CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

**SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD**
1601 Response Road, Suite 260, Sacramento, CA 95815
P (916) 287-7915 | www.speechandhearing.ca.gov

# BOARD MEETING NOTICE AND AGENDA

The Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board (Board) will hold a Board Meeting in person in accordance with Government Code section 11123, subdivision (a) on

***Thursday, December 4, 2025, beginning at 1:00 p.m., and continuing on Friday, December 5, 2025, beginning at 9:00 a.m.***

## *LOCATION FOR OBSERVATION AND PUBLIC COMMENT:*

*Cerritos Community College*
*Conference Center (CC)*
*11110 Alondra Blvd,*
*Norwalk, CA 90650* map

## *IMPORTANT NOTICE TO THE PUBLIC:*

To observe the meeting without the ability to provide public comment, a live stream of the Board Meeting will available during each day of the meeting at https://thedcapage.blog/webcasts/

Please consider submitting written comments by 5:00 pm, Tuesday, December 2, 2025, to speechandhearing@dca.ca.gov for consideration.

**Action may be taken on any agenda item. Items may be taken out of order to facilitate the effective transaction of Board business.**

## *Thursday, December 4, 2025, beginning at 1:00 p.m.*

**Board Members**
Gilda Dominguez, Speech-Language Pathologist, Board Chair
Amy White, Dispensing Audiologist, Board Vice Chair
Tod Borges, Hearing Aid Dispenser
Tamara Chambers, Otolaryngologist, Public Member
Karen Chang, Public Member
Francis David, Speech-Language Pathologist
Charles Sanders, Dispensing Audiologist
VACANT, Hearing Aid Dispenser
VACANT, Public Member

**Full Board Meeting Agenda**

**OPEN SESSION**

1. Call to Order / Roll Call / Establishment of Quorum

2. Welcome and Thank You to Cerritos Community College and their Speech-Language Pathology Assistant Associate Degree Program Staff and Students

3. Public Comment for Items Not on the Agenda *(The Board may not discuss or take any action on any item raised during this public comment section, except to decide whether to place the matter on the agenda of a future meeting (Government Code Sections 11125, 11125.7(a))*

***Recess to Committee Meeting***

**Speech-Language Pathology Practice Committee Members**
Gilda Dominguez, Speech-Language Pathologist, Committee Chair
Tamara Chambers, Otolaryngologist, Public Member
Francis David, Speech-Language Pathologist

**Speech-Language Pathology Practice Committee Agenda**

1. Call to Order / Roll Call / Establishment of Quorum

2. Public Comment for Items Not on the Agenda
*(The Committee may not discuss or take any action on any item raised during this public comment section, except to decide whether to place the matter on the agenda of a future meeting (Government Code Sections 11125, 11125.7(a))*

3. Discussion and Possible Action to Amend Regulations Regarding Scope of Responsibility, Duties, and Functions of Speech-Language Pathology Assistants Related to Swallow Therapy as Stated in Title 16, California Code of Regulations (CCR) sections 1399.170.1, 1399.170.2, and 1399.170.3

4. Adjournment

## *Upon Adjournment of the Speech-Language Pathology Practice Committee Meeting*

**Hearing Aid Dispensing Committee Members**
Tod Borges, Hearing Aid Dispenser, Committee Chair
Tamara Chambers, Otolaryngologist, Public Member
Charles Sanders, Dispensing Audiologist
Amy White, Dispensing Audiologist
VACANT, Hearing Aid Dispenser

**Hearing Aid Dispensing Committee Agenda**

1. Call to Order / Roll Call / Establishment of Quorum

2. Public Comment for Items Not on the Agenda
   *(The Committee may not discuss or take any action on any item raised during this public comment section, except to decide whether to place the matter on the agenda of a future meeting (Government Code Sections 11125, 11125.7(a))*

3. Discussion and Possible Action to Add and Amend Regulations Regarding Postfitting Counseling and Foreign Body In The Ear Canal Related to Hearing Aid Dome Removal at Title 16, CCR Sections 1399.125 and 1399.126, as used in BPC Sections 2538.11, 2538.36, and 2539.6

4. Adjournment

## *Upon Adjournment of the Hearing Aid Dispensing Committee Meeting*

**Audiology Practice Committee Members**
Amy White, Dispensing Audiologist, Committee Chair
Tamara Chambers, Otolaryngologist, Public Member
Karen Chang, Public Member
Charles Sanders, Dispensing Audiologist

**Audiology Practice Committee Agenda**

1. Call to Order / Roll Call / Establishment of Quorum

2. Public Comment for Items Not on the Agenda
   *(The Committee may not discuss or take any action on any item raised during this public comment section, except to decide whether to place the matter on the agenda of a future meeting (Government Code Sections 11125, 11125.7(a))*

3. Discussion and Possible Action to Add and Amend Regulations Regarding General Application Requirements and Speech-Language Pathology Aide and Audiology Aide Requirements and Scope of Activities, Duties and Functions at Title 16, CCR Sections 1399.151.2, 1399.151.3, 1399.151.4, 1399.154 through 1399.154.12, and 1399.157

4. Adjournment

## *Upon Adjournment of the Audiology Practice Committee*

**Board Members**
Gilda Dominguez, Speech-Language Pathologist, Board Chair
Amy White, Dispensing Audiologist, Board Vice Chair
Tod Borges, Hearing Aid Dispenser
Tamara Chambers, Otolaryngologist, Public Member
Karen Chang, Public Member
Francis David, Speech-Language Pathologist
Charles Sanders, Dispensing Audiologist
VACANT, Hearing Aid Dispenser
VACANT, Public Member

## Full Board Meeting Agenda

### OPEN SESSION

4. Call to Order / Roll Call / Establishment of Quorum

5. Public Comment for Items Not on the Agenda *(The Board may not discuss or take any action on any item raised during this public comment section, except to decide whether to place the matter on the agenda of a future meeting (Government Code Sections 11125, 11125.7(a))*

### CLOSED SESSION

6. Pursuant to Government Code section 11126(a)(1) the Board will conduct the annual performance evaluation and consider the salary of its Executive Officer.

## *Friday, December 5, 2025, beginning at 9:00 a.m.*

**Board Members**
Gilda Dominguez, Speech-Language Pathologist, Board Chair
Amy White, Dispensing Audiologist, Board Vice Chair
Tod Borges, Hearing Aid Dispenser
Tamara Chambers, Otolaryngologist, Public Member
Karen Chang, Public Member
Francis David, Speech-Language Pathologist
Charles Sanders, Dispensing Audiologist
VACANT, Hearing Aid Dispenser
VACANT, Public Member

## Full Board Meeting Agenda

### OPEN SESSION

7. Call to Order / Roll Call / Establishment of Quorum

8. Public Comment for Items Not on the Agenda *(The Board may not discuss or take any action on any item raised during this public comment section, except to decide whether to place the matter on the agenda of a future meeting (Government Code Sections 11125, 11125.7(a))*

9. Review and Possible Approval of the August 21 - 22, 2025, Board Meeting Minutes

10. DCA Update – DCA Board and Bureau Relations

11. Board Chair's Report
    a) Board and Committee Meeting Calendar
    b) Board Committee Reports
        i. Speech-Language Pathology Practice Committee
        ii. Hearing Aid Dispensing Committee
        iii. Audiology Practice Committee

12. Executive Officer's Report
    a) Administration Update
    b) Outreach Update
    c) Budget Report
    d) Regulations Report
    e) Licensing Report
    f) Practical Examination Report
    g) Enforcement Report

13. Regulatory Report: Update, Review, and Possible Action on Board Regulation Packages
    a) Update on Regulations Regarding Processing Times as Stated in Title 16, CCR Sections 1399.113, 1399.141, 1399.151.1, 1399.153.2, 1399.160.6, 1399.170.4, and 1399.170.13
    b) Update on Regulations Regarding Audiology Licensing Requirements Related to Supervised Clinical Experience as Stated in Title 16, CCR section 1399.152.2
    c) Update on Regulations Regarding Hearing Aid Dispensers Trainee and Temporary Licensee Supervision as Stated in Title 16, CCR sections 1399.102 and 1399.115 through 1399.119
    d) Update on Regulations Regarding General Application Requirements and Hearing Aid Dispensers and Dispensing Audiologists Examination Requirements as Stated in Title 16, CCR sections 1399.112, 1399.120, 1399.121, 1399.122, and 1399.152.4
    e) Update on Regulations Regarding Approved Institutions as Stated in Title 16, CCR section 1399.152
    f) Update on Regulations Regarding Fingerprinting Requirements as Stated in Title 16, CCR sections 1399.112, 1399.151.2, and 1399.170.14

14. Discussion and Possible Action on the Board's 2026 Sunset Review Report:
    a) Section 1 – Background and Description of the Board and Regulated Profession
    b) Section 2 – Fiscal and Staff
    c) Section 3 – Licensing Program
    d) Section 4 – Enforcement Program
    e) Section 5 – Public Information Policies
    f) Section 6 – Online Practice Issues
    g) Section 7 – Workforce Development and Job Creation
    h) Section 8 – Current Issues
    i) Section 9 – Board Action and Response to Prior Sunset Issues
    j) Section 10 – New Issues
        i. Discussion and Possible Action to Propose Amendments to Business and Professions Code (BPC) Sections 2538.33 and 2538.34 Related to Hearing Aid Dispenser Address of Record and Branch Office Requirements

k) Section 11 – Attachments

**BREAK 12:00 – 12:30 pm (Time Approximate)**

15. Legislative Report: Update, Review, and Possible Action on Proposed Legislation
    a) Legislative Calendar and Deadlines
    b) 2025 Board-Sponsored Legislation
        i. Senate Bill (SB) 861 (Committee on Business, Professions and Economic Development) Consumer affairs.
    c) Bills with Recommended Watch Status
        i. Assembly Bill (AB) 45 (Bauer-Kahan) Privacy: health data: location and research.
        ii. AB 322 (Ward) Precise geolocation information.
        iii. AB 346 (Nguyen) In-home supportive services: licensed health care professional certification.
        iv. AB 364 (DeMaio) Personal information: maintenance.
        v. AB 410 (Wilson) Bots: disclosure.
        vi. AB 485 (Ortega) Labor Commissioner: unsatisfied judgments: nonpayment of wages.
        vii. AB 489 (Bonta) Health care professions: deceptive terms or letters: artificial intelligence.
        viii. AB 742 (Elhawary) Department of Consumer Affairs: licensing: applicants who are descendants of slaves.
        ix. AB 784 (Hoover) Special education: specialized deaf and hard-of-hearing services.
        x. AB 970 (McKinnor) Child abuse and neglect reporting.
        xi. AB 1015 (Patel) Discrimination and harassment prevention training.
        xii. AB 1110 (Ortega) Safety rules and regulations: notice.
        xiii. AB 1192 (Carrillo) Child abuse or neglect: reporting.
        xiv. AB 1326 (Ahrens) Masks: individual or public health.
        xv. AB 1327 (Aguiar-Curry) Home improvement and home solicitation: right to cancel contracts: notice.
        xvi. SB 81 (Arreguín) Health and care facilities: information sharing.
        xvii. SB 82 (Umberg) Contracts: consumer goods and services: dispute resolution provisions.
        xviii. SB 294 (Reyes) The Workplace Know Your Rights Act.
        xix. SB 402 (Valladares) Health care coverage: autism.
        xx. SB 446 (Hurtado) Data breaches: customer notification.
        xxi. SB 470 (Laird) Bagley-Keene Open Meeting Act: teleconferencing.
        xxii. SB 497 (Wiener) Legally protected health care activity.
        xxiii. SB 641 (Ashby) Department of Consumer Affairs and Department of Real Estate: states of emergency: waivers and exemptions.
        xxiv. SB 744 (Cabaldon) Accrediting agencies.

16. Legislative Items for Future Meeting *(The Board May Discuss Other Items of Legislation in Sufficient Detail to Determine Whether Such Items Should be on a Future Board Meeting Agenda and/or Whether to Hold a Special Meeting of the Board to Discuss Such Items Pursuant to Government Code section 11125.4)*

17. Election of Board Officers for 2026

18. Discussion of Potential Dates for Board Meetings in 2026

19. Solicitation of Future Agenda Items

20. Adjournment

*Agendas and materials can be found on the Board's website at www.speechandhearing.ca.gov.*

*Action may be taken on any item on the agenda. The time and order of agenda items are subject to change at the discretion of the Board Chair and may be taken out of order. In accordance with the Bagley-Keene Open Meeting Act, all meetings of the Board are open to the public. In the event a quorum of the board is unable to attend the meeting, or the board is unable to maintain a quorum once the meeting is called to order, the members present may, at the Chair's discretion, continue to discuss items from the agenda and make recommendations to the full board at a future meeting. Adjournment, if it is the only item that occurs after a closed session, may not be webcast.*

*The meeting facility is accessible to persons with a disability. Any person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting the Board office at (916) 287-7915 or making a written request to Michael Magat, Assistant Executive Officer, 1601 Response Road, Suite 260, Sacramento, California 95815. Providing your request at least five (5) business days before the meeting will help ensure availability of the requested accommodation.*

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# MEMORANDUM

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|---|---|
| DATE | November 19, 2025 |
| TO | Speech-Language Pathology Practice Committee |
| FROM | Maria Liranzo, Legislation/Regulation/Budget Analyst |
| SUBJECT | Agenda Item 3: Discussion and Possible Action to Amend Regulations Regarding Scope of Responsibility, Duties, and Functions of Speech-Language Pathology Assistants Related to Swallow Therapy as Stated in Title 16, California Code of Regulations (CCR) sections 1399.170.1, 1399.170.2, and 1399.170.3 |

## Background

On November 30, 2023, the Speech-Language Pathology Practice Committee (Committee) discussed the restrictions on speech-language pathology assisants (SLPAs) performing oral pharyngeal swallow therapy with bolus material.

The Committee met on December 5, 2024, and May 15, 2025, to determine if SLPAs should be allowed to perform oral pharyngeal swallow therapy with bolus material by comparing neighboring state and national requirements and requirements of other healing arts professions such as occupational therapy. The Committee determined that SLPAs should be able perform feeding and swallowing therapy with bolus material and began discussion on possible requirements that would allow them to do so, such as:

- Requiring a specified number of hours of experience under immediate supervision before a SLPA can perform feeding and swallowing therapy with bolus material under direct supervision,
- Requiring a SLPA to perform feeding and swallowing therapy with bolus material in specific settings, and
- Prohibiting SLPAs from performing feeding and swallowing therapy with bolus material on patients with contraindications and specifying what those contraindications would be.

The Committee met on August 21, 2025, to continue discussing possible requirements that would allow SLPAs to perform feeding and swallowing therapy with bolus material such as:

- Requiring a specified number of hours of education in swallowing/dysphasia and anatomy and physiology of swallowing from an approved continuing education provider,

- Requiring the supervised experience to be from direct client care with patients that covers all phases of swallowing and a variety of ages,

- Requiring the supervised experience to be under the supervision of a SLP licensed in California who performs feeding and swallowing therapy with bolus material as part of their practice,

- Requiring a written verification of competency, education and experience to include the SLP signature and license number, and

- Requiring documentation of the approval that a SLPA can provide feeding and swallowing therapy with bolus material to a patient be from a California licensed SLP who performs feeding and swallowing therapy with bolus material as part of their practice.

The Committee directed Board staff to draft regulatory text to remove restrictions and specifiy requirements for SLPAs to perform feeding and swallowing therapy with bolus material (Attachment A).

**Discussion Questions**

1. In section 1399.170.1(c)(1), is the SLP who signs the verification the same SLP who provides immediate supervision for all one hundred hours of feeding and swallowing therapy with bolus material?

2. Should 1399.170.1(c)(4) also includes “unwillingness” to cooperate with the examination as a contraindication? Currently, the subsection lists “severe movement disorders, severe agitation, and inability to cooperate with the examination.” What about a patient who is physically able, but otherwise unwilling, to cooperate? Consider whether that is worth including, or is sufficiently covered by “inability to cooperate”/or otherwise understood.

3. As currently drafted, proposed requirements are very specific and could limit the professional community from creating education and/or experience opportunities for SLPAs to become competent to perform feeding and swallowing therapy with bolus material. If the text moves through the rulemaking process, Board staff will keep an eye out for comments from the public on this issue. However, the Committee should consider the following before recommending the text to the Board:

   Do any of the following create barriers to SLPAs to obtain education and experience to perform feeding and swallowing therapy with bolus material?

   - Requiring education from an approved continuing education (CE) provider only, rather than also allowing education from an employer who may not be an approved CE provider,

   - Requiring the supervised experience to be under the supervision of a SLP licensed in California only, rather than allowing supervision by a SLP licensed in other states as well, and

- Requiring the supervised experience to be from direct client care with patients only, rather than allowing supervised experience based on work with students/volunteers or mannequins.

4. Should there be restrictions and/or specified requirements to feeding and swallowing therapy with bolus material for specific age groups (i.e. newborns or infants) or conditions (i.e., patients with artificial airways)?

5. Education in swallowing/dysphasia may lack clarity for the rulemaking process. What exactly about swallowing/dysphasia should a SLPA know that would provide them with the knowledge they need to perform feeding and swallowing therapy with bolus material (i.e., causes, signs and symptoms, screening and assessments, treatment, ethical considerations)?

## Action Requested

Staff recommends the Committee review and discuss the materials provided, and consider whether to recommend the regulatory text to the Board to initiate the rulemaking process.

Attachment A: SLPA Feeding and Swallowing Therapy Requirements Text Proposal
Attachment B: Flexible Endoscopic Evaluation of Swallowing (FEES) requirements
Attachment C: California Occupational Therapy Board Laws and Regulations
Attachment D: ASHA Scope of Practice for the Speech-Language Pathology Assistant (SLPA)
Attachment E: ASHA Swallowing Disorders in Adults
Attachment F: ASHA Pediatric Feeding and Swallowing

**Text Proposal**
**Speech-Language Pathology Assistant Feeding and Swallowing Therapy Requirements**

| | |
|---|---|
| **Legend:** | Added text is indicated with an underline.<br>Omitted text is indicated by (* * * *)<br>Deleted text is indicated by ~~strikeout~~. |

**§ 1399.170.1. Responsibilities, Duties, and Functions of a Speech-Language Pathology Assistant.**

(a) A speech-language pathology assistant shall be limited to the responsibilities, duties, and functions as provided in Section 2538.1 of the Code.

(b) A speech-language pathology assistant shall disclose while working, his or her name and registration status, as granted by the state, on a name tag in at least 18-point type.

(c) A speech-language pathology assistant may perform feeding and swallowing therapy with bolus material if the following conditions are met:

(1) The speech-language pathology assistant received written and signed verification from a California-licensed speech-language pathologist that the speech-language pathology assistant has completed forty-five (45) hours of education, performed one hundred (100) hours of feeding and swallowing therapy with bolus material under immediate supervision, and is competent to perform these procedures.

(A) The California-licensed speech-language pathologist who signs the verification and provides immediate supervision to the speech-language pathologist assistant must perform feeding and swallowing therapy with bolus material as part of their practice.

(B) Education under this section must be from an approved continuing education provider and the course content must cover swallowing/dysphasia and anatomy and physiology of swallowing.

(C)The one hundred (100) hours of feeding and swallowing therapy with bolus material under this section must be performed under the immediate supervision of a California licensed speech-language pathologist who performs feeding and swallowing therapy with bolus material as part of their practice, and shall be direct client care with patients that covers all phases of swallowing and a variety of ages.

(D)The written and signed verification must include the supervising speech-language pathologist’s license number.

(E) The speech-language pathology assistant shall maintain a copy of the written verification and make it available for inspection upon request by the Board.

(2) The speech-language pathology assistant received prior approval from the supervising speech-language pathologist each time they perform feeding and swallowing therapy with bolus material on a patient, and the approval is documented in the patient records.

(3) The speech-language pathology assistant is working in the following settings that require the facility to have protocols for emergency medical backup procedures, including requiring a physician and surgeon or other appropriate medical professional being readily available.

(A) A clinic, as defined in Section 1200 of the Health and Safety Code.

(B) A facility described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(C) A health facility, as defined in Section 1250 of the Health and Safety Code.

(D) A hospice facility licensed pursuant to Chapter 8.5 (commencing with Section 1745) of Division 2 of the Health and Safety Code.

(E) A medical group practice, including a professional medical corporation, as defined in Section 2406 of the Code, another form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure, or another lawfully organized group of physicians and surgeons that provides health care services.

(4) The patient has no contraindications. For purposes of this section, contraindications may include, but are not limited to, cases of severe movement disorders, severe agitation, and inability to cooperate with the examination.

(4) The supervising speech-language pathologist provides the speech-language pathology assistant with direct supervision that consists of on-site observation and guidance supervision when the speech-language pathology assistant is performing feeding and swallowing therapy with bolus material on patients.

NOTE: Authority cited: Sections 2531.95 and 2538.1~~(a)~~, Business and Professions Code. Reference: Sections 2538.1~~(b)(3) and (4)~~ and 2538.7~~(b)~~, Business and Professions Code.

**§ 1399.170.2. Types of Supervision Required for Duties Performed by a Speech-Language Pathology Assistant.**

(a) Duties performed by the speech-language pathology assistant that require immediate supervision may include, but are not limited to, any direct client activity involving medically fragile patients. In such instances, the speech-language pathology assistant shall act only under the direction of the supervisor.

(b) Duties performed by the speech-language pathology assistant that require direct supervision may include, but are not limited to, any new screening or treatment activity that the assistant has been trained to perform by the supervisor, but has not yet been performed by the speech-language pathology assistant in direct client care.

(c) Duties performed by the speech-language pathology assistant that require indirect supervision may include, but are not limited to, the following:

(1) Screening or treatment activities where the supervisor has previously given instructions as to how to perform the task, has observed the assistant in the conduct of these activities, and is satisfied that the activities can be competently performed by the speech-language pathology assistant, i.e., repetitive drill exercises, generalization or carryover activities;

(2) Clerical tasks such as record keeping, materials preparation, scheduling, equipment maintenance; and,

(3) Other non-client care activities.

(d) Notwithstanding subdivisions (a), (b), and (c), the supervisor shall provide supervision to the speech-language pathology assistant following their initial licensure in accordance with Section 1399.170.15(b)(4) of the California Code of Regulations.

(e) Notwithstanding subdivisions (a), (b), (c) and (d), the supervisor shall provide supervision to the speech-language pathology assistant who performs feeding and swallowing therapy with bolus material in accordance with Section 1399.170.1(c)(4) of the California Code of Regulations.

Note: Authority cited: Sections 2531.95 and 2538.1~~(a)~~, Business and Professions Code. Reference: Section 2538.1~~(b)(7)~~, Business and Professions Code.

**§ 1399.170.3. Activities, Duties, and Functions Outside the Scope of Responsibilities of a Speech-Language Pathology Assistant.**

A speech-language pathology assistant may not conduct evaluations, interpret data, alter treatment plans, or perform any task without the express knowledge and approval of a supervising speech-language pathologist. The speech-language pathology assistant may not perform any of the following functions:

(a) Participate in parent conferences, case conferences, or inter-disciplinary team conferences without the supervising speech-language pathologist or another speech-language pathologist being present;

(b) Provide counseling or advice to a client or a client's parent or guardian which is beyond the scope of the client's treatment;

(c) Sign any documents in lieu of the supervising speech-language pathologist, i.e., treatment plans, client reimbursement forms, or formal reports;

(d) Discharge clients from services;

(e) Make referrals for additional services;

(f) Unless required by law, disclose confidential information either orally or in writing to anyone not designated by the supervising speech-language pathologist;

(g) Represent himself or herself as a speech-language pathologist; and,

(h) Perform procedures that require a high level of clinical acumen and technical skill, i.e., vocal tract prosthesis shaping or fitting, and vocal tract imaging~~, and oropharyngeal swallow therapy with bolus material~~.

NOTE: Authority cited: Sections 2531.95 and 2538.1~~(a)~~, Business and Professions Code. Reference: Section 2538.1~~(b)(3)~~, Business and Professions Code.

**Flexible Endoscopic Evaluation of Swallowing (FEES) Requirements**

## Business and Profession Code section 2530.2.

As used in this chapter, unless the context otherwise requires:

(d) The practice of speech-language pathology means all of the following:

(1) The application of principles, methods, instrumental procedures, and noninstrumental procedures for measurement, testing, screening, evaluation, identification, prediction, and counseling related to the development and disorders of speech, voice, language, or swallowing.

(2) The application of principles and methods for preventing, planning, directing, conducting, and supervising programs for habilitating, rehabilitating, ameliorating, managing, or modifying disorders of speech, voice, language, or swallowing in individuals or groups of individuals.

(3) Conducting hearing screenings.

(4) Performing suctioning in connection with the scope of practice described in paragraphs (1) and (2), after compliance with a medical facility's training protocols on suctioning procedures.

(e) (1) Instrumental procedures referred to in subdivision (d) are the use of rigid and flexible endoscopes to observe the pharyngeal and laryngeal areas of the throat in order to observe, collect data, and measure the parameters of communication and swallowing as well as to guide communication and swallowing assessment and therapy. Passage of these instruments without the presence of a physician and surgeon is subject to paragraph (2).

(2) Nothing in this subdivision shall be construed as a diagnosis. Any observation of an abnormality shall be referred to a physician and surgeon.

(f) (1) A licensed speech-language pathologist shall not perform a flexible fiber optic transnasal endoscopic procedure unless they have received written verification from one otolaryngologist certified by the American Board of Otolaryngology – Head and Neck Surgery that the speech-language pathologist has performed a minimum of 25 supervised flexible fiber optic transnasal endoscopic procedures and they are competent to perform these procedures. Of these 25 procedures, the first 10 procedures shall be supervised by a licensed physician and surgeon who performs nasal endoscopy as part of their practice and the subsequent 15 procedures shall be supervised by either a licensed physician and surgeon who performs nasal endoscopy as part of their practice or by another licensed speech-language pathologist who is verified as competent in performing flexible fiber optic transnasal endoscopic procedures. The speech-language pathologist shall have this written verification on file and readily available for inspection upon request by the board. A speech-language pathologist with a verification on file shall pass a flexible fiber optic transnasal

endoscopic instrument only upon the orders of a licensed physician and surgeon. The order by a physician and surgeon is deemed to allow a speech-language pathologist with verification, in accordance with this paragraph, to perform fiber optic transnasal endoscopic procedures at a location based on the patient's medical needs that complies with procedures specified in paragraph (1) of subdivision (g).

(2) A licensed speech-language pathologist who holds a written verification pursuant to this subdivision that was issued before January 1, 2023, shall be deemed to meet the requirements described in paragraph (1).

(g) (1) A licensed speech-language pathologist shall only perform flexible endoscopic procedures described in subdivision (e) in the following settings that requires the facility to have protocols for emergency medical backup procedures, including a physician and surgeon or other appropriate medical professionals being readily available.

(A) A clinic, as defined in Section 1200 of the Health and Safety Code.

(B) A facility described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(C) A health facility, as defined in Section 1250 of the Health and Safety Code.

(D) A hospice facility licensed pursuant to Chapter 8.5 (commencing with Section 1745) of Division 2 of the Health and Safety Code.

(E) A medical group practice, including a professional medical corporation, as defined in Section 2406, another form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure, or another lawfully organized group of physicians and surgeons that provides health care services.

(2) A licensed speech-language pathologist performing flexible fiber optic transnasal endoscopic procedures on patients who have contraindications to the procedure shall consult and document clearance with the physician and surgeon that the licensed speech-language pathologist can safely perform the procedure. For purposes of this paragraph, contraindications for these procedures may include, but are not limited to, cases of bilateral obstruction of nasal passages, refractory epistaxis, cardiac disorder with acute risk of vasovagal episode and bradycardia, history of vasovagal episodes, facial trauma, recent trauma to the nasal cavity, or surrounding tissue and structures secondary to surgery or injury, severe bleeding disorders, severe movement disorders, severe agitation, and inability to cooperate with the examination.

## Business and Profession Code section 2570.3.

(a) A person shall not practice occupational therapy or hold themselves out as an occupational therapist or as being able to practice occupational therapy, or to render occupational therapy services in this state unless the person is licensed as an occupational therapist under the provisions of this chapter. A person shall not hold themselves out as an occupational therapy assistant or work as an occupational therapy assistant under the supervision of an occupational therapist unless the person is licensed as an occupational therapy assistant under this chapter.

(b) Only an individual may be licensed under this chapter.

(c) This chapter does not authorize an occupational therapist to practice physical therapy, as defined in Section 2620; speech-language pathology or audiology, as defined in Section 2530.2; nursing, as defined in Section 2725; psychology, as defined in Section 2903; marriage and family therapy, as defined in Section 4980.02; clinical social work, as defined in Section 4996.9; professional clinical counseling, as defined in Section 4999.20; educational psychology, as defined in Section 4989.14; or spinal manipulation or other forms of healing, except as authorized by this section.
(d) An occupational therapist may provide advanced practices if the occupational therapist has the knowledge, skill, and ability to do so and has demonstrated to the satisfaction of the board that the occupational therapist has met educational training and competency requirements. These advanced practices include the following:

(1) Hand therapy.

(2) The use of physical agent modalities.

(3) Swallowing assessment, evaluation, or intervention.

(e) An occupational therapist providing hand therapy services shall demonstrate to the satisfaction of the board that the occupational therapist has completed education and training in all of the following areas:

(1) Anatomy of the upper extremity and how it is altered by pathology.

(2) Histology as it relates to tissue healing and the effects of immobilization and mobilization on connective tissue.

(3) Muscle, sensory, vascular, and connective tissue physiology.

(4) Kinesiology of the upper extremity, such as biomechanical principles of pulleys, intrinsic and extrinsic muscle function, internal forces of muscles, and the effects of external forces.

(5) The effects of temperature and electrical currents on nerve and connective tissue.

(6) Surgical procedures of the upper extremity and their postoperative course.

(f) An occupational therapist using physical agent modalities shall demonstrate to the satisfaction of the board that the occupational therapist has completed education and training in all of the following areas:

(1) Anatomy and physiology of muscle, sensory, vascular, and connective tissue in response to the application of physical agent modalities.

(2) Principles of chemistry and physics related to the selected modality.

(3) Physiological, neurophysiological, and electrophysiological changes that occur as a result of the application of a modality.

(4) Guidelines for the preparation of the client, including education about the process and possible outcomes of treatment.

(5) Safety rules and precautions related to the selected modality.

(6) Methods for documenting immediate and long-term effects of treatment.

(7) Characteristics of the equipment, including safe operation, adjustment, indications of malfunction, and care.

(g) An occupational therapist in the process of achieving the education, training, and competency requirements established by the board for providing hand therapy or using physical agent modalities may practice these techniques under the supervision of an occupational therapist who has already met the requirements established by the board, a physical therapist, or a physician and surgeon.

(h) The board shall develop and adopt regulations regarding the educational training and competency requirements for advanced practices in collaboration with the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board, the Board of Registered Nursing, and the Physical Therapy Board of California.

(i) This chapter does not authorize an occupational therapist to seek reimbursement for services other than for the practice of occupational therapy as defined in this chapter.

(j) “Supervision of an occupational therapy assistant” means that the responsible occupational therapist shall at all times be responsible for all occupational therapy services provided to the client. The occupational therapist who is responsible for appropriate supervision shall formulate and document in each client’s record, with the occupational therapist’s signature, the goals and plan for that client, and shall make

sure that the occupational therapy assistant assigned to that client functions under appropriate supervision. As part of the responsible occupational therapist's appropriate supervision, the occupational therapist shall conduct at least weekly review and inspection of all aspects of occupational therapy services by the occupational therapy assistant.

(1) The supervising occupational therapist has the continuing responsibility to follow the progress of each client, provide direct care to the client, and to ensure that the occupational therapy assistant does not function autonomously.

(2) An occupational therapist shall not supervise more occupational therapy assistants, at any one time, than can be appropriately supervised in the opinion of the board. Three occupational therapy assistants shall be the maximum number of occupational therapy assistants supervised by an occupational therapist at any one time, but the board may permit the supervision of a greater number by an occupational therapist if, in the opinion of the board, there would be adequate supervision and the public's health and safety would be served. In no case shall the total number of occupational therapy assistants exceed three times the number of occupational therapists regularly employed by a facility at any one time.

California Code of Regulations Title 16, Division 39, Article 6.

**§ 4150. Definitions.**

For the purpose of this article:

(a) "ACOTE" means the Accreditation Council for Occupational Therapy Education.

(b) "Post professional education and training" means education and training obtained subsequent to the qualifying degree program or beyond current ACOTE standards for the qualifying degree program.

(c) "Contact hour" means sixty (60) minutes of coursework or classroom instruction.

(d) "Semester unit" means fifteen (15) contact hours.

(e) "Quarter unit" means ten (10) contact hours.

(f) "Rehabilitation of the hand, wrist, and forearm" as used in Code section 2570.2(l) refers to occupational therapy services performed as a result of surgery or injury to the hand, wrist, or forearm.

(g) "Upper extremity" as used in Code section 2570.3(e) includes education relating to the hand, wrist, or forearm.

(h) “Swallowing” as used in Code section 2570.3 is the passage of food, liquid, or medication through the pharyngeal and esophageal phases of the swallowing process.

(i) “Instrumental evaluation” is the assessment of any aspect of swallowing using imaging studies that include, but are not limited to, endoscopy and videofluoroscopy.

(1) “Endoscopic evaluation of swallowing” or “endoscopy” is the process of observing structures and function of the swallowing mechanism to include the nasopharynx, oropharynx, and hypopharynx.

(2) “Videofluoroscopic swallowing study” or “videofluoroscopy” is the fluoroscopic recording and videotaping of the anatomy and physiology of the oral cavity, pharynx, and upper esophagus using a variety of bolus consistencies to assess swallowing function. This procedure may also be known as videofluorography, modified barium study, oral-pharyngeal motility study and videoradiography.

**§ 4153. Swallowing Assessment, Evaluation, or Intervention.**

(a) The role of an occupational therapist in instrumental evaluations is to observe structure and function of the swallowing mechanism in order to assess swallowing capability and determine swallowing interventions. The occupational therapist may not perform the physically invasive components of the instrumental evaluation.

(b) Swallowing assessment, evaluation or intervention may be performed only when an occupational therapist has demonstrated to the Board that they have met the post professional education and training requirements established by this section as follows:

(1) Education: Completion of 45 contact hours in the following subjects:

(A) Anatomy, physiology and neurophysiology of the head and neck with focus on the structure and function of the aerodigestive tract;

(B) The effect of pathology on the structures and functions of the aerodigestive tract including medical interventions and nutritional intake methods used with patients with swallowing problems;

(C) Interventions used to improve pharyngeal swallowing function.

(2) Training: Completion of 240 hours of supervised on-the-job training, clinical internship or affiliation, which may be paid or voluntary, pertaining to swallowing assessment, evaluation or intervention. An occupational therapist in the process of completing the training requirements of this section may practice swallowing assessment, evaluation or intervention under the supervision of an occupational therapist who has been approved under this article, a speech language pathologist with expertise in this area, or a physician and surgeon.

c) An occupational therapist may provide only those swallowing assessment, evaluation or intervention services the occupational therapist is competent to perform.

**§ 4154. Post Professional Education and Training.**

(a) Post professional education courses shall be obtained at any of the following:

(1) College or university degree programs accredited or approved by ACOTE;

(2) College or university degree programs accredited or approved by the Commission on Accreditation in Physical Therapy Education;

(3) Colleges or universities with Speech and Hearing Programs accredited or approved by the Council on Academic Accreditation in Audiology and Speech-Language Pathology;

(4) Any approved provider. To be approved by the Board the provider shall submit the following:

(A) A clear statement as to the relevance of the course to the advanced practice area.

(B) Information describing, in detail, the depth and breadth of the content covered (e.g., a course syllabus and the goals and objectives of the course) particularly as it relates to the advanced practice area.

(C) Information that shows the course instructor's qualifications to teach the content being taught (e.g., their education, training, experience, scope of practice, licenses held, and length of experience and expertise in the relevant subject matter), particularly as it relates to the advanced practice area.

(D) Information that shows the course provider's qualifications to offer the type of course being offered (e.g., the provider's background, history, experience, and similar courses previously offered by the provider), particularly as it relates to the advanced practice area; or

(5) A provider that has not been approved by the Board, if the applicant occupational therapist demonstrates that the course content meets the subject matter requirements set forth in sections 2570.3(e) or 2570.3(f) of the Code, or section 4153 of these regulations, and submits the following:

(A) Information describing, in detail, the depth and breadth of the content covered (e.g., a course syllabus and the goals and objectives of the course) particularly as it relates to the advanced practice area.

(B) Information that shows the course instructor's qualifications to teach the content being taught (e.g., their education, training, experience, scope of practice, licenses held, and length of experience and expertise on the relevant subject matter), particularly as it relates to the advanced practice area.

(b) Post professional training shall be supervised which means, at a minimum:

(1) The supervisor and occupational therapist have a written agreement, signed and dated by both parties prior to accruing the supervised experience, outlining the plan of supervision and training in the advanced practice area. The level of supervision is determined by the supervisor whose responsibility it is to ensure that the amount, degree, and pattern of supervision is consistent with the knowledge, skill and ability of the occupational therapist, and appropriate for the complexity of client needs and number of clients for whom the occupational therapist is providing advanced practice services.

(2) The supervisor is readily available in person or by telecommunication to the occupational therapist while the therapist is providing advanced practice services.

(3) The supervisor does not have a co-habitative, familial, intimate, business, excluding employment relationships, or other relationship that could interfere with professional judgment and objectivity necessary for effective supervision, or that violates the Ethical Standards of Practice, pursuant to section 4170.

(c) Any course instructor providing post-professional education under section 4154(a)(4) or (5) who is a health care practitioner as defined in section 680 of the Code shall possess an active, current, and unrestricted license.

(d) Post professional education and training must be completed within the five years immediately preceding the application for approval in each advanced practice area.

# SCOPE OF PRACTICE FOR THE SPEECH-LANGUAGE PATHOLOGY ASSISTANT (SLPA)

AD HOC COMMITTEE TO UPDATE THE SCOPE OF PRACTICE FOR SPEECH-LANGUAGE PATHOLOGY ASSISTANTS

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# ABOUT THIS DOCUMENT

This Scope of Practice for the Speech-Language Pathology Assistant (SLPA) was developed by the American Speech-Language-Hearing Association (ASHA) Ad Hoc Committee to Update the Scope of Practice for Speech-Language Pathology Assistants (hereafter, "the Ad Hoc Committee"). In January 2021, the ASHA Board of Directors approved a resolution for the development of the ad hoc committee to complete this task. Members of the committee were Jerrold Jackson, MA, CCC-SLP (chair, Texas),

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Tyler T. Christopulos, PhD, CCC-SLP (Utah), Erin Judd, C-SLPA (Minnesota), Ashley Northam, CCC-SLP (Oregon), Katie Orzechowski, MS, CCC-SLP (Illinois), Jennifer Schultz, MA, CCC-SLP (South Dakota), Nancy Thul, MS, CCC-SLP (Minnesota), Nicole Wilson-Friend, C-SLPA (California), and Lemmietta McNeilly, PhD, CCC-SLP (ex officio). Linda I. Rosa-Lugo, EdD, CCC-SLP, Vice President for Speech-Language Pathology Practice, served as the Board liaison. The composition of the Ad Hoc committee included ASHA-certified speech-language pathologists (SLPs) and SLPAs with specific knowledge and experience working with/as support personnel in clinical practice in schools, health care, and/or private practice settings.

This document is intended to provide guidance for SLPAs and their SLP supervisors regarding ethical considerations related to the SLPA practice parameters. It addresses how services performed by SLPAs should be utilized and what specific responsibilities are within and outside their roles of clinical practice. This information was developed by analyzing current practice standards, certification requirements, methods of academic and clinical training (from academic program directors, clinical educators, etc.), and feedback from stakeholders in communication sciences and disorders. Given that standards, state credentialing (e.g., licensure, etc.), and practice issues vary from state to state, this document's purpose is to provide information regarding ASHA's guidelines for the use of SLPAs for the treatment of communication disorders across practice settings.

# DEDICATION

In loving memory of Steve Ritch, whose dedication, commitment, and perseverance contributed to ensuring integrity and quality in addressing the topic of SLPAs within the ASHA structure.

# ACKNOWLEDGEMENTS

We would like to acknowledge others who provided feedback and insights that aided in the development of this document. The Ad Hoc Committee would also like to acknowledge the expertise shared by Marianne Gellert-Jones, MA, CCC-SLP (Pennsylvania), Ianessa Humbert, PhD, CCC-SLP (Washington, D.C.), and Rosemary Montiel, C-SLPA (California).

# EXECUTIVE SUMMARY

ASHA has identified critical shortages of speech-language pathologists (SLP) in all regions of the country, particularly in school settings. These shortages impede the ability of individuals with communication and related disorders to reach their full academic, social, and emotional potential. The use of speech-language pathologist assistants (SLPAs) is an essential element of aiding those professionals who provide services and individuals who rely on such services. It is the position of ASHA that the use of any support personnel be done with the explicit purpose of support for the SLP rather than used as an alternative.

This scope of practice presents minimum recommendations for the training, use, and supervision of speech-language pathology assistants. SLPAs perform tasks as prescribed, directed, and supervised by

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ASHA-certified and/or state-credentialed SLPs. Support personnel can be used to increase the availability, frequency, and efficiency of services.

Some tasks, procedures, or activities used to treat individuals with communication and related disorders can be successfully performed by individuals other than SLPs if the persons conducting the activity are properly trained and supervised by ASHA-certified and/or state-credentialed SLPs. The use of evidence as well as ethical and professional judgment should be at the heart of the selection, management, training, supervision, and use of SLPAs.

This scope of practice specifies the minimum qualifications and responsibilities for an SLPA and delineates the tasks that are the exclusive responsibilities of the SLP. In addition, the document provides guidance regarding ethical considerations when SLPAs provide clinical services and outlines the supervisory responsibilities of the supervising SLP.

# INTRODUCTION

The *Scope of Practice for the SLPA* provides information regarding the training, use, and supervision of assistants in speech-language pathology – a designation that ASHA established to be applicable in a variety of work settings. Training for SLPAs should be based on the type of tasks specified in their scope of responsibility. Specific education and training may be necessary to prepare assistants for unique roles in various professional settings.

ASHA has addressed the topic of support personnel in speech-language pathology since the 1960s. In 1967, the ASHA Executive Board established the Committee on Supportive Personnel and, in 1969, the document ASHA Legislative Council (LC) approved the document *Guidelines on the Role, Training and Supervision of the Communicative Aide*. In the 1990s, several entities—including committees, a task force, and a consensus panel—were established and the LC approved a position statement, technical report, guidelines, and curriculum content for support personnel. In 2002, ASHA developed an approval process for SLPA programs, and in 2003 ASHA established a registration process for SLPAs. Both were discontinued by vote of the LC because of fiscal concerns. In 2004, the LC approved a position statement on the training, use, and supervision of support personnel in speech-language pathology. Since then, the number of SLPAs has increased primarily in schools and private practice settings. ASHA members in many states continue to request specific guidance from ASHA. In 2016, the ASHA Board of Directors (BOD) completed a feasibility study for the standardization of requirements for assistants; that study demonstrated strong support for certifying assistants, across all stakeholders. The ASHA BOD voted to approve the Assistants Certification program in 2017. In December 2020, the ASHA Assistants Certification Program launched; this program sets standards for the practices and operations for SLPAs as well as for audiology assistants.

**This document does not supersede federal legislation and regulation requirements or any existing state credentialing laws, nor does it affect the interpretation or implementation of such laws.** The

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document may serve, however, as a guide for the development of new laws or, at the appropriate time, for revising existing licensure laws.

# STATEMENT OF PURPOSE

The purpose of this document is to define what is within and outside the scope of responsibilities for SLPAs who work under the supervision of properly credentialed SLPs. The following aspects are addressed:

- parameters for education and professional development for SLPAs
- SLPAs' responsibilities within and outside the scope of practice
- varied practice settings
- information for others (e.g., special educators, parents, consumers, health professionals, payers, regulators, members of the general public) regarding services that SLPAs perform
- information regarding the ethical and liability considerations for the supervising SLP and the SLPA
- supervisory requirements for the SLP and the SLPA.

# MINIMUM REQUIREMENTS FOR AN SLPA

An SLPA must complete an approved course of academic study, complete a supervised clinical experience, successfully pass the ASHA Assistants Certification Exam, **meet credentialing requirements for the state in which they practice**, and receive orientation as well as on-the-job training of SLPA responsibilities specific to the setting.

The minimum educational, clinical, and examination requirements for all SLPAs are outlined in the subsections below:

## THREE EDUCATIONAL OPTIONS

An SLPA has three educational options:

1. Completion of an SLPA program from a regionally accredited institution (e.g., an associate degree, a technical training program, a certificate program).

**OR**

2. Receipt of a bachelor's degree in communication sciences and disorders from a regionally accredited institution AND completion of ASHA education modules.

**OR**

3. Receipt of a bachelor's degree in a field other than communication sciences and disorders AND completion of ASHA education modules AND successful completion of coursework from a regionally or nationally accredited institution in all of the following areas:
    - introductory or overview course in communication disorders
    - phonetics
    - speech sound disorders
    - language development

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- language disorders
- anatomy and physiology of speech and hearing mechanisms

### ADDITIONAL REQUIREMENTS

In addition to having satisfied one of the above three educational options, the SLPA must also meet all the following three requirements:

1. Completion of a supervised clinical experience that consists of a minimum of one hundred (100) hours under the direct supervision of an ASHA certified SLP. The supervising SLP must meet all ASHA certification and supervising requirements and state credentialing requirements.
2. Achieve a passing score on the ASHA Assistants Certification Exam.
3. Meet all state credentialing requirements.

## EXPECTATIONS OF AN SLPA

The following list details of the roles and performance expectations of an ASHA-certified SLPA:

- Adhere to all applicable state laws and rules regulating the practice of speech-language pathology.
- Adhere to the responsibilities for SLPAs specified in this scope of practice document and in state requirements.
- Avoid performing tasks or activities that are the exclusive responsibility of the SLP.
- Perform only those tasks approved by the supervising SLP.
- Work only in settings for which the SLPA has been trained and in which state regulations allow for SLPA employment.
- Deliver services only with an ASHA-certified and state licensed SLP providing direct and indirect supervision on a regular and systematic basis. Frequency and type of supervision should be based on the SLPA's competencies, and the caseload need, both of which are determined by the supervising SLP.
- Conduct oneself ethically within the *ASHA Assistant's Code of Conduct* (ASHA, 2020b) and state ethical codes.
- Self-advocate for needed supervision and training and for adherence to this SLPA scope of practice and other requirements.
- Provide culturally responsive services while communicating and collaborating with students, patients, clients, the supervising SLP, colleagues, families, caregivers, and other stakeholders.
- Actively pursue continuing education and professional development activities.
- Obtain information regarding availability and need for liability insurance.

## RESPONSIBILITIES WITHIN THE SCOPE OF PRACTICE FOR SLPAS

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The supervising SLP retains full legal and ethical responsibility for students, patients, and clients served but may delegate specific tasks to the SLPA. The SLPA may execute components of services as specified by the SLP in the plan of care. Services performed by the SLPA are only those within the scope of practice and are tasks that the SLPA has the training and skill to perform as verified by the supervising SLP. The SLP must provide appropriate and adequate direct and indirect supervision to ensure quality care for all persons served. The amount of supervision may vary depending on the case's complexity and the SLPA's experience. Under no circumstances should the use of an SLPA's services (a) violate the *ASHA Code of Ethics* (2016a) or the *ASHA Assistants Code of Conduct* (2020b) or (b) negatively impact the quality of services. An SLPA's services are designed to enhance the quality of care provided by the SLP.

Decisions regarding the tasks that are appropriate to assign to the SLPA should be made by the supervising SLP in collaboration with the SLPA. The SLPA is responsible for communicating their knowledge, experience, and self-assessment of competence with specific skills to the supervising SLP. It is the SLP's responsibility to observe the SLPA performing specific tasks; to provide feedback regarding clinical performance; to recommend or provide education and training to develop skills to meet the needs of the students, patients, and clients served; and to validate the SLPA's competence. The SLPA's competence in practice areas can be determined by observations, collaboration between the supervising SLP and the SLPA, as well as other resources deemed significant by the supervisor/supervisee pair.

If the SLPA has demonstrated the necessary competencies and the supervising SLP provides the appropriate amount and type of supervision, the SLPA may engage in or assigned to perform the following tasks:

- service delivery
- culturally responsive practices
- responsibilities for all practitioners
- responsibilities for practitioners who use multiple languages
- administration and support
- prevention and advocacy.

## SERVICE DELIVERY

The SLPA should engage in the following activities when performing necessary tasks related to speech-language service provision:

- Self-identifying (e.g., verbally, in writing, signage, titles on name badges, etc.) as an SLPA to students, patients, clients, families, staff, and others.
- Exhibiting compliance with federal, state, and local regulations including: The Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA); reimbursement requirements; and state statutes and rules regarding SLPA education, training, and scope of practice.
- Administering and scoring screenings for clinical interpretation by the SLP.

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- Assisting the SLP during assessment of students, patients, and clients (e.g., setting up the testing environment, gathering and prepping materials, taking notes as advised by the SLP, etc.).
- Administering and scoring assessment tools that (a) the SLPA meets the examiner requirements specified in the examiner's manual and (b) the supervising SLP has verified the SLPA's competence in administration, exclusive of clinical interpretation.
- Administering and scoring progress monitoring tools exclusive of clinical interpretation if (a) the SLPA meets the examiner requirements specified in the examiner's manual and (b) the supervisor has verified the SLPA's competence in administration.
- Implementing documented care plans or protocols (e.g., individualized education plan [IEP], individualized family service plan [IFSP], treatment plan) developed and directed by the supervising SLP.
- Providing direct therapy services addressing treatment goals developed by the supervising SLP to meet the needs of the student, patient, client, and family.
- Adjusting and documenting the amount and type of support or scaffolding provided to the student, patient, or client in treatment to facilitate progress.
- Developing and implementing activities and materials for teaching and practice of skills to address the goals of the student, patient, client, and family per the plan of care developed by the supervising SLP.
- Providing treatment through a variety of service delivery models (e.g., individual, group, classroom-based, home-based, co-treatment with other disciplines) as directed by the supervising SLP.
- Providing services via telepractice to students, patients, and clients who are selected by the supervising SLP.
- Documenting student, patient, or client performance (e.g., collecting data and calculating percentages for the SLP to use; preparing charts, records, and graphs) and report this information to the supervising SLP in a timely manner.
- Providing caregiver coaching (e.g., model and teach communication strategies, provide feedback regarding caregiver-child interactions) for facilitation and carryover of skills.
- Sharing objective information (e.g., accuracy in speech and language skills addressed, participation in treatment, response to treatment) regarding student, patient, and client performance to students, patients, clients, caregivers, families and other service providers without interpretation or recommendations as directed by the SLP.
- Programming augmentative and alternative communication (AAC) devices.
- Providing training and technical assistance to students, patients, clients, and families in the use of AAC devices.
- Developing low-tech AAC materials for students, patients, and clients.
- Demonstrating strategies included in the feeding and swallowing plan developed by the SLP and share information with students, patients, clients, families, staff, and caregivers.

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- Assisting students, patients, and clients with feeding and swallowing skills developed and directed by the SLP when consuming food textures and liquid consistencies.

# CULTURALLY RESPONSIVE PRACTICES

Cultural responsiveness has been described as providing individuals "with a broader perspective from which to view our behaviors as they relate to our actions with individuals across a variety of cultures that are different from our own" (Hyter & Salas-Provance, 2019, p.7).

Engaging in culturally responsive practices refers to the "explicit use of culturally based care and health knowledge in sensitive, creative, and meaningful ways" (Leininger, 2002, p. 84). It is important to remember that cultural and linguistic backgrounds exist on a continuum and not all individuals will exhibit characteristics of one group at any given time. Practitioners must meet the student, patient, client, and their families or caregivers in a space of mutual understanding and respect.

Not only is the supervising SLP responsible for engaging in these practices, but they should also train and provide support for the SLPA to develop these skills

## RESPONSIBILITIES FOR SLPS AND SLPAS

All practitioners have the following responsibilities related to cultural and linguistic supports:

- Adjust communication style and expectations to meet the needs of clients, patients, and students from different cultural groups and to provide services in a culturally responsive manner. For more information, see the ASHA Practice Portal on *Cultural Competence* [ASHA, n.d.-b].
- Provide information to families and staff regarding the influence of first language on the development of communication and related skills in a second language (under the direction of the supervising SLP).
- Develop an understanding of the family dynamic from a cultural perspective to effectively engage in meetings surrounding intake, discussions of the therapy plan of care and other communication scenarios surrounding practices for addressing communication concerns
- Engage in continuing education and training opportunities focusing on the assessment and intervention process when working with individuals from culturally and linguistically diverse backgrounds.

## RESPONSIBILITIES FOR PRACTITIONERS WHO USE MULTIPLE LANGUAGES

Based on prior training and experiences in working with multilingual students, patients or clients and their families, the SLPA may engage in the following tasks:

- Assist the SLP with interpretation and translation in the student's, patient's, or client's first language during screening and assessment activities exclusive of clinical interpretation of results. For more information, see *Issues in Ethics: Cultural and Linguistic Competence* (ASHA 2017) and the ASHA Practice Portal Page on *Bilingual Service Delivery* (ASHA, n.d.-a)

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- Interpret for students, patients, clients, and families who communicate using a language other than English, when the provider has received specialized training with interpreting skills in the student's, patient's, or client's first language. For more information, see *Issues in Ethics: Cultural and Linguistic Competence* (ASHA 2017) and the ASHA Practice Portal Page on *Bilingual Service Delivery* (ASHA, n.d.-a)
- Provide services in another language for individuals who communicate using a language other than English or for those who are developing English language skills. Such services are based on the provider's skills and knowledge of the language spoken by the student, patient, or client. For more information, see *Issues in Ethics: Cultural and Linguistic Competence* (ASHA 2017) and the ASHA Practice Portal Page on *Bilingual Service Delivery* (ASHA, n.d.-a).

## ADMINISTRATIVE SUPPORT

Depending on the setting, adequate training, and guidance from the supervising SLP, the SLPA may:

- assist with clerical duties and site operations (e.g., scheduling, recordkeeping, maintaining inventory of supplies and equipment);
- perform safety checks and maintenance of equipment, and
- prepare materials for screening, assessment, and treatment services.

## PREVENTION AND ADVOCACY

Depending on the setting, adequate training, and guidance from the supervising SLP, the SLPA may

- present primary prevention information to individuals and groups known to be at risk for communication and swallowing disorders;
- promote early identification and early intervention activities;
- advocate for individuals and families through community awareness, health literacy, education, and training programs to promote and facilitate access to full participation in communication—including addressing the social determinants of health and health disparities;
- provide information to emergency response agencies for individuals who have communication, swallowing, and/or related disorders;
- advocate at the local, state, and national levels for improved public policies affecting access to services and research funding;
- support the supervising SLP in research projects, in-service training, marketing, and public relations programs; and
- participate actively in professional organizations.

## RESPONSIBILITIES OUTSIDE THE SCOPE OF PRACTICE FOR SPEECH-LANGUAGE PATHOLOGY ASSISTANTS

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There is potential for misuse of an SLPA's services, particularly when responsibilities are delegated by other staff members (e.g., administrators, nursing staff, physical therapists, occupational therapists, psychologists, etc.) without the approval of the supervising SLP. It is highly recommended that this *ASHA SLPA Scope of Practice* as well as the *ASHA Code of Ethics* (ASHA, 2016a) and the *ASHA Assistants Code of Conduct* (ASHA, 2020b) be reviewed with all personnel involved when employing an SLPA. It should be emphasized that an individual's communication and/or related disorders and/or other factors may preclude the use of services from anyone other than an ASHA-certified and/or licensed SLP. The SLPA should not perform any task without the approval of the supervising SLP. The student, patient, or client should be informed that they are receiving services from an SLPA under the supervision of an SLP.

**The SLPA should *NOT* engage in any of the following activities:**

- representing themselves as the SLP;
- interpreting assessment tools for the purpose of diagnosing disability, determining eligibility or qualification for services;
- administering or interpreting feeding and/or swallowing screenings, checklists, and assessments;
- diagnosing communication and feeding/swallowing disorders;
- developing or determining the feeding and/or swallowing strategies or precautions for students, patients, and clients;
- disclosing clinical or confidential information (e.g., diagnosis, services provided, response to treatment) either orally or in writing to individuals who have not been approved by the SLP to receive information unless mandated by law;
- writing, developing, or modifying a student's, patient's, or client's plan of care in any way;
- making referrals for additional services;
- assisting students, patients, and clients without following the individualized plan of care prepared by the ASHA certified SLP;
- assisting students, patients, and clients without access to supervision;
- selecting AAC systems or devices;
- treating medically fragile students, patients, and clients without 100% direct supervision;
- performing procedures that require specialized knowledge and training (e.g., vocal tract prosthesis shaping or fitting, vocal tract imaging);
- providing input in care conferences, case conferences, or any interdisciplinary team meeting without the presence or prior approval of the supervising SLP or other designated SLP;
- providing interpretative information to the student, patient, client, family, or others regarding the student's, patient's, or client's status or service;
- signing or initialing any formal documents (e.g., plans of care, reimbursement forms, reports) without the supervising SLP's co-signature;
- discharging a student, patient, or client from services.

# PRACTICE SETTINGS

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Under the specified guidance and supervision of an ASHA-certified and/or state-credentialed SLP, SLPAs may provide services in a wide variety of settings, which may include, but are not limited to, the following:

- public, private, and charter elementary and secondary schools
- early intervention settings (e.g., homes, preschools, daycare settings)
- hospitals (inpatient and outpatient)
- residential health care settings (e.g., long-term care and skilled nursing facilities)
- nonresidential health care settings (e.g., adult daycare, home health services, and clinics)
- private practice settings
- university/college clinics
- research facilities
- corporate and industrial settings
- student's, patient's, or client's residences

# ETHICAL CONSIDERATIONS

ASHA strives to ensure that its members and certificate holders preserve the highest standards of integrity and ethical practice. ASHA maintains two separate documents that set forth the fundamentals of ethical conduct in the professions. The *ASHA Code of Ethics* (2016a) sets forth the fundamental principles and rules deemed essential for SLPs. This code applies to every individual who is (a) an ASHA member, whether certified or not, (b) a nonmember holding the ASHA Certificate of Clinical Competence, (c) an applicant for membership or certification, or (d) a Clinical Fellow seeking to fulfill standards for certification.

The *ASHA Assistants Code of Conduct* (2020b) sets forth the principles and fundamentals of ethical practice for SLPAs. The Assistants Code of Conduct applies to all ASHA-certified audiology and speech-language pathology assistants, as well as applicants for assistant certification. It defines the SLPA's role in the provision of services under the SLP's supervision and provides a framework to support decision-making related to the SLPA's actions. The Assistants Code of Conduct holds assistants to the same level of ethical conduct as the supervising SLP with respect to responsibilities to people served professionally, the public, and other professionals; however, it does not address ethics in supervision and other duties that are outside the SLPA Scope of Practice.

It is imperative that the supervising SLP and the SLPA are knowledgeable about the provisions of both codes and that they behave in a manner consistent with the principles and rules outlined in the ASHA Code of Ethics and the ASHA Assistants Code of Conduct. Because the ethical responsibility for students, patients, and clients--or for subjects in research studies--cannot be delegated, the supervising SLP takes overall responsibility for the actions of any SLPA when that SLPA is performing their assigned duties. If the SLPA engages in activities that violate the Assistants Code of Conduct, then the supervising SLP may be found in violation of the Code of Ethics--if it is found that adequate oversight has not been provided.

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The following principles and rules of the Code of Ethics specifically address issues that are pertinent when an SLP supervises SLPAs in the provision of services or when conducting research. Failure to comply with principles and rules related to supervisory activities in the Code of Ethics or failure to ensure that the SLPA complies with the Assistants Code of Conduct could result in a violation of the Code of Ethics by the supervisor.

**Principle of Ethics I, Rule of Ethics A:** Individuals shall provide all clinical services and scientific activities competently.

**Guidance:**

The supervising SLP must ensure that all services, including those provided directly by the SLPA, meet practice standards, and are administered competently. The supervising SLP is responsible for providing training as needed or requested by the SLPA, identifying the services that the SLPA is competent to perform, monitoring the provision of those services to ensure quality of care, and intervening to correct the actions of the SLPA as needed.

**Principle of Ethics I, Rule of Ethics D:** Individuals shall not misrepresent the credentials of aides, assistants, technicians, support personnel, students, research interns, Clinical Fellows, or any others under their supervision, and they shall inform those they serve professionally of the name, role, and professional credentials of persons providing services.

**Guidance:**

The supervising SLP must ensure that students, patients, clients, caregivers, and research subjects are informed of the title and qualifications of the SLPA. This is not a passive responsibility; that is, the supervisor must make this information easily available and understandable to the students, patients, clients, caregivers, and research subjects and not rely on the individual to inquire about or ask directly for this information.

**Principle of Ethics I, Rule of Ethics E:** Individuals who hold the Certificate of Clinical Competence may delegate tasks related to the provision of clinical services to aides, assistants, technicians, support personnel, or any other persons only if those persons are adequately prepared and are appropriately supervised. The responsibility for the welfare of those being served remains with the certified individual.

**Guidance:**

The supervising SLP is responsible for providing appropriate and adequate direct and indirect supervision to ensure that the services provided are appropriate and meet practice standards. The SLP must consider student, patient, or client needs and the SLPA's knowledge and skills to determine what constitutes appropriate supervision, which may be more than the minimum required in state regulations. The SLP must document supervisory activities and adjust the amount and type of supervision to ensure that the Code of Ethics and Assistants Code of Conduct are followed.

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**Principle of Ethics I, Rule of Ethics F:** Individuals who hold the Certificate of Clinical Competence shall not delegate tasks that require the unique skills, knowledge, judgment, or credentials that are within the scope of their profession to aides, assistants, technicians, support personnel, or any nonprofessionals over whom they have supervisory responsibility.

**Guidance:**

The supervising SLP is responsible for monitoring the professional activities performed by the SLPA and ensuring that they remain within the guidelines set forth in the ASHA SLPA Scope of Practice and applicable state and facility guidelines. In some cases, ASHA requirements may differ from state regulations. ASHA requirements do not supersede state licensure laws or affect the interpretation or implementation of such laws. The supervising SLP should ensure that the highest standards of ethical conduct are maintained.

**Principle of Ethics II, Rule of Ethics A:** Individuals who hold the Certificate of Clinical Competence shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their certification status, education, training, and experience.

**Guidance:**

The supervising SLP is responsible for ensuring that they have the skills and competencies needed to provide appropriate supervision. This includes completion of required continuing education in supervision and may include seeking additional continuing education in supervision to remain current in this area.

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

**Guidance:**

The supervising SLP must ensure that the SLPA only performs those activities that are defined as appropriate for the level of training and experience and in accordance with applicable state regulations and facility guidelines. If the SLPA exceeds the practice role that has been defined for them, the SLP must intervene to correct the actions of the SLPA as needed.

**Principle of Ethics III, Rule of Ethics D:** Individuals shall not defraud through intent, ignorance, or negligence or engage in any scheme to defraud in connection with obtaining payment, reimbursement, or grants and contracts for services provided, research conducted, or products dispensed.

**Guidance:**

States and third-party payers (e.g., insurance, Medicaid) vary in their policies regarding recognition of SLPAs as approved service providers, rate of reimbursement for assistant-level services, and other

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policies. The supervising SLP and SLPA are jointly responsible for knowing and understanding federal and state regulations and individual payer policies, billing for services at the appropriate level, and providing the amount and type of supervision required by the payer when billing for SLPA services.

**Principle of Ethics IV, Rule of Ethics I:** Individuals shall not knowingly allow anyone under their supervision to engage in any practice that violates the Code of Ethics.

**Guidance:**

Because the SLPA provides services as an extension of those provided by the certified SLP, the SLP is responsible for ensuring the SLPA adheres to the Assistants Code of Conduct and monitoring the performance of the SLPA.

# LIABILITY ISSUES

Individuals who engage in the delivery of services to persons with communication and swallowing disorders are potentially vulnerable to accusations of engaging in unprofessional practices. Therefore, ASHA recommends that SLPAs secure liability insurance as a protection for malpractice. SLPAs should consider the need for liability coverage. Some employers provide it for all employees. Other employers defer to the employee to independently acquire liability insurance. Some universities provide coverage for students involved in practicum and fieldwork. Obtaining or verifying liability insurance coverage is the SLPA's responsibility and needs to be done prior to providing services.

# GUIDELINES FOR SLP SUPERVISION OF SLPAS

For SLPAs to practice, a supervising SLP must be identified. The following indicates considerations for the supervising SLP:

- qualifications for the supervising SLP
- expectations of the supervising SLP
- considerations for the ratio of SLPs to SLPAs
- requirements for frequency and duration of supervision.

## MINIMUM QUALIFICATIONS FOR A SUPERVISING SLP

The minimum qualifications for an SLP to supervise the SLPA include the following:

- Hold the Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP) from ASHA and/or possess the necessary state-credentials
- Completion of a minimum of 9 months of experience after being awarded ASHA certification (i.e., completion of the 9-month Clinical Fellowship followed by 9 months of experience)
- Completion of a minimum of 2 hours of professional development in clinical instruction/supervision
- Adherence to state guidelines for supervision of the SLPA

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- It is recommended that the professional development course taken in clinical instruction or supervision include content related to the supervision of SLPAs

## EXPECTATIONS FOR THE SUPERVISING SLP

In addition to the minimum qualifications listed above, the following are additional roles and behavior that are expected of the supervising SLP:

- Adhere to the principles and rules of the ASHA Code of Ethics (ASHA, 2016a)
- Adhere to applicable licensure laws and rules regulating the practice of speech-language pathology
- Conduct ongoing competency evaluations of the SLPAs
- Provide and encourage ongoing education and training opportunities for the SLPA consistent with competency and skills required to meet the needs of the students, patients, and clients served
- Develop, review, and modify treatment plans for students, patients, and clients that the SLPA implements under the supervision of the SLP
- Make all case management decisions
- Adhere to the supervisory responsibilities for SLPs
- Retain legal and ethical responsibility for all students, patients, and clients served
- Maintain an active interest in collaborating with SLPAs

## SUPERVISION OF SLPAS

The relationship between the supervising SLP and the SLPA is paramount to the welfare of the student, patient, or client. Because the clinical supervision process is a close, interpersonal experience, the supervising SLP should participate in the selection of the SLPA when possible. It is the SLP's responsibility to design and implement a supervision system that protects the students', patients', and clients' care and that maintains the highest possible standards of quality. The amount and type of supervision must meet (a) minimum requirements as specified in this document and (b) state requirements. Supervision must be based on (a) the needs, competencies, skills, expectations, philosophies, and experience of the SLPA and the supervisor; (b) the needs of students, patients, and clients served; (c) the service setting; (d) the tasks assigned; and (e) other factors. More intense supervision, for example, would be required in such instances as the orientation of a new SLPA; initiation of a new program, equipment, or task; or a change in student, patient, or client status (e.g., medical complications). Functional assessment of the SLPA's skills with assigned tasks should be an ongoing, regular, and integral element of supervision. SLPs and SLPAs should treat each other with respect and should interact in a manner that will provide the best possible outcomes for student, patient, and client care. It is also critical that the SLP and SLPA understand that their language, culture, and experiences will be different within the dyad and across the triad (SLP, SLPA, and patient, client, and student). It is expected that the practitioners stay grounded in cultural responsiveness and culturally responsive practices when engaged in all aspects of interactions.

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As the SLP's supervisory responsibility increases, overall responsibilities will change because the SLP is responsible for the students, patients, and clients as well as supervision of the SLPA. Therefore, adequate time for direct and indirect supervision of the SLPA(s) and caseload management must be allotted as a critical part of the SLP's workload. The purpose of the assistant level position is not to significantly increase the caseload size for SLPs. The specialized skills should be utilized to support the SLP with the care of individuals on the SLP's caseload. Under no circumstances should an assistant have their own caseload.

Diagnosis, treatment, and support of the students, patients, and clients served remains the legal and ethical responsibility of the supervisor. Therefore, the level of supervision required is considered the minimum level necessary for the supervisor to retain direct contact with the students, patients, and clients. The supervising SLP is responsible for designing and implementing a supervisory plan that protects consumer care, maintains the highest quality of practice, and documents the supervisory activities.

## SLP-TO-SLPA RATIO

The supervising SLP should determine the appropriate number of assistants whose practice can be supervised within their workload. Although more than one SLP may provide supervision of an SLPA, it is recommended that the SLP not supervise or be listed as a supervisor for more than three full-time equivalent (FTE) SLPAs in any setting. The number of SLPAs who can be appropriately supervised by a single SLP will depend on a variety of factors including caseload characteristics, SLPA experience, and SLP experience. The SLP is responsible for determining how many SLPAs can be supervised while maintaining the highest level of quality for services provided. When multiple SLPs supervise a single SLPA, it is critical that the supervisors coordinate and communicate with each other so that they collectively meet minimum supervisory requirements and ensure that they maintain the highest quality of services.

## REQUIREMENTS FOR THE FREQUENCY AND AMOUNT OF SUPERVISION

Supervision requirements may vary based on a variety of factors. The amount and type of supervision required must be consistent with (a) the SLPA's skills and experience; the needs of the students, patients, and clients; (c) the service setting; (d) the tasks assigned; and (e) the laws and regulations that govern SLPAs. To ensure adequate and appropriate supervision, the supervising SLP should outline their expectations in collaboration with the SLPA. As the relationship continues to develop over time, the SLP/SLPA team can decide how and to what extent supervision is needed.

Before the SLPA begins to provide support independently, the supervising SLP must have first contact with all individuals on the caseload. "First contact" includes establishing rapport, gathering baseline data, and securing other necessary documentation to begin (or continue) the plan of care for the student, patient, or client. As the SLP/SLPA team dynamic continues to develop beyond the initial onboarding, minimum ongoing supervision must always include documentation of direct supervision provided by the SLP for each student, patient, or client **at least every 30–60 days (depending on frequency of visits/sessions and setting).**

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The SLP can adjust the amount of supervision if they determine that the SLPA has met appropriate competencies and skill levels in treating students, patients, and clients who have a variety of communication disorders. Data on every student, patient, and client serviced by the SLPA should be reviewed by the supervisor in regular intervals and can be considered “indirect supervision.” Supervisors should arrange designated days and times of day (morning or afternoon) in such a way that all students, patients, and clients receive direct contact with the supervising SLP.

The supervising SLP must accurately document and regularly record all supervisory activities, both direct and indirect. Further, 100% direct supervision (synchronous or “live” telesupervision is acceptable) of SLPAs for medically fragile students, patients, or clients is required.

The supervising SLP is responsible for designing and implementing a supervisory plan, which ensures that the SLP maintains the highest standard of quality care for students, patients, and clients. A written supervisory plan is a tangible way to document progress and outline the practices of the supervising SLP and the SLPA. Care of the student, patient, or client remains the supervisor’s responsibility.

Direct supervision means in-view observation and guidance while the SLPA is performing a clinical activity. This can include the supervising SLP viewing and communicating with the SLPA via telecommunication technology as the SLPA provides clinical services, this scenario allows the SLP to provide ongoing immediate feedback. Direct supervision does not include reviewing an audio or video recorded session later.

Supervision feedback should provide information about the quality of the SLPA's performance of assigned tasks and should verify that clinical activity is limited to tasks specified in the list of an SLPA's ASHA-approved responsibilities. Information obtained during direct supervision may include, but is not limited to, data relative to (a) agreement (reliability) between the SLPA and the supervisor on correct or incorrect recording of target behavior, (b) accuracy implementing assigned treatment procedures, (c) accuracy recording data, and (d) ability to interact effectively with the student, patient, or client during presentation and implementation of assigned procedures or activities.

Indirect supervision does not require the SLP to be physically present or available via telecommunication while the SLPA is providing services. Indirect supervisory activities may include (a) reviewing demonstration videos; (b) reviewing student, client, or patient files; (c) reviewing and evaluating audio or video recorded sessions; and/or (d) conducting supervisory conferences either in person or via telephone and/or live, secure virtual meetings. The SLP will review each care plan as needed for timely implementation of modifications.

An SLPA may not perform tasks when a supervising SLP cannot be reached by personal contact, that is, phone, pager, or other immediate or electronic means. If, for any reason (i.e., maternity leave, illness, change of jobs) the supervisor is no longer available to provide the level of supervision stipulated, then the SLPA may not perform assigned tasks until an ASHA-certified and/or state-licensed SLP with experience and training in supervision has been designated as the new supervising SLP.

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Any supervising SLP who will not be able to supervise an SLPA for more than 1 week will need to (a) inform the SLPA of the planned absence, (b) notify the employer or site administrator that other arrangements for the SLPA's supervision of services need to be made while the SLP is unavailable, and (c) inform the students, patients, or clients that their speech-language services will be rescheduled.

In some instances, multiple SLPs may supervise the SLPA. Those doing so must give special consideration to, and think carefully about, the impact that this supervisory arrangement may have on service providers. It is recommended that the SLPA not be supervised by more than three SLPs.

# CONCLUSION

This document aims to provide guidance for the use of SLPAs in appropriate settings, thereby increasing access to timely and efficient speech-language services. The supervising SLP or SLPs are responsible for staying abreast of current guidelines (including state credentialing guidelines) and ensuring the quality of services rendered. Given that standards, state credentialing (e.g., licensure, etc.), and practice issues vary from state to state, this document's purpose is to provide information regarding ASHA's guidelines for the use of SLPAs for the treatment of communication disorders across practice settings.

# DEFINITIONS

**accountability**—refers to being legally responsible and answerable for actions and inactions of self or others during the performance of a task by the SLPA.

**aide/technician**—individual who has completed on-the-job training, workshops, and other related tasks and who works under the direct supervision of an ASHA-certified SLP. See also *speech-language pathology aide/technician*.

**assessment**—procedures implemented by the SLP for the differential diagnosis of communication and swallowing disorders, which may include, per the *ASHA Speech-Language Pathology Scope of Practice* [PDF], "culturally and linguistically appropriate behavioral observation and standardized and/or criterion-referenced tools; use of instrumentation; review of records, case history, and prior test results; and interview of the individual and/or family to guide decision making" (ASHA, 2016b, p. 11). *Assessments* may also be referred to as *evaluations*, *tests*, and so forth.

**cultural responsiveness**—provides individuals with "a broader perspective from which to view our behaviors as they relate to our actions with individuals across a variety of cultures that are different from our own". (Hyter and Salas-Provance, 2019, p. 7)

**culturally responsive practices**—Care that takes the client's cultural perspectives, beliefs, and values into consideration in all aspects of education and/or service provision. Leininger (2002) defines this term as "the explicit use of culturally based care and health knowledge in sensitive, creative, and meaningful ways".

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**direct supervision**—in-view observation and guidance by an SLP while the SLPA performs an assigned activity. Direct supervision activities performed by the supervising SLP may include, but are not limited to, the following: observing a portion of the screening or treatment procedures performed by the SLPA, coaching the SLPA, and modeling for the SLPA. The supervising SLP must be present during all services provided to a medically fragile client by the SLPA (e.g., on-site or via synchronous telesupervision). The SLP can view and communicate with the student, patient, or client and SLPA via "real-time" telecommunication technology to supervise the SLPA, giving the SLP the opportunity to provide immediate feedback. This does not include reviewing a recorded session later.

**indirect supervision**—the monitoring or reviewing of an SLPA's activities outside of observation and guidance during direct services provided to a student, patient, or client. Indirect supervision activities performed by the supervising SLP may include, but are not limited to, demonstration, records review, review and evaluation of audio or video recorded sessions, and interactive conferences that may be conducted by telephone, email, or other forms of telecommunication (e.g., virtual platforms).

**interpretation**—summarizing, integrating, and using of data for the purpose of clinical decision making, which may only be done by SLPs. SLPAs may summarize objective data from a session to the family or team members.

**medically fragile**—a term used to describe an individual who is acutely ill and in an unstable health condition. If an SLPA treats such an individual that treatment requires 100% direct supervision by an SLP.

**plan of care**—a written service plan developed and monitored by the supervising SLP to meet the needs of an individual student, patient, or client. The plan may address needs for screening, observation, monitoring, assessment, treatment, and other services. Examples of care plans include Individualized Education Plans (IEPs), Individualized Family Service Plans (IFSPs), rehabilitation services plans, and so forth.

**progress monitoring**—a process of collecting, graphing, and reviewing data on an individual's target skills to assess their response to treatment and then comparing their growth to a target trend line or goal to determine whether sufficient progress is being made. Definition adapted from Progress Monitoring webpage. (*National Center on Intensive Intervention*, n.d.)

**screening**—a pass-fail procedure to identify, without interpretation, students, patients, or clients who may require further assessment following specified screening protocols developed by and/or approved by the supervising SLP.

**social determinants of health**—the conditions in which people are born, grow, live, work, and age, including the health system. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities-the unfair and avoidable differences in health status seen within and between countries. (World Health Organization, n.d.)

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**speech-language pathology aides/technician**—an individual who has completed on-the-job training, workshops, and other related tasks and who works under the direct supervision of an ASHA-certified SLP; this is another type of support personnel that may not meet the requirements as an ASHA certified SLPA. See also aide/technician

**speech-language pathology assistant**—an individual who, following academic coursework, clinical practicum, and credentialing can perform tasks prescribed, directed, and supervised by ASHA-certified SLPs.

**supervising speech-language pathologist**—an SLP who holds a Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP) from ASHA and/or a state licensure (where applicable), has an active interest and desire to collaborate with support personnel, has a minimum of 9 months of experience after being awarded ASHA certification, has completed the 2-hour supervision requirement per the *ASHA Certification Standards* (ASHA,2020a) and adheres to state credentialing guidelines for supervision of the SLPA, and who is licensed and/or credentialed by the state (where applicable).

**supervision**—the provision of direction and evaluation of the tasks assigned to an SLPA. Methods for providing supervision include direct supervision, indirect supervision, and telesupervision.

**support personnel**—these individuals perform speech-language tasks as prescribed, directed, and supervised by ASHA-certified SLPs. There are different levels of support personnel based on training and scope of responsibilities. The term support personnel includes SLPAs and speech-language pathology aides/technicians. ASHA is operationally defining these terms for ASHA resources. Some states use different terms and definitions for support personnel (e.g., *assistant speech-language pathologist*, *speech-language pathologist paraprofessional*, and *SLP assistant*, among others).

**telepractice**—applying telecommunications technology to the delivery of professional services at a distance by linking clinician to client, or clinician to clinician, for assessment, intervention, and/or consultation (ASHA, n.d.).

**telesupervision**—the SLP can view and communicate with the patient and SLPA in real time via telecommunication software (e.g., virtual platforms), webcam, telephone, and similar devices and services to supervise the SLPA. This enables the SLP to give immediate feedback. Telesupervision does not include reviewing a recorded session later.

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## Adult Dysphagia

### Overview

The scope of this page is swallowing disorders in adults (18+). See the Dysphagia Evidence Map for summaries of the available research on this topic.

Dysphagia is a swallowing disorder involving the oral cavity, pharynx, esophagus, or gastroesophageal junction. Consequences of dysphagia include malnutrition and dehydration, aspiration pneumonia, compromised general health, chronic lung disease, choking, and even death. Adults with dysphagia may also experience disinterest, reduced enjoyment, embarrassment, and/or isolation related to eating or drinking. Dysphagia may increase caregiver costs and burden and may require significant lifestyle alterations for the patient and the patient's family. Speech-language pathologists (SLPs) are the preferred providers of dysphagia services and are integral members of an interprofessional team to diagnose and manage oral and pharyngeal dysphagia. SLPs also recognize causes and signs/symptoms of esophageal dysphagia and make appropriate referrals for its diagnosis and management. Dysphagia intervention may concentrate on swallowing exercises, compensatory swallowing strategies (including posture considerations), bolus consistency modification, and caregiver/patient education.

### Incidence and Prevalence

Incidence refers to the number of new cases of dysphagia identified in a specified time period. Prevalence refers to the number of people who are living with dysphagia in a given time period.

Each year, approximately one in 25 adults will experience a swallowing problem in the United States (Bhattacharyya, 2014). Dysphagia cuts across so many diseases and age groups that its true prevalence in adult populations is not fully known and is often underestimated.

A number of epidemiologic reports indicate that the prevalence of dysphagia is more common among older individuals and that sarcopenia is positively associated with dysphagia (Barczi et al., 2000; Bhattacharyya, 2014; Bloem et al., 1990; Cabré et al., 2014; Roden & Altman, 2013; Sura et al., 2012; Zhao et al., 2018). Conservative estimates suggest that dysphagia rates may be

- as low as 3% in U.S. inpatients aged 45 years or older to as high as 22% in adults over 50 years of age (Lindgren & Janzon, 1991; National Foundation of Swallowing Disorders, n.d.; Patel et al., 2018; Tibbling & Gustafsson, 1991);
- as high as 30% in elderly populations receiving inpatient medical treatment (Layne et al., 1989);
- up to 68% for residents in long-term care settings (National Institute on Deafness and Other Communication Disorders, n.d.; Steele et al., 1997); and

- 13%–38% among elderly individuals who are living independently (Kawashima et al., 2004; Serra-Prat et al., 2011).

Advanced age is a risk factor for aspiration pneumonia (Loeb et al., 1999). A report by the Agency for Health Care Policy and Research (now the Agency for Healthcare Research and Quality) estimates that approximately one third of patients with dysphagia develop pneumonia and that 60,000 individuals die each year from such complications (Agency for Health Care Policy and Research, 1999). The prevalence of dysphagia in community-dwelling adults over the age of 50 years is estimated to be somewhere between 15% and 22% (Aslam & Vaezi, 2013; Barczi et al., 2000), and in skilled nursing facilities, the prevalence rises to over 60% (Steele et al., 1997; Suiter & Gosa, 2019).

Various neurological diseases are known to be associated with dysphagia. The exact epidemiological numbers by condition or disease also remain poorly defined. This, in part, is due to the concomitant medical conditions being reported and the timing and type of diagnostic procedures being used to identify swallowing disorders across neurological populations. Other studies have such findings as follows:

- A systematic review by Martino et al. (2005) found that the incidence of dysphagia in stroke populations was as low as 37% when identified using cursory screening procedures and as high as 78% when identified using instrumental assessments.
- A later study by Falsetti et al. (2009) found that dysphagia occurs in over one third of patients admitted to stroke rehabilitation units.
- Other studies suggest that dysphagia occurs in 29%–64% of stroke patients (Barer, 1989; Flowers et al., 2013; Gordon et al., 1987; Mann et al., 1999).
- Additional systematic reviews and studies have reported varied estimates of dysphagia prevalence in the following:
    - Amyotrophic lateral sclerosis (ALS) or Parkinson’s disease—ALS is also known as Lou Gehrig’s disease; as high as 90% in individuals diagnosed with Parkinson’s disease or amyotrophic lateral sclerosis (Coates & Bakheit, 1997).
    - Critical illness—3% to 62% in patients recovering from a critical illness (Macht et al., 2013). One study found that 20.6% of patients diagnosed with COVID-19 suffered from dysphagia (Korkmaz et al., 2020)
    - Dementia—13% to 57% (Alagiakrishnan et al., 2013).
    - Endotracheal intubation—3% to 64% (Skoretz et al., 2010). Brodsky et al. (2017) looked more narrowly at dysphagia following endotracheal intubation for acute respiratory distress syndrome (ARDS) and found that 32% of patients reported clinically significant dysphagia symptoms.

- Gastroesophageal reflux disease (GERD)—approximately 14% (Mold et al., 1991; Spechler, 1999).
- Head and neck cancer—50% (oropharyngeal dysphagia) in patients with head and neck cancer, with these numbers increasing after chemoradiation treatment (García-Peris et al., 2007).
- Intellectual disabilities (adult)—5% to 8% (Chadwick et al., 2006).
- Multiple sclerosis—24% to 58% (Aghaz et al., 2018; Calcagno et al., 2002; De Pauw et al., 2002; Roden & Altman, 2013).
- Neurologic conditions requiring intubation—may be as high as 93% following extubation (Macht et al., 2013).
- Parkinson's disease—35% to 82% (Kalf et al., 2012).
- Sjögren's syndrome—32% to 71% (Pierce et al., 2016).
- Systemic lupus erythematosus—2% to 25% of individuals with systemic lupus erythematosus (Chua et al., 2002). Porto de Toledo et al. (2019) found that aspiration frequency was highest in the first 3 months following treatment.
- Traumatic brain injury—38% to 65% (Terré & Mearin, 2009).
- Vocal fold immobility (unilateral)—55% to 69% immobility (Zhou et al., 2019).
- Whiplash injuries—2% to 28% (Stone et al., 2021).

## Signs and Symptoms

Not all signs and symptoms are seen in all types of dysphagia, and the evidence supporting the predictive value of these signs and symptoms is mixed. For example, coughing and throat clearing may not be correlated with penetration or aspiration of a bolus but may be the result of gastroesophageal reflux, esophageal dysmotility, and common medications (Elvevi et al., 2014; Madanick, 2013; Tafreshi & Weinacker, 1999). Signs and symptoms of dysphagia include

- drooling and poor oral management of secretions and/or bolus;
- ineffective chewing, in consideration of the individual variability in mastication cycles and time (Shiga et al., 2012);
- food or liquid remaining in the oral cavity after the swallow (oral residue);
- inability to maintain lip closure, leading to food and/or liquids leaking from the oral cavity (anterior loss of bolus);
- extra time needed to chew or swallow;

- food and/or liquids leaking from the nasal cavity (nasopharyngeal regurgitation);
- complaints of food “sticking” or complaints of a “fullness” in the neck (globus sensation);
- complaints of pain when swallowing (odynophagia);
- changes in vocal quality (e.g., wet or gurgly sounding voice) during or after eating or drinking;
- coughing or throat clearing during or after eating or drinking;
- difficulty coordinating breathing and swallowing;
- acute or recurring aspiration pneumonia/respiratory infection and/or fever (Bock et al., 2017; DiBardino & Wunderink, 2015; Marik, 2010);
- changes in eating habits, for example, avoidance of certain foods/drinks (Sura et al., 2012);
- weight loss, malnutrition, or dehydration from not being able to eat enough (Saito et al., 2017; Via & Mechanick, 2013); and
- complaints of discomfort related to suspected esophageal dysphagia (e.g., globus sensation, regurgitation). See ASHA’s Practice Portal page on Aerodigestive Disorders.

Silent aspiration may be present, meaning the patient presents without overt signs or symptoms of dysphagia.

It is important to consider signs and symptoms of dysphagia in the context of other clinical indicators such as the etiology of the dysphagia and the overall health of the patient, rather than relying on a single sign or symptom.

## Causes

Dysphagia may develop secondary to damage to the central nervous system (CNS) and/or cranial nerves, and to unilateral or bilateral cortical and subcortical lesions, such as

- stroke;
- traumatic brain injury;
- spinal cord injury;
- dementia;
- Parkinson’s disease;
- multiple sclerosis (De Pauw et al., 2002);

- amyotrophic lateral sclerosis (ALS, Lou Gehrig's disease; e.g., Ruoppolo et al., 2013);
- muscular dystrophy (e.g., Tabor et al., 2018);
- developmental disabilities in an adult population (e.g., intellectual disability; Chadwick & Jolliffe, 2009);
- post-polio syndrome (e.g., Sonies & Dalakas, 1991);
- myasthenia gravis (e.g., Llabrés et al., 2005; Romo González et al., 2010); and
- polymyositis and dermatomyositis (González-Fernández & Daniels, 2008).

Dysphagia may also occur from problems affecting the head and neck, including

- cancer in the oral cavity, pharynx, nasopharynx, or esophagus;
- radiation and/or chemoradiation for head and neck cancer treatment;
- trauma or surgery involving the head and neck;
- decayed or missing teeth; and
- critical care that may have included oral intubation and/or tracheostomy.

Dysphagia may be associated with other factors, such as

- side effects of some medications (e.g., Balzer, 2000);
- metabolic disturbances (e.g., hyperthyroidism);
- infectious diseases (e.g., COVID-19, sepsis, acquired immune deficiency syndrome [AIDS]); Meux & Wall, 2003);
- pulmonary diseases (e.g., chronic obstructive pulmonary disease [COPD]);
- gastroesophageal reflux disease (GERD);
- following cardiothoracic surgery;
- decompensation; and
- frailty (Bahat et al., 2019).

## Roles and Responsibilities

Knowledge, skills, and clinical experience related to the evaluation and management of individuals with swallowing and swallowing problems may be acquired on the graduate or postgraduate level, in formal coursework, and/or via continuing education.
The standards for ASHA certification effective in 2020 require competence in dysphagia. The American Board of Swallowing and Swallowing Disorders, under the auspices of ASHA's specialty certification program, offers clinical specialty certification in swallowing

and swallowing disorders. Specialty certification is a voluntary program and is not required by ASHA to practice in any disorder area. Board Certified Specialists in Swallowing and Swallowing Disorders are individuals who hold ASHA certification and have demonstrated advanced knowledge and clinical expertise in diagnosing and treating individuals with swallowing disorders.

SLPs have knowledge of the anatomy, physiology, and functional aspects of the upper aerodigestive tract as they relate to swallowing and speech. SLPs also have expertise in communication disorders that may affect the diagnosis and management of swallowing disorders. SLPs work collaboratively with other professionals, individuals, families, and caregivers. Interprofessional practice (IPP) is critical to successfully achieving the desired improvements and outcomes due to complexities of assessment and treatment of swallowing disorders.

SLPs play a central role in the assessment and management of individuals with swallowing disorders. An SLP's roles include

- identifying signs and symptoms of dysphagia;
- identifying normal and abnormal swallowing anatomy and physiology supported by imaging;
- identifying indications and contraindications specific to each patient for various assessment procedures;
- identifying signs of potential disorders in the upper aerodigestive and/or digestive tracts and making referrals to appropriate medical personnel;
- assessing swallow function as well as analyzing and integrating information from such assessments collaboratively with medical professionals, as appropriate;
- providing treatment for swallowing disorders, documenting progress, adapting and adjusting treatment plans based on patient performance, and determining appropriate discharge criteria;
- identifying and using appropriate functional outcome measures;
- understanding a variety of medical diagnoses and their potential impact(s) on swallowing;
- recognizing possible contraindications to clinical decisions and/or treatment;
- being aware of typical age-related changes in swallow function;
- providing education and counseling to individuals and caregivers;
- incorporating the client's/patient's dietary preferences and personal/cultural practices as they relate to food choices during evaluation and treatment services;
- respecting issues related to quality of life for individuals and/or caregivers;

- practicing interprofessional collaboration;
- educating and consulting with other professionals on the needs of individuals with swallowing and feeding disorders and the SLP's role in the diagnosis and management of swallowing and feeding disorders;
- advocating for services for individuals with swallowing and feeding disorders;
- performing research to advance the clinical knowledge base; and
- determining the effectiveness and possible impact of current diet on overall health (e.g., positioning, feeding dependency, environment, diet modification, compensations).

As indicated in the ASHA Code of Ethics (American Speech-Language-Hearing Association [ASHA], 2023), SLPs who serve this population should be specifically educated and appropriately trained to do so. SLPs should maintain competency of skills through reading current research and engaging in continuing education.

### Dysphagia Teams

The causes and consequences of dysphagia cross traditional boundaries between professional disciplines. Therefore, management of dysphagia may require input of multiple specialists serving on an interprofessional team. Members of the dysphagia team may vary across settings.

The SLP frequently serves as a coordinator for the team management of dysphagia. SLPs lead the team in

- identifying core team members and support services,
- facilitating communication between team members,
- tracking and documenting team activity,
- actively consulting with team members, and
- assisting in discharge planning.

## Assessment

See the Assessment section of the Dysphagia Evidence Map for pertinent scientific evidence, expert opinion, and client/caregiver perspective.

### Screening

Screening identifies the need for further assessment and may be completed prior to a comprehensive evaluation. Swallowing screening is a procedure to identify individuals who require a comprehensive assessment of swallowing function or a referral for other professional and/or medical services (ASHA, 2004). Screening for dysphagia may be conducted by an SLP or any other member of the patient's care team. Individuals of all

ages are screened as needed, requested, or mandated or when presenting medical conditions (e.g., neurological or structural deficits) suggest that they are at risk for dysphagia. The purpose of the screening is to determine the likelihood that dysphagia exists and the need for further swallowing assessment (see ASHA's resource on Swallowing Screening). It is important to note that, currently, no bedside screening protocol has been shown to provide adequate predictive value for the presence of aspiration. Several tools have demonstrated reasonable sensitivity, but reproducibility and consistency of these protocols have not been established (O'Horo et al., 2015). During any screening process, the members of the patient care team may note proper posture and positioning for eating, as well as any potential sensory deficits that may affect swallowing.

Screening may include the following:

- Administration of an interview or a questionnaire that addresses the patient's perception of and/or concern with swallowing function (e.g., the 10-item Eating Assessment Tool [EAT-10]; Cheney, 2015).
- Monitoring the presence of the signs and symptoms of oropharyngeal and/or esophageal swallowing dysfunction.
- Patient/caregiver report or observation of difficulty with per os (P.O.) intake.
- Administration of standardized screening protocols, such as
    - the 3-oz water swallow test (DePippo et al., 1992) and
    - the Yale Swallow Protocol (Suiter et al., 2014).
- Administration of the modified Evans blue dye test in patients with a tracheotomy by tinting oral feedings blue/green with the intent to identify aspiration in these patients (Béchet et al., 2016). For further information on the modified Evans blue dye test, please see the FDA public health advisory.

All screening procedures include communication of results and recommendations to the team responsible for the individual's care and to the patient and caregivers.

Screening may result in

- recommendations for rescreening;
- recommendations for additional assessment to determine whether, and the degree to which, swallowing anatomy and/or physiology may be impaired; and
- referrals for other examinations or services (ASHA, 2004).

The medical team may make temporary recommendations (e.g., no oral intake, stipulation of specific dietary precautions) while the patient is awaiting further assessment.

**Comprehensive Assessment**

Assessment and treatment of swallowing and swallowing disorders includes consideration of infection control and personal protective equipment (PPE) as necessary. Special considerations may need to be made regarding PPE for COVID-19. For further information see ASHA's resource on Aerosol Generating Procedures. Consistent with the World Health Organization's (2001) International Classification of Functioning, Disability and Health framework, the purpose of assessment is to identify and describe

- typical and atypical parameters of structures and functions affecting swallowing;
- effects of swallowing impairments on the individual's capacity for, performance in, and participation in activities; and
- contextual factors that serve as barriers to or facilitators of successful swallowing and participation for individuals with swallowing impairments.

Comprehensive assessment includes non-instrumental and instrumental procedures. Instrumental procedures may not be indicated in select patients (e.g., a patient with ill-fitting dentures resulting in oral dysphagia or some patients with low levels of alertness who are unable to participate in the study). Instrumental procedures are the only method that provides visualization of swallowing physiology and laryngeal, pharyngeal, and upper esophageal anatomy, which help diagnose dysphagia.

Swallowing assessment allows the SLP to integrate information from the following:

- A review of medical/clinical records, including the potential impact of medications and treatment of other medical diagnoses such as
    - radiation treatment protocols in head and neck cancer;
    - metabolic disturbances;
    - medical status;
    - nutritional status; and
    - psychosocial, environmental, and behavioral factors.
- An evaluation of the impact of cognitive deficits on safety/functionality of swallowing. Please see ASHA's Practice Portal pages on Dementia and Traumatic Brain Injury (Adult) for further information.
- Results of previous screening and non-instrumental and instrumental assessments of swallowing.
- An inspection of the oral mechanism, cranial nerve assessment, and other observations such as

    - structural assessment of the face, jaw, lips, tongue, hard and soft palate, oropharynx, and oral mucosa;
    - functional assessment of muscles and structures used in swallowing, including symmetry, sensation, strength, tone, range and rate of motion, and coordination of movement;
    - analysis of head–neck control, posture, oral reflexes, and involuntary movements; and
    - assessment of respiratory status, cough, and throat clearing abilities.
- Additional assessment of voice, motor speech patterns, cognition, and communication, as warranted.

Assessment may result in one or more of the following outcomes:

- description of the characteristics of suspected swallowing status
- diagnosis of dysphagia
- recommendations to support oral and non-oral nutrition and hydration identification of the need for intervention and support
- recommendations for intervention and support
- prognosis for improvement or maintenance of function and identification of relevant factors
- referral for other services or professionals
- counseling, education, and training to the patient, health care providers, and caregivers

Patients with suspected dysphagia may warrant further instrumental assessment to examine the impact of swallowing anatomy and physiology on clinical presentation (McCullough et al., 2005; O'Horo et al., 2015). Patients may also require further assessment or reassessment depending on changes in functional or medical status. SLPs may make recommendations for modifications of texture and viscosity and discuss their implications with other team members (e.g., dietary team, the patient). Ongoing assessment can also include evaluation of changes in patients' swallow function as a result of intervention, including diet modification, while implementing a plan of care.

SLPs conduct assessments in a manner that is sensitive to the individual's cultural background, religious beliefs, and preferences for medical treatment (see ASHA's Practice Portal page on Cultural Responsiveness for additional information). SLPs should consider how culture influences activities of daily living (Riquelme, 2004). For example, spiritual practices that involve food and drink might be impacted by diet modifications. Using ethnographic interviewing strategies during the assessment

process is an excellent way to gather information about an individual's specific needs (Westby et al., 2003). SLPs should discuss any dietary texture/consistency-related changes with the patient and caregivers who prepare food. In some cases, caregivers may be encouraged to bring familiar food and drink.

**Non-Instrumental Swallowing Assessment**

The purpose of a non-instrumental swallowing assessment is to determine the presence (or absence) of signs and symptoms of dysphagia, with consideration for factors such as fatigue during a meal, posture, positioning, and environmental conditions. Verification of aspiration and thorough assessment of impairments in swallowing physiology or laryngeal/pharyngeal/upper esophageal anatomy require instrumental assessment.

A non-instrumental swallowing assessment may include a medical chart review as well as an assessment or consideration of

- overall physical, social, behavioral, and cognitive/communicative status;
- the patient's perception of function, severity, change in functional status, and quality of life;
- vocal quality at baseline;
- physiological status and vital signs, including heart rate, oxygen saturation, and respiratory rate as well as respiratory/swallowing pattern, which may vary across individuals and across the life span (Martin-Harris et al., 2005);
- secretion management skills, which might include frequency and adequacy of spontaneous saliva swallowing and the ability to swallow voluntarily;
- cranial nerve function;
- posture and positioning for feeding; and
- status of oral care.

During or following bolus delivery during per os (P.O.) trials including consistencies typically consumed by the patient in their natural environment, the SLP may assess

- labial seal, anterior spillage and evidence of oral control, including mastication and transit, manipulation of the bolus, presence of hyolaryngeal excursion as observed externally or to palpation, and time required to complete the swallow sequence;
- behavioral signs and symptoms, such as throat clearing or coughing before/during/after the swallow, which may not always be indicators of penetration and/or aspiration;
- the impact of fatigue and/or respiratory function on swallowing;

- changes to physiological status/vital signs/voice quality; and
- the patient's use of additional equipment, as appropriate (e.g., adaptive drinking cups).

The clinical examination may inform recommendations for the management of dysphagia (Garand et al., 2020), including

- identifying clinical presentations of dysphagia;
- identifying potential risks and benefits initiating or modifying oral intake (e.g., risks of dehydration/malnutrition);
- determining the need for additional instrumental evaluation; and
- specifying diagnostic questions to be answered by instrumental evaluations.

The non-instrumental assessment of swallowing is insufficient to infer specific information about laryngeal, pharyngeal, or upper esophageal anatomy and physiology required to develop effective treatment options and prevent consequences of dysphagia, such as dehydration, malnutrition, pneumonia, and death (Garand et al., 2020).

**Instrumental Swallowing Assessment**

SLPs use instrumental techniques to evaluate oral, pharyngeal, laryngeal, upper esophageal, and respiratory function as they apply to normal and abnormal swallowing. Instrumental procedures are also used to determine appropriateness and effectiveness of treatment strategies.

In clinical settings, SLPs typically use one of two types of instrumental evaluation: the videofluoroscopic swallowing study (VFSS) or the flexible endoscopic evaluation of swallowing (FEES), sometimes also called fiber-optic endoscopic evaluation of swallowing. The VFSS is also known as the modified barium swallow study (MBSS) and is a radiographic procedure used to gain further information regarding dysphagia. Please see ASHA's resource on the Videofluroscopic Swallowing Study for further information on the VFSS. The FEES is a portable procedure that may be completed in outpatient clinic space or at bedside by passing an endoscope transnasally (Langmore et al., 1988). Please see ASHA's resource on Flexible Endoscopic Evaluation of Swallowing for further information on the FEES.

Instrumental techniques are usually conducted either independently by the SLP or by the SLP in conjunction with other members of the interprofessional team (e.g., radiologist, radiologic technologist, physiatrist, otolaryngologist). SLPs help guide medical decision making regarding the appropriateness of these procedures given the severity and nature of the patient's swallowing deficits. SLPs interpret and apply the results of imaging to dysphagia treatment plans and make recommendations and referrals as appropriate. SLPs do not require special certification from any entity to

perform instrumental assessments. However, per the ASHA Code of Ethics, SLPs should have appropriate training and demonstrate competency before completing instrumental techniques. Instrumental assessments may be recommended and completed regardless of setting (e.g., hospital, skilled nursing facility) in which the services are delivered.

Indications for an instrumental exam include the following:

- concerns regarding the safety and efficiency of swallow function
    - contribution of dysphagia to nutritional compromise
    - contribution of dysphagia to pulmonary compromise
    - contribution of dysphagia to concerns for airway safety (e.g., choking)
- the need to identify disordered swallowing physiology to guide management and treatment
- the need to assist in the determination of a differential medical diagnosis related to the presence of dysphagia
- the presence of a medical condition or diagnosis associated with a high risk of dysphagia
- previously identified dysphagia with a suspected change in swallow function; and
- the presence of a chronic degenerative condition with a known progression or the recovery from a condition that may require further information for the management of oropharyngeal function

General contraindications for an instrumental exam include, but are not limited to, the following:

- The patient is not medically stable enough to participate in the procedure.
- The patient is severely agitated, unable to remain alert, or unable to follow simple commands.
- The patient has anatomical deviations (e.g., head/neck, digestive tract) that preclude use of barium or use of an endoscopy.

Instrumental assessment may include components of non-instrumental swallowing assessment (see above for further details). The purpose of the instrumental examination is to enable the SLP to perform the following tasks:

- Assess the anatomy and physiology of the structures involved in swallowing and to analyze and measure range of motion and coordination or timing of movement. Some inferences may be made concerning sensation and pressure generation of the swallowing mechanism.

- Determine the presence, cause, and severity of dysphagia by visualizing bolus control, the flow and timing of the bolus, and the individual's response to bolus misdirection and residue.
- Visualize the presence, location, and amount of secretions in the hypopharynx and larynx the patient's sensitivity to the secretions; and the ability of spontaneous or facilitated efforts to clear the secretions.
- Determine the presence and cause(s) of laryngeal penetration and/or aspiration.
- Determine with specificity the relative safety and efficiency of various bolus consistencies and volumes.
- Determine the presence of silent aspiration.
- Visualize the structures of the upper aerodigestive tract.

Implementation of any instrumental procedure requires the SLP to have advanced knowledge and specific skills in order to

- determine an appropriate test protocol;
- make decisions regarding examination administration/procedures during the examination, as necessary;
- integrate knowledge of anatomy and physiology in order to assess oral, pharyngeal, and cervical esophageal swallowing physiology;
- make informed treatment diagnoses and diet consistency recommendations;
- help inform prognosis for imminent and long-term improvement; and
- understand issues relative to radiation equipment, equipment maintenance, and safety.

Qualified SLPs may also screen for esophageal motility and gastroesophageal reflux disease (GERD) to identify the need for appropriate referral. Oropharyngeal function may be potentially affected in some patients with esophageal motility issues.

ASHA recognizes the autonomy of SLPs in completing the VFSS. However, other parties (e.g., state regulatory agencies) may require a radiologist to be present during the VFSS. For further information please see ASHA's resource on the Videofluroscopic Swallowing Study.

**Other Instrumental Procedures**

Other instrumental procedures are used primarily in research at this time but may develop into clinical diagnostic tools. Ultrasonography involves the use of a transducer to observe movement of structures used for swallowing, such as the tongue and hyoid (Hsiao et al., 2013; Sonies et al., 2003). High-resolution manometry is a technique used

to measure pressures generated in the pharynx and esophagus. A thin catheter with pressure sensors < 1 cm apart is placed through the nose, pharynx, and esophagus. Various pressure measures can be calculated and compared to normative data (Omari & Schar, 2018).

SLPs should also be familiar with other diagnostic procedures performed by different medical specialists that yield information about swallowing function. These include procedures such as the esophagram/barium swallow, manofluorography, scintigraphy, 24-hr pH monitoring, and esophagoscopy.

## Treatment

See the Treatment section of the Dysphagia Evidence Map for pertinent scientific evidence, expert opinion, and client/caregiver perspective.

The primary goals of dysphagia intervention are to

- support adequate nutrition and hydration and return to oral intake (including incorporating the patient's dietary preferences and consulting with family members/caregivers to ensure that the patient's daily living activities are being considered);
- determine the optimum supports (e.g., posture, or assistance) to reduce patient and caregiver burden while maximizing the patient's quality of life; and
- develop a treatment plan to improve the safety and efficiency of the swallow.

Management of individuals with dysphagia should be based on results of comprehensive assessment, including both instrumental and non-instrumental assessments as applicable. Decision making must take into account many factors about each individual's overall status and prognosis. This might include information concerning the individual's health and diagnosis, prognosis, cognition, social situation, cultural values, economic status, motivation, and personal choice. Maintenance and/or maximization of an individual's health status is a primary concern. The SLP should consider and integrate the patient's wishes and advocate on behalf of the patient to the health care team, the family, and other relevant individuals.

### Treatment Approaches and Principles

Consideration of the underlying neurophysiological impairment is necessary for understanding swallow function and deficits. Different management approaches may be necessary for individuals with dysphagia that has resulted from an acute event, a chronic/stable condition, or a progressive neurological disorder. Treatment targeting a specific function or structure may also affect function in other structures.

Treatment of dysphagia may include restoration of normal swallow function (rehabilitative) and/or modifications to diet consistency and patient behavior (compensatory).

Rehabilitative techniques, such as exercises, are designed to create lasting change in an individual's swallowing over time by improving underlying physiological function. The intent of many exercises is to provide lasting functional improvement.

Compensatory techniques alter the swallow when used but do not create lasting functional change. An example of a compensatory technique includes a head rotation, which is used during the swallow to direct the bolus toward one of the lateral channels of the pharyngeal cavity. Although this technique may increase swallow safety and/or efficiency during the swallow, there is no lasting benefit or improvement in physiology. The purpose of the technique is to compensate for deficits that cannot be or are not yet rehabilitated sufficiently.

Some techniques may be used for both compensatory and rehabilitative purposes. For example, the super-supraglottic swallow is a rehabilitative technique that increases closure at the entrance to the airway and may also serve as a compensation to protect the airway (McCabe et al., 2009).

### Treatment Options and Techniques

Upon completion of the comprehensive assessment, the clinician uses the acquired data to identify which treatment options would be most beneficial. Treatment options for patients with dysphagia are selected on the basis of evidence-based practice, which includes a combination of the best available internal and external evidence. This includes external scientific research as well as data gathered on a specific person. Internal and external evidence may come from

- published literature,
- the patient's and family's wishes, and
- the clinician's experience.

Treatment options should be selected on a case-by-case basis as there are many etiologies of dysphagia. Clinicians should be aware that research into the overall efficacy of dysphagia treatment is ongoing; therefore, treatment options may evolve. Please see ASHA's Dysphagia Evidence Map.

### Biofeedback

Biofeedback incorporates the patient's ability to sense changes and aids in the treatment of feeding or swallowing disorders. For example, patients with sufficient cognitive skills can be taught to interpret the visual information provided by these assessments (e.g., surface electromyography, ultrasound, flexible endoscopic evaluation of swallowing [FEES], manometry, Iowa Oral Performance Instrument [IOPI], or mirror) and to make physiological changes during the swallowing process.

### Diet Texture Modifications

Modifications to diet texture may include changing the viscosity of liquids and/or altering the texture of solid foods using standardized criteria (e.g., International Dysphagia Diet Standardisation Initiative [IDDSI]). Modifications to the taste or temperature may also be made to change the sensory input of a bolus. SLPs examine the influence of diet texture modifications on swallowing physiology, including airway protection, during a comprehensive assessment of an individual's swallowing status prior to recommending these changes as part of treatment. Clinicians consult with the patients and care partners to identify patient preferences and values for food when discussing modifications to oral intake. Consulting with the interprofessional team, including a dietician and pharmacist, when altering a diet can help ensure that the patient's nutritional and medication needs continue to be met.

Some factors to consider while evaluating diet texture modifications for patients with dysphagia include:

- Clinical presentation of swallowing difficulties.
- Impact of the modified consistency/viscosity on the individual's swallowing physiology.
- Aspiration risk – texture modified foods and thickened fluids may not eliminate the risk of aspiration and associated pneumonia (e.g., Kaneoka et al., 2017; Robbins et al., 2008; Wirth et al., 2016). In some cases, more viscous materials (i.e., thickened liquids) may be more likely to be silently aspirated (e.g., Miles et al., 2018).
- Presence and severity of co-morbidities (e.g., dehydration, renal disease, respiratory infections).
- Increased risk of dehydration and associated conditions (e.g., renal failure, gastroparesis, constipation, urinary tract infections, confusion/delirium, and poor recovery from illness (Cichero & Lam, 2014; Leibovitz et al., 2007; Murray et al., 2016, Wheelan, 2001).
- Impact of texture modifications on medications (e.g., some medications may not be available in liquid form, and crushing others may change their effectiveness; Cichero, 2013; Steadman et al., 2022).
- Physical and cognitive ability to follow texture modification procedures.
- Patient/care partner's access to thickened liquids and/or thickening agents and ability to modify regular texture foods/liquids after discharge.
- Preferences of the person with dysphagia and their care partners, related cultural and/or religious considerations and the impact on the patient's overall quality of life.

Despite the risk of aspiration, alternatives to liquid consistency modifications may support overall health of persons with dysphagia when pristine oral health can be maintained (e.g., Frazier Free Water Protocol; Gaidos et al., 2023; Kaneoka et al., 2017; Murray et al., 2016).

### Electrical Stimulation

Although the body of literature concerning the value of electrical stimulation for swallowing is large, the benefits remain unclear (Carnaby-Mann & Crary, 2007; Clark et al., 2009; Humbert et al., 2012; Sun et al., 2020). Electrical stimulation uses an electrical current in order to stimulate the peripheral nerve. SLPs with appropriate training and competence in performing electrical stimulation may provide the intervention. ASHA does not require any additional certifications.

### Equipment/Environmental Modifications

Patients may benefit from the use of adaptive equipment or environmental modifications to more effectively manage the bolus (Granell et al., 2012). SLPs collaborate with other team members in identifying and implementing use of adaptive equipment.

### Maneuvers

Maneuvers are specific strategies that clinicians use to change the timing or strength of particular movements of swallowing. Some maneuvers require following multistep directions and may not be appropriate for patients with cognitive impairments. Examples of maneuvers include the following:

- Effortful swallow—The effortful swallow is known to increase orolingual pressure (Fukuoka et al., 2013) increase pressure in the upper pharynx (Huckabee & Steele, 2006) and to improve tongue base retraction. Additionally, the effortful swallow increases the duration of temporal events such as laryngeal vestibule closure, hyoid maximum anterior excursion, upper esophageal sphincter opening, and total swallow time (Hind et al., 2001). There is some evidence to suggest that the effortful swallow may worsen pyriform sinus residue (Molfenter et al., 2018). To perform an effortful swallow, the patient is instructed to swallow hard while pushing hard with the tongue against the hard palate (Huckabee & Steele, 2006).
- Mendelsohn maneuver—The Mendelsohn maneuver is designed to elevate the larynx and open the esophagus during the swallow to prevent food/liquid from falling into the airway. The patient holds the larynx in an elevated position at the peak of hyolaryngeal elevation.
- Supraglottic swallow—The supraglottic swallow is designed to close the vocal folds by voluntarily holding one's breath before and during swallow in order to protect the airway. The patient is instructed to hold their breath just before

swallowing to close the vocal folds. The swallow is followed immediately by a volitional cough (Guedes et al., 2017; Logemann et al., 1997).

- Super-supraglottic swallow—The super-supraglottic swallow is designed to voluntarily move the arytenoids anteriorly, closing the entrance to the laryngeal vestibule before and during the swallow. The super-supraglottic swallow is similar to the supraglottic swallow; however, it involves increased effort during the breath-hold before the swallow, which facilitates glottal closure (Donzelli & Brady, 2004; Vose et al., 2014).

### Swallowing Exercises

Swallowing exercises include exercises of the lips, jaw, tongue, soft palate, pharynx, larynx, and/or respiratory muscles to improve function. Some of these interventions can also incorporate sensory stimulation. Oral-motor treatments range from passive to active (e.g., range-of-motion activities, resistance exercises, or chewing and swallowing exercises). Examples of exercises include the following:

- Laryngeal elevation—The patient uses laryngeal elevation exercises to lift and maintain the larynx in an elevated position. This is similar to the Mendelsohn maneuver (described in the Maneuvers section above). The patient is asked to slide up a pitch scale and hold a high note for several seconds. This maintains the larynx in an elevated position.
- Masako or tongue-hold—The patient holds the tongue forward between the teeth while swallowing; this is performed without food or liquid in the mouth, to prevent coughing or choking. Although sometimes referred to as the Masako maneuver, the Masako (tongue-hold) is considered an exercise (not a maneuver), and its intent is to improve movement and strength of the posterior pharyngeal wall during the swallow. However, this maneuver may be contraindicated for those with decreased hyoid displacement and/or poor pharyngeal motility. Participants experienced reduced oral pharyngeal pressures when using this intervention. Studies have also found increased pharyngeal residue (particularly in the vallecula), shortened duration of airway closure, increased pharyngeal delay, and increased time in triggering the pharyngeal swallow (Doeltgen et al., 2011; Fujiu-Kurachi, 2002; Fujiu-Kurachi et al., 2014).
- Shaker exercise, head-lifting exercises—The patient rests in a supine position and lifts their head to look at the toes to facilitate an increased opening of the upper esophageal sphincter and strengthen suprahyoid muscles (Langmore & Pisegna, 2015).
- Resistive lingual isometric exercises—The patient is provided lingual resistance across exercises to increase strength (Kim et al., 2017; Park et al., 2015; Robbins et al., 2007).

### Pacing and Feeding Strategies

Specific bolus volumes per swallow may result in faster pharyngeal swallow responses (Barikroo et al., 2015). Clinicians modify bolus size particularly for patients that require a greater volume to adequately stimulate a swallow response (increase bolus size) or for patients that require multiple swallows per bolus (decrease bolus size). Patients may also require cuing and assistance to maintain an appropriate rate during meals. Cognitive deficits (e.g., impulsivity, decreased initiation) may affect a patient's pace during meals.

### Postural/Position Techniques

Postural techniques redirect the movement of the bolus in the oral cavity and pharynx and modify pharyngeal dimensions. Postural techniques may be appropriate to use with patients with neurological impairments, head and neck cancer resections, and other structure damage. Examples of postural techniques include the following:

- Chin-down posture—The chin is tucked down toward the neck during the swallow, which may bring the tongue base closer to the posterior pharyngeal wall, narrow the opening to the airway, and widen the vallecular space. This posture may reduce penetration/aspiration in some patients (Bülow et al., 2001; Ra et al., 2014; Shanahan et al., 1993). The effectiveness of the chin-tuck maneuver is related to the overall severity of dysphagia (i.e., the more severe the dysphagia, the less effective the maneuver; Saconato et al., 2016).
- Chin-up posture—The chin is tilted up, which may facilitate movement of the bolus from the oral cavity. The chin-up posture may improve oral bolus transport (Solazzo, 2012). This posture has a possible rehabilitative impact on pharyngeal swallow (Calvo et al., 2017).
- Head rotation (turn to the side)—The head is turned to either the left or the right side, typically toward the damaged or weak side (although the opposite side may be attempted if there is limited success with the first side) to direct the bolus to the stronger of the lateral channels of the pharynx (Logemann et al., 1989).
- Head tilt—The head is tilted toward the strong side to keep the food on the chewing surface.

Postures and maneuvers may be combined, taking care to minimize patient effort/burden when possible.

### Prosthetics/Intraoral Appliances

Prosthetics (e.g., palatal obturator, palatal lift prosthesis) can be used to normalize pressure and movement in the intraoral cavity by providing compensation or physical support for patients with structural deficits/damage to the oropharyngeal mechanism. With this support, swallowing efficiency and function may be improved. Intraoral appliances (e.g., palatal plates) are removable devices with small knobs that provide tactile stimulation inside the mouth to encourage lip closure and appropriate lip and

tongue position for improved swallow function. This treatment option is most often used with patients following treatment for head and neck cancer; however, it may be implemented with other patients suffering from similar challenges.

### Sensory Stimulation

Patients who are tactically defensive may need approaches that reduce the level of sensory input initially, with incremental increases as tolerance improves. Sensory stimulation may be useful for those with reduced response, overactive response, or limited opportunity for sensory experience.

### Medical Management of Swallowing Disorders

Due to the interprofessional nature of dysphagia management, clinicians should be aware of multiple options for dysphagia intervention, including medical, surgical, and behavioral treatment. Such knowledge increases pertinent communication with other health care providers and facilitates selection of the best treatment options for individual patients (Groher & Crary, 2010).

### Common Medical Options for Dysphagia Treatment

*Pharmacologic Management*

- anti-reflux medications
- prokinetic agents
- salivary management

### Common Surgical Options for Conditions That May Cause Dysphagia

*Improved Glottal Closure*

- medialization thyroplasty
- injection of biomaterials

*Airway Interventions*

- stents
- laryngotracheal separation
- laryngectomy
- tracheostomy tubes

*Improved Pharyngoesophageal Segment Opening*

- dilation
- myotomy

- botulinum toxin injection

### Tube Feeding for Dysphagia Treatment

If the individual's swallowing does not support nutrition and hydration via oral intake, the swallowing and feeding team may recommend alternative avenues of intake (e.g., nasogastric [NG] tube, gastrostomy). In these instances, team members consider whether the individual will need the alternative source for a short or an extended period of time. Education and counseling may be provided concerning issues related to tube feeding, such as appropriate positioning and duration of feeding times.

Alternative feeding does not preclude the need for rehabilitative techniques to facilitate sensory and motor capabilities necessary for oral feeding. Percutaneous endoscopic gastrostomy (PEG) tubes may not be appropriate in all populations and may not necessarily improve outcomes or quality of life (Ayman et al., 2016; Plonk, 2005). Please see ASHA's resource on Alternative Nutrition and Hydration in Dysphagia Care for further information.

The decision to recommend use of a feeding tube is made in collaboration with the medical team. The physician is ultimately responsible for selecting which type of tube is used, but a brief description of several options is provided below.

- Gastrostomy tube (PEG, G-tube)—inserted through the abdomen to provide non-oral nutrition. A percutaneous endoscopic gastrostomy tube, or PEG tube, is a common type of G-tube.
- Jejunostomy tube (PEJ, J-tube)—inserted through the abdomen and into the jejunum, the second part of the small intestine, to provide non-oral nutrition.
- Nasogastric tube (NG-tube)—inserted through the patient's nose and passed through the esophagus to the stomach to provide non-oral nutrition. NG-tubes are often the preferred option for short-term use (over G-tubes or J-tubes). Tube size may vary and may influence swallow function.

The patient, with their proxy, then chooses to accept or reject use of alternative nutrition and hydration following a shared decision making, informed consent discussion.

### Treatment Considerations Related to Progressive Disorders and End-of-Life Issues

The role of the SLP in treating individuals with progressive neurological disorders is designed to maximize current function, compensate for irreversible loss of function, assess and reassess changes in status, and educate and counsel patients regarding the progression of the disorder and potential options, including non-oral means of nutrition.

SLPs may encounter patients approaching the end of life. These patients may have complex medical conditions related to feeding and swallowing. SLPs may work with

these patients and caregivers to develop compensatory strategies that will allow the patients to eat an oral diet for as long as they desire. As a member of the interprofessional team, the SLP may contribute to decision making regarding the use of alternative nutrition and hydration. SLPs may also make recommendations regarding continuing per os (P.O.) intake as pleasure feeds given extensive education to the patient, the patient's family/caregiver(s), and the clinical/medical team.

Understanding emotional and psychological issues related to death is essential to treating patients with swallowing problems at the end of life. When considering end-of-life issues, it is important for clinicians to respect the patient's wishes, including social and cultural considerations. Patients and caregivers may not agree with clinical recommendations and may feel that these recommendations do not provide the best quality of life for their loved one.

**Ethical Concerns**

One model for ethical decision making includes consideration of the following (Jonsen et al., 1992):

- Medical indications—Consider the patient's medical history, prognosis, and available viable treatment options.
- Patient preferences—Consider the patient's cultural and personal background influence, their preference to pursue or reject treatment, the patient's ability to make and communicate these decisions, and the presence of an advance directive.
- Quality of life—Consider if the treatment creates a burden that outweighs the potential benefit.
- Contextual features—Consider the implications for caregiver burden if the patient chooses to pursue or reject treatment and if there are relevant legal ramifications to consider.

Clinicians provide information regarding these considerations without factoring in their own personal beliefs. Conflict may occur when medical recommendations do not match patient preferences. A patient with decision-making capacity, the patient's family, or other established decision-maker has the right to accept or refuse such recommendations (Krekeler et al., 2018). After being educated about the risks and benefits of a particular recommendation (e.g., oral vs. non-oral means of nutrition, diet level, rehabilitative technique), if a patient (or their decision-maker) chooses an alternate course of action, the SLP makes recommendations and offers treatment as appropriate. The SLP educates involved parties on possible health consequences and documents all communication with the patient and caretakers (Horner et al., 2016). If no treatment is warranted, then the SLP may make recommendations about the safest course of intake (and still document the risks of such action) and may provide training to caregivers and family, as appropriate. The SLP may then decide to discontinue speech-

language pathology services to the patient but should avail themselves to additional consultation or communication with the parties involved, as appropriate. Palliative care teams can assist a patient and/or family in establishing goals of care, which can then guide some of these complex decisions. Many facilities have an ethics consultation service that can help clinicians, patients, and families address challenges when an ethical issue arises.

### Service Delivery

See the Service Delivery section of the Dysphagia Evidence Map for pertinent scientific evidence, expert opinion, and client/caregiver perspective.

In addition to determining the type of assessment and treatment that is optimal for adults with dysphagia, SLPs consider other service delivery variables that may affect swallowing outcomes—variables such as format, provider, dosage, and timing.

### Format

Format refers to the structure of the assessment or treatment session, such as whether a person is seen for treatment one on one (i.e., individual), as part of a group during mealtime, or via telepractice. Please see ASHA's Practice Portal page on Telepractice for further detail.

### Provider

Provider refers to the person providing the assessment or treatment (e.g., SLP, trained volunteer, caregiver).

### Dosage

Dosage primarily refers to the amount of treatment provided (e.g., the frequency, intensity, and duration of service).

### Timing

Timing refers to the timing of rehabilitation relative to the onset of dysphagia.

### Setting

Setting refers to the location of treatment (e.g., home-based, community-based).

## Resources

### ASHA Resources

- Aerosol Generating Procedures
- ASHA Evidence Maps—Dysphagia (Adults)
- Consent, Refusal, and Waivers in Patient-Centered Dysphagia Care: Using Law, Ethics, and Evidence to Guide Clinical Practice

- Dysphagia On-the-Job Resources
- Flexible Endoscopic Evaluation of Swallowing (FEES)
- Normal Swallowing Poster (ASHA Store)
- Palliative and End-of-Life Care
- Patient Wishes Before Risk: How do we honor patients' decisions about their swallowing treatment when they have dementia-and there's aspiration risk?
- State Instrumental Assessment Requirements
- Summary of Systemic Review—Blue Dye
- Swallowing Screening
- Videofluoroscopic Swallowing Study (VFSS)

**Consumer Information about Swallowing**

- Swallowing Problems From Head and Neck Cancer Treatment
- Swallowing Disorders in Adults

**Other Resources**

- Royal College of Speech and Language Therapists: Statement on Thickened Fluids
- Specialty Board in Swallowing and Swallowing Disorders (ABSSD)

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## Pediatric Feeding and Swallowing

Overview

The scope of this page is feeding and swallowing disorders in infants, preschool children, and school-age children up to 21 years of age. This page covers pediatric dysphagia and pediatric feeding disorder (PFD). These are separate diagnoses but may co-occur.

Speech-language pathologists (SLPs) are the preferred providers of dysphagia services and are integral members of an interprofessional team. Interprofessional collaboration is the preferred practice pattern.

See the Pediatric Feeding and Swallowing Evidence Map for summaries of the available research on this topic.

### Feeding and Swallowing

**Feeding** is the term for supplying someone with nourishment. The term feeding includes all aspects of eating or drinking, including gathering and preparing food and liquid for intake, sucking or chewing, and swallowing (Arvedson & Brodsky, 2002). Feeding may also be achieved by non-oral routes (e.g., percutaneous endoscopy gastronomy tube). Feeding provides children and caregivers with opportunities for communication and social experiences that form the basis for future interactions (Lefton-Greif, 2008).

**Swallowing** is a complex skill during which saliva, liquids, and foods are transported from the mouth into the stomach while keeping the airway protected. The integration of six cranial nerves and over 30 muscles responsible for swallowing ensures the precise coordination required to safely and effectively transport foods and liquids (Steele & Miller, 2010). Swallowing is commonly divided into the following four phases (Arvedson & Brodsky, 2002; Logemann, 1998):

1. **Oral preparatory**—This is a voluntary phase during which foods or liquids are manipulated in the mouth to form a cohesive bolus, which includes sucking liquids, manipulating soft boluses, and chewing solid foods.
2. **Oral transit**—This is a voluntary phase that begins with the posterior propulsion of the bolus by the tongue and ends with the initiation of the pharyngeal swallow.
3. **Pharyngeal**—This phase begins with a voluntary pharyngeal swallow that, in turn, propels the bolus through the pharynx via an involuntary contraction of the pharyngeal constrictor muscles.
4. **Esophageal**—This is an involuntary phase during which the bolus is carried to the stomach through the process of esophageal peristalsis.

### Feeding Disorders

The term **feeding disorders** describes a range of eating activities and behaviors that may or may not include problems with swallowing. Goday, et. al (2019) note the following:

- **Pediatric feeding disorder (PFD)** is any difficulty a person has with oral intake as compared to same age peers. PFD is associated with medical, nutritional, feeding skill, and/or psychosocial dysfunction. **Impaired oral intake** is the inability to consume sufficient foods and liquids to meet nutritional and hydration requirements.
- PFD should be diagnosed only if not better attributed to body image disturbances or dysmorphia.
- Impairments result in activity limitations or participation restrictions due to interactions with personal and environmental factors.
- PFD may be diagnosed as acute if the disorder has been present for less than 3 months or chronic if the disorder has been present for 3 months or more.

Food avoidance (e.g., throwing food on the ground, refusing to take a bite) should be interpreted as communicating a message—not as conveying a negative behavior. This approach can lead to better collaboration between the child and the adult (e.g., caregiver, clinician).

**Avoidant/Restrictive Food Intake Disorder (ARFID)**

According to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; American Psychiatric Association, 2022), **avoidant/restrictive food intake disorder (ARFID)**[1] is an eating or a feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food, concern about aversive consequences of eating) associated with one (or more) of the following:

- significant weight loss (or failure to achieve expected weight gain or faltering growth in children)
- significant nutritional deficiency
- dependence on enteral feeding or oral nutritional supplements
- marked interference with psychosocial functioning

Selective eating in ARFID is due to disinterest in eating or food in general, sensory sensitivity, and/or a fear of consequences (e.g., choking; Kambanis et al., 2020).

SLPs don’t diagnose or treat ARFID. SLPs can, however, recognize signs of ARFID, screen for the condition, assess for PFD, and make appropriate referrals to an ARFID treatment team or mental health practitioner when appropriate.

SLPs may work as part of an interprofessional team managing patients or clients with ARFID, addressing related skill or other deficits that would qualify a concurrent diagnosis of PFD.

ARFID differs from PFD in the following ways:

- ARFID does not include children whose primary challenge is a skill deficit (e.g., dysphagia).
- ARFID includes a severity of eating difficulty that exceeds the severity typically associated with a certain condition (e.g., Down syndrome).

For further information about the overlap and distinction of PFD and ARFID, please see Estrem et. al (2024).

[1] ***An Important Note About ARFID***: Avoidant/restrictive food intake disorder (ARFID) is considered a mental health disorder and outside the scope of practice of an SLP. Although SLPs may screen or make referrals for ARFID, they do not diagnose or treat it. The information about ARFID in this section is meant to be an informational resource for SLPs—although they do not diagnose or treat ARFID, they still need to know about it in the context of clinical patient care.

**Swallowing Disorders (Dysphagia)**

**Dysphagia** is a swallowing disorder involving difficulty processing and/or moving liquid and/or food boluses through the oral cavity, pharynx, esophagus, or gastroesophageal junction. SLPs also recognize causes and signs/symptoms of esophageal dysphagia and make appropriate referrals for its diagnosis and management.

The consequences and associated symptoms of feeding and swallowing disorders may include

- aspiration pneumonia and/or compromised pulmonary status;
- dehydration;
- feeding and swallowing problems that persist into adulthood;
- food aversion;
- gastrointestinal issues (e.g., motility disorders, constipation, diarrhea);
- ongoing need for enteral (gastrointestinal) or parenteral (intravenous) nutrition;
- oral aversion;
- poor weight gain and/or undernutrition;
- psychosocial effects on the child and their family; and
- undernutrition or malnutrition.

## Incidence and Prevalence

**Incidence** refers to the number of new cases identified in a specified time period.

**Prevalence** refers to the number of children who are living with feeding and swallowing problems in a given time period.

It is assumed that the incidence of feeding and swallowing disorders is increasing because of the improved survival rates of children with complex and medically fragile conditions (Lefton-Greif, 2008; Lefton-Greif et al., 2006; Newman et al., 2001) and the improved longevity of persons with dysphagia that develops during childhood (Lefton-Greif et al., 2017).

Estimated reports of the incidence and prevalence of pediatric feeding and swallowing disorders vary widely due to factors including

- variations in the conditions and populations sampled;
- how the terms **pediatric feeding disorder**, **avoidant/restrictive food intake disorder** (ARFID; please see the "ARFID" section above for further details), and/or **swallowing impairment** are defined; and the choice of assessment methods and measures (Arvedson, 2008; Lefton-Greif, 2008). The data below reflect this variability.

According to the *2022 National Survey of Children's Health* (Child and Adolescent Health Measurement Initiative, 2022), survey interviews indicated that within the past 12 months, 1.6% of children (approximately 1,188,828) ages 0–17 years were reported to have eating or swallowing problems because of a health condition. Prevalence varied for a variety of co-occurring conditions:

- **Cerebral palsy** (ages 0–18 years)—The prevalence of swallowing problems was 50.4%. There was a trend toward increased swallowing difficulty with more severely impaired functioning, but this did not reach the level of significance (Speyer et al., 2019).
- **Craniofacial microsomia**—The prevalence of swallowing difficulties was estimated to be 13.5% (van de Lande et al., 2018).
- **Laryngeal cleft, type 1**—The prevalence of swallowing difficulties was 86%, which decreased by up to 26% postsurgical intervention (Liao & Ulualp, 2022).
- **Laryngomalacia**—The prevalence of swallowing disorders was 72%, which was reduced by 59% postsurgery (Rossoni et al., 2024).
- **Unilateral vocal fold paralysis (partial or complete)**—The prevalence of dysphagia was 92.9%, while 53.6% exhibited silent aspiration (Irace et al., 2019).

- **Congenital heart disease**—The overall pooled prevalence of dysphagia was 42.9%, with the pooled mean prevalence of aspiration in this population estimated to be 32.9% (Norman et al., 2022).
- **Neuromuscular diseases** (ages 2–18 years)—The prevalence of dysphagia was 47.2% (Kooi-van Es et al., 2020).
- **Acute stroke**
    - Newborns—The frequency of feeding and swallowing impairment was 39%. At the time of discharge, feeding and swallowing disorders persisted for 19% of newborns (Sherman et al., 2021).
    - Children—The frequency of feeding and swallowing impairment was 41%. At the time of discharge, feeding and swallowing disorders persisted for 17% of children (Sherman et al., 2021).

The overall annual prevalence of pediatric feeding disorders in the United States is estimated to be between 2.7% and 4.4% (Kovacic et al., 2021). Estimates varied across a variety of co-occurring conditions:

- **Preterm**
    - Infants (ages 6–12 months) who were born preterm—The prevalence of feeding problems was 43%.
    - Children (ages 1–7 years) who were born preterm—The prevalence of feeding problems was 25% (Walton et al., 2022).
- **Cerebral palsy** (ages 0–18 years)—The prevalence of feeding problems was 53.5%. There was a trend toward increased feeding difficulty with more severely impaired functioning, but this did not reach the level of significance (Speyer et al., 2019).
- **Craniofacial microsomia**—The prevalence of feeding difficulties is estimated to be 26.4% (Caron et al., 2018).
- **Cleft palate**
    - With Pierre Robin sequence—The prevalence of feeding difficulties was estimated to be 91%.
    - With isolated cleft palate only—The prevalence of feeding difficulties was estimated to be 72% (Paes et al., 2017).
- **Acute stroke**
    - Newborns—The frequency of feeding and swallowing impairment was 39%. At the time of discharge, feeding and swallowing disorders persisted for 19% of newborns (Sherman et al., 2021).

    - Children—The frequency of feeding and swallowing impairment was 41%. At the time of discharge, feeding and swallowing disorders persisted for 17% of children (Sherman et al., 2021).

- **Autism**—The prevalence of food selectivity was 69.1% in children and adolescents, with 48.8% displaying food selectivity several times per week or even daily. The prevalence of mealtime behaviors was 64.3% (Babinska et al., 2020).

## Signs and Symptoms

Pediatric feeding disorder (PFD) may co-occur with dysphagia. Signs and symptoms of PFD vary based on the domain(s) affected and the child's age and developmental level. They include, but are not limited to, the following (Goday et al., 2019):

### Medical Factors

- Slowed motility, vomiting, and/or constipation due to gastrointestinal (GI) conditions
- Nasopharyngeal and laryngeal perceptual changes, such as stertor (noisy breathing, low-pitched sound that sounds like snoring), stridor (noisy breathing, high-pitched sound on inspiration), and congestion during or after eating
- Frequent respiratory illnesses, tachypnea (fast breathing), or apnea (temporary cessation of breathing)
- Cyanosis (turning blue), tachycardia (fast heart rate), bradycardia (slowed heart rate), and mottling (blotchy, red and purple marbling on the skin) due to cardiac conditions
- Neurological impairments characterized by severe motor and cognitive delays

### Nutritional Factors

- Malnutrition
- Restricted dietary diversity or quality, quantity, and/or variety of beverages and foods consumed
- Micronutrient deficiencies related to the exclusion of certain food groups

### Feeding Skill Factors

- Oral sensory impairments, including
    - limited tolerance for age-appropriate textures and viscosities, which may be associated with specific flavors, temperatures, tastes, bolus size, or appearance;

    - lack of awareness of food within the mouth, poor bolus formation, anterior loss, large bolus sizes, and gagging or refusal of liquid and food textures that provide inadequate sensory input; and
    - gagging with specific textures or bolus sizes, the need for excessive chewing, and limited variety of intake resulting in the need for bland flavors, finely grained textures, small bolus sizes, and room-temperature foods.
- Oral motor impairments, including
    - poor bolus control and manipulation resulting in anterior loss or gagging and coughing;
    - inefficient intake;
    - slow, ineffective mastication;
    - oral residue;
    - poor secretion management; and
    - an uncoordinated suck–swallow–breathe sequence.
- Pharyngeal swallowing impairments, including
    - audible or gulping swallows;
    - wet vocalizations;
    - multiple swallows per bolus;
    - throat clearing or coughing; and
    - chronic congestion.

**Psychosocial Factors**

- Learned feeding aversions
- Stress and distress during mealtimes
- Disruptive behavior during mealtimes
- Food overselectivity or picky eating
- Failure to advance to age-appropriate diet
- Grazing
- Caregiver use of maladaptive strategies to increase intake

Causes

Oral feeding requires coordination of the central and peripheral nervous systems, the oropharyngeal mechanism, the cardiopulmonary system, and the GI tract, with support from craniofacial structures and the musculoskeletal system. Because of how these systems interact, an impairment in one area can lead to a disruption or dysfunction in another, resulting in PFD (Goday et al., 2019). PFD may be caused by any singular factor or a combination of factors across the four domains:

**Medical Factors**

- GI tract conditions, such as gastroesophageal reflux disease, eosinophilic esophagitis, or motility disorders
- Oropharyngeal and laryngeal anomalies, such as laryngomalacia, vocal fold paralysis, or laryngeal cleft
- Pulmonary or other aerodigestive conditions, such as chronic lung disease
- Congenital heart disease or other cardiac conditions
- Neurological impairments, such as cerebral palsy

**Nutritional Factors**

- Metabolic disorders
- Medication side effects resulting in decreased appetite
- Neurodevelopmental disorders that affect energy expenditure and growth

**Feeding Skill Factors**

- Oral sensory impairments that may lead to
    - Oral hyposensitivity (or under-responsiveness)
    - Oral hypersensitivity (or over-responsiveness)
- Oral motor impairments affecting lip closure, tongue movement, and chewing abilities
- Pharyngeal swallowing impairments affecting airway protection and closure and that require an instrumental evaluation to fully assess anatomy and physiology

**Psychosocial Factors**

The factors within the child, the caregiver, and the feeding environment that can adversely affect feeding development and ultimately contribute to and maintain PFD, such as developmental delays, mood disorders, anxiety, stress, a distracting mealtime environment, and inappropriate social influences

Roles and Responsibilities

SLPs play a central role in the assessment, diagnosis, and treatment of infants and children with swallowing and feeding disorders. The professional roles and activities in speech-language pathology include clinical/educational services (diagnosis, assessment, planning, and treatment); prevention and advocacy; and education, administration, and research. See ASHA's Scope of Practice in Speech-Language Pathology (ASHA, 2016).

Appropriate roles for SLPs include the following:

**Assessment**

- Conducting a comprehensive assessment, including clinical and instrumental evaluations as appropriate
- Considering culture as it pertains to food choices/habits, perception of disabilities, and beliefs about intervention (Davis-McFarland, 2008; Villaluna & Dolby, 2024)
- Diagnosing pediatric oral and pharyngeal swallowing disorders (dysphagia)
- Recognizing signs of avoidant/restrictive food intake disorder and making appropriate referrals with collaborative treatment as needed
- Recommending a feeding and swallowing plan for the individualized family service plan, individualized health plan, individualized education program, or 504 plan
- Referring the patient to other professionals as needed to rule out other conditions, determine etiology, and facilitate patient access to comprehensive services

**Counseling and Education**

- Educating caregivers of children at risk for pediatric feeding and swallowing disorders
- Educating other professionals on the needs of children with feeding and swallowing disorders and the role of SLPs in diagnosis and management
- Educating children and their families to prevent complications related to feeding and swallowing disorders

**Treatment**

- Advocating for people with feeding and swallowing disorders at the local, state, and national levels
- Consulting and collaborating with other professionals, family members, caregivers, and others to develop programs

- Providing supervision, evaluation, and/or expert testimony, as appropriate
- Helping to advance the knowledge base related to the nature and treatment of these disorders
- Remaining informed of feeding and swallowing disorders research
- Serving as an integral member of an interdisciplinary feeding and swallowing team
- Providing evidence-based treatment for the remediation of pediatric feeding and swallowing disorders

SLPs who serve a pediatric population should be educated and appropriately trained to do so (ASHA, 2023). SLPs require specific knowledge of pediatric swallowing anatomy and physiology to treat pediatric feeding disorders and dysphagia.

**Feeding and Swallowing Teams**

Evaluation, assessment, and treatment of pediatric feeding and swallowing disorders may require the efforts of multiple specialists on an interprofessional team. Members of the feeding and swallowing team may vary across settings.

SLPs may be the team coordinator, who leads the team in

- identifying core team members and support services,
- training team members,
- facilitating communication between team members,
- tracking and documenting team activity,
- actively consulting with team members, and
- assisting in discharge planning.

**School Setting Considerations**

School-based SLPs play a significant role in the management of feeding and swallowing disorders. SLPs assess and treat students and educate families, teachers, and other professionals who work with the student. SLPs develop and lead the school-based feeding and swallowing team.

Feeding, swallowing, and dysphagia are not specifically mentioned in the Individuals with Disabilities Education Improvement Act of 2004 (IDEA, 2004). However, school districts have a responsibility to protect the health and safety of students with disabilities, including those with feeding and swallowing disorders. Students with disabilities have the right to access services to address safe mealtimes regardless of their special education classification (IDEA, 2004).

The U.S. Department of Education acknowledges that chronic health conditions could make a student eligible for special education and related services under the disability category "Other Health Impairment," if the disorder interferes with the student's strength, vitality, or alertness and limits the student's ability to access the educational curriculum.

Students who do not qualify for IDEA services and have swallowing and feeding disorders may receive services through the Rehabilitation Act of 1973, Section 504, so long as the swallowing and feeding disorder substantially limits one or more of life's major activities.

School districts that participate in the U.S. Department of Agriculture Food and Nutrition Service Program in the schools (i.e., the National School Lunch Program) must follow regulations (see 7 C.F.R. § 210.10[m][1]) to provide substitutions or modifications in meals for children who are considered disabled and whose disabilities restrict their diet (Meal Requirements for Lunches and Requirements for Afterschool Snacks, 2021). [2]

For more information, see also *Accommodating Children With Disabilities in the School Meal Programs: Guidance for School Food Service Professionals* [PDF] (U.S. Department of Agriculture, 2017).

[2] Here, we cite the most current, updated version of 7 C.F.R. § 210.10 (from 2021), in which the section letters and numbers are "210.10(m)(1)." The original version was codified in 2011 and has had many updates since. Those section letters and numbers from 2011 are "210.10(g)(1)" and can be found at https://www.govinfo.gov/content/pkg/CFR-2011-title7-vol4/pdf/CFR-2011-title7-vol4-sec210-10.pdf

**Educational Relevance**

IDEA ensures free and appropriate public education and protects the rights of students with disabilities. Feeding and swallowing disorders may be considered educationally relevant and part of the school system's responsibility to ensure

- adequate time to eat meals, which includes the ability to eat within the school's mealtime schedule and the need for accommodations such as extended mealtime or shorter, more frequent meals;
- safety while eating and drinking at school, including access to appropriate personnel, foods, liquids, and procedures to minimize risks of choking and aspiration while eating;
- adequate nourishment and hydration so that students can attend to and fully access the school curriculum;
- student health and well-being (e.g., free from aspiration pneumonia or other illnesses related to malnutrition or dehydration) to maximize their attendance and academic ability/achievement at school; and

- skill development for eating and drinking efficiently during meals and snack times so that students can complete these activities with their peers safely and in a timely manner.

Please see the Clinical Evaluation: School Setting section below for further details.

## Assessment

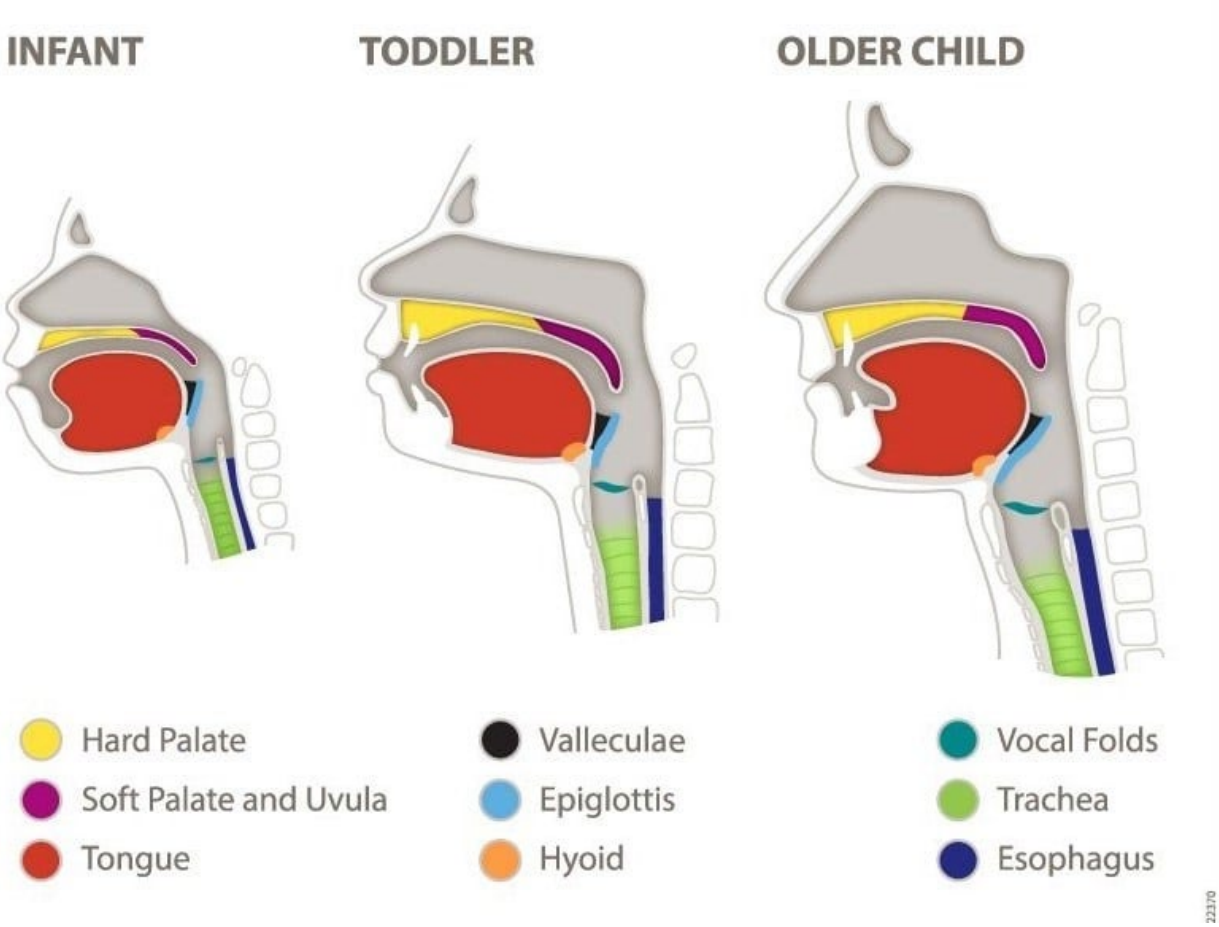
See the Assessment section of the Pediatric Feeding and Swallowing Evidence Map for pertinent scientific evidence, expert opinion, and client/caregiver perspective.
See *Person-Centered Focus on Function: Pediatric Feeding and Swallowing* [PDF] for examples of assessment data consistent with the International Classification of Functioning, Disability and Health framework (World Health Organization, 2001).

Assessment and treatment of swallowing and swallowing disorders require the use of appropriate personal protective equipment and universal precautions as needed.

Clinicians may consider the following factors when assessing feeding and swallowing disorders in the pediatric population:

- Congenital abnormalities and/or chronic conditions can affect feeding and swallowing function.
- Feeding skills of premature infants will be consistent with neurodevelopmental level rather than chronological age or adjusted age.
- Positioning limitations and abilities (e.g., children who use a wheelchair) may affect intake and respiration.
- Infants cannot describe their symptoms, and children with reduced communication skills may not be able to adequately do so either. Clinicians may rely on
    - a thorough case history;
    - caregiver interviews;
    - weight gain and growth trajectory;
    - data from monitoring devices (e.g., for patients in the hospital or on home respiratory support);
    - nonverbal forms of communication (e.g., behavioral cues signaling feeding or swallowing problems); and
    - observations of the caregiver's behaviors and ability to read the child's cues as they feed the child.

As infants and children grow and develop, the absolute and relative size and shape of oral and pharyngeal structures change. See figures below.




Lateral views of infant head, toddler head, and older child head showing structures involved in swallowing. From Arvedson, J.C., & Lefton-Greif, M.A. (1998). *Pediatric Videofluroscopic Swallow Studies: A Professional Manual With Caregiver Guidelines.* Copyright ©1998 Joan C. Arvedson. Reproduced and adapted with permission. All rights reserved.

Anatomical and physiological differences in infants include the following:

- The tongue fills the oral cavity, and the velum hangs lower than the adult velum. The hyoid bone and the larynx are positioned higher than in adults, and the larynx elevates less than in adults during the pharyngeal phase of the swallow.
- Each swallow of solids is discrete once the infant begins eating pureed food, as opposed to sequential swallows in bottle-fed or breastfed/chestfed infants.
- Swallowing anatomy and physiology change as the child gets older (Logemann, 1998).
    - The intraoral space increases as the mandible grows down and forward.
    - Deciduous teeth erupt, and the buccal fat pads are reabsorbed.

- The oral cavity elongates in the vertical dimension.
- The pharynx becomes elongated and enlarged as the child grows. This happens because the space between the tongue and the palate increases, and that between the larynx and the hyoid bone lowers.

Chewing matures as the child develops (see, e.g., Delaney et al., 2021; Gisel, 1988; Le Révérend et al., 2014; Wilson & Green, 2009). Concurrent medical issues may affect this timeline. Foods given during the assessment should be consistent with the child's current level of chewing skills.

**Clinical Evaluation**

A clinical evaluation of feeding and swallowing is necessary to determine the presence or absence of a feeding and/or swallowing disorder.

The evaluation may address

- eating,
- drinking,
- secretion management,
- oral hygiene,
- sensory status,
- the ability to accept food,
- the amount of diversity in their diet,
- management of oral medications,
- the caregiver's behaviors while feeding their child, and
- the psychosocial impact of feeding and swallowing difficulties on the family-and-child dynamic.

SLPs conduct assessments in a culturally responsive manner to acknowledge and honor the family's cultural background, religious beliefs, dietary beliefs/practices/habits, history of disordered eating behaviors, and preferences for medical intervention. Families are encouraged to bring foods and drinks common to their household and utensils typically used by the child. Typical feeding practices and positioning should be used during assessment. Cultural, religious, and individual beliefs about food and eating practices may affect an individual's comfort level or willingness to participate in the assessment. Some eating habits that appear to be a sign or symptom of a feeding disorder (e.g., avoiding certain foods or refusing to eat in front of others) may, in fact, be related to cultural differences in meal habits or may be symptoms of an eating disorder (National Eating Disorders Association, n.d.).

SLPs do not diagnose or treat eating disorders such as bulimia, anorexia, and avoidant/restrictive food intake disorder; in cases where these disorders are suspected, the SLP should refer to the appropriate behavioral health professional.

The clinical evaluation typically begins with a case history based on a comprehensive review of medical/clinical records and interviews with the family and health care professionals.

During a clinical evaluation, the SLP may assess the following:

- Overall physical, social, behavioral, and communicative development
- Gross and fine motor development
- Cranial nerve function
- Structures of the face, jaw, lips, tongue, hard and soft palate, oral pharynx, and oral mucosa
- Functional use of muscles and structures used in swallowing, including
    - symmetry,
    - sensation,
    - strength,
    - tone,
    - range and rate of motion, and
    - coordination of movement
- Head–neck control, posture, oral and pharyngeal reflexes, and involuntary movements and responses in the context of the child's developmental level
- Observation of the child eating or being fed by a family member, caregiver, or classroom staff member using foods from the home and oral abilities (e.g., lip closure) related to
    - typically used utensils or
    - utensils that the child may reject or find challenging
- Functional swallowing ability, including, but not limited to, typical developmental skills and task components, such as
    - suckling and sucking in infants,
    - mastication in older children,
    - oral containment (i.e., of bolus and secretions),

    - manipulation and transfer of the bolus, and
    - the ability to eat efficiently or within the time allotted at school
- Environmental factors, such as
    - mealtime schedule and routine;
    - distractions such as televisions and electronic devices; and
    - seating, positioning, and other environmental factors that impact feeding safety and efficiency
- Psychosocial factors, including
    - child and caregiver stress and other mental health factors that can affect mealtime interactions,
    - caregiver approaches to feeding,
    - caregiver expectations,
    - caregiver–child interactions and interpretation of hunger and satiety cues, and
    - the impact of feeding and swallowing needs on social interactions with adults and peers
- Ability to remain alert during intake to maintain swallow safety
- Impression of airway adequacy and coordination of respiration and swallowing
- Developmentally appropriate secretion management, which might include frequency and adequacy of spontaneous dry swallowing and the ability to swallow voluntarily
- Modifications in bolus delivery and/or use of rehabilitative/habilitative or compensatory techniques on the swallow and their effectiveness/impact
- Interventions by and referrals to
    - medical or surgical specialists,
    - a registered dietitian,
    - a psychologist or social worker,
    - an occupational therapist (OT), or
    - a physical therapist (PT)

Please see the *Pediatric Clinical Swallowing Evaluation Template* [PDF].

**Team Approach**

A team approach is necessary for appropriately diagnosing and managing pediatric feeding and swallowing disorders. The severity and complexity of these disorders vary widely in this population (McComish et al., 2016).

SLPs who specialize in feeding and swallowing disorders typically lead the professional care team in the clinical or educational setting.

Additional team members may include

- family/caregivers;
- a registered dietitian;
- a lactation consultant (infants);
- a nurse;
- an OT or a PT;
- a physician, such as
    - a pediatrician,
    - a neonatologist,
    - an otolaryngologist,
    - a gastroenterologist,
    - a dentist, or
    - a psychologist or psychiatrist;
- a psychologist/mental health professional (outpatient or school-based);
- a social worker (outpatient or school-based);
- a classroom teacher and/or a classroom teaching assistant; and/or
- school-based administrators/leaders.

Additional medical and rehabilitation specialists may be included, depending on the type of facility, the professional expertise needed, and the specific population being served.

See ASHA's resources on interprofessional education/interprofessional practice (IPE/IPP) and focusing care on individuals and their care partners.

For further information on the importance of a team approach, see Gosa et al. (2020), Desai et al. (2022), Homer (2008), and Dawson et al. (2024).

**Screening**

**Screening** identifies the need for further assessment and may be completed prior to a comprehensive evaluation. Swallowing screening is a procedure to identify individuals

who require a comprehensive assessment of feeding and swallowing function or a referral for other professional and/or medical services (ASHA, 2004). Screening for pediatric feeding disorder and/or dysphagia may be conducted by an SLP or any other member of the patient's care team. Individuals of all ages are screened as needed, requested, or mandated or when presenting medical conditions (e.g., neurological or structural deficits) suggest that they are at risk for pediatric feeding disorder and/or dysphagia. The purpose of the screening is to determine the likelihood that pediatric feeding disorder and/or dysphagia exists and the need for further assessment (see ASHA's resource on swallowing screening).

Screening may include the following:

- Administration of an interview or a questionnaire that addresses the patient's/caregiver's perception of and/or concern with swallowing function (e.g., the Feeding Impact Scales or Family Management of Feeding).
- Monitoring the presence of the signs and symptoms of oropharyngeal and/or esophageal swallowing dysfunction.
- Patient/caregiver report or observation of difficulty with *per os.*
- Administration of standardized screening protocols. Please see About the Feeding Assessment Tools—Infant Feeding Care for evidence-based screening tools.
- Observation of the student while eating snacks or a meal.
- Teacher/parent interview.

All screening procedures include communication of results and recommendations to the team responsible for the individual's care and to the patient and caregivers.

Screening may result in

- recommendations for rescreening;
- recommendations for additional assessment to determine whether, and the degree to which, feeding skill may be impaired; and
- referrals for other examinations or services (ASHA, 2004).

The medical team may make temporary recommendations (e.g., no oral intake, stipulation of specific dietary precautions) while the patient is awaiting further assessment.

**Clinical Evaluation: Infants**

The clinical evaluation for infants from birth to 1 year of age includes an evaluation of prefeeding skills, an assessment of readiness for oral feeding, an evaluation of

breastfeeding/chestfeeding and bottle-feeding ability, and observations of caregivers feeding the child.

SLPs should have extensive knowledge of

- embryology,
- prenatal and perinatal development,
- medical issues common to preterm and medically fragile newborns,
- typical early infant development,
- neuroprotection,
- neonatal care and its influence on neurodevelopment,
- respiratory support in the hospital and at home,
- alternative feeding modalities, and
- medical comorbidities common in the neonatal intensive care unit and after discharge.

Appropriate referrals to medical professionals should be made when anatomical or physiological abnormalities are found during the clinical evaluation. The clinical evaluation of infants typically involves the following:

- A case history, which includes (Arvedson, 2008)
    - gestational and birth history (to include Apgar scores if available);
    - general health;
    - medical comorbidities;
    - pertinent medical history including growth patterns, neurodevelopmental status, orofacial structures, and cardiopulmonary and gastrointestinal function;
    - any known allergies or intolerances;
    - the caregivers'/family's cultural/religious beliefs/preferences regarding food and feeding practices; and
    - the caregivers'/family's perceptions of the mealtime process related to schedule, location, specific strategies, and oral and enteral intake
- A physical examination, which includes (Arvedson, 2008)
    - oral reflexes/oral peripheral examination;
    - infant and caregiver interactions;

    - developmental motor assessment looking at head, neck, and trunk positioning;
    - respiratory status and supports;
    - overall state, alertness, and autonomic functions such as temperature, heart rate, respiratory rate, and oxygen saturation (physiologic stability);
    - response to sensory stimulation; and
    - self-regulatory behaviors
- A determination of oral feeding readiness
- An assessment of the infant's ability to engage in non-nutritive sucking (NNS)
- Developmentally appropriate clinical assessments of feeding and swallowing behavior (nutritive sucking [NS])
- An identification of additional disorders that may have an impact on feeding and swallowing
- A determination of the optimal feeding method
- An assessment of the duration of mealtime experience, including the potential impact on physiologic stability (SLP may refer to the medical team, as necessary)
- An assessment of issues related to fatigue and volume limitations
- An assessment of the effectiveness of parent/caregiver and infant interactions for feeding and communication
- Consideration of the infant's ability to obtain sufficient nutrition/hydration across settings (e.g., hospital, home, day care)

For further information on case history and physical examination, please see Gosa and Dodrill (2023) and Delaney (2019).

**Non-Nutritive Sucking (NNS)**

NNS is sucking for comfort without fluid release (e.g., with a pacifier, finger, or recently emptied breast). NNS does not determine readiness to orally feed, but it is helpful for assessment. NNS patterns can typically be evaluated with skilled observation and without the use of instrumental assessment.

A noninstrumental assessment of NNS includes an evaluation of the following:

- The infant's oral structures and functions, including palatal integrity, jaw movement, and tongue movements for cupping and compression (Note: Lip closure is not required for infant feeding because the tongue typically seals the anterior opening of the oral cavity.)

- The infant's ability to turn the head and open the mouth (rooting) when stimulated on the lips or cheeks and to accept a pacifier into the mouth
- The presence and strength of **compression** (positive pressure of the jaw and tongue on the pacifier)
- The presence and strength of **suction** (negative pressure created with tongue cupping and jaw movement)
- The infant's ability to maintain stable status (e.g., oxygen saturation, heart rate, respiratory rate) during NNS

**Nutritive Sucking (NS)**

The clinician can determine the appropriateness of NS following an NNS assessment. Any change in physiologic, motoric, or behavioral status from baseline should be taken into consideration at the time of the assessment.

NS skills are assessed during breastfeeding/chestfeeding and bottle-feeding if both modes are going to be used. SLPs should be sensitive to family values, beliefs, and access regarding bottle-feeding and breastfeeding/chestfeeding and should consult with parents and collaborate with nurses, lactation consultants, and other medical professionals to help identify parent preferences.

Assessment of NS includes an evaluation of the following:

- sucking–swallowing–breathing coordination
- the feeding relationship—interaction between the infant and the feeder
- **efficiency**—volume of intake per minute
- **endurance**—ability to remain engaged in the feeding to finish the required volumes while sustaining appropriate feeding patterns

The infant's communication behaviors during feeding can be used to guide a flexible assessment. These cues can communicate the infant's ability to tolerate bolus size, if any additional postural support is needed and if swallowing and breathing are no longer synchronized. The caregiver can use these cues to optimize feeding by immediately responding to the infant's needs (Shaker, 2013b).

**Breastfeeding/Chestfeeding/Lactation**

SLPs collaborate with parents, nurses, and lactation consultants prior to assessing feeding skills when appropriate. This requires a working knowledge of nursing strategies to facilitate safe and efficient swallowing.

Lactation assessment typically includes an evaluation of the following:

- the infant's behavior (e.g., positive rooting, willingness to suckle)

- the infant's position (e.g., well supported, tucked against the caregiver's body)
- the infant's ability to latch
- efficiency and coordination of the infant's suck–swallow–breathe pattern
- health of the caregiver's mammary tissue, if present
- the caregiver's behavior (e.g., comfort with lactation, confidence in handling the infant, awareness of the infant's cues during feeding)

For an example, see *Community Management of Uncomplicated Acute Malnutrition in Infants < 6 Months of Age (C-MAMI)* [PDF].

**Bottle-Feeding**

The assessment of bottle-feeding includes an evaluation of the following:

- the infant's behavior (e.g., positive rooting, willingness to suckle)
- the infant's readiness to accept a nipple
- the caregiver's behavior while feeding the infant
- efficiency and coordination of the infant's suck–swallow–breathe pattern
- nipple type and form of nutrition (breast milk or formula)
- the infant's position
- quantity of intake
- the length of time the infant takes for one feeding
- the infant's response to attempted interventions, such as
    - a different nipple for flow control,
    - external pacing,
    - a different bottle to control air intake, and
    - different positions (e.g., side feeding)

**Spoon-Feeding**

The assessment of spoon-feeding includes an evaluation of the optimal spoon type and the infant's ability to

- move their head toward the spoon and then open their mouth,
- turn their head away from the spoon to show that they have had enough or are not interested,
- close their lips around the spoon for bolus extraction,

- clear food from the spoon with their top lip,
- move food from the spoon to the back of their mouth, and
- attempt to spoon-feed independently.

**Clinical Evaluation: Toddlers, Preschoolers, and School-Age Children**

The clinical evaluation of toddlers and preschool-age children typically includes the following (Arvedson, 2008):

- A thorough case history, including a review of family, medical, developmental, and feeding history
- A physical examination, including the parent–child dynamic; head, neck, and trunk mobility and positioning; cardiorespiratory status; overall state and response to sensory stimulation; and self-regulation
- A functional oral mechanism and cranial nerve examination
- A feeding assessment that replicates the home environment as closely as possible, such as
    - the child seated in a highchair, a chair, or other specialized seating system as needed;
    - offering textures and consistencies that are both familiar and preferred, in addition to varied, more challenging, and novel presentations;
    - assessing for the effectiveness of both compensatory and active interventions for oral sensory and oral motor feeding needs;
    - assessing stimulability for sensory motor–based interventions based on perceived deficits or trialing different utensils, cups, and so on; and/or
    - providing caregiver training through psychosocial support and coaching to facilitate child-led, responsive mealtimes

Results of a clinical assessment are integrated to form a plan that answers the following questions:

- Are further referrals or testing, such as an instrumental swallowing evaluation, warranted?
- Can the child eat and drink orally in a way that meets nutrition and hydration needs?
- Are modifications needed in positioning, sensory aspects of foods and liquids, scheduling, or mealtime structure to facilitate success?
- What feeding skill–based deficits are suspected or present (motor)?

## Clinical Evaluation: School Setting

Evaluation in the school setting includes students aged 3–21 years. The process may begin with a referral to a team of professionals within the school district trained in identifying and treating feeding and swallowing disorders. The referral can be initiated by families/caregivers or school personnel. In other cases, children may enter the school setting with a documented history of a feeding and swallowing disorder and prior or current treatment.

A physician's order is typically not required to evaluate a student for feeding and swallowing disorder in the school setting; however, it is best practice to collaborate with the student's physician, particularly if the student is medically fragile or under the care of a physician. See the School Collaboration With Outside Medical Professionals section below.

Parental/caregiver consent is required to initiate an evaluation in schools. Case history information is gathered from caregivers and via record review (e.g., videofluoroscopic swallowing study [VFSS] report, outpatient feeding team evaluation) about the child's medical history, current health status, eating habits, and feeding or swallowing concerns.

The school-based SLP conducts the evaluation in collaboration with team members (OT, PT, school nurse), which includes observation of the student eating a typical meal or snack. Implementation of strategies and modifications is part of the diagnostic process. Trials of specific interventions may be warranted based on the assessment findings.

A feeding and swallowing evaluation includes a determination of a child's ability to eat and drink enough food safely within the school's mealtime schedule. Not being able to eat within the allotted time can decrease a child's ability to access the curriculum. SLPs make recommendations for accommodations such as extended mealtimes or shorter, more frequent meals. Consideration of inclusive time and impact on peer interactions should be considered.

Additional components of the evaluation include the following:

- An assessment of oral structures and function during intake
- An assessment to determine the developmental level of feeding skills
- An assessment of various textures and consistencies of food to assess oral sensory and oral motor feeding skills
- An assessment to determine the effectiveness of both compensatory and active interventions for oral sensory and oral motor feeding needs
- An assessment of issues related to fatigue and access to adequate levels of nutrition and hydration during school

- An assessment of oral feeding abilities, including the ability to manipulate and propel the bolus, and effective mastication
- An assessment for any signs of feeding and swallowing concerns, including coughing, choking, prolonged mastication time, oral holding, wet vocal quality, or congestion
- An assessment of adaptive equipment for eating and positioning by an OT and a PT
- An assessment to determine the effectiveness of accommodations to reduce the educational impact of feeding and swallowing disorders
- An assessment to determine the impact of feeding and swallowing on inclusive time

**Team Approach**

The school-based feeding and swallowing team includes professionals within the school setting and works closely with families in all phases of evaluation and treatment. Professionals who treat the child outside of the school setting (e.g., physicians, dietitians, psychologists) are consulted to collaborate and share information (with parental consent). See the School Collaboration With Outside Medical Professionals section below.

Members of the team include, but are not limited to, the following:

- SLP
- family/caregiver
- classroom teacher and assistant
- school nurse
- dietitian and/or cafeteria staff
- OT
- PT
- school administrator
- behavioral specialist
- school psychologist
- social worker

The team works together to

- develop an individualized health plan that includes compensatory strategies, food and drink consistency recommendations, and emergency procedures for choking;
- provide information and training to staff and families for compensatory strategies;
- develop an individualized education program (IEP) to include goals and accommodations needed for safe feeding and swallowing;
- oversee the day-to-day implementation of the feeding and swallowing plan and any individualized education program strategies to help prevent aspiration, choking, undernutrition, or dehydration while in school;
- identify and provide direct treatment for feeding and swallowing if an adverse impact on educational or functional performance is found to be present (IDEA, 2004); and
- work with families to seek physician referral for instrumental assessment and/or follow-up as needed.

**School Collaboration With Outside Medical Professionals**

Best practice indicates establishing open lines of communication with the student's physician or other health care provider—either through the caregiver or directly—with the caregiver's consent. Any communication by the school team to an outside physician, facility, or individual requires signed parental consent.

A physician's order or prescription is not required to perform clinical evaluations, modify diets, or provide intervention in the school setting. However, there are times when a prescription, referral, or medical clearance from the student's primary care physician or other health care provider is indicated, such as when the student

- receives part or all of their nutrition or hydration via enteral or parenteral tube feeding,
- has a complex medical condition and experiences a significant change in status,
- has recently been hospitalized with aspiration pneumonia,
- has had a recent choking incident and has required emergency care,
- is suspected of having aspirated food or liquid into the lungs,
- has suspected structural abnormalities (requires an assessment from a medical professional), and/or
- requires modification of their school-provided meals (see the U.S. Department of Agriculture guidance discussed in the School Setting Considerations section above).

See ASHA's resources on interprofessional education/interprofessional practice (IPE/IPP) and collaboration and teaming for guidance on successful collaborative service delivery across settings.

See the Treatment in the School Setting section below for further information.

**Instrumental Evaluation**

Instrumental evaluation is conducted after a clinical evaluation when more information is needed to determine the presence and pathophysiology of dysphagia. Instrumental assessments can help provide specific information about anatomy and physiology otherwise not accessible by noninstrumental evaluation. Instrumental evaluation identifies the appropriate treatment plan based on swallowing physiology and can also help determine if swallow safety can be improved with strategies such as modifying food textures, liquid consistencies, and positioning.

Instrumental evaluation is completed in a medical setting. These studies are a team effort and may include the radiologist, radiology technician, and SLP. The SLP or radiology technician typically prepares and presents the barium items, whereas the radiologist records the swallow for visualization and analysis. Please see ASHA's resource on state instrumental assessment requirements for further details.

The two most commonly used instrumental evaluations of swallowing for the pediatric population are

- videofluoroscopic swallowing study (VFSS) and
- flexible endoscopic evaluation of swallowing (FEES).

The roles of the SLP in the instrumental evaluation of swallowing and feeding disorders include

- participating in decisions regarding the appropriateness of these procedures;
- conducting the VFSS and FEES instrumental procedures;
- interpreting and applying data from instrumental evaluations to
    - determine the severity and nature of the swallowing disorder and the child's potential for safe oral feeding
    - develop feeding and swallowing treatment plans, including recommendations for optimal feeding techniques;
- being familiar with and using information from various diagnostic procedures that give information related to swallowing, including
    - manofluorography,

- scintigraphy (which, in the pediatric population, may also be referred to as "radionuclide milk scanning"),
- pharyngeal manometry,
- 24-hour pH monitoring,
- flexible fiberoptic laryngoscopy (usually completed in the office),
- direct laryngoscopy and bronchoscopy (usually completed in the operating room), and
- esophagoscopy.

**General Considerations for Instrumental Evaluations**

Determining the appropriate procedure to use depends on what needs to be visualized and which procedure will be best tolerated by the child. Prior to the instrumental evaluation, clinicians may consult with the team to coordinate feeding schedules that will maximize feeding readiness during the evaluation.

Examinations should be completed only for infants or children when (Martin-Harris et al., 2020)

- there are documented or suspected oropharyngeal swallowing impairments,
- the patient is medically stable and has the skills needed to participate, and
- the findings are needed to determine the plan of care.

These points should also be considered when planning for repeat instrumental exams, which should not be completed at arbitrary time intervals but rather dictated by a change in status or the need for new information, understanding the cumulative effects of radiation exposure over the lifespan for infants and young children (Martin-Harris et al., 2020). When conducting an instrumental evaluation, SLPs should consider the following:

- Infants are obligate nasal breathers, and the placement of a flexible endoscope in one nostril when a nasogastric tube is in the other nostril could compromise breathing. Clinicians should discuss this with the medical team to determine options, including the temporary removal of the feeding tube and/or use of another means of swallowing assessment.
- Anxiety and crying are common reactions. Anxiety may be reduced by using distractions (e.g., preferred toys, videos), allowing the child to sit on the parent's or the caregiver's lap (for FEES procedures), and decreasing the number of observers in the room.

- Positioning for the VFSS depends on the size of the child and their medical condition (Arvedson & Lefton-Greif, 1998; Geyer & McGowan, 1995). Infants under 6 months old typically require head, neck, and trunk support.
- Children are positioned as they are typically fed at home and in a manner that avoids spontaneous or reflexive movements that could reduce safety. Modifications to positioning are made as needed and are documented as part of the assessment findings.
- Any study in which a natural feeding process is impossible may not represent typical swallow function and should be interpreted with caution. Disruptions to the natural feeding process include
    - inappropriate positioning,
    - lack of caregiver involvement, and
    - the use of unfamiliar foods.

**Test Environment**

Procedures take place in a child-friendly environment if possible and appropriate. They can involve toys, visual distractors, rewards, and a familiar caregiver. Various items are available in the room to promote success and to simulate a typical mealtime experience. Such items include preferred foods, familiar food containers, utensil options, and seating options.

**Preparing the Child and Family**

The clinician prepares the child and family by

- explaining the procedure, its purpose, and the test environment in a health-literate way;
- implementing a trauma-informed care approach that allows the child to be calm and get used to the room, the equipment, and the professionals who will be present;
- instructing the family to schedule meals and snacks so that the child will be hungry and more likely to accept foods needed for the study, as appropriate;
- collaborating with interprofessional team members, such as child life specialists, to support the child and their caregivers before, during, and after the exam; and
- asking the family to provide familiar utensils, preferred foods, and specialized seating from home to make the environment as natural as possible and increase the child's comfort.

**Tube Feeding**

Tube feeding, also known as enteral nutrition, is used when nutrition cannot be maintained through oral intake. Types of tubes include the following:

- nasogastric (passed through the nose down the esophagus and into the stomach)
- transpyloric (placed in the duodenum or jejunum)
- gastrostomy (a tube placed in the stomach)
- gastronomy–jejunostomy (placed in the jejunum)

Alternative feeding does not preclude the need for feeding-related treatment. These approaches may be considered by the medical team if the child's swallowing safety and efficiency cannot reach a level of adequate function or does not adequately support nutrition and hydration. In these instances, the swallowing and feeding team considers

- the optimum tube-feeding method that best meets the child's needs and
- whether the child will need tube feeding for a short or an extended period of time.

SLPs do not make medical decisions regarding enteral feeding. However, information provided by SLPs may contribute to medical providers' decision-making process. Please see ASHA's resource on alternative nutrition and hydration in dysphagia care for further information.

## Treatment

See the Treatment section of the Pediatric Feeding and Swallowing Evidence Map for pertinent scientific evidence, expert opinion, and client/caregiver perspective.

The primary goals of feeding and swallowing intervention for children are to

- support safe and adequate nutrition and hydration;
- determine the optimum feeding methods and techniques to maximize swallowing safety and feeding efficiency;
- incorporate dietary preferences by collaborating with caregivers;
- help individuals achieve age-appropriate eating skills in the most normal setting and manner possible (i.e., eating meals with peers in the school, mealtime with the family);
- minimize the risk of pulmonary complications;
- maximize the quality of life;
- support caregiver–child interactions and encourage child and caregiver autonomy and independence; and

- prevent future feeding issues with positive feeding-related experiences to the extent possible, given the child's medical situation.

Medical, surgical, and nutritional factors are important considerations in treatment planning. The underlying disease state(s), the chronological and developmental age of the child, social and environmental factors, and psychological and behavioral factors also affect treatment recommendations. Not every child will have the same access to food, health care providers, or other resources that are necessary to comply with recommendations. Clinicians take each patient's and caregiver's unique circumstances into account when providing education, counseling, and community resource recommendations. See ASHA's resource on social determinants of health for further information.

An interdisciplinary team approach is essential for individualized treatment of children with complex feeding problems (McComish et al., 2016; West, 2024). See ASHA's resources on interprofessional education/interprofessional practice (IPE/IPP) and collaboration and teaming.

Questions to ask when developing an appropriate treatment plan include the following:

**Can the child eat and drink safely?**

Consider the child's overall swallowing function and how these factors affect feeding efficiency and safety, as follows:

- pulmonary status
- nutritional status
- overall medical condition
- physical mobility, positioning, and their influence on overall health
- feeding and swallowing abilities
- cognition

**Can the child receive adequate nutrition and hydration by mouth alone, given length of time to eat, efficiency, and fatigue factors?**

This question is answered by the child's interprofessional team. If the child cannot meet nutritional needs by mouth, the team may make recommendations for nonoral intake and/or the inclusion of dietary supplements.

**How can the child's functional abilities be maximized?**

This might involve questions and decisions about what the child's current skill level is, if the child can safely eat an oral diet that meets nutritional needs, if that diet needs to be modified in any way, and if the child needs compensatory strategies to eat the diet. Does the child have the potential to improve swallowing function with direct treatment?

### How can the child's quality of life be preserved and/or enhanced?

The family's customs and traditions around mealtimes and food should be respected and incorporated into therapy recommendations and education. Caregivers may prioritize the following quality-of-life concerns (Simione et al., 2020):

- enjoyable stress-free mealtimes
- eating without medical interventions (e.g., tube feedings)
- health-related outcomes
    - expanding the child's diet
    - eating healthy foods
    - meeting nutritional needs
    - maintaining or gaining weight

See also Simione et al. (2023).

### What are the family's preferences and goals, and how does the family dynamic influence mealtimes?

Are the family's expectations congruent with the child's current developmental age and skill set? Does the family use a responsive feeding approach, attending to the child's hunger and satiety cues and respond in a supportive manner? Are there other psychosocial factors that require support from other interprofessional practice team members, such as a mental health practitioner?

### Treatment Considerations

The health and well-being of the child is the primary concern in treating pediatric feeding and swallowing disorders. Beliefs about the medicinal value of some foods or liquids vary among cultures, religions, and individual families. Some beliefs and healing practices may not be consistent with recommendations that an SLP typically makes. The clinician works with the family to determine alternatives that promote safety while aligning with their culture, beliefs, and customs around food.

Appropriate treatment approaches consider the child's age, cognitive and physical abilities, and specific swallowing and feeding problems. Infants, young children, and children with an intellectual disability or language disorder may have difficulty following verbal or nonverbal directions. In these cases, intervention might consist of changes in the environment or caregiver training for improving safety and efficiency of feeding.

The management of feeding and swallowing disorders in infants, toddlers, and older children is facilitated by a multidisciplinary approach. This is especially important for children with complex medical conditions.

Treatment considers the following:

- **Readiness for oral feeding**—Children who are beginning to eat orally for the first time or after an extended period of nonoral feeding will need time to become comfortable in the presence of food and to explore food without experiencing physiological responses (e.g., for children with significant gastrointestinal problems).
- **Communication**—SLPs can help caregivers understand emerging communication and interpret their behavior as it relates to feeding and swallowing while also providing language stimulation related to food vocabulary (e.g., names of foods and various flavors) as well as how children might be using feeding behaviors (e.g., food refusal responses) to communicate.
- **Physical conditions**—Treatment for children with conditions and disorders that affect movement (e.g., cerebral palsy or muscular dystrophy) needs to consider the length of time to fatigue, optimal feeding methods, and positioning to maximize safe feeding and swallowing.

### Compensatory Treatment

#### Postural and Positioning Techniques

**Postural and positioning techniques** involve adjusting the child's posture or position to increase feeding safety. These techniques serve to protect the airway and support functional transit of food and liquid. No single posture works for all people. Postural changes differ between infants and older children. Instrumental assessments provide necessary information regarding the effectiveness of any of the techniques of swallow safety, which include the following:

- chin down—tucking the chin down toward the neck
- chin up—slightly tilting the head up
- head rotation—turning the head to the weak side to protect the airway
- upright positioning—supports the head, neck, and trunk alignment in a way that is functional considering the child's physical needs
- head stabilization—supported so as to present in a chin-neutral position
- reclining position—using pillow support or a reclined infant seat with trunk and head support
- side-lying positioning (for infants)

#### Diet Modifications

**Diet modifications** are any changes made to the viscosity, texture, temperature, portion size, or taste of foods or liquids to increase safety and decrease difficulty of

swallowing. Typical modifications may include thickening thin liquids, softening, cutting/chopping, or pureeing solid foods. Taste or temperature of a food may be changed to increase sensory input for swallowing. See the International Dysphagia Diet Standardisation Initiative (IDDSI).

Diet modifications include individual and family preferences whenever feasible. SLPs consult with families regarding safety of medical treatments, such as swallowing medication in liquid or pill form, which may be contraindicated by the disorder. Diet modifications should consider the nutritional needs of the child and be guided by clinical and instrumental assessment findings.

**Precautions**

Consumers should use caution regarding the use of commercial, gum-based thickeners for infants of any age (Beal et al., 2012; U.S. Food and Drug Administration, 2017). SLPs should be aware of these precautions and consult, as appropriate, with their facility to develop guidelines for using thickened liquids with infants (Gosa, Dodrill, & Robbins, 2020).

**Equipment and Utensils**

Adaptive equipment and utensils may be used with children who have feeding problems to foster independence with eating and increase swallow safety. These tools can help by controlling bolus size or achieving the optimal flow rate of liquids.

Examples of adaptive equipment include the following:

- modified nipples
- cutout cups
- weighted forks and spoons
- angled forks and spoons
- sectioned plates
- non-tip bowls
- Dycem® to prevent plates and cups from sliding
- metered straws
- feeder-assisted straw cups

SLPs work with oral and pharyngeal implications of adaptive equipment. SLPs may collaborate with occupational therapists, because motor control is an important consideration for using adaptive equipment.

**Direct Interventions**

### Swallowing Maneuvers

**Swallowing maneuvers** are strategies used to change the timing or strength of movements of swallowing (Logemann, 2000). Some maneuvers require following multistep directions and may not be appropriate for young children and/or older children with cognitive impairments. Please see the Treatment section of ASHA's Practice Portal page on Adult Dysphagia for further information. Examples of maneuvers include the following:

- **Effortful swallow**—Posterior tongue base movement is increased to facilitate bolus clearance.
- **Mendelsohn maneuver**—Elevation of the larynx is voluntarily prolonged at the peak of the swallow to help the bolus pass more efficiently through the pharynx and to prevent food/liquid from falling into the airway.
- **Supraglottic swallow**—Vocal folds are closed by voluntarily holding one's breath before and during the swallow in order to protect the airway.
- **Super-supraglottic swallow**—An effortful breath hold tilts the arytenoid forward, which closes the airway entrance before and during the swallow.

Although sometimes referred to as the **Masako maneuver**, the Masako (or "tongue-hold") is considered an exercise, not a maneuver. In the Masako, the tongue is held forward between the teeth while swallowing; this is performed without food or liquid in the mouth to prevent coughing or choking.

Swallowing maneuvers and other rehabilitation techniques commonly utilized in adult populations have limited application in pediatric populations due to physical and cognitive immaturity of infants and children (Gosa & Dodrill, 2017).

### Oral Motor Treatments and Sensory Techniques

There is limited high-quality evidence supporting the use of oral motor exercises or sensory techniques in the treatment of pediatric feeding disorder–related sensory deficits and swallowing dysfunction in isolation (Arvedson et al., 2010; Gosa et al., 2017; Gosa & Dodrill, 2017). Motor learning is experience dependent, meaning that children establish motor patterns through opportunities that are frequent and are as closely related to the desired task as possible (Kleim & Jones, 2008; Zimmerman et al., 2020). For example, if a child wants to chew a banana, they should be provided with frequent opportunities and modifications that encourage them to engage in the motor task of chewing a banana. As compared with oral motor exercises, modifying the sensory components of food-like taste, texture, temperature, and shape is more effective as facilitating desired oral motor patterns, such as chewing or tongue lateralization (Arvedson et al., 2010).

Evidence-based practice is a guiding principle of speech-language pathology. Clinicians should consider any available evidence before using any product or technique. See

ASHA's Evidence-Based Practice (EBP) page, and visit ASHA's Pediatric Feeding and Swallowing Evidence Map for further information.

### Infant Feeding Strategies

Pacing

**Pacing** involves decreasing the rate of eating by controlling the rate of presentation of the food or liquid and the time between bites or swallows. Feeding strategies for children may include alternating bites of food with sips of liquid or swallowing two to three times per bite or sip. For infants, pacing involves limiting the number of consecutive sucks. Strategies that slow the feeding rate may allow for more time between swallows to clear the bolus and may support more timely breaths.

### Flow Rate Modifications

Nipple flow rate selection is one of the most important considerations for keeping the airway safe during bottle-feeding. Using a slower flow nipple can support and regulate suck–swallow–breathe coordination (Goldfield et al., 2013). Bottle nipple manufacturing is an unregulated industry. Therefore, there can be high performance variability between brands and sometimes between individual nipples. This variability can also be altered by external variables such as infant sucking pressures, pliability, hydrostatic pressure, and viscosity modifications (Pados, 2021).

Elevated Side-Lying Positioning

**Elevated side-lying positioning** aims to support better bolus control and reduce the work of breathing (Girgin et al., 2018; Park et al., 2014; Raczyńska et al., 2022). The infant is positioned on their side, with the head, shoulders, and hips neutrally aligned and facing upward and elevated to approximately 45 degrees. Flexion is provided through swaddling.

Viscosity Modifications (Thickening)

Thickening may be necessary to treat dysphagia for some infants, based on the results of an instrumental assessment. The goals of thickening agents are to

- establish safe oral feeding that is least disruptive to developing feeding skills and
- reduce and stop using a thickener as quickly as possible.

There is limited evidence about the effects of **viscosity modifications**, or thickening, as an intervention for dysphagia in infants (Gosa et al., 2011). Some anecdotal data link some thickened liquids and harmful side effects (Beal et al., 2012; Clarke & Robinson, 2004). The interprofessional team discusses the risks and benefits of viscosity modifications as well as the infant's unique comorbidities, health status, and parent preferences (Duncan et al., 2019).

Cue-Based Feeding

**Cue-based feeding** is an approach that views the feeding experience as a partnership with the infant. The infant's cues are viewed as communication that guides the caregiver and allows the infant to set the pace of feeding and have more opportunity to enjoy the experience of feeding when the quality of feeding is prioritized over the quantity ingested. As a result, intake may be improved (Shaker, 2013a).

The infant's cues during feeding, such as lack of active sucking, passivity, or pushing away, provide information about the infant's physiologic stability during feeding and inform the feeder's response to cues, which allows them to provide immediate intervention to support positive oral feeding experiences. Cue-based feeding is an approach that is predominantly used in the neonatal intensive care unit (NICU); however, knowing that motor learning is experience dependent, a trauma-informed, cue-based approach to oral feeding can be adapted and is appropriate for clinicians working with infants and their families in other settings.

SLPs in the NICUs educate caregivers to improve their understanding of and response to the infant's communication during feeding. Most NICUs have begun to move away from volume-driven feeding to cue-based feeding (Gosa & Dodrill, 2023; Shaker, 2013a).

Responsive Feeding

Like cue-based feeding, **responsive feeding** focuses on the caregiver-and-child dynamic. Responsive feeders attempt to understand and read a child's cues for both hunger and satiety; respect that communication in a nurturing, reciprocal way; and support the child in developing preferences for age-appropriate, nutritionally balanced foods. Responsive feeding encourages the child to eat autonomously, in response to their developmental and physiologic needs, which supports self-regulation and cognitive, emotional, and social development (Pérez-Escamilla et al., 2021).

### Biofeedback

**Biofeedback** treatment for swallowing uses instrumental methods (e.g., surface electromyography, ultrasound, nasendoscopy) to give visual feedback during feeding and swallowing. Children with sufficient cognitive skills can be taught to interpret this visual information and make physiological changes during the swallowing process.

### Electrical Stimulation

**Electrical stimulation** uses an electrical current to stimulate the peripheral nerve. SLPs with appropriate training and competence in performing electrical stimulation may provide the intervention. ASHA does not require any additional certifications to perform electrical stimulation and urges members to follow the ASHA Code of Ethics, Principle II, Rule A, which states: "Individuals who hold the Certificate of Clinical Competence shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their certification status, education, training, and experience" (ASHA, 2023).

There is concern that using neuromuscular electrical stimulation (NMES) with neonates and infants may impact neuromuscular development in ways that are not yet well understood. Clinicians should use discretion when considering using NMES to minimize potential harm to patients (Epperson & Sandage, 2019). High-risk infants may exhibit dampened responses or cues to pain, and that pairing the potentially painful experience of NMES with feeding may affect neuromuscular development and increase aversion to feeding by pairing a painful stimulus with swallowing (Bustamante et al., 2022). ASHA is strongly committed to evidence-based practice and urges members to consider the best available evidence before using any product or technique.

Please see the NMES section of the Pediatric Feeding and Swallowing Evidence Map for further information.

### Intraoral Prosthetics and Appliances

**Intraoral prosthetics** (e.g., palatal obturator, palatal lift prosthesis) can be used to stabilize the intraoral cavity by providing compensation or physical support for children with congenital abnormalities (e.g., cleft palate) or damage to the oropharyngeal mechanism. This support may help improve swallowing efficiency and function.

**Intraoral appliances** (e.g., palatal plates) are removable devices with small knobs that provide tactile stimulation inside the mouth to encourage lip closure and appropriate lip and tongue position for improved functional feeding skills. Referrals may be made to dental professionals for assessment and fitting of these devices.

### Treatment in the School Setting

SLPs who address feeding and swallowing in schools should be familiar with IDEA, which protects students with disabilities. This includes students with feeding and swallowing disorders. School-based treatment addresses the impact of the disorder on a student's educational performance to promote swallow safety for adequate hydration and nutrition. Maximizing the health of the students is key to facilitating their academic progress and access to the educational curriculum. Goals are implemented through individualized education programs (IEPs) written specifically for the students' individual needs.

### Individualized Education Program (IEP)

Information from the referral, caregiver interview/case history, and clinical evaluation of the student is used to develop IEP goals and objectives for improved feeding and swallowing, if appropriate. The IEP may include direct therapy aimed at improving oral feeding and swallowing skills, in addition to accommodations needed for safe and efficient oral intake throughout the school day.

### Feeding and Swallowing Plan

A **feeding and swallowing plan** addresses diet and environmental modifications and procedures to minimize aspiration and choking risks while optimizing nutrition and

hydration. Ongoing staff and family education is essential to student safety. The plan should be reviewed annually along with the IEP goals and objectives or sooner if significant changes occur or if it is found to be ineffective.

A feeding and swallowing plan may include, but not be limited to, the following:

- student demographic information
- appropriate positioning of the student for a safe oral intake
- specialized equipment indicated for positioning or feeding, as needed
- environmental modifications to minimize distractions, enhance efficiency, and promote safe and sufficient oral intake
- adapted utensils or supplies for mealtimes (e.g., specialized cup, curved spoon/fork)
- recommended diet consistency, including food and liquid preparation/modification
- sensory modifications, including temperature, taste, or texture
- food presentation techniques, including wait time and amount
- the level of assistance required for eating and drinking
- cues or prompts for eating and drinking
- specific diet levels according to IDDSI and ways for school-based teams to ensure a child's diet meets the required level of modification (e.g., IDDSI flow rate testing)
- any additional accommodation and compensatory supports needed to support safe and sufficient oral intake during the school day.

### Individualized Health Plan or Individualized Health Care Plan

An **individualized health plan** or **individualized health care plan** may be developed as part of the IEP or 504 plan to establish appropriate health care that may be needed for students with feeding and/or swallowing disorders. The plan includes a response protocol in a student health emergency (Homer, 2008). Staff who work closely with the student should have training in cardiopulmonary resuscitation (CPR) and the Heimlich maneuver, in addition to being trained on overt signs and symptoms of aspiration

### Postsecondary Transition Planning for Adolescents

Feeding and swallowing challenges can persist well into adolescence and adulthood. Precautions, accommodations, and adaptations must be considered and implemented as students transition from high school to postsecondary settings. See ASHA's resource on postsecondary transition planning for information about transition planning for students with disabilities.

Periodic assessment and monitoring of any changes are necessary to ensure ongoing swallow safety and adequate nutrition throughout adulthood. A risk assessment for choking and an assessment of nutritional status should be considered part of a routine examination for adults with disabilities, particularly those with a history of feeding and swallowing problems. See, for example, Moreno-Villares (2014) and Thacker et al. (2008).

### Service Delivery

See the Service Delivery section of the Pediatric Feeding and Swallowing Evidence Map for pertinent scientific evidence, expert opinion, and client/caregiver perspective.

SLPs also consider other nontreatment/assessment service delivery variables that may affect treatment outcomes, including format, provider, dosage, and setting. Decisions are made based on the child's needs, their caregivers' preferences and beliefs, and the setting in which services are provided. SLPs consider social determinants of health (e.g., caregivers' ability to access services) when providing services.

### Format

**Format** refers to the structure of the treatment session (e.g., group and/or individual). The appropriateness of the treatment format often depends on the child's age, the type and severity of the feeding or swallowing problem, and the service delivery setting.

Supporting evidence for telepractice in pediatric feeding and swallowing is still emerging (Edwards et al., 2022; Malandraki & Kantarcigil, 2017). Telepractice can be used to deliver specialized multidisciplinary feeding assessments and treatment to children. Telepractice assessment and treatment models are feasible and can help families avoid travel and receive services that may not be available in their local communities (Clawson et al., 2008; Edwards et al., 2022; Malandraki & Kantarcigil, 2017; Raatz et al., 2020, 2021).

For further reading, see Ward et al. (2022).

### Provider

**Provider** refers to the professional providing treatment (e.g., SLP, occupational therapist, or other feeding specialist). Recommended practices follow a collaborative process that involves an interdisciplinary team, including the child, family, caregivers, and other related professionals. When treatment incorporates accommodations, modifications, and supports in everyday settings, SLPs often provide training and education in how to use strategies to facilitate safe swallowing.

**Caregiver coaching** is an important aspect of feeding and swallowing service delivery. Providers build relationships with families to understand and support them throughout the duration of therapy. Caregiver coaching empowers families to support their child's feeding and swallowing needs and facilitate improvement when the therapist is not present. A strengths-based approach should be used to promote cooperation between

therapists and families. Caregiver coaching allows SLPs to help families recognize their child's strengths and facilitates therapeutic progress.

**Dosage**

**Dosage** refers to the frequency, intensity, and duration of service. Dosage depends on individual factors, including the child's medical status, nutritional needs, and readiness for oral intake.

**Setting**

**Setting** refers to the location of treatment and varies across the continuum of care (e.g., NICU, intensive care unit, inpatient acute care, outpatient clinic, home, or school).

Resources

**ASHA Resources**

- Aerosol Generating Procedures
- Clinical Feeding and Swallowing Evaluation for the School-Based Speech-Language Pathologist
- Dysphagia Management for School Children: Dealing With Ethical Dilemmas
- Dysphagia On-the-Job Resources
- Dysphagia Service Delivery in the Educational Setting: Pediatric Feeding Disorder and the Culturally Responsive Clinician
- Evidence-Based Practice (EBP)
- Feeding and Swallowing Disorders in Children [Consumer Information]
- Flexible Endoscopic Evaluation of Swallowing (FEES)
- Focusing Care on Individuals and Their Care Partners
- Interprofessional Education/Interprofessional Practice (IPE/IPP)
- Legal Issues and Opportunities Associated With Serving Children With Pediatric Feeding Disorders in Schools
- Medicaid Reimbursement in Schools
- Palliative and End-of-Life Care
- Pediatric Feeding Assessments and Interventions [Webinar]
- Pediatric Feeding Disorder and the School-Based Speech-Language Pathologist: An Evidence-Based Update for Clinical Practice
- *Person-Centered Focus on Function: Pediatric Feeding and Swallowing* [PDF]

- Postsecondary Transition Planning
- Preferred Practice Patterns for the Profession of Speech-Language Pathology
- Scope of Practice in Speech-Language Pathology
- Social Determinants of Health
- Sorting Through Pediatric Feeding Confusion: SLPs and ARFID
- State Instrumental Assessment Requirements
- *Swallowing and Feeding Team Referral Plan* (Sample Form) [PDF]
- Swallowing Screening
- *The Value of the Speech-Language Pathologist (SLP) in Pediatric Feeding and Swallowing Disorders (FSDs)* [PDF]
- Trauma-Informed Care
- Treating Pediatric Feeding Disorders and Dysphagia: Evidence-Based Interventions for School-Based Clinicians
- Videofluoroscopic Swallow Study (VFSS)
- What School-Based Speech-Language Pathologists Need to Know About Pediatric Swallowing and Feeding Development and Disorders

**Other Resources**

This list of resources is not exhaustive, and the inclusion of any specific resource does not imply endorsement from ASHA.

- *Accommodating Children With Disabilities in the School Meal Programs: Guidance for School Food Service Professionals* [PDF]
- Accommodating Disabilities in the School Meal Programs: Guidance and Q&As
- *American Academy of Pediatrics Policy Statement—Prevention of Choking Among Children* [PDF]
- Americans with Disabilities Act (ADA)
- Consensus Paper: Diagnostic Overlap of PFD and ARFID [PDF]
- Code of Federal Regulations
- Feeding Matters
- Individuals with Disabilities Education Act (IDEA)
- Infant Feeding Care Assessment Tools

- International Association of Pediatric Feeding and Swallowing
- International Commission on Radiological Protection (ICRP)
- La Leche League International
- Management of Swallowing and Feeding Disorders in Schools
- National Foundation of Swallowing Disorders
- Radiologyinfo.org | Video Fluoroscopic Swallowing Exam (VFSE)
- RCSLT | New Long COVID Guidance and Patient Handbook

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## About This Content

Content for ASHA's Practice Portal is developed through a comprehensive process that includes multiple rounds of subject matter expert input and review. ASHA extends its gratitude to the following subject matter experts who were involved in the development of the Pediatric Feeding and Swallowing page:

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ASHA seeks input from subject matter experts representing differing perspectives and backgrounds. At times a subject matter expert may request to have their name removed from our acknowledgment. We continue to appreciate their work.

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# MEMORANDUM

| | |
|---|---|
| DATE | November 7, 2025 |
| TO | Hearing Aid Dispensing Committee |
| FROM | Maria Liranzo, Legislation/Regulation/Budget Analyst |
| SUBJECT | Agenda Item 3: Discussion and Possible Action to Add and Amend Regulations Regarding Postfitting Counseling and Foreign Body In The Ear Canal Related to Hearing Aid Dome Removal at Title 16, CCR Sections 1399.125 and 1399.126, as used in BPC Sections 2538.11, 2538.36, and 2539. |

## Background

On December 1, 2023, the Hearing Aid Dispensing Committee (Committee) delegated two Committee Members to work with staff to draft regulatory text that would define the terms "postfitting counseling" as used in BPC section 2538.11 and "foreign body" as used in BPC sections 2538.36 and 2539.6, and permit hearing aid dispensers and dispensing audiologists to remove hearing aid domes. This is in response to an inquiry the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board (Board) received in July 2022 asking whether there is any statutory or regulatory language that would restrict a hearing aid dispenser (HAD) from performing a dome removal if appropriate training is provided, and appropriate safeguards and policies are in place to limit dome removal to lower-risk clients. The Committee met on December 5, 2024, May 15, 2025,and August 21, 2025, to review and discuss the draft regulatory text.

## Summary of Changes

The following changes were made to the text presented on August 21, 2025:

- Amended CCR section 1399.125(b)(2) to require verbal identification of the second bend of the ear canal for each supervised removal,
- Amended CCR section 1399.126(a) to specify octave frequencies to include thousand (1000) Hertz and two thousand (2000) Hertz to the definition of signification air-bone gap, and
- Amended CCR section 1399.126(b) to replace ear dam with ear impression blocking material in paragraphs (1) and (2).

## Action Requested

Staff recommends the HAD Committee review and discuss the materials provided, and determine whether to recommend to the Board to initiate the rulemaking process with the proposed regulatory text.

### Suggested Motion Language

Move to recommend the regulatory text for Title 16, CCR Sections 1399.125 and 1399.126 to the Board to initiate the rulemaking process, as noticed/amended, and direct Board staff to prepare the regulatory text for Board review and approval.

Attachment : Hearing Aid Dome Removal Text Proposal as amended August 21, 2025

**PROPOSED REGULATORY TEXT**

**Hearing Aid Dome Removal**
As Amended August 21, 2025

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| **Legend:** | Added text is indicated with an underline.<br>Deleted text is indicated by ~~strikeout~~. |

## § 1399.125. Postfitting Counseling.

(a) For purposes of Section 2538.11 of the Code, "postfitting counseling" means adjustments and servicing of a hearing aid or aids sold, removal and replacement of a hearing aid that has malfunctioned or is no longer operational, resolving client issues including physical fit and acoustic targets, and educating the client on optimizing communication while using hearing aids and accessories. "Postfitting counseling" also includes the removal of a hearing aid dome in the ear canal.

(b) A licensed hearing aid dispenser shall not remove a hearing aid dome unless:

(1) They received written and signed verification from an otolaryngologist certified by the American Board of Otolaryngology – Head and Neck Surgery or a licensed audiologist that the dispenser has performed and is competent to remove the hearing aid dome. The written verification shall be maintained in the personnel file of the licensed hearing aid dispenser.

(2) They performed a minimum of five (5) supervised hearing aid dome removals, each of which included verbal identification of the second bend of the ear canal and was supervised by an otolaryngologist certified by the American Board of Otolaryngology – Head and Neck Surgery or a licensed audiologist prior to receiving the written verification specified in (b)(1).

(3) The hearing aid dome is before the second bend of the ear canal.

(c) A licensed dispensing audiologist shall not remove a hearing aid dome unless they comply with (b)(3).

(d) A licensed hearing aid dispenser or licensed dispensing audiologist shall not remove a hearing aid dome where the client has contraindications to the procedure. For purposes of this paragraph, examples of contraindications include:

(1) Visible congenital or traumatic deformity of the ear or other signs of infection.

(2) Active drainage from the ear.

NOTE: Authority cited: Section 2531.95, Business and Professions Code. Reference: Section 2538.11, Business and Professions Code.

**§ 1399.126. ~~Significant Air-Bone Gap~~ Referral for Medical Opinion.**

~~(a)~~ For purposes of Sections 2538.36 and 2539.6 of the Code:

(a) A "significant air-bone gap" means ~~is defined as~~ a difference of fifteen (15) decibels or more between the higher air conduction and the lower bone conduction pure tone thresholds at two (2) or more succeeding octave frequencies of five hundred (500) Hertz ~~through and including~~, one thousand (1000) Hertz, two thousand (2000) Hertz, and four thousand (4000) Hertz.

(1)~~(b)~~ Tests for significant air-bone gap shall be performed in a suitable environment using appropriate equipment to establish threshold values and with appropriate masking procedures employed.

(b) A "foreign body" means any organic or non-organic object or material that is not a natural part of the human body that would normally be present in the ear canal.

(1) Nothing in this Section shall be construed to prevent a person licensed in the practice of fitting or selling hearing aids from removing a complete and intact hearing aid, ear mold impression, ear impression blocking material, or dome of a hearing aid from a client's ear.

(2) Nothing in this Section shall be construed to restrict persons licensed or registered under the laws of the State of California from practicing their licensed profession and operating within the scope of their licensed profession or supervised by someone operating within the scope of their licensed professions that allows them to remove a complete and intact hearing aid, ear mold impressions, ear impression blocking material, or dome of a hearing aid from a client's ear.

(3) A licensed hearing aid dispenser or licensed dispensing audiologist shall comply with Section 1399.125 prior to removing a hearing aid dome.

NOTE: Authority cited: Sections 2531.06 and 2531.95, Business and Professions Code. Reference: Sections 2538.36 and 2539.6, Business and Professions Code.

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

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# MEMORANDUM

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| DATE | November 10, 2025 |
| TO | Audiology Practice Committee |
| FROM | Maria Liranzo, Legislation/Regulation/Budget Analyst |
| SUBJECT | Agenda Item 3: Discussion and Possible Action to Amend Regulations Regarding General Application Requirements and Speech-Language Pathology and Audiology Aide Requirements and Scope of Activities, Duties and Functions at Title 16, California Code of Regulations (CCR) Sections 1399.151.2, 1399.151.3, 1399.151.4, 1399.154 through 1399.154.12, and 1399.157 |

## Background

On November 30, 2023, the Audiology Pathology Practice Committee (Committee) directed Board staff to amend the previously drafted proposed regulatory language that will implement statutory changes relating to audiology aides. The Committee met on September 5, 2024, and December 5, 2024, to review and discuss the draft regulatory text. At its August 21, 2025, meeting, the Committee met to discuss levels of supervision and responsibility required of an audiology aid.

## Summary of Changes

The following are changes Board staff made in response to Committee discussion on August 21, 2025:

- Section 1399.154 was amended to define industrial audiology aide as an audiology aide and not person.
- Section 1399.154.9 was amended to permit indirect supervision following initial registration and include clerical tasks and servicing hearing aids under indirect supervision.
- Section 1399.154.11 was amended to add altering hearing aid programming or settings as outside the scope of responsibility of an audiology aid.

## Discussion Question

1. Are screenings the same as evaluations? Would screenings be within the scope of responsibility of an audiology aid?

Medicare identifies the following screenings though they are not billable: air only pure tone test, evoked otoacoustic emissions, and Bekesy audiometry.

BPC sections 2530.2(o) and 2538.12 define hearing screening as “binary puretone screening at a preset intensity level for the purpose of determining if the screened individuals are in need of further medical or audiological evaluation.”

2. Does the fitting, selling, or independently adjusting a hearing aid as used in Section 1399.154.11(j) have the same meaning as the practice of fitting or selling hearing as defined in BPC section 2538.11?

   BPC 2538.11 states *“Practice of fitting or selling hearing aids,” as used in this article, means those practices used for the purpose of selection and adaptation of hearing aids, including direct observation of the ear, testing of hearing in connection with the fitting and selling of hearing aids, taking of ear mold impressions, fitting or sale of hearing aids, and any necessary postfitting counseling.*

## Action Requested

Staff recommends the Committee review and discuss the materials provided, and determine whether to recommend the regulatory language to the Board to initiate the rulemaking process.

### Suggested Motion Language

Move to recommend the regulatory text for Title 16, CCR Sections 1399.151.2, 1399.151.3, 1399.151.4, 1399.154 through 1399.154.12, and 1399.157 to the Board to initiate the rulemaking process, as noticed/amended, and direct Board staff to prepare the regulatory text for Board review and approval.

Attachment A: Proposed Text as of November 10, 2025
Attachment B: SLPA Scope of Responsibility, Duties, and Functions Laws and Regulations
Attachment C: ASHA Audiology Assistants

**General Application Requirements and Speech-Language Pathology and Audiology Aide Requirements**
as of November 10, 2025

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| **Legend:** | Added text is indicated with an underline.<br>Omitted text is indicated by (* * * *)<br>Deleted text is indicated by ~~strikeout~~. |

**§ 1399.151.2. Expedited Licensure or Registration Process.**

The Board shall expedite any application of an applicant who:

(a) Pursuant to Section 115.4 of the Code, identifies themself as an honorably discharged member of the United States Armed Forces, and who provides a Certificate of Release or Discharge from Active Duty (DD-214) or other documentary evidence showing the date and type of discharge, pursuant to Section 115.4 of the Code.

(b) Pursuant to Section 115.6 of the Code, identifies themself as a person who is married to, or in a domestic partnership or other legal union with an active-duty member of the Armed Forces of the United States who is assigned to a duty station in California under official active-duty military orders, and the applicant holds a valid license, or comparable authority, to practice as a hearing aid dispenser or audiologist in another United States state, district, or territory, and who provides documentary evidence as specified in paragraphs (1) through (3). application:

(1) Certificate of marriage or certified declaration or registration of domestic partnership filed with the California Secretary of State or other documentary evidence of legal union with an active-duty member of the Armed Forces,

(2) A copy of their current license or registration in another state, district, or territory of the United States, and,

(3) A copy of the military orders establishing their spouse or partner's duty station in California.

(c) Pursuant to Section 135.4 of the Code, identifies themself as an applicant who was admitted to the United States as a refugee pursuant to Section 1157 of Title 8 of the United States Code, or was granted asylum by the Secretary of Homeland Security or the United States Attorney General pursuant to Section 1158 of Title 8 of the United States Code, or has a special immigrant visa (SIV) pursuant to Section 1244 of Public Law 110-181, Public Law 109-163, or Section 602(b) of Title VI of Division F of Public Law 111-8, relating to Iraqi and Afghan translators/interpreters or those who worked for or on behalf of the United States government, and who provides the appropriate documentary evidence specified in paragraphs (1) through (4).

(1) Form I-94, arrival or departure record, with an admission class code such as "RE" (refugee) or "AY" (asylee) or other information designating the person a refugee or asylee;

(2) Special Immigrant Visa that includes the "SI" or "SQ";

(3) Permanent Resident Card (Form I-551), commonly known as a "green card," with a category designation indicating that the person was admitted as a refugee or asylee; or,

(4) An order from a court of competent jurisdiction or other documentary evidence that provides reasonable assurances to the Bureau that the applicant qualifies for expedited licensure or registration per Section 135.4 of the Code.

NOTE: Authority cited: Section 2531.95, Business and Professions Code. Reference: Sections 115.4, 115.5, 115.6 and 135.4, Business and Professions Code

**§ 1399.151.3. Licensure or Registration, Discipline, and Conviction Disclosure.**

(a) An applicant for licensure or registration shall disclose if they have been licensed to practice speech-language pathology or audiology in any other state or country, and if applicable, the state and country where the license or registration was issued.

(b) An applicant for licensure or registration shall disclose if they have been denied a license or registration to practice speech-language pathology or audiology in any other state or country, and if applicable, the state and country where a license or registration was denied. Applicants are not required to disclose any information regarding a denial based upon any of the following:

(1) Convictions dismissed pursuant to Sections 1203.4, 1203.4a, 1203.41, 1203.42, or 1203.425 of the Penal Code, or a comparable dismissal or expungement;

(2) Convictions for which the person has obtained a certificate of rehabilitation under Chapter 3.5 (commencing with Section 4852.01) of Title 6 of Part 3 of the Penal Code;

(3) Convictions for which the person has been granted clemency or a pardon by a state or federal executive;

(4) An arrest that resulted in a disposition other than a conviction including an infraction or citation;

(5) Convictions that were adjudicated in the juvenile court; or,

(6) Convictions under California Health and Safety Code Sections 11357(b), (c), (d), (e), or Section 11360(b) which are two (2) years or older.

(c) An applicant for licensure or registration shall disclose if, within the preceding seven (7) years, they have had a license or registration subjected to formal discipline by a licensing board in or outside of California. Discipline includes suspension, revocation, voluntary surrender, probation, reprimand, or any other restriction on a license or registration held by the applicant. However, an applicant shall not be required to disclose prior disciplinary action if the basis for that disciplinary action was a conviction that has been dismissed pursuant to Sections 1203.4, 1203.4a, 1203.41, 1203.42, or 1203.425 of the Penal Code, or a comparable dismissal or expungement. If the applicant identifies that they meet this criterion, they shall provide the Board the following information:

(1) Name of the disciplinary action taken against the applicant;

(2) Date of the offense;

(3) Name of the licensing entity;

(4) Dates of probation, if applicable;

(5) Description of the circumstances of the incident;

(6) A certified copy of the determination made by the licensing entity that includes the date and location of the incident, specific violation(s), dates of disciplinary action, sanctions or penalties imposed and the completion dates;

(7) A letter from the applicant describing the applicant's rehabilitation efforts or changes;

(8) Any written statement or documentary evidence that the applicant may wish to submit to present regarding rehabilitation and demonstration of the applicant's fitness for licensure or registration.

(9) A written statement, signed by the applicant, certifying that all of the information provided about the formal discipline in the application is true and correct under penalty of perjury under the laws of the state of California.

(d) As a condition of renewal, a licensee or registrant shall certify whether they, since they last renewed their registration, they have been convicted of any violation of the law in this or any other state, district, or territory of the United States, or in another country, omitting traffic infractions under one thousand dollars ($1,000) not involving alcohol, dangerous drugs, or controlled substances.

(e) As a condition of renewal, a licensee or registrant shall certify whether, since they last renewed their registration, they have had a license or registration disciplined by a government agency or other disciplinary body. Discipline includes suspension, revocation, voluntary surrender, probation, reprimand, or any other restriction on a license or registration.

(f) If the licensee or registrant affirmatively states they meet the criterion in subsections (d) and (e), they shall provide the Board the following information:

(1) Name of the disciplinary action taken against the applicant;

(2) Date of the offense;

(3) Name of the licensing entity;

(4) Dates of probation, if applicable;

(5) Description of the circumstances of the incident;

(6) A certified copy of the determination made by the licensing entity that includes the date and location of the incident, specific violation(s), dates of disciplinary action, sanctions or penalties imposed and the completion dates;

(7) A letter from the applicant describing the applicant's rehabilitation efforts or changes;

(8) Any written statement or documentary evidence that the applicant may wish to submit to present regarding rehabilitation and demonstration of the applicant's fitness for licensure or registration.

(9) A written statement, signed by the applicant, certifying that all of the information provided in the application is true and correct under penalty of perjury under the laws of the state of California.

NOTE: Authority cited: Section 2531.95, Business and Professions Code. Reference: Sections 144.5, 480, and 2533, Business and Professions Code.

**§ 1399.151.4. Fingerprinting.**

(a) An applicant for licensure or registration is required to furnish to the Department of Justice a full set of fingerprints for the purpose of conducting a criminal history record check and to successfully complete a state and federal level criminal offender record information search conducted through the Department of Justice.

(1) The applicant shall submit a receipt showing the transmission of Live Scan fingerprints to the Department of Justice or two (2) classifiable sets of fingerprints

with the current fees charged by the California Department of Justice and the Federal Bureau of Investigation with the licensure or registration form required in Section 1399.154.1 and fee required in Section 1399.157.

(2)The applicant shall pay any costs for furnishing the fingerprints and conducting the criminal history record check.

(3) If an applicant is unable to Live Scan or complete the classifiable sets of fingerprints, the Board will work with the Department of Justice to obtain a criminal history record check on the applicant. The applicant shall comply with any instructions and pay any costs to conduct the criminal history record check for any rejected fingerprints.

NOTE: Authority cited: Section 2531.95, Business and Professions Code. Reference: Sections 144, 480, and 2533, Business and Professions Code.

**§ 1399.154. Definitions.**

As used in this article, the following definitions apply:

(a) “Speech-language pathology aide” means a person who

(1) assists or facilitates while the speech-language pathologist is evaluating the speech ~~and/~~or language of individuals or is treating individuals with a speech-language ~~and/~~or language disorder, and

(2) is registered by the supervisor with the Board and the registration is approved by the Board.

(b) “Audiology aide” means a person who

(1) assists or facilitates while an audiologist or dispensing audiologist is evaluating the hearing of individuals ~~and/~~or is treating individuals with hearing disorders, and

(2) is registered by the supervisor with the Board and the registration is approved by the Board.

(c) “Supervisor” means a licensed speech-language pathologist who supervises a speech-language pathology aide or a licensed audiologist or dispensing audiologist who supervises an audiology aide.

(d) “Industrial audiology aide” means an audiology aide who is certified by the Council for Accreditation in Occupational Hearing Conservation and whose primary duty is to assist in a hearing conservation program as described in Section 5097 of Article 105 of Group 15 of Subchapter 7 of Chapter 4 of Division 1 of Title 8 of the California Code of

Regulations.~~an audiology aide who conducts pure tone air conduction threshold audiograms for the purpose of industrial hearing testing in addition to other acts and services as provided in these regulations.~~

NOTE: Authority cited: Section 2531.95, Business and Professions Code. Reference: Sections 2530.2 and 2530.6, Business and Professions Code.

**§ 1399.154.1. Registration of Aides.**

(a) Before allowing an aide to assist in the practice of speech-language pathology or audiology under ~~his or her~~ their supervision, a supervisor shall register each aide with the Board and pay the registration fee required in Section 1399.157. The form submitted to the Board shall include:

(1) Applicant's full legal name, other names used such as maiden name, address of record which will be publicly disclosed, home address, telephone number, social security number or individual tax identification number, and date of birth;

(2) Applicant's email address, if any;

(3) The applicant has the option to disclose whether they are serving or have previously served in the United States military.

(4) The applicant has the option to disclose their eligibility for an expedited registration process and provide evidence in accordance with Section 1399.151.2.

(5) The applicant shall disclose the information required in Section 1399.151.3.

(6) Certification from the applicant that all of the information provided in the application and any attachments is true and correct under penalty of perjury under the laws of the state of California.

(7) Supervisor's full legal name, address of record, license number, business telephone number, business name, business address, and the supervisor's email address, if any;

(8) Duties the aide will perform while assisting the supervisor in the practice of speech-language pathology or audiology and the level of supervision as defined in Sections 1399.154.2 and 1399.154.9 that will be provided for each duty,

(A) If the applicant identifies themselves as an industrial audiology aide, as defined in Section 1399.154, they must provide a copy of their Council for Accreditation in Occupational Hearing Conservation certification with their application.

(9) Training program, training methods, the length of the training program, the minimum competency level of the aide, assessment methods the supervisor will utilize to ensure the aide's competency, and a summary of past education, training, and experience the aide may already have acquired, if any;

(A) The training shall be in accordance with Section 1399.154.4 or 1399.154.10, as applicable.

(10) A written statement, signed by the applicant, certifying that they have discussed the plan for supervision with the supervisor and agree to its implementation, and further certifying under penalty of perjury under the laws of the state of California that all of the statements made in the application are true and correct, and that any misrepresentation shall be cause for denial of a license.

(11) A written statement, signed by the supervisor, certifying that the supervisor has discussed the plan for supervision with the aide and accepts professional and ethical responsibility for their performance, and further certifying that under penalty of perjury under the laws of the state of California that all of the statements made in the application are true and correct.

(12) A signature from the aide and the supervisor under penalty of perjury under the laws of the state of California that they reviewed all the laws and regulation pretraining to their duties and responsibilities as an aide or supervisor.

(b) The applicant in subsection (a) is required to furnish to the Department of Justice a full set of fingerprints in accordance with Section 1399.151.4.

(c) Regardless of their title or job classification, any support person who functions as a speech-language pathology or audiology aide and facilitates or assists a supervisor in evaluations or treatment shall be registered with the Board. ~~In the application for registration, the supervisor shall provide to the Board, his or her proposed plan for supervising and training the speech-language pathology or audiology aide. The proposed plan for training shall be in accordance with Section 1399.154.4 and shall include the supervisor's training methods, the necessary minimum competency level of the aide, the manner in which the aide's competency will be assessed, the persons responsible for training, a summary of any past education, training and experience the aide may have already undertaken, and the length of the training program and assessment of the aide's competency level.~~

(d) The Board shall review the application for compliance with the requirements of this article and notify the supervisor of the disposition of the application for registration and whether further information is required in order to complete its review.

(e) If an aide has more than one supervisor, each supervisor shall register the aide as stated in subsection (a).

NOTE: Authority cited: Section 2531.25, Business and Professions Code. Reference: Sections 30, 31, 114.5, 115.4, 115.5, 144, 144.5, 480, 2530.2, 2530.6 ~~and~~,2532.4, and 2533, Business and Professions Code.

**§ 1399.154.2. Responsibilities of Speech-Language Pathology Aide's Supervisor.**

A supervisor of a speech-language pathology ~~or audiology~~ aide shall:

(a) Have legal responsibility for the health, safety, and welfare of the patients.

(b) Have legal responsibility for the acts and services provided by the speech-language pathology ~~or audiology~~ aide, including compliance with the provisions of the Act and these regulations.

(c) ~~Be physically present~~ Provide immediate supervision while the speech-language pathology ~~or audiology~~ aide is assisting during evaluations or treatment of ~~with~~ patients, and direct supervision while the speech-language pathology aide is assisting when patients are not undergoing evaluations or receiving treatment or when patients are not present. ~~, unless an alternative plan of supervision has been approved by the Board. A supervisor of industrial audiology aides shall include a proposed plan for alternative supervision with the application form. An industrial audiology aide may only be authorized to conduct puretone air conduction threshold audiograms when performing outside the physical presence of a supervisor. The supervisor shall review the patient histories and the audiograms and make necessary referrals for evaluation and treatment.~~

(1) "Immediate supervision" as used in this Section means the supervisor is physically present when the speech-language pathology aide is performing their duties.

(2) "Direct supervision" as used in this Section means on-site observation and guidance by the supervisor while the speech-language pathology aide is performing their duties.

(d) Evaluate, treat, and manage all patient care~~and determine the future dispositions of patients~~.

(e) Appropriately train the speech-language pathology ~~or audiology~~ aide to perform duties to effectively assist in the practice of speech-language pathology ~~evaluation and/or treatment. A supervisor shall establish and complete a training program for a speech-language pathology or audiology aide~~ in accordance with Section 1399.154.4 ~~which~~ that is unique to the duties of the aide and the setting in which ~~he or she~~the aide will be assisting the supervisor.

(f) Define the services ~~which~~that may be provided by the speech-language pathology ~~or audiology~~ aide. Those services shall not exceed the competency of the aide as

determined by ~~his or her~~their education, training, and experience nor shall they be services that require a separate license under Section 2538.1 of the Code~~, and shall not include any treatment beyond the plan established by the supervisor for the patient~~.

(g) Possess and maintain a current, active, and unrestricted California license as a speech-language pathologist pursuant to Sections 2532 of the Code, and have at least two years of full-time experience or 3,120 hours of experience providing services as a licensed speech-language pathologist. “Full-time experience” as used in this section means the individual works a minimum of thirty (30) hours per week for at least thirty-six (36) weeks in a calendar year.

(h) Notify the speech-language pathology aide immediately of any disciplinary action, including revocation, suspension (even if stayed), probation terms, inactive license, or lapse in licensure, which affects the supervisor's ability or right to supervise.

(i) Complete a minimum of six (6) hours of continuing professional development in supervision prior to assuming responsibility as a supervisor, and three (3) hours of continuing professional development in supervision every four (4) years thereafter. Continuing professional development training obtained from a Board-approved provider may be applied towards the supervisor’s continuing professional development requirement set forth in Section 1399.160.3. The supervisor shall maintain records of course completion in supervision training for a period of four (4) years after the renewal period in which it was earned.

(j) Review with the speech-language pathology aide the laws and regulations pertaining to the supervision and practice of speech-language pathology.

(k) Provide the aide with a plan for how to handle emergencies.

NOTE: Authority cited: Section 2531.95, Business and Professions Code. Reference: Sections 2530.2 and 2530.6, Business and Professions Code.

**§ 1399.154.3. Maximum Number of Aides.**

~~A supervisor shall not supervise more than three (3) speech-language pathology or audiology aides. The Board may authorize more than three supervisees if, in its discretion, the supervisor demonstrates that the public health and safety would not be jeopardized and that he or she can adequately supervise more than three aides.~~
(a) The number of speech-language pathology aides a supervisor can supervise shall not exceed the number specified in Section 1399.170.16.

(b) A supervisor of an audiology aide shall not supervise more than three (3) full-time equivalent support personnel and shall not exceed more than six (6) support personnel at any time. Support personnel include audiology aides, hearing aid dispenser trainee licensees under Section 2538.28 of the Code, and hearing aid dispenser temporary

licensees under Section 2538.27 of the Code. “Full-time equivalent” as used in this section means the individual works a minimum of thirty (30) hours per week.

NOTE: Authority cited: Section 2531.95, Business and Professions Code. Reference: Sections 2530.2 and 2530.6, Business and Professions Code.

**§ 1399.154.4. Training of Speech-Language Pathology Aide~~Aides~~.**

Before a speech-language pathologist ~~or audiologist~~ allows an aide to assist in the practice of speech-language pathology ~~or audiology~~ under ~~his or her~~ their supervision, a speech-language pathology ~~or audiology~~ aide shall complete a training program established by the supervisor. The training program shall include, but is not limited to:

(a) Instruction in the skills necessary to perform any acts or services which are within the practice of speech-language pathology ~~or audiology~~ as defined in Section 2530.2 of the Code. The supervisor is not required to repeat training the speech-language pathology aide may have already received ~~which may have already been received by the aide~~ as a result of any prior education, training, ~~and~~ or experience.

(b) A supervisor shall require a speech-language pathology ~~or audiology~~ aide to demonstrate ~~his or her~~ their competence to perform any acts or provide any services which are the practice of speech-language pathology ~~or audiology~~ as defined in Section 2530.2 of the Code which may be assigned to the aide or which the aide may assist in providing to patients. A supervisor shall allow a speech-language pathology ~~or audiology~~ aide only to perform those acts or to provide those services for which ~~he or she has~~ they have been provided training and has demonstrated competency, and that are within the scope of responsibility of a speech-language pathology aide.

(c) A supervisor shall instruct a speech-language pathology ~~or audiology~~ aide as to the limitations imposed upon ~~his or her~~ their duties, acts, or services by these regulations, by ~~his or her~~ their training and skills, and ~~by the~~ their role in assisting during the evaluation and treatment ~~plan for~~ of any patient.

~~(d) In addition to the requirements of this section, an industrial audiology aide shall be provided training in the use of an audiometer and in the necessary techniques for obtaining valid and reliable audiograms.~~

NOTE: Authority cited: Section 2531.95, Business and Professions Code. Reference: Sections 2530.2 and 2530.6, Business and Professions Code.

**§ 1399.154.5. Notice of Termination.**

Within 30 days after the termination of the supervision of a speech-language pathology or audiology aide, the supervisor shall notify the Board, in writing, of such termination and the date thereof. Written notification shall include the following:

(a) The aide's full legal name and registration number;

(b) The supervisor's full legal name, license number, business address, telephone number, and email address, if any;

(c) The effective date of the termination; and

(d) A written statement, signed by the supervisor, certifying under penalty of perjury that all statements made in the notification are true in every respect and that misstatements or omissions of material facts shall be cause for denial of the application to terminate supervision, or for suspension or revocation of a license.

NOTE: Authority cited: Section 2531.95, Business and Professions Code. Reference: Sections 2530.2 and 2530.6, Business and Professions Code.

**§ 1399.154.6. Noncompliance with Article.**

Failure ~~of a supervising licensee~~ to comply with the provisions of this article ~~may~~shall result in a forfeiture of the privilege to supervise an aide.

NOTE: Authority cited: Section 2531.95, Business and Professions Code. Reference: Section 2530.6, Business and Professions Code.

**§ 1399.154.7. Aide Experience Not Applicable to Qualifications for Licensure.**

Any experience obtained acting as a speech-language pathology aide or audiology aide shall not be creditable toward the supervised clinical experience ~~required in Section 2532.2(c) of the code~~ or the required professional experience required in Sections 2532.2~~(d)~~ and 2532.25 of the Code~~code~~, or the field work experience required in Section 1399.170.8.

NOTE: Authority cited: Section 2531.95, Business and Professions Code. Reference: Section 2530.6, Business and Professions Code.

**§ 1399.154.8. Responsibilities of Audiology Aide's Supervisor.**

A supervisor of an audiology aide shall:

(a) Have legal responsibility for the health, safety, and welfare of the patients.

(b) Have legal responsibility for the acts and services provided by the audiology aide, including compliance with the provisions of the Act and these regulations.

(c) Provide supervision to the audiology aide in accordance with Section 1399.154.9.

(d) Evaluate, treat, and manage all patient care.

(e) Appropriately train the audiology aide to perform duties to effectively assist in the practice of audiology in accordance with Section 1399.154.10 that is unique to the duties of the aide and the setting in which the aide will be assisting the supervisor.

(f) Define the services that may be provided by the audiology aide. Those services shall not exceed the competency of the aide as determined by their education, training, and experience nor shall they be services specified in Section 1399.154.11.

(g) Possess and maintain a current, active, and unrestricted California license as an audiologist or dispensing audiologist pursuant to Sections 2532 or 2539.1 of the Code, and have at least two (2) years of full-time experience or 3,120 hours of experience providing services as a licensed audiologist. “Full-time experience” as used in this section means the individual works a minimum of thirty (30) hours per week for at least thirty-six (36) weeks in a calendar year.

(h) Notify the audiology aide immediately of any disciplinary action, including revocation, suspension (even if stayed), probation terms, inactive license, or lapse in licensure, which affects the supervisor's ability or right to supervise.

(i) Complete a minimum of six (6) hours of continuing professional development in supervision prior to assuming responsibility as a supervisor, and three (3) hours of continuing professional development in supervision every four (4) years thereafter. Continuing professional development training obtained from a Board-approved provider may be applied towards the supervisor’s continuing professional development requirement set forth in Section 1399.160.3. The supervisor shall maintain records of course completion in supervision training for a period of four (4) years after the renewal period in which it was earned

(j) Review with the audiology aide the laws and regulations pertaining to the supervision and practice of audiology.

(k) Provide the audiology aide with a plan for how to handle emergencies.

NOTE: Authority cited: Section 2531.95, Business and Professions Code. Reference: Sections 2530.2 and 2530.6, Business and Professions Code.

**§ 1399.154.9. Supervision of Audiology Aide.**

(a) For the purposes of the supervision of an audiology aide, the following definitions apply:

(1) “Immediate supervision” means the supervisor is physically present while the audiology aide is performing their duties.

(2) “Medically fragile” means a client who is acutely ill and in an unstable condition.

(3) “Direct supervision” means on-site observation and guidance by the supervisor while the audiology aide is performing their duties.

(4) “Indirect supervision” means the supervisor is not at the same facility or in close proximity to the audiology aide but is available to provide supervision by telephonic or other electronic means.

(b) Immediate supervision shall be provided when an audiology aide performs any acts or services involving medically fragile patients.

(c) Immediate supervision shall be provided when an audiology aide performs any acts or services that the supervisor has trained the audiology aide to perform but the audiology aide has yet to perform the act or service with patients.

(d) Following initial registration, the supervisor shall provide immediate supervision at all times during the first ninety (90) calendar days of work, except as provided in subsection (f). The supervisor shall maintain in the audiology aide’s personnel file a record that verifies the aide meets the requirements of this subsection.

(e) After ninety (90) calendar days or until the supervisor determines the audiology aide is competent, whichever occurs later, with the exception of those services provided in subsection (b) and (c), the supervisor shall provide direct supervision at all times when the aide is assisting with patients.

(f) At a minimum, indirect supervision shall be provided when:

(1) An industrial audiology aide, as defined in Section 1399.154, is performing duties for a hearing conservation program as described in Section 5097 of Article 105 of Group 15 of Subchapter 7 of Chapter 4 of Division 1 of Title 8 of the California Code of Regulations.

(2) An audiology aide is performing clerical tasks or servicing hear aids such as record keeping, material preparation, scheduling, equipment maintenance, cleaning, programming, or repairing hearing aids, or handing out wax guard, cleaning brushes, batteries, or other supplies for the use and care of a hearing aid.

NOTE: Authority cited: Section 2531.95, Business and Professions Code. Reference: Sections 2530.2 and 2530.6, Business and Professions Code.

**§ 1399.154.10. Training of Audiology Aide.**

Before an audiologist or dispensing audiologist allows an aide to assist in the practice of audiology under their supervision, an audiology aide shall complete a training program established by the supervisor. The training program shall, at a minimum, include:

(a) Instruction in the skills necessary to perform any acts or services that are within the practice of audiology as defined in Section 2530.2 of the Code. The supervisor is not required to repeat any training the audiology aide may have already received as the result of any prior education, training, or experience.

(b) A supervisor shall require an audiology aide to demonstrate their competence to perform any acts or provide any services that are within the practice of audiology as defined in Section 2530.2 of the Code, and which may be assigned to the aide or which the aide may assist in providing to patients. A supervisor shall allow an audiology aide only to perform those acts or to provide those services for which they have been provided training and demonstrated competency, and that are within the scope of responsibility of an audiology aide.

(c) A supervisor shall instruct an audiology aide as to the limitations imposed upon their duties, acts, or services by these regulations, by their training and skills, and their role in assisting during the evaluation and treatment of any patient.

(d) A supervisor shall provide training to an industrial audiology aide, as defined in Section 1399.154, to perform the duties required for a hearing conservation program as described in Section 5097 of Article 105 of Group 15 of Subchapter 7 of Chapter 4 of Division 1 of Title 8 of the California Code of Regulations.

NOTE: Authority cited: Section 2531.95, Business and Professions Code. Reference: Sections 2530.2 and 2530.6, Business and Professions Code.

**§ 1399.154.11. Activities, Duties, and Functions Outside the Scope of Responsibility of an Audiology Aide.**

An audiology aide shall not perform any of the following functions:

(a) Conduct diagnostic evaluations, including impedance test battery, videonystagmography (VNG), electronystagmography (ENG), or auditory brainstem response (ABR);

(b) Interpret diagnostic data;

(c) Alter treatment plans or hearing aid programming or settings;

(d) Provide counseling or advice to a client or to a client’s parent or guardian that is beyond the scope of the client’s treatment;

(e) Sign any documents in lieu of a supervisor , including treatment plans, client reimbursement forms, or formal reports;

(f) Discharge clients from services;

(g) Make referrals for additional services outside of the audiology practice;

(h) Unless required by law, disclose confidential information either orally or in writing to anyone not designated by the supervisor;

(i) Represent themself as an audiologist or dispensing audiologist;

(j) Fit, sell, or independently adjust a hearing aid without possessing a valid hearing aid dispensers license or a valid hearing aid trainee license;

(k) Independently adjust cochlear implant settings;

(l) Perform those procedures that require a high level of clinical acumen and technical skill, such as cerumen removal;

(m) Perform any task without the express knowledge and approval of a supervisor; or

(n) Violate laws or regulations pertaining to the Health Insurance Portability and Accountability Act.

NOTE: Authority cited: Section 2531.95, Business and Professions Code. Reference: Sections 2530.2 and 2530.6, Business and Professions Code.

**§ 1399.154.12. Registration Renewal of Aides.**

(a) A supervisor shall renew the registration of each aide with the Board and pay the renewal fee required in Section 1399.157. The form submitted to the Board shall include:

(1) The aide's full name, business name, business address, business telephone number, aide's registration number, and the aide's email address, if any;

(2) Supervisor's full legal name, address of record, license number, business telephone number, business name, business address, and the supervisor's email address, if any;

(3) Duties the aide performs while assisting the supervisor in the practice of speech-language pathology or audiology and the level of supervision as defined in Sections 1399.154.2 and 1399.154.9 that will be provided for each duty,

(4) Training program, training methods, the length of the training program, the minimum competency level of the aide, assessment methods the supervisor is utilizing to ensure the aide's continued competency, and a summary of past education, training, and experience the aide may already have acquired, if any.

(A) The training shall be in accordance with Section 1399.154.4 or 1399.154.10.

(5) A written statement, signed by the aide, certifying that the aide has discussed the plan for supervision with the supervisor and agrees to its implementation, and further certifying under penalty of perjury under the laws of the state of California that all of the statements made in the application are true and correct, and that any misrepresentation may be cause for denial of a registration.

(6) A written statement, signed by the supervisor, certifying that the supervisor has discussed the plan for supervision with the aide and accepts professional and ethical responsibility for their performance, and further certifying that under penalty of perjury under the laws of the state of California that all of the statements made in the application are true and correct.

(b) Any aide registered with the Board prior to Month XX, 20XX (next full year after the effective date) must renew their registration in accordance with subsection (a).

(c) An aide is exempt from subsection (a) if during the aide's previous registration period they were called to active duty as defined in Section 114.3 of the Code.

NOTE: Authority cited: Section 2531.95, Business and Professions Code. Reference: Sections 114.3, 144.5, 703, 704, 2530.2, 2530.6, 2533, 2535, and 2535.2 Business and Professions Code.

**§ 1399.157. Fees.**

(a) The application fee and biennial renewal fee for a speech-language pathologist shall be $150.00. The application fee and biennial renewal fee for ~~a non-dispensing~~ an audiologist shall be $150.00.

(b) The application fee and annual renewal fee for a dispensing audiologist shall be $280.00.

(c) The ~~application~~registration fee for a speech-language pathology assistant shall be $50.00. The biennial renewal fee for a speech-language pathology assistant shall be $100.00.

(d) The delinquency fee to renew an expired license or registration shall be $25.00.

(e) The fee for registration of an aide shall be $30.00. The biennial renewal fee for an aide shall be $30.00.

(f) The application and biennial renewal fee for a continuing professional development provider shall be $200.00.

(g) The fee for each license or registration status and history certification letter shall be $25.00.

(h) The duplicate wall certificate fee shall be $25.00.

(i) The Board shall waive the application or registration fee for an applicant who meets the requirements set forth in Section 115.5 of the Code. Applicant must submit the following with the application:

(1) Certificate of marriage or certified declaration or registration of domestic partnership filed with the California Secretary of State or other documentary evidence of legal union with an active-duty member of the Armed Forces,

(2) A copy of the military orders establishing their spouse's or partner's duty station in California and,

(3) Written verification from the applicant's issuing licensing entity that the applicant's license or registration in another state, district, or territory of the United States is current in that jurisdiction. The verification shall include all of the following:

(A) the full legal name of the applicant and any other name(s) the applicant has used or has been known by,

(B) the license or registration type and number issued to the applicant by the original licensing entity,

(C) the name and location of the licensing entity, and,

(D) the issuance and expiration date of the license.

NOTE: Authority cited: Section 2531.95, Business and Professions Code. Reference: Sections 115.5, 163.5, 2532.6(f), 2534.2, 2535, 2535.2, 2538.1 and 2538.53, Business and Professions Code.

**Speech-Language Pathology Assistant**
**Scope of Responsibility, Duties, and Functions Laws and Regulations**

**2538.1.**

(a) The board shall adopt regulations, in collaboration with the State Department of Education, the Commission on Teacher Credentialing, and the Advisory Commission on Special Education, that set forth standards and requirements for the adequate supervision of speech-language pathology assistants.

(b) The board shall adopt regulations as reasonably necessary to carry out the purposes of this article, that shall include, but need not be limited to, the following:

(1) Procedures and requirements for application, registration, renewal, suspension, and revocation.

(2) Standards for approval of Associate Degree Speech-Language Pathology Assistant training programs based upon standards and curriculum guidelines established by the National Council on Academic Accreditation in Audiology and Speech-Language Pathology, or the American Speech-Language-Hearing Association, or equivalent formal training programs consisting of two years of technical education, including supervised field placements. The board may impanel site review committees to conduct onsite evaluations, inspections, and investigations of a speech-language pathology assistant training program and to assess the training program's compliance with the board's laws and regulations. The members of the site review committee shall receive no compensation but shall be reimbursed for their actual travel and per diem expenses by the institution that is the subject of the evaluation, inspection, or investigation.

(3) Standards for accreditation of a Speech-Language Pathology Assistant training program's institution by the Accrediting Commission for Community and Junior Colleges of the Western Association of Schools and Colleges or the Senior College Commission of the Western Association of Schools and Colleges, or equivalent accreditation.

(4) The scope of responsibility, duties, and functions of speech-language pathology assistants, that shall include, but not be limited to, all of the following:

(A) Conducting speech-language screening, without interpretation, and using screening protocols developed by the supervising speech-language pathologist.

(B) Providing direct treatment assistance to patients or clients under the supervision of a speech-language pathologist.

(C) Following and implementing documented treatment plans or protocols developed by a supervising speech-language pathologist.

(D) Documenting patient or client progress toward meeting established objectives, and reporting the information to a supervising speech-language pathologist.

(E) Assisting a speech-language pathologist during assessments, including, but not limited to, assisting with formal documentation, preparing materials, and performing clerical duties for a supervising speech-language pathologist.

(F) When competent to do so, as determined by the supervising speech-language pathologist, acting as an interpreter for non-English-speaking patients or clients and their family members.

(G) Scheduling activities and preparing charts, records, graphs, and data.

(H) Performing checks and maintenance of equipment, including, but not limited to, augmentative communication devices.

(I) Assisting with speech-language pathology research projects, in-service training, and family or community education.

The regulations shall provide that speech-language pathology assistants are not authorized to conduct evaluations, interpret data, alter treatment plans, or perform any task without the express knowledge and approval of a supervising speech-language pathologist.

(5) The requirements for the wearing of distinguishing name badges with the title of speech-language pathology assistant.

(6) Minimum continuing professional development requirements for the speech-language pathology assistant, not to exceed 12 hours in a two-year period. The speech-language pathology assistant's supervisor shall act as a professional development advisor. The speech-language pathology assistant's professional growth may be satisfied with successful completion of state or regional conferences, workshops, formal in-service presentations, independent study programs, or any combination of these concerning communication and related disorders.

(7) Minimum continuing professional development requirements for the supervisor of a speech-language pathology assistant.

(8) The type and amount of direct and indirect supervision required for speech-language pathology assistants.

(9) The maximum number of assistants permitted per supervisor.

(10) A requirement that the supervising speech-language pathologist shall remain responsible and accountable for clinical judgments and decisions and the maintenance of the highest quality and standards of practice when a speech-language pathology assistant is utilized.

**California Code of Regulations (CCR) section 1399.170.1. Responsibilities, Duties, and Functions of a Speech-Language Pathology Assistant.**

(a) A speech-language pathology assistant shall be limited to the responsibilities, duties, and functions as provided in Section 2538.1 of the Code.

(b) A speech-language pathology assistant shall disclose while working, his or her name and registration status, as granted by the state, on a name tag in at least 18-point type.

Note: Authority cited: Sections 2531.95 and 2538.1(a), Business and Professions Code. Reference: Sections 2538.1(b)(3) and (4) and 2538.7(b), Business and Professions Code.

**CCR section 1399.170.2. Types of Supervision Required for Duties Performed by a Speech-Language Pathology Assistant.**

(a) Duties performed by the speech-language pathology assistant that require immediate supervision may include, but are not limited to, any direct client activity involving medically fragile patients. In such instances, the speech-language pathology assistant shall act only under the direction of the supervisor.

(b) Duties performed by the speech-language pathology assistant that require direct supervision may include, but are not limited to, any new screening or treatment activity that the assistant has been trained to perform by the supervisor, but has not yet been performed by the speech-language pathology assistant in direct client care.

(c) Duties performed by the speech-language pathology assistant that require indirect supervision may include, but are not limited to, the following:

(1) Screening or treatment activities where the supervisor has previously given instructions as to how to perform the task, has observed the assistant in the conduct of these activities, and is satisfied that the activities can be competently performed by the speech-language pathology assistant, i.e., repetitive drill exercises, generalization or carryover activities;

(2) Clerical tasks such as record keeping, materials preparation, scheduling, equipment maintenance; and,

(3) Other non-client care activities.

(d) Notwithstanding subdivisions (a), (b), and (c), the supervisor shall provide supervision to the speech-language pathology assistant following their initial licensure in accordance with Section 1399.170.15(b)(4) of the California Code of Regulations.

Note: Authority cited: Sections 2531.95 and 2538.1, Business and Professions Code. Reference: Section 2538.1, Business and Professions Code.

**CCR section 1399.170.3. Activities, Duties, and Functions Outside the Scope of Responsibilities of a Speech-Language Pathology Assistant.**

A speech-language pathology assistant may not conduct evaluations, interpret data, alter treatment plans, or perform any task without the express knowledge and approval of a supervising speech-language pathologist. The speech-language pathology assistant may not perform any of the following functions:

(a) Participate in parent conferences, case conferences, or inter-disciplinary team conferences without the supervising speech-language pathologist or another speech-language pathologist being present;

(b) Provide counseling or advice to a client or a client's parent or guardian which is beyond the scope of the client's treatment;

(c) Sign any documents in lieu of the supervising speech-language pathologist, i.e., treatment plans, client reimbursement forms, or formal reports;

(d) Discharge clients from services;

(e) Make referrals for additional services;

(f) Unless required by law, disclose confidential information either orally or in writing to anyone not designated by the supervising speech-language pathologist;

(g) Represent himself or herself as a speech-language pathologist; and,

(h) Perform procedures that require a high level of clinical acumen and technical skill, i.e., vocal tract prosthesis shaping or fitting, vocal tract imaging, and oropharyngeal swallow therapy with bolus material.

Note: Authority cited: Sections 2531.95 and 2538.1(a), Business and Professions Code. Reference: Section 2538.1(b)(3), Business and Professions Code.

## Audiology Assistants

### Overview

An audiology assistant is a person who, after appropriate training and demonstration of competency, performs delegated tasks that are prescribed, directed, and supervised by a certified and/or licensed audiologist. When hearing aid dealers are serving in the role of assistant, their duties will always be clarified by the supervising audiologist.

Audiology assistants may or may not be regulated by state laws and regulations, and the supervising audiologist is responsible for determining the applicable requirements in his or her state and work setting. See ASHA's State-by-State page for a summary of state requirements for audiology assistants.

Audiology assistants improve access to patient care by increasing the availability of audiology services, increase productivity by reducing wait times and enhancing patient satisfaction, and reduce costs by performing tasks that do not require the professional skills of a certified and/or licensed audiologist (Dunlop et al., 2006; Kasewurm, 2006; Saccone & Steiger, 2008).

Support personnel may assist audiologists in the delivery of services, where appropriate, provided these guidelines are followed.

- The roles and tasks of audiology assistants are assigned *only* by supervising audiologists.
- Supervising audiologists provide appropriate training that is competency-based and specific to job performance.
- Supervision is comprehensive, periodic, and documented.
- The supervising audiologist maintains the legal and ethical responsibilities for all assigned audiology activities provided by support personnel.
- Services delegated to the assistant are those that are permitted by state law, and the assistant is appropriately registered/licensed if the state so requires.
- The needs of the consumer of audiology services and protection of that consumer are always paramount. (AAA, 2010a, 2010b; ASHA, 2010; National Hearing Conservation Association, 1990)

***Note:*** Teleaudiology Clinical Technicians (TCTs) provide patient/equipment interface support under the supervision of a licensed audiologist who is delivering audiology services from a site located at a distance from the actual patient testing site. TCTs are currently only being used in the Veterans Administration and are not specifically included in the scope of this document

### Affiliation with ASHA

ASHA has established an Assistants Certification Program for support personnel in speech-language pathology and audiology, open to individuals who

- are currently employed in support positions providing audiology or speech-language pathology assistant services and
- work under the supervision of an ASHA-certified audiologist (CCC-A) or speech-language pathologist (CCC-SLP).

Applicants are required to obtain the signature of their ASHA-certified supervisor(s) in order to become ASHA Associates.

Key Issues

**Audiology Assistants**

**Minimum Qualifications for Audiology Assistants**

Minimum qualifications for audiology assistants include the following:

- minimum educational standards required by the state [PDF]
- communication and interpersonal skills necessary for the tasks assigned
- a basic understanding of the needs of the population being served
- successful completion of the training requirements and competency-based skills necessary for the performance of specific, assigned tasks
- additional qualifications established by the supervising audiologist to meet the specific needs of the audiology program and the population being served
- additional requirements established by the facility of employment

**Roles and Responsibilities of the Audiology Assistant**

Audiology assistants engage in only those tasks that are planned, delegated, and supervised by the audiologist and permitted by state law. The duties and responsibilities assigned are based on the training, available supervision, and specific work setting. The scope of practice of the supervising audiologist also dictates the duties and responsibilities assigned to the audiology assistant. The list below provides examples and is not meant to be all inclusive.

The types of services that audiology assistants perform—if permitted by state law and when the assistant has demonstrated competence—include the following:

- greeting and escorting patients
- scheduling patients
- packaging and mailing earmold orders, device repairs, and manufacturer/lab returns

- maintaining inventories of supplies and checking function of equipment
- performing checks on hearing aids and other amplification devices
- performing troubleshooting and minor repairs to hearing aids, earmolds, and other amplification devices
- cleaning hearing aids and other amplification devices
- performing electroacoustic analysis of hearing aids and other amplification devices
- instructing patients in proper use and care of hearing aids and other amplification devices
- demonstrating alerting and assistive listening devices
- instructing patients in proper ear hygiene
- assisting audiologists in treatment programs
- assisting audiologists with setup and technical tasks
- preparing materials for ear impressions
- maintaining and restocking test and treatment rooms
- performing equipment maintenance and biological checks
- conducting hearing and tympanometric screening on older children and adults (without interpretation)
- conducting otoacoustic emission screening
- performing nondiagnostic otoscopy
- performing pure-tone audiologic reassessment on established patients
- preparing the patient for VNG/ENG or evoked testing
- assisting audiologists in hearing testing of pediatric patients
- performing pure-tone hearing screening and universal newborn hearing screening tests
- performing infection control duties within the clinic/service
- assisting patients in completing case history or other relevant forms
- interacting with hearing instrument manufacturers/suppliers regarding status of orders/repairs

Audiology assistants who are fluent in a language or languages in addition to spoken English and who have the necessary training and skills may serve as translators, interpreters, and/or cultural brokers, when needed.

Audiology assistants will not perform any task without the express knowledge and approval of the supervising audiologist or any task that may be prohibited by state or federal law. The list below provides examples and is not meant to be all inclusive.

Actions that audiology assistants are not to perform include the following:

- determining case selection or evaluation protocols
- interpreting observations or data into diagnostic statements of clinical management strategies or procedures
- participating in team or case conferences or on any interdisciplinary team, without the presence of the supervising audiologist or an audiologist designated by the supervising audiologist
- writing, developing, or modifying a patient's individualized treatment plan
- assisting with patients without following the treatment plan prepared by the audiologist or without proper supervision
- composing or signing any formal documents (e.g., treatment plans, reimbursement forms, or reports)—progress notes written by audiology assistants may be reviewed and cosigned by the supervising audiologist, subject to local facility policy
- transmitting or disclosing clinical information, either orally or in writing, to anyone, including the patient, without the approval of the supervising audiologist
- selecting patients for treatment services or discharging patients from treatment services
- counseling or consulting with the patient, family, or others regarding the patient status or service or making referrals for additional services
- referring to themselves either orally or in writing with a title other than one determined by the supervising audiologist

Audiology assistants with specialized training from the Council for Accreditation in Occupational Hearing Conservation (CAOHC) perform the following services under the supervision of a certified and/or licensed audiologist or physician:

- checks and calibration of audiometric instrumentation
- otoscopic screening and pure-tone threshold testing for the purpose of hearing conservation

- basic counseling of employees concerning test results and criteria for employee referral
- fit and training of employees on personal hearing protection devices
- fit testing of hearing protection devices
- assistance to CAOHC course directors in conducting training courses
- employee hearing conservation education, training, and motivation
- recordkeeping
- generation of periodic hearing conservation statistical reports

Tasks that CAOHC-certified occupational hearing conservationists shall *not* do include

- assuming the role of a professional supervisor of the audiometric monitoring portion of a hearing conservation program,
- assuming the role of an instructor of other occupational hearing conservationists,
- interpreting audiograms,
- conducting any type of audiometric testing other than air conduction, such as bone-conduction testing or speech audiometry,
- diagnosing hearing disorders,
- independently evaluating hearing conservation program effectiveness,
- conducting noise surveys and analyses or being responsible for noise-control solutions.

**Ethical Obligations of Audiology Assistants**

Although the ASHA Code of Ethics does not apply directly to any individual who is working in a support role (e.g., technician, aide, or assistant) under the supervision of an audiologist, those individuals in a support role must be knowledgeable about the provisions of the Code. Individual state licensing boards may have ethical requirements for audiology assistants. See ASHA's State Overviews for specific information.

Because the ethical responsibility for patient care or for subjects in research studies cannot be delegated, the audiologist or hearing scientist takes overall responsibility for the actions of the assistants when they are performing assigned duties. If the assistant engages in activities that violate the Code of Ethics, the supervising professional may be found in violation of the Code. It is imperative that the supervising professional and the assistant behave in a manner that is consistent with the principles and rules outlined in the Code. See ASHA's Issues in Ethics: Audiology Assistants.

**Education and Training for Audiology Assistants**

Consider the following in developing training programs for audiology assistants:

- Training for audiology assistants should be well defined and specific to the assigned task(s).
- Supervising audiologists ensure that the scope and intensity of training encompass all of the activities assigned to audiology assistants.
- Training should be competency based and provided through a variety of formal and informal instructional methods with written policies and procedures.
- Audiologists should provide audiology assistants with written information on roles and functions. Ongoing training opportunities should be provided to ensure that practices are current and that skills are maintained.
- Training includes, but is not limited to, the identification of and appropriate response to cultural and linguistic factors affecting service delivery.

The supervising audiologist is responsible for maintaining written documentation of completed training activity. Most audiology assistants receive their education and training on-site by the supervising audiologist/employer. Currently, ASHA is aware of only one formal audiology assistant training program in the country, at Nova Southeastern University.

**Supervision**

**Qualifications of a Supervising Audiologist**

In order to serve as a supervisor, ASHA requires that an audiologist hold a full, current, and unrestricted license to practice audiology from a state, territory, commonwealth, or the District of Columbia (where applicable) and recommends that the audiologist have a Certificate of Clinical Competence in Audiology granted by ASHA. In the case of an individual exempted from state licensure based on practice in a specific institution or setting, ASHA recommends the individual meet one of the following conditions:

- have a Certificate of Clinical Competence in Audiology granted by ASHA
- have met the requirements for certification from ASHA
- passed a national examination in audiology

**Roles and Resonsibilities of the Supervising Audiologist**

The supervising audiologist has the ultimate clinical, ethical, and legal responsibility for the care provided to the patient. Responsibilities of the supervising audiologist include

- administrative actions related to audiology assistants, such as hiring, training, determining competency, and conducting performance evaluations;

- final approval of all directives given by administrators and other professionals regarding audiology tasks;
- delegation and supervision of specific tasks to the support person (such tasks must not exceed the knowledge and skills of audiology assistants or exceed their scope of practice—specifically the exercise of professional judgment, interpretation of results, or development or modification of treatment plans);
- assessment of the audiology assistant's proficiency in performing assigned tasks on a predetermined, periodic basis;
- providing feedback to the audiology assistant to promote continuous performance improvement.

**Amount and Frequency of Supervision**

The supervising audiologist is responsible for determining the level of supervision that is required based on the activities that are delegated to the assistant, the skills of the assistant, and the clinical setting. On some occasions, multiple levels of supervision are utilized. Permissible levels of supervision for audiology assistants include the following direct and indirect services.

**Direct:** The supervising audiologist is present in the same room while the audiology assistant is engaged in direct health care activities.

**Indirect:** The supervising audiologist is in the same physical area and is immediately accessible to the audiology assistant. The supervising audiologist meets and interacts with patients/clients as needed. The audiology assistant and supervising audiologist discuss, plan, or review evaluation and treatment. Area supervision is available only when the audiology assistant has been formally assigned a graduated level of responsibility commensurate with this type of supervision. This level is synonymous with direct supervision.

**General:** Services are furnished by the audiology assistant under the supervising audiologist's guidance. The supervising audiologist's presence is not required during services, but the supervising audiologist must be immediately available by phone or pager and able to be physically present as needed.

The amount and type of supervision required are based on the skills and experience of the audiology assistant, the needs of patients/clients served, the service delivery setting, the tasks assigned, and other factors.

- More intense supervision will be required during the orientation of a new audiology assistant; at the initiation of a new program, task, or equipment; or when there is a change in patient/client status. In general, audiology assistants with less education, training, or experience require more intense and more immediate supervision than do those with more advanced education and training or experience

- The level of supervision is determined by the experience and demonstrated competence of the audiology assistant and the complexity of the patient/client's health care needs. The supervising audiologist directs the care of the patient and provides supervision based on the nature of the patient/client's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the audiology assistant being supervised.
- Audiology practices encourage and permit trainees to assume increasing levels of responsibility commensurate with their individual progress, experience, skills, knowledge, and judgment, provided those responsibilities remain within the scope appropriate for an assistant.
- The number of audiology assistants supervised by an audiologist must be consistent with the delivery of appropriate, quality service, and any applicable state law. It is the responsibility of the individual supervisor to protect the interests of patients/clients in a manner consistent with state licensure requirements, where applicable, and the ASHA Code of Ethics.

See Teleaudiology Clinical Technicians for specific information on TCT supervision.

**Ethical Requirements for Supervising Audiologists**

ASHA strives to ensure that its members, certificate holders, and applicants preserve the highest standards of integrity and ethical practice. The ASHA Code of Ethics (ASHA, 2023) sets forth the fundamental principles and rules considered essential to this purpose. The Code of Ethics applies to all individuals who are members of ASHA, regardless of whether they are certified members, nonmembers holding the Certificate of Clinical Competence from the Association, or applicants for certification.

The following principles and rules of the ASHA Code of Ethics specifically address issues that are pertinent when an audiologist supervises support personnel in the provision of services or when conducting research:

**Principle of Ethics I:** Individuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally or who are participants in research and scholarly activities.

*Guidance:* The supervising audiologist remains responsible for the care and well-being of the client or research subject. If the supervisor fails to intervene when the assistant's behavior puts the client or subject at risk or when services or procedures are implemented inappropriately, the supervisor could be in violation of the Code of Ethics.

**Principle of Ethics I, Rule A:** Individuals shall provide all clinical services and scientific activities competently.

*Guidance:* The supervising audiologist must ensure that all services, including those provided directly by the assistant, meet practice standards and are administered

competently. If the supervisor fails to intervene or correct the actions of the assistant as needed, this could be a violation of the Code of Ethics.

**Principle of Ethics I, Rule C:** Individuals shall not discriminate in the delivery of professional services or in the conduct of research and scholarly activities on the basis of age; citizenship; disability; ethnicity; gender; gender expression; gender identity; genetic information; national origin, including culture, language, dialect, and accent; race; religion; sex; sexual orientation; or veteran status.

*Guidance:* The supervising audiologist is responsible for ensuring that there is no discrimination in service delivery, as indicated above. Discrimination exhibited by the audiology assistant could be a violation of the Code of Ethics.

**Principle of Ethics I, Rule D:** Individuals shall not misrepresent the credentials of aides, assistants, technicians, students, research assistants, Clinical Fellows, or any others under their supervision, and they shall inform those they serve professionally of the name, role, and professional credentials of persons providing services.

*Guidance:* The supervising audiologist must ensure that clients and subjects are informed of the title and qualifications of the assistant. This is not a passive responsibility; that is, the supervisor must make this information easily available and understandable to the clients or subjects and not rely on the individual to inquire about or ask directly for this information. Any misrepresentation of the assistant's qualifications or role could result in a violation of the Code of Ethics by the supervisor.

**Principle of Ethics I, Rule E:** Individuals who hold the Certificate of Clinical Competence may delegate tasks related to the provision of clinical services to aides, assistants, technicians, or any other persons only if those persons are adequately prepared and are appropriately supervised. The responsibility for the welfare of those being served remains with the certified audiologist or speech-language pathologist.

*Guidance:* The supervising audiologist is responsible for providing appropriate and adequate direct and indirect supervision to ensure that the services provided are appropriate and meet practice standards. The audiologist should document supervisory activities and adjust the amount and type of supervision to ensure that the Code of Ethics is not violated.

**Principle of Ethics I, Rule F:** Individuals who hold the Certificate of Clinical Competence may delegate tasks related to provision of clinical services to assistants, technicians, support personnel, or any other persons only if those services are appropriately supervised, realizing that the responsibility for client welfare remains with the certified individual.

*Guidance:* The supervising audiologist is responsible for providing appropriate and adequate direct and indirect supervision to ensure that the services provided are appropriate and meet practice standards. The audiologist should document supervisory

activities and adjust the amount and type of supervision to ensure that the Code of Ethics is not violated.

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

*Guidance*: The supervising audiologist must ensure that the assistant only performs those activities and duties that are defined as appropriate for the level of training and experience and in accordance with applicable licensure laws. If the assistant exceeds the practice role that has been defined for them, and the supervising audiologist fails to correct this, the supervisor could be found in violation of the Code of Ethics.

**Principle of Ethics IV, Rule F:** Individuals who mentor Clinical Fellows, act as a preceptor to audiology externs, or supervise undergraduate and graduate students, assistants or other staff shall provide appropriate supervision and shall comply - fully and in a timely manner - with all ASHA certification and supervisory requirements.

*Guidance*: This rule emphasizes the need to provide supervision consistent with state law, as well as all ASHA supervisory requirements. Failing to meet ASHA requirements, such as not having the proper practice experience post-certification or failing to earn the required 2 hours of supervision continuing education required to serve as a clinical instructor or supervisor, could result in a Code of Ethics violation.

**Principle of Ethics IV, Rule J:** Individuals shall not knowingly allow anyone under their supervision to engage in any practice that violates the Code of Ethics.

*Guidance:* Because the assistant provides services as "an extension" of those provided by the professional, the audiologist is responsible for informing the assistant about the Code of Ethics and monitoring the performance of the assistant. Failure to do so could result in the audiologist's being found in violation of the Code.

**Principle of Ethics IV, Rule R:** Individuals shall comply with local, state, and federal laws and regulations applicable to professional practice, research ethics, and the responsible conduct of research.

*Guidance*: This rule emphasizes the importance of the audiologist ensuring that the assistant complies with all laws and regulations applicable to their setting/facility and practice, not only state codes of ethics and state licensure laws.

**State/Federal Laws and Regulations**

Laws and regulations for audiology support personnel in educational and other practice settings vary from state-to-state. Differences may be reflected in a number of requirements including the following: education, supervision, continuing education, titles used for support personnel, and regulation or laws or lack thereof. See ASHA's State-by-State page for a summary of state requirements for audiology assistants. For the

most current information, always check with your state licensure board and/or department of education for the requirements for specific practice settings.

**Reimbursement**

The use of assistants can improve access to and reduce costs of quality audiology services. State policies regarding Medicaid reimbursement of services provided by an audiology assistant are limited. Nationally, audiology assistant services are not covered by Medicare. For private health plans, check with the payer in question to determine their provider qualifications. In general, Medicaid, Medicare, and private health plan reimbursements are limited for audiology services provided by assistants or audiologists using teleaudiology to deliver services.

## Resources

**ASHA Resources**

- ASHA Assistants Certification Recognition in States
- ASHA State Overviews
- Assistants Certification Program
- Experience, Attitudes and Competencies of Audiologic Support Personnel in a Rehabilitation Hospital
- Issues in Ethics: Audiology Assistants
- School Assistants Trends [PDF]
- State Assistants Trends [PDF]

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About This Content

Acknowledgements

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# Hand Carry Item

Agenda Item 9:
Review and Possible Approval of the
August 21 - 22, 2025, Board Meeting Minutes

# Hand Carry Item

Agenda Item 10:
DCA Update – DCA Board and Bureau Relations

**SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD**
1601 Response Road, Suite 260, Sacramento, CA 95815
P (916) 287-7915 | www.speechandhearing.ca.gov

# MEMORANDUM

| | |
|---|---|
| DATE | November 25, 2025 |
| TO | Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board |
| FROM | Gilda Dominguez, Board Chair |
| SUBJECT | Agenda Item 11: Board Chair's Report |

The Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board (Board) Chair will provide a verbal update on Board and Committee activities and assignments.

## a. Board and Committee Meeting Calendar

| Meeting Date | Location | Agenda | Meeting Materials | Minutes | Webcast |
|---|---|---|---|---|---|
| **2025** | | | | | |
| December 4 – 5, 2025 | Cerritos College, Norwalk, CA | Agenda | | | |
| August 21 – 22, 2025 | Teleconference | Agenda | Materials<br>Hand Carry – Agenda Item 7 | | |
| May 15 – 16, 2025 | Teleconference | May 15 Agenda<br><br>May 16 Agenda | May 15 Committee Meeting Materials<br>May 16 Meeting Materials<br>Hand Carry – Agenda Item 6<br>Hand Carry – Agenda Item 11 | | Board Meeting Webcast<br>Pathology Practice Committee Webcast<br>Audiology Practice Committee Webcast<br>Hearing Aid Dispensing Committee Webcast |
| February 21, 2025 | Sacramento, California and Teleconference | Agenda | Materials | Minutes | Webcast |

## b. Board Committee Reports

The Speech-Language Pathology Practice Committee, Hearing Aid Dispensing Committee, and Audiology Practice Committee will provide a verbal report regarding their committee meeting.

## STANDING COMMITTEES

Standing Committee composition and leadership are determined by the Board President and are fully within the scope of the Open Meetings Act. Standing Committee meetings are often held in conjunction with regularly scheduled Board Meetings.

**SLP PRACTICE COMMITTEE**
***Addresses changes in practice patterns and recommends position statements and/or scope of practice amendments for consideration.***

| Name | Position | Profession |
|---|---|---|
| Gilda Dominguez | Chair | SLP |
| Francis David | Member | SLP |
| Tamara Chambers | Member | ORL/Public |

**AUDIOLOGY PRACTICE COMMITTEE**
***Addresses changes in practice patterns and recommends position statements and/or scope of practice amendments for consideration.***

| Name | Position | Profession |
|---|---|---|
| Amy White | Chair | DAU |
| Charles Sanders | Member | DAU |
| Tamara Chambers | Member | ORL/Public |
| Karen Chang | Member | Public |

**HEARING AID DISPENERS PRACTICE COMMITTEE**
***Addresses changes in practice patterns and recommends position statements and/or scope of practice amendments for consideration.***

| Name | Position | Profession |
|---|---|---|
| Tod Borges | Chair | HAD |
| VACANT | Member | HAD |
| Karen Chang | Member | Public |

**HEARING AID DISPENSING COMMITTEE**
***Provides policy and regulatory guidance with respect to hearing aid dispensing practices and recommends scope of practice amendments for consideration.***

| Name | Position | Profession |
|---|---|---|
| Tod Borges | Chair | HAD |
| VACANT | Member | HAD |
| Charles Sanders | Member | DAU |
| Amy White | Member | DAU |
| Tamara Chambers | Member | ORL/Public |

## AD HOC COMMITTEES

Ad Hoc Committees may be established by the Board President as needed. Composition and leadership will be appointed by the Board President. Ad Hoc Committees may include the appointment of non-Board members at the Board President's discretion. Ad Hoc Committees are not fully within the scope of the Open Meetings act, however all recommendations made by Ad Hoc Committees must be reviewed and voted on by the Board in a public Board Meeting.

| **SUNSET REVIEW AD HOC COMMITTEE**<br>***Develop for the Board's review the Board's Sunset Review Report to the California Legislature*** | | |
|---|---|---|
| **Name** | **Position** | **Profession** |
| Gilda Dominguez | Chair | SLP |
| Amy White | Member | DAU |
| **ENFORCEMENT AD HOC COMMITTEE**<br>***Review and recommend to the Board proposed revisions to the laws, regulations, and policies related to the Board's enforcement of the Boards Practice Act.*** | | |
| **Name** | **Position** | **Profession** |
| Gilda Dominguez | Chair | SLP |
| Tod Borges | Member | HAD |
| **LEGISLATIVE AD HOC COMMITTEE**<br>***Review and recommend to the Board proposed positions on legislation impacting the Board, its licensees, and the Board's Practice Act*** | | |
| **Name** | **Position** | **Profession** |
| Karen Chang | Chair | Public |
| Gilda Dominguez | Member | SLP |

***Legend:***
DAU - Dispensing Audiologist
HAD - Hearing Aid Dispenser
ORL/ENT - Otolaryngologist/Ear, Nose & Throat
SLP - Speech-Language Pathologist

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD
1601 Response Road, Suite 260, Sacramento, CA 95815
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# MEMORANDUM

| | |
|---|---|
| DATE | November 25, 2025 |
| TO | Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board |
| FROM | Cherise Burns, Executive Officer |
| SUBJECT | Agenda Item 12: Executive Officer's Report |

This report and the statistical information are provided by leadership and staff to update members on the current operations of the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board (Board).

## a) Administration Update

The Board is currently fully staffed, minus the one position in the Enforcement Unit that is not funded and therefore not filled.

## b) Outreach Update

Since the Board's August meeting, the Board's Chair or Vice Chair and I have attended conference calls with representatives from the California Speech Language Hearing Association (CSHA) and California Academy of Audiology (CAA), at their request, to discuss issues affecting Speech-Language Pathologists and Audiologists in California.

On September 19, 2025, the Board's Vice Chair Dr. White and Dr. Sanders presented at the 2025 CAA Annual Conference on the Board's behalf. Unfortunately, I was unable to attend virtually due to illness. Dr. White and Dr. Sanders delivered a presentation that included updates on the Board's Laws and Regulations related to requirements for continuing professional development (CPD), the most common reasons for failing a CPD audit, and the differences between the role of the Board vs the role of professional associations and the associated legislative advocacy seen with each.

On September 30, 2025, the Board's Assistant Executive Officer and I attended the Fall meeting of the California Chapter of the Council of Academic Programs In Communication Sciences And Disorders (CAPCSD). At this meeting the Board's leadership learned about issues related to electronic databases that track clinical clock

hours for students, issues clinical sites have had with professional dress codes, updates on the creation of a health professions track for California pre-doctoral students, and updates from the Commission on Teacher Credentialing on program requirements.

## c) Budget Report

Included in your Board meeting materials is the FY 2025-26 Budget Report – FM 3 that reflects operating expenditures through the fiscal month 3 (September 30, 2025) of the 2025-26 budget year as well as the projections through the fiscal year-end. Due to extremely high Office of Attorney General (OAG) and Office of Administrative Hearings (OAH) expenditures (including projected costs for cases set for hearing later in the fiscal year), the Budget Report shows a deficit of approximately -$244,380, a deficit of -7.84 percent of the Board's budget.

Due to this projected deficit, the Board is actively reducing current-year expenditures in any way it can by closely monitoring spending during the 2025-26 budget year, but most importantly, will be seeking a statutorily authorized current year augmentation to the Board's budget authority for OAG and OAH costs. The Board will be pursuing these augmentations to ensure the Board has adequate funding to continue upholding consumer protection through enforcement actions as well as fund Board operations. As a reminder, when these types of augmentations are sought and approved, they come directly from the Board's Fund. As part of the Board meeting materials, I have also provided an estimate of what the FY 2025-26 Budget Report – FM 3 could look like with a requested OAG and OAH augmentation. The Budget Report with prospective OAG and OAH augmentations shows a surplus of approximately $19,620, a surplus of 0.58 percent of the Board's budget.

Board leadership will work closely with DCA's Budget Office to submit the necessary requests, documentation, and legislative testimony for the OAG and OAH augmentation requests and will keep the Board appraised of these efforts at upcoming meetings.

Also included in your materials are two Fund Condition Reports prepared November 25, 2025, that reflect the current projections as well as the current projections with the prospective OAG and OAH augmentation. This report is a snapshot of the Board's fund condition and shows the Board's revenue and budget allocation for the current 2025-26 budget year plus two future years. While these show a significantly reducing Fund Condition trend in the projections, Board leadership notes that the Fund Condition statement is based on conservative revenue projections that do not grow year-over-year, which in reality the Board's revenue annual growth has ranged from 5.11 percent to 17.48 percent, or an average of 11.93 percent over the last four fiscal years. With the Board's continued growth in its licensing population and revenues, Board leadership is confident that the Board's Fund will continue to be healthy in the coming fiscal years.

## d) Regulations Report

Below is a table with the Board's pending rulemaking files that are already in the Official Rulemaking Process with the Office of Administrative Law (OAL). The Board is making great strides in completing rulemaking files with the help of each Board member, staff, and the Department of Consumer Affairs (DCA) Legal. The Board is currently working on getting more packages ready to enter the Official Rulemaking Process, however these packages are larger and more complex than some packages we have been able to complete over the last five years.

| Rulemaking File | Final OAL Filing Date | Status | Comments |
|---|---|---|---|
| Processing Times | 3/13/2026 | 9/23/2025 – Approved and filed with the Secretary of State by OAL<br>8/11/2025 – Submitted to OAL<br>7/14/2025 – Submitted for DCA review<br>6/12/2025 – Submitted for Budget review<br>6/12/2025 – Submitted for Legal review<br>3/14/2025 – Initial 45-day comment period<br>2/26/2025 – Submitted to OAL<br>1/29/2025 – Submitted for Agency review<br>1/27/2025 – Submitted for DCA Director review<br>12/18/2025 – Submitted for DCA Legal & Budget review<br>9/6/2024 – Board approved revised language<br>12/1/2023 – Board approved revised language<br>10/8/2021 – Board approved language | Becomes Effective January 1, 2026. |
| Audiology Supervised Clinical Experience | 5/1/2026 | 9/22/2025 – Approved and filed with the Secretary of State by OAL<br>8/11/2025 – Submitted to OAL<br>7/24/2025 – Submitted for DCA review<br>6/18/2025 Submitted for Budget review<br>6/18/2025 – Submitted for Legal review<br>5/2/2025 – Initial 45-day comment period<br>4/22/2025 – Submitted to OAL<br>3/13/2025 – Submitted for Agency review<br>3/5/2025 – Submitted for DCA Director review<br>1/8/2025 – Submitted for DCA Legal & Budget review<br>12/6/2024 – Board approved revised language<br>12/1/2023 – Board approved language | Becomes Effective January 1, 2026. |

## e) Licensing Report

Licensing cycle times continue to be dramatically better than previous years, with an overall reduction of 73 percent compared to 2020, 2021, and 2022. We evaluate the online licensing program and application processes on an ongoing basis.

| Average Processing Times in Weeks (Complete Applications) | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Year | January | February | March | April | May | June | July | August | September | October | November | December |
| 2020 | 4 | 3 | 4 | 3 | 3 | 3 | 5 | 7 | 6 | 4 | 3 | 5 |
| 2021 | 5 | 5 | 6 | 4 | 5 | 6 | 6 | 8 | 9 | 8 | 9 | 7 |
| 2022 | 4 | 5 | 4 | 3 | 3 | 3 | 4 | 5 | 7 | 7 | 7 | 10 |
| 2023 | 11 | 11 | 11 | 13 | 13 | 12 | 11 | 12 | 11 | 10 | 10 | 8 |
| 2024 | 5 | 3 | 2 | 1 | 2 | 2 | 2 | 2 | 1 | 1 | 1 | 1 |
| 2025 | 2 | 1 | 1 | 1 | 1 | 2 | 2 | 1 | 1 | 1 | TBD | TBD |
| Average Reduction | 61% | 75% | 74% | 68% | 69% | 48% | 57% | 85% | 86% | 82% | 80% | 86% |

Licensing Cycle Times – The chart below provides a snapshot of the Board's current and past licensing processing times.

| Licensing Cycle Times | 11/22/24 | 2/5/25 | 5/5/25 | 6/26/25 | 8/8/25 | 11/21/25 |
|---|---|---|---|---|---|---|
| Speech-Language Pathologists (SLP) and Audiologists (AUD) Complete Licensing Applications | 1 week | 1 week | 1 week | 2 weeks | 1 week | 1 week |
| Review and Process SLP and AUD Supporting Licensing Documents | 1 week | 1 week | 1 week | 1 week | 1 week | 1 week |
| Review and Process RPE Applicant's Verification of Experience Forms for Full Licensure | 1 week | 1 week | 1 week | 1 week | 1 week | 1 week |
| Hearing Aid Dispensers (HAD) Complete Applications | 1 week | 1 week | 1 week | 2 weeks | 1 week | 1 week |

## f) Practical Examination Report

The most recent practical exam was held on November 7 - 8, 2025. These exam results are not yet available.

The previous exam was held on September 26 - 27, 2025. The exam results are noted below.

Future practical exams are posted on the website.
https://www.speechandhearing.ca.gov/applicants/exam_dates.shtml

| HAD Practical Examination Results for September 26 – 27, 2025 | | | | | |
|---|---|---|---|---|---|
| **Candidate Type** | **Number of Candidates** | **Passed** | **%** | **Failed** | **%** |
| **Applicants with Supervision (Temporary Trainee License)** | | | | | |
| Hearing Aid Dispensers | 30 | 24 | | 6 | |
| Audiologists | 6 | 4 | | 2 | |
| Required Professional Experience | 4 | 3 | | 1 | |
| Aide | | | | | |
| **Applicants Licensed in Another State (Temporary License)** | | | | | |
| Hearing Aid Dispenser | 2 | 2 | | | |
| Audiologist | 2 | 2 | | | |
| **Applicants without Supervision** | | | | | |
| Hearing Aid Dispensers | 3 | 2 | | 1 | |
| Audiologists | 3 | 2 | | 1 | |
| **Total** | | | | | |
| Total Number of Candidates | 50 | 39 | 78% | 11 | 22% |

## g) Enforcement Report

The Board has received 83 complaints and subsequent arrest notifications through the first quarter of 2025-2026 fiscal year. During this same period, the Board has issued eight (8) citations and fines (including CE/CPD related citations and fines).

There are currently five (5) formal discipline cases pending with the Attorney General's Office. The Board is currently monitoring 14 probationers of which five (5) probationers require drug or alcohol testing and three (3) are in a tolled status.

The following Attorney General outcomes have been adopted by the Board during the past 12 months (this list includes actions taken while a licensee was on probation and thus subsequent discipline):

| Name | License No. | License Type | Case No. | Effective Date | Action Taken |
|---|---|---|---|---|---|
| Sandhu, Avneet Kaur | SP 33000 | Speech-Language Pathologist | 1I-2022-016 | July 11, 2025 | Revocation Stayed, Seven Years Probation with Specified Terms and Conditions |
| Aiello-O'Connor, Erika Anne | SP 33238 | Speech-Language Pathologist | 1I-2023-033 | July 7, 2025 | Voluntary Surrender of License |
| Avina, Arturo Frank | SP 27490 | Speech-Language Pathologist | 1I-2019-032 | April 3, 2025 | Petition for Early Termination of Probation Granted. Probation Terminated. |
| Lenhares, Susannah Corwin | SP 12116 | Speech-Language Pathologist | 1I-2019-194 | March 29, 2025 | Revocation of License |
| Hamburger, Howard | AU 2092 | Audiologist | 1I-2014-029 | March 17, 2025 | Voluntary Surrender of License |
| Berger, Claire | SP 25040 | Speech-Language Pathologist | 1I-2023-084 | February 28, 2025 | Revocation Stayed, Three Years Probation with Specified Terms and Conditions |
| Godinez, Andres | AU 2267 | Audiologist | 1I-2015-077 | January 5, 2025 | Probation extended 2.5 Years with Specified Terms and Conditions |
| Williams, Jacob Tanner | HA 8116 | Hearing Aid Dispenser | 1C-2021-011 | December 15, 2024 | Revocation Stayed, Three Years Probation with Specified Terms and Conditions |

CE/CPD Audits

In December 2024, the Board completed its first continuing education audit since 2018. The first audit was a five (5) percent random selection of Speech-Language Pathologists, Speech-Language Pathology Assistants, Audiologists, and Hearing Aid Dispensers who renewed in January of 2024. Since that time, the Board has now completed audits of five (5) percent of the licensees identified above through June of 2024, excluding a small number of licensees that have approved extensions for providing their documentation. The Board has also started the audit process for five (5) percent of licensees that renewed in July through September of 2024, totaling 135 licensees over the three months.

The results for the January through June 2024 audits are provided in the table below.

| CE/CPD Audit Results | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Audit Period** | **Number Audited** | **Passed** | **%** | **Failed** | **%** | **Exemption Granted** | **%** | **Citation Issued** | **%** |
| January 2024 | 38 | 23 | 61% | 9 | 24% | 6 | 16% | 8 | 21% |
| February 2024 | 39 | 22 | 56% | 11 | 28% | 6 | 15% | 6 | 15% |
| March 2024 | 43 | 21 | 49% | 15 | 35% | 6 | 14% | 8 | 19% |
| April 2024 | 49 | 27 | 55% | 12 | 24% | 7 | 14% | 4 | 8% |
| May 2024 | 40 | 23 | 58% | 9 | 23% | 7 | 18% | 3 | 8% |
| June 2024 | 40 | 21 | 53% | 14 | 35% | 4 | 10% | 1 | 3% |

## Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board - 0376

## FY 2025-26 BUDGET REPORT - FM 3 (Current Projection)

December 4 - 5, 2025 Board Meeting

| OBJECT DESCRIPTION | FY 2020-21 ACTUAL EXPENDITURES (Prelim FM13) | FY 2021-22 ACTUAL EXPENDITURES (Prelim FM13) | FY 2022-23 ACTUAL EXPENDITURES (Prelim FM13) | FY 2023-24 ACTUAL EXPENDITURES (Prelim FM13) | FY 2024-25 ACTUAL EXPENDITURES (Prelim FM13) | FY 2025-26 GOVERNOR'S BUDGET 2025-26 | FY 2025-26 CURRENT YEAR EXPENDITURES 9.30.2025 | FY 2025-26 % SPENT | FY 2025-26 PROJECTIONS TO YEAR END | FY 2025-26 UNENCUMBERED BALANCE |
|---|---|---|---|---|---|---|---|---|---|---|
| **PERSONNEL SERVICES** | | | | | | | | | | |
| Salary & Wages (Staff) | 599,726 | 746,598 | 842,376 | 809,790 | 887,678 | 984,000 | 224,818 | 23% | **952,077** | 31,923 |
| Statutory Exempt (EO) | 92,318 | 106,164 | 114,225 | 111,479 | 107,634 | 109,000 | 27,768 | 25% | **109,506** | (506) |
| Temp Help | 38,449 | 57,039 | 56,831 | 4,749 | 0 | 1,000 | 0 | 0% | **0** | 1,000 |
| Board Member Per Diem | 1,700 | 5,100 | 5,600 | 2,400 | 2,050 | 6,000 | 0 | 0% | **4,000** | 2,000 |
| Overtime/Flex Elect/Lump Sum | 54,620 | 67,286 | 67,655 | 75,927 | 45,100 | 5,000 | 7,239 | 145% | **20,000** | (15,000) |
| Staff Benefits | 418,932 | 489,282 | 582,080 | 581,545 | 582,291 | 673,000 | 166,407 | 25% | **699,383** | (26,383) |
| ***TOTALS, PERSONNEL SVC*** | **1,205,746** | **1,471,470** | **1,668,767** | **1,585,890** | **1,626,803** | **1,778,000** | **426,232** | **24%** | **1,784,966** | **(6,966)** |
| **OPERATING EXPENSE AND EQUIPMENT** | | | | | | | | | | |
| General Expense | 67,144 | 74,273 | 59,288 | 54,010 | 57,831 | 57,000 | 7,765 | 14% | **57,171** | (171) |
| Printing | 19,251 | 40,231 | 42,470 | 86,218 | 40,540 | 27,000 | 0 | 0% | **38,902** | (11,902) |
| Communication | 7,482 | 3,518 | 3,158 | 1,725 | 1,525 | 13,000 | 64 | 0% | **3,627** | 9,373 |
| Postage | 1,725 | 6,407 | 4,232 | 4,943 | 9,000 | 15,000 | 1,957 | 13% | **3,000** | 12,000 |
| Insurance | 158 | 22 | 17 | 23 | 23 | 0 | 0 | 0% | **23** | (23) |
| Travel In State | 9,148 | 11,088 | 15,381 | 15,534 | 35,339 | 27,000 | 0 | 0% | **35,000** | (8,000) |
| Training | 0 | 175 | 2,845 | 0 | 8 | 11,000 | 0 | 0% | **0** | 11,000 |
| Facilities Operations | 82,568 | 126,495 | 140,624 | 143,422 | 143,498 | 148,000 | 35,101 | 24% | **146,246** | 1,754 |
| C & P Services - Interdept. | 70 | 82 | 83 | 0 | 0 | 24,000 | 0 | 0% | **0** | 24,000 |
| **Attorney General** | **298,782** | **200,014** | **86,055** | **151,478** | **372,624** | **143,000** | **86,368** | **60%** | **380,198** | **(237,198)** |
| **Office Admin. Hearings** | **128,785** | **38,496** | **30,808** | **24,708** | **48,520** | **61,000** | **0** | **0%** | **86,872** | **(25,872)** |
| C & P Services - External | 79,957 | 64,415 | 73,311 | 103,164 | 141,852 | 116,000 | 18,621 | 16% | **113,669** | 2,331 |
| DCA Pro Rata | 355,665 | 463,371 | 138,234 | 441,400 | 749,862 | 531,000 | 276,500 | 52% | **531,000** | 0 |
| DOI - Investigations | 32,198 | 96,124 | 58,523 | 7,262 | 6,806 | 108,000 | 49,500 | 46% | **108,000** | 0 |
| Interagency Services | 2,196 | 118 | 621 | 633 | 519 | 1,000 | 157 | 16% | **536** | 464 |
| IA w/ OPES | 24,264 | 47,009 | 17,086 | 46,414 | 61,923 | 28,000 | | 0% | **36,484** | (8,484) |
| Consolidated Data Center | 14,553 | 20,198 | 23,753 | 23,517 | 7,081 | 29,000 | 0 | 0% | **7,081** | 21,919 |
| Information Technology | 5,210 | 4,171 | 5,115 | 8,928 | 15,334 | 17,000 | 10,749 | 63% | **59,926** | (42,926) |
| Equipment | 30,670 | 1,193 | 2,236 | 1,239 | 5,470 | 0 | 0 | 0% | **155** | (155) |
| Other Items of Expense | 2,553 | 1,746 | 2,076 | 462 | 620 | 15,000 | 0 | 0% | **548** | 14,452 |
| ***TOTALS, OE&E*** | **1,117,103** | **1,194,721** | **706,337** | **1,115,687** | **1,698,352** | **1,371,000** | **486,781** | 36% | **1,608,414** | **(237,414)** |
| ***TOTAL EXPENSE*** | **2,322,849** | **2,666,191** | **2,375,104** | **2,630,237** | **3,325,155** | **3,149,000** | **913,013** | 29% | **3,393,380** | **(244,380)** |
| Reimbursments | | | | | **33,000** | **0** | | | **33,000** | (33,000) |
| Budget Letter 24-20: Vacancy Reduction | | | | | 29,000 | **0** | 0 | | **0** | 0 |
| Budget Letter 24-24: 7.95% Budget Efficiency Reduction | | | | | 21,000 | **0** | 0 | | **0** | 0 |
| ***NET APPROPRIATION*** | | | | | 3,253,815 | **3,116,000** | 913,013 | 29% | **3,360,380** | **(244,380)** |
| | | | | | | | | | **SURPLUS/(DEFICIT):** | **-7.84%** |

Updated 11/25/2025

**0376 - Speech-Language Pathology and Audiology and Hearing Aid Dispensers Fund**
**Analysis of Fund Condition**
**(Dollars in Thousands)**
**2025 Budget Act with FM 3 Projections**

**Prepared 11.25.2025**

| | Actual 2024-25 | CY 2025-26 | BY 2026-27 | BY +1 2027-28 | BY +2 2028-29 |
|---|---|---|---|---|---|
| **BEGINNING BALANCE** | $ 1,927 | $ 1,920 | $ 1,680 | $ 1,307 | $ 820 |
| Prior Year Adjustment | $ -26 | $ - | $ - | $ - | $ - |
| Adjusted Beginning Balance | $ 1,901 | $ 1,920 | $ 1,680 | $ 1,307 | $ 820 |
| **REVENUES, TRANSFERS AND OTHER ADJUSTMENTS** | | | | | |
| Revenues | | | | | |
| 4121200 - Delinquent fees | $ 37 | $ 34 | $ 34 | $ 34 | $ 34 |
| 4127400 - Renewal fees | $ 2,472 | $ 2,502 | $ 2,502 | $ 2,502 | $ 2,502 |
| 4129200 - Other regulatory fees | $ 75 | $ 75 | $ 75 | $ 75 | $ 75 |
| 4129400 - Other regulatory licenses and permits | $ 759 | $ 732 | $ 732 | $ 732 | $ 732 |
| 4163000 - Income from surplus money investments | $ 106 | $ 75 | $ 19 | $ 12 | $ 3 |
| 4171400 - Escheat of unclaimed checks and warrants | $ 5 | $ - | $ - | $ - | $ - |
| Totals, Revenues | $ 3,454 | $ 3,418 | $ 3,362 | $ 3,355 | $ 3,346 |
| **TOTALS, REVENUES, TRANSFERS AND OTHER ADJUSTMENTS** | $ 3,454 | $ 3,418 | $ 3,362 | $ 3,355 | $ 3,346 |
| **TOTAL RESOURCES** | $ 5,355 | $ 5,338 | $ 5,042 | $ 4,662 | $ 4,166 |
| Expenditures: | | | | | |
| 1111 Department of Consumer Affairs (State Operations) | $ 3,275 | $ 3,488 | $ 3,593 | $ 3,700 | $ 3,811 |
| 9892 Supplemental Pension Payments (State Operations) | $ 10 | $ 28 | $ - | $ - | $ - |
| 9900 Statewide General Administrative Expenditures (Pro | $ 150 | $ 142 | $ 142 | $ 142 | $ 142 |
| **TOTALS, EXPENDITURES AND EXPENDITURE ADJUSTMENTS** | $ 3,435 | $ 3,658 | $ 3,735 | $ 3,842 | $ 3,953 |
| **FUND BALANCE** | | | | | |
| Reserve for economic uncertainties | $ 1,920 | $ 1,680 | $ 1,307 | $ 820 | $ 213 |
| Months in Reserve | 6.2 | 5.4 | 4.1 | 2.5 | 0.6 |

**NOTES:**
1. Assumes workload and revenue projections are realized in CY and ongoing
2. Expenditure growth projected at 3% beginning BY.

## Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board - 0376

## FY 2025-26 BUDGET REPORT - FM 3 (Current Projection with Augmentation and Savings Estimated)

December 4 - 5, 2025 Board Meeting

| OBJECT DESCRIPTION | FY 2020-21 ACTUAL EXPENDITURES (Prelim FM13) | FY 2021-22 ACTUAL EXPENDITURES (Prelim FM13) | FY 2022-23 ACTUAL EXPENDITURES (Prelim FM13) | FY 2023-24 ACTUAL EXPENDITURES (Prelim FM13) | FY 2024-25 ACTUAL EXPENDITURES (Prelim FM13) | FY 2025-26 GOVERNOR'S BUDGET 2025-26 | FY 2025-26 CURRENT YEAR EXPENDITURES 9.30.2025 | FY 2025-26 % SPENT | FY 2025-26 PROJECTIONS TO YEAR END | FY 2025-26 UNENCUMBERED BALANCE |
|---|---|---|---|---|---|---|---|---|---|---|
| **PERSONNEL SERVICES** | | | | | | | | | | |
| Salary & Wages (Staff) | 599,726 | 746,598 | 842,376 | 809,790 | 887,678 | 984,000 | 224,818 | 23% | **952,077** | 31,923 |
| Statutory Exempt (EO) | 92,318 | 106,164 | 114,225 | 111,479 | 107,634 | 109,000 | 27,768 | 25% | **109,506** | (506) |
| Temp Help | 38,449 | 57,039 | 56,831 | 4,749 | 0 | 1,000 | 0 | 0% | **0** | 1,000 |
| Board Member Per Diem | 1,700 | 5,100 | 5,600 | 2,400 | 2,050 | 6,000 | 0 | 0% | **4,000** | 2,000 |
| Overtime/Flex Elect/Lump Sum | 54,620 | 67,286 | 67,655 | 75,927 | 45,100 | 5,000 | 7,239 | 145% | **20,000** | (15,000) |
| Staff Benefits | 418,932 | 489,282 | 582,080 | 581,545 | 582,291 | 673,000 | 166,407 | 25% | **699,383** | (26,383) |
| ***TOTALS, PERSONNEL SVC*** | **1,205,746** | **1,471,470** | **1,668,767** | **1,585,890** | **1,626,803** | **1,778,000** | **426,232** | **24%** | **1,784,966** | **(6,966)** |
| **OPERATING EXPENSE AND EQUIPMENT** | | | | | | | | | | |
| General Expense | 67,144 | 74,273 | 59,288 | 54,010 | 57,831 | 57,000 | 7,765 | 14% | **57,171** | (171) |
| Printing | 19,251 | 40,231 | 42,470 | 86,218 | 40,540 | 27,000 | 0 | 0% | **38,902** | (11,902) |
| Communication | 7,482 | 3,518 | 3,158 | 1,725 | 1,525 | 13,000 | 64 | 0% | **3,627** | 9,373 |
| Postage | 1,725 | 6,407 | 4,232 | 4,943 | 9,000 | 15,000 | 1,957 | 13% | **3,000** | 12,000 |
| Insurance | 158 | 22 | 17 | 23 | 23 | 0 | 0 | 0% | **23** | (23) |
| Travel In State | 9,148 | 11,088 | 15,381 | 15,534 | 35,339 | 27,000 | 0 | 0% | **35,000** | (8,000) |
| Training | 0 | 175 | 2,845 | 0 | 8 | 11,000 | 0 | 0% | **0** | 11,000 |
| Facilities Operations | 82,568 | 126,495 | 140,624 | 143,422 | 143,498 | 148,000 | 35,101 | 24% | **146,246** | 1,754 |
| C & P Services - Interdept. | 70 | 82 | 83 | 0 | 0 | 24,000 | 0 | 0% | **0** | 24,000 |
| **Attorney General** | **298,782** | **200,014** | **86,055** | **151,478** | **372,624** | **381,000** | **86,368** | **23%** | **380,198** | **802** |
| **Office Admin. Hearings** | **128,785** | **38,496** | **30,808** | **24,708** | **48,520** | **87,000** | **0** | **0%** | **86,872** | **128** |
| C & P Services - External | 79,957 | 64,415 | 73,311 | 103,164 | 141,852 | 116,000 | 18,621 | 16% | **113,669** | 2,331 |
| DCA Pro Rata | 355,665 | 463,371 | 138,234 | 441,400 | 749,862 | 531,000 | 276,500 | 52% | **531,000** | 0 |
| DOI - Investigations | 32,198 | 96,124 | 58,523 | 7,262 | 6,806 | 108,000 | 49,500 | 46% | **108,000** | 0 |
| Interagency Services | 2,196 | 118 | 621 | 633 | 519 | 1,000 | 157 | 16% | **536** | 464 |
| IA w/ OPES | 24,264 | 47,009 | 17,086 | 46,414 | 61,923 | 28,000 | | 0% | **36,484** | (8,484) |
| Consolidated Data Center | 14,553 | 20,198 | 23,753 | 23,517 | 7,081 | 29,000 | 0 | 0% | **7,081** | 21,919 |
| Information Technology | 5,210 | 4,171 | 5,115 | 8,928 | 15,334 | 17,000 | 10,749 | 63% | **59,926** | (42,926) |
| Equipment | 30,670 | 1,193 | 2,236 | 1,239 | 5,470 | 0 | 0 | 0% | **155** | (155) |
| Other Items of Expense | 2,553 | 1,746 | 2,076 | 462 | 620 | 15,000 | 0 | 0% | **548** | 14,452 |
| ***TOTALS, OE&E*** | **1,117,103** | **1,194,721** | **706,337** | **1,115,687** | **1,698,352** | **1,635,000** | **486,781** | 30% | **1,608,414** | **26,586** |
| ***TOTAL EXPENSE*** | **2,322,849** | **2,666,191** | **2,375,104** | **2,630,237** | **3,325,155** | **3,413,000** | **913,013** | 27% | **3,393,380** | **19,620** |
| Reimbursments | | | | | **33,000** | **0** | | | **33,000** | (33,000) |
| Budget Letter 24-20: Vacancy Reduction | | | | | 29,000 | **0** | 0 | | **0** | 0 |
| Budget Letter 24-24: 7.95% Budget Efficiency Reduction | | | | | 21,000 | **0** | 0 | | **0** | 0 |
| ***NET APPROPRIATION*** | | | | | 3,253,815 | **3,380,000** | 913,013 | 27% | **3,360,380** | **19,620** |
| | | | | | | | | | **SURPLUS/(DEFICIT):** | **0.58%** |

Updated 11/25/2025

**0376 - Speech-Language Pathology and Audiology and Hearing Aid Dispensers Fund**
**Analysis of Fund Condition**
**(Dollars in Thousands)**
**2025 Budget Act with FM 3 Projections**

**Prepared 11.25.2025**

| | Actual 2024-25 | CY 2025-26 | BY 2026-27 | BY +1 2027-28 | BY +2 2028-29 |
|---|---|---|---|---|---|
| **BEGINNING BALANCE** | $ 1,927 | $ 1,920 | $ 1,680 | $ 1,307 | $ 820 |
| Prior Year Adjustment | $ -26 | $ - | $ - | $ - | $ - |
| Adjusted Beginning Balance | $ 1,901 | $ 1,920 | $ 1,680 | $ 1,307 | $ 820 |
| **REVENUES, TRANSFERS AND OTHER ADJUSTMENTS** | | | | | |
| Revenues | | | | | |
| 4121200 - Delinquent fees | $ 37 | $ 34 | $ 34 | $ 34 | $ 34 |
| 4127400 - Renewal fees | $ 2,472 | $ 2,502 | $ 2,502 | $ 2,502 | $ 2,502 |
| 4129200 - Other regulatory fees | $ 75 | $ 75 | $ 75 | $ 75 | $ 75 |
| 4129400 - Other regulatory licenses and permits | $ 759 | $ 732 | $ 732 | $ 732 | $ 732 |
| 4163000 - Income from surplus money investments | $ 106 | $ 75 | $ 19 | $ 12 | $ 3 |
| 4171400 - Escheat of unclaimed checks and warrants | $ 5 | $ - | $ - | $ - | $ - |
| Totals, Revenues | $ 3,454 | $ 3,418 | $ 3,362 | $ 3,355 | $ 3,346 |
| **TOTALS, REVENUES, TRANSFERS AND OTHER ADJUSTMENTS** | $ 3,454 | $ 3,418 | $ 3,362 | $ 3,355 | $ 3,346 |
| **TOTAL RESOURCES** | $ 5,355 | $ 5,338 | $ 5,042 | $ 4,662 | $ 4,166 |
| Expenditures: | | | | | |
| 1111 Department of Consumer Affairs (State Operations) | $ 3,275 | $ 3,224 | $ 3,593 | $ 3,700 | $ 3,811 |
| 2025-26 AG/OAH Augmentation | $ - | $ 264 | $ - | $ - | $ - |
| 9892 Supplemental Pension Payments (State Operations) | $ 10 | $ 28 | $ - | $ - | $ - |
| 9900 Statewide General Administrative Expenditures (Pro | $ 150 | $ 142 | $ 142 | $ 142 | $ 142 |
| **TOTALS, EXPENDITURES AND EXPENDITURE ADJUSTMENTS** | $ 3,435 | $ 3,658 | $ 3,735 | $ 3,842 | $ 3,953 |
| **FUND BALANCE** | | | | | |
| Reserve for economic uncertainties | $ 1,920 | $ 1,680 | $ 1,307 | $ 820 | $ 212 |
| Months in Reserve | 6.2 | 5.4 | 4.1 | 2.5 | 0.6 |

**NOTES:**
1. Assumes workload and revenue projections are realized in CY and ongoing
2. Expenditure growth projected at 3% beginning BY.

Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board

Licensing Report 2025-26

| LICENSES ISSUED | FY 18/19 | FY 19/20 | FY 20/21 | FY 21/22 | FY 22/23 | FY 23/24 | FY 24/25 | FY 25/26 |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | QTR 1 |
| AIDE | 32 | 44 | 22 | 44 | 52 | 60 | 53 | 21 |
| AU | 63 | 63 | 71 | 79 | 51 | 89 | 98 | 57 |
| DAU | 35 | 31 | 23 | 28 | 26 | 33 | 31 | 13 |
| AUT | 4 | 3 | 1 | 4 | 1 | 0 | 2 | 0 |
| PDP | 15 | 5 | 13 | 14 | 10 | 29 | 19 | 6 |
| RPE | 977 | 1,059 | 1,039 | 1,177 | 1,095 | 1,469 | 1,305 | 716 |
| SLP | 1,446 | 1,444 | 1,621 | 1,782 | 1,664 | 2,129 | 2,296 | 642 |
| SPT | 0 | 0 | 0 | 1 | 1 | 4 | 3 | 1 |
| SLPA | 602 | 615 | 505 | 649 | 640 | 914 | 821 | 245 |
| HAD | 135 | 95 | 55 | 108 | 83 | 145 | 139 | 23 |
| HAD Trainee | 156 | 116 | 93 | 124 | 142 | 173 | 153 | 33 |
| HAD Licensed in Another State | 17 | 12 | 11 | 22 | 7 | 13 | 13 | 6 |
| HAD Branch | 333 | 312 | 249 | 263 | 162 | 256 | 247 | 44 |
| TRP (Military Temporary) | N/A | N/A | N/A | N/A | N/A | 0 | 1 | 0 |
| TSA (Military Temporary) | N/A | N/A | N/A | N/A | N/A | 2 | 0 | 0 |
| TSP (Military Temporary) | N/A | N/A | N/A | N/A | N/A | 6 | 0 | 0 |
| ***TOTAL LICENSES ISSUED*** | **3,783** | **3,755** | **3,681** | **4,251** | **3,934** | **5,322** | **5,181** | **1,807** |

| LICENSEE POPULATION | FY 18/19 | FY 19/20 | FY 20/21 | FY 21/22 | FY 22/23 | FY 23/24 | FY 24/25 | FY 25/26 |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | QTR 1 |
| AIDE | 245 | 273 | 290 | 306 | 310 | 344 | 295 | 301 |
| AU | 831 | 837 | 830 | 869 | 840 | 869 | 907 | 943 |
| DAU | 1,334 | 1,384 | 1,375 | 1,416 | 1,453 | 1,487 | 1,505 | 1,528 |
| *Both License Types* | *2,165* | *2,221* | *2,205* | *2,285* | *2,293* | *2,356* | *2,412* | *2,471* |
| AUT | 4 | 7 | 8 | 8 | 7 | 7 | 8 | 8 |
| PDP | 178 | 165 | 160 | 152 | 141 | 160 | 161 | 161 |
| RPE | 1,364 | 1,595 | 1,626 | 1,740 | 1,871 | 2,304 | 1,656 | 1,942 |
| SLP | 21,374 | 22,527 | 23,309 | 24,894 | 25,929 | 27,403 | 28,956 | 29,488 |
| SPT | 0 | 0 | 0 | 1 | 1 | 5 | 5 | 6 |
| SLPA | 4,822 | 5,297 | 5,538 | 5,962 | 6,260 | 6,825 | 7,215 | 7,362 |
| HAD | 1,380 | 1,407 | 1,398 | 1,439 | 1,399 | 1,429 | 1,479 | 1,485 |
| HAD Trainees | 214 | 237 | 243 | 267 | 297 | 314 | 227 | 248 |
| HAD Licensed in Another State | 31 | 42 | 47 | 66 | 59 | 66 | 72 | 76 |
| HAD Branch Office | 1,347 | 1,401 | 1,411 | 1,429 | 1,267 | 1,297 | 1,256 | 1,280 |
| TRP (Military Temporary) | N/A | N/A | N/A | N/A | N/A | 0 | 1 | 1 |
| TSA (Military Temporary) | N/A | N/A | N/A | N/A | N/A | 2 | 0 | 0 |
| TSP (Military Temporary) | N/A | N/A | N/A | N/A | N/A | 4 | 0 | 0 |
| ***TOTAL LICENSEES*** | **32,879** | **34,899** | **35,945** | **38,243** | **39,834** | **42,516** | **43,743** | **44,829** |

* Data as of October 1, 2025

Legend:

AID = Speech-Language Pathology/Audiology
AU = Audiologist
DAU = Dispensing Audiologist
AUT = Audiologist (6-month Temporary)
PDP = Continuing Education Provider
RPE = Required Professional Experience
SP = Speech-Language Pathologist
SPT = Speech-Language Pathologist (6-Month
SPA = Speech-Language Pathology Assistant
HAD = Hearing Aid Dispenser
HTL = Hearing Aid Dispenser Temporary (1-year)
HT = Hearing Aid Dispenser Trainee
BR = Hearing Aid Dispenser Branch
TIA = Military Spouse/Domestic Partner 1- Year Temporary AID
TAU = Military Spouse/Domestic Partner 1- Year Temporary AU
TRP = Military Spouse/Domestic Partner 1- Year Temporary RPE
TSP = Military Spouse/Domestic Partner 1- Year Temporary SP
TSA = Military Spouse/Domestic Partner 1- Year Temporary SPA
THA = Military Spouse/Domestic Partner 1- Year Temporary HAD
THT = Military Spouse/Domestic Partner 1- Year Temporary HT

# Hand Carry Item

Agenda Item 12(g):
Executive Officer's Report:
Enforcement Report

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD
1601 Response Road, Suite 260, Sacramento, CA 95815
P (916) 287-7915 | www.speechandhearing.ca.gov

# MEMORANDUM

| | |
|---|---|
| DATE | November 10, 2025 |
| TO | Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board |
| FROM | Maria Liranzo, Legislation/Regulation/Budget Analyst |
| SUBJECT | Agenda Item 13 Regulatory Report: Update, Review, and Possible Action on Board Regulation Packages |

The following is a list of the Board's regulatory packages and their status in the rulemaking process:

**a) Processing Times as Stated in Title 16, CCR Sections 1399.113, 1399.141, 1399.151.1, 1399.153.2, 1399.160.6, 1399.170.4, and 1399.170.13**

| Regulation Development | Preparing Regulatory Package | Departmental Review | OAL Public Comment Period | Finalizing Regulatory Package | DCA Regulations Final Review | Final Departmental Review | Submission to OAL for Review | OAL Decision |
|---|---|---|---|---|---|---|---|---|

The Office of Administrative Law (OAL) approved and filed the rulemaking with the Secretary of State on September 23, 2025. The regulatory changes will become effective on January 1, 2026.

This regulatory change will remove processing times and references to processing times in multiple regulation sections.

**b) Audiology Licensing Requirements Related to Supervised Clinical Experience as stated in Title 16, CCR section 1399.152.2**

| Regulation Development | Preparing Regulatory Package | Departmental Review | OAL Public Comment Period | Finalizing Regulatory Package | DCA Regulations Final Review | Final Departmental Review | Submission to OAL for Review | OAL Decision |
|---|---|---|---|---|---|---|---|---|

OAL approved and filed the rulemaking with the Secretary of State on September 22, 2025. The regulatory changes will become effective on January 1, 2026.

This regulatory change will codify the number of clock hours of supervised clinical practice required for audiology licensure applicants who have completed an audiology doctoral program.

### c) Hearing Aid Dispensers Trainee and Temporary Licensee Supervision as stated in Title 16, CCR sections 1399.102 and 1399.115 through 1399.119

| Regulation Development | Preparing Regulatory Package | Departmental Review | OAL Public Comment Period | Finalizing Regulatory Package | DCA Regulations Final Review | Final Departmental Review | Submission to OAL for Review | OAL Decision |
|---|---|---|---|---|---|---|---|---|

The Board approved revisions to the proposed regulatory text on August 25, 2023. As of May 1, 2024, Board staff is preparing the regulatory package for Departmental Review. The proposed rulemaking is on hold for the preparation and submission of other pressing regulations.

This proposed regulatory change will clarify that supervision is required for the entire duration of the trainee or temporary license, specify different levels of supervision, require a higher level of supervision during the first ninety (90) days of supervision, specify tasks and knowledge supervisors must provide to trainees, require supervisors to complete a training in supervision, specify criteria to request a waiver to supervise more than one trainee or temporary license holder, make requirements applicable to all temporary license types who require supervision, and make requirements applicable to all license types who can supervise.

### d) General Application Requirements and Hearing Aid Dispensers and Dispensing Audiologists Examination Requirements as Stated in Title 16, California Code of Regulations (CCR) Sections 1399.112, 1399.120, 1399.121, 1399.122, and 1399.152.4

| Regulation Development | Preparing Regulatory Package | Departmental Review | OAL Public Comment Period | Finalizing Regulatory Package | DCA Regulations Final Review | Final Departmental Review | Submission to OAL for Review | OAL Decision |
|---|---|---|---|---|---|---|---|---|

The Board approved revisions to the proposed regulatory text on December 1, 2023. As of April 19, 2024, Board staff is preparing the regulatory package for Departmental Review. The proposed rulemaking is on hold for the preparation and submission of other pressing regulations.

This proposed regulatory change will codify general application requirements such as the expedited licensure process, make current the written and practical examinations process, codify the written and practical examination application forms and their examination fees, change the practical examination appeal deadline, specify a deadline for the Board to notify an applicant of its decision on their practical examination appeal, and change the hearing aid dispenser examination requirement for applicants of a dispensing audiology license.

### e) Approved Institutions as stated in Title 16, CCR section 1399.152

| Regulation Development | Preparing Regulatory Package | Departmental Review | OAL Public Comment Period | Finalizing Regulatory Package | DCA Regulations Final Review | Final Departmental Review | Submission to OAL for Review | OAL Decision |
|---|---|---|---|---|---|---|---|---|

The Board approved revisions to the proposed regulatory text on August 25, 2023. As of August 13, 2024, Board staff is preparing the regulatory package for Departmental Review. The proposed rulemaking is on hold for further analysis.

This proposed regulatory change will permit the Board to review and approve accrediting bodies that wish to provide accreditation to programs where individuals can complete their academic and clinical requirements for licensure in the practices of speech-language pathology or audiology.

**f) Fingerprinting Requirements as stated in Title 16, CCR sections 1399.112, 1399.151.2, and 1399.170.14**

| Regulation Development | Preparing Regulatory Package | Departmental Review | OAL Public Comment Period | Finalizing Regulatory Package | DCA Regulations Final Review | Final Departmental Review | Submission to OAL for Review | OAL Decision |
|---|---|---|---|---|---|---|---|---|

The Board approved revisions to the proposed regulatory text on May 13, 2022. As of September 9, 2022, Board staff is preparing the regulatory package for Departmental Review. The proposed rulemaking is on hold due to fiscal impact.

This proposed regulatory change will require licensees who were initially licensed prior to January 1, 1999, or for whom an electronic fingerprints record does not exist, to be fingerprinted as a condition of renewal.

Attachment: Stages of the Regulatory Process

# Regulatory Report Attachment - Stages of the Regulatory Process

The Department of Consumer Affairs (DCA) has a four-phase process to approve regulatory packages: (1) Concept; (2) Production; (3) Initial and (4) Final.

## (1) CONCEPT PHASE

| Regulation Development | Preparing Regulatory Package | Departmental Review | OAL Public Comment Period | Finalizing Regulatory Package | DCA Regulations Final Review | Final Departmental Review | Submission to OAL for Review | OAL Decision |
|---|---|---|---|---|---|---|---|---|

**Regulation Development:** The first stage of the regulatory process is to develop the regulatory proposal. This is known as the concept phase. Regulations may be required to implement a new law or regulatory changes may be necessary to address an issue raised by Board members, Board staff, the Legislature, licensees, or other stakeholders. In this phase, the Board and/or Board Committee(s) may work on drafting regulatory language, Board staff will work with DCA Legal staff to address any concerns with the draft regulatory text, and the Board will ultimately adopt the regulatory language.

## (2) PRODUCTION PHASE

| Regulation Development | Preparing Regulatory Package | Departmental Review | OAL Public Comment Period | Finalizing Regulatory Package | DCA Regulations Final Review | Final Departmental Review | Submission to OAL for Review | OAL Decision |
|---|---|---|---|---|---|---|---|---|

**Preparing Regulatory Package:** In this stage, Board staff are working on preparing the required regulatory documents including the Notice of Proposed Regulatory Action, Initial Statement of Reasons, and the Economic and Fiscal Impact Statement. Board staff review Board meeting materials, webcasts, and meeting minutes to assist in the development of these documents which must justify why the regulatory changes are necessary. Board staff may also work closely with DCA's Budget Office to develop the Economic and Fiscal Impact Statement.

In this stage, Board staff work collaboratively with DCA Regulations Counsel. DCA Regulations Counsel propose recommended changes to the regulatory documents (Note: Since the regulatory text is already approved at this time, ideally, there should be no changes to the text. Regulatory Counsel would have already reviewed and sought second-level review of the text to ensure the language is clear, concise, non-repetitive, etc.). Board staff then incorporate recommended changes prior to submitting the regulatory package back to the Board's Regulations Counsel. Board staff may also meet with Regulations Counsel and/or Budget Staff to provide additional information about the Board's licensing or enforcement processes in relation to the proposed regulation. At this stage, Legal and Budget approval of the package is obtained. (i.e., Regulatory Counsel approves the package and Budgets signs off on Form 399.)

| Regulation Development | Preparing Regulatory Package | Departmental Review | OAL Public Comment Period | Finalizing Regulatory Package | DCA Regulations Final Review | Final Departmental Review | Submission to OAL for Review | OAL Decision |
|---|---|---|---|---|---|---|---|---|

**Departmental Review:** Upon approval by the Board's Regulations Counsel and DCA Budget staff, the entire regulatory package is submitted to the Regulations Coordinator, who then prepares the package for the DCA Director and the Business, Consumer Services and Housing Agency's review and approval. Throughout this stage, additional changes to the regulatory language and/or regulatory documents may be requested by DCA or the Business, Consumer Services and Housing Agency.

## (3) INITIAL PHASE

| Regulation Development | Preparing Regulatory Package | Departmental Review | OAL Public Comment Period | Finalizing Regulatory Package | DCA Regulations Final Review | Final Departmental Review | Submission to OAL for Review | OAL Decision |
|---|---|---|---|---|---|---|---|---|

**OAL Public Comment Period:** Upon approval by the Business, Consumer Services and Housing Agency, the regulatory proposal will be submitted to the Office of Administrative Law (OAL) to be published in the California Regulatory Notice Register. This commences the initial phase of the process. OAL publishes the Notice Register every Friday and the publication date starts the formal 45-day public comment period as well as the one-year deadline to submit the completed rulemaking file to OAL. If the Board makes changes to the regulatory language in response to public comments, the regulatory proposal must be made available to the public for an additional 15-day.

## (4) FINAL PHASE

| Regulation Development | Preparing Regulatory Package | Departmental Review | OAL Public Comment Period | Finalizing Regulatory Package | DCA Regulations Final Review | Final Departmental Review | Submission to OAL for Review | OAL Decision |
|---|---|---|---|---|---|---|---|---|

**Finalizing Regulatory Package:** The Board must respond in writing to every comment received during the public comment period. In this stage, Board staff work with the Board's Regulations Counsel to develop proposed responses to the public comments, which must be approved by the Board. Board staff then prepare the Final Statement of Reasons which must outline any changes made to the regulatory language and updates to any information contained in the Initial Statement of Reasons such as changes to the fiscal and/or economic impact or additional materials to include in the record. The Final Statement of Reasons will also include the Board's approved responses to the public comments.

| Regulation Development | Preparing Regulatory Package | Departmental Review | OAL Public Comment Period | Finalizing Regulatory Package | DCA Regulations Final Review | Final Departmental Review | Submission to OAL for Review | OAL Decision |
|---|---|---|---|---|---|---|---|---|

**DCA Regulations Final Review:** Upon completion of the Final Statement of Reasons, Board staff submits the entire regulatory proposal to the Board's Regulations Counsel for final review. In this stage, Board staff work collaboratively with the Board's Regulations Counsel. The Regulations Counsel may propose recommended changes to the Final Statement of Reasons or request additional underlying documents. Board staff will work with the Board's Regulations Counsel to address any concerns prior to the final submission to DCA.

| Regulation Development | Preparing Regulatory Package | Departmental Review | OAL Public Comment Period | Finalizing Regulatory Package | DCA Regulations Final Review | Final Departmental Review | Submission to OAL for Review | OAL Decision |
|---|---|---|---|---|---|---|---|---|

**Final Departmental Review:** Upon approval by the Board's Regulations Counsel, Board staff submits the entire regulatory package for the Final Departmental Review which involves reviews by the DCA Director, DCA Budget Office, and the Business, Consumer Services and Housing Agency (Note: Agency review may not be required if there are no comments or the comments do not result in substantive modifications to the text). Throughout this stage, additional documents may be requested or changes to the regulatory documents may be requested by DCA or the Business, Consumer Services and Housing Agency.

| Regulation Development | Preparing Regulatory Package | Departmental Review | OAL Public Comment Period | Finalizing Regulatory Package | DCA Regulations Final Review | Final Departmental Review | Submission to OAL for Review | OAL Decision |
|---|---|---|---|---|---|---|---|---|

**Submission to OAL for Review:** Upon approval by the Business, Consumer Services and Housing Agency, the completed rulemaking file is submitted to OAL. OAL has 30 working days to approve or deny the regulatory proposal. During this stage, Board staff will work with the OAL Attorney to address any concerns with the regulatory documents or make non-substantive changes to the regulatory language. Board and DCA staff may also work with the Department of Finance to obtain approval of the Economic and Fiscal Impact Statement.

| Regulation Development | Preparing Regulatory Package | Departmental Review | OAL Public Comment Period | Finalizing Regulatory Package | DCA Regulations Final Review | Final Departmental Review | Submission to OAL for Review | OAL Decision |
|---|---|---|---|---|---|---|---|---|

**OAL Decision:** Unless the Board requested an early effective date, upon approval by OAL, regulations become effective on one of four quarterly dates based on when OAL files the final regulations with the Secretary of State (SOS). Following approval by OAL, Board staff will work internally to implement the new regulations.

| OAL Decision Date and Filing with SOS | Effective Date |
|---|---|
| September 1 to November 30 | January 1st |
| December 1 to February 29 | April 1st |
| March 1 to May 31 | July 1st |
| June 1 to August 31 | October 1st |

SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD
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# MEMORANDUM

| | |
|---|---|
| DATE | November 25, 2025 |
| TO | Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board |
| FROM | Cherise Burns, Executive Officer |
| SUBJECT | Agenda Item 14: Discussion and Possible Action on the Board's 2026 Sunset Review Report |

## Background

Each year, the Assembly Business and Professions Committee and the Senate Business, Professions, and Economic Development Committee hold joint Sunset Review oversight hearings to review the boards and bureaus under the Department of Consumer Affairs (DCA). The sunset review process provides the opportunity for DCA, the Legislature, the boards and bureaus, and stakeholders to discuss the performance of the boards and bureaus, make recommendations for improvements, and extend the sunset date of a board or bureau. The Board's sunset date and provisions can be found in Business and Professions Code section 2531, which is currently January 1, 2027. A full timeline is provided below.

Sunset Review Report and Oversight Hearing Timeline:

- Summer 2025 –
  - Board staff receive Sunset Review questions from Legislature
  - Board considers potential legislative proposals for inclusion in the Sunset Bill
- Fall 2025 –
  - Sunset Review Ad Hoc Committee and Board leadership develop Sunset Review Report for Board consideration
  - Board reviews and approves Sunset Review Report by December 2025
- Winter 2026 – Board leadership meets with Legislative Offices regarding Board's Sunset Review Report
- Spring 2026 – Sunset Review Oversight Hearings – Board Chair and Executive Officer speak on the Board's behalf
- Summer 2026 – Sunset Bills make their way through the Legislature
- Fall 2026 – Sunset Bills are approved by the Legislature and then signed by the Governor
- January 1, 2027 – Board's new sunset date becomes effective

## Sunset Review Ad Hoc Committee Actions

Board leadership started preparing the necessary data and documentation during the Summer and Fall of 2025 and met with the Sunset Review Ad Hoc Committee (Committee) in October 2025 to begin review of draft materials. In October and November of 2025, the Committee reviewed and revised each section of the draft Sunset Review Report before approving the draft for presentation to the full Board for review and approval at the December 2025 Board Meeting.

Attached for the Board's review is the draft 2026 Sunset Review Report as approved by the Committee. This report is required to be submitted to the Senate Committee on Business, Professions and Economic Development and Assembly Committee on Business and Professions by January 5th, 2026. To have the report printed by this deadline, Board staff must submit the final version of the report to DCA's Digital Print Services teams by December 12, 2025.

## Board Discussion Item

At the Hearding Aid Dispensing Committee's May 2025 Board Meeting, it was determined that allowing a hearing aid trainee to maintain a branch office license pursuant to BPC section 2538.34 would be inconsistent with BPC section 2538.30, which prohibits the management or independent operation of a business that engages in the fitting or sale of hearing aids by temporary and trainee licensees, and suggested that statutory changes should be considered. The Hearing Aid Dispensing Committee also determined that the word "maintain", as used in BPC section 2538.34, may not accurately capture the situation a hearing aid dispenser trainee may be in and suggested that statutory changes should also be considered.

At its August 2025 meeting, the Hearing Aid Dispensing Committee approved the proposed language in Section 10, bullet point "New issues not previously discussed in this report," subdivision (b), for inclusion in the Board's Sunset Review Report.

## Action Requested

The Board should discuss the Board Discussion Item first for potential inclusion in the Board's Sunset Review Report. The Board may wish to determine whether to approve the legislative proposal to be included as part of the Board's Sunset Review Report. If accepted, move to adopt the legislative proposal as part of the Board's Sunset Review as noticed/amended.

The Board should then go section by section, to review, discuss, and amend the draft Sunset Review Report (Attached) for submission to the Legislature. After review, discussion, and revisions are made, move to approve the Sunset Review Report, as amended, and delegate to the Executive Officer to make technical or editorial changes necessary for submission by the January 5, 2026 deadline.

Attachments:

1. Draft Sunset Review Report
2. Attachment A – Board Administrative Manual
3. Attachment B – Board Organizational Structure/Chart
4. Attachment C – Major Studies completed by the Board
5. Attachment D – Year-end Organization Charts for Last Four Fiscal Years
6. Attachment E – Board 2025 – 2028 Strategic Plan

# SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD

## BACKGROUND INFORMATION AND OVERVIEW OF THE CURRENT REGULATORY PROGRAM

## As of December 5, 2025

## Section 1 – Background and Description of the Board and Regulated Profession

Provide a short explanation of the history and function of the board.[1] Describe the occupations/professions that are licensed and/or regulated by the board (Practice Acts vs. Title Acts).[2]

**Function of the Board**

The Board serves to protect the public by licensing and regulating Speech-Language Pathologists, Audiologists, and Hearing Aid Dispensers; three separate and distinct professions with their own scopes of practice and professional settings. The Board sets entry-level licensing standards, which includes examination requirements that measure the candidate's professional knowledge and clinical abilities that are consistent with the demands of the current delivery systems.

Speech-Language Pathologists provide services in the areas of speech, language, cognition, swallowing disorders, and voice to individuals across the lifespan. They provide services to individuals who have speech difficulties with respiratory, phonatory, resonance, articulation, and fluency. These difficulties may be the result of neurogenic or structural etiologies. Services are provided to individuals who have language difficulties affecting verbal expression, auditory comprehension, reading comprehension, or written expression. Speech-Language Pathologists also provide services to individuals with cognition difficulties affecting skills such as memory, attention, problem solving, reasoning, and sequencing. These difficulties could be a result of stroke, head injury, or neurogenic cause. Speech-Language Pathologists provide services to individuals who demonstrate problems with swallowing (dysphagia). These difficulties may be a result of neurological impairment, head/neck cancer or surgeries, tracheostomy, or developmental disorder. They also provide services to individuals who have voice disorders due to abuse or misuse of their voice, neurological impairment, head/neck cancer or surgery, or tracheostomy. Speech-Language Pathologists perform instrumental procedures within their scope of practice (e.g., Motion fluoroscopic evaluation of swallowing by cine or video recording, Flexible Fiberoptic Endoscopic Evaluation of Swallowing by cine or videorecording, laryngoscopy with stroboscopy). Speech-Language Pathologists coordinate care with otolaryngologists and physicians for such procedures. Speech-Language Pathologists also provide aural rehabilitation for individuals who are deaf or hard of hearing and provide therapy in the augmentative and alternative communication domain for individuals with diagnoses such as autism spectrum disorder and progressive neurological disorders. Speech-Language Pathologists work independently and collaboratively on interdisciplinary teams with other school or health care professionals in a range of settings including schools, medical, community-based facilities, and in private practice.

[1] The term "board" in this document refers to a board, bureau, commission, committee, council, department, division, program, or agency, as applicable. Please change the term "board" throughout this document to appropriately refer to the entity being reviewed.
[2] The term "license" in this document includes a license, certificate, permit or registration.

Audiologists provide services for individuals with hearing and balance (vestibular) disorders across the lifespan. They see individuals who may have difficulty with auditory processing skills, diminished hearing sensitivity, tinnitus (ringing in the ears), deafness, balance deficits, tumors impacting the auditory system, and medically complex individuals requiring specialized interventions. Audiologists work in various professional settings including; hospitals that provide newborn hearing screenings, pediatric clinics, university and hospital audiology clinics, private practice, professional retail, military facilities, academic institutions, and industrial, research, and forensic settings. More recently, there are an increasing number of Audiologists who participate in intraoperative neuromonitoring in the operating rooms of the state's leading hospitals. Audiologists are experts in an array of assistive technologies designed to provide individuals with access to sound, including cochlear implants, bone-anchored hearing systems, hearing aids, remote microphones and other listening aids. They provide all services to include fitting, selection, programming, and counseling on use and care of all such devices. Dispensing Audiologists are licensed to complete the sale of hearing aids for populations that range from infants to the elderly.

Hearing Aid Dispensers provide services primarily to adult individuals with hearing loss, and children over the age of sixteen. They see adults with diminished hearing sensitivity to specifically test hearing for the purpose of fitting, selecting, and programming hearing aids. Hearing Aid Dispensers are experts in an array of assistive technologies designed to provide individuals with access to sound, including hearing aids, remote microphones and other listening aids used to assist individuals with hearing in challenging environments. They provide counseling on the use and care of hearing devices as well as on-going support and programming. Hearing Aid Dispensers primarily work in professional retail settings. Under specified circumstances, Hearing Aid Dispensers may work with individuals younger than the age of sixteen (e.g., replacing a hearing aid).

To ensure ongoing consumer protection, the Board enforces standards of professional conduct by investigating applicant backgrounds, investigating complaints against licensed and unlicensed practitioners, and taking disciplinary action whenever appropriate.

As of July 1, 2025, the Board's licensing population is over 44,800 individuals and entities. According to the Occupational Outlook Handbook published by the U.S. Department of Labor's Bureau of Labor Statistics, the Speech-Language Pathologist profession is expected to grow by 15 percent, the Audiologist profession by nine (9) percent, and the Hearing Aid Dispenser profession by 18 percent in the United States from 2024-2034.

The growth rates for California have been higher than the U.S. rate in the past and are expected to continue to increase. California's demand for Speech-Language Pathologists, Audiologists, and Hearing Aid Dispensers will continue to grow in the coming years due to an aging population who will experience hearing loss, as well as those who will suffer strokes and other debilitating illnesses. In addition, there is a growing need for speech-language pathology services in California schools. This consumer demand will make the role of the Board even more critical to ensure the safety and efficacy of these professions.

It is imperative that the Board balance its education, outreach, and enforcement efforts to ensure that the Board policies are current and consistent with the acceptable standard of care in each discipline.

The Board believes the level of education and experience required to secure a license assures the public that these licensees are well trained and able to deliver the appropriate level of service. At the same time, the potential for harm to consumers in these professions is significant as testing and

evaluation involves the use of sound, air pressure, electricity, and other physical stimuli in the ear and to the head. Speech-language pathology patients are at risk of aspiration of food or liquids into their lungs when undergoing swallowing evaluations. Audiologists insert a variety of instruments into the ear canal, and there is a risk of physical harm such as punctures of the skin in the ear, ear canal, ear drum and allergic reactions by electrodes or electrode paste. Likewise, hearing aid consumers can suffer damage to their ears if dispensers are not qualified or trained properly to perform otoscopy or take ear impressions for hearing aids.

The Board is responsible for regulating the following license types and categories:

- Speech-Language Pathologist [Business and Professions Code (BPC) Section 2530.2(d)-(g)] – licensed to provide assessment and therapy for individuals who have speech, language, swallowing, and voice disorders.

- Audiologist [BPC Section 2530.2(j)-(k)] – licensed to identify hearing, auditory system, and balance disorders, and provide rehabilitative services, including hearing aids and other assistive listening devices.

- Dispensing Audiologist [BPC Section 2530.2(l)] – licensed to perform the duties of an Audiologist as described above and authorized to sell hearing aids.

- Speech-Language Pathology Assistant (SLPA) [BPC Sections 2530.2(i), 2538-2538.7] – registered paraprofessionals who complete formal education and training and serve under the direction of a licensed Speech-Language Pathologist.

- Required Professional Experience Temporary License [BPC Sections 2532.2(d), 2532.25, & 2532.7] – speech-language pathology and audiology applicants completing required professional experience to qualify for full licensure, practicing under the supervision of a licensed practitioner.

- Speech-Language Pathology Aide [BPC Section 2530.2(h)] – support personnel approved to work directly under the supervision of a Speech-Language Pathologist. No requirement for formal education and training, but on-the-job training must be provided.

- Audiology Aide [BPC Section 2530.2(m)] – support personnel approved to work under the supervision of a licensed Audiologist. No requirement for formal education and training, but on-the-job training must be provided.

- Speech-Language Pathology or Audiology Temporary License [BPC Section 2532.3] – Speech-Language Pathologist or Audiologist, licensed in another state, who qualifies for a six-month license while seeking permanent licensure.

- Hearing Aid Dispenser [BPC Section 2538.11] – licensed to fit and sell hearing aids, take ear mold impressions, postfitting procedures, and directly observe the ear and test hearing in connection with the fitting and selling hearing aids.

- Hearing Aid Dispenser Temporary License [BPC Section 2538.27] – Hearing Aid Dispenser, licensed in another state, who qualifies for a 12-month temporary license while seeking permanent licensure.

- Hearing Aid Dispenser Trainee License [BPC Section 2538.28] – allows a Hearing Aid Dispenser trainee applicant to work under the supervision of a licensed Hearing Aid Dispenser for up to 18 months.

- Branch License [BPC Section 2538.34] – licenses issued to Hearing Aid Dispensers authorizing the dispenser to work at additional branch locations.

The Board is also responsible for the approval of the following:

- SLPA Training Program [BPC Section 2538.1] – Board-approved training/educational programs.

- Continuing Professional Development (CPD) Providers [BPC Section 2532.6] – entities that offer CPD courses required for license renewal of speech-language pathology and audiology licensees.

- Continuing Education Courses (CE) [BPC Section 2538.18] – CE courses offered to Hearing Aid Dispensers required for license renewal.

**History of the Hearing Aid Dispensers Examining Committee**

In 1970, legislation was passed (Chapter 1514, Statutes of 1970) that added Section 651.4 to Division 2 of the BPC to establish the Hearing Aid Dispensers Examining Committee (HADEC), under the jurisdiction of the Medical Board of California (MBC). The intent of the HADEC was to prepare, grade, and conduct examinations of applicants for a Hearing Aid Dispenser's license. The MBC was responsible for the HADEC's enforcement program including any disciplinary actions.

In 1988, legislation was passed (SB 225, Chapter 1162, Statutes of 1988), which transferred authority from the MBC to the HADEC, to administer the enforcement program. The legislation also allowed Hearing Aid Dispensers to use fictitious names for fitting and selling hearing aids but prohibited licensees from owning or having interest in a hearing aid dispensing business if their license had been suspended or revoked.

In 1996, SB 1592 (Chapter 441, Statutes of 1996) provided HADEC the authority to adopt, amend or repeal regulations related to the practice of fitting or selling hearing aid devices.

During the 1997-98 legislative session, the HADEC and the Speech-Language Pathology and Audiology Board (SLPAB) were reviewed by the Joint Legislative Sunset Review Committee (Joint Committee). The Joint Committee raised the issue of merging the two programs but voted against the idea. Two bills were introduced in 1998 (SB 1982 and AB 2658) which would have extended the regulation of Hearing Aid Dispensers. One proposal merged the HADEC with the SLPAB, while the other extended the sunset date of the Committee. Both bills failed and the HADEC was sunset.

In 1999, the Department of Consumer Affairs (DCA) assumed responsibility for regulating hearing aid dispensing.

In 2000, legislation was chaptered creating the Hearing Aid Dispensers Bureau within DCA and converted the former Commission to an Advisory Committee made up of professional members to provide input and recommendations regarding policy and regulatory issues to the DCA Director.

**History of the Speech-Language Pathology and Audiology Board (SLPAB)**

The SLPAB (formerly a Committee) was created in 1973 and enacted in 1974 under the jurisdiction of the MBC (Chapter 5.3, Statutes of 1974, BPC Section 2530 et seq.). As recently as 2010, the Board regulated the speech-language pathology and audiology professions, which are two separate professions, each with individual scopes of practice, entry-level requirements, and descriptive titles.

On July 1, 1999, the SLPAB was sunset and became a program under DCA due to the failure of Senate Bill (SB) 1982 (merger bill referenced above). Subsequently, Assembly Bill (AB)124, introduced in the 1998-99 legislative session, passed, and restored the SLPAB as a Board effective January 1, 2000.

**Merger of the Hearing Aid Dispensers Bureau and the Speech-Language Pathology and Audiology Board**

On October 11, 2009, Governor Schwarzenegger signed Assembly Bill 1535 which merged the Hearing Aid Dispensers Bureau into the Speech-Language Pathology and Audiology Board to create the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board (Board) (BPC Section 2531), effective January 1, 2010.

1. Describe the make-up and functions of each of the board's committees (cf., Section 12, Attachment B).

   To balance the professional expertise and public input on the Board, the governance structure of the Board consists of two Speech-Language Pathologists; two Audiologists, one of whom must be a Dispensing Audiologist; two Hearing Aid Dispensers; and three public members, one of which who must be a licensed, Board-certified physician and surgeon in otolaryngology. Each of these members (except two public members) are appointed by the Governor. One public member is appointed by the Senate Rules Committee and one by the Speaker of the Assembly.

   The Board has four standing committees that address issues and changes in the respective practices of speech-language pathology, audiology, and hearing aid dispensing. The members of these committees are appointed by the Board Chair, and the structure of these committees is at the Board Chair's discretion.

   Two distinct standing committees for hearing aid dispensing exist: Hearing Aid Dispensing Committee and Hearing Aid Dispensers Practice Committee. The Hearing Aid Dispensing Committee was previously statutorily mandated but repealed by AB 2686 (Chapter 415, Statutes of 2022) due to issues with quorum. The Board continues to task this committee with reviewing and researching the practice of fitting or selling hearing aids and advises the board about this practice based on that review and research but with a membership that allows for quorum on a regular basis. The Hearing Aid Dispensers Practice Committee is tasked to address issues and changes impacting only licensed Hearing Aid Dispensers and not Dispensing Audiologists.

   The Board also has three ad hoc committees consisting of two members for the purpose of working with staff to research and gather information on Board issues related to enforcement, legislation, and Sunset Review. Due to the Board's limited resources, these informal meetings are a cost-efficient means of gathering information for discussion by the full Board, which enhances the process of the Board's public meetings and addresses the needs of the professions and consumers in California. If the Board requires additional information, it invites interested parties to either a Board or committee meeting to provide the needed input and information.

The Board's current committees and their membership are provided below:

| **Board Committee Membership and Structure** | | |
|---|---|---|
| **Audiology Practice Committee (Standing)** | | |
| Description: Addresses changes in practice patterns and recommends position statements and/or scope of practice amendments for consideration. | | |
| **Member Name** | **Position** | **Member Type** |
| Amy White | Chair | DAU Member |
| Charles Sanders | Member | DAU Member |
| Tamara Chambers | Member | ORL/Public Member |
| Karen Chang | Member | Public Member |
| **Hearing Aid Dispensers Practice Committee (Standing)** | | |
| Description: Addresses changes in practice patterns and recommends position statements and/or scope of practice amendments for consideration. | | |
| **Member Name** | **Position** | **Member Type** |
| Tod Borges | Chair | HAD Member |
| VACANT | Member | HAD Member |
| Karen Chang | Member | Public Member |
| **Speech-Language Pathology Practice Committee (Standing)** | | |
| Description: Addresses changes in practice patterns and recommends position statements and/or scope of practice amendments for consideration. | | |
| **Member Name** | **Position** | **Member Type** |
| Gilda Dominguez | Chair | SLP Member |
| Francis David | Member | SLP Member |
| Tamara Chambers | Member | ORL/Public Member |
| **Hearing Aid Dispensing Committee (Standing)** | | |
| Description: Provides policy and regulatory guidance with respect to HAD practices and recommends scope of practice amendments for consideration. | | |
| **Member Name** | **Position** | **Member Type** |
| Tod Borges | Chair | HAD Member |
| VACANT | Member | HAD Member |
| Charles Sanders | Member | DAU Member |
| Amy White | Member | DAU Member |
| Tamara Chambers | Member | ORL/Public Member |
| **Enforcement Committee (Ad Hoc)** | | |
| Description: Review and recommend to the Board proposed revisions to the laws, regulations, and policies related to the Board's enforcement of the Boards Practice Act. | | |
| **Member Name** | **Position** | **Member Type** |
| Gilda Dominguez | Chair | SLP Member |
| Tod Borges | Member | HAD Member |

| Board Committee Membership and Structure | | |
|---|---|---|
| **Legislative Committee (Ad Hoc)** | | |
| Description: Review and recommend to the Board proposed positions on legislation impacting the Board, its licensees, and the Board's Practice Act | | |
| **Member Name** | **Position** | **Member Type** |
| Karen Chang | Chair | Public Member |
| Gilda Dominguez | Member | DAU Member |
| **Sunset Review Committee (Ad Hoc)** | | |
| Description: Develop for the Board's review, the Board's Sunset Review Report to the California Legislature | | |
| **Member Name** | **Position** | **Member Type** |
| Gilda Dominguez | Chair | SLP Member |
| Amy White | Member | DAU Member |
| DAU: Dispensing Audiologist<br>HAD: Hearing Aid Dispenser | ORL: Otolaryngology<br>SLP: Speech-Language Pathologist | |

Below are tables of Board Member attendance from January 2022 through December 2025. For a detailed list of Board membership, please refer to the table after the tables of Board Member attendance.

| Table 1a. Attendance | | | |
|---|---|---|---|
| Tod Borges, HAD Member | | | |
| Date Appointed: 12/04/2019; Date Re-Appointed: 11/24/2023 | | | |
| **Meeting Type** | **Meeting Date** | **Meeting Location** | **Attended?** |
| Board Meeting | January 13, 2022 | Teleconference | Yes |
| Board Meeting | February 25, 2022 | Teleconference | Yes |
| Board Meeting | May 12–13, 2022 | Sacramento, Glendora, and Teleconference | Yes |
| Hearing Aid Dispensing Committee | May 12–13, 2022 | Sacramento, Glendora, and Teleconference | Yes |
| Board Meeting | August 11-12, 2022 | Teleconference | Yes |
| Hearing Aid Dispensing | August 11-12, 2022 | Teleconference | Yes |
| Board Meeting | October 27–28, 2022 | Teleconference | Yes |
| Hearing Aid Dispensing Committee | October 27–28, 2022 | Teleconference | Yes |
| Board Meeting | December 13, 2022 | Teleconference | Yes |
| Board Meeting | February 24, 2023 | Teleconference | Yes |
| Hearing Aid Dispensing Committee | February 24, 2023 | Teleconference | Yes |
| Board Meeting | April 27, 2023 | Teleconference | Yes |
| Board Meeting | August 25, 2023 | Teleconference: Sacramento, Glendora, Daly City, Simi Valley, and Stanford | No |
| Board Meeting | November 30 – December 1, 2023 | Sacramento and Teleconference | Yes |
| Hearing Aid Dispensing Committee | November 30 – December 1, 2023 | Sacramento and Teleconference | Yes |
| Board Meeting | February 2, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark | Yes |

| Table 1a. Attendance | | | |
|---|---|---|---|
| Tod Borges, HAD Member | | | |
| Date Appointed: 12/04/2019; Date Re-Appointed: 11/24/2023 | | | |
| **Meeting Type** | **Meeting Date** | **Meeting Location** | **Attended?** |
| Public Hearing | March 1, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark, Stanford | Yes |
| Board Meeting | March 1, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark, Stanford | Yes |
| Board Meeting | June 12, 2024 | Sacramento and Teleconference | Yes |
| Board Meeting | July 18, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark, French Camp | Yes |
| Board Meeting | September 5 – 6, 2024 | Walnut | Yes |
| Board Meeting | November 1, 2024 | Teleconference: Sacramento, Glendora, Lodi, City of Industry, Los Angeles, French Camp | Yes |
| Board Meeting | December 5 – 6, 2024 | Sacramento and Teleconference | Yes |
| Hearing Aid Dispensing Committee | December 5 – 6, 2024 | Sacramento and Teleconference | Yes |
| Board Meeting | February 21, 2025 | Sacramento and Teleconference | Yes |
| Hearing Aid Dispensing Committee | May 15, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Board Meeting | May 16, 2025 | Teleconference, Sacramento, Glendora, | Yes |
| Hearing Aid Dispensing Committee | August 21, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Board Meeting | August 22, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Hearing Aid Dispensing Committee | December 4 - 5, 2025 | Cerritos Community College | Yes |
| Board Meeting | December 4 – 5, 2025 | Cerritos Community College | Yes |

| Table 1a. Attendance | | | |
|---|---|---|---|
| Tamara Chambers, Otolaryngologist/Public Member | | | |
| Date Appointed: 8/16/2024 | | | |
| **Meeting Type** | **Meeting Date** | **Meeting Location** | **Attended?** |
| Board Meeting | September 5 – 6, 2024 | Walnut | Yes |
| Audiology Practice Committee | September 5 – 6, 2024 | Walnut | Yes |
| Board Meeting | November 1, 2024 | Teleconference: Sacramento, Glendora, Lodi, City of Industry, Los Angeles, French Camp | Yes |
| Board Meeting | December 5 – 6, 2024 | Sacramento and Teleconference | Yes |
| Hearing Aid Dispensing Committee | December 5 – 6, 2024 | Sacramento and Teleconference | Yes |
| Audiology Practice Committee | December 5 – 6, 2024 | Sacramento and Teleconference | Yes |
| Speech-Language Pathology Practice Committee | December 5 – 6, 2024 | Sacramento and Teleconference | Yes |
| Board Meeting | February 21, 2025 | Sacramento and Teleconference | Yes |

| Table 1a. Attendance | | | |
|---|---|---|---|
| Tamara Chambers, Otolaryngologist/Public Member | | | |
| Date Appointed: 8/16/2024 | | | |
| **Meeting Type** | **Meeting Date** | **Meeting Location** | **Attended?** |
| Hearing Aid Dispensing Committee | May 15, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Audiology Practice Committee | May 15, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Speech-Language Pathology Practice Committee | May 15, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Board Meeting | May 16, 2025 | Teleconference, Sacramento, Glendora, | Yes |
| Speech-Language Pathology Practice Committee | August 21, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Hearing Aid Dispensing Committee | August 21, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Audiology Practice Committee | August 21, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Board Meeting | August 22, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Speech-Language Pathology Practice Committee | December 4 – 5, 2025 | Cerritos Community College | Yes |
| Hearing Aid Dispensing Committee | December 4 – 5, 2025 | Cerritos Community College | Yes |
| Audiology Practice Committee | December 4 – 5, 2025 | Cerritos Community College | Yes |
| Board Meeting | December 4 – 5, 2025 | Cerritos Community College | Yes |

| Table 1a. Attendance | | | |
|---|---|---|---|
| Karen Chang, Public Member | | | |
| Date Appointed: 12/6/2017; Date Re-Appointed: 10/21/2022 | | | |
| **Meeting Type** | **Meeting Date** | **Meeting Location** | **Attended?** |
| Board Meeting | January 13, 2022 | Teleconference | Yes |
| Board Meeting | February 25, 2022 | Teleconference | Yes |
| Board Meeting | May 12–13, 2022 | Sacramento, Glendora, and Teleconference | Yes |
| Hearing Aid Dispensing Committee | May 12–13, 2022 | Sacramento, Glendora, and Teleconference | Yes |
| Audiology Practice Committee | May 12–13, 2022 | Sacramento, Glendora, and Teleconference | Yes |
| Board Meeting | August 11-12, 2022 | Teleconference | Yes |
| Audiology Practice Committee | August 11-12, 2022 | Teleconference | Yes |
| Hearing Aid Dispensing | August 11-12, 2022 | Teleconference | Yes |
| Board Meeting | October 27–28, 2022 | Teleconference | Yes |
| Audiology Practice Committee | October 27–28, 2022 | Teleconference | Yes |
| Hearing Aid Dispensing Committee | October 27–28, 2022 | Teleconference | Yes |
| Board Meeting | December 13, 2022 | Teleconference | No |
| Board Meeting | February 24, 2023 | Teleconference | Yes |
| Audiology Practice Committee | February 24, 2023 | Teleconference | Yes |

| Table 1a. Attendance | | | |
|---|---|---|---|
| Karen Chang, Public Member | | | |
| Date Appointed: 12/6/2017; Date Re-Appointed: 10/21/2022 | | | |
| **Meeting Type** | **Meeting Date** | **Meeting Location** | **Attended?** |
| Board Meeting | April 27, 2023 | Teleconference | Yes |
| Board Meeting | August 25, 2023 | Teleconference: Sacramento, Glendora, Daly City, Simi Valley, and Stanford | Yes |
| Audiology Practice Committee | August 25, 2023 | Teleconference: Sacramento, Glendora, Daly City, Simi Valley, and Stanford | Yes |
| Board Meeting | November 30 – December 1, 2023 | Sacramento and Teleconference | Yes |
| Audiology Practice Committee | November 30 – December 1, 2023 | Sacramento and Teleconference | Yes |
| Board Meeting | February 2, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark | Yes |
| Public Hearing | March 1, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark, Stanford | Yes |
| Board Meeting | March 1, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark, Stanford | Yes |
| Board Meeting | June 12, 2024 | Sacramento and Teleconference | No |
| Board Meeting | July 18, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark, French Camp | Yes |
| Board Meeting | September 5 – 6, 2024 | Walnut | Yes |
| Audiology Practice Committee | September 5 – 6, 2024 | Walnut | Yes |
| Board Meeting | November 1, 2024 | Teleconference: Sacramento, Glendora, Lodi, City of Industry, Los Angeles, French Camp | Yes |
| Board Meeting | December 5 – 6, 2024 | Sacramento and Teleconference | Yes |
| Audiology Practice Committee | December 5 – 6, 2024 | Sacramento and Teleconference | Yes |
| Board Meeting | February 21, 2025 | Sacramento and Teleconference | Yes |
| Audiology Practice Committee | May 15, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Board Meeting | May 16, 2025 | Teleconference, Sacramento, Glendora, | No |
| Audiology Practice Committee | August 21, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Board Meeting | August 22, 2025 | Teleconference: Sacramento, Glendora, City of Industry | No |
| Audiology Practice Committee | December 4 – 5, 2025 | Cerritos Community College | Yes |
| Board Meeting | December 4 – 5, 2025 | Cerritos Community College | Yes |

| Table 1a. Attendance | | | |
|---|---|---|---|
| John Dandurand, HAD Member | | | |
| Date Appointed: 8/02/2023 | | | |
| **Meeting Type** | **Meeting Date** | **Meeting Location** | **Attended?** |
| Board Meeting | August 25, 2023 | Teleconference: Sacramento, Glendora, Daly City, Simi Valley, and Stanford | Yes |
| Board Meeting | December 1, 2023 | Sacramento and Teleconference | Yes |
| Hearing Aid Dispensing Committee | November 30 – December 1, 2023 | Sacramento and Teleconference | Yes |
| Board Meeting | February 2, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark | Yes |
| Public Hearing | March 1, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark, Stanford | Yes |
| Board Meeting | March 1, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark, Stanford | Yes |
| Board Meeting | June 12, 2024 | Sacramento and Teleconference | Yes |
| Board Meeting | July 18, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark, French Camp | Yes |
| Board Meeting | September 5 – 6, 2024 | Walnut | Yes |
| Board Meeting | November 1, 2024 | Teleconference: Sacramento, Glendora, Lodi, City of Industry, Los Angeles, French Camp | No |
| Board Meeting | December 5 – 6, 2024 | Sacramento and Teleconference | Yes |
| Hearing Aid Dispensing Committee | December 5 – 6, 2024 | Sacramento and Teleconference | Yes |

| Table 1a. Attendance | | | |
|---|---|---|---|
| Francis David, SLP Member | | | |
| Date Appointed: 8/15/2025 | | | |
| **Meeting Type** | **Meeting Date** | **Meeting Location** | **Attended?** |
| Speech-Language Pathology Practice Committee | August 21, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Board Meeting | August 22, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Speech-Language Pathology Practice Committee | December 4 – 5, 2025 | Cerritos Community College | Yes |
| Board Meeting | December 4 – 5, 2025 | Cerritos Community College | Yes |

| Table 1a. Attendance | | | |
|---|---|---|---|
| Gilda Dominguez, SLP Member | | | |
| Date Appointed: 5/21/2021 | | | |
| **Meeting Type** | **Meeting Date** | **Meeting Location** | **Attended?** |
| Board Meeting | January 13, 2022 | Teleconference | Yes |
| Board Meeting | February 25, 2022 | Teleconference | Yes |
| Board Meeting | May 12–13, 2022 | Sacramento, Glendora, and Teleconference | Yes |
| Board Meeting | August 11-12, 2022 | Teleconference | Yes |
| Board Meeting | October 27–28, 2022 | Teleconference | Yes |
| Board Meeting | December 13, 2022 | Teleconference | Yes |
| Board Meeting | February 24, 2023 | Teleconference | Yes |
| Board Meeting | April 27, 2023 | Teleconference | Yes |
| Board Meeting | August 25, 2023 | Teleconference: Sacramento, Glendora, Daly City, Simi Valley, and Stanford | Yes |
| Board Meeting | November 30 – December 1, 2023 | Sacramento and Teleconference | Yes |
| Speech-Language Pathology Practice Committee | November 30 – December 1, 2023 | Sacramento and Teleconference | Yes |
| Board Meeting | February 2, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark | Yes |
| Public Hearing | March 1, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark, Stanford | Yes |
| Board Meeting | March 1, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark, Stanford | Yes |
| Board Meeting | June 12, 2024 | Sacramento and Teleconference | Yes |
| Board Meeting | July 18, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark, French Camp | Yes |
| Board Meeting | September 5 – 6, 2024 | Walnut | Yes |
| Board Meeting | November 1, 2024 | Teleconference: Sacramento, Glendora, Lodi, City of Industry, Los Angeles, French Camp | Yes |
| Board Meeting | December 5 – 6, 2024 | Sacramento and Teleconference | Yes |
| Speech-Language Pathology Practice Committee | December 5 – 6, 2024 | Sacramento and Teleconference | Yes |
| Board Meeting | February 21, 2025 | Sacramento and Teleconference | Yes |
| Speech-Language Pathology Practice Committee | May 15, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Board Meeting | May 16, 2025 | Teleconference, Sacramento, Glendora, | Yes |
| Speech-Language Pathology Practice Committee | August 21, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Board Meeting | August 22, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Speech-Language Pathology Practice Committee | December 4 – 5, 2025 | Cerritos Community College | Yes |

| Table 1a. Attendance | | | |
|---|---|---|---|
| Gilda Dominguez, SLP Member | | | |
| Date Appointed: 5/21/2021 | | | |
| **Meeting Type** | **Meeting Date** | **Meeting Location** | **Attended?** |
| Board Meeting | December 4 – 5, 2025 | Cerritos Community College | Yes |

| Table 1a. Attendance | | | |
|---|---|---|---|
| Holly Kaiser, SLP Member | | | |
| Date Appointed: 5/14/2020 | | | |
| **Meeting Type** | **Meeting Date** | **Meeting Location** | **Attended?** |
| Board Meeting | January 13, 2022 | Teleconference | Yes |
| Board Meeting | February 25, 2022 | Teleconference | Yes |
| Board Meeting | May 12–13, 2022 | Sacramento, Glendora, and Teleconference | Yes |
| Board Meeting | August 11-12, 2022 | Teleconference | Yes |
| Board Meeting | October 27–28, 2022 | Teleconference | Yes |
| Board Meeting | December 13, 2022 | Teleconference | Yes |
| Board Meeting | February 24, 2023 | Teleconference | Yes |
| Board Meeting | April 27, 2023 | Teleconference | Yes |
| Board Meeting | August 25, 2023 | Teleconference: Sacramento, Glendora, Daly City, Simi Valley, and Stanford | No |
| Board Meeting | November 30 – December 1, 2023 | Sacramento and Teleconference | Yes |
| Speech-Language Pathology Practice Committee | November 30 – December 1, 2023 | Sacramento and Teleconference | Yes |

| Table 1a. Attendance | | | |
|---|---|---|---|
| Marcia Raggio, DAU Member | | | |
| Date Appointed: 12/17/2012 Date Re-Appointed: 11/14/2019 | | | |
| **Meeting Type** | **Meeting Date** | **Meeting Location** | **Attended?** |
| Board Meeting | January 13, 2022 | Teleconference | Yes |
| Board Meeting | February 25, 2022 | Teleconference | Yes |
| Board Meeting | May 12–13, 2022 | Sacramento, Glendora, and Teleconference | Yes |
| Hearing Aid Dispensing Committee | May 12–13, 2022 | Sacramento, Glendora, and Teleconference | Yes |
| Audiology Practice Committee | May 12–13, 2022 | Sacramento, Glendora, and Teleconference | Yes |
| Board Meeting | August 11-12, 2022 | Teleconference | Yes |
| Audiology Practice Committee | August 11-12, 2022 | Teleconference | Yes |
| Hearing Aid Dispensing | August 11-12, 2022 | Teleconference | Yes |
| Board Meeting | October 27–28, 2022 | Teleconference | Yes |
| Audiology Practice Committee | October 27–28, 2022 | Teleconference | Yes |

| Table 1a. Attendance | | | |
|---|---|---|---|
| Marcia Raggio, DAU Member | | | |
| Date Appointed: 12/17/2012 Date Re-Appointed: 11/14/2019 | | | |
| **Meeting Type** | **Meeting Date** | **Meeting Location** | **Attended?** |
| Hearing Aid Dispensing Committee | October 27–28, 2022 | Teleconference | Yes |
| Board Meeting | December 13, 2022 | Teleconference | Yes |
| Board Meeting | February 24, 2023 | Teleconference | Yes |
| Audiology Practice Committee | February 24, 2023 | Teleconference | Yes |
| Hearing Aid Dispensing Committee | February 24, 2023 | Teleconference | Yes |
| Board Meeting | April 27, 2023 | Teleconference | Yes |
| Board Meeting | August 25, 2023 | Teleconference: Sacramento, Glendora, Daly City, Simi Valley, and Stanford | Yes |
| Audiology Practice Committee | August 25, 2023 | Teleconference: Sacramento, Glendora, Daly City, Simi Valley, and Stanford | Yes |

| Table 1a. Attendance | | | |
|---|---|---|---|
| Charles Sanders, DAU Member | | | |
| Date Appointed: 11/20/2023 | | | |
| **Meeting Type** | **Meeting Date** | **Meeting Location** | **Attended?** |
| Board Meeting | November 30 – December 1, 2023 | Sacramento and Teleconference | Yes |
| Audiology Practice Committee | November 30 – December 1, 2023 | Sacramento and Teleconference | Yes |
| Hearing Aid Dispensing Committee | November 30 – December 1, 2023 | Sacramento and Teleconference | Yes |
| Board Meeting | February 2, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark | Yes |
| Public Hearing | March 1, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark, Stanford | Yes |
| Board Meeting | March 1, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark, Stanford | Yes |
| Board Meeting | June 12, 2024 | Sacramento and Teleconference | Yes |
| Board Meeting | July 18, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark, French Camp | Yes |
| Board Meeting | September 5 – 6, 2024 | Walnut | Yes |
| Audiology Practice Committee | September 5 – 6, 2024 | Walnut | Yes |
| Board Meeting | November 1, 2024 | Teleconference: Sacramento, Glendora, Lodi, City of Industry, Los Angeles, French Camp | Yes |
| Board Meeting | December 5 – 6, 2024 | Sacramento and Teleconference | Yes |
| Hearing Aid Dispensing Committee | December 5 – 6, 2024 | Sacramento and Teleconference | Yes |
| Audiology Practice Committee | December 5 – 6, 2024 | Sacramento and Teleconference | Yes |

| Table 1a. Attendance | | | |
|---|---|---|---|
| Charles Sanders, DAU Member | | | |
| Date Appointed: 11/20/2023 | | | |
| **Meeting Type** | **Meeting Date** | **Meeting Location** | **Attended?** |
| Board Meeting | February 21, 2025 | Sacramento and Teleconference | Yes |
| Hearing Aid Dispensing Committee | May 15, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Audiology Practice Committee | May 15, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Board Meeting | May 16, 2025 | Teleconference, Sacramento, Glendora, | Yes |
| Hearing Aid Dispensing Committee | August 21, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Audiology Practice Committee | August 21, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Board Meeting | August 22, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Hearing Aid Dispensing Committee | December 4 – 5, 2025 | Cerritos Community College | Yes |
| Audiology Practice Committee | December 4 – 5, 2025 | Cerritos Community College | Yes |
| Board Meeting | December 4 – 5, 2025 | Cerritos Community College | Yes |

| Table 1a. Attendance | | | |
|---|---|---|---|
| Deborah "Debbie" Snow, Public Member | | | |
| Date Appointed: 11/30/2013 Date Re-Appointed: 12/06/2017 | | | |
| **Meeting Type** | **Meeting Date** | **Meeting Location** | **Attended?** |
| Board Meeting | January 13, 2022 | Teleconference | Yes |
| Board Meeting | February 25, 2022 | Teleconference | Yes |
| Board Meeting | May 12–13, 2022 | Sacramento, Glendora, and Teleconference | Yes |
| Board Meeting | August 11-12, 2022 | Teleconference | Yes |
| Board Meeting | October 27–28, 2022 | Teleconference | Yes |

| Table 1a. Attendance | | | |
|---|---|---|---|
| Tulio Valdez, Otolaryngologist/Public Member | | | |
| Date Appointed: 1/12/2022 | | | |
| **Meeting Type** | **Meeting Date** | **Meeting Location** | **Attended?** |
| Board Meeting | February 25, 2022 | Teleconference | Yes |
| Board Meeting | May 12–13, 2022 | Sacramento, Glendora, and Teleconference | No |
| Hearing Aid Dispensing Committee | May 12–13, 2022 | Sacramento, Glendora, and Teleconference | No |
| Audiology Practice Committee | May 12–13, 2022 | Sacramento, Glendora, and Teleconference | No |
| Board Meeting | August 11-12, 2022 | Teleconference | No |

| Table 1a. Attendance | | | |
|---|---|---|---|
| Tulio Valdez, Otolaryngologist/Public Member | | | |
| Date Appointed: 1/12/2022 | | | |
| **Meeting Type** | **Meeting Date** | **Meeting Location** | **Attended?** |
| Audiology Practice Committee | August 11-12, 2022 | Teleconference | Yes |
| Hearing Aid Dispensing | August 11-12, 2022 | Teleconference | Yes |
| Board Meeting | October 27–28, 2022 | Teleconference | Yes |
| Audiology Practice Committee | October 27–28, 2022 | Teleconference | Yes |
| Hearing Aid Dispensing Committee | October 27–28, 2022 | Teleconference | Yes |
| Board Meeting | December 13, 2022 | Teleconference | Yes |
| Board Meeting | February 24, 2023 | Teleconference | Yes |
| Audiology Practice Committee | February 24, 2023 | Teleconference | Yes |
| Hearing Aid Dispensing Committee | February 24, 2023 | Teleconference | Yes |
| Board Meeting | April 27, 2023 | Teleconference | No |
| Board Meeting | August 25, 2023 | Teleconference: Sacramento, Glendora, Daly City, Simi Valley, and Stanford | Yes |
| Audiology Practice Committee | August 25, 2023 | Teleconference: Sacramento, Glendora, Daly City, Simi Valley, and Stanford | Yes |
| Board Meeting | November 30 – December 1, 2023 | Sacramento and Teleconference | No |
| Audiology Practice Committee | November 30 – December 1, 2023 | Sacramento and Teleconference | No |
| Hearing Aid Dispensing Committee | November 30 – December 1, 2023 | Sacramento and Teleconference | No |
| Board Meeting | February 2, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark | No |
| Public Hearing | March 1, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark, Stanford | No |
| Board Meeting | March 1, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark, Stanford | No |

| Table 1a. Attendance | | | |
|---|---|---|---|
| Amy White, DAU Member | | | |
| Date Appointed: 1/07/2022 | | | |
| **Meeting Type** | **Meeting Date** | **Meeting Location** | **Attended?** |
| Board Meeting | January 13, 2022 | Teleconference | Yes |
| Board Meeting | February 25, 2022 | Teleconference | Yes |
| Board Meeting | May 12–13, 2022 | Sacramento, Glendora, and Teleconference | Yes |
| Hearing Aid Dispensing Committee | May 12–13, 2022 | Sacramento, Glendora, and Teleconference | Yes |
| Audiology Practice Committee | May 12–13, 2022 | Sacramento, Glendora, and Teleconference | Yes |

| Table 1a. Attendance | | | |
|---|---|---|---|
| Amy White, DAU Member | | | |
| Date Appointed: 1/07/2022 | | | |
| **Meeting Type** | **Meeting Date** | **Meeting Location** | **Attended?** |
| Board Meeting | August 11-12, 2022 | Teleconference | Yes |
| Audiology Practice Committee | August 11-12, 2022 | Teleconference | Yes |
| Hearing Aid Dispensing | August 11-12, 2022 | Teleconference | Yes |
| Board Meeting | October 27–28, 2022 | Teleconference | Yes |
| Audiology Practice Committee | October 27–28, 2022 | Teleconference | Yes |
| Hearing Aid Dispensing Committee | October 27–28, 2022 | Teleconference | Yes |
| Board Meeting | December 13, 2022 | Teleconference | Yes |
| Board Meeting | February 24, 2023 | Teleconference | Yes |
| Audiology Practice Committee | February 24, 2023 | Teleconference | Yes |
| Hearing Aid Dispensing Committee | February 24, 2023 | Teleconference | Yes |
| Board Meeting | April 27, 2023 | Teleconference | Yes |
| Board Meeting | August 25, 2023 | Teleconference: Sacramento, Glendora, Daly City, Simi Valley, and Stanford | Yes |
| Audiology Practice Committee | August 25, 2023 | Teleconference: Sacramento, Glendora, Daly City, Simi Valley, and Stanford | Yes |
| Board Meeting | November 30 – December 1, 2023 | Sacramento and Teleconference | Yes |
| Audiology Practice Committee | November 30 – December 1, 2023 | Sacramento and Teleconference | Yes |
| Hearing Aid Dispensing Committee | November 30 – December 1, 2023 | Sacramento and Teleconference | Yes |
| Board Meeting | February 2, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark | No |
| Public Hearing | March 1, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark, Stanford | Yes |
| Board Meeting | March 1, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark, Stanford | Yes |
| Board Meeting | June 12, 2024 | Sacramento and Teleconference | Yes |
| Board Meeting | July 18, 2024 | Teleconference: Sacramento, Glendora, Lodi, Moorpark, French Camp | Yes |
| Board Meeting | September 5 – 6, 2024 | Walnut | Yes |
| Audiology Practice Committee | September 5 – 6, 2024 | Walnut | Yes |
| Board Meeting | November 1, 2024 | Teleconference: Sacramento, Glendora, Lodi, City of Industry, Los Angeles, French Camp | Yes |
| Board Meeting | December 5 – 6, 2024 | Sacramento and Teleconference | Yes |
| Hearing Aid Dispensing Committee | December 5 – 6, 2024 | Sacramento and Teleconference | Yes |
| Audiology Practice Committee | December 5 – 6, 2024 | Sacramento and Teleconference | Yes |
| Board Meeting | February 21, 2025 | Sacramento and Teleconference | Yes |

| Table 1a. Attendance | | | |
|---|---|---|---|
| Amy White, DAU Member | | | |
| Date Appointed: 1/07/2022 | | | |
| **Meeting Type** | **Meeting Date** | **Meeting Location** | **Attended?** |
| Hearing Aid Dispensing Committee | May 15, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Audiology Practice Committee | May 15, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Board Meeting | May 16, 2025 | Teleconference, Sacramento, Glendora, | Yes |
| Hearing Aid Dispensing Committee | August 21, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Audiology Practice Committee | August 21, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Board Meeting | August 22, 2025 | Teleconference: Sacramento, Glendora, City of Industry | Yes |
| Hearing Aid Dispensing Committee | December 4 – 5, 2025 | Cerritos Community College | Yes |
| Audiology Practice Committee | December 4 – 5, 2025 | Cerritos Community College | Yes |
| Board Meeting | December 4 – 5, 2025 | Cerritos Community College | Yes |

Below is the Board Member roster as of December 2025. For a detailed list of attendance at Board and Committee meetings, please refer to the tables above.

| Table 1b. Board Member Roster | | | | | |
|---|---|---|---|---|---|
| Member Name | Date First Appointed | Date Reappointed | Date Term Expires | Appointing Authority | Type |
| Karen Chang, Public Member | 12/6/17 | 10/21/22 | 11/30/25 | Assembly | Public |
| Tod Borges, Hearing Aid Dispenser | 12/04/19 | 11/24/23 | 1/1/28 | Governor | Professional |
| Gilda Dominguez, Speech-Language Pathologist | 5/10/21 | N/A | 1/1/26 | Governor | Professional |
| Amy White, Dispensing Audiologist | 1/7/22 | N/A | 1/1/26 | Governor | Professional |
| Charles Sanders, Dispensing Audiologist | 11/20/23 | N/A | 1/1/28 | Governor | Professional |
| Tamara Chambers, Otolaryngologist, Public Member | 8/16/24 | N/A | 1/1/29 | Governor | Public |
| Francis David, Speech-Language Pathologist | 8/15/25 | N/A | 1/1/29 | Governor | Professional |
| VACANT, Hearing Aid Dispenser | N/A | N/A | N/A | Governor | Professional |
| VACANT, Public Member | N/A | N/A | N/A | Senate | Public |
| *Note: All "Appointment Dates" are when the Member signed their Oath of Office, and "Expiration Dates" include the one-year grace period unless their replacement was appointed prior to that date or the member resigned.* | | | | | |

2. In the past four years, was the board unable to hold any meetings due to lack of quorum? If so, please describe. Why? When? How did it impact operations?

   The Board has not experienced a lack of a quorum within the past four years.

3. Describe any major changes to the board since the last Sunset Review, including, but not limited to:

   - Internal changes (i.e., reorganization, relocation, change in leadership, strategic planning)

     In December of 2023, the Board elected a new Board Chair, Gilda Dominguez, M.S., CCC–SLP, Speech-Language Pathologist, and new Board Vice Chair, Amy E. White, Au.D., Dispensing Audiologist.

     In November of 2024, the Board appointed Cherise Burns as the Interim Executive Officer while working to fill the vacancy created when Executive Officer Paul Sanchez accepted a position within another state agency in October of 2024. During this leadership transition, Board leadership focused on maintaining core functions and services of the Board.

     In December of 2024, the Board adopted its Strategic Plan for 2025-2028 (see Section 11, Attachment E). The plan was developed through the Board's collaboration with its stakeholders and strongly emphasizes consumer protection around five goal areas with objectives focused on improving services to consumers and licensees, increasing outreach to stakeholders, and enhancing the Board's enforcement program. Through interviews and surveys of its stakeholders, the Board identified challenges and opportunities in moving forward to build a foundation for the protection of, service to, and excellence in care of consumers with communication and hearing disorders.

     In February of 2025, the Board appointed Cherise Burns as the new Executive Officer. During the leadership transition, Board leadership focused on filling the vacancy of the Assistant Executive Officer.

     In August of 2025, the Board hired a new Assistant Executive Officer, Michael Magat. During the transition, Board leadership focused on retaining institutional knowledge, transferring managerial and supervisory responsibilities, and understanding of the Board's workload and process improvements underway.

   - All legislation sponsored by the board and affecting the board since the last sunset review.

| Legislation Sponsored by or Affecting the Board | | | | |
|---|---|---|---|---|
| Legislative Session | Bill Number | Code Sections | Amendment | Operative Date |
| 2021-2022 | AB 107 (Salas) | BPC 115.6, 115.8, and 115.9 | Requires the Board to issue a nonrenewable, 12-month temporary license to military spouses or domestic partners who 1) holds a current, active and unrestricted audiology license in another state, 2) is married to or in a domestic partnership with an active duty member of the military, and 3) where that active duty military member is currently stationed in California; Requires the license to expires 12 months after issuance, upon issuance of a permanent license, or upon denial of an application for permanent licensure; requires the Board to issue the temporary license 30 days after receipt of all necessary documentation and clearance of the applicants Department of Justice and Federal Bureau of Investigation background check; and requires the Board to publish information of all licensing options available to military spouses on the Board's website. | July 1, 2023 |

| Legislation Sponsored by or Affecting the Board | | | | |
|---|---|---|---|---|
| Legislative Session | Bill Number | Code Sections | Amendment | Operative Date |
| 2021-2022 | AB 2686 (Berman) | BPC sections 2530.2, 2530.5, 2530.6, 2530.7, 2531, 2531.05, 2531.1, 2531.75, 2532.25, 2532.8, 2533, 2533.1, 2533.4, 2533.6, 2534.2, 2538.3, and 2539.1 | Extends the Board's sunset date until January 1, 2027; requires licensees to provide the Board with their email address; creates a renewal requirement for Audiology and Speech-Language Pathology Aide (Aide) registrations to be renewed every two years; removes the statutory requirement and membership for the Hearing Aid Dispensing Committee; expands the reasons for which the Board is authorized to take disciplinary action; revises the process for licensees seeking to petition the Board for reinstatement or modification of penalty, including specifying a minimum period of time before the licensee can petition the Board again; and changes the licensing requirements for Audiologists by clarifying that the required clinical practice must be under the direction of an audiology doctoral program and removing the requirement that the required professional experience must follow the completion of the didactic and clinical rotation requirements. | January 1, 2023 |
| 2021-2022 | SB 1237 (Newman) | BPC section 114.3 | Expands the requirement that boards waive renewal fees and continuing education requirements to include individuals on duty in the California National Guard or on active duty in the United States Armed Forces. | January 1, 2023 |

| Legislation Sponsored by or Affecting the Board | | | | |
|---|---|---|---|---|
| Legislative Session | Bill Number | Code Sections | Amendment | Operative Date |
| 2021-2022 | *SB 1453 (Ochoa Bogh) | BPC section 2530.2 | Requires 10 supervised flexible fiber optic transnasal endoscopic procedure from a physician who performs nasal endoscopy as part of their practice and 15 supervised by a physician who performs nasal endoscopy as part of their practice or speech-language pathologist who has been verified by from an Otolaryngologist that they performed the minimum of 25 procedures and are competent to perform the procedure; requires the procedure to be performed upon the orders of a licensed physician and on patients without contraindications that would prevent the procedure from being performed safely; and requires the procedure to be performed in primary care and specialty clinics, county medical facilities, hospitals and skilled nursing facilities, hospice facilities, and medical group practices, without the presence of a physician, as long as the facility has emergency medical backup procedures, including a physician or other appropriate medical professional being readily available. | January 1, 2023 |
| 2023-2024 | AB 883 (Mathis) | BPC section 115.4 | Additionally requires the Board to expedite the licensure process for an applicant who supplies evidence to the Board that the applicant is an active duty member of a regular component of the Armed Forces of the United States enrolled in the United States Department of Defense SkillBridge program, and permit the Board to assist the applicant in the initial licensure process starting July 1, 2024. | July 1, 2024 |

| Legislation Sponsored by or Affecting the Board | | | | |
|---|---|---|---|---|
| Legislative Session | Bill Number | Code Sections | Amendment | Operative Date |
| 2023-2024 | SB 372 (Menjivar) | BPC section 27.5 | Requires the Board to update a licensee's or registrant's license and any references to their name or gender displayed on the internet if the board receives from the licensee or registrant government-issued documentation demonstrating that their legal name or gender has been changed. The bill would require the Board to post an online statement and direct the public to contact the Board for more information if the licensee or registrant has enforcement records online referencing their former name or gender or if a search on the online license verification system is performed using a licensee's or registrant's former name. | January 1, 2024 |
| 2023-2024 | SB 544 (Laird) | Government Code sections 11123.2, 11123.5, and11124 | Provides the Board an alternative set of provisions to hold meetings by teleconference. | January 1, 2024 |
| 2023-2024 | *SB 612 (Ochoa Bogh) | BPC section 2530.2 | Specifies that a licensed speech-language pathologist, who obtained a written verification before January 1, 2023, meets the requirements to perform a flexible fiber optic transnasal endoscopic procedure described in BPC section 2530.2(f)(1). | January 1, 2024 |
| 2023-2024 | SB 887ad | BPC sections 2530.3, 2532, 2532.5, 2535.4, 2537.3, 2538.20, 2538.21, 2538.27, 2538.28, 2538.30, 2538.32, 2538.33, 2538.34, 2538.36, 2538.40, 2538.49, 2538.50, 2538.51, 2538.56, 2539.1, and 2539.6, | Replaces gendered pronouns with non-gendered pronouns | January 1, 2024 |
| 2023-2024 | SB 1451 (Ashby) | BPC section 2054 | Requires licensees who use the word "doctor" or the letters or prefix "Dr." if they have earned it to provide the exact field in which the doctoral degree was earned in any sign, business card, or letterhead, or, in an advertisement. | January 1, 2025 |

| Legislation Sponsored by or Affecting the Board | | | | |
|---|---|---|---|---|
| Legislative Session | Bill Number | Code Sections | Amendment | Operative Date |
| 2023-2024 | SB 1526 | BPC sections 2538.3, 2538.10, 2538.25, 2538.27, and 2539.1 | Clarifies the degree required for speech–language pathology assistant licensure and make grammatic correction. | January 1, 2025 |
| 2025-2026 | AB 489 | BPC sections 4999.8 and 4999.9 | Prohibits the use of specified terms, letters, or phrases to indicate or imply possession of a license to practice a health care profession without at that time having the appropriate license required for that practice or profession by an entity who develops or deploys artificial intelligence (AI) or generative artificial intelligence (GenAI) technology that uses one or more of those terms, letters, or phrases in the advertising or functionality of AI or GenAI technology; and the use by AI or GenAI technology of a term, letter, or phrase that indicates or implies that the care, advice, reports, or assessments being offered through the AI or GenAI technology is being provided by a natural person in possession of the appropriate license to practice as a health care profession. Gives the Board the authority to pursue an injunction, restraining order, or any remedy authorized under the law to enforce these prohibitions, and allow the Board to consider each use of a prohibited term, letter, or phrases as a separate violation. | January 1, 2026 |
| 2025-2026 | SB 470 | Government Code sections 11123.2 and 11123.5 | Extends the alternative set of provisions the Board can use to hold meetings by teleconference through January 1, 2030. | January 1, 2026 |
| 2025-2026 | SB 744 | BPC section 144.7 | Authorizes the Board through January 1, 2030, to approve after its review any educational intuitions and programs whose accreditation is no longer recognized by the United States Department of Education on and after January 2, 2025, to retain that recognition until July 1, 2029 provided that the accrediting agency continues to operate in substantially the same manner as it did on January 1, 2025. | January 1, 2026 |

| Legislation Sponsored by or Affecting the Board | | | | |
|---|---|---|---|---|
| Legislative Session | Bill Number | Code Sections | Amendment | Operative Date |
| 2025-2026 | SB 861 | BPC sections 2532.2, 2532.3, 2532.4, 2532.6, 2532.7,and 2536; Welfare and Institutions Code section 14132.55; and Education Code section 44831 | Replaces gendered pronouns with non-gendered pronouns and replaces the Board's former name with its current name. | January 1, 2026 |
| * Board Sponsored | | | | |

- All regulation changes approved by the board since the last sunset review. Include the status of each regulatory change approved by the board.

| Regulation Changes Approved by the Board | | | |
|---|---|---|---|
| Regulation Section in Title 16 | Regulation Title | Board Approval Date | Package Status |
| Sections 1399.112, 1399.151.2, and 1399.170.14 | Fingerprints Requirements | February 13, 2009 | Additional text changes approved by Board May 7, 2009, March 24-25, 2010, May 11-12, 2017, August 10-11, 2017, and May 12-13, 2022. Additional review needed. |
| Sections 1399.102, 399.131 1399.131.1, 1399.155 and 1399.155.1 | Uniform Standards | July 26–27, 2012 | Additional text changes approved by Board on February 4–5, 2016, February 9-10, 2017, and August 13, 2021. Approved by the Office of Administrative Law and filed with the Secretary of State on February 13, 2023. Became effective April 1, 2023. |
| Sections 1399.131 and 1399.155 | Disciplinary Guidelines | July 26–27, 2012 | Additional text changes approved by Board on February 4–5, 2016, February 9-10, 2017, and May 30 – June 1, 2018. The Enforcement Ad Hoc Committee reviewed the regulatory text and 2018 proposed disciplinary guidelines in 2022, 2023, 2024, and 2025. Board staff is currently developing the regulatory package. |
| Sections 1399.160, 1399.160.1, 1399.160.2, 1399.160.3, and 1399.160.4 | Continuing Professional Development Requirements | November 6, 2015 | Additional text changes approved by Board on May 12-13, 2022, August 11-12, 2022, and April 27, 2023. Approved by the Office of Administrative Law and filed with the Secretary of State on September 9, 2024. Became effective January 1, 2025. |

| Regulation Changes Approved by the Board | | | |
|---|---|---|---|
| Regulation Section in Title 16 | Regulation Title | Board Approval Date | Package Status |
| Section 1399.127 | Hearing Aid Dispenser Advertising | August 10-11, 2017 | Additional text changes approved by Board on April 27, 2023. Approved by the Office of Administrative Law and filed with the Secretary of State on December 30, 2024. Became effective April 1, 2025. |
| Sections 1399.129 and 1399.157.1 | Notice to Consumer | August 10-11, 2017 | Additional text changes approved by Board on February 8-9, 2018, February 25, 2022, and October 28, 2022. Approved by the Office of Administrative Law and filed with the Secretary of State on February 6, 2023. Became effective April 1, 2023. |
| Section 1399.120, 1399.121,1399.122, and 1399.152.4 | Hearing Aid Dispenser Examination Process and Dispensing Audiologist Examination Requirement | October 26-27, 2017 | Additional text changes approved by Board on November 29-30, 2018, May 12-13, 2022, and December 1, 2023. Additional review needed. |
| Section 1399.152 | Approved Institutions | February 8-9, 2018 | Additional text changes approved by Board on August 25, 2023. Additional review needed. |
| Sections 1399.170, 1399.170.2, 1399.170.15, 1399.170.16, 1399.170.17, and 1399.170.18 | Speech-Language Pathology Assistant Supervision Requirements | May 31-June 1, 2018 | Additional text changes approved by Board on February 20-21, 2020 and August 13, 2021. Rulemaking split into two rulemaking. Text approved by Board on May 12-13, 2022. Approved by the Office of Administrative Law and filed with the Secretary of State on March 19, 2024. Became effective July 1, 2024. |
| Sections 1399.170.4, 1399.170.10, and 1399.170.11 | Speech-Language Pathology Assistant Program and Academic Requirements | May 31-June 1, 2018 | Additional text changes approved by Board on February 20-21, 2020 and August 13, 2021. Rulemaking split into two rulemaking. Text approved by Board on August 11-12, 2022. Approved by the Office of Administrative Law and filed with the Secretary of State on July 18, 2023. Became effective October 1, 2023. |

| Regulation Changes Approved by the Board | | | |
|---|---|---|---|
| Regulation Section in Title 16 | Regulation Title | Board Approval Date | Package Status |
| Sections 1399.153 and 1399.153.3 | Required Professional Experience Direct Supervision Requirements and Tele Supervision | August 9-10, 2018 | Additional text changes approved by Board on April 11-12, 2019, February 20-21, 2020, May 13-14, 2021, and October 28, 2022. Approved by the Office of Administrative Law and filed with the Secretary of State on February 13, 2023. Became effective April 1, 2023. |
| Sections 1399.102 and 1399.115 through 1399.119 | Hearing Aid Dispensers Trainee and Supervisor Requirements | November 29-30, 2018 | Additional text changes approved by Board on August 25, 2023. Additional review needed. |
| Sections 1399.101, 1399.150.1 and 1399.160.6 | Board Location | October 8, 2021 | Approved by the Office of Administrative Law and filed with the Secretary of State on May 17, 2022. Became effective July 1, 2022. |
| Sections 1399.113, 1399.141, 1399.151.1, 1399.153.2 , 1399.160.6, 1399.170.4, and 1399.170.13 | Processing Times | October 8, 2021 | Additional text changes approved by Board on December 1, 2023, and September 6, 2024**.** Approved by the Office of Administrative Law and filed with the Secretary of State on September 23, 2025. Became effective January 1, 2026. |
| Sections 1399.140, 1399.140.1, and 1399.144 | Hearing Aid Dispensers Continuing Education Requirements | August 11-12, 2022 | Additional text changes approved by Board April 27, 2023. Approved by the Office of Administrative Law and filed with the Secretary of State on August 14, 2024. Became effective October 1, 2024. |
| Section 1399.152.2 | Audiology Supervised Clinical Experience | December 1, 2023 | Additional text changes approved by Board on December 6, 2024. Approved by the Office of Administrative Law and filed with the Secretary of State on September 22, 2025. Became effective January 1, 2026. |

4. Describe any major studies conducted by the board (cf. Section 11, Attachment C).

BPC Section 139 and DCA policy require that California state licensing Boards conduct regular occupational analyses (OA) of the professions as a fundamental part of each licensure program. In addition, BPC Section 139 and DCA policy also requires a review of any national examination program used by a California licensing Board as part of its licensure program.

**2025 Occupational Analysis for Speech–Language Pathologists**
The Board held two OA workshops in 2025 to complete the occupational analysis for speech–language pathology. The workshops consisted of speech–language pathologists or subject matter experts with diverse backgrounds in the profession.

The Board utilizes the Educational Testing Service Praxis speech–language pathology examination which is based on the American Speech-Language-Hearing Association's (ASHA's) OA. In preparing for the OA, the Board requested the assistance of licensees in providing to the Office of Professional Examination Services (OPES) the results of ASHA's most recent national occupational analysis including:

- Process used to develop OA survey;
- Demographic items and their results;
- The rating scales employed in the OA survey;
- List of tasks and knowledge statements with their respective ratings;
- Information (group demographics) regarding the initial and final respondent samples;
- Method used to link test plan to occupational analysis;
- Process used to determine relative weights of the test plan.

Following completion of the OA, the list of task and knowledge statements is the most pertinent aspect. The additional information is utilized for the required review of the national examination program for speech–language pathology.

It is important for OPES to review the task and knowledge statements from the national occupational analysis. For examination publishers that consider this proprietary information, a model security agreement is available as a basis upon which to build a custom security agreement.

5. List the status of all national associations to which the board belongs.

The Board is a member of the National Council of State Boards (NCSB) of Examiners in Speech-Language Pathology and Audiology, which is a national professional organization for state licensing Boards to network and discuss practice issues. Topics include licensing and examination changes, enforcement trends and consumer protection issues, expansion of scopes of practice, and general health care evolution.

- Does the board's membership include voting privileges?

  The Board is a voting member of the NCSB.

- List committees, workshops, working groups, task forces, etc., on which the board participates.

  None.

- How many meetings did board representative(s) attend? When and where?

  Since the last Sunset, the Board has attended one NCSB Annual Conference in Santa Fe, New Mexico in October of 2022. The Conference theme was, "Good Governance: Inclusion and Collaboration in the Regulation of Audiology and Speech-Language Pathology." Topics included, amongst others, Diversity, Equity, and Inclusion - Initiatives in the Regulatory Space and Consumer Protection; National Practitioner Databank Reporting; Over-the-Counter Hearing Aids; and State Information Exchanges. Travel restrictions have limited the Board's ability to participate in the NCSB Annual Conferences, as it is an in-person conference held out-of-state and with no virtual attendance options available for the Board to take advantage of.

- If the board is using a national exam, how is the board involved in its development, scoring, analysis, and administration?

  The Board accepts two national examinations, the Praxis Examination for both speech-language pathology and audiology, both administered by the Educational Testing Service (ETS). While the Board is not directly involved with the development, scoring, and administration of the examination, the Board does conduct periodic audits through examination validation studies. These studies review the content and rigor of each examination to ensure that the scope of the examination and passing scores reflect the minimum standards of practice and entry-level requirements for licensure in California. The last audit conducted by the Board, with the facilitation of the Department's Office of Professional Examination Services, was completed in 2017 for the audiology examination, and 2025 for the speech-language pathology examination. The next occupational analysis of the audiology profession will be completed in fiscal year 2026-27.

  The ETS commissions American Speech-Language-Hearing Association (ASHA) to conduct national job analysis studies which are linked to the examination validation process. The Board reviews the national ASHA studies during its examination validation and audit process to determine whether the current national professional expectations and job standards for speech-language pathology and audiology are congruent to those found in the California job analysis.

## Section 2 – Fiscal and Staff

**Fiscal Issues**

6. Is the board's fund continuously appropriated? If yes, please cite the statute outlining this continuous appropriation.

   The Board's fund is not continuously appropriated.

7. Using *Table 2.* ***Fund Condition****,* describe the board's current reserve level, spending, and if a statutory reserve level exists.

   During the past four budget years, the Board's reserve level has ranged from 5.5 months to its current level of 7.0 months. At the end of FY 2025-26, the Board is projected to have a balance of $3.2 million or 10.7 months of reserve, in its fund.

   There is no reserve level mandated by statute for the Board; however, the DCA Budget Office has historically recommended that smaller programs maintain a contingency fund slightly above the standard three to six months of reserve, which is typically recommended for agencies with moderate to larger budgets. Maintaining an adequate reserve of at least six months provides for a reasonable contingency fund so that the Board has the fiscal resources to absorb any unforeseen costs, such as costly enforcement actions or other unexpected client service costs.

   The Board in coordination with DCA's Organizational Improvement Office and Office of Information Services undertook a Business Modernization Project to move to new data systems that provide access for licensees and applicants to apply for licensure online and complete online transactions. The Board completed this project in June of 2023. During the Fiscal Year 2022-

23, the Board spent $411,000 in external vendor costs to transition to a new system, which was paid for by funds awarded to the Board through the California Department of Technology's Technology Modernization Fund. The level of expenditure decreased significantly after Fiscal Year 2023-24 to cover the cost of ongoing maintenance and operations of the online applications in the amount of $20,000 annually and in the future includes ongoing system licensing costs ranging from $35,860 to $41,580 annually (based on applicant usage of the system and therefore could change over time).

**Table 2. Fund Condition** (list dollars in thousands)

| | FY 2021/22 | FY 2022/23 | FY 2023/24 | FY 2024/25 | FY 2025/26* | FY 2026/27* |
|---|---|---|---|---|---|---|
| Beginning Balance | $1,440 | $1,165 | $1,595 | $1,901 | $1,920 | $2,292 |
| Revenues and Transfers | $2,512 | $2,955 | $3,286 | $3,454 | $3,660 | $3,623 |
| **Total Resources** | $3,952 | $4,120 | $4,881 | $5,355 | $5,580 | $5,915 |
| Budget Authority | $2,520 | $2,518 | $3,054 | $3,615 | $3,288 | $3,354 |
| Expenditures | $2,818 | $2,486 | $2,954 | $3,435 | $3,288 | $3,354 |
| Loans to General Fund | $0 | $0 | $0 | $0 | $0 | $0 |
| Accrued Interest, Loans to General Fund | $0 | $0 | $0 | $0 | $0 | $0 |
| Loans Repaid From General Fund | $0 | $0 | $0 | $0 | $0 | $0 |
| **Fund Balance** | $1,134 | $1,634 | $1,927 | $1,920 | $2,292 | $2,561 |
| **Months in Reserve** | **5.5** | **6.6** | **6.7** | **6.9** | **8.2** | **8.9** |

[1] Actuals include prior year adjustments
[2] Expenditures include reimbursements and direct draws to the fund
*Includes EO transfer to GF (AB 84)
**Estimate

8. Describe if/when a deficit is projected to occur and if/when a fee increase or reduction is anticipated. Describe the fee changes (increases or decreases) anticipated by the board.

   Due to the growing licensee population in most licensing categories, the Board's expenditures have steadily increased during the past four budget years. The most recent projections do not project fund insolvency in the near future. The Board works with DCA's Budget Office to closely monitor its revenues and expenditures.

   The Board anticipates fee changes to the HAD written and practical examinations through the rulemaking process within the next four years. The Board is authorized to establish the fees for taking and retaking the written and practical examinations, "which shall be equal to the actual cost of preparing, grading, analyzing, and administering the examinations" (BPC section 2538.57). The current HAD examination fees were established by resolution of the Board on February 1, 2011. Applicants are currently paying $225 for the written examination and $500 for the practical examination. In its November – December 2023 meeting, the Board proposed increasing the written examination by $25 and the practical examination by $100 after reviewing the actual cost of conducting the written and practical examinations in FY 2023-24. This proposed fee increase would have to go through the formal rulemaking process before it can become effective.

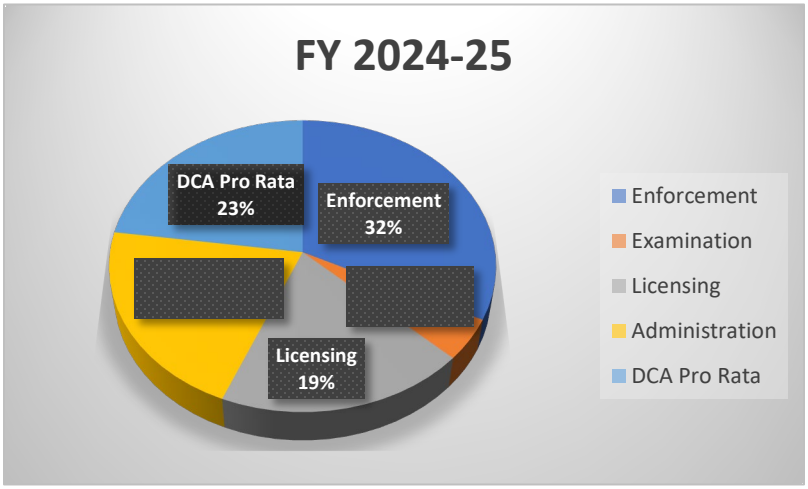
9. Using *Table 2,* ***Fund Condition***, describe year over year expenditure fluctuations and the cause for the fluctuations.

   The biggest contributors to expenditure fluctuations in the Board's budget are the Board's Attorney General costs for prosecuting enforcement cases and its Office of Professional Examination Services costs for examination development and occupational analysis and examination validation services.

   Enforcement is one of the biggest drivers of year over year expenditure fluctuations, with year over year changes ranging from a reduction of 57 percent to increases of up to 146 percent. This includes two fiscal years in which the Board had to request an augmentation for its Attorney General costs as the Board was not able to reduce other expenditures enough to absorb the additional Attorney General costs. These significant cost fluctuations depend on the volume of cases up for prosecution and the nature and severity of the cases being prosecuted in any given year, as well as whether the Board must respond to a writ filed against it.

   Examination costs accrued through the Office of Professional Examination Services fluctuate depending on whether the Board needs to perform a new occupational analysis for one of the three professions it regulates. This has become difficult to plan with the substantial fluctuations in Attorney General spending, so the Board has been investigating spreading out the costs of each occupational analysis over multiple fiscal years to make these costs more consistent annually and easier to build into our annual budget.

10. Using *Table 3*, ***Expenditures by Program Component****,* describe the amounts and percentages of expenditures by program component, including the cause of fluctuations aside from increasing personnel costs. Provide a breakdown of the expenditures by the board in each program area. Expenditures by each component (except for pro rata) should be broken out by personnel expenditures and other expenditures.




The Board operates on an annual budget of $3.32 million, with approximately 32 percent of its budget devoted to enforcement, 23 percent to DCA pro rata, 21 percent to administration, 19 percent to licensing, and five (5) percent to examinations (see chart to the left).

The Board's enforcement budget includes expenditures for services from other agencies that contribute to the investigative and disciplinary processes, such as the Office of the Attorney General, the Office of Administrative Hearings, and the Department of Consumer Affairs' Division of Investigation. In addition, the Department of Consumer Affairs is paid pro rata to provide support in areas that include human resources, accounting, information technology, and other administrative services.

Since the Board's last Sunset Review, printing and postage costs have risen significantly and are double to quadruple the costs the Board saw prior to Fiscal Year 2021-22. This large ongoing increase is a result of moving from State operated printers to contracted private vendors for the printing of licenses and renewal notices. As part of the Board's Budget Efficiency Reductions

related to Budget Letter 24-24, in Fiscal Year 2025-26 the Board initiated renewal postcard reminders instead of the very expensive renewal notice and coupon mailed out to licensees that require printing and postage costs. Currently, over 73 percent of licensees renew online, with an additional 7.7 percent that renew manually using a form downloaded from the Board's website, resulting in 80.7 percent of the renewal notices and coupons mailed each year not being utilized. The Board expects to see reductions in printing and postage costs as well as achieving a reduction in paper and materials costs.

**Table 3. Expenditures by Program Component** (list dollars in thousands)

| | FY 2021/22 | | FY 2022/23 | | FY 2023/24 | | FY 2024/25 | |
|---|---|---|---|---|---|---|---|---|
| | Personnel Services | OE&E | Personnel Services | OE&E | Personnel Services | OE&E | Personnel Services | OE&E |
| Enforcement | $432 | $347 | $492 | $229 | $504 | $306 | $519 | $558 |
| Examination | $- | $81 | $- | $47 | $- | $119 | $- | $153 |
| Licensing | $432 | $101 | $492 | $108 | $504 | $126 | $519 | $120 |
| Administration * | $607 | $116 | $685 | $125 | $578 | $116 | $589 | $110 |
| DCA Pro Rata | $- | $559 | $- | $197 | $- | $449 | $- | $757 |
| Diversion (if applicable) | $- | $- | $- | $- | $- | $- | $- | $- |
| **TOTALS** | $1,471 | $1,204 | $1,669 | $706 | $1,586 | $1,116 | $1,627 | $1,698 |

* Administration includes costs for executive staff, board, administrative support, and fiscal services.

11. Describe the amount the board has spent on business modernization, including contributions to the BreEZe program, which should be described separately.

    The Board ceased paying into the DCA BreEZe pro rata in FY 2017-18 as it was determined that the Board would pursue a different business modernization process and platform.

    During Fiscal Years 2021-22 and 2022-23, the Board in coordination with DCA's Organizational Improvement Office and Office of Information Services undertook a Business Modernization Project to move to new data system that provides access to online transactions for licensees, applicants and consumers. During the process of the Business Modernization Project, the Board determined that the larger project scope of enforcement complaints, renewal applications, and general licensure forms would have to be reduced to a smaller project scope of initial licensure applications in order for the Board's Fund Condition to accommodate the costs of the project (initial and ongoing). Additionally, during the 2021-22 Fiscal Year the Board was made aware of and applied for project funding through the California Department of Technology's competitive Technology Modernization Fund program. The Board was awarded over $411,000 during the Fiscal Years 2022-23 to cover the external vendor costs to transition to a new online system for initial application and payment submissions. The Board completed this project in March of 2023. The level of expenditure decreased significantly after Fiscal Year 2023-24 to only the cost of ongoing maintenance and operation of the Board's application workflows in the amount of $20,000 annually and soon will include covering the Board's portion of ongoing DCA system licensing costs ranging from $35,860 to $41,580 annually (based on our Board's applicant usage of the system). The Board expects ongoing costs of over $61,850 annually as the Board's application workload continues to grow to meet the high workforce demands for Speech-Language Pathologists and Speech-Language Pathology Assistants.

12. Describe license renewal cycles and the history of fee changes over the last 10 years. Give the fee authority (Business and Professions Code and California Code of Regulations citations) for each fee charged by the board.

Speech-Language Pathologists, Speech-Language Pathology Assistants, Audiologists (non-dispensing), and Continuing Professional Development Providers' licenses all renew biennially, expiring on the last day of the licensees' birth month. All Hearing Aid Dispensers' and Dispensing Audiologists' licenses renew annually.

The fees established for Hearing Aid Dispensers, Hearing Aid Dispenser Trainees, and Hearing Aid Dispenser Temporary licenses are set in statute and are currently at their maximum levels.

The Board was able to finalize a regulatory fee increase with the Office of Administrative Law for Audiologists, Speech-Language Pathologists, Speech-Language Pathology Assistants, and Speech-Language Pathology or Audiology Aides on June 29, 2021, with an implementation date of November 1, 2021 for the specified fee increases. With that regulatory fee increase, most license types are at their statutory maximum level.

**Table 4. Fee Schedule and Revenue** (list revenue dollars in thousands)

| Fee | Current Fee Amount | Statutory Limit | FY 2021/22 Revenue | FY 2022/23 Revenue | FY 2023/24 Revenue | FY 2024/25 Revenue | % of Total Revenue |
|---|---|---|---|---|---|---|---|
| **Other Regulatory Fee** | | | | | | | |
| License Certification Letter (7700) | $10 | $25 | $15 | $24 | $20 | $18 | 0.6% |
| Citation & Fine (6700) | Various | $2,500 | $30 | $13 | $9 | $17 | 0.6% |
| Citation & Fine (7700) | Various | $5,000 | $10 | $18 | $14 | $21 | 0.5% |
| Duplicate License (7700) | $25 | $25 | $13 | $13 | $13 | $15 | 0.4% |
| Duplicate License (6700) | $25 | $25 | $2 | $2 | $2 | $2 | 0.1% |
| License Certification Letter (6700) | $15 | $15 | $2 | $1 | $1 | $1 | 0.0% |
| **Licenses & Permits** | | | | | | | |
| SLP App | $150 | $150 | $109 | $254 | $312 | $345 | 8.3% |
| Practical Exam* | $500 | $500 | $105 | $91 | $132 | $122 | 3.7% |
| Written Exam* | $225 | $225 | $67 | $76 | $85 | $89 | 2.6% |
| SLPA App | $50 | $150 | $34 | $42 | $42 | $42 | 1.3% |
| HAD Initial License (HAD/DAU) | $280 | $280 | $37 | $24 | $46 | $46 | 1.2% |
| CE Provider | $50 | $50 | $31 | $30 | $33 | $30 | 1.0% |
| HAD App | $75 | $75 | $18 | $19 | $24 | $23 | 0.7% |
| AU App | $150 | $150 | $4 | $13 | $20 | $21 | 0.5% |
| HAD Trainee License | $100 | $100 | $14 | $16 | $17 | $16 | 0.5% |
| Branch License | $25 | $25 | $7 | $6 | $7 | $6 | 0.2% |
| CPD Provider App | $200 | $200 | $4 | $2 | $7 | $4 | 0.1% |
| Aide Registration | $10 | $30 | $1 | $2 | $3 | $2 | 0.1% |
| HAD Temporary License | $100 | $100 | $2 | $1 | $2 | $1 | 0.0% |

| **Table 4. Fee Schedule and Revenue** | | | | | | | (list revenue dollars in thousands) |
|---|---|---|---|---|---|---|---|
| Fee | Current Fee Amount | Statutory Limit | FY 2021/22 Revenue | FY 2022/23 Revenue | FY 2023/24 Revenue | FY 2024/25 Revenue | % of Total Revenue |
| **Renewal Fees** | | | | | | | |
| Biennial SLP | $110 | $150 | $1,154 | $1,363 | $1,460 | $1,533 | 44.9% |
| Biennial SLPA | $75 | $150 | $155 | $192 | $204 | $223 | 6.3% |
| Biennial AU | $110 | $150 | $36 | $35 | $40 | $36 | 1.2% |
| Biennial CPD | $200 | $200 | $11 | $11 | $10 | $10 | 0.3% |
| Annual DAU | $280 | $280 | $316 | $310 | $323 | $332 | 10.4% |
| Annual HAD | $280 | $280 | $297 | $294 | $295 | $301 | 9.7% |
| Annual Branch | $25 | $25 | $14 | $12 | $11 | $12 | 0.4% |
| HAD Trainee(6-month period) | $100 | $100 | $15 | $20 | $22 | $17 | 0.6% |
| **Delinquent Fees** | | | | | | | |
| SLP Delinquent Renewal | $25 | $25 | $20 | $20 | $24 | $25 | 0.7% |
| SLPA Delinquent Renewal | $25 | $25 | $5 | $6 | $5 | $7 | 0.2% |
| HAD Delinquent Renewal | $25 | $25 | $2 | $2 | $2 | $1 | 0.1% |
| AU Delinquent Renewal | $25 | $25 | $1 | $0 | $1 | $1 | 0.0% |
| DAU Delinquent Renewal | $25 | $25 | $1 | $1 | $1 | $1 | 0.0% |
| Branch Delinquent Renewal | $25 | $25 | $1 | $2 | $1 | $2 | 0.0% |
| Income from Surplus Money Investments | Not Applicable | Not Applicable | $6 | $34 | $87 | $106 | 1.9% |
| Revenue Cancelled Warrants | Not Applicable | Not Applicable | $3 | $3 | $6 | $5 | 0.1% |
| Dishonored Check Fee | $25 | Cost to DCA | $0 | $1 | $0 | $0 | 0.0% |

*HAD Examination Fees are established by the Board. The fees listed in this table have been in effect since February 1, 2011.

**Legend**

AU = Audiologist
CPD = Continuing Professional Development
DAU = Dispensing Audiologist
HAD = Hearing Aid Dispenser
SLP = Speech-Language Pathologist
SLPA = Speech-Language Pathology Assistant
7700 = AU/CPD/DAU/SLP/SLPA/AIDE
6700 = HAD/ HAD Trainee/ HAD Temporary

13. Describe Budget Change Proposals (BCPs) submitted by the board in the past four fiscal years.

The Board submitted two BCPs from 2020-21 to 2024-25, both of which were approved. The 2021-22 BCP was to complete planning activities and begin implementing the Board's Business Modernization Project including system integration, software licensing, project management, and staffing cost. This BCP resulted in the Board receiving permanent position authority for a 1.0 Associate Governmental Program Analyst position, but limited term funding for the position. The 2023-24 BCP was for additional staff to address increasing licensing and examination workload and unfulfilled continuing education (CE) audit workload. This BCP resulted in the Board receiving authority and funding for two positions, a 1.0 Office Technician and a 1.0 Staff Services Analyst position.

| Table 5. Budget Change Proposals (BCPs) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Personnel Services | | | | OE&E | |
| BCP ID # | Fiscal Year | Description of Purpose of BCP | # Staff Requested (include classification) | # Staff Approved (include classification) | $ Requested | $ Approved | $ Requested | $ Approved |
| 1111-124-BCP-2021-A1 | 2021-22 | Complete planning activities and begin implementing the Board's Business Modernization Project | 1.0 Associate Governmental Program Analyst | 1.0 Associate Governmental Program Analyst | $111,000 | $111,000 | $1,006,000 | $1,006,000 |
| 1111-026-BCP-2023-GB | 2023-24 | Address increasing licensing and examination workload and unfulfilled continuing education audit workload | 1.0 Office Technician<br>1.0 Staff Services Analyst | 1.0 Office Technician<br>1.0 Staff Services Analyst | $186,000 | $186,000 | $66,000 | $66,000 |

**Staffing Issues**

14. Describe any board staffing issues/challenges, i.e., vacancy rates, efforts to reclassify positions, staff turnover, recruitment and retention efforts, succession planning.

    For the oversight and responsibility of over 44,800 licensees, the Board is significantly understaffed, as the office is allocated 14.6 positions but only funded for 13.6 positions. This responsibility includes all aspects of licensing, examinations, enforcement, development of regulations, continuing education provider approval and licensee CE audits, and now includes maintenance and operation of the new online licensing system. The Board has considerably high retention of employees, with a retention rate averaging 88 percent over the past four fiscal years, with almost all Board vacancies being created through promotional opportunities for the employee or employee retirement from State service. The Board has been fortunate to have a considerably low number of vacancies, averaging only two vacant positions per year (one of which is unfunded and therefore unfilled). Since the last Sunset Review, the Board has had a 16 percent vacancy rate, compared to the State government average of 20 percent in February of 2024. However, with such a small number of staff, the loss of even one member can have a deleterious impact on the Board's ability to handle current workload demands. Currently, the Board is only able to handle its current workload demands by utilizing business modernization improvements that resulted in an increase in processing capacity and significant overtime. The Board's ability to maintain these workload demands using improved technology and overtime will become strained in the coming years if annual growth rates in the Board's application workload and licensee population continue their current trajectory.

    One area the Board highlighted in its 2025 - 2028 Strategic Plan (see Section 11, Attachment E) under Board Administration is better defining necessary staffing levels and, if needed, obtaining additional staffing through the budget process, as well as reviewing the organizational structure to ensure appropriate oversight of Board operations and supervision of staff. Board management believes the necessary organizational review required to accomplish these goals will also help facilitate Board succession planning, to ensure long-term leadership continuity and smooth delivery of services by the Board well into the future.

15. Describe the board's staff development efforts and total spent annually on staff development. (cf., Section 11, Attachment D).

All staff are encouraged to take courses related to their roles and responsibilities, broaden their knowledge base, and better prepare for advancement opportunities. Cross-training is encouraged for further development and allows our small Board to function more efficiently. In addition to the training available, staff is given the opportunity to grow professionally, working on special assignments and projects.

During the past four years, the Board has spent approximately $3,028 on staff training. The majority of training courses attended by staff are provided by DCA's SOLID training office and are included in pro rata costs. External trainings are taken by staff, such as the National Certified Investigator and Inspector Training (NCIT) Programs enforcement training for all enforcement staff through the national Council on Licensure, Enforcement and Regulation (CLEAR). CLEAR is the premier resource nationally for professional regulation and its NCIT training program has set the standard for regulatory investigation and inspection training. Some examples of classes staff have taken through DCA's SOLID training office include Responsible AI for Public Professionals, Leadership Roundtable: The Truth about Employee Engagement, Beyond the Obvious: Cultivate Human Skills & Critical Thinking, Unleash the Power of Generational Differences, An Introduction to Regulations, and Finding Time - Improving your Time Management Skills.

## Section 3 – Licensing Program

**Table 6. Licensee Population**

| | | FY 2021/22 | FY 2022/23 | FY 2023/24 | FY 2024/25 |
|---|---|---|---|---|---|
| Aide | Active[3] | 79 | 82 | 116 | 117 |
| | Out of State | 0 | 0 | 0 | 0 |
| | Out of Country | 0 | 0 | 0 | 0 |
| | Delinquent/Expired | 207 | 222 | 228 | 177 |
| | Retired Status *if applicable* | N/A | N/A | N/A | N/A |
| | Inactive | N/A | N/A | N/A | N/A |
| | Other[4] | 190 | 233 | 259 | 376 |
| Audiologist | Active* | 1,661 | 1,784 | 1,803 | 1,794 |
| | Out of State | 209 | 208 | 208 | 224 |
| | Out of Country | 4 | 5 | 5 | 5 |
| | Delinquent/Expired | 365 | 395 | 401 | 418 |
| | Retired Status *if applicable* | N/A | N/A | N/A | N/A |
| | Inactive | 66 | 122 | 121 | 54 |
| | Other | 1,095 | 984 | 1,221 | 1,300 |
| Audiologist Temporary | Active | 0 | 0 | 0 | 1 |
| | Out of State | 0 | 0 | 0 | 1 |
| | Out of Country | 0 | 0 | 0 | 0 |
| | Delinquent/Expired | 8 | 7 | 7 | 7 |
| | Retired Status *if applicable* | N/A | N/A | N/A | N/A |
| | Inactive | N/A | N/A | N/A | N/A |
| | Other | 6 | 8 | 8 | 9 |

[3] Active status is defined as able to practice. This includes licensees that are renewed, current, and active.
[4] Other is defined as a status type that does not allow practice in California, other than retired or inactive.

| Table 6. Licensee Population | | | | | |
|---|---|---|---|---|---|
| | | FY 2021/22 | FY 2022/23 | FY 2023/24 | FY 2024/25 |
| Continuing Professional Development Provider | Active | 143 | 134 | 160 | 149 |
| | Out of State | 21 | 19 | 22 | 23 |
| | Out of Country | 0 | 0 | 0 | 0 |
| | Delinquent/Expired | 6 | 9 | 1 | 8 |
| | Retired Status *if applicable* | N/A | N/A | N/A | N/A |
| | Inactive | N/A | N/A | N/A | N/A |
| | Other | 264 | 274 | 297 | 322 |
| Hearing Aid Dispenser | Active | 1,101 | 1,110 | 1,162 | 1,164 |
| | Out of State | 70 | 73 | 55 | 54 |
| | Out of Country | 0 | 0 | 0 | 0 |
| | Delinquent/Expired | 270 | 252 | 229 | 234 |
| | Retired Status *if applicable* | N/A | N/A | N/A | N/A |
| | Inactive | 11 | 36 | 33 | 13 |
| | Other | 1,974 | 2,059 | 2,195 | 2,327 |
| Hearing Aid Dispenser Trainee | Active | 135 | 177 | 170 | 147 |
| | Out of State | 0 | 1 | 2 | 2 |
| | Out of Country | 0 | 0 | 0 | 0 |
| | Delinquent/Expired | 119 | 117 | 141 | 32 |
| | Retired Status *if applicable* | N/A | N/A | N/A | N/A |
| | Inactive | 0 | 1 | 0 | 0 |
| | Other | 1,360 | 1,451 | 1,604 | 1,991 |
| Hearing Aid Dispenser Temporary License | Active | 20 | 8 | 13 | 13 |
| | Out of State | 14 | 3 | 7 | 9 |
| | Out of Country | 0 | 0 | 0 | 0 |
| | Delinquent/Expired | 41 | 50 | 53 | 58 |
| | Retired Status *if applicable* | N/A | N/A | N/A | N/A |
| | Inactive | N/A | N/A | N/A | N/A |
| | Other | 126 | 137 | 143 | 152 |
| Hearing Aid Dispenser Branch License | Active | 573 | 519 | 683 | 510 |
| | Out of State | N/A | N/A | N/A | N/A |
| | Out of Country | N/A | N/A | N/A | N/A |
| | Delinquent/Expired | 721 | 690 | 626 | 619 |
| | Retired Status *if applicable* | N/A | N/A | N/A | N/A |
| | Inactive | N/A | N/A | N/A | N/A |
| | Other | 2,424 | 2,731 | 3,006 | 3,349 |
| Required Professional Experience | Active | 1,147 | 1,254 | 1,665 | 1265 |
| | Out of State | 87 | 43 | 54 | 49 |
| | Out of Country | 0 | 0 | 4 | 0 |
| | Delinquent/Expired | 493 | 605 | 638 | 381 |
| | Retired Status *if applicable* | N/A | N/A | N/A | N/A |
| | Inactive | N/A | N/A | N/A | N/A |
| | Other | 5,866 | 6,743 | 7,776 | 10,153 |
| Speech-Language Pathologist | Active | 19,228 | 20,558 | 22,005 | 22,775 |
| | Out of State | 3,787 | 3,995 | 4,392 | 4,709 |
| | Out of Country | 43 | 46 | 56 | 47 |
| | Delinquent/Expired | 3,706 | 4,169 | 4,240 | 4,523 |
| | Retired Status *if applicable* | N/A | N/A | N/A | N/A |
| | Inactive | 506 | 1,031 | 1,034 | 350 |
| | Other | 8,279 | 7,056 | 9,561 | 10,433 |

| Table 6. Licensee Population | | | | | |
|---|---|---|---|---|---|
| | | FY 2021/22 | FY 2022/23 | FY 2023/24 | FY 2024/25 |
| Speech-Language Pathologist Temporary | Active | 0 | 1 | 1 | 2 |
| | Out of State | 0 | 1 | 1 | 1 |
| | Out of Country | 0 | 0 | 0 | 0 |
| | Delinquent/Expired | 0 | 0 | 4 | 3 |
| | Retired Status *if applicable* | N/A | N/A | N/A | N/A |
| | Inactive | N/A | N/A | N/A | N/A |
| | Other | 1 | 1 | 1 | 4 |
| Speech-Language Pathology Assistant | Active | 4,166 | 4,635 | 5,169 | 5,323 |
| | Out of State | 154 | 148 | 160 | 177 |
| | Out of Country | 0 | 0 | 1 | 2 |
| | Delinquent/Expired | 1,145 | 1,247 | 1,296 | 1,339 |
| | Retired Status *if applicable* | N/A | N/A | N/A | N/A |
| | Inactive | 160 | 333 | 338 | 125 |
| | Other | 1,744 | 2,017 | 2,363 | 2,915 |

Note: 'Out of State' and 'Out of Country' are two mutually exclusive categories. A licensee should not be counted in both.
* Due to system reporting limitations, Audiologist data cannot be separated out from Dispensing Audiologist data.

16. What are the board's performance targets/expectations for its licensing[5] program? Is the board meeting those expectations? If not, what is the board doing to improve performance?

    Since 2016-17, the Department of Consumer Affairs publishes Board application processing targets and timeframes in its Open Data Portal. The Board's data is provided below. With the exception of fiscal years 2022-23 and 2023-24, when the Board was undertaking its initial licensing Business Modernization Project and working through the application backlogs created during the project, the Board met its performance targets. The Board's Business Modernization Project required substantial staff resources in order to implement successfully, but once fully implemented has generated a significant decrease in overall processing timeframes throughout the year that the Board firmly believes will continue into the future.

| Complete Applications Licensing Processing Timeframes (in days) | | | | | |
|---|---|---|---|---|---|
| License Type | Target Processing Timeframe | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
| Aide | 30 | 22 | 65 | 56 | 9 |
| Audiologist | 30 | 28 | 60 | 48 | 12 |
| Audiologist Temporary | 30 | 1 | N/A | N/A | 6 |
| Hearing Aid Dispensers (License Application) | 21 | 12 | 13 | 23 | 6 |
| Hearing Aid Dispenser Temporary | 21 | 21 | 14 | 16 | N/A |
| Hearing Aid Dispenser Trainee | 21 | 25 | 53 | 48 | 12 |
| Required Professional Experience Temporary | 30 | 12 | 60 | 57 | 17 |
| Speech-Language Pathologist | 30 | 29 | 58 | 43 | 9 |
| Speech-Language Pathology Assistant | 30 | 44 | 53 | 59 | 15 |

17. Using *Table 7a,* ***Licensing Data by Type***, describe any increase or decrease in the board's average time to process applications, administer exams and/or issue licenses. Have pending applications grown at a rate that exceeds completed applications? If so, what has been done

by the board to address them? What are the performance barriers and what improvement plans are in place? What has the board done and what is the board going to do to address any performance issues, i.e., process efficiencies, regulations, BCP, legislation?

During the Board's last Sunset Review, the Board saw increases in its application processing timeframes despite extensive use of staff overtime due to increased application workload and manual paper-based processes. During that period, 2017-18 to 2020-21, the Board averaged 3,694 applications received annually. Since that time, the annual application workload continued to increase by approximately 32% over the last four years, with the Board averaging 4,864 applications received annually. Without the Board's Business Modernization Project, which streamlined and automated many licensing processes, the Board would not have been able to meet the continued growth in application workload within processing timeframe targets with current staff resources.

The Board's Business Modernization Project created a new online licensing system that provides applicants the ability to apply for licensure, complete online payment transactions, and remedy application deficiencies using the online system. The new online licensing system also provides streamlined and automated processes related to staff review and processing of applications, including built-in calculation capacity when evaluating professional/clinical experience accrued by applicants, automated deficiency functionality and emails sent through the system to the applicant, and reduction in time spent manually collecting various forms and documents related to a single application.

The new online application system streamlined and automated the vast majority of application processes for both applicants and Board staff, excluding verification of examination scores and college transcripts. For example, an applicant for an RPE license used to have to obtain the wet signature of their graduate program director and their future supervisor and submit these with their application for licensure. With the new online application system, once the applicant enters their information into the system along with the email addresses of their graduate program director and their future supervisor, the system sends emails to the graduate program director and supervisor to obtain completion and secure digital signature of the necessary form. The new online application system also sends periodic email reminders to these individuals and the applicant when the form has not been completed or signed. The new online application system also streamlines processing of applications as it allows staff to review all necessary application components within one screen with access to downloadable attachments of items such as college transcripts or digital copies of the signed forms. The new online application system also sends email status updates to applicants as they progress through the licensing process and has the functionality to receive and respond to deficiency notice emails from Board staff, including the ability to upload additional documents as well as copies of completed documents and forms when needed. Altogether, this project created a more streamlined and user-friendly application process for the applicant, that helped improve application accuracy and reduce processing timeframes.

The Board undertook this project with an intensely short timeframe of under one year from start to finish. The Board obtained the necessary contracts to start the project in Summer 2023, began launching online applications for initial licensure in multiple releases starting in the Fall of 2022, and completed the creation and deployment of all initial applications for licensure in February of 2023. In total, the Board launched 29 application workflows that support the various qualification methods and online payment for the Board's 13 license types. The Board then used the same technology solution to create its new online applications to develop and launch new legislatively mandated online military spouse/domestic partner temporary license applications in June 2023.

With the short timeframe and extensive work required to create, test, and deploy the many application workflows, the Board had to divert a significant amount of staff time to successfully complete the project. This is evidenced in the higher processing timeframes seen in fiscal years 2022-23 and 2023-24, but the benefits of the new online licensing system are evidenced in fiscal year 2024-25 and ongoing.

The Board's internal tracking showed that within one year of implementation of the new online licensing system, there was a 48 percent reduction in processing times, and within two years of implementation the Board showed an average reduction of 71 percent in processing times for licensing applications. The Board now consistently averages between 1 – 2 weeks processing times for complete applications throughout the year. Additionally, the new online licensing system also increased Board application processing capacity, allowing the same four Board licensing analysts to process 27 percent more applications within one year of implementation and 34 percent more applications within two years of implementation. This has made it possible for Board staff to meet the challenge of continued application workload growth without impacting licensing timeframes.

**Table 7a. Licensing Data by Type**

| | | Received | Approved /Issued | Closed | Pending Applications | | | Application Process Times | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Total (Close of FY) | Complete (within Board control)* | Incomplete (outside Board control)* | Complete Apps* | Incomplete Apps* | Total (Close of FY)) |
| FY 2021/22 | (Exam) | | | | | | | | | |
| | HAD Written | 397 | 306 | N/A | ** | ** | ** | ** | ** | ** |
| | HAD Practical | 243 | 243 | N/A | ** | ** | ** | ** | ** | ** |
| | (License) | | | | | | | | | |
| | AIDE | 53 | 44 | 1 | 8 | ** | ** | 22 | 47 | ** |
| | AU | 97 | 79 | 2 | 12 | ** | ** | 28 | 90 | ** |
| | AUT | 5 | 4 | 0 | 1 | ** | ** | 1 | 5 | ** |
| | DAU | 53 | 28 | UA | UA | ** | ** | UA | UA | ** |
| | CPD | 19 | 14 | 0 | 0 | ** | ** | 5 | 5 | ** |
| | HA | 118 | 114 | 0 | 43 | ** | ** | 12 | N/A | ** |
| | HTL | 26 | 22 | 1 | 2 | ** | ** | 21 | 56 | ** |
| | HT | 122 | 124 | 0 | 2 | ** | ** | 25 | 67 | ** |
| | HA Branch | 228 | 263 | UA | UA | ** | ** | UA | UA | ** |
| | RPE | 1,278 | 1,177 | 0 | 42 | ** | ** | 12 | 75 | ** |
| | SP | 1,765 | 1,782 | 3 | 87 | ** | ** | 29 | 105 | ** |
| | SPT | 1 | 1 | 0 | 0 | ** | ** | 1 | N/A | ** |
| | SPA | 671 | 649 | 4 | 18 | ** | ** | 44 | 83 | ** |
| | (Renewal) | | | | | | | | | |
| | AU | 295 | 253 | ** | ** | ** | ** | ** | ** | 5 |
| | DAU | 1,145 | 1,132 | ** | ** | ** | ** | ** | ** | 4 |
| | CPD | 57 | 54 | ** | ** | ** | ** | ** | ** | 4 |
| | HA | 1,083 | 1,056 | ** | ** | ** | ** | ** | ** | 8 |
| | HT | 162 | 158 | ** | ** | ** | ** | ** | ** | 2 |
| | HA Branch | 542 | 541 | ** | ** | ** | ** | ** | ** | 6 |
| | SP | 8,993 | 8,736 | ** | ** | ** | ** | ** | ** | 7 |
| | SPA | 1,799 | 1,732 | ** | ** | ** | ** | ** | ** | 7 |

| Table 7a. Licensing Data by Type | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Pending Applications | | | Application Process Times | | |
| | | Received | Approved /Issued | Closed | Total (Close of FY) | Complete (within Board control)* | Incomplete (outside Board control)* | Complete Apps* | Incomplete Apps* | Total (Close of FY)) |
| FY 2022/23 | (Exam) | | | | | | | | | |
| | HAD Written | 342 | 309 | ** | ** | ** | ** | ** | ** | ** |
| | HAD Practical | 181 | 181 | ** | ** | ** | ** | ** | ** | ** |
| | (License) | | | | | | | | | |
| | AIDE | 84 | 52 | 5 | 22 | ** | ** | 65 | 83 | ** |
| | AU | 114 | 50 | 1 | 15 | ** | ** | 60 | 129 | ** |
| | AUT | 2 | 1 | 0 | 1 | ** | ** | N/A | 149 | ** |
| | DAU | 37 | 37 | UA | UA | ** | ** | UA | UA | ** |
| | CPD | 12 | 11 | 0 | 0 | ** | ** | 23 | 23 | ** |
| | HA | 50 | 50 | 0 | 55 | ** | ** | 13 | 10 | ** |
| | HTL | 15 | 7 | 2 | 2 | ** | ** | 14 | N/A | ** |
| | HT | 170 | 142 | 0 | 6 | ** | ** | 53 | 82 | ** |
| | HA Branch | 183 | 213 | UA | UA | ** | ** | UA | UA | ** |
| | RPE | 1,512 | 1,089 | 11 | 54 | ** | ** | 60 | 130 | ** |
| | SP | 2,396 | 1,665 | 10 | 146 | ** | ** | 58 | 128 | ** |
| | SPT | 4 | 1 | 3 | 4 | ** | ** | 8 | N/A | ** |
| | SPA | 873 | 639 | 5 | 35 | ** | ** | 53 | 143 | ** |
| | (Renewal) | | | | | | | | | |
| | AU | 248 | 223 | ** | ** | ** | ** | ** | ** | 4 |
| | DAU | 1,132 | 1,131 | ** | ** | ** | ** | ** | ** | 7 |
| | CPD | 56 | 54 | ** | ** | ** | ** | ** | ** | 5 |
| | HA | 1,054 | 1,031 | ** | ** | ** | ** | ** | ** | 8 |
| | HT | 205 | 206 | ** | ** | ** | ** | ** | ** | 2 |
| | HA Branch | 481 | 476 | ** | ** | ** | ** | ** | ** | 4 |
| | SP | 9,380 | 9,227 | ** | ** | ** | ** | ** | ** | 6 |
| | SPA | 2,027 | 1,992 | ** | ** | ** | ** | ** | ** | 6 |
| FY 2023/24 | (Exam) | | | | | | | | | |
| | HAD Written | 396 | 377 | ** | ** | ** | ** | ** | ** | ** |
| | HAD Practical | 331 | 331 | ** | ** | ** | ** | ** | ** | ** |
| | (License) | | | | | | | | | |
| | AIDE | 85 | 60 | 4 | 29 | ** | ** | 56 | 57 | ** |
| | AU | 128 | 89 | 3 | 19 | ** | ** | 48 | 109 | ** |
| | AUT | 0 | 0 | 0 | 0 | ** | ** | N/A | N/A | ** |
| | DAU | 54 | 33 | UA | UA | ** | ** | UA | UA | ** |
| | CPD | 32 | 29 | 0 | 24 | ** | ** | 16 | 24 | ** |
| | HA | 112 | 145 | 0 | 65 | ** | ** | 23 | 23 | ** |
| | HTL | 15 | 13 | UA | 1 | ** | ** | 16 | 83 | ** |
| | HT | 169 | 173 | 2 | 7 | ** | ** | 48 | 110 | ** |
| | HA Branch | 226 | 256 | 11 | UA | ** | ** | UA | UA | ** |
| | RPE | 1,415 | 1,469 | 3 | 67 | ** | ** | 57 | 182 | ** |
| | SP | 1,937 | 2,129 | 13 | 153 | ** | ** | 43 | 120 | ** |
| | SPT | 9 | 4 | 2 | 4 | ** | ** | 20 | 28 | ** |
| | SPA | 886 | 914 | 3 | 55 | ** | ** | 59 | 134 | ** |

## Table 7a. Licensing Data by Type

| | | Received | Approved /Issued | Closed | Pending Applications | | | Application Process Times | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Total (Close of FY) | Complete (within Board control)* | Incomplete (outside Board control)* | Complete Apps* | Incomplete Apps* | Total (Close of FY)) |
| FY 2023/24 | (Renewal) | | | | | | | | | |
| | AU | 288 | 249 | ** | ** | ** | ** | ** | ** | 7 |
| | DAU | 1,154 | 1,177 | ** | ** | ** | ** | ** | ** | 4 |
| | CPD | 53 | 53 | ** | ** | ** | ** | ** | ** | 2 |
| | HA | 1,058 | 1,039 | ** | ** | ** | ** | ** | ** | 6 |
| | HT | 217 | 207 | ** | ** | ** | ** | ** | ** | 3 |
| | HA Branch | 489 | 482 | ** | ** | ** | ** | ** | ** | 2 |
| | SP | 9,922 | 9,714 | ** | ** | ** | ** | ** | ** | 5 |
| | SPA | 2,080 | 2,002 | ** | ** | ** | ** | ** | ** | 3 |
| FY 2024/25 | (Exam) | | | | | | | | | |
| | HAD Written | 408 | 418 | ** | ** | ** | ** | ** | ** | ** |
| | HAD Practical | 267 | 267 | ** | ** | ** | ** | ** | ** | ** |
| | (License) | | | | | | | | | |
| | AIDE | 81 | 53 | 1 | 23 | ** | ** | 9 | 117 | ** |
| | AU | 135 | 89 | 0 | 24 | ** | ** | 12 | 74 | ** |
| | AUT | 2 | 2 | 0 | 0 | ** | ** | 6 | 110 | ** |
| | DAU | 45 | 40 | UA | UA | ** | ** | UA | UA | ** |
| | CPD | 20 | 19 | 0 | 7 | ** | ** | 13 | 111 | ** |
| | HA | 120 | 139 | 1 | 45 | ** | ** | 6 | 31 | ** |
| | HTL | 14 | 13 | 0 | 2 | ** | ** | N/A | 82 | ** |
| | HT | 157 | 153 | 3 | 8 | ** | ** | 12 | 45 | ** |
| | HA Branch | 240 | 265 | UA | UA | ** | ** | UA | UA | ** |
| | RPE | 1,304 | 1,306 | 1 | 80 | ** | ** | 17 | 110 | ** |
| | SP | 1,523 | 2,298 | 7 | 435 | ** | ** | 9 | 66 | ** |
| | SPT | 13 | 3 | 5 | 43 | ** | ** | N/A | 132 | ** |
| | SPA | 846 | 821 | 1 | 0 | ** | ** | 15 | 83 | ** |
| | (Renewal) | | | | | | | | | |
| | AU | 272 | 243 | ** | ** | ** | ** | ** | ** | 8 |
| | DAU | 1,202 | 1,204 | ** | ** | ** | ** | ** | ** | 4 |
| | CPD | 53 | 54 | ** | ** | ** | ** | ** | ** | 5 |
| | HA | 1,099 | 1,079 | ** | ** | ** | ** | ** | ** | 3 |
| | HT | 208 | 168 | ** | ** | ** | ** | ** | ** | 2 |
| | HA Branch | 471 | 464 | ** | ** | ** | ** | ** | ** | 3 |
| | SP | 10,601 | 10,505 | ** | ** | ** | ** | ** | ** | 4 |
| | SPA | 2,372 | 2,324 | ** | ** | ** | ** | ** | ** | 4 |

* Optional. List if tracked by the board.

** The Board's data systems cannot extract or calculate this data item as requested

| Table 7b. License Denial | | | | |
|---|---|---|---|---|
| | FY 2021/22 | FY 2022/23 | FY 2023/24 | FY 2024/25 |
| License Applications Denied (no hearing requested) | 1 | 0 | 1 | 1 |
| SOIs Filed | 0 | 2 | 0 | 2 |
| Average Days to File SOI (from request for hearing to SOI filed) | N/A | 102 | N/A | 38 |
| SOIs Declined | 0 | 0 | 0 | 0 |
| SOIs Withdrawn | 0 | 0 | 0 | 1 |
| SOIs Dismissed (license granted) | 0 | 0 | 0 | 0 |
| License Issued with Probation / Probationary License Issued | 1 | 0 | 2 | 0 |
| Average Days to Complete (from SOI filing to outcome) | 341 | N/A | 221 | N/A |

18. How many licenses or registrations has the board denied over the past four years based on criminal history that is determined to be substantially related to the qualifications, functions, or duties of the profession, pursuant to BPC § 480? Please provide a breakdown of each instance of denial and the acts the board determined were substantially related.

    License or Registration Denials Based on Criminal History:
    - FY 2021-22: 1
    - FY 2022/23: 2
    - FY 2023/24: 1
    - FY 2024/25: 3

    Criminal Acts For Each Denial:
    - FY 2021-22:
        - Applicant 1 denied based on conviction(s) of: DUI convictions (2).
    - FY 2022-23:
        - Applicant 1 denied based on conviction(s) of: Misdemeanor for battery and child abuse and endangerment; Misdemeanor for inflicting corporal injury on spouse/cohabitant; DUI conviction; and Driving on a suspended license.
        - Applicant 2 denied based on conviction(s) of: DUI convictions (2).
    - FY 2023-24:
        - Applicant 1 denied based on conviction(s) of: DUI conviction, Misdemeanor for willful cruelty to child and child endangerment.
    - FY 2024-25:
        - Applicant 1 denied based on conviction(s) of: DUI conviction; DUI reduced to reckless driving.
        - Applicant 2 denied based on conviction(s) of: DUI conviction, Misdemeanor conviction of vandalism related to domestic violence incident.
        - Applicant 3 denied based on conviction(s) of: DUI convictions (2).

19. How does the board verify information provided by the applicant?

    The Board requires primary source documentation for all educational transcripts, clinical experience records, license verifications from other states, national examination scores, and professional certifications. In addition, applicants for licensure as a Speech-Language Pathologist or Audiologist must complete an externship or required professional experience (RPE). This experience is completed under a temporary license which enables the individual to work under limited supervision. The externship is recorded on the Board's RPE Verification form which is

completed by an approved licensed or credentialed supervisor. The RPE supervisor is responsible for certifying the completion of the requisite hours of experience, as well as determining whether the RPE temporary licensee is competent to practice independently. Even with the new online licensing system, primary source verification is still completed, whether that is obtaining electronic signatures from supervisors or with electronic transcripts and examination scores that are submitted directly to the Board and then entered into the system.

- What process does the board use to check prior criminal history information, prior disciplinary actions, or other unlawful acts of the applicant? Has the board denied any licenses over the last four years based on the applicant's failure to disclose information on the application, including failure to self-disclose criminal history? If so, how many times and for what types of crimes (please be specific)?

  Applicants are required to declare, under penalty of perjury, whether they have ever been denied a professional license or had license privileges suspended, revoked or disciplined or if they have ever voluntarily surrendered a professional license in California or any other state. If an applicant reports such an act, the Board requires the applicant to provide a written explanation, documentation relating to the disciplinary action, and rehabilitative efforts or changes made to prevent future occurrences.

- Does the board fingerprint all applicants?

  Prior to licensure, all applicants are required to submit fingerprints to the Department of Justice and to the Federal Bureau of Investigation.

- Have all current licensees been fingerprinted? If not, explain.

  All current licensees have been fingerprinted.

- Is there a national databank relating to disciplinary actions? Does the board check the national databank prior to issuing a license? Renewing a license?

  The National Practitioner Data Bank (NPDB) is the national databank for reporting discipline on healthcare professionals. Information contained in the databank is provided by state regulatory agencies and other entities that are required to report disciplinary information. The Board reports disciplinary actions taken against its licensees to NPDB. However, not all entities consistently comply with the reporting requirement. Therefore, the information may be either non-existent or out of date. The Board or the applicant is required to pay a fee for each query prior to receiving a response. Currently, the Board does not query the NPDB prior to issuing or renewing a license because of the fiscal impact.

  The Board verifies an out-of-state applicant's licensure status through other state regulatory Boards. This verification process also provides any disciplinary history, if it exists. For verification of in-state licensure status the Board can check for prior disciplinary actions through the Commission on Teacher Credentialing (CTC), and the Consumer Affairs System (CAS). At each renewal, all licensees and registrants are required to report to the Board any conviction or disciplinary action taken against their license or registration during the last renewal cycle. The Board also receives subsequent conviction information on its licensees from DOJ via email notification. Once notified of the conviction or disciplinary action, the Board requests all relevant documentation to determine if any action by the Board is necessary.

- Does the board require primary source documentation?

  The Board requires primary source documentation for all educational transcripts, clinical experience records, license verifications from other states, national examination scores, and professional certifications. These documents must be submitted to the Board by the originating source but can be submitted electronically.

- Does the board send No Longer Interested notifications to DOJ on a regular and ongoing basis? Is this done electronically? Is there a backlog? If so, describe the extent and efforts to address the backlog.

  The Board submits No Longer Interested (NLI) notifications to the DOJ when a license status is canceled, deceased, revoked, surrendered, or when an application is deemed abandoned. Since the launch of the CAS NLI automated implementation, staff has worked with DCA OIS to ensure data is verified and submitted to DOJ.

20. Describe the board's legal requirement and process for out-of-state and out-of-country applicants to obtain licensure.

    Hearing Aid Dispensers
    Pursuant to Business & Professions Code Section 2538.27, applicants applying for a license in California and who possess a valid license in another state (or states) for two or more years may apply for a temporary license. To attain full licensure as a Hearing Aid Dispenser in California, temporary license applicants are required to pass the written and practical examinations. The temporary license is valid for up to 12 months and allows applicants to immediately begin practice in California while preparing for the written and practical examinations.

    Currently, there are no legal provisions for granting a license or temporary license to an individual who has practiced as a Hearing Aid Dispenser in another country.

    Speech-Language Pathologist/Audiologist
    Business & Professions Code (BPC) Section 2532.3 allows an individual who holds an unrestricted license in another state or territory of the United States to obtain a temporary license for a period of six months. The temporary license authorizes the out-of-state applicant to begin work immediately, as long as fingerprinting was completed, while all other required documents and supporting information are being transmitted to the Board for review. Once all licensing information has been submitted, reviewed, and approved, the individual is eligible for a permanent license. The statute authorizes the Board to renew the temporary license one time if an extenuating circumstance exists, surrounding the individual's ability to complete the license application.

    Another option for out-of-state applicants is equivalence through national certification. BPC Section 2532.8 provides a simplified application process for those who hold a national Certificate of Clinical Competence (CCC) in speech-language pathology or audiology, issued by the American Speech-Language-Hearing Association (ASHA), or American Board of Audiology (ABA) certification issued by the American Academy of Audiology. This law deems that a person has met the educational and experience requirements identified in BPC Section 2532.2 if the individual holds the national certificate.

    Out-of-Country Applicants

BPC Section 2532.2 and California Code of Regulations Code Section 1399.152.1 include an equivalency pathway for foreign-trained Speech-Language Pathologists and Audiologists. The regulations require that in lieu of a master's degree from an accredited university, an applicant may submit evidence of completion of at least 30 semester units acceptable toward a master's degree while registered in a degree program in speech-language pathology or audiology. The foreign-trained applicant must have their educational transcripts evaluated by an approved transcript evaluation service. The service provides the Board with a report of the courses taken and the academic units and clinical hours earned. The report also provides a conversion of the foreign grading scale and credit system into the U.S. grading scale, and an equivalency of the degree conferred at the international institution to that which would be earned in the U.S.

Once the Board receives an application and the transcript evaluation report, the transcripts and the evaluation report are reviewed by Board staff and, when necessary, sent to a Board-appointed expert reviewer to determine that equivalent educational and experience qualifications are met. The applicant must also take and pass the required national examination and complete the required professional experience to be eligible for a permanent license.

21. Describe the board's process, if any, for considering military education, training, and experience for purposes of licensing or credentialing requirements, including college credit equivalency.

    The Board is unaware of any military education, training, and experience that would satisfy the requirements for licensure as Speech-Language Pathologists, Speech-Language Pathology Assistants, or Audiologists. Hearing Aid Dispensers do not have minimum educational requirements for licensure.

    - How many applicants offered military education, training or experience towards meeting licensing or credentialing requirements, and how many applicants had such education, training or experience accepted by the board?

      To date, the Board has not received an application in which military education, training or experience was submitted toward the licensing requirements.

    - How many licensees has the board waived fees or requirements for pursuant to BPC § 114.3, and what has the impact been on board revenues?

      Since 2021-22, the Board has waived the renewal requirements and fees for one (1) licensee called to active duty as a member of the United States Armed Forces or California National Guard. Since 2021-22, the impact to the Board's revenue was minimal.

    - How many applications has the board expedited pursuant to BPC § 115.5?

      Since the Board's last Sunset Review, the Board received 86 military spouse applications. Applicants have typically encountered delays due to fingerprinting issues or when the applicant had convictions or discipline against their license in the other state; both of these issues are outside of the Board's control. The Board will continue to track and expedite military spouse applications.

**Examinations**

22. Describe the examinations required for licensure. Is a national examination used? Is a California specific examination required? Are examinations offered in a language other than English?

Hearing Aid Dispensers

Written and Practical examinations are developed, maintained and evaluated with facilitation by Office of Professional Examination Services (OPES) and in collaboration with licensed and practicing, Hearing Aid Dispensers and Dispensing Audiologists.

The Hearing Aid Dispenser's Written Examination is administered by the exam contractor PSI and assesses an applicant's knowledge and abilities as follows:

- Evaluating and interpreting audiometric test results
- Assessing client history and hearing ability (through audiometric testing)
- Selecting and evaluation of hearing aids
- Fitting a hearing aid and providing the instructions on care and use
- Troubleshooting and evaluating hearing aids.

The Board provides an English-only version of the written examination for administration under our computer-based testing contract.

The practical examination is required by BPC Section 2538.31 to be administered a minimum of two times per year. Typically, the Board administers the examination four to five times per year to accommodate applicants interested in entering the field. The practical examination requires actual demonstration of the knowledge and techniques for using instruments and equipment necessary for the fitting and selling of hearing aids.

OPES facilitates ongoing examination development workshops where subject matter experts (licensed Hearing Aid Dispensers and Dispensing Audiologists) review and update both the written and practical examinations. Approximately every five to seven years, an occupational analysis is conducted by OPES, on behalf of the Board. The most recent study was completed in 2020.

Speech-Language Pathologists/Audiologists

The Board does not administer a state licensing examination for Speech-Language Pathologists or Audiologists. Rather a national examination, the Praxis Series Test in Speech-Language Pathology, and the Praxis Series Test in Audiology, are administered by the Educational Testing Service (ETS), are reviewed and validated by the DCA's OPES.

OPES has worked with both ETS and American Speech-Language-Hearing Association (ASHA) regarding ongoing examination development and modification. ASHA representatives have stated that they are continually working with ETS to update the national examinations' content to reflect the evolving practices of speech-language pathology and audiology.

ETS only provides an English version of the Praxis exam. However, ETS does offer examinees needing Primary Language Not English (PLNE) accommodations. If English is not the examinee's primary language, they may be eligible for extended testing times.

PLNE accommodations are available on all test dates and at all established test centers. Examinees' who meet ETS requirements will be allowed 50 percent additional testing time.

Examinees are required to register for PLNE accommodations by completing the following:

- Complete the Certification of Documentation Form. An embossed school seal must be affixed over the signature on the certification of documentation form or the signature must be notarized. ETS has the right to request further verification, if needed, of the professional's credentials and expertise relevant to the certification of documentation form;
- Complete the Eligibility Form for Examinees Whose Primary Language Is Not English;
- Complete the Test Authorization Voucher Request Form;
- Mail the completed Test Authorization Voucher Request Form, the Certification of Documentation Form and the Eligibility Form with payment to the appropriate address.

Once the accommodation request is approved, ETS contacts the examinee with a voucher number that is used to register for a test appointment.

23. What are pass rates for first time vs. retakes in the past 4 fiscal years? Please include pass rates for **all** examinations offered, including examinations offered in a language other than English. *Include a separate data table for each language offered.*

Examinations are not offered in a language other than English. The pass rates for the examinations required for licensure are provided in Table 8(a).

For state examinations, the Board has not historically tracked first time passing scores separately from overall passing scores and has only been able to calculate the 2024-25 results for first time test takers for the Board's Written Examination and Practical Examination for Hearing Aid Dispensing. For 2024-25, the Written Examination had 106 first time test takers with a passage rate of 57 percent, and the Practical Examination had 177 first time test takers with a passage rate of 64 percent.

For the National Examinations, the Praxis in Speech-Language Pathology and the Praxis in Audiology, the Board does not approve applications to take the examination, so therefore does not get all score reports for each applicant. Thus, the Board relies on score reports to be ordered by applicants, resulting in the Board only getting score reports limited to qualifying for licensure (thus many applicants do not report failed examinations to the Board). In prior Sunset Reviews, the Board reported the test data it had available from applicants, but this led to an artificially higher passage rate being reported due to the limited data available to the Board. For this reason, the Board has requested national data trends from ETS, the Praxis administrator, and this request to provide testing passing rates for all test takers and/or first time test takers has not been provided by the time this report was approved by the Board.

**Table 8(a). Examination Data[6]**

**California Examinations**

| | | | |
|---|---|---|---|
| | License Type | Hearing Aid Dispensing | Hearing Aid Dispensing |
| | Exam Title | Written Examination | Practical Examination |
| FY 2021/22 | Number of Candidates | 240 | 165 |
| | Overall Pass % | 61% | 61% |
| | Overall Fail % | 39% | 39% |
| FY 2022/23 | Number of Candidates | 249 | 150 |

[6] This table includes all exams for all license types as well as the pass/fail rate. Include as many examination types as necessary to cover all exams for all license types.

| Table 8(a). Examination Data[6] | | | |
|---|---|---|---|
| **California Examinations** | | | |
| | License Type | Hearing Aid Dispensing | Hearing Aid Dispensing |
| | Exam Title | Written Examination | Practical Examination |
| | Overall Pass % | 57% | 57% |
| | Overall Fail % | 43% | 43% |
| FY 2023/24 | Number of Candidates | 269 | 313 |
| | Overall Pass % | 66% | 68% |
| | Overall Fail % | 34% | 32% |
| FY 2024/25 | Number of Candidates | 345 | 251 |
| | Overall Pass % | 62% | 73% |
| | Overall Fail % | 38% | 27% |
| | Date of Last OA | 2020 | 2020 |
| | Name of OA Developer | DCA OPES | DCA OPES |
| | Target OA Date | 2028 | 2028 |

| Table 8(b). National Examination. | | | |
|---|---|---|---|
| **National Examinations** | | | |
| | License Type | Speech-Language Pathologist | Audiologist |
| | Exam Title | Praxis (Speech-Language Pathology) | Praxis (Audiology) |
| FY 2021/22 | Number of Candidates | Awaiting Data from ETS | Awaiting Data from ETS |
| | Overall Pass % | Awaiting Data from ETS | Awaiting Data from ETS |
| | Overall Fail % | Awaiting Data from ETS | Awaiting Data from ETS |
| FY 2022/23 | Number of Candidates | Awaiting Data from ETS | Awaiting Data from ETS |
| | Overall Pass % | Awaiting Data from ETS | Awaiting Data from ETS |
| | Overall Fail % | Awaiting Data from ETS | Awaiting Data from ETS |
| FY 2023/24 | Number of Candidates | Awaiting Data from ETS | Awaiting Data from ETS |
| | Overall Pass % | Awaiting Data from ETS | Awaiting Data from ETS |
| | Overall Fail % | Awaiting Data from ETS | Awaiting Data from ETS |
| FY 2024/25 | Number of Candidates | Awaiting Data from ETS | Awaiting Data from ETS |
| | Overall Pass % | Awaiting Data from ETS | Awaiting Data from ETS |
| | Overall Fail % | Awaiting Data from ETS | Awaiting Data from ETS |
| | Date of Last OA | 2024 | 2024 |
| | Name of OA Developer | ASHA | ASHA |
| | Target OA Date | Unknown | Unknown |

24. Is the board using computer based testing? If so, for which tests? Describe how it works. Where is it available? How often are tests administered?

    Hearing Aid Dispensers
    The Hearing Aid Dispenser's written examination is administered as a computer-based test. The Board currently contracts with the examination administrator, PSI. PSI handles the registration, scheduling, candidate handbook, eligibility notification, exam administration, and scoring examinations for the Board. There are 26 test centers located throughout the state and computer-based tests are administered six days per week, with the exception of specified holidays.

    Speech-Language Pathology & Audiology
    The ETS does offer the Praxis Series Test for speech-language pathology and audiology as a computer-based test. The Praxis Series Test for speech-language pathology and audiology are administered through an international network of testing centers.

25. Are there existing statutes that hinder the efficient and effective processing of applications and/or examinations? If so, please describe. Has the Board approved any amendments, or is the Board considering amendments to address the hindrances presented by these statutes?

    The Board has reviewed and adopted proposed amendments to its hearing aid dispensing examination administration regulatory requirements (Title 16 California Code of Regulations Section 1399.120) that restrict Board staff's management of examination applications. These regulations are currently undergoing development of regulatory documents and cost estimates required prior to filing with the Office of Administrative Law.

26. When did the Board last conduct an occupational analysis that validated the requirement for a California-specific examination? When does the Board plan to revisit this issue? Has the Board identified any reason to update, revise, or eliminate its current California-specific examination?

    The Board last conducted an occupational analysis of the Hearing Aid Dispenser profession in 2020 that validated the California specific Written Examination and Practical Examination for the hearing aid dispensing profession does accurately reflect the requirements for practice in the state. However, this occupational analysis did not involve a national examination review and linkage study to compare the content of the national examination with the results of the 2020 California occupational analysis to determine the extent to which the content of the national examination reflects critical California practice. The Board discussed this issue at its August 22, 2025 Board meeting and will continue to discuss the possibility of performing a national examination review and linkage study of the International Hearing Society's (IHS's) International Licensing Examination (ILE) and Practical Examination for Hearing Health Professionals in the future. Some considerations include the additional costs and resources necessary to perform the national examination review and linkage study versus the potential benefit of an alternative examination requirement in light of California-specific hearing aid dispensing laws and regulations. The Board determined at its August 2025 Board meeting to continue researching this issue and to have IHS come to a future Board meeting to provide additional information and materials on its ILE and Practical Examination.

**School Approvals**

27. Describe legal requirements regarding school approval. Who approves your schools? What role does BPPE have in approving schools? How does the board work with BPPE in the school approval process?

    Title 16 California Code of Regulations Section 1399.152 defines Board approved institutions. The Board has the authority to approve the professional training programs awarding graduate or doctorate degrees in speech-language pathology or audiology; however, it does not exercise such authority as the Board does not have the expertise or staff resources to serve as an accrediting body for professional training programs. Instead, the Board recognizes the accreditation of two professional accrediting organizations, the Council of Academic Accreditation, which is a subsidiary of American Speech-Language- Hearing Association and accredits both speech-language pathology and audiology programs, and the relatively new accrediting body, the Accreditation Commission for Audiology Education (ACAE) which accredits professional doctoral programs in audiology.

    The Board independently reviews Speech-Language Pathology Assistant training programs. These programs are Associate of Arts or Science programs. Individuals with an undergraduate degree in Communication Disorders and Sciences may qualify for Speech-Language Pathology Assistant registration; however, the undergraduate program does not require independent review and approval by the Board. California Code of Regulations Sections 1399.170.4-1399.170.10 provide for the institutional and program requirements that must be met in order for the program to be awarded Board approval. The Board utilizes the services of subject matter experts to review applications and supporting documentation for Speech-Language Pathology Assistant programs and makes recommendations to Board staff regarding program approval.

    The BPPE does not approve the professional training programs for Speech-Language Pathologists or Audiologists. Hearing Aid Dispensers do not have minimum educational requirements for licensure.

28. How many schools are approved by the board? How often are approved schools reviewed? Can the board remove its approval of a school?

    The Board has approved eight Speech-Language Pathology Assistant programs in total, one of which was approved since the Board's last Sunset, these are offered at community colleges and can be found throughout the State. These programs must be accredited by the Accrediting Commission for Community and Junior Colleges, Western Association of Schools and Colleges. The Speech-Language Pathology Assistant programs may be reviewed or audited at any time; however, the Board only conducts subsequent site reviews for an approved school if there are concerns raised regarding the administration of the Speech-Language Pathology Assistant program. If a program fails to comply with the requirements for approval as set forth in California Code of Regulations sections 1399.170.4 - 1399.170.10, the Board can remove its approval of a Speech-Language Pathology Assistant program.

29. What are the board's legal requirements regarding approval of international schools?

    There are no legal requirements for the Board to approve international schools.

**Continuing Education/Competency Requirements**

30. Describe the board's continuing education/competency requirements, if any. Describe any changes made by the board since the last review.

Speech-Language Pathologists, Audiologists, Dispensing Audiologists, & Speech- Language Pathology Assistants

Licensed Speech-Language Pathologists and non-dispensing Audiologists are required to complete 24 hours of CPD/CE from a Board-approved provider during their preceding two-year license renewal cycle. The term "Board-approved providers" refers to entities directly approved by the Board and entities explicitly recognized in statute because of their comprehensive educational review program for the respective professions. Dispensing Audiologists are required to obtain 12 hours for each renewal with at least 50 percent of the CPD/CE in hearing aid related course work and the other 50 percent in courses directly relevant to the practice of audiology. Additionally, Speech-Language Pathologists and Audiologists that supervise required professional experience temporary license holders and Speech-Language Pathology Assistants must initially obtain six (6) hours of CPD related to supervision prior to commencing supervision and also must obtain three (3) hours of CPD related to supervision every four (4) years for required professional development supervisors and every two (2) years for Speech-Language Pathology Assistant supervisors.

Speech-Language Pathology Assistants are also required to complete CPD/CE every two years; however, the 12 hours required of Speech-Language Pathology Assistants do not have to be obtained by Board- approved providers. Instead, the Speech-Language Pathology Assistant supervisor serves as a professional development coordinator for the Speech-Language Pathology Assistant and assists the paraprofessional in developing a plan to complete the required hours through attendance at state or regional conferences, workshops or formal in-service presentations.

CPD/CE requirements allow for a specified number of self-study courses, related coursework which may include more general medical or educational course offerings, and indirect client care courses which cover legal or ethical issues, managed care issues, consultation, etc.

Hearing Aid Dispensers

Hearing Aid Dispensers are required to complete at least 12 hours of CE annually. At a minimum, nine (9) hours of CE must be related to direct patient care in the practice of dispensing and fitting hearing aids, while the remaining three hours may be in courses related to the discipline of hearing aid dispensing, ethics, office management, or managed care issues.

CE providers must have their courses approved by the Board. Board staff reviews the content of each course, along with the instructor's qualifications, and issues approval. If Board staff is unfamiliar with the subject area, an outside expert may be consulted.

| Continuing Education | | | |
|---|---|---|---|
| Type | Frequency of Renewal | Number of CE Hours Required Each Cycle | Percentage of Licensees Audited |
| Speech-Language Pathologists | 2 Years | 24 | 5% |
| Speech-Language Pathology Assistant | 2 Years | 12 | 5% |
| Audiologist | 2 Years | 24 | 5% |
| Dispensing Audiologist | 1 Year | 12 | 5% |
| Hearing Aid Dispenser | 1 Year | 12 | 5% |

In 2024 the Board updated the CE and CPD regulations for Speech-Language Pathologists, Audiologists, Dispensing Audiologists, and Hearing Aid Dispensers.

Effective October 1, 2024, the Board updated regulations related to CE requirements for Hearing Aid Dispensers to allow updated activities and more flexible limits on the types of courses and delivery methods allowed. This included increasing the number of hours that may be obtained in related or indirect client care courses from three to four hours per renewal period but permitting no more than six hours per renewal period for courses related to equipment, devices, or other products. The updated regulations also included allowing licensees to take courses related to equipment, devices, or other products related to the fitting, programming, and troubleshooting of equipment, devices, or other products of a particular manufacturer or company only as it relates to benefiting a client's hearing and functional use of the equipment, device, or product. The updates also created parity with other Board licensees by allowing licensees who teach a course to receive the same number of hours, once per renewal, as a licensee who attended the course. The updated regulations also clarified how many hours of CE credit Hearing Aid Dispensers and Dispensing Audiologists can receive for participating in board–sponsored examination development or administration related functions and for completing a board sponsored occupational analysis.

Effective January 1, 2025, the Board updated the CPD regulations for Speech-Language Pathologists, Audiologists, and Dispensing Audiologists to include updated activities and more flexible limits on the types of courses and delivery methods allowed. This included updating the number of hours allowed to be accrued via self-study to 50 percent of the required hours and updating the definition to a course where the course instruction and licensee participation do not occur simultaneously and requires the completion of an evaluation on what was learned during the course or at the conclusion of the course. The updated regulations also removed limitations to the number of hours that can be obtained from courses that are related to the practice of speech-language pathology or audiology and increasing the number of hours that can be obtained from indirect patient/client care courses to 25 percent of the total required hours. These updates also now permit licensees to take courses related to instruments and technology used for assessment/diagnosis or intervention, and equipment, devices, or other products that are not on the marketing, launching, or demonstrating the marketability of equipment, devices, or other products regardless of whether it focuses on a particular manufacturer's or company's equipment, devices, or products. Lastly, the updates also clarified how many hours of CPD can be accrued for completing a Board sponsored Occupational Analysis.

- How does the board verify CE or other competency requirements? Has the Board worked with the Department to receive primary source verification of CE completion through the Department's cloud?

  Certification of completion of the required CPD/CE is documented on the license renewal form, which includes a statement of compliance that must be signed by the licensee. Subsequent random audits are performed by the Board wherein actual course completion documents are requested of the licensees to verify the statements of compliance.

  The Board has not had the opportunity to work with DCA regarding receiving primary source verification of CE completion through the DCA Cloud.

- Does the board conduct CE audits of licensees? Describe the board's policy on CE audits.

  Prior to the Board's last Sunset, the Board was only able to complete one (1) audit in 2018. After the Board's last Sunset, the Board requested and received authority to hire one Staff Services Analyst to perform ongoing CE Audits. The Board began conducting random audits to ensure compliance with CE requirements for license renewal of five percent of its licensees on an ongoing basis starting with licensees that renewed in January 2024. These ongoing audits started in Fiscal Year 2024-25, once the Board was able to fill and train the CE Auditor position on auditing procedures and citation and fine procedures. During the 2024-25 Fiscal Year, the new CE Auditor was able to complete CE audits for 5% of licensees renewing from January 2024 through June 2024.

  Licensees, as a condition of renewal, must certify that they have met the CE requirements specified in regulation for their license type. During a CE audit, the Board notifies licensees of their selection and requests course completion documents for the renewal cycle being audited. The course completion documents are reviewed by Board staff to determine compliance with the CE requirements in terms of total number of hours obtained, approved provider status, and whether the course content is applicable to the profession.

  California Code of Regulations Section 1399.140 requires Hearing Aid Dispensers and Dispensing Audiologists to maintain records of course completion for a period of at least two years from the renewal period in which the courses were completed, and Section 1399.160.12 requires Speech-Language Pathologists and non-dispensing Audiologists to maintain records of course completion for a period of at least two years from the date of license renewal for which the course was completed.

- What are consequences for failing a CE audit?

  Certification of completion of the required CPD/CE is documented on the licensee's renewal form, which includes a statement of compliance that must be signed by the licensee. If a licensee does not submit verification of enough hours or submits certificates that do not meet the Board's requirements, the licensee is sent a deficiency letter or Notice of Probable Violation to see if there are any additional CPD/CE documents that the licensee has that may satisfy the CPD/CE requirements or has evidence that the licensee qualified for exemption from CPD/CE requirements due to living in a foreign country, active duty military service, or had a period of disability or primary care responsibilities for a disabled family member.

  The consequences for failing a CPD/CE audit can include issuance of any of the following: educational letter, citation and fine, or formal disciplinary documents such as a letter of public

reproval or accusation. The Board normally issues a licensee a citation and fine ranging from $100 to $5,000, depending on the number and type of hours deficient and the number of CPD/CE audits the licensee has previously failed. The citation and fine for CPD/CE will include an order of abatement to remediate the deficient hours if they have not already been made-up. Any licensee who wants to contest a Notice of Probable Violation and/or citation and fine can request an office mediation/informal conference or a formal administrative hearing with the Office of Administrative Law.

- How many CE audits were conducted in the past four fiscal years? How many fails? What is the percentage of CE failure?

  Since Fall 2024, the Board has completed a 5 percent random selection of Speech-Language Pathologists, Speech-Language Pathology Assistants, Audiologists, and Hearing Aid Dispensers who renewed between January through June of 2024. The results for the January through June 2024 audits are provided in the table below. Overall, there is an average failure rate of 28 percent for the first six months of renewals that have been audited, which is relatively higher than the 19 percent average amongst healing arts boards who underwent Sunset Review in 2025.

**CE/CPD Audit Results**

| Audit Period | Number Audited | Passed | % | Failed | % | Exemption Granted | % | Citation Issued | % |
|---|---|---|---|---|---|---|---|---|---|
| January 2024 | 38 | 23 | 61% | 9 | 24% | 6 | 16% | 8 | 21% |
| February 2024 | 39 | 22 | 56% | 11 | 28% | 6 | 15% | 6 | 15% |
| March 2024 | 43 | 21 | 49% | 15 | 35% | 6 | 14% | 8 | 19% |
| April 2024 | 49 | 27 | 55% | 12 | 24% | 7 | 14% | 4 | 8% |
| May 2024 | 40 | 23 | 58% | 9 | 23% | 7 | 18% | 3 | 8% |
| June 2024 | 40 | 21 | 53% | 14 | 35% | 4 | 10% | 1 | 3% |

The most common reasons for failure of the CE audit are having over the maximum number of self-study hours, not having enough CE hours total (either CE hours taken outside the renewal cycle or completed hours with non-approved providers), and insufficient documentation of courses taken (lacking certificates, certificates do not show if course was self-study, or certificate does not indicate the provider's approval status or other critical course details). During the course of auditing CE records of Board licensees, Board staff had to dedicate significant time and energy to educating current licensees regarding acceptable types of CE, limitations on self-study, and about what entities are approved CE providers under the Board's Practice Act.

During the audit process, Board staff have raised the question as to whether some of these issues that cause confusion or even audit failure might merit review for potential statutory amendments as part of the Board's Sunset Review. Specifically, Board staff raised the following concerns for Board consideration as potential New Issues to recommend at the Joint Sunset Review Oversight Hearings:

- Clarifying that both the national and California chapters of professional organizations qualify as approved and exempt CE providers,

- Allow mandatory training courses required by either state (e.g., California Department of Education, California Department of Developmental Services, and California Department of Health Care Services), federal, or local government entities (e.g., regional centers, county offices of education, and local departments of public or mental health) that cover professional issues that impact the provision of services to qualify as CE under the Board's Practice Act.
- Allow Speech-Language Pathology Assistants to meet their CPD requirements through the same course providers that their supervisors are allowed to fulfil their CPD requirement.
- Prohibit Speech-Language Pathology Assistants from using coursework towards a master's degree that would qualify an applicant for licensure as a speech-language pathologist pursuant to BPC Section 2532.2 towards meeting their CPD requirements as the intent of master's level coursework is to prepare the individual for a different professional role not to expand the knowledge related to practicing as a SLPA.

During the 2025-26 Fiscal Year, the Board will be auditing licensees who renewed in July through December 2024. Currently, a considerable amount of time is dedicated to citation and fine related duties associated with the CE Audit process as well as the processing of exemptions. The Board expects that it will be able to accelerate the pace of these audits in future years as Board licensees are more mindful of the Board's CPD/CE requirements and their responsibility to complete the appropriate hours as well as maintain adequate records of completion.

- Who approves CE courses? What is the board's course approval policy?

  Board staff reviews and approves CE courses in accordance with regulatory requirements, if there is uncertainty regarding course content, a subject matter expert may be utilized to provide guidance.

- Who approves CE providers? If the board approves them, what is the board's application review process?

  Board staff reviews and approves applications for both Board approved CPD providers and CE courses. Board staff review applications for compliance with the respective regulations for CPD provider applications and CE course content requirements. Subject matter experts may be utilized if the course content is unfamiliar to staff or requires expert review by a licensed professional in order to determine the practice relevance of the course.

  The Board also accepts through statutory authority CPD provided by accredited institutions of higher learning and organizations approved as continuing education providers by either the American Speech-Language Hearing Association, the American Academy of Audiology, or the California Medical Association's Institute for Medical Quality Continuing Medical Education Program.

- How many applications for CE providers and CE courses were received? How many were approved?

  The CE course and CPD provider application data are provided below for the last four years

| CE Courses and CPD Providers Applications | | | | | |
|---|---|---|---|---|---|
| | FY 2021/22 | FY 2022/23 | FY 2023/24 | FY 2024/25 | Total |
| CE Course Applications Received | 196 | 129 | 221 | 253 | 799 |
| CE Course Applications Approved | 186 | 125 | 221 | 253 | 785 |
| CPD Provider Applications Received | 19 | 12 | 32 | 20 | 83 |
| CPD Provider Applications Approved | 14 | 11 | 29 | 19 | 73 |

- Does the board audit CE providers? If so, describe the board's policy and process.

  The Board's goal is to conduct random audits of five percent of its providers. Due to staff shortages over the past four years, the Board has been unable to conduct an audit of CPD providers since its last Sunset Review.

  During a CPD provider review, a letter is sent to the provider notifying them of the audit and requesting the following information to be submitted to the Board within 30 days:
  - Course syllabi;
  - Information regarding the time and location of the course offering;
  - Course advertisements;
  - Course instructor resumes or curriculum vitas;
  - Attendance rosters including names and license numbers of the attendees;
  - Records of course completion.

  Staff reviews the provider documentation and consults with the Board's Executive Officer if a compliance issue is noted. The Board may revoke a provider approval for failing to comply with the continuing professional development program requirements (California Code of Regulations Section 1399.160.8).

- Describe the board's effort, if any, to review its CE policy for purpose of moving toward performance based assessments of the licensee's continuing competence.

  The Board is not moving toward performance-based assessments of its licensees.

## Section 4 – Enforcement Program

31. What are the board's performance targets/expectations for its enforcement program? Is the board meeting those expectations? If not, what is the board doing to improve performance?

    DCA established standard performance measures (PM) for each Board and Bureau and set an overall goal of 12-18 months to complete consumer complaints. Each Board or Bureau was responsible for determining its performance target for each PM to achieve the 12-18 month goal.

    The DCA Performance Measures and Targets and the Board's Enforcement Performance data are provided below.

| Performance Measure (PM) | Definition | Performance Target |
|---|---|---|
| PM 1 - Volume | Number of complaints/convictions received. | * |
| PM 2 - Intake | Average number of days from complaint receipt, to the date the complaint was assigned to an investigator. | 10 Days |
| PM 3 - Intake & Investigation | Average number of days from complaint receipt to closure of the investigation process for cases not transmitted to the AG. (Includes intake and investigation). | 90 Days |
| PM 4 - Formal Discipline | Average number of days to complete the entire enforcement process for cases transmitted to the AG for formal discipline. (Includes intake, investigation, and transmittal outcome). | 540 Days |
| PM 5 - Costs | Average costs of intake and investigation for complaints not resulting in formal discipline. | ** |
| PM 6 - Customer Satisfaction | Customer satisfaction with the service received during the enforcement process. | *** |
| PM 7 – Probation-Initial Contact | Average number of days from monitor assignment, to the date the monitor first makes contact with the probationer. | 7 Days |
| PM 8 - Probation Violation | Average number of days from time a violation is reported against a probationer to the time the monitor responds. | 10 Days |

* Complaint volume is counted and not considered a performance measure
** Data not collected by DCA
*** Data not disseminated

*Board Enforcement Performance Measures* *(in days)*

| Performance Measure | Target | FY 2021/22 | FY 2022/23 | FY 2023/24 | FY 2024/25 | Four-Year Average |
|---|---|---|---|---|---|---|
| PM 1 - Volume | * | 127 | 149 | 142 | 263 | 170 |
| PM 2 - Intake | 10 | 5 | 3 | 5 | 4 | 4 |
| PM 3 - Intake & Investigation | 90 | 524 | 321 | 149 | 232 | 307 |
| PM 4 - Formal Discipline | 540 | 1,010 | 1,304 | 404** | 1,297 | 1,004 |
| PM 7 – Probation-Initial Contact | 7 | 1 | 1 | 1 | 1 | 1 |
| PM 8 - Probation Violation | 10 | 2 | 1 | 10 | 2 | 4 |

* Complaint volume is counted and not considered a performance measure
** FY 2023/24 was affected by a small number of formal disciplinary actions being taken, both of which had short investigation timeframes

The Board consistently meets performance measure targets for complaint intake, probation initial contacts, and probation violations. However, since the Board's last Sunset Review, the Board's has had difficulty meeting performance measure targets related to intake and investigation timeframes (90 days) and formal discipline timeframes (540 days).

Over the last four fiscal years (2021-22 through 2024-25), the Board has been able to increase from 27 percent to 46 percent the percentage of complaints it closes within 90 days, however there are multiple factors contributing to the Board's inability to meet the intake and investigation timeframe target of 90 days.

First, turnover within the Enforcement Unit has impacted the Board since its last Sunset Review, with either a vacancy or training of new investigative staff occurring in each fiscal year. With an enforcement staff of only three investigators, vacancies and training of new staff take considerable time away from ongoing investigations.

Another factor that impacts the Board's ability to meet investigation timeframes is closure of multiple related cases with extended investigation timeframes, sworn and/or desk investigations, especially when the cases ultimately are not actionable and closed within the same fiscal year, such as 2021/22. When multiple related cases with high investigation timeframes are closed at the same time, they have an outsized impact on the Board's average investigation timeframes in that specific fiscal year.

On the technical side, the Board's legacy system used for enforcement does not have the ability to pause investigation timeframes while waiting for consumers or licensees to provide the Board with necessary medical release forms, copies of necessary documentation, or responses to the Board's investigation, all of which are necessary to proceed with investigations. Waiting for releases and documentation significantly impacts processing timeframes for most consumer complaints the Board investigates. This extends to the evidence a consumer states they have when submitting an online complaint via the DCA portal, as this system does not have the capacity for consumers to upload documents and evidence into that system. Prior to 2025, the Board used to struggle more with waiting for licensees to respond to Board investigation requests but has more recently begun utilizing citation and fine against licensees that fail to participate in the Board's investigation within the legally required timeframe. This has sped up one part of the process more recently. A similar example of cases aging unnecessarily is when a licensee is arrested, the Board opens a complaint based on the date it was notified of the arrest. The case then ages for as long as the criminal case takes to be adjudicated in addition to the Board's investigation time and administrative discipline process (if warranted), resulting in high investigation timeframes for most all conviction related cases. While the Board had intended to streamline its enforcement processes and include complaint investigations in the Board's Business Modernization Project, this was ultimately not part of the project, therefore the Board has not streamlined its investigative processes to date and therefore some complaints continue to age while waiting on consumers to respond and the criminal justice system to conclude its processes.

Lastly, due to resource constraints and a significant decrease in the number of complaints and convictions received since the start of the COVID-19 pandemic, Board management reassigned one enforcement analyst, on a parttime basis, to the Business Modernization Project and its maintenance and operation thereafter. This reassignment was essential to the Board's success during the Business Modernization Project, and it was the Board's intention that the same employee would be able to lead the enforcement modernization project in the near future using the insights and skills gained during the initial licensing modernization project. However, given the Board's continued inability to meet investigation performance measures, the increase in complaints and convictions received in 2024-25, and uncertainty about when a future enforcement business modernization project may be possible, Board management is currently considering different strategies to address both needs within current Board resources.

In relation to the Board not meeting the formal discipline timeframe target of 540 days, the primary contributor to this is the aging of criminal conviction related cases. Of the 18 formal disciplinary actions taken by the Board since its last Sunset, more than half of those cases were criminal conviction related cases that had aged over the 540-day target. Board management will be consulting with other boards and bureaus still utilizing the same legacy system to research

interim steps it can take to reduce these timeframes until an enforcement business modernization project can be undertaken to streamline all enforcement processes.

32. Explain trends in enforcement data and the board's efforts to address any increase in volume, timeframes, ratio of closure to pending cases, or other challenges. What are the performance barriers? What improvement plans are in place? What has the board done and what is the board going to do to address these issues, i.e., process efficiencies, regulations, BCP, legislation?

    Since the Board's last Sunset Review, the Board continued to see lower than expected complaints and licensee arrest/convictions, which started with the onset of the COVID-19 pandemic and continued for multiple years, which saw a 135 percent increase in complaints and a 14 percent increase in licensee arrests/convictions in just a single fiscal year. The increase in licensee arrests/convictions climbed modestly over the past four fiscal years, but the increase in complaints is extremely steep and the Board is not confident that this trend at this magnitude will continue.

    Two of the largest factors contributing to the steep increase in complaints in the last fiscal year include the Board's discovery of various speech and audiology businesses being inappropriately organized, and the Board's ongoing CE audits of its licensees. During the course of the Board's research related to a policy inquiry from a licensee, the Board discovered that there are at least 44 speech and audiology companies organized as limited liability companies (LLCs), which is not allowed under the Moscone-Knox Professional Corporation Act and the Board's Speech-Language Pathology Corporation and Audiology Corporation laws. The Board then opened these internal complaints to work with licensees to remedy these violations. Separately, the Board's ongoing CE audits have also created complaints due to licensee failure to meet renewal requirements related to CE. For CE audit failures, the Board opens an internal complaint to start the process for remediation, which may result in the issuance of a citation and fine or other enforcement action. By the end of 2024-25, this included 28 complaints opened related to CE audit failure. Thus, these two factors together account for 66 percent of the increase in complaints in 2024-25. The Board would not expect to see another surge in complaints based on the Board's discovery of other code violations but does expect to continue to see higher complaint levels related to CE audit failures for the next few years. There was also a modest increase in the number of licensee and anonymous complaints in the last fiscal year, the Board will continue to monitor whether these increases continue and if any violation trends emerge from the investigation of these complaints.

    As discussed in the prior question on performance measures, there are multiple factors impacting the Board's ability to close more intake and investigations within the 90-day target. Within the limited resources the Board has, one area that the Board has been able to invest in since the Board's last Sunset Review was in advanced training for its enforcement staff. The Board sent its enforcement staff that perform investigations to the National Certified Investigator and Inspector Training (NCIT) Program's enforcement training through the national Council on Licensure, Enforcement and Regulation (CLEAR). CLEAR is the premier resource nationally for professional regulation and its NCIT training program has set the standard for regulatory investigation and inspection training. This training was helpful to enforcement staff in their daily duties. Unfortunately, one of the three staff that completed the training has since left the Board for a promotional opportunity within State service and the Board has not been able to send the new enforcement staff member to this training yet.

    The Board has continued looking into additional training measures for the Board's enforcement Subject Matter Experts (SMEs) to ensure consistency with the expert reports and preparedness for

witness testimony during administrative hearings. Due to a change in Board leadership since the last Sunset Review, the Board has only been able to complete a review of another board's SME training materials for potential use with its SMEs.

Unfortunately, other options for improvement and streamlining of enforcement processes and systems that would result in significant improvements are currently limited due to limitations on Board and DCA resources for business modernization. As stated in the last question, the Board will be looking into intermediate improvements that might be possible within existing resources, but these would lead to moderate improvements at best, not the type of timeframe reductions and workload capacity increases that were demonstrated through the Board's initial application business modernization.

| **Table 9. Enforcement Statistics** | | | | |
|---|---|---|---|---|
| | FY 2021/22 | FY 2022/23 | FY 2023/24 | FY 2024/25 |
| **COMPLAINTS** | | | | |
| Intake | | | | |
| Received | 77 | 89 | 81 | 190 |
| Closed without Referral for Investigation | 0 | 0 | 0 | 0 |
| Referred to INV | 78 | 90 | 80 | 192 |
| Pending (close of FY) | 1 | 0 | 1 | 0 |
| Conviction / Arrest | | | | |
| CONV Received | 48 | 60 | 65 | 76 |
| CONV Closed Without Referral for Investigation | 0 | 0 | 0 | 0 |
| CONV Referred to INV | 51 | 61 | 62 | 79 |
| CONV Pending (close of FY) | 0 | 0 | 3 | 0 |
| Source of Complaint[7] | | | | |
| Public | 61 | 64 | 42 | 41 |
| Licensee/Professional Groups | 13 | 12 | 15 | 29 |
| Governmental Agencies | 25 | 36 | 56 | 56 |
| Internal | 22 | 29 | 14 | 104 |
| Other | 0 | 0 | 0 | 3 |
| Anonymous | 4 | 8 | 19 | 33 |
| Average Time to Refer for Investigation (from receipt of complaint / conviction to referral for investigation) | 5 | 3 | 5 | 5 |
| Average Time to Closure (from receipt of complaint / conviction to closure at intake) | N/A | N/A | N/A | N/A |
| Average Time at Intake (from receipt of complaint / conviction to closure or referral for investigation) | 5 | 3 | 5 | 4 |
| **INVESTIGATION** | | | | |
| Desk Investigations | | | | |
| Opened | 129 | 151 | 143 | 270 |
| Closed | 183 | 144 | 116 | 192 |
| Average days to close (from assignment to investigation closure) | 576 | 318 | 200 | 224 |

[7] Source of complaint refers to complaints and convictions received. The summation of intake and convictions should match the total of source of complaint.

| Table 9. Enforcement Statistics | | | | |
|---|---|---|---|---|
| | FY 2021/22 | FY 2022/23 | FY 2023/24 | FY 2024/25 |
| Pending (close of FY) | 134 | 131 | 171 | 237 |
| Non-Sworn Investigation | | | | |
| Opened | N/A | N/A | N/A | N/A |
| Closed | N/A | N/A | N/A | N/A |
| Average days to close (from assignment to investigation closure) | N/A | N/A | N/A | N/A |
| Pending (close of FY) | N/A | N/A | N/A | N/A |
| Sworn Investigation | | | | |
| Opened | 1 | 5 | 7 | 10 |
| Closed | 2 | 3 | 5 | 5 |
| Average days to close (from assignment to investigation closure) | 258 | 290 | 242 | 220 |
| Pending (close of FY) | 2 | 1 | 7 | 13 |
| All investigations[8] | | | | |
| Opened | 130 | 156 | 150 | 280 |
| Closed | 185 | 147 | 121 | 197 |
| Average days for all investigation outcomes (from start investigation to investigation closure or referral for prosecution) | 579 | 318 | 197 | 190 |
| Average days for investigation closures (from start investigation to investigation closure) | 572 | 318 | 195 | 179 |
| Average days for investigation when referring for prosecution (from start investigation to referral for prosecution) | 1017 | 299 | 699 | 473 |
| Average days from receipt of complaint to investigation closure | 1021 | 320 | 207 | 481 |
| Pending (close of FY) | 136 | 132 | 178 | 250 |
| **CITATION AND FINE** | | | | |
| Citations Issued | 7 | 7 | 4 | 33 |
| Average Days to Complete (from complaint receipt / inspection conducted to citation issued) | 1,009 | 507 | 211 | 131 |
| Amount of Fines Assessed | $8,600 | $11,100 | $4,500 | $33,350 |
| Amount of Fines Reduced, Withdrawn, Dismissed | $1,200 | 0 | $0 | $1,550 |
| Amount Collected | $5,800 | $3,800 | $2,700 | $24,100 |
| **CRIMINAL ACTION** | | | | |
| Referred for Criminal Prosecution | 0 | 0 | 4 | 4 |
| **ACCUSATION** | | | | |
| Accusations Filed | 6 | 1 | 4 | 2 |
| Accusations Declined | 1 | 0 | 0 | 0 |
| Accusations Withdrawn | 0 | 1 | 0 | 0 |
| Accusations Dismissed | 0 | 2 | 0 | 0 |
| Average Days from Referral to Accusations Filed (from AG referral to Accusation filed) | 138 | 80 | 85 | 111 |
| **INTERIM ACTION** | | | | |
| ISO & TRO Issued | 0 | 0 | 0 | 0 |
| PC 23 Orders Issued | 0 | 0 | 0 | 0 |
| Other Suspension/Restriction Orders Issued | 0 | 0 | 0 | 0 |
| Referred for Diversion | N/A | N/A | N/A | N/A |
| Petition to Compel Examination Ordered | 0 | 0 | 0 | 0 |

[8] The summation of desk, non-sworn, and sworn investigations should match the total of all investigations.

| Table 9. Enforcement Statistics | | | | |
|---|---|---|---|---|
| | FY 2021/22 | FY 2022/23 | FY 2023/24 | FY 2024/25 |
| **DISCIPLINE** | | | | |
| AG Cases Initiated (cases referred to the AG in that year) | 6 | 3 | 5 | 4 |
| AG Cases Pending Pre-Accusation (close of FY) | 3 | 1 | 2 | 2 |
| AG Cases Pending Post-Accusation (close of FY) | 3 | 2 | 4 | 2 |
| **DISCIPLINARY OUTCOMES** | | | | |
| Revocation | 2 | 0 | 0 | 0 |
| Surrender | 2 | 0 | 0 | 1 |
| Suspension only | 0 | 0 | 0 | 0 |
| Probation with Suspension | 1 | 0 | 0 | 0 |
| Probation only | 3 | 4 | 2 | 3 |
| Public Reprimand / Public Reproval / Public Letter of Reprimand | 0 | 0 | 0 | 0 |
| Other | 0 | 0 | 0 | 0 |
| **DISCIPLINARY ACTIONS** | | | | |
| Proposed Decision | 2 | 0 | 1 | 0 |
| Default Decision | 2 | 0 | 0 | 0 |
| Stipulations | 4 | 4 | 1 | 4 |
| Average Days to Complete After Accusation (from Accusation filed to imposing formal discipline) | 267 | 248 | 221 | 262 |
| Average Days from Closure of Investigation to Imposing Formal Discipline | 420 | 543 | 322 | 642 |
| Average Days to Impose Discipline (from complaint receipt to imposing formal discipline) | 1150 | 1050 | 404 | 929 |
| **PROBATION** | | | | |
| Probations Completed | 2 | 2 | 6 | 5 |
| Probationers Pending (close of FY) | 19 | 22 | 17 | 15 |
| Probationers Tolled | 3 | 4 | 4 | 3 |
| Petitions to Revoke Probation / Accusation and Petition to Revoke Probation Filed | 1 | 1 | 5 | 3 |
| **SUBSEQUENT DISCIPLINE[9]** | | | | |
| Probations Revoked | 0 | 1 | 1 | 3 |
| Probationers License Surrendered | 0 | 0 | 3 | 1 |
| Additional Probation Only | 1 | 0 | 0 | 1 |
| Suspension Only Added | 0 | 0 | 0 | 0 |
| Other Conditions Added Only | 0 | 0 | 0 | 0 |
| Other Probation Outcome | 0 | 0 | 0 | 0 |
| **SUBSTANCE ABUSING LICENSEES** | | | | |
| Probationers Subject to Drug Testing | 4 | 8 | 6 | 8 |
| Drug Tests Ordered | 126 | 285 | 240 | 259 |
| Positive Drug Tests | 15 | 30 | 7 | 8 |
| **PETITIONS** | | | | |
| Petition for Termination or Modification Granted | 1 | 0 | 0 | 1 |
| Petition for Termination or Modification Denied | 0 | 0 | 0 | 0 |
| Petition for Reinstatement Granted | 0 | 0 | 0 | 0 |
| Petition for Reinstatement Denied | 0 | 0 | 0 | 1 |
| **DIVERSION** | | | | |
| New Participants | N/A | N/A | N/A | N/A |

[9] Do not include these numbers in the Disciplinary Outcomes section above.

| Table 9. Enforcement Statistics | | | | |
|---|---|---|---|---|
| | FY 2021/22 | FY 2022/23 | FY 2023/24 | FY 2024/25 |
| Successful Completions | N/A | N/A | N/A | N/A |
| Participants (close of FY) | N/A | N/A | N/A | N/A |
| Terminations | N/A | N/A | N/A | N/A |
| Terminations for Public Threat | N/A | N/A | N/A | N/A |
| Drug Tests Ordered | N/A | N/A | N/A | N/A |
| Positive Drug Tests | N/A | N/A | N/A | N/A |
| *Note: Data results may differ from DCA Annual Report Data to ensure data metrics reported in this table are internally consistent for comparison purposes. | | | | |

| Table 10. Enforcement Aging | | | | | | |
|---|---|---|---|---|---|---|
| | FY 2021/22 | FY 2022/23 | FY 2023/24 | FY 2024/25 | Cases Closed | Average % |
| **Investigations (Average %)** | | | | | | |
| Closed Within: | | | | | | |
| 90 Days | 48 | 55 | 50 | 89 | 242 | 38% |
| 91 - 180 Days | 12 | 21 | 26 | 40 | 99 | 16% |
| 181 - 1 Year | 16 | 23 | 20 | 28 | 87 | 14% |
| 1 - 2 Years | 38 | 21 | 13 | 17 | 89 | 14% |
| 2 - 3 Years | 33 | 19 | 4 | 11 | 67 | 11% |
| Over 3 Years | 36 | 5 | 3 | 7 | 51 | 8% |
| Total Investigation Cases Closed | 183 | 144 | 116 | 192 | 635 | |
| **Attorney General Cases (Average %)** | | | | | | |
| Closed Within: | | | | | | |
| 0 - 1 Year | 0 | 0 | 1 | 1 | 2 | 12% |
| 1 - 2 Years | 1 | 0 | 1 | 2 | 4 | 24% |
| 2 - 3 Years | 3 | 2 | 0 | 0 | 5 | 29% |
| 3 - 4 Years | 2 | 2 | 0 | 0 | 4 | 24% |
| Over 4 Years | 2 | 0 | 0 | 0 | 2 | 12% |
| Total Attorney General Cases Closed | 8 | 4 | 2 | 3 | 17 | |

33. What do overall statistics show as to increases or decreases in disciplinary action since last review?

    In alignment with the drop in complaints and convictions the Board has received since its last Sunset Review, there has been a similar decrease in the volume of disciplinary actions the Board has taken.

34. How are cases prioritized? What is the board's compliant prioritization policy?

    The Board prioritizes cases as urgent, high, or routine in accordance with DCA's Complaint Prioritization and Referral Guidelines, which were recently revised in March of 2024. Each case is reviewed and expedited according to the alleged violations in the complaint. The Board takes immediate action to involve the Division of Investigations and/or the Office of the Attorney General when a complaint alleges any activity in which the probability of public harm is imminent.

- Please provide a brief summary of the Board's formal disciplinary process. (new question)

  The Board conducts disciplinary proceedings in accordance with the Administrative Procedure Act, GC § 11370, and those sections that follow. The Board conducts investigations and hearings pursuant to Government Code §§ 11180 through 11191.

  The Board also uses its Disciplinary Guidelines and the Uniform Standards Related to Substance Abusing Licensees as a guide when determining appropriate levels of discipline. The Disciplinary Guidelines were established in an effort to provide consistency in determining penalties. Enforcement staff consider the Disciplinary Guidelines when determining whether to seek revocation, suspension, and/or probation of a license. Board members use them when considering cases during hearings.

  The Board has two options available to take enforcement action against a licensee who has violated the law or standard of care. In cases in which the violations do not warrant the revocation of a license or terms and conditions of probation, a citation and fine is issued. In cases in which the violations are egregious and warrant revocation, probation, or public reprimand of the licensee, the Board forwards the matter to the Office of the Attorney General (OAG) to pursue formal disciplinary action. Each decision is made in consultation with the Executive Officer.

  If after the completion of an investigation, evidence substantiates gross negligence, incompetence, or unprofessional conduct, the enforcement staff, in consultation with the Enforcement Coordinator and Executive Officer, determines whether the case should be forwarded to the OAG for disciplinary action.

  The OAG is responsible for prosecuting the administrative case against licensees and registrants (respondents). A respondent might be suspended from practice, have their license revoked, be placed on probation, or be publicly reprimanded, or an applicant may be denied licensure or licensed with probation. A Deputy Attorney General (DAG) in the OAG's Office Licensing Unit is assigned to these cases. The DAG works with the Board's enforcement staff to determine whether the necessary evidence exists for a successful prosecution. The burden of proof in these matters must be clear and convincing. Based on the evidence, the DAG makes recommendations regarding prosecution. Although the Board generally takes the advice of counsel, the Board has the discretion to take other action.

  Formal charges are almost always filed in cases in which the health and safety of the consumer have been compromised, and in which supporting evidence can be established. The Board's Executive Officer determines whether to file formal charges for any violation of the Board's licensing laws. These formal charges are referred to as pleadings and are either in the form of an Accusation (against a licensee) or a Statement of Issues (against an applicant). In each pleading, the Executive Officer of the Board is the complainant. These documents are a written statement of charges against the individual and specify the statutes and rules allegedly violated, and the acts or omissions comprising the alleged violations.

  Once an Accusation or Statement of Issues has been filed and the respondent has been served, the Board may settle with the respondent prior to a formal hearing or proceed to a formal administrative hearing at the Office of Administrative Hearing (OAH), or if the

respondent fails to respond to the accusation/statement of issues a default decision is issued. Default decisions result in the revocation or denial of a license.

The licensee or applicant and Board may decide to settle at any time during the administrative process. Usually, stipulations or negotiated settlements are entered into before an administrative hearing is held to avoid the expense of the hearing while achieving discipline in alignment with the Board's Disciplinary Guidelines.

If a settlement is not reached, the Board will proceed to an administrative hearing, where an Administrative Law Judge (ALJ) with OAH presides over the hearing; an attorney (DAG) represents the Board and presents the case; and the respondent or the respondent's representative or attorney presents its case. If the respondent fails to appear at an administrative hearing, a default decision is issued. Defaults result in the revocation or denial of a license. At the hearing, testimony and evidence are presented and there is a transcript of the proceedings available after the hearing for purchase from the court reporting company. Upon the conclusion of the administrative hearing, the ALJ will consider all testimony and evidence and will prepare a proposed decision. Once the hearing is finished, the ALJ has 30 days to prepare the proposed decision and send it to the Board. The proposed decision is submitted to the Board for consideration. Upon receipt of the proposed decision, the Board then has 100 days to take action to either adopt or reject it. If no action is taken within 100 days, the proposed decision becomes effective by operation of law.

Board members review and vote on each case where the matter is either settled prior to hearing or the ALJ issues a proposed decision. In all cases, the Board members have the option to adopt/accept, adopt/accept with edits (technical/minor), reject, or hold for discussion. If the decision is held for discussion, the Board will discuss the case during its next Board meeting in closed session and will determine whether to adopt/accept, adopt/accept with edits (technical/minor), or reject the settlement or proposed decision and write their own decision. Once adopted, the final decision is served to the respondent and becomes effective on the date specified in the final order.

35. Are there mandatory reporting requirements? For example, requiring local officials or organizations, or other professionals to report violations, or for civil courts to report to the board actions taken against a licensee. Are there problems with the board receiving the required reports? If so, what could be done to correct the problems?

The Board is included in the Business & Professions Code Section 800 series which, among other reporting requirements, requires professional liability insurers to notify the Board of situations involving professional negligence or incompetence by licensed Speech-Language Pathologists and Audiologists, including any relevant settlement reports, arbitration awards, and judgments against the licensee. Business & Professions Code Section 803 requires the courts to report any acts of negligence, errors or omissions in practice by a licensee where death or personal injury resulted in a judgment for an amount exceeding $30,000.

While there is no specific statutory requirement for reporting, other state licensing Boards, governmental agencies, rehabilitation facilities, etc., send disciplinary reports, audit findings, and personnel action reports to the Board for review.

There are no other laws in the Board's specific practice act(s) which require other professionals to report misconduct by a licensee; however, professionals are encouraged to report any acts of

unprofessional conduct and/or matters that pose a risk to the public. The Board typically receives very few reports and is not aware of any problems with receiving the required reports.

- What is the dollar threshold for settlement reports received by the board?

  The dollar threshold for settlement reports received by the Board is $30,000.

- What is the average dollar amount of settlements reported to the board?

  Since the Board's last Sunset Review, the Board has not received any settlement reports.

36. Describe settlements the board, and Office of the Attorney General on behalf of the board, enter into with licensees.

    The Board refers cases to the Office of the Attorney General for disciplinary action and considers many factors when choosing to settle cases. Settlements are based on the Board's Disciplinary Guidelines and the recommendations of the Office of the Attorney General. The Board also considers the gravity of the violations pled in the accusation or statement of issues, potential or actual consumer harm, rehabilitation factors demonstrated by the licensee or applicant, and licensee or applicant complaint history when considering a settlement. In addition, the Board considers the costs and length of an administrative hearing versus the likely outcome of a hearing to determine if there is benefit in reaching a settlement.

    - What is the number of cases, pre-accusation, that the board settled for the past four years, compared to the number that resulted in a hearing?

      The Board did not enter into any pre-accusation settlement agreements since the Board's last Sunset Review.

    - What is the number of cases, post-accusation, that the board settled for the past four years, compared to the number that resulted in a hearing?

      Since its last Sunset Review, all stipulated settlement agreements the Board made were made and approved post-accusation.

    - What is the overall percentage of cases for the past four years that have been settled rather than resulted in a hearing?

      Since the Board's last Sunset Review, 72 percent of cases were settled compared to the 28 percent that went to hearing or were default decisions. This is in alignment with the prior Sunset Review, where 75 percent of cases were settled compared to 25 percent that went to hearing or were default decisions.

37. Does the board operate with a statute of limitations? If so, please describe and provide the citation. If so, how many cases have been lost due to statute of limitations? If not, what is the board's policy on statute of limitations?

    The Board does not operate with a specific statute of limitations, however, the Office of the Attorney General has communicated the following statute of limitations criteria they follow which is used by many other healing arts Boards (including Medical Board, Board of Psychology, etc.):

Accusations shall be filed within three years after the Board discovers the act or omission alleged as the grounds for disciplinary action, or within seven years after the act or omission alleged as the grounds for disciplinary action occurs, whichever occurs first. Exceptions in which there is no statute of limitations: accusations filed against a licensee alleging procurement of a license by fraud or misrepresentation; certain circumstances alleging unprofessional conduct based on incompetence; gross negligence; repeated negligent acts of the licensee. An accusation filed against a licensee on or after January 1, 2002 alleging sexual misconduct shall be filed within three years after the Board discovers the act or omission alleged as the ground for disciplinary action, or within 10 years after the act occurs, whichever occurs first. Additionally, if an alleged act or omission involves a minor, the seven-year limitation period from when the alleged act occurred, and the 10-year limitation period from when the alleged act occurred shall be tolled until the minor reaches the age of majority.

38. Describe the board's efforts to address unlicensed activity and the underground economy.

All allegations of unlicensed activity are handled with at least high priority. Many of the Board's unlicensed activity cases involve previously licensed practitioners who allow their license to become delinquent by failing to renew on time or involve support personnel who fail to file the appropriate licensing paperwork to practice under supervision. These cases typically result in the issuance of a citation and fine to the unlicensed individual, and depending upon the circumstance, also to the supervisor responsible for aiding and abetting unlicensed practice.

**Cite and Fine**

39. Discuss the extent to which the board utilizes cite and fine authority. Discuss any changes from last review and describe the last time regulations were updated and any changes that were made. Has the board increased its maximum fines to the $5,000 statutory limit? Does the board have authority to issue fines greater than $5,000? If so, under what circumstances?

The Board is authorized by Business & Professions Code section 125.9 to issue citations which may contain an order of abatement and an order to pay an administrative fine. The Board issues citations for minor violations of the laws and regulations governing the practices of speech-language pathology, audiology, and hearing aid dispensing which do not warrant formal discipline. The Board does not have the authority to issue fines greater than $5,000.

Since the Board's last Sunset Review, no action has been taken to modify the regulations the Board operates under for the issuance of citations and fines. Review and revision of the citation and fine regulations is something the Board will be pursuing over the next four years to create alignment between the regulations for all of the Board's regulated professions.

40. How is cite and fine used? What types of violations are the basis for citation and fine?

Citations and fines are issued for minor infractions of the laws and regulations (e.g., advertising violations, failure to comply with continuing professional development requirements, failure to renew a license prior to the expiration, failure to keep updated records with the Board, failure to appropriately register support personnel or trainees prior to employing the personnel to provide services, etc.). The Board has also started making greater use of citation and fine for failure to cooperate with the Board's investigations. This has improved the speed with which licensees respond to Board investigators and helped lower unnecessary case aging for some cases.

41. How many informal office conferences, Disciplinary Review Committees reviews and/or Administrative Procedure Act appeals of a citation or fine in the last 4 fiscal years?

    The Board scheduled and conducted 28 informal conferences/office mediations since the Board's last Sunset Review. Only one licensee requested and had a formal hearing to dispute their citation, which was upheld at hearing. The Board does not have an established Disciplinary Review Committee.

42. What are the five most common violations for which citations are issued?

    The five most common violations for which citations are issued are:
    - Failure to Comply with Continuing Professional Development Requirements
    - Failure to Cooperate with the Board's investigation (or request for information related to a complaint)
    - Unlicensed Practice
    - False/Misleading Advertising
    - Aiding and Abetting Unlicensed Practice

43. What is average fine pre- and post- appeal?

    Since the last Sunset Review, the average pre-appeal fine is around $1,250 and average post-appeal fine was $750.

44. Describe the board's use of Franchise Tax Board intercepts to collect outstanding fines. If the board does not use Franchise Tax Board intercepts, describe the rationale behind that decision and steps the board has taken to increase its collection rate.

    When a fine is not paid within the required time, or by the next renewal date, the licensee or non-licensee's information is forwarded to DCA for referral to Franchise Tax Board for collection through its offset program.

**Cost Recovery and Restitution**

45. Describe the board's efforts to obtain cost recovery. Discuss any changes from the last review.

    In cases that proceed to an administrative hearing, the Board seeks full cost recovery for all contracted investigation and prosecution costs (enforcement SME costs and OAG costs prior to hearing), including costs to prepare for the hearing. Note that this does not include the cost of Board staff investigation, nor does it include the OAH costs of an administrative hearing or the OAG representation costs at an administrative hearing. Additionally, the ALJ may reduce or dismiss cost recovery in a proposed decision. Business & Professions Code section 125.3 indicates, in part, that the ALJ may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case. Cost recovery is a standard term and condition specified in the Board's Disciplinary Guidelines for all proposed decisions and stipulations. Cost recovery amounts may be negotiated when entering into a stipulated settlement if such agreement encourages the respondent to settle the case with appropriate discipline and avoids further costs and delays associated with the administrative hearing process.

    There have been no changes in this policy since the last review.

46. How many and how much is ordered by the board for revocations, surrenders and probationers? How much do you believe is uncollectable? Explain.

There is no specific amount of cost recovery ordered for revocations, surrenders, and probations. Each disciplinary case has its own amount of cost recovery ordered depending on the investigation and prosecution costs incurred by the Board. Probationers may request a payment plan to reimburse the Board, and final payments are generally due within six months prior to the termination of probation. In some instances where the cost recovery amount is lower, it may be negotiated that cost recovery be paid in full within the first or second year of probation.

Cases of revocations and surrenders are typically uncollectable as the former licensee has no motivation to pay the ordered cost, either because the individual relocates to another state or changes professions.

47. Are there cases for which the board does not seek cost recovery? Why?

The Board cannot order cost recovery for cases that are categorized as "Default Decisions." Default Decisions are cases where an accusation has been filed but the respondent fails to file a Notice of Defense or fails to appear at the scheduled administrative hearing. Additionally, the Board does not have authority to seek cost recovery in cases where it has denied a license or registration and a statement of issues has been filed, since cost recovery is applicable to licensees and not license applicants.

48. Describe the board's use of Franchise Tax Board intercepts to collect cost recovery. If the board does not use Franchise Tax Board intercepts, describe methods the board uses to collect cost recovery.

Failure to pay cost recovery is generally a violation of probation, so it is not common for a licensee on probation to fail to pay cost recovery. Generally, the Board uses Franchise Tax Board to collect monies due if not collected within the agreed upon timeframe.

**Table 11. Cost Recovery**[10] (list dollars in thousands)

| | FY 2021/22 | FY 2022/23 | FY 2023/24 | FY 2024/25 |
|---|---|---|---|---|
| Total Enforcement Expenditures | $779 | $721 | $810 | $1,077 |
| Potential Cases for Recovery * | 8 | 4 | 2 | 4 |
| Cases Recovery Ordered | 5 | 3 | 0 | 4 |
| Amount of Cost Recovery Ordered | $77 | $20 | $0 | $63 |
| Amount Collected | $38 | $29 | $16 | $13 |

* "Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on violation of the license practice act.

49. Describe the board's efforts to obtain restitution for individual consumers, any formal or informal board restitution policy, and the types of restitution that the board attempts to collect, i.e., monetary, services, etc. Describe the situation in which the board may seek restitution from the licensee to a harmed consumer.

The Board seeks monetary restitution for consumers in cases regarding hearing aid returns and refunds, pursuant to the provisions of the Song-Beverly Consumer Warranty Act. The vast majority of cases related to hearing aid refunds result in the consumer receiving their refund during the

[10] Cost recovery may include information from prior fiscal years.

initial complaint investigation stages, but the Board has been unable to track the amount of these refunds as consumers do not typically respond to the Board after receiving the refund to verify the amount received. If initial attempts by the Board to achieve refunds for consumers are unsuccessful, the Board will order the licensee to pay restitution in full to the consumer by means of an administrative order, stipulated settlement, or in less egregious cases, through citation and fine. Payment to the consumer must be made within a specified period of time, typically not more than 30 days, and is tracked by the Board. Additionally, the Board can order restitution in cases involving Medi-Cal fraud, insurance fraud or in cases where a patient or client paid for services that were not provided.

As shown below, restitution by administrative order, stipulated settlement, and citation and fine are uncommon. This was also true during the Board's prior Sunset Review, which only had one fiscal year (2018-19) in which $1,000 in restitution had been ordered and two fiscal years (2018-19 and 2020-21) in which $1,000 was collected in each of those fiscal years.

**Table 12. Restitution** (list dollars in thousands)

| | FY 2021/22 | FY 2022/23 | FY 2023/24 | FY 2024/25 |
|---|---|---|---|---|
| Amount Ordered | $0 | $0 | $0 | $0 |
| Amount Collected | $0 | $0 | $0 | $0 |

## Section 5 – Public Information Policies

50. How does the board use the internet to keep the public informed of board activities? Does the board post board-meeting materials online? When are they posted? How long do they remain on the board's website? When are draft-meeting minutes posted online? When does the board post final meeting minutes? How long do meeting minutes remain available online?

The Board's website features among other items, license verification, consumer complaint information, licensing applications and forms, and licensing processing timeframes, the Board's laws and regulations, publications and reports, and customer satisfaction surveys. The Board Activity page includes the Board's history; biographies and photos of our Board members; a listing of our committees, committee functions and members; and opportunities for public participation. During the strategic planning session in June of 2024, the Board members reviewed the mission and vision statement, and key values of the Board, which were adopted in September of 2024. The website has been updated to reflect these changes.

All Board and committee meeting agendas, materials, and minutes are posted online. Agendas are posted at least 10 days in advance of the meeting in accordance with the Bagley-Keene Open Meeting Act (Government Code section 11120-11132), and meeting materials are posted as early as possible given staff resources, but typically no more than the week of the meeting. The Board's goal over the next four years is to work to meet DCA's goal of posting meeting materials at least 10 days prior to the meeting. Draft meeting minutes from the previous meeting are included as an agenda item for approval in the subsequent meeting. Once edits to the minutes are completed, the approved meeting minutes are posted on the website. Due to AB 434 (Baker, Chapter 780, Statutes of 2017), the Board may need to limit accessibility to historical meeting minutes or materials to ensure our website meets current Americans with Disability Act accessibility requirements; however, all materials will be available to the public upon request.

51. Does the board webcast its meetings? What is the board's plan to webcast future board and committee meetings? How long will archived webcast meetings remain available online?

    The Board webcasts both Board and committee meetings when DCA's webcasting services are available. These services are limited to the number of DCA webcasters available for any given day, and when the Board is not simultaneously using Webex teleconferencing for the meeting as Webex teleconferencing allows both live streaming and participation for users. If the Board utilizes Webex for the meeting, the meeting will be recorded and made into an accessible video linked to our website similar to DCA webcasts. The links to view these meetings are on the Board Activity page under Board Meetings on the website. The Board plans to continue webcasting its meetings when webcasting services are available, and links to webcast or Webex captured video will remain active to the extent that AB 434 requirements and DCA hosting policies allow.

52. Does the board establish an annual meeting calendar and post it on the board's web site?

    The Board has an established meeting calendar on its website that lists important dates during the calendar year. The upcoming year's calendar is typically established at the last meeting of the calendar year. The calendar is updated throughout the year to reflect any changes to the meeting information. The website currently includes scheduled meetings for 2026 and prior calendar years.

53. Is the board's complaint disclosure policy consistent with DCA's *Recommended Minimum Standards for Consumer Complaint Disclosure*?

    The Board's regulations (California Code of Regulations Sections 1399.180 - 1399.187) governing the disclosure of information are consistent with DCA's Recommended Standards for Consumer Complaint Disclosure and DCA's Web Site Posting of Accusations and Disciplinary Actions.

    - Does the board post accusations and disciplinary actions consistent with BPC § 27, if applicable?

      While the Board is not subject to BPC Section 27, the Board posts accusations and disciplinary actions consistent with BPC Section 27 on its website as well as in the DCA License Search. The information can be viewed on the Enforcement page under the Consumer tab of the website.

    - Does the board post complaint date on its website? If so, please provide a brief description of each data point reported on the website along with any statutory or regulatory authorization.

      The Board does not post complaint date or complaint information on its website; complaints are confidential pursuant to Government Code section 7923.600.

54. What information does the board provide to the public regarding its licensees (i.e., education completed, awards, certificates, certification, specialty areas, disciplinary action, etc.)?

    California Code of Regulations Sections 1399.182 through 1399.187 provides, upon request, information discloser including the identity and date of all undergraduate and graduate degrees awarded, summaries of any disciplinary actions taken at a health care facility that result in the termination or revocation of staff privileges for medical or disciplinary cause or reason, the date, nature, and disposition of complaints on file which have been investigated and referred to the Office of the Attorney General for legal action, civil actions against a licensee in the amount of $30,000 or more as recovery of damages for death or personal injury caused by professional

negligence. The public may access a licensee's record through the Board's website. The following information is provided on the Board's website: the licensee's name, license number, license status, issue date of license, expiration date of license, address of record (upon request) or business address, citations issued, and pending and final disciplinary actions.

Also, subject to limitations set forth in the Information Practices Act, the Public Records Act, and the California Constitution regarding personal privacy, information contained in the licensee's file may be disclosed to the public upon request.

55. What methods does the board use to provide consumer outreach and education?

California's travel restrictions have limited much of the in-person outreach that can be conducted by Board staff to consumers. However, the Executive Officer has provided virtual presentations to consumers, licensees, and students regarding Board requirements, actions, and issues relevant to various stakeholder groups. For example, the Board did live demonstrations of its new online license application system for students, including San Francisco State University, and for the members of the California Council of Academic Programs in Communication Sciences and Disorders, whose members are the chairs and directors of Communication Science and Disorders Programs. The most convenient and cost-effective platform for the Board to educate consumers, applicants, and licensees is through its website. The Board continues to work to improve its website by making it easier to navigate, ensure content is up-to-date, clear, accessible, and that language is user-friendly. The Board has also encouraged the public, licensees, and associations to join the Board's various listservs to receive regular notifications regarding Board Meetings and agendas, disciplinary actions taken by the Board, and legislation and regulation changes that impact consumers and Board licensees.

## Section 6 – Online Practice Issues

56. Discuss the prevalence of online practice and whether there are issues with unlicensed activity.

- How does the board regulate online/internet practice?

  The Board has received and investigated a limited number of cases regarding unlicensed activity occurring through online practice and online sales of hearing aids, as well as improper supervision of Speech-Language Pathology Assistants via telehealth.

  <u>Telehealth</u>
  Treatment for both speech and hearing disorders may be effectively delivered via telehealth which includes some form of online interaction between the patient and the provider. The Board provides practice guidance on its website to assist its licensees. During and after the COVID-19 pandemic, the Board has seen a large growth in telehealth provision of speech services, including schools contracting with companies that solely provide speech services via telehealth. Complaints submitted related to telehealth often involve improper supervision of Speech-Language Pathology Assistants by either out-of-state supervisors or other issues related to the supervision requirements for Speech-Language Pathology Assistants.

  <u>Online Business Practices</u>
  The online purchase of hearing aids and online hearing testing has become a common business model as more companies have started marketing devices to consumers directly via

the internet with claims of one-size fits all or the ability to remotely adapt the hearing aid to fit the purchaser's needs without the need for an office visit. Complaints submitted related to online sales of hearing aids usually relate to either unlicensed practice or failure to abide by the Song-Beverly Consumer Warranty Act and properly issue a refund to the consumer.

BPC Section 2538.23 governs the sale of hearing aids by catalog or direct mail. While this section does not specifically include the term "internet" sales, the intent of the section is to regulate similar business transactions. This law requires that the seller be licensed as a Hearing Aid Dispenser or dispensing audiologist in California. The law also requires that there is not "fitting, selection, or adaptation" or "advice is given with respect to fitting, selection, or adaptation" of the hearing aid. The law also requires that the seller has "received a statement which is signed by a physician and surgeon, audiologist, or a hearing aid dispenser, licensed by the State of California which verifies that Section 2538.36 and subdivision (b) of Section 2538.49 have been complied with." This would ensure that examination of the consumer's ear canal by a licensed physician, Audiologist, or a Hearing Aid Dispenser, and medical referral under certain conditions has occurred. Eliminating these requirements places the consumer at risk if underlying medical conditions are undetected and have resulted in hearing loss which may require medical or surgical procedures. The Board believes it is vitally important to continue to regulate the remote acquisition of hearing aids and require an examination of a consumer's ear canal and medical clearance.

However, regulation of hearing aid devices falls under the Federal Drug Administration (FDA), and FDA provisions do not specifically restrict the sale of hearing aids via the Internet. Further, federal law provides that no state may establish any requirement which is different from, or in addition to, the federal provisions unless the state is granted an exemption from the federal government to enforce more restrictive regulations. To date there is no federal exemption being granted for Section 2538.23; however, for well over a decade California has been effectively regulating the sale of hearing aids acquired by mail order.

On May 30, 2012, the Board sent an exemption request to the FDA. The Board received a response to its 2012 request on August 31, 2023, stating that "the applicable Federal requirements for hearing aids have changed since the Board submitted the Application, and the bases for the requested exemption are no longer in effect. As such, FDA has determined that the Application is moot." Essentially, with the changes the FDA promulgated in October of 2022 regarding Over-The-Counter hearing aids, the old sections of federal law were amended or removed. Therefore the FDA does not need to consider or approve any exemptions related to state laws regarding prescription hearing aid requirements. It is the Board's understanding that it can still require compliance with BPC Section 2538.23 for online sale of prescription hearing aids to California consumers.

- How does the board regulate online/internet business practices outside of California?

The Board will investigate online business practices outside of California if a complaint is filed by a California consumer. The Board has received and investigated a limited number of cases regarding unlicensed activity occurring through online practice and online sales of hearing aids, as well as improper supervision of Speech-Language Pathology Assistants via telehealth. To date, no complaint related to telehealth or online/internet business has resulted in an enforcement action. Complaints related to telehealth or online businesses are difficult for the Board to investigate, either due to the anonymous nature of the complaint submitted, resulting in a lack of critical detailed information that is necessary for the Board's investigation, or due to the lack of requirements for out-of-state based companies to cooperate with the Board's

investigation. If at least one California licensee works for the online company, that can make it somewhat easier to obtain information related to the complaint, and that individual is who the Board would hold responsible for upholding Board laws and regulations related to speech-language pathology, audiology, and hearing aid dispensing. However, if the complaint is regarding unlicensed activity, the Board often encounters non-responsive businesses residing out-of-state that are not required to cooperate with our investigation and have no incentive to cooperate. At times, the Board will engage the DCA Division of Investigation to assist with an investigation of online sales, and on rare occasions the Board may refer the complaint to a District Attorney if it might merit their investigation and prosecution, but at that point the Board is unable to investigate or prosecute the complaint any further.

- Does the Board need statutory authority or statutory clarification to more effectively regulate online practice, if applicable?

  While the Board has not had the opportunity to test its authority in any cases related to online practice or online businesses using the disciplinary process, the Board's statutory authority could benefit from additional clarification in relation to hearing aid dispensing laws to clarify that online sales to California consumers of non-OTC or prescription hearing aids are governed by BPC Section 2538.23.

## Section 7 – Workforce Development and Job Creation

57. What actions has the board taken in terms of workforce development?

In the area of expanding the current workforce, during the Board's prior Sunset Review, the Board recommended the revision of BPC Section 2532.8 to include Audiologists with a valid American Board of Audiology (ABA) certificate issued by the American Academy of Audiology as well as a Certificate of Clinical Competence in audiology (CCC-A) issued by the American Speech-Language-Hearing Association, which was allowed only for those who graduated before 2008. This amendment was accepted and included in the Board's 2022 Sunset bill AB 2686, and the Board began licensing Audiologists with ABA and CCC-A certificates the following year, thus streamlining licensure for Audiologists who hold these certifications and enhancing access to audiology services for California consumers. Since the implementation of AB 2686, the Board has seen a significant growth in the number of Audiologists applying for licensure with the ABA and CCC-A certificates, resulting in the Board issuing an average of 36 audiology licenses per fiscal year post implementation compared to prior fiscal years which on average resulted in the issuance of only five audiology licenses per fiscal year.

During the Audiology Practice Committee review of the scope of responsibilities regulations for Audiology Aides, the Audiology Practice Committee questioned whether a higher level of support personnel similar to the Speech-Language Pathology Assistant license type was needed in the profession of audiology. As a result of this discussion, the Board reviewed the Sunrise Process required when a licensing board wishes to create a new license type at its October 2022 Board meeting and delegated to the Audiology Practice Committee the task of researching this option and providing the Board with a recommendation as to whether it was an appropriate action for the Board to take to pursue the Sunrise Process to create an audiology assistant license type. In January 2025, the California Academy of Audiology, the professional association representing Audiologists in California, submitted a letter to the Board requesting to open discussions with the board on the possibility of creating a new license type for audiology assistants and requesting the

item be added to a future Board meeting agenda. The Audiology Practice Committee completed its research and discussed the Sunrise Process at its May 2025 meeting, after being delayed by other committee work including the revisions of the Audiology Aide regulations. At that meeting, the Audiology Practice Committee determined the Board should not pursue the Sunrise Process to create an audiology assistant license type, as it would be difficult to justify the creation of the audiology assistant license category as necessary to protect the public health, safety, or welfare as required by the Sunrise Process. Since it believes the creation of an audiology assistant license type would both advance the profession and improve access to audiological services in California, the Audiology Practice Committee instead recommended that a professional association should seek a State Assembly or Senate Member to author a bill to create an audiology assistant license type with similar licensing requirements to the Speech-Language Pathology Assistant license. At its August 2025 meeting, the Board discussed and agreed with the Audiology Practice Committee's recommendation, voted on a motion to support the idea in concept, and instructed Board staff to provide technical assistance to the professional association that seeks to sponsor a bill to create an audiology assistant license type regarding concerns over consumer protection and fiscal impacts to the Board.

In an effort to improve access to swallow therapy services to California consumers, in December 2024 the Speech-Language Pathology Practice Committee began reviewing and discussing the limitations on swallow therapy with bolus material (drinks/liquids or foods) in the current Scope of Responsibilities of a Speech-Language Pathology Assistant regulations. At its August 2025 meeting, the Speech-Language Pathology Practice Committee reviewed a "Workforce Needs Assessment in California" related to Occupational Therapy Assistants that was done as a collaboration between the California Board of Occupational Therapy (CBOT) and the California Community Colleges' Centers of Excellence for Labor Market Research (COE) and Health Workforce Initiative (HWI). During this review, the Speech-Language Pathology Practice Committee discussed how this level of workforce research related to Speech-Language Pathology Assistants could be helpful to the Board as currently the Board does not get this type of workforce data related to its support level license types (assistant or aide level). To this end, Board staff have been directed to explore how CBOT started this work with the COE and HWI and any costs associated with it to provide information to the Board in case it wishes to pursue this type of workforce assessment of its support level license types.

At the staff level, the Board's Executive Officer meets with training programs, academic groups, and students to ensure that accurate information is conveyed about the Board's licensure process and requirements. For example, the Board conducted demonstrations of the Board's new online application system the Board did live demonstrations of its new online license application system for students, including San Francisco State University, and for the members of the California Council of Academic Programs in Communication Sciences and Disorders, whose members are the chairs and directors of Communication Science and Disorders Programs.

58. Describe any assessment the board has conducted on the impact of licensing delays.

Since the Board's last Sunset Review, there have been no assessments of the impact of licensing delays. Instead of performing a study, the Board decided to positively contribute to workforce development and remove one barrier to licensure for our licensed professions, by dedicating intense resources and focus to streamlining and automating as much of the initial licensure process as was possible within the scope of the Board's Business Modernization Project. Outside of the primary source verification of examination scores and college transcripts, the Board was able to streamline and automate most all of the Board's initial licensure processes, including electronically gathering payment, signatures of applicants, supervisors, college training program

directors, and human resources officials when necessary. As a result, at two years post-project implementation, the Board has been able to shorten licensing timeframes by 71 percent overall and since March of 2024 processes complete applications within one (1) to two (2) weeks.

59. Describe the board's efforts to work with schools to inform potential licensees of the licensing requirements and licensing process.

    The Executive Officer and Board members have developed presentations to share with college training programs regarding licensing requirements. In addition to making presentations directly to the colleges or their students, the Executive Officer attends meetings of the California Council of Academic Programs in Communication Sciences and Disorders, a group composed of the State's chairs and directors of Communication Science and Disorders Programs. This open line of communication allows schools to ask the Board questions related to licensing requirements and processes directly.

60. Describe any barriers to licensure and/or employment the board believes exist.

    A longstanding issue in California has been the insufficient number of audiology doctoral programs and insufficient enrollment capacity in speech-language pathology master's programs to meet the needs of California consumers of speech and hearing services. This is a barrier to increasing the licensing populations that would meet the demand for speech-language pathology and audiology services in the state. While there have been improvements, especially in the number of audiology programs in the state, this progress has not been able to meet the demand.

    The Board continues to review and approve Speech-Language Pathology Assistant associate's degree programs as they are ready to apply for approval, and since our last Sunset have approved one additional program and is awaiting the application of another potential program, both located in Southern California. There has also been growth in Speech-Language Pathology Assistant bachelor's level programs since the Board's last Sunset. These programs offer individuals with a bachelor's degree in speech-language pathology or communication disorders an opportunity to complete the 100-hour fieldwork requirement and one or more courses specific to the Speech-Language Pathology Assistant clinical practice that cover the roles and responsibilities of the license, however the Board is not required to review and approve bachelor's level programs and therefore does not track these programs or their development.

    The Board will continue to collaborate with educational stakeholders to address the growing speech and hearing services needs of the state.

61. Provide any workforce development data collected by the board, such as:

    As required by BPC Section 502, the Board, through DCA, collects demographic and workforce data from licensees that renew online and that data is provided directly to the California Department of Health Care Access and Information (HCAI).

    HCAI data is reviewed periodically by Board executive leadership, but trends have consistently shown that the Speech-Language Pathology Assistant licensee population is our most diverse population both racially/ethnically and linguistically, and more closely aligns with the ethnic/racial and linguistic diversity of California's population overall. For speech-language pathology, this trend is not surprising since the Speech-Language Pathology Assistant license type allows entry into the speech-language pathology field with either an associate or bachelor's

degree and 100 hours of fieldwork compared to a master's degree with nine months of professional experience. This also allows these individuals to work and earn a living in the field while trying to obtain further education and/or acceptance into a master's program to pursue licensure as a speech-language pathologist. As discussed earlier, there is not currently an audiology assistant level license type, but it would be expected to see greater diversity both ethnically/racially and linguistically in that population if such a license type were created with educational requirements expected for entry to the license type to be significantly lower than a doctoral degree.

Interestingly, in looking at the hearing health services, while the Hearing Aid Dispenser's license does not require any formal education in hearing health sciences compared to the doctoral degree in audiology and 12 months of professional experience required of the Audiologist, the Hearing Aid Dispenser licensee population is only modestly more diverse racially/ethnically and linguistically than the Audiologist licensee population. However, our 2020 Occupational Analysis of the Hearing Aid Dispenser profession showed that while only a high school diploma is required for licensure, the majority of Hearing Aid Dispensers have a college degree, ranging from 47.7 percent having either an associate or bachelor's degree, and 14.1 percent having a master's or doctoral degree.

**Race/Ethnicity and Language Diversity Data of Licensee Populations**

| | CA Population | SLPA | SLP | HAD | AU |
|---|---|---|---|---|---|
| **Race/Ethnicity Data** | | | | | |
| White, Non-Hispanic | 34.6% | 30.4% | 61.1% | 53.0% | 64.4% |
| Asian, Non-Hispanic | 15.1% | 10.4% | 15.9% | 9.4% | 17.4% |
| Hispanic, Any Race | 39.8% | 50.7% | 15.6% | 27.7% | 10.4% |
| Black, Non-Hispanic | 5.3% | 3.5% | 2.4% | 2.3% | 3.7% |
| Multiracial, Non-Hispanic | 4.1% | 3.5% | 3.5% | 4.7% | 3.3% |
| Other Race, Non-Hispanic | 0.5% | 1.0% | 1.2% | 1.9% | 0.7% |
| Pacific Islander, Non-Hispanic | 0.4% | 0.2% | 0.1% | 0.2% | 0.1% |
| American Indian, Non-Hispanic | 0.3% | 0.3% | 0.1% | 0.8% | 0.1% |
| **Language Data** | | | | | |
| English Only | 55.9% | 51.3% | 72.2% | 65.2% | 69.6% |
| Spanish | 28.2% | 38.5% | 15.5% | 24.4% | 14.8% |
| Asian and Pacific Islander | 10.0% | 3.9% | 4.8% | 8.4% | 7.5% |
| Other Indo-European | 4.8% | 3.2% | 6.1% | 5.5% | 6.1% |
| Other | 1.1% | 7.1% | 4.6% | 4.2% | 7.8% |

SLPA = Speech-Language Pathology Assistant
SLP = Speech-Language Pathologist
HAD = Hearing Aid Dispenser
AU = Audiologist

Data Source: https://hcai.ca.gov/workforce/health-workforce/workforce-data/

a. Workforce shortages

Neither the Board nor DCA have formally collected data regarding workforce shortages since the Board's last Sunset. The Board does not currently have the resources, staff or funding, to be able to perform independent studies on workforce shortages and would have to rely on professional associations to compile this information.

b. Successful training programs.

Neither the Board nor DCA have collected data regarding successful training programs since the Board's last Sunset. The Board does not currently have the resources, staff or funding, to be able to research, develop, or provide training programs for future licensees and would have to rely on professional associations and schools to create and provide this type of training.

One area of training the Board is aware of is post-baccalaureate leveling programs at some universities that help prepare students that want to pursue a career in speech-language pathology but whose undergraduate degree is not in speech-language pathology or communication science disorders. These programs get students ready to apply for and start the master's program by giving them baccalaureate level courses such as anatomy and physiology of speech, principles of audiology, and other communication science disorders courses that were required of students with a bachelor's degree in speech-language pathology or communication science disorders. The Board does not track or approve these programs and is unaware of how many licensees have participated in these programs.

For Hearing Aid Dispensers, the training options the Board is aware of include on-the-job training provided through private companies while the individual is a licensed Hearing Aid Dispenser Trainee for the company (earn and learn option). Alternatively, the national professional association, the International Hearing Society, has training manuals and programs individuals can purchase, and there are a couple other non-school and non-employment based training programs that are provided by private individuals that can be taken prior to or after obtaining the Hearing Aid Dispenser Trainee license. Most of these programs use some component of learning/training while working in a trainee/apprentice capacity. These training programs may provide information on hearing health and the auditory system, audiometric assessments, performing ear impressions, information on hearing aids, and guidance on hearing aid fitting and post-fitting counseling. Some of these programs are online and others have in-person seminars where they can obtain hands-on practice with performing auditory assessments and ear impressions. These courses appear to be designed to provide the hearing health information necessary to pass a knowledge-based written examination and the basic clinical practice information necessary to pass the practical examination required for licensure or certification in various states. The Board does not track or approve these programs and is unaware of how many licensees have participated in these programs.

62. What actions has the board taken to help reduce or eliminate inequities experienced by vulnerable communities, including low- and moderate-income communities, communities of color, and other marginalized communities, or otherwise avoid harming those communities?

In June 2024, the Board met to review stakeholder input on the Board's operations and receive training from DCA SOLID on Diversity, Equity and Inclusion (DEI) in relation to the development of the Board's new Strategic Plan. During this meeting and the Board's September 2024 meeting, the Board developed and adopted a new Strategic Plan that emphasizes inclusion, accessibility, consumer education, and meaningful engagement with all stakeholders.

In September of 2024, the Board finalized updates to continuing professional development regulations for Speech-Language Pathologists and Audiologists that adds coursework related to diversity, equity, and inclusion as it applies to service delivery for diverse populations as acceptable courses related to the practice of speech-language pathology and audiology. These regulations also removed the cap to the number of courses a licensee can accrue in courses related to the practice, allowing licensees to broaden their learning opportunities by taking more

cultural competency and diversity, equity, and inclusion courses so that they can better serve California's diverse communities.

## Section 8 – Current Issues

63. Describe how the board is participating in development of online application and payment capability and any other secondary IT issues affecting the board.

- Is the board utilizing BreEZe? What Release was the board included in? What is the status of the board's change requests?

  The Board is not utilizing BreEZe, but was originally assigned to be part of Release 3.

- If the board is not utilizing BreEZe, what is the board's plan for future IT needs? What discussions has the board had with DCA about IT needs and options? Is the board currently using a bridge or workaround system?

  The Board in coordination with DCA's Organizational Improvement Office and Office of Information Services (OIS), undertook a Business Modernization Project to provide the Board with an information technology solution that would transition the Board from a legacy database to a new system that would provide access for licensees and applicants to apply for licensure and complete online transactions. In 2020, the Board received budgetary authority to proceed with the project and position authority for an analyst position to address the increased workload during the development and transition to the system. However, during the solution development phase of the project, it was determined that full replacement of the Board's legacy systems could not be supported by the Board's Fund and instead the Board would need to pursue an encapsulated service layer that web-enables the legacy systems currently in place. This decision would still allow online transactions and processing of applications while also increasing the variety of product options available to the Board as technological solutions, including seeking a more cost-effective option for the Board over the long run.

  In late 2021, the Board was given an opportunity to compete for an award to fund part of its Business Modernization Project through the State's Technology Modernization Fund (TMF). The TMF funding was provided through the California Department of Technology (CDT) that provided an opportunity to California state departments to submit business challenges that require an IT solution to modernize government and improve digital services for California residents and state employees. Funding from the TMF involved a multi-stage process including proposal submission, readiness assessment by the CDT, and a presentation to pitch the proposal to a TMF Selection Committee composed of executives from other state agencies and departments. Board management in partnership with the OIS developed a presentation for the TMF Selection Committee that pitched the Board's proposed online system with application, processing, and payment functionality for thirteen license types administered by the Board.

  As a result of the joint presentation, in January 2022 the Board was accepted into the TMF program and was awarded funding to cover all external vendor costs for our Board's Business Modernization Project of approximately $411,000. In the Spring of 2022, the Board was able to secure the necessary contracts with external vendors to implement the new online

applications and began the project in the Summer of 2022. The Board undertook the project within an intensely short timeframe of under one year from start to finish. The Board began launching online applications for initial licensure in multiple releases starting in the Fall of 2022 and completing the creation and deployment of all initial applications for licensure in February of 2023. In total, the Board launched 29 application workflows that support the various qualification methods and online payment for the Board's 13 license types.

The new online application system streamlined and automated the vast majority of application processes for both applicants and Board staff, excluding verification of examination scores and college transcripts. The new online application system sends emails to applicants as they progress through the licensing process to provide status updates, including the functionality to receive and respond to deficiency notice emails from Board staff and the ability to upload additional documents as well as copies of completed documents and forms. Altogether, this project created a more streamlined and user-friendly application process that helped improve application accuracy and reduce processing timeframes.

In coordination with DCA's Communications Division, Board staff also created an Apply Simply! page on the Board's website, as well as updated the normal application pages for each license type to increase visibility and access to the new online applications. To make the information easily visible to applicants, Board staff have also added a button to the Board's website homepage to link applicants to all of the new online applications.

In 2023, the Board also launched its Application Status & Details online tool for applicants to look up their application, which was developed and deployed by DCA OIS.

The Board then used the same technology solution used to create its new online applications to develop and launch new online military spouse/domestic partner temporary license applications in June 2023. These military spouse/domestic partner temporary license applications all have the same technology and usability features that provide applicants with a more streamlined and user-friendly application process.

Within one year of implementation of the new online licensing system, the Board saw a 48 percent reduction in processing times, and within two years of implementation the Board now shows an average reduction of 71 percent in processing times for licensing applications. The Board now consistently averages between 1 – 2 weeks for application processing times for complete applications throughout the year. Additionally, the new online licensing system also increased Board processing capacity, allowing the same four Board licensing analysts to process 27 percent more applications within one year of implementation and 34 percent more applications within two years of implementation. This has allowed Board staff to accommodate continued growth in application workload compared to prior years without impacting licensing timeframes.

Considering the size of the Board's staff and funding resources, the project's success was monumental. This success was due to the combination of having a dedicated and flexible team of staff and external vendors on the project, a structurally solid technology platform to work with, and the willingness of all team members to work together for the best outcome for the Board's success. Unfortunately, due to the scope and timeframe for the TMF funding proposal, the Board had to limit the scope of its Business Modernization Project to initial licensure applications. The Board's Business Modernization Project related to consumer complaints, enforcement processes, licensee supervision and address change forms, license verifications/letters of good standing, and CE audits are all still manual paper-based processes

and online renewal of licensure remains limited in its functionality. Since the Board was also able to make so many time-saving changes to processes as well as data system improvements during the Business Modernization Project related to initial licensure applications, the Board looks forward to being able to tackle the remaining modernization projects from the Board's original Business Modernization Project as Board and DCA resources and funding allow.

## Section 9 – Board Action and Response to Prior Sunset Issues

Include the following:

- Background information concerning the issue as it pertains to the board.
- Short discussion of recommendations made by the Committees during prior sunset review.
- What action the board took in response to the recommendation or findings made under prior sunset review.
- Any recommendations the board has for dealing with the issue, if appropriate.

***BOARD ADMINISTRATION ISSUES***

**ISSUE #1: (BOARD COMPOSITION.) Does the Board's composition need to be updated to include additional members of the public?**

**Background:** In 2010, the Federal Trade Commission (FTC) brought an administrative complaint against the North Carolina State Board of Dental Examiners (BDE) for exclusion of non-dentists from the practice of teeth whitening. The FTC alleged that the BDE's decision was an uncompetitive and unfair method of competition under the FTC Act. This opened the BDE to lawsuits and substantial damages from affected parties.

The BDE was composed of 6 licensed, practicing dentists and 2 public members. The practice of teethwhitening was not addressed in the statutes comprising the Dental Practice Act. Instead of initiating a rulemaking effort to clarify the appropriate practice of teeth whitening, the BDE sent cease-and-desistletters to non-dentists in the state offering teeth whitening services. The BDE argued that the FTC's complaint was invalid because the BDE was acting as an agent of North Carolina, and according to state-action immunity, one cannot sue the state acting in its sovereign capacity for anticompetitive conduct. A federal appeals court sided with the FTC, and the BDE appealed to the United States Supreme Court (Court).

In February 2015, the Court agreed with the FTC and determined that the BDE was not acting as a state agent and could be sued for its actions. The Court ruled, "Because a controlling number of the Board's decision-makers are active participants in the occupation the Board regulates, the Board can invoke state-action antitrust immunity only if it was subject to active supervision by the State, and herethat requirement is not met."

The Court was not specific about what may constitute "active participants" or "active supervision."However, the Court did say that "active supervision" requires "that state officials have and exercisepower to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy," and that "the supervisor must review the substance of the anticompetitivedecision, not merely the procedures followed to produce it."

In October 2015, the FTC released a staff guidance, *Active Supervision of State Regulatory Boards*

*Controlled by Market Participants,* in order to better explain when active supervision of a state regulatory board would be required in order for a board to invoke the state action defense. The guidance also aimed to highlight what factors are relevant when determining if the active supervisionrequirement has been satisfied. The FTC states that active supervision includes the ability of a state supervisor to review the substance of the anticompetitive decision and have the power to veto or modify a decision. The state supervisor may not be an active market participant. In addition, the FTC states that active supervision must precede the implementation of the alleged anticompetitive restraint.

The FTC states that the guidance addresses only the active supervision requirement of the state actiondefense, and antitrust analysis is fact-specific and context-dependent. This means that although a stateaction defense might not be applicable in a certain case, this does not mean that the conduct of a regulatory board necessarily violates federal antitrust laws.

On October 22, 2015, the Committees held a joint informational hearing to explore the implications ofthe Court decision on the DCA's professional regulatory boards and consider recommendations.

In response to the Court's decision, State Senator Jerry Hill requested an opinion from the Office of Attorney General Kamala Harris (AG). The AG released the following:

"North Carolina Dental has brought both the composition of licensing boards and the conceptof active state supervision into the public spotlight, but the standard it imposes is flexible and context-specific. This leaves the state with many variables to consider in deciding how to responds.

"Whatever the chosen response may be, the state can be assured that North Carolina Dental's 'active state supervision' requirement is satisfied when a non-market-participant state officialhas and exercises the power to substantively review a board's action and determines whether the action effectuates the state's regulatory policies."

Boards like SLPAHADB are semiautonomous bodies whose members are appointed by the Governor. Although most of the non-healing arts boards have statutory authority for a public majority allotment in their makeup, most healing arts and non-healing arts boards are comprised of a majority of membersrepresenting the profession.

*North Carolina State Board of Dental Examiners v. FTC* placed limitations on the immunity of regulatory boards controlled by active market participants. This is because individuals who are directlyaffected by their own rulemaking may not be able to detect their biases, potentially placing their benefit over those of the public. As the Supreme Court stated, "Dual allegiances are not always apparent to an actor."

Although the boards are tied to the state through various structural and statutory oversights, it is presently unclear whether current laws and practices are sufficient to ensure that the boards are state actors and, thus, immune from legal action. Changing SLPAHADB's composition to increase the number of public members may provide certain benefits such as: limiting the potential for Board actionto be viewed as providing marketplace advantages to licensees, particularly in the hearing aid dispensing arena in light of recent federal action to make devises more accessible; decreasing SLPAHADB's risk of exposure to lawsuits and; orient the Board towards a more public, patient, and client centric program.

**Staff Recommendation:** ***The Committees should discuss whether a proposal to alter the Board's composition may be beneficial to the Board, patients, clients, and the public.***

**Board's 2022 Response:**

Currently, the Board has three (3) public members, one (1) of whom is a licensed physician and ENT. The Board is open to discussing the possibility of increasing the number of public members on our Board. We would note that increasing the number of Board members could have additional cost and quorum implications.

**Board's 2025 Update:**

Currently, the Board's primary concern is that the public member seat appointed by the Senate has remained empty since it was vacated by Debbie Snow in November of 2022, additionally the public member seat appointed by the Assembly entered its grace year as of November 30, 2025. Without adequate public member participation due to vacancies of public members, this increases the risks of creating the perception of market interest that the committee mentions regardless of how much the Board may try to ensure that consumer protection remains paramount in all decisions. Additionally, the composition of the Board having two licensed members for each of the professions of speech-language pathology, audiology, and hearing aid dispensing has remained vital to receiving adequate input for Board decisions, therefore the Board would not recommend reducing the number of licensed positions. The Board would again reiterate that it is open to the discussion of adding additional public member seats but notes this would be less critical than ensuring that the current public member seats are always filled.

## ISSUE #2: (HEARING AID DISPENSING COMMITTEE.) Should the size of the Hearing AidDispensing Committee be reduced?

**Background:** The Hearing Aid Dispensing Committee is the Board's only statutorily required committee and must include the Board's two Audiologist board members, two Hearing Aid Dispenser board members, the Otolaryngologist public member, and one of the Board's two other public members. The Governor is responsible for appointing each of the Board members except for two public members, one of whom is appointed by the Senate Rules Committee and the other by the Speaker of the Assembly. The Hearing Aid Dispensing Committee has not had a quorum of members since January 1, 2021 due to the Dispensing Audiologist, one Hearing Aid Dispenser, and the Otolaryngologist positions being vacant. The Board asserts that the lack of a quorum requires the Board to address issues that would otherwise be under the Hearing Aid Dispensing Committee's purview.

For comparison, the Speech-Language Pathology and Audiology committees each have three and four members, respectively. The Board recommends reducing the size of the Hearing Aid Dispensing Committee to four members, specifically by eliminating one Audiologist position and allowing for another public member to serve on the Hearing Aid Dispensing Committee if the Otolaryngologist position is vacant.

**Staff Recommendation**: ***The Board should explain to the Committees the difficulty filling the current vacancies and provide more information about what the Hearing Aid Dispensing Committee does. Moreover, the Committees should work with the Board to determinate the universe of options to address this issue.***

**Board's 2022 Response:**

The primary responsibilities of the Hearing Aid Dispensing Committee (HAD Committee) are to provide policy and regulatory guidance with respect to hearing aid dispensing practices and recommend scope of practice amendments for consideration by the board. Accordingly, the HAD Committee is responsible for investigating issues involving the practice of fitting or selling of hearing aids and provides advice to the Board based on the committee's review and research of pertinent practice findings. Essential to this process is the composition of the committee's professional and public representation that provides critical perspectives to the deliberations of pertinent practice issues that ultimately lead to appropriate and effective recommendations to the board. The committee consistently operates with an awareness of relevant consumer protection issues. Thus, it monitors the needed requirements for maintaining the appropriate scope of practice for hearing aid dispensers, including issues involving continuing education and the supervision of hearing aid dispensing trainees.

The HAD Committee is the Board's only legislatively mandated committee and is required to have six members: two hearing aid dispensers, two audiologists, and two public members, one of which must be a licensed otolaryngologist (ENT). For the majority of 2021, this committee had three vacancies including a hearing aid dispenser, an audiologist, and a licensed otolaryngologist. Thus, the committee was unable to complete its work involving the potential development, review and revision of important policies related to the profession due to the lack of quorum. Consumers can be harmed if the Board is unable to address issues related to the hearing aid dispensing profession in a timely manner. Filling Board Member positions is outside the Board's control, and it cannot speak to the difficulties of filling vacancies for the appointing authorities.

The Board recommends amending BPC Section 2531.05 to change the membership of the HAD Committee from six (6) members to four (4) members. The recommended language would eliminate one licensed Audiologist and one public member and allow for another public member to serve on the committee if the Otolaryngologist public member position is vacant. Alternatively, the Board and HAD Committee would benefit from having more flexibility in the mandated, specified positions.

**Board's 2025 Update:**

As part of the Board's prior sunset bill, AB 2686 (Ch. 415, Statutes of 2022), the statutory requirement for the composition of the Board's Hearing Aid Dispensing Committee was removed from BPC Section 2531.05. The Board continues to utilize a smaller group of members as the Hearing Aid Dispensing Committee to provide policy and regulatory guidance with respect to hearing aid dispensing practices. The current composition of the committee includes two Dispensing Audiologists, two Hearing Aid Dispensers, and the Otolaryngologist public member, which can be substituted by either of the two public member positions in case of a vacancy. The flexibility to determine the appropriate size and composition of the Hearing Aid Dispensing Committee has ensured that there have not been any quorum issues since the Board's last Sunset, allowing a variety of issues to be fully discussed by the Committee including hearing aid dispensing advertising and hearing aid trainee supervision regulations.

**ISSUE #3: (LICENSEE CONTACT INFORMATION.) Should the Board be authorized torequire licensees to share and keep current their e-mail address with the Board?**

**Background:** Under existing law, the Board has no authority to require licensees to provide an email address to facilitate communication with the Board. The Board asserts that email is critically important for information to be shared quickly, efficiently, and inexpensively. The Board notes that it relied heavily on email during the COVID-19 pandemic to provide licensees with updates regarding the Board's office closure and waivers to various rules and regulations.

It is a stated goal in the Board's Strategic Plan for 2021-2024 to receive the statutory authority to collect email addresses to better communicate with licensees. It does not propose requiring licensees to create an email account for the purposes of providing an email address to the Board.

**Staff Recommendation:** ***The Board should explain to the Committees how it communicates with licensees who do not have an e-mail address on file and consider whether an opt-out would be appropriate for those licensees who prefer an alternative method of the communication.***

**Board's 2022 Response:**

The Board communicates with its licensees in a variety of ways, including its website, traditional mail, and voluntary email/list serv groups based on their interests.

The current limitations on the Board's ability to require email addresses from its licensees limits the effectiveness of Board communication of critical practice and emergency communications, such as those related to COVID-19, and changes to laws and regulations that impact the Board's licensees. If given the authority to require licensees to provide their email address to the Board, an opt-out policy would be appropriate, and those licensees could continue to get information and updates from the Board on its website.

**Board's 2025 Update:**

As part of the Board's prior sunset bill, AB 2686 (Ch. 415, Statutes of 2022), the statutory requirement that Board applicants, registrants, and licensees provide their email address to the Board was established. The Board's new online licensing system ensures that we capture all applicant email address information during the application process. Unfortunately, due to the limited nature of the Board's online renewal platform, the online renewal system does not capture registrant and licensee email addresses, therefore the Board must rely on paper-based registrant and licensee address change forms to update their email address. This has slowed the Board's progress in obtaining registrant and licensee emails since the Board's last Sunset. If the Board had access to a more robust online renewal system, the Board could not only begin capturing registrant and licensee emails, but it could also start updating their address of record using the same transaction. This would also broaden who can renew online to include registrants and licensees in an inactive status (currently not available).

## ISSUE #4: (REGULATIONS.) What is the current timeframe for Board regulatory packages tobe approved and finalized?

**Background:** Promulgating regulations is at the heart of the Board's work to implement the law and establish a framework for consumer protection. According to the OAL, a "regulation" is any rule, regulation, order or standard of general application or the amendment, supplement, or revision of any rule, regulation, order, or standard adopted by any state agency to implement, interpret, or make specific the law enforced or administered by it. When adopting regulations, every department, division, office, officer, bureau, board or commission in the executive branch of the California state government must follow the rulemaking procedures in the Administrative Procedure Act (APA) (Government Code section 11340 et seq.) and regulations adopted by OAL, unless expressly exempted by statute from some or all of these requirements. The APA requirements are designed to provide the public with a meaningful opportunity to participate in the adoption of regulations or rules that have the force of law by California state agencies and to ensure the creation of an adequate record for the OAL and judicial review.

The rulemaking process does provide some discretion to agencies. While each agency must comply with timeframe requirements and must produce the same uniform documents supporting rulemaking efforts to submit to OAL, there are not the same standards for how regulation packages are determined, written, and produced.

Prior to 2016, boards and bureaus like the Board that are organized within DCA filed rulemaking packages directly with OAL. Boards and bureaus were not required to submit rulemaking packages to DCA or the overseeing agency for review and approval prior to submission for publication in the Notice Register. OAL reported that this process was unusual within state government: most programs must submit regulations packages to their respective agency for approval. As a result, in September 2016, the Secretary of the Business, Consumer Services and Housing Agency (BCSH) changed the procedures: boards and bureaus were now required to submit rulemaking packages to the DCA and BCSH for review prior to filing with OAL. BCSH stated that the reason for the decision was an increase in the number of regulations disapproved by OAL for failing to meet their statutory requirements.

According to a 2019 DCA report to the Legislature, Internal Review of Regulation Procedures, "the resulting enhanced scrutiny from Agency and DCA's Legal Affairs Division successfully reduced the number of disapproved regulation packages, with the number of disapprovals falling from nine in 2016 to only one in 2018." The report also found that "while disapproval rates plummeted, a consequence was lengthened timelines to adopt regulations. Several boards and bureaus raised objections to the lengthened review time and reported difficulty obtaining timely updates about regulation packages under review." The "pre-review" process required regulations to go through DCA's entire review process prior to the package being submitted for public comment. DCA established a formal Regulations Unit to "minimize the length of time it currently takes to review regulatory packages; allow board and bureau attorneys to focus on the increased workload of non-regulatory work; respond to the demand of regulation packages under review and the increase of regulation packages from AB 2138 (Chiu and Low; Chapter 995, Statutes of 2018); avoid the habitual carry-over of regulation packages; and, enhance the level of regulation training provided to boards and bureaus to improve the quality of regulations and create efficiencies by having better quality packages submitted for review."

It would be helpful for the Committees to have a better understanding of the status of necessary Board regulations, the timeframe for regulations to be processed and complete and what efficiencies the Board has realized since the creation of the Regulations Unit.

**Staff Recommendation:** ***The Board should provide the Committees with an update on pending regulations and the current timeframes for regulatory packages. In addition, the Board should inform the Committees of any achieved efficiencies in promulgating regulations in recent years.***

**Board's 2022 Response:**

The Board is pleased with the recent progress Board staff have been making on its regulatory packages. The Board completed two (2) regulatory packages in 2021, is actively working on seven (7) regulatory packages and has four (4) regulatory packages that need additional staff and legal review prior to actively working on these regulatory packages.

The timeframe of each regulatory package depends on the complexity of the proposed changes, but the Board expects to notice four (4) more regulatory packages by the end of 2022 and expects these four (4) regulatory packages to be completed in early to mid-2023. For example, even making small changes to reduce barriers to licensure for some applicants leads to extensive changes being needed due to some of the antiquated regulations the Board has.

In August of 2021, the Board was able to fill a fulltime regulations analyst position that is dedicated to working on regulatory packages, prior to that, the Board's parttime legislative analyst was working on regulations packages as time permitted. The additional resources made available through the DCA Regulations Unit was a critical addition for the Board in 2020 and allowed the Board to continue its regulatory work for much of the year even as Board leadership was dealing with added pandemic related responsibilities and staff leave during that time period.

**Board's 2025 Update:**

Since the Board's last Sunset, the Board had to discontinue the use of a parttime legislative analyst starting in FY 2023-24, at which time the Board's fulltime regulatory analyst assumed those legislative duties. This change has caused only a modest slowdown in the Board's regulatory output in recent years, as the Board has still been able to promulgate nine regulatory packages since its last Sunset Review. This includes one regulatory package in FY 2021-22, three regulatory packages in FY 2022-23, two regulatory packages in FY 2023-24, and three regulatory packages in FY 2024-25. These packages range in complexity and length from updating continuing professional development requirements for licensees and supervision requirements for specified license types, down to lower complexity packages including updating the Board's location in regulations and removing outdated processing times. The Board continues to work on five regulatory packages that have been under development for multiple years, as well as starting new regulatory packages related to supervision of speech-language pathology and audiology aides. Additionally, the Board has already promulgated two additional packages in the first half of FY 2025-26, both of which become effective January 1, 2026. While this continued progress within the regulatory area is based on low legislative workload, the Board believes that this is currently acceptable given other competing demands for Board resources and recent budget austerity measures required at the State level.

**ISSUE #5: (COST PRESSURES BEYOND THE BOARD'S CONTROL AND IMPACTS TO THE FUND) The Board pays over 20 percent of its revenue to pro rata costs charged for variousservices. Recent increases to the Attorney General's client billing rate for hours spent representing the Board in disciplinary matters may result in cost pressures for the Board's fund.What options does the Board have when cost pressures beyond its control impact revenue and expenses?**

**Background**: The DCA is almost entirely funded by a portion of the licensing fees paid by California's state-regulated professionals in the form of "pro rata." Pro rata funds DCA's two divisions, the Consumer and Client Services Division (CCSD) and the Division of Investigations (DOI). CCSD is the primary focus of this issue and contains the Administrative and Information Services Division (the Executive Office, Legislation, Budgets, Human Resources, Business Services Office, Fiscal Operations, Office of Information Services, Equal Employment Office, Legal, Internal Audits, and SOLID training services), the Communications Division (Public Affairs, Publications Design and Editing, and Digital Print Services), and the Division of Program and Policy Review (Policy Review Committee, Office of Professional Examination Services, and Consumer Information Center).

Pro rata is apportioned primarily based on the number of authorized staff at each board, rather than based on the amount of DCA's services programs use. DCA does charge boards based on actual use for some services, such as the Office of Information Services, the Consumer Information Center, the Office of Professional Examination Services, and DOI. Based on DCA's own figures, actual pro rata costs for every board have increased of an average of over 100 percent since FY 2012-2013.

The Board pays pro rata from its fund, the majority of revenue for which comes from licensing and renewal fees. It would be helpful for the Committees to understand what services it receives for the high pro rata costs it pays DCA.

In July of 2019, the California Department of Justice announced that it was utilizing language included in the Governor's Budget authorizing it to increase the amount it billed to client agencies for legal services. The change was substantial: the attorney rate increased by nearly 30% from $170 to $220, the paralegal rate increased over 70% from $120 to $205, and the analyst rate increased 97% from $99 to $195. While justification was provided for why an adjustment to the rates was needed, the rate hike occurred almost immediately and without meaningful notice to client agencies. For special funded entities such as the Committee, unexpected cost pressures can quickly prove problematic. It would be helpful to understand whether the Board has had any fiscal challenges resulting from the increase in the Attorney General's billing rate.

The Board does not have dedicated information technology staff and utilizes DCA Web and SharePoint Services staff to post and update content on the Board's website. The Board pays DCA Pro Rata that covers the Board's shared costs for these services.

***Staff Recommendation:*** ***DCA and the Board should explain to the Committees what services the Board receives for the pro rata costs it pays DCA. Furthermore, the Committees may wish to inquire about the Board's ability to update its website as needed.***

**Board's 2022 Response:**

The Board addresses cost pressures within its control by continuously monitoring its budget and costs, and when necessary, reduce expenditures for a variety of costs including supplies, mailings, travel, and occasionally delaying examination workload until the Board can fund the work.

When Office of Attorney General (OAG) costs exceed the Board's budget, the Board can request a current year augmentation for those costs and for Office of Administrative Hearings, which the Board had to do in the 2020-21 Fiscal Year. This ensures the Board can continue its mission critical consumer protection enforcement actions. The Board closely monitors each AG case including monthly billing reports and actively provides direction for each case.

In the first year after the OAG fee increases, the Board saw a 28 percent increase in its OAG costs over the prior two fiscal years average. In terms of OAG and other legal fees, these costs can be significantly increased by even one case where the respondent licensee exercises their right to appeal all the way up to the superior court (Writ).

The Board gets some of the following services for DCA Pro Rata:

- Human Resources including payroll processing and positing of job vacancies,
- SOLID Training and Planning Solutions for their WebEx meeting moderation services, Strategic Planning, surveys, and staff training;
- Legal Affairs for legal advice and counsel;
- Business Services Office for contracts, purchases, and payments;
- Office of Information Services for PC support, telecom needs, networking needs, web posting, and business modernization projects; and
- Publication design and digital print services.

It would be extremely difficult for the Board to be able to afford to hire staff to perform any or all these functions and thus utilizing DCA resources that are paid for through Pro Rata are the best utilization of the Board's resources for these types of functions.

Regarding the Board's ability to update its own website, the Board does not have the staff resources necessary for current Licensing and Enforcement workload let alone any resources it could dedicate to the ADA remediation and posting of content to our website. DCA Web and SharePoint Services fairly intakes and triages board and bureau requests for website updates based on legal posting requirements, urgency, and level of ADA remediation needed for content.

**Board's 2025 Update:**

The Board reiterates the indispensable nature of the services that DCA Pro Rata and the OAG provide to the Board. The Board's Fund could not absorb the costs for staffing to complete these human resources, information technology, legal counsel, or OAG prosecutorial functions. However, due to the cost cutting measures necessary to comply with Budget Letters 24-20 and 24-24, the Board has trimmed all expenditure areas that would have previously given the Board some flexibility to absorb increased OAG costs when OAG caseload and/or case complexity is high in any given fiscal year. Such cost-cutting measures include committing to keeping half of all Board meetings as teleconference meetings every year to save on travel costs as well as making full usage of no-cost or minimal-cost location options for in-person meetings. The Board expects that with the reductions taken from Budget Letters 24-20 and 24-24, it will have to make more frequent use of current year augmentation requests for OAG and Office of Administrative Hearing (OAH) costs due to the lack of flexibility remaining in its budget. The Board continues to actively monitor both OAG and OAH

workload and costs but remains committed to ensuring that prosecution of cases involving patient harm, sexual misconduct, and substance abusing licensees are fully prosecuted in order to protect the public.

## ***BOARD LICENSING ISSUES***

### ISSUE #6: (SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY AIDES) Should renewal and CE requirements for Speech-Language Pathology and Audiology Aides be enacted?

**Background:** Speech-Language Pathology and Audiology Aides are permitted to assist licensed Speech-Language Pathologists and Audiologists under direct supervision or under an alternative plan of supervision. As a permitted designation, Speech-Language Pathology and Audiology Aides have no formal education requirements, standards for discipline, or CE requirements. In FY 20-21, there were only 28 registered Speech Language-Pathology Aides operating in California. In contrast, in FY 20-21, there were 4,146 Speech-Language Pathology Assistants, a licensed position that fills many of the same roles of care and has annual renewal requirements.

In 2016, the Board sought to eliminate the Speech-Language Pathology Aide designation, but the Committees chose not to pursue the Board's recommendation given the impact it would have on current Speech-Language Pathology Aides. The Board remains concerned that the lack of renewal or CE requirements for this designation jeopardizes consumer protection. The Board proposes to establish renewal and CE requirements for Speech-Language Pathology and Audiology Aides.

**Staff Recommendation:** ***The Board should provide more information to the Committees about harm that has occurred, consumer complaints, and any enforcement actions taken by the Board. The Committees may wish to consider the potential impacts of imposing renewal or CE requirements, including benefit to consumers, costs to Speech-Language Pathology Aides, and enforcement by the Board.***

**Board's 2022 Response:**

The Board receives very few complaints against Speech-Language Pathology and Audiology Aides (Aides); however, the law stipulates that the supervising Audiologist or Speech-Language Pathologist is always responsible for support personnel under their supervision and the quality of care and services provided to the client. Patients served by Audiology Aides could be at risk of physical harm such as punctures of the skin in the ear, ear canal, and ear drum if audiological or tympanometric procedures or ear mold impressions are performed incorrectly or without adequate training and supervision.

While most support for Speech-Language Pathologists comes from licensed Speech-Language Pathology Assistants (SLPAs), support personnel that are registered as Speech-Language Pathology Aides are not required by law to renew or receive ongoing training. For Audiologists, support comes from Audiology Aides that may have a broader range of duties (there is no distinction for individuals with more education and experience like there is for SLPAs) but who are also not required by law to renew or receive ongoing training.

Support personnel for other professions, such as veterinary assistants, certified nurse assistants, and registered dental assistants have renewal requirements, and certified nurse assistants and registered dental assistants also must complete in-service or continuing education hours to keep abreast of necessary skills.

The Board recommends the Committees consider strengthening consumer protections related to the Aides registration by creating renewal and CE requirements for these registrants that will help ensure these individuals keep abreast of necessary knowledge and skills specific to their support duties.

**Board's 2025 Update:**

As part of the Board's prior sunset bill, AB 2686 (Ch. 415, Statutes of 2022), the Board was given the statutory authority to require Speech-Language Pathology and Audiology Aides (Aides) to renew their registration every two years, including setting a renewal fee and updating the board on their duties performed while assisting their supervisor and the training program and assessment methods used to ensure continued competency. Unfortunately, due to the need to also update the respective scope of responsibilities and supervision requirements for aides to ensure consumer protection, the regulatory package needed to implement these renewal requirements has been delayed. This licensee population is extremely low in comparison to other Board license types, at 0.7% of the Board's licensees, and therefore the package's urgency was lower than other packages the Board has been working on. The Board expects this regulatory package to be completed within the next two fiscal years given Board staff resources.

## ISSUE #7: (AUDIOLOGY LICENSING REQUIREMENTS) Should the audiology licensing requirements be updated to reflect current educational and professional experience standards?

**Background:** Current law requires applicants for licensure as an Audiologist to satisfactorily complete 12 months of full-time professional experience, or the part-time equivalent, following the didactic and clinical rotation requirements of their doctoral program. CCR require students to complete a minimum of 300 clinical hours, although California State University system and private audiology doctoral programs generally require students to complete about 1,850 clinical and professional experience hours.

The Board asserts that the requirement to complete 12 months of professional experience, or the part- time equivalent, following the didactic and clinical rotation requirements impedes licensure for international students who are unable to complete the 12-month professional education requirement due to visa limitations; applicants who completed their doctoral education in another state where 12 months of professional experience are not required; students who accrue 12 months' worth of hours in fewer than 12 months; and students who are unable to complete 1,850 hours in 12 months.

The Board proposes allowing hours accumulated in clinical rotations or experiences to count towards the 12-month professional experience requirement. This change would make California aligned with national standards.

**Staff Recommendation:** ***The Committees may wish to gain information from program directors about current program requirements for clinical training and professional experience. Moreover, the Committees should consider whether program completion or completion of a minimum number of hours of clinical training or professional development could provide greater flexibility to aspiring Audiologists while maintaining the same level of rigorous education and training.***

**Board's 2022 Response:**

In 2008, California changed its entry level requirement for licensure in audiology to that of a clinical doctorate (see Business and Professions Code (BPC) Section 2532.25.) Under these updated requirements, applicants must complete the requirements in BPC Section 2532.25 (b)(2), which states that applicants must submit evidence of no less than 12 months of satisfactorily completed supervised professional full-time experience or its part-time equivalent obtained under the supervision of a licensed audiologist. The statute further states that the required professional experience shall follow completion of the didactic and clinical rotation requirements of the audiology doctoral program.

In 2020, it was brought to the board's attention by the audiology doctoral program directors in California that while they saw the value in requiring the RPE license, the requirement that all RPE clinical hours had to be earned following the completion of all programmatic coursework and clinical rotations was creating a significant hardship for their students. During multiple meetings between the board's Audiology Practice Committee and the program directors of the audiology doctoral training programs in California, it was learned that there were several roadblocks created by the requirements of this statute:

1) International students who were earning their clinical doctorates in California, were limited by visa requirements that only allow them to accrue external professional experience in the US for a total of 12 months, of which some of the time already had to be used during their clinical rotations. Leaving these students ineligible for a California license.
2) Students who completed their RPE in another state and were attempting to gain licensure in California were not able to do so if their clinical experience requirement was less than 12 months, but due to their total program clinical and professional experience hours combined would have benefited from greater flexibility.
3) Some students who were unable to complete all of the RPE hours in 12 months would have benefited from the flexibility to meet the remaining month(s) with clinical rotations.

The Board had extensive discussions with doctoral audiology program representatives throughout 2020 regarding the potential to move to an hours requirement as opposed to a month's requirement, the biggest concern with simply moving to an hours requirement is that students can work extensive overtime hours to reach the 1,850 within as little as 8-9 months, which results in a crammed and non-optimal experience where the student does not learn all of the necessary components of the professional experience. Many programs expressed the need for a minimum number of months of professional experience was necessary to accrue all the necessary components of the professional experience. There were two additional problems identified by doctoral programs with moving to an hours-based requirement. Doctoral training program directors informed the Board that it is already very difficult to secure acceptable professional experience sites (called externship sites), and not being able to guarantee the student would be working at the site for a specified period of time would make this even more difficult to secure high-quality sites. The other problem doctoral programs expressed with moving to an hours-based requirement, was that it could create issues with the program's accreditation depending on their accreditation agency.

During the 2020 Audiology Practice Committee and Board meetings, information was provided by audiology doctoral program directors regarding potential statutory changes. It was learned that due to the design of most clinical doctoral program curricula in audiology, students were receiving fully supervised training in a number of clinical rotations during the first few years of their programs. Thus, discussions arose that suggested that the board might allow part of the time spent in some pre-RPE experiences to count toward the RPE requirement of 12 months. These discussions on how to

implement the changed statutory requirements through regulations are currently ongoing, but considering these discussions, allowing at least some aspects of the supervised clinical rotation time should be counted. The Board is currently developing a survey to seek more detailed clinical training and professional experience data from program directors to better inform the Board's future development of regulations.

The Board recommends updating the Audiology licensing requirements to reflect current educational and professional experience standards while also reducing barriers to licensure for students that hold international visas or were educated outside of California.

**Board's 2025 Update:**

As part of the Board's prior sunset bill, AB 2686 (Ch. 415, Statutes of 2022), the Board was given statutory flexibility regarding when the audiology RPE could begin. However, upon completion and review of the survey of audiology doctoral program directors in 2023, the Board found that most audiology doctoral program directors did not want students to start the RPE experience any earlier than they currently do but would appreciate the flexibility if required for international students and clarification and clean-up to the clinical experience regulations. From that point forward, the Board asks as part of the audiology RPE application when the applicant is expected to complete, or has completed, all clinical program requirements (excluding any externship related course). However, the Board no longer requires the applicant to start their RPE after that date and bases approval of the start of the RPE experience on the recommendation of the audiology doctoral program director that is guiding the experience. This allows audiology doctoral program directors clarity on the clinical experience and flexibility in when to recommend a student for the audiology RPE.

**ISSUE #8: (RECPIROCITY) Should the Board grant reciprocity for licensure to applicants whohold the national Certificate of Clinical Competence in audiology (CCC-A) issued by the American Speech-Language-Hearing Association, or the American Board of Audiology certification issued by the American Academy of Audiology?**

**Background:** Prior to 2009, the Board was authorized to grant licensure as an Audiologist to applicants who had earned a national CCC-A from the American Speech-Language-Hearing Association. However, when the licensing requirements for Audiologists were amended in 2009 to require a doctoral degree, reciprocity was limited those individuals who earned a CCC-A on or before December 31, 2007.

The American Academy of Audiology similarly issues the American Board of Audiology certification, although the Board does not have the authority to accept the certification in lieu of the state's specified licensing requirements. Both certifications have specific education and training requirements for certification and require audiologists to participate in CPD and ethics training to maintain the certification.

The Board proposes to extend reciprocity to Audiologists who hold a CCC-A that was issued on or after January 1, 2008 and to Audiologists who hold the American Board of Audiology certification from the American Academy of Audiology.

**Staff Recommendation:** ***The Board should provide additional information the Committees about the comparability of the CCC-A issued by the American Speech-Language-Hearing Association and the***

***American Board of Audiology certification issued by the American Academy of Audiology to the state's current licensing requirements for Audiologists.***

**Board's 2022 Response:**

Nationally, there are 13,727 ASHA certified CCC-A holders and 1,292 American Academy of Audiology certified ABA holders, many from other states, that would potentially qualify for California licensure and would benefit from this form of reciprocity.

The Board has reviewed and approved the CCC-A and ABA certifications as comparable to state licensure.

Both certifications require the following:

- A doctoral degree in audiology from accredited programs;
- The equivalence of a year of fulltime professional experience;
- Adherence to their own associations code of ethics; and
- CE for renewal of certification and require ethics as part of that CE.

The differences between the two certifications include:

- For initial certification –
  - ABA certification allows doctoral programs to be accredited by Accreditation Commission for Audiology Education (ACAE);
  - ABA requires 2,000 hours of supervised direct patient care experience while CCC-A requires 1,820 and after 2020 bases the experience on meeting 106 knowledge and skill points rather than number of hours over 9 months;
- For renewal of certification –
  - ABA requires 20 hours of CE per year while CCC-A requires 30 hours of CE every 3 years.

Due to current workforce shortages in the field of audiology, the lack of the deemed equivalent options further exacerbates the lack of access to audiological services for California consumers. The Board recommends the Committees consider extending the deemed equivalent options to ABA holders and CCC-A holders who graduated after 2008, which will enhance reciprocity for out-of-state license holders and most importantly enhance access to audiology services to California consumers.

**Board's 2025 Response:**

As noted in Section 7, during the Board's prior Sunset Review, the Board recommended the revision of BPC Section 2532.8 to include Audiologists with a valid American Board of Audiology (ABA) certificate issued by the American Academy of Audiology as well as a Certificate of Clinical Competence in audiology (CCC-A) issued by the American Speech-Language-Hearing Association, which was allowed only for those who graduated before 2008. This amendment was added to the Board's Issues and accepted and included in the Board's 2022 Sunset bill AB 2686 (Ch. 415, Statutes of 2022). The Board began licensing Audiologists with ABA and CCC-A certificates the following year, thus streamlining licensure for Audiologists who hold these certifications and enhancing access to audiology services for California consumers.

Since implementation, the Board has seen significant growth in the number of Audiologists applying for licensure with the ABA and CCC-A certificates, resulting in the Board issuing an average of 36 audiology licenses per fiscal year post implementation compared to the prior fiscal years, 2020-21 through 2022-23, which on average resulted in the issuance of only six audiology licenses per fiscal

year. This is in comparison with the average number of Audiologists licensed through the audiology RPE pathway of 86 annually or 51 percent. This licensure pathway has now grown from an average of seven percent of audiology licenses issued per year, from 2020-21 through 2022-23, to an average of 28 percent of audiology licenses issued per year in 2023-24 and 2024-25. The Board hopes that this additional licensure avenue continues to allow for significant growth in the number of Audiologists serving California consumers.

**ISSUE #9: (HEARING AID DISPENSER REGULATION MODERNIZATION) Should regulations and licensure requirements related to hearing aids and Hearing Aid Dispensers beupdated to reflect the evolving marketplace?**

**Background:** Hearing Aid Dispensers do not have any formal education requirements but must pass a written and practical exam for licensure in California. Hearing Aid Dispensers may fit and sell hearing aids, take ear mold impressions, perform postfitting procedures, directly observe the ear, and test hearing for the purpose of fitting and selling hearing aids. Hearing Aid Dispensers licensed by another state may qualify for a temporary license in California for 12 months while seeking permanent licensure, and a Hearing Aid Dispenser Trainee License allows an applicant to work under the supervision of a licensed Hearing Aid Dispenser for up to 18 months.

Hearing Aid Dispensers must complete a minimum of 12 hours of approved CE annually. Nine (9) hours must be related to patient care while the other three (3) may be related to the practice of hearing aid dispensing, ethics, office management, or managed care issues. The Board has not completed an audit of CPD providers or licensees since 2018.

Hearing aids are available for purchase online, often advertised as one-size fits all or capable of being remotely modified for the buyer. The Federal Drug Administration (FDA) regulates hearing aid devices and does not restrict the sale of hearing aids online. Moreover, states are prohibited from imposing more restrictive regulations, unless granted a federal exemption. The Board requested an exemption from the FDA on May 30, 2012, and has not received a response.

Nonetheless, California has been regulating the sale of mail order hearing aids. California law requires the consumer's ear canal to be examined by a licensed physician, Audiologist, or a Hearing Aid Dispenser, and a medical referral in some cases. The Board maintains that these requirements protect consumer safety and should not be eliminated.

On October 20, 2021, the FDA issued a proposed rule to establish a new category of OTC hearing aids for adults with mild to moderate hearing loss. OTC hearing aids would be subject to specific manufacturing and labeling requirements to protect user safety but could be sold directly to consumers in person and online without the need for a medical exam or fitting. Hearing aids for adults with severe hearing loss and minors would be considered prescription devices subject to additional regulation. The proposed rule would continue to prohibit states from enacting more stringent requirements on the sale of OTC hearing aids.

**Staff Recommendation:** ***The Board should provide the Committees with information about potential impacts stemming from the federal proposed rule on the licensure of Hearing Aid Dispensers and the sale of hearing aids in California. The Committees may wish to further study the evolution of the marketplace for hearing aids in California and collect more information about national occupational licensing trends.***

**Board's 2022 Response:**

The Food and Drug Administration has proposed creating a new category of Over-The-Counter (OTC) hearing aids for mild to moderate hearing loss. Under the proposed regulation, individuals would not need a Board license to sell, dispense, distribute, or provide customer support for OTC hearing aids. However, sale and fitting of prescription hearing aids will still require Board licensure and oversight under the proposed regulations. Prescription hearing aids will continue to be needed for the foreseeable future as OTC hearing aids cannot address moderate to severe hearing loss, and most consumers are not able to discern their actual level of hearing loss.

Concerns raised by the Board include the following:

- Lack appropriate consumer protections in regard to device output levels and limits that could allow harm to the consumers ear, especially consumers with disabilities
- Need for age verification so that minors are adequately protected from purchasing inappropriate hearing devices
- Need for a federal return policy to ensure consumer protections

Consumers of hearing aid services are some of the State's most vulnerable populations, including disabled young children and the elderly. Patients of Hearing Aid Dispensers could be at risk of punctures to the skin in the ear, ear canal, and ear drum if otoscopy or ear mold impressions are performed incorrectly. Therefore, for both consumer protection and enforcement of laws regarding warranties for prescription hearing aids licensure of Hearing Aid Dispensers continues to be necessary despite the creation of OTC hearing aids for mild to moderate hearing loss.

**Board's 2025 Update:**

As of August 16, 2022, the FDA issued its final rule regarding OTC hearing aids. The FDA finalized the rule after receiving and reviewing more than 1,000 public comments. Comments were summarized in the final rule, along with FDA's responses. The final rule incorporated several changes from the proposed rule, including lowering the maximum sound output to reduce the risk to hearing from over-amplification of sound, revising the insertion depth limit in the ear canal, requiring that all OTC hearing aids have a user-adjustable volume control, and simplifying the phrasing throughout the required device labeling to ensure it is easily understood. The final rule also included performance specifications and device design requirements specific to OTC hearing aids.

The effective date for the final rule was October 17, 2022. Manufacturers of hearing aids sold prior to the effective date of the final rule had 240 days after its publication to comply with the new or revised requirements. For hearing aids that have not been offered for sale prior to the effective date, compliance with the new or revised requirements had to be achieved before marketing the device, including obtaining 510(k) clearance if applicable.

The Board had suggested that the FDA, at a minimum, should have a warning on the outside package to advise consumers of the danger of prolonged exposure to the upper limit output and amend the text in in proposed Section 800.30(c)(2)(i)(B) to include an identical warning on the inside packaging, as well as require a gain limit of 25dB or a low and high gain limit range. However, the FDA declined to add labeling requirements regarding prolonged exposure to the upper limit output and declined to include a gain limit. The FDA did lower output limits to 111 and 117 dB SPL.

The Board had also suggested requiring age verification at the time of purchase as an added consumer protection measure, however the FDA also declined to require age verification at the time of purchase of OTC hearing aids.

Lastly, the Board had suggested a minimal standard of return policy in the regulations governing OTC hearing aids and that this information be provided to consumers on the Outside Package Labeling prior to the "Manufacturer's return policy" in proposed Section 800.30(c)(1)(i)(F). The Board also recommends that the "Manufacturer's return policy" include a phone number and web address where consumers can contact the manufacturer regarding returns. However, the FDA declined to establish minimal standard of return policy or change the "Manufacturer's return policy."

The Board has received very few complaints mentioning OTC hearing aids and the Board has not seen any significant drop in the number of Hearing Aid Dispenser and Dispensing Audiologist applications since the implementation of the FDA rule. The Board is also not aware of the percentage of Hearing Aid Dispensers and Dispensing Audiologists that in addition to prescription hearing aids also sell OTC hearing aids. When the Board conducts the next Occupational Analysis for Hearing Aid Dispensers and Audiologists, this issue should be incorporated into the survey data to get a better idea of the percentage of licensees selling OTC hearing aids.

Licensure for Hearing Aid Dispensers and Dispensing Audiologists continues to be necessary despite the creation of OTC hearing aids. The use of OTC hearing aids is limited to use for general mild to moderate hearing loss, during which time many consumers may not even realize they are suffering from hearing loss. Therefore, the board continues to believe that licensure is necessary for both consumer protection and enforcement of laws regarding warranties for prescription hearing aids.

## ISSUE #10: (CE) Should the state's CE requirements for licensees be revised?

**Background:** Each profession licensed by the Board is required to complete CPD or CE requirements. Licensed Speech-Language Pathologists and Audiologists must complete 24 hours of CPD/CE every two-year license period. Dispensing Audiologists must obtain 12 hours of CPD/CE each renewal period, with six hours related to hearing aids and six hours related to audiology. Speech-Language Pathologists and Audiologists who will be responsible for supervising temporary license holders and assistants must take an additional six (6) hours of CPD related to supervision beforehand and complete three (3) hours of CPD every four (4) years for professional development supervisors and every two (2) years for Speech-Language Pathology Assistant supervisors. Speech-Language Pathology Assistants are also required to complete 12 hours of CPD/CE every two (2) years, achievable by attending conferences, workshops, formal presentations, self-study courses, related courses, none of which are required to be approved by the Board. Hearing Aid Dispensers must complete a minimum of 12 hours of approved CE annually. Nine (9) hours must be related to patient care while the other three (3) may be related to the practice of hearing aid dispensing, ethics, office management, or managed care issues.

Licensees must certify on their license renewal form that they have completed the required CPD/CE. Although the Board's goal is to annually audit five (5) percent of licensees, staff and resource shortages have prevented the Board from conducting an audit of all licensees since 2018. The COVID- 19 pandemic delayed a scheduled audit in 2020, though the Board plans to resume CE audits this year.

If audited, licensees must provide documentation demonstrating completion of the CPD/CE requirements. To date, the Board and the DCA have not utilized CE document submission via the DCA Cloud. The Board has stated that is has been focused on priorities identified in their Business

Modernization Project, including online application submission and application status tracking, but will be focusing on technological solutions to enhance the Board's CE audit capacity in the future.

Failure to meet the CPD/CE requirements may result in a citation and fine. The 2018 audit revealed that roughly 78 percent compliance rate among licensees. 17 percent of licensees were initially out of compliance and ultimately two (2) percent were cited and fined for failing to come into compliance.

The Board is also responsible for approving CPD providers and CE courses. Although the Board's goal is to conduct random audits of five (5) percent of CPD/CE providers, the Board has not conducted an audit since 2018 due to staff shortages and the impact of COVID-19 on CPD/CE completion.

**Staff Recommendation:** ***The Board should provide more information about its staff and resource shortages and licensees' compliance with CPD/CE requirements. Moreover, the Committees may wish to evaluate the merit of CPD/CE and consider alternative strategies to ensure competency of licensees.***

**Board's 2022 Response:**

The Board takes the continued competency of its licensees and the related continuing education requirements very seriously. Continuing Professional Development (CPD) and Continuing Education (CE) requirements are intended to protect consumers by ensuring licensees increase their professional knowledge and skill to maintain ethical and competent practice and enhance services to consumers. Over the last two years during the COVID-19 pandemic, there have been considerable advances in on-line self-study course offerings. Entire multi-day conferences were conducted that could be seen through live streaming (which is considered a live course) but also were recorded to be seen afterwards by even more learners as self-study courses. This provides far greater opportunities for licensees to learn. Many licensees who are juggling busy schedules and perhaps childcare, appreciate the flexibility of self-study so that they can have access to more CPD opportunities. Ultimately, consumer benefit when professionals are better trained to provide the best evidence-based services and practices. The Board discussed all these considerations and has been revising the current CPD requirements for Speech-Language Pathologists and Audiologists to reduce the burdens of the current 25 percent limitation on self-study to 50 percent as well as clarifying the definition of what constitutes self-study. This change will bring conformity with the self-study limitation for Hearing Aid Dispensers and Dispensing Audiologists.

Regarding CE Audits, the Board last conducted a CE Audit in 2018, where 5 percent of licensees were audited. For the 2018 CE Audit, the initial pass rate was 79 percent (a fail rate of 21 percent), where 17 percent failed to meet CE/CPD requirements and 4 percent did not respond to the Board. Of those that initially failed the audit, approximately 70 percent of those that failed corrected their deficiency within 30 days, resulting in 11 percent of those that failed or did not respond to the CE Audit being cited and fined. Of those that initially failed the audit, the reasons for failure included the following:

- 73 percent did not have evidence of completion of the required hours (most were able to get this evidence and correct the deficiency within 30 days)
- 17 percent exceeded self-study limitations
- 10 percent took non-approved CE courses or courses from non-approved providers

The Board had planned to conduct another CE Audit in 2020, however with the onset of the COVID-19 pandemic and the waiving of all CPD and CE requirements under DCA Waivers, the Board determined that it would have been extremely tone-deaf and onerous to require licensees to

undergo an audit during this time of crisis. Board licensees will need adequate time to accrue the necessary CPD and CE hours in 2022 (requirement to complete within 6 months of waiver expiration) and the Board will restart its auditing of licensees in late 2022.

The Board continues to seek additional staff resources to conduct CPD and CE audits as the growing workload demands in the Licensing and Enforcement Units have overwhelmed staff's ability to keep abreast of workload. The Board is working the DCA Budget Office to attain additional staff resources through the State Budget process.

The Board is open to looking into enhancing its CPD and CE requirements to include competency-based models and components. Due to the extensive research and collaboration needed to develop profession specific competency-based CE models, the efforts the Board knows of by other boards to implement these profession specific competency-based models were often spearheaded nationally (national association of licensing boards or national professional associations) then tailored to state specific needs and goals. One important aspect of this type of endeavor for our Board that may differ from other Boards is that each of the three professions may need to incorporate different learning modalities or professional activities. If this type of endeavor were initiated by the Board instead of by a national board or professional association, this could be very complex and resource consuming project for our small staff.

**Board's 2025 Update:**

In September of 2024, the Board finalized the rulemaking for the CPD requirements for Speech-Language Pathologists and Audiologists discussed in the prior Sunset Review. Per the Board's guidance, this package did not include a competency-based model or component.

Effective January 1, 2025, Speech-Language Pathologists, Audiologists, and Dispensing Audiologists have new requirements and activities to fulfill their continuing professional development (CPD) requirements. These finalized regulations instituted the following changes:

- Increases the number of hours that may be obtained from self-study to half (50 percent) of the total required hours;
- Defines self-study as a course where the course instruction and licensee participation do not occur simultaneously, and requires the completion of an evaluation on what was learned during the course or at the conclusion of the course;
- Removes limitations to the number of hours that can be obtained from courses that are related to the practice of speech-language pathology or audiology;
- Increases the number of hours that can be obtained from indirect patient/client care courses to 25 percent of the total required hours;
- Permits courses related to hearing aid dispensing to be on equipment, devices, or other products that is not on the marketing, launching, or demonstrating the marketability of equipment, devices, or other products regardless of whether it focuses on a particular manufacturer's or company's equipment, devices, or products;
- Permits two hours for completing a Board sponsored Occupational Analysis;
- Permits two hours of hearing aid dispensing related coursework for each day of service for a maximum of four hours per renewal for Dispensing Audiologists serving the Board as a selected participant in Board–sponsored examination development or administration related functions;
- Defines direct patient/client care as courses that covers the current practice of speech-language pathology or audiology and may include content on instruments and technology used for assessment/diagnosis or intervention;

- Prohibits courses related to instruments and technology that are on the marketing, launching, or demonstrating the marketability of instruments and technology regardless of whether it focuses on a particular manufacturer's or company's instruments and technology; and
- Clarified current regulations by making CPD requirements consistent with the Board's CPD audit process and the professional learning requirements for similar license types and course content.

Altogether these regulations provide additional flexibility in the course delivery formats that licensees can accrue their CPD hours with as well as broadening and enhancing the types of courses that licensees can use towards their CPD requirements to enhance their competency.

As stated in Section 3, due to obtaining additional staff resources through the State budget process, the Board was able to begin conducting ongoing CE audits of licensees CPD starting in Fall 2024. The Board has completed a 5 percent random selection of Speech-Language Pathologists, Speech-Language Pathology Assistants, Audiologists, and Hearing Aid Dispensers who renewed between January through June of 2024. The results for the January through June 2024 audits are provided in the table below.

**CE/CPD Audit Results**

| Audit Period | Number Audited | Passed | % | Failed | % | Exemption Granted | % | Citation Issued | % |
|---|---|---|---|---|---|---|---|---|---|
| January 2024 | 38 | 23 | 61% | 9 | 24% | 6 | 16% | 8 | 21% |
| February 2024 | 39 | 22 | 56% | 11 | 28% | 6 | 15% | 6 | 15% |
| March 2024 | 43 | 21 | 49% | 15 | 35% | 6 | 14% | 8 | 19% |
| April 2024 | 49 | 27 | 55% | 12 | 24% | 7 | 14% | 4 | 8% |
| May 2024 | 40 | 23 | 58% | 9 | 23% | 7 | 18% | 3 | 8% |
| June 2024 | 40 | 21 | 53% | 14 | 35% | 4 | 10% | 1 | 3% |

As the data shows, there is currently an average failure rate of 28 percent for the first six months of renewals that have been audited. This percentage is relatively higher than the average for most healing arts boards who underwent Sunset Review in 2025, where the average failure rate across those boards was around 19 percent. However, those boards have a longer history of ongoing CPD audits of their licensees. The most common reasons for failure of the CPD audit are having over the maximum number of self-study hours, not having enough CPD hours total (either CPD hours taken outside the renewal cycle or completed hours with non-approved providers), and insufficient documentation of courses taken (lacking certificates, certificates do not show if course was self-study, or certificate does not indicate the provider's approval status or other critical course details).

During the 2025-26 Fiscal Year, the Board will be continuing its ongoing audits of licensees. Currently, a considerable amount of time is dedicated to citation and fine related duties associated with the CPD Audit process. The Board expects that it will be able to accelerate the pace of these audits in future years as Board licensees are more mindful of the Board's CPD requirements and their responsibility to complete the appropriate hours as well as maintain adequate records of completion.

## *BOARD ENFORCEMENT ISSUES*

**ISSUE #11: (ENFORCEMENT) Should the Board be given explicit authorization to discipline licensees who offer or receive kickbacks in exchange for patient referrals?**

**Background:** Existing law prohibits licensees from offering or receiving kickbacks in exchange for patient referrals, but the Board is not expressly permitted to enforce violations of this kind. The Board has indicated that is cannot effectively prosecute these violations unless the licensee is criminally convicted for the same office. As such, the Board stipulated that the Office of the Attorney General encouraged the Board to seek statutory authorization to enforce these violations. The Board notes that third party administrators who work with insurance companies to direct patients/clients to licensed Audiologists and Hearing Aid Dispensers are creating incentives for unlawful referrals. Currently, the Board has approximately 26 cases of alleged unlawful referrals pending investigation.

**Staff Recommendation:** ***The Board should advise the Committees on how many licensees violate this prohibition and whether another entity is responsible for enforcement.***

**Board's 2022 Response:**

The Board does not know how many licensees may be in violation of this prohibition, but we currently have 26 pending investigations of alleged unlawful referrals, which the Board cannot comment on at this time. The Board would note that its jurisdiction is limited to the conduct of its licensees.

The primary enforcer of Business and Professions Code section 650 in reference to the Board's licensees, is the Board. The Board received guidance from the Office of Attorney General that for these types of violations to be independent grounds for unprofessional conduct, the Board should include the reference to BPC Section 650 in its statutory provisions related to grounds for action against a licensee in BPC Section 2533. Without this provision in our Practice Act, licensees would have to be criminally convicted for the same offense to effectively prosecute these violations. This seems to be an unnecessarily high burden to enforce BPC Section 650 and the Board therefore recommends the Committee consider adding it to the Board's Practice Act.

**Board's 2025 Update:**

*As part of the Board's prior sunset bill, AB 2686 (Ch. 415, Statutes of 2022), the Board was given statutory authority to refuse to suspend, revoke, or impose terms and conditions upon the license of any licensee for engaging in any act in violation of BPC Section 650. However, the Board has not received any complaints related to BPC Section 650 since its last Sunset Review.*

**ISSUE #12: (DISCIPLINE GOALS AND TIMEFRAMES) Is the Board meeting the performance targets of its enforcement program?**

**Background:** DCA has established a number of performance measures such as the number of complaints/convictions received, the average number of days from complaint receipt to the date the complaint was assigned to an investigator, the average number of days from complaint receipt to closure of the investigation process for cases not transmitted to the Attorney General, and the average number of days to complete the entire enforcement process for cases transmitted to the Attorney General for formal discipline.

The Board regularly does not meet the performance targets for complaint investigation or formal discipline timeframes. The Board notes that most of investigations are resolved within the 90-day performance target, but some require more time due to the complexity of the complaints.

Although the Board does not operate according to specific statutes of limitation, the Office of the Attorney General does, consistent with the statutes of limitation it follows for many other hearing arts boards. However, the Board notes that it has not been limited in taking enforcement actions against licensees due to statutes of limitation.

The Board reports that its enforcement workload has increased with the growth of its licensee population. While the number of complaints and licensee arrest/convictions declined during the COVID-19 pandemic, complaints and licensee arrests/convictions have increased 66 percent on average over the last five (5) years. Nonetheless, the Board reports that there has been little change in the number of disciplinary actions the Board has taken since its last Sunset Review. The Board notes that there is no direct correlation between the number of complaints received and the disciplinary actions taken by the Board in a particular year. Disciplinary action is taken based on the nature and specific evidence in each case, therefore in some years there could be more complaints that result in discipline due to the nature and evidence of the specific complaint than other years. The types of complaints that the Board received prior to and during the COVID-19 pandemic have not changed. The most common complaints the Board receives are refund/warranty issues, false or misleading advertising, unprofessional conduct, criminal charges/convictions, and unlicensed activities. Some significant differences the Board has seen are the decline in arrests and convictions of Board licensees during the pandemic as well as a general decline in complaints due to consumers accessing fewer services, which the Board attributes to worksite closures and social distancing measures during the pandemic.

The Board is authorized to issue citations which may include an order of abatement and/or an order to pay a fine. Citations are issued in response of minor violations of related laws and regulations that do not warrant formal discipline

In 2006, the former SLPAB increased the maximum allowable fine for Speech-Language Pathology and Audiology from $2,500 to $5,000. The maximum allowable fine for Hearing Aid Dispensers has not been increased.

**Staff Recommendation: *The Committees may wish to gather more information from the Board and the Office of the Attorney General about the investigative process and the Board's citation, cost recovery, and restitution practices.***

**Board's 2022 Response:**

According to the Board's Enforcement Performance Measure data, the Board consistently meets the targets for complaint intake and probation initial contact and violations but does not meet the performance targets for complaint investigation or formal discipline timeframes. Staffing vacancies in the Enforcement Unit since the last Sunset ranging from a 2/3 vacancy rate to a 1/3 vacancy rate had a big impact on the Board's enforcement timeframes. With such a small enforcement team, even one vacancy has a big impact on the Board's ability to meet enforcement timeframes.

While the Board has not been able to meet the performance targets for complaint investigation, the majority of investigations are closed within the performance target of 90 days, but due to the complexity of some complaints, additional investigative time is necessary.

The Board has worked to reduce the amount of time for PM 4 by ensuring regular and consistent follow-up with the Office of the Attorney General on cases referred for discipline, by proactively engaging in early settlement negotiations when deemed appropriate, and by limiting the amount of time given to a respondent during settlement negotiations. However, there are several time factors that are outside of the Board's control with regard to PM 4, including the case processing done by the Office of the Attorney General and the Office of Administrative Hearings.

**Board's 2025 Update:**

As discussed in Section 4, the Board's Enforcement Performance Measure data continues to show that the Board consistently meets performance measure targets for complaint intake, probation initial contacts, and probation violations. However, since the Board's last Sunset Review, the Board's has continued to have difficulty meeting performance measures related to intake and investigation timeframes and formal discipline timeframes.

*Board Enforcement Performance Measures* *(in days)*

| Performance Measure | Target | FY 2021/22 | FY 2022/23 | FY 2023/24 | FY 2024/25 | Four-Year Average |
|---|---|---|---|---|---|---|
| PM 1 – Volume | * | 127 | 149 | 142 | 263 | 170 |
| PM 2 – Intake | 10 | 5 | 3 | 5 | 4 | 4 |
| PM 3 - Intake & Investigation | 90 | 524 | 321 | 149 | 232 | 307 |
| PM 4 - Formal Discipline | 540 | 1,010 | 1,304 | 404** | 1,297 | 1,004 |
| PM 7 – Probation-Initial Contact | 7 | 1 | 1 | 1 | 1 | 1 |
| PM 8 - Probation Violation | 10 | 2 | 1 | 10 | 2 | 4 |

* Complaint volume is counted and not considered a performance measure

** FY 2023/24 was affected by a small number of formal disciplinary actions being taken, both of which had short investigation timeframes

Over the last four years, the Board has been able to increase from 27 percent to 46 percent the percentage of complaints it closes within 90 days, however there are multiple factors contributing to the Board's inability to meet the intake and investigation timeframe target of 90 days. One factor includes turnover within the Enforcement Unit in each fiscal year since its last Sunset Review. With an enforcement staff of only three investigators, vacancies and training of new staff take considerable time away from ongoing investigations. Another factor impacting the Board's ability to meet intake and investigation timeframes was closure of multiple related cases that had extended investigation timeframes, sworn and/or desk investigations, but were ultimately not actionable. Additionally, the Board's lack of an enforcement business modernization project along with the legacy data system leaves the Board with manual and slow processes that allow many complaints to age unnecessarily. Lastly, due to Board resource constraints and a significant decrease in the number of complaints and convictions received since the pandemic, Board management reassigned one enforcement analyst, on a parttime basis, to the Business Modernization Project and its maintenance and operation thereafter. This reassignment was essential to the Board's success during the Licensing Business Modernization Project, and it was the Board's hope that the same employee would be able to lead the enforcement modernization project in the near future using the insights and skills gained during the initial licensing modernization project. However, given the Board's continued inability to meet intake and investigation performance measures, the increase in complaints and convictions received in 2024-25, and uncertainty about when a future enforcement business modernization project may be possible. Board management is currently considering different strategies to address both needs within current Board resources.

In relation to the Board not meeting the formal discipline timeframe target of 540 days, the primary contributor to this is the aging of criminal conviction related cases. Of the 18 formal disciplinary actions taken by the Board since its last Sunset, more than half of those cases were criminal conviction related cases that had aged over the 540-day target. Board management will be consulting with other boards and bureaus still utilizing the same legacy system to research interim steps it can take to reduce these timeframes until an enforcement business modernization project can be undertaken to streamline all enforcement processes.

## ***TECHNICAL CHANGES***

**ISSUE #13: (TECHNICAL CHANGES MAY IMPROVE EFFECTIVENESS OF THE ACT AND BOARD OPERATIONS.) There are amendments to the Act that are technical in naturebut may improve Board operations and the enforcement of the Act.**

**Background:** There are instances in the Act where technical clarifications may improve Board operations and application of the statutes governing SLPAHADB's work.

**Staff Recommendation:** ***The Committees may wish to amend the Act to include technical clarifications.***

**Board's 2022 Response:**

The Board appreciates the Committees assistance in amending its Practice Act to provide additional clarity and technical clean-up where needed.

**Board' 2025 Update:**

The Board appreciated the Committees assistance in providing additional clarity and technical clean-up to the Board's Practice Act during its 2022 Sunset Review and looks forward to working with the Committees on additional clarifying and technical clean-up items during our 2026 Sunset Review.

## ***COVID-19***

**ISSUE #14: (IMPACTS OF THE COVID-19 PANDEMIC.) Since March 2020, there have been a number of waivers issued through executive orders that impact Board operations, licensees, providers, and patients throughout the state. Do any of these waivers warrant an extension or statutory changes? How has the Speech-Language, Audiology, and Hearing Aid Dispensers Board addressed issues resulting from the pandemic and how does the Board aim to continue to address these issues as the pandemic endures?**

**Background:** In response to the COVID-19 pandemic, a number of actions were taken by the Governor, including the issuance of numerous executive orders in order to address the immediate crisis. For example, on March 30, 2020, the Governor issued Executive Order N-39-20 authorizing the Director of DCA to waive any statutory or regulatory professional licensing relating to healing arts during the duration of the COVID-19 pandemic – including rules relating to examination, education, experience, and training.

Some of the waivers impact Board work and licenses. For example, Executive Order N-40-20 permits the Director of DCA to waive any statutory or regulatory requirements with respect to CE for a

number of healing arts licensees. The Board noted in its 2021 Sunset Review Report that it worked with DCA on the following approved waivers:

- **Modification of the Direct Monitoring Requirements for RPE Licenses and the Direct Supervision Requirements for Speech-Language Pathology Assistant Licenses (DCA-22-214) –** Originally approved May 6, 2020 and extended on July 1, August 27, October 22, and December 15 of 2020, and February 26, April 30, July 1, August 31 of 2021, and October 31, 2021. This waived the in-person supervision requirements for RPE License holders and Speech-Language Pathology Assistants through March 31, 2022.

- **Modification of License Reactivation or Restoration Requirements (DCA-22-212)** – Approved on January 11, 2022, this waives CE requirements for reactivation of a license and any fees associated with reactivation of a license (including any renewal, delinquency, penalties, late fees, or any other statutory or regulatory fees) for Speech-Language Pathologists through April 1, 2022.

- **Modification of the Limitations on Renewing of Hearing Aid Dispenser Temporary Licenses and Hearing Aid Dispenser Trainee Licenses (DCA-21-188) –** Originally approved May 29, 2020 and extended on September 17, and December 15 of 2020, and February 26, April 30, July 1, and August 31 of 2021. This waived the statutory limitations on renewing Hearing Aid Dispenser Temporary Licenses and the limitation on the number of times a Hearing Aid Dispenser Trainee License can be renewed. Specifically, this waiver removes the limitation that Hearing Aid Dispenser Temporary Licenses cannot be renewed in BPC section 2538.27(b) and removes the limitation that Hearing Aid Dispenser Trainee Licenses cannot be renewed more than twice in BPC section 2538.28(c). DCA-20-16 authorizes the Board to extend the expiration date of Hearing Aid Dispenser Temporary Licenses and Hearing Aid Dispenser Trainee Licenses by six (6) months for eligible licensees. This waiver only applies to Hearing Aid Dispenser Temporary Licenses that expire between March 31, 2020, through October 31, 2021, and Hearing Aid Dispenser Trainee Licenses that have been renewed twice and expire between October 31, 2020, through October 31, 2021.

- **Modification of Limitations and Requirements for Extension of RPE Licenses (DCA-21-171)** – Originally approved July 17, 2020, and extended on September 17, and December 15 of 2020, and on February 26, April 30, July 1, and August 31 of 2021. This waived the limitation that an RPE License cannot be reissued for more than 12 months in Title 16 CCR Section 1399.153.10(a) and waives the associated fee. The waiver also removes the limitation that a Speech-Language Pathology or Audiology RPE License cannot be reissued or extended due to the licensee's inability to take and pass the licensing examinations in 16 CCR section 1399.153.10(a). The waiver authorizes the Board to extend an already reissued RPE License for an additional six (6) months without paying the $35 application fee and to approve an RPE License reissuance for the purposes of taking and passing the respective licensing examinations in Speech-Language Pathology and Audiology. The 6-month extension and fee waiver allowed by this waiver for an already reissued RPE License only applies to RPEs who have a reissued RPE License that would expire between March 31, 2020 and October 31, 2021. The allowance for RPE Licenses to be reissued due to the RPE License holder's inability to take and pass the licensing examinations applies to all RPE License holders who have not already had their RPE License reissued before October 31, 2021.

Two (2) of the Board's waiver request were denied, a summary of each is provided below.

- **Modification of the 12-Month Fulltime Professional Experience Requirement for Licensure as an Audiologist** – This waiver would have waived the requirement that Audiology applicants submit evidence of no less than 12 months of supervised professional full-time experience for licensure (as stated in BPC Section 2532.25). This waiver was denied on May 12, 2020 as the Department did not believe that waiving pre-licensure requirements, such as experience or competency exams, at this time is in the best interests of consumer protection.

- **Modification of Board CE Requirements to Remove Self-Study Restrictions** – This waiver would have waived the limitations on self-study CE and CPD for the purposes of renewal in Title 16 CCR Sections 1399.140 and 1399.160. This would allow licensees to accrue all CE and CPD through self-study during the COVID-19 pandemic. This waiver was denied on December 30, 2020 as the DCA had provided waivers of CE requirements for licensees of the Board and believed it would be unreasonable to allow licensees to complete all CE requirements via self-study as this would weaken consumer protections by not requiring some training be provided by a type of classroom or lecture type training that is verified.

COVID-19 led to a strong interest in developing frameworks for telehealth and telesupervision. On September 27, 2021, Governor Newsom issued a news release to announce the signing of Executive Order N-16-21 to extend telehealth services expansion. The Board stipulates that Speech-Language Pathology Assistants and RPE Licensees that have been trained to use telehealth technology and receive the appropriate direct telesupervision can provide telehealth. All tasks performed still need to meet the same standard of care as in-person therapy.

Due to COVID-19 and any future State of Emergencies, the Board believes it is necessary to require all licensees to provide the Board with a current email address in order to communicate urgent information in a quick, efficient, and cost-effective manner. The Board should discuss how it will implement this collection of all licensee email addresses.

Despite COVID-19 limitations and challenges, the Board was able to conduct Hearing Aid Dispenser practical examinations. After having to cancel most of its 2020 practical examinations due to COVD-19, examinations resumed in October 2020 with robust safety and sanitation precautions. Board staff used larger examination rooms and utilized sanitation measures as required by State health and safety guidelines. The Board should discuss future plans for these procedures.

The Speech-Language Pathology, Audiology, and Hearing Aid Dispensers Board reports that during the COVID-19 pandemic, the Board implemented rotational teleworking policies for staff. At the beginning of the COVID-19 pandemic, the paper-based application and complaint processes and older computer equipment presented unique teleworking difficulties. These difficulties included coordination efforts amongst staff and delayed updates to applicants and consumers when paper applications or complaint materials were not immediately available to staff. In 2021, the Board utilized funds available to it to outfit all staff members with laptops and Microsoft Teams in an effort to ameliorate some of these issues.

Overall, as COVID-19 still has a sizeable infection rate in California and infection rates may increase with new variants in the future, the Board should discuss plans to adapt throughout the ongoing pandemic.

**Staff Recommendation:** ***The Board should update the Committees on the impact to licensees and patients stemming from the pandemic and potential challenges for practitioners. The Board should discuss any statutory changes that are warranted as a result of the pandemic.***

**Board's 2022 Response:**

All Board licensees were significantly impacted by the COVID-19 pandemic, and Board staff worked diligently to help mitigate impacts where it was able to in order to ensure continued services to California consumers. During this critical period, the DCA Waivers allowed licensees to stay focused on meeting the immediate needs of consumers during such extraordinary times.

Speech-Language Pathologists were significantly impacted by the COVID-19 pandemic. Prior to the pandemic the majority of Speech-Language Pathologists had been seeing their patients or students in-person individually or in small groups. With the pandemic, they had to immediately shift to using telehealth services for safe distancing. It required reformulating therapy practices and business models to accommodate this change and with it came many technological challenges. The profession rapidly stepped up in order to serve consumers with quality therapeutic services. For those new to telehealth, it meant purchasing and learning to use new equipment and therapy tools. Not only was telehealth critical to use throughout the pandemic but it is still used currently in schools and other settings to ease safety concerns and to help with consumer access to therapy services.

Audiologists and Hearing Aid Dispensers were also significantly impacted by the COVID-19 pandemic, with many Audiologists and Hearing Aid Dispensers having to close their private practices or retail locations at the beginning of the pandemic or only operating at minimal capacity for emergency hearing aid repairs and programming. This had an enormous impact on licensee's livelihoods with some closing branch offices during this time. Further into the pandemic, licensees were able to reopen or fully open their practices and retail locations for services, with a strong emphasis on safety and sanitation protocols in our practices.

At the beginning of the pandemic, Board management worked quickly to mobilize all available resources to aid licensees to continue providing necessary services to consumers in a safe manner. The Board immediately began working with the Department to utilize the Governor's Executive Orders to ensure continuity of consumer services during the pandemic. The Board submitted a total of five (5) waiver requests and also supported and utilized the Department's CE waivers for healing arts professionals and license reactivation waivers for Speech-Language Pathologists.

The Board hopes that as we all get back to a more normal status in the coming months, that the DCA waivers the Board requested or supported will have allowed licensees the ability to continue providing services safely while not completely disrupting the pipeline for future licensees or being overly burdensome on licensees.

The Board is currently reviewing all CE and CPD requirements and the allowance of telesupervision for Required Professional Experience and Speech-Language Pathology Assistants, at this point the Board's Practice Committees have all expressed concerns that having no self-study limitations or no in-person supervision requirements on a permanent basis has inherent drawbacks and expressed that while they were critical emergency measures, they are not the direction the Board wishes to pursue at this time.

One statutory change that the Board is requesting that came to light due to the pandemic, is the change to when Audiology doctoral students can start accruing professional experience towards licensure. While this issue came to the Board's attention because of the pandemic, it highlighted issues that out-of-state students and students with Federal Visa restrictions struggled with prior to the pandemic. The Board and clinical doctoral audiology programs all believe this is a reasonable change and that is why the Board is seeking this change as part of our Sunset Review.

**Board's 2025 Update:**

The Board has not identified any additional COVID-19 measures that warrant statutory changes but was grateful for the ability to utilize DCA waivers during the pandemic.

***CONTINUED REGULATION OF HEATH CARE PROFESSIONALS BY THE SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD OF CALIFORNIA***

**ISSUE # 15: (CONTINUED REGULATION BY SPEECH LANGUAGE PATHOLOGY AND AUDIOLOGY AND HEARING AID DISPENSERS BOARD.) Should the licensing andregulation of various professionals be continued and be regulated by the current Board membership?**

**Background**: Patients, clients, and the public are best protected by strong regulatory boards with oversight of licensed professions. The Board has shown a strong commitment toward efficiency and effectiveness, responding to practice and operational issues in a proactive, forward-thinking manner.

***Staff Recommendation: The licensing and regulation of various health professionals by the Speech Language Pathology and Audiology and Hearing Aid Dispensers Board should be continued, to be reviewed again on a future date to be determined.***

**Board's 2022 Response:**

The Board appreciates Committee Staff's analysis and recommendation that the Board continue to regulate the professions of Speech-Language Pathology and Audiology and Hearing Aid Dispensers. The Board is proud of the work that members and Board staff have accomplished since our last Sunset Review and look forward to the improvements that will be coming to fruition in the near future.

**Board's 2025 Update:**

The Board appreciates Committee Staff's commitment to reviewing and analyzing the Board's 2026 Sunset Review report and looks forward to working with the Committees to ensure the continued regulation of the professions of Speech-Language Pathology and Audiology and Hearing Aid Dispensers.

## Section 10 – New Issues

This is the opportunity for the board to inform the Committees of solutions to issues identified by the board and by the Committees. Provide a short discussion of each of the outstanding issues, and the board's recommendation for action that could be taken by the board, by DCA or by the Legislature to resolve these issues (i.e., policy direction, budget changes, and legislative changes) for each of the following:

- Issues raised under prior Sunset Review that have not been addressed.

  The only remaining issue from the Board's prior Sunset Review is the promulgation of regulations related to Speech-Language Pathology and Audiology Aides, which is still under

review by the Board and is expected to be completed within the next two fiscal years with the Board's current staff resources.

- New issues identified by the board in this report.

**a) <u>Continuing Professional Development Updates for Speech-Language Pathologists and Audiologists</u>**

**Background**

During the course of auditing CPD records of Board licensees, Board staff had to educate a lot of current licensees regarding acceptable types of CPD and about what entities are approved CPD providers under the Board's Practice Act. During this process, Board staff have raised the question as to whether this issue might merit review for potential statutory amendments as part of the Board's Sunset Review.

BPC section 2532.6 requires that CPD services shall be obtained from the following entities:

- Accredited institutions of higher learning.
- Organizations approved as continuing education providers by the:
  - American Speech-Language Hearing Association (ASHA),
  - American Academy of Audiology (AAA), or
  - California Medical Association's (CMA's) Institute for Medical Quality Continuing Medical Education Program (note this is now only called the CMA Continuing Medical Education Program).
- Entities or organizations approved as continuing professional development providers by the Board.

BPC section 2532.6 also exempts the following entities from any application or registration fees that the Board may charge for continuing education providers:

- Accredited institutions of higher learning.
- Organizations approved as continuing education providers by the following entities:
  - ASHA
  - AAA, or
  - CMA's Institute for Medical Quality Continuing Medical Education Program (note this is now only called the CMA Continuing Medical Education Program).

What became apparent through the CPD audit process was that licensees were often not paying close attention to the CPD approval status of course providers if they looked like they were approved by either the national or state professional associations. In practice, the California chapters of ASHA and AAA are both approved providers of CPD by the national association for their CPD courses, therefore this is not a problem, but it would be clearer if the statute named these providers separately.

This is less clear with the national American Medical Association (AMA) and CMA (which is the Accreditation Council for Continuing Medical Education (ACCME) accreditor for CME in California). Both of these entities, AMA and CMA (through ACCME), participate in the same AMA Physician's Recognition Award (PRA) Credit System, where AMA and ACCME have simplified and aligned their expectations for accredited CME activities certified for AMA PRA Category 1 Credit. The AMA PRA credit system standards are designed to encourage innovation and flexibility in CME activities certified for AMA PRA Category 1 Credit while continuing to ensure that activities meet education standards and are

independent of commercial influence. These aligned criteria ensure providers have to meet Educational Planning and Evaluation Criteria, including ensuring that providers:

- incorporate into CME activities the educational needs (knowledge, competence, or performance) that underlie the professional practice gaps of their learners;
- generate activities/educational interventions that are designed to change competence, performance, or patient outcomes as described in its mission statement;
- use educational formats for activities/interventions that are appropriate for the setting, objectives, and desired results of the activity; the provider develops activities/educational interventions in the context of desirable physician attributes (competencies);
- analyze changes in learners (competence, performance, or patient outcomes) achieved as a result of the overall program's activities/educational interventions.

While it is less common for Board licensees to take AMA PRA Category 1 Credit courses, the Board has seen licensees taking American Academy of Pediatric courses that were approved as AMA PRA Category 1 Credit such as Building Blocks To Create Medical Homes for Children With Autism, Intellectual Disability; Heads Up on Headphones: Protecting Kids' Hearing Health; Social-Emotional Development of Infants and Young Children During COVID Recovery; or Implicit Bias: Enhancing Pediatric Care and Minimizing Harm for Children and Families. Licensees have to specify how physician approved courses relate to their practice as a speech-language pathologist or audiologist, since these courses can be very beneficial to a licensees practice and clearly allowing both AMA and CMA courses would be beneficial.

Another issue that became clear during CPD audits of licensees was that many were taking mandatory training courses required by either state (California Department of Education, California Department of Developmental Services, and California Department of Health Care Services), federal, or local government entities (such as regional centers, county offices of education, and local departments of public or mental health) that cover a variety of professional issues that impact their provision of services. These include courses addressing neurodevelopmental strategies to help children in different care environments, mandatory child abuse and neglect reporting requirements, implicit bias training, cultural humility and client-centered practice, and courses to train SLPs in the specific documentation requirements for state or local systems for tracking patient/student progress. These types of courses are different than employment required sexual harassment prevention trainings in that they directly impact the delivery and documentation of patient/student care. Additionally, even if a licensee were required to take a course like mandatory child abuse and neglect reporting requirements annually, with the Board's regulations it would only be allowed to count once per renewal cycle due to the Board's regulations, and it is critical to consumer protection that licensees have updated information on legal reporting requirements meant to protect children, elderly, and developmentally disabled individuals.

**Committee and Board Actions**

At the August 2025 meeting, the Board reviewed and approved amendments to the CPD requirements for Speech-Language Pathologists and Audiologists for inclusion as part of the Sunset Review Report. The Board voted to include the following entities as acceptable CPD service providers and exempt these entities from any application or registration fees that the Board may charge for continuing education providers:

- California Academy of Audiology,
- California Speech-Language Hearing Association,
- American Medical Association, or
- Federal, state, or local government entities

**Effect on Consumers**

This would extend to the Board the opportunity to allow required courses from federal, state, or local government entities to count for CPD credit. The Board could further define in regulations how courses related to consumer protection and direct patient care as a speech-language pathologist or audiologist would count for CPD credit. This would also make changes consistent with the Board's interpretation of statutes regarding approved or exempt CPD providers and provide better clarity regarding the CPD requirements for Speech-Language Pathologists and Audiologists.

**Proposed Text**

**BPC section 2532.6.**
(a) The Legislature recognizes that the education and experience requirements of this chapter constitute only minimal requirements to assure the public of professional competence. The Legislature encourages all professionals licensed and registered by the board under this chapter to regularly engage in continuing professional development and learning that is related and relevant to the professions of speech-language pathology and audiology.
(b) The board shall not renew any license or registration pursuant to this article~~chapter~~ unless the applicant certifies to the board that he or she has completed in the preceding two years not less than the minimum number of continuing professional development hours established by the board pursuant to subdivision (c) for the professional practice authorized by his or her license or registration.
(c) (1) The board shall prescribe the forms utilized ~~for~~ and the number of hours of required continuing professional development for persons licensed ~~or registered~~ under this article~~chapter~~ .
(2) The board shall have the right to audit the records of any applicant to verify the completion of the continuing professional development requirements.
(3) Applicants shall maintain records of completion of required continuing professional development coursework for a minimum of two years and shall make these records available to the board for auditing purposes upon request.
(d) The board shall establish exceptions from the continuing professional development requirements of this section for good cause as defined by the board.
(e) (1) The continuing professional development services shall be obtained from:
(A) Accredited~~accredited~~ institutions of higher learning,
(B) Organizations~~organizations~~ approved as continuing education providers by either the American Speech-Language Hearing Association or the American Academy of Audiology, the California Medical Association's ~~Institute for Medical Quality~~ Continuing Medical Education Program, the California Academy of Audiology, the California Speech-Language Hearing Association, or the American Medical Association,
(C) A federal, state, or local government entity, or
(D) Other~~other~~ entities or organizations approved as continuing professional development providers by the board, in its discretion.

(2) No hours shall be credited for any course enrolled in by a licensee that has not first been approved and certified by the board, if the board has sufficient funding and staff resources to implement the approval and certification process.
(3) The continuing professional development services offered by these entities may, but are not required to, utilize pretesting and posttesting or other evaluation techniques to measure and demonstrate improved professional learning and competency.
(4) An accredited institution of higher learning, an organization approved as continuing education providers by either the American Speech-Language Hearing Association or the American Academy of Audiology, and the California Medical Association's Institute for Medical Quality Continuing Education Program, the California Academy of Audiology, the California Speech-Language Hearing Association, or the American Medical Association, or a federal, state, or local government entity shall be exempt from any application or registration fees that the board may charge for continuing education providers.
(5) Unless a course offered by entities listed in paragraph (4) meets the requirements established by the board, the course may not be credited towards the continuing professional development requirements for license renewal.
(6) The licensee shall be responsible for obtaining the required course completion documents for courses offered by entities specified in paragraph (1).

(f) The board, by regulation, shall fund the administration of this section through professional development services provider and licensing fees to be deposited in the Speech-Language Pathology and Audiology Board Fund. The fees related to the administration of this section shall be sufficient to meet, but shall not exceed, the costs of administering the corresponding provisions of this section.
(g) The continuing professional development requirements adopted by the board shall comply with any guidelines for mandatory continuing education established by the Department of Consumer Affairs.

## b) Continuing Professional Development Updates for Speech-Language Pathology Assistants

### Background

Similar to the previous issue, during the course of auditing CPD records for Speech-Language Pathology Assistants (SLPAs), Board staff had to educate current SLPAs regarding the limitations on the acceptable types of CPD that are allowed according to the Board's statutes and regulations. This became clear when SLPAs were responding to the audit with self-selected self-study courses that would have been acceptable for their supervisor's CPD requirements, but due to the statutes and regulations for SLPAs, it is not allowed unless it is the independent study program approved by the supervisor. During this process, Board staff again raised the question as to whether this issue might merit review for potential statutory amendments as part of the Board's Sunset Review.

BPC section 2538.1.(b) (6) states that the Board shall adopt regulations regarding the:

> *Minimum continuing professional development requirements for the speech-language pathology assistant, not to exceed 12 hours in a two-year period. The speech-language pathology assistant's supervisor shall act as a professional development advisor. The speech-language pathology assistant's professional growth may be satisfied with*

*successful completion of state or regional conferences, workshops, formal in-service presentations, independent study programs, or any combination of these concerning communication and related disorders.*

The Board specifies the number of hours in Title 16 CCR 1399.170.14:

*When applying for renewal, a speech-language pathology assistant shall certify in writing, by signing a statement under penalty of perjury that, during the preceding two years, the speech-language pathology assistant has completed twelve (12) hours of continuing professional development through state or regional conferences, workshops, formal in-service presentations, independent study programs, or any combination of these concerning communication disorders.*

**Committee and Board Actions**

The Speech-Language Pathology Practice Committee (SLP Committee) met on May 15, 2025, to discuss if SLPAs should be allowed to fulfil their CPD requirement from other course providers.

BPC section 2538.1(b)(6) states that SLPAs may satisfy their CPD requirements only through:

- State or regional conferences,
- Workshops,
- Formal in-service presentations,
- Independent study programs, or
- Any combination of these.

However, BPC section 2532.6 allows the SLPAs supervisor to fulfil their CPD requirement from courses provided by:

- Accredited institutions of higher learning.
- Organizations approved as continuing education providers by the
  - American Speech-Language Hearing Association,
  - American Academy of Audiology, or
  - California Medical Association's Continuing Medical Education Program.
- Other entities or organizations approved as continuing professional development providers by the Board.

At its May 2025 meeting, the SLP Committee determined that SLPAs should be allowed to satisfy their CPD through the same course providers their supervisors are allowed to fulfill their CPD requirement.

At the August 2025 meeting, the SLP Committee also considered whether to statutorily define independent study programs to have the same meaning as self-study and whether SLPAs should be prohibited from using coursework towards a master's degree that would qualify an applicant for licensure as a speech-language pathologist pursuant to BPC Section 2532.2 towards meeting SLPA CPD requirements. The SLP Committee determined that defining independent study to mean the same as self-study in statute was not preferrable and that they would prefer the Board to engage stakeholders and define independent study in regulations. In contrast, the Committee did agree with the prohibition against using coursework towards a master's degree being accepted as CPD for SLPAs as the intent of master's level coursework is to prepare the individual for a different professional role not to expand the knowledge related to practicing as a SLPA.

At the August 2025 meeting, the SLP Committee and subsequently the Board reviewed and approved the proposed language, as amended during the SLP Committee, related to SLPA CPD requirements to be included as part of the Board's Sunset Review Report.

**Effect on Consumers**

These proposed statutory changes provide clarity and consistency across license types on CPD requirements and will broaden the types of continuing education opportunities available to SLPAs to enhance their provision of services to consumers.

**Proposed Text**

**BPC section 2538.1**

(a) The board shall adopt regulations, in collaboration with the State Department of Education, the Commission on Teacher Credentialing, and the Advisory Commission on Special Education, that set forth standards and requirements for the adequate supervision of speech-language pathology assistants.

(b) The board shall adopt regulations as reasonably necessary to carry out the purposes of this article, that shall include, but need not be limited to, the following:

(1) Procedures and requirements for application, registration, renewal, suspension, and revocation.

(2) Standards for approval of ~~Associate Degree~~ Speech-Language Pathology Assistant associate degree-training programs based upon standards and curriculum guidelines established by the National Council on Academic Accreditation in Audiology and Speech-Language Pathology, or the American Speech-Language-Hearing Association, or equivalent formal training programs consisting of two years of technical education, including supervised field placements. The board may impanel site review committees to conduct onsite evaluations, inspections, and investigations of a speech-language pathology assistant training program and to assess the training program's compliance with the board's laws and regulations. The members of the site review committee shall receive no compensation but shall be reimbursed for their actual travel and per diem expenses by the institution that is the subject of the evaluation, inspection, or investigation.

(3) Standards for accreditation of a Speech-Language Pathology Assistant associate degree-training program's institution by the Accrediting Commission for Community and Junior Colleges of the Western Association of Schools and Colleges or the Senior College Commission of the Western Association of Schools and Colleges, or equivalent accreditation.

(4) The scope of responsibility, duties, and functions of speech-language pathology assistants, that shall include, but not be limited to, all of the following:

(A) Conducting speech-language screening, without interpretation, and using screening protocols developed by the supervising speech-language pathologist.

(B) Providing direct treatment assistance to patients or clients under the supervision of a speech-language pathologist.

(C) Following and implementing documented treatment plans or protocols developed by a supervising speech-language pathologist.

(D) Documenting patient or client progress toward meeting established objectives, and reporting the information to a supervising speech-language pathologist.

(E) Assisting a speech-language pathologist during assessments, including, but not limited to, assisting with formal documentation, preparing materials, and performing clerical duties for a supervising speech-language pathologist.
(F) When competent to do so, as determined by the supervising speech-language pathologist, acting as an interpreter for non-English-speaking patients or clients and their family members.
(G) Scheduling activities and preparing charts, records, graphs, and data.
(H) Performing checks and maintenance of equipment, including, but not limited to, augmentative communication devices.
(I) Assisting with speech-language pathology research projects, in-service training, and family or community education.

The regulations shall provide that speech-language pathology assistants are not authorized to conduct evaluations, interpret data, alter treatment plans, or perform any task without the express knowledge and approval of a supervising speech-language pathologist.

(5) The requirements for the wearing of distinguishing name badges with the title of speech-language pathology assistant.

(6) Minimum continuing professional development requirements for the speech-language pathology assistant, not to exceed 12 hours in a two-year period. The speech-language pathology assistant's supervisor shall act as a professional development advisor. The speech-language pathology assistant's professional growth may be satisfied with successful completion of state or regional conferences, workshops, formal in-service presentations, independent study programs, courses offered by entities listed in paragraph (1) of subdivision (e) of Section 2532.6, or any combination of these concerning communication and related disorders. Coursework from a master's degree that would qualify an applicant for licensure as a speech-language pathologist pursuant to Section 2532.2 shall not be used to satisfy this requirement.

(7) Minimum continuing professional development requirements for the supervisor of a speech-language pathology assistant.

(8) The type and amount of direct and indirect supervision required for speech-language pathology assistants.

(9) The maximum number of assistants permitted per supervisor.

(10) A requirement that the supervising speech-language pathologist shall remain responsible and accountable for clinical judgments and decisions and the maintenance of the highest quality and standards of practice when a speech-language pathology assistant is utilized.

- New issues not previously discussed in this report.

**a) Authority to Create a Retired License Status for Board Specified Licensees with Board Specific Requirements**

**Background**

At its May 2025 meeting, the Board discussed possible action to create a retired license status under the authority of BPC section 464 or to seek statutory authority in its Practice Act. For a considerable number of years, Board licensees have requested to be placed in a retired status instead of having to continue to renew their license or having their license expire for a specified time before it can be cancelled.

During the CPD audits, this became a growing concern when Board staff came across a handful of licensees who failed their CPD audit because they have professionally retired and should have been in an inactive status, but instead kept renewing as active status because they were either unaware of the inactive status and what it meant or made a mistake on their renewal form. Many of these licensees chose to maintain their license as they preferred to have a license that appeared to be in good standing instead of having an expired or cancelled status, which licensees feel has a negative connotation.

**Committee and Board Actions**

In May 2025, the Board discussed possible action to create a retired license status under the BPC section 464 but determined that it lacked the following standards that should be required of a retired license status to maintain public safety:

1. Restricting licensees from placing their license on retired status if they are currently on a restricted license (i.e., license subject to a Board imposed disciplinary order such as probation), they have not abated any issued Board citation and fine, or they are currently under investigation for an active complaint or conviction.
2. Restricting licensees from reinstating their license to active status if they have been out of practice for a specified number of years.
3. Restricting the number of times a licensee can reinstate from retired to active status.

To address these concerns, the Board determined that it should seek statutory authority in its Practice Act to create a retired license and directed Board staff to draft proposed legislative language that could be included as part of the Board's Sunset Review.

In August 2025, the Board additionally discussed whether a licensee on retired status for more than three years who has continuously maintained a current valid active and clear license in the same profession in another state or US territory should be allowed to reinstate their license to active status without retaking any examination or reapplying for initial licensure. At this meeting, the Board also discussed whether licensees on retired status should be able to use the title "retired," which they agreed to, or abbreviations denoting retired status, which the Board did not agree with. The Board then voted to adopt the proposed language provided below for inclusion in the Board's Sunset Review Report.

**Effect on Consumers**

This bill will make it easier for consumers seeking local practicing licensees for services, as currently, there are many retired licensees maintaining an active license but not providing services to consumers.

**Proposed Text**

**Add BPC Article 1, section XXXX.X**
(a) The board shall issue, upon an application prescribed by the board and payment of a fee of $75, a retired license to a licensed speech-language pathologist, audiologist, hearing aid dispenser, or dispensing audiologist who holds a license that is current and active or a license that is inactive, and whose license is not suspended, revoked, surrendered, is subject to disciplinary action under this chapter, has an Accusation filed against their license by the Attorney General's office and the charges are pending, or is

confirmed by an internal investigation report signed by the Executive Officer to be under investigation by the board .
(b) The holder of a retired license issued pursuant to this section shall not engage in any activity for which an active license is required or represent that they have an active license.
(c) A retired license shall not be subject to renewal.
(d) The holder of a retired license may apply once to restore their license to active status if the holder of a retired license meets all of the following requirements:
(1) Has not committed an act or crime constituting grounds for denial, revocation, or discipline of a license.
(1) Pays the renewal fee required.
(2) Completes the required continuing education as specified in subdivision (e) .
(3) Complies with the fingerprint submission requirements established by the board in regulation.
(4) (i) The retired license was issued less than three years from the date of issuance, or.
(ii) The retired license was issued more than three years from the date of issuance, but the holder has continuously maintained a current, valid, active, and clear license in the same profession in another state or US territory within the United States.
(e) A holder of a retired license requesting to restore their license to active status pursuant to subdivision (d) shall complete continuing education equivalent to that required for a single license renewal period. Continuing education shall be completed in accordance with Section 2532.6 or Section 2538.18 except that all hours may be completed through self-study as defined by the board in regulation.
(f) The board shall issue a retired license for a second time pursuant to subdivision (a). A license shall remain on retired status after it has been placed on retired status for the second time.
(g) The holder of a retired license shall apply for and obtain a new license if they have been on retired status for more than three years from the date of issuance, unless the holder continuously maintains a current, valid, active, and clear license in the same profession in another state or US territory within the United States.
(h) The holder of a retired license shall be permitted to use the title "retired." The designation of retired shall not be abbreviated in any way.

## b) Hearing Aid Dispensing Branch Office Language Clean-up

### Background

At the December 2024 Board meeting, the Board was asked if a Hearing Aid Dispenser Trainee can do their unsupervised hours at a location other than their primary place of business and if they need a branch license to practice at those other locations. It was also asked whether the supervisor needs a branch license for the trainee to work there. At its May 2025 meeting, the Hearing Aid Dispensing Committee (HAD Committee) reviewed statutory and regulatory requirements regarding hearing aid dispenser trainees' supervision and operating at locations of their supervisor.

### Committee and Board Actions

At its May 2025 meeting, the HAD Committee determined that allowing a hearing aid trainee to maintain a branch office license pursuant to BPC section 2538.34 would be

inconsistent with BPC section 2538.30, which prohibits the management or independent operation of a business that engages in the fitting or sale of hearing aids by temporary and trainee licensees, and suggested that statutory changes should be considered. The HAD Committee identified that words like "manage" and "independently operate a business" as used in BPC section 2538.30 should be defined in regulation but not the word "maintain" as used in BPC section 2538.34. The Committee determined that the word "maintain" as used in BPC section 2538.34 may not accurately capture the situation a hearing aid dispenser trainee may be in and suggested that statutory changes should be considered. At its May 2025 meeting, the HAD Committee also discussed whether businesses could be maintained, operated, or managed by a different hearing aid dispenser. Businesses could also be maintained, operated, or managed by someone who does not fit or sell a hearing and are employed by a corporation, partnership, trust, association, or other like organization provided that any and all fitting or selling of hearing aids is conducted by the individuals who are licensed pursuant to BPC section 2538.20. The Committee also identified that "temporary basis" as used in BPC section 2538.34 should be clarified and suggested that statutory changes should be considered as part of the Board's Sunset Review Report.

The proposed statutory changes were reviewed and approved [as amended] at the December 2025 Board meeting for inclusion in the Board's Sunset Review Report.

**Effect on Consumers**

None; these proposed statutory changes provide clarity and consistency on the requirements for addresses of record and Branch Office requirements for Board licensees and staff.

**Proposed Text**

**Business and Professions Code (BPC) section 2538.33**
(a) Before engaging in the practice of fitting or selling hearing aids, each licensee shall notify the board in writing of the address or addresses where they are to engage, or intend to engage, in the practice of fitting or selling hearing aids, and of any changes in the address or addresses ~~their place of business~~ within 30 days of engaging in that practice.
(b) If ~~a street~~ the address provided pursuant to subdivision (a) is not the address at which the licensee receives mail, the licensee shall also notify the board in writing of the mailing address for each location where the licensee is to engage, or intends to engage, in the practice of fitting or selling hearing aids, and of any change in the mailing address or address ~~of their place or places of business~~.

**BPC section 2538.34**
(a) Every hearing aid dispenser ~~licensee~~ who engages in the practice of fitting or selling hearing aids shall have ~~and maintain~~ an established retail business address ~~to engage in that fitting or selling,~~ routinely open for service to customers or clients. The address of ~~the licensee's~~ that place of business shall be registered with the board as provided in Section 2538.33.
(b) Except as provided in subdivision (c), if a hearing aid dispenser engages in the practice of fitting or selling hearing aids at ~~licensee maintains~~ more than one place of business within this state, they shall apply for and procure a branch office ~~duplicate~~ license for each place of business ~~branch office maintained~~. The application shall state

the name of the person and the address ~~location~~ of the place or places of business for which the branch office ~~duplicate~~ license is desired.
(c) A hearing aid dispenser may, without obtaining a branch office ~~duplicate~~ license ~~for a branch office~~, engage on a temporary basis in the practice of fitting or selling hearing aids at ~~the primary or branch location of~~ another ~~licensee's~~ business or at a location or facility that they may use on a temporary basis, provided that the hearing aid dispenser notifies the board in advance in writing of the dates and addresses of those businesses, locations, or facilities at which they will engage in the practice of fitting or selling hearing aids.
(1) For purposes of this subdivision, "temporary basis" means a limited and short period of time that is not intended to occur repeatedly.

## c) Proposed Technical Clean-up and Non-Substantive Statutory Amendments

### Recommendations

The Board respectfully submits the following technical and non-substantive statutory amendments to the Board's Practice Act for consideration.

### BPC Section 2530.2.

As used in this chapter, unless the context otherwise requires:
(a) "Board" means the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board.
(b) "Person" means any individual, partnership, corporation, ~~limited liability company~~, or other organization or combination thereof, except that only individuals can be licensed or registered under this chapter.
(c) A "speech-language pathologist" is a person who practices speech-language pathology.
(d) The practice of speech-language pathology means all of the following:
(1) The application of principles, methods, instrumental procedures, and noninstrumental procedures for measurement, testing, screening, evaluation, identification, prediction, and counseling related to the development and disorders of speech, voice, language, or swallowing.
(2) The application of principles and methods for preventing, planning, directing, conducting, and supervising programs for habilitating, rehabilitating, ameliorating, managing, or modifying disorders of speech, voice, language, or swallowing in individuals or groups of individuals.
(3) Conducting hearing screenings.
(4) Performing suctioning in connection with the scope of practice described in paragraphs (1) and (2), after compliance with a medical facility's training protocols on suctioning procedures.
(e) (1) Instrumental procedures referred to in subdivision (d) are the use of rigid and flexible endoscopes to observe the pharyngeal and laryngeal areas of the throat in order to observe, collect data, and measure the parameters of communication and swallowing as well as to guide communication and swallowing assessment and therapy. Passage of these instruments without the presence of a physician and surgeon is subject to paragraph (2).
(2) Nothing in this subdivision shall be construed as a diagnosis. Any observation of an abnormality shall be referred to a physician and surgeon.

(f) (1) A licensed speech-language pathologist shall not perform a flexible fiber optic transnasal endoscopic procedure unless they have received written verification from one otolaryngologist certified by the American Board of Otolaryngology – Head and Neck Surgery that the speech-language pathologist has performed a minimum of 25 supervised flexible fiber optic transnasal endoscopic procedures and they are competent to perform these procedures. Of these 25 procedures, the first 10 procedures shall be supervised by a licensed physician and surgeon who performs nasal endoscopy as part of their practice and the subsequent 15 procedures shall be supervised by either a licensed physician and surgeon who performs nasal endoscopy as part of their practice or by another licensed speech-language pathologist who is verified as competent in performing flexible fiber optic transnasal endoscopic procedures. The speech-language pathologist shall have this written verification on file and readily available for inspection upon request by the board. A speech-language pathologist with a verification on file shall pass a flexible fiber optic transnasal endoscopic instrument only upon the orders of a licensed physician and surgeon. The order by a physician and surgeon is deemed to allow a speech-language pathologist with verification, in accordance with this paragraph, to perform fiber optic transnasal endoscopic procedures at a location based on the patient's medical needs that complies with procedures specified in paragraph (1) of subdivision (g).

(2) A licensed speech-language pathologist who holds a written verification pursuant to this subdivision that was issued before January 1, 2023, shall be deemed to meet the requirements described in paragraph (1).

(g) (1) A licensed speech-language pathologist shall only perform flexible endoscopic procedures described in ~~subdivision (e)~~ subdivision (f) in the following settings that requires the facility to have protocols for emergency medical backup procedures, including a physician and surgeon or other appropriate medical professionals being readily available.

(A) A clinic, as defined in Section 1200 of the Health and Safety Code.

(B) A facility described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(C) A health facility, as defined in Section 1250 of the Health and Safety Code.

(D) A hospice facility licensed pursuant to Chapter 8.5 (commencing with Section 1745) of Division 2 of the Health and Safety Code.

(E) A medical group practice, including a professional medical corporation, as defined in Section 2406, another form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure, or another lawfully organized group of physicians and surgeons that provides health care services.

(2) A licensed speech-language pathologist performing flexible fiber optic transnasal endoscopic procedures on patients who have contraindications to the procedure shall consult and document clearance with the physician and surgeon that the licensed speech-language pathologist can safely perform the procedure. For purposes of this paragraph, contraindications for these procedures may include, but are not limited to, cases of bilateral obstruction of nasal passages, refractory epistaxis, cardiac disorder with acute risk of vasovagal episode and bradycardia, history of vasovagal episodes, facial trauma, recent trauma to the nasal cavity, or surrounding tissue and structures secondary to surgery or injury, severe bleeding disorders, severe movement disorders, severe agitation, and inability to cooperate with the examination.

(h) "Speech-language pathology aide" means any person meeting the minimum requirements established by the board, who works directly under the supervision of a speech-language pathologist.

(i) (1) "Speech-language pathology assistant" means a person who meets the academic and supervised training requirements set forth by the board and who is approved by the board to assist in the provision of speech-language pathology under the direction and supervision of a speech-language pathologist who shall be responsible for the extent, kind, and quality of the services provided by the speech-language pathology assistant.

(2) The supervising speech-language pathologist employed or contracted for by a public school may hold a valid and current license issued by the board, a valid, current, and professional clear clinical or rehabilitative services credential in language, speech, and hearing issued by the Commission on Teacher Credentialing, or other credential authorizing service in language, speech, and hearing issued by the Commission on Teacher Credentialing that is not issued on the basis of an emergency permit or waiver of requirements. For purposes of this paragraph, a "clear" credential is a credential that is not issued pursuant to a waiver or emergency permit and is as otherwise defined by the Commission on Teacher Credentialing. Nothing in this section referring to credentialed supervising speech-language pathologists expands existing exemptions from licensing pursuant to Section 2530.5.

(j) An "audiologist" is one who practices audiology.

(k) "The practice of audiology" means the application of principles, methods, and procedures of measurement, testing, appraisal, prediction, consultation, counseling, and instruction related to auditory, vestibular, and related functions and the modification of communicative disorders involving speech, language, auditory behavior, or other aberrant behavior resulting from auditory dysfunction; and the planning, directing, conducting, supervising, or participating in programs of identification of auditory disorders, hearing conservation, cerumen removal, aural habilitation, and rehabilitation, including hearing aid recommendation and evaluation procedures, including, but not limited to, specifying amplification requirements and evaluation of the results thereof, auditory training, ~~and~~ speech reading, and the ~~selling~~ fitting of hearing aids.

(l) A "dispensing audiologist" is ~~a person~~ an audiologist who is authorized to sell hearing aids ~~pursuant to their audiology license~~.

(m) "Audiology aide" means any person meeting the minimum requirements established by the board who works directly under the supervision of an audiologist. The board may by regulation exempt certain functions performed by an industrial audiology aide from supervision provided that their employer has established a set of procedures or protocols that the aide shall follow in performing these functions.

(n) "Medical board" means the Medical Board of California.

(o) A "hearing screening" performed by a speech-language pathologist means a binary puretone screening at a preset intensity level for the purpose of determining if the screened individuals are in need of further medical or audiological evaluation.

(p) "Cerumen removal" means the nonroutine removal of cerumen within the cartilaginous ear canal necessary for access in performance of audiological procedures that shall occur under physician and surgeon supervision. Cerumen removal, as provided by this section, shall only be performed by a licensed audiologist. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but shall include all of the following:

(1) Collaboration on the development of written standardized protocols. The protocols shall include a requirement that the supervised audiologist immediately

refer to an appropriate physician any trauma, including skin tears, bleeding, or other pathology of the ear discovered in the process of cerumen removal as defined in this subdivision.
(2) Approval by the supervising physician of the written standardized protocol.
(3) The supervising physician shall be within the general vicinity, as provided by the physician-audiologist protocol, of the supervised audiologist and available by telephone contact at the time of cerumen removal.
(4) A licensed physician and surgeon may not simultaneously supervise more than two audiologists for purposes of cerumen removal.

**BPC section 2530.3.**
(a) A person represents themselves to be a speech-language pathologist when they hold themselves out to the public by any title, business name, or description of services incorporating the words "speech pathologist," "speech pathology," "speech therapy," "speech correction," "speech correctionist," "speech therapist," "speech clinic," "speech clinician," "language pathologist," "language pathology," "logopedics," "logopedist," "communicology," "communicologist," "aphasiologist," "voice therapy," "voice therapist," "voice pathology," or "voice pathologist," "language therapist," or "phoniatrist," or any similar titles; or when they purport to treat stuttering, stammering, or other disorders of speech.
(b) A person represents themselves to be an audiologist when they hold themselves out to the public by any title, business name, or description of services incorporating the terms "audiology," "audiologist," "audiological," "hearing clinic," "hearing clinician," "hearing therapist," or any similar titles.

**BPC section 2530.5.**
(a) Nothing in this chapter shall be construed as restricting hearing testing conducted by licensed physicians and surgeons or by persons conducting hearing tests under the direct supervision of a physician and surgeon.
(b) Nothing in this chapter shall be construed to prevent a licensed hearing aid dispenser from engaging in testing of hearing and other practices and procedures used solely for the fitting and selling of hearing aids nor does this chapter restrict persons practicing their licensed profession and operating within the scope of their licensed profession or employed by someone operating within the scope of their licensed professions, including persons fitting and selling hearing aids who are properly licensed or registered under the laws of the State of California.
(c) Nothing in this chapter shall be construed as restricting or preventing the practice of speech-language pathology or audiology by personnel holding the appropriate credential from the Commission on Teacher Credentialing as long as the practice is conducted within the confines of or under the jurisdiction of a public preschool, elementary, or secondary school by which they are employed and those persons do not either offer to render or render speech-language pathology or audiology services to the public for compensation over and above the salary they receive from the public preschool, elementary, or secondary school by which they are employed for the performance of their official duties.
(d) Nothing in this chapter shall be construed as restricting the activities and services of a student or speech-language pathology intern in speech-language pathology pursuing a course of study leading to a degree in speech-language pathology at an accredited or approved college or university or an approved clinical training facility, provided that these activities and services constitute a part of their supervised course of study and that those persons are designated by the title as "speech-language pathology intern," "speech-

language pathology trainee," or other title clearly indicating the training status appropriate to their level of training.
(e) Nothing in this chapter shall be construed as restricting the activities and services of a student or audiology intern in audiology pursuing a course of study leading to a degree in audiology at an accredited or approved college or university or an approved clinical training facility, provided that these activities and services constitute a part of their supervised course of study and that those persons are designated by the title as "audiology intern," "audiology trainee," or other title clearly indicating the training status appropriate to their level of training.
(f) Nothing in this chapter shall be construed as restricting the practice of an applicant who is obtaining the required professional experience specified in subdivision (c) of Section 2532.2 or subdivision (b) of Section 2532.25 and who has been issued a temporary license pursuant to Section 2532.7. The number of applicants who may be supervised by a licensed speech-language pathologist or a speech-language pathologist having qualifications deemed equivalent by the board shall be determined by the board. The supervising speech-language pathologist shall register with the board the name of each applicant working under their supervision~~, and shall submit to the board a description of the proposed professional responsibilities of the applicant working under their supervision~~. The number of applicants who may be supervised by a licensed audiologist or an audiologist having qualifications deemed equivalent by the board shall be determined by the board. The supervising audiologist shall register with the board the name of each applicant working under their supervision, and shall submit to the board a description of the proposed professional responsibilities of the applicant working under their supervision.
(g) Nothing in this chapter shall be construed as restricting hearing screening services in public or private elementary or secondary schools so long as these screening services are provided by persons registered as qualified school audiometrists pursuant to Sections 1685 and 1686 of the Health and Safety Code or hearing screening services supported by the State Department of Health Care Services so long as these screening services are provided by appropriately trained or qualified personnel.
(h) Persons employed as speech-language pathologists or audiologists by a federal agency shall be exempt from this chapter.
(i) Nothing in this chapter shall be construed as restricting consultation or the instructional or supervisory activities of a faculty member of an approved or accredited college or university for the first 60 days following appointment after the effective date of this subdivision.

**BPC section 2530.6.**
(a) Speech-language pathologists and audiologists supervising speech-language pathology or audiology aides shall register with the board the name of each aide working under their supervision.
(b) The number of aides who may be supervised by a licensee shall be determined by the board.
(c) The supervising audiologist or speech-language pathologist shall be responsible for the extent, kind, and quality of services performed by the aide, consistent with the board's designated standards and requirements.
(d) A speech-language pathology and audiology aide registration shall expire every two years and is subject to the renewal requirements in Article 6 (commencing with Section 2535).
(e) At the time of registration renewal, the speech-language pathologist or audiologist supervising the speech-language pathology or audiology aide shall update the board on the duties the aide performs while assisting the supervisor in the practice of speech-

language pathology or audiology, and the training program and assessment methods the supervisor is utilizing to ensure the aide's continued competency.
(f) An aide shall not advertise or otherwise represent that they hold a license as a speech-language pathologist, speech-language pathology assistant, or audiologist.

**BPC section 2530.8.**
Every person holding a license or registration under this chapter shall display it conspicuously in their primary place of practice or business.

**BPC section 2530.9**
(a) An aide or a required professional experience license holder shall not be the sole proprietor of, manage, or independently operate a business that engages in the practice of practice of speech-language pathology or audiology.
(b) A speech-language pathology assistant shall not be the sole proprietor of, manage, or independently operate a business that engages in the practice of speech-language pathology.

~~**BPC section 2531.3.**~~
~~The board shall examine every applicant for a speech-language pathology license or an audiology license at the time and place designated by the board in its discretion, but at least once in each year; and for that purpose may appoint qualified persons to give the whole or any portion of the examination, who shall be designated as commissioners on examination. A commissioner on examination need not be a member of the board, but shall be subject to the same rules and regulations and shall be entitled to the same fee as if he or she were a member of the board.~~
~~The board shall perform all examination functions, including but not limited to, participation in uniform examination systems.~~

~~**BPC section 2531.4.**~~
~~The board shall have full authority to investigate and to evaluate each and every applicant applying for a license to practice speech-language pathology or a license to practice audiology and to determine the admission of the applicant to the examination, if administered by the board, or to issue a license, in conformance with the provisions of, and qualifications required by, this chapter.~~

**BPC section 2531.5.**
The board shall issue, suspend, and revoke licenses or registrations and approvals to practice speech-language pathology ~~and audiology~~, audiology, and hearing aid dispensing as authorized by this chapter.

**BPC section 2532.**
No person shall engage in the practice of speech-language pathology or audiology or represent themselves as a speech-language pathologist or audiologist unless they are licensed in accordance with this article~~chapter~~.

**BPC section 2532.2.**
Except as required by Section 2532.25, to be eligible for licensure by the board as a speech-language pathologist or audiologist, the applicant shall possess all of the following qualifications:
(a) Possess at least a master's degree in speech-language pathology, communication disorders, communication sciences and disorders, communicative disorders, speech,

language, and hearing sciences or audiology from an educational institution approved by the board or qualifications deemed equivalent by the board.

(b) (1) Submit evidence of the satisfactory completion of supervised clinical practice with individuals representative of a wide spectrum of ages and communication disorders. The board shall establish by regulation the required number of clock hours, not to exceed 375 clock hours, of supervised clinical practice necessary for the applicant.

(2) The clinical practice shall be under the direction of an educational institution approved by the board.

~~(c) Submit~~(c) (1) Submit evidence of no less than 36 weeks of satisfactorily completed supervised professional full-time experience or 72 weeks of professional part-time experience obtained under the supervision of a licensed speech-language pathologist or audiologist or a speech-language pathologist or audiologist having qualifications deemed equivalent by the board. This experience shall be evaluated and approved by the board. The required professional experience shall follow completion of the requirements listed in subdivisions (a) and (b). Full time is defined as at least 36 weeks in a calendar year and a minimum of 30 hours per week. Part time is defined as a minimum of 72 weeks and a minimum of 15 hours per week.

(2) A speech-language pathologist or audiologist who holds a license from another state or territory of the United States or who holds equivalent qualifications as determined by the board and who has completed no less than one year of full-time continuous employment as a speech-language pathologist or audiologist within the past three years is exempt from the supervised professional experience in subdivision (c).

(d) ~~(1) Pass~~Pass an examination or examinations approved by the board. ~~The board shall determine the subject matter and scope of the examinations and may waive the examination upon evidence that the applicant has successfully completed an examination approved by the board. Written examinations may be supplemented by oral examinations as the board shall determine. An applicant who fails his or her examination may be reexamined at a subsequent examination upon payment of the reexamination fee required by this chapter.~~

~~(2) A speech-language pathologist or audiologist who holds a license from another state or territory of the United States or who holds equivalent qualifications as determined by the board and who has completed no less than one year of full-time continuous employment as a speech-language pathologist or audiologist within the past three years is exempt from the supervised professional experience in subdivision (c).~~

(e) As applied to licensure as an audiologist, this section shall apply to applicants who graduated from an approved educational institution on or before December 31, 2007.

**BPC section 2532.25.**

(a) An applicant seeking licensure as an audiologist shall possess a doctorate in audiology earned from an educational institution approved by the board. The board may, in its discretion, accept qualifications it deems to be equivalent to a doctoral degree in audiology. The board shall not, however, accept as equivalent qualifications graduation from a master's program that the applicant was enrolled in on or after January 1, 2008.

(b) In addition to meeting the qualifications specified in subdivision (a), an applicant seeking licensure as an audiologist shall do all of the following:

(1) Submit evidence of the satisfactory completion of supervised clinical practice with individuals representative of a wide spectrum of ages and audiological disorders. The board shall establish by regulation the required number of clock hours

of supervised clinical practice necessary for the applicant. The clinical practice shall be under the direction of an audiology doctoral program at an educational institution approved by the board.

(2) Submit evidence of no less than 12 months of satisfactorily completed supervised professional full-time experience or its part-time equivalent obtained under the supervision of a licensed audiologist or an audiologist having qualifications deemed equivalent by the board. This experience shall be completed under the direction of an audiology doctoral program at an educational institution approved by the board.

(3) Pass an examination or examinations approved by the board. ~~The board shall determine the subject matter and scope of the examination or examinations and may waive an examination upon evidence that the applicant has successfully completed an examination approved by the board. Written examinations may be supplemented by oral examinations as the board shall determine. An applicant who fails an examination may be reexamined at a subsequent examination upon payment of the reexamination fee required by this chapter.~~

(c) This section shall apply to applicants who graduate from an approved educational institution on and after January 1, 2008.

**BPC section 2532.4.**

(a) The board shall~~may~~ direct applicants to be examined for knowledge in whatever theoretical or applied fields in speech-language pathology or audiology it deems appropriate. It shall~~may~~ examine the applicant with regard to their~~his or her~~ professional skills and their~~his or her~~ judgment in the utilization of speech-language pathology or audiology techniques and methods.

(b) ~~The examination may be written or oral or both. The examination shall be given at least once a year at the time and place and under such supervision as the board may determine.~~ The board shall determine what shall constitute a passing grade.

(c) ~~The board shall keep an accurate recording of any oral examination and keep the recordings as well as any written examination as part of its records for at least two years following the date of examination.~~ The board at its discretion may waive the examination or examinations when in the judgment of the board the applicant has already demonstrated competence in areas covered by the examination or examinations.

(d) The examination or examinations required by the board for a license under this article may be conducted by the board or by a public or private organization specified by the board. The examination or examinations may be conducted under a uniform examination system, and for that purpose, the board may make arrangements with organizations furnishing examination or examinations materials as may, in its discretion, be desirable. All aspects of the examination or examinations shall be in compliance with Section 139.

**~~BPC section 2532.5.~~**

~~Every person holding a license under this chapter shall display it conspicuously in their primary place of practice.~~

**BPC section 2533.**

The board may refuse to issue, or issue subject to terms and conditions, a license or registration on the grounds specified in Section 480, or may suspend, revoke, or impose terms and conditions upon the license or registration of any licensee or registrant for any of the following:

(a) Conviction of a crime substantially related to the qualifications, functions, and duties of a speech-language pathologist or audiologist or hearing aid dispenser, as the case may be. The record of the conviction shall be conclusive evidence thereof.
(b) Securing a license or registration by fraud or deceit.
(c) (1) The use or administering to themselves of any controlled substance.
(2) The use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent or in a manner as to be dangerous or injurious to the licensee or registrant, to any other person, or to the public, or to the extent that the use impairs the ability of the licensee or registrant to practice speech-language pathology or audiology or hearing aid dispensing safely.
(3) More than one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances referred to in this section.
(4) Any combination of paragraph (1), (2), or (3).
The record of the conviction shall be conclusive evidence of unprofessional conduct.
(d) Engaging in any act in violation of Section 650.
(e) Advertising in violation of Section 17500. Advertising an academic degree that was not validly awarded or earned under the laws of this state or the applicable jurisdiction in which it was issued is deemed to constitute a violation of Section 17500.
(f) Committing a dishonest or fraudulent act that is substantially related to the qualifications, functions, or duties of a ~~licensee~~license or registration.
(g) Incompetence, gross negligence, or repeated negligent acts.
(h) Other acts that have endangered or are likely to endanger the health, welfare, and safety of the public.
(i) Use by a hearing aid dispenser of the term "doctor" or "physician" or "clinic" or "audiologist," or any derivation thereof, except as authorized by law.
(j) The use, or causing the use, of any advertising or promotional literature in a manner that has the capacity or tendency to mislead or deceive purchasers or prospective purchasers.
(k) Any cause that would be grounds for denial of an application for a license or registration.
(l) Violation of Section 1689.6 or 1793.02 of the Civil Code.
(m) Violation of a term or condition of a probationary order of a license or registration issued by the board pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.
(n) Violation of a term or condition of a conditional license or registration issued by the board pursuant to this section.
(o) Disciplinary action taken by any public agency in any state or territory for any act substantially related to the practice of speech-language pathology, audiology, or hearing aid dispensing.
(p) Aiding or abetting any person to engage in the unlicensed practice of speech-language pathology, audiology, or hearing aid dispensing.
(q) Violating or attempting to violate, directly or indirectly, any of the provisions of this chapter.
(n) Rendering professional services in violation of Section 13404.5 and 17701.04 of the Corporation Code.

**BPC section 2533.1.**
A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, and duties of a speech-language pathologist, audiologist, or hearing aid dispenser is deemed to be a conviction within the meaning of this article. The board may order a licensee or registrant be disciplined or denied a license or a registration as provided in Section 2533 when the time

for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or when an order granting probation is made suspending the imposition of sentence irrespective of a subsequent order under Section 1203.4, 1203.4a, or 1203.41 of the Penal Code allowing the person to withdraw their plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

**BPC section 2533.4.**
Whenever a person other than a person licensed or registered under this chapters~~peech-language pathologist, audiologist, or hearing aid dispenser~~ has engaged in an act or practice which constitutes an offense under this chapter, a superior court of any county, on application of the board, may issue an injunction or other appropriate order restraining the conduct. Proceedings under this section shall be governed by Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure. The board may commence action in the superior court under this section on its own motion.

**BPC section 2533.6.**
(a) A person whose license or registration has been revoked, suspended, or surrendered ~~or suspended~~, or who has been placed on probation, may petition the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board for reinstatement or modification of penalty, including modification or termination of probation, after a period of not less than the following minimum period of time has elapsed from the effective date of the decision ordering that disciplinary action:

(1) At least three years for reinstatement of a license or registration revoked for unprofessional conduct or surrendered, except that the board may, for good cause shown, specify in a revocation order that a petition for reinstatement may be filed after two years.

(2) At least two years for early termination or one year for modification of a condition of probation of three years or more.

(3) At least one year for reinstatement of a license or registration revoked for mental or physical illness, or for modification of a condition, or termination of probation of less than three years.

(b) The petition shall be on a form provided by the board and shall state any facts and information as may be required by the board, including, but not limited to, proof of compliance with the terms and conditions of the underlying disciplinary order. The petition shall be verified by the petitioner who shall file an original and sufficient copies of the petition, together with any supporting documents, for the members of the board, the administrative law judge, and the Attorney General.
(c) The petition may be heard by the board, with the matter presided over by an administrative law judge. After a hearing on the petition, the administrative law judge shall provide a decision as determined by the board which shall be acted upon in accordance with the Administrative Procedure Act.
(d) The board or the administrative law judge hearing the petition may consider all activities of the petitioner since the disciplinary action was taken, the offense for which the petitioner was disciplined, the petitioner's activities during the time the license or registration was in good standing, and the petitioner's rehabilitative efforts, general reputation for truth, and professional ability. The hearing may be continued, as the board or the administrative law judge finds necessary.
(e) The administrative law judge when hearing a petition for reinstating a license or registration, or modifying a penalty, may recommend the imposition of any terms and conditions deemed necessary.

(f) No petition shall be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole. No petition shall be considered while there is an accusation or petition to revoke probation pending against the petitioner. The board may deny, without a hearing or argument, any petition filed pursuant to this section within a period of two years from the effective date of the prior decision following a hearing under this section.
(g) The board may deny, without a hearing or argument, any petition for termination or modification of probation filed pursuant to this section for any of the following:

(1) The petitioner has failed to comply with the terms and conditions of the disciplinary order.

(2) The board is conducting an investigation of the petitioner while they are on probation.

(3) The petitioner has a subsequent arrest that is substantially related to the qualifications, functions, or duties of the licensee or registrant and this arrest occurred while on probation.

(4) The petitioner's probation with the board is currently tolled.

(h) Nothing in this section shall be deemed to alter Sections 822 and 823.

**BPC section 2534.2.**
The amount of the fees prescribed by this chapter is that established by the following schedule:

(a) (1) The application fee and renewal fee for speech-language pathologists and nondispensing audiologists shall be established by the board in an amount that does not exceed one hundred fifty dollars ($150) but is sufficient to support the functions of the board that relate to the functions authorized by this chapter, excluding Article 9 (commencing with Section 2539.1).

(2) The application fee and renewal fee for dispensing audiologists shall be established by the board in an amount that does not exceed two hundred eighty dollars ($280) but is sufficient to support the functions of the board that relate to the functions authorized by this chapter.

(b) The delinquency fee shall be twenty-five dollars ($25).
(c) The reexamination fee shall be established by the board in an amount that does not exceed seventy-five dollars ($75).
(d) The registration fee and renewal fee of an aide shall be established by the board in an amount that does not exceed thirty dollars ($30).
(e) A fee to be set by the board of not more than one hundred dollars ($100) shall be charged for each application for approval as a speech-language pathology assistant.
(f) A fee of one hundred fifty dollars ($150) shall be charged for the issuance of and for the renewal of each approval as a speech-language pathology assistant, unless a lower fee is established by the board.
(g) The duplicate wall certificate fee is twenty-five dollars ($25).
(h) The duplicate renewal receipt fee is twenty-five dollars ($25).
(i) The application fee and renewal fee for a temporary license is thirty dollars ($30).
(j) The fee for issuance of a license or registration status and history certification letter shall be established by the board in an amount not to exceed twenty-five dollars ($25).

**BPC section 2535.**
~~(a) All licenses issued under Section 2532.2 as of January 1, 1992, shall expire at 12 a.m. of the last date of the birth month of the licensee during the second year of a two-year term if not renewed.~~

~~(b)~~(a) All licenses or registrations issued under Section 2530.6, 2532, and 2538~~this chapter, except those licenses issued pursuant to subdivision (a),~~ shall expire at 12 a.m. of the last date of the birth month of the licensee or registrant during the second year of a two-year term, if not renewed.
(c) To renew an unexpired license or registration, the licensee or registrant shall, on or before the date of expiration of the license or registration, apply for renewal on a form provided by the board, accompanied by the prescribed renewal fee.

**BPC section 2535.2.**
Except as provided in Section 2535.3, a license or registration that has expired may be renewed at any time within five years after its expiration upon filing of an application for renewal on a form prescribed by the board and payment of all accrued and unpaid renewal fees. If the license or registration is not renewed on or before its expiration, the licensee or registrant, as a condition precedent to renewal, shall also pay the prescribed delinquency fee. Renewal under this section shall be effective on the date on which the application is filed, on the date on which all renewal fees are paid, or on the date on which the delinquency fee is paid, whichever last occurs. If so renewed, the license or registration shall continue in effect through the expiration date provided in Section 2535, after the effective date of the renewal, when it shall expire and become invalid if it is not again renewed.

**BPC section 2535.4.**
A person who fails to renew their license or registration within the five years after its expiration may not renew it, and it may not be restored, reissued, or reinstated thereafter, but that person may apply for and obtain a new license or registration if they meet all of the following requirements:
(a) Have not committed any acts or crimes constituting grounds for denial of licensure or registration under Division 1.5 (commencing with Section 475).
(b) Take and pass the examination or examinations, if any, that would be required of them if an initial application for licensure or registration was being made, or otherwise establishes to the satisfaction of the board that, with due regard for the public interest, they are qualified to practice as a speech-language pathologist or audiologist, as the case may be.
(c) Pays all of the fees that would be required if an initial application for licensure or registration was being made. In addition, the board may charge the applicant a fee to cover the actual costs of any examination that it may administer.

**BPC section 2538.3.**
A person applying for approval as a speech-language pathology assistant shall have graduated from a speech-language pathology assistant associate degree program, or equivalent course of study, approved by the board. A person who has successfully graduated from a board-approved bachelor's degree program in speech-language pathology, ~~or~~ communication disorders, speech, language and hearing sciences, communication sciences and disorders, or communicative disorders shall be deemed to have satisfied an equivalent course of study.

**BPC section 2538.5.**
This article shall not be construed to limit the utilization of a speech aide or other personnel employed by a public school working under the direct supervision of a credentialed speech-language pathologist as set forth in subdivision (c) of Section 3051.1 of Title 5 of the California Code of Regulations so long as the speech or personnel is not performing the

scope of responsibility, duties, and functions of speech-language pathology assistants as described in 2538.1(b)(4).

**BPC section 2538.7.**
(a) No person who is not registered as a speech-language pathology assistant shall utilize the title speech-language pathology assistant, SLP assistant, or the letters "SLPA," or a similar title that includes the words speech or language when combined with the term assistant.
(b) No person who is not registered as a speech-language pathology assistant shall perform the duties or functions of a speech-language pathology assistant, except as provided by this article~~chapter~~.

**BPC section 2538.8**
A speech-language pathology assistant shall not advertise or otherwise represent that they hold a license as a speech-language pathologist.

**BPC section 2538.10**
For the purposes of this article, the following definitions shall apply:
(a) "Advertise" and its variants include the use of a newspaper, magazine, social media, or other publication, book, notice, circular, pamphlet, letter, handbill, poster, bill, sign, placard, card, label, tag, window display, store sign, radio, or television announcement, or any other means or methods now or hereafter employed to bring to the attention of the public the practice of fitting or selling of hearing aids.
(b) "License" means a ~~hearing aid dispenser~~ license to engage in the practice of fitting or selling hearing aids to an individual or individuals with impaired hearing ~~issued pursuant to this article and includes a temporary or trainee license.~~
(c) "Licensee" means a person holding a license issued pursuant to this article and includes a permanent, temporary, or trainee license.
(d) "Hearing aid" means any wearable instrument or device designed for, or offered for the purpose of, aiding or compensating for impaired human hearing.
(e) "Fund" means the Speech-Language Pathology and Audiology and Hearing Aid

**BPC section 2538.11**
(a) "Practice of fitting or selling hearing aids," as used in this article, means those practices used for the purpose of selection and adaptation of hearing aids, including direct observation of the ear, testing of hearing in connection with the fitting and selling of hearing aids, taking of ear mold impressions, fitting or sale of hearing aids, and any necessary postfitting counseling.
The practice of fitting or selling hearing aids does not include the act of concluding the transaction by a retail clerk.
When any audiometer or other equipment is used in the practice of fitting or selling hearing aids, it shall be kept properly calibrated and in good working condition, and the calibration of the audiometer or other equipment shall be checked at least annually.
(b) A ~~hearing aid dispenser~~ licensee shall not conduct diagnostic hearing tests when conducting tests in connection with the practice of fitting or selling hearing aids.
(c) Hearing tests conducted pursuant to this article shall include those that are in compliance with the Food and Drug Administration Guidelines for Hearing Aid Devices and those that are specifically covered in the licensing examination prepared and administered by the board.

**BPC section 2538.13**
In fitting hearing aids, a ~~hearing aid dispenser~~ licensee shall not take facial measurements or fit, adjust, or adapt lenses or spectacle frames, except that a hearing aid dispenser may replace the temple or temples of a person's spectacle frames with a temple or temples incorporating hearing aid components.

**BPC section 2538.14**
"Hearing aid dispenser," as used in this article, means a person issued a permanent license pursuant to this article~~engaged in the practice of fitting or selling hearing aids to an individual with impaired hearing~~.

**BPC section 2538.18.**
All ~~holders of licenses to sell or fit hearing aids~~hearing aid dispensers shall continue their education after receiving ~~the~~their license. The board shall provide by regulation, as a condition to the renewal of a license, that ~~licensees~~the hearing aid dispenser shall submit documentation satisfactory to the board that they have informed themselves of current practices related to the fitting of hearing aids by having pursued courses of study satisfactory to the board or by other means defined as equivalent by the board.

Continuing education courses shall be subject to monitoring to ensure compliance with the regulations adopted by the board pursuant to this section.

**BPC section 2538.20.**
Except for what is prohibited by Section 655.2 and Section 13404.5 and 17701.04 of the Corporations Code, it~~:~~ is unlawful for an individual to engage in the practice of fitting or selling hearing aids, or to display a sign or in any other way to advertise or hold themselves out as being so engaged without having first obtained a license from the board under the provisions of this article. Nothing in this article shall prohibit a corporation, partnership, trust, association, or other like organization maintaining an established business address from engaging in the business of fitting or selling, or offering for sale, hearing aids at retail without a license, provided that any and all fitting or selling of hearing aids is conducted by the individuals who are licensed pursuant to the provisions of this article. A person whose license as a hearing aid dispenser has been suspended or revoked shall not be the proprietor of a business that engages in the practice of fitting or selling hearing aids nor shall that person be a partner, shareholder, member, or fiduciary in a partnership, corporation, association, or trust that maintains or operates that business, during the period of the suspension or revocation. This restriction shall not apply to stock ownership in a corporation that is listed on a stock exchange regulated by the Securities and Exchange Commission if the stock is acquired in a transaction conducted through that stock exchange.

**BPC section 2538.23.**
(a) Hearing aids may be sold online, by catalog, or direct mail provided that:
(1) The seller is licensed as a hearing aid dispenser in this state.
(2) There is no fitting, selection, or adaptation of the instrument and no advice is given with respect to fitting, selection, or adaptation of the instrument and no advice is given with respect to the taking of an ear impression for an earmold by the seller.
(3) The seller has received a statement which is signed by a physician and surgeon, audiologist, or a hearing aid dispenser, licensed by the State of California which

verifies that Section 2538.36 and subdivision (b) of Section 2538.49 have been complied with.

(b) A copy of the statement referred to in paragraph (3) of subdivision (a) shall be retained by the seller for the period provided for in Section 2538.38.

(c) A licensed hearing aid dispenser who sells a hearing aid under this section shall not be required to comply with subdivision (b) of Section 2538.49.

**BPC section 2538.26.**

The board shall issue a license to all applicants who have satisfied this article~~chapter~~, who are at least 18 years of age, who possess a high school diploma or its equivalent, who have not committed acts or crimes constituting grounds for denial of licensure under Section 480, and who have paid the fees provided for in Section 2538.57. No license shall be issued to any person other than an individual.

**BPC section 2538.28.**

(a) An applicant who has fulfilled the requirements of Section 2538.24, and has made application therefor, and who proves to the satisfaction of the board that they will be supervised and trained by a hearing aid dispenser who is approved by the board may have a trainee license issued to them. The trainee license shall entitle the trainee licensee to fit or sell hearing aids as set forth in regulations of the board. The supervising dispenser shall be responsible for any acts or omissions committed by a trainee licensee under their supervision that may constitute a violation of this article~~chapter~~.

(b) The board shall adopt regulations setting forth criteria for its refusal to approve a hearing aid dispenser to supervise a trainee licensee, including procedures to appeal that decision.

(c) A trainee license issued pursuant to this section is effective and valid for six months from date of issue. The board may renew the trainee license for an additional period of six months. Except as provided in subdivision (d), the board shall not issue more than two renewals of a trainee license to any applicant. Notwithstanding subdivision (d), if a trainee licensee who is entitled to renew a trainee license does not renew the trainee license and applies for a new trainee license at a later time, the new trainee license shall only be issued and renewed subject to the limitations set forth in this subdivision.

(d) A new trainee license may be issued pursuant to this section if a trainee license issued pursuant to subdivision (c) has lapsed for a minimum of three years from the expiration or cancellation date of the previous trainee license. The board may issue only one new trainee license under this subdivision.

**BPC section 2538.37.**

No hearing aid shall be sold by an individual licensed under this article~~chapter~~, to a person 16 years of age or younger, unless within the preceding six months a recommendation for a hearing aid has been made by both a board-certified, or a board-eligible physician specializing in otolaryngology, and by a state licensed audiologist. A replacement of an identical hearing aid within one year shall be an exception to this requirement.

**BPC section 2538.38.**

A ~~licensee~~ hearing aid dispenser shall, upon the consummation of a sale of a hearing aid, keep and maintain records in the licensee's office or place of business at all times and each record shall be kept and maintained for a seven-year period. All records related to the sale and fitting of hearing aids shall be open to inspection by the board or its authorized representatives upon reasonable notice. The records kept shall include:

(a) Results of test techniques as they pertain to fitting of the hearing aid.

(b) A copy of the written notice and the written receipt required by Section 2538.35 and the written recommendation and receipt required by Section 2538.36 when applicable.
(c) Records of maintenance or calibration of equipment used in the practice of fitting or selling hearing aids.

**2538.48.**
It is unlawful to engage in the practice of fitting or selling hearing aids in this state without having at the time of so doing a valid, unrevoked, and unexpired license ~~or temporary license~~.

**BPC section 2538.49**
It is unlawful for a licensee ~~licensed hearing aid dispenser~~ to fit or sell a hearing aid unless they first do all of the following:
(a) Comply with all provisions of state laws and regulations relating to the fitting or selling of hearing aids.
(b) Conduct a direct observation of the purchaser's ear canals.
(c) Inform the purchaser of the address and office hours at which the licensee shall be available for fitting or postfitting adjustments and servicing of the hearing aid or aids sold.

**BPC section 2538.50.**
It is unlawful to advertise by displaying a sign or otherwise or hold themselves out to be a person engaged in the practice of fitting or selling hearing aids without having at the time of so doing a valid, unrevoked license ~~or temporary license~~.

**BPC section 2538.51**
It is unlawful to engage in the practice of fitting or selling hearing aids without the ~~licensee~~hearing aid dispenser having ~~and maintaining~~ an established business address, routinely open for service to their clients.

**BPC section 2538.53.**
(a) A license issued under this article expires at midnight on its assigned renewal date.
(b) To renew an unexpired permanent license, the ~~licensee~~hearing aid dispenser shall, on or before the date of expiration of the license, apply for renewal on a form provided by the board, accompanied by the prescribed renewal fee.
(c) ~~Temporary~~Trainee license holders shall renew their ~~licenses~~license in accordance with Section 2538.28~~2538.27~~, and apply for that renewal on a form provided by the board, accompanied by the prescribed renewal fee for ~~temporary licenses~~trainee license.
(d) Each ~~duplicate~~ license issued for a branch office shall expire on the same date as the permanent license of the hearing aid dispenser to whom the ~~duplicate~~branch office license was issued. ~~These duplicate~~Branch office license or licenses shall be renewed according to subdivision (b).

**BPC section 2538.57**
The amount of fees and penalties prescribed by this article shall be those set forth in this section unless a lower fee is fixed by the board:
(a) The fee for applicants applying for the first time for a license is seventy-five dollars ($75), which shall not be refunded, except to applicants who are found to be ineligible to take an examination for a license. Those applicants are entitled to a refund of fifty dollars ($50).
(b) The fees for taking or retaking the written and practical examinations shall be amounts fixed by the board, which shall be equal to the actual cost of preparing, grading, analyzing, and administering the examinations.

(c) The initial temporary or trainee license fee is one hundred dollars ($100). The fee for renewal of a ~~temporary~~trainee license is one hundred dollars ($100) for each renewal.
(d) The initial permanent license fee is two hundred eighty dollars ($280). The fee for renewal of a permanent license is not more than two hundred eighty dollars ($280) for each renewal.
(e) The initial branch office license fee is twenty-five dollars ($25). The fee for renewal of a branch office license is twenty-five dollars ($25) for each renewal.
(f) The delinquency fee is twenty-five dollars ($25).
(g) The fee for issuance of a replacement license is twenty-five dollars ($25).
(h) The continuing education course approval application fee is fifty dollars ($50).
(i) The fee for official certification of licensure is fifteen dollars ($15).

**BPC section 2539.1.**

(a) (1) ~~On and after January 1, 2010, in~~In addition to satisfying the licensure and examination requirements described in Sections 2532, 2532.2, and 2532.25, no licensed audiologist shall sell hearing aids unless they complete an application for a dispensing audiology license, pay all applicable fees, and pass an examination, approved by the board, relating to selling hearing aids.
(2) The board shall issue a dispensing audiology license to a licensed audiologist who meets the requirements of paragraph (1).

(b) ~~(1) On and after January 1, 2010, a licensed audiologist with an unexpired license to sell hearing aids pursuant to Article 8 (commencing with Section 2538.10) may continue to sell hearing aids pursuant to that license until that license expires pursuant to Section 2538.53, and upon that expiration the licensee shall be deemed to have satisfied the requirements described in subdivision (a) and may continue to sell hearing aids pursuant to their audiology license subject to this chapter. Upon the expiration of the audiologist's license to sell hearing aids, the board shall issue them a dispensing audiology license pursuant to paragraph (2) of subdivision (a). This paragraph~~The Board shall not prevent an audiologist who also has a hearing aid dispenser license from maintaining dual or separate licenses if they choose to do so. ~~(2) A licensed audiologist whose license to sell hearing aids, issued pursuant to Article 8 (commencing with Section 2538.10), is suspended, surrendered, or revoked shall not be authorized to sell hearing aids pursuant to this subdivision and they shall be subject to the requirements described in subdivision (a) and the other provisions of this chapter.~~

(c) A licensed hearing aid dispenser who meets the qualifications for licensure as an audiologist described in Sections 2532, 2532.2, and 2532.25 shall be deemed to have satisfied the requirements of paragraph (1) of subdivision (a) for the purposes of obtaining a dispensing audiology license.
(d) For purposes of subdivision (a), the board shall provide the hearing aid dispenser examination provided by the former Hearing Aid Dispensers Bureau until the next examination validation and occupational analysis is completed by the Department of Consumer Affairs pursuant to Section 139 and a determination is made that a different examination is to be administered.

**BPC section 2539.2.**

(a) Hearing aids may be sold online, by catalog, or direct mail provided that:
(1) The seller is licensed as an audiologist in this state and is authorized to sell hearing aids pursuant to Section 2539.1.
(2) There is no fitting, selection, or adaptation of the instrument and no advice is given with respect to fitting, selection, or adaptation of the instrument and no

advice is given with respect to the taking of an ear impression for an earmold by the seller.

(3) The seller has received a statement which is signed by a physician and surgeon, audiologist, or a hearing aid dispenser, licensed by the State of California which verifies that Section 2539.6 has been complied with.

(b) A copy of the statement referred to in paragraph (3) of subdivision (a) shall be retained by the seller for the period provided for in Section 2539.10.

**BPC section 2539.6.**

(a) Whenever any of the following conditions are found to exist either from observations by the licensed dispensing audiologist or on the basis of information furnished by the prospective hearing aid user, a licensed dispensing audiologist shall, prior to fitting or selling a hearing aid to any individual, suggest to that individual in writing that the individual's best interests would be served if they consult a licensed physician and surgeon specializing in diseases of the ear or, if none are available in the community, a duly licensed physician and surgeon:

(1) Visible congenital or traumatic deformity of the ear.

(2) History of, or active, drainage from the ear within the previous 90 days.

(3) History of sudden or rapidly progressive hearing loss within the previous 90 days.

(4) Acute or chronic dizziness.

(5) Unilateral hearing loss of sudden or recent onset within the previous 90 days.

(6) Significant air-bone gap (when generally acceptable standards have been established).

(7) Visible evidence of significant cerumen accumulation or a foreign body in the ear canal.

(8) Pain or discomfort in the ear.

(b) No referral for medical opinion need be made by any licensed dispensing audiologist in the instance of replacement only of a hearing aid that has been lost or damaged beyond repair within one year of the date of purchase. A copy of the written recommendation shall be retained by the licensed dispensing audiologist for the period provided for in Section 2539.10. A person receiving the written recommendation who elects to purchase a hearing aid shall sign a receipt for the same, and the receipt shall be kept with the other papers retained by the licensed dispensing audiologist for the period provided for in Section 2539.10. Nothing in this section required to be performed by a licensed dispensing audiologist shall mean that the licensed dispensing audiologist is engaged in the diagnosis of illness or the practice of medicine or any other activity prohibited by the provisions of this code.

**BPC section 2539.8.**

~~No hearing aid shall be sold by an individual licensed as an audiologist under this chapter to a person 16 years of age or younger, unless within the preceding six months a recommendation for a hearing aid has been made by both a board-certified, or a board-eligible physician specializing in otolaryngology, and by a state licensed audiologist. A replacement of an identical hearing aid within one year shall be an exception to this requirement.~~

**BPC section 2539.12.**

A licensed dispensing audiologist who is the owner, manager, or franchisee at a location where hearing aids are fit or sold, shall be responsible for the adequacy of the fitting or selling of any hearing aid fit and sold by any licensee or licensees at that location.

**BPC section 2539.14.**
(a) A licensed dispensing audiologist who satisfies the requirements of Section 2539.1 is authorized to sell hearing aids pursuant to the requirements in Article 8 (commencing with Section 2538.10).
(b) TheThe provisions of subdivisions (b) and (c) of Section 2538.11, and the provisions of Section 2538.12, and the provisions of Section 2538.37 do not apply to a licensed audiologist who satisfies the requirements of Section 2539.1.

**BPC section 2539.15**
All dispensing audiologists shall continue their education after receiving their license. The board shall provide by regulation, as a condition to the renewal of a license, that the dispensing audiologist shall submit documentation satisfactory to the board that they have informed themselves of current practices related to audiology and the fitting of hearing aids by having pursued courses of study satisfactory to the board or by other means defined as equivalent by the board.
Continuing education courses shall be subject to monitoring to ensure compliance with the regulations adopted by the board pursuant to this section.

**BPC section 2539.16**
(a) A license issued under this article expires at midnight on its assigned renewal date.
(b) To renew an unexpired license, the licensee shall, on or before the date of expiration of the license, apply for renewal on a form provided by the board, accompanied by the prescribed renewal fee.

**BPC section 2539.17**
Except as otherwise provided in this article, an expired license may be renewed at any time within three years after its expiration on filing of an application for renewal on a form prescribed by the board, and payment of all accrued and unpaid renewal fees. If the license is renewed after its expiration the licensee, as a condition precedent to renewal, shall also pay the delinquency fee prescribed by this article. Renewal under this section shall be effective on the date on which the application is filed, on the date on which the renewal fee is paid, or on the date on which the delinquency fee, if any, is paid, whichever last occurs. If so renewed, the license shall continue in effect through the date provided in Section 2539.16 which next occurs after the effective date of the renewal, when it shall expire if it is not again renewed.

**BPC section 2539.18**
A license which has been suspended is subject to expiration and shall be renewed as provided in this article but such renewal does not entitle the holder of the license, while it remains suspended and until it is reinstated, to engage in the fitting or selling of hearing aids, or in any other activity or conduct in violation of the order or judgment by which the license was suspended. A license which has been revoked is subject to expiration, but it may not be renewed. If it is reinstated after its expiration, the licensee, as a condition precedent to its reinstatement, shall pay a reinstatement fee in an amount equal to the renewal fee in effect on the last regular renewal date before the date on which it is reinstated, plus the delinquency fee, if any, accrued at the time of its revocation.

**BPC section 2539.19**
A license that is not renewed within three years after its expiration may not be renewed, restored, reissued, or reinstated thereafter, but the holder of the expired license may apply for and obtain a new license if all of the following apply:

(a) They have not committed acts or crimes constituting grounds for denial of licensure under Section 480.
(b) They pay all of the fees that would be required if they were applying for a license for the first time.
(c) They take and pass the examination that would be required if they were applying for a license for the first time or otherwise establish to the satisfaction of the board that, with due regard for the public interest, they are qualified to practice as a dispensing audiologist.

- New issues raised by the Committees.

  None at this time.

## Section 11
## Attachments

Please provide the following attachments:

A. Board's administrative manual

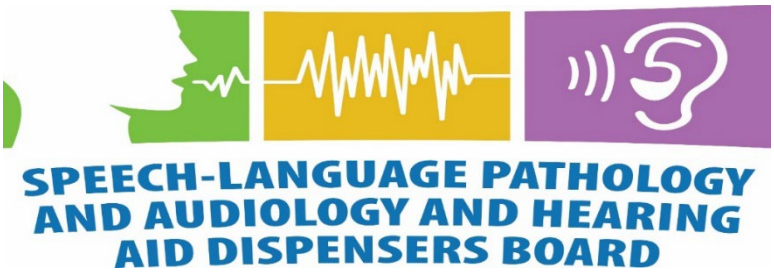
B. Current organizational chart showing relationship of committees to the board and membership of each committee (cf., Section 1, Question 1)

C. Major studies, if any (cf., Section 1, Question 4)

D. Year-end organization charts for last four fiscal years. Each chart should include number of staff by classifications assigned to each major program area (licensing, enforcement, administration, etc.) (cf., Section 2, Question 15)

E. Board's Strategic Plan 2025 - 2028

# Attachment A




# Board Administrative Procedure Manual

**May 2025**

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**ATTACHMENTS**
Attachment A: Guide to the Bagley-Keene Open Meeting Act
Attachment B: Department of Consumer Affairs Travel Guide
Attachment C: Sunset Review Report
Attachment D: Strategic Plan
Attachment E: Law Book

# CHAPTER 1. INTRODUCTION

## Overview

In 1973, the Legislature established the Speech-Language Pathology and Audiology Board (SLPAB) to protect the public from the unauthorized and unqualified practice of speech-language pathology and audiology. The SLPAB licensed speech-language pathologists and audiologists. A speech-language pathologist provides services in the areas of speech, language, voice, cognition, fluency, and swallowing disorders to individuals across the lifespan. They see individuals who may have language difficulties with verbal expression, auditory comprehension, reading comprehension, and/or written expression. A speech-language pathologist also provides aural rehabilitation for individuals who are deaf or hard of hearing and provides therapy in the augmentative and alternative communication domain for individuals with diagnoses such as autism spectrum disorder and progressive neurological disorders. An audiologist provides services for individuals with hearing loss and balance (vestibular) disorders across the lifespan.

In 2001, the Legislature created the Hearing Aid Dispensers Bureau (HADB) as the licensing and regulatory agency for hearing aid dispensers, defined in statute as individuals engaged in the fitting or selling of hearing aids to an individual with impaired hearing. The HADB was charged with the education and protection of consumers in the purchase of hearing aids by ensuring the competency of hearing aid dispensers.

In 2010 the SLPAB and HADB were merged to create a new entity, the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board (Board). It also changed the governance structure of the Board to the following: two speech-language pathologists, two audiologists (one of whom must be a dispensing audiologist), and two hearing aid dispensers, all to be appointed by the Governor. The Governor also has the appointing authority for a public member seat to be occupied by a licensed physician and surgeon, certified in otolaryngology. Two other public member seats are to be appointed by the Senate Committee on Rules and the Speaker of the Assembly, respectively. Board members may serve up to two, four-year terms. Board members are paid $100 for each day actually spent in the discharge of official duties and are reimbursed travel expenses.

The Board is one of the boards, bureaus, commissions, and committees within the Department of Consumer Affairs (DCA), part of the Business, Consumer Services and Housing Agency under the aegis of the Governor. DCA is responsible for consumer protection and representation through the regulation of licensed professions and the provision of consumer services. While DCA provides administrative oversight and support services, the Board has policy autonomy and sets its own policies, procedures, and initiates its own regulations.

Protection of the public is the highest priority for the Board in exercising its licensing, regulatory and disciplinary functions. Whenever the protection of the public is

inconsistent with other interests sought to be promoted, the protection of the public shall be paramount (Business and Professions Code (BPC) §2531.02.)

The purpose of this handbook is to provide guidance to Board members regarding general processes and procedures involved with their position on the Board. It also serves as a useful source of information for new Board members as part of the induction process.

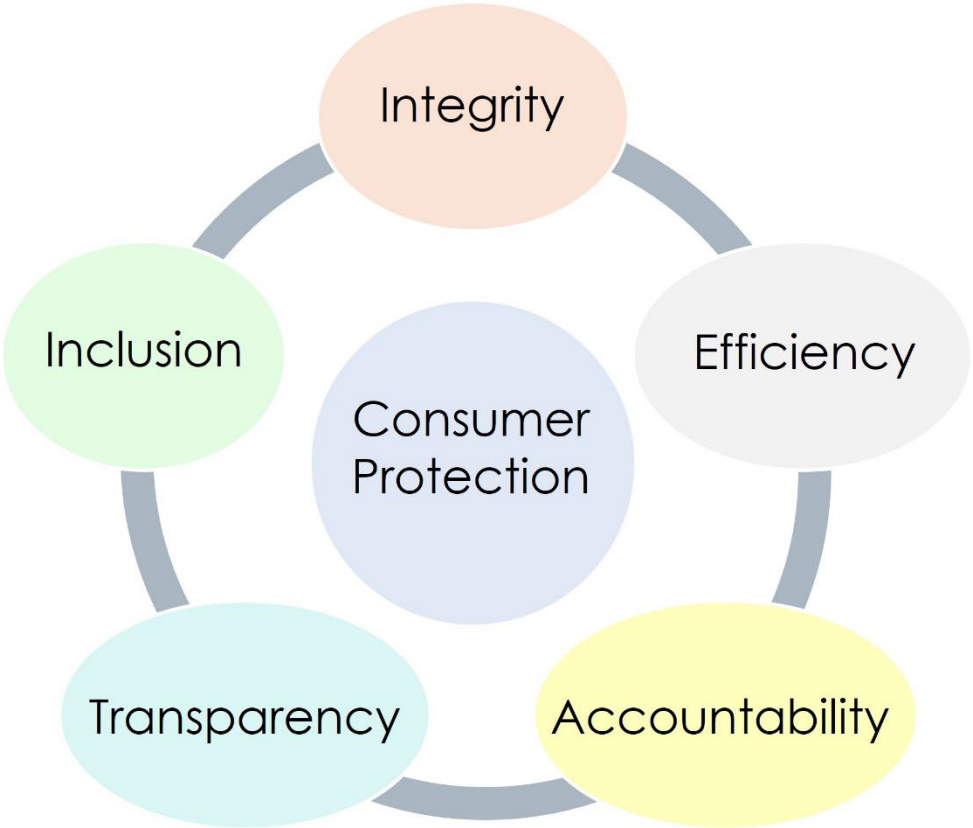
**Mission**

We protect the people of California by promoting standards and enforcing the laws and regulations that ensure the qualifications and competence of providers of speech-language pathology, audiology and hearing aid dispensing services.

**Vision**

Every person in the State of California has access to the highest quality diagnosis and treatment of communication and hearing disorders, and related services.

**Values**




**Board Function**

The Board regulates the practices of speech-language pathology, audiology, and hearing aid dispensing in California by licensing those who meet minimum standards of competency. Among its functions, the Board promulgates laws and regulations; issues, renews, suspends, and revokes licenses; and imposes disciplinary sanctions, when necessary.

**General Rules of Conduct**

The following rules of conduct detail expectations of Board members. The Board is comprised of both public and professional members with the intention that, together, the Board can collectively protect the public and regulate the speech-language pathology, audiology and hearing aid dispensing professions.

- Board members' actions shall serve to uphold the principle that the Board's primary mission is to protect the public.
- Board members shall recognize the equal role and responsibilities of all Board members.
- Board members shall adequately prepare for Board responsibilities.
- Board members shall not speak or act for the Board without proper authorization.
- Board members shall maintain the confidentiality of non-public documents and information.
- Board members shall act fairly and be nonpartisan, impartial and unbiased in their role of protecting the public.
- Board members shall treat all applicants, candidates, and licensees in a fair and impartial manner.
- Board members shall not use their positions on the Board for personal, familial or financial gain.

## CHAPTER 2. BOARD MEETING PROCEDURES

All healing arts boards under DCA, including the Board must meet in accordance with the provisions set forth by the Bagley-Keene Open Meeting Act. The Board will use Robert's Rules of Order, to the extent that it does not conflict with state law (e.g., Bagley-Keene Open Meeting Act), as a guide when conducting the meetings.

### Bagley-Keene Open Meetings Act

The Bagley-Keene Act of 1967, officially known as the Bagley-Keene Open Meeting Act, implements a provision of the California Constitution which declares that "the meetings of public bodies and the writings of public officials and agencies shall be open to public scrutiny," and explicitly mandates open meetings for California State agencies, Boards, and commissions. The act facilitates accountability and transparency of government activities and protects the rights of citizens to participate in State government deliberations. Similarly, California's Brown Act of 1953 protects citizen rights with regard to open meetings at the county and local government level.

The Bagley-Keene Act stipulates that the Board is to provide adequate notice of meetings to be held to the public as well as provide an opportunity for public comment. The meeting is to be conducted in an open session, except where closed session is specifically noted.

The Bagley-Keene Act also stipulates that a majority of the Board members cannot participate in a series of communications of any kind, directly or through personal intermediaries, or technological devices (such as email) to discuss, deliberate, or take action on any matter within the subject matter of the Board's jurisdiction outside of the Board meetings.

To learn all of the provisions set forth by the Bagley-Keene Open Meeting Act, see Attachment A entitled *Guide to the Bagley-Keene Open Meeting Act*.

### Frequency of Meetings

The Board is mandated to hold two meetings annually (BPC section 101.7) but generally meets four times annually to make policy decisions and review committee recommendations. Additional meetings may be called by the Chair or by written request of any two members of the Board. The Board is required to hold at least one meeting in Northern California and one meeting in Southern California, but endeavors to meet in different geographic locations throughout the state when possible as a convenience to the public and licensees. To enhance opportunities for public participation, web-based teleconference is offered at all meetings, when available.

### Board Member Attendance at Board Meetings

Board members must attend each meeting of the Board. Meeting dates are approved by the Board at the last Board meeting of the calendar year.

If a member is unable to attend, they are asked to contact the Board Chair and the Executive Officer and provide a reason to be excused from the meeting.

**Quorum**

Five Board members constitute a quorum of the Board for the transaction of business. Either having members physically in attendance or by teleconference, with proper notice, can meet the requirement for a quorum. The concurrence of a majority of those members of the Board present and voting at a meeting duly held at which a quorum is present shall be necessary to constitute an act or decision of the Board.

**Agenda Items (Government Code (GC) § 11125 et seq.)**

Any Board members may submit items for a Board Meeting agenda to the Board Chair with a copy to the Executive Officer six to eight weeks prior to the meeting. Members may also recommend agenda items for a future meeting agenda during a meeting under Future Agenda Items. A motion and vote may be taken but is not necessary. The Board Chair will confer with the Executive Officer and Board Legal Counsel regarding the future agenda items. It will be a standing item to review the status of future agenda items that have been recommend by Board members that may not have made the current Board Meeting agenda.

Staff maintains a list of action items to research and bring back to a future Board Meeting. Staff may recommend the issue be referred to a Committee first to be vetted. Prior to items being placed on the agenda, staff conducts research to determine if an item is appropriate for Board discussion. This research starts with identifying how the item meets our mandate to protect the health and safety of California consumers. In addition, staff researches potential benefits to the State, identifies the current professional trends and what other states are doing. For items requiring legislative and/or regulatory changes, staff identifies potential concerns by anticipating who would be in support of or in opposition to the bill and/or rulemaking.

No item shall be added to the agenda subsequent to the provision of the meeting notice.

If the agenda contains matters that are appropriate for closed session, the agenda shall cite the particular statutory section and subdivision authorizing the closed session.

Items not included on the agenda may not be discussed.

**Notice of Meetings (GC § 11120 et seq.)**

The minutes are a summary, not a transcript, of each Board Meeting. They shall be prepared by Board staff and submitted for review by Board members before the next

Board Meeting. Board Minutes shall be approved at the next scheduled meeting of the Board. When approved, the minutes shall serve as the official record of the meeting and be made available to the public on the Board's website.

**Recording of Meetings**

The meetings are recorded and available to the public on the Board's website.

**Use of Electronic Devices During Meetings**

Members should not text or email each other during an open meeting on any matter within the Board's jurisdiction.

Use of electronic devices, including laptops, during the meetings is solely limited to access the Board Meeting materials that are in electronic format or to participate in web-based teleconference meetings.

**Making a Motion at Meetings**

When new business is to be introduced or a decision or action is to be proposed, Board members should make a motion to introduce a new piece of business or to propose a decision or action. All motions must reflect the content of the meeting's agenda – the Board cannot act on business that is not listed on the agenda.

Upon making a motion, Board members must speak slowly and clearly as the motion is being recorded. Members who opt to second a motion simply say, "I second the motion," "I second it," or "Second." Additionally, it is important to remember that once a motion has been made and seconded, it is inappropriate to make a second motion until the initial one has been resolved or withdrawn.

The basic process of a motion is as follows:

1. An agenda item has been thoroughly discussed and reviewed.

2. The Board Chair opens a forum for a member to make a motion on the discussed item.

3. A member makes a motion before the Board.

4. Another member seconds the motion.

5. The Board Chair solicits additional comment from the Board and then the public.

6. The Board Chair puts forth the motion to a vote.

7. The vote of each Board member shall be recorded via rollcall vote. Members in favor of the motion say “aye” and members opposed to the motion say “no.” Members may also vote to “abstain” meaning a non-vote. Members may also vote to “recuse” meaning that they disqualify themselves from participation in a decision on grounds such as potential conflict of interest or personal involvement. Recusal is the proper response to a conflict of interest. No vote will be recorded for a member who has been “recused” for a particular item. A member who has recused themselves from an item must leave the dais and not participate in discussion or voting on the item.

8. Upon completion of the voting, the result of the vote will be announced (e.g., “the ayes have it and the motion passes” or “the no’s have it and the motion fails”).

## CHAPTER 3. TRAVEL & SALARY POLICIES & PROCEDURES

### Travel Approval (DCA Travel Guide)

Board members shall have the Executive Officer's approval for travel except for regularly scheduled Board and Committee Meetings to which the Board member is assigned.

### Travel Arrangements

Board staff will assist Board members in making travel arrangements for each Board member as required. These arrangements will be made through the appropriate State employee systems for booking travel.

### Out-of-State Travel (State Administrative Manual § 700 et seq.)

For out-of-state travel, Board members will be reimbursed for actual lodging expenses, supported by vouchers, and will be reimbursed for meal and supplemental expenses. Out-of-state travel for all persons representing the state of California is controlled and must be approved by the Governor's Office and the Department of Consumer Affairs.

### Travel Claims (State Administrative Manual § 700 et seq. and DCA Travel Guide)

Rules governing reimbursement of travel expenses for Board members are the same as for management-level state staff. All expenses shall be claimed on the appropriate travel expense claim forms. Board members will be provided with completed travel claim forms submitted on their behalf. Board staff maintains these forms and completes them as needed. It is advisable for Board members to submit their travel expense forms immediately after returning from a trip and not later than two weeks following the trip.

In order for the expenses to be reimbursed, Board members shall follow the procedures contained in DCA Travel Guide provided as Attachment B.

### Salary Per Diem (BPC § 103)

Compensation in the form of salary per diem and reimbursement of travel and other related expenses for Board members is regulated by BPC § 103.

This section also provides for the payment of salary per diem for Board members "for each day actually spent in the discharge of official duties," and provides that the Board members "shall be reimbursed for traveling and other expenses necessarily incurred in the performance of official duties." "Official duties" includes, but is not limited to, authorized attendance at other gatherings, events, meetings, hearings, or conferences, and committee work; review of enforcement cases to submit a ballot vote; time spent to prepare for Board or Committee Meetings; and time spent traveling to and from a Board or Committee Meeting.

## CHAPTER 4. SELECTION OF OFFICERS AND COMMITTEES

### Officers of the Board

The Board shall elect from its members a Chair and Vice Chair to hold office for one year or until their successors are duly elected and qualified.

### Roles and Responsibilities of Board Officers

### Chair

- **Board Business**: Conducts the Board's business in a professional manner and with appropriate transparency. Adheres to the highest ethical standards and uses Roberts Rules of Order as a guide and the Bagley-Keene Open Meetings Act during all Board Meetings.

- **Board Vote**: Conducts rollcall vote or delegates it to a staff.

- **Board Affairs**: Ensures that Board matters are handled properly, including preparation of pre-meeting materials, committee functioning, and orientation of new Board members.

- **Governance**: Ensures the prevalence of Board governance policies and practices. Acts as a representative of the Board as a whole.

- **Board Meeting Agendas**: Develops agendas for meetings with the Executive Officer and Legal Counsel. Presides at Board Meetings.

- **Executive Officer**: Establishes search and selection committee who will work with DCA in hiring an Executive Officer. Convenes Board discussions for the annual performance appraisal of the Executive Officer each calendar year.

- **Board Committees**: Seeks volunteers for committees and coordinates individual Board members assignments. Makes sure each committee has a chairperson, and stays in touch with chairpersons to be sure that their work is carried out. Obtains a debrief from each Board Committee chairperson at the next Board Meeting.

- **Yearly Board Officers Elections**: Notify members of Board Officers election prior to the last Board meeting of the calendar year.

- **Community and Professional Representation**: Represents the Board in the community on behalf of the organization as does the Executive Officer.

- **Sunset**: Develops, with the Vice Chair and staff, the Board's Sunset Review Report to the California Legislature for the Board's review.

**Vice Chair**

- **Board Business**: Performs the duties and responsibilities of the Chair when the Chair is absent.

- **Board Budget**: Serves as the Board's budget liaison with staff and may assist staff in the monitoring and reporting of the budget to the Board. Reviews budget change proposals with staff.

- **Strategic Plan**: Serves as the Board's strategic planning liaison with staff and may assist staff in the monitoring and reporting of the strategic plan to the Board.

- **Board Member On-Boarding**: Welcomes new members to the Board and is available to answer questions. May participate in on-Boarding meeting with staff and new members.

- **Sunset**: Develops, with the Chair and staff, the Board's Sunset Review Report to the California Legislature for the Board's review.

**Election of Board Officers**

The Board elects Board Officers at the last meeting of the calendar year. Officers serve a term of one-year, beginning January 1 of the next calendar year. All officers may be elected on one motion as a slate of officers unless more than one Board member is running per office. An officer may be re-elected and serve for more than one term.

**Board Officer Vacancies**

If an office becomes vacant during the year, an election shall be held at the next Board meeting. If the office of the Chair becomes vacant, the Vice Chair shall assume the office of the Chair until the election for Chair is held. Elected officers shall then serve the remainder of the term.

**Committees and Creation of Committees**

The Chair shall establish committees, whether standing or special, as necessary.

The following committees have been created by the Board and consist of Board members that meet on a regular basis for the purpose of discussing specific issues in depth and provide feedback and any recommendations to the full Board:

- Hearing Aid Dispensing Committee – Provides policy and regulatory guidance with respect to HAD practices and recommends scope of practice amendments for consideration.

- Audiology Practice Committee – Addresses changes in practice patterns and recommends position statements and/or scope of practice amendments for consideration.

- Hearing Aid Dispensing Practice Committee – Addresses changes in practice patterns and recommends position statements and/or scope of practice amendments for consideration.

- Speech-Language Pathology Practice Committee – Addresses changes in practice patterns and recommends position statements and/or scope of practice amendments for consideration.

- Sunset Review Ad Hoc Committee – Develop for the Board's review the Board's Sunset Review Report to the California Legislature. See Attachment C for the Sunset Review Report.

- Enforcement Ad Hoc Committee – Review and recommend to the Board proposed revisions to the laws, regulations, and policies related to the Board's enforcement of the Boards Practice Act.

- Legislative Ad Hoc Committee – Review and recommend to the Board proposed positions on legislation impacting the Board, its licensees, and the Board's Practice Act.

**Committee Appointments**

The composition of the committees and the appointment of the members shall be determined by the Board Chair in consultation with the Vice Chair and the Executive Officer. In determining the composition of each committee, the Chair shall solicit interest from the Board members during a public meeting. The Chair shall strive to give each Board member an opportunity to serve on at least one committee. Appointment of non-Board members to a committee is subject to the approval of the Board.

# CHAPTER 5. BOARD ADMINISTRATION AND STAFF

## Board Administration

Board members should be concerned primarily with formulating decisions on Board policies rather than decisions concerning the means for carrying out a specific course of action. It is inappropriate for Board members to become involved in the details of program delivery. Strategies for the day-to-day management of programs, operations and staff shall be the responsibility of the Executive Officer. Board members should not interfere with day-to-day operations, which are under the authority of the Executive Officer.

## Board Staff

The Board's essential functions are comprised of ensuring speech-language pathologists, audiologists, and hearing aid dispensers licensed in the State of California meet professional licensure and examination requirements and follow legal, legislative and regulatory mandates. The Board is also responsible for the enforcement of State of California requirements and regulations as they pertain to licensure and the professions.

## Appointment of Executive Officer

The Board shall employ an Executive Officer and other necessary staff in carrying out the provisions of the Board's Practice Act.

The Executive Officer serves at the pleasure of the Board members who provide direction to the Executive Officer in the areas of program administration, budget, strategic planning, and coordination of meetings. The Executive Officer's salary is based on pay scales set by California Department of Human Resources (Cal HR). The Executive Officer shall be entitled to traveling and other necessary expenses in the performance of their duties as approved by the Board.

## Executive Officer Performance Appraisal

Board members shall conduct an appraisal of the performance of the Executive Officer on an annual basis using the forms created by DCA Office of Human Resources.

## Legal Counsel

The Board's Legal Counsel provides "in-house" counsel. Opinions and counsel provided by the Board's Legal Counsel is protected from public disclosure by the attorney-client privilege.

## Strategic Planning

The Board should update the strategic plan periodically (i.e., every three to five years) with the option to use a facilitator to conduct the plan update. At the end of the calendar year, an annual review conducted by the Board will evaluate the progress toward strategic goal achievement as stated in the strategic plan and identify any areas that may require amending. See Attachment D for the Strategic Plan.

## Legislation

In the event that time constraints preclude Board action on legislation, the Board delegates to the Executive Officer and the Board Chair and Vice Chair the authority to take action on legislation that would affect the Board. The Board shall be notified of such action as soon as possible.

## CHAPTER 6. OTHER POLICIES AND PROCEDURES

### Board Member Orientation and Training (BPC § 453, GC § 11121.9, GC § 12950.1)

Newly appointed and re-appointed members shall complete a training and orientation program provided by DCA within one year of assuming office. This one-day class will discuss Board member obligations and responsibilities.

All Board members shall complete all required training and submit compliance documentation including, but not limited to, the documents specified below:

- Board Member Orientation Training (BMOT) provided by DCA (complete within one (1) year of assuming office).

- Ethics Training provided by the Office of the Attorney General (complete within first six (6) months of assuming office and every two (2) years thereafter).

- Conflict of Interest Filing, *Form 700 – Statement of Economic Interests*, provided by DCA (complete within thirty (30) days of assuming office, every April 1st thereafter, and within thirty (30) days of leaving the Board).

- Sexual Harassment Prevention Training provided by DCA (complete within thirty (30) days of assuming office and every two (2) years thereafter on odd numbered years).

- Defensive Driver Training provided by Department of General Services (complete once every four years).

Upon assuming office, members will receive a copy of the Bagley-Keene Open Meetings Act, which lists public meeting laws that provide the guidelines for Board Meetings (see Attachment A).

Members will also receive a Law book, which includes a copy of the Board's practice act, regulations, disciplinary guidelines, and other related statues (see Attachment E).

Additional Board member resources can be found at https://www.dca.ca.gov/about_us/board_members/.

Business cards can be provided to each Board member with the Board's name, address, telephone, and website address. A Board member's business address, telephone, and email address may be listed on the card at the member's request.

### Board Member Disciplinary Actions

The Board may censure a member if, after a hearing before the Board, the Board determines that the member has acted in an inappropriate manner. The Chair of the

Board shall sit as chair of the hearing unless the censure involves the Chair's own actions, in which case the Vice Chair of the Board shall sit as chair. In accordance with the Bagley-Keene Open Meetings Act, the censure hearing shall be conducted in open session.

**Removal of Board Members (BPC §§ 106 and 106.5)**

The Governor has the power to remove from office at any time any member of any Board appointed by them for continued neglect of duties required by law or for incompetence, unprofessional, or dishonorable conduct. The Governor may also remove from office a Board member who directly or indirectly discloses examination questions from an examination for licensure to an applicant or candidate.

**Resignation of Board Members (GC § 1750)**

In the event that it becomes necessary for a Board member to resign, a letter shall be sent to the appropriate appointing authority (Governor, Senate Rules Committee, or Speaker of the Assembly) with the effective date of the resignation. State law requires written notification. A copy of this letter shall also be sent to the director of DCA, the Board Chair, and the Executive Officer.

**Conflict of Interest (GC § 87100)**

No Board member may make, participate in making, or in any way attempt to use their official position to influence a governmental decision in which they know or have reason to know they have a financial interest. Any Board member who has a financial interest shall disqualify themself from making or attempting to use their official position to influence the decision. Any Board member who believes they are entering into a situation where there is a potential for a conflict of interest should immediately consult the Board's Legal Counsel.

**Contact with Candidates, Applicants and Licensees**

Board members should not intervene on behalf of a candidate or an applicant for licensure for any reason, nor should they intervene on behalf of a licensee. All inquiries regarding licensees, applications, and enforcement matters should be referred to the Executive Officer.

**Communication with Other Organizations and Individuals**

Any and all representations made on behalf of the Board must be made by the Executive Officer or Board Chair, unless approved otherwise. All correspondence shall be issued on the Board's standard letterhead or email and will be created and disseminated by the Executive Officer, or their designee.

## Gifts from Candidates and Applicants

Gifts of any kind to Board members or staff from candidates and applicants for licensure is not permitted and will be promptly returned unless they are perishable goods that cannot effectively be returned to the sender.

## Request for Records Access

Board member may not access the file of a licensee, candidate, or applicant without the Executive Officer's knowledge and approval of the conditions for access. Records or copies of records shall not be removed from the Board's Office.

## Ex Parte Communications (GC § 11430.10 et seq.)

The Government Code contains provisions prohibiting ex parte communications. An ex parte communication is a communication to the decision-maker made by one party to an enforcement action without participation by the other party. While there are specified exceptions to the general prohibition, the key provision is found in subdivision (a) of GC § 11430.10, which states:

> "While the proceeding is pending, there shall be no communication, direct or indirect, regarding any issue in the proceeding to the presiding officer from an employee or representative of an agency that is a party or from an interested person outside the agency, without notice and an opportunity for all parties to participate in the communication."

Board members are prohibited from an ex parte communication with Board enforcement staff while a proceeding is pending. Occasionally, an applicant who is being formally denied licensure, or a licensee against whom disciplinary action is being taken, will attempt to directly contact Board members.

- If the communication is written, the Board member should read only far enough to determine the nature of the communication. Once they realize it is from a person against whom an action is pending, they should reseal any physical documents received and send them to the Executive Officer.

- If the communication is a telephone call, the Board member should immediately tell the person they cannot speak to them about the matter. If the person insists on discussing the case, the person should be told that the Board member will be required to recuse themselves from any participation in the matter. Therefore, continued discussion is of no benefit to the applicant or licensee.

If a Board member believes that they have received an unlawful ex parte communication, they should contact the Board's Legal Counsel for further guidance.

## CHAPTER 7. COMPLAINT AND DISCIPLINARY PROCESS

The Board conducts disciplinary proceedings in accordance with the Administrative Procedure Act, GC § 11370, and those sections that follow. The Board conducts investigations and hearings pursuant to Government Code §§ 11180 through 11191.

The Board also uses its Disciplinary Guidelines and the Uniform Standards Related to Substance Abusing Licensees as a guide when determining appropriate levels of discipline. The Disciplinary Guidelines were established in an effort to provide consistency in determining penalties. Enforcement staff consider the Disciplinary Guidelines when determining whether to seek revocation, suspension, and/or probation of a license. Board members use them when considering cases during hearings. The guidelines are updated when necessary and are distributed to Deputy Attorney Generals and Administrative Law Judges who work on cases with the Board. Disciplinary Guidelines can be found in the Law Book provided as Attachment E.

### Disciplinary Options

The Board has two options available to impose discipline against a licensee. In cases in which the violations do not warrant the revocation of a license or terms and conditions of probation, a citation and fine is issued. In cases in which the violations are egregious and warrant revocation, probation, or public reprimand of the licensee, the Board forwards the matter to the Attorney General's office to pursue formal disciplinary action. Each decision is made in consultation with the Executive Officer.

### Citation and Fine

A citation and fine issued to the licensee is considered an administrative action and is subject to public disclosure. The fines range from $100 to a maximum of $2,500 for each investigation. In specified circumstances, a fine up to a maximum of $5,000 may be issued. All citation and fines issued include an order of abatement in which the licensee must provide information or documentation that the violation has been corrected. The licensee is afforded the opportunity to informally and formally appeal the issuance of the citation and fine as described is Title 16 California Code of Regulations Sections 1399.135-1399.139 and 1399.159-1399.159.4.

### Formal Disciplinary Actions

If after the completion of an investigation, evidence substantiates gross negligence, incompetence, or unprofessional conduct, the enforcement analyst, in consultation with the Enforcement Coordinator and Executive Officer, determines whether the case should be forwarded to the Attorney General's Office for disciplinary action.

### Attorney General's Office

The Attorney General's Office is responsible for prosecuting the administrative case against licensees and registrants (respondents). A respondent might be suspended from practice, have their license revoked, be placed on probation, or be publicly reprimanded, or an applicant may be denied licensure or licensed with probation. A Deputy Attorney General (DAG) in the Attorney General's Office Licensing Unit is assigned to these cases. The DAG works with the Board's enforcement staff to determine whether the necessary evidence exists for a successful prosecution. The burden of proof in these matters must be clear and convincing. Based on the evidence, the DAG makes recommendations regarding prosecution. Although the Board generally takes the advice of counsel, the Board has the discretion to take other action.

**Filing Formal Charges**

Formal charges are almost always filed in cases in which the health and safety of the consumer has been compromised, and in which supporting evidence can be established. The Board's Executive Officer determines whether to file formal charges for any violation of the Board's licensing laws. These formal charges are referred to as pleadings. In each pleading, the Executive Officer of the Board is the complainant.

Pleadings are:

- Accusations: A written statement of charges against the holder of a license or registration, to revoke, suspend or limit the license, specifying the statutes and rules allegedly violated, and the acts or omissions comprising the alleged violations.

- Statement of Issues: A written statement of the reasons for denial of an application for a license or registration, specifying the statutes and rules allegedly violated, and the acts or omissions comprising the alleged violations.

- Petition for reinstatement or reduction of penalty: A person whose license or registration was revoked, suspended or placed on probation can petition for that license or registration to be reinstated, to have the penalty reduced, or for the probation to be terminated.

Many boards have specific regulations relating to petitions. Hearings on petitions usually take place before the Board itself at a scheduled board meeting, with an Administrative Law Judge (ALJ) presiding. The Board usually goes into closed session after the hearing to deliberate and decide the outcome. The ALJ usually prepares the Decision, for signature of the Board Chair. Some boards prefer to have the ALJ, sitting alone, hear petitions and render a proposed decision to the board. This may also happen when the Board does not have a quorum at a board meeting.

**Actions Preceding an Administrative Hearing**

Once an Accusation or Statement of Issues has been filed and the respondent has been served, several outcomes may occur:

- The respondent may wish to settle the matter prior to a formal hearing.

- The respondent may file a notice of defense and request an administrative hearing. All hearings are held before an ALJ from the Office of Administrative Hearings.

- The respondent may fail to respond to the accusation/statement of issues and not file a notice of defense.

At any stage of this process, the Board may withdraw the Accusation or Statement of Issues for any reason or enter into a stipulated settlement with the respondent.

If the respondent fails to respond within fifteen (15) days of receiving the Accusation or Statement of Issues, a Default Decision is issued. Default Decisions result in the revocation or denial of a license.

**Stipulation or Negotiated Settlements**

The licensee or applicant and Board may decide to settle at any time during the administrative process. Usually, stipulations or negotiated settlements, are entered into before an administrative hearing is held to avoid the expense of the hearing while achieving discipline in alignment with the Disciplinary Guidelines. Stipulations prior to an administrative hearing eliminate the six months to one-year delay that may result from attempting to schedule a mutually agreeable hearing date. In some circumstances, the public is better served because the resolution time is reduced, the Board and respondent save time and money, and consumer protection is still maintained.

In negotiating a stipulation, the DAG works closely with the Board's Executive Officer and Enforcement Coordinator to arrive at a stipulation or negotiated settlement that will be acceptable to the Board. Stipulation terms are given to the DAG representing the Board by the enforcement staff with approval of the Executive Officer, utilizing the Board's Disciplinary Guidelines. Stipulations are negotiated and drafted by the DAG, the respondent, and the respondent's legal counsel. Pre-hearing conferences are a more formal method for developing a negotiated settlement. These hearings involve the Executive Officer and/or the Enforcement Coordinator, the respondent, respondent's attorney, and an ALJ.

The settlement is reduced to a written stipulation and order which sets forth the settlement terms and proposed disciplinary order. The written stipulation and order is forwarded to the Board for its consideration.

During the settlement process, the DAG has been advised by the Executive Officer or through the Enforcement Coordinator regarding acceptable terms. The DAG may

advocate before the Board for approval of the settlement. The Board may accept the settlement and issue its decision and order based on the settlement. If the Board rejects the settlement, a new settlement may be submitted to the Board at a later time, or the case may proceed to an administrative hearing before an ALJ.

**Office of Administrative Hearings**

The Office of Administrative Hearings (OAH) consists of two divisions located in six regional offices at major population centers throughout the State. The General Jurisdiction Division conducts hearings, mediations, and settlement conferences for more than 1,000 state, local, and county agencies. This is the division that conducts the hearings for the Board. The Special Education Division conducts hearings and mediations for school districts and parents of children with special education needs throughout the State.

In an administrative hearing, the ALJ presides over the hearing; an attorney (DAG) represents the Board and presents the case; and the respondent or the respondent's representative or attorney presents its case. Testimony and evidence are presented and there is a transcript of the proceedings available after the hearing. Upon the conclusion of the administrative hearing, the ALJ will consider all of the testimony and evidence and will prepare a Proposed Decision. Once the hearing is finished, the ALJ has thirty (30) days to prepare the proposed decision and send it to the Board. The Proposed Decision is submitted to the Board for consideration. Upon receipt of the Proposed Decision, the Board then has one hundred (100) days to take action to either adopt or reject it. If no action is taken within one hundred (100) days, the proposed decision becomes effective by operation of law.

If the respondent fails to appear at an administrative hearing, a Default Decision is issued. Defaults result in the revocation or denial of a license.

**Board Review of Stipulations and Proposed Decisions**

The Board members review and vote on each case where the matter is either settled prior to hearing or the ALJ issues a proposed decision. In all cases, the Board members have the option to adopt/accept, adopt/accept with edits (technical/minor), reject, or hold for discussion.

**Ballot Procedure**

Proposed Stipulations and Proposed Decisions are usually presented to the Board for its consideration by ballot. Ballot is done by electronic mail. Ballot packet materials are confidential and include the following:

- Memo from enforcement staff listing the cases for review and decision
- Ballot

- Legal documents (Proposed Decision, Proposed Stipulation or Default Decision, and Accusation or Statement of Issues)

- Memo from the assigned Deputy Attorney General (Proposed Stipulated Settlement cases only)

Deliberation and decision-making should be done independently and confidentially by each Board member. Voting members may not communicate with each other, and may not contact the DAG, the respondent, anyone representing the respondent, any witnesses, the "complainant," the ALJ, or anyone else associated with the case.

Additionally, Board members should not discuss pending cases with staff, except as to technical questions of procedure or to ask whether additional information is available, and whether the Board may properly consider such information. If a Board member has any procedural questions not specific to evidence, or any question specifically related to the cases, the questions should be directed to the Board's Legal Counsel.

Completed ballots are due at the Board office no later than the due date indicated in the ballot package. The due dates are established in accordance with the timelines indicated in Administrative Procedure Act. Therefore, it is critical that Board members return their votes by the due date. It may be your vote that is the deciding vote in the outcome of a case.

Ballot materials should be retained until notification by enforcement staff that the outcome of cases has been decided. Once a decision is final, the ballot packet materials must be confidentially destroyed.

**Ballot Vote Definitions**

- Adopt/Accept: A vote to adopt/accept means that you agree with the action as written.

- Adopt/Accept with Edits: A vote to adopt/accept with edits means that you agree with the action but it needs technical or minor changes that do not affect the factual or legal base of the stipulation.

- Reject: A vote to reject means that you disagree with one or more portions of the proposed action and do not want it adopted as the Board's decision.

- Hold for Discussion: A vote to hold for discussion means that you wish to have some part of the action changed in some way (e.g., increase penalty, reduce penalty, etc.) or you may believe an additional or a different term or condition of probation should be added, or that a period of suspension should be longer.

**Ballot Outcome for Stipulations or Negotiated Settlements**

- Adopt/Accept – If the decision of the Board is to adopt the terms proposed in the stipulation, the stipulation becomes effective within thirty (30) days and the respondent is notified.

- Adopt/Accept with Edits – If the decision of the Board is to adopt the terms proposed in the stipulation with technical or minor changes, the changes are made, the stipulation becomes effective within thirty (30) days, and the respondent is notified.

- Reject– If the Board decides to reject the stipulation, the respondent is notified, and the matter resumes the process for a formal administrative hearing before an ALJ or a new settlement may be submitted to the Board at a later date. *Note: a majority vote to adopt will prevail over a minority vote to reject.*

- Hold for Discussion – If one (1) Board member votes to hold the case for discussion, the case is discussed at the next available meeting during a closed session. *Note: A Board member may seek procedural clarification from the Board's Legal Counsel without holding the case for discussion.*

**Ballot Outcome for Proposed Decisions**

- Adopt/Accept – If the decision of the Board is to adopt the proposed decision, the decision becomes effective within thirty (30) days and the respondent is notified.

- Adopt/Accept with Edits – If the decision of the Board is to adopt the proposed decision with technical or minor changes, the changes are made, the decision becomes effective within thirty (30) days, and the respondent is notified.

- Reject – If the Board decides to reject the proposed decision, the respondent is notified. Transcripts from the administrative hearing are requested. Board members review the transcripts and evidence and meet during a closed session to write their own decision. *Note: a majority vote to adopt will prevail over a minority vote to reject.*

- Hold for Discussion – If one (1) Board member votes to hold the case for discussion, the case is discussed at the next available meeting during a closed session. *Note: A Board member may seek procedural clarification from the Board's Legal Counsel without holding the case for discussion.*

**Disqualification**

With some limited exception, a Board member cannot decide a case if that Board member investigated, prosecuted or advocated in the case, or is subject to the authority of someone who investigated, prosecuted, or advocated in the case. A Board member

may also be disqualified for bias, prejudice, financial conflict of interest or other conflicts of interest related to the case.

# Attachment B

## BOARD MEMBERS

| Name | Position | Member Type |
|---|---|---|
| Gilda Dominguez | Board Chair | Speech–Language Pathologist |
| Amy White | Board Vice Chair | Audiologist |
| Tod Borges | Board Member | Hearing Aid Dispenser |
| Tamara Chambers | Board Member | Public Member, Otolaryngologist |
| Karen Chang | Board Member | Public Member |
| Francis David | Board Member | Speech–Language Pathologist |
| Charles Sanders | Board Member | Audiologist |
| VACANT | Board Member | Hearing Aid Dispenser |
| VACANT | Board Member | Public Member |

## STANDING COMMITTEES

Standing Committee composition and leadership are determined by the Board President and are fully within the scope of the Open Meetings Act. Standing Committee meetings are often held in conjunction with regularly scheduled Board Meetings. Standing Committees bring all matters to the full Board for a vote.

| **SLP PRACTICE COMMITTEE**<br>***Addresses changes in practice patterns and recommends position statements and/or scope of practice amendments for consideration.*** | | |
|---|---|---|
| **Name** | **Position** | **Profession** |
| Gilda Dominguez | Chair | SLP |
| Francis David | Member | SLP |
| Tamara Chambers | Member | ORL/Public |

| **AUDIOLOGY PRACTICE COMMITTEE**<br>***Addresses changes in practice patterns and recommends position statements and/or scope of practice amendments for consideration.*** | | |
|---|---|---|
| **Name** | **Position** | **Profession** |
| Amy White | Chair | DAU |

| | | |
|---|---|---|
| Charles Sanders | Member | DAU |
| Tamara Chambers | Member | ORL/Public |
| Karen Chang | Member | Public |

**HEARING AID DISPENERS PRACTICE COMMITTEE**
***Addresses changes in practice patterns and recommends position statements and/or scope of practice amendments for consideration.***

| Name | Position | Profession |
|---|---|---|
| Tod Borges | Chair | HAD |
| VACANT | Member | HAD |
| Karen Chang | Member | Public |

**HEARING AID DISPENSING COMMITTEE**
***Provides policy and regulatory guidance with respect to hearing aid dispensing practices and recommends scope of practice amendments for consideration.***

| Name | Position | Profession |
|---|---|---|
| Tod Borges | Chair | HAD |
| VACANT | Member | HAD |
| Charles Sanders | Member | DAU |
| Amy White | Member | DAU |
| Tamara Chambers | Member | ORL/Public |

## AD HOC COMMITTEES

Ad Hoc Committees may be established by the Board President as needed. Composition and leadership will be appointed by the Board President. Ad Hoc Committees may include the appointment of non-Board members at the Board President's discretion. Ad Hoc Committees are not fully within the scope of the Open Meetings act, however all recommendations made by Ad Hoc Committees must be reviewed and voted on by the Board in a public Board Meeting.

**SUNSET REVIEW AD HOC COMMITTEE**
***Develop for the Board's review the Board's Sunset Review Report to the California Legislature***

| Name | Position | Profession |
|---|---|---|
| Gilda Dominguez | Chair | SLP |
| Amy White | Member | DAU |

| **ENFORCEMENT AD HOC COMMITTEE**<br>***Review and recommend to the Board proposed revisions to the laws, regulations, and policies related to the Board's enforcement of the Boards Practice Act.*** | | |
|---|---|---|
| **Name** | **Position** | **Profession** |
| Gilda Dominguez | Chair | SLP |
| Tod Borges | Member | HAD |
| **LEGISLATIVE AD HOC COMMITTEE**<br>***Review and recommend to the Board proposed positions on legislation impacting the Board, its licensees, and the Board's Practice Act*** | | |
| **Name** | **Position** | **Profession** |
| Karen Chang | Chair | Public |
| Gilda Dominguez | Member | SLP |

***Legend:***
DAU - Dispensing Audiologist
HAD - Hearing Aid Dispenser
ORL/ENT - Otolaryngologist/Ear, Nose & Throat
SLP - Speech-Language Pathologist

# Attachment C

# SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY AND HEARING AID DISPENSERS BOARD

# OCCUPATIONAL ANALYSIS OF THE SPEECH-LANGUAGE PATHOLOGIST PROFESSION

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS
OFFICE OF PROFESSIONAL EXAMINATION SERVICES

SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY AND HEARING AID DISPENSERS BOARD

# OCCUPATIONAL ANALYSIS OF THE SPEECH-LANGUAGE PATHOLOGIST PROFESSION

February 2025

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

OFFICE OF PROFESSIONAL EXAMINATION SERVICES

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This occupational analysis report is mandated by California Business and Professions Code § 139 and by DCA *OPES 22-01 Licensure Examination Validation Policy*.

## EXECUTIVE SUMMARY

The Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board (Board) requested that the Department of Consumer Affairs' Office of Professional Examination Services (OPES) conduct an occupational analysis (OA) of the speech-language pathologist profession in California. The purpose of the OA is to define the profession in terms of critical tasks that speech-language pathologists must be able to perform competently at the time of licensure. The results of this OA provide a description of practice for the speech-language pathologist profession that can be used to review the Praxis Speech-Language Pathology Test.

OPES test specialists began by researching the profession and conducting telephone interviews with licensed speech-language pathologists working throughout California. The purpose of these interviews was to identify the tasks performed by speech-language pathologists and to determine the knowledge required to perform those tasks safely and competently. Using the information gathered from the research and the interviews, OPES test specialists developed a preliminary list of tasks performed by speech-language pathologists in their profession, along with statements representing the knowledge needed to perform those tasks.

In April 2024, OPES test specialists convened a workshop to review and refine the preliminary lists of tasks and knowledge statements describing speech-language pathologist practice in California. Speech-language pathologists participated in the workshops as subject matter experts (SMEs). The SMEs were from diverse backgrounds in the profession (e.g., work setting, geographic location of practice, years licensed). The SMEs identified changes and trends in speech-language pathologist practice, determined demographic questions for the OA questionnaire, and performed a preliminary linkage of the tasks and knowledge statements to ensure that all tasks had a related knowledge statement, and all knowledge statements had a related task. Additional tasks and knowledge statements were created as needed to complete the scope of the content areas of the description of practice.

After the workshop, OPES test specialists developed a three-part OA questionnaire to be completed by speech-language pathologists statewide. Development of the OA questionnaire included a pilot study that was conducted with a group of speech-language pathologists who participated in the telephone interviews and the April 2024 workshop. The pilot study participants' feedback was incorporated into the final questionnaire, which was administered August 15, 2024–September 13, 2024.

In the first part of the OA questionnaire, speech-language pathologists were asked to provide demographic information related to their practice and work setting. In the second part, speech-language pathologists were asked to rate how often they perform each task in their current practice (Frequency) and how important the task is to effective performance in their current practice (Importance). In the third part, speech-language pathologists were asked to rate how important each knowledge statement is to effective performance in their current practice (Importance).

In August 2024, OPES sent an online OA questionnaire invitation email to 13,169 licensed speech-language pathologists. The list of licensees was provided by the Board. As of the writing of this report, there are a total of 15,658 licensed speech-language pathologists in California.

A total of 2,520 speech-language pathologists responded to the OA questionnaire email invitation. The final number of respondents included in the data analysis was 916 (19% of those who initially responded). This response rate reflects two adjustments. First, OPES excluded data from respondents who indicated they were not currently licensed and working as a speech-language pathologist in California. Second, OPES excluded questionnaires containing responses that were less than 75% complete.

OPES test specialists then performed data analyses on the task and knowledge ratings obtained from the questionnaire respondents. The task importance and frequency ratings were combined to derive an overall criticality index for each task statement. The mean of importance ratings was used as the criticality index for each knowledge statement.

Once the data were analyzed, OPES test specialists conducted an additional workshop with speech-language pathologists in September 2024. The SMEs evaluated the criticality indices and determined whether any tasks or knowledge statements should be eliminated. The SMEs in this group also established the final linkage between tasks and knowledge statements, reviewed the task and knowledge statement content areas, and defined those content areas. The SMEs then evaluated the preliminary content area weights and determined the final weights for the description of practice.

The California Speech-Language Pathology Description of Practice is structured into five content areas that are weighted relative to the other content areas. It identifies the tasks and knowledge critical to competent speech-language pathologist practice in California at the time of licensure.

OVERVIEW OF THE CALIFORNIA SPEECH-LANGUAGE PATHOLOGY DESCRIPTION OF PRACTICE

| CONTENT AREAS | CONTENT AREA DESCRIPTIONS | PERCENT WEIGHT |
|---|---|---|
| 1. General Competencies | This area assesses a candidate's knowledge of linguistic and cultural awareness, applicable regulations, and professional and ethical standards related to core areas of practice across clients, disorders, and treatment settings. | 15 |
| 2. Assessment | This area assesses a candidate's knowledge of identifying and evaluating speech, language, social communication, cognition, voice, and swallowing disorders. | 25 |
| 3. Diagnosis, Goal Setting, and Treatment Planning | This area assesses a candidate's knowledge of interpreting and analyzing assessment information for accurate diagnosis and developing treatment plans and interventions. | 25 |
| 4. Treatment Intervention and Procedures | This area assesses a candidate's knowledge of delivering culturally relevant treatment interventions and procedures based on assessment and diagnostic information that are measurable, objective, and consistent with the client's readiness and ability to engage in treatment. | 25 |
| 5. Treatment Outcomes and Effectiveness | This area assesses a candidate's knowledge of interpreting data to determine client progress and treatment efficacy in relation to goals and of modifying treatment plans as appropriate. | 10 |
| Total | | 100 |

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# CHAPTER 1 | INTRODUCTION

## PURPOSE OF THE OCCUPATIONAL ANALYSIS

The Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board (Board) requested that the Department of Consumer Affairs' Office of Professional Examination Services (OPES) conduct an occupational analysis (OA) as part of the Board's comprehensive review of the speech-language pathologist profession in California. The purpose of the OA is to identify critical activities performed by speech-language pathologists in California. The results of this OA provide a description of practice for the speech-language pathologist profession that can then be used to review the Praxis Speech-Language Pathology Test developed by the Educational Testing Service (ETS).

To become a fully licensed speech-language pathologist in California, a candidate must:

1. Submit to fingerprinting.
2. Hold a Master's degree or equivalent in speech-language pathology from an accredited educational institution.
3. Have completed 300 hours of supervised clinical practicum in three different clinical settings.
4. Have completed 36 weeks of full-time or 72 weeks of part-time supervised Required Professional Experience (RPE) while holding an RPE temporary license. If experience was completed in California, applicants must have held an RPE temporary license during that time.
5. Effective September 1, 2014, pass the Praxis Speech-Language Pathology Test administered by the Educational Testing Service (ETS) Praxis Series with a minimum score of 162. The exam must not be more than five years old. Applicants must authorize ETS to report their test score to the Board using Report Code R8544.

To become a licensed speech-language pathologist in California, applicants must complete one of the following five pathways to licensure:

Option #1

Required Professional Experience (RPE). Upon completion of 36 full-time weeks (or 72 part-time weeks) of required professional experience under an RPE Temporary License, applicants must submit the Permanent License Application, including the RPE Verification Form.

Option #2

Equivalent qualifications. For those with a current Certificate Competence issued by ASHA.

Option #3

Licensed in another state. Must possess an active and current license from another state. If applicants also hold a current ASHA certification, the applicant must use Option #2.

Option #4

Previously licensed in California. Held a license in California that expired more than 5 years ago.

Option #5

Foreign educated graduates. Completed graduate education outside the United States. Upon completion of all required weeks of required professional experience under an RPE Temporary License, applicants must submit the Permanent License Application, including the RPE Verification Form.

## PARTICIPATION OF SUBJECT MATTER EXPERTS

California speech-language pathologists participated as subject matter experts (SMEs) during the OA to ensure that the description of practice directly reflects current speech-language pathologist practice in California. These SMEs represented the profession in terms of work setting, geographic location of practice, and years licensed. The SMEs provided technical expertise and

information regarding different aspects of practice through workshops. During workshops, the SMEs developed and reviewed the tasks and knowledge statements describing speech-language pathologist practice, organized the tasks and knowledge statements into content areas, evaluated the results of the OA, and developed the description of practice.

## ADHERENCE TO LEGAL STANDARDS AND GUIDELINES

Licensure, certification, and registration programs in the State of California adhere strictly to federal and state laws and regulations, as well as to professional guidelines and technical standards. For the purposes of OAs, the following laws and guidelines are authoritative:

- California Business and Professions Code (BPC) § 139.
- 29 Code of Federal Regulations Part 1607 – Uniform Guidelines on Employee Selection Procedures (1978).
- California Fair Employment and Housing Act, Government Code § 12944.
- *Principles for the Validation and Use of Personnel Selection Procedures* (2018), Society for Industrial and Organizational Psychology (SIOP).
- *Standards for Educational and Psychological Testing* (2014), American Educational Research Association, American Psychological Association, and National Council on Measurement in Education.

For a licensure program to meet these standards, it must be solidly based upon the job activities required for practice.

## DESCRIPTION OF OCCUPATION

The speech-language pathologist occupation is described as follows in BPC § 2530.2:

> (c) A "speech-language pathologist" is a person who practices speech-language pathology.
>
> (d) The practice of speech-language pathology means all of the following:

(1) The application of principles, methods, instrumental procedures, and noninstrumental procedures for measurement, testing, screening, evaluation, identification, prediction, and counseling related to the development and disorders of speech, voice, language, or swallowing.

(2) The application of principles and methods for preventing, planning, directing, conducting, and supervising programs for habilitating, rehabilitating, ameliorating, managing, or modifying disorders of speech, voice, language, or swallowing in individuals or groups of individuals.

(3) Conducting hearing screenings.

(4) Performing suctioning in connection with the scope of practice described in paragraphs (1) and (2), after compliance with a medical facility's training protocols on suctioning procedures.

# **CHAPTER 2** | OCCUPATIONAL ANALYSIS QUESTIONNAIRE

## TASKS AND KNOWLEDGE STATEMENTS

To develop preliminary lists of tasks and knowledge statements, OPES test specialists gathered information from literature reviews of profession-related sources (e.g., previous OA reports, articles, industry publications, laws and regulations) and conducted telephone interviews with licensed speech-language pathologists working throughout California.

In April 2024, OPES test specialists facilitated a workshop to review and refine the tasks and knowledge statements. Five SMEs from diverse backgrounds (e.g., work setting, geographic location of practice, years licensed) participated in the workshop. During the workshop, the SMEs evaluated the tasks and knowledge statements for technical accuracy, level of specificity, and comprehensiveness. In addition, the SMEs evaluated the organization of tasks within content areas to ensure that the content areas were independent and non-overlapping.

During this workshop, the SMEs also reviewed proposed demographic questions and evaluated the scales that would be used for rating tasks and knowledge statements in an online OA questionnaire to be sent to speech-language pathologists statewide.

OPES used the final lists of tasks and knowledge statements, demographic questions, and rating scales to develop the online OA questionnaire.

## QUESTIONNAIRE DEVELOPMENT

OPES test specialists developed the online OA questionnaire designed to solicit ratings by speech-language pathologists of the tasks and knowledge statements. Those surveyed were instructed to rate how often they perform each task in their current practice (Frequency) and how important each task is to the effective performance in their current practice (Importance). In addition, they were instructed to rate how important each item of knowledge is to effective performance in their current practice (Importance). The OA questionnaire also included a demographic section to obtain relevant

professional background information about responding speech-language pathologists. The OA questionnaire is Appendix A.

## PILOT STUDY

Before administering the final questionnaire, OPES conducted a pilot study of the online questionnaire. The draft questionnaire was reviewed by the Board and then sent to 14 SMEs who had participated in the telephone interviews and the workshop. OPES received feedback on the pilot study from 10 respondents. The SMEs reviewed the tasks and knowledge statements in the questionnaire for technical accuracy and for whether they reflected speech-language pathologist practice. The SMEs also provided the estimated time for completion of the questionnaire, as well as information about online navigation and ease of use. OPES test specialists used this feedback to refine the final questionnaire, which was administered August 15, 2024–September 13, 2024.

# CHAPTER 3 | RESPONSE RATE AND DEMOGRAPHICS

## SAMPLING STRATEGY AND RESPONSE RATE

In August 2024, OPES sent an online OA questionnaire invitation email to 13,169 licensed speech-language pathologists who had an email address on file with the Board. As of the writing of this report, there are a total of 15,658 licensed speech-language pathologists in California. The email invitation is Appendix B.

A total of 2,520 speech-language pathologists responded to the OA questionnaire email invitation. The final number of respondents included in the data analysis was 916 (19% of those who initially responded). This response rate reflects two adjustments. First, OPES excluded data from respondents who indicated they were not currently licensed and working as a speech-language pathologist in California. Second, OPES excluded questionnaires containing responses that were less than 75% complete. The final respondent sample appears to represent the California speech-language pathologist profession based on the sample's demographic composition.

## DEMOGRAPHIC SUMMARY

As shown in Table 1 and Figure 1, the responding speech-language pathologists reported a range of years of experience. Of the respondents, 50.7% reported that they had worked as a speech-language pathologist for less than 5 years, 36.2% reported that they had worked as a speech-language pathologist for 6–10 years, 7.8% reported working as a speech-language pathologist for 11–20 years, 2.7% reported working as a speech-language pathologist for 21–29 years, and 2.6% reported having worked as a speech-language pathologist for 30 or more years.

Table 2 and Figure 2 show that 63.0% of respondents reported that they work 31–40 hours per week as a speech-language pathologist, while 20.1% reported that they work 41 or more hours per week, 7.5% reported that they work 21–30 hours per week, 5.7% reported that they work 11–20 hours per week, and 3.7% reported that they work 10 or fewer hours per week.

When asked about their highest level of education, 97.2% of respondents reported a master's degree and 1.9% reported a doctorate degree (Table 3 and Figure 3).

Table 4 and Figure 4 show that 55.2% of the respondents reported that the majority of their responsibilities are as a school-based service provider, while 35.8% are as a clinical services provider, 2.7% as a supervisor of clinicians, 1.2% as a director/supervisor of a clinical program, and 0.8% as a college/university professor/instructor.

Respondents were asked to identify the service that was their primary activity. Table 5 and Figure 5 show that 79.5% reported their primary activity to be direct client care, 4.6% reported treatment planning/preparation, 3.7% reported client IEP, 3.1% reported client documentation/reports, 3.1% reported supervision, 2.6% reported case management, and 1.4% reported teaching/training.

When respondents were asked to identify the service that was their secondary activity, 42.7% reported client documentation/reports, 19.8% reported client IEP, 7.4% reported case management, 6.0% reported direct client care, 5.9% reported treatment planning/preparation, 5.5% reported family and caregiver contact/counseling, 4.4% reported collaboration/consultation, 4.3% reported supervision, 2.1% reported administrative, and 1.3% reported teaching/training (Table 6 and Figure 6).

Respondents were asked to identify their primary work setting. Table 7 and Figure 7 show that the majority of respondents, 61.9%, reported that they work in a public school setting, while 14.4% reported a private practice setting, 12.3% reported a speech and language clinic, 12% reported a hospital setting, 12% reported a web-based treatment/telemedicine setting, 8.5% reported a preschool/day care setting, 7.2% reported a Regional Center setting, 6.6% reported a skilled nursing/acute rehab/long-term care/subacute care setting, 5.3% reported a home health/assisted living setting, 3.4% reported a nonpublic school setting, and 1.9% reported a university/university clinic setting.

Table 8 and Figure 8 show the age groups that speech-language pathologists serve. Respondents reported 66.4% for both children 6–8 years of age and for preschool, 63.8% reported children 9–11 years of age, 44.9% reported young adolescents, 30.1% reported adolescents, 24.3% reported young adults, 23.9%

reported toddlers, 22.8% reported adults, 19.5% reported older adults, and 10% reported infants.

As shown in Table 9 and Figure 9, 66.2% of speech-language pathologists reported speech sound disorders as their area of specialization, 57.8% reported developmental language disorder, 54.6% reported autism and related disorders, 43.9% reported phonological disorders, 36.5% reported early intervention, 34.6% reported augmentative and alternative communication, 33% reported developmental disabilities, 28.9% reported cognitive linguistic disorders, 25.3% reported fluency and fluency disorders, 21% reported feeding and swallowing disorder, 14.1% reported voice and voice disorders, 13% reported neurophysiological/neurogenic disorders, 4.5% reported orofacial disorders, 4.4% reported hearing and hearing disorders, 4.1% reported gerontology, 1.9% reported aural rehabilitation, and 1.5% reported alaryngeal speech.

Table 10 shows that 90.7% of respondents do not hold other state-issued licenses. Table 11 and Figure 10 show that 60.7% do not hold other certificates/credentials, 10.4% reported that they hold a teaching certification, 3.6% reported that they hold a special education certification, 3.5% reported that they have an assistive technology certification, and 2.2% reported that they have a Bilingual, Crosscultural, Language and Academic Development (BCLAD) certification.

Table 12 and Figure 11 show the location of respondents' primary work setting, with 83.1% responding that they work in an urban setting, and 16.0% work in a rural setting.

Table 13 shows the location of respondents' primary practice by geographical region, with the highest percentage (30.0%) of respondents practicing in Los Angeles County and its vicinity, and 17.5% practicing in the San Francisco Bay Area. A breakdown of regional data organized by county is Appendix C.

TABLE 1 – YEARS LICENSED

| YEARS | NUMBER (N) | PERCENT |
|---|---|---|
| 0–5 | 464 | 50.7 |
| 6–10 | 332 | 36.2 |
| 11–20 | 71 | 7.8 |
| 21–29 | 25 | 2.7 |
| 30 or more | 24 | 2.6 |
| Total | 916 | 100 |

FIGURE 1 – YEARS LICENSED

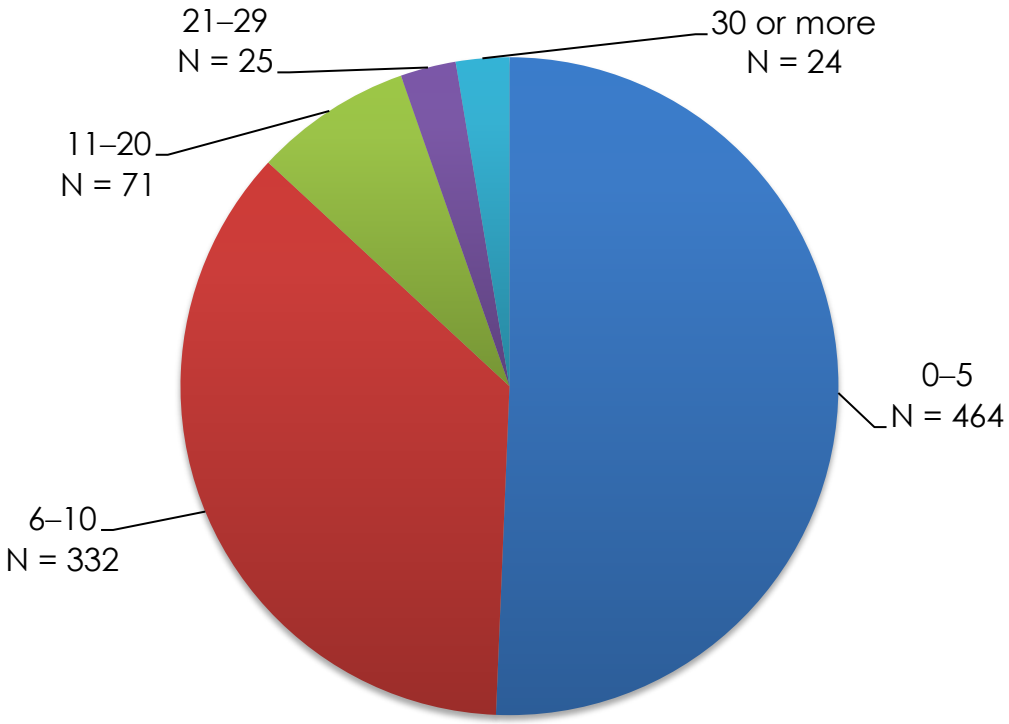


TABLE 2 – HOURS WORKED PER WEEK

| HOURS | NUMBER (N) | PERCENT |
|---|---|---|
| 10 or fewer | 34 | 3.7 |
| 11–20 | 52 | 5.7 |
| 21–30 | 69 | 7.5 |
| 31–40 | 577 | 63.0 |
| 41 or more | 184 | 20.1 |
| Total | 916 | 100 |

FIGURE 2 – HOURS WORKED PER WEEK

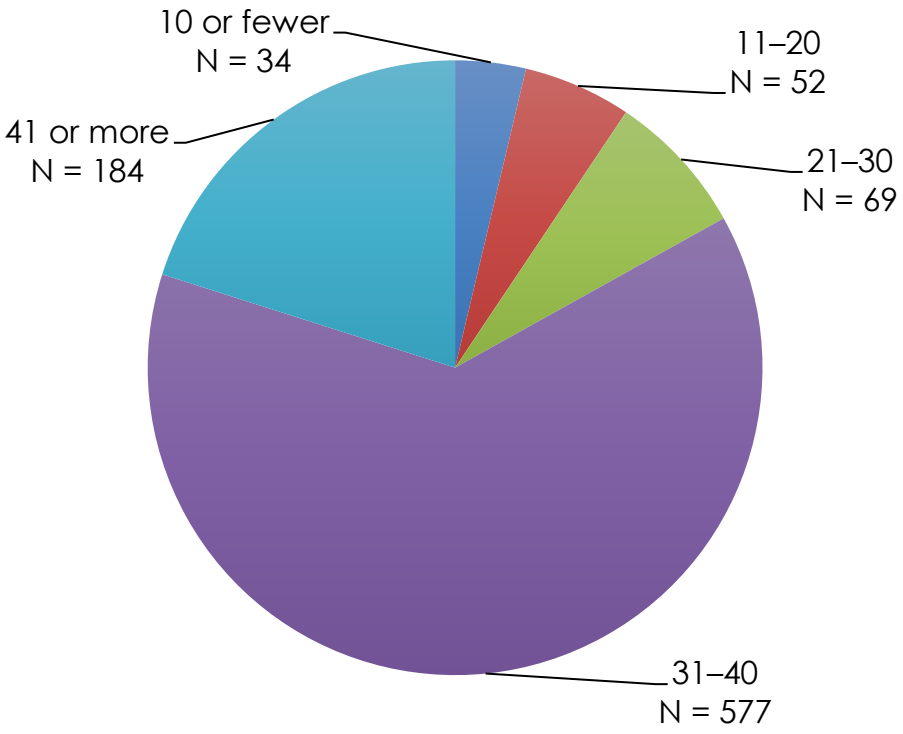


TABLE 3 – HIGHEST LEVEL OF EDUCATION ACHIEVED

| TYPE | NUMBER (N) | PERCENT |
|---|---|---|
| Master's in speech-language pathology or communications | 890 | 97.2 |
| Doctorate in speech-language pathology or communications | 17 | 1.9 |
| Other | 9 | 1.0 |
| Total | 916 | *100.1 |

*NOTE: Percentages do not add to 100 due to rounding.

FIGURE 3 – HIGHEST LEVEL OF EDUCATION ACHIEVED

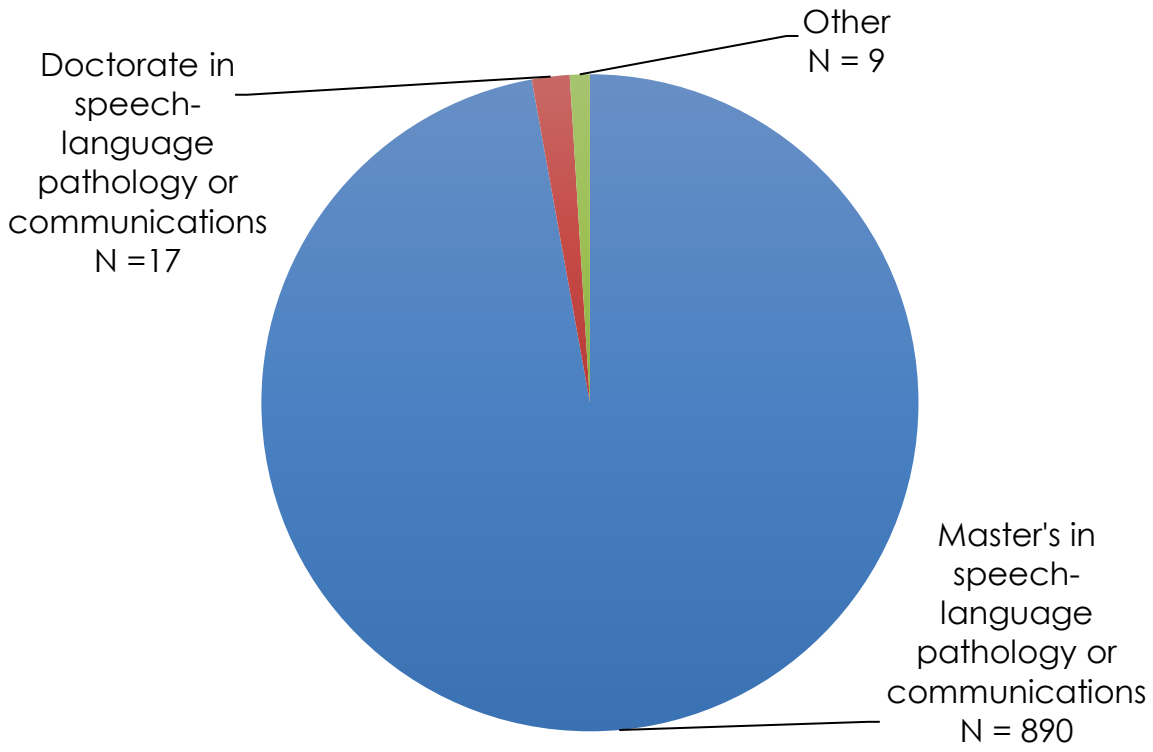


TABLE 4 – MAJORITY OF RESPONSIBILITIES

| CLASSIFICATION | NUMBER (N) | PERCENT |
|---|---|---|
| Clinical services provider | 328 | 35.8 |
| College / university professor / instructor | 7 | .8 |
| Consultant | 1 | .1 |
| Director / Chair of education program | 1 | .1 |
| Director / Supervisor of a clinical program | 11 | 1.2 |
| School-based service provider | 506 | 55.2 |
| Supervisor of clinicians | 25 | 2.7 |
| CEU provider | 1 | .1 |
| Other | 35 | 3.8 |
| Missing | 1 | .1 |
| Total | 916 | *99.9 |

*NOTE: Percentages do not add to 100 due to rounding.

FIGURE 4 – MAJORITY OF RESPONSIBILITIES

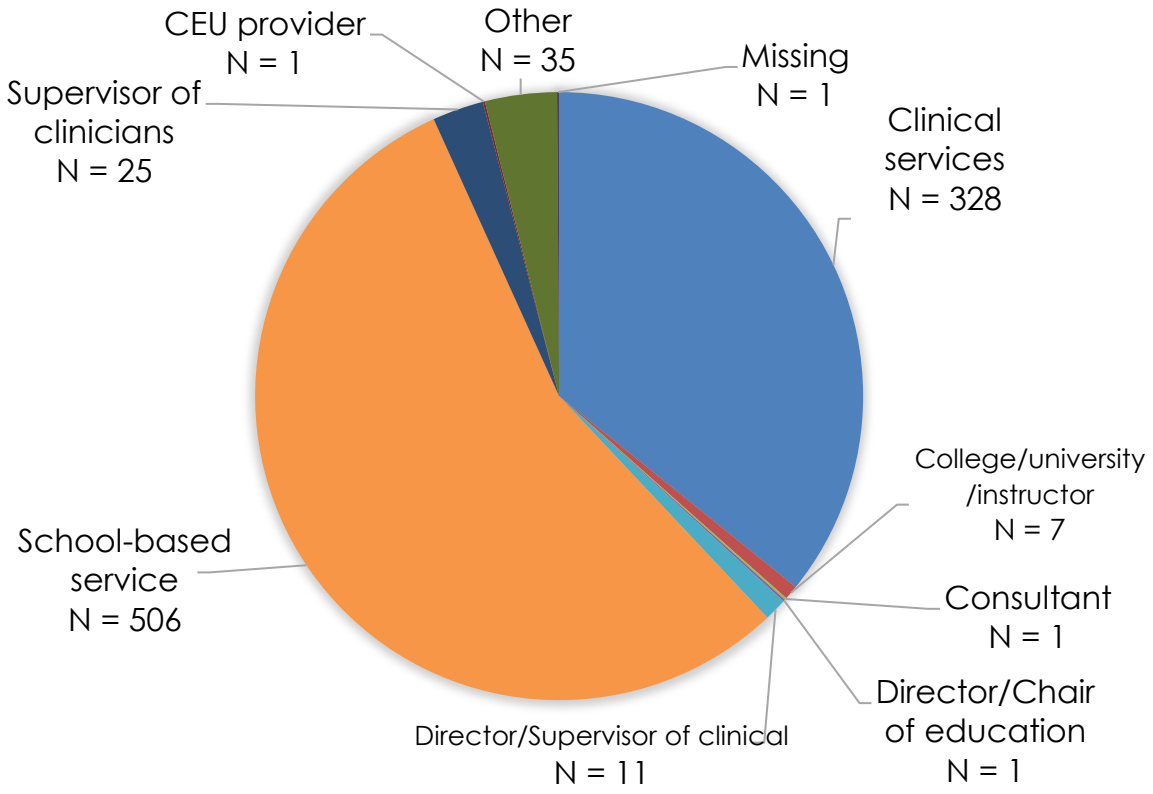


TABLE 5 – PRIMARY SERVICE ACTIVITY PROVIDED

| SERVICES | NUMBER (N) | PERCENT |
|---|---|---|
| Client IEP (IDT meetings) | 34 | 3.7 |
| Client documentation / reports | 28 | 3.1 |
| Family and caregiver contact / counseling | 4 | .4 |
| Direct client care (screening, assessment, treatment) | 728 | 79.5 |
| Treatment planning / preparation | 42 | 4.6 |
| Collaboration / consultation (professional staff, teachers) | 5 | .5 |
| Supervision (SLP-associated medical staff, support staff) | 28 | 3.1 |
| Research / grant writing | 2 | .2 |
| Teaching / training (staff, students, parents) | 13 | 1.4 |
| Case management (intake, referrals, follow-up) | 24 | 2.6 |
| Administrative (scheduling, staffing, HR, meetings) | 8 | .9 |
| Professional development | 0 | 0 |
| Total | 916 | 100 |

FIGURE 5 – PRIMARY SERVICE ACTIVITY PROVIDED

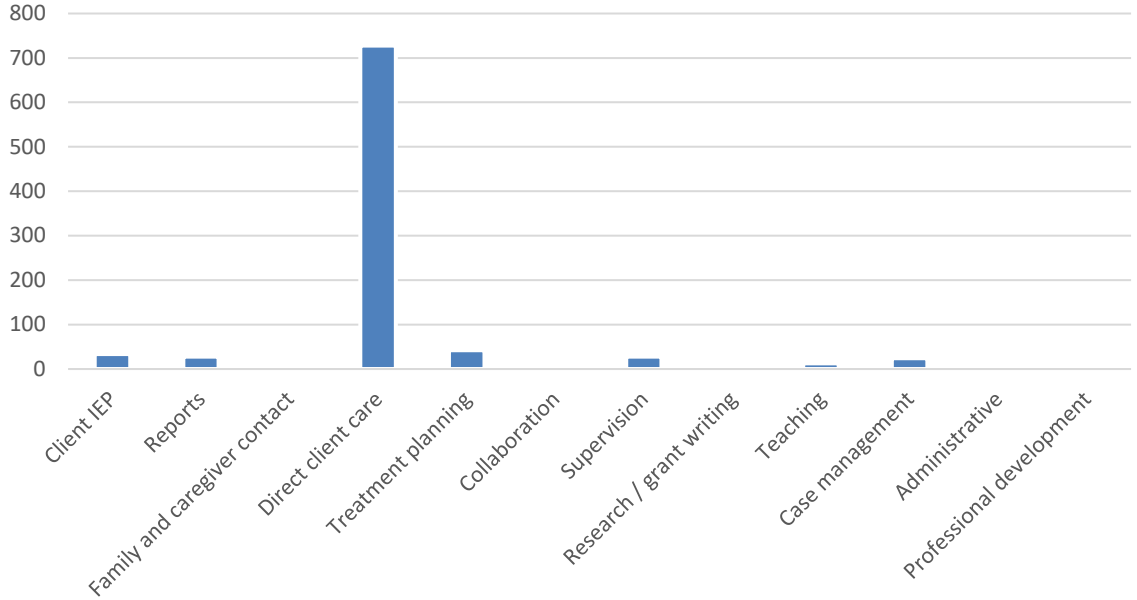


TABLE 6 – SECONDARY SERVICE ACTIVITY PROVIDED

| SECONDARY ACTIVITY | NUMBER (N) | PERCENT |
|---|---|---|
| Client IEP (IDT meetings) | 181 | 19.8 |
| Client documentation / reports | 391 | 42.7 |
| Family and caregiver contact / counseling | 50 | 5.5 |
| Direct client care (screening, assessment, treatment) | 55 | 6.0 |
| Treatment planning / preparation | 54 | 5.9 |
| Collaboration / consultation (professional staff, teachers) | 40 | 4.4 |
| Supervision (SLP-associated medical staff, support staff) | 39 | 4.3 |
| Research / grant writing | 1 | .1 |
| Teaching / training (staff, students, parents) | 12 | 1.3 |
| Case management (intake, referrals, follow-up) | 68 | 7.4 |
| Administrative (scheduling, staffing, HR, meetings) | 19 | 2.1 |
| Professional development | 3 | .3 |
| Missing | 3 | .3 |
| Total | 916 | *100.1 |

*NOTE: Percentages do not add to 100 due to rounding.

FIGURE 6 – SECONDARY SERVICE ACTIVITY PROVIDED

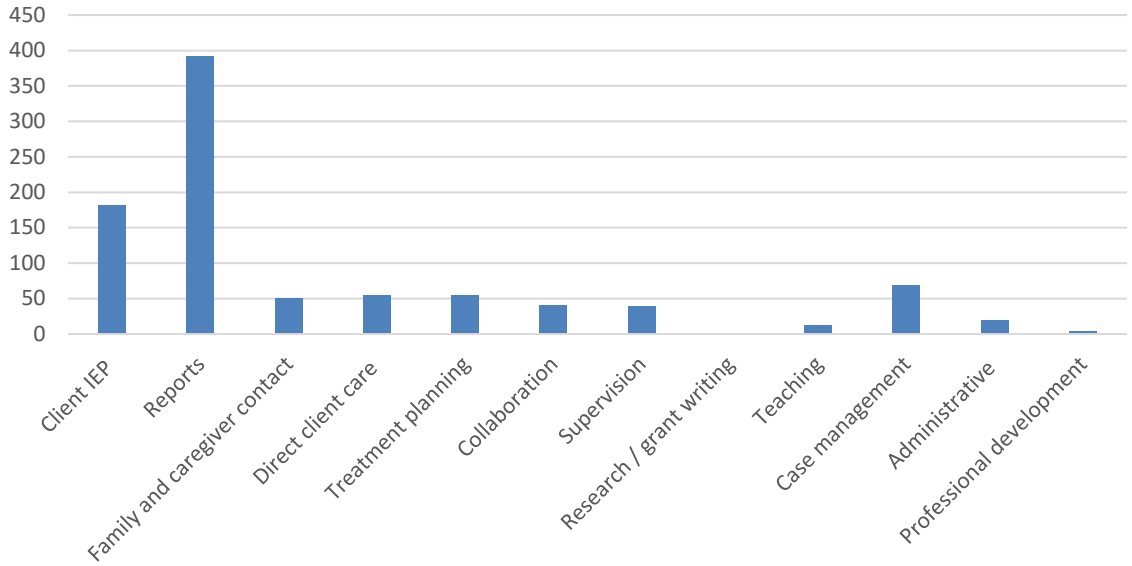


TABLE 7 – PRIMARY WORK SETTING WHERE SERVICES ARE PROVIDED

| SETTING | NUMBER (N) | PERCENT |
|---|---|---|
| Correctional facility | 2 | 0.2 |
| Public school | 566 | 61.9 |
| Group home / sheltered workshop | 2 | 0.2 |
| Regional Center | 66 | 7.2 |
| Home health / assisted living | 49 | 5.3 |
| Skilled nursing / acute rehab / long-term care / subacute care | 60 | 6.6 |
| Hospital | 111 | 12.0 |
| Speech and language clinic | 114 | 12.3 |
| Nonpublic school (NPS) | 31 | 3.4 |
| University / university clinic | 17 | 1.9 |
| Preschool / day care | 78 | 8.5 |
| Web-based treatment / telemedicine | 110 | 12.0 |
| Private practice | 133 | 14.4 |
| Other (please specify) | 35 | 3.8 |

Note: Respondents were asked to select all that apply.

FIGURE 7 – PRIMARY WORK SETTING WHERE SERVICES ARE PROVIDED

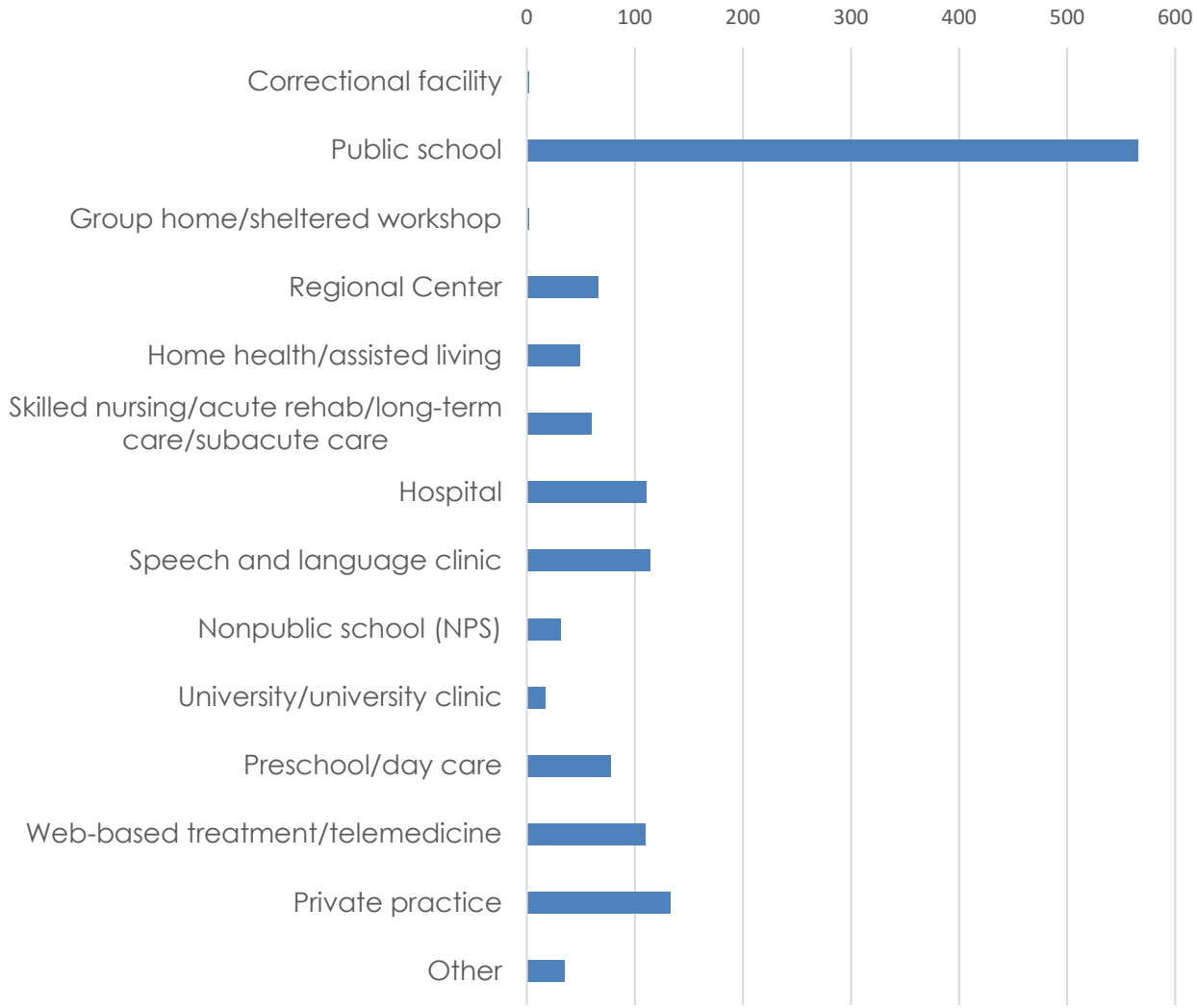


TABLE 8 – AGE GROUPS RECEIVING SERVICES

| AGE GROUP | NUMBER (N) | PERCENT |
|---|---|---|
| Older adults (71+ years of age) | 179 | 19.5 |
| Adults (23–70 years of age) | 209 | 22.8 |
| Young adults (18–22 years of age) | 224 | 24.3 |
| Adolescents (15–17 years of age) | 277 | 30.1 |
| Young adolescents (12–14 years of age) | 411 | 44.9 |
| Children (9–11 years of age) | 584 | 63.8 |
| Children (6–8 years of age) | 608 | 66.4 |
| Preschool (3–5 years of age) | 608 | 66.4 |
| Toddlers (1–2 years of age) | 218 | 23.9 |
| Infants (0–12 months of age) | 92 | 10.0 |
| Other | 7 | 0.8 |

Note: Respondents were asked to select all that apply.

FIGURE 8 – AGE GROUPS RECEIVING SERVICES

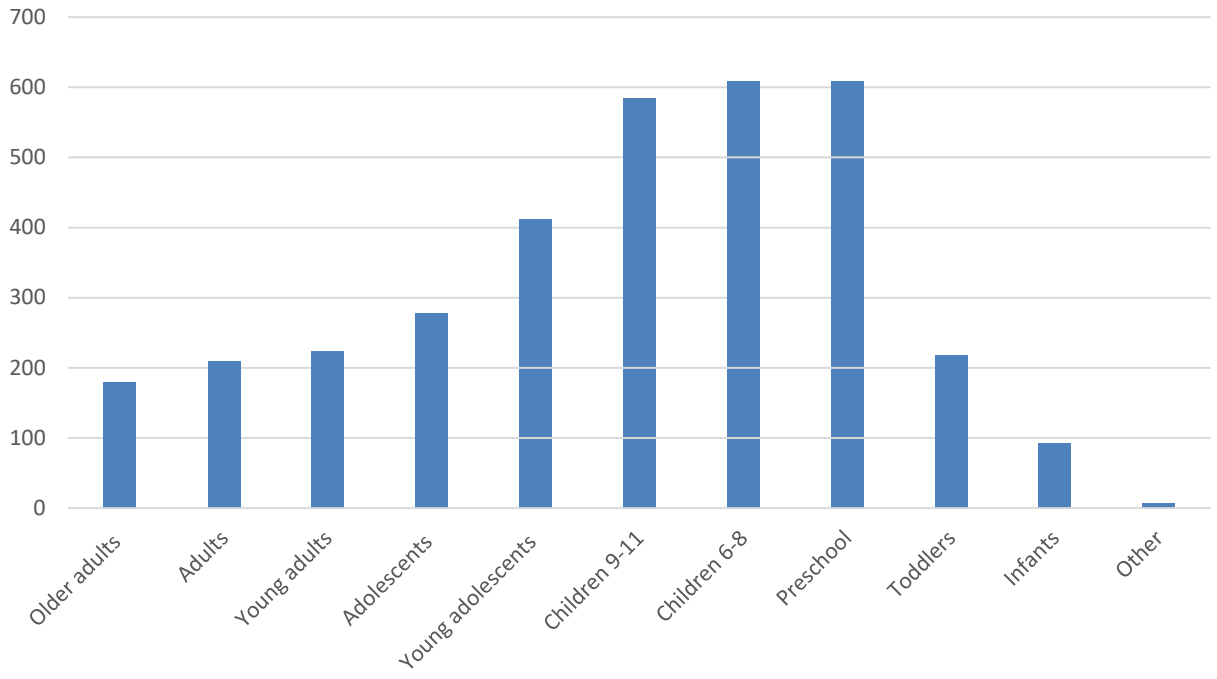


TABLE 9 – AREA OF SPECIALIZATION

| AREA OF SPECIALIZATION | NUMBER (N) | PERCENT |
|---|---|---|
| Alaryngeal speech | 14 | 1.5 |
| Augmentative and alternative communication | 316 | 34.6 |
| Aural rehabilitation | 17 | 1.9 |
| Autism and related disorders | 499 | 54.6 |
| Cognitive linguistic disorders | 264 | 28.9 |
| Developmental disabilities | 302 | 33.0 |
| Developmental language disorder | 529 | 57.8 |
| Early intervention | 334 | 36.5 |
| Feeding and swallowing disorder | 192 | 21.0 |
| Fluency and fluency disorders | 233 | 25.3 |
| Gerontology | 38 | 4.1 |
| Hearing and hearing disorders | 40 | 4.4 |
| Neurophysiological/neurogenic disorders | 119 | 13.0 |
| Orofacial disorders | 41 | 4.5 |
| Phonological disorders | 402 | 43.9 |
| Speech sound disorders (articulation/phonology) | 606 | 66.2 |
| Voice and voice disorders | 129 | 14.1 |
| Other (Please specify) | 52 | 5.7 |

Note: Respondents were asked to select all that apply.

FIGURE 9 – AREA OF SPECIALIZATION

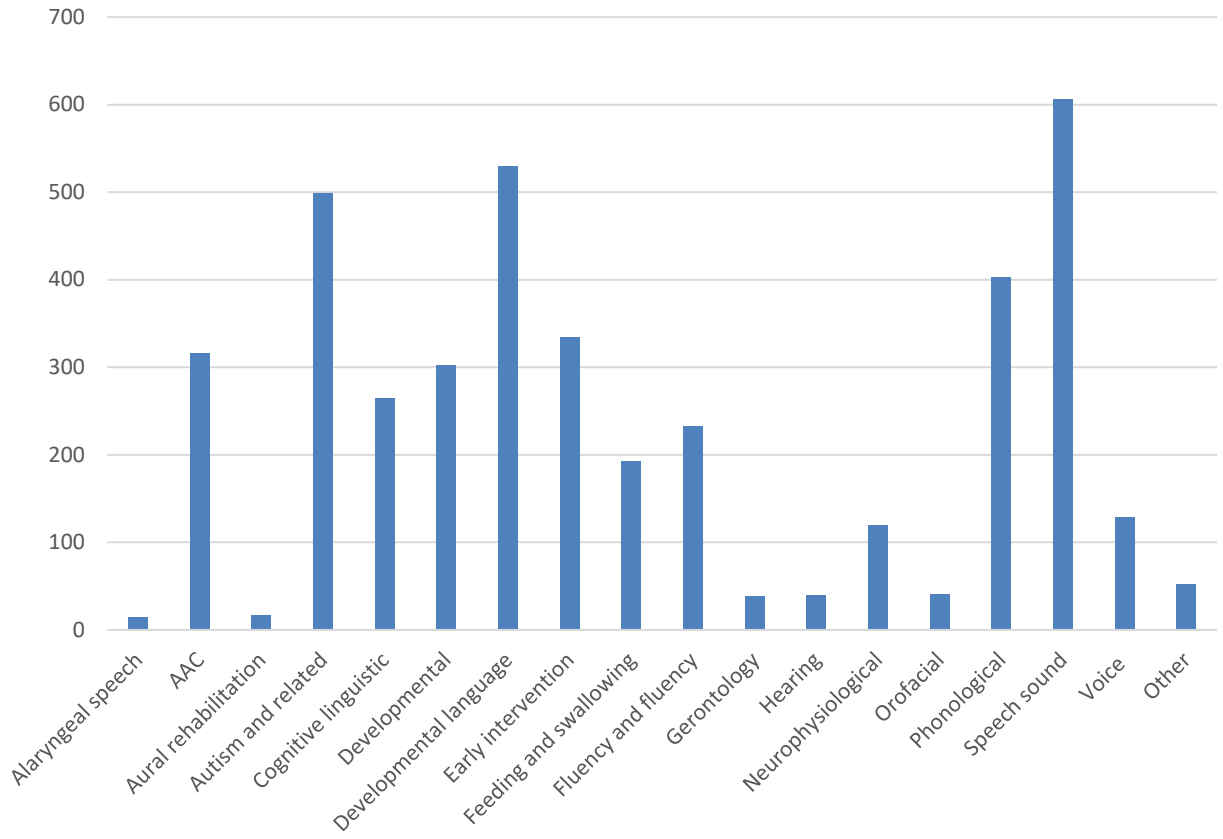


TABLE 10 – OTHER STATE-ISSUED LICENSES

| STATE-ISSUED LICENSES | NUMBER (N) | PERCENT |
|---|---|---|
| None | 831 | 90.7 |
| Audiologist | 1 | 0.1 |
| Hearing Aid Dispenser | 0 | 0 |
| Occupational Therapist | 0 | 0 |
| Physical Therapist | 0 | 0 |
| Other (please specify) | 22 | 2.4 |

Note: Respondents were asked to select all that apply.

TABLE 11 – OTHER CERTIFICATES/CREDENTIALS

| CERTIFICATES/CREDENTIALS | NUMBER (N) | PERCENT |
|---|---|---|
| None | 556 | 60.7 |
| Administrative Services | 6 | 0.7 |
| Applied Behavior Analysis | 8 | 0.9 |
| Assistive Technology | 32 | 3.5 |
| Bilingual, Crosscultural, Language and Academic Development (BCLAD) | 20 | 2.2 |
| Crosscultural, Language and Academic Development (CLAD) | 8 | 0.9 |
| Resource Specialist | 5 | 0.5 |
| Special Education | 33 | 3.6 |
| Teaching | 95 | 10.4 |
| Other (please specify) | 86 | 9.3 |

Note: Respondents were asked to select all that apply.

FIGURE 10 – OTHER CERTIFICATES/CREDENTIALS

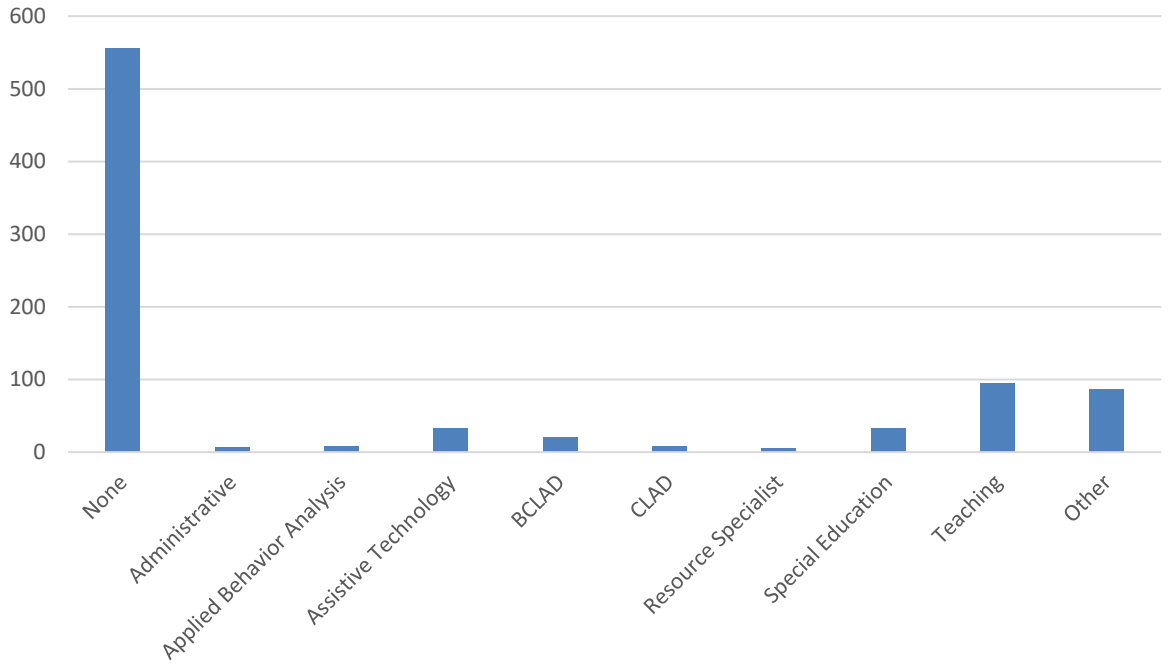


TABLE 12 – LOCATION OF PRIMARY WORK SETTING

| LOCATION | NUMBER (N) | PERCENT |
|---|---|---|
| Urban (more than 50,000 people) | 761 | 83.1 |
| Rural (fewer than 50,000 people) | 147 | 16.0 |
| Missing | 8 | 0.9 |
| Total | 916 | 100.0 |

FIGURE 11 – LOCATION OF PRIMARY WORK SETTING

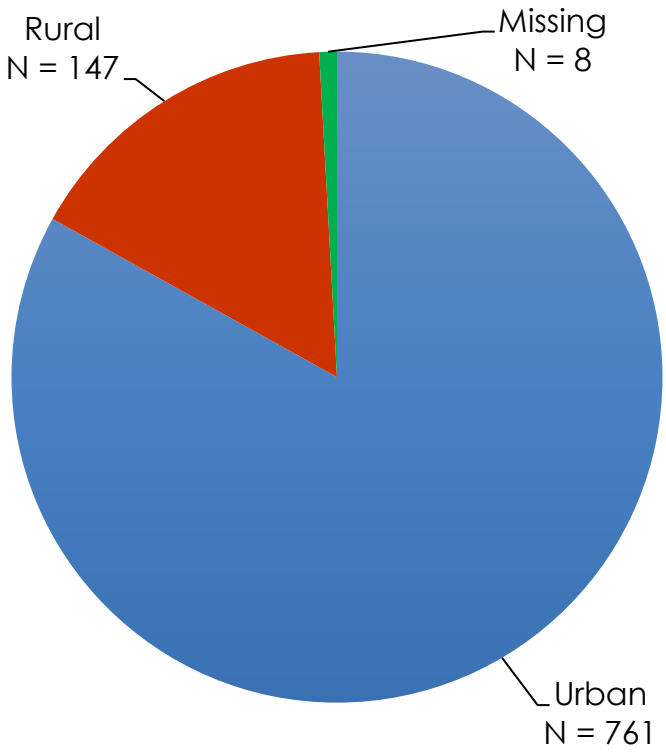


TABLE 13 – RESPONDENTS BY REGION

| REGION NAME | NUMBER (N) | PERCENT |
|---|---|---|
| Los Angeles County and Vicinity | 275 | 30.0 |
| San Francisco Bay Area | 160 | 17.5 |
| San Diego County and Vicinity | 97 | 10.6 |
| San Joaquin Valley | 94 | 10.3 |
| Riverside and Vicinity | 92 | 10.0 |
| South/Central Coast | 72 | 7.9 |
| Sacramento Valley | 58 | 6.3 |
| Sierra Mountain Valley | 29 | 3.2 |
| North Coast | 23 | 2.5 |
| Shasta-Cascade | 5 | .5 |
| Missing | 11 | 1.2 |
| Total | 916 | 100.0 |

# CHAPTER 4 | DATA ANALYSIS AND RESULTS

## RELIABILITY OF RATINGS

OPES evaluated the task and knowledge ratings obtained from the questionnaire respondents with a standard index of reliability, coefficient alpha (a), which ranges from 0 to 1. Coefficient alpha is an estimate of the internal consistency of the respondents' ratings of the tasks and knowledge statements. A higher coefficient value indicates more consistency between respondent ratings. Coefficients were calculated for all respondent ratings.

Table 14 displays the reliability coefficients for the task rating scale in each content area. The overall ratings of task frequency and task importance within each content area showed moderate reliability. Table 15 displays the reliability coefficients for the knowledge statement rating scale in each content area. The overall ratings of knowledge importance across each content area were highly reliable. These results indicate that the responding speech-language pathologists rated the tasks and knowledge statements consistently throughout the questionnaire.

TABLE 14 – TASK SCALE RELIABILITY

| CONTENT AREA | NUMBER OF TASKS | a FREQUENCY | a IMPORTANCE |
|---|---|---|---|
| 1. General Competencies | 15 | .790 | .783 |
| 2. Assessment | 21 | .848 | .852 |
| 3. Diagnosis, Goal Setting, and Treatment Planning | 6 | .687 | .664 |
| 4. Treatment Intervention and Procedures | 13 | .751 | .804 |
| 5. Treatment Outcomes and Effectiveness | 5 | .869 | .887 |
| Total | 60 | | |

TABLE 15 – KNOWLEDGE SCALE RELIABILITY

| CONTENT AREA | NUMBER OF KNOWLEDGE STATEMENTS | α IMPORTANCE |
|---|---|---|
| 1. General Competencies | 15 | .908 |
| 2. Assessment | 41 | .935 |
| 3. Diagnosis, Goal Setting, and Treatment Planning | 20 | .919 |
| 4. Treatment Intervention and Procedures | 23 | .906 |
| 5. Treatment Outcomes and Effectiveness | 5 | .911 |
| Total | 104 | |

## TASK CRITICALITY INDICES

To calculate the criticality indices of the task statements, OPES test specialists used the following formula. For each respondent, OPES first multiplied the frequency rating (Fi) and the importance rating (Ii) for each task. Next, OPES averaged the multiplication products across respondents as shown below:

Task criticality index = mean [(Fi) X (Ii)]

The tasks included in the survey are Appendix D, which includes their mean frequency and importance ratings and their associated criticality indices.

OPES test specialists convened a workshop of eight SMEs in September 2024. The purpose of this workshop was to identify the essential tasks and knowledge required for safe and competent speech-language pathologist practice at the time of licensure. The SMEs reviewed the mean frequency and importance ratings for each task and its criticality index to determine whether to establish a cutoff value below which tasks should be eliminated. Based on their review of the relative importance of tasks to speech-language pathologist practice, the SMEs determined that no cutoff value should be set and that all the tasks should be retained except for task 7 from Content Area 1 – General Competencies.

SMEs agreed to eliminate task 7 because ASHA requires 2 years of experience before allowing SLPs to supervise others. The eliminated task is highlighted in Appendix D.

## KNOWLEDGE IMPORTANCE RATINGS

To determine the importance of each knowledge statement, the mean importance (K Imp) rating for each knowledge statement was calculated. The knowledge statements included in the survey are presented in Appendix E, along with their mean importance ratings, sorted in descending order by content area.

The SMEs participating in the September 2024 workshop also reviewed the knowledge statement mean importance ratings. After reviewing the mean importance ratings and considering their relative importance to speech-language pathologist practice, the SMEs determined that no cutoff value should be set, and all the knowledge statements should be retained except for knowledge statements 10 and 11 from Content Area 1 – General Competencies. Knowledge statements 10 and 11 were eliminated because they were linked to the eliminated Task 7. The eliminated knowledge statements are highlighted in Appendix E.

## TASK-KNOWLEDGE LINKAGE

The SMEs who participated in the September 2024 workshop reviewed the preliminary assignments of the tasks and knowledge statements to content areas from the April 2024 workshop. They then confirmed the final linkage between tasks and knowledge statements.

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# **CHAPTER 5** | DESCRIPTION OF PRACTICE

## CONTENT AREAS AND WEIGHTS

The SMEs in the September 2024 workshop were also asked to finalize the weights of the content areas that would form the California Speech-Language Pathologist Description of Practice. OPES test specialists presented the SMEs with preliminary weights of the content areas, which were calculated by dividing the sum of the criticality indices for the tasks in each content area by the overall sum of the criticality indices for all tasks, as shown below.

$$\frac{\text{Sum of Criticality Indices for Tasks in Content Area}}{\text{Sum of Criticality Indices for All Tasks}} = \text{Percent Weight of Content Area}$$

The SMEs evaluated the preliminary content area weights in terms of how well they reflected the relative importance of each content area to entry-level speech-language pathologist practice in California. Through discussion, the SMEs determined that adjustments to the preliminary weights were necessary to reflect the relative importance of each area to speech-language pathologist practice more accurately. A summary of the preliminary and final content area weights is presented in Table 16.

TABLE 16 – CONTENT AREA WEIGHTS

| CONTENT AREA | PERCENT PRELIMINARY WEIGHT | PERCENT FINAL WEIGHT |
|---|---|---|
| 1. General Competencies | 27 | 15 |
| 2. Assessment | 32 | 25 |
| 3. Diagnosis, Goal Setting, and Treatment Planning | 13 | 25 |
| 4. Treatment Intervention and Procedures | 18 | 25 |
| 5. Treatment Outcomes and Effectiveness | 10 | 10 |
| Total | 100 | 100 |

The SMEs reviewed the content areas and wrote descriptions for each content area. The content areas and associated weights were then finalized and provide the basis of the California Speech-Language Pathology Description of Practice. The final description of practice is presented in Table 17.

TABLE 17 – CALIFORNIA SPEECH-LANGUAGE PATHOLOGY DESCRIPTION OF PRACTICE

**Content Area 1: General Competencies (15%)**

This area assesses a candidate's knowledge of linguistic and cultural awareness, applicable regulations, and professional and ethical standards related to core areas of practice across clients, disorders, and treatment settings.

| Tasks | | Associated Knowledge Statements | |
|---|---|---|---|
| T1. | Provide treatment plan to client that is consistent with professional and ethical standards. | K1. | Knowledge of professional guidelines, standards, and ethics related to Speech-Language Pathologist practice. |
| T2. | Maintain client confidentiality and security of documentation in compliance with federal and state regulations. | K4. | Knowledge of state and federal laws and regulations related to client rights and legal protections. |
| T3. | Maintain health and safety protocols for preventing disease transmission in compliance with state regulations. | K3. | Knowledge of laws and regulations related to client and worker health and safety, including universal precautions. |
| T4. | Provide culturally and linguistically relevant services in assessment and treatment decisions. | K7. | Knowledge of cultural and linguistic differences that affect assessment and treatment of diverse client populations, families, and caregivers. |
| T5. | Collaborate with other professionals to provide a treatment plan that is culturally and linguistically relevant. | K6.<br>K7. | Knowledge of collaboration models used to develop relationships with clients, client families, caregivers, and other professionals.<br>Knowledge of cultural and linguistic differences that affect assessment and treatment of diverse client populations, families, and caregivers. |

**Content Area 1: General Competencies (15%), continued**

This area assesses a candidate's knowledge of linguistic and cultural awareness, applicable regulations, and professional and ethical standards related to core areas of practice across clients, disorders, and treatment settings.

| Tasks | | Associated Knowledge Statements | |
|---|---|---|---|
| T6. | Refer client to other professionals or agencies based on the Speech-Language Pathologist competency level and client needs. | K5. | Knowledge of procedures to use to advocate for specialized programs that support quality client care. |
| | | K8. | Knowledge of different approaches to communicate information about client condition, care, and treatment to clients, the client families, caregivers, and other professionals. |
| | | K15. | Knowledge of available resources for clients, client families, and caregivers to support quality client care. |
| T8. | Communicate clinical information to the client, the client's family, and other professionals in compliance with regulatory guidelines. | K1. | Knowledge of professional guidelines, standards, and ethics related to Speech-Language Pathologist practice. |
| | | K2. | Knowledge of state and federal regulations that impact Speech-Language Pathologist practice. |
| | | K12. | Knowledge of professional standards of written communication for different clinical and educational purposes. |
| T9. | Educate and train the client, the client's family, and other care providers in techniques and strategies that will support the client's treatment. | K6. | Knowledge of collaboration models used to develop relationships with clients, client families, caregivers, and other professionals. |
| | | K9. | Knowledge of procedures for counseling and educating the clients, client families, caregivers, and other professionals about client care and treatment. |
| | | K15. | Knowledge of available resources for clients, client families, and caregivers to support quality client care. |

**Content Area 1: General Competencies (15%), continued**

This area assesses a candidate's knowledge of linguistic and cultural awareness, applicable regulations, and professional and ethical standards related to core areas of practice across clients, disorders, and treatment settings.

| Tasks | | Associated Knowledge Statements | |
|---|---|---|---|
| T10. | Review diagnostic and treatment reports, treatment plans, and professional correspondence when developing client's treatment plan. | K1.<br>K14. | Knowledge of professional guidelines, standards, and ethics related to Speech-Language Pathologist practice.<br>Knowledge of methods for integrating research outcomes into evidence-based clinical and educational practice. |
| T11. | Document diagnostic and treatment reports, treatment plans, treatment activities, session logs, and professional correspondence consistent with professional standards. | K12. | Knowledge of professional standards of written communication for different clinical and educational purposes. |
| T12. | Implement research and evidence-based practices to provide quality care to clients. | K13.<br>K14. | Knowledge of procedures for applying research methodology and the scientific method to clinical and educational practice.<br>Knowledge of methods for integrating research outcomes into evidence-based clinical and educational practice. |
| T13. | Provide in-service training to increase awareness of communication and swallowing disorders. | K8. | Knowledge of different approaches to communicate information about client condition, care, and treatment to clients, the client families, caregivers, and other professionals. |

**Content Area 1: General Competencies (15%), continued**

This area assesses a candidate's knowledge of linguistic and cultural awareness, applicable regulations, and professional and ethical standards related to core areas of practice across clients, disorders, and treatment settings.

| Tasks | | Associated Knowledge Statements | |
|---|---|---|---|
| T14. | Participate in community education to increase awareness of communication and swallowing disorders. | K4. | Knowledge of state and federal laws and regulations related to client rights and legal protections. |
| | | K5. | Knowledge of procedures to use to advocate for specialized programs that support quality client care. |
| | | K8. | Knowledge of different approaches to communicate information about client condition, care, and treatment to clients, the client families, caregivers, and other professionals. |
| | | K15. | Knowledge of available resources for clients, client families, and caregivers to support quality client care. |
| T15. | Follow guidelines for use of interpreters and translators for non-English speaking clients. | K1. | Knowledge of professional guidelines, standards, and ethics related to Speech-Language Pathologist practice. |
| | | K7. | Knowledge of cultural and linguistic differences that affect assessment and treatment of diverse client populations, families, and caregivers. |

**Content Area 2: Assessment (25%)**

This area assesses a candidate's knowledge of identifying and evaluating speech, language, social communication, cognition, voice, and swallowing disorders.

| Tasks | Associated Knowledge Statements |
|---|---|
| T16. Identify individuals and groups at risk for communication and swallowing disorders based on work setting protocols. | K16. Knowledge of effects of cognitive, behavioral, and cultural and linguistic factors on communication, feeding, and swallowing behaviors.<br>K25. Knowledge of the phonologic, morphologic, syntactic, semantic, and social-pragmatic aspects of typical human communication and their development.<br>K26. Knowledge of neurodiversity and its impact on social-pragmatic communication development.<br>K47. Knowledge of typical progression and development in the acquisition of English for learners who are non-native English speakers.<br>K48. Knowledge of social, familial, cultural, and linguistic influences on communication. |

**Content Area 2: Assessment (25%), continued**

This area assesses a candidate's knowledge of identifying and evaluating speech, language, social communication, cognition, voice, and swallowing disorders.

| Tasks | | Associated Knowledge Statements | |
|---|---|---|---|
| T17. | Screen for presence of communication and swallowing disorders based on federal and state regulations and work setting protocols. | K17. | Knowledge of screening procedures for social-pragmatic communication disorders. |
| | | K18. | Knowledge of screening procedures for feeding and swallowing disorders. |
| | | K19. | Knowledge of screening procedures for hearing impairments. |
| | | K20. | Knowledge of screening procedures for speech and language disorders involving voice, resonance, and fluency. |
| | | K21. | Knowledge of screening procedures for cognitive-linguistic impairments. |
| | | K22. | Knowledge of screening procedures for language disorders. |
| | | K23. | Knowledge of screening procedures for articulation, phonology, and motor-speech disorders. |
| | | K55. | Knowledge of procedures for performing and interpreting client screenings and assessments using augmentative and alternative communication (AAC) and prosthetic communication devices. |
| T18. | Identify indicators that prompt further assessment or referral. | K27. | Knowledge of effects of communication and feeding and swallowing impairments on client behavior, emotional adjustment, health status, and client academic, vocational, and social success. |
| | | K30. | Knowledge of psychosocial impact of communication and feeding and swallowing disorders across the lifespan. |
| | | K31. | Knowledge of epidemiology of communication and feeding and swallowing disorders. |

**Content Area 2: Assessment (25%), continued**

This area assesses a candidate's knowledge of identifying and evaluating speech, language, social communication, cognition, voice, and swallowing disorders.

| Tasks | | Associated Knowledge Statements | |
|---|---|---|---|
| T19. | Assess client history to identify potential causal factors and correlates related to client communication and swallowing status. | K28.<br>K32.<br>K49. | Knowledge of methods and procedures for obtaining client case history and performing client assessment.<br>Knowledge of effects of neurotoxins and drugs on communication, feeding, and swallowing.<br>Knowledge of procedures for basic interpretation of audiograms. |
| T20. | Document observed client behaviors and emotions that impact assessment. | K17.<br>K45.<br>K46.<br>K48. | Knowledge of screening procedures for social-pragmatic communication disorders.<br>Knowledge of strategies for managing challenging client behaviors during assessment.<br>Knowledge of strategies for engaging clients and client families in the assessment process.<br>Knowledge of social, familial, cultural, and linguistic influences on communication. |
| T21. | Select assessment instruments, procedures, settings, and materials based on client needs including cultural and linguistic factors. | K33. | Knowledge of standardized methods and procedures for conducting objective assessments. |

**Content Area 2: Assessment (25%), continued**

This area assesses a candidate's knowledge of identifying and evaluating speech, language, social communication, cognition, voice, and swallowing disorders.

| Tasks | | Associated Knowledge Statements | |
|---|---|---|---|
| T22. | Assess client in all areas of suspected disorder or impairment including voice, resonance, swallowing, fluency, articulation, phonology, morphology, syntax, semantics, pragmatics, cognitive-communication, and communication modalities. | K33. | Knowledge of standardized methods and procedures for conducting objective assessments. |
| T23. | Assess client's communication in the area of fluency. | K54. | Knowledge of procedures for assessing fluency including types of dysfluency, concomitant behaviors, and cognitive-affective and social-emotional factors. |
| T24. | Assess client's communication in the areas of articulation and intelligibility. | K34. | Knowledge of procedures for assessing speech sound production including perceptual characteristics, oral and physiological structure, motor planning, and execution. |
| T25. | Assess client's language including phonology, morphology, syntax, semantics, and social-pragmatics. | K25. | Knowledge of the phonologic, morphologic, syntactic, semantic, and social-pragmatic aspects of typical human communication and their development. |
| | | K26. | Knowledge of neurodiversity and its impact on social-pragmatic communication development. |
| | | K38. | Knowledge of procedures for assessing language and communication including phonology, morphology, syntax, semantics, social-pragmatics, and oral language aspects of literacy and prelinguistic communication. |

**Content Area 2: Assessment (25%), continued**

This area assesses a candidate's knowledge of identifying and evaluating speech, language, social communication, cognition, voice, and swallowing disorders.

| Tasks | | Associated Knowledge Statements | |
|---|---|---|---|
| T26. | Assess client's cognitive-linguistic functioning. | K39. | Knowledge of procedures for assessing cognition including attention, memory retention, memory retrieval, sequencing, problem solving, thought organization, and executive functioning. |
| T27. | Assess client's feeding and swallowing. | K27. | Knowledge of effects of communication and feeding and swallowing impairments on client behavior, emotional adjustment, health status, and client academic, vocational, and social success. |
| | | K29. | Knowledge of effects of medical conditions, procedures, and treatments on communication, feeding and swallowing. |
| | | K32. | Knowledge of effects of neurotoxins and drugs on communication, feeding, and swallowing. |
| | | K40. | Knowledge of procedures for identifying structural, physiological, sensory, or behavior-based oropharyngeal and esophageal deficits and their effects on client feeding and swallowing. |
| | | K43. | Knowledge of procedures for assessing orofacial myofunctional disorders. |
| | | K50. | Knowledge of principles of assessing adequacy of anatomical and physiological structures using imaging. |
| | | K51. | Knowledge of principles of assessing adequacy of anatomical and physiological structures using aerodynamic analysis. |
| | | K52. | Knowledge of principles of assessing adequacy of anatomical and physiological structures by applying acoustic measures, tactile cues, and electromyography (EMG). |
| | | K53. | Knowledge of principles of calibration and operation of instrumentation. |

**Content Area 2: Assessment (25%), continued**

This area assesses a candidate's knowledge of identifying and evaluating speech, language, social communication, cognition, voice, and swallowing disorders.

| Tasks | | Associated Knowledge Statements | |
|---|---|---|---|
| T28. | Assess client's communication in the areas of motor speech and intelligibility. | K24.<br>K34. | Knowledge of the characteristics of speech, including acoustics, aerodynamics, and articulatory movements.<br>Knowledge of procedures for assessing speech sound production including perceptual characteristics, oral and physiological structure, motor planning, and execution. |
| T29. | Assess client's communication skills as they relate to aural rehabilitation. | K41.<br>K49.<br>K53. | Knowledge of procedures for assessing language processing.<br>Knowledge of procedures for basic interpretation of audiograms.<br>Knowledge of principles of calibration and operation of instrumentation. |
| T30. | Assess client's options for alaryngeal communication. | K37. | Knowledge of procedures for assessing alaryngeal speech. |
| T31. | Assess impact of client communication impairment on academic, social, and vocational functioning based on federal and state eligibility criteria. | K27.<br>K44. | Knowledge of effects of communication and feeding and swallowing impairments on client behavior, emotional adjustment, health status, and client academic, vocational, and social success.<br>Knowledge of procedures for performing school assessments in compliance with California Education Code. |

**Content Area 2: Assessment (25%), continued**

This area assesses a candidate's knowledge of identifying and evaluating speech, language, social communication, cognition, voice, and swallowing disorders.

| Tasks | | Associated Knowledge Statements | |
|---|---|---|---|
| T32. | Assess client readiness for prosthetic management as related to functional communication. | K24.<br>K35.<br>K36.<br>K55. | Knowledge of the characteristics of speech, including acoustics, aerodynamics, and articulatory movements.<br>Knowledge of procedures for assessing resonance including oral, nasal, and velopharyngeal structures and functions.<br>Knowledge of procedures for assessing voice including respiratory, supralaryngeal, laryngeal, and pharyngeal structure and functions.<br>Knowledge of procedures for performing and interpreting client screenings and assessments using augmentative and alternative communication (AAC) and prosthetic communication devices. |
| T33. | Assess client readiness for augmentative and alternative communication (AAC) for functional communication. | K42.<br>K55. | Knowledge of procedures for assessing client ability to use and benefit from augmentative and alternative communication (AAC).<br>Knowledge of procedures for performing and interpreting client screenings and assessments using augmentative and alternative communication (AAC) and prosthetic communication devices. |
| T34. | Perform instrumental assessment of supralaryngeal, laryngeal, and pharyngeal subsystems to further assess swallowing function and severity of dysphagia. | K36.<br>K40.<br>K50. | Knowledge of procedures for assessing voice including respiratory, supralaryngeal, laryngeal, and pharyngeal structure and functions.<br>Knowledge of procedures for identifying structural, physiological, sensory, or behavior-based oropharyngeal and esophageal deficits and their effects on client feeding and swallowing.<br>Knowledge of principles of assessing adequacy of anatomical and physiological structures using imaging. |

**Content Area 2: Assessment (25%), continued**

This area assesses a candidate's knowledge of identifying and evaluating speech, language, social communication, cognition, voice, and swallowing disorders.

| Tasks | | Associated Knowledge Statements | |
|---|---|---|---|
| T35. | Consider client English language proficiency level when determining the need for bilingual assessment of English language learners. | K47. | Knowledge of typical progression and development in the acquisition of English for learners who are non-native English speakers. |
| T36. | Provide assessment results to the client, the client's family, other professionals, and referral sources to facilitate service transition. | K48.<br>K56. | Knowledge of social, familial, cultural, and linguistic influences on communication.<br>Knowledge of potential impacts of client communication impairment on client-family or -caregiver relationships. |

**Content Area 3: Diagnosis, Goal Setting, and Treatment Planning (25%)**

This area assesses a candidate's knowledge of interpreting and analyzing assessment information for accurate diagnosis and of developing treatment plans and interventions.

| Tasks | | Associated Knowledge Statements | |
|---|---|---|---|
| T37. | Analyze assessment results to identify and prioritize treatment of communication or swallowing disorders. | K64. | Knowledge of effects of oral, pharyngeal, and laryngeal anomalies on communication, feeding, and swallowing. |
| | | K66. | Knowledge of effects of neurological disorder and dysfunction on communication, feeding, and swallowing. |
| | | K71. | Knowledge of components of diagnostic assessment reports that provide comprehensive description of client communication, feeding, and swallowing. |
| | | K72. | Knowledge of procedures for determining eligibility, initiating treatment, and prioritizing treatment targets. |
| | | K74. | Knowledge of procedures for differential diagnosis. |

**Content Area 3: Diagnosis, Goal Setting, and Treatment Planning (25%), continued**

This area assesses a candidate's knowledge of interpreting and analyzing assessment information for accurate diagnosis and of developing treatment plans and interventions.

| Tasks | | Associated Knowledge Statements | |
|---|---|---|---|
| T38. | Analyze assessment results to identify accommodations or modifications that may be required in client environment. | K57. | Knowledge of effects of genetic disorders on communication, feeding, and swallowing. |
| | | K58. | Knowledge of effects of neonatal risk factors on communication, feeding, and swallowing. |
| | | K61. | Knowledge of procedures for identifying and adapting to the demands of client linguistic abilities, cognitive abilities, and social environments to improve communication. |
| | | K62. | Knowledge of effects of developmental disabilities on communication, feeding, and swallowing. |
| | | K63. | Knowledge of effects of auditory deficits on client communication and on client academic, social, and vocational skills. |
| | | K64. | Knowledge of effects of oral, pharyngeal, and laryngeal anomalies on communication, feeding, and swallowing. |
| | | K65. | Knowledge of effects of respiratory compromise on communication, feeding, and swallowing. |
| | | K66. | Knowledge of effects of neurological disorder and dysfunction on communication, feeding, and swallowing. |
| | | K67. | Knowledge of effects of psychiatric disorders on communication, feeding, and swallowing. |
| | | K68. | Knowledge of effects of gastrointestinal disorders on communication, feeding, and swallowing. |
| | | K75. | Knowledge of effects of sensory processing and behavioral disorders on communication, feeding, and swallowing. |

**Content Area 3: Diagnosis, Goal Setting, and Treatment Planning (25%), continued**

This area assesses a candidate's knowledge of interpreting and analyzing assessment information for accurate diagnosis and of developing treatment plans and interventions.

| Tasks | | Associated Knowledge Statements | |
|---|---|---|---|
| T39. | Document assessment results to develop comprehensive description of client communication strengths and weaknesses. | K60. | Knowledge of professional standards for documenting assessment results and treatment recommendations. |
| | | K71. | Knowledge of components of diagnostic assessment reports that provide comprehensive description of client communication, feeding, and swallowing. |
| T40. | Develop evidence-based treatment plans that includes goals, objectives, and interventions based on client needs. | K60. | Knowledge of professional standards for documenting assessment results and treatment recommendations. |
| | | K61. | Knowledge of procedures for identifying and adapting to the demands of client linguistic abilities, cognitive abilities, and social environments to improve communication. |
| | | K69. | Knowledge of procedures for developing and defining treatment goals, service delivery options, treatment supports, and resources. |
| | | K73. | Knowledge of procedures for determining optimal treatment settings based on assessment results. |
| T41. | Determine specific augmentative and alternative communication systems and treatment plans. | K59. | Knowledge of interventions and procedures for using aided and unaided augmentative and alternative communication (AAC) applications in diagnosis and treatment. |
| | | K72. | Knowledge of procedures for determining eligibility, initiating treatment, and prioritizing treatment targets. |

**Content Area 3: Diagnosis, Goal Setting, and Treatment Planning (25%), continued**

This area assesses a candidate's knowledge of interpreting and analyzing assessment information for accurate diagnosis and of developing treatment plans and interventions.

| Tasks | Associated Knowledge Statements |
|---|---|
| T42. Collaborate with clients, client families, caregivers, other professionals, and referral sources to gain consensus on the treatment plan based on assessment results and treatment plan. | K70. Knowledge of procedures for gaining consensus and support with clients and client families regarding options for the treatment plans.<br>K76. Knowledge of procedures for addressing family and caregiver factors that impact client care and treatment. |

**Content Area 4: Treatment Intervention and Procedures (25%)**

This area assesses a candidate's knowledge of delivering culturally relevant treatment interventions and procedures based on assessment and diagnostic information that are measurable, objective, and consistent with the client's readiness and ability to engage in treatment.

| Tasks | | Associated Knowledge Statements | |
|---|---|---|---|
| T43. | Provide treatment interventions to improve client articulation and phonological skills. | K77. | Knowledge of interventions for treating speech sound disorders including perceptual characteristics, physiological structure, and function. |
| | | K88. | Knowledge of the phonemic repertoire of the English language and its grammatical structure and other aspects of speech and language sufficient to discriminate and produce acoustically correct models for client. |
| T44. | Provide treatment interventions to improve client voice and resonance given medical clearance. | K79. | Knowledge of interventions for treating resonance disorders including those related to oral, nasal, and velopharyngeal structures and functions. |
| | | K80. | Knowledge of interventions for treating voice disorders including those related to respiratory, supralaryngeal, and laryngeal structures and functions. |
| T45. | Provide treatment interventions to improve client fluency. | K97. | Knowledge of interventions for treating fluency disorders, including types of dysfluency, concomitant behaviors, and cognitive-affective and social-emotional factors. |
| T46. | Provide treatment interventions to improve client language morphology, syntax, semantics, pragmatics, and communication modalities. | K82. | Knowledge of interventions for treating language and communication disorders in the areas of phonology, morphology, syntax, semantics, social-pragmatics, and oral language as they apply to literacy and prelinguistic communication. |

**Content Area 4: Treatment Intervention and Procedures (25%), continued**

This area assesses a candidate's knowledge of delivering culturally relevant treatment interventions and procedures based on assessment and diagnostic information that are measurable, objective, and consistent with the client's readiness and ability to engage in treatment.

| Tasks | | Associated Knowledge Statements | |
|---|---|---|---|
| T47. | Provide treatment interventions to improve client cognitive-communication skills. | K78. | Knowledge of interventions for treating neurogenic speech disorders. |
| | | K83. | Knowledge of interventions for treating cognition in the areas of attention, memory retention, memory retrieval, sequencing, problem solving, thought organization, and executive functioning. |
| T48. | Provide treatment interventions to improve client feeding and swallowing. | K84. | Knowledge of interventions for treating feeding and swallowing disorders including those related to oral, pharyngeal, laryngeal, and esophageal structures and functions. |
| | | K85. | Knowledge of interventions for treating feeding and swallowing disorders including those related to nutritional and hydration status, sensory issues, and behavior. |
| | | K87. | Knowledge of interventions for treating orofacial myofunctional disorders. |
| T49. | Provide treatment interventions to improve client communication skills related to aural rehabilitation. | K98. | Knowledge of interventions and procedures for treating communication impairments in the area of language processing. |
| | | K99. | Knowledge of interventions, procedures, and equipment for aural rehabilitation related to hearing loss. |

**Content Area 4: Treatment Intervention and Procedures (25%), continued**

This area assesses a candidate's knowledge of delivering culturally relevant treatment interventions and procedures based on assessment and diagnostic information that are measurable, objective, and consistent with the client's readiness and ability to engage in treatment.

| Tasks | | Associated Knowledge Statements |
|---|---|---|
| T50. | Provide treatment interventions that consider client age, primary language background, cognitive and physical abilities, emotional and behavioral status, and culture. | K92. Knowledge of interventions for adapting to the demands of client linguistic, cognitive, and social environments to improve client communication.<br>K93. Knowledge of instructional accommodations and modifications for improving client learning environment.<br>K94. Knowledge of strategies for maintaining client engagement in treatment programs.<br>K95. Knowledge of strategies for managing challenging client behavior. |
| T51. | Provide treatment interventions and strategies that support communication between clients and communication partners. | K86. Knowledge of interventions for treating neurodiverse clients diagnosed with communication disorders.<br>K94. Knowledge of strategies for maintaining client engagement in treatment programs.<br>K95. Knowledge of strategies for managing challenging client behavior.<br>K96. Knowledge of strategies for facilitating and managing group therapy sessions. |
| T52. | Provide training to family and caregivers to support client treatment. | K91. Knowledge of procedures for training family, caregivers, and support personnel in the programming and use of clients augmentative and alternative communication (AAC) device.<br>K94. Knowledge of strategies for maintaining client engagement in treatment programs. |

**Content Area 4: Treatment Intervention and Procedures (25%), continued**

This area assesses a candidate's knowledge of delivering culturally relevant treatment interventions and procedures based on assessment and diagnostic information that are measurable, objective, and consistent with the client's readiness and ability to engage in treatment.

| Tasks | | Associated Knowledge Statements | |
|---|---|---|---|
| T53. | Produce acoustically correct models for targeted phonemes, grammatical features, and other aspects of speech and language as identified in treatment plans. | K77. | Knowledge of interventions for treating speech sound disorders including perceptual characteristics, physiological structure, and function. |
| | | K88. | Knowledge of the phonemic repertoire of the English language and its grammatical structure and other aspects of speech and language sufficient to discriminate and produce acoustically correct models for client. |
| T54. | Provide treatment for alaryngeal speech using instrumental and non-instrumental interventions. | K81. | Knowledge of interventions for treating communication disorders involving alaryngeal speech. |
| T55. | Implement augmentative and alternative communication (AAC) interventions that meet client immediate and ongoing treatment needs. | K89. | Knowledge of interventions using aided and unaided augmentative and alternative communication (AAC) applications in treatment. |
| | | K90. | Knowledge of procedures for selecting augmentative and alternative communication (AAC) applications that meet client treatment needs. |
| | | K91. | Knowledge of procedures for training family, caregivers, and support personnel in the programming and use of clients augmentative and alternative communication (AAC) device. |

**Content Area 5: Treatment Outcomes and Effectiveness (10%)**

This area assesses a candidate's knowledge of interpreting data to determine client progress and treatment efficacy in relation to goals and of modifying treatment plans as appropriate.

| Tasks | | Associated Knowledge Statements | |
|---|---|---|---|
| T56. | Establish methods for monitoring treatment progress and outcomes to evaluate treatment plan efficacy. | K100.<br>K102. | Knowledge of data collection and analysis methodologies for assessing status, evaluating progress, and modifying treatment plans.<br>Knowledge of procedures for evaluating the effectiveness of specific treatment strategies. |
| T57. | Collect treatment outcome data to measure client functional gains and efficacy of targeted environmental modifications. | K100.<br>K102. | Knowledge of data collection and analysis methodologies for assessing status, evaluating progress, and modifying treatment plans.<br>Knowledge of procedures for evaluating the effectiveness of specific treatment strategies. |
| T58. | Use data to modify client treatment plans and to determine client readiness for dismissal or discharge from treatment. | K103. | Knowledge of components of progress reports and discharge summaries to provide post-treatment status and recommendations for follow-up. |
| T59. | Write progress reports or discharge summaries to document client progress and level of functioning related to focus of treatment. | K100.<br>K104. | Knowledge of data collection and analysis methodologies for assessing status, evaluating progress, and modifying treatment plans.<br>Knowledge of professional standards for written communication regarding client progress reports and discharge summaries. |

**Content Area 5: Treatment Outcomes and Effectiveness (10%), continued**

This area assesses a candidate's knowledge of interpreting data to determine client progress and treatment efficacy in relation to goals and of modifying treatment plans as appropriate.

| Tasks | Associated Knowledge Statements |
|---|---|
| T60. Provide recommendations to client at completion of treatment. | K101. Knowledge of the defined guidelines for discharge from treatment.<br>K103. Knowledge of components of progress reports and discharge summaries to provide post-treatment status and recommendations for follow-up.<br>K104. Knowledge of professional standards for written communication regarding client progress reports and discharge summaries. |

# CHAPTER 6 | CONCLUSION

The OA of the speech-language pathologist profession described in this report provides a comprehensive description of current speech-language pathologist practice in California. The procedures employed to perform the OA were based on a content validation strategy to ensure that the results accurately represent speech-language pathologist practice. Results of this OA provide information regarding current practice that can be used to review the Praxis Speech-Language Pathology Test developed by ETS.

Use of the California Speech-Language Pathology Description of Practice contained in this report ensures that the Board is compliant with BPC § 139.

This report provides all documentation necessary to verify that the analysis has been completed in accordance with legal, professional, and technical standards.

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## **APPENDIX A** | QUESTIONNAIRE

## Message from the California Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD
1601 Response Road, Suite 260, Sacramento, CA 95815
P (916) 287-7915 | www.speechandhearing.ca.gov

06/20/2024

Dear Licensed Speech-Language Pathologist:

Thank you for opening this online survey. You have been selected to participate in an occupational analysis of the speech-language pathologist profession by the California Speech-Language Pathology and Audiology and Hearing Aid Dispensers (Board).

The Board is collecting information about the tasks currently performed by speech-language pathologists in California, the importance of the tasks, and the knowledge needed to perform the tasks safely and effectively. We will use this information to ensure that the national speech-language pathologist examinations reflect current practice in California. We worked with different groups of speech-language pathologists to develop a survey to capture this information.

The survey should take about one hour to complete. For your convenience, you do not have to complete the survey in a single session. You can resume where you stopped as long as you reopen the survey from the same computer and use the same web browser. Before you exit, complete the page that you are on. The program will save responses only on completed pages.

Your responses will be kept confidential. They will not be tied to your license or personal information. Individual responses will be combined with responses from other speech-language pathologists, and only group data will be analyzed.

The weblink is available 24 hours a day, 7 days a week. Please submit your completed survey by September 13, 2024. If you have questions or need assistance with the survey, please contact Maria Avalos with the Office of Professional Examination Services at Maria.Avalos@dca.ca.gov.

We value your contributions and appreciate your dedication to the speech-language pathologist profession in California. You will be credited two hours of continuing education upon completion of the survey.

Sincerely,

Paul Sanchez
Executive Officer




## Part I - Personal Data

**Complete this survey only if you are currently licensed and have worked as a speech-language pathologist in California within the last 12 months.**

**The Board recognizes that every licensed speech-language pathologist may not perform all of the tasks or use all of the knowledge contained in this survey. However, your participation is essential to the success of this study.**

**The information you provide here is voluntary and confidential. It will be treated as personal information subject to the Information Practices Act (Civil Code section 1798 et seq.) and will be used only for the purpose of analyzing the data from this survey.**

* 1. Do you currently work as a licensed speech-language pathologist in California?

- ◯ Yes
- ◯ No




## Part I - Personal Data

2. How many years have you been licensed as a speech-language pathologist in California?

- ◯ 0–5
- ◯ 6–10
- ◯ 11–20
- ◯ 21–29
- ◯ 30 or more

3. How many hours a week do you work as a speech-language pathologist?

- ◯ 10 or fewer
- ◯ 11–20
- ◯ 21–30
- ◯ 31–40
- ◯ 41 or more

4. What is your highest level of education?

- ◯ Master's in speech-language pathology or communication
- ◯ Doctorate in speech-language pathology or communication
- ◯ Other formal education (please specify)

5. How would you classify the majority of your responsibilities as a licensed speech-language pathologist?

- ◯ Clinical services provider
- ◯ College / university professor / instructor
- ◯ Consultant
- ◯ Director / Chair of an education program
- ◯ Director / Supervisor of a clinical program
- ◯ School-based service provider
- ◯ Supervisor of clinicians
- ◯ CEU provider
- ◯ Other (Please specify)

6. Which of the following services is your primary activity?

- ◯ Client IEP (IDT meetings)
- ◯ Client documentation / reports
- ◯ Family and caregiver contact / counseling
- ◯ Direct client care (screening, assessment, treatment)
- ◯ Treatment planning / preparation
- ◯ Collaboration / consultation (professional staff, teachers)
- ◯ Supervision (SLP-associated medical staff, support staff)
- ◯ Research / grant writing
- ◯ Teaching / training (staff, students, parents)
- ◯ Case management (intake, referrals, follow-up)
- ◯ Pre-referral interventions
- ◯ Administrative (scheduling, staffing, HR, meetings)
- ◯ Professional development

7. Which of the following services is your secondary activity?

- ◯ Client IEP (IDT meetings)
- ◯ Client documentation / reports
- ◯ Family and caregiver contact / counseling
- ◯ Direct client care (screening, assessment, treatment)
- ◯ Treatment planning / preparation
- ◯ Collaboration / consultation (professional staff, teachers)
- ◯ Supervision (SLP-associated medical staff, support staff)
- ◯ Research / grant writing
- ◯ Teaching / training (staff, students, parents)
- ◯ Case management (intake, referrals, follow-up)
- ◯ Prereferral interventions
- ◯ Administrative (scheduling, staffing, HR, meetings)
- ◯ Professional development

8. In which of the following settings do you currently provide services? (Check all that apply.)

- ☐ Correctional facility
- ☐ Public school
- ☐ Group home / sheltered workshop
- ☐ Regional Center
- ☐ Home health / assisted living
- ☐ Skilled nursing / acute rehab / long-term care / subacute care
- ☐ Hospital
- ☐ Speech and language clinic
- ☐ Nonpublic school (NPS)
- ☐ University / university clinic
- ☐ Preschool / day care
- ☐ Web-based treatment / telemedicine
- ☐ Private practice
- ☐ Other (please specify)

9. What age groups do you currently serve? (Check all that apply.)

- [ ] Older adults (71+ years of age)
- [ ] Adults (23–70 years of age)
- [ ] Young adults (18–22 years of age)
- [ ] Adolescents (15–17 years of age)
- [ ] Young adolescents (12–14 years of age)
- [ ] Children (9–11years of age)
- [ ] Children (6–8 years of age)
- [ ] Preschool (3–5 years of age)
- [ ] Toddlers (1–2 years of age)
- [ ] Infants (0–12 months of age)
- [ ] Other (please specify)

10. What are your area(s) of specialization? (Check all that apply.)

- [ ] Alaryngeal speech
- [ ] Alternative and augmentative communication
- [ ] Aural rehabilitation
- [ ] Autism and related disorders
- [ ] Cognitive linguistic disorders
- [ ] Developmental disabilities
- [ ] Developmental language disorder
- [ ] Early intervention
- [ ] Feeding and swallowing disorders
- [ ] Fluency and fluency disorders
- [ ] Gerontology
- [ ] Hearing and hearing disorders
- [ ] Neurophysiological / neurogenic disorders
- [ ] Orofacial disorders
- [ ] Phonological disorders
- [ ] Speech sound disorders (articulation / phonology)
- [ ] Voice and voice disorders
- [ ] Other (please specify)

11. What other state-issued licenses do you hold? (Check all that apply.)

- [ ] None
- [ ] Audiologist
- [ ] Hearing Aid Dispenser
- [ ] Occupational Therapist
- [ ] Physical Therapist
- [ ] Other (please specify)

12. What other certificates / credentials do you hold? (Check all that apply.)

- [ ] None
- [ ] Administrative Services
- [ ] Applied Behavior Analysis
- [ ] Assistive Technology
- [ ] Bilingual, Crosscultural, Language and Academic Development (BCLAD)
- [ ] Crosscultural, Language and Academic Development (CLAD)
- [ ] Resource Specialist
- [ ] Special Education
- [ ] Teaching
- [ ] Other (please specify)

13. What is the location of your primary work setting?

- ( ) Urban (more than 50,000 people)
- ( ) Rural (fewer than 50,000 people)




**Part I - Personal Data**

14. In what California county do you perform the majority of your work as a speech-language pathologist?

- Alameda
- Alpine
- Amador
- Butte
- Calaveras
- Colusa
- Contra Costa
- Del Norte
- El Dorado
- Fresno
- Glenn
- Humboldt
- Imperial
- Inyo
- Kern
- Kings
- Lake
- Lassen
- Los Angeles
- Madera
- Marin
- Mariposa
- Mendocino
- Merced
- Modoc
- Mono
- Monterey
- Napa
- Nevada
- Orange
- Placer
- Plumas
- Riverside
- Sacramento
- San Benito
- San Bernardino
- San Diego
- San Francisco
- San Joaquin
- San Luis Obispo
- San Mateo
- Santa Barbara
- Santa Clara
- Santa Cruz
- Shasta
- Sierra
- Siskiyou
- Solano
- Sonoma
- Stanislaus
- Sutter
- Tehama
- Trinity
- Tulare
- Tuolumne
- Ventura
- Yolo
- Yuba




## Part II - Task Ratings

**INSTRUCTIONS FOR RATING TASKS**

**This part of the survey lists 60 tasks. Please rate each task as it relates to your current job as a speech-language pathologist.**
**Rate the tasks based on how often you perform the task (Frequency) and how important the task is for effective performance of your current job (Importance).**
**The boxes for rating the Frequency and Importance of each task have drop-down lists. Click on the "down" arrow in each box to see the rating options, and then select the value that applies to your current job. Your Frequency and Importance ratings should be separate and independent. The ratings that you assign using one rating scale should not influence the ratings that you assign using the other rating scale.**
**If the task is NOT part of your current job, rate the task "0" (zero) Frequency and "0" (zero) Importance. Use the following Frequency and Importance rating scales to rate each task statement.**
**FREQUENCY SCALE**
**HOW OFTEN do you perform these tasks in your current job? Make your ratings relative to all other tasks you have performed over the past year.**
**0 - DOES NOT APPLY TO MY CURRENT JOB. I do not perform this task in my current job.**
**1 - RARELY. I perform this task least often in my current job relative to other tasks I perform in my current job.**
**2 - SELDOM. I perform this task less often than most other tasks I perform in my current job.**
**3 - REGULARLY. I perform this task as often as other tasks I perform in my current job.**
**4 - OFTEN. I perform this task more often than most other tasks I perform in my current job.**
**5 - VERY OFTEN. I perform this task most often in my current job relative to other tasks I perform.**
**IMPORTANCE RATING SCALE**
**HOW IMPORTANT are these tasks in the effective performance of your current job?**
**0 - NOT IMPORTANT; DOES NOT APPLY TO MY CURRENT JOB. I do not perform this task in my current job.**
**1 - OF MINOR IMPORTANCE. This task is of minor importance for effective performance in my current job.**
**2 - FAIRLY IMPORTANT. This task is fairly important for effective performance in my current job.**
**3 - MODERATELY IMPORTANT. This task is moderately important for effective**

**performance in my current job.**
**4 - VERY IMPORTANT. This task is very important for effective performance in my current job.**
**5 - CRITICALLY IMPORTANT. This task is extremely**




## Part II - Task Ratings

### Content Area 1: General Competencies

15. Please rate the following tasks based on how often you perform the task (Frequency) and how important the task is for effective performance of your current job (Importance).

| | Frequency | Importance |
|---|---|---|
| 1 Provide treatment plan to client that is consistent with professional and ethical standards. | | |
| 2 Maintain client confidentiality and security of documentation in compliance with federal and state regulations. | | |
| 3 Maintain health and safety protocols for preventing disease transmission in compliance with state regulations. | | |
| 4 Provide culturally and linguistically relevant services into assessment and treatment decisions. | | |
| 5 Collaborate with other professionals to provide a treatment plan that is culturally and linguistically relevant. | | |
| 6 Refer client to other | | |

| | | |
|---|---|---|
| professionals or agencies based on the Speech-Language Pathologist competency level and client needs. | | |
| 7 Supervise Clinical Fellows, Required Professional Experience temporary license holders, Speech-Language Pathology Assistants, or interns who are acquiring a speech-language pathology services credentials according to professional and ethical standards. | | |
| 8 Communicate clinical information to the client, the client's family, and other professionals in compliance with regulatory guidelines. | | |
| 9 Educate and train the client, the client's family, and other care providers in techniques and strategies that will support the client's treatment. | | |
| 10 Review diagnostic and treatment reports, treatment plans, and professional correspondence when developing client's | | |

| | | |
|---|---|---|
| treatment plan. | | |
| 11 Document diagnostic and treatment reports, treatment plans, treatment activities, session logs, and professional correspondence consistent with professional standards. | | |
| 12 Implement research and evidence-based practices to provide quality care to clients. | | |
| 13 Provide in-service training to increase awareness of communication and swallowing disorders. | | |
| 14 Participate in community education to increase awareness of communication and swallowing disorders. | | |
| 15 Follow guidelines for use of interpreters and translators for non-English speaking clients. | | |




## Part II - Task Ratings

### Content Area 2: Assessment

16. Please rate the following tasks based on how often you perform the task (Frequency) and how important the task is for effective performance of your current job (Importance).

| | Frequency | Importance |
|---|---|---|
| 16 Identify individuals and groups at risk for communication and swallowing disorders based on work setting protocols. | | |
| 17 Screen for presence of communication and swallowing disorders based on federal and state regulations and work setting protocols. | | |
| 18 Identify indicators that prompt further assessment or referral. | | |
| 19 Assess client history to identify potential causal factors and correlates related to client communication and swallowing status. | | |
| 20 Document observed client behaviors and emotions that impact assessment. | | |
| 21 Select assessment instruments, procedures, | | |

| | | |
|---|---|---|
| settings, and materials based on client needs including cultural and linguistic factors. | | |
| 22 Assess client in all areas of suspected disorder or impairment including voice, resonance, swallowing, fluency, articulation, phonology, morphology, syntax, semantics, pragmatics, cognitive-communication, and communication modalities. | | |
| 23 Assess client's communication in the area of fluency. | | |
| 24 Assess client's communication in the areas of articulation and intelligibility. | | |
| 25 Assess client's language including phonology, morphology, syntax, semantics, and social-pragmatics. | | |
| 26 Assess client's cognitive-linguistic functioning. | | |
| 27 Assess client's feeding and swallowing. | | |
| 28 Assess client's communication in the areas of | | |

| | | |
|---|---|---|
| motor speech and intelligibility. | | |
| 29 Assess client's communication skills as they relate to aural rehabilitation. | | |
| 30 Assess client's options for alaryngeal communication. | | |
| 31 Assess impact of client communication impairment on academic, social, and vocational functioning based on federal and state eligibility criteria. | | |
| 32 Assess client readiness for prosthetic management as related to functional communication. | | |
| 33 Assess client readiness for alternative and augmentative communication (AAC) for functional communication. | | |
| 34 Perform instrumental assessment of supralaryngeal, laryngeal, and pharyngeal subsystems to further assess swallowing function and severity of dysphagia. | | |
| 35 Consider client English language proficiency level when determining the need for | | |

| | | |
|---|---|---|
| bilingual assessment of English language learners. | | |
| 36 Provide assessment results to the client, the client's family, other professionals, and referral sources to facilitate service transition. | | |




## Part II - Task Ratings

### Content Area 3: Diagnosis, Goal Setting, and Treatment Planning

17. Please rate the following tasks based on how often you perform the task (Frequency) and how important the task is for effective performance of your current job (Importance).

| | Frequency | Importance |
|---|---|---|
| 37 Analyze assessment results to identify and prioritize treatment of communication or swallowing disorders. | | |
| 38 Analyze assessment results to identify accommodations or modifications that may be required in client environment. | | |
| 39 Document assessment results to develop comprehensive description of client communication strengths and weaknesses. | | |
| 40 Develop evidence-based treatment plans that includes goals, objectives, and interventions based on client needs. | | |
| 41 Determine specific alternative and augmentative communication systems and | | |

| | | |
|---|---|---|
| treatment plans. | | |
| 42 Collaborate with clients, client families, caregivers, other professionals, and referral sources to gain consensus on the treatment plan based on assessment results and treatment plan. | | |

## Part II - Task Ratings

**Content Area 4: Treatment Interventions and Procedures**

**18. Please rate the following tasks based on how often you perform the task (Frequency) and how important the task is for effective performance of your current job (Importance).**

| | Frequency | Importance |
|---|---|---|
| 43 Provide treatment interventions to improve client articulation and phonological skills. | | |
| 44 Provide treatment interventions to improve client voice and resonance given medical clearance. | | |
| 45 Provide treatment interventions to improve client fluency. | | |
| 46 Provide treatment interventions to improve client language morphology, syntax, semantics, pragmatics, and communication modalities. | | |
| 47 Provide treatment interventions to improve client cognitive-communication skills. | | |
| 48 Provide treatment | | |

| | | |
|---|---|---|
| interventions to improve client feeding and swallowing. | | |
| 49 Provide treatment interventions to improve client communication skills related to aural rehabilitation. | | |
| 50 Provide treatment interventions that consider client age, primary language background, cognitive and physical abilities, emotional and behavioral status, and culture. | | |
| 51 Provide treatment interventions and strategies that support communication between clients and communication partners. | | |
| 52 Provide training to family and caregivers to support client treatment. | | |
| 53 Produce acoustically correct models for targeted phonemes, grammatical features, and other aspects of speech and language as identified in treatment plans. | | |
| 54 Provide treatment for alaryngeal speech using | | |

| | | |
|---|---|---|
| instrumental and non-instrumental interventions. | | |
| 55 Implement alternative and augmentative communication (AAC) interventions that meet client immediate and ongoing treatment needs. | | |




Part II - Task Ratings

**Content Area 5: Treatment Outcomes and Effectiveness**

19. Please rate the following tasks based on how often you perform the task (Frequency) and how important the task is for effective performance of your current job (Importance).

| | Frequency | Importance |
|---|---|---|
| 56 Establish methods for monitoring treatment progress and outcomes to evaluate treatment plan efficacy. | | |
| 57 Collect treatment outcome data to measure client functional gains and efficacy of targeted environmental modifications. | | |
| 58 Use data to modify client treatment plans and to determine client readiness for dismissal or discharge from treatment. | | |
| 59 Write progress reports or discharge summaries to document client progress and level of functioning related to focus of treatment. | | |
| 60 Provide recommendations to client at completion of treatment. | | |




## Part III - Knowledge Ratings

### INSTRUCTIONS FOR RATING KNOWLEDGE STATEMENTS

**This part of the survey contains 104 knowledge statements. Please rate each knowledge statement based on how important the knowledge is to the effective performance of the tasks in your current job as a speech-language pathologist. If a knowledge statement is NOT part of your current job, rate the statement "Does not apply to my current job; not required" for importance.**

### IMPORTANCE RATING SCALE

**HOW IMPORTANT is this knowledge in the effective performance of your current job? Use the following scale to make your ratings.**

**0 - DOES NOT APPLY TO MY CURRENT JOB; NOT REQUIRED. This knowledge is not required to perform my current job.**
**1 - OF MINOR IMPORTANCE. This knowledge is of minor importance for effective performance of my current job.**
**2 - FAIRLY IMPORTANT. This knowledge is fairly important for effective performance of my current job.**
**3 - MODERATELY IMPORTANT. This knowledge is moderately important for effective performance of my current job.**
**4 - VERY IMPORTANT. This knowledge is very important for effective performance of my current job.**
**5 - CRITICALLY IMPORTANT. This knowledge is essential for effective performance of my current job.**




## Part III - Knowledge Ratings

### Content Area 1: General Competencies

20.
How important is this knowledge for effective performance of tasks in your current job?

| | Does not apply to my job; not required | Of minor importance | Fairly important | Moderately important | Very important | Critically important |
|---|---|---|---|---|---|---|
| 1 Knowledge of professional guidelines, standards, and ethics related to Speech-Language Pathologist practice. | ○ | ○ | ○ | ○ | ○ | ○ |
| 2 Knowledge of state and federal regulations that impact Speech-Language Pathologist practice. | ○ | ○ | ○ | ○ | ○ | ○ |
| 3 Knowledge of laws and regulations related to client and worker health and safety, including universal precautions. | ○ | ○ | ○ | ○ | ○ | ○ |
| 4 Knowledge of state and federal laws and regulations related to client rights and legal protections. | ○ | ○ | ○ | ○ | ○ | ○ |
| 5 Knowledge of procedures to use to advocate for specialized programs that support quality client care. | ○ | ○ | ○ | ○ | ○ | ○ |
| 6 Knowledge of collaboration models used to develop relationships with clients, client families, caregivers, and other professionals. | ○ | ○ | ○ | ○ | ○ | ○ |
| 7 Knowledge of cultural and linguistic differences that affect assessment and treatment of diverse client populations, families, and caregivers. | ○ | ○ | ○ | ○ | ○ | ○ |
| 8 Knowledge of different approaches to communicate information about client condition, care, and treatment to clients, the client families, caregivers, and other professionals. | ○ | ○ | ○ | ○ | ○ | ○ |
| 9 Knowledge of procedures for counseling and educating the clients, client families, caregivers, and other professionals about client care and treatment. | ○ | ○ | ○ | ○ | ○ | ○ |
| 10 Knowledge of California regulations regarding supervision of Clinical | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Fellows, Required Professional Experience temporary license holders, Speech-Language Pathology Assistants, and interns acquiring speech-language pathology services credentials. | ○ | ○ | ○ | ○ | ○ | ○ |
| 11 Knowledge of procedures for mentoring and training Clinical Fellows, Required Professional Experience temporary license holders, Speech-Language Pathology Assistants, and interns acquiring speech-language pathology services credentials. | ○ | ○ | ○ | ○ | ○ | ○ |
| 12 Knowledge of professional standards of written communication for different clinical and educational purposes. | ○ | ○ | ○ | ○ | ○ | ○ |
| 13 Knowledge of procedures for applying research methodology and the scientific method to clinical and educational practice. | ○ | ○ | ○ | ○ | ○ | ○ |
| 14 Knowledge of methods for integrating research outcomes into evidence-based clinical and educational practice. | ○ | ○ | ○ | ○ | ○ | ○ |
| 15 Knowledge of available resources for clients, client families, and caregivers to support quality client care. | ○ | ○ | ○ | ○ | ○ | ○ |




## Part III - Knowledge Ratings

**Content Area 2: Assessment**

21.
How important is this knowledge for effective performance of tasks in your current job?

| | Does not apply to my job; not required | Of minor importance | Fairly important | Moderately important | Very important | Critically important |
|---|---|---|---|---|---|---|
| 16 Knowledge of effects of cognitive, behavioral, and cultural and linguistic factors on communication, feeding, and swallowing behaviors. | ○ | ○ | ○ | ○ | ○ | ○ |
| 17 Knowledge of screening procedures for social-pragmatic communication disorders. | ○ | ○ | ○ | ○ | ○ | ○ |
| 18 Knowledge of screening procedures for feeding and swallowing disorders. | ○ | ○ | ○ | ○ | ○ | ○ |
| 19 Knowledge of screening procedures for hearing impairments. | ○ | ○ | ○ | ○ | ○ | ○ |
| 20 Knowledge of screening procedures for speech and language disorders involving voice, resonance, and fluency. | ○ | ○ | ○ | ○ | ○ | ○ |
| 21 Knowledge of screening procedures for cognitive-linguistic impairments. | ○ | ○ | ○ | ○ | ○ | ○ |
| 22 Knowledge of screening procedures for language disorders. | ○ | ○ | ○ | ○ | ○ | ○ |
| 23 Knowledge of screening procedures for articulation, phonology, and motor-speech disorders. | ○ | ○ | ○ | ○ | ○ | ○ |
| 24 Knowledge of the characteristics of speech, including acoustics, aerodynamics, and articulatory movements. | ○ | ○ | ○ | ○ | ○ | ○ |
| 25 Knowledge of the phonologic, morphologic, syntactic, semantic, and social-pragmatic aspects of typical human communication and their development. | ○ | ○ | ○ | ○ | ○ | ○ |
| 26 Knowledge of neurodiversity and its impact on social-pragmatic communication development. | ○ | ○ | ○ | ○ | ○ | ○ |

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|---|---|---|---|---|---|---|
| 27 Knowledge of effects of communication and feeding and swallowing impairments on client behavior, emotional adjustment, health status, and client academic, vocational, and social success. | ○ | ○ | ○ | ○ | ○ | ○ |
| 28 Knowledge of methods and procedures for obtaining client case history and performing client assessment. | ○ | ○ | ○ | ○ | ○ | ○ |
| 29 Knowledge of effects of medical conditions, procedures, and treatments on communication, feeding and swallowing. | ○ | ○ | ○ | ○ | ○ | ○ |
| 30 Knowledge of psychosocial impact of communication and feeding and swallowing disorders across the lifespan. | ○ | ○ | ○ | ○ | ○ | ○ |
| 31 Knowledge of epidemiology of communication and feeding and swallowing disorders. | ○ | ○ | ○ | ○ | ○ | ○ |
| 32 Knowledge of effects of neurotoxins and drugs on communication, feeding, and swallowing. | ○ | ○ | ○ | ○ | ○ | ○ |
| 33 Knowledge of standardized methods and procedures for conducting objective assessments. | ○ | ○ | ○ | ○ | ○ | ○ |
| 34 Knowledge of procedures for assessing speech sound production including perceptual characteristics, oral and physiological structure, motor planning, and execution. | ○ | ○ | ○ | ○ | ○ | ○ |
| 35 Knowledge of procedures for assessing resonance including oral, nasal, and velopharyngeal structures and functions. | ○ | ○ | ○ | ○ | ○ | ○ |
| 36 Knowledge of procedures for assessing voice including respiratory, supralaryngeal, laryngeal, and pharyngeal structure and functions. | ○ | ○ | ○ | ○ | ○ | ○ |
| 37 Knowledge of procedures for assessing alaryngeal speech. | ○ | ○ | ○ | ○ | ○ | ○ |
| 38 Knowledge of procedures for assessing language and communication including phonology, morphology, syntax, semantics, social-pragmatics, and oral language aspects of literacy and prelinguistic communication. | ○ | ○ | ○ | ○ | ○ | ○ |
| 39 Knowledge of procedures for assessing cognition including attention, memory retention, memory retrieval, sequencing, problem solving, thought organization, and executive functioning. | ○ | ○ | ○ | ○ | ○ | ○ |
| 40 Knowledge of procedures for identifying structural, physiological, sensory, or behavior-based oropharyngeal and esophageal deficits | ○ | ○ | ○ | ○ | ○ | ○ |

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|---|---|---|---|---|---|---|
| and their effects on client feeding and swallowing. | | | | | | |
| 41 Knowledge of procedures for assessing language processing. | ○ | ○ | ○ | ○ | ○ | ○ |
| 42 Knowledge of procedures for assessing client ability to use and benefit from alternative and augmentative communication (AAC). | ○ | ○ | ○ | ○ | ○ | ○ |
| 43 Knowledge of procedures for assessing orofacial myofunctional disorders. | ○ | ○ | ○ | ○ | ○ | ○ |
| 44 Knowledge of procedures for performing school assessments in compliance with California Education Code. | ○ | ○ | ○ | ○ | ○ | ○ |
| 45 Knowledge of strategies for managing challenging client behaviors during assessment. | ○ | ○ | ○ | ○ | ○ | ○ |
| 46 Knowledge of strategies for engaging clients and client families in the assessment process. | ○ | ○ | ○ | ○ | ○ | ○ |
| 47 Knowledge of typical progression and development in the acquisition of English for learners who are non-native English speakers. | ○ | ○ | ○ | ○ | ○ | ○ |
| 48 Knowledge of social, familial, cultural, and linguistic influences on communication. | ○ | ○ | ○ | ○ | ○ | ○ |
| 49 Knowledge of procedures for basic interpretation of audiograms. | ○ | ○ | ○ | ○ | ○ | ○ |
| 50 Knowledge of principles of assessing adequacy of anatomical and physiological structures using imaging. | ○ | ○ | ○ | ○ | ○ | ○ |
| 51 Knowledge of principles of assessing adequacy of anatomical and physiological structures using aerodynamic analysis. | ○ | ○ | ○ | ○ | ○ | ○ |
| 52 Knowledge of principles of assessing adequacy of anatomical and physiological structures by applying acoustic measures, tactile cues, and electromyography (EMG). | ○ | ○ | ○ | ○ | ○ | ○ |
| 53 Knowledge of principles of calibration and operation of instrumentation. | ○ | ○ | ○ | ○ | ○ | ○ |
| 54 Knowledge of procedures for assessing fluency including types of dysfluency, concomitant behaviors, and cognitive-affective and social-emotional factors. | ○ | ○ | ○ | ○ | ○ | ○ |
| 55 Knowledge of procedures for performing and interpreting client screenings and assessments using alternative and augmentative communication (AAC) and prosthetic communication devices. | ○ | ○ | ○ | ○ | ○ | ○ |

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|---|---|---|---|---|---|---|
| 56 Knowledge of potential impacts of client communication impairment on client-family or -caregiver relationships. | ○ | ○ | ○ | ○ | ○ | ○ |




## Part III - Knowledge Ratings

### Content Area 3: Diagnosis, Goal Setting, and Treatment Planning

22.
How important is this knowledge for effective performance of tasks in your current job?

| | Does not apply to my job; not required | Of minor importance | Fairly important | Moderately important | Very important | Critically important |
|---|---|---|---|---|---|---|
| 57 Knowledge of effects of genetic disorders on communication, feeding, and swallowing. | ○ | ○ | ○ | ○ | ○ | ○ |
| 58 Knowledge of effects of neonatal risk factors on communication, feeding, and swallowing. | ○ | ○ | ○ | ○ | ○ | ○ |
| 59 Knowledge of interventions and procedures for using aided and unaided alternative and augmentative communication (AAC) applications in diagnosis and treatment. | ○ | ○ | ○ | ○ | ○ | ○ |
| 60 Knowledge of professional standards for documenting assessment results and treatment recommendations. | ○ | ○ | ○ | ○ | ○ | ○ |
| 61 Knowledge of procedures for identifying and adapting to the demands of client linguistic abilities, cognitive abilities, and social environments to improve communication. | ○ | ○ | ○ | ○ | ○ | ○ |
| 62 Knowledge of effects of developmental disabilities on communication, feeding, and swallowing. | ○ | ○ | ○ | ○ | ○ | ○ |
| 63 Knowledge of effects of auditory deficits on client communication and on client academic, social, and vocational skills. | ○ | ○ | ○ | ○ | ○ | ○ |
| 64 Knowledge of effects of oral, pharyngeal, and laryngeal anomalies on communication, feeding, and swallowing. | ○ | ○ | ○ | ○ | ○ | ○ |
| 65 Knowledge of effects of respiratory compromise on communication, feeding, and swallowing. | ○ | ○ | ○ | ○ | ○ | ○ |
| 66 Knowledge of effects of neurological | | | | | | |

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|---|---|---|---|---|---|---|
| disorder and dysfunction on communication, feeding, and swallowing. | ○ | ○ | ○ | ○ | ○ | ○ |
| 67 Knowledge of effects of psychiatric disorders on communication, feeding, and swallowing. | ○ | ○ | ○ | ○ | ○ | ○ |
| 68 Knowledge of effects of gastrointestinal disorders on communication, feeding, and swallowing. | ○ | ○ | ○ | ○ | ○ | ○ |
| 69 Knowledge of procedures for developing and defining treatment goals, service delivery options, treatment supports, and resources. | ○ | ○ | ○ | ○ | ○ | ○ |
| 70 Knowledge of procedures for gaining consensus and support with clients and client families regarding options for the treatment plans. | ○ | ○ | ○ | ○ | ○ | ○ |
| 71 Knowledge of components of diagnostic assessment reports that provide comprehensive description of client communication, feeding, and swallowing. | ○ | ○ | ○ | ○ | ○ | ○ |
| 72 Knowledge of procedures for determining eligibility, initiating treatment, and prioritizing treatment targets. | ○ | ○ | ○ | ○ | ○ | ○ |
| 73 Knowledge of procedures for determining optimal treatment settings based on assessment results. | ○ | ○ | ○ | ○ | ○ | ○ |
| 74 Knowledge of procedures for differential diagnosis. | ○ | ○ | ○ | ○ | ○ | ○ |
| 75 Knowledge of effects of sensory processing and behavioral disorders on communication, feeding, and swallowing. | ○ | ○ | ○ | ○ | ○ | ○ |
| 76 Knowledge of procedures for addressing family and caregiver factors that impact client care and treatment. | ○ | ○ | ○ | ○ | ○ | ○ |




## Part III - Knowledge Ratings

### Content Area 4: Treatment Interventions and Procedures

23.
How important is this knowledge for effective performance of tasks in your current job?

| | Does not apply to my job; not required | Of minor importance | Fairly important | Moderately important | Very important | Critically important |
|---|---|---|---|---|---|---|
| 77 Knowledge of interventions for treating speech sound disorders including perceptual characteristics, physiological structure, and function. | ○ | ○ | ○ | ○ | ○ | ○ |
| 78 Knowledge of interventions for treating neurogenic speech disorders. | ○ | ○ | ○ | ○ | ○ | ○ |
| 79 Knowledge of interventions for treating resonance disorders including those related to oral, nasal, and velopharyngeal structures and functions. | ○ | ○ | ○ | ○ | ○ | ○ |
| 80 Knowledge of interventions for treating voice disorders including those related to respiratory, supralaryngeal, and laryngeal structures and functions. | ○ | ○ | ○ | ○ | ○ | ○ |
| 81 Knowledge of interventions for treating communication disorders involving alaryngeal speech. | ○ | ○ | ○ | ○ | ○ | ○ |
| 82 Knowledge of interventions for treating language and communication disorders in the areas of phonology, morphology, syntax, semantics, social-pragmatics, and oral language as they apply to literacy and prelinguistic communication. | ○ | ○ | ○ | ○ | ○ | ○ |
| 83 Knowledge of interventions for treating cognition in the areas of attention, memory retention, memory retrieval, sequencing, problem solving, thought organization, and executive functioning. | ○ | ○ | ○ | ○ | ○ | ○ |
| 84 Knowledge of interventions for treating feeding and swallowing disorders including those related to oral, pharyngeal, laryngeal, and esophageal structures and functions. | ○ | ○ | ○ | ○ | ○ | ○ |

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|---|---|---|---|---|---|---|
| 85 Knowledge of interventions for treating feeding and swallowing disorders including those related to nutritional and hydration status, sensory issues, and behavior. | ○ | ○ | ○ | ○ | ○ | ○ |
| 86 Knowledge of interventions for treating neurodiverse clients diagnosed with communication disorders. | ○ | ○ | ○ | ○ | ○ | ○ |
| 87 Knowledge of interventions for treating orofacial myofunctional disorders. | ○ | ○ | ○ | ○ | ○ | ○ |
| 88 Knowledge of the phonemic repertoire of the English language and its grammatical structure and other aspects of speech and language sufficient to discriminate and produce acoustically correct models for client. | ○ | ○ | ○ | ○ | ○ | ○ |
| 89 Knowledge of interventions using aided and unaided alternative and augmentative communication (AAC) applications in treatment. | ○ | ○ | ○ | ○ | ○ | ○ |
| 90 Knowledge of procedures for selecting alternative and augmentative communication (AAC) applications that meet client treatment needs. | ○ | ○ | ○ | ○ | ○ | ○ |
| 91 Knowledge of procedures for training family, caregivers, and support personnel in the programming and use of clients alternative and augmentative communication (AAC) device. | ○ | ○ | ○ | ○ | ○ | ○ |
| 92 Knowledge of interventions for adapting to the demands of client linguistic, cognitive, and social environments to improve client communication. | ○ | ○ | ○ | ○ | ○ | ○ |
| 93 Knowledge of instructional accommodations and modifications for improving client learning environment. | ○ | ○ | ○ | ○ | ○ | ○ |
| 94 Knowledge of strategies for maintaining client engagement in treatment programs. | ○ | ○ | ○ | ○ | ○ | ○ |
| 95 Knowledge of strategies for managing challenging client behavior. | ○ | ○ | ○ | ○ | ○ | ○ |
| 96 Knowledge of strategies for facilitating and managing group therapy sessions. | ○ | ○ | ○ | ○ | ○ | ○ |
| 97 Knowledge of interventions for treating fluency disorders, including types of dysfluency, concomitant behaviors, and cognitive-affective and social-emotional factors. | ○ | ○ | ○ | ○ | ○ | ○ |
| 98 Knowledge of interventions and procedures for treating communication impairments in the area of language processing. | ○ | ○ | ○ | ○ | ○ | ○ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 99 Knowledge of interventions, procedures, and equipment for aural rehabilitation related to hearing loss. | ○ | ○ | ○ | ○ | ○ | ○ |




## Part III - Knowledge Ratings

**Content Area 5: Treatment Outcomes and Effectiveness**

24. How important is this knowledge for effective performance of tasks in your current job?

| | Does not apply to my job; not required | Of minor importance | Fairly important | Moderately important | Very important | Critically important |
|---|---|---|---|---|---|---|
| 100 Knowledge of data collection and analysis methodologies for assessing status, evaluating progress, and modifying treatment plans. | ○ | ○ | ○ | ○ | ○ | ○ |
| 101 Knowledge of the defined guidelines for discharge from treatment. | ○ | ○ | ○ | ○ | ○ | ○ |
| 102 Knowledge of procedures for evaluating the effectiveness of specific treatment strategies. | ○ | ○ | ○ | ○ | ○ | ○ |
| 103 Knowledge of components of progress reports and discharge summaries to provide post-treatment status and recommendations for follow-up. | ○ | ○ | ○ | ○ | ○ | ○ |
| 104 Knowledge of professional standards for written communication regarding client progress reports and discharge summaries. | ○ | ○ | ○ | ○ | ○ | ○ |




**Thank you!**

**Thank you for taking the time to complete this survey! The California Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board values your contribution to this study.**

## **APPENDIX B** | QUESTIONNAIRE EMAIL INVITATION

## Message from the California Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD
1601 Response Road, Suite 260, Sacramento, CA 95815
P (916) 287-7915 | www.speechandhearing.ca.gov

06/20/2024

Dear Licensed Speech-Language Pathologist:

Thank you for opening this online survey. You have been selected to participate in an occupational analysis of the speech-language pathologist profession by the California Speech-Language Pathology and Audiology and Hearing Aid Dispensers (Board).

The Board is collecting information about the tasks currently performed by speech-language pathologists in California, the importance of the tasks, and the knowledge needed to perform the tasks safely and effectively. We will use this information to ensure that the national speech-language pathologist examinations reflect current practice in California. We worked with different groups of speech-language pathologists to develop a survey to capture this information.

The survey should take about one hour to complete. For your convenience, you do not have to complete the survey in a single session. You can resume where you stopped as long as you reopen the survey from the same computer and use the same web browser. Before you exit, complete the page that you are on. The program will save responses only on completed pages.

Your responses will be kept confidential. They will not be tied to your license or personal information. Individual responses will be combined with responses from other speech-language pathologists, and only group data will be analyzed.

The weblink is available 24 hours a day, 7 days a week. Please submit your completed survey by September 13, 2024. If you have questions or need assistance with the survey, please contact Maria Avalos with the Office of Professional Examination Services at Maria.Avalos@dca.ca.gov.

We value your contributions and appreciate your dedication to the speech-language pathologist profession in California. You will be credited two hours of continuing education upon completion of the survey.

Sincerely,

Paul Sanchez
Executive Officer

## **APPENDIX C** | RESPONDENTS BY REGION

LOS ANGELES COUNTY AND VICINITY

| County of Practice | Frequency |
|---|---|
| Los Angeles | 211 |
| Orange | 64 |
| Total | 275 |

RIVERSIDE AND VICINITY

| County of Practice | Frequency |
|---|---|
| Riverside | 50 |
| San Bernardino | 43 |
| Total | 93 |

NORTH COAST

| County of Practice | Frequency |
|---|---|
| Humboldt | 5 |
| Mendocino | 3 |
| Sonoma | 15 |
| Total | 23 |

SACRAMENTO VALLEY

| County of Practice | Frequency |
|---|---|
| Butte | 6 |
| Colusa | 1 |
| Glenn | 1 |
| Lake | 1 |
| Sacramento | 40 |
| Sutter | 5 |
| Yolo | 2 |
| Yuba | 2 |
| Total | 58 |

SAN DIEGO COUNTY AND VICINITY

| County of Practice | Frequency |
|---|---|
| Imperial | 5 |
| Inyo | 1 |
| San Diego | 92 |
| Total | 98 |

SAN FRANCISCO BAY AREA

| County of Practice | Frequency |
|---|---|
| Alameda | 43 |
| Contra Costa | 18 |
| Marin | 4 |
| Napa | 4 |
| San Francisco | 19 |
| San Mateo | 15 |
| Santa Clara | 42 |
| Santa Cruz | 3 |
| Solano | 11 |
| Total | 159 |

SAN JOAQUIN VALLEY

| County of Practice | Frequency |
|---|---|
| Fresno | 32 |
| Kern | 17 |
| Kings | 3 |
| Mariposa | 1 |
| Madera | 4 |
| Merced | 4 |
| San Joaquin | 16 |
| Stanislaus | 12 |
| Tulare | 6 |
| Total | 95 |

SHASTA-CASCADE

| County of Practice | Frequency |
|---|---|
| Lassen | 1 |
| Shasta | 3 |
| Tehama | 1 |
| Total | 5 |

SIERRA MOUNTAIN VALLEY

| County of Practice | Frequency |
|---|---|
| Amador | 1 |
| Calaveras | 2 |
| El Dorado | 7 |
| Nevada | 3 |
| Placer | 13 |
| Tuolumne | 1 |
| Total | 27 |

SOUTH COAST AND CENTRAL COAST

| County of Practice | Frequency |
|---|---|
| Monterey | 17 |
| San Benito | 3 |
| San Luis Obispo | 10 |
| Santa Barbara | 14 |
| Ventura | 28 |
| Total | 72 |

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# **APPENDIX D** | CRITICALITY INDICES IN DESCENDING ORDER FOR ALL TASKS BY CONTENT AREA

**Content Area 1: General Competencies**

| | Tasks | Frequency | Importance | Criticality |
|---|---|---|---|---|
| T2. | Maintain client confidentiality and security of documentation in compliance with federal and state regulations. | 4.78 | 4.79 | 22.90 |
| T1. | Provide treatment plan to client that is consistent with professional and ethical standards. | 4.51 | 4.58 | 21.34 |
| T11. | Document diagnostic and treatment reports, treatment plans, treatment activities, session logs, and professional correspondence consistent with professional standards. | 4.63 | 4.41 | 20.71 |
| T4. | Provide culturally and linguistically relevant services in assessment and treatment decisions. | 4.49 | 4.56 | 20.70 |
| T12. | Implement research and evidence-based practices to provide quality care to clients. | 4.38 | 4.45 | 19.80 |
| T10. | Review diagnostic and treatment reports, treatment plans, and professional correspondence when developing client's treatment plan. | 4.28 | 4.33 | 19.05 |
| T8. | Communicate clinical information to the client, the client's family, and other professionals in compliance with regulatory guidelines. | 4.24 | 4.36 | 18.89 |
| T9. | Educate and train the client, the client's family, and other care providers in techniques and strategies that will support the client's treatment. | 3.92 | 4.24 | 17.16 |
| T5. | Collaborate with other professionals to provide a treatment plan that is culturally and linguistically relevant. | 3.97 | 4.20 | 17.09 |

| | Tasks | Frequency | Importance | Criticality |
|---|---|---|---|---|
| T3. | Maintain health and safety protocols for preventing disease transmission in compliance with state regulations. | 3.63 | 3.71 | 15.25 |
| T15. | Follow guidelines for use of interpreters and translators for non-English speaking clients. | 3.43 | 4.04 | 15.18 |
| T6. | Refer client to other professionals or agencies based on the Speech-Language Pathologist competency level and client needs. | 2.80 | 3.41 | 10.83 |
| T7. | Supervise Clinical Fellows, Required Professional Experience temporary license holders, Speech-Language Pathology Assistants, or interns who are acquiring a speech-language pathology services credentials according to professional and ethical standards. | 1.89 | 2.45 | 6.97 |
| T13. | Provide in-service training to increase awareness of communication and swallowing disorders. | 1.60 | 2.31 | 5.19 |
| T14. | Participate in community education to increase awareness of communication and swallowing disorders. | 1.30 | 1.99 | 4.03 |

**Content Area 2: Assessment**

| Tasks | Frequency | Importance | Criticality |
|---|---|---|---|
| T21. Select assessment instruments, procedures, settings, and materials based on client needs including cultural and linguistic factors. | 4.39 | 4.48 | 20.14 |
| T22. Assess client in all areas of suspected disorder or impairment including voice, resonance, swallowing, fluency, articulation, phonology, morphology, syntax, semantics, pragmatics, cognitive-communication, and communication modalities. | 4.28 | 4.41 | 19.74 |
| T36. Provide assessment results to the client, the client's family, other professionals, and referral sources to facilitate service transition. | 4.20 | 4.34 | 19.15 |
| T25. Assess client's language including phonology, morphology, syntax, semantics, and social-pragmatics. | 4.22 | 4.22 | 18.70 |
| T24. Assess client's communication in the areas of articulation and intelligibility. | 4.18 | 4.15 | 18.07 |
| T20. Document observed client behaviors and emotions that impact assessment. | 4.15 | 4.09 | 17.61 |
| T31. Assess impact of client communication impairment on academic, social, and vocational functioning based on federal and state eligibility criteria. | 3.83 | 3.91 | 17.00 |

| Tasks | Frequency | Importance | Criticality |
|---|---|---|---|
| T35. Consider client English language proficiency level when determining the need for bilingual assessment of English language learners. | 3.71 | 4.14 | 16.79 |
| T19. Assess client history to identify potential causal factors and correlates related to client communication and swallowing status. | 3.73 | 3.79 | 15.57 |
| T28. Assess client's communication in the areas of motor speech and intelligibility. | 3.64 | 3.97 | 15.44 |
| T18. Identify indicators that prompt further assessment or referral. | 3.61 | 3.86 | 14.91 |
| T26. Assess client's cognitive-linguistic functioning. | 3.10 | 3.41 | 12.82 |
| T16. Identify individuals and groups at risk for communication and swallowing disorders based on work setting protocols. | 2.96 | 3.19 | 11.92 |
| T33. Assess client readiness for augmentative and alternative communication (AAC) for functional communication. | 2.73 | 3.66 | 11.54 |
| T23. Assess client's communication in the area of fluency. | 2.71 | 3.55 | 10.60 |
| T17. Screen for presence of communication and swallowing disorders based on federal and state regulations and work setting protocols. | 2.59 | 2.89 | 10.14 |
| T27. Assess client's feeding and swallowing. | 1.40 | 1.70 | 5.42 |
| T29. Assess client's communication skills as they relate to aural rehabilitation. | 1.14 | 1.80 | 3.78 |
| T34. Perform instrumental assessment of supralaryngeal, laryngeal, and pharyngeal subsystems to further assess swallowing function and severity of dysphagia. | 0.69 | 0.96 | 2.64 |

| Tasks | Frequency | Importance | Criticality |
|---|---|---|---|
| T32. Assess client readiness for prosthetic management as related to functional communication. | 0.59 | 0.91 | 1.85 |
| T30. Assess client's options for alaryngeal communication. | 0.53 | 0.97 | 1.63 |

**Content Area 3: Diagnosis, Goal Setting, and Treatment Planning**

| Tasks | Frequency | Importance | Criticality |
|---|---|---|---|
| T40. Develop evidence-based treatment plans that includes goals, objectives, and interventions based on client needs. | 4.55 | 4.56 | 21.23 |
| T39. Document assessment results to develop comprehensive description of client communication strengths and weaknesses. | 4.43 | 4.42 | 20.04 |
| T42. Collaborate with clients, client families, caregivers, other professionals, and referral sources to gain consensus on the treatment plan based on assessment results and treatment plan. | 4.20 | 4.37 | 18.79 |
| T37. Analyze assessment results to identify and prioritize treatment of communication or swallowing disorders. | 3.98 | 4.12 | 18.25 |
| T38. Analyze assessment results to identify accommodations or modifications that may be required in client environment. | 4.09 | 4.16 | 17.85 |
| T41. Determine specific augmentative and alternative communication systems and treatment plans. | 2.69 | 3.57 | 11.17 |

**Content Area 4: Treatment Intervention and Procedures**

| Tasks | Frequency | Importance | Criticality |
|---|---|---|---|
| T50. Provide treatment interventions that consider client age, primary language background, cognitive and physical abilities, emotional and behavioral status, and culture. | 4.35 | 4.38 | 19.86 |
| T51. Provide treatment interventions and strategies that support communication between clients and communication partners. | 4.13 | 4.25 | 18.48 |
| T46. Provide treatment interventions to improve client language morphology, syntax, semantics, pragmatics, and communication modalities. | 4.12 | 4.07 | 18.19 |
| T43. Provide treatment interventions to improve client articulation and phonological skills. | 3.92 | 3.95 | 17.18 |
| T53. Produce acoustically correct models for targeted phonemes, grammatical features, and other aspects of speech and language as identified in treatment plans. | 3.75 | 3.72 | 16.07 |
| T52. Provide training to family and caregivers to support client treatment. | 3.50 | 4.02 | 15.07 |
| T55. Implement augmentative and alternative communication (AAC) interventions that meet client immediate and ongoing treatment needs. | 2.92 | 3.72 | 12.54 |
| T47. Provide treatment interventions to improve client cognitive-communication skills. | 3.00 | 3.34 | 12.42 |
| T45. Provide treatment interventions to improve client fluency. | 2.31 | 3.26 | 8.88 |
| T48. Provide treatment interventions to improve client feeding and swallowing. | 1.21 | 1.51 | 4.73 |

| Tasks | Frequency | Importance | Criticality |
|---|---|---|---|
| T44. Provide treatment interventions to improve client voice and resonance given medical clearance. | 1.30 | 2.01 | 4.24 |
| T49. Provide treatment interventions to improve client communication skills related to aural rehabilitation. | 0.85 | 1.49 | 2.75 |
| T54. Provide treatment for alaryngeal speech using instrumental and non-instrumental interventions. | 0.41 | 0.67 | 1.17 |

**Content Area 5: Treatment Outcomes and Effectiveness**

| Tasks | Frequency | Importance | Criticality |
|---|---|---|---|
| T58. Use data to modify client treatment plans and to determine client readiness for dismissal or discharge from treatment. | 4.15 | 4.22 | 18.28 |
| T56. Establish methods for monitoring treatment progress and outcomes to evaluate treatment plan efficacy. | 4.11 | 4.15 | 17.82 |
| T57. Collect treatment outcome data to measure client functional gains and efficacy of targeted environmental modifications. | 4.04 | 4.05 | 17.24 |
| T59. Write progress reports or discharge summaries to document client progress and level of functioning related to focus of treatment. | 3.99 | 4.01 | 16.74 |
| T60. Provide recommendations to client at completion of treatment. | 3.71 | 3.75 | 14.90 |

# **APPENDIX E** | KNOWLEDGE IMPORTANCE RATINGS IN DESCENDING ORDER BY CONTENT AREA

**Content Area 1: General Competencies**

| Knowledge Statements | Importance |
|---|---|
| K7. Knowledge of cultural and linguistic differences that affect assessment and treatment of diverse client populations, families, and caregivers. | 4.59 |
| K1. Knowledge of professional guidelines, standards, and ethics related to Speech-Language Pathologist practice. | 4.54 |
| K2. Knowledge of state and federal regulations that impact Speech-Language Pathologist practice. | 4.48 |
| K4. Knowledge of state and federal laws and regulations related to client rights and legal protections. | 4.44 |
| K8. Knowledge of different approaches to communicate information about client condition, care, and treatment to clients, the client families, caregivers, and other professionals. | 4.23 |
| K9. Knowledge of procedures for counseling and educating the clients, client families, caregivers, and other professionals about client care and treatment. | 4.19 |
| K15. Knowledge of available resources for clients, client families, and caregivers to support quality client care. | 4.15 |
| K6. Knowledge of collaboration models used to develop relationships with clients, client families, caregivers, and other professionals. | 4.11 |
| K3. Knowledge of laws and regulations related to client and worker health and safety, including universal precautions. | 4.10 |
| K12. Knowledge of professional standards of written communication for different clinical and educational purposes. | 4.02 |
| K5. Knowledge of procedures to use to advocate for specialized programs that support quality client care. | 4.00 |
| K14. Knowledge of methods for integrating research outcomes into evidence-based clinical and educational practice. | 3.98 |
| K13. Knowledge of procedures for applying research methodology and the scientific method to clinical and educational practice. | 3.80 |

| | Knowledge Statements | Importance |
|---|---|---|
| K10. | Knowledge of California regulations regarding supervision of Clinical Fellows, Required Professional Experience temporary license holders, Speech-Language Pathology Assistants, and interns acquiring speech-language pathology services credentials. | |
| K11. | Knowledge of procedures for mentoring and training Clinical Fellows, Required Professional Experience temporary license holders, Speech-Language Pathology Assistants, and interns acquiring speech-language pathology services credentials. | 3.58 |

**Content Area 2: Assessment**

| Knowledge Statements | Importance |
|---|---|
| K33. Knowledge of standardized methods and procedures for conducting objective assessments. | 4.44 |
| K26. Knowledge of neurodiversity and its impact on social-pragmatic communication development. | 4.40 |
| K48. Knowledge of social, familial, cultural, and linguistic influences on communication. | 4.38 |
| K38. Knowledge of procedures for assessing language and communication including phonology, morphology, syntax, semantics, social-pragmatics, and oral language aspects of literacy and prelinguistic communication. | 4.37 |
| K28. Knowledge of methods and procedures for obtaining client case history and performing client assessment. | 4.36 |
| K25. Knowledge of the phonologic, morphologic, syntactic, semantic, and social-pragmatic aspects of typical human communication and their development. | 4.33 |
| K45. Knowledge of strategies for managing challenging client behaviors during assessment. | 4.31 |
| K22. Knowledge of screening procedures for language disorders. | 4.30 |
| K46. Knowledge of strategies for engaging clients and client families in the assessment process. | 4.27 |
| K34. Knowledge of procedures for assessing speech sound production including perceptual characteristics, oral and physiological structure, motor planning, and execution. | 4.26 |
| K23. Knowledge of screening procedures for articulation, phonology, and motor-speech disorders. | 4.25 |
| K56. Knowledge of potential impacts of client communication impairment on client-family or -caregiver relationships. | 4.19 |
| K16. Knowledge of effects of cognitive, behavioral, and cultural and linguistic factors on communication, feeding, and swallowing behaviors. | 4.18 |
| K41. Knowledge of procedures for assessing language processing. | 4.09 |
| K47. Knowledge of typical progression and development in the acquisition of English for learners who are non-native English speakers. | 4.08 |
| K42. Knowledge of procedures for assessing client ability to use and benefit from augmentative and alternative communication (AAC). | 3.96 |

| Knowledge Statements | Importance |
|---|---|
| K17. Knowledge of screening procedures for social-pragmatic communication disorders. | 3.93 |
| K29. Knowledge of effects of medical conditions, procedures, and treatments on communication, feeding and swallowing. | 3.84 |
| K24. Knowledge of the characteristics of speech, including acoustics, aerodynamics, and articulatory movements. | 3.84 |
| K44. Knowledge of procedures for performing school assessments in compliance with California Education Code. | 3.83 |
| K20. Knowledge of screening procedures for speech and language disorders involving voice, resonance, and fluency. | 3.76 |
| K55. Knowledge of procedures for performing and interpreting client screenings and assessments using augmentative and alternative communication (AAC) and prosthetic communication devices. | 3.72 |
| K39. Knowledge of procedures for assessing cognition including attention, memory retention, memory retrieval, sequencing, problem solving, thought organization, and executive functioning. | 3.66 |
| K54. Knowledge of procedures for assessing fluency including types of dysfluency, concomitant behaviors, and cognitive-affective and social-emotional factors. | 3.65 |
| K27. Knowledge of effects of communication and feeding and swallowing impairments on client behavior, emotional adjustment, health status, and client academic, vocational, and social success. | 3.64 |
| K21. Knowledge of screening procedures for cognitive-linguistic impairments. | 3.55 |
| K30. Knowledge of psychosocial impact of communication and feeding and swallowing disorders across the lifespan. | 3.52 |
| K35. Knowledge of procedures for assessing resonance including oral, nasal, and velopharyngeal structures and functions. | 3.40 |
| K31. Knowledge of epidemiology of communication and feeding and swallowing disorders. | 3.31 |
| K32. Knowledge of effects of neurotoxins and drugs on communication, feeding, and swallowing. | 3.30 |

| Knowledge Statements | Importance |
|---|---|
| K36. Knowledge of procedures for assessing voice including respiratory, supralaryngeal, laryngeal, and pharyngeal structure and functions. | 2.97 |
| K19. Knowledge of screening procedures for hearing impairments. | 2.87 |
| K43. Knowledge of procedures for assessing orofacial myofunctional disorders. | 2.76 |
| K49. Knowledge of procedures for basic interpretation of audiograms. | 2.75 |
| K18. Knowledge of screening procedures for feeding and swallowing disorders. | 2.53 |
| K40. Knowledge of procedures for identifying structural, physiological, sensory, or behavior-based oropharyngeal and esophageal deficits and their effects on client feeding and swallowing. | 2.52 |
| K50. Knowledge of principles of assessing adequacy of anatomical and physiological structures using imaging. | 2.32 |
| K37. Knowledge of procedures for assessing alaryngeal speech. | 2.02 |
| K51. Knowledge of principles of assessing adequacy of anatomical and physiological structures using aerodynamic analysis. | 1.96 |
| K53. Knowledge of principles of calibration and operation of instrumentation. | 1.87 |
| K52. Knowledge of principles of assessing adequacy of anatomical and physiological structures by applying acoustic measures, tactile cues, and electromyography (EMG). | 1.78 |

**Content Area 3: Diagnosis, Goal Setting, and Treatment Planning**

| Knowledge Statements | Importance |
|---|---|
| K72. Knowledge of procedures for determining eligibility, initiating treatment, and prioritizing treatment targets. | 4.51 |
| K60. Knowledge of professional standards for documenting assessment results and treatment recommendations. | 4.50 |
| K69. Knowledge of procedures for developing and defining treatment goals, service delivery options, treatment supports, and resources. | 4.49 |
| K61. Knowledge of procedures for identifying and adapting to the demands of client linguistic abilities, cognitive abilities, and social environments to improve communication. | 4.31 |
| K74. Knowledge of procedures for differential diagnosis. | 4.27 |
| K73. Knowledge of procedures for determining optimal treatment settings based on assessment results. | 4.26 |
| K70. Knowledge of procedures for gaining consensus and support with clients and client families regarding options for the treatment plans. | 4.20 |
| K71. Knowledge of components of diagnostic assessment reports that provide comprehensive description of client communication, feeding, and swallowing. | 4.15 |
| K76. Knowledge of procedures for addressing family and caregiver factors that impact client care and treatment. | 4.13 |
| K62. Knowledge of effects of developmental disabilities on communication, feeding, and swallowing. | 3.91 |
| K59. Knowledge of interventions and procedures for using aided and unaided augmentative and alternative communication (AAC) applications in diagnosis and treatment. | 3.86 |
| K75. Knowledge of effects of sensory processing and behavioral disorders on communication, feeding, and swallowing. | 3.85 |
| K63. Knowledge of effects of auditory deficits on client communication and on client academic, social, and vocational skills. | 3.75 |
| K66. Knowledge of effects of neurological disorder and dysfunction on communication, feeding, and swallowing. | 3.57 |
| K57. Knowledge of effects of genetic disorders on communication, feeding, and swallowing. | 3.43 |

| Knowledge Statements | Importance |
|---|---|
| K67. Knowledge of effects of psychiatric disorders on communication, feeding, and swallowing. | 3.24 |
| K64. Knowledge of effects of oral, pharyngeal, and laryngeal anomalies on communication, feeding, and swallowing. | 3.24 |
| K65. Knowledge of effects of respiratory compromise on communication, feeding, and swallowing. | 3.21 |
| K58. Knowledge of effects of neonatal risk factors on communication, feeding, and swallowing. | 2.95 |
| K68. Knowledge of effects of gastrointestinal disorders on communication, feeding, and swallowing. | 2.76 |

**Content Area 4: Treatment Intervention and Procedures**

| Knowledge Statements | Importance |
|---|---|
| K94. Knowledge of strategies for maintaining client engagement in treatment programs. | 4.34 |
| K95. Knowledge of strategies for managing challenging client behavior. | 4.31 |
| K86. Knowledge of interventions for treating neurodiverse clients diagnosed with communication disorders. | 4.29 |
| K82. Knowledge of interventions for treating language and communication disorders in the areas of phonology, morphology, syntax, semantics, social-pragmatics, and oral language as they apply to literacy and prelinguistic communication. | 4.23 |
| K92. Knowledge of interventions for adapting to the demands of client linguistic, cognitive, and social environments to improve client communication. | 4.16 |
| K88. Knowledge of the phonemic repertoire of the English language and its grammatical structure and other aspects of speech and language sufficient to discriminate and produce acoustically correct models for client. | 4.12 |
| K77. Knowledge of interventions for treating speech sound disorders including perceptual characteristics, physiological structure, and function. | 4.05 |
| K93. Knowledge of instructional accommodations and modifications for improving client learning environment. | 4.04 |
| K98. Knowledge of interventions and procedures for treating communication impairments in the area of language processing. | 4.01 |
| K89. Knowledge of interventions using aided and unaided augmentative and alternative communication (AAC) applications in treatment. | 3.95 |
| K91. Knowledge of procedures for training family, caregivers, and support personnel in the programming and use of clients augmentative and alternative communication (AAC) device. | 3.85 |
| K90. Knowledge of procedures for selecting augmentative and alternative communication (AAC) applications that meet client treatment needs. | 3.81 |

| Knowledge Statements | Importance |
|---|---|
| K96. Knowledge of strategies for facilitating and managing group therapy sessions. | 3.74 |
| K83. Knowledge of interventions for treating cognition in the areas of attention, memory retention, memory retrieval, sequencing, problem solving, thought organization, and executive functioning. | 3.68 |
| K97. Knowledge of interventions for treating fluency disorders, including types of dysfluency, concomitant behaviors, and cognitive-affective and social-emotional factors. | 3.62 |
| K78. Knowledge of interventions for treating neurogenic speech disorders. | 3.36 |
| K79. Knowledge of interventions for treating resonance disorders including those related to oral, nasal, and velopharyngeal structures and functions. | 2.90 |
| K80. Knowledge of interventions for treating voice disorders including those related to respiratory, supralaryngeal, and laryngeal structures and functions. | 2.70 |
| K87. Knowledge of interventions for treating orofacial myofunctional disorders. | 2.59 |
| K99. Knowledge of interventions, procedures, and equipment for aural rehabilitation related to hearing loss. | 2.52 |
| K84. Knowledge of interventions for treating feeding and swallowing disorders including those related to oral, pharyngeal, laryngeal, and esophageal structures and functions. | 2.44 |
| K85. Knowledge of interventions for treating feeding and swallowing disorders including those related to nutritional and hydration status, sensory issues, and behavior. | 2.39 |
| K81. Knowledge of interventions for treating communication disorders involving alaryngeal speech. | 1.98 |

**Content Area 5: Treatment Outcomes and Effectiveness**

| Knowledge Statements | Importance |
|---|---|
| K100. Knowledge of data collection and analysis methodologies for assessing status, evaluating progress, and modifying treatment plans. | 4.31 |
| K102. Knowledge of procedures for evaluating the effectiveness of specific treatment strategies. | 4.24 |
| K101. Knowledge of the defined guidelines for discharge from treatment. | 4.22 |
| K104. Knowledge of professional standards for written communication regarding client progress reports and discharge summaries. | 4.20 |
| K103. Knowledge of components of progress reports and discharge summaries to provide post-treatment status and recommendations for follow-up. | 4.10 |

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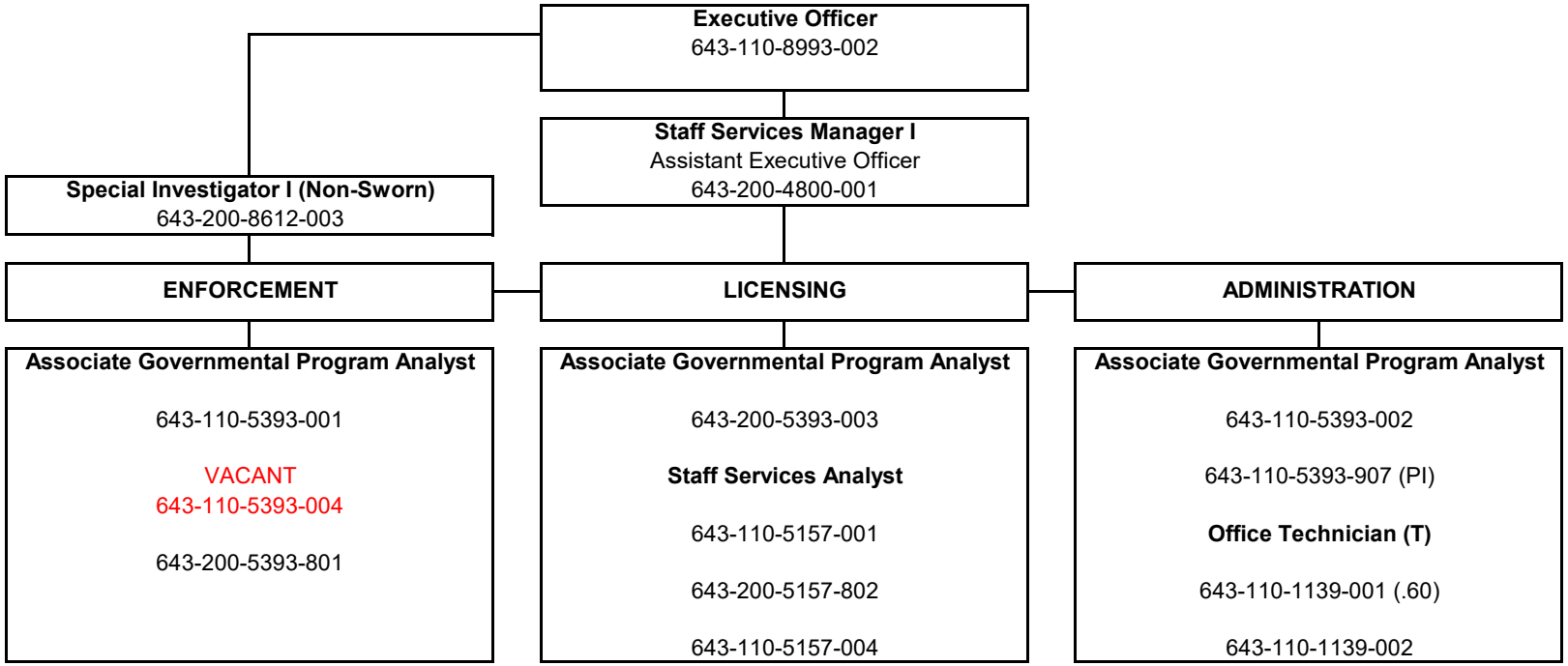
# Attachment D

**DEPARTMENT OF CONSUMER AFFAIRS**

**Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board**

**June 30, 2022**

Current
FY 2021-22
Authorized Positions: 12.6
Temp Help: 1




Paul Sanchez, Executive Officer

Jill Field, Classification and Recruitment Analyst

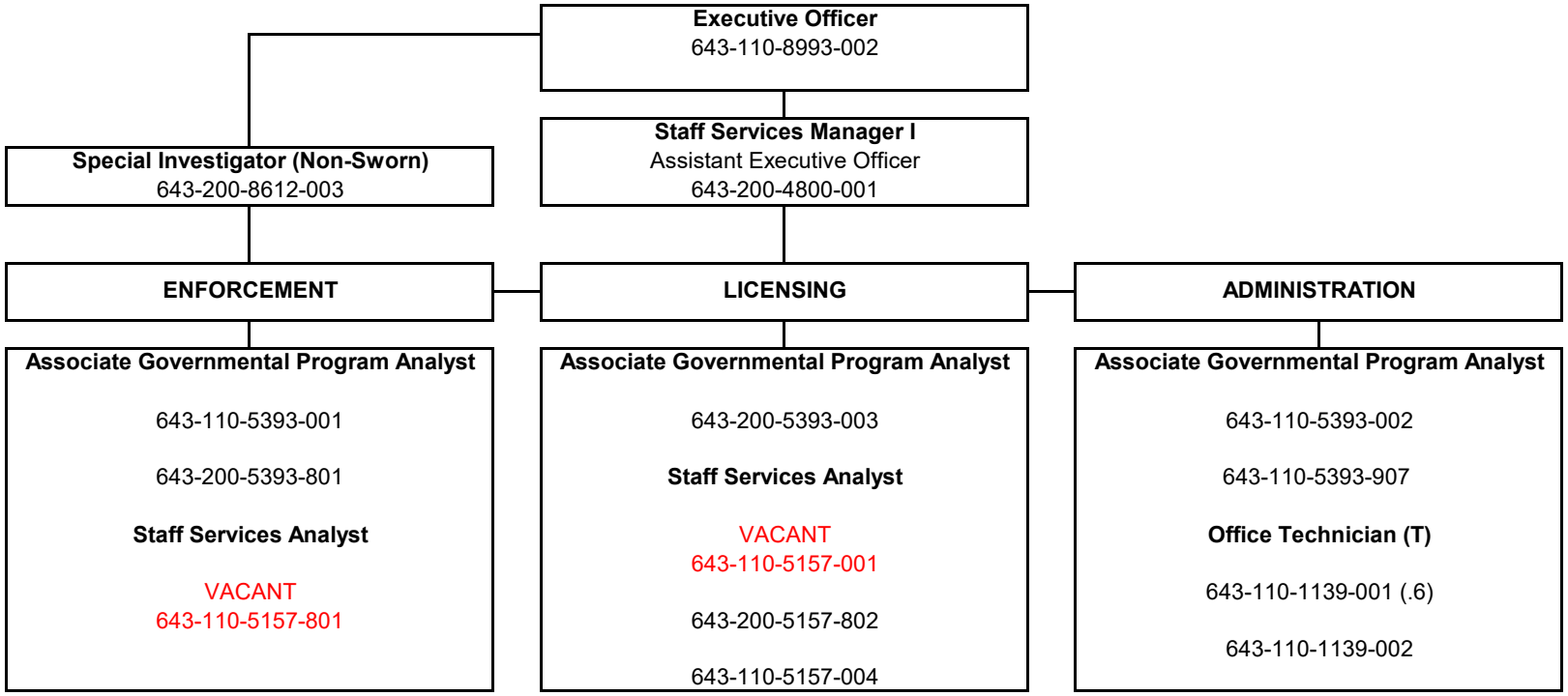
**Note: All positions designated CORI**

**DEPARTMENT OF CONSUMER AFFAIRS**

**Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board**

**June 30, 2023**

Current
FY 2022-23
Authorized Positions: 12.6
Temp Help: 1.4



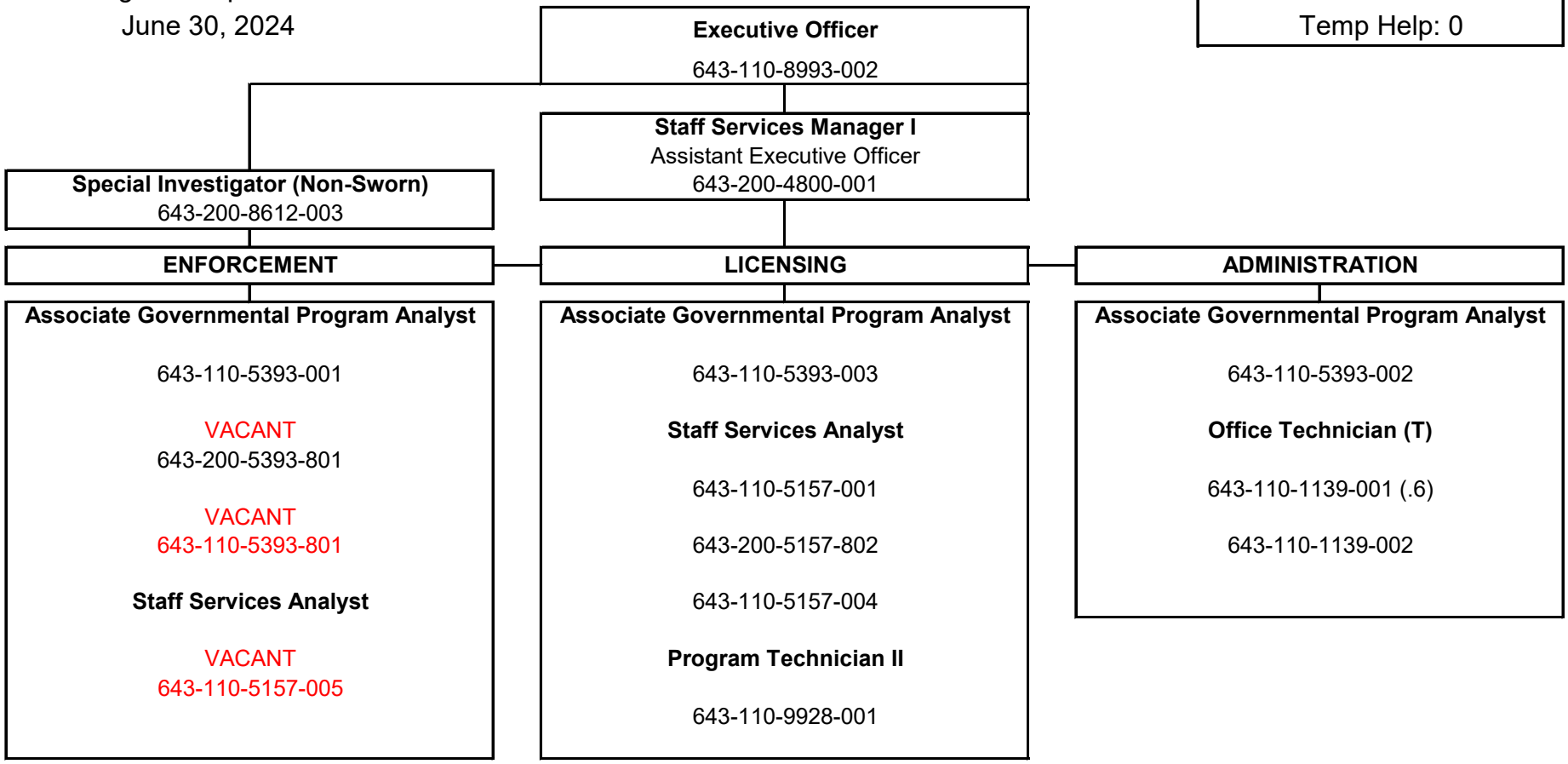

Paul Sanchez, Executive Officer

Jill Field, Classification and Recruitment Analyst

**Note: All positions designated CORI**

DEPARTMENT OF CONSUMER AFFAIRS
Speech-Language Pathology & Audiology
& Hearing Aid Dispensers Board
June 30, 2024

Current
FY 2023-24
Authorized Positions: 14.6
Temp Help: 0



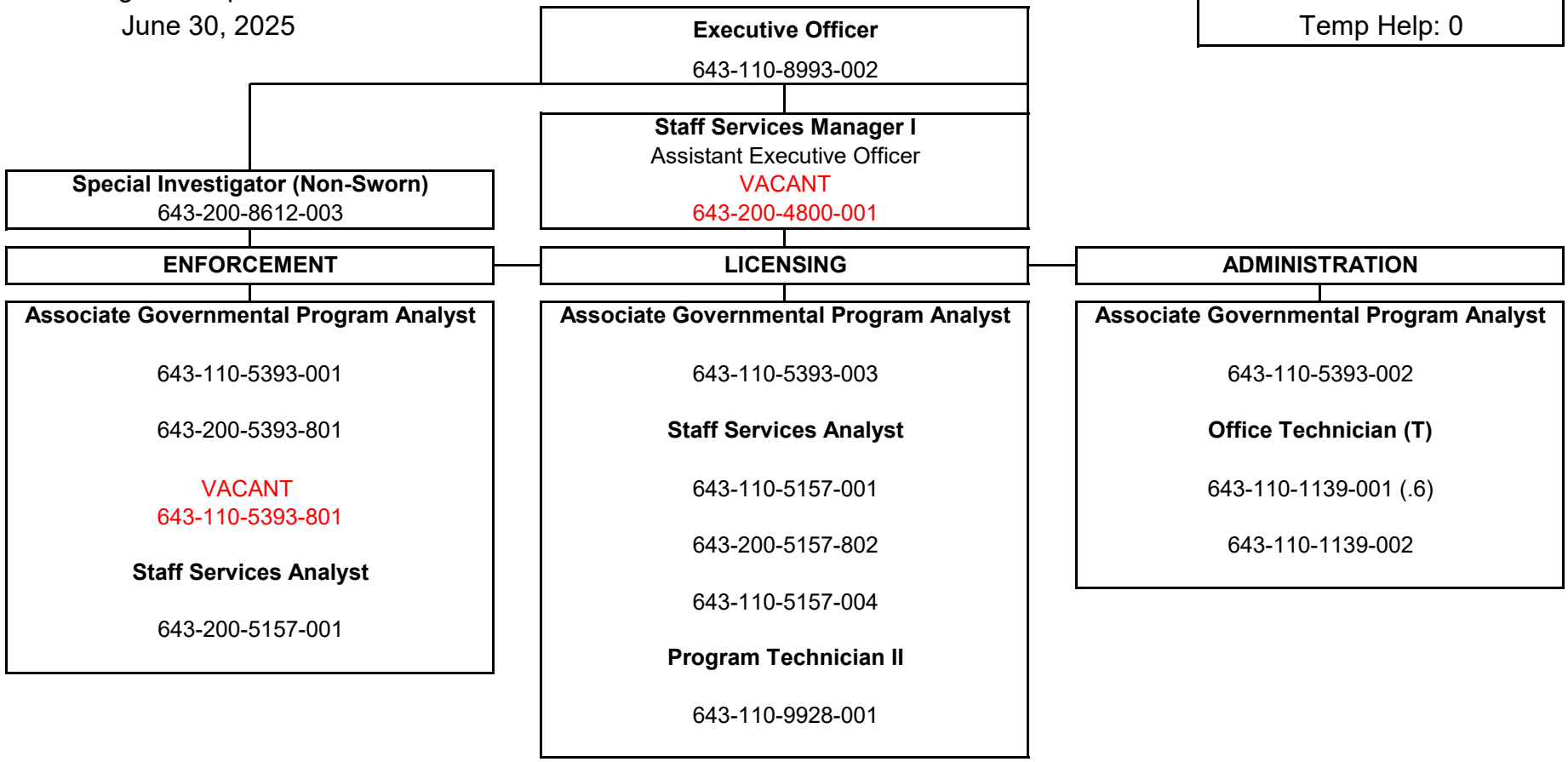

Paul Sanchez, Executive Officer

Lauren Haleem, Classification and Recruitment Analyst

**Note: All positions designated CORI**

DEPARTMENT OF CONSUMER AFFAIRS
Speech-Language Pathology & Audiology
& Hearing Aid Dispensers Board
June 30, 2025

Current
FY 2024-25
Authorized Positions: 14.6
Temp Help: 0




Cherise Burns, Executive Officer

Katelyn Leymon, Classification and Recruitment Analyst

**Note: All positions designated CORI**

# Attachment E




# Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board

## 2025-2028 Strategic Plan

Adopted: September 5, 2024

**Prepared by:**

SOLID Planning Solutions

Department of Consumer Affairs

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## Board Members

Gilda Dominguez, M.S., CCC-SLP, Speech-Language Pathologist, Chair

Dr. Amy E. White, Au.D., Audiologist, Vice Chair

Tod Borges, Hearing Aid Dispenser

Dr. Tamara Chambers, MD, FACS, Otolaryngologist, Public Member

Karen Chang, Public Member

John Dandurand, BC-HIS, Hearing Aid Dispenser

Dr. Charles Sanders, Au.D., Audiologist

VACANT, Public Member

VACANT, Speech-Language Pathologist

**Gavin Newsom, Governor**

**Tomiquia Moss, Secretary, Business, Consumer Services and Housing Agency**

**Kimberly Kirchmeyer, Director, Department of Consumer Affairs**

**Paul Sanchez, Executive Officer, Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board**

# About the Board

The Board serves to protect the public by licensing and regulating Speech-Language Pathologists, Audiologists, and Hearing Aid Dispensers; three separate and distinct professions with their own scopes of practice and professional settings. The Board sets entry-level licensing standards, which includes examination requirements that measure the candidate's professional knowledge and clinical abilities that are consistent with the demands of the current delivery systems.

Speech-Language Pathologists provide services in the areas of speech, language, voice, cognition, fluency, and swallowing disorders to individuals across their lifespan. They see individuals who may have language difficulties with verbal expression, auditory comprehension, reading comprehension, and/or written expression. These difficulties could be the result of a stroke, brain injury, or other neurogenic causes. Speech-Language Pathologists perform instrumental procedures within their scope of practice (e.g., Motion fluoroscopic evaluation of swallowing by cine or video recording, Flexible Fiberoptic Endoscopic Evaluation of Swallowing by cine or videorecording, laryngoscopy with stroboscopy). Speech-Language Pathologists coordinate care with otolaryngologists and physicians for such procedures. Speech-Language Pathologists also provide aural rehabilitation for individuals who are deaf or hard of hearing and provide therapy in the augmentative and alternative communication domain for individuals with diagnoses such as autism spectrum disorder and progressive neurological disorders. Speech-Language Pathologists work independently and collaboratively on interdisciplinary teams with other school or health care professionals in a range of settings including schools, medical, community-based facilities, and in private practice.

Audiologists provide services for individuals with hearing loss and balance (vestibular) disorders across their lifespan. Audiologists work in a number of professional settings, including hospitals that provide newborn hearing screenings, pediatric clinics, university and hospital audiology clinics, private practice, military facilities, academic institutions, and industrial, research, and forensic settings. More recently, there are an increasing number of Audiologists who participate in intraoperative neuromonitoring in the state's leading hospitals. Dispensing Audiologists are licensed to fit hearing aids for populations that range from infants to the elderly.

Hearing Aid Dispensers provide services to individuals with hearing loss, including fitting, selection, and adaptation of hearing aids and hearing tests for the purposes of fitting and selling hearing aids. Hearing Aid Dispensers generally work with individuals over the age of 16 but can work with younger individuals under specified circumstances.

To ensure ongoing consumer protection, the Board enforces standards of professional conduct by investigating applicant backgrounds, investigating complaints against licensed and unlicensed practitioners, and taking disciplinary action whenever appropriate.

# Message from the Chair

On behalf of the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board, I am pleased to present our 2025-2028 Strategic Plan.

The Board carries out its Mission of consumer protection by promoting standards and enforcing the laws and regulations that address the qualifications and competence of providers of speech-language pathology, audiology and hearing aid dispensing services. The Board carries out its Vision ensuring that every person in the State of California has access to diagnosis, treatment of communication disorders, and related services of the highest quality. The Values of Consumer Protection, Integrity, Efficiency, Accountability, Transparency, and Inclusion are sustained through the work of its Executive Director, Office Staff, Board Members, and its Standing and Ad Hoc Committees.

The Board's strategic planning process and goals are guided by our Mission, Vision, and Values. Input for the 2025-2028 Strategic Plan was obtained from stakeholders, as consideration for the future direction and focus of the Board. Stakeholders included our California consumers, licensees, Board members, and office staff. Stakeholders were asked to provide feedback, via a survey about the Board, pertaining to each of its focus areas. This feedback provided insight as to how the Board is doing by identifying strengths, weaknesses, opportunities and threats in five (5) focus areas: Licensing, Enforcement, Outreach and Communications, Laws and Regulations, and Program Administration.
In addition, a public planning session with the Board was facilitated by the Department of Consumer Affairs Office of Strategic Organization, Leadership, and Individual Development (SOLID) to establish key goals and activities that were to be included in the revised Strategic Plan.

Goals have been established in each of the five (5) aforementioned focus areas to ensure effective board operations aligned with our Mission, Vision, and Values. In the Strategic Plan document, specific activities are outlined that are considered to be vital to the fulfillment of the Board's function. Our 2025-2028 Strategic Plan expands upon previous goals achieved and continues to support our Mission of consumer protection.

We invite all stakeholders to review this strategic plan and support its goals, activities, and progress by participating in Board meetings, rulemakings, and other activities presented. We also encourage stakeholders to remain abreast of regulations and information available for the respective disciplines of practice. Information can be found on the Board's website at: https://www.speechandhearing.ca.gov/.

# Board Mission, Vision, and Values

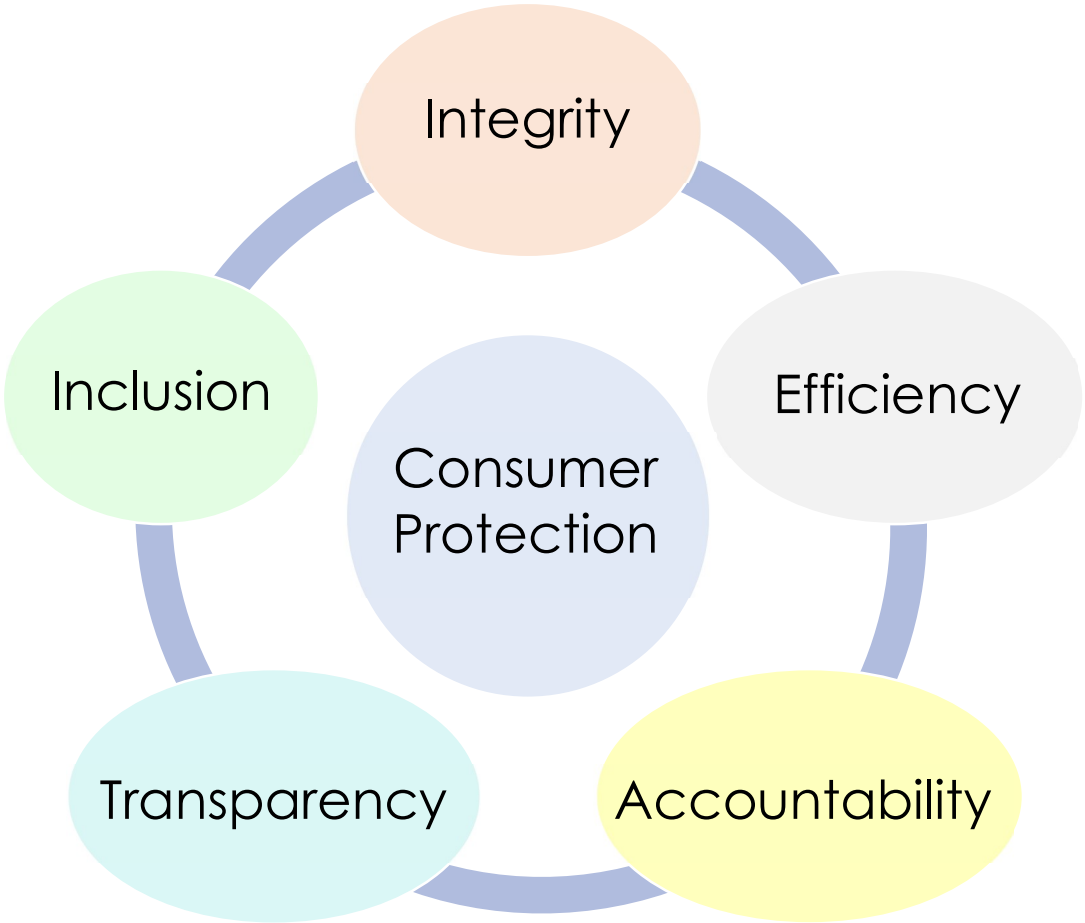
## Mission

We protect the people of California by promoting standards and enforcing the laws and regulations that ensure the qualifications and competence of providers of speech-language pathology, audiology, and hearing aid dispensing services.

## Vision

Every person in the State of California has access to the highest quality diagnosis and treatment of communication and hearing disorders, and related services.

## Values



# Goal 1: Licensing

**The Board's licensing standards protect consumers while permitting reasonable access into the professions.**

1.1 Improve responsiveness and communication to applicants and licensees.

1.2 Increase accessibility to the hearing aid dispensing practical exam.

1.3 Expand online licensing services to improve efficiency.

1.4 Create educational materials to clearly explain the application and licensing processes.

1.5 Research the impact of joining the interstate compact.

1.6 Research and evaluate creating a mid-level license type for entry into the profession of audiology to promote workforce development.

## Goal 2: Enforcement

**The Board protects consumers through the active enforcement of the laws and regulations governing the practices of speech-language pathology, audiology, and hearing aid dispensing.**

2.1 Review and update the Board's disciplinary guidelines to ensure more consistent disciplinary actions for similar violations.

2.2 Improve communication with complainants and respondents to clarify the enforcement process and promote consumer satisfaction.

2.3 Collaborate with DCA's Office of Information Services (OIS) to research the feasibility of creating a Board specific online complaint system that provides status updates to complainants and respondents.

## Goal 3: Outreach and Communications

**The Board educates and informs consumers and other stakeholders about the practices and laws and regulations governing the professions of speech-language pathology, audiology, and hearing aid dispensing.**

3.1 Improve outreach and communication about the Board's purpose and role to promote stakeholder understanding.

3.2 Improve all communications to ensure transparency, and enhance clarity and understanding by consumers.

3.3 Increase visibility and awareness of Board activities to promote stakeholder engagement and awareness.

3.4 Continue to develop informational materials about the regulatory process and the importance of public comment to increase timely and meaningful engagement.

3.5 Improve the Board's website to increase accessibility and user friendliness.

3.6 Clarify and educate stakeholders on the Board's jurisdiction to address school speech therapist caseload and other concerns.

3.7 Communicate the risks and limitations of over-the-counter hearing aids to increase consumer awareness.

## Goal 4: Laws and Regulations

**The Board protects California consumers by the laws and regulations governing the speech-language pathology, audiology, and hearing aid dispensing professions.**

4.1 Communicate and educate licensees about the recently changed continuing education regulations to keep licensees informed.

4.2 Continue periodic reviews of Board regulations, and update, if necessary, to ensure clarity and understanding, and to reflect current professional practices and their use of technologies.

4.3 Update regulations about supervision to increase clarity and address ethical issues.

4.4 Prioritize regulatory packages to improve the Board's responsiveness to high priority issues.

4.5 Advocate for a balance of specialty areas during the appointment process for members of the Board to achieve more balanced input into Board decisions and their impacts on different work settings.

# Goal 5: Board Administration

**The Board is committed to efficiently and effectively utilizing resources and personnel to meet its goals and objectives.**

5.1 Define necessary staffing levels and, if needed, obtain additional staffing through the budget process to achieve the Board's goals and mission.

5.2 Review the organizational structure to ensure appropriate oversight of Board's operations and supervision of staff.

# Strategic Planning Process

To understand the environment in which the Board operates as well as identify factors that could impact the Board's success in carrying out its regulatory duties, the Department of Consumer Affairs' SOLID Planning Solutions Unit (SOLID) conducted an environmental scan of the Board's internal and external environments by collecting information through the following methods:

- Phone/online interviews with board members and executive leadership during March and April of 2024.
- Online surveys distributed to board staff, as well as external stakeholders, during the month of April of 2024.

The most significant themes and trends identified from the environmental scan were discussed by board members, board leadership and staff, and members of the public during a strategic planning session facilitated by SOLID on June 12, 2024. This information guided the Board in the development of its strategic objectives outlined in this 2025-2028 strategic plan.

**Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board**

1601 Response Road, Suite 260
Sacramento, CA 95815
Phone: (916) 287-7915
https://www.speechandhearing.ca.gov/

Strategic plan adopted on September 5, 2024

This strategic plan is based on stakeholder information and discussions facilitated by SOLID for the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board on June 12, 2024. Subsequent amendments may have been made after the adoption of this plan.




Prepared by:
**SOLID Planning Solutions**
1747 N. Market Blvd., Ste. 270
Sacramento, CA 95834

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD
1601 Response Road, Suite 260, Sacramento, CA 95815
P (916) 287-7915 | www.speechandhearing.ca.gov

# MEMORANDUM

| | |
|---|---|
| DATE | November 24, 2025 |
| TO | Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board |
| FROM | Maria Liranzo, Legislation/Regulation/Budget Analyst |
| SUBJECT | Agenda Item 15: Legislative Report: Update, Review, and Possible Action on Proposed Legislation |

## a. Legislative Calendar and Deadlines

- September 12, 2025 – Last day for each house to pass bills. Interim Recess begins upon adjournment.
- October 12, 2025 – Last day for Governor to sign or veto bills passed by the Legislature on or before September 12 and in the Governor's possession after September 12.
- January 1, 2026 – Statutes take effect unless otherwise stated.
- January 5, 2026 – Legislature reconvenes.
- January 16, 2026 – Last day for policy committees to hear and report to fiscal committees fiscal bills introduced in their house in the odd-numbered year.
- January 23, 2026 – Last day for any committee to hear and report to the Floor bills introduced in that house in the odd-numbered year. Last day to submit bill requests to the Office of Legislative Counsel.
- January 31, 2026 – Last day for each house to pass bills introduced in that house in the odd-numbered year.
- February 20, 2026 – Last day for bills to be introduced.

## b. Board-Sponsored Legislation

### i. Senate Bill (SB) 861 (Committee on Business, Professions and Economic Development) Consumer affairs.

**Status:** This bill was approved by the Governor and chaptered by Secretary of State (Chapter 592, Statutes of 2025.)

**Summary:** This bill replaces gendered pronouns with non-gendered pronouns and replace the Board's former name with its current name. The bill makes nonsubstantive technical changes for other boards and bureau under the jurisdiction of the Department of Consumer Affairs. The bill makes conforming changes, and incorporate additional changes proposed by other bills.

## c. Bills on Watch Status

### i. Assembly Bill (AB) 45 (Bauer-Kahan) Privacy: health data: location and research.

**Status:** This bill was approved by the Governor and chaptered by Secretary of State (Chapter 134, Statutes of 2025.)

**Summary:** This bill prohibits geofencing, or selling or sharing personal information with a third party to geofence an entity that provides in-person health care services in California for purposes specified in the bill, and prohibits the use of personal information obtained in violation of these geofencing provisions. The bill provides that a statement signed under penalty of perjury that the personal information will not be used for selling or sharing personal information in violation of these geofencing provisions is prima facie evidence that the personal information was not sold or shared in violation of these geofencing provisions. The bill provides that violators are subject to an injunction and liable for a civil penalty assessed and recovered in a civil action brought by the Attorney General, and deposited in the California Reproductive Justice and Freedom Fund. This bill excludes any person that owns, operates, manages, or otherwise provides services to an in-person health care entity from geofencing the entity's own location to provide necessary health care services as specified in the bill.

Current law prohibits a person or business from collecting, using, disclosing, or retaining the personal information of a person who is physically located at, or within a precise geolocation of, a family planning center, except as necessary to perform the services or provide the goods requested and not sold or shared. Current law authorizes an aggrieved person or entity to institute and prosecute a civil action against a person or business for a violation of these provisions and specify damages and costs authorized to be recovered.

### ii. AB 322 (Ward) Precise geolocation information.

**Status:** This bill is in the Senate Appropriations Committee on Suspense File.

**Summary:** This bill would require a business that collects precise geolocation information to prominently display a notice to the consumer whose information is being collected in a manner and for the reasons specified in the bill. This bill would prohibit a business that collects precise geolocation information from retaining the information longer than necessary to provide the goods or services requested by the consumer or longer than one year after the consumer's last intentional interaction with the business, whichever is earlier.

Current law, known as the California Consumer Privacy Act of 2018 (CCPA), grants a consumer various rights with respect to personal information that is collected by a business including the right to direct a business that collects sensitive personal information about the consumer to limit its use. Current law defines "sensitive personal information" to mean personal information that reveals a consumer's precise geolocation, among other things.

### iii. AB 346 (Nguyen) In-home supportive services: licensed health care professional certification.

**Status:** This bill is in the Senate Appropriations Committee on Suspense File.

**Summary:** This bill would define “licensed health care professional” to mean individual licensed in California by the appropriate California regulatory agency, acting within the scope of their license or certificate, as defined in the Business and Professions Code, including a physician or surgeon, physician assistant, podiatrist, dentist, or nurse practitioner.

Current law defines a licensed health care professional to mean an individual licensed in California by the appropriate California regulatory agency, acting within the scope of their license or certificate as defined in the Business and Professions Code. Current law also defines supportive services to include those necessary paramedical services that are ordered by a licensed health care professional for purposes of the IHSS program Current law requires an applicant for, or recipient of, IHSS services obtain a certification from a licensed health care professional declaring that the applicant or recipient is unable to perform some activities of daily living independently, and that without services to assist the applicant or recipient with activities of daily living, the applicant or recipient is at risk of placement in out-of-home care.

### iv. AB 364 (DeMaio) Personal information: maintenance.

**Status:** This bill is in the Assembly Privacy and Consumer Protection Committee.

**Summary:** This bill would enact the Stop Foreign Governments from Accessing Californians’ Sensitive Personal Information Act as Sections 1798.100 and 1798.122 of the Civil Code and would additionally require a business to disclose to a consumer if the business intends to maintain the consumer’s personal information outside of the United States. The bill would prohibit a business from maintaining a consumer’s personal information outside of the United States unless, among other things, the consumer explicitly consented to the business maintaining the consumer’s personal information outside of the United States. The bill would also prohibit a business from maintaining personal information that is health care information, financial information, or geolocation data in the custody of a foreign government or a third party that is owned or controlled by a foreign government.

Current law, known as the California Consumer Privacy Act of 2018 (CCPA), grants a consumer various rights with respect to personal information that is collected by a business including the right to direct a business that sells or shares personal information about the consumer to third parties not to sell or share the consumer’s personal information. The CCPA requires a business that controls the collection of a consumer’s personal information to, at or before the point of collection, inform a consumer of, among other things, the categories of personal information to be collected, the purposes for which the categories of personal information are collected or used, and whether that information is sold or shared.

### v. AB 410 (Wilson) Bots: disclosure.

**Status:** This bill is in the Senate Appropriations Committee on Suspense File.

**Summary:** This bill would require a person who uses a bot to autonomously communicate with another to ensure that the bot discloses to any person with whom the bot communicates when the bot first communicates with the person that the bot is a bot and not a human being, answer truthfully any query from a person regarding its identity as a bot or a human, and refrain from attempting to mislead a person regarding its identity as a bot. The bill would redefine "bot" to mean an automated online account or application that a reasonable person could believe is a human being and with respect to which substantially all of the actions or posts of that account or application are the outputs of generative artificial intelligence. The bill would define "generative artificial intelligence" to mean artificial intelligence that can generate derived synthetic content, including text, images, video, and audio that emulates the structure and characteristics of the system's training data. The bill would also define "artificial intelligence" to mean an engineered or machine-based system that varies in its level of autonomy and that can, for explicit or implicit objectives, infer from the input it receives how to generate outputs that can influence physical or virtual environments. The bill would exempt a person who uses a bot that is required to comply with a more prescriptive disclosure scheme. The bill would the definition of online platform and exemption for service providers of online platforms. The bill would permit the Attorney General, a district attorney, a county counsel, a city attorney, or a city prosecutor to bring an action against a person who violates this law to obtain either an injunctive relief or a civil penalty of one thousand dollars ($1,000) per violation.

Current law makes it unlawful for any person to use a bot to communicate or interact with another person in this state online with the intent to mislead the other person about its artificial identity for the purposes of knowingly deceiving the person about the content of the communication in order to incentivize a purchase or sale of goods or services in a commercial transaction or to influence a vote in an election, unless the person using the bot discloses that it is a bot. Current law defines a "bot" as an automated online account where all or substantially all of the actions or posts of that account are not the result of a person.

### vi. AB 485 (Ortega) Labor Commissioner: unsatisfied judgments: nonpayment of wages.

**Status:** This bill is in the Senate Appropriations Committee on Suspense File.

**Summary:** This bill would require any state agency to deny a new license or permit or the renewal of an existing license if the applicant, licensee, or registrant is in violation of Section 238 of the Labor Code regarding unpaid wages. The bill would also require the Labor Commissioner to notify the state agency of any licensees or registrants who are in violation of Section 238 of the Labor Code. This bill would repeal similar provisions applicable to employers in the long-term care industry and instead would permit the State Public Health Officer to exempt a hospital employer from the bill's requirements upon a determination that a denial, suspension, or revocation of the hospital's license, permit, or renewal could have imminent or substantial adverse effects upon public health or safety or would violate constitutional law.

Current law generally prohibits an employer with an unsatisfied final judgment for nonpayment of wages from continuing to conduct business in California, unless that employer has obtained a bond from a surety company and filed that bond with the Labor Commissioner. Current law requires the State Department of Public Health or the State Department of Social Services to deny a new license or the renewal of an existing license if an employer who is required to obtain a license from such department has violated this law. Current law requires the Labor Commissioner to notify those departments upon finding that an employer in the long-term care industry is violating this law.

**vii. AB 489 (Bonta) Health care professions: deceptive terms or letters: artificial intelligence.**

**Status:** This bill was approved by the Governor and chaptered by Secretary of State (Chapter 615, Statutes of 2025.)

**Summary:** This bill prohibits the use of terms, letters, or phrases that indicate or imply possession of a license to practice a health care profession without at that time having the appropriate license required for that practice or profession by a person or entity who develops or deploys a system or device that uses one or more of those terms, letters, or phrases in the advertising or functionality of an artificial intelligence (AI) or a generative artificial intelligence (GenAI) program, device, or similar technology. This bill also prohibits the use of terms, letters, or phrases in the advertising or functionality of an AI or GenAI system, program, device, or similar technology that indicates or implies that the care, advice, reports, or assessments being offered through the AI or GenAI technology is being provided by a natural person in possession of the appropriate license to practice as a health care professional. The bill makes this violation subject to the jurisdiction of the appropriate health care profession board, and would make each use of a prohibited term, letter, or phrase punishable as a separate violation. The bill also permits the authority for a health care professional licensing board or enforcement agency to pursue an injunction or restraining order to enforce these provisions as authorized by Section 125.5, and any remedy otherwise authorized under the law.

Current law makes it a crime for a person who is not licensed as a health care professional to use certain words, letters, and phrases or any other terms that imply that they are authorized to practice that profession, and provides that a violation of these laws be subject to the jurisdiction of the appropriate health care profession board

**viii. AB 742 (Elhawary) Department of Consumer Affairs: licensing: applicants who are descendants of slaves.**

**Status:** This bill was vetoed by the Governor.

**Summary:** This bill would have required boards under the jurisdiction of the Department of Consumer Affairs to expedite a applications for applicants seeking licensure who are descendants of American slaves once a process to certify descendants of American slaves is established. The bill would have made this operative when the certification process was established. The bill would have made this effective for four (4) years from the date on which this became operative or until January 1, 2032, whichever is earlier, and as of that date is

repealed. The bill would have also made this operative only if SB 518 of the 2025–26 Regular Session is enacted establishing the Bureau for Descendants of American Slavery.

Current law requires boards under the jurisdiction of the Department of Consumer Affairs to expedited licensure process for honorably discharged members of the United States Armed Forces; military spouse or domestic partner; service members enrolled in Skillbridge; and refugees, asylees, and holders of special immigrant visas (SIVS).

**Veto Message:** I am returning Assembly Bill 7 42 without my signature.

This bill would require boards and bureaus under the Department of Consumer Affairs to expedite applicants seeking licensure who are descendants of slaves, once a certification process for the descendants of American Slaves is implemented by the Bureau for Descendants of American Slavery.

I appreciate the author's intent to increase diversity within the professional licensed population and improve licensure opportunities for historically underrepresented communities. However, as the number of applicants who qualify for expedited licensure increases, the benefits of mandated prioritization may start to diminish, creating negative impacts on other applicants. Additionally, licensing fee increases may result from this bill, as an increase in staff will be necessary to ensure expedited applications.

I vetoed two similar measures seeking to expedite licensure for specified populations last year for these same concerns, and I believe more data is needed on the effectiveness and consequences of expedited licensure before committing to similar frameworks.

For these reasons, I cannot sign this bill.

**ix. AB 784 (Hoover) Special education: specialized deaf and hard-of-hearing services.**

**Status:** This bill was approved by the Governor and chaptered by Secretary of State (Chapter 44, Statutes of 2025.)

**Summary:** This bill prohibits provisions from being construed to prohibit an individualized education program from including specialized deaf and hard-of-hearing related services as the only services.

Current law requires local educational agencies to identify, locate, and assess individuals with exceptional needs and to provide those individuals with a free appropriate public education in the least restrictive environment, with special education and related services, as reflected in an individualized education program. Current law defines “special education” as specially designed instruction, at no cost to the parent, to meet the unique needs of individuals with exceptional needs. Current law includes in that definition speech-language pathology services and certain other services if the service is considered special education rather than a designated instruction and service or related service under state standards.

**x. AB 970 (McKinnor) Child abuse and neglect reporting.**

**Status:** This bill is in the Assembly Public Safety Committee.

**Summary:** This bill would authorize the County of Los Angeles to establish a *2-year* pilot program to test a new model for the mandatory reporting of child abuse or neglect. The bill would require the pilot program to include a comprehensive County of Los Angeles mandated reporter training that may be made available to all mandated reporters in the county. The bill would also require the pilot program to also include the development and deployment of an internet-based decision-support tool, developed through a collaborative process with, among others, the State Department of Social Services for mandated reporters who have completed that training. The bill would also require the decision-support tool to, among other things, make a recommendation on whether or not to report and would prohibit the decision-support tool from using predictive analysis. The bill would, during the time the pilot program is in effect, deem a mandated reporter to have satisfied their reporting duties if the reporter completed the training, used the decision-support tool, and complied with the recommended action. The bill would shield a mandated reporter who satisfied their reporting duties pursuant to this bill from civil liability or criminal penalty, and from penalties impacting their professional licenses, credentials, and certifications, for failing to report known or suspected child abuse or neglect, as well as the reporter's supervisor, employer, superior, or principal. The bill would repeal its provisions on January 1, 2030.

Current law authorizes a county welfare agency to develop a program for internet-based reporting of child abuse and neglect. Current law also authorizes a mandated reporter in a county where the program is active to use the internet-based reporting tool in lieu of the required initial telephone report.

**xi. AB 1015 (Patel) Discrimination and harassment prevention training.**

**Status:** This bill is in the Assembly Labor and Employment Committee.

**Summary:** This bill would authorize an employer to satisfy the training requirements by demonstrating that the employee possesses a certificate of completion within the past two (2) years.

Current law requires employer with five (5) or more employees to provide at least two (2) hours of classroom or other effective interactive training and education regarding sexual harassment to all supervisory employees and at least one (1) hour of classroom or other effective interactive training and education regarding sexual harassment to all nonsupervisory employees in California. Current law requires each employer provide sexual harassment training and education to each employee in California once every two years. Current law requires that an employee who has received training in compliance with the law within the prior two (2) years either from a current or a prior employer be given, and be required to read and acknowledge receipt of, the employer's antiharassment policy and requires that the employee then be put on a two-year tracking schedule based on the employee's last training. Current law places the burden of establishing that prior training was legally compliant on the employer.

**xii. AB 1110 (Ortega) Safety rules and regulations: notice.**

**Status:** This bill is in the Assembly Appropriations Committee.

**Summary:** This bill would additionally require the notice containing information regarding safety rules and regulations in the workplace to contain the email address of the nearest division office.

Current law requires the Division of Occupational Safety and Health of the Department of Industrial Relations to prepare a notice, to be posted by employers, containing information regarding safety rules and regulations in the workplace. Current law requires the notice to contain specified items of information, including, among other things, the address and telephone number of the nearest division office.

**xiii. AB 1192 (Carrillo) Child abuse or neglect: reporting.**

**Status:** This bill is in the Assembly Appropriations Committee on Suspense File.

**Summary:** This bill would require an employee of an agency specified in Section 11165.9 of the Penal Code to additionally send a copy of the report to the attorney who represents a parent or legal guardian of the child, except when a parent whose parental rights have been terminated or a parent who is not entitled to reunification services. The bill would require the agency to redact all personal identifying information regarding all persons, other than the child, who are identified in the report. The bill would also require an employee of the agency to send a copy of the report to all attorneys who represent children with an open dependency case in that placement, subject to specified redaction if the suspected abuse or neglect occurred in a placement.

Current law requires certain professionals, including specified health practitioners and social workers, known as “mandated reporters,” employed by an agency specified in Section 11165.9 of the Penal Code to report known or suspected child abuse or neglect to a local law enforcement agency or a county welfare or probation department. Current law requires the agency to maintain a copy of the written report and provide all information requested by the attorney for the child or the child’s guardian ad litem within 30 days of the request. Current law also requires an employee of those agencies to send or have sent, within 36 hours, a copy of a report made pursuant to these laws to the attorney who represents the child, who is the subject of the report, in dependency court.

**xiv. AB 1326 (Ahrens) Masks: individual or public health.**

**Status:** This bill was vetoed by the Governor.

**Summary:** This bill would have given an individual the right to wear a mask on their face in a public place for the purpose of protecting their individual health or the public health with regard to communicable disease, air quality, or other health factors. The bill would have defined a mask and a public place for purposes of this bill. The bill would not have been construed as limiting or otherwise modifying the application or implementation of certain requirements for the removal of a mask relating to security protocols to identify an individual, a bona fide occupational qualification, emergency health care protocols, and among other contexts.

Current law sets forth various provisions on the wearing of a mask for health purposes and other circumstances.

**Veto Message:** I am returning Assembly Bill 1326 without my signature.

This bill states an individual has the right to wear a mask in public spaces and workplaces for the purpose of protecting their health or the public's health, except under specified situations.

I appreciate the author's goal of ensuring Californians may wear a mask for public health reasons, but I am not convinced this measure is necessary. Existing law appears sufficient to allow a person to wear a mask for health reasons in most public situations. This bill creates a sweeping new policy with numerous exceptions, and may create confusion about the application of existing state and federal legal protections.

For these reasons, I cannot sign this bill.

**xv. AB 1327 (Aguiar-Curry) Home improvement and home solicitation: right to cancel contracts: notice.**

**Status:** This bill was approved by the Governor and chaptered by Secretary of State (Chapter 348, Statutes of 2025.)

**Summary:** This bill requires that a notice of cancellation of a home solicitation contract or offer to also be delivered by email and requires the seller to include in the contract an address and email address to which the notice of cancellation is to be sent and a telephone number of a support line to assist the buyer with locating and completing the notice of cancellation. This bill makes conforming changes for home improvement contracts, and incorporates additional changes proposed by other bills.

Current law requires a home improvement or home solicitation contract or offer to include a notice of cancellation form with specified statements as to the buyer’s right to cancel, including the deliverance of such notice to the seller by mail, delivery, or telegram.

**xvi. SB 81 (Arreguín) Health and care facilities: information sharing.**

**Status:** This bill was approved by the Governor and chaptered by Secretary of State (Chapter 123, Statutes of 2025.)

**Summary:** To take effect immediately as an urgency statute, this bill revises the definition of “medical information” to include immigration status, including current and prior immigration status, and place of birth. This bill defines “immigration enforcement” to mean any and all efforts to investigate, enforce, or assist in the investigation or enforcement of any federal civil immigration law and federal criminal immigration that penalizes a person’s presence in, entry or reentry to, or employment in, the United States. The bill additionally requires that a provider of health care, health care service plan, or contractor disclose medical information regarding a patient of the provider of health care or an enrollee or subscriber or a health care service plan without first obtaining an authorization if the disclosure is compelled by a court order issued by a valid state or a federal court order, and a valid search warrant issued by a judicial officer to a governmental law enforcement agency as long it does not interfere with California law. The bill prohibits a provider of health care, health care service plan, contractor, or corporation and its subsidiaries and affiliates from disclosing medical information for

immigration enforcement except to the extent expressly authorized by a patient, enrollee, or subscriber, or as otherwise required by law. This bill requires health care provider entities to establish or amend procedures for monitoring and receiving visitors to health care provider entities, and encourage them to post a “notice to authorities” at facility entrances. This bill requires health care provider entity personnel to notify health care provider entity management, administration, or legal counsel of any request for access to a health care provider entity site or patient for immigration enforcement, review of health care provider entity documents, especially for immigration enforcement. The bill requires a health care provider entity to designate areas where patients are receiving treatment or care or where a patient is discussing protected health information as nonpublic, and encourage to designate these areas through mapping, signage, key entry, policy, or a combination of those. The bill prohibits a health care provider entity and its personnel from allowing access to the nonpublic areas of the facility for immigration enforcement purposes unless required by state or federal law or a valid judicial warrant or court order that specifically grants access to the nonpublic areas of the facility. The bill requires a health care provider entity and its personnel to have the denial of permission for access to nonpublic areas of the facility witnessed and documented by at least one health care provider entity personnel, and requires health care provider entities to inform staff and relevant volunteers on how to respond to requests relating to immigration enforcement that grants access to health care provider entity sites or to patients. This bill defines “health care provider entity” and “immigration enforcement” for the purposes of these provisions. The bill prohibits a health care provider entity and its personnel from allowing access to nonpublic areas of the provider’s facilities for immigration enforcement without a valid judicial warrant or court order to the extent permitted by state and federal law, and require health care provider entities to inform staff and relevant volunteers on how to respond to requests relating to immigration enforcement that grants access to health care provider entity sites or to patients. The bill does not prohibit a person who is in lawful custody from being accompanied to access health care services and for their transportation and arrangement to health care provider entities, and does not prohibit any person from entering nonpublic areas of a hospital to receive care for themselves or someone in their care or custody. The bill applies to all health care provider entities that receive public funding, and all other health care provider entities that are not subject to this bill are encouraged to adopt the requirements specified in this bill. The bill requires health care provider entities to comply with the requirements contained in the bill within 45 days from the effective date of the bill.

Current law prohibits a provider of health care, health care service plan, or contractor from disclosing medical information regarding a patient of the provider of health care or an enrollee or subscriber or a health care service plan without first obtaining an authorization if the disclosure unless compelled under specified conditions. Current law prohibits a provider of health care, health care service plan, contractor, or corporation and its subsidiaries and affiliates shall not intentionally share, sell, use for marketing, or otherwise use medical information for a purpose not necessary to provide health care services to the patient except to the extent expressly authorized by a patient or enrollee or subscriber or specified conditions. Current law prohibits a contractor or corporation and its subsidiaries and affiliates from further disclosing medical information regarding a patient of the provider of health care or an enrollee or subscriber of a health care service plan or insurer or self-insured employer to a person or entity that is not engaged in providing direct health care services to the patient or the patient’s provider of health care or health care service plan or insurer or self-insured

employer except to the extent expressly authorized by a patient or enrollee or subscriber or specified conditions.

**xvii. SB 82 (Umberg) Contracts: consumer goods and services: dispute resolution provisions.**

**Status:** This bill was approved by the Governor and chaptered by Secretary of State (Chapter 350, Statutes of 2025.)

**Summary:** This bill limits the dispute resolution terms and conditions to the use, payment, or provision of the good, service, money, or credit provided by the consumer use agreement. The bill makes a waiver of these provisions void and unenforceable, and requires that the provisions be liberally construed for the purpose of protecting consumers. The bill provides that the duties and obligations it imposes are cumulative with, and do not limit or expand, duties and obligations imposed under any other law, and do not limit any rights or remedies under any other law. The bill defines terms for purposes of these provisions.

Current law regulates the formation and enforcement of contracts, including imposing certain restrictions on the terms of a contract for the sale or lease of consumer goods or services. Current law prohibits a provision waiving the consumer's right to make any statement regarding the seller, lessor, or its employees or agents, or concerning the goods or services; and from limiting a consumer's ability to file a complaint with a licensing board that regulates the consumer service provider or to participate in the board's investigation into the consumer service provider.

**xviii. SB 294 (Reyes) The Workplace Know Your Rights Act.**

**Status:** This bill was approved by the Governor and chaptered by Secretary of State (Chapter 667, Statutes of 2025.)

**Summary:** This bill establishes the Workplace Know Your Rights Act, which requires an employer to provide a stand-alone written notice with to each current employee, each new employee upon hire, and an employee's authorized representative, if any, of workers' rights information specified in the Act in a manner specified in the Act after the Labor Commissioner posts a template notice on its internet website, and every year thereafter. This bill requires an employer to notify the designated emergency contact if the employee is arrested or detained on their worksite if the employee has designated an emergency contact for this purpose and, if the arrest or detention occurs during work hours or the performance of the employee's job duties but not on the worksite, only if the employer has actual knowledge of the arrest or detention of the employee is the employer required to notify the designated emergency contact. This bill prohibits an employer from discharging, threatening to discharge, demoting, suspending, or in any manner discriminating or retaliating against an employee for exercising or attempting to exercise their rights under the Act. The bill provides that an employer who violates the provision under this Act may be subject to a civil penalty per employee.

Current law prescribes the duties and rights of employers and employees relating to specified labor laws, including, among other things, paid sick days, workers' compensation, and notice requirements related to inspections conducted by an immigration agency.

**xix. SB 402 (Valladares) Health care coverage: autism.**

**Status:** This bill was approved by the Governor and chaptered by Secretary of State (Chapter 413, Statutes of 2025.)

**Summary:** This bill defines "qualified autism service provider," "qualified autism service professional," and "qualified autism service paraprofessional" in the Business and Professions Code. The bill also makes technical and conforming changes, and incorporates additional changes proposed by other bills.

Current law defines "qualified autism service provider," "qualified autism service professional," and "qualified autism service paraprofessional" in the Health and Safety Code and the Insurance Code.

**xx. SB 446 (Hurtado) Data breaches: customer notification.**

**Status:** This bill was approved by the Governor and chaptered by Secretary of State (Chapter 319, Statutes of 2025.)

**Summary:** This bill requires that data breach disclosure be made within 30 calendar days of discovery or notification of the data breach and permit an individual or business to delay the disclosure to accommodate the legitimate needs of law enforcement or to determine the scope of the breach and restore the reasonable integrity of the data system. This bill also requires an individual or business that is required to issue the security breach notification to more than 500 California residents as a result of a single breach of the security system to electronically submit a single sample copy of that security breach notification, excluding any personally identifiable information, to the Attorney General within 15 calendar days of notifying affected consumers of the security breach.

Current law requires a person or business that conducts business in California, and that owns or licenses computerized data that includes personal information, to disclose a breach of the security of the system in a manner specified by the law following discovery or notification of the breach in the security of the data to a resident of California whose unencrypted personal information was compromised and requires that disclosure to be made in the most expedient time possible and without unreasonable delay, consistent with the legitimate needs of law enforcement or any measures necessary to determine the scope of the breach and restore the reasonable integrity of the data system. Current law also requires a person or business that is required to issue the security breach notification described above to more than 500 California residents as a result of a single breach of the security system to electronically submit a single sample copy of that security breach notification, excluding any personally identifiable information, to the Attorney General.

**xxi. SB 470 (Laird) Bagley-Keene Open Meeting Act: teleconferencing.**

**Status:** This bill was approved by the Governor and chaptered by Secretary of State (Chapter 222, Statutes of 2025.)

**Summary:** This bill extends the additional, alternative set of provisions under which a state body may hold a meeting by teleconference through January 1, 2030.

Current law authorizes an additional, alternative set of provisions under which a state body may hold a meeting by teleconference subject to specified requirements, including, among others, that at least one member of the state body is physically present at each teleconference location, that a majority of the members of the state body are physically present at the same teleconference location, and that members of the state body visibly appear on camera during the open portion of a meeting that is publicly accessible via the internet or other online platform. Current law authorizes, under specified circumstances, a member of the state body to participate pursuant to these provisions from a remote location, which would not be required to be accessible to the public and which the act prohibits the notice and agenda from disclosing. Current law repeals these provisions on January 1, 2026.

Current law authorizes a multimember state advisory body to hold an open meeting by teleconference pursuant to an alternative set of provisions that are in addition to the above-described provisions generally applicable to state bodies. These alternative provisions specify requirements, including, among others, that the multimember state advisory body designates the primary physical meeting location in the notice of the meeting where members of the public may physically attend the meeting, observe and hear the meeting, and participate, that at least one staff member of the state body to be present at the primary physical meeting location during the meeting, and that the members of the state body visibly appear on camera during the open portion of a meeting that is publicly accessible via the internet or other online platform. Current law repeals these provisions on January 1, 2026. Current law removes the above-described requirements for the alternative set of teleconferencing provisions for multimember state advisory bodies, and, instead, requires, among other things, that the multimember state advisory body designates the primary physical meeting location in the notice of the meeting where members of the public may physically attend the meeting and participate beginning January 1, 2026.

**xxii. SB 497 (Wiener) Legally protected health care activity.**

**Status:** This bill was approved by the Governor and chaptered by Secretary of State (Chapter 764, Statutes of 2025.)

**Summary:** To take effect immediately as an urgency statute, this bill prohibits a provider of health care, a health care service plan, or a contractor from releasing medical information related to a person seeking or obtaining gender-affirming health care in response to any subpoena or request, including a foreign subpoena, based on another state's law that interferes with an individual's right to seek or obtain gender-affirming health care, or authorizes a person to bring a civil or criminal action against a person receiving gender-affirming health care or gender-affirming mental health care. The bill also prohibits a provider of health care, health care service plan, contractor, or employer from cooperating with or providing medical information to an individual, agency, or department from another state or, to the extent permitted by federal law, to a federal law enforcement agency that would identify an individual and that is related to an individual seeking or obtaining gender-affirming health care that is lawful under the laws of this state. The bill does not prohibit the release of such medical information for purposes specified in the bill. The bill also makes technical and conforming changes, and incorporates additional changes proposed by other bills.

Current law prohibits a provider of health care, a health care service plan, or a contractor from releasing medical information related to a person or entity allowing a child to receive gender-affirming health care in response to a civil action, including a foreign subpoena, based on another state's law that authorizes a person to bring a civil action against a person or entity that allows a child to receive gender-affirming health care. Current law generally authorizes a California court or attorney to issue a subpoena if a foreign subpoena has been sought in this state, but prohibits the issuance of a subpoena based on another state's law that interferes with a person's right to allow a child to receive gender-affirming health care.

**xxiii. SB 641 (Ashby) Department of Consumer Affairs and Department of Real Estate: states of emergency: waivers and exemptions.**

**Status:** This bill was vetoed by the Governor.

**Summary:** This bill would have taken effect immediately as an urgency statute. This bill would have authorized the Department of Real Estate and boards under the jurisdiction of the Department of Consumer Affairs to waive the application of certain provisions of the licensure requirements that the board or department is charged with enforcing for licensees and applicants impacted by a declared federal, state, or local emergency or whose home or business is located in a declared disaster area, including certain examination, fee, and continuing education requirements. The bill would have exempted impacted licensees boards under the jurisdiction of the Department of Consumer Affairs from payment of duplicate license fees and notifying the board of its home or business mailing address if their home or business is located in a declared disaster area. The bill would have required all applicants and licensees of boards under the Department of Consumer Affairs to provide the board or department with an email address. The bill would have made additional changes affecting the Contractors State License Law and the Department of Real Estate.

Current law permit boards under the jurisdiction of the Department of Consumer Affairs to charge a fee for the processing and issuance of a duplicate copy of any certificate of licensure or other form evidencing licensure or renewal of licensure. Current law requires each person holding a license, certificate, registration, permit, or other authority to engage in a profession or occupation issued by a board under the jurisdiction of the Department of Consumer Affairs to notify the issuing board of any change in the person's mailing address within 30 days after the change, unless the board has specified by regulations a shorter time period.

**Veto Message:** I am returning Senate Bill 641 without my signature.

This bill would authorize licensing boards under the Department of Consumer Affairs and the Department of Real Estate to waive the application of specified laws for licensees and applicants who are impacted by a proclaimed federal, state, or local emergency, or whose homes or businesses are located in a disaster area. Additionally, this bill would ban unsolicited offers by real estate licensees and their clients that are below market value, as it was the day before the disaster, and would ban it throughout the entire geographic area in which the disaster is proclaimed.

I appreciate the intent of the author to help those impacted by natural disasters to find regulatory relief quickly and to protect those with property in disaster areas. In response to

recent disasters, my Administration worked closely with the Legislature to coordinate targeted relief and consumer protections to disaster victims - absent the authority sought in this bill .

With respect to the real estate protection provisions, the bill is overly brood, applying to all natural disasters even when housing is unaffected. It also leaves on enforcement gap by regulating licensees only when acting for clients, not for themselves. Together, these issues call into question whether the bill is properly tailored to achieve its stated goals.

For these reasons, I cannot sign this bill.

**xxiv. SB 744 (Cabaldon) Accrediting agencies.**

**Status:** This bill was approved by the Governor and chaptered by Secretary of State (Chapter 425, Statutes of 2025.)

**Summary:** This bill requires national or regional accrediting agency recognized by the United States Department of Education as of January 1, 2025, to retain that recognition until July 1, 2029, provided that the accrediting agency continues to operate in substantially the same manner as it did on January 1, 2025. The bill repeals those provisions on January 1, 2030, and makes technical and conforming changes.

Current law requires certain postsecondary educational institutions to be accredited by an accrediting agency recognized by the United States Department of Education to qualify as an independent institution of higher education to be eligible for certain programs and to receive an approval to operate. Current law requires applicants for licensure or licensees of various professions and vocations regulated by a board under the Department of Consumer Affairs to satisfy educational requirements from institutions or universities accredited by a regional or national accrediting agency or association recognized by the United States Department of Education or impose a requirement that a school or program be accredited by an accrediting agency recognized by the United States Department of Education.

Attachments:

1. SB 861 (Committee on Business, Professions and Economic Development) Consumer affairs.
2. AB 45 (Bauer-Kahan) Privacy: health data: location and research.
3. AB 489 (Bonta) Health care professions: deceptive terms or letters: artificial intelligence.
4. AB 784 (Hoover) Special education: specialized deaf and hard-of-hearing services.
5. AB 1327 (Aguiar-Curry) Home improvement and home solicitation: right to cancel contracts: notice.
6. SB 81 (Arreguín) Health and care facilities: information sharing.
7. SB 82 (Umberg) Contracts: consumer goods and services: dispute resolution provisions.
8. SB 294 (Reyes) The Workplace Know Your Rights Act.
9. SB 402 (Valladares) Health care coverage: autism.
10. SB 446 (Hurtado) Data breaches: customer notification.
11. SB 470 (Laird) Bagley-Keene Open Meeting Act: teleconferencing.
12. SB 497 (Wiener) Legally protected health care activity.

13. SB 744 (Cabaldon) Accrediting agencies.

**SB 861 - (C) Amends the Law**

**SECTION 1.**

Section27 of the Business and Professions Code is amended to read:

**SEC. 1.5.**

Section27 of the Business and Professions Code is amended to read:

**SEC. 2.**

Section144 of the Business and Professions Code is amended to read:

**SEC. 3.**

Section1602 of the Business and Professions Code is amended to read:

**SEC. 4.**

Section1603 of the Business and Professions Code is amended to read:

**SEC. 5.**

Section1901 of the Business and Professions Code is amended to read:

**SEC. 6.**

Section1903 of the Business and Professions Code is amended to read:

**SEC. 7.**

Section1905 of the Business and Professions Code is amended to read:

**SEC. 8.**

Section1926.3 of the Business and Professions Code is amended to read:

**SEC. 9.**

Section1944 of the Business and Professions Code is amended to read:

**SEC. 10.**

Section2532.2 of the Business and Professions Code is amended to read:

Except as required by Section 2532.25, to be eligible for licensure by the board as a speech-language pathologist or audiologist, the applicant shall possess all of the following qualifications:

(a) Possess at least a master's degree in speech-language pathology or audiology from an educational institution approved by the board or qualifications deemed equivalent by the board.

(b) (1) Submit evidence of the satisfactory completion of supervised clinical practice with individuals representative of a wide spectrum of ages and communication disorders. The board shall establish by regulation the required number of clock hours, not to exceed 375 clock hours, of supervised clinical practice necessary for the applicant.

(2) The clinical practice shall be under the direction of an educational institution approved by the board.

(c) Submit evidence of no less than 36 weeks of satisfactorily completed supervised professional full-time experience or 72 weeks of professional part-time experience obtained under the supervision of a licensed speech-language pathologist or audiologist or a speech-language pathologist or audiologist having qualifications deemed equivalent by the board. This experience shall be evaluated and approved by the board. The required professional experience shall follow completion of the requirements listed in subdivisions (a) and (b). Full time is defined as at least 36 weeks in a calendar year and a minimum of 30 hours per week. Part time is defined as a minimum of 72 weeks and a minimum of 15 hours per week.

(d) (1) Pass an examination or examinations approved by the board. The board shall determine the subject matter and scope of the examinations and may waive the examination upon evidence that the applicant has successfully completed an examination approved by the board. Written examinations may be supplemented by oral examinations as the board shall determine. An applicant who fails ~~his or her~~ *their* examination may be reexamined at a subsequent examination upon payment of the reexamination fee required by this chapter.

(2) A speech-language pathologist or audiologist who holds a license from another state or territory of the United States or who holds equivalent qualifications as determined by the board and who has completed no less than one year of full-time continuous employment as a speech-language pathologist or audiologist within the past three years is exempt from the supervised professional experience in subdivision (c).

(e) As applied to licensure as an audiologist, this section shall apply to applicants who graduated from an approved educational institution on or before December 31, 2007.

**SEC. 11.**

Section2532.3 of the Business and Professions Code is amended to read:

(a) Upon approval of an application filed pursuant to Section 2532.1, and upon the payment of the fee prescribed by subdivision (i) of Section 2534.2, the board may issue a temporary license for a period of six months from the date of issuance to a speech-language pathologist or audiologist who holds an unrestricted license from another state or territory of the United States or who holds equivalent qualifications as determined by the board and has made application to the board for a license in this state.

(b) A temporary license shall terminate upon notice thereof by certified mail, return receipt requested, if it is issued by mistake or if the application for permanent licensure is denied.

(c) Upon written application, the board may reissue a temporary license to any person who has applied for a regular renewable license pursuant to Section 2532.1, and who, in the judgment of the board, has been excusably delayed in completing ~~his or her~~ *their* application or the minimum requirements for a regular license. The board may not reissue a temporary license more than twice to any one person.

**SEC. 12.**

Section2532.4 of the Business and Professions Code is amended to read:

(a) The board may direct applicants to be examined for knowledge in whatever theoretical or applied fields in speech-language pathology or audiology it deems appropriate. It may examine the applicant with regard to ~~his or her~~ *their* professional skills and ~~his or her~~ *their* judgment in the utilization of speech-language pathology or audiology techniques and methods.

(b) The examination may be written or oral or both. The examination shall be given at least once a year at the time and place and under such supervision as the board may determine. The board shall determine what shall constitute a passing grade.

(c) The board shall keep an accurate recording of any oral examination and keep the recordings as well as any written examination as part of its records for at least two years following the date of examination.

**SEC. 13.**

Section2532.6 of the Business and Professions Code is amended to read:

(a) The Legislature recognizes that the education and experience requirements of this chapter constitute only minimal requirements to assure the public of professional competence. The Legislature encourages all professionals licensed and registered by the board under this chapter to regularly engage in continuing professional development and learning that is related and relevant to the professions of speech-language pathology and audiology.

(b) The board shall not renew any license or registration pursuant to this chapter unless the applicant certifies to the board that ~~he or she has~~ *they have* completed in the preceding two years not less than the minimum number of continuing professional development hours established by the board pursuant to subdivision (c) for the professional practice authorized by ~~his or her~~ *their* license or registration.

(c) (1) The board shall prescribe the forms utilized for and the number of hours of required continuing professional development for persons licensed or registered under this chapter.

(2) The board shall have the right to audit the records of any applicant to verify the completion of the continuing professional development requirements.

(3) Applicants shall maintain records of completion of required continuing professional development coursework for a minimum of two years and shall make these records available to the board for auditing purposes upon request.

(d) The board shall establish exceptions from the continuing professional development requirements of this section for good cause as defined by the board.

(e) (1) The continuing professional development services shall be obtained from accredited institutions of higher learning, organizations approved as continuing education providers by either the American ~~Speech-Language Hearing~~ *Speech-Language-Hearing* Association or the American Academy of Audiology, the California Medical Association's Institute for Medical Quality Continuing Medical Education Program, or other entities or organizations approved as continuing professional development providers by the board, in its discretion.

(2) No hours shall be credited for any course enrolled in by a licensee that has not first been approved and certified by the board, if the board has sufficient funding and staff resources to implement the approval and certification process.

(3) The continuing professional development services offered by these entities may, but are not required to, utilize pretesting and posttesting or other evaluation techniques to measure and demonstrate improved professional learning and competency.

(4) An accredited institution of higher learning, an organization approved as continuing education providers by either the American ~~Speech-Language Hearing~~ *Speech-Language-Hearing* Association or the American Academy of Audiology, and the California Medical Association's Institute for Medical Quality Continuing Education Program shall be exempt from any application or registration fees that the board may charge for continuing education providers.

(5) Unless a course offered by entities listed in paragraph (4) meets the requirements established by the board, the course may not be credited towards the continuing professional development requirements for license renewal.

(6) The licensee shall be responsible for obtaining the required course completion documents for courses offered by entities specified in paragraph (1).

(f) The board, by regulation, shall fund the administration of this section through professional development services provider and licensing fees to be deposited in the Speech-Language Pathology and Audiology ~~Board~~ *and Hearing Aid Dispensers* Fund. The fees related to the administration of this section shall be sufficient to meet, but shall not exceed, the costs of administering the corresponding provisions of this section.

(g) The continuing professional development requirements adopted by the board shall comply with any guidelines for mandatory continuing education established by the Department of Consumer Affairs.

**SEC. 14.**

Section2532.7 of the Business and Professions Code is amended to read:

(a) Upon approval of an application filed pursuant to Section 2532.1, and upon payment of the fee prescribed by Section 2534.2, the board may issue a required professional experience (RPE) temporary license for a period to be determined by the board to an applicant who is obtaining the required professional experience specified in subdivision (c) of Section 2532.2 or paragraph (2) of subdivision (b) of Section 2532.25.

(b) Effective July 1, 2003, no person shall obtain the required professional experience for licensure in either an exempt or nonexempt setting, as defined in Section 2530.5, unless ~~he or she is~~ *they are* licensed in accordance with this section or ~~is~~ *are* completing the final clinical externship of a board-approved audiology doctoral training program in accordance with paragraph (2) of subdivision (b) of Section 2532.25 in another state.

(c) A person who obtains an RPE temporary license outside the State of California shall not be required to hold a temporary license issued pursuant to subdivision (a) if the person is completing the final clinical externship of an audiology doctoral training program in accordance with paragraph (2) of subdivision (b) of Section 2532.25.

(d) Any experience obtained in violation of this act shall not be approved by the board.

(e) An RPE temporary license shall terminate upon notice thereof by certified mail, return receipt requested, if it is issued by mistake or if the application for permanent licensure is denied.

(f) Upon written application, the board may reissue an RPE temporary license for a period to be determined by the board to an applicant who is obtaining the required professional experience specified in subdivision (c) of Section 2532.2 or paragraph (2) of subdivision (b) of Section 2532.25.

**SEC. 15.**

Section2536 of the Business and Professions Code is amended to read:

A speech-language pathology corporation or an audiology corporation is a corporation which is authorized to render professional services, as defined in Section 13401 of the Corporations Code, so long as that corporation and its shareholders, officers, directors, and employees rendering professional services who are speech-language pathologists or audiologists are in compliance with the Moscone-Knox Professional Corporation Act, this article, and all other statutes and regulations now or hereafter enacted or adopted pertaining to the corporation and the conduct of its affairs.

With respect to a speech-language pathology corporation or an audiology corporation, the governmental agency referred to in the Moscone-Knox Professional Corporation Act is the Speech-Language Pathology and Audiology *and Hearing Aid Dispensers* Board.

**SEC. 16.**

Section6501 of the Business and Professions Code is amended to read:

**SEC. 17.**

Section6584 of the Business and Professions Code is amended to read:

**SEC. 18.**

Section7076.5 of the Business and Professions Code is amended to read:

**SEC. 19.**

Section7137 of the Business and Professions Code is amended to read:

**SEC. 20.**

Section7152 of the Business and Professions Code is amended to read:

**SEC. 21.**

Section7524 of the Business and Professions Code is amended to read:

**SEC. 22.**

Section8027 of the Business and Professions Code is amended to read:

**SEC. 23.**

Section8764.5 of the Business and Professions Code is amended to read:

**SEC. 24.**

Section9889.1 of the Business and Professions Code is amended to read:

**SEC. 25.**

Section9889.2 of the Business and Professions Code is amended to read:

**SEC. 26.**

Section9889.9 of the Business and Professions Code is amended to read:

**SEC. 27.**

Section12107 of the Business and Professions Code is amended to read:

**SEC. 28.**

Section12211 of the Business and Professions Code is amended to read:

**SEC. 29.**

Section12500.8 of the Business and Professions Code is amended to read:

**SEC. 30.**

Section12609 of the Business and Professions Code is amended to read:

**SEC. 31.**

Section13404.5 of the Business and Professions Code is amended to read:

**SEC. 32.**

Section13711 of the Business and Professions Code is amended to read:

**SEC. 33.**

Section19094 of the Business and Professions Code is amended to read:

**SEC. 34.**

Section26051.5 of the Business and Professions Code is amended to read:

**SEC. 34.5**

Section26051.5 of the Business and Professions Code is amended to read:

**SEC. 35.**

Section26067 of the Business and Professions Code is amended to read:

**SEC. 35.5.**

Section26067 of the Business and Professions Code is amended to read:

**SEC. 36.**

Section44831 of the Education Code is amended to read:

The governing board of a school district shall employ persons in public school service requiring certification qualifications as provided in this code, except that the governing board or a county office of education may contract with or employ an individual who holds a license issued by the Speech-Language Pathology and Audiology *and Hearing Aid Dispensers* Board and has earned a ~~masters~~ *master's* degree in communication disorders to provide speech and language services if that individual meets the requirements of Section 44332.6 before employment or execution of the contract.

**SEC. 37.**

Section94834 of the Education Code is amended to read:

**SEC. 38.**

Section94866 of the Education Code is amended to read:

**SEC. 39.**

Section94880.1 of the Education Code is repealed.

**SEC. 40.**

Section94897 of the Education Code is amended to read:

**SEC. 41.**

Section94900 of the Education Code is amended to read:

**SEC. 42.**

Section94902 of the Education Code is amended to read:

**SEC. 43.**

Section94909 of the Education Code is amended to read:

**SEC. 44.**

Section94910 of the Education Code is amended to read:

**SEC. 45.**

Section94929.9 of the Education Code is repealed.

**SEC. 46.**

Section94949 of the Education Code is repealed.

**SEC. 47.**

Section14132.55 of the Welfare and Institutions Code is amended to read:

For the purposes of reimbursement under the Medi-Cal program, a speech pathologist or audiologist shall be licensed by the Speech-Language Pathology and Audiology ~~Examining Committee of the Medical Board of California~~ *and Hearing Aid Dispensers Board* or similarly licensed by a comparable agency in the state in which ~~he or she practices.~~ *they practice.* Licensed speech-language pathologists or licensed audiologists are authorized to utilize and shall be reimbursed for the services of those personnel in the process of completing requirements under the provisions of subdivision (c) of Section 2532.2 of the Business and Professions Code.

***SEC. 48.***

*Section1.5 of this bill incorporates amendments to Section 27 of the Business and Professions Code proposed by both this bill and Senate Bill 775. That section of this bill shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2026, (2) each bill amends Section 27 of the Business and*

*Professions Code, and (3) this bill is enacted after Senate Bill 775, in which case Section 1 of this bill shall not become operative.*

***SEC. 49.***

*Section34.5 of this bill incorporates amendments to Section 26051.5 of the Business and Professions Code proposed by both this bill and Assembly Bill 8. That section of this bill shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2026, (2) each bill amends Section 26051.5 of the Business and Professions Code, and (3) this bill is enacted after Assembly Bill 8, in which case Section 34 of this bill shall not become operative.*

***SEC. 50.***

*Section35.5 of this bill incorporates amendments to Section 26067 of the Business and Professions Code proposed by both this bill and Assembly Bill 8. That section of this bill shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2026, (2) each bill amends Section 26067 of the Business and Professions Code, and (3) this bill is enacted after Assembly Bill 8, in which case Section 35 of this bill shall not become operative.*

**AB 45 - (C) Amends the Law**

***SECTION 1.***

*The heading of Title 1.81.49 (commencing with Section 1798.99.90) of Part 4 of Division 3 of the Civil Code is amended to read:*

***TITLE 1.81.49. Health and Location Data Privacy***

**SEC. 2.**

Section 1798.99.90 of the Civil Code is amended to read:

~~(a) A person or business shall not collect, use, disclose, or retain the personal information of a person who is physically located at, or within a precise geolocation of, a family planning center, except as specified in subdivision (c).~~

~~(b)~~ For purposes of this ~~section,~~ *title,* the following definitions apply:

~~(1)~~ *(a)* ~~"Business" means the same as defined in subdivision (c) of Section 1798.140.~~ *"Collect," "collected," or "collection" means buying, renting, gathering, obtaining, receiving, or accessing any personal information pertaining to a natural person by any means. This includes receiving information from the natural person, either actively or passively, or by observing the natural person's behavior.*

~~(2) "Collect" means the same as defined in subdivision (f) of Section 1798.140.~~

~~(3)~~ *(b)* "Family planning center" means a ~~business~~ *facility* categorized as a family planning center by the North American Industry Classification System adopted by the United States Census Bureau, including, but not limited to, a clinic or center that provides reproductive health care services as defined in Section ~~1798.300 of the Civil Code.~~ *1798.300.*

*(c) "Geofence" means any technology that enables spatial or location detection to establish a virtual boundary around, and detect an individual's presence within, a "precise geolocation" as defined in subdivision (w) of Section 1798.140.*

*(d) "Health care services" means any service provided to a natural person of a medical, surgical, psychiatric, therapeutic, diagnostic, mental health, behavioral health, preventative, rehabilitative, supportive, consultative, referral, or prescribing nature.*

*(e) "Person" means a natural person, association, proprietorship, corporation, trust, foundation, partnership, or any other organization or group of people acting in concert.*

~~(4)~~ *(f)* "Personal information" has the same definition as that term is defined in subdivision (v) of Section 1798.140, except as applied to all *natural* persons and not limited to consumers and households, as those terms are defined in subdivisions (i) and (q), respectively, of that section.

~~(5)~~ *(g)* "Precise geolocation" means a geographic area that is equal to or less than the area of a circle with a radius of 1,850 feet as derived from a device that is used or intended to be used to locate a person. *If the geographic scope of the term "precise*

*geolocation" as defined in Section 1798.140 is expanded beyond 1,850 feet, then that larger scope shall apply to this definition of precise geolocation.*

~~(6) "Sell" means the same as defined in subdivision (ad) of Section 1798.140.~~

~~(7) "Share" means the same as defined in subdivision (ah) of Section 1798.140.~~

~~(c) A person or business shall not collect, use, disclose, or retain the personal information of a person who is physically located at, or within a precise geolocation of, a family planning center, except only as necessary to perform the services or provide the goods requested by the person. A person or business shall not sell or share this personal information.~~

~~(d)~~ *(h)* ~~(1)~~ *"Research"* ~~An aggrieved person or entity, including a family planning center, may institute and prosecute a civil action against any person or business who violates this section for injunctive and monetary relief and attorney's fees within three years of discovery of the violation.~~ *means systematic investigation, including research development, testing, and evaluation, that has as its primary purpose the development of, or contribution to, generalizable knowledge.*

~~(2)~~ *(i)* ~~If the court finds for the petitioner in an action authorized by paragraph (1), recovery shall be in the amount of three times the amount of actual damages and any other expenses, costs, or reasonable attorney's fees incurred in connection with the litigation.~~ *"Sell," "selling," "sale," or "sold" means selling, renting, releasing, disclosing, disseminating, making available, transferring, or otherwise communicating orally, in writing, or by electronic or other means, a natural person's personal information by another person to a third party for monetary or other valuable consideration.*

~~(e)~~ *(j)* ~~This section does not apply to a provider of health care, a health care service plan, or contractor, as those terms are defined in Section 56.05.~~ *"Share," "shared," or "sharing" means sharing, renting, releasing, disclosing, disseminating, making available, transferring, or otherwise communicating orally, in writing, or by electronic or other means, a natural person's personal information by another person to a third party, whether or not for monetary or other valuable consideration.*

***SEC. 3.***

*Section 1798.99.91 is added to the Civil Code, immediately following Section 1798.99.90, to read:*

*(a) It shall be unlawful to collect, use, disclose, sell, share, or retain the personal information of a natural person who is physically located at, or within a precise geolocation of, a family planning center, except as specified in subdivision (b) or as otherwise provided by law or in a collective bargaining agreement.*

*(b) Notwithstanding subdivision (a), it is permissible to collect or use the personal information of a natural person who is physically located at, or within a precise geolocation of, a family planning center, but only as necessary to perform the services or provide the goods requested by the natural person. All other prohibitions under subdivision (a) shall continue to apply.*

*(c) (1) An aggrieved person or entity, including a family planning center, may institute and prosecute a civil action against any person who violates this section for injunctive and monetary relief and attorney's fees within three years of discovery of the violation.*

*(2) If the court finds for the petitioner in an action authorized by paragraph (1), recovery shall be in the amount of three times the amount of actual damages and any other expenses, costs, or reasonable attorney's fees incurred in connection with the litigation.*

*(d) (1) This section does not apply to a provider of health care, a health care service plan, or contractor, as those terms are defined in Section 56.05 or to a covered entity or its business associate, as defined in Section 160.103 of Title 45 of the Code of Federal Regulations.*

*(2) In order to qualify for this exemption, a contractor or business associate must be contractually obligated to comply with all applicable state and federal privacy laws.*

*(e) (1) Nothing in this section shall be construed to alter applicable law, including pursuant to Section 3010 of the Penal Code, regarding use by a law enforcement agency of personal information, including geolocation information, generated by an electronic monitoring device.*

*(2) For purposes of this section, "law enforcement agency" means any department or agency of the state or any local government, special district, or other political subdivision thereof that employs any peace officer, as described in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code.*

***SEC. 4.***

*Section 1798.99.92 is added to the Civil Code, immediately following Section 1798.99.91, to read:*

*(a) Except as provided in subdivision (f), it shall be unlawful to geofence an entity that provides in-person health care services in California for any of the following purposes:*

*(1) To identify or track a person seeking, receiving, or providing health care services.*

*(2) To collect personal information from a person seeking, receiving, or providing health care services.*

*(3) To send notifications to a person related to their personal information or health care services.*

*(4) To send advertisements to a person related to the person's personal information or health care services.*

*(b) It shall be unlawful to sell personal information to, or share personal information with, a third party for the use of such information to violate subdivision (a). A statement signed under penalty of perjury, pursuant to Section 2015.5 of the Code of Civil Procedure, by a natural person authorized to enter into agreements on behalf of the third party that the personal information will not be used for these purposes shall be*

*prima facie evidence that the personal information was not sold or shared in violation of this subdivision.*

*(c) Except as provided in subdivision (f), it shall be unlawful to use personal information obtained in violation of subdivision (a) or (b).*

*(d) (1) Any person that violates this section shall be subject to an injunction and liable for a civil penalty of twenty-five thousand dollars ($25,000) for each violation, which shall be assessed and recovered in a civil action brought in the name of the people of the State of California by the Attorney General. The court may consider the good faith cooperation of the entity or person in determining the amount of the civil penalty.*

*(2) Any civil penalty recovered by an action brought by the Attorney General for a violation of this section, and the proceeds of any settlement of any said action, shall be deposited in the California Reproductive Justice and Freedom Fund established pursuant to Section 140 of the Health and Safety Code.*

*(e) This section shall be implemented consistent with state and federal law.*

*(f) (1) (A) This section does not prohibit any person that owns, operates, manages, or otherwise provides services to an in-person health care entity from geofencing the entity's own location to provide necessary health care services, including the use of location-based alarm devices to monitor newborns and memory-impaired individuals.*

*(B) This section does not prohibit any person that provides reproductive health care services, as defined in Section 1798.300, from utilizing geofencing for the purpose of providing security services to protect patients, staff, or property.*

*(2) Nothing in this section shall exempt any person from complying with any of the following:*

*(A) A lawfully executed search warrant.*

*(B) A lawful subpoena issued pursuant to existing California law.*

*(C) Law enforcement if law enforcement, in good faith, believes that an emergency involving danger of death or serious physical injury to any person requires access to such geofencing data. For purposes of this subparagraph, accessing, procuring, or searching for services regarding contraception, pregnancy care, and perinatal care, including, but not limited to, abortion services, shall not constitute being at risk or danger of death or serious physical injury.*

*(3) Nothing in this section abrogates or limits the requirements of the Electronic Communications Privacy Act (Chapter 3.6 (commencing with Section 1546) of Title 12 of Part 2 of the Penal Code).*

*(4) Nothing in this section shall apply to geofencing activities conducted solely for research purposes by an investigator within an institution that holds an assurance with the federal Department of Health and Human Services pursuant to Part 46 (commencing with Section 46.101) of Title 45 of the Code of Federal Regulations and who obtains informed consent in the method and manner required by those regulations.*

*(5) (A) This section does not prohibit geofencing activities conducted by a labor organization, as defined in Section 1117 of the Labor Code, or an employee organization, as defined in subdivision (a) of Section 3501 of, subdivision (a) of Section 3513 of, or subdivision (f) of Section 3562 of, the Government Code, if geofencing does not result in the labor union's collection of names or personal information without the express consent of an individual and is for activities concerning workplace conditions, worker or patient safety, labor disputes, or organizing.*

*(B) A third party vendor, including, but not limited to, a social media platform, that collects personal information from a labor organization or employee organization pursuant to subparagraph (A) shall be prohibited from selling, using, or sharing that personal information for any purpose other than the activities described in subparagraph (A).*

***SEC. 5.***

*Section 1798.99.93 is added to the Civil Code, immediately following Section 1798.99.92, to read:*

*(a) Research records, in a personally identifying form, developed or acquired by a person in the course of conducting research relating to anyone seeking or obtaining health care services, or relating to personal information, shall be subject to the restrictions on release set forth in this section.*

*(b) Research records, in a personally identifying form, developed or acquired by a person in the course of conducting research relating to anyone seeking or obtaining health care services, or relating to personal information, shall not be released in response to a subpoena or request if that subpoena or request is based on either another state's laws that interfere with a person's rights under the Reproductive Privacy Act (Article 2.5 (commencing with Section 123460) of Chapter 2 of Part 2 of Division 106 of the Health and Safety Code) or a foreign penal civil action, as defined in Section 2029.200 of the Code of Civil Procedure.*

*(c) Research records, in a personally identifying form, developed or acquired by a person in the course of conducting research relating to anyone seeking or obtaining health care services, or relating to personal information, shall not be released to law enforcement for either of the following purposes, unless that release is pursuant to a subpoena not otherwise prohibited by subdivision (b):*

*(1) Enforcement of another state's law that interferes with a person's rights under the Reproductive Privacy Act (Article 2.5 (commencing with Section 123460) of Chapter 2 of Part 2 of Division 106 of the Health and Safety Code).*

*(2) Enforcement of a foreign penal civil action, as defined in Section 2029.200 of the Code of Civil Procedure.*

**SEC. 6.**

Section 140 of the Health and Safety Code is amended to read:

(a) The California Reproductive Justice and Freedom Fund (RJ Fund) is hereby established. The goal of the RJ Fund is to dismantle historic and standing systemic reproductive and sexual health inequities through medically accurate, culturally congruent education and outreach, as well as to create innovative strategies that meaningfully address and function to eliminate root causes of reproductive oppression.

(b) Upon appropriation by the Legislature, the State Department of Public Health shall award grants from the RJ Fund to eligible community-based organizations over a three-year period.

(1) On or before July 1, 2023, the department shall post the grant application on its internet website and solicit applications.

(2) On or before December 31, 2023, the department shall award grants to selected entities based on the eligibility criteria.

*(c) Notwithstanding paragraphs (1) and (2) of subdivision (b), any civil penalties deposited in the RJ Fund pursuant to Section 1798.99.92 of the Civil Code shall be awarded by the State Department of Public Health in the form of grants, subject to the criteria specified in subdivisions (d) to (h), inclusive.*

~~(c)~~ *(d)* A grant recipient shall use any grant funds awarded pursuant to this section to implement a program or fund an existing program that provides and promotes medically accurate, comprehensive reproductive and sexual health education.

~~(d)~~ *(e)* A program funded pursuant to this section shall do all of the following:

(1) Promote reproductive justice.

(2) Provide medically accurate, culturally congruent reproductive and sexual health education that is inclusive of information on abortion rights, care, and services. The education or outreach provided by a program shall include information on how to obtain an abortion or provide abortion referrals, especially upon request.

(3) Be targeted at communities that have experienced or continue to experience high reproductive or sexual health inequities or disparities. This includes communities that have experienced reproductive or sexual health inequities or disparities because of historic and systemic oppression, including based on their race and ethnicity, immigration status, sexual orientation, gender expression, foster youth status, or disability.

~~(e)~~ *(f)* A grant recipient may use a portion of grant funds to pay for costs associated with carrying out grant activities. An assessment of associated costs shall contemplate the community-based organization, the community served, and the nature of services it provides, and may include all of the following:

(1) Building staff capacity.

(2) Development and dissemination of materials.

(3) Travel costs.

~~(f)~~ *(g)* The department shall not spend more than 5 percent of the funds appropriated for the purposes of this section on administrative costs.

~~(g)~~ *(h)* For purposes of this section:

(1) "Community-based organization" means a public or private not-for-profit organization that provides education, resources, or services and is representative of a disparately impacted community or significant segments of a community or has demonstrated status as a trusted part of the community that it serves.

(2) "Culturally congruent education" means education that takes account of the cultural beliefs, values, norms, patterns, way of life, or practices of the target audience to provide appropriate and meaningful education. Culturally congruent education and outreach fits a person's or community's lifestyle, values, and systems of meaning. It requires acknowledgment, respect, and adaptation of information to the cultural needs of the communities served. Additionally, it contemplates sociocultural and situational factors into education.

(3) "Medically accurate" means factual information, verified or supported by research conducted in compliance with scientific methods, published in peer-reviewed journals, if appropriate, and recognized as accurate and objective by the relevant professional organizations.

(4) "Racial equity" means the condition achieved when race can no longer be used to predict life outcomes and when conditions for all groups are improved. Racial equity includes transforming the behaviors, institutions, and systems that harm disparately impacted communities, including by increasing access to power, redistributing and providing additional resources, and eliminating barriers to opportunity, in order to empower Black, Indigenous, and communities of color to thrive and realize their full potential.

(5) "Reproductive health" means the state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. "Reproductive health" implies that a person is able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so.

(6) "Reproductive justice" means the human right to control our sexuality, our gender, our work, and our reproduction, which can only be achieved when all people, particularly women and girls, have the complete economic, social, and political power and resources to make healthy decisions about their bodies, their families, and their communities in all areas of their lives. At the core of "reproductive justice" is the belief that all people have the right to have children, the right to not have children, and the right to parent the children they have with dignity and respect, in safe and sustainable communities.

(7) "Sexual health" means the state of physical, emotional, mental, and social well-being in relation to sexuality, and not merely the absence of disease, dysfunction, or infirmity. "Sexual health" requires a positive and respectful approach to sexuality and sexual

relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence.

***SEC. 7.***

*No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.*

**AB 489 - (C) Amends the Law**

***SECTION 1.***

*Chapter 15.5 (commencing with Section 4999.8) is added to Division 2 of the Business and Professions Code, to read:*

***CHAPTER 15.5. Health Advice From Artificial Intelligence***

***4999.8*** *For purposes of this chapter, the following definitions apply:*

*(a) "Artificial intelligence" or "AI" has the same meaning as set forth in Section 11546.45.5 of the Government Code.*

*(b) "Generative artificial intelligence" or "GenAI" has the same meaning as set forth in Section 11549.64 of the Government Code.*

*(c) "Health care profession" means any profession that is the subject of licensure or regulation under this division or under any initiative act referred to in this division.*

***4999.9*** *(a) (1) A violation of this chapter is subject to the jurisdiction of the appropriate health care professional licensing board or enforcement agency.*

*(2) The appropriate health care professional licensing board may pursue an injunction or restraining order to enforce the provisions of this chapter, as authorized by Section 125.5.*

*(3) Nothing in this section limits the authority for a health care professional licensing board or enforcement agency to pursue any remedy otherwise authorized under the law.*

*(b) Any provision of this division that prohibits the use of specified terms, letters, or phrases to indicate or imply possession of a license or certificate to practice a health care profession, without at that time having the appropriate license or certificate required for that practice or profession, shall be enforceable against a person or entity who develops or deploys a system or device that uses one or more of those terms, letters, or phrases in the advertising or functionality of an artificial intelligence or generative artificial intelligence system, program, device, or similar technology.*

*(c) The use of a term, letter, or phrase in the advertising or functionality of an AI or GenAI system, program, device, or similar technology that indicates or implies that the care, advice, reports, or assessments being offered through the AI or GenAI technology is being provided by a natural person in possession of the appropriate license or certificate to practice as a health care professional, is prohibited.*

*(d) Each use of a prohibited term, letter, or phrase shall constitute a separate violation of this chapter.*

***SEC. 2.***

*No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.*

**AB 784 - (C) Amends the Law**

*SECTION 1.*

*The Legislature finds and declares all of the following:*

*(a) Deaf or hard-of-hearing pupils have unique communication, language, and educational access needs that may not always require placement in a special day class or receipt of core academic instruction by a special education teacher.*

*(b) Sections 3051.16 and 3051.18 of Title 5 of the California Code of Regulations establish specialized services for pupils with hearing impairments that may include language and communication development, auditory skill development, and educational accommodations and supports.*

*(c) "Specialized deaf and hard of hearing services," as identified by Service Code 710 of the California Special Education Management Information System, refers to related services that may be provided in isolation from other special education services, based solely on the pupil's assessed needs.*

*(d) There is a need to clarify that these services may be delivered as standalone services and may be appropriately contracted through certified nonpublic, nonsectarian agencies when a teacher of a deaf or hard-of-hearing pupil is not delivering core academic instruction, but rather is delivering related services supporting the pupil's access and communication.*

**SEC. 2.**

Section 56031 of the Education Code is amended to read:

(a) "Special education," in accordance with Section 1401(29) of Title 20 of the United States Code, means specially designed instruction, at no cost to the parent, to meet the unique needs of individuals with exceptional needs, including instruction conducted in the classroom, in the home, in hospitals and institutions, and other settings, and instruction in physical education.

(b) In accordance with Section 300.39 of Title 34 of the Code of Federal Regulations, special education includes each of the following, if the services otherwise meet the requirements of subdivision (a):

(1) Speech-language pathology services, or any other designated instruction and service or related service, pursuant to Section 56363, if the service is considered special education rather than a designated instruction and service or related service under state standards.

(2) Travel training.

(3) Vocational education.

(c) Transition services for individuals with exceptional needs may be special education, in accordance with Section 300.43(b) of Title 34 of the Code of Federal Regulations, if

provided as specially designed instruction, or a related service, if required to assist an individual with exceptional needs to benefit from special education.

(d) Individuals with exceptional needs shall be grouped for instructional purposes according to their instructional needs.

*(e) This section shall not be construed to prohibit an individualized education program from including specialized deaf and hard-of-hearing related services as the only services.*

**AB 1327 - (C) Amends the Law**

**SECTION 1.**

Section 7159 of the Business and Professions Code is amended to read:

(a) (1) This section identifies the projects for which a home improvement contract is required, outlines the contract requirements, and lists the items that shall be included in the contract, or may be provided as an attachment.

(2) This section does not apply to service and repair contracts that are subject to Section 7159.10, if the contract for the applicable services complies with Sections 7159.10 to 7159.14, inclusive.

(3) This section does not apply to the sale, installation, and servicing of a fire alarm sold in conjunction with an alarm system, as defined in Section 7590.1, if all costs attributable to making the fire alarm system operable, including sale and installation costs, do not exceed five hundred dollars ($500), and the licensee complies with the requirements set forth in Section 7159.9.

(4) This section does not apply to any costs associated with monitoring a burglar or fire alarm system.

(5) Failure by the licensee, their agent or salesperson, or by a person subject to be licensed under this chapter, to provide the specified information, notices, and disclosures in the contract, or to otherwise fail to comply with any provision of this section, is cause for discipline.

*(6) If the applicable "Notice of Cancellation" is not included in or attached to the contract as required by this section, the buyer may file a complaint with the Contractors State License Board.*

(b) For purposes of this section, "home improvement contract" means an agreement, whether oral or written, or contained in one or more documents, between a contractor and an owner or between a contractor and a tenant, regardless of the number of residence or dwelling units contained in the building in which the tenant resides, if the work is to be performed in, to, or upon the residence or dwelling unit of the tenant, for the performance of a home improvement, as defined in Section 7151, and includes all labor, services, and materials to be furnished and performed thereunder, if the aggregate contract price specified in one or more improvement contracts, including all labor, services, and materials to be furnished by the contractor, exceeds five hundred dollars ($500). "Home improvement contract" also means an agreement, whether oral or written, or contained in one or more documents, between a salesperson, whether or not they are a home improvement salesperson, and an owner or a tenant, regardless of the number of residence or dwelling units contained in the building in which the tenant resides, which provides for the sale, installation, or furnishing of home improvement goods or services.

(c) In addition to the specific requirements listed under this section, every home improvement contract and any person subject to licensure under this chapter or their agent or salesperson shall comply with all of the following:

(1) The writing shall be legible.

(2) Any printed form shall be readable. Unless a larger typeface is specified in this article, text in any printed form shall be in at least 10-point typeface and the headings shall be in at least 10-point boldface type.

(3) (A) Before any work is started, the contractor shall give the buyer a copy of the contract signed and dated by both the contractor and the buyer. The buyer's receipt of the copy of the contract initiates the buyer's rights to cancel the contract pursuant to Sections 1689.5 to 1689.14, inclusive, of the Civil Code.

(B) The contract shall contain on the first page, in a typeface no smaller than that generally used in the body of the document, both of the following:

(i) The date the buyer signed the contract.

(ii) The ~~name~~ *name, address,* and *email* address of the contractor to which the applicable "Notice of Cancellation" is to be ~~mailed,~~ *sent,* immediately preceded by a statement advising the buyer that the "Notice of Cancellation" may be sent to the contractor at the address *or email address* noted on the contract.

*(iii) The telephone number of the contractor, or the contractor's representative, to assist the buyer with locating and filling out the "Notice of Cancellation."*

(4) The contract shall include a statement that, upon satisfactory payment being made for any portion of the work performed, the contractor, prior to any further payment being made, shall furnish to the person contracting for the home improvement or swimming pool work a full and unconditional release from any potential lien claimant claim or mechanics lien authorized pursuant to Sections 8400 and 8404 of the Civil Code for that portion of the work for which payment has been made.

(5) A change-order form for changes or extra work shall be incorporated into the contract and shall become part of the contract only if it is in writing and signed by the parties prior to the commencement of any work covered by a change order.

(6) The contract shall contain, in close proximity to the signatures of the owner and contractor, a notice stating that the owner or tenant has the right to require the contractor to have a performance and payment bond.

(7) If the contract provides for a contractor to furnish joint control, the contractor shall not have any financial or other interest in the joint control.

(8) The provisions of this section are not exclusive and do not relieve the contractor from compliance with any other applicable provision of law.

(d) A home improvement contract and any changes to the contract shall be in writing and signed by the parties to the contract prior to the commencement of work covered by

the contract or an applicable change order and, except as provided in paragraph (8) of subdivision (a) of Section 7159.5, shall include or comply with all of the following:

(1) The name, business address, and license number of the contractor.

(2) If applicable, the name and registration number of the home improvement salesperson that solicited or negotiated the contract.

(3) The following heading on the contract form that identifies the type of contract in at least 10-point boldface type: “Home Improvement.”

(4) The following statement in at least 12-point boldface type: “You are entitled to a completely filled in copy of this agreement, signed by both you and the contractor, before any work may be started.”

(5) The heading: “Contract Price,” followed by the amount of the contract in dollars and cents.

(6) If a finance charge will be charged, the heading: “Finance Charge,” followed by the amount in dollars and cents. The finance charge is to be set out separately from the contract amount.

(7) The heading: “Description of the Project and Description of the Significant Materials to be Used and Equipment to be Installed,” followed by a description of the project and a description of the significant materials to be used and equipment to be installed. For swimming pools, the project description required under this paragraph also shall include a plan and scale drawing showing the shape, size, dimensions, and the construction and equipment specifications.

(8) If a downpayment will be charged, the details of the downpayment shall be expressed in substantially the following form, and shall include the text of the notice as specified in subparagraph (C):

(A) The heading: “Downpayment.”

(B) A space where the actual downpayment appears.

(C) The following statement in at least 12-point boldface type:

“THE DOWNPAYMENT MAY NOT EXCEED $1,000 OR 10 PERCENT OF THE CONTRACT PRICE, WHICHEVER IS LESS.”

(9) If payments, other than the downpayment, are to be made before the project is completed, the details of these payments, known as progress payments, shall be expressed in substantially the following form, and shall include the text of the statement as specified in subparagraph (C):

(A) A schedule of progress payments shall be preceded by the heading: “Schedule of Progress Payments.”

(B) Each progress payment shall be stated in dollars and cents and specifically reference the amount of work or services to be performed and materials and equipment to be supplied.

(C) The section of the contract reserved for the progress payments shall include the following statement in at least 12-point boldface type:

"The schedule of progress payments must specifically describe each phase of work, including the type and amount of work or services scheduled to be supplied in each phase, along with the amount of each proposed progress payment. IT IS AGAINST THE LAW FOR A CONTRACTOR TO COLLECT PAYMENT FOR WORK NOT YET COMPLETED, OR FOR MATERIALS NOT YET DELIVERED. HOWEVER, A CONTRACTOR MAY REQUIRE A DOWNPAYMENT."

(10) The contract shall address the commencement of work to be performed in substantially the following form:

(A) A statement that describes what constitutes substantial commencement of work under the contract.

(B) The heading: "Approximate Start Date."

(C) The approximate date on which work will be commenced.

(11) The estimated completion date of the work shall be referenced in the contract in substantially the following form:

(A) The heading: "Approximate Completion Date."

(B) The approximate date of completion.

(12) If applicable, the heading: "List of Documents to be Incorporated into the Contract," followed by the list of documents incorporated into the contract.

(13) The heading: "Note About Extra Work and Change Orders," followed by the following statement:

"Extra Work and Change Orders become part of the contract once the order is prepared in writing and signed by the parties prior to the commencement of work covered by the new change order. The order must describe the scope of the extra work or change, the cost to be added or subtracted from the contract, and the effect the order will have on the schedule of progress payments."

(e) Except as provided in paragraph (8) of subdivision (a) of Section 7159.5, all of the following notices shall be provided to the owner as part of the contract form as specified or, if otherwise authorized under this subdivision, may be provided as an attachment to the contract:

(1) A notice concerning commercial general liability insurance. This notice may be provided as an attachment to the contract if the contract includes the following statement: “A notice concerning commercial general liability insurance is attached to this contract.” The notice shall include the heading “Commercial General Liability Insurance (CGL),” followed by whichever of the following statements is both relevant and correct:

(A) “(The name on the license or 'This contractor’) does not carry commercial general liability insurance.”

(B) “(The name on the license or 'This contractor’) carries commercial general liability insurance written by (the insurance company). You may call (the insurance company) at _____ _____ to check the contractor’s insurance coverage.”

(C) “(The name on the license or 'This contractor’) is self-insured.”

(D) “(The name on the license or ‘This contractor’) is a limited liability company that carries liability insurance or maintains other security as required by law. You may call (the insurance company or trust company or bank) at ____ to check on the contractor’s insurance coverage or security.”

(2) A notice concerning workers’ compensation insurance. This notice may be provided as an attachment to the contract if the contract includes the statement: “A notice concerning workers’ compensation insurance is attached to this contract.” The notice shall include the heading “Workers’ Compensation Insurance” followed by whichever of the following statements is correct:

(A) “(The name on the license or 'This contractor’) has no employees and is exempt from workers’ compensation requirements.”

(B) “(The name on the license or 'This contractor’) carries workers’ compensation insurance for all employees.”

(3) A notice that provides the buyer with the following information about the performance of extra or change-order work:

(A) A statement that the buyer may not require a contractor to perform extra or change-order work without providing written authorization prior to the commencement of work covered by the new change order.

(B) A statement informing the buyer that extra work or a change order is not enforceable against a buyer unless the change order also identifies all of the following in writing prior to the commencement of work covered by the new change order:

(i) The scope of work encompassed by the order.

(ii) The amount to be added or subtracted from the contract.

(iii) The effect the order will make in the progress payments or the completion date.

(C) A statement informing the buyer that the contractor’s failure to comply with the requirements of this paragraph does not preclude the recovery of compensation for

work performed based upon legal or equitable remedies designed to prevent unjust enrichment.

(4) A notice with the heading “Mechanics Lien Warning” written as follows:

“MECHANICS LIEN WARNING:

Anyone who helps improve your property, but who is not paid, may record what is called a mechanics lien on your property. A mechanics lien is a claim, like a mortgage or home equity loan, made against your property and recorded with the county recorder.

Even if you pay your contractor in full, unpaid subcontractors, suppliers, and laborers who helped to improve your property may record mechanics liens and sue you in court to foreclose the lien. If a court finds the lien is valid, you could be forced to pay twice or have a court officer sell your home to pay the lien. Liens can also affect your credit.

To preserve their right to record a lien, each subcontractor and material supplier must provide you with a document called a ‘Preliminary Notice.’ This notice is not a lien. The purpose of the notice is to let you know that the person who sends you the notice has the right to record a lien on your property if they are not paid.

BE CAREFUL. The Preliminary Notice can be sent up to 20 days after the subcontractor starts work or the supplier provides material. This can be a big problem if you pay your contractor before you have received the Preliminary Notices.

You will not get Preliminary Notices from your prime contractor or from laborers who work on your project. The law assumes that you already know they are improving your property.

PROTECT YOURSELF FROM LIENS. You can protect yourself from liens by getting a list from your contractor of all the subcontractors and material suppliers that work on your project. Find out from your contractor when these subcontractors started work and when these suppliers delivered goods or materials. Then wait 20 days, paying attention to the Preliminary Notices you receive.

PAY WITH JOINT CHECKS. One way to protect yourself is to pay with a joint check. When your contractor tells you it is time to pay for the work of a subcontractor or supplier who has provided you with a Preliminary Notice, write a joint check payable to both the contractor and the subcontractor or material supplier.

For other ways to prevent liens, visit CSLB’s internet website at www.cslb.ca.gov or call CSLB at 800-321-CSLB (2752).

REMEMBER, IF YOU DO NOTHING, YOU RISK HAVING A LIEN PLACED ON YOUR HOME. This can mean that you may have to pay twice, or face the forced sale of your home to pay what you owe.”

(5) The following notice shall be provided in at least 12-point typeface:

“Information about the Contractors State License Board (CSLB): CSLB is the state consumer protection agency that licenses and regulates construction contractors.

Contact CSLB for information about the licensed contractor you are considering, including information about disclosable complaints, disciplinary actions, and civil judgments that are reported to CSLB.

Use only licensed contractors. If you file a complaint against a licensed contractor within the legal deadline (usually four years), CSLB has authority to investigate the complaint. If you use an unlicensed contractor, CSLB may not be able to help you resolve your complaint. Your only remedy may be in civil court, and you may be liable for damages arising out of any injuries to the unlicensed contractor or the unlicensed contractor’s employees.

For more information:

Visit CSLB’s internet website at www.cslb.ca.gov

Call CSLB at 800-321-CSLB (2752)

Write CSLB at P.O. Box 26000, Sacramento, CA 95826.”

(6) (A) The notice set forth in subparagraph (B) and entitled “Three-Day Right to Cancel,” or entitled “Five-Day Right to Cancel” for contracts with a senior citizen, shall be provided to the buyer unless the contract is:

(i) Negotiated at the contractor’s place of business.

(ii) Subject to the “Seven-Day Right to Cancel,” as set forth in paragraph (7).

(iii) Subject to licensure under the Alarm Company Act (Chapter 11.6 (commencing with Section 7590)), provided the alarm company licensee complies with Sections 1689.5, 1689.6, and 1689.7 of the Civil Code, as applicable.

(B) (i) “Three-Day Right to Cancel

You, the buyer, have the right to cancel this contract within three business days. You may cancel by emailing, mailing, faxing, or delivering a written notice to the contractor at the contractor’s place of business by midnight of the third business day after you received a signed and dated copy of the contract that includes this notice. Include your name, your address, and the date you received the signed copy of the contract and this notice.

If you cancel, the contractor must return to you anything you paid within 10 days of receiving the notice of cancellation. For your part, you must make available to the contractor at your residence, in substantially as good condition as you received them, goods delivered to you under this contract or sale. Or, you may, if you wish, comply with the contractor’s instructions on how to return the goods at the contractor’s expense and

risk. If you do make the goods available to the contractor and the contractor does not pick them up within 20 days of the date of your notice of cancellation, you may keep them without any further obligation. If you fail to make the goods available to the contractor, or if you agree to return the goods to the contractor and fail to do so, then you remain liable for performance of all obligations under the contract."

(ii) References to "three" and "third" in the notice set forth in clause (i) shall be changed to "five" and "fifth," respectively, for a buyer who is a senior citizen.

(C) The notice required by this paragraph shall comply with all of the following:

(i) The text of the notice is at least 12-point boldface type.

(ii) The notice is in immediate proximity to a space reserved for the owner's signature.

(iii) The owner acknowledges receipt of the notice by signing and dating the notice form in the signature space.

(iv) The notice is written in the same language, e.g., Spanish, as that principally used in any oral sales presentation.

(v) The notice may be attached to the contract if the contract includes, in at least 12-point boldface type, a checkbox with one of the following statements, as applicable:

(I) For a contract with a senior citizen: "The law requires that the contractor give you a notice explaining your right to cancel. Initial the checkbox if the contractor has given you a 'Notice of the Five-Day Right to Cancel.' "

(II) For all other contracts: "The law requires that the contractor give you a notice explaining your right to cancel. Initial the checkbox if the contractor has given you a 'Notice of the Three-Day Right to Cancel.'"

(vi) (I) The notice shall be accompanied by a completed form in duplicate, captioned "Notice of Cancellation," which also shall be attached to the agreement or offer to purchase and be easily detachable, and which shall contain the following statement written in the same language, e.g., Spanish, as used in the contract:

"Notice of Cancellation"

**/enter date of transaction/**

**(Date)**

"You may cancel this transaction, without any penalty or obligation, within three business days from the above date.

If you cancel, any property traded in, any payments made by you under the contract or sale, and any negotiable instrument executed by you will be returned within 10 days following receipt by the seller of your cancellation notice, and any security interest arising out of the transaction will be canceled.

If you cancel, you must make available to the seller at your residence, in substantially as good condition as when received, any goods delivered to you under this contract or sale, or you may, if you wish, comply with the instructions of the seller regarding the return shipment of the goods at the seller's expense and risk.

If you do make the goods available to the seller and the seller does not pick them up within 20 days of the date of your notice of cancellation, you may retain or dispose of the goods without any further obligation. If you fail to make the goods available to the seller, or if you agree to return the goods to the seller and fail to do so, then you remain liable for performance of all obligations under the contract."

To cancel this transaction, ~~mail~~ *email, mail,* or deliver a signed and dated copy of this cancellation notice, or any other written notice, or send a telegram

to ,

/name of seller/

at

/address of seller's place of business/

not later than midnight of .

(Date)

I hereby cancel this transaction.

(Date)

(Buyer's signature)

(II) The reference to "three" in the statement set forth in subclause (I) shall be changed to "five" for a buyer who is a senior citizen.

(7) (A) The following notice entitled "Seven-Day Right to Cancel" shall be provided to the buyer for any contract that is written for the repair or restoration of residential premises damaged by any sudden or catastrophic event for which a state of emergency has been declared by the President of the United States or the Governor, or for which a local emergency has been declared by the executive officer or governing body of any city, county, or city and county:

"Seven-Day Right to Cancel

You, the buyer, have the right to cancel this contract within seven business days. You may cancel by emailing, mailing, faxing, or delivering a written notice to the contractor at the contractor's place of business by midnight of the seventh business day after you received a signed and dated copy of the contract that includes this notice. Include your name, your address, and the date you received the signed copy of the contract and this notice.

If you cancel, the contractor must return to you anything you paid within 10 days of receiving the notice of cancellation. For your part, you must make available to the contractor at your residence, in substantially as good condition as you received them,

goods delivered to you under this contract or sale. Or, you may, if you wish, comply with the contractor's instructions on how to return the goods at the contractor's expense and risk. If you do make the goods available to the contractor and the contractor does not pick them up within 20 days of the date of your notice of cancellation, you may keep them without any further obligation. If you fail to make the goods available to the contractor, or if you agree to return the goods to the contractor and fail to do so, then you remain liable for performance of all obligations under the contract."

(B) The "Seven-Day Right to Cancel" notice required by this subdivision shall comply with all of the following:

(i) The text of the notice is at least 12-point boldface type.

(ii) The notice is in immediate proximity to a space reserved for the owner's signature.

(iii) The owner acknowledges receipt of the notice by signing and dating the notice form in the signature space.

(iv) The notice is written in the same language, e.g., Spanish, as that principally used in any oral sales presentation.

(v) The notice may be attached to the contract if the contract includes, in at least 12-point boldface type, a checkbox with the following statement: "The law requires that the contractor give you a notice explaining your right to cancel. Initial the checkbox if the contractor has given you a 'Notice of the Seven-Day Right to Cancel.' "

(vi) The notice shall be accompanied by a completed form in duplicate, captioned "Notice of Cancellation," which shall also be attached to the agreement or offer to purchase and be easily detachable, and which shall contain the following statement written in the same language, e.g., Spanish, as used in the contract:

"Notice of Cancellation"

**/enter date of transaction/**

**(Date)**

"You may cancel this transaction, without any penalty or obligation, within seven business days from the above date.

If you cancel, any property traded in, any payments made by you under the contract or sale, and any negotiable instrument executed by you will be returned within 10 days following receipt by the seller of your cancellation notice, and any security interest arising out of the transaction will be canceled.

If you cancel, you must make available to the seller at your residence, in substantially as good condition as when received, any goods delivered to you under this contract or sale, or you may, if you wish, comply with the instructions of the seller regarding the return shipment of the goods at the seller's expense and risk.

If you do make the goods available to the seller and the seller does not pick them up within 20 days of the date of your notice of cancellation, you may retain or dispose of the goods without any further obligation. If you fail to make the goods available to the seller, or if you agree to return the goods to the seller and fail to do so, then you remain liable for performance of all obligations under the contract."

To cancel this transaction, ~~mail~~ *email, mail,* or deliver a signed and dated copy of this cancellation notice, or any other written notice, or send a telegram

to ,

/name of seller/

at

/address of seller's place of business/

not later than midnight of .

(Date)

I hereby cancel this transaction.

(Date)

(Buyer's signature)

(f) The five-day right to cancel added by the act that amended paragraph (6) of subdivision (e) shall apply to contracts entered into on or after January 1, 2021.

**SEC. 1.5.**

Section 7159 of the Business and Professions Code is amended to read:

(a) (1) This section identifies the projects for which a home improvement contract is required, outlines the contract requirements, and lists the items that shall be included in the contract, or may be provided as an attachment.

(2) This section does not apply to service and repair contracts that are subject to Section 7159.10, if the contract for the applicable services complies with Sections 7159.10 to 7159.14, inclusive.

(3) This section does not apply to the sale, installation, and servicing of a fire alarm sold in conjunction with an alarm system, as defined in Section 7590.1, if all costs attributable to making the fire alarm system operable, including sale and installation costs, do not exceed five hundred dollars ($500), and the licensee complies with the requirements set forth in Section 7159.9.

(4) This section does not apply to any costs associated with monitoring a burglar or fire alarm system.

(5) *(A)* Failure by the licensee, their agent or salesperson, or by a person subject to be licensed under this chapter, to provide the specified information, notices, and disclosures in the contract, or to otherwise fail to comply with any provision of this section, is cause for discipline.

*(B) For purposes of administrative discipline under this chapter, the prime or direct contractor is responsible for completion of the project in accordance with the home improvement contract, plans, and specifications. This prime or direct contractor responsibility shall not preclude administrative discipline against any subcontractor or home improvement salesperson on a home improvement contract for violation of this chapter.*

*(6) If the applicable "Notice of Cancellation" is not included in or attached to the contract as required by this section, the buyer may file a complaint with the Contractors State License Board.*

(b) For purposes of this section, "home improvement contract" means an agreement, whether oral or written, or contained in one or more documents, between a contractor and an owner or between a contractor and a tenant, regardless of the number of residence or dwelling units contained in the building in which the tenant resides, if the work is to be performed in, to, or upon the residence or dwelling unit of the tenant, for the performance of a home improvement, as defined in Section 7151, and includes all labor, services, and materials to be furnished and performed thereunder, if the aggregate contract price specified in one or more improvement contracts, including all labor, services, and materials to be furnished by the contractor, exceeds five hundred dollars ($500). "Home improvement contract" also means an agreement, whether oral or written, or contained in one or more documents, between a salesperson, whether or not they are a home improvement salesperson, and an owner or a tenant, regardless of the number of residence or dwelling units contained in the building in which the tenant resides, which provides for the sale, installation, or furnishing of home improvement goods or services.

(c) In addition to the specific requirements listed under this section, every home improvement contract and any person subject to licensure under this chapter or their agent or salesperson shall comply with all of the following:

(1) The writing shall be legible.

(2) Any printed form shall be readable. Unless a larger typeface is specified in this article, text in any printed form shall be in at least 10-point typeface and the headings shall be in at least 10-point boldface type.

(3) (A) Before any work is started, the contractor shall give the buyer a copy of the contract *that is* signed and dated by both the contractor and the buyer. The buyer's receipt of the copy of the contract initiates the buyer's rights to cancel the contract pursuant to Sections 1689.5 to 1689.14, inclusive, of the Civil Code.

(B) The contract shall contain on the first page, in a typeface no smaller than that generally used in the body of the document, both of the following:

(i) The date the buyer signed the contract.

(ii) The ~~name~~ *name, address,* and *email* address of the contractor to ~~which~~ *whom* the applicable "Notice of Cancellation" is to be ~~mailed,~~ *sent,* immediately preceded by a

statement advising the buyer that the “Notice of Cancellation” may be sent to the contractor at the address *or email address* noted on the contract.

*(iii) The telephone number of the contractor, or the contractor’s representative, to assist the buyer with locating and filling out the “Notice of Cancellation.”*

(4) The contract shall include a statement that, upon satisfactory payment being made for any portion of the work performed, the contractor, prior to any further payment being made, shall furnish to the person contracting for the home improvement or swimming pool work a full and unconditional release from any potential lien claimant claim or mechanics lien authorized pursuant to Sections 8400 and 8404 of the Civil Code for that portion of the work for which payment has been made.

(5) A change-order form for changes or extra work shall be incorporated into the contract and shall become part of the contract only if it is in writing and signed by the parties prior to the commencement of any work covered by a change order.

(6) The contract shall contain, in close proximity to the signatures of the owner and contractor, a notice stating that the owner or tenant has the right to require the contractor to have a performance and payment bond.

*(7) (A) The contract shall contain a statement regarding whether or not a subcontractor will be used on the project, including a portion to be checked in response, as follows:*

*[__] Yes*

*[__] No*

*(B) If checked “Yes,” indicating that a subcontractor will be used on the project, the contract shall contain a disclaimer that states the following:*

*“One or more subcontractors will be used on this project, and the contractor is aware that a list of subcontractors is required to be provided, upon request, along with the names, contact information, license number, and classification of those subcontractors.”*

*(C) If there is a change order during the project, the same disclaimer set forth in subparagraph (B) shall be on each change order.*

~~(7)~~ *(8)* If the contract provides for a contractor to furnish joint control, the contractor shall not have any financial or other interest in the joint control.

~~(8)~~ *(9)* The provisions of this section are not exclusive and do not relieve the contractor from compliance with any other applicable provision of law.

(d) A home improvement contract and any changes to the contract shall be in writing and signed by the parties to the contract prior to the commencement of work covered by the contract or an applicable change order and, except as provided in paragraph (8) of subdivision (a) of Section 7159.5, shall include or comply with all of the following:

(1) The name, business address, and license number of the contractor.

(2) If applicable, the name and registration number of the home improvement salesperson that solicited or negotiated the contract.

(3) The following heading on the contract form that identifies the type of contract in at least 10-point boldface type: “Home Improvement.”

(4) The following statement in at least 12-point boldface type: “You are entitled to a completely filled in copy of this agreement, signed by both you and the contractor, before any work may be started.”

(5) The heading: “Contract Price,” followed by the amount of the contract in dollars and cents.

(6) If a finance charge will be charged, the heading: “Finance Charge,” followed by the amount in dollars and cents. The finance charge is to be set out separately from the contract amount.

(7) The heading: “Description of the Project and Description of the Significant Materials to be Used and Equipment to be Installed,” followed by a description of the project and a description of the significant materials to be used and equipment to be installed. For swimming pools, the project description required under this paragraph also shall include a plan and scale drawing showing the shape, size, dimensions, and the construction and equipment specifications.

(8) If a downpayment will be charged, the details of the downpayment shall be expressed in substantially the following form, and shall include the text of the notice as specified in subparagraph (C):

(A) The heading: “Downpayment.”

(B) A space where the actual downpayment appears.

(C) The following statement in at least 12-point boldface type:

“THE DOWNPAYMENT MAY NOT EXCEED $1,000 OR 10 PERCENT OF THE CONTRACT PRICE, WHICHEVER IS LESS.”

(9) If payments, other than the downpayment, are to be made before the project is completed, the details of these payments, known as progress payments, shall be expressed in substantially the following form, and shall include the text of the statement as specified in subparagraph (C):

(A) A schedule of progress payments shall be preceded by the heading: “Schedule of Progress Payments.”

(B) Each progress payment shall be stated in dollars and cents and specifically reference the amount of work or services to be performed and materials and equipment to be supplied.

(C) The section of the contract reserved for the progress payments shall include the following statement in at least 12-point boldface type:

“The schedule of progress payments must specifically describe each phase of work, including the type and amount of work or services scheduled to be supplied in each phase, along with the amount of each proposed progress payment. IT IS AGAINST THE LAW FOR A CONTRACTOR TO COLLECT PAYMENT FOR WORK NOT YET COMPLETED, OR FOR MATERIALS NOT YET DELIVERED. HOWEVER, A CONTRACTOR MAY REQUIRE A DOWNPAYMENT.”

(10) The contract shall address the commencement of work to be performed in substantially the following form:

(A) A statement that describes what constitutes substantial commencement of work under the contract.

(B) The heading: “Approximate Start Date.”

(C) The approximate date on which work will be commenced.

(11) The estimated completion date of the work shall be referenced in the contract in substantially the following form:

(A) The heading: “Approximate Completion Date.”

(B) The approximate date of completion.

(12) If applicable, the heading: “List of Documents to be Incorporated into the Contract,” followed by the list of documents incorporated into the contract.

(13) The heading: “Note About Extra Work and Change Orders,” followed by the following statement:

“Extra Work and Change Orders become part of the contract once the order is prepared in writing and signed by the parties prior to the commencement of work covered by the new change order. The order must describe the scope of the extra work or change, the cost to be added or subtracted from the contract, and the effect the order will have on the schedule of progress payments.”

(e) Except as provided in paragraph (8) of subdivision (a) of Section 7159.5, all of the following notices shall be provided to the owner as part of the contract form as specified or, if otherwise authorized under this subdivision, may be provided as an attachment to the contract:

(1) A notice concerning commercial general liability insurance. This notice may be provided as an attachment to the contract if the contract includes the following statement: “A notice concerning commercial general liability insurance is attached to this contract.” The notice shall include the heading “Commercial General Liability Insurance (CGL),” followed by whichever of the following statements is both relevant and correct:

(A) “(The name on the license or 'This contractor’) does not carry commercial general liability insurance.”

(B) “(The name on the license or 'This contractor’) carries commercial general liability insurance written by (the insurance company). You may call (the insurance company) at _____ to check the contractor’s insurance coverage.”

(C) “(The name on the license or 'This contractor’) is self-insured.”

(D) “(The name on the license or ‘This contractor’) is a limited liability company that carries liability insurance or maintains other security as required by law. You may call (the insurance company or trust company or bank) at ____ to check on the contractor’s insurance coverage or security.”

(2) A notice concerning workers’ compensation insurance. This notice may be provided as an attachment to the contract if the contract includes the statement: “A notice concerning workers’ compensation insurance is attached to this contract.” The notice shall include the heading “Workers’ Compensation Insurance” followed by whichever of the following statements is correct:

(A) “(The name on the license or 'This contractor’) has no employees and is exempt from workers’ compensation requirements.”

(B) “(The name on the license or 'This contractor’) carries workers’ compensation insurance for all employees.”

(3) A notice that provides the buyer with the following information about the performance of extra or change-order work:

(A) A statement that the buyer may not require a contractor to perform extra or change-order work without providing written authorization prior to the commencement of work covered by the new change order.

(B) A statement informing the buyer that extra work or a change order is not enforceable against a buyer unless the change order also identifies all of the following in writing prior to the commencement of work covered by the new change order:

(i) The scope of work encompassed by the order.

(ii) The amount to be added or subtracted from the contract.

(iii) The effect the order will make in the progress payments or the completion date.

(C) A statement informing the buyer that the contractor’s failure to comply with the requirements of this paragraph does not preclude the recovery of compensation for work performed based upon legal or equitable remedies designed to prevent unjust enrichment.

(4) A notice with the heading “Mechanics Lien Warning” written as follows:

“MECHANICS LIEN WARNING:

Anyone who helps improve your property, but who is not paid, may record what is called a mechanics lien on your property. A mechanics lien is a claim, like a mortgage or home equity loan, made against your property and recorded with the county recorder.

Even if you pay your contractor in full, unpaid subcontractors, suppliers, and laborers who helped to improve your property may record mechanics liens and sue you in court to foreclose the lien. If a court finds the lien is valid, you could be forced to pay twice or have a court officer sell your home to pay the lien. Liens can also affect your credit.

To preserve their right to record a lien, each subcontractor and material supplier must provide you with a document called a 'Preliminary Notice.' This notice is not a lien. The purpose of the notice is to let you know that the person who sends you the notice has the right to record a lien on your property if they are not paid.

BE CAREFUL. The Preliminary Notice can be sent up to 20 days after the subcontractor starts work or the supplier provides material. This can be a big problem if you pay your contractor before you have received the Preliminary Notices.

You will not get Preliminary Notices from your prime contractor or from laborers who work on your project. The law assumes that you already know they are improving your property.

PROTECT YOURSELF FROM LIENS. You can protect yourself from liens by getting a list from your contractor of all the subcontractors and material suppliers that work on your project. Find out from your contractor when these subcontractors started work and when these suppliers delivered goods or materials. Then wait 20 days, paying attention to the Preliminary Notices you receive.

PAY WITH JOINT CHECKS. One way to protect yourself is to pay with a joint check. When your contractor tells you it is time to pay for the work of a subcontractor or supplier who has provided you with a Preliminary Notice, write a joint check payable to both the contractor and the subcontractor or material supplier.

For other ways to prevent liens, visit CSLB's internet website at www.cslb.ca.gov or call CSLB at 800-321-CSLB (2752).

REMEMBER, IF YOU DO NOTHING, YOU RISK HAVING A LIEN PLACED ON YOUR HOME. This can mean that you may have to pay twice, or face the forced sale of your home to pay what you owe."

(5) The following notice shall be provided in at least 12-point typeface:

"Information about the Contractors State License Board (CSLB): CSLB is the state consumer protection agency that licenses and regulates construction contractors.

Contact CSLB for information about the licensed contractor you are considering, including information about disclosable complaints, disciplinary actions, and civil judgments that are reported to CSLB.

Use only licensed contractors. If you file a complaint against a licensed contractor within the legal deadline (usually four years), CSLB has authority to investigate the complaint. If you use an unlicensed contractor, CSLB may not be able to help you resolve your complaint. Your only remedy may be in civil court, and you may be liable for damages arising out of any injuries to the unlicensed contractor or the unlicensed contractor's employees.

For more information:

Visit CSLB's internet website at www.cslb.ca.gov

Call CSLB at 800-321-CSLB (2752)

Write CSLB at P.O. Box 26000, Sacramento, CA 95826."

(6) (A) The notice set forth in subparagraph (B) and entitled "Three-Day Right to Cancel," or entitled "Five-Day Right to Cancel" for contracts with a senior citizen, shall be provided to the buyer unless the contract is:

(i) Negotiated at the contractor's place of business.

(ii) Subject to the "Seven-Day Right to Cancel," as set forth in paragraph (7).

(iii) Subject to licensure under the Alarm Company Act (Chapter 11.6 (commencing with Section 7590)), provided the alarm company licensee complies with Sections 1689.5, 1689.6, and 1689.7 of the Civil Code, as applicable.

(B) (i) "Three-Day Right to Cancel

You, the buyer, have the right to cancel this contract within three business days. You may cancel by emailing, mailing, faxing, or delivering a written notice to the contractor at the contractor's place of business by midnight of the third business day after you received a signed and dated copy of the contract that includes this notice. Include your name, your address, and the date you received the signed copy of the contract and this notice.

If you cancel, the contractor must return to you anything you paid within 10 days of receiving the notice of cancellation. For your part, you must make available to the contractor at your residence, in substantially as good condition as you received them, goods delivered to you under this contract or sale. Or, you may, if you wish, comply with the contractor's instructions on how to return the goods at the contractor's expense and risk. If you do make the goods available to the contractor and the contractor does not pick them up within 20 days of the date of your notice of cancellation, you may keep them without any further obligation. If you fail to make the goods available to the contractor, or if you agree to return the goods to the contractor and fail to do so, then you remain liable for performance of all obligations under the contract."

(ii) References to "three" and "third" in the notice set forth in clause (i) shall be changed to "five" and "fifth," respectively, for a buyer who is a senior citizen.

(C) The notice required by this paragraph shall comply with all of the following:

(i) The text of the notice is at least 12-point boldface type.

(ii) The notice is in immediate proximity to a space reserved for the owner's signature.

(iii) The owner acknowledges receipt of the notice by signing and dating the notice form in the signature space.

(iv) The notice is written in the same language, e.g., Spanish, as that principally used in any oral sales presentation.

(v) The notice may be attached to the contract if the contract includes, in at least 12-point boldface type, a checkbox with one of the following statements, as applicable:

(I) For a contract with a senior citizen: "The law requires that the contractor give you a notice explaining your right to cancel. Initial the checkbox if the contractor has given you a 'Notice of the Five-Day Right to Cancel.' "

(II) For all other contracts: "The law requires that the contractor give you a notice explaining your right to cancel. Initial the checkbox if the contractor has given you a 'Notice of the Three-Day Right to Cancel.'"

(vi) (I) The notice shall be accompanied by a completed form in duplicate, captioned "Notice of Cancellation," which also shall be attached to the agreement or offer to purchase and be easily detachable, and which shall contain the following statement written in the same language, e.g., Spanish, as used in the contract:

"Notice of Cancellation"

**/enter date of transaction/**

**(Date)**

"You may cancel this transaction, without any penalty or obligation, within three business days from the above date.

If you cancel, any property traded in, any payments made by you under the contract or sale, and any negotiable instrument executed by you will be returned within 10 days following receipt by the seller of your cancellation notice, and any security interest arising out of the transaction will be canceled.

If you cancel, you must make available to the seller at your residence, in substantially as good condition as when received, any goods delivered to you under this contract or sale, or you may, if you wish, comply with the instructions of the seller regarding the return shipment of the goods at the seller's expense and risk.

If you do make the goods available to the seller and the seller does not pick them up within 20 days of the date of your notice of cancellation, you may retain or dispose of the goods without any further obligation. If you fail to make the goods available to the seller, or if you agree to return the goods to the seller and fail to do so, then you remain liable for performance of all obligations under the contract."

To cancel this transaction, ~~mail~~ *email, mail,* or deliver a signed and dated copy of this cancellation notice, or any other written notice, or send a telegram

to ,

/name of seller/

at

/address of seller's place of business/

not later than midnight of .

(Date)

I hereby cancel this transaction.

(Date)

(Buyer's signature)

(II) The reference to "three" in the statement set forth in subclause (I) shall be changed to "five" for a buyer who is a senior citizen.

(7) (A) The following notice entitled "Seven-Day Right to Cancel" shall be provided to the buyer for any contract that is written for the repair or restoration of residential premises damaged by any sudden or catastrophic event for which a state of emergency has been declared by the President of the United States or the Governor, or for which a local emergency has been declared by the executive officer or governing body of any city, county, or city and county:

"Seven-Day Right to Cancel

You, the buyer, have the right to cancel this contract within seven business days. You may cancel by emailing, mailing, faxing, or delivering a written notice to the contractor at the contractor's place of business by midnight of the seventh business day after you received a signed and dated copy of the contract that includes this notice. Include your name, your address, and the date you received the signed copy of the contract and this notice.

If you cancel, the contractor must return to you anything you paid within 10 days of receiving the notice of cancellation. For your part, you must make available to the contractor at your residence, in substantially as good condition as you received them, goods delivered to you under this contract or sale. Or, you may, if you wish, comply with the contractor's instructions on how to return the goods at the contractor's expense and risk. If you do make the goods available to the contractor and the contractor does not pick them up within 20 days of the date of your notice of cancellation, you may keep them without any further obligation. If you fail to make the goods available to the contractor, or if you agree to return the goods to the contractor and fail to do so, then you remain liable for performance of all obligations under the contract."

(B) The "Seven-Day Right to Cancel" notice required by this subdivision shall comply with all of the following:

(i) The text of the notice is at least 12-point boldface type.

(ii) The notice is in immediate proximity to a space reserved for the owner's signature.

(iii) The owner acknowledges receipt of the notice by signing and dating the notice form in the signature space.

(iv) The notice is written in the same language, e.g., Spanish, as that principally used in any oral sales presentation.

(v) The notice may be attached to the contract if the contract includes, in at least 12-point boldface type, a checkbox with the following statement: "The law requires that the contractor give you a notice explaining your right to cancel. Initial the checkbox if the contractor has given you a 'Notice of the Seven-Day Right to Cancel.' "

(vi) The notice shall be accompanied by a completed form in duplicate, captioned "Notice of Cancellation," which shall also be attached to the agreement or offer to purchase and be easily detachable, and which shall contain the following statement written in the same language, e.g., Spanish, as used in the contract:

"Notice of Cancellation"

**/enter date of transaction/**

**(Date)**

"You may cancel this transaction, without any penalty or obligation, within seven business days from the above date.

If you cancel, any property traded in, any payments made by you under the contract or sale, and any negotiable instrument executed by you will be returned within 10 days following receipt by the seller of your cancellation notice, and any security interest arising out of the transaction will be canceled.

If you cancel, you must make available to the seller at your residence, in substantially as good condition as when received, any goods delivered to you under this contract or sale, or you may, if you wish, comply with the instructions of the seller regarding the return shipment of the goods at the seller's expense and risk.

If you do make the goods available to the seller and the seller does not pick them up within 20 days of the date of your notice of cancellation, you may retain or dispose of the goods without any further obligation. If you fail to make the goods available to the seller, or if you agree to return the goods to the seller and fail to do so, then you remain liable for performance of all obligations under the contract."

To cancel this transaction, ~~mail~~ *email, mail,* or deliver a signed and dated copy of this cancellation notice, or any other written notice, or send a telegram

to ,

/name of seller/

at

/address of seller’s place of business/

not later than midnight of .

(Date)

I hereby cancel this transaction.

(Date)

(Buyer’s signature)

(f) The five-day right to cancel added by the act that amended paragraph (6) of subdivision (e) shall apply to contracts entered into on or after January 1, 2021.

**SEC. 2.**

Section 17511.5 of the Business and Professions Code is amended to read:

In addition to complying with the requirements of Section 17500.3, as applicable, a telephonic seller, shall, at the time the solicitation is made and prior to consummation of a sales transaction, provide all of the following information to a prospective purchaser:

(a) If the telephonic seller represents or implies that a prospective purchaser will receive, without charge therefor, certain specific items or one item from among designated items, whether the items are denominated as gifts, premiums, bonuses, prizes, or otherwise, the seller shall provide the following:

(1) The information required to be filed by subparagraphs (A) and (B) of paragraph (4) of, and paragraph (5) of, subdivision (l) of Section 17511.4. In addition, each time the telephonic seller makes reference to an item or items, the telephonic seller shall state that no purchase is necessary, and that the purchase of goods will have no greater chance of receiving the more valuable item or items than the person who does not purchase. The seller shall state, in a manner enabling a consumer to copy the information, the method, including the telephonic seller’s address, for obtaining without purchase the item or items or for a chance to obtain the item or items. The provisions of Section 17537.2 of the Business and Professions Code shall apply to all offers.

(2) The complete street address of the location from which the salesperson is calling the prospective purchaser and, if different, the complete street address of the telephonic seller’s principal location.

(3) The total number of individuals who have actually received from the telephonic seller, during the preceding 12 months (or if the seller has not been in business that long, during the period the telephonic seller has been in business), the item having the greatest value and the item with the smallest odds of being received.

(b) If the telephonic seller is offering to sell any metal, stone, or mineral, the seller shall provide the following information:

(1) The complete street address of the location from which the salesperson is calling the prospective purchaser and, if different, the complete street address of the telephonic seller’s principal location.

(2) When required to be filed pursuant to Section 17511.4, the information specified in subparagraphs (A) and (B) of paragraph (2) of, and paragraph (5) of, subdivision (m) of Section 17511.4.

(c) If the telephonic seller is offering to sell an interest in oil, gas, or mineral fields, wells, or exploration sites the seller shall provide the following information:

(1) The complete street address of the location from which the salesperson is calling the prospective purchaser and, if different, the complete street address of the telephonic seller's principal location.

(2) The information required to be filed by paragraphs (1), (2), and (4) of, and subparagraph (A) of paragraph (3) of, subdivision (n) of Section 17511.4.

(d) If the telephonic seller represents that office equipment or supplies being offered are offered at prices which are below those usually charged for these items, the seller shall provide the following information:

(1) The complete street address of the location from which the salesperson is calling the prospective purchaser and, if different, the complete street address of the telephonic seller's principal location.

(2) The name of the manufacturer of each of the items the telephonic seller has represented for sale and in which the prospective purchaser expresses interest.

(e) If the solicitation is a "home solicitation contract or offer" within the meaning of Section 1689.5 of the Civil Code, the seller shall comply with the following:

(1) At the time the solicitation is made, the telephonic seller shall inform the buyer orally of the following:

(A) The buyer has the right to cancel the contract or offer until midnight of the third business day after the day on which the buyer receives the product or products ordered or the notice of confirmation of services ordered. This right of cancellation begins to run from the date of the buyer's receipt of the product or products ordered or, in the case of services ordered, from the buyer's receipt of the notice of confirmation of services ordered.

(B) A written notice of cancellation will be sent with the product or products ordered or, in the case of services, the notice of cancellation shall accompany a notice of confirmation that shall be sent to the purchaser immediately following the telephonic agreement to purchase those services.

(2) The telephonic seller shall provide the buyer with a written notice of cancellation that shall accompany and be attached to any product or products sent to the purchaser in response to a telephone solicitation or, in the case of services, shall accompany a notice of confirmation of the agreement to purchase services. The notice of cancellation shall be in duplicate, captioned "Notice of Buyer's Right of Cancellation," which shall be separate from or easily detachable from any agreement or offer to purchase which accompanies the product or products or notice of confirmation, and shall contain, in type

of at least 10-point, the following cancellation statement, and no other information or statement, written in the same language used in the telephone solicitation:

**"NOTICE OF BUYER'S RIGHT OF CANCELLATION"**

You may cancel this transaction, without any penalty or obligation, within three business days following your receipt of this notice of cancellation and the receipt of any products, or in the case of services, within three business days following receipt of the attached notice of confirmation.

If you cancel, any payments made by you or authorized by you, pursuant to any telephonic solicitation and purchase agreement shall be returned to you within 10 days following receipt by the seller of your cancellation notice.

If you cancel, you must make available to the seller at your residence, in substantially as good condition as when received, any goods delivered to you under this contract, agreement, or sale, or you may, if you wish, comply with the instructions of the seller regarding the return shipment of the goods at the seller's expense and risk.

If you do make the goods available to the seller and the seller does not pick them up within 20 days of the date of your notice of cancellation, you may retain or dispose of the goods without any further obligation. If you fail to make the goods available to the seller, or if you agree to return the goods to the seller and fail to do so, then you remain liable for the performance of all obligations under the contract.

To cancel this transaction, ~~mail~~ *email, mail,* or deliver a signed and dated copy of this cancellation notice, or any other written notice, or send a telegram to_____(name of seller), at_____(address of seller's place of business) not later than midnight of the third business day after receipt of the products and this notice of cancellation.

I HEREBY CANCEL THIS TRANSACTION.

DATE _____

BUYER'S SIGNATURE _____

**SEC. 3.**

Section 1689.6 of the Civil Code is amended to read:

(a) (1) Except for a contract written pursuant to Section 7151.2 or 7159.10 of the Business and Professions Code, in addition to any other right to revoke an offer, the buyer has the right to cancel a home solicitation contract or offer until midnight of the third business day, or until midnight of the fifth business day if the buyer is a senior citizen, after the day on which the buyer signs an agreement or offer to purchase which complies with Section 1689.7.

(2) In addition to any other right to revoke an offer, the buyer has the right to cancel a home solicitation contract written pursuant to Section 7151.2 of the Business and Professions Code until midnight of the third business day, or until midnight of the fifth

business day if the buyer is a senior citizen, after the buyer receives a signed and dated copy of the contract or offer to purchase that complies with Section 1689.7 of this code.

(3) (A) In addition to any other right to revoke an offer, the buyer has the right to cancel a home solicitation contract or offer to purchase written pursuant to Section 7159.10 of the Business and Professions Code, until the buyer receives a signed and dated copy of a service and repair contract that complies with the contract requirements specified in Section 7159.10 of the Business and Professions Code and the work commences.

(B) For any contract written pursuant to Section 7159.10 of the Business and Professions Code, or otherwise presented to the buyer as a service and repair contract, unless all of the conforming requirements listed under subdivision (a) of that section are met, the requirements set forth under Section 7159 of the Business and Professions Code shall be applicable, regardless of the aggregate contract price, including the right to cancel as set forth under this section.

(4) The five-day right to cancel added by the act that amended paragraphs (1) and (2) shall apply to contracts entered into, or offers to purchase conveyed, on or after January 1, 2021.

(b) In addition to any other right to revoke an offer, any buyer has the right to cancel a home solicitation contract or offer for the purchase of a personal emergency response unit until midnight of the seventh business day after the day on which the buyer signs an agreement or offer to purchase which complies with Section 1689.7. This subdivision shall not apply to a personal emergency response unit installed with, and as part of, a home security alarm system subject to the Alarm Company Act (Chapter 11.6 (commencing with Section 7590) of Division 3 of the Business and Professions Code) which has two or more stationary protective devices used to enunciate an intrusion or fire and is installed by an alarm company operator operating under a current license issued pursuant to the Alarm Company Act, which shall instead be subject to subdivision (a).

(c) In addition to any other right to revoke an offer, a buyer has the right to cancel a home solicitation contract or offer for the repair or restoration of residential premises damaged by a disaster that was not void pursuant to Section 1689.14, until midnight of the seventh business day after the buyer signs and dates the contract unless the provisions of Section 1689.15 are applicable.

(d) Cancellation occurs when the buyer gives written notice of cancellation to the seller at the address *or email address* specified in the agreement or offer.

(e) Notice of cancellation, if given by mail, is effective when deposited in the mail properly addressed with postage prepaid.

(f) Notice of cancellation given by the buyer need not take the particular form as provided with the contract or offer to purchase and, however expressed, is effective if it indicates the intention of the buyer not to be bound by the home solicitation contract or offer.

(g) “Personal emergency response unit,” for purposes of this section, means an in-home radio transmitter device or two-way radio device generally, but not exclusively, worn on a neckchain, wrist strap, or clipped to clothing, and connected to a telephone line through which a monitoring station is alerted of an emergency and emergency assistance is summoned.

**SEC. 4.**

Section 1689.7 of the Civil Code is amended to read:

(a) (1) Except for contracts written pursuant to Sections 7151.2 and 7159.10 of the Business and Professions Code, in a home solicitation contract or offer, the buyer’s agreement or offer to purchase shall be written in the same language, e.g., Spanish, as principally used in the oral sales presentation, shall be dated, shall be signed by the buyer, and except as provided in paragraph (2), shall contain in immediate proximity to the space reserved for the buyer’s signature, a conspicuous statement in a size equal to at least 10-point boldface type, as follows:

(A) For a buyer who is a senior citizen: “You, the buyer, may cancel this transaction at any time prior to midnight of the fifth business day after the date of this transaction. See the attached notice of cancellation form for an explanation of this right.”

(B) For all other buyers: “You, the buyer, may cancel this transaction at any time prior to midnight of the third business day after the date of this transaction. See the attached notice of cancellation form for an explanation of this right.”

(2) The statement required pursuant to this subdivision for a home solicitation contract or offer for the purchase of a personal emergency response unit, as defined in Section 1689.6, that is not installed with and as part of a home security alarm system subject to the Alarm Company Act (Chapter 11.6 (commencing with Section 7590) of Division 3 of the Business and Professions Code) that has two or more stationary protective devices used to enunciate an intrusion or fire and is installed by an alarm company operator operating under a current license issued pursuant to the Alarm Company Act, is as follows: “You, the buyer, may cancel this transaction at any time prior to midnight of the seventh business day after the date of this transaction. See the attached notice of cancellation form for an explanation of this right.”

(3) Except for contracts written pursuant to Sections 7151.2 and 7159.10 of the Business and Professions Code, the statement required pursuant to this subdivision for the repair or restoration of residential premises damaged by a disaster pursuant to subdivision (c) of Section 1689.6 is as follows: “You, the buyer, may cancel this transaction at any time prior to midnight of the seventh business day after the date of this transaction. See the attached notice of cancellation form for an explanation of this right.”

(4) (A) A home solicitation contract written pursuant to Section 7151.2 of the Business and Professions Code shall be written in the same language, e.g., Spanish, as principally used in the oral sales presentation. The contract, or an attachment to the contract that is subject to Section 7159 of the Business and Professions Code shall

include in immediate proximity to the space reserved for the buyer's signature, the following statement in a size equal to at least 12-point boldface type, which shall be dated and signed by the buyer:

~~**"Three-Day Right to Cancel**~~

*"Three-Day Right to Cancel*
You, the buyer, have the right to cancel this contract within three business days. You may cancel by ~~e-mailing,~~ *emailing,* mailing, faxing, or delivering a written notice to the contractor at the contractor's place of business by midnight of the third business day after you received a signed and dated copy of the contract that includes this notice. Include your name, your address, and the date you received the signed copy of the contract and this notice.

If you cancel, the contractor must return to you anything you paid within 10 days of receiving the notice of cancellation. For your part, you must make available to the contractor at your residence, in substantially as good condition as you received it, any goods delivered to you under this contract or sale. Or, you may, if you wish, comply with the contractor's instructions on how to return the goods at the contractor's expense and risk. If you do make the goods available to the contractor and the contractor does not pick them up within 20 days of the date of your notice of cancellation, you may keep them without any further obligation. If you fail to make the goods available to the contractor, or if you agree to return the goods to the contractor and fail to do so, then you remain liable for performance of all obligations under the contract."

(B) References to "three" and "third" in the statement set forth in subparagraph (A) shall be changed to "five" and "fifth," respectively, for a buyer who is a senior citizen.

(b) The agreement or offer to purchase shall contain on the first page, in a type size no smaller than that generally used in the body of the document, the following: (1) the ~~name~~ *name, address,* and *email* address of the seller to which the notice is to be ~~mailed, and~~ *sent,* (2) the date the buyer signed the agreement or offer to ~~purchase.~~ *purchase, and (3) the telephone number of the seller, or the seller's representative, to assist the buyer with locating and filling out the "Notice of Cancellation."*

(c) (1) Except for contracts written pursuant to Sections 7151.2 and 7159.10 of the Business and Professions Code, or except as provided in subdivision (d), the agreement or offer to purchase shall be accompanied by a completed form in duplicate, captioned "Notice of Cancellation" which shall be attached to the agreement or offer to purchase and be easily detachable, and which shall contain in type of at least 10-point the following statement written in the same language, e.g., Spanish, as used in the contract:

"Notice of Cancellation"

/enter date of transaction/

(Date)

"You may cancel this transaction, without any penalty or obligation, within three business days from the above date.

If you cancel, any property traded in, any payments made by you under the contract or sale, and any negotiable instrument executed by you will be returned within 10 days following receipt by the seller of your cancellation notice, and any security interest arising out of the transaction will be canceled.

If you cancel, you must make available to the seller at your residence, in substantially as good condition as when received, any goods delivered to you under this contract or sale, or you may, if you wish, comply with the instructions of the seller regarding the return shipment of the goods at the seller's expense and risk.

If you do make the goods available to the seller and the seller does not pick them up within 20 days of the date of your notice of cancellation, you may retain or dispose of the goods without any further obligation. If you fail to make the goods available to the seller, or if you agree to return the goods to the seller and fail to do so, then you remain liable for performance of all obligations under the contract."

To cancel this transaction, ~~mail~~ *email, mail,* or deliver a signed and dated copy of this cancellation notice, or any other written notice, or send a telegram

to _____ /name of seller/ _____ ,

at _____ /address of seller's place of business/ _____

not later than midnight of(Date).

I hereby cancel this transaction. _____ (Date) _____

_____ (Buyer's signature)

(2) The reference to "three" in the statement set forth in paragraph (1) shall be changed to "five" for a buyer who is a senior citizen.

(d) Any agreement or offer to purchase a personal emergency response unit, as defined in Section 1689.6, which is not installed with and as part of a home security alarm system subject to the Alarm Company Act which has two or more stationary protective devices used to enunciate an intrusion or fire and is installed by an alarm company operator operating under a current license issued pursuant to the Alarm Company Act, shall be subject to the requirements of subdivision (c), and shall be accompanied by the "Notice of Cancellation" required by subdivision (c), except that the first paragraph of that notice shall be deleted and replaced with the following paragraph:

You may cancel this transaction, without any penalty or obligation, within seven business days from the above date.

(e) A home solicitation contract written pursuant to Section 7151.2 of the Business and Professions Code for the repair or restoration of residential premises damaged by a disaster that is subject to subdivision (c) of Section 1689.6, shall be written in the same language, e.g., Spanish, as principally used in the oral sales presentation. The contract, or an attachment to the contract that is subject to Section 7159 of the Business and Professions Code shall include, in immediate proximity to the space reserved for the buyer's signature, the following statement in a size equal to at least 12-point boldface type, which shall be signed and dated by the buyer:

~~**"Seven-Day Right to Cancel**~~

*"Seven-Day Right to Cancel*
You, the buyer, have the right to cancel this contract within seven business days. You may cancel by ~~e-mailing,~~ *emailing,* mailing, faxing, or delivering a written notice to the contractor at the contractor's place of business by midnight of the seventh business day after you received a signed and dated copy of the contract that includes this notice. Include your name, your address, and the date you received the signed copy of the contract and this notice.

If you cancel, the contractor must return to you anything you paid within 10 days of receiving the notice of cancellation. For your part, you must make available to the contractor at your residence, in substantially as good condition as you received it, any goods delivered to you under this contract or sale. Or, you may, if you wish, comply with the contractor's instructions on how to return the goods at the contractor's expense and risk. If you do make the goods available to the contractor and the contractor does not pick them up within 20 days of the date of your notice of cancellation, you may keep them without any further obligation. If you fail to make the goods available to the contractor, or if you agree to return the goods to the contractor and fail to do so, then you remain liable for performance of all obligations under the contract."

(f) The seller shall provide the buyer with a copy of the contract or offer to purchase and the attached notice of cancellation, and shall inform the buyer orally of the buyer's right to cancel and the requirement that cancellation be in writing, at the time the home solicitation contract or offer is executed.

(g) Until the seller has complied with this section the buyer may cancel the home solicitation contract or offer.

(h) "Contract or sale" as used in subdivision (c) means "home solicitation contract or offer" as defined by Section 1689.5.

(i) The five-day right to cancel added by the act that added subparagraph (A) to paragraph (1) and subparagraph (B) to paragraph (4) of subdivision (a), and paragraph (2) to subdivision (c) applies to contracts, or offers to purchase conveyed, entered into, on or after January 1, 2021.

**SEC. 5.**

Section 1689.20 of the Civil Code is amended to read:

(a) (1) In addition to any other right to revoke an offer, the buyer has the right to cancel a seminar sales solicitation contract or offer until midnight of the third business day, or until midnight of the fifth business day if the buyer is a senior citizen, after the day on which the buyer signs an agreement or offer to purchase which complies with Section 1689.21.

(2) The five-day right to cancel added by the act that amended paragraph (1) shall apply to contracts entered into, or offers to purchase conveyed, on or after January 1, 2021.

(b) Cancellation occurs when the buyer gives written notice of cancellation to the seller at the address *or email address* specified in the agreement or offer.

(c) Notice of cancellation, if given by mail, is effective when deposited in the mail properly addressed with postage prepaid.

(d) Notice of cancellation given by the buyer need not take the particular form as provided with the contract or offer to purchase and, however expressed, is effective if it indicates the intention of the buyer not to be bound by the seminar sales solicitation contract or offer.

**SEC. 6.**

Section 1689.21 of the Civil Code is amended to read:

(a) In a seminar sales solicitation contract or offer, the buyer's agreement or offer to purchase shall be written in the same language, e.g., Spanish, as principally used in the oral sales presentation, shall be dated, signed by the buyer, and shall contain in immediate proximity to the space reserved for the buyer's signature, a conspicuous statement in a size equal to at least 10-point bold type, as follows:

(1) For a buyer who is a senior citizen: "You, the buyer, may cancel this transaction at any time prior to midnight of the fifth business day after the date of this transaction. See the attached notice of cancellation form for an explanation of this right."

(2) For all other buyers: "You, the buyer, may cancel this transaction at any time prior to midnight of the third business day after the date of this transaction. See the attached notice of cancellation form for an explanation of this right."

(b) The agreement or offer to purchase shall contain on the first page, in a type size no smaller than that generally used in the body of the document, each of the following:

(1) The ~~name~~ *name, address,* and *email* address of the seller to which the notice is to be ~~mailed.~~ *sent.*

(2) The date the buyer signed the agreement or offer to purchase.

*(3) The telephone number of the seller, or the seller's representative, to assist the buyer with locating and filling out the "Notice of Cancellation."*

(c) (1) The agreement or offer to purchase shall be accompanied by a completed form in duplicate, captioned "Notice of Cancellation," which shall be attached to the agreement or offer to purchase and be easily detachable, and which shall contain in type of at least 10-point, the following statement written in the same language, e.g., Spanish, as used in the contract:

"Notice of Cancellation"

/enter date of transaction/ _____
(Date) _____
You may cancel this transaction, without any penalty or obligation, within three business days from the above date.

If you cancel, any property traded in, any payments made by you under the contract or sale, and any negotiable instrument executed by you will be returned within 10 days following receipt by the seller of your cancellation notice, and any security interest arising out of the transaction will be canceled.

If you cancel, you must make available to the seller at your residence, in substantially as good condition as when received, any goods delivered to you under this contract or sale, or you may, if you wish, comply with the instructions of the seller regarding the return shipment of the goods at the seller's expense and risk.

If you do make the goods available to the seller and the seller does not pick them up within 20 days of the date of your notice of cancellation, you may retain or dispose of the goods without any further obligation. If you fail to make the goods available to the seller, or if you agree to return the goods to the seller and fail to do so, then you remain liable for performance of all obligations under the contract.

To cancel this transaction, ~~mail~~ *email, mail,* or deliver a signed and dated copy of this cancellation notice, or any other written notice, or send a telegram to

_____at

/name of seller//Address of sellers place of business/

not later than midnight of

_____ (Date)

I hereby cancel this transaction

_____ (Date)

(Buyer's signature) _____

(2) The reference to "three" in the statement set forth in paragraph (1) shall be changed to "five" for a buyer who is a senior citizen.

(d) The seller shall provide the buyer with a copy of the contract or offer to purchase and the attached notice of cancellation, and shall inform the buyer orally of the buyer's right to cancel at the time the seminar sales solicitation contract or offer is executed.

(e) Until the seller has complied with this section, the buyer may cancel the seminar sales solicitation contract or offer.

(f) "Contract or sale" as used in subdivision (c), means "seminar sales solicitation contract or offer" as defined by Section 1689.24.

(g) The five-day right to cancel added by the act that added paragraph (1) to subdivision (a) and added paragraph (2) to subdivision (c) shall apply to contracts entered into or offers to purchase conveyed on or after January 1, 2021.

***SEC. 7.***

*Section 1.5 of this bill incorporates amendments to Section 7159 of the Business and Professions Code proposed by both this bill and Senate Bill 517. That section of this bill shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2026, (2) each bill amends Section 7159 of the Business and*

*Professions Code, and (3) this bill is enacted after Senate Bill 517, in which case Section 1 of this bill shall not become operative.*

**SB 81 - (C) Amends the Law**

**SECTION 1.**

Section 56.05 of the Civil Code is amended to read:

For purposes of this part:

(a) “Authorization” means permission granted in accordance with Section 56.11 or 56.21 for the disclosure of medical information.

(b) “Authorized recipient” means a person who is authorized to receive medical information pursuant to Section 56.10 or 56.20.

(c) “Confidential communications request” means a request by a subscriber or enrollee that health care service plan communications containing medical information be communicated to them at a specific mail or email address or specific telephone number, as designated by the subscriber or enrollee.

(d) “Contractor” means a person or entity that is a medical group, independent practice association, pharmaceutical benefits manager, or a medical service organization and is not a health care service plan or provider of health care. “Contractor” does not include insurance institutions as defined in subdivision (k) of Section 791.02 of the Insurance Code or pharmaceutical benefits managers licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(e) “Enrollee” has the same meaning as that term is defined in Section 1345 of the Health and Safety Code.

(f) “Expiration date or event” means a specified date or an occurrence relating to the individual to whom the medical information pertains or the purpose of the use or disclosure, after which the provider of health care, health care service plan, pharmaceutical company, or contractor is no longer authorized to disclose the medical information.

(g) “Health care service plan” means an entity regulated pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(h) “Licensed health care professional” means a person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act or the Chiropractic Initiative Act, or Division 2.5 (commencing with Section 1797) of the Health and Safety Code.

(i) “Marketing” means to make a communication about a product or service that encourages recipients of the communication to purchase or use the product or service.

“Marketing” does not include any of the following:

(1) Communications made orally or in writing for which the communicator does not receive direct or indirect remuneration, including, but not limited to, gifts, fees, payments, subsidies, or other economic benefits, from a third party for making the communication.

(2) Communications made to current enrollees solely for the purpose of describing a provider’s participation in an existing health care provider network or health plan network of a Knox-Keene licensed health plan to which the enrollees already subscribe; communications made to current enrollees solely for the purpose of describing if, and the extent to which, a product or service, or payment for a product or service, is provided by a provider, contractor, or plan or included in a plan of benefits of a Knox-Keene licensed health plan to which the enrollees already subscribe; or communications made to plan enrollees describing the availability of more cost-effective pharmaceuticals.

(3) Communications that are tailored to the circumstances of a particular individual to educate or advise the individual about treatment options, and otherwise maintain the individual’s adherence to a prescribed course of medical treatment, as provided in Section 1399.901 of the Health and Safety Code, for a chronic and seriously debilitating or life-threatening condition as defined in subdivisions (d) and (e) of Section 1367.21 of the Health and Safety Code, if the health care provider, contractor, or health plan receives direct or indirect remuneration, including, but not limited to, gifts, fees, payments, subsidies, or other economic benefits, from a third party for making the communication, if all of the following apply:

(A) The individual receiving the communication is notified in the communication in typeface no smaller than 14-point type of the fact that the provider, contractor, or health plan has been remunerated and the source of the remuneration.

(B) The individual is provided the opportunity to opt out of receiving future remunerated communications.

(C) The communication contains instructions in typeface no smaller than 14-point type describing how the individual can opt out of receiving further communications by calling a toll-free number of the health care provider, contractor, or health plan making the remunerated communications. Further communication shall not be made to an individual who has opted out after 30 calendar days from the date the individual makes the opt-out request.

(j) *(1)* “Medical information” means any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient’s medical history, mental health application information, reproductive or sexual health application information, mental or physical condition, or treatment. “Individually identifiable” means

that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the identity of the individual.

*(2) If individually identifying information regarding immigration status, including current and prior immigration status, or place of birth, is known or collected in electronic or physical form by a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, it shall be treated as medical information, as defined in paragraph (1).*

(k) "Mental health application information" means information related to a consumer's inferred or diagnosed mental health or substance use disorder, as defined in Section 1374.72 of the Health and Safety Code, collected by a mental health digital service.

(l) "Mental health digital service" means a mobile-based application or internet website that collects mental health application information from a consumer, markets itself as facilitating mental health services to a consumer, and uses the information to facilitate mental health services to a consumer.

(m) "Patient" means a natural person, whether or not still living, who received health care services from a provider of health care and to whom medical information pertains.

(n) "Pharmaceutical company" means a company or business, or an agent or representative thereof, that manufactures, sells, or distributes pharmaceuticals, medications, or prescription drugs. "Pharmaceutical company" does not include a pharmaceutical benefits manager, as included in subdivision (c), or a provider of health care.

(o) "Protected individual" means any adult covered by the subscriber's health care service plan or a minor who can consent to a health care service without the consent of a parent or legal guardian, pursuant to state or federal law. "Protected individual" does not include an individual that lacks the capacity to give informed consent for health care pursuant to Section 813 of the Probate Code.

(p) "Provider of health care" means a person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code; a person licensed pursuant to the Osteopathic Initiative Act or the Chiropractic Initiative Act; a person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code; or a clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. "Provider of health care" does not include insurance institutions as defined in subdivision (k) of Section 791.02 of the Insurance Code.

(q) "Reproductive or sexual health application information" means information about a consumer's reproductive health, menstrual cycle, fertility, pregnancy, pregnancy

outcome, plans to conceive, or type of sexual activity collected by a reproductive or sexual health digital service, including, but not limited to, information from which one can infer someone's pregnancy status, menstrual cycle, fertility, hormone levels, birth control use, sexual activity, or gender identity.

(r) "Reproductive or sexual health digital service" means a mobile-based application or internet website that collects reproductive or sexual health application information from a consumer, markets itself as facilitating reproductive or sexual health services to a consumer, and uses the information to facilitate reproductive or sexual health services to a consumer.

(s) "Sensitive services" means all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender-affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.

(t) "Subscriber" has the same meaning as that term is defined in Section 1345 of the Health and Safety Code.

*(u) "Immigration enforcement" means any and all efforts to investigate, enforce, or assist in the investigation or enforcement of any federal civil immigration law, and also includes any and all efforts to investigate, enforce, or assist in the investigation or enforcement of any federal criminal immigration law that penalizes a person's presence in, entry or reentry to, or employment in, the United States.*

**SEC. 2.**

Section 56.10 of the Civil Code is amended to read:

(a) A provider of health care, health care service plan, or contractor shall not disclose medical information regarding a patient of the provider of health care or an enrollee or subscriber of a health care service plan without first obtaining an authorization, except as provided in subdivision (b) or (c).

(b) A provider of health care, a health care service plan, or a contractor shall disclose medical information if the disclosure is compelled by any of the following:

(1) *(A)* A court ~~order.~~ *order issued by a court of this state or a federal court, including, but not limited to, a court order issued by a court of this state pursuant to Section 2029.300 of the Code of Civil Procedure relating to a foreign subpoena.*

*(B) A provider of health care, health care service plan, or contractor shall not comply with a court order that constitutes a foreign subpoena, absent a court order issued pursuant to Section 2029.300 of the Code of Civil Procedure.*

(2) A board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority.

(3) A party to a proceeding before a court or administrative agency pursuant to a subpoena, subpoena duces tecum, notice to appear served pursuant to Section 1987 of the Code of Civil Procedure, or any provision authorizing discovery in a proceeding before a court or administrative agency.

(4) A board, commission, or administrative agency pursuant to an investigative subpoena issued under Article 2 (commencing with Section 11180) of Chapter 2 of Part 1 of Division 3 of Title 2 of the Government Code.

(5) An arbitrator or arbitration panel, when arbitration is lawfully requested by either party, pursuant to a subpoena duces tecum issued under Section 1282.6 of the Code of Civil Procedure, or another provision authorizing discovery in a proceeding before an arbitrator or arbitration panel.

(6) A *valid* search warrant ~~lawfully issued~~ *issued by a judicial officer, including a magistrate,* to a governmental law enforcement ~~agency.~~ *agency, including a search warrant from another state that is based on either of the following and execution of the search warrant would not constitute a violation of Section 13778.2 of the Penal Code:*

*(A) Another state's law, so long as that state's law does not interfere with California law, including, but not limited to, the Reproductive Privacy Act (Article 2.5 (commencing with Section 123460) of Chapter 2 of Part 2 of Division 106 of the Health and Safety Code).*

*(B) A foreign penal civil action, as defined in Section 2029.200 of the Code of Civil Procedure.*

(7) The patient or the patient's representative pursuant to Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

(8) A medical examiner, forensic pathologist, or coroner, when requested in the course of an investigation by a medical examiner, forensic pathologist, or coroner's office for the purpose of identifying the decedent or locating next of kin, or when investigating deaths that may involve public health concerns, organ or tissue donation, child abuse, elder abuse, suicides, poisonings, accidents, sudden infant deaths, suspicious deaths, unknown deaths, or criminal deaths, or upon notification of, or investigation of, imminent deaths that may involve organ or tissue donation pursuant to Section 7151.15 of the Health and Safety Code, or when otherwise authorized by the decedent's representative. Medical information requested by a medical examiner, forensic pathologist, or coroner under this paragraph shall be limited to information regarding the patient who is the decedent and who is the subject of the investigation or who is the

prospective donor and shall be disclosed to a medical examiner, forensic pathologist, or coroner without delay upon request. A medical examiner, forensic pathologist, or coroner shall not disclose the information contained in the medical record obtained pursuant to this paragraph to a third party without a court order or authorization pursuant to paragraph (4) of subdivision (c) of Section 56.11.

(9) When otherwise specifically required by law.

(c) A provider of health care or a health care service plan may disclose medical information as follows:

(1) The information may be disclosed to providers of health care, health care service plans, contractors, or other health care professionals or facilities for purposes of diagnosis or treatment of the patient. This includes, in an emergency situation, the communication of patient information by radio transmission or other means between emergency medical personnel at the scene of an emergency, or in an emergency medical transport vehicle, and emergency medical personnel at a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(2) The information may be disclosed to an insurer, employer, health care service plan, hospital service plan, employee benefit plan, governmental authority, contractor, or other person or entity responsible for paying for health care services rendered to the patient, to the extent necessary to allow responsibility for payment to be determined and payment to be made. If (A) the patient is, by reason of a comatose or other disabling medical condition, unable to consent to the disclosure of medical information and (B) no other arrangements have been made to pay for the health care services being rendered to the patient, the information may be disclosed to a governmental authority to the extent necessary to determine the patient's eligibility for, and to obtain, payment under a governmental program for health care services provided to the patient. The information may also be disclosed to another provider of health care or health care service plan as necessary to assist the other provider or health care service plan in obtaining payment for health care services rendered by that provider of health care or health care service plan to the patient.

(3) The information may be disclosed to a person or entity that provides billing, claims management, medical data processing, or other administrative services for providers of health care or health care service plans or for any of the persons or entities specified in paragraph (2). However, that disclosed information shall not be further disclosed by the recipient in a way that would violate this part.

(4) The information may be disclosed to organized committees and agents of professional societies or of medical staffs of licensed hospitals, licensed health care service plans, professional standards review organizations, independent medical review organizations and their selected reviewers, utilization and quality control peer review organizations as established by Congress in Public Law 97-248 in 1982, contractors, or

persons or organizations insuring, responsible for, or defending professional liability that a provider may incur, if the committees, agents, health care service plans, organizations, reviewers, contractors, or persons are engaged in reviewing the competence or qualifications of health care professionals or in reviewing health care services with respect to medical necessity, level of care, quality of care, or justification of charges.

(5) The information in the possession of a provider of health care or a health care service plan may be reviewed by a private or public body responsible for licensing or accrediting the provider of health care or a health care service plan. However, no patient-identifying medical information may be removed from the premises except as expressly permitted or required elsewhere by law, nor shall that information be further disclosed by the recipient in a way that would violate this part.

(6) The information may be disclosed to a medical examiner, forensic pathologist, or county coroner in the course of an investigation by a medical examiner, forensic pathologist, or coroner's office when requested for all purposes not included in paragraph (8) of subdivision (b). A medical examiner, forensic pathologist, or coroner shall not disclose the information contained in the medical record obtained pursuant to this paragraph to a third party without a court order or authorization pursuant to paragraph (4) of subdivision (c) of Section 56.11.

(7) The information may be disclosed to public agencies, clinical investigators, including investigators conducting epidemiologic studies, health care research organizations, and accredited public or private nonprofit educational or health care institutions for bona fide research purposes. However, no information so disclosed shall be further disclosed by the recipient in a way that would disclose the identity of a patient or violate this part.

(8) A provider of health care or health care service plan that has created medical information as a result of employment-related health care services to an employee conducted at the specific prior written request and expense of the employer may disclose to the employee's employer that part of the information that:

(A) Is relevant in a lawsuit, arbitration, grievance, or other claim or challenge to which the employer and the employee are parties and in which the patient has placed in issue the patient's medical history, mental or physical condition, or treatment, provided that information may only be used or disclosed in connection with that proceeding.

(B) Describes functional limitations of the patient that may entitle the patient to leave from work for medical reasons or limit the patient's fitness to perform the patient's present employment, provided that no statement of medical cause is included in the information disclosed.

(9) Unless the provider of health care or a health care service plan is notified in writing of an agreement by the sponsor, insurer, or administrator to the contrary, the information may be disclosed to a sponsor, insurer, or administrator of a group or individual insured

or uninsured plan or policy that the patient seeks coverage by or benefits from, if the information was created by the provider of health care or health care service plan as the result of services conducted at the specific prior written request and expense of the sponsor, insurer, or administrator for the purpose of evaluating the application for coverage or benefits.

(10) The information may be disclosed to a health care service plan by providers of health care that contract with the health care service plan and may be transferred between providers of health care that contract with the health care service plan, for the purpose of administering the health care service plan. Medical information shall not otherwise be disclosed by a health care service plan except in accordance with this part.

(11) This part does not prevent the disclosure by a provider of health care or a health care service plan to an insurance institution, agent, or support organization, subject to Article 6.6 (commencing with Section 791) of Chapter 1 of Part 2 of Division 1 of the Insurance Code, of medical information if the insurance institution, agent, or support organization has complied with all of the requirements for obtaining the information pursuant to Article 6.6 (commencing with Section 791) of Chapter 1 of Part 2 of Division 1 of the Insurance Code.

(12) The information relevant to the patient's condition, care, and treatment provided may be disclosed to a probate court investigator in the course of an investigation required or authorized in a conservatorship proceeding under the Guardianship-Conservatorship Law as defined in Section 1400 of the Probate Code, or to a probate court investigator, probation officer, or domestic relations investigator engaged in determining the need for an initial guardianship or continuation of an existing guardianship.

(13) The information may be disclosed to an organ procurement organization or a tissue bank processing the tissue of a decedent for transplantation into the body of another person, but only with respect to the donating decedent, for the purpose of aiding the transplant. For the purpose of this paragraph, "tissue bank" and "tissue" have the same meanings as defined in Section 1635 of the Health and Safety Code.

(14) The information may be disclosed when the disclosure is otherwise specifically authorized by law, including, but not limited to, the voluntary reporting, either directly or indirectly, to the ~~federal~~ *United States* Food and Drug Administration of adverse events related to drug products or medical device problems, or to disclosures made pursuant to subdivisions (b) and (c) of Section 11167 of the Penal Code by a person making a report pursuant to Sections 11165.9 and 11166 of the Penal Code, provided that those disclosures concern a report made by that person.

(15) Basic information, including the patient's name, city of residence, age, sex, and general condition, may be disclosed to a state-recognized or federally recognized disaster relief organization for the purpose of responding to disaster welfare inquiries.

(16) The information may be disclosed to a third party for purposes of encoding, encrypting, or otherwise anonymizing data. However, no information so disclosed shall be further disclosed by the recipient in a way that would violate this part, including the unauthorized manipulation of coded or encrypted medical information that reveals individually identifiable medical information.

(17) For purposes of disease management programs and services as defined in Section 1399.901 of the Health and Safety Code, information may be disclosed as follows: (A) to an entity contracting with a health care service plan or the health care service plan's contractors to monitor or administer care of enrollees for a covered benefit, if the disease management services and care are authorized by a treating physician, or (B) to a disease management organization, as defined in Section 1399.900 of the Health and Safety Code, that complies fully with the physician authorization requirements of Section 1399.902 of the Health and Safety Code, if the health care service plan or its contractor provides or has provided a description of the disease management services to a treating physician or to the health care service plan's or contractor's network of physicians. This paragraph does not require physician authorization for the care or treatment of the adherents of a well-recognized church or religious denomination who depend solely upon prayer or spiritual means for healing in the practice of the religion of that church or denomination.

(18) The information may be disclosed, as permitted by state and federal law or regulation, to a local health department for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events, including, but not limited to, birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions, as authorized or required by state or federal law or regulation.

(19) The information may be disclosed, consistent with applicable law and standards of ethical conduct, by a psychotherapist, as defined in Section 1010 of the Evidence Code, if the psychotherapist, in good faith, believes the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a reasonably foreseeable victim or victims, and the disclosure is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

(20) The information may be disclosed as described in Section 56.103.

(21) (A) The information may be disclosed to an employee welfare benefit plan, as defined under Section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1002(1)), which is formed under Section 302(c)(5) of the Taft-Hartley Act (29 U.S.C. Sec. 186(c)(5)), to the extent that the employee welfare benefit plan provides medical care, and may also be disclosed to an entity contracting with the employee welfare benefit plan for billing, claims management, medical data processing, or other administrative services related to the provision of medical care to persons enrolled in

the employee welfare benefit plan for health care coverage, if all of the following conditions are met:

(i) The disclosure is for the purpose of determining eligibility, coordinating benefits, or allowing the employee welfare benefit plan or the contracting entity to advocate on the behalf of a patient or enrollee with a provider, a health care service plan, or a state or federal regulatory agency.

(ii) The request for the information is accompanied by a written authorization for the release of the information submitted in a manner consistent with subdivision (a) and Section 56.11.

(iii) The disclosure is authorized by and made in a manner consistent with the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

(iv) Any information disclosed is not further used or disclosed by the recipient in any way that would directly or indirectly violate this part or the restrictions imposed by Part 164 of Title 45 of the Code of Federal Regulations, including the manipulation of the information in any way that might reveal individually identifiable medical information.

(B) For purposes of this paragraph, Section 1374.8 of the Health and Safety Code shall not apply.

(22) Information may be disclosed pursuant to subdivision (a) of Section 15633.5 of the Welfare and Institutions Code by a person required to make a report pursuant to Section 15630 of the Welfare and Institutions Code, provided that the disclosure under subdivision (a) of Section 15633.5 concerns a report made by that person. Covered entities, as they are defined in Section 160.103 of Title 45 of the Code of Federal Regulations, shall comply with the requirements of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rule pursuant to subsection (c) of Section 164.512 of Title 45 of the Code of Federal Regulations if the disclosure is not for the purpose of public health surveillance, investigation, intervention, or reporting an injury or death.

(23) The information may be disclosed to a school-linked services coordinator pursuant to a written authorization between the health provider and the patient or client that complies with the federal Health Insurance Portability and Accountability Act of 1996.

(24) Mental health records, as defined in subdivision (c) of Section 5073 of the Penal Code, may be disclosed by a county correctional facility, county medical facility, state correctional facility, or state hospital, as required by Section 5073 of the Penal Code.

(d) Except to the extent expressly authorized by a patient, enrollee, or subscriber, or as provided by subdivisions (b) and (c), a provider of health care, health care service plan, contractor, or corporation and its subsidiaries and affiliates shall not intentionally share, sell, use for marketing, or otherwise use medical information for a purpose not necessary to provide health care services to the patient.

(e) Except to the extent expressly authorized by a patient or enrollee or subscriber or as provided by subdivisions (b) and (c), a contractor or corporation and its subsidiaries and affiliates shall not further disclose medical information regarding a patient of the provider of health care or an enrollee or subscriber of a health care service plan or insurer or self-insured employer received under this section to a person or entity that is not engaged in providing direct health care services to the patient or the patient's provider of health care or health care service plan or insurer or self-insured employer.

*(f) Except to the extent expressly authorized by a patient, enrollee, or subscriber, or as required by subdivision (b), or as permitted by subdivision (c), a provider of health care, health care service plan, contractor, or corporation and its subsidiaries and affiliates shall not disclose medical information for immigration enforcement.*

~~(f)~~ *(g)* For purposes of this section, the following definitions apply:

(1) "Medical examiner, forensic pathologist, or coroner" means a coroner or deputy coroner, as described in subdivision (c) of Section 830.35 of the Penal Code, or a licensed physician who currently performs official autopsies on behalf of a county coroner's office or a medical examiner's office, whether as a government employee or under contract to that office.

(2) "School-linked services coordinator" means an individual located on a school campus or under contract by a county behavioral health provider agency for the treatment and health care operations and referrals of students and their families that holds any of the following:

(A) A services credential with a specialization in pupil personnel services, as described in Section 44266 of the Education Code.

(B) A services credential with a specialization in health authorizing service as a school nurse, as described in Section 44877 of the Education Code.

(C) A license to engage in the practice of marriage and family therapy issued pursuant to Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code.

(D) A license to engage in the practice of educational psychology issued pursuant to Chapter 13.5 (commencing with Section 4989.10) of Division 2 of the Business and Professions Code.

(E) A license to engage in the practice of professional clinical counseling issued pursuant to Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code.

***SEC. 3.***

*Chapter 2 (commencing with Section 24250) is added to Division 20 of the Health and Safety Code, to read:*

***CHAPTER 2. Patient Access and Protection***

***24250.*** *(a) A health care provider entity shall, to the extent possible, establish or amend procedures for monitoring, documenting, and receiving visitors to health care provider entities consistent with this chapter. Health care provider entities are encouraged to post a "notice to authorities" at facility entrances.*

*(b) (1) Health care provider entity personnel shall immediately notify health care provider entity management, administration, or legal counsel of any request for access to a health care provider entity site or patient for immigration enforcement.*

*(2) Health care provider entity personnel shall immediately provide any requests for review of health care provider entity documents, including through a lawfully issued subpoena, warrant, or court order, to health care provider entity management, administration, or legal counsel.*

*(3) If a request is made to access a health care provider entity site or patient, including to obtain information about a patient or their family, for immigration enforcement, health care provider entity personnel shall direct that request to the designated health care provider entity management, administrator, or legal counsel.*

***24251.*** *(a) To enhance privacy available to facility users and promote a safe environment conducive to the facility's mission and patient care, a health care provider entity shall designate areas where patients are receiving treatment or care, or where a patient is discussing protected health information, as nonpublic. The facility is encouraged to designate these areas through mapping, signage, key entry, policy, or a combination of those.*

*(b) Unless required by state or federal law, a health care provider entity and its personnel shall not allow any person access to the nonpublic areas of the facility, as described in subdivision (a), for immigration enforcement purposes, unless that person has a valid judicial warrant or court order that specifically grants access to the nonpublic areas of the facility.*

*(c) A health care provider entity and its personnel shall, to the extent possible, have the denial of permission for access to nonpublic areas of the facility pursuant to subdivision (b) witnessed and documented by at least one health care provider entity personnel.*

*(d) Health care provider entities shall inform staff and relevant volunteers on how to respond to requests relating to immigration enforcement that grants access to health care provider entity sites or to patients.*

***24252.*** *For purposes of this chapter, "health care provider entity" includes all of the following:*

*(a) (1) Public hospitals, which means a hospital that is licensed to a county, a city, a city and county, the State of California, the University of California, a local health care district, a local health authority, or any other political subdivision of the state.*

*(2) Nonpublic hospitals, which means a hospital that meets both of the following conditions:*

*(A) The hospital does not meet the definition of a public hospital, as defined in paragraph (1).*

*(B) The hospital is licensed as a general acute care hospital, as defined in Section 1250, pursuant to Chapter 2 (commencing with Section 1250) of Division 2.*

*(b) Clinics, as defined in Section 1200 and 1200.1, a clinic licensed pursuant to Section 1204, and a clinic exempt from licensure pursuant to subdivisions (b) and (h) of Section 1206.*

*(c) A physician organization, as defined in subdivision (p) of Section 127500.2.*

*(d) Providers, as defined in subdivision (q) of Section 127500.2.*

*(e) Integrated health care delivery systems, as defined in Section 1182.14 of the Labor Code.*

*(f) Other heath care providers that deliver or furnish services related to physical or mental health and wellness, education, or access to justice.*

***24253.*** *For purposes of this chapter, "immigration enforcement" means any and all efforts to investigate, enforce, or assist in the investigation or enforcement of any federal civil immigration law, and also includes any and all efforts to investigate, enforce, or assist in the investigation or enforcement of any federal criminal immigration law that penalizes a person's presence in, entry or reentry to, or employment in, the United States.*

***24254.*** *This section does not prohibit a person who is in lawful custody from being accompanied to access health care services and for their transportation and arrangement to health care provider entities, and does not prohibit any person from entering nonpublic areas of a hospital to receive care for themselves or someone in their care or custody.*

***24255.*** *This chapter shall apply to all health care provider entities that receive public funding. All other health care provider entities that are not subject to this chapter are encouraged to adopt the requirements specified in this chapter.*

***24256.*** *Health care provider entities shall have 45 days from the effective date of this chapter to comply with the requirements contained herein.*

***24257.*** *The provisions of this chapter are severable. If any provision of this chapter or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.*

***SEC. 4.***

*No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because, in that regard, this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.*

*However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.*

***SEC. 5.***

*This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the California Constitution and shall go into immediate effect. The facts constituting the necessity are:*

*To ensure that vulnerable families and their children are able to access their medical and health care services and needs without fear of deportation, harassment, or intimidation, it is necessary that this act take effect immediately.*

**SB 82 - (C) Amends the Law**

***SECTION 1.***

*Section 1670.15 is added to the Civil Code, to read:*

*(a) As used in this section, the following definitions shall apply:*

*(1) "Consumer" has the same meaning as defined in subdivision (c) of Section 302 of the Business and Professions Code.*

*(2) "Consumer use agreement" means a contract between a person and a consumer that the consumer enters into in order to use, receive, or otherwise enjoy a good, service, money, or credit.*

*(3) "Person" has the same meaning as defined in subdivision (d) of Section 302 of the Business and Professions Code.*

*(b) Dispute resolution terms and conditions of a consumer use agreement shall be limited to the use, payment, or provision of the good, service, money, or credit provided by that consumer use agreement.*

*(c) A waiver of the provisions of this section is contrary to public policy and void and unenforceable.*

*(d) This section shall be liberally construed for the purpose of protecting consumers.*

*(e) The duties and obligations imposed by this section are cumulative with duties or obligations imposed under any other law, shall not be construed to relieve any party from any duties or obligations imposed under any other law, and do not limit any rights or remedies under any other law.*

**SB 294 - (C) Amends the Law**

***SECTION 1.***

*Part 5.6 (commencing with Section 1550) is added to Division 2 of the Labor Code, to read:*

***PART 5.6. WORKPLACE KNOW YOUR RIGHTS***

***1550.*** *This part shall be known, and may be cited, as the Workplace Know Your Rights Act.*

***1551.*** *(a) It is the intent of the Legislature that California workers have a strong understanding of their rights as workers, as well as their constitutional rights.*

*(b) It is further the intent of the Legislature to equip workers with knowledge of their rights that they can also use to protect their families, neighbors, and communities at a time of potential disruption, dislocation, and fear for many Californians.*

***1552.*** *For purposes of this part, "authorized representative" means an exclusive collective bargaining representative.*

***1553.*** *(a) On or before February 1, 2026, and annually thereafter, an employer shall provide a stand-alone written notice to each current employee pursuant to this section in a manner the employer normally uses to communicate employment-related information. The notice may include, but is not limited to, personal service, email, or text message, if it can reasonably be anticipated to be received by the employee within one business day of sending. The written notice shall also be provided to each new employee upon hire. Written notice shall also be annually provided to the employee's authorized representative, if any, by either electronic or regular mail. The notice shall contain a description of workers' rights in the following areas:*

*(1) The right to workers' compensation benefits, including disability pay and medical care for work-related injuries or illness, as well as the contact information for the Division of Workers' Compensation.*

*(2) The right to notice of inspection by immigration agencies pursuant to subdivision (a) of Section 90.2.*

*(3) Protection against unfair immigration-related practices against a person exercising protected rights.*

*(4) The right to organize a union or engage in concerted activity in the workplace.*

*(5) Constitutional rights when interacting with law enforcement at the workplace, including an employee's right under the Fourth Amendment to the United States Constitution to be free from unreasonable searches and seizures and rights under the Fifth Amendment to the United States Constitution to due process and against self-incrimination.*

*(b) The notice shall also contain both of the following:*

*(1) A description of new legal developments pertaining to laws enforced by the Labor and Workforce Development Agency that the Labor Commissioner deems material and necessary. The Labor Commissioner shall include a list of those developments, if any, in the template notice described in paragraph (a) of Section 1554.*

*(2) A list, developed by the Labor Commissioner, of the enforcement agencies that may enforce the underlying rights in the notice. The Labor Commissioner shall include this list in the template notice described in paragraph (a) of Section 1554.*

*(c) The written notice shall be provided to an employee in the language the employer normally uses to communicate employment-related information to the employee and which the employee understands if the template notice is available in that language on the Labor Commissioner's internet website. If the template notice is not available in that language, then the written notice may be provided in English.*

*(d) An employer may, in addition to the required written notice, choose to provide a link to, or show, the video developed by the Labor Commissioner's office pursuant to subdivision (b) of Section 1554.*

*(e) An employer shall keep records of compliance with the requirements of this section for three years, including the date that each written notice is provided or sent.*

***1554.** (a) The Labor Commissioner shall develop a template notice that an employer may use to comply with the requirements of Section 1553. On or before January 1, 2026, the Labor Commissioner shall post the template notice on its internet website so that it is accessible to an employer. The Labor Commissioner shall post an updated template notice annually thereafter. The template notice shall be written in plain terminology that is easily understood by a worker. The Labor Commissioner shall make the template notice available in different languages, including English, Spanish, Chinese, Tagalog, Vietnamese, Korean, Hindi, Urdu, and Punjabi. The Labor Commissioner may also provide the template notice in additional languages.*

*(b) On or before July 1, 2026, the Labor Commissioner shall develop a video for employees advising them of their rights under the areas listed in Section 1553. The Labor Commissioner shall make the video available in English and Spanish and may also make the video available in other languages.*

*(c) On or before July 1, 2026, the Labor Commissioner shall develop a video for employers advising them of their rights and requirements under the areas listed in Section 1553, including constitutional rights when interacting with law enforcement at the workplace.*

*(d) The Labor Commissioner shall post the videos developed pursuant to subdivisions (b) and (c) on the Labor Commissioner's internet website.*

*(e) (1) The Labor Commissioner shall consult with the Agricultural Labor Relations Board and the Public Employment Relations Board in developing the template notice described in subdivision (a) and the videos described in subdivisions (b) and (c). The*

*Agricultural Labor Relations Board and the Public Employment Relations Board shall provide suggested language for the template notice described in subdivision (a) and a suggested script for the videos described in subdivisions (b) and (c) to the Labor Commissioner regarding workers' rights to organize, form, join, or assist a union, engage in collective bargaining, and participate in concerted activities for mutual aid or protection.*

*(2) The Labor Commissioner shall consult with the Attorney General's office to develop suggested language for the template notice described in subdivision (a) and a suggested script for the videos described in subdivisions (b) and (c) regarding workers' and employers' constitutional rights when interacting with law enforcement at the workplace.*

***1555.** (a) If an employee has notified their employer that they would like their designated emergency contact to be notified in the event the employee is arrested or detained, the employer shall notify the designated emergency contact if the employee is arrested or detained on their worksite. If the arrest or detention occurs during work hours, or during the performance of the employee's job duties, but not on the worksite, the employer shall notify the employee's designated emergency contact only if the employer has actual knowledge of the arrest or detention of the employee.*

*(b) An employer shall provide an employee the opportunity to name an emergency contact no later than March 30, 2026, for an existing employee, and at the time of hiring for a new employee hired after March 30, 2026. The employer shall also allow an employee to provide updated emergency contact information through the duration of employment. The employer shall allow the employee to indicate whether the emergency contact should be notified if the employee is arrested or detained on their worksite, or during work hours or during the performance of the employee's job duties, but not on the worksite, if the employer has actual knowledge of the arrest or detention of the employee.*

***1556.** Parties subject to this part may provide, by collective bargaining agreement, that the agreement supersedes the requirements of this part, in whole or in part, if the waiver is explicitly set forth in the agreement in clear and unambiguous terms.*

***1557.** An employer shall not discharge, threaten to discharge, demote, suspend, or in any manner discriminate or retaliate against an employee for exercising or attempting to exercise their rights under this part, filing a complaint with the Labor Commissioner alleging a violation of this part, cooperating in an investigation or prosecution of an alleged violation of this part, or for any action taken by an employee to invoke, or assist in any manner in, the enforcement of this part.*

***1558.** (a) The Labor Commissioner shall enforce this part, including investigating an alleged violation, and ordering appropriate temporary relief to mitigate a violation or maintain the status quo pending the completion of a full investigation or hearing through the procedures set forth in Section 98, 98.3, 98.7, 98.74, or 1197.1, including issuing a citation against an employer who violates this section and filing a civil action. If a citation*

*is issued, the procedures for issuing, contesting, and enforcing judgments for citations and civil penalties issued by the Labor Commissioner shall be the same as those set out in Section 98.74 or 1197.1, as applicable.*

*(b) This part may also alternatively be enforced by a public prosecutor pursuant to Chapter 8 (commencing with Section 180) of Division 1.*

*(c) In any civil action brought pursuant to subdivision (a) or (b), the petitioner may seek appropriate temporary or preliminary injunctive relief, including punitive damages, and reasonable attorney's fees and costs.*

*(d) (1) Except as provided in paragraph (2), in addition to any other remedy, an employer who violates this part may be subject to a penalty of up to five hundred dollars ($500) per employee for each violation.*

*(2) The penalty for a violation of Section 1555 shall be an amount up to five hundred dollars ($500) per employee for each day the violation occurs, up to a maximum of ten thousand dollars ($10,000) per employee.*

*(3) An employee, the Labor Commissioner, or a public prosecutor may recover a penalty under this part as a statutory penalty paid to the employee or a civil penalty, but not both, for the same violation.*

*(e) An action brought pursuant to this section may be brought in the superior court in any county in which the violation in question is alleged to have occurred or in which the employer resides or transacts business.*

***1559.** This part does not preempt any city, county, or city and county ordinance that provides equal or greater protection to employees who are covered by this part.*

**SB 402 - (C) Amends the Law**

**SECTION 1.**

Section 2290.5 of the Business and Professions Code is amended to read:

(a) For purposes of this division, the following definitions apply:

(1) “Asynchronous store and forward” means the transmission of a patient’s medical information from an originating site to the health care provider at a distant site.

(2) “Distant site” means a site where a health care provider who provides health care services is located while providing these services via a telecommunications system.

(3) “Health care provider” means any of the following:

(A) A person who is licensed under this division.

(B) An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3.

(C) A qualified autism service provider ~~or qualified autism service professional~~ certified by a national entity ~~pursuant to Section 1374.73 of the Health and Safety Code and Section 10144.51 of the Insurance Code.~~ *as defined in Section 4999.200 or a qualified autism service professional as defined in Section 4999.201.*

(D) An associate clinical social worker functioning pursuant to Section 4996.23.2.

(E) An associate professional clinical counselor or clinical counselor trainee functioning pursuant to Section 4999.46.3.

(4) “Originating site” means a site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.

(5) “Synchronous interaction” means a real-time interaction between a patient and a health care provider located at a distant site.

(6) “Telehealth” means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

(b) Before the delivery of health care via telehealth, the health care provider initiating the use of telehealth shall inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health. The consent shall be documented.

(c) This section does not preclude a patient from receiving in-person health care delivery services during a specified course of health care and treatment after agreeing to receive services via telehealth.

(d) The failure of a health care provider to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

(e) This section does not alter the scope of practice of a health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

(f) All laws regarding the confidentiality of health care information and a patient's rights to the patient's medical information shall apply to telehealth interactions.

(g) All laws and regulations governing professional responsibility, unprofessional conduct, and standards of practice that apply to a health care provider under the health care provider's license shall apply to that health care provider while providing telehealth services.

(h) This section shall not apply to a patient under the jurisdiction of the Department of Corrections and Rehabilitation or any other correctional facility.

(i) (1) Notwithstanding any other law and for purposes of this section, the governing body of the hospital whose patients are receiving the telehealth services may grant privileges to, and verify and approve credentials for, providers of telehealth services based on its medical staff recommendations that rely on information provided by the distant-site hospital or telehealth entity, as described in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

(2) By enacting this subdivision, it is the intent of the Legislature to authorize a hospital to grant privileges to, and verify and approve credentials for, providers of telehealth services as described in paragraph (1).

(3) For the purposes of this subdivision, "telehealth" shall include "telemedicine" as the term is referenced in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

***SEC. 2.***

*Chapter 17 (commencing with Section 4999.200) is added to Division 2 of the Business and Professions Code, to read:*

***CHAPTER 17. Qualified Autism Service Providers***

***4999.200.*** *"Qualified autism service provider" means an individual who meets either of the following criteria:*

*(a) Is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the individual who is nationally certified.*

*(b) Is licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social*

*worker, professional clinical counselor, speech-language pathologist, or audiologist, pursuant to Division 2 (commencing with Section 500), and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.*

***4999.201.*** *"Qualified autism service professional" means an individual who meets all of the following criteria:*

*(a) Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider.*

*(b) Is supervised by a qualified autism service provider.*

*(c) Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.*

*(d) Is either of the following:*

*(1) A behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program.*

*(2) (A) A psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology.*

*(B) If an individual meets the requirement described in subparagraph (A), they shall also meet the criteria set forth in the regulations adopted pursuant to Section 4686.4 of the Welfare and Institutions Code for a Behavioral Health Professional.*

*(e) (1) Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.*

*(f) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.*

***4999.202.*** *"Qualified autism service paraprofessional" means an unlicensed and uncertified individual who meets all of the following criteria:*

*(a) Is supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.*

*(b) Provides treatment and implements services pursuant to a treatment plan that was developed and approved by the qualified autism service provider.*

*(c) Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.*

*(d) Has adequate education, training, and experience, as certified by a qualified autism service provider or an entity or group that employs qualified autism service providers.*

*(e) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.*

**SEC. 3.**

Section 1367.27 of the Health and Safety Code is amended to read:

**SEC. 3.5.**

Section 1367.27 of the Health and Safety Code is amended to read:

**SEC. 4.**

Section 1374.72 of the Health and Safety Code is amended to read:

**SEC. 5.**

Section 1374.73 of the Health and Safety Code is amended to read:

(a) (1) Every health care service plan contract that provides hospital, medical, or surgical coverage shall also provide coverage for behavioral health treatment for pervasive developmental disorder or autism no later than July 1, 2012. The coverage shall be provided in the same manner and ~~shall be~~ *is* subject to the same requirements as provided in Section 1374.72.

(2) Notwithstanding paragraph (1), as of the date that proposed final rulemaking for essential health benefits is issued, this section does not require any benefits to be provided that exceed the essential health benefits that all health plans will be required by federal regulations to provide under Section 1302(b) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(3) This section ~~shall~~ *does* not affect services for which an individual is eligible pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

(4) This section ~~shall~~ *does* not affect or reduce any obligation to provide services under an individualized education program, as defined in Section 56032 of the Education Code, or an individual service plan, as described in Section 5600.4 of the Welfare and Institutions Code, or under the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.) and its implementing regulations.

(b) Every health care service plan subject to this section shall maintain an adequate network that includes qualified autism service providers who supervise or employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment. A health care service plan is not prevented from selectively contracting with providers within these requirements.

(c) For the purposes of this section, the following definitions shall apply:

(1) “Behavioral health treatment” means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism and that meet all of the following criteria:

(A) The treatment is prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or is developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the Business and Professions Code.

(B) The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:

(i) A qualified autism service provider.

(ii) A qualified autism service professional supervised by the qualified autism service provider.

(iii) A qualified autism service paraprofessional supervised by a qualified autism service provider or qualified autism service professional.

(C) The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:

(i) Describes the patient’s behavioral health impairments or developmental challenges that are to be treated.

(ii) Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan’s goal and objectives, and the frequency at which the patient’s progress is evaluated and reported.

(iii) Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.

(iv) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

(D) The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the health care service plan upon request.

~~(2) “Pervasive developmental disorder or autism” shall have the same meaning and interpretation as used in Section 1374.72.~~

~~(3) "Qualified autism service provider" means either of the following:~~

~~(A) A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified.~~

~~(B)~~ *(2)* ~~A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500)~~ *"Qualified autism service provider" means an individual described in Section 4999.200* of the Business and Professions ~~Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.~~ *Code.*

~~(4)~~ *(3)* "Qualified autism service professional" means an individual who meets all of the ~~following criteria:~~ *criteria set forth in Section 4999.201 of the Business and Professions Code.*

~~(A) Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider.~~

~~(B) Is supervised by a qualified autism service provider.~~

~~(C) Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.~~

~~(D) Is either of the following:~~

~~(i) A behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program.~~

~~(ii) A psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology.~~

~~(E) (i) Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.~~

~~(ii) If an individual meets the requirement described in clause (ii) of subparagraph (D), the individual shall also meet the criteria set forth in the regulations adopted pursuant to Section 4686.4 of the Welfare and Institutions Code for a Behavioral Health Professional.~~

~~(F) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.~~

~~(5)~~ *(4)* "Qualified autism service paraprofessional" means an unlicensed and uncertified individual who meets all of the ~~following criteria:~~ *criteria set forth in Section 4999.202 of the Business and Professions Code.*

~~(A) Is supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.~~

~~(B) Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.~~

~~(C) Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.~~

~~(D) Has adequate education, training, and experience, as certified by a qualified autism service provider or an entity or group that employs qualified autism service providers.~~

~~(E) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.~~

(d) This section ~~shall~~ *does* not apply to *any of* the following:

(1) A specialized health care service plan that does not deliver mental health or behavioral health services to enrollees.

(2) A health care service plan contract in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(e) This section does not limit the obligation to provide services under Section 1374.72.

(f) As provided in Section 1374.72 and in paragraph (1) of subdivision (a), in the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing.

**SEC. 5.5.**

Section 1374.73 of the Health and Safety Code is amended to read:

(a) (1) Every health care service plan contract that provides hospital, medical, or surgical coverage shall also provide coverage for behavioral health treatment for pervasive developmental disorder or autism no later than July 1, 2012. The coverage shall be provided in the same manner and ~~shall be~~ *is* subject to the same requirements as provided in Section 1374.72.

(2) Notwithstanding paragraph (1), as of the date that *the* proposed final rulemaking for essential health benefits is issued, this section does not require any benefits to be provided that exceed the essential health benefits that all health plans will be required

by federal regulations to provide under Section 1302(b) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(3) This section ~~shall~~ *does* not affect services for which an individual is eligible pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

(4) This section ~~shall~~ *does* not affect or reduce any obligation to provide services under an individualized education program, as defined in Section 56032 of the Education Code, or an individual service plan, as described in Section 5600.4 of the Welfare and Institutions Code, or under the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.) and its implementing regulations.

(b) Every health care service plan subject to this section shall maintain an adequate network that includes qualified autism service providers who supervise or employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment. A health care service plan is not prevented from selectively contracting with providers within these requirements.

*(c) (1) A health care service plan contract issued, amended, or renewed on or after January 1, 2026, shall not require an enrollee previously diagnosed with pervasive developmental disorder or autism to receive a rediagnosis to maintain coverage for behavioral health treatment for pervasive developmental disorder or autism.*

*(2) This subdivision does not prohibit or restrict a treating provider from reevaluating an enrollee for purposes of determining the appropriate treatment. The treatment plan shall be made available to the health care service plan upon request.*

*(3) This subdivision does not prohibit a treating provider from prescribing a rediagnosis at the discretion of the physician licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code.*

*(4) A health care service plan shall not discontinue or delay existing treatment while waiting for a rediagnosis to be completed.*

*(5) This subdivision does not prohibit a health care service plan from requiring utilization review. For the purpose of this section, utilization review is distinct from a rediagnosis.*

~~(c)~~ *(d)* For the purposes of this section, the following definitions shall apply:

(1) “Behavioral health treatment” means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism and that meet all of the following criteria:

(A) The treatment is prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or is developed by a psychologist

licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the Business and Professions Code.

(B) The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:

(i) A qualified autism service provider.

(ii) A qualified autism service professional supervised by the qualified autism service provider.

(iii) A qualified autism service paraprofessional supervised by a qualified autism service provider or qualified autism service professional.

(C) The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:

(i) Describes the patient's behavioral health impairments or developmental challenges that are to be treated.

(ii) Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.

(iii) Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.

(iv) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

(D) The treatment plan is not used for purposes of providing or for the reimbursement of respite, ~~day care,~~ *daycare,* or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the health care service plan upon request.

~~(2) "Pervasive developmental disorder or autism" shall have the same meaning and interpretation as used in Section 1374.72.~~

~~(3) "Qualified autism service provider" means either of the following:~~

~~(A) A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified.~~

~~(B)~~ *(2)* ~~A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical~~

~~social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500)~~ *"Qualified autism service provider" means an individual described in Section 4999.200* of the Business and Professions ~~Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.~~ *Code.*

~~(4)~~ *(3)* "Qualified autism service professional" means an individual who meets all of the ~~following criteria:~~ *criteria set forth in Section 4999.201 of the Business and Professions Code.*

~~(A) Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider.~~

~~(B) Is supervised by a qualified autism service provider.~~

~~(C) Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.~~

~~(D) Is either of the following:~~

~~(i) A behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program.~~

~~(ii) A psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology.~~

~~(E) (i) Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.~~

~~(ii) If an individual meets the requirement described in clause (ii) of subparagraph (D), the individual shall also meet the criteria set forth in the regulations adopted pursuant to Section 4686.4 of the Welfare and Institutions Code for a Behavioral Health Professional.~~

~~(F) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.~~

~~(5)~~ *(4)* "Qualified autism service paraprofessional" means an unlicensed and uncertified individual who meets all of the ~~following criteria:~~ *criteria set forth in Section 4999.202 of the Business and Professions Code.*

~~(A) Is supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.~~

~~(B)~~ *(5)* ~~Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.~~ *"Rediagnosis" means a subsequent undertaking by any method, device, or procedure, whether gratuitous or not, to ascertain or establish if a person is suffering from a physical or mental health disorder, pursuant to Section 2038 of the Business and Professions Code. "Rediagnosis" also means prescription of a subsequent diagnosis of pervasive developmental disorders or autism to ascertain or establish if a person is suffering from a pervasive developmental disorder or autism.*

~~(C)~~ *(6)* ~~Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.~~ *"Utilization review" means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code before, after, or concurrent with the provision of medical treatment services. "Utilization review" refers to an evaluation of existing treatment to ensure an enrollee receives the proper care at the proper time.*

~~(D) Has adequate education, training, and experience, as certified by a qualified autism service provider or an entity or group that employs qualified autism service providers.~~

~~(E) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.~~

~~(d)~~ *(e)* This section ~~shall~~ *does* not apply to *either of* the following:

(1) A specialized health care service plan that does not deliver mental health or behavioral health services to enrollees.

(2) A health care service plan contract in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

~~(e)~~ *(f)* This section does not limit the obligation to provide services under Section 1374.72.

~~(f)~~ *(g)* As provided in Section 1374.72 and in paragraph (1) of subdivision (a), in the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing.

**SEC. 6.**

Section 10133.15 of the Insurance Code is amended to read:

**SEC. 6.5.**

Section 10133.15 of the Insurance Code is amended to read:

**SEC. 7.**

Section 10144.5 of the Insurance Code is amended to read:

**SEC. 8.**

Section 10144.51 of the Insurance Code is amended to read:

(a) (1) Every health insurance policy shall also provide coverage for behavioral health treatment for pervasive developmental disorder or autism no later than July 1, 2012. The coverage shall be provided in the same manner and ~~shall be~~ *is* subject to the same requirements as provided in Section 10144.5.

(2) Notwithstanding paragraph (1), as of the date that proposed final rulemaking for essential health benefits is issued, this section does not require any benefits to be provided that exceed the essential health benefits that all health insurers will be required by federal regulations to provide under Section 1302(b) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(3) This section ~~shall~~ *does* not affect services for which an individual is eligible pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

(4) This section ~~shall~~ *does* not affect or reduce any obligation to provide services under an individualized education program, as defined in Section 56032 of the Education Code, or an individual service plan, as described in Section 5600.4 of the Welfare and Institutions Code, or under the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.) and its implementing regulations.

(b) Pursuant to Article 6 (commencing with Section 2240) of Subchapter 2 of Chapter 5 of Title 10 of the California Code of Regulations, every health insurer subject to this section shall maintain an adequate network that includes qualified autism service providers who supervise or employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment. A health insurer is not prevented from selectively contracting with providers within these requirements.

(c) For the purposes of this section, the following definitions shall apply:

(1) “Behavioral health treatment” means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism, and that meet all of the following criteria:

(A) The treatment is prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or is developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the Business and Professions Code.

(B) The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:

(i) A qualified autism service provider.

(ii) A qualified autism service professional supervised by the qualified autism service provider.

(iii) A qualified autism service paraprofessional supervised by a qualified autism service provider or qualified autism service professional.

(C) The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:

(i) Describes the patient's behavioral health impairments or developmental challenges that are to be treated.

(ii) Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.

(iii) Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.

(iv) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

(D) The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the insurer upon request.

~~(2) "Pervasive developmental disorder or autism" shall have the same meaning and interpretation as used in Section 10144.5.~~

~~(3) "Qualified autism service provider" means either of the following:~~

~~(A) A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified.~~

~~(B)~~ *(2)* ~~A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500)~~ *"Qualified autism service provider" means an individual described in Section 4999.200* of the Business

and Professions ~~Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.~~ *Code.*

~~(4)~~ *(3)* "Qualified autism service professional" means an individual who meets all of the ~~following criteria:~~ *criteria set forth in Section 4999.201 of the Business and Professions Code.*

~~(A) Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider.~~

~~(B) Is supervised by a qualified autism service provider.~~

~~(C) Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.~~

~~(D) Is either of the following:~~

~~(i) A behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program.~~

~~(ii) A psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology.~~

~~(E) (i) Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.~~

~~(ii) If an individual meets the requirement described in clause (ii) of subparagraph (D), the individual shall also meet the criteria set forth in the regulations adopted pursuant to Section 4686.4 of the Welfare and Institutions Code for a Behavioral Health Professional.~~

~~(F) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.~~

~~(5)~~ *(4)* "Qualified autism service paraprofessional" means an unlicensed and uncertified individual who meets all of the ~~following criteria:~~ *criteria set forth in Section 4999.202 of the Business and Professions Code.*

~~(A) Is supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.~~

~~(B) Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.~~

~~(C) Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.~~

~~(D) Has adequate education, training, and experience, as certified by a qualified autism service provider or an entity or group that employs qualified autism service providers.~~

~~(E) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.~~

(d) This section ~~shall~~ *does* not apply to *any* the following:

(1) A specialized health insurance policy that does not cover mental health or behavioral health services or an accident only, specified disease, hospital indemnity, or Medicare supplement policy.

(2) A health insurance policy in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(e) This section does not limit the obligation to provide services under Section 10144.5.

(f) As provided in Section 10144.5 and in paragraph (1) of subdivision (a), in the provision of benefits required by this section, a health insurer may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing.

**SEC. 8.5.**

Section 10144.51 of the Insurance Code is amended to read:

(a) (1) Every health insurance policy shall also provide coverage for behavioral health treatment for pervasive developmental disorder or autism no later than July 1, 2012. The coverage shall be provided in the same manner and ~~shall be~~ *is* subject to the same requirements as provided in Section 10144.5.

(2) Notwithstanding paragraph (1), as of the date that *the* proposed final rulemaking for essential health benefits is issued, this section does not require any benefits to be provided that exceed the essential health benefits that all health insurers will be required by federal regulations to provide under Section 1302(b) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(3) This section ~~shall~~ *does* not affect services for which an individual is eligible pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

(4) This section ~~shall~~ *does* not affect or reduce any obligation to provide services under an individualized education program, as defined in Section 56032 of the Education Code, or an individual service plan, as described in Section 5600.4 of the Welfare and Institutions Code, or under the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.) and its implementing regulations.

(b) Pursuant to Article 6 (commencing with Section 2240) of Subchapter 2 of Chapter 5 of Title 10 of the California Code of Regulations, every health insurer subject to this section shall maintain an adequate network that includes qualified autism service providers who supervise or employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment. A health insurer is not prevented from selectively contracting with providers within these requirements.

*(c) (1) A health insurance policy issued, amended, or renewed on or after January 1, 2026, shall not require an insured previously diagnosed with pervasive developmental disorder or autism to receive a rediagnosis to maintain coverage for behavioral health treatment for pervasive developmental disorder or autism.*

*(2) This subdivision does not prohibit or restrict a treating provider from reevaluating an insured for purposes of determining the appropriate treatment. The treatment plan shall be made available to the insurer upon request.*

*(3) This subdivision does not prohibit a treating provider from prescribing a rediagnosis at the discretion of the physician licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code.*

*(4) A health insurer shall not discontinue or delay existing treatment while waiting for a rediagnosis to be completed.*

*(5) This subdivision does not prohibit a health insurer from requiring utilization review. For the purpose of this section, utilization review is distinct from a rediagnosis.*

~~(c)~~ *(d)* For the purposes of this section, the following definitions shall apply:

(1) “Behavioral health treatment” means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism, and that meet all of the following criteria:

(A) The treatment is prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or is developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the Business and Professions Code.

(B) The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:

(i) A qualified autism service provider.

(ii) A qualified autism service professional supervised by the qualified autism service provider.

(iii) A qualified autism service paraprofessional supervised by a qualified autism service provider or qualified autism service professional.

(C) The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:

(i) Describes the patient's behavioral health impairments or developmental challenges that are to be treated.

(ii) Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.

(iii) Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.

(iv) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

(D) The treatment plan is not used for purposes of providing or for the reimbursement of respite, ~~day care,~~ *daycare,* or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the insurer upon request.

~~(2) "Pervasive developmental disorder or autism" shall have the same meaning and interpretation as used in Section 10144.5.~~

~~(3) "Qualified autism service provider" means either of the following:~~

~~(A) A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified.~~

~~(B)~~ *(2)* ~~A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500)~~ *"Qualified autism service provider" means an individual described in Section 4999.200* of the Business and Professions ~~Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.~~ *Code.*

~~(4)~~ *(3)* "Qualified autism service professional" means an individual who meets all of the ~~following criteria:~~ *criteria set forth in Section 4999.201 of the Business and Professions Code.*

~~(A) Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider.~~

~~(B) Is supervised by a qualified autism service provider.~~

~~(C) Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.~~

~~(D) Is either of the following:~~

~~(i) A behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program.~~

~~(ii) A psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology.~~

~~(E) (i) Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.~~

~~(ii) If an individual meets the requirement described in clause (ii) of subparagraph (D), the individual shall also meet the criteria set forth in the regulations adopted pursuant to Section 4686.4 of the Welfare and Institutions Code for a Behavioral Health Professional.~~

~~(F) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.~~

~~(5)~~ *(4)* "Qualified autism service paraprofessional" means an unlicensed and uncertified individual who meets all of the ~~following criteria:~~ *criteria set forth in Section 4999.202 of the Business and Professions Code.*

~~(A) Is supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.~~

~~(B)~~ *(5)* ~~Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.~~ *"Rediagnosis" means a subsequent undertaking by any method, device, or procedure, whether gratuitous or not, to ascertain or establish if a person is suffering from a physical or mental health disorder, pursuant to Section 2038 of the Business and Professions Code. "Rediagnosis" also means prescription of a subsequent diagnosis of pervasive developmental disorders or autism to ascertain or establish if a person is suffering from a pervasive developmental disorder or autism.*

~~(C)~~ *(6)* ~~Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.~~ *"Utilization review" means utilization*

*review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code before, after, or concurrent with the provision of medical treatment services. "Utilization review" refers to an evaluation of existing treatment to ensure the insured receives the proper care at the proper time.*

~~(D) Has adequate education, training, and experience, as certified by a qualified autism service provider or an entity or group that employs qualified autism service providers.~~

~~(E) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.~~

~~(d)~~ *(e)* This section ~~shall~~ *does* not apply to *either of* the following:

(1) A specialized health insurance policy that does not cover mental health or behavioral health services or an ~~accident only,~~ *accident-only,* specified disease, hospital indemnity, or Medicare supplement policy.

(2) A health insurance policy in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

~~(e)~~ *(f)* This section does not limit the obligation to provide services under Section 10144.5.

~~(f)~~ *(g)* As provided in Section 10144.5 and in paragraph (1) of subdivision (a), in the provision of benefits required by this section, a health insurer may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing.

**SEC. 9.**

Section 11165.7 of the Penal Code is amended to read:

**SEC. 9.1.**

Section 11165.7 of the Penal Code is amended to read:

**SEC. 9.2.**

Section 11165.7 of the Penal Code is amended to read:

(a) As used in this article, "mandated reporter" is defined as any of the following:

(1) ~~A teacher.~~ *An employee, volunteer, or governing board or body member of a school district, county office of education, charter school, or private school. For purposes of this paragraph, a volunteer is a person who is over 18 years of age and who interacts with pupils outside of the immediate supervision and control of the pupil's parent or guardian or a school employee.*

~~(2) An instructional aide.~~

~~(3)~~ *(2)* ~~A teacher's aide or teacher's assistant employed by~~ *An employee, volunteer, or board member of* a public or private ~~school.~~ *school, contractor to a school district, county office of education, charter school, state special school or diagnostic center operated by the State Department of Education, or private school whose duties require contact with or supervision of pupils at that school district, county office of education, charter school, state special school or diagnostic center operated by the State Department of Education, or private school. For purposes of this paragraph, a volunteer is a person who is over 18 years of age and who interacts with pupils outside of the immediate supervision and control of the pupil's parent or guardian or a school employee.*

~~(4)~~ *(3)* ~~A classified employee of a public school.~~ *An employee or volunteer assigned to a state special school or diagnostic center operated by the State Department of Education. For purposes of this paragraph, a volunteer is a person who is over 18 years of age and who interacts with pupils outside of the immediate supervision and control of the pupil's parent or guardian or a school employee.*

*(4) [Reserved]*

(5) ~~An administrative officer or supervisor of child welfare and attendance, or a certificated pupil personnel employee of a public or private school.~~ *[Reserved]*

(6) An administrator of a public or private day camp.

(7) An administrator or employee of a public or private youth center, youth recreation program, or youth organization.

(8) An administrator, board member, or employee of a public or private organization whose duties require direct contact and supervision of children, including a foster family agency.

(9) ~~An employee of a county office of education or the State Department of Education whose duties bring the employee into contact with children on a regular basis.~~ *[Reserved]*

(10) A licensee, an administrator, or an employee of a licensed child daycare facility or community care facility, except those licensed community care facilities exclusively serving adults and seniors.

(11) A Head Start program teacher.

(12) A licensing worker or licensing evaluator employed by a licensing agency, as defined in Section 11165.11.

(13) A public assistance worker.

(14) An employee of a childcare institution, including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities.

(15) A social worker, probation officer, or parole officer.

(16) ~~An employee of a school district police or security department.~~ *[Reserved]*

(17) A person who is an administrator or presenter of, or a counselor in, a child abuse prevention program in a public or private school.

(18) A district attorney investigator, inspector, or local child support agency caseworker, unless the investigator, inspector, or caseworker is working with an attorney appointed pursuant to Section 317 of the Welfare and Institutions Code to represent a minor.

(19) A peace officer, as defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2, who is not otherwise described in this section.

(20) A firefighter, except for volunteer firefighters.

(21) A physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, marriage and family therapist, clinical social worker, professional clinical counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

(22) An emergency medical technician I or II, paramedic, or other person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code.

(23) A psychological assistant registered pursuant to Section 2913 of the Business and Professions Code.

(24) A marriage and family therapist trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code.

(25) An unlicensed associate marriage and family therapist registered under Section 4980.44 of the Business and Professions Code.

(26) A state or county public health employee who treats a minor for venereal disease or any other condition.

(27) A coroner.

(28) A medical examiner or other person who performs autopsies.

(29) A commercial film and photographic print or image processor as specified in subdivision (e) of Section 11166. As used in this article, “commercial film and photographic print or image processor” means a person who develops exposed photographic film into negatives, slides, or prints, or who makes prints from negatives or slides, or who prepares, publishes, produces, develops, duplicates, or prints any representation of information, data, or an image, including, but not limited to, any film, filmstrip, photograph, negative, slide, photocopy, videotape, video laser disc, computer hardware, computer software, computer floppy disk, data storage medium, CD-ROM, computer-generated equipment, or computer-generated image, for compensation. The term includes any employee of that person; it does not include a person who develops film or makes prints or images for a public agency.

(30) A child visitation monitor. As used in this article, “child visitation monitor” means a person who, for financial compensation, acts as a monitor of a visit between a child and another person when the monitoring of that visit has been ordered by a court of law.

(31) An animal control officer or humane society officer. For the purposes of this article, the following terms have the following meanings:

(A) “Animal control officer” means a person employed by a city, county, or city and county for the purpose of enforcing animal control laws or regulations.

(B) “Humane society officer” means a person appointed or employed by a public or private entity as a humane officer who is qualified pursuant to Section 14502 or 14503 of the Corporations Code.

(32) A clergy member, as specified in subdivision (d) of Section 11166. As used in this article, “clergy member” means a priest, minister, rabbi, religious practitioner, or similar functionary of a church, temple, or recognized denomination or organization.

(33) Any custodian of records of a clergy member, as specified in this section and subdivision (d) of Section 11166.

(34) An employee of any police department, county sheriff’s department, county probation department, or county welfare department.

(35) An employee or volunteer of a Court Appointed Special Advocate program, as defined in Rule 5.655 of the California Rules of Court.

(36) A custodial officer, as defined in Section 831.5.

(37) A person providing services to a minor child under Section 12300 or 12300.1 of the Welfare and Institutions Code.

(38) An alcohol and drug counselor. As used in this article, an “alcohol and drug counselor” is a person providing counseling, therapy, or other clinical services for a state licensed or certified drug, alcohol, or drug and alcohol treatment program. However, alcohol or drug abuse, or both alcohol and drug abuse, is not, in and of itself, a sufficient basis for reporting child abuse or neglect.

(39) A clinical counselor trainee, as defined in subdivision (g) of Section 4999.12 of the Business and Professions Code.

(40) An associate professional clinical counselor registered under Section 4999.42 of the Business and Professions Code.

(41) An employee or administrator of a public or private postsecondary educational institution, whose duties bring the administrator or employee into contact with children on a regular basis, or who supervises those whose duties bring the administrator or employee into contact with children on a regular basis, as to child abuse or neglect occurring on that institution’s premises or at an official activity of, or program conducted by, the institution. Nothing in this paragraph shall be construed as altering the lawyer-client privilege as set forth in Article 3 (commencing with Section 950) of Chapter 4 of Division 8 of the Evidence Code.

(42) An athletic coach, athletic administrator, or athletic director employed by any public or private school that provides any combination of instruction for kindergarten, or grades 1 to 12, inclusive.

(43) (A) A commercial computer technician as specified in subdivision (e) of Section 11166. As used in this article, “commercial computer technician” means a person who works for a company that is in the business of repairing, installing, or otherwise servicing a computer or computer component, including, but not limited to, a computer part, device, memory storage or recording mechanism, auxiliary storage recording or memory capacity, or any other material relating to the operation and maintenance of a computer or computer network system, for a fee. An employer who provides an electronic communications service or a remote computing service to the public shall be deemed to comply with this article if that employer complies with Section 2258A of Title 18 of the United States Code.

(B) An employer of a commercial computer technician may implement internal procedures for facilitating reporting consistent with this article. These procedures may direct employees who are mandated reporters under this paragraph to report materials described in subdivision (e) of Section 11166 to an employee who is designated by the employer to receive the reports. An employee who is designated to receive reports under this subparagraph shall be a commercial computer technician for purposes of this article. A commercial computer technician who makes a report to the designated employee pursuant to this subparagraph shall be deemed to have complied with the requirements of this article and shall be subject to the protections afforded to mandated reporters, including, but not limited to, those protections afforded by Section 11172.

(44) Any athletic coach, including, but not limited to, an assistant coach or a graduate assistant involved in coaching, at public or private postsecondary educational institutions.

(45) An individual certified by a licensed foster family agency as a certified family home, as defined in Section 1506 of the Health and Safety Code.

(46) An individual approved as a resource family, as defined in Section 1517 of the Health and Safety Code and Section 16519.5 of the Welfare and Institutions Code.

(47) A qualified autism service provider, a qualified autism service professional, or a qualified autism service ~~paraprofessional,~~ *paraprofessional* as defined in ~~Section 1374.73 of the Health and Safety Code and Section 10144.51 of the Insurance~~ *Chapter 17 (commencing with Section 4999.200) of Division 2 of the Business and Professions* Code.

(48) A human resource employee of a business subject to Part 2.8 (commencing with Section 12900) of Division 3 of Title 2 of the Government Code that employs minors. For purposes of this section, a “human resource employee” is the employee or employees designated by the employer to accept any complaints of misconduct as required by Chapter 6 (commencing with Section 12940) of Part 2.8 of Division 3 of Title 2 of the Government Code.

(49) An adult person whose duties require direct contact with and supervision of minors in the performance of the minors' duties in the workplace of a business subject to Part 2.8 (commencing with Section 12900) of Division 3 of Title 2 of the Government Code is a mandated reporter of sexual abuse, as defined in Section 11165.1. Nothing in this paragraph shall be construed to modify or limit the person's duty to report known or suspected child abuse or neglect when the person is acting in some other capacity that would otherwise make the person a mandated reporter.

(b) Except as provided in ~~paragraph~~ *paragraphs (1), (2), (3), and* (35) of subdivision (a), volunteers of public or private organizations whose duties require direct contact with and supervision of children are not mandated reporters but are encouraged to obtain training in the identification and reporting of child abuse and neglect and are further encouraged to report known or suspected instances of child abuse or neglect to an agency specified in Section 11165.9.

(c) (1) Except as provided in subdivision (d) and paragraph (2), employers are strongly encouraged to provide their employees who are mandated reporters with training in the duties imposed by this article. This training shall include training in child abuse and neglect identification and training in child abuse and neglect reporting. Whether or not employers provide their employees with training in child abuse and neglect identification and reporting, the employers shall provide their employees who are mandated reporters with the statement required pursuant to subdivision (a) of Section 11166.5.

(2) Employers subject to paragraphs (48) and (49) of subdivision (a) shall provide their employees who are mandated reporters with training in the duties imposed by this article. This training shall include training in child abuse and neglect identification and training in child abuse and neglect reporting. The training requirement may be met by completing the general online training for mandated reporters offered by the Office of Child Abuse Prevention in the State Department of Social Services.

(d) Pursuant to Section 44691 of the Education Code, school districts, county offices of education, state special schools and diagnostic centers operated by the State Department of Education, ~~and charter schools~~ *charter schools, and, commencing July 1, 2026, private schools,* shall annually train their employees and persons working on their behalf specified in subdivision (a) in the duties of mandated reporters under the child abuse reporting laws. The training shall include, but not necessarily be limited to, training in child abuse and neglect identification and child abuse and neglect reporting.

(e) (1) On and after January 1, 2018, pursuant to Section 1596.8662 of the Health and Safety Code, a childcare licensee applicant shall take training in the duties of mandated reporters under the child abuse reporting laws as a condition of licensure, and a childcare administrator or an employee of a licensed child daycare facility shall take training in the duties of mandated reporters during the first 90 days when that administrator or employee is employed by the facility.

(2) A person specified in paragraph (1) who becomes a licensee, administrator, or employee of a licensed child daycare facility shall take renewal mandated reporter training every two years following the date on which that person completed the initial

mandated reporter training. The training shall include, but not necessarily be limited to, training in child abuse and neglect identification and child abuse and neglect reporting.

(f) Unless otherwise specifically provided, the absence of training shall not excuse a mandated reporter from the duties imposed by this article.

(g) Public and private organizations are encouraged to provide their volunteers whose duties require direct contact with and supervision of children with training in the identification and reporting of child abuse and neglect.

**SEC. 9.3.**

Section 11165.7 of the Penal Code is amended to read:

(a) As used in this article, "mandated reporter" is defined as any of the following:

(1) ~~A teacher.~~ *An employee, volunteer, or governing board or body member of a school district, county office of education, charter school, or private school. For purposes of this paragraph, a volunteer is a person who is over 18 years of age and who interacts with pupils outside of the immediate supervision and control of the pupil's parent or guardian or a school employee.*

~~(2) An instructional aide.~~

~~(3)~~ *(2)* ~~A teacher's aide or teacher's assistant employed by~~ *An employee, volunteer, or board member of* a public or private ~~school.~~ *school, contractor to a school district, county office of education, charter school, state special school or diagnostic center operated by the State Department of Education, or private school whose duties require contact with or supervision of pupils at that school district, county office of education, charter school, state special school or diagnostic center operated by the State Department of Education, or private school. For purposes of this paragraph, a volunteer is a person who is over 18 years of age and who interacts with pupils outside of the immediate supervision and control of the pupil's parent or guardian or a school employee.*

~~(4)~~ *(3)* ~~A classified employee of a public school.~~ *An employee or volunteer assigned to a state special school or diagnostic center operated by the State Department of Education. For purposes of this paragraph, a volunteer is a person who is over 18 years of age and who interacts with pupils outside of the immediate supervision and control of the pupil's parent or guardian or a school employee.*

*(4) [Reserved]*

(5) ~~An administrative officer or supervisor of child welfare and attendance, or a certificated pupil personnel employee of a public or private school.~~ *[Reserved]*

(6) An administrator of a public or private day camp.

(7) An administrator or employee of a public or private youth center, youth recreation program, or youth organization.

(8) An administrator, board member, or employee of a public or private organization whose duties require direct contact and supervision of children, including a foster family agency.

(9) ~~An employee of a county office of education or the State Department of Education whose duties bring the employee into contact with children on a regular basis.~~ *[Reserved]*

(10) A licensee, an administrator, or an employee of a licensed child daycare facility or community care facility, except those licensed community care facilities exclusively serving adults and seniors.

(11) A Head Start program teacher.

(12) A licensing worker or licensing evaluator employed by a licensing agency, as defined in Section 11165.11.

(13) A public assistance worker.

(14) An employee of a childcare institution, including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities.

(15) A social worker, probation officer, or parole officer.

(16) ~~An employee of a school district police or security department.~~ *[Reserved]*

(17) A person who is an administrator or presenter of, or a counselor in, a child abuse prevention program in a public or private school.

(18) A district attorney investigator, inspector, or local child support agency caseworker, unless the investigator, inspector, or caseworker is working with an attorney appointed pursuant to Section 317 of the Welfare and Institutions Code to represent a minor.

(19) A peace officer, as defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2, who is not otherwise described in this section.

(20) A firefighter, except for volunteer firefighters.

(21) A physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, marriage and family therapist, clinical social worker, professional clinical counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

(22) An emergency medical technician I or II, paramedic, or other person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code.

(23) A psychological assistant registered pursuant to Section 2913 of the Business and Professions Code.

(24) A marriage and family therapist trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code.

(25) An unlicensed associate marriage and family therapist registered under Section 4980.44 of the Business and Professions Code.

(26) A state or county public health employee who treats a minor for venereal disease or any other condition.

(27) A coroner.

(28) A medical examiner or other person who performs autopsies.

(29) A commercial film and photographic print or image processor as specified in subdivision (e) of Section 11166. As used in this article, “commercial film and photographic print or image processor” means a person who develops exposed photographic film into negatives, slides, or prints, or who makes prints from negatives or slides, or who prepares, publishes, produces, develops, duplicates, or prints any representation of information, data, or an image, including, but not limited to, any film, filmstrip, photograph, negative, slide, photocopy, videotape, video laser disc, computer hardware, computer software, computer floppy disk, data storage medium, CD-ROM, computer-generated equipment, or computer-generated image, for compensation. The term includes any employee of that person; it does not include a person who develops film or makes prints or images for a public agency.

(30) A child visitation monitor. As used in this article, “child visitation monitor” means a person who, for financial compensation, acts as a monitor of a visit between a child and another person when the monitoring of that visit has been ordered by a court of law.

(31) An animal control officer or humane society officer. For the purposes of this article, the following terms have the following meanings:

(A) “Animal control officer” means a person employed by a city, county, or city and county for the purpose of enforcing animal control laws or regulations.

(B) “Humane society officer” means a person appointed or employed by a public or private entity as a humane officer who is qualified pursuant to Section 14502 or 14503 of the Corporations Code.

(32) A clergy member, as specified in subdivision (d) of Section 11166. As used in this article, “clergy member” means a priest, minister, rabbi, religious practitioner, or similar functionary of a church, temple, or recognized denomination or organization.

(33) Any custodian of records of a clergy member, as specified in this section and subdivision (d) of Section 11166.

(34) An employee of any police department, county sheriff’s department, county probation department, or county welfare department.

(35) An employee or volunteer of a Court Appointed Special Advocate program, as defined in Rule 5.655 of the California Rules of Court.

(36) A custodial officer, as defined in Section 831.5.

(37) A person providing services to a minor child under Section 12300 or 12300.1 of the Welfare and Institutions Code.

(38) An alcohol and drug counselor. As used in this article, an “alcohol and drug counselor” is a person providing counseling, therapy, or other clinical services for a state licensed or certified drug, alcohol, or drug and alcohol treatment program. However, alcohol or drug abuse, or both alcohol and drug abuse, is not, in and of itself, a sufficient basis for reporting child abuse or neglect.

(39) A clinical counselor trainee, as defined in subdivision (g) of Section 4999.12 of the Business and Professions Code.

(40) An associate professional clinical counselor registered under Section 4999.42 of the Business and Professions Code.

(41) An employee or administrator of a public or private postsecondary educational institution, whose duties bring the administrator or employee into contact with children on a regular basis, or who supervises those whose duties bring the administrator or employee into contact with children on a regular basis, as to child abuse or neglect occurring on that institution’s premises or at an official activity of, or program conducted by, the institution. Nothing in this paragraph shall be construed as altering the lawyer-client privilege as set forth in Article 3 (commencing with Section 950) of Chapter 4 of Division 8 of the Evidence Code.

(42) An athletic coach, athletic administrator, or athletic director employed by any public or private school that provides any combination of instruction for kindergarten, or grades 1 to 12, inclusive.

(43) (A) A commercial computer technician as specified in subdivision (e) of Section 11166. As used in this article, “commercial computer technician” means a person who works for a company that is in the business of repairing, installing, or otherwise servicing a computer or computer component, including, but not limited to, a computer part, device, memory storage or recording mechanism, auxiliary storage recording or memory capacity, or any other material relating to the operation and maintenance of a computer or computer network system, for a fee. An employer who provides an electronic communications service or a remote computing service to the public shall be deemed to comply with this article if that employer complies with Section 2258A of Title 18 of the United States Code.

(B) An employer of a commercial computer technician may implement internal procedures for facilitating reporting consistent with this article. These procedures may direct employees who are mandated reporters under this paragraph to report materials described in subdivision (e) of Section 11166 to an employee who is designated by the employer to receive the reports. An employee who is designated to receive reports under this subparagraph shall be a commercial computer technician for purposes of this article. A commercial computer technician who makes a report to the designated employee pursuant to this subparagraph shall be deemed to have complied with the requirements of this article and shall be subject to the protections afforded to mandated reporters, including, but not limited to, those protections afforded by Section 11172.

(44) Any athletic coach, including, but not limited to, an assistant coach or a graduate assistant involved in coaching, at public or private postsecondary educational institutions.

(45) An individual certified by a licensed foster family agency as a certified family home, as defined in Section 1506 of the Health and Safety Code.

(46) An individual approved as a resource family, as defined in Section 1517 of the Health and Safety Code and Section 16519.5 of the Welfare and Institutions Code.

(47) A qualified autism service provider, a qualified autism service professional, or a qualified autism service ~~paraprofessional,~~ *paraprofessional* as defined in ~~Section 1374.73 of the Health and Safety Code and Section 10144.51 of the Insurance~~ *Chapter 17 (commencing with Section 4999.200) of Division 2 of the Business and Professions* Code.

(48) A human resource employee of a business subject to Part 2.8 (commencing with Section 12900) of Division 3 of Title 2 of the Government Code that employs minors. For purposes of this section, a "human resource employee" is the employee or employees designated by the employer to accept any complaints of misconduct as required by Chapter 6 (commencing with Section 12940) of Part 2.8 of Division 3 of Title 2 of the Government Code.

(49) An adult person whose duties require direct contact with and supervision of minors in the performance of the minors' duties in the workplace of a business subject to Part 2.8 (commencing with Section 12900) of Division 3 of Title 2 of the Government Code is a mandated reporter of sexual abuse, as defined in Section 11165.1. Nothing in this paragraph shall be construed to modify or limit the person's duty to report known or suspected child abuse or neglect when the person is acting in some other capacity that would otherwise make the person a mandated reporter.

*(50) An individual employed as a talent agent, talent manager, or talent coach, who provides services to a minor.*

(b) Except as provided in ~~paragraph~~ *paragraphs (1), (2), (3), and* (35) of subdivision (a), volunteers of public or private organizations whose duties require direct contact with and supervision of children are not mandated reporters but are encouraged to obtain training in the identification and reporting of child abuse and neglect and are further encouraged to report known or suspected instances of child abuse or neglect to an agency specified in Section 11165.9.

(c) (1) Except as provided in subdivision (d) and paragraph (2), employers are strongly encouraged to provide their employees who are mandated reporters with training in the duties imposed by this article. This training shall include training in child abuse and neglect identification and training in child abuse and neglect reporting. Whether or not employers provide their employees with training in child abuse and neglect identification and reporting, the employers shall provide their employees who are mandated reporters with the statement required pursuant to subdivision (a) of Section 11166.5.

(2) Employers subject to paragraphs (48) and (49) of subdivision (a) shall provide their employees who are mandated reporters with training in the duties imposed by this article. This training shall include training in child abuse and neglect identification and training in child abuse and neglect reporting. The training requirement may be met by completing the general online training for mandated reporters offered by the Office of Child Abuse Prevention in the State Department of Social Services.

(d) Pursuant to Section 44691 of the Education Code, school districts, county offices of education, state special schools and diagnostic centers operated by the State Department of Education, ~~and charter schools~~ *charter schools, and, commencing July 1, 2026, private schools,* shall annually train their employees and persons working on their behalf specified in subdivision (a) in the duties of mandated reporters under the child abuse reporting laws. The training shall include, but not necessarily be limited to, training in child abuse and neglect identification and child abuse and neglect reporting.

(e) (1) On and after January 1, 2018, pursuant to Section 1596.8662 of the Health and Safety Code, a childcare licensee applicant shall take training in the duties of mandated reporters under the child abuse reporting laws as a condition of licensure, and a childcare administrator or an employee of a licensed child daycare facility shall take training in the duties of mandated reporters during the first 90 days when that administrator or employee is employed by the facility.

(2) A person specified in paragraph (1) who becomes a licensee, administrator, or employee of a licensed child daycare facility shall take renewal mandated reporter training every two years following the date on which that person completed the initial mandated reporter training. The training shall include, but not necessarily be limited to, training in child abuse and neglect identification and child abuse and neglect reporting.

(f) Unless otherwise specifically provided, the absence of training shall not excuse a mandated reporter from the duties imposed by this article.

(g) Public and private organizations are encouraged to provide their volunteers whose duties require direct contact with and supervision of children with training in the identification and reporting of child abuse and neglect.

***SEC. 10.***

*Section 3.5 of this bill incorporates amendments to Section 1367.27 of the Health and Safety Code proposed by both this bill and Assembly Bill 280. That section of this bill shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2026, (2) each bill amends Section 1367.27 of the Health and Safety Code, and (3) this bill is enacted after Assembly Bill 280, in which case Section 3 of this bill shall not become operative.*

***SEC. 11.***

*Section 5.5 of this bill incorporates amendments to Section 1374.73 of the Health and Safety Code proposed by both this bill and AB 951. That section of this bill shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2026, (2) each bill amends Section 1374.73 of the Health and Safety Code,*

*and (3) this bill is enacted after AB 951, in which case Section 5 of this bill shall not become operative.*

***SEC. 12.***

*Section 6.5 of this bill incorporates amendments to Section 10133.15 of the Insurance Code proposed by both this bill and Assembly Bill 280. That section of this bill shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2026, (2) each bill amends Section 10133.15 of the Insurance Code, and (3) this bill is enacted after Assembly Bill 280, in which case Section 6 of this bill shall not become operative.*

***SEC. 13.***

*Section 8.5 of this bill incorporates amendments to Section 10144.51 of the Insurance Code proposed by both this bill and AB 951. That section of this bill shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2026, (2) each bill amends Section 10144.51 of the Insurance Code, and (3) this bill is enacted after AB 951, in which case Section 8 of this bill shall not become operative.*

***SEC. 14.***

*(a) Section 9.1 of this bill incorporates amendments to Section 11165.7 of the Penal Code proposed by both this bill and Assembly Bill 653. That section of this bill shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2026, (2) each bill amends Section 11165.7 of the Penal Code, (3) Senate Bill 848 is not enacted or as enacted does not amend that section, and (4) this bill is enacted after Assembly Bill 653, in which case Sections 9, 9.2, and 9.3 of this bill shall not become operative.*

*(b) Section 9.2 of this bill incorporates amendments to Section 11165.7 of the Penal Code proposed by both this bill and Senate Bill 848. That section of this bill shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2026, (2) each bill amends Section 11165.7 of the Penal Code, (3) Assembly Bill 653 is not enacted or as enacted does not amend that section, and (4) this bill is enacted after Senate Bill 848, in which case Sections 9, 9.1, and 9.3 of this bill shall not become operative.*

*(c) Section 9.3 of this bill incorporates amendments to Section 11165.7 of the Penal Code proposed by this bill, Assembly Bill 653, and Senate Bill 848. That section of this bill shall only become operative if (1) all three bills are enacted and become effective on or before January 1, 2026, (2) all three bills amend Section 11165.7 of the Penal Code, and (3) this bill is enacted after Assembly Bill 653 and Senate Bill 848, in which case Sections 9, 9.1, and 9.2 of this bill shall not become operative.*

**SB 446 - (C) Amends the Law**

**SECTION 1.**

Section 1798.82 of the Civil Code is amended to read:

(a) ~~A~~ *(1)* ~~person~~ *An individual* or business that conducts business in California, and that owns or licenses computerized data that includes personal information, shall disclose a breach of the security of the system following discovery or notification of the breach in the security of the data to a resident of California ~~(1)~~ whose unencrypted personal information was, or is reasonably believed to have been, acquired by an unauthorized person, ~~or, (2)~~ *or* whose encrypted personal information was, or is reasonably believed to have been, acquired by an unauthorized person and the encryption key or security credential was, or is reasonably believed to have been, acquired by an unauthorized ~~person~~ *person,* and the person or business that owns or licenses the encrypted information has a reasonable belief that the encryption key or security credential could render that personal information readable or usable. ~~The disclosure shall be made in the most expedient time possible and without unreasonable delay, consistent with the legitimate needs of law enforcement, as provided in subdivision (c), or any measures necessary to determine the scope of the breach and restore the reasonable integrity of the data system.~~

*(2) (A) Subject to subparagraph (B), the disclosure required by this subdivision shall be made within 30 calendar days of discovery or notification of the data breach.*

*(B) An individual or business may delay the disclosure required by this subdivision to accommodate the legitimate needs of law enforcement, pursuant to subdivision (c), or as necessary to determine the scope of the breach and restore the reasonable integrity of the data system.*

(b) ~~A person~~ *An individual* or business that maintains computerized data that includes personal information that the ~~person~~ *individual* or business does not own shall notify the owner or licensee of the information of the breach of the security of the data immediately following discovery, if the personal information was, or is reasonably believed to have been, acquired by an unauthorized person.

(c) The notification required by this section may be delayed if a law enforcement agency determines that the notification will impede a criminal investigation. The notification required by this section shall be made promptly after the law enforcement agency determines that it will not compromise the investigation.

(d) ~~A person~~ *An individual* or business that is required to issue a security breach notification pursuant to this section shall meet all of the following requirements:

(1) The security breach notification shall be written in plain language, shall be titled "Notice of Data Breach," and shall present the information described in paragraph (2) under the following headings: "What ~~Happened,"~~ *Happened?"* "What Information Was ~~Involved,"~~ *Involved?"* "What We Are Doing," "What You Can Do," and "For More Information." Additional information may be provided as a supplement to the notice.

(A) The format of the notice shall be designed to call attention to the nature and significance of the information it contains.

(B) The title and headings in the notice shall be clearly and conspicuously displayed.

(C) The text of the notice and any other notice provided pursuant to this section shall be no smaller than 10-point type.

(D) For a written notice described in paragraph (1) of subdivision (j), use of the model security breach notification form prescribed below or use of the headings described in this paragraph with the information described in paragraph (2), written in plain language, shall be deemed to be in compliance with this subdivision.

[NAME OF INSTITUTION / LOGO] _____ _____ Date: [insert date]

NOTICE OF DATA BREACH

What Happened?

What Information Was Involved?

What We Are Doing.

What You Can Do.

Other Important Information.
[insert other important information]

| | |
|---|---|
| For More Information. | Call [telephone number] or go to [internet website] |

(E) For an electronic notice described in paragraph (2) of subdivision (j), use of the headings described in this paragraph with the information described in paragraph (2), written in plain language, shall be deemed to be in compliance with this subdivision.

(2) The security breach notification described in paragraph (1) shall include, at a minimum, the following information:

(A) The name and contact information of the reporting ~~person~~ *individual* or business subject to this section.

(B) A list of the types of personal information that were or are reasonably believed to have been the subject of a breach.

(C) If the information is possible to determine at the time the notice is provided, then any of the following: (i) the date of the breach, (ii) the estimated date of the breach, or (iii) the date range within which the breach occurred. The notification shall also include the date of the notice.

(D) Whether notification was delayed as a result of a law enforcement investigation, if that information is possible to determine at the time the notice is provided.

(E) A general description of the breach incident, if that information is possible to determine at the time the notice is provided.

(F) The toll-free telephone numbers and addresses of the major credit reporting agencies if the breach exposed a social security number or a driver's license or California identification card number.

(G) If the ~~person~~ *individual* or business providing the notification was the source of the breach, an offer to provide appropriate identity theft prevention and mitigation services, if any, shall be provided at no cost to the affected ~~person~~ *individual* for not less than 12 months along with all information necessary to take advantage of the offer to any ~~person~~ *individual* whose information was or may have been breached if the breach exposed or may have exposed personal information defined in subparagraphs (A) and (B) of paragraph (1) of subdivision (h).

(3) At the discretion of the ~~person~~ *individual* or business, the security breach notification may also include any of the following:

(A) Information about what the ~~person~~ *individual* or business has done to protect individuals whose information has been breached.

(B) Advice on steps that people whose information has been breached may take to protect themselves.

(C) In breaches involving biometric data, instructions on how to notify other entities that used the same type of biometric data as an authenticator to no longer rely on data for authentication purposes.

(e) A covered entity under the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Sec. 1320d et seq.) will be deemed to have complied with the notice requirements in subdivision (d) if it has complied completely with Section 13402(f) of the federal Health Information Technology for Economic and Clinical Health Act (Public Law 111-5). However, nothing in this subdivision shall be construed to exempt a covered entity from any other provision of this section.

(f) ~~A person~~ *An individual* or business that is required to issue a security breach notification pursuant to this section to more than 500 California residents as a result of a single breach of the security system shall electronically submit a single sample copy of that security breach notification, excluding any personally identifiable information, to the Attorney ~~General.~~ *General within 15 calendar days of notifying affected consumers of the security breach.* A single sample copy of a security breach notification shall not be deemed to be within Article 1 (commencing with Section 7923.600) of Chapter 1 of Part 5 of Division 10 of Title 1 of the Government Code.

(g) For purposes of this section, “breach of the security of the system” means unauthorized acquisition of computerized data that compromises the security, confidentiality, or integrity of personal information maintained by the ~~person~~ *individual* or business. Good faith acquisition of personal information by an employee or agent of the ~~person~~ *individual* or business for the purposes of the ~~person~~ *individual* or business is not a breach of the security of the system, provided that the personal information is not used or subject to further unauthorized disclosure.

(h) For purposes of this section, “personal information” means either of the following:

(1) An individual’s first name or first initial and last name in combination with any one or more of the following data elements, when either the name or the data elements are not encrypted:

(A) Social security number.

(B) Driver's license number, California identification card number, tax identification number, passport number, military identification number, or other unique identification number issued on a government document commonly used to verify the identity of a specific individual.

(C) Account number or credit or debit card number, in combination with any required security code, access code, or password that would permit access to an individual's financial account.

(D) Medical information.

(E) Health insurance information.

(F) Unique biometric data generated from measurements or technical analysis of human body characteristics, such as a fingerprint, retina, or iris image, used to authenticate a specific individual. Unique biometric data does not include a physical or digital photograph, unless used or stored for facial recognition purposes.

(G) Information or data collected through the use or operation of an automated license plate recognition system, as defined in Section 1798.90.5.

(H) Genetic data.

(2) A username or email address, in combination with a password or security question and answer that would permit access to an online account.

(i) (1) For purposes of this section, "personal information" does not include publicly available information that is lawfully made available to the general public from federal, state, or local government records.

(2) For purposes of this section, "medical information" means any information regarding an individual's medical history, mental or physical condition, or medical treatment or diagnosis by a health care professional.

(3) For purposes of this section, "health insurance information" means an individual's health insurance policy number or subscriber identification number, any unique identifier used by a health insurer to identify the individual, or any information in an individual's application and claims history, including any appeals records.

(4) For purposes of this section, "encrypted" means rendered unusable, unreadable, or indecipherable to an unauthorized person through a security technology or methodology generally accepted in the field of information security.

(5) "Genetic data" means any data, regardless of its format, that results from the analysis of a biological sample of an individual, or from another source enabling equivalent information to be obtained, and concerns genetic material. Genetic material includes, but is not limited to, deoxyribonucleic acids (DNA), ribonucleic acids (RNA), genes, chromosomes, alleles, genomes, alterations or modifications to DNA or RNA, single nucleotide polymorphisms (SNPs), uninterpreted data that results from analysis

of the biological sample or other source, and any information extrapolated, derived, or inferred therefrom.

(j) For purposes of this section, “notice” may be provided by one of the following methods:

(1) Written notice.

(2) Electronic notice, if the notice provided is consistent with the provisions regarding electronic records and signatures set forth in Section 7001 of Title 15 of the United States Code.

(3) Substitute notice, if the ~~person~~ *individual* or business demonstrates that the cost of providing notice would exceed two hundred fifty thousand dollars ($250,000), or that the affected class of subject persons to be notified exceeds 500,000, or the ~~person~~ *individual* or business does not have sufficient contact information. Substitute notice shall consist of all of the following:

(A) Email notice when the ~~person~~ *individual* or business has an email address for the subject persons.

(B) Conspicuous posting, for a minimum of 30 days, of the notice on the internet website page of the ~~person~~ *individual* or business, if the ~~person~~ *individual* or business maintains one. For purposes of this subparagraph, conspicuous posting on the ~~person's~~ *individual's* or business's internet website means providing a link to the notice on the home page or first significant page after entering the internet website that is in larger type than the surrounding text, or in contrasting type, font, or color to the surrounding text of the same size, or set off from the surrounding text of the same size by symbols or other marks that call attention to the link.

(C) Notification to major statewide media.

(4) In the case of a breach of the security of the system involving personal information defined in paragraph (2) of subdivision (h) for an online account, and no other personal information defined in paragraph (1) of subdivision (h), the ~~person~~ *individual* or business may comply with this section by providing the security breach notification in electronic or other form that directs the ~~person~~ *individual* whose personal information has been breached promptly to change the ~~person's~~ *individual's* password and security question or answer, as applicable, or to take other steps appropriate to protect the online account with the ~~person~~ *individual* or business and all other online accounts for which the ~~person~~ *individual* whose personal information has been breached uses the same username or email address and password or security question or answer.

(5) In the case of a breach of the security of the system involving personal information defined in paragraph (2) of subdivision (h) for login credentials of an email account furnished by the ~~person~~ *individual* or business, the ~~person~~ *individual* or business shall not comply with this section by providing the security breach notification to that email address, but may, instead, comply with this section by providing notice by another method described in this subdivision or by clear and conspicuous notice delivered to the resident online when the resident is connected to the online account from an Internet

Protocol address or online location from which the ~~person~~ *individual* or business knows the resident customarily accesses the account.

(k) For purposes of this section, “encryption key” and “security credential” mean the confidential key or process designed to render data usable, readable, and decipherable.

(l) Notwithstanding subdivision (j), ~~a person~~ *an individual* or business that maintains its own notification procedures as part of an information security policy for the treatment of personal information and is otherwise consistent with the timing requirements of this ~~part,~~ *part* shall be deemed to be in compliance with the notification requirements of this section if the ~~person~~ *individual* or business notifies subject ~~persons~~ *individuals* in accordance with its policies in the event of a breach of security of the system.

**SB 470 - (C) Amends the Law**

**SECTION 1.**

Section 11123.2 of the Government Code is amended to read:

(a) For purposes of this section, the following definitions apply:

(1) “Teleconference” means a meeting of a state body, the members of which are at different locations, connected by electronic means, through either audio or both audio and video.

(2) “Teleconference location” means a physical location that is accessible to the public and from which members of the public may participate in the meeting.

(3) “Remote location” means a location from which a member of a state body participates in a meeting other than a teleconference location.

(4) “Participate remotely” means participation by a member of the body in a meeting at a remote location other than a teleconference location designated in the notice of the meeting.

(b) (1) In addition to the authorization to hold a meeting by teleconference pursuant to subdivision (b) of Section 11123 and Section 11123.5, a state body may hold an open or closed meeting by teleconference as described in this section, provided the meeting complies with all of this section’s requirements and, except as set forth in this section, it also complies with all other applicable requirements of this article relating to the specific type of meeting.

(2) This section does not limit or affect the ability of a state body to hold a teleconference meeting under another provision of this article, including Sections 11123 and 11123.5.

(c) The portion of the teleconferenced meeting that is required to be open to the public shall be visible and audible to the public at each teleconference location.

(d) (1) The state body shall provide a means by which the public may remotely hear audio of the meeting, remotely observe the meeting, remotely address the body, or attend the meeting by providing on the posted agenda a teleconference telephone number, an internet website or other online platform, and a physical address for each teleconference location. The telephonic or online means provided to the public to access the meeting shall be equivalent to the telephonic or online means provided to a member of the state body participating remotely.

(2) The applicable teleconference telephone number, internet website or other online platform, and physical address of each teleconference location, as well as any other information indicating how the public can access the meeting remotely and in person, shall be specified in any notice required by this article.

(3) If the state body allows members of the public to observe and address the meeting telephonically or otherwise electronically, the state body shall do both of the following:

(A) Implement a procedure for receiving and swiftly resolving requests for reasonable modification or accommodation from individuals with disabilities, consistent with the federal Americans with Disabilities Act of 1990 (42 U.S.C. Sec. 12101 et seq.), and resolving any doubt whatsoever in favor of accessibility.

(B) Advertise that procedure each time notice is given of the means by which members of the public may observe the meeting and offer public comment.

(e) This section does not prohibit a state body from providing members of the public with additional locations from which the public may observe or address the state body by electronic means, through either audio or both audio and video.

(f) (1) The agenda shall provide an opportunity for members of the public to address the state body directly pursuant to Section 11125.7.

(2) Members of the public shall be entitled to exercise their right to directly address the state body during the teleconferenced meeting without being required to submit public comments before the meeting or in writing.

(g) The state body shall post the agenda on its internet website and, on the day of the meeting, at each teleconference location.

(h) This section does not affect the requirement prescribed by this article that the state body post an agenda of a meeting in accordance with the applicable notice requirements of this article, including Section 11125, requiring the state body to post an agenda of a meeting at least 10 days in advance of the meeting, Section 11125.4, applicable to special meetings, and Sections 11125.5 and 11125.6, applicable to emergency meetings.

(i) At least one member of the state body shall be physically present at each teleconference location.

(j) (1) Except as provided in paragraph (2), a majority of the members of the state body shall be physically present at the same teleconference location. Additional members of the state body in excess of a majority of the members may attend and participate in the meeting from a remote location. A remote location is not required to be accessible to the public. The notice and agenda shall not disclose information regarding a remote location.

(2) A member attending and participating from a remote location may count toward the majority required to hold a teleconference if both of the following conditions are met:

(A) The member has a need related to a physical or mental disability, as those terms are defined in Sections 12926 and 12926.1, that is not otherwise reasonably accommodated pursuant to the federal Americans with Disability Act of 1990 (42 U.S.C. Sec. 12101 et seq.).

(B) The member notifies the state body at the earliest opportunity possible, including at the start of a meeting, of their need to participate remotely, including providing a general description of the circumstances relating to their need to participate remotely at the given meeting.

(3) If a member notifies the body of the member's need to attend and participate remotely pursuant to paragraph (2), the body shall take action to approve the exception and shall request a general description of the circumstances relating to the member's need to participate remotely at the meeting, for each meeting in which the member seeks to participate remotely. The body shall not require the member to provide a general description that exceeds 20 words or to disclose any medical diagnosis or disability, or any personal medical information that is already exempt under existing law, such as the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code).

(4) If a member of the state body attends the meeting by teleconference from a remote location, the member shall disclose whether any other individuals 18 years of age or older are present in the room at the remote location with the member, and the general nature of the member's relationship with any such individuals.

(k) (1) Except as provided in paragraph (2), the members of the state body shall visibly appear on camera during the open portion of a meeting that is publicly accessible via the internet or other online platform.

(2) The visual appearance of a member of the state body on camera may cease only when the appearance would be technologically impracticable, including, but not limited to, when the member experiences a lack of reliable broadband or internet connectivity that would be remedied by joining without video, or when the visual display of meeting materials, information, or speakers on the internet or other online platform requires the visual appearance of a member of a state body on camera to cease.

(3) If a member of the state body does not appear on camera due to challenges with internet connectivity, the member shall announce the reason for their nonappearance when they turn off their camera.

(l) All votes taken during the teleconferenced meeting shall be by rollcall.

(m) The state body shall publicly report any action taken and the vote or abstention on that action of each member present for the action.

(n) The portion of the teleconferenced meeting that is closed to the public shall not include the consideration of any agenda item being heard pursuant to Section 11125.5.

(o) Upon discovering that a means of remote public access and participation required by subdivision (d) has failed during a meeting and cannot be restored, the state body shall end or adjourn the meeting in accordance with Section 11128.5. In addition to any other requirements that may apply, the state body shall provide notice of the meeting's end or adjournment on the state body's internet website and by email to any person who has requested notice of meetings of the state body by email under this article. If the meeting will be adjourned and reconvened on the same day, further notice shall be provided by an automated message on a telephone line posted on the state body's agenda, internet website, or by a similar means, that will communicate when the state body intends to reconvene the meeting and how a member of the public may hear audio of the meeting or observe the meeting.

(p) This section shall remain in effect only until January 1, ~~2026,~~ *2030,* and as of that date is repealed.

**SEC. 2.**

Section 11123.5 of the Government Code, as amended by Section 2 of Chapter 216 of the Statutes of 2023, is amended to read:

(a) For purposes of this section, the following definitions apply:

(1) “Participate remotely” means participation in a meeting at a location other than the physical location designated in the agenda of the meeting.

(2) “Remote location” means a location other than the primary physical location designated in the agenda of a meeting.

(3) “Teleconference” has the same meaning as in Section 11123.

(b) In addition to the authorization to hold a meeting by teleconference pursuant to subdivision (b) of Section 11123 or Section 11123.2, any state body that is an advisory board, advisory commission, advisory committee, advisory subcommittee, or similar multimember advisory body may hold an open meeting by teleconference as described in this section, provided the meeting complies with all of the section’s requirements and, except as set forth in this section, it also complies with all other applicable requirements of this article.

(c) A member of a state body as described in subdivision (b) who participates in a teleconference meeting from a remote location subject to this section’s requirements shall be listed in the minutes of the meeting.

(d) The state body shall provide notice to the public at least 24 hours before the meeting that identifies any member who will participate remotely by posting the notice on its internet website and by emailing notice to any person who has requested notice of meetings of the state body under this article. The location of a member of a state body who will participate remotely is not required to be disclosed in the public notice or email and need not be accessible to the public. The notice of the meeting shall also identify the primary physical meeting location designated pursuant to subdivision (f).

(e) This section does not affect the requirement prescribed by this article that the state body post an agenda of a meeting at least 10 days in advance of the meeting. The agenda shall include information regarding the physical meeting location designated pursuant to subdivision (f), but is not required to disclose information regarding any remote location.

(f) A state body described in subdivision (b) shall designate the primary physical meeting location in the notice of the meeting where members of the public may physically attend the meeting, observe and hear the meeting, and participate. At least one staff member of the state body shall be present at the primary physical meeting location during the meeting. The state body shall post the agenda at the primary physical meeting location, but need not post the agenda at a remote location.

(g) When a member of a state body described in subdivision (b) participates remotely in a meeting subject to this section's requirements, the state body shall provide a means by which the public may remotely hear audio of the meeting or remotely observe the meeting, including, if available, equal access equivalent to members of the state body participating remotely. The applicable teleconference phone number or internet website, or other information indicating how the public can access the meeting remotely, shall be in the 24-hour notice described in subdivision (b) that is available to the public.

(h) (1) Except as provided in paragraph (2), the members of the state body shall visibly appear on camera during the open portion of a meeting that is publicly accessible via the internet or other online platform.

(2) The visual appearance of a member of a state body on camera may cease only when the appearance would be technologically impracticable, including, but not limited to, when the member experiences a lack of reliable broadband or internet connectivity that would be remedied by joining without video, or when the visual display of meeting materials, information, or speakers on the internet or other online platform requires the visual appearance of a member of a state body on camera to cease.

(3) If a member of the body does not appear on camera due to challenges with internet connectivity, the member shall announce the reason for their nonappearance when they turn off their camera.

(i) Upon discovering that a means of remote access required by subdivision (g) has failed during a meeting, the state body described in subdivision (b) shall end or adjourn the meeting in accordance with Section 11128.5. In addition to any other requirements that may apply, the state body shall provide notice of the meeting's end or adjournment on its internet website and by email to any person who has requested notice of meetings of the state body under this article. If the meeting will be adjourned and reconvened on the same day, further notice shall be provided by an automated message on a telephone line posted on the state body's agenda, or by a similar means, that will communicate when the state body intends to reconvene the meeting and how a member of the public may hear audio of the meeting or observe the meeting.

(j) This section does not limit or affect the ability of a state body to hold a teleconference meeting under another provision of this article.

(k) This section shall remain in effect only until January 1, ~~2026,~~ *2030,* and as of that date is repealed.

**SEC. 3.**

Section 11123.5 of the Government Code, as added by Section 3 of Chapter 216 of the Statutes of 2023, is amended to read:

(a) In addition to the authorization to hold a meeting by teleconference pursuant to subdivision (b) of Section 11123, any state body that is an advisory board, advisory commission, advisory committee, advisory subcommittee, or similar multimember advisory body may hold an open meeting by teleconference as described in this section,

provided the meeting complies with all of the section's requirements and, except as set forth in this section, it also complies with all other applicable requirements of this article.

(b) A member of a state body as described in subdivision (a) who participates in a teleconference meeting from a remote location subject to this section's requirements shall be listed in the minutes of the meeting.

(c) The state body shall provide notice to the public at least 24 hours before the meeting that identifies any member who will participate remotely by posting the notice on its internet website and by emailing notice to any person who has requested notice of meetings of the state body under this article. The location of a member of a state body who will participate remotely is not required to be disclosed in the public notice or email and need not be accessible to the public. The notice of the meeting shall also identify the primary physical meeting location designated pursuant to subdivision (e).

(d) This section does not affect the requirement prescribed by this article that the state body post an agenda of a meeting at least 10 days in advance of the meeting. The agenda shall include information regarding the physical meeting location designated pursuant to subdivision (e), but is not required to disclose information regarding any remote location.

(e) A state body described in subdivision (a) shall designate the primary physical meeting location in the notice of the meeting where members of the public may physically attend the meeting and participate. A quorum of the members of the state body shall be in attendance at the primary physical meeting location, and members of the state body participating remotely shall not count towards establishing a quorum. All decisions taken during a meeting by teleconference shall be by rollcall vote. The state body shall post the agenda at the primary physical meeting location, but need not post the agenda at a remote location.

(f) When a member of a state body described in subdivision (a) participates remotely in a meeting subject to this section's requirements, the state body shall provide a means by which the public may remotely hear audio of the meeting or remotely observe the meeting, including, if available, equal access equivalent to members of the state body participating remotely. The applicable teleconference phone number or internet website, or other information indicating how the public can access the meeting remotely, shall be in the 24-hour notice described in subdivision (a) that is available to the public.

(g) Upon discovering that a means of remote access required by subdivision (f) has failed during a meeting, the state body described in subdivision (a) shall end or adjourn the meeting in accordance with Section 11128.5. In addition to any other requirements that may apply, the state body shall provide notice of the meeting's end or adjournment on its internet website and by email to any person who has requested notice of meetings of the state body under this article. If the meeting will be adjourned and reconvened on the same day, further notice shall be provided by an automated message on a telephone line posted on the state body's agenda, or by a similar means, that will communicate when the state body intends to reconvene the meeting and how a member of the public may hear audio of the meeting or observe the meeting.

(h) For purposes of this section:

(1) “Participate remotely” means participation in a meeting at a location other than the physical location designated in the agenda of the meeting.

(2) “Remote location” means a location other than the primary physical location designated in the agenda of a meeting.

(3) “Teleconference” has the same meaning as in Section 11123.

(i) This section does not limit or affect the ability of a state body to hold a teleconference meeting under another provision of this article.

(j) This section shall become operative on January 1, ~~2026.~~ *2030.*

***SEC. 4.***

*The Legislature finds and declares that Section 1 of this act, which amends Section 11123.2 of the Government Code, and Sections 2 and 3 of this act, which amend and repeal Section 11123.5 of the Government Code, modify the public’s right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:*

*(a) By continuing to ensure that agendas are not required to be posted at, and that agendas and notices do not disclose information regarding, the location of each public official participating in a public meeting remotely, including from the member’s private home or hotel room, this act protects the personal, private information of public officials and their families while preserving the public’s right to access information concerning the conduct of the people’s business.*

*(b) During the COVID-19 public health emergency, audio and video teleconference were widely used to conduct public meetings in lieu of physical location meetings, and those public meetings have been productive, increased public participation by all members of the public regardless of their location and ability to travel to physical meeting locations, increased the pool of people who are able to serve on these bodies, protected the health and safety of civil servants and the public, and have reduced travel costs incurred by members of state bodies and reduced work hours spent traveling to and from meetings.*

*(c) Conducting audio and video teleconference meetings enhances public participation and the public’s right of access to meetings of the public bodies by improving access for individuals who often face barriers to physical attendance.*

**SB 497 - (C) Amends the Law**

***SECTION 1.***

*The Legislature finds and declares that California residents and visitors, especially transgender and gender nonconforming people, are being targeted for harassment, intimidation, and other harm, as are family members, teachers, and others who support them. The Legislature intends to comprehensively protect these Californians and visitors from both instate and out-of-state abuse, including from individuals purporting to act on behalf of the United States Government.*

**SEC. 2.**

Section 56.109 of the Civil Code is amended to read:

(a) Notwithstanding subdivision (b) of Section 56.10, a provider of health care, health care service plan, or contractor shall not release medical information related to a person ~~or~~ *seeking or obtaining gender-affirming health care or gender-affirming mental health care or a person or* entity allowing a child to receive gender-affirming health care or gender-affirming mental health care in response to any ~~civil action,~~ *subpoena or request,* including a foreign subpoena, based on another state's law that *interferes with an individual's right to seek or obtain gender-affirming health care or gender-affirming mental health care or* authorizes a person to bring a civil *or criminal* action against a person or entity that allows a child to receive gender-affirming health care or gender-affirming mental health care.

(b) Notwithstanding subdivision (c) of Section 56.10, a provider of health care, health care service plan, or contractor shall not release medical information to persons or entities who have requested that information and who are authorized by law to receive that information pursuant to subdivision (c) of Section 56.10, if the information is related to *an individual seeking or obtaining gender-affirming health care or gender-affirming mental health care or to* a person or entity allowing a child to receive gender-affirming health care or gender-affirming mental health care, and the information is being requested pursuant to another state's law that authorizes a person to bring a civil *or criminal* action against a person or entity *that provides, seeks, obtains, or receives gender-affirming health care or gender-affirming mental health care or* who allows a child to receive gender-affirming health care or gender-affirming mental health care.

*(c) Notwithstanding subdivisions (b) and (c) of Section 56.10 or subdivision (c) of Section 56.20, a provider of health care, health care service plan, contractor, or employer shall not cooperate with any inquiry or investigation by, or provide medical information to, any individual, agency, or department from another state or, to the extent permitted by federal law, to a federal law enforcement agency that would identify an individual and that is related to an individual seeking or obtaining gender-affirming health care or gender-affirming mental health care that is lawful under the laws of this state.*

*(d) This section does not prohibit compliance with the investigation of activity that is punishable as a crime under the laws of this state.*

*(e) This section does not prohibit compliance with an audit or investigation of activity that is unlawful under the laws of this state or federal law, or with an audit, review, or investigation conducted for purposes of licensure, registration, accreditation, or certification under the laws of this state or federal law or pursuant to an accrediting organization recognized by the State Department of Public Health or the federal Centers for Medicare and Medicaid Services.*

*(f) This section does not prohibit the Department of Corrections and Rehabilitation from disclosing medical information of an individual to a health care facility that is run by an agency or department from another state, or to a federal law enforcement agency, for treatment purposes and direct medical care for the specified individual and is narrowly limited to the request.*

~~(c)~~ *(g)* For the purposes of this section, ~~"person" means an individual or governmental subdivision, agency, or instrumentality.~~ *the following terms have the following meanings:*

~~(d)~~ *(1)* ~~For the purpose of this section, "gender-affirming~~ *"Gender-affirming* health care" and "gender-affirming mental health care" shall have the same ~~meaning~~ *meanings* as provided in Section 16010.2 of the Welfare and Institutions Code.

*(2) "Person" means an individual or governmental subdivision, agency, or instrumentality.*

**SEC. 3.**

Section 2029.300 of the Code of Civil Procedure is amended to read:

(a) To request issuance of a subpoena under this section, a party shall submit the original or a true and correct copy of a foreign subpoena to the clerk of the superior court in the county in which discovery is sought to be conducted in this state. A request for the issuance of a subpoena under this section does not constitute making an appearance in the courts of this state.

(b) In addition to submitting a foreign subpoena under subdivision (a), a party seeking discovery shall do both of the following:

(1) Submit an application requesting that the superior court issue a subpoena with the same terms as the foreign subpoena. The application shall be on a form prescribed by the Judicial Council pursuant to Section 2029.390. No civil case cover sheet is required.

(2) Pay the fee specified in Section 70626 of the Government Code.

(c) When a party submits a foreign subpoena to the clerk of the superior court in accordance with subdivision (a), and satisfies the requirements of subdivision (b), the clerk shall promptly issue a subpoena for service upon the person to which the foreign subpoena is directed.

(d) A subpoena issued under this section shall satisfy all of the following conditions:

(1) It shall incorporate the terms used in the foreign subpoena.

(2) It shall contain or be accompanied by the names, addresses, and telephone numbers of all counsel of record in the proceeding to which the subpoena relates and of any party not represented by counsel.

(3) It shall bear the caption and case number of the out-of-state case to which it relates.

(4) It shall state the name of the court that issues it.

(5) It shall be on a form prescribed by the Judicial Council pursuant to Section 2029.390.

(e) Notwithstanding subdivision (a), a subpoena shall not be issued pursuant to this section in any of the following circumstances:

(1) If the foreign subpoena is based on a violation of another state's laws that interfere with a person's right to *seek or obtain gender-affirming health care or gender-affirming mental health care or to* allow a child to receive gender-affirming health care or gender-affirming mental health care. For the purpose of this paragraph, "gender-affirming health care" and "gender-affirming mental health care" shall have the same ~~meaning~~ *meanings* as provided in Section 16010.2 of the Welfare and Institutions Code.

(2) If the submitted foreign subpoena relates to a foreign penal civil action and would require disclosure of information related to sensitive services. For purposes of this paragraph, "sensitive services" has the same meaning as defined in Section 791.02 of the Insurance Code.

**SEC. 4.**

Section 2029.350 of the Code of Civil Procedure is amended to read:

(a) Notwithstanding Sections 1986 and 2029.300, if a party to a proceeding pending in a foreign jurisdiction retains an attorney licensed to practice in this state, who is an active member of the State Bar, and that attorney receives the original or a true and correct copy of a foreign subpoena, the attorney may issue a subpoena under this article.

(b) (1) Notwithstanding subdivision (a), an authorized attorney shall not issue a subpoena pursuant to subdivision (a) if the foreign subpoena is based on a violation of another state's laws that interfere with a person's right to *seek or obtain gender-affirming health care or gender-affirming mental health care or to* allow a child to receive gender-affirming health care or gender-affirming mental health care.

(2) For the purpose of this subdivision, "gender-affirming health care" and "gender-affirming mental health care" shall have the same ~~meaning~~ *meanings* as provided in Section 16010.2 of the Welfare and Institutions Code.

(c) Notwithstanding subdivision (a), an attorney shall not issue a subpoena under this article based on a foreign subpoena that relates to a foreign penal civil action and that would require disclosure of information related to sensitive services. For purposes of this subdivision, "sensitive services" has the same meaning as defined in Section 791.02 of the Insurance Code.

(d) A subpoena issued under this section shall satisfy all of the following conditions:

(1) It shall incorporate the terms used in the foreign subpoena.

(2) It shall contain or be accompanied by the names, addresses, and telephone numbers of all counsel of record in the proceeding to which the subpoena relates and of any party not represented by counsel.

(3) It shall bear the caption and case number of the out-of-state case to which it relates.

(4) It shall state the name of the superior court of the county in which the discovery is to be conducted.

(5) It shall be on a form prescribed by the Judicial Council pursuant to Section 2029.390.

**SEC. 5.**

Section 11165 of the Health and Safety Code is amended to read:

(a) To assist health care practitioners in their efforts to ensure appropriate prescribing, ordering, administering, furnishing, and dispensing of controlled substances, law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II, Schedule III, Schedule IV, and Schedule V controlled substances, and for statistical analysis, education, and research, the Department of Justice shall, contingent upon the availability of adequate funds in the CURES Fund, maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of, and internet access to information regarding, the prescribing and dispensing of Schedule II, Schedule III, Schedule IV, and Schedule V controlled substances by all practitioners authorized to prescribe, order, administer, furnish, or dispense these controlled substances.

(b) The department may seek and use grant funds to pay the costs incurred by the operation and maintenance of CURES. The department shall annually report to the Legislature and make available to the public the amount and source of funds it receives for support of CURES.

(c) (1) The operation of CURES shall comply with all applicable federal and state privacy and security laws and regulations.

(2) (A) CURES shall operate under existing provisions of law to safeguard the privacy and confidentiality of patients. Data obtained from CURES shall only be provided to appropriate state, local, and federal public agencies for disciplinary, civil, or criminal purposes and to other agencies or entities, as determined by the department, for the purpose of educating practitioners and others in lieu of disciplinary, civil, or criminal actions. Data may be provided to public or private entities, as approved by the department, for educational, peer review, statistical, or research purposes, if patient information, including information that may identify the patient, is not compromised. The University of California shall be provided access to identifiable data for research purposes if the requirements of subdivision (t) of Section 1798.24 of the Civil Code are satisfied. Further, data disclosed to an individual or agency as described in this

subdivision shall not be disclosed, sold, or transferred to a third party, unless authorized by, or pursuant to, state and federal privacy and security laws and regulations. The department shall establish policies, procedures, and regulations regarding the use, access, evaluation, management, implementation, operation, storage, disclosure, and security of the information within CURES, consistent with this subdivision.

(B) Notwithstanding subparagraph (A), a regulatory board whose licensees do not prescribe, order, administer, furnish, or dispense controlled substances shall not be provided data obtained from CURES.

*(C) (i) Notwithstanding subparagraph (A) or any other law, a state or local agency or employee, appointee, officer, contractor, or official or any other person acting on behalf of a public agency shall not knowingly provide any CURES data or knowingly expend or use time, money, facilities, property, equipment, personnel, or other resources in furtherance of any interstate investigation or proceeding seeking to impose civil, criminal, or disciplinary liability based on another state's laws for the provision or receipt of legally protected health care activity, as defined in Section 1798.300 of the Civil Code.*

*(ii) This section does not prohibit the investigation of any activity that is punishable as a crime under the laws of this state so long as CURES data related to any legally protected health care activity, as defined in Section 1798.300 of the Civil Code, is not knowingly shared with any individual or entity from another state.*

*(iii) This section does not prohibit compliance with an audit or investigation of activity that is unlawful under the laws of this state or federal law, or with an audit, review, or investigation conducted for purposes of licensure, registration, accreditation, or certification under the laws of this state or federal law or pursuant to an accrediting organization recognized by the State Department of Public Health or the federal Centers for Medicare and Medicaid Services.*

(3) The department ~~shall, no later than January 1, 2021,~~ *may* adopt regulations regarding the access and use of the information within CURES. The department shall consult with all stakeholders identified by the department during the rulemaking process. The regulations shall, at a minimum, address all of the following in a manner consistent with this chapter:

(A) The process for approving, denying, and disapproving individuals or entities seeking access to information in CURES.

(B) The purposes for which a health care practitioner may access information in CURES.

(C) The conditions under which a warrant, subpoena, or court order is required for a law enforcement agency to obtain information from CURES as part of a criminal investigation.

(D) The process by which information in CURES may be provided for educational, peer review, statistical, or research purposes.

(4) In accordance with federal and state privacy laws and regulations, a health care practitioner may provide a patient with a copy of the patient's CURES patient activity report as long as no additional CURES data are provided and the health care practitioner keeps a copy of the report in the patient's medical record in compliance with subdivision (d) of Section 11165.1.

(d) For each prescription for a Schedule II, Schedule III, Schedule IV, or Schedule V controlled substance, as defined in the controlled substances schedules in federal law and regulations, specifically Sections 1308.12, 1308.13, 1308.14, and 1308.15, respectively, of Title 21 of the Code of Federal Regulations, the dispensing pharmacy, clinic, or other dispenser shall report the following information to the department or contracted prescription data processing vendor as soon as reasonably possible, but not more than one working day after the date a controlled substance is released to the patient or patient's representative, in a format specified by the department:

(1) Full name, address, and, if available, telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender and date of birth of the ultimate user.

(2) The prescriber's category of licensure, license number, national provider identifier (NPI) number, if applicable, the federal controlled substance registration number, and the state medical license number of a prescriber using the federal controlled substance registration number of a government-exempt facility.

(3) Pharmacy prescription number, license number, NPI number, and federal controlled substance registration number.

(4) National Drug Code (NDC) number of the controlled substance dispensed.

(5) Quantity of the controlled substance dispensed.

(6) The International Statistical Classification of Diseases (ICD) Code contained in the most current ICD revision, or any revision deemed sufficient by the State Board of Pharmacy, if available.

(7) Number of refills ordered.

(8) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

(9) Prescribing date of the prescription.

(10) Date of dispensing of the prescription.

(11) The serial number for the corresponding prescription form, if applicable.

(e) The department may invite stakeholders to assist, advise, and make recommendations on the establishment of rules and regulations necessary to ensure the proper administration and enforcement of the CURES database. A prescriber or dispenser invitee shall be licensed by one of the boards or committees identified in

subdivision (d) of Section 208 of the Business and Professions Code, in active practice in California, and a regular user of CURES.

(f) The department shall, prior to upgrading CURES, consult with prescribers licensed by one of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, one or more of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, and any other stakeholder identified by the department, for the purpose of identifying desirable capabilities and upgrades to the CURES Prescription Drug Monitoring Program (PDMP).

(g) The department may establish a process to educate authorized subscribers of the CURES PDMP on how to access and use the CURES PDMP.

(h) (1) The department may enter into an agreement with an entity operating an interstate data sharing hub, or an agency operating a prescription drug monitoring program in another state, for purposes of interstate data sharing of prescription drug monitoring program information. *An out-of-state authorized user who obtains CURES data through the interstate data sharing hub shall not provide any CURES data in furtherance of any investigation or proceeding seeking to impose civil, criminal, or disciplinary liability based on another state's laws for the provision or receipt of legally protected health care activity, as defined in Section 1798.300 of the Civil Code.*

(2) Data obtained from CURES may be provided to authorized users of another state's prescription drug monitoring program, as determined by the department pursuant to subdivision (c), if the entity operating the interstate data sharing hub, and the prescription drug monitoring program of that state, as applicable, have entered into an agreement with the department for interstate data sharing of prescription drug monitoring program information.

(3) An agreement entered into by the department for purposes of interstate data sharing of prescription drug monitoring program information shall ensure that all access to data obtained from CURES and the handling of data contained within CURES comply with California law, including regulations, and meet the same patient privacy, audit, and data security standards employed and required for direct access to CURES.

(4) For purposes of interstate data sharing of CURES information pursuant to this subdivision, an authorized user of another state's prescription drug monitoring program shall not be required to register with CURES, if the authorized user is registered and in good standing with that state's prescription drug monitoring program.

(5) The department shall not enter into an agreement pursuant to this subdivision until the department has issued final regulations regarding the access and use of the information within CURES as required by paragraph (3) of subdivision (c).

*(6) Notwithstanding subdivision (c), the department shall not provide CURES data to out-of-state law enforcement absent a warrant, subpoena, or court order, issued pursuant to Section 2029.300 or 2029.350 of the Code of Civil Procedure, or Section 1326 of the Penal Code.*

(i) Notwithstanding subdivision (d), a veterinarian shall report the information required by that subdivision to the department as soon as reasonably possible, but not more than seven days after the date a controlled substance is dispensed.

(j) If the dispensing pharmacy, clinic, or other dispenser experiences a temporary technological or electrical failure, it shall, without undue delay, seek to correct any cause of the temporary technological or electrical failure that is reasonably within its control. The deadline for transmitting prescription information to the department or contracted prescription data processing vendor pursuant to subdivision (d) shall be extended until the failure is corrected. If the dispensing pharmacy, clinic, or other dispenser experiences technological limitations that are not reasonably within its control, or is impacted by a natural or manmade disaster, the deadline for transmitting prescription information to the department or contracted prescription data processing vendor shall be extended until normal operations have resumed.

*(k) (1) Any person who accesses the CURES database and who is not authorized by law to do so is guilty of a misdemeanor.*

*(2) Any person authorized by law to access the CURES database and who knowingly furnishes the information from the CURES database to a person who is not authorized by law to receive that information is guilty of a misdemeanor.*

*(3) This subdivision does not apply to a provider of health care as defined in Section 56.06 of the Civil Code that is subject to applicable state and federal medical privacy laws.*

**SEC. 5.5.**

Section 11165 of the Health and Safety Code is amended to read:

(a) To assist health care practitioners in their efforts to ensure appropriate prescribing, ordering, administering, furnishing, and dispensing of controlled substances, law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II, Schedule III, Schedule IV, and Schedule V controlled substances, and for statistical analysis, education, and research, the Department of Justice shall, contingent upon the availability of adequate funds in the CURES Fund, maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of, and internet access to information regarding, the prescribing and dispensing of Schedule II, Schedule III, Schedule IV, and Schedule V controlled substances by all practitioners authorized to prescribe, order, administer, furnish, or dispense these controlled substances.

(b) The department may seek and use grant funds to pay the costs incurred by the operation and maintenance of CURES. The department shall annually report to the Legislature and make available to the public the amount and source of funds it receives for support of CURES.

(c) (1) The operation of CURES shall comply with all applicable federal and state privacy and security laws and regulations.

(2) (A) CURES shall operate under existing provisions of law to safeguard the privacy and confidentiality of patients. Data obtained from CURES shall only be provided to appropriate state, local, and federal public agencies for disciplinary, civil, or criminal purposes and to other agencies or entities, as determined by the department, for the purpose of educating practitioners and others in lieu of disciplinary, civil, or criminal actions. Data may be provided to public or private entities, as approved by the department, for educational, peer review, statistical, or research purposes, if patient information, including information that may identify the patient, is not compromised. The University of California shall be provided access to identifiable data for research purposes if the requirements of subdivision (t) of Section 1798.24 of the Civil Code are satisfied. Further, data disclosed to an individual or agency as described in this subdivision shall not be disclosed, sold, or transferred to a third party, unless authorized by, or pursuant to, state and federal privacy and security laws and regulations. The department shall establish policies, procedures, and regulations regarding the use, access, evaluation, management, implementation, operation, storage, disclosure, and security of the information within CURES, consistent with this subdivision.

(B) Notwithstanding subparagraph (A), a regulatory board whose licensees do not prescribe, order, administer, furnish, or dispense controlled substances shall not be provided data obtained from CURES.

*(C) (i) Notwithstanding subparagraph (A) or any other law, a state or local agency or employee, appointee, officer, contractor, or official or any other person acting on behalf of a public agency shall not knowingly provide any CURES data or knowingly expend or use time, money, facilities, property, equipment, personnel, or other resources in furtherance of any interstate investigation or proceeding seeking to impose civil, criminal, or disciplinary liability based on another state's laws for the provision or receipt of legally protected health care activity, as defined in Section 1798.300 of the Civil Code.*

*(ii) This section does not prohibit the investigation of any activity that is punishable as a crime under the laws of this state so long as CURES data related to any legally protected health care activity, as defined in Section 1798.300 of the Civil Code, is not knowingly shared with any individual or entity from another state.*

*(iii) This section does not prohibit compliance with an audit or investigation of activity that is unlawful under the laws of this state or federal law, or with an audit, review, or investigation conducted for purposes of licensure, registration, accreditation, or certification under the laws of this state or federal law or pursuant to an accrediting organization recognized by the State Department of Public Health or the federal Centers for Medicare and Medicaid Services.*

(3) The department ~~shall, no later than January 1, 2021,~~ *may* adopt regulations regarding the access and use of the information within CURES. The department shall consult with all stakeholders identified by the department during the rulemaking process. The regulations shall, at a minimum, address all of the following in a manner consistent with this chapter:

(A) The process for approving, denying, and disapproving individuals or entities seeking access to information in CURES.

(B) The purposes for which a health care practitioner may access information in CURES.

(C) The conditions under which a warrant, subpoena, or court order is required for a law enforcement agency to obtain information from CURES as part of a criminal investigation.

(D) The process by which information in CURES may be provided for educational, peer review, statistical, or research purposes.

(4) In accordance with federal and state privacy laws and regulations, a health care practitioner may provide a patient with a copy of the patient's CURES patient activity report as long as no additional CURES data are provided and the health care practitioner keeps a copy of the report in the patient's medical record in compliance with subdivision (d) of Section 11165.1.

(d) ~~For~~ *Except as provided in subdivision (k), for* each prescription for a Schedule II, Schedule III, Schedule IV, or Schedule V controlled substance, as defined in the controlled substances schedules in federal law and regulations, specifically Sections 1308.12, 1308.13, 1308.14, and 1308.15, respectively, of Title 21 of the Code of Federal Regulations, the dispensing pharmacy, clinic, or other dispenser shall report the following information to the department or contracted prescription data processing vendor as soon as reasonably possible, but not more than one working day after the date a controlled substance is released to the patient or patient's representative, in a format specified by the department:

(1) Full name, address, and, if available, telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender and date of birth of the ultimate user.

(2) The prescriber's category of licensure, license number, national provider identifier (NPI) number, if applicable, the federal controlled substance registration number, and the state medical license number of a prescriber using the federal controlled substance registration number of a government-exempt facility.

(3) Pharmacy prescription number, license number, NPI number, and federal controlled substance registration number.

(4) National Drug Code (NDC) number of the controlled substance dispensed.

(5) Quantity of the controlled substance dispensed.

(6) The International Statistical Classification of Diseases (ICD) Code contained in the most current ICD revision, or any revision deemed sufficient by the State Board of Pharmacy, if available.

(7) Number of refills ordered.

(8) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

(9) Prescribing date of the prescription.

(10) Date of dispensing of the prescription.

(11) The serial number for the corresponding prescription form, if applicable.

(e) The department may invite stakeholders to assist, advise, and make recommendations on the establishment of rules and regulations necessary to ensure the proper administration and enforcement of the CURES database. A prescriber or dispenser invitee shall be licensed by one of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, in active practice in California, and a regular user of CURES.

(f) The department shall, prior to upgrading CURES, consult with prescribers licensed by one of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, one or more of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, and any other stakeholder identified by the department, for the purpose of identifying desirable capabilities and upgrades to the CURES Prescription Drug Monitoring Program (PDMP).

(g) The department may establish a process to educate authorized subscribers of the CURES PDMP on how to access and use the CURES PDMP.

(h) (1) The department may enter into an agreement with an entity operating an interstate data sharing hub, or an agency operating a prescription drug monitoring program in another state, for purposes of interstate data sharing of prescription drug monitoring program information. *An out-of-state authorized user who obtains CURES data through the interstate data sharing hub shall not provide any CURES data in furtherance of any investigation or proceeding seeking to impose civil, criminal, or disciplinary liability based on another state's laws for the provision or receipt of legally protected health care activity, as defined in Section 1798.300 of the Civil Code.*

(2) Data obtained from CURES may be provided to authorized users of another state's prescription drug monitoring program, as determined by the department pursuant to subdivision (c), if the entity operating the interstate data sharing hub, and the prescription drug monitoring program of that state, as applicable, have entered into an agreement with the department for interstate data sharing of prescription drug monitoring program information.

(3) An agreement entered into by the department for purposes of interstate data sharing of prescription drug monitoring program information shall ensure that all access to data obtained from CURES and the handling of data contained within CURES comply with California law, including regulations, and meet the same patient privacy, audit, and data security standards employed and required for direct access to CURES.

(4) For purposes of interstate data sharing of CURES information pursuant to this subdivision, an authorized user of another state's prescription drug monitoring program

shall not be required to register with CURES, if the authorized user is registered and in good standing with that state's prescription drug monitoring program.

(5) The department shall not enter into an agreement pursuant to this subdivision until the department has issued final regulations regarding the access and use of the information within CURES as required by paragraph (3) of subdivision (c).

*(6) Notwithstanding subdivision (c), the department shall not provide CURES data to out-of-state law enforcement absent a warrant, subpoena, or court order, issued pursuant to Section 2029.300 or 2029.350 of the Code of Civil Procedure, or Section 1326 of the Penal Code.*

(i) Notwithstanding subdivision (d), a veterinarian shall report the information required by that subdivision to the department as soon as reasonably possible, but not more than seven days after the date a controlled substance is dispensed.

(j) If the dispensing pharmacy, clinic, or other dispenser experiences a temporary technological or electrical failure, it shall, without undue delay, seek to correct any cause of the temporary technological or electrical failure that is reasonably within its control. The deadline for transmitting prescription information to the department or contracted prescription data processing vendor pursuant to subdivision (d) shall be extended until the failure is corrected. If the dispensing pharmacy, clinic, or other dispenser experiences technological limitations that are not reasonably within its control, or is impacted by a natural or manmade disaster, the deadline for transmitting prescription information to the department or contracted prescription data processing vendor shall be extended until normal operations have resumed.

*(k) (1) Notwithstanding subdivision (d), a prescription for or the dispensing of testosterone or mifepristone shall not be reported to the department, CURES, or a contracted prescription data processing vendor.*

*(2) On or before January 1, 2027, the department shall remove existing records of a prescription described in this subdivision created or maintained prior to January 1, 2026.*

*(l) (1) Any person who accesses the CURES database and who is not authorized by law to do so is guilty of a misdemeanor.*

*(2) Any person authorized by law to access the CURES database and who knowingly furnishes the information from the CURES database to a person who is not authorized by law to receive that information is guilty of a misdemeanor.*

*(3) This subdivision does not apply to a provider of health care as defined in Section 56.06 of the Civil Code that is subject to applicable state and federal medical privacy laws.*

**SEC. 6.**

Section 1326 of the Penal Code is amended to read:

(a) The process by which the attendance of a witness before a court or magistrate is required is a subpoena. It may be signed and issued by any of the following:

(1) A magistrate before whom a complaint is laid or their clerk, the district attorney or their investigator, or the public defender or their investigator, for witnesses in the state.

(2) The district attorney, their investigator, or, upon request of the grand jury, any judge of the superior court, for witnesses in the state, in support of an indictment or information, to appear before the court in which it is to be tried.

(3) The district attorney or their investigator, the public defender or their investigator, or the clerk of the court in which a criminal action is to be tried. The clerk shall, at any time, upon application of the defendant, and without charge, issue as many blank subpoenas, subscribed by them, for witnesses in the state, as the defendant may require.

(4) The attorney of record for the defendant.

(b) A subpoena issued in a criminal action that commands the custodian of records or other qualified witness of a business to produce books, papers, documents, or records shall direct that those items be delivered by the custodian or qualified witness in the manner specified in subdivision (b) of Section 1560 of the Evidence Code. Subdivision (e) of Section 1560 of the Evidence Code shall not apply to criminal cases.

(c) (1) Notwithstanding subdivision (b), a provider of health care, health care service plan, or contractor shall not release medical information related to *an individual seeking or obtaining gender-affirming health care or gender-affirming mental health care or* a person or entity allowing a child to receive gender-affirming health care or gender-affirming mental health care in response to any foreign subpoena that is based on a violation of another state's laws authorizing a criminal action *that interferes with an individual's rights to seek or obtain gender-affirming health care or gender-affirming mental health care or* against a person or entity that allows a child to receive gender-affirming health care or gender-affirming mental health care.

(2) For the purpose of this subdivision, "gender-affirming health care" and "gender-affirming mental health care" shall have the same ~~meaning~~ *meanings* as provided in Section 16010.2 of the Welfare and Institutions Code.

*(d) Notwithstanding subdivision (b), a provider of health care, health care service plan, or contractor shall not release medical information related to sensitive services in response to any foreign subpoena that is based on a violation of another state's laws authorizing a criminal action against a person or entity for the provision or receipt of legally protected health care activity, as defined in Section 1798.300 of the Civil Code. For purposes of this subdivision, "sensitive services" has the same meaning as defined in Section 791.02 of the Insurance Code.*

~~(d)~~ *(e)* In a criminal action, no party, or attorney or representative of a party, may issue a subpoena commanding the custodian of records or other qualified witness of a business to provide books, papers, documents, or records, or copies thereof, relating to a person or entity other than the subpoenaed person or entity in any manner other than that specified in subdivision (b) of Section 1560 of the Evidence Code. When a defendant has issued a subpoena to a person or entity that is not a party for the production of books, papers, documents, or records, or copies thereof, the court may order an in camera hearing to determine whether or not the defense is entitled to

receive the documents. The court may not order the documents disclosed to the prosecution except as required by Section 1054.3.

~~(e)~~ *(f)* This section shall not be construed to prohibit obtaining books, papers, documents, or records with the consent of the person to whom the books, papers, documents, or records relate.

***SEC. 7.***

*The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.*

***SEC. 8.***

*Section 5.5 of this bill incorporates amendments to Section 11165 of the Health and Safety Code proposed by both this bill and Assembly Bill 82. That section of this bill shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2026, but this bill becomes operative first, (2) each bill amends Section 11165 of the Health and Safety Code, and (3) this bill is enacted after Assembly Bill 82, in which case Section 11165 of the Health and Safety Code, as amended by Section 5 of this bill, shall remain operative only until the operative date of Assembly Bill 82, at which time Section 5.5 of this bill shall become operative.*

***SEC. 9.***

*No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.*

***SEC. 10.***

*This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the California Constitution and shall go into immediate effect. The facts constituting the necessity are:*

*To address the ongoing efforts to decrease legal protections for the transgender community, it is necessary that this act take effect immediately.*

**SB 744 - (C) Amends the Law**

***SECTION 1.***

*Section 144.7 is added to the Business and Professions Code, to read:*

*(a) For purposes of any code or statute, a national or regional accrediting agency recognized by the United States Department of Education as of January 1, 2025, shall retain that recognition until July 1, 2029, provided that the accrediting agency continues to operate in substantially the same manner as it did on January 1, 2025.*

*(b) This section shall remain in effect only until January 1, 2030, and as of that date is repealed.*

**SEC. 2.**

Section 66010 of the Education Code is amended to read:

(a) Public higher education consists of (1) the California Community Colleges, (2) the California State University, and each campus, branch, and function thereof, and (3) each campus, branch, and function of the University of California.

(b) ~~As~~ *(1) Except as provided in paragraph (2), as* used in this part, "independent institutions of higher education" are those nonpublic higher education institutions that grant undergraduate degrees, graduate degrees, or both, and that are formed as nonprofit corporations in this state and are accredited by an agency recognized by the United States Department of Education.

*(2) For purposes of any code or statute, a national or regional accrediting agency recognized by the United States Department of Education as of January 1, 2025, shall retain that recognition until July 1, 2029, provided that the accrediting agency continues to operate in substantially the same manner as it did on January 1, 2025.*

(c) No provision of this part is intended to regulate, subsidize, or intrude upon private education, including, but not limited to, independent educational institutions and religious schools, nor to vary existing state law or state constitutional provisions relating to private education.

*(d) This section shall remain in effect only until January 1, 2030, and as of that date is repealed.*

***SEC. 3.***

*Section 66010 is added to the Education Code, to read:*

*(a) Public higher education consists of (1) the California Community Colleges, (2) the California State University, and each campus, branch, and function thereof, and (3) each campus, branch, and function of the University of California.*

*(b) As used in this part, "independent institutions of higher education" are those nonpublic higher education institutions that grant undergraduate degrees, graduate degrees, or both, and that are formed as nonprofit corporations in this state and are accredited by an agency recognized by the United States Department of Education.*

*(c) No provision of this part is intended to regulate, subsidize, or intrude upon private education, including, but not limited to, independent educational institutions and religious schools, nor to vary existing state law or state constitutional provisions relating to private education.*

*(d) This section shall become operative on January 1, 2030.*