionals in speech pathology to work in non-educational settings.
- 1970 American Speech and Hearing Association published Elaine Pagel Paden's book tracing its 1925 origins.
- 1978 American Speech and Hearing Association renamed the American Speech-Language-Hearing Association (ASHA).
- 1978 Certification and membership requirements were separated. One could become certified without being a member of the association (this has since been reversed).
- 1988 Formation of the American Academy of Audiology (AAA).
- 1993 Language requirements were instituted for certification.
- 1997 The professional doctorate in audiology was established. It went into effect in 2012.
- 1999 First national convention of AAA was held.
- 1999 First issue of the Journal of the American Academy of Audiology was published.
- 1999 Continuing education requirement was established for continued membership in ASHA.
- 2009 James Jerger's book on the history of audiology was published.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 204,000 audiologists, speech-language pathologists and speech, language and hearing scientists, speech-language hearing support personnel, and students. (ASHA, 2019). The vision of the Association for all speech-language pathologists is making effective communication a human right, accessible and achievable for all (ASHA, 2019). The mission is to encourage and support audiologists, speech-language pathologists, and speech, language and hearing scientists by advancing science, setting standards, building excellence in professional practice, and advocating for members and consumers (ASHA, 2019).

Other names by which this profession may be known

Over the years, individuals in the field have been called speech therapists, speech-language pathologists, and speech teachers. The name formally applied to masters or doctoral level practicing clinicians and academicians is speech-language pathologist (SLP) (ASHA, 2019). The term speech therapist is typically used for bachelors level SLPs, some of whom practice in the schools and medical facilities as support personnel. Support personnel use a variety of names including speech-language pathology assistant (SLPA), paraprofessionals, communication aide, or SLP aide.

Content included in basic education

Academic and clinical training begins in the first four years of the undergraduate program with two years of general education courses followed by two years devoted to core courses in communication sciences and disorders, including but not limited to anatomy and physiology, neuroscience, speech science, speech and language development, stuttering, voice, cognitive communication, audiology and speech sound disorders. Undergraduate students may also be introduced to clinical assessment methodology as well as the possibility of some supervised treatment. This varies from program to program and is dependent on the philosophy of the training program. Some programs prefer to wait until the entry level degree which is the master's degree to teach assessment and treatment methodology. The Master's program typically consists of four to seven semesters of advanced study in communication sciences and disorders. Graduate plans of study may include language disorders in children and adults, phonological disabilities, speech and hearing science, augmentative and alternative communication (AAC), stuttering, medical and functional voice disorders including transgender voice therapy, oral and pharyngeal dysphagia (swallowing), craniofacial anomalies, neuromotor disorders of speech, social communication, and research methods and practice. Graduate students receive assessment and treatment training across medical and educational settings. Clinical practicum settings may include medical placements such as inpatient and acute care, rehabilitation, outpatient, long term care, and home health services and educational settings such as early intervention, private and public school settings, and vocational training. Students are trained in the business aspects of private practice settings, in telehealth, and in supervision. Graduate students must obtain 400 clock hours, of which 325 clinical hours must be completed while the student is in the graduate program, and 75 may be obtained at the undergraduate level.

Licensing or mandated certification requirements and authorizing entity that permits practice in this profession

Speech-language pathologists will have a master, doctorate, or other recognized post-baccalaureate degree from a graduate program accredited by the Council on Academic Accreditation in Speech-Language Pathology (CAA). Once the academic coursework and clinical experiences are completed, meeting the knowledge and skills delineated in the CAA standards, the clinical fellowship experience occurs under the mentorship of an individual who holds the ASHA Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP). Prior to applying for certification (the Certificate of Clinical Competence), the applicant must also take the Praxis Examination in Speech-Language Pathology from the Educational Testing Services (ETS) and submit a passing score directly from ETS to ASHA (ASHA, 2019). This Praxis Examination is based on information gathered across all practice settings compiled through skills validation studies and practice analyses.

The Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP), is a nationally recognized professional credential that represents a level of excellence through meeting rigorous academic and professional standards in the field of Speech-Language Pathology. The American Speech-Language-Hearing Association is the nation's leading professional, credentialing, and scientific organization for speech-language pathologists, audiologists, and speech/language/hearing scientists. The American Speech-Language-Hearing Association (ASHA) has been certifying professionals since 1952. The Clinical Certification Program is overseen by the ASHA Council for Clinical Certification in Audiology and Speech-Language Pathology (CFCC)) which establishes minimum standards for the specialty areas of practice.

Speech language pathologists who hold the CCC in Speech-Language Pathology must obtain 30 certification maintenance hours of professional development during every three year period. Collecting the 30 hours and submitting the compliance documentation, following the ASHA Code of Ethics, and paying annual dues or certification fees is required to maintain certification.

The doctoral degrees are the Doctorate of Philosophy (Ph.D.) and Doctor of Education (Ed.D.) degrees, recognized to prepare individuals for careers in research and/or teaching. In 2015, the Ad Hoc Committee on Guidelines for Clinical Doctorate in Speech-Language Pathology developed clinical doctorate guidelines for academic programs offering the clinical doctorate in speech-language pathology (SLP-D)(ASHA, 2015). These guidelines were created in lieu of developing a recognition program or an accreditation program for the SLP clinical doctorate.

Individuals who receive their education outside of the United States or its territories must confirm that the institution bestowing the degree is regionally accredited or recognized by that country. These individuals must also meet the CAA standards including the program of study, knowledge outcomes, skills outcomes, assessment requirements, and then must complete the clinical fellowship experience (ASHA, 2014).

Individuals completing a bachelor's degree may practice as support personnel under the supervision of a certified master's level or certified doctoral level speech-language pathologist.

The following list of requirements addresses more specific state teacher requirements and licensing trends for speech-language pathologists in school/education-based settings. This list can be accessed on the ASHA website (www.asha.org) and is useful in determining the requirements for an SLP to practice in particular states. The chart lists states that allow or require state licensure for school-based SLPs, states that allow or require state licensure with additional requirements for teaching certificate/licensure/endorsements for school-based SLPs, states that require Master's degree for teaching certificate/license for school-based SLPs, states that allow a minimum of a bachelor's degree for emergency and temporary situations (often with proof of enrollment in a master's program), states that allow a minimum of a bachelor's degree for teaching certificate/licensure for school based SLPs and states that allow/require ASHA certification for school-based SLPs. A growing number of states are considering universal licensure, one license for SLPs regardless of where they practice. At this time, approximately twenty states have some form of universal licensure (ASHA, 2019).

The future of speech-language pathology over the next ten years (2019-2029) is positive with an expected growth of 18%, faster than the average for all occupations. This growth is projected because of an expanding aging population (Administration on Aging, 2010; United States Census Bureau, 2018) with medical conditions in speech, language and swallowing, medical advances improving the survival rate of premature infants and trauma and stroke victims, improved awareness and early identification of speech, language and swallowing disorders in young children, increased growth in school enrollments, including special education students, and an increase in the use of SLPs in hospitals and nursing care facilities (ASHA, 2019).

Common specialty areas, roles, and credentials that can expand expertise and scope of contribution to life care plans

Current specialty areas of speech-language pathology beyond the bachelor, master and doctoral degrees include specialty recognitions that are developed within the association structure. The American-Speech-Language-Hearing Association also has a Specialty Certification Board (SCB) which approves applications for new clinical specialty areas listed above. As noted on the ASHA website (ASHA, 2019) currently-approved specialty areas are child language and language disorders supported by the American Board of

Child Language and Language Disorders, fluency and fluency disorders supported by the American Board of Fluency and Fluency Disorders, swallowing and swallowing disorders supported by the American Board of Swallowing and Swallowing Disorders, and intraoperative monitoring supported by the American Audiology Board of Intraoperative Monitoring. In addition, several special interest groups (SIGS) are seeking to establish new specialty certification programs, including augmentative and alternative communication and voice and upper airways disorders. Clinical specialty certification enables a speech-language pathologist with advanced knowledge, skills, and experience beyond the Certificate of Clinical Competence (CCC) to be identified to the public as a Board Certified Specialist (BCS) in a specific area of clinical practice. Holding specialty certification is completely voluntary in an area of clinical practice and is not currently required to practice in that area. However, the added credibility of the BCS in the specific practice area enhances the credibility of the individual's practice skills and knowledge. Each Specialty Certification Board (SCB) is responsible for specifying the educational, experiential, and clinical experience beyond the CCC-SLP with the minimum standards set by the CFCC that must be met to qualify for specialty certification in that BCS's area of practice. Additionally, each BCS is responsible for implementing its specific specialty certification program, including reviewing of individual applications and conferring Board Certified Specialist (BCS) status on qualified applicants (ASHA, 2019).

The kinds of patients and problems usually seen and addressed

Listed below are many of the types of patients and problems typically treated by speech language pathologists.

Misconceptions about what this profession is, or can do,

Accent modification
Augmentative/alternative communication
Assistive technology for communication
Assistive technology for cognition
Aural rehabilitation for adults
Auditory processing disorders
Autism spectrum disorder
Balance system disorders
Bilingual service delivery
Childhood apraxia
Central auditory processing disorders
Classroom acoustics
Craniofacial anomalies; cleft palate/cleft lip
Clinical education and supervision
Cochlear implants for children and adults
Collaborating with interpreters, transliterators, translators
Computer access for speech-language impairments
Cultural competence

Acquired apraxia
Dementia
Dysarthria
Oral and pharyngeal dysphagia
Early intervention
Fluency disorders
Head and neck cancer
Hearing aids
Hearing loss
Hearing screenings
Intellectual disabilities
Late language emergence
Orofacial myofunctional disorders
Permanent childhood hearing loss
Resonance disorders
Right hemisphere damage
Selective mutism
Social communication disorders
Speech sound disorders
Transgender voice
Traumatic brain injuries
Medical and functional voice disorders/ pathologies
Tracheotomy and ventilator dependent patients
Written language disorders

or cannot do

Speech language pathologists make clinical decisions, not medical decisions. Speech-language pathologists consider all medical, neurological and rehabilitation information and then make the best decisions based on all available information. The American Speech Language Hearing Association's Code of Ethics (American Speech-Language-Hearing Association [ASHA], 2016) is the basis for ethical conduct described by Principles of Ethics and by Rules of Ethics. The American Speech Language Hearing Association's (2019) four Principles of Ethics form the underlying philosophical basis for the Code of Ethics and are reflected in the following areas:

> (I) responsibility to persons served professionally and to research participants, both human and animal; (II) responsibility for one's professional competence; (III) responsibility to the public; and (IV) responsibility for professional relationships. Individuals shall honor and abide by these Principles as affirmative obligations under all conditions of applicable professional activity.

The ASHA Code of Ethics is the guidance to members for professional decision-making giving consumers the most successful outcomes.

Information a life care planner who comes from the profession should include in a resume or CV to support the ability to make future care recommendations and information to understand the scope of practice, independence, or limitations of the profession

The speech-language pathologist who is contributing to a life care plan should include his or her degree designation (e.g., Masters, Ph.D., Ed.D.), as well as years of experience in different settings and with different communication disorders in the supporting documentation. This is an important consideration, since a master's level CCC-SLP practicing in one setting (i.e., schools or early intervention) will be less likely to be able to provide the details and prognoses that a life care planner would need for treatment and economic predictions for a child or an adult. Advanced degrees, clinical certification, specialty certification, and a strong foundation of experiences, as well as an interdisciplinary approach, will yield stronger and more accurate information for the life care planner. In addition, the ability to project prognosis and future needs, the economic implications of equipment, technology, and services assists the life care planner in facilitating the most accurate and appropriate life care plan.

Differences between Canadian and U.S. practitioners in this profession

There are differences as well as similarities between US and Canada in the discipline of speech-language pathology (Speech-Language and Audiology, Canada, 2019). First, all of the programs are master's entry level, meaning there are no undergraduate degrees in SLP. The University of Montreal was the last program to have an undergraduate program followed by a master's program. Applicants to SLP programs generally hold degrees in a related field (e.g., linguistics, psychology, neuroscience, etc.), but they can come from any undergraduate field as long as they have the prerequisite coursework. The prerequisites are not in Communication Sciences and Disorders/SLP, but in linguistics, psychology, statistics, neuroanatomy, etc. The specific prerequisites differ across the 12 programs. Dalhousie, Halifax is the exception as it has a three year program and no prerequisites.

Some of the programs have an in-house clinic for introductory placements, but many prefer their students to get all of their clinical practical in real-life settings. Graduates apply for "registration" in the province in which they choose to work (similar to United States state licensure). Speech language pathology is a regulated profession in most provinces, and those provinces have a regulatory "college" that handles registration. In some provinces, the college is separate from the association, but in others, they are part of the same organization. Registration is required to work in any setting including hospitals, rehab centers, clinics, schools, early intervention, private practice, etc. Settings are similar to the settings in the United States. Some school-based SLPs are hired through the healthcare system, but assigned to work in schools, while others are employed by the school boards.

There are currently eight regulated provinces of: British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, and Newfoundland and Labrador (Speech-Language and Audiology, Canada, 2019). They are part of an alliance and are making great progress towards harmonization. Speech language pathologists and audiologists can also earn certification through Speech-Language and Audiology Canada (SAC, formerly Canadian Association of Speech-Language Pathologists and Audiologists, CASLPA). To be "certified" applicants must meet all of the academic and clinical requirements and pass a national certification exam. However, certification is not required to practice in regulated provinces, where it remains optional. Many programs promote certification as the gold standard. In addition, the Mutual Recognition Agreement with ASHA and the Royal College of Speech and Language Therapists (RCSLT) (ASHA Mutual Recognition, 2019) are with SAC and not with the provincial regulators. However, The Canadian Alliance of Audiology and Speech Language Pathology Regulators (CAASPR) will be introducing an "entry to practice" exam in 2020, and at that time the SAC certification exam will be discontinued. It is uncertain what SAC plans to do in terms of certification, and if they will continue to have some additional requirements that set certified professionals apart from registered ones. The questions will be how SAC certification develops and what these new developments will mean for the international mutual recognition agreements. The regulators, at this time, do not acknowledge the mutual recognition agreements, and evaluate internationally educated applicants on an individual

basis following a review of their coursework, clinical hours, etc.

Other information important for life care planners to know

In reviewing someone else's work, speech-language pathologists need information to understand that individual's scope of practice and independence/limitations which includes the individual's credentials (i.e., certification, licensure), training and education, and currency of treatment or assessment of the patient/client. Typically, a speech-language pathologist's most accurate information is gathered from treating or assessing physicians, licensed psychologists, and licensed rehabilitation providers. Additional useful information comes from educators, vocational experts, and mental health providers. Recent assessment and treating information should be given more weight in the review process than more dated information.

The "best" selection of a speech-language pathologist for a life care planning team, is one with advanced degrees, specialty trainings, a wide range of professional experiences, as well as a transdisciplinary understanding of related disciplines and team members' professional perspectives. Background and knowledge in business and economics, an understanding of federal and state educational policies, an introductory knowledge of the legal system, and an understanding of evidence-based outcomes of rehabilitation medicine are added benefits. Although it seems to be a given, the "best" speech-language pathologist should be able to demonstrate excellent written and verbal communication abilities and leadership skills.

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Table 1 Occupational therapist at-a-glance

Definition	"Occupational therapy is a client-centered health profession concerned with promoting health and well-being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement". (WFOT 2012)
Standards of Practice Source	Canada: Essential Competencies of Practice for Occupational Therapists in Canada, 3rd edition. (ACOTRO, 2012) U.S.: Standards and Interpretive Guide (AOTA, 2018) and National Board for Certification in Occupational Therapy, Inc. Professional Practice Standards (NBCOT, 2018).
Scope of Practice	Canada: Determined by each province. Examples: British Columbia states "A registrant may assess occupational performance and modify human and environmental conditions to maintain, restore or enhance occupational performance and health". (Health professions act, 2008). Ontario states "The practice of occupational therapy is the assessment of function and adaptive behaviour and the treatment and prevention of disorders which affect function or adaptive behaviour to develop, maintain, rehabilitate or augment function or adaptive behaviour in the areas of self-care, productivity and leisure." (Occupational Therapy Act, 1991) U.S.: While AOTA has published a document that describes occupational therapy scope of practice they defer to the individual states for specifics. In Minnesota for example, scope of practice includes: skilled observation, or the administration and interpretation of tests and measures. Sensory integrative, neuromuscular, and motor components of performance; development of emotional motivational cognitive or psychosocial components of performance; daily living skills; feeding and swallowing skills; play and leisure skills; education performance; work performance and readiness; ergonomics; orthotics and prosthetics; assistive technology; environmental control; wheelchair and positioning; applying physical agent modalities and the promotion of health and wellness. (State of Minnesota, 2017)
General Goals	To enhance performance of tasks (occupations) through restorative and compensatory treatment approaches.
Use of Diagnoses	Canada: Do not identify diagnoses; use medical diagnoses to guide assessment & intervention U.S.: Provide treatment diagnoses which guides assessment and treatment of the medical diagnoses
Interventions	Wide range of services provided from hands on treatment, to provision of education, program development, and consultation. Populations served range from pediatrics to geriatrics. Treatment interventions address both mental health issues (e.g. cognitive rehabilitation, psychiatric interventions/groups, stress management; pain management skill training) and rehabilitation for physical disabilities (splinting, orthotics, hand therapy, work conditioning, low vision rehabilitation, cardiac rehabilitation, ergonomics, prescribe adaptive equipment/strategies); address basic activities of daily living (eating/swallowing; dressing, bathing) and instrumental activities (e.g. driving rehabilitation, community living skills; housekeeping, employment).
Collaboration in Planning	In clinical practice, the OT coordinates treatment with other disciplines involved. Co-treatment sessions with another discipline occur as needed. Numerous areas of the life care plan such as those dealing with environmental modification, task analysis, task modification, and assistive technology prescription fall within the scope of an occupational therapist. OT life care planners can critique the entirety of an opposing life care plan, however, the occupational therapist must be mindful of the limits of their scope of practice in the development of a life care plan.

American Occupational Therapy Association. 2018. https://www.aota.org/~/media/Corporate/Files/EducationCareers/Accredit/Standards/2011-Standards-and-Interpretive-Guide.pdf

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World Federation Of Occupational Therapists, 2012. http://www.wfot.org/faqs/aboutoccupationaltherapy.aspx

Table 2 Physical therapist at-a-glance

Definition	"Physical therapists are health care professionals who maintain, restore, and improve movement, activity, and health enabling an individual to have optimal functioning and quality of life, while ensuring patient safety and applying evidence to provide efficient and effective care. Physical therapists evaluate, diagnose, and manage individuals of all ages who have impairments, activity limitations, and participation restrictions. In addition, physical therapists are involved in promoting health, wellness, and fitness through risk factor identification and the implementation of services to reduce risk, slow the progression of or prevent functional decline and disability, and enhance participation in chosen life situations. Physical therapy scope of practice is dynamic, evolving with evidence and societal needs." [APTA, 2011]
Standards of Practice Source	The American Physical Therapy Association (APTA) publishes standards of practice. Membership in this professional organization is not required. Each state has laws and rules regulating the practice of physical therapy in that particular state. Every PT is legally obligated to follow the regulations of the state in which they practice, and ethically obligated to follow the professional standards and code of ethics created by the APTA.
Scope of Practice	As provided by the APTA: 1. examining (history, system review and tests and measures) individuals with impairment, functional limitation, and disability or other health-related conditions in order to determine a diagnosis, prognosis, and intervention, 2. alleviating impairment and functional limitation by designing, implementing, and modifying therapeutic interventions, 3. preventing injury, impairment, functional limitation, and disability, including the promotion and maintenance of health, wellness, fitness, and quality of life in all age populations, and 4. engaging in consultation, education, and research.
General Goals	Physical Therapists provide care to patients/ clients of all ages who have impairments, activity limitations, and participation restrictions due to musculoskeletal, neuromuscular, cardiovascular/pulmonary, and/or integumentary disorders.
Use of Diagnoses	The diagnostic process describes the individual condition in terms that will guide the physical therapist in determining the prognosis, plan of care, and intervention strategies. The diagnostic description or classification relates to the primary impairments, activity limitations, and participation restrictions toward which the physical therapist establishes goals and selects interventions.
Interventions	Examination and assessment, therapeutic exercise, gait training, neuromuscular re-education, functional therapeutic activities training, manual therapy, vestibular treatment/ canalith repositioning, various modalities such as electrical stimulation, ultrasound, heat and cold therapy, dry needling, education, collaboration and conferencing with other care providers.
Collaboration in Planning	A physical therapist, many times, is the care provider who, by the nature of the treatment plan, is afforded the most one on one time with the patient/client. Physical therapists therefore have a unique opportunity to monitor and discuss responses to interventions not only provided by the PT, but by other medical professionals. A PT must discuss those interventions out of the scope of PT practice with the appropriate provider.

American Physical Therapy Association (2011). Today's Physical Therapist: A Comprehensive Review of a 21st Century Health Profession.

Table 3 Physician Physiatrist at-a-glance

Definition	A physician deals with promoting, maintaining, and restoring health. This is accomplished through diagnosis and treatment of the disease. This may include physical or mental diagnoses.
Standards of Practice Source	American Medical Association (AMA, 2016); American Academy of Physical Medicine and Rehabilitation
Scope of Practice	PM&R specialists take care of patients in both the inpatient and outpatient setting. In the inpatient setting, the PM&R may take over care of the patient when in the acute rehabilitation setting. The physiatrist will coordinate all aspects of the patient care while inpatient. The physiatrist is sufficiently knowledgeable about other medical specialties to determine whether proper treatment is being ordered.
General Goals	To appropriately diagnose conditions and offer appropriate treatment options. To improve functional ability and prevent additional complications. Focus is on relieving impairments in functional status arising from physical and/or mental diagnoses, including personal care activities of daily living, instrumental activities of daily living, social function, work function, community function.
Use of Diagnoses	ICD-10-CM is a diagnosis identification tool, which is developed and maintained by National Center for Health Statistics (NCHS) under the Centers for Disease Control and Prevention (CDC). The Health Insurance Portability and Accountability Act (HIPPA) named it as the standard code for reporting diagnoses. The ICD-10 is copyrighted by the World Health Organization (WHO), which owns and publishes the classification. (CDC NCHS 2018).
Interventions	Must demonstrate competency to perform procedures either in residencies, fellowship or undergo proctoring in the clinical setting. Interventions are described by Current Procedural Terminology (CPT) codes, which is developed and maintained by the AMA. Interventions are also described by ICD-10-PCS. Permitted to perform all coded interventions in which competency is demonstrated. (AMA 2018)
Collaboration in Planning	The physician functions as the quarterback taking in information from all the subspecialists, therapists, and nurses involved with a patient and recommending a treatment plan. In the quarterback role, a PM&R specialist will discuss/suggest what other specialists are going to do and has the authority to agree whether or not other peoples' interventions are appropriate. Highly specialized or uncommon interventions may require consultation with other specialists to include in a life care plan.

American Medical Association. 2018. https://www.ama-assn.org/practice-management/cpt-current-procedural-terminology

Centers for Disease Control and Prevention National Center for Health Statistics. 2018. https://www.cdc.gov/nchs/icd/icd10cm.htm

Table 4 Psychologist at-a-glance

Definition	Psychology is the study of the mind and behavior. The discipline embraces all aspects of the human experience — from the functions of the brain to the actions of nations, from child development to care for the aged. In every conceivable setting from scientific research centers to mental healthcare services, "the understanding of behavior" is the enterprise of psychologists. (American Psychological Association, 2018.)
Standards of Practice Source	The American Psychological Association (APA) is considered a primary reference regarding standards of practice. The APA has a wide range of guidelines for the general practice of psychology, as well as a wide range of specialty issues including evaluations, clinical issues, diverse populations, treatment, etc. Different psychology specialty boards outside of the APA, such as forensic psychology, neuropsychology, medical prescribing psychology, etc., may also offer their own standards.
Scope of Practice	Scope of practice is determined by licensure, training and experience. Psychologists practice in solo, group, educational, community, medical, institutional and other settings. Areas of practice can expand with additional training and/or supervised experience. Psychologists often work in in multi-disciplinary, inter-disciplinary or trans-disciplinary settings.
General Goals	To accurately describe, explain, predict, and change human behavior and mental processes. Behavior and mental processes include trauma, grief, learning, intelligence, cognition, emotional and behavioral reactions, thinking, reasoning, intra and interpersonal interactions, socialization, developmental processes, behavioral / emotional / psychiatric decompensation, crisis intervention, addictions, assessment, rehabilitation, medical issues, criminality, etc.
Use of Diagnoses	The type of diagnosis used depends on the nature of the referring question, requested services, the psychologist's involvement and other professionals involved in the case. DSM5 taxonomies and ICD-10-CM coding are the most prevalent, but functional behavior analysis, developmental profiles, psychoeducational assessments and other evaluative profiles are also pertinent according to the case.
Interventions	Ranging from assessment to individual 1:1 therapeutic process to group and cultural interventions. Interventions may occur in clinics, schools, medical and rehabilitative facilities, natural environments and most any other environment or situation where humans exist. With the exception of prescribing psychologists, most states preclude psychologists from making medical decisions or representing that they can do so.
Collaboration in Planning	Psychologists frequently share their professional opinions with other involved disciplines and participate in treatment team and other multiple disciplinary meetings. They also provide guidance regarding issues of psychological well-being and vulnerability in terms of how services by others or conditions or situations outside of their purview can affect a person's actions, outcomes and safety. Psychologists may also solicit the recommendations and findings of other involved parties in developing their own assessments and service delivery. Psychologists are required by law to report concerns regarding possible abuse, neglect, potential imminent harm to self or others to appropriate state agencies.

Table 5 Registered Nurse at-a-glance

Definition	Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, facilitation of healing, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, groups, communities, and populations. (American Nurses Association 2018)
Standards of Practice Source	RN: American Nurses Association, applicable to all registered nurses. Clinical or role specialty may have additional Standards. Nurses may engage in multidisciplinary roles that have additional Standards. Thus, a nurse may simultaneously be subjected to multiples Standards.
Scope of Practice	Generalist and specialist roles in a variety of provider-based and community-based settings. Competency should be demonstrated in all activities encompassed by a role and setting. All RNs have authority to assess, interpret, define nursing diagnoses, set goals, plan interventions, implement, and evaluate. Specialty training and/or certification expands the scope and abilities. The nurse may have prescriptive authority if a nurse practitioner.
General Goals	To achieve or improve self-management of conditions and bodily functions; to prevent complications and co-morbidities; to promote full participation in all community roles and settings. Goals encompass physical, emotional, psychological, social aspects using a holistic approach that considers the individual, significant other, community, resources, and environmental factors.
Use of Diagnoses	Nursing diagnoses identify human responses to health, illness, and injury; nursing diagnoses are created and approved by NANDA-I. Nurses do not determine medical diagnoses, but use them to inform their assessment and planning.
Interventions	Ranges from hands-on treatments to education and consultation. Permitted to perform certain invasive procedures. Collaborates with others to identify all interventions and may perform interventions identified by other disciplines (trans-disciplinary). Becomes liable when performing or facilitating interventions ordered by another disciple, thus the collaboration includes ascertaining appropriateness of the intervention.
Collaboration in Planning	RNs routinely assess the impact of interventions done by other disciplines and must be prepared to implement actions in the case of adverse consequences. RNs contribute to team conferencing that includes discussion of proposed actions. RNs may perform actions ordered by other disciplines and share legal liability, thus RNs must believe that those actions are appropriate and safe. RNs facilitate communication and planning between disciplines so need to be aware of compatibility and risks of planned actions.

Table 6 Rehabilitation Counselor at-a-glance

Definition	A rehabilitation counselor reflects the discipline's focus of providing required services to return a person, with a disability, to the highest degree of community, vocational, recreational and independent functioning possible.
Standards of Practice Source	CRCC Code of Professional Ethics
Scope of Practice	https://www.crccertification.com/crc-crcc-scope-of-practice
General Goals	Return a person, with a disability, to the highest degree of community, vocational, recreational and independent functioning possible. Addresses ability and adjustment to disability, particularly vocational potential.
Use of Diagnoses	Depending on training acquired, some counselors diagnose mental health conditions based on the DSM-V, others diagnose potential for employment. Rules about the ability to diagnose mental disorders vary from state to state. State licensing boards can be referenced for specific state allowances regarding diagnoses.
Interventions	Vocational Assessments, including vocational evaluation interviews, testing and rehabilitation plan development.
Collaboration in Planning	Rehabilitation Counselors work frequently with inter-disciplinary treatment teams, rehabilitation facilities, education and training programs, and families to develop, monitor, adjust, and ensure the success of rehabilitation plans.

Table 7 Speech-Language Pathologist at-a-glance

Definition	"The speech-language pathologist is the professional who engages in clinical services, prevention, advocacy, education, administration, and research in the areas of communication and swallowing across the life span from infancy through geriatrics. Speech-language pathologists address typical and atypical impairs and disorders related to communication and swallowing in the areas of speech sound production, resonance, voice, fluency, language (comprehension and expression), cognition, and feeding and swallowing." (ASHA, 2014)
Standards of Practice Source	Speech-Language & Audiology Canada: The Canadian Alliance of Audiology and Speech Language Pathology Regulators (Speech-Language and Audiology Canada, 2019) American Speech-Language-Hearing Association: Council of Academic Accreditation (ASHA, 2014)
Scope of Practice	The overall objective of speech-language pathology services is to optimize individuals' abilities to communicate and to swallow, thereby improving quality of life. Services are provided across the lifespan. Service delivery areas include all aspects of communication and swallowing and related areas that impact communication and swallowing: speech production, fluency, language, cognition, voice, resonance, feeding, swallowing, and hearing. With the practice of speech-language pathology continually evolving, SLPs play critical roles in health literacy; screening, diagnosis, and treatment of autism spectrum disorder; and use of the *International Classification of Functioning, Disability and Health* (ICF; World Health Organization [WHO], 2014) to develop functional goals and collaborative practice. As technology and science advance, the areas of assessment and intervention related to communication and swallowing disorders grow accordingly. (ASHA, 2016)
General Goals	The eight domains of speech-language pathology service delivery are collaboration; counseling; prevention and wellness; screening; assessment; treatment; modalities, technology, and instrumentation; and population and systems. SLPs address communication, speech, language, hearing, and swallowing within these eight domains. For more detail please refer to the ASHA Scope of Practice (ASHA, 2016)
Use of Diagnoses	Current Procedural Terminology (CPT), Healthcare Common Procedure Codes (HCPCS), International Classification of Diseases, 10th revision, Clinical Modifications (ICD-10) are used for diagnostic and billing determinations.
Interventions	Clinical areas of service may include, but are not limited to: speech sound production; resonance; voice; fluency; pre-linguistic communication; language comprehension and expression; pre-literacy and literacy skills; cognitive communication; social (pragmatic) communication; executive functions; feeding and swallowing; alternative and augmentative communication; aural (re)habilitation; accent modification; and the impacts of communication and swallowing disorders on everyday life across the lifespan. Must demonstrate competency to perform procedures such as oral peripheral examinations, administer tests and interpret the obtained data during internships, clinical fellowship year, understand diagnosis provided, and contribute to the overall well-being of the client. (ASHA,2019)
Collaboration in Planning	Speech-language pathologists may practice independently or within an inter-professional framework, collaborating with other professionals such as audiologists, physicians, nurses, educators, dietitians, occupational therapists, physiotherapists, psychologists, child care staff and social workers, as well as communication health assistants. Speech-language pathologists provide a broad range of clinical and other professional services. Work collaboratively with other disciplines, educate, mentor and train caregivers, school and allied health professionals, participate in multi-disciplinary treatment teams and provide plans and recommendations focused on speech, language and communication skills.

American Speech-Language-Hearing Association (2016) Scope of Practice in Speech-Language Pathology. Retrieved February 20, 2019. https://www.asha.org/policy/SP2016-00343/

American Speech-Language-Hearing Association. (2014). "New National Definition Broadens SLPs' Scope of Practice". https://leader.pubs.asha.org/doi/10.1044/leader.NIB2.19112014.11 Retrieved January 23, 2019.

Council for Clinical Certification in Audiology and Speech-Language Pathology of the American Speech-Language-Hearing Association (2014). 2014 Standards for the Certificate of Clinical Competence in Speech-Language Pathology. Retrieved [February 19, 2019] from http://www.asha.org/Certification/2014-Speech-Language-Pathology-Certification-Standards/

Table 1 Occupational Therapist Contributions to Life Care Plan Recommendations

Care Category	Can Occupational Therapist Make Recommendation?
Physician (MD, DO, DC, DDS) Referral to Evaluate/Consult	Can refer to some specialists within scope of practice, otherwise collaborative
Physician (MD, DO) On-Going Visits	Outside of scope of practice
Chiropractic Visits	Outside of scope of practice
Dentist On-Going Visits and Sedation	Outside of scope of practice
Ancillary (Non-physician Professionals) Referrals	Within scope of practice to recommend referrals
Ancillary On-Going Visits	Within scope of practice for OT, otherwise not within scope of practice
Diagnostic Testing	Outside of scope of practice
Surgery	Outside of scope of practice
Aggressive Interventions (e.g., Invasive Procedures, Specialty Programs)	Outside of scope of practice, except that acupuncture may be performed by Canadian OT with training
Wheelchairs, Including Features and Accessories	Within scope of practice
Other Mobility Equipment	Within scope of practice
Orthotics	Within scope of practice
Prosthetics	Collaborative
Other Medical Equipment	Collaborative for some equipment or outside of scope of practice
Adaptive Aids for Independent Function	Within scope of practice
Drugs Requiring Prescription	Outside of scope of practice
Over-the-Counter Drugs	Outside of scope of practice
Disposable Supplies	Outside of scope of practice
Home Care Skill Level (to Attend to Person) (i.e., unlicensed aide, licensed nurse)	Within scope of practice to identify need for assistance and level of assistance
Home Care Hours	Within scope of practice
Household (housekeeping, yard care, house repairs) Services and Hours	Within scope of practice

Table 2 Physical Therapist Contributions to Life Care Plan Recommendations

Care Category	Can Physical Therapist Make Recommendation?
Physician (MD, DO, DC, DDS) Referral to Evaluate/Consult	Within scope of practice for specialists within similar practice area, otherwise outside of scope of practice
Physician (MD, DO) On-Going Visits	Outside of scope of practice
Chiropractic Visits	Within scope of practice
Dentist On-Going Visits and Sedation	Outside of scope of practice
Ancillary (Non-physician Professionals) Referrals	Within scope of practice for OT, SLP, acupressure, massage; collaborative for psychology
Ancillary On-Going Visits	Within scope of practice for PT, OT, acupressure, massage, otherwise outside of scope of practice
Diagnostic Testing	Collaborative for some tests, otherwise outside of scope of practice
Surgery	Outside of scope of practice
Aggressive Interventions (e.g., Invasive Procedures, Specialty Programs)	Within scope of practice for specialty programs within practice area, such as chronic pain functional restoration program or TBI program, otherwise outside of scope of practice
Wheelchairs, Including Features and Accessories	Within scope of practice
Other Mobility Equipment	Within scope of practice
Orthotics	Within scope of practice
Prosthetics	Collaborative
Other Medical Equipment	Within scope of practice or collaborative
Adaptive Aids for Independent Function	Within scope of practice
Drugs Requiring Prescription	Outside of scope of practice
Over-the-Counter Drugs	Outside of scope of practice
Disposable Supplies	Within scope of practice or collaborative
Home Care Skill Level (to Attend to Person) (i.e., unlicensed aide, licensed nurse)	Within scope of practice
Home Care Hours	Within scope of practice

Table 3 Physician Physiatrist Contributions to Life Care Plan Recommendations

Care Category	Can Physician Physiatrist Make Recommendation?
Physician (MD, DO, DC, DDS) Referral to Evaluate/Consult	Within scope of practice
Physician (MD, DO) On-Going Visits	Within scope of practice
Chiropractic Visits	Collaborative
Dentist On-Going Visits and Sedation	Within scope of practice
Ancillary (Non-physician Professionals) Referrals	Within scope of practice
Ancillary On-Going Visits	Collaborative
Diagnostic Testing	Within scope of practice
Surgery	Within scope of practice to identify need; may be collaborative to determine some details
Aggressive Interventions (e.g., Invasive Procedures, Specialty Programs)	Within scope of practice or collaborative depending on intervention
Wheelchairs, Including Features and Accessories	Within scope of practice to identify need; may be collaborative to determine some details
Other Mobility Equipment	Within scope of practice to identify need; may be collaborative to determine some details
Orthotics	Within scope of practice or collaborative
Prosthetics	Collaborative
Other Medical Equipment	Within scope of practice or collaborative depending on equipment
Adaptive Aids for Independent Function	Within scope of practice to identify need; may be collaborative to determine some details
Drugs Requiring Prescription	Within scope of practice
Over-the-Counter Drugs	Within scope of practice
Disposable Supplies	Within scope of practice to identify need; collaborative to determine details
Home Care Skill Level (to Attend to Person) (i.e., unlicensed aide, licensed nurse)	Collaborative
Home Care Hours	Collaborative
Household (housekeeping, yard care, house repairs) Services and Hours	Collaborative

Table 4 Psychologist Contributions to Life Care Plan Recommendations

Care Category	Can Psychologist Make Recommendation?
Physician (MD, DO, DC, DDS) Referral to Evaluate/Consult	Within scope of practice
Physician (MD, DO) On-Going Visits	Outside of scope of practice
Chiropractic Visits	Outside of scope of practice
Dentist On-Going Visits and Sedation	Outside of scope of practice
Ancillary (Non-physician Professionals) Referrals	Within scope of practice
Ancillary On-Going Visits	Collaborative
Diagnostic Testing	Within scope of practice for psychological testing, otherwise outside of scope of practice
Surgery	Outside of scope of practice
Aggressive Interventions (e.g., Invasive Procedures, Specialty Programs)	Within scope of practice for psychological interventions, otherwise outside of scope of practice
Wheelchairs, Including Features and Accessories	Outside of scope of practice to prescribe but collaborative on factors that affect use
Other Mobility Equipment	Outside of scope of practice to prescribe but collaborative on factors that affect use
Orthotics	Outside of scope of practice to prescribe but collaborative on factors that affect use
Prosthetics	Within scope of practice for cognitive/behavioral prosthetics, otherwise outside of scope of practice
Other Medical Equipment	Outside of scope of practice to prescribe but collaborative on factors that affect use
Adaptive Aids for Independent Function	Within scope of practice for cognitive/behavioral aids, otherwise outside of scope of practice
Drugs Requiring Prescription	Outside of scope of practice except for allowed drugs for prescribing psychologists (4 states, U.S. Defense Department, U.S. Public Health Service, and Indian Health Service)
Over-the-Counter Drugs	Outside of scope of practice except for prescribing psychologists
Disposable Supplies	Within scope of practice if related to psychological treatment, otherwise outside of scope of practice
Home Care Skill Level (to Attend to Person) (i.e., unlicensed aide, licensed nurse)	Collaborative related to cognitive and behavioral capacity or needs
Home Care Hours	Collaborative related to cognitive and behavioral capacity or needs

Table 5 Registered Nurse Contributions to Life Care Plan Recommendations

Care Category	Can Registered Nurse Make Recommendation?
Physician (MD, DO, DC, DDS) Referral to Evaluate/Consult	Within scope of practice
Physician (MD, DO) On-Going Visits	Within scope of using evidence-based practice guidelines or collaborative
Chiropractic Visits	Collaborative
Dentist On-Going Visits and Sedation	Collaborative
Ancillary (Non-physician Professionals) Referrals	Within scope of using evidence-based practice guidelines or collaborative
Ancillary On-Going Visits	Collaborative
Diagnostic Testing	Within scope of using evidence-based practice guidelines or collaborative
Surgery	Outside of scope of practice
Aggressive Interventions (e.g., Invasive Procedures, Specialty Programs)	Within scope of using evidence-based practice guidelines, such as TBI rehabilitation programs, outside of scope of practice
Wheelchairs, Including Features and Accessories	Within scope of practice for standard chairs, collaborative for custom chairs, outside of scope of practice for fitting
Other Mobility Equipment	Within scope of practice or collaborative
Orthotics	Collaborative
Prosthetics	Collaborative
Other Medical Equipment	Within scope of practice or collaborative
Adaptive Aids for Independent Function	Within scope of practice or collaborative
Drugs Requiring Prescription	Within scope of practice for nurses with prescriptive authority, otherwise outside of scope of practice
Over-the-Counter Drugs	Within scope of practice or collaborative
Disposable Supplies	Within scope of practice or collaborative
Home Care Skill Level (to Attend to Person) (i.e., unlicensed aide, licensed nurse)	Within scope of practice or collaborative
Home Care Hours	Within scope of practice or collaborative

Table 6 Rehabilitation Counselor Contributions to Life Care Plan Recommendations

Care Category	Can Rehabilitation Counselor Make Recommendation?
Physician (MD, DO, DC, DDS) Referral to Evaluate/Consult	Outside of scope of practice
Physician (MD, DO) On-Going Visits	Outside of scope of practice
Chiropractic Visits	Outside of scope of practice
Dentist On-Going Visits and Sedation	Outside of scope of practice
Ancillary (Non-physician Professionals) Referrals	Within scope of practice
Ancillary On-Going Visits	Within scope of practice for rehabilitation counseling and case management, otherwise outside of scope of practice
Diagnostic Testing	Outside of scope of practice
Surgery	Outside of scope of practice
Aggressive Interventions (e.g., Invasive Procedures, Specialty Programs)	Outside of scope of practice
Wheelchairs, Including Features and Accessories	Collaborative
Other Mobility Equipment	Collaborative
Orthotics	Outside of scope of practice
Prosthetics	Outside of scope of practice
Other Medical Equipment	Within scope of practice for some equipment, otherwise collaborative or outside scope of practice
Adaptive Aids for Independent Function	Within scope of practice for some aids, otherwise collaborative or outside scope of practice
Drugs Requiring Prescription	Outside of scope of practice
Over-the-Counter Drugs	Outside of scope of practice
Disposable Supplies	Within scope of practice for some supplies, otherwise collaborative or outside scope of practice
Home Care Skill Level (to Attend to Person) (i.e., unlicensed aide, licensed nurse)	Within scope of practice
Home Care Hours	Within scope of practice
Household (housekeeping, yard care, house repairs) Services and Hours	Within scope of practice

Table 7 Speech-Language Pathologist (SLP) Contributions to Life Care Plan Recommendations

Care Category	Can SLP Make Recommendation?
Physician (MD, DO, DC, DDS) Referral to Evaluate/Consult	Within scope of practice
Physician (MD, DO) On-Going Visits	Must collaborate with others
Chiropractic Visits	Outside of scope of practice
Dentist On-Going Visits and Sedation	Outside of scope of practice
Ancillary (Non-physician Professionals) Referrals	Within scope of practice
Ancillary On-Going Visits	Within scope of practice for SLP services Otherwise must collaborate with others
Diagnostic Testing	Within scope of practice for tests within ASHA Scope of Practice and Code of Ethics Other tests outside of scope of practice
Surgery	Outside of scope of practice
Aggressive Interventions (e.g., Invasive Procedures, Specialty Programs)	Within scope of practice for fiberoptic endoscopic assessments (invasive) and treatment; video fluoroscopic assessments of swallowing, neuromuscular electrical stimulation for swallowing impairments Other interventions outside of scope of practice
Wheelchairs, Including Features and Accessories	Within scope of practice for features to accommodate augmentative communication technology for communication, writing, reading Otherwise outside of scope of practice
Other Mobility Equipment	Within scope of practice for features to accommodate augmentative communication technology for communication, writing, reading Otherwise outside of scope of practice
Orthotics	Outside of scope of practice
Prosthetics	Within scope of practice for voice prosthetics Otherwise outside of scope of practice
Other Medical Equipment	Within scope of practice for: • communication tools • voice prosthetics • tools to assist memory • apps to assist communication, reading writing and memory skills • computer technology