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School-Based Telepractice Assessment (STA)

Guidance for Evaluating School-Based Speech–Language Telepractice Service Delivery

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Over 50% of American Speech-Language-Hearing Association (ASHA)-certified speech–language pathologists (SLPs) are employed in schools (ASHA, n.d.). Speech–language pathologists increasingly provide services to students with speech and language disorders via telepractice. ASHA's Roles and Responsibilities of Speech-Language Pathologists in Schools document states that telepractice services must be comparable to in-person services (ASHA, 2010). This article presents the School-Based Telepractice Assessment (STA; Lundblom et al., 2021), comprising aspirational questions related to compliance with federal legislation; personnel; roles and responsibilities of school-based SLPs; and privacy and security issues. The STA is designed for use by SLPs, school administrators, and contracted providers. The guide comprehensively evaluates the range of school-based telepractice components such as diagnostic and therapeutic services, the use of support personnel consultation, preventative services, integration with the school culture and curricula, and compliance with federal regulations. The STA can guide both school-based SLPs and administrators as they prepare for telepractice service delivery and later appraise whether the telepractice services are comparable to in-person school-based practice. **Key words:** *ASHA Code of Ethics*, *IDEA*, *schools*, *telepractice*

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THIS ARTICLE and the School-Based Telepractice Assessment (STA) tool described therein were primarily written for speech–language pathologists (SLPs) newly coming to both telepractice and school-based practice who may not be familiar with U.S. federal educational law and/or the requirements of effective and lawful telepractice. Although the article focuses on school practice based in the United States, the aspirational components of the STA also can be applied

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to international telepractice. The STA also may be helpful to administrators, as they prepare for telepractice service delivery and later appraise whether the telepractice-delivered services are comparable to in-person school-based practice.

INTRODUCTION TO SCHOOL-BASED TELEPRACTICE

Telepractice is a maturing and expanding service delivery mechanism for school-based speech–language pathology services. The coronavirus disease-2019 (COVID-19) pandemic necessitated a precipitous shift to remote schooling and the adoption of telepractice to enable many SLPs to continue providing clinical services during the pandemic. Challenges brought about by the pandemic, paired with personnel shortages, influenced some districts' capacity to provide in-person speech and language services to students in school-based settings, hence fueling the growth of telepractice.

Even before the COVID-19 pandemic resulted in an expansion of telepractice, schools were the most common settings for telepractice. This was due to a number of factors, including shortages of clinicians in some school districts and distances between schools in rural areas (American Speech-Language-Hearing Association [ASHA], 2019b). The ASHA Schools Surveys provide some historical data on telepractice use in educational settings pre-pandemic. In 2014, nearly all respondents (97%) indicated telepractice was not used in their school district (ASHA, 2014). Respondents on the 2020 Schools Survey indicated they provided less than 1 hr per week of services via telepractice (ASHA, 2020). Some ASHA Schools Survey data indicated telepractice services were used by contracted service providers for a school district (ASHA, 2014, 2018). The exponential increase in telepractice to adjust to the COVID-19 pandemic makes it imperative to gauge how widespread the use of telepractice has become in educational settings, how telepractice will be used in the future, and the quality of telepractice services.

Preceding the expansion of telepractice, the roles and responsibilities of school-based SLPs have expanded over the past decades, as legal mandates, including education reform, emphasized the need to promote integration of services for students with disabilities with the general curriculum. Challenges have persisted for school-based clinicians: personnel shortages, large amounts of paperwork, high caseloads/workloads, volume of meetings, budget constraints, incorporating optimal service delivery models, and limited time for collaboration (ASHA, 2016b, 2018, 2020).

An increasing body of research provides evidence that telepractice service delivery can be as effective as in-person service delivery for a variety of clinical disorders, including for children with language disorders (Gabel et al., 2013; Musaji et al., 2021). The ASHA Telepractice website states:

> The effectiveness of telepractice as a service delivery model in the schools is well documented (Gabel et al., 2013; Grogan-Johnson et al., 2010, 2011, 2013; Lewis et al., 2008; McCullough, 2001).

It is not the purpose of this article to review the evidence for telepractice across types of disorders; readers instead are referred to the frequently updated content in the Telepractice section of the ASHA website for research relating to the use of telepractice for specific speech, language, and swallowing disorders. This website also reports that telepractice is an effective service delivery model in schools and provides updated resources and references (ASHA, 2019b). Although a detailed presentation of such research is beyond the scope of this article, the premise that telepractice (specifically, school-based telepractice) is an effective service delivery model is foundational to this article.

THE SCHOOL TELEPRACTICE ASSESSMENT TOOL

To recognize and address some of the challenges faced for telepractice to achieve parity

with SLP practice delivered in-person or in a student's home, this article provides a broad-based audit instrument. The STA (Lundblom et al., 2021) presented in Appendix A consists of aspirational questions, bundled into five categories: (1) compliance of telepractice delivery with federal legislation; (2) personnel policies; (3) roles and responsibilities of SLPs in schools; (4) telepractice privacy, security, and safety protocols; and (5) consent policies and program evaluation. The STA is designed for use by SLPs, school administrators, and contracted providers to document what aspects of traditional (i.e., in-person) school-based speech–language services are or will be provided by telepractice. It also includes questions that examine the operational imperatives for safe and competent telepractice. This tool uniquely brings together multiple components that must be considered for telepractice service delivery that is comparable to in-person service.

The content of the STA draws upon U.S. federal legislation (U.S. Department of Education, 2000), the ASHA Code of Ethics (ASHA, 2016a), ASHA's Professional Issues Policy Statement: Roles and Responsibilities of the School-based Speech-Language Pathologist (2010), the American Telemedicine Association Standards and Guidelines (Richmond et al., 2017), and published work by Gupta et al. (2014), Watzlaf et al. (2015), Zhou et al. (2019), and Cohn and Cason (2019). The STA was originally presented in an open-source, subscription-free repository of knowledge (Lundblom et al., 2021). Readers may download the STA without permission and use it with attribution. Questions may be reframed, added, or deleted to suit the specific needs of a clinician, researcher, and/or school. In addition to guiding program evaluation (e.g., via an analysis of strengths, weaknesses, threats, and opportunities [SWOT], or a quality improvement process), the tool is meant to be aspirational and to assist school personnel in planning for and/or evaluating the scope of their school-based telepractice to ensure that the scope is comparable to in-person school-based practice. These self-examinations can be implemented in any country with the evaluation taking into account the unique cultural and regulatory considerations of that country. Although the STA is not a standardized assessment tool that yields a score, it has high face validity with current literature. It should not be used to derive a percentage of compliance, because many of the elements are singularly essential to the safe and lawful use of telepractice in the U.S. school environment.

STA CONSIDERATIONS

Compliance with educational law

Telepractice use in educational settings must meet educational legislation and regulations for service providers. Three federal laws, the Individuals with Disabilities Education Act (IDEA, 2004), Title II of the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act, variously address the obligations of public schools to meet the needs of students with disabilities as noted in Table 1, with content informed by Gupta et al. (2014). Each is important to consider when providing speech and language services, because state education agencies (SEAs) and local education agencies (LEAs) must comply with all. Furthermore, these regulatory requirements were not rescinded or revised during the COVID-19 pandemic; SEAs and LEAs were required to comply to help ensure that students with disabilities received an equitable educational opportunity to meet their individual needs (U.S. Department of Education Office of Special Education and Rehabilitative Services and Office of Special Education Programs, 2021).

In response to the COVID-19 pandemic, SEAs and LEAs were advised that the requirements of Section 504 and Title II of the Americans with Disabilities Act (Title II) must be met. To meet the requirements of these laws, schools must make individualized decisions to ensure that students with disabilities are receiving appropriate aids, services, and accommodations/modifications

Table 1. Overview of federal legislation

Legislation	Description
The Individuals with Disabilities Education Improvement Act (IDEA) of 2004	Requires public schools to provide every student with a disability a free appropriate public education (FAPE) designed to provide meaningful educational benefit through an individualized education program (IEP) in the least restrictive environment (LRE).
Title II of the Americans with Disabilities Act of 1990	Students with disabilities have equal opportunity to participate in all school activities. Requires schools to provide, without charge, auxiliary aids and services to ensure that students with disabilities can communicate as effectively as all other students, with primary consideration of students' and parents' preferences. Students with disabilities are covered regardless of their eligibility for special education and related services under the IDEA.
Section 504 of the Rehabilitation Act of 1973	Applies to the operations of all public school districts and prohibits discrimination based on disability. Students with disabilities receive FAPE and related aids and services to meet individual education needs as adequately as nondisabled students. Students with disabilities are covered regardless of their eligibility for special education and related services under the IDEA.

(U.S. Department of Education Office for Civil Rights, 2020b). Previously the Office of Special Education and Rehabilitative Services (OSEP) indicated that IDEA requirements must be implemented regardless of public educational setting (Ryder & Swenson, 2016; U.S. Department of Education, 2009). Similar guidance was shared during the COVID-19 pandemic. The OSEP reiterated that SEAs and LEAs remain responsible for ensuring that a free appropriate public education (FAPE) is provided to all eligible children with disabilities through an individualized education program (IEP) provided in the least restrictive environment (LRE) regardless of instructional delivery approach (U.S. Department of Education Office of Special Education and Rehabilitative Services and Office of Special Education Programs, 2021). Further, the U.S. Department of Education offered no waivers or exceptions to LEAs for special education eligibility evaluation or reevaluations during the COVID-19 pandemic, reinforcing that eligibility determinations must document the student has a recognized disability that adversely impacts educational performance and requires specially designed instruction or SDI (U.S. Department of Education Office for Civil Rights, 2020a).

The IDEA stipulates eligible children must be provided with SDI to address the needs of the child within the general education curriculum "so that he or she can meet the educational standards within the jurisdiction of the public agency that apply to all children" (34 CFR 330.39). Specially designed instruction describes the type of individualized instructional services provided to a child with a disability, which is documented in the IEP. These services may include adaptations in instructional methods, materials, techniques, physical setting, or environment. The SDI is determined by the specific and individualized areas of need for a student to help the student access the general education curriculum. Guidance from the U.S. Department of Education in March 2020 indicated that SDI can be provided in-person, virtually, online, telephonically, and/or in a combination. Guidance further indicated that many disability-related accommodations and modifications may be effectively provided to

some students either in-person or online; additional accommodations may need to be added to support the student's access to instruction if in the remote environment (U.S. Department of Education Office for Civil Rights and Office of Special Education and Rehabilitative Services, 2020).

Related to SDI is LRE, which is explained in the IDEA as "to the maximum extent appropriate, children with disabilities are educated with nondisabled children" (34 CFR 300.550). A consideration for LRE is how to provide services in a remote environment, including through telepractice, and ensure that students with disabilities are not further segregated from nondisabled peers (U.S. Department of Education Office of Special Education and Rehabilitative Services and Office of Special Education Programs, 2021). Service delivery options are not directly addressed in IDEA (2004). Instead, the need to consider a continuum of alternative placements has been addressed in correspondence and memoranda (ASHA, 2019a; Posny, 2007). Such correspondence has indicated that service delivery and placement decisions that impact LRE must be based upon the unique needs of the student on an individual basis and should consider a continuum of options rather than predetermined options such as the availability of telepractice (ASHA, 2019a; Federal Register, 2016; Posny, 2007).

Another area of consideration for IDEA is how to support access to the general education curriculum for children with disabilities. The regulations for implementing Part B of the IDEA explain that the general education curriculum is "the same curriculum as for nondisabled children" (34 CFR §300.320(a)(1)(i). Given this verbiage, SDI should be individualized for a child with a disability to ensure access to the core general education curriculum used for typically developing students, which reinforces that services provided by SLPs should be educationally relevant regardless of service delivery mode.

Another important concept inherent within the IDEA is the need for all stakeholders—special education, regular education, families, and more—to collaborate. The IEP team may include the student as appropriate, regular education teachers, special education teachers, a person to interpret evaluation results, an LEA representative, a transition representative, telepractice providers, others knowledgeable about the child, and parents or guardians. All members of the team are important contributors, and how to collaborate with the various stakeholders is an important consideration when services are provided via telepractice, and more so when service providers may be in a remote environment. Failure to coordinate services and communicate about a child with a disability can result in the unlawful denial of FAPE and a lack of faithful implementation of the IEP (refer to Houston Ind. Sch. Dist., 2009).

Roles and Responsibilities of Speech-Language Pathologists in Schools

The Roles and Responsibilities of Speech-Language Pathologists in Schools (ASHA, 2010) serves as the official professional issues statement for speech–language services in schools indicating the critical roles of professionals: working across all educational levels; serving a range of disorders; ensuring educational relevance; providing unique contributions to curriculum; highlighting language and literacy; and providing culturally competent services. It further addresses the range of responsibilities of school-based SLPs including prevention, assessment, data collection and analysis, intervention, program design, and compliance. In addition, emphasis is placed on collaboration with others (i.e., professionals, universities, communities, families, and students) to meet student needs. Leadership is identified as a defining role of school-based SLPs to ensure the delivery of appropriate services to students. Telepractice is addressed within the statement as a potentially promising use of technology for service delivery in school settings, and that telepractice

services must be comparable to in-person services (ASHA, 2010).

Privacy, security, and safety policies

Speech–language pathologists have a sacred responsibility to uphold the welfare of their clients. Telepractitioners must therefore look beyond their own practices to uphold privacy, to determine whether the provider (i.e., vendor) abides by policies that meet federal and state guidelines. Toward that end, a Business Associate Agreement (BAA) should be in place between the telehealth system vendor and the school or contractor.

The telepractice environment must be supportive of the client's privacy. The telepractitioner should not conduct a session within an environment in which unauthorized colleagues, family members, friends, or others are able to observe or hear the session. Care should also be taken not to inadvertently record minors in the client's environment unless the parent or guardian has offered consent.

Unauthorized viewing of telepractice sessions or data must be prevented. If the recordings or other content from a session is stored, a policy should dictate for how long, and when the recordings will be erased. A serious privacy infraction might occur if a mobile phone or any other device is stolen or lost. Therefore, the telepractice sessions on these devices must be able to be remotely erased.

Encryption is an essential privacy safeguard. All of the telepractice devices used must be encrypted and password protected. Furthermore, the encryption practices must meet the applicable federal (HIPAA, HITECH, ISO, and NIST) and state(s) standards. The encryption keys should be regularly updated (e.g., rotated every 90 days).

The telepractice must be conducted on a secure, password-protected network, never using free and public Wi-Fi that might be widely observable. To help prevent unauthorized incursions, current anti-virus and anti-malware programs should be installed on all devices used for telepractice sessions, and the clinician and the client should avoid use of insecure mobile apps.

And finally, a system should be in place to authenticate a user of the telepractice equipment. Use of the telepractice equipment for other purposes may compromise a system's security. There should be an audit trail to determine whether there has been unauthorized access to a client's protected health information, and procedures to notify the client (Watzlaf et al., 2015; Zhou et al., 2019).

Procedures must be in place to ensure the safety of the client. Before a session begins, the clinician should have ready access to the exact address of the client and know how to reach an emergency contact. The local phone numbers of emergency personnel (e.g., fire department; police department) must be known; it is not sufficient to rely upon calling 911 in a distant location. At the conclusion of a session, the clinician should not disconnect until assured the client is in the presence of others.

Consent policies and program evaluation

Informed consent should be obtained from the student's parent or guardian before telepractice sessions begin. This should include information about privacy and security features and disclose vulnerabilities of the telehealth system. Families should be informed of a notification mechanism (e.g., a text message or phone call) and a back-up plan to resume communication if the videoconferencing fails during a session.

Families should be made aware that they may initially reject or discontinue teleservices, and that if possible, in-person services will be substituted if needed.

A plan should be in place for an annual program evaluation to determine service outcomes, as well as evaluation and improvement efforts related to stakeholder (e.g., clients, teachers, family, and support personnel) satisfaction.

DISCUSSION

The STA is presented as a tool for SLPs, administrators, and school districts to employ in advance of their considerations to transition to telepractice and later, to assess their telepractice services. The assessment is designed to be completed for an individual student who receives telepractice services and/or to review an entire telepractice caseload.

The first section of the STA is provided as general guidance about federal legislation and lawful practice that should be considered for all students who will be enrolled in telepractice, just as it should be for in-person service delivery.

The ensuing sections of the STA (i.e., Telepractice Personnel Practices; Roles and Responsibilities of Speech-Language Pathologists in Schools; Privacy, Security, and Safety Policies; and Consent Policies and Program Evaluation) are specific to telepractice policies and procedures. The STA highlights some best practices in each of these areas.

Creation of the STA prompted fundamental questions related to ASHA's requirement for comparable telepractice and in-person services. How exactly is "comparable" conceptualized? The *Merriam-Webster Dictionary* (2021) offers two definitions: "1. Capable or suitable for comparison. 2. Similar, like."

In the context of telepractice:

- Does "comparability" require the achievement of similar results (improvement of communication deficits, client satisfaction, etc.)?
- Does "comparability" require use of similar clinical methodologies and interactions as typical for therapy delivered in-person?
- Is there an expectation that the telepractitioner will relate to the school community (e.g., establishing collegial interactions, coteaching for prevention, and contributing to curriculum development) in a "comparable" manner as would an on-site clinician?
- Beyond the students served clinically, to what extent might the larger population of students and teachers become secondary beneficiaries of SLP services, and does this differ for telepractice versus in-person services?

An alternative to comparability based upon "sameness" is an expectation of "equifinality," defined as "the property of having the same effect or results from different events" (*Merriam-Webster Dictionary*, 2021). Equifinality suggests that different approaches can achieve similar outcomes, and that all are equally valued. However, the concept of equifinality cannot be used to rationalize failures to uphold federal educational law or to protect a student's privacy and security. We suggest that the reader carefully review the STA (Lundblom et al., 2021) in Appendix A and arrive at their own conclusions as to how "comparability" is best operationalized.

However one conceptualizes "comparability," providing telepractice service that is "comparable" to in-person service requires creative solutions to the lack of the clinician's physical presence in a school. Telepractice that is limited to the student's presence in a cubicle or a therapy room with a computer and webcam occurs in a relatively isolated setting. How will the telepractitioner observe a student's communication with peers in the school's classroom, in the hallway, or in the cafeteria? How will a telepractitioner compensate for not establishing collegial workplace relationships with teachers and staff in the "break room" or in faculty meetings? One solution is for districts to plan for a hybrid approach, with some of the SLP's time spent at the school site, "in residence." Although it would be desirable to designate certain ages and disorder groups as requiring a hybrid approach, the research basis for such assignments is not yet robust. Another option is the use of mobile "robots" that can be controlled by the distant therapist to move around the school and expand their perceived presence as a member of the school community. Tablets and other portable devices held by students and

teachers and eventually "smart rooms" could be used to expand the SLPs "school-based presence."

Much of school-based in-person speech and language treatment occurs with groups of students, often due to the need to serve large caseloads. A positive aspect of group-based therapy is that it promotes generalization and enhances social communication. The use of groups in school-based telepractice will place additional technical and procedural demands on the telepractitioner but is achievable. The clinician might need to simultaneously relate to several students, each located in a different site; this could multiply the technical troubleshooting demands. The clinician's lack of physical proximity to the students could make it more difficult to monitor their behavior and distribute individualized materials.

School-based telepractitioners must be highly focused, knowledgeable, competent, and efficient clinicians who have expertise in providing telepractice and working alongside telefacilitators (Douglass et al., 2021). Telefacilitators are often referred to as e-helpers. In addition to performing the functions of a speech–language pathology assistant, they might set up equipment, ensure student safety, and prepare and manipulate online therapy materials.

Prior knowledge of school-based practice is essential. Telepractitioners must be knowledgeable in telepractice policy, procedures, and equipment. Corporations that establish telepractice contracts therefore have the responsibility to hire and train clinicians who can best provide services that are as "comparable to in-person services" as possible. Obviously, schools who employ SLPs who conduct telepractice must ensure their employees fulfill this requirement meaning high-quality professional development in this area will be needed.

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Appendix A. School Telepractice Assessment (STA)

COMPLIANCE OF TELEPRACTICE DELIVERY WITH FEDERAL LEGISLATION

Guided by information from Gupta et al. (2014); U.S. Department of Education. (2000); and U.S. Department of Education. (2021).

INDIVIDUALS WITH DISABILITIES EDUCATION IMPROVEMENT ACT OF 2004 (IDEA)

Q1. Is funding provided for audiology and speech–language pathology (SLP) services delivered by telepractice in the public school/district?

Q2. Does the public school/district employing telepractice provide every student with a disability a free appropriate public education (FAPE) designed to provide meaningful educational benefit through an individualized education program (IEP) in the least restrictive environment (LRE)?

(Guidance: FAPE violations could occur in any of the following areas of the special education process under the IDEA: evaluation, reevaluation, IEP development/revision/annual review, IEP implementation, discipline, or transportation. A thorough audit of the IDEA is beyond the scope of this assessment but is of critical importance for compliance in provision of FAPE.)

Q2.a. If not detailed in an IEP, is a Memorandum of Understanding (MOU) in place to delineate what is required and what will be provided by the LEA and the SLP telepractitioner?

Q3. Is eligibility appropriately determined?

The following questions are applicable to speech–language pathologists, administrators, and local education agencies (LEAs) including those providing telepractice services.

Q3.a. Are decisions in the eligibility process made by an interprofessional team of qualified LEA representatives and parents or guardians?

Q3.b. Does the eligibility team review existing data?

Q3.c. Does the eligibility team determine the need for additional data to support the eligibility decision and determine the present level of academic achievement and functional performance?

Q3.d. Were vision and hearing screenings performed before evaluations were conducted? Was there an assessment of physical modifications needed for the student?

Q3.e. Was a comprehensive evaluation completed using a variety of assessment tools and strategies? *(Guidance: A single measure cannot be used as the sole criterion for determining eligibility.)*

Q3.f. Does the eligibility team follow the three-step determination process for IDEA eligibility?

Step 1. Does the student have one (e.g., speech–language impairment) of the 13 specified disabilities in the IDEA?

Step 2. Does the disability have an adverse educational effect?

Step 3. As a result of the disability, does the student need specially designed instruction?

Q3.g. Does the student have a primary disability (other than speech–language impaired) and need speech–language-related services to benefit from specially designed instruction?

Q4. Is the Individualized Education Plan (IEP) appropriate?

The following questions are applicable to speech–language pathologists, administrators, and LEAs including those providing telepractice services.

Q4.a. Is a statement of the student's present levels of academic and functional performance included? *(Guidance: This statement must include how the disability affects the student's involvement and progress in the general education curriculum.)*

(*continues*)

Appendix A. School Telepractice Assessment (STA) (*Continued*)

Q4.b. Are measurable annual goals that enable the student to be involved and make progress in the general education curriculum included? *(Guidance: The measurable annual goals should include how and when progress will be reported.)*

Q4.c. Are special education and related services listed? This could include supplementary aids and services including training or professional development in telepractice provided to school personnel to assist the child.

Q4.d. Is an explanation of the extent (if any) to which the student will *not* participate with nondisabled students in the regular class and other school activities included?

Q4.e. Are modifications or accommodations that are needed in the administration of state or district achievement tests explained? If a test is not appropriate, the IEP must state why the test is not appropriate and how the child will be tested.

Q4.f. Are the projected dates for the beginning of services and modifications including duration stated?

Q5. Is placement and the least restrictive environment (LRE) appropriate?

The following questions are applicable to speech–language pathologists, administrators, and LEAs including those providing telepractice services.

Q5.a. Was the student's placement decision made by an IEP team?

Q5.b. Is the placement decision (i.e., provision of telehealth services) consistent with the student's needs to promote educational success in the general education curriculum? *(Guidance: The placement will reasonably promote educational success based on the student's unique abilities and needs.)*

Q5.c. Is the placement decision made at least annually and documented on the IEP?

Q5.d. Was the placement decision influenced by predetermined options, like the availability of telepractice? (*Guidance: Determinations cannot be solely based on factors related to disability type, severity, administrative convenience, availability of services, or current service delivery system.)*

Q5.e. Was a continuum of placements reviewed by the LEA based on the individual abilities and needs of the student and not influenced by predetermined options (i.e., administrative convenience of telepractice availability)?

Q5.f. Is there any negative effect on the student or the quality of services the student needs if delivered via telepractice?

Q5.g. If the student is removed from the general education environment for services via telepractice, to what extent does the student remain in the regular education setting for other academic, nonacademic, and extracurricular activities?

Q5.h. Is the telepractice placement decision documented in the IEP as follows?

- Type of support.
- Amount of time in the regular education classroom.
- Amount of time out of the regular education classroom.
- Supplementary aids and serviced to be provided.
- Specialized transportation needs (if applicable).
- Data collection procedures for monitoring progress on IEP goals in assigned placement.

Q6. Is the specially designed instruction (SDI) appropriate?

The following questions are applicable to speech–language pathologists, administrators, and LEAs including those providing telepractice services.

Q6.a. What are the characteristics, strengths, and needs of the student?

Q6.b. What are the characteristics of the general education classroom and curriculum?

Q6.c. How do telepractice services meet the characteristics, strengths, and needs of the student in consideration of the general education classroom and curriculum?

(*continues*)

Appendix A. School Telepractice Assessment (STA) (*Continued*)

Q6.d. What program accommodations/modifications or supports need to be made for this student to advance toward attaining annual goals, progress in the general curriculum, and participate with nondisabled children?
Q6.e. What additional considerations need to be made for program accommodations/modifications or supports for the student when considering telepractice?
Q6.f. What supplementary aids and services are needed to enable the student to advance toward attaining annual goals, progress in the general curriculum, and participate with nondisabled children?
Q6.g. What additional considerations of supplementary aids and services need to be made for the student when considering telepractice?
Q7. Is the collaboration optimal?
The following questions are applicable to speech–language pathologists, administrators, and LEAs including those providing telepractice services.
Q7.a. Are parents or guardians included in the design and implementation of services?
Q7.b. Are regular education and special education teachers consulted in the design and implementation of services?
Q7.c. Do all individuals involved in service provision to the student understand their responsibilities with implementing the IEP?
Q7.d. Who is in charge of monitoring services to oversee that services are delivered as planned?
Q7.e. Is there sufficient time to plan or work together on a student's IEP to address the unique needs of the student?
Q7.f. Do all service providers routinely communicate about a student's IEP?
Q7.g. How is communication for IEP implementation documented?

TITLE II OF THE AMERICANS WITH DISABILITIES ACT OF 1990
Q1. Does the public school/district employing telepractice provide, without charge, auxiliary aids and services to ensure that students with disabilities can communicate as effectively as all other students, with primary consideration of students' and parents' preferences?
Q2. Is the telepractice delivered to students with disabilities covered financially regardless of their eligibility for special education and related services under the IDEA?

SECTION 504 OF THE REHABILITATION ACT OF 1973
Q1. Does the telepractice provider prohibit discrimination based on disability?
Q2. Are the needs of students with disabilities met through educational services delivered by telepractice as adequately as the needs of students without disabilities?

TELEPRACTICE PERSONNEL POLICIES
Q1. Is telepractice permitted in the state?
Q2. Do telepractice SLP personnel meet all state requirements (e.g., state licensure, educational certification if required) to practice in the school?
Q3. Are the telepractice SLP personnel covered by professional malpractice insurance?
Q4. Are the telepractice SLP personnel certified by the American Speech-Language-Hearing Association (ASHA) (CCC-SLP; whether or not they are currently members of the ASHA) and have no violation that prevents current clinical practice?
Q5. What is the level of prior training and experience of the speech–language pathologist who provides telepractice?
Q5.a. How and to what extent was such training provided?
Q6. Does the SLP possess the knowledge and skills to function as a telepractitioner?

(*continues*)

Appendix A. School Telepractice Assessment (STA) (*Continued*)

Q7. How will support personnel such as e-helpers and Speech–Language Pathology Assistants (SLP-As) be trained to support telepractice?
Q8. How will support personnel (e-helpers and SLP-As) be supervised when the supervising SLP is offsite?
Q9. Is there a plan in place for the supervision of SLP telepractice practitioners?
Q10. Is there on-site support in the school to support telepractice, as follows?
- Technical support?
- Escorting the child to and from the tele-session?
- Providing support during the tele-session?

Q11. Is there a plan to have ongoing contact with parents, teachers, and other personnel to be certain that therapy is relevant to a student's academic and home environments?
Q12. Is there a policy concerning caseloads for telepractice?
Q13. Is there a policy concerning session length for the telepractice therapy sessions?
Q14. Is there a policy concerning the "student-to-practitioner" ratio?
Q15. Is there a policy concerning the maximum group size in a telepractice therapy session?
Q16. What is the approximate minimum active individual therapy time (specify minutes) per client, per session?
Q17. Is sufficient compensated time provided for the SLP to complete meetings, paperwork, and assessments required by federal legislation?
Q18. Is sufficient compensated time provided for the SLP to interact with and collaborate with school personnel?

ROLES AND RESPONSIBILITIES OF SPEECH–LANGUAGE PATHOLOGISTS IN SCHOOLS
Q1. Are speech and language services offered via telepractice across all grade levels (including early intervention if provided)?
Q2. Are speech and language services offered via telepractice for a range of disorders?
Q3. Do the speech and language services offered via telepractice have educational relevance?
Q4. Do the speech and language services offered via telepractice provide unique contributions to the curriculum?
Q5. Do the speech and language services offered via telepractice highlight language/literacy?
Q6. Do the speech and language services offered via telepractice follow culturally competent practices?
Q7. Does the school-based SLP telepractitioner exercise a role in prevention?
Q8. Does the school-based SLP telepractitioner engage in assessment and can the telepractice environment support all types of assessment?
Q9. Does the school-based SLP telepractitioner engage in educational program design?
Q10. Does the school-based SLP telepractitioner engage in data collection and analyses and compliance monitoring?
Q11. Does the SLP telepractitioner place a high priority on collaboration with others (i.e., professionals, universities, community, family, and other students) to meet student needs?
Q12. Will the SLP telepractitioner become engaged in school and after-school activities as part of the larger school community?
Q13. Will the SLP telepractitioner be able to observe and interact with students outside of the "therapy room" or classroom, to assess progress and promote generalization?

(*continues*)

Appendix A. School Telepractice Assessment (STA) (*Continued*)

PRIVACY, SECURITY, AND SAFETY POLICIES

Parameters are based upon the work of Watzlaf et al. (2015) and Zhou et al. (2019), presented in condensed form.

TELEPRACTICE PRIVACY

Q1. Does the telepractice provider (i.e., vendor) have privacy policies in place?
Q2. Do the privacy policies meet federal and state(s) guidelines?
Q3. Is a Business Associate Agreement (BAA) in place between the telehealth system vendor and the school or contractor?
Q4. Is the telepractice environment sufficiently private if/when recordings occur?
Q5. Are minors whose parents/guardians have not given consent to be recorded captured on recordings?
Q6. How is unauthorized viewing of telepractice sessions or data prevented?

STORAGE POLICIES

Q1. Are recordings or other content from a telepractice session stored? (If yes, by whom and for how long?)
Q2. Is protected health information (PHI) securely stored?
Q3. Can information stored on a mobile phone or any other device used for telepractice sessions be remotely erased if lost or stolen?

ENCRYPTION

Q1. Are all of the telepractice devices used encrypted and password protected?
Q2. Do the encryption practices meet the applicable federal (HIPAA, HITECH, ISO, and NIST) and state(s) standards?
Q3. What data are encrypted?
Q4. Are encryption keys regularly updated (e.g., rotated every 90 days)?
Q6. Is there a system in place to authenticate a user of the telepractice equipment?

DATA BACK-UP PLAN

Q1. If equipment fails, is there a data back-up plan to retrieve the data?
Q2. If the video conferencing fails, is there a back-up plan to resume communication?

AUTHENTICATION/ACCESS CONTROL

Q1. Is written authorization required before granting requests for Protected Health Information (PHI)?
Q2. Is approval for disclosures of PHI given by qualified individuals?
Q3. If requested by law enforcement or government officials, will the PHI from sessions be made available? Will the granting of such a request be done in a manner that is compliant with the school district's policy or protocol?

SECURE NETWORKS

Q1. Does the telepractitioner use secure networks to connect to telehealth sessions and avoid use of public Wi-Fi?
Q2. Does the telepractitioner avoid connecting to insecure mobile apps?
Q3. Is there an audit trail to learn who is gaining access to PHI?
Q4. Is there a policy in place to report incursions to the system?
Q5. Are there current anti-virus and anti-malware programs installed on all devices used for telepractice sessions?

(*continues*)

Appendix A. School Telepractice Assessment (STA) (*Continued*)

TELE-SESSION SAFETY
Q1. Are there procedures in place in the event of an emergency during the session?
Q2. Is there a policy in place concerning how students are escorted to and from a session?
CONSENT POLICIES AND PROGRAM EVALUATION
Q1. Is informed consent obtained from the student's parent or guardian before telepractice sessions begin?
Q2. Does informed consent include information about privacy and security features and vulnerabilities of the telehealth system?
Q3. Is there an accessible and confidential mechanism for parents to provide feedback about a tele-session or the telepractice program?
Q4. Are families made aware that they may initially reject or discontinue tele-services, and that in-person services will be substituted if needed?
Q5. Is there a plan for an annual program evaluation to determine service outcomes?
Q6. Is there a plan for an annual program evaluation and improvement efforts related to stakeholder (e.g., clients, teachers, family, and support personnel) satisfaction?