

# **GUIDELINES FOR SPEECH-LANGUAGE PATHOLOGY PRACTICE IN THE PHILIPPINES DURING THE COVID-19 PANDEMIC**

PHILIPPINE ASSOCIATION OF SPEECH PATHOLOGISTS  
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Prepared by the PASP Hospital and Pediatric Speech-Language Pathology Practice  
Technical Working Groups

Endorsed by the PASP Officers and Board of Trustees

These guidelines were designed to advise clinicians in their assessment and treatment practices of various speech-language pathology cases across age groups with careful consideration of the current infection prevention and control protocols released by the WHO, DOH, IATF, and other related policy-making bodies.

The Philippine Association of Speech Pathologists (PASP) emphasizes that these guidelines should not be interpreted to include all proper treatment decisions or methods of service delivery. It does not state the exclusion of other treatment decisions or methods of service delivery reasonably directed to obtaining the same results.

The PASP does not endorse individual decisions to operate or maintain the closure of therapy centers, nor does it endorse individual clinicians' decisions to offer or abstain from doing in-person sessions. Centers and clinicians are advised to monitor news from WHO, DOH, IATF, DTI, respective local government units, and other related policy-making bodies. It is generally acknowledged that during these times, information about the virus and infection control policies are continuously changing. Running directives from WHO, DOH, IATF, DTI and the centers' respective local government units supersede/overrule these guidelines.

In consideration of the circumstances in this pandemic, the responsible clinician must exercise due diligence in determining the resumption of center services, of in-person clinical work, and in determining the appropriate management for each patient at each situation. Upholding the principles of beneficence and non-maleficence, the clinician is expected to base all decision-making by prioritizing and ensuring the safety of all parties concerned, beginning with his or her own.

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## I. BACKGROUND

The coronavirus disease 2019 (COVID-19) is an infectious disease caused by SARS-CoV-2, a newly-discovered coronavirus which causes anywhere from a mild respiratory illness to severe-to-critical disease. Although most infections were reported to be mild, patients who were older and have underlying comorbidities (e.g., cardiovascular disease, diabetes, hypertension, chronic lung disease, cancer) were found to possess a higher risk of developing severe illness.<sup>1,2</sup>

As of May 13, 2020, a total of 11,618 laboratory-confirmed cases of COVID-19 have already been reported in the Philippines, with 772 (6.6%) deaths and 2,251 (19.4%) recovered cases. Sustained local transmission of the virus has posed a significant burden on the Philippine healthcare system and has already affected at least 2,125 (18%) healthcare workers. At present, the medical frontliners with 35 deaths (0.3%) and 669 (5.8%) recovered.<sup>3</sup>

### Dynamics of transmission

Current data suggest that SARS-CoV-2 is mainly transmitted from person to person via exposure to respiratory droplets or close contact with a person infected with COVID-19.<sup>4</sup> Respiratory droplets produced during coughing, sneezing, or speaking can land in human mouths, noses, or eyes, and can be inhaled by people within close proximity. Transmission may also occur through contact with contaminated surfaces (i.e., fomites) followed by self-delivery by touching one's eyes, nose, or mouth. Airborne transmission is still uncertain, although aerosolized SARS-CoV-2 was found viable for three hours in controlled, experimental settings.<sup>5</sup> Asymptomatic and pre-symptomatic infections were also found to contribute to the transmission of COVID-19 in long-term care facilities in these and other healthcare settings.<sup>6,7</sup>

Interventions to reduce the transmission of COVID-19 include source control (i.e., covering the nose and mouth to contain respiratory secretions with a facemask or cloth face coverings), early detection, contact tracing and isolation of suspected cases, social (physical) distancing, hand hygiene, environmental disinfection, and the use of appropriate personal protective equipment (PPE). Current guidelines recommend the use of masks across people, whether one presented with symptoms or not.<sup>8,9</sup> Considering the global shortage in PPEs, WHO recommends reserving the use of medical masks and respirators for healthcare workers.<sup>10</sup>

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<sup>1</sup>Wu Z, McGoogan JM. (2020). *JAMA*

<sup>2</sup>Zhou F, Yu T, Du R, et al. (2020). *Lancet*; 395: 1054–62.

<sup>3</sup>CNN Philippines (2020). 13 May 2020.

<sup>4</sup>WHO (2020). Modes of transmission of virus causing COVID-19. Scientific brief, 29 March 2020.

<sup>5</sup>van Doremalen et al. (2020). *N Engl J Med*; 382(16):1564-1567.

<sup>6</sup>Chan JF et al. (2020). *Lancet*; 395(10223):514.

<sup>7</sup>CDC (2020). 3 April 2020. 69(13);377–381.

<sup>8</sup>DILG (2020). Memorandum Circular No. 2020-071.

<sup>9</sup>CDC (2020). 3 April 2020.

<sup>10</sup>WHO (2020). Advice on the use of face masks: interim guidance. 6 April 2020

## COVID-19 Case Definitions

The Department of Health (DOH) currently uses the following case definitions to classify patients into Suspect, Probable, or Confirmed COVID-19 cases:<sup>11</sup>

Classification	Case Definition (DOH, 09 April 2020)
Suspect	<p>a. All <b>SARI* cases</b> where NO other etiology fully explains the clinical presentation;</p> <p>b. ILI** cases with any of the following:</p> <ul style="list-style-type: none"> <li>● no other etiology that fully explains the clinical presentation AND a <b>history of travel</b> to or residence in an area that reported local transmission of COVID-19 during the 14 days prior to symptom onset</li> <li>● with <b>contact with a probable or confirmed COVID-19 case</b> in the two days prior to onset of illness of the probable/confirmed COVID-19 case until the time the probable/confirmed COVID-19 case became negative on repeat testing</li> </ul> <p>c. Individuals with <b>fever, cough, shortness of breath</b>, or other <b>respiratory signs or symptoms</b> fulfilling any one of the following conditions:</p> <ul style="list-style-type: none"> <li>● Age 60 years and above</li> <li>● With a comorbidity</li> <li>● Assessed as having a high-risk pregnancy</li> <li>● Health worker</li> </ul>
Probable	<p>a. Suspect case whom testing for COVID-19 is inconclusive; OR</p> <p>b. Suspect case who tested positive for COVID-19 but whose test was not conducted in a national or subnational reference laboratory or officially accredited laboratory for COVID-19 confirmatory testing</p>
Confirmed	Any individual, irrespective of presence or absence of clinical signs and symptoms, who was laboratory confirmed for COVID-19 in a test conducted at the national reference laboratory, a subnational reference laboratory, and/or DOH-certified laboratory testing facility
<p><b>* SARI (Severe Acute Respiratory Infection)</b> - acute respiratory illness with onset during the previous 7 days requiring overnight hospitalization. A SARI case should meet the ILI case definition AND any one of the following: (a) shortness of breath or difficulty of breathing, (b) severe pneumonia of unknown etiology, acute respiratory distress, or severe respiratory disease possibly due to novel respiratory pathogens (such as COVID-19)</p> <p><b>** ILI (Influenza-like Illness)</b> - sudden onset (within 3 days of presentation) of fever of <math>\geq 38^{\circ}\text{C}</math> (fever must be measured at the time of presentation), AND cough or sore throat in the absence of other diagnoses</p>	

<sup>11</sup>DOH (2020). Administrative Order No. 2020-0013. 09 April 2020.

## **II. PURPOSE AND SCOPE OF THE GUIDELINES**

### **A. Purpose**

These documents aim to provide guidance on how to:

1. Ensure the safety of speech-language pathologists working in centers situated within hospitals, school-based therapy centers, pediatric therapy centers / private clinics when performing their clinical duties.
2. Ensure the safety of clients/patients during in-person assessment and treatment sessions.
3. Modify assessment and treatment services for the duration of the COVID-19 pandemic and upon relaxation and lifting of the community quarantine measures.

### **B. How the Guidelines were made**

In creating Philippine-based speech-language pathology (SLP) service delivery guidelines, a collective team of Filipino speech-language pathologists actively practicing in hospital-based settings, school-based therapy centers, pediatric therapy centers / private centers and institutions examined, reviewed, and adapted international and local research, models, and guidelines regarding SARS-CoV-2 (COVID-19). These include service delivery guidelines on pandemic prevention and management set internationally by the World Health Organization (WHO), guidelines set locally by the Department of Health (DOH), Department of Trade and Industry (DTI) as well as various models and guidelines from the international community of speech-language pathologists.

To provide data representative of the needs and perceptions of Filipino speech-language pathologists on the creation of safe workspaces during the COVID-19 pandemic, an online survey was conducted among PASP members who worked with the pediatric population from May 4 to 6, 2020. Pediatric SLPs make up majority of the Association's membership body.<sup>12</sup> The survey results from 182 respondents were used to create specific guidelines for pediatric private / school-based centers.

### **C. Age groups**

Speech-language pathologists (SLPs) provide assessment procedures and interventions for clients/patients with speech, language, cognitive-communication, voice and swallowing disorders. Services of SLPs are available in hospitals, in-patient /

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<sup>12</sup> Concepcion, J.R.M. et al. (2010)

out-patient rehabilitation, acute care units, schools, and pediatric therapy centers as well as long-term care units.

SLPs meet with pediatric, adult, and geriatric clients/patients with the following conditions:

1. Children aged 0 to 18 years with speech, language, cognitive-communication, voice and swallowing disorders secondary to neurologic conditions, craniofacial abnormalities, other birth defects and developmental disorders.
2. Adults aged over 18 years and geriatric clients/patients with speech, language, cognitive-communication, voice and swallowing disorders secondary to neurologic conditions, craniofacial abnormalities secondary to stroke, head injury, neurological disorders, cancer, pulmonary diseases, etc.

#### D. Types of SLP Cases Who Were Infected with COVID-19

Respiratory compromise refers to the decline in the function of the respiratory system that presents a heightened risk for life-threatening respiratory failure.<sup>13</sup> It spans an array of respiratory dysfunction from chronic respiratory insufficiency<sup>14,15</sup> to severe degradation that requires immediate resuscitation via mechanical ventilation.<sup>16</sup> While non-invasive approaches such as appropriate and timely antibiotic therapy for patients with moderate to severe community-acquired pneumonia are used,<sup>17</sup> invasive procedures such as intubation in its various forms are used in order to stabilize the patient's condition. The consequences of intubation—particularly prolonged intubation—are many and varied, as well as the neurological deficits that occur alongside with or as a result of respiratory compromise.

The following conditions cite the general conditions that fall under the purview of the speech-language pathologist.

1. **Post Extubation Dysphagia:** the inability to effectively transfer food from the mouth into the stomach brought about by endotracheal intubation. Of the 517,000 patients that are weaned off mechanical ventilation per year in the US, the prevalence of post-extubation dysphagia ranges between the wide range of 3% to 93%, with aspiration and aspiration pneumonia as foremost medical concerns of patients seeking to return to oral feeding.<sup>18</sup> The condition is said to be independently associated with protracted hospital

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<sup>13</sup>Morris et al. (2017). *Respiratory care*, 62(4), 497-512.

<sup>14</sup>Broniatowski et al. (2010). *Laryngoscope*, 120(1):76-83.

<sup>15</sup>Bloom & Wilson. *Respirology*, 14(6):906- 907.

<sup>16</sup>Andersen et al. (2016). *Resuscitation*, 105:123-129.

<sup>17</sup>Lee et al. (2016). *JAMA*, 315(6):593-602.

<sup>18</sup>Brodsky et al. (2020). *Am J Phys Med Rehab*

stays following extubation and is related to hospital-acquired pneumonia, reintubation and mortality.<sup>19</sup>

2. **Post Extubation Voice Disorders:** changes in the ability to produce voice following endotracheal intubation, typically due to resulting vocal fold paresis or paralysis.<sup>20</sup> Tracheal intubation is often associated with a number of complications (tissue injury in the path of intubation, arytenoid dislocation, hematomas and avulsion of the vocal folds, etc.<sup>21</sup> Proposed risk factors are >50 years of age, prolonged intubation, co-existing conditions (diabetes, hypertension), smokers, and gastro-esophageal reflux disease.<sup>22</sup> Protracted ICU stays typically result in longer intubation, hence a higher prevalence for laryngeal injuries such as vocal fold paralysis, erythema, edema, ulcerations, intubation granulomas<sup>23</sup> that result to dysphonia,<sup>24,25</sup> particularly loss of voice, hoarseness, frequent throat clearing, sore throat, and vocal fatigue.<sup>26</sup>
3. **Speech and Voice Disorders secondary to Respiratory Compromise:** the resulting neurologic deficits may stem from damage to one or several parts of the nervous system such as the cerebral cortex, brainstem, basal ganglia, spinal cord, anterior horn cell, peripheral nerve, neuromuscular junction, and the myopathies,<sup>27</sup> which in turn may result in dysarthria.<sup>28</sup> Altered respiratory, phonatory, articulatory, resonance, and prosodic systems produce speech disorders as well as other physical changes (e.g. change in tone, strength, rate and speed, volitionality of movement, etc.) impair the production of voice and the shaping of voice into speech sounds necessary for effective communication.<sup>29</sup> Oral motor planning deficits may arise from these neurological deficits, leading to impaired movements necessary for producing speech with intact phonetic and prosodic components.<sup>30</sup> Several aspects of these altered systems likewise contribute to feeding and swallowing impairments.
4. **Language and Cognitive-Communication Disorders secondary to Hypoxemic Respiratory Failure:** along with the neurologic deficits described in Item D-3, the consequences of respiratory compromise give way to an array of neurocognitive impairments,<sup>31</sup> posing as significant barriers to the patient's

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<sup>19</sup>Macht et al. (2011). *Critical Care*, 15:R231.

<sup>20</sup>Ellis & Pallister. (1975). *J Laryngol Otol*, 89:823–6.

<sup>21</sup>Dorsch JA, Dorsch SE, editors. 5th ed. pp. 581–90.

<sup>22</sup>Kikura et al. (2007). *Br J Anaesth*, 98:524–30.

<sup>23</sup>Brodsky et al. (2018). *Critical Care Medicine*, 1

<sup>24</sup>Brandwein et al. (1986). *Arch Otolaryngol Head Neck Surg*, 112:877–882

<sup>25</sup>Massard G et al. (1996). *Ann Thorac Surg*, 61:1483–1487

<sup>26</sup>Brodsky et al. (2018). *Critical Care Medicine*, 1.

<sup>27</sup>Mangera et al. (2012). *Int J Gen Med*, 5, 255

<sup>28</sup>American Speech-Language-Hearing Association. (n.d.). *Dysarthria in Adults*. (Practice Portal)

<sup>29</sup>*Ibid.*

<sup>30</sup>Duffy (2013). Motor speech disorders: Substrates, differential diagnosis, and management.

<sup>31</sup>Al-Saidi et al. (2003). *Am J Respir Crit Care Med*; 167:A737



efficient use of language in understanding, processing and expressing the self in various daily communication contexts.

The above conditions are not exhaustive and may present as co-occurring conditions across clients/patients and may manifest at any age as a consequence of COVID-19. This paper recognizes that other conditions may present from various combinations of neurological, structural or functional deficits or as a result from the virus' mutations.

## **E. Epidemiology of COVID-19 in Children**

### **Pediatric Multisystem Inflammatory Syndrome - TS**

Recent reports have described clusters of children and adolescents presenting with what is now identified as Pediatric Multisystem Inflammatory Syndrome<sup>32</sup>. This new syndrome appears to be exceptionally rare with a yet undetermined etiology according to the World Health Organization (WHO)<sup>33</sup>. It remains uncertain if the syndrome is directly associated with the virus that causes COVID-19 or the result of the immune response to it. Further, current researches have not fully explored and established a direct link between the virus (SARS-CoV-2) and another medical condition, the Kawasaki disease.

Some of the PMIS' features are similar to those of Kawasaki disease and toxic shock syndrome. PMIS' symptomatology includes fever, bloodshot eyes, red lips, red tongue, skin rashes, swelling and redness of the hands and feet as well as swelling of the lymph nodes and neck. Other signs in children are inflammation, hypotension and shock, prolonged abdominal pain, increased heart rate<sup>34</sup>, body aches, sneezing, sore throat, cough. In severe cases, children show signs of pneumonia, with frequent fever, productive cough and wheeze but without the shortness of breath and difficulty in breathing.<sup>35</sup>

PMIS, although not usually life threatening, is serious enough to require hospitalization. Patients have reportedly responded to standard treatment for inflammation, including steroids and immunoglobulins.<sup>34</sup> One possible explanation for the positive clinical outcome is that the immune system of children is primed to fight new pathogens in various ways compared to adults. Children, especially those in nursery or early education level, are exposed to a high number of novel respiratory infections which provide them with more antibodies against viruses than adults. There is a possibility that the children's immune systems are able to localize the virus to the upper airways without further damage - eventually leading to the elimination of the virus.<sup>35</sup>

### **COVID 19 in Children**

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<sup>32</sup> The Lancet. (2020) Kawasaki-like disease: emerging complication during the COVID-19 pandemic.

<sup>33</sup> World Health Organization. (2020). Multisystem inflammatory syndrome in children and adolescents temporally related to COVID-19.

<sup>34</sup> Euronews. (2020). Coronavirus: What is Kawasaki disease and its possible link with COVID-19 in children?

<sup>35</sup> BBC News. (2020). Why children are not immune to Covid-19.

Available data on COVID – 19 affecting children show low mortality rate compared to adults. Confirmed cases of children affected are reportedly just 1-2% of all cases of coronavirus infection. Cases affecting children younger than 18 years are as follows: 1.7% (USA),1.1% (Netherlands), 2% (UK).<sup>32</sup> In the Philippines, the Department of Health reported the following as of May 20,2020<sup>36</sup>:

Age	Gender	Confirmed	Recoveries	Death
0-4 years old	M	0.8%	0.3%	0.6%
	F	0.5 %	0.2%	0.2%
5-9 years old	M	0.5%	0.2%	0%
	F	0.5 %	0.4%	0.2%
10-14 years old	M	0.8%	0.2%	0.1%
	F	0.7%	0.1%	0.1%
15-19 years old	M	1.2%	0.2%	0.4%
	F	1.2%	0.3%	0.1%

Median age of infected children worldwide is 6.7<sup>37</sup> years and 7<sup>38</sup> years (interquartile range: 2–13) with ages ranging from 1 day to 18 years. These findings suggest that all ages of childhood are susceptible to 2019-nCoV.

Current data in Asia, particularly in China, report only 1 death (0.6 %). Local data likewise shows 1 mortality in Cebu City according to the Department of Health in Central Visayas (DOH – 7).<sup>39</sup>

Majority of children who suffered from COVID - 19 (83%) had pre-existing illness that required feeding tubes or tracheostomies. Comorbidities such as chronic lung disease (including asthma), cardiovascular disease, congenital heart disease, cerebral palsy, immunosuppression (e.g. cancer)<sup>40</sup>,hydronephrosis (enlarged kidney due to retention of urine), leukemia (including receipt of chemotherapy), and intussusception (intestinal blockage)<sup>37</sup> were likewise noted.

Proper and immediate measures should be undertaken according to UNICEF. If the child is presenting symptoms, then parents should seek medical care immediately

<sup>36</sup> DOH. (2020). COVID-19 Mobile Tracker

<sup>37</sup> Center for Infectious Disease Research Policy, University of Minnesota. (2020). Children's COVID-19 risks unique, Chinese studies find.

<sup>38</sup> American Academy of Pediatrics. (2020). Epidemiology of COVID-19 Among Children in China.

<sup>39</sup> Cebu Daily News. (2020). 1-year-old is Cebu's youngest COVID-19 fatality.

<sup>40</sup> NBC News. (2020). Which kids get sickest from COVID-19? The 'medically complex,' study finds.

and follow prescribed instructions. Children with respiratory infections such as flu should avoid going to public places to avoid transmission and should be kept well-rested at home. As with other settings and age groups, following infection prevention protocols is strongly advised.<sup>41</sup>

## F. Effectivity

These guidelines and recommendations were made based on their best current available evidence and the prevailing global and local situation at the time these were formulated. Given that this time of the COVID-19 pandemic is fluid and ever-changing, readers and stakeholders are reminded to note the date and version of this document as information and situations may have changed. These guidelines will be reviewed and updated as new information is made available. Until such time that the WHO declares the pandemic has ended, these guidelines will continue to serve its intended purpose.

## III. DEFINITION OF TERMS

### A. CLIENTS/PATIENTS

1. **High-risk** clients/patients include those with (a) acute respiratory illness (e.g., pneumonia), (b) suspected/probable/confirmed COVID-19.
2. **Low-risk** clients/patients include the (a) asymptomatic, (b) non-COVID, or (c) recovered suspect/probable/confirmed COVID patients (more than 37 days from symptom onset<sup>42</sup>).

### B. EXPOSURE

1. **HIGH** exposure risk is if:
  - a. infection prevention and control measures were **NOT followed 100%** of the time during health care interactions, which includes:
    - i. not wearing the appropriate personal protective equipment (PPE)
    - ii. improper removal and disposal of PPE according to protocol
    - iii. not performing '5 Moments of Hand Hygiene'
    - iv. contact with contaminated high-touch surfaces
  - b. there is any **accidental exposure to body fluid/respiratory secretions/direct contact** from a suspected or confirmed COVID-19 patient, which includes:

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<sup>41</sup> UNICEF. (2020). Coronavirus disease (COVID-19): What parents should know.

<sup>42</sup> He X, Lau EHY, Wu P, et al. (2020) *Nat Med*

- i. splash of biological fluid/respiratory secretions in the mucous membrane of eyes, mouth/nose, or non-intact skin, or
- ii. puncture/sharp accident with any material contaminated with biological fluid/respiratory secretions
- iii. direct contact with infected people
- iv. indirect contact with surfaces in the immediate environment or with objects used on the infected person.

2. **LOW** exposure risk is if:

- a. infection prevention and control measures were followed 100% of the time during health care interactions.
- b. there is NO accidental exposure to body fluid/respiratory secretions/direct contact/indirect contact from a suspected, probable or confirmed COVID-19 patient.

### **C. HOSPITAL-BASED SETTING**

These refer to acute and long term care facilities as well as specialty centers located within hospital grounds that provide SLP services for prevention, habilitation and rehabilitation of patients with communication needs. Most centers based in hospitals provide in-patient/bedside and out-patients evaluation services and intervention services via this facility. Other specialty centers, while these exist within hospital premises, render services to out-patients alone. The SLPs collaborate with the medical team to provide a holistic approach and quality care for the patient.

### **D. PRIVATE THERAPY CENTERS**

These refer to stand-alone or independent centers or clinics that cater to clients in need of early intervention programs, school-related language support, out-patient rehabilitation. Pediatric/adolescent clients are usually seen in these clinics. SLPs working in private practice collaborate with the educational and medical professionals in their community to achieve the client's optimal development.

### **E. SCHOOL-BASED CENTERS**

The service delivery of SLP, in these settings, is focused on collaborating with schools for the integration of the clients' speech-language-related problems to meet performance standards in their class. A wide range of students in special class, pre-elementary, mainstreaming, elementary and secondary schools are provided with prevention, assessment, intervention<sup>43</sup> and individualized education programs that are integrated in their curriculum.

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<sup>43</sup>ASHA. (2010). Roles and responsibilities of speech-language pathologists in schools.

## **F. HOME VISIT**

Also termed as home care or home health, home visit refers to a mode speech-language pathology service delivery which allows for one-on-one interaction in an environment where the patient/client is most comfortable, which is typically the patient's/client's living space. In the context of pandemic, healthcare providers like speech-language pathologists are expected to take extra precautions to mitigate the risks of transmission and keep the patients as safe as possible.

## **G. TELEPRACTICE**

This pertains to the utilization of telecommunications technology to the delivery of speech-language pathology and audiology professional services at a distance by linking clinician to client or clinician to clinician for assessment, intervention, and/or consultation. This is another viable option for service delivery in the context of the pandemic. Risks for both the service providers, the clients/patients and their families are greatly reduced while ensuring the continuity and quality of services.

## **IV. ETHICAL CONSIDERATIONS**

Given the impact that COVID-19 has on the manner and safety of delivering healthcare services, decisions regarding patient care are to be made basing on the SLP's clinical expertise, professional judgment, in accordance to the PASP's Code of Ethics<sup>44</sup> and Standards of Practice,<sup>45</sup> and in line with the guidelines from DOH and WHO.

With particular reference to the Code of Ethics, the following key values are to be considered:

- A. **Professional Duty:** Where, as stated, the "SLP's commitment is first and foremost to his/her service recipients but that his/her commitment also extends beyond to include the public in general, his/her professional colleagues, and the speech-language pathology profession as a whole." (Preamble, Code of Ethics, Philippine Association of Speech Pathologists). This is further elaborated in Principle I: Duty to Clients of the same document, where beneficence / non-maleficence—even clinician autonomy and patient autonomy where both are exercised to allay risk—are paramount in patient care:
  1. SLPs shall hold paramount the well-being of those they serve professionally or participants in their research or other scholarly activities.

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<sup>44</sup>PASP (2019). Code of Ethics

<sup>45</sup>PASP (2019). Standards of practice for speech-language pathologists in the Philippines.

2. SLPs shall provide professional services competently.
  3. SLPs shall not discriminate in the delivery of professional services on the basis of age, gender, race, socio-economic status, sexual preference, disability, religion, beliefs, and others.
  4. SLPs shall refer or consult with other SLPs if doing so shall prove to be for the best interest of the client/patient. The referral or consultation process, however, shall be done with the expressed knowledge and consent of the client/patient.
  5. SLPs shall respect the right of the clients/patients to choose whether and from whom they wish to obtain professional services for their problems,
    - a. particularly in light of the present crisis when clients/patients may opt to seek services at facilities and with clinicians located outside of the center/hospital, or via alternative means that do not involve in-person meetings.
    - b. In such cases, the SLP is to perform the necessary referrals and endorsements as stated in the PASP Standards of Practice, Item A-4 and Item D-5.
    - c. the necessary documentation must be completed regarding the patient's/family's request to be referred out.
  6. SLPs shall respect an individual's right to refuse certain therapeutic procedures or involvement in any research or educational activities,
    - a. particularly in light of the present crisis when clients/patients may regard a procedure as an infection risk even if the medical team has counseled the patient and family of its necessity.
    - b. the necessary documentation must be completed regarding the patient's/family's deferral.
- B. Prudence:** The desire to serve one's patients/clients must not result in the reckless delivery of care nor exposure to infection. Placing one's self at serious risk of infection is not in line with the goals of public health practice in a pandemic. Not only will the SLP's own welfare be compromised: it will likewise impact one's ability to provide care for others and can place other clients/patients, colleagues, and one's own family and immediate community at risk of contamination. Such risk factors may likewise increase the likelihood of morbidity or mortality, hence the *SLP is under no ethical obligation to accept unreasonable risks in discharging their duty of care nor be required to perform and/or in aerosol-generating procedures to:*
1. confirmed COVID-19 clients/patients particularly in instances when there are inadequate supplies of personal protective equipment (PPE).

2. suspected and probable COVID clients/patients as well as asymptomatic clients/patients in instances when the minimum requirements for infection prevention and control (IPC) are lacking or unavailable.

Such considerations however shall depend on the client's/patient's needs, the scale of exposure to the SLP, if there are alternative treatments that do not involve the same level of exposure, or if there is a possibility of delaying a particular treatment or procedure until such time when PPE and/or minimum IPC requirements are available.

- C. **Solidarity:** responding to one's call to duty and exercising one's professional roles in a time of a national crisis stems from the value of solidarity. By understanding how SLP intervention may alleviate the difficulties of those with feeding, swallowing, cognitive-communication, language and speech conditions—whether or not these are due to COVID-19—the aspects inherent to the SLP profession such as compassion and care are enhanced.

Just as the SLP does one's duty to the clients/patients and the institution, similar solidarity is to be given by the institution to the clinician via the following (as adapted from the WHO 2016 Guidance for managing ethical issues in infectious disease outbreaks):<sup>46</sup>

1. Guaranteeing that IPC procedures are met through the provision of PPEs for medically-necessary procedures for confirmed COVID clients/patients, provision of minimal yet protective IPC equipment for suspected and probable COVID clients/patients or asymptomatic clients/patients.
2. Ascertain that the clinician has undergone infection control training and is cleared to see said clients/patients.
3. Ascertain that clinicians undergo regular risk screening.<sup>47</sup>
4. Provide clinicians with regular information updates on the virus and the situation in the local scenario.
5. Provide the hospital SLP's priority access to healthcare—including the clinician's family/domestic companions, including priority access to vaccines.
6. Appropriate remuneration, including financial support for the SLP in times when illness and recuperation bars the clinician from exercising his/her professional duties
7. Provision of basic needs to the clinician's family when the SLP is made to abstain from work due to being placed in quarantine. This assistance includes death

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<sup>46</sup>World Health Organization. (2016). Guidance for managing ethical issues in infectious disease outbreaks.

<sup>47</sup>WHO (2020). Risk assessment and management of exposure of health care workers in the context of COVID-19: interim guidance.

benefits due to the SLP's family should the clinician expire.

Employment and other administrative-related concerns may vary across SLPs, and the benefits/compensations due to the clinician are dependent on their employer-employee agreements with their facility/institution. The clinician is encouraged to inquire at their facility's respective offices regarding these matters.

## V. INFECTION PREVENTION AND CONTROL (IPC) RECOMMENDATIONS

Prevention is vital in controlling the spread of the infection. Most data show that complications in children 0-14 years are milder to SARS-CoV-2 infection than adults 15-64 years of age compared to individuals over 65 years old who are more susceptible to COVID-19 infection.<sup>48</sup> It is still highly recommended that children and older adults be monitored especially those with the following underlying conditions: lung disease (including asthma), cardiovascular disease, immunosuppression,<sup>49</sup> severe obesity (body mass index [BMI]≥40), diabetes, chronic kidney disease on dialysis or liver disease as they have a higher risk to have severe illness from this infection. They are advised to be monitored for signs and symptoms at home or at the hospital by clinical providers.<sup>50</sup>

The safety of both the clinicians and clients/patients must be prioritized during the COVID-19 pandemic. Specific infection prevention and control measures must be strictly followed whenever engaging in in-person interactions with clients/patients in order to reduce transmission risk. To facilitate the adherence of SLPs to these IPC recommendations, the following factors must be considered: (a) clear communication of IPC guidelines, (b) gain support from managers, (c) workplace culture, (d) IPC training, (e) physical space, (f) access to appropriate and trust in personal protective equipment, and (g) desire to deliver good patient care.<sup>51</sup>

### A. Infection Prevention and Control (IPC) Training

1. The SLP is to **coordinate with the hospital's local infection control service / unit or refer to the therapy center's infection control procedures** to be familiar with the facility's infection prevention and control (IPC) procedures. This is to ensure that the SLP follows appropriate procedures to reduce risk of infection or transmission to clients / patients and other people.
2. The SLP is to procure an **updated IPC training or certification** *prior to seeing* clients/patients, or **seek IPC training** from his or her center/hospital. If training is not available at the moment, SLPs are strongly encouraged to take free online

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<sup>48</sup>Zhang, J. et. al. (2020) Science. Changes in contact patterns shape the dynamics of the COVID-19 outbreak in China.

<sup>49</sup>US Department of Health & Human Services, Centers for Disease Control and Prevention Mortality & Morbidity Weekly Report (2020).

<sup>50</sup>Centers for Disease Control and Prevention (2020). Information for Pediatric Healthcare Providers. May 3, 2020.

<sup>51</sup>Houghton C et al. (2020). Cochrane Database of Systematic Reviews, Issue 4. Art. No.: CD013582.



courses (e.g., WHO courses: Infection Prevention and Control (IPC) for Novel Coronavirus <https://openwho.org/courses/COVID-19-IPC-EN>) and review relevant guidelines on IPC.<sup>52,53,54,55</sup>

## **B. Assessment and Management of Exposure Risk**

1. SLPs are to check the COVID-19 status of *each* client/patient (whether in-patient or out-patient ) prior to in-person contact.
2. SLPs are to regularly assess their own infection risk when caring for clients / patients with confirmed, probable, or suspected COVID-19 and be aware of the steps to take if exposed.
3. SLPs are to use the WHO risk assessment tool<sup>34</sup> to identify if he/she has been at high risk of exposure to COVID-19. This is also recommended by the DOH.<sup>56</sup>
4. If there is **HIGH** risk of exposure, the SLP must do the following:
  - a. Stop all health care interactions with clients/patients for a period of 14 days after the last day of exposure to a suspected, probable, or confirmed COVID-19 patient
  - b. Be tested for COVID-19 (serologic testing/reverse transcriptase polymerase chain reaction (RT-PCR))
  - c. Quarantine for 14 days in a designated area
  - d. Review infection prevention and control protocols
  - e. Consult the therapy center/hospital regarding psychosocial support and compensation during quarantine or throughout the duration of illness if confirmed to have COVID-19
  - f. Inform clients/patients that he or she will be on quarantine for 14 days
  - g. Endorse clients/patients appropriately to other SLPs in the therapy center/hospital
5. If there is **LOW** risk of exposure, the SLP must do the following

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<sup>52</sup>WHO (2020). Infection prevention and control during health care when COVID-19 is suspected: interim guidance. 19 March 2020

<sup>53</sup>WHO & UNICEF (2020). Water, sanitation, hygiene, and waste management for the COVID-19 virus: interim guidance, 19 March 2020.

<sup>54</sup>WHO (2020). Rational use of personal protective equipment for coronavirus disease (COVID-19): interim guidance. 19 March 2020.

<sup>55</sup>DOH (2020). Department Memorandum 2020-0157, 10 April 2020

<sup>56</sup>DOH. (2020). Department Circular 2020-0106, 06 March 2020.

- a. Self-monitor temperature and respiratory symptoms daily for 14 days after the last day of exposure to a suspected, probable, or COVID-19 patient
  - b. Contact the health care facility if they develop any symptoms suggestive of COVID-19 (e.g., fever  $> 37.6^{\circ}\text{C}$ , shortness of breath, dry cough, fatigue, anosmia, etc.)
  - c. Reinforce the rational, correct, and consistent use of PPE
  - d. Continue practicing appropriate precautions when handling clients/patients:
    - i. Contact and droplet precautions for clients/patients with acute respiratory illness
    - ii. Standard precautions for all other clients/patients
    - iii. Airborne precautions during aerosol-generating procedures on all suspected, probable, or confirmed COVID-19 clients/patients
  - e. Apply the '5 Moments for Hand Hygiene'
  - f. Practice respiratory etiquette at all times
6. The SLP may resume patient handling when:
- a. COVID-19 test indicates negative results
  - b. Completed the 14-day quarantine period without developing symptoms
  - c. Given clearance by the hospital/local health center to return to work

### C. IPC Precautions for Facilities

IPC Precautions for Facilities		
(Hospital- Based/ Private/ School- Based Centers)		
Target group		Activity
SLP/ Personnel	Clients/ Patients and Companions	
<b>PREVENTION</b>		
SLP/ Personnel		Ensure adequate supplies of alcohol (60%), soap, cleaning/disinfecting materials, tissues. Availability and accessibility of disinfecting alcohol sprays (at least 60% alcohol) at the entryway, waiting area and therapy rooms.
SLP/ Personnel	Clients/ Patients/ Parents/ Guardians	Use disinfection foot mats at the doorway.
SLP/ Personnel		Rearrange offices, and waiting areas so that adequate physical distancing(at least one meter) between the clinician, parent and the client/patient must be maintained. Visual cues such as floor markings and markings on seats can serve as a guide in specified areas.
SLP/ Personnel		Rearrange treatment areas such that adequate physical distancing (at least one meter) between the clinician and the client/patient can be maintained.
SLP/ Personnel		Place plastic sheet coverings on bookshelves/shelves with therapy materials and files.
SLP/ Personnel		Place posters, reminders, and informational materials on infection prevention and control around the treatment areas and office. WHO's risk communication package for healthcare facilities may be used for this purpose: ( <a href="https://iris.wpro.who.int/bitstream/handle/10665.1/14482/COVID-19-022020.pdf">https://iris.wpro.who.int/bitstream/handle/10665.1/14482/COVID-19-022020.pdf</a> ) <sup>57</sup>
SLP/ Personnel		Clean and disinfect high-touch/frequently touched surfaces at work at least 3 times a day, or follow the recommended disinfection procedures of the center/hospital in order to reduce the risk of droplet contamination.
<b>PATIENT/CLIENT CARE EQUIPMENT</b>		
SLP/ Personnel		Assessment tools like test booklets/boards need necessary shielding of the pages/boards, and are to be properly disinfected before and after use.
SLP/ Personnel	Clients/ Patients/ Parents/ Guardians	Use client's/patient's dedicated materials (e.g. food, utensils such measuring cups/ spoon, medicine cups, stethoscope, sphygmomanometer). Sharing materials between clients/patients are to be avoided. These materials are to be prepared by the client's/patient's caregiver or family prior to consultation.

<sup>57</sup> WHO (2020). COVID-19 Risk Communication Package. 10 Mar 2020

SLP/ Personnel		Toys, therapy materials, workbook and notebook covers, surfaces of electronic gadgets used for therapy, mirrors, chairs and tables are to be disinfected with alcohol spray before/after each therapy session. Allot specific tools for the sole use of the client/patient (i.e. chair, writing materials).
SLP/ Personnel		Limit number of toys/therapy materials used per client/patient during in-person assessment/treatment to the essentials.
<b>ENVIRONMENTAL CLEANING</b>		
SLP/ Personnel		Ultraviolet (UV) light disinfection (if available) can be done at the end of the day.
SLP/ Personnel		Allot rooms that have adequate space and ventilation for client/patients and/or companions during in-person assessment.
SLP/ Personnel		installing and using HEPA filters and similar air filter systems in air-conditioning are recommended
<b>WASTE MANAGEMENT</b>		
SLP/ Personnel	Clients/ Patients/ Parents/ Guardians	Dispose wastes (e.g. tongue depressor, gloves, cotton) properly, preferably in SEPARATE bins marked YELLOW indicating their use as specifically for infected waste disposal.
SLP/ Personnel		Dispose, disinfect and replace these materials appropriately.

#### **D. HANDLING LOW- and HIGH-RISK PATIENTS IN HOSPITAL-BASED SETTING**

- a. It is recommended that hospital-based clinicians are to see low risk-patients first and high-risk patients last.
- b. If there is more than one SLP, designate specific SLP staff who will be working exclusively with high-risk patients in order to limit potential exposure to other staff.
- c. In centers where there is only one SLP, it is the hospital-based setting's prerogative to decide if only low-risk patients will be seen.

**E. IPC Precautions for Low-Risk Clients / Patients and Staff Across ALL Work Settings**

IPC Precautions for LOW RISK Clients/Patients			
All Settings			
Target group		Activity	Procedure
SLP/Personnel	Clients/Patients and Companions		
<b>HAND HYGIENE</b>			
SLP/Personnel	Clients/Patients/ Parents/ Guardians	<p>Do this during the following moments (“My 5 Moments for Hand Hygiene”):</p> <p><u>BEFORE</u></p> <ol style="list-style-type: none"> <li>1) touching a client/patient / before therapy sessions</li> <li>2) any clean or aseptic procedure is performed</li> </ol> <p><u>AFTER</u></p> <ol style="list-style-type: none"> <li>1) exposure to body fluid (especially saliva and respiratory secretions)</li> <li>2) touching a client /patient / after therapy sessions</li> <li>3) touching a patient’s surroundings and belongings (toys, door handle, etc.)</li> </ol>	Handwashing : 40-60 seconds using soap and running water or using alcohol-based hand rub for 20-30 seconds (containing at least 60% alcohol) with or without gloves.
SLP/Personnel	Clients/Patients/ Parents/ Guardians	Before coming into the treatment area, after coughing or sneezing, and after touching high-touch surfaces (e.g., door knobs, chairs).	
SLP/Personnel	Clients/Patients/ Parents/ Guardians	Avoid touching the eyes, nose and mouth.	
	Clients/Patients/ Parents/ Guardians	It is recommended that clients/patients bring their own disinfection kits.	
<b>RESPIRATORY HYGIENE</b>			
SLP/Personnel	Clients/Patients/ Parents/ Guardians	Cover the nose and mouth with a tissue or elbow when coughing or sneezing.	
<b>PERSONAL PROTECTIVE EQUIPMENT</b>			

SLP/Personnel		Private/ School-based centers	<ol style="list-style-type: none"> <li>1) surgical mask (clear window-type mask)</li> <li>2) eye protection (face shield OR goggles/protective glasses)</li> <li>3) single-use gloves</li> </ol>
SLP/Personnel		Hospital-based centers / Home Visit	<ol style="list-style-type: none"> <li>1) clean, non-sterile, disposable gown</li> <li>2) surgical mask</li> <li>3) eye protection (face shield OR goggles/protective glasses)</li> <li>4) single-use gloves</li> </ol>
SLP/Personnel		Wear, remove, and replace PPE according to hospital/center protocol. PPE protocols may vary between institutions and are subject to the availability of supplies.	The appropriate PPE must be worn by the SLP at all times. Proper donning and doffing procedures are to be checked.
	Clients / Patients (NEWBORN / INFANTS)	The use of any form of facial protective covering (masks, face shields) is NOT recommended as it poses a high risk of suffocation, may restrict breastfeeding, and possibility of strangulation risk when poorly positioned. <sup>58</sup>	
	Clients / Patients (CHILDREN)	<p>Children wearing masks could be beneficial. Children aged 3 years old and above may wear cloth masks / surgical masks / face shields as long as they are comfortable with its presence and/or can tolerate its use. Parents are requested to practice desensitization of children to masks.</p> <p><u>Children are not required to wear masks.</u></p> <p>Situations in which children SHOULD NOT wear a mask include:</p> <ol style="list-style-type: none"> <li>1) Children under the age of 2 years, due to risks of suffocation.</li> <li>2) If the only face covering available is a possible choking or strangulation hazard.</li> <li>3) If the child has difficulty breathing with the face covering or is unconscious, incapacitated or otherwise unable to remove the cover without assistance.</li> <li>4) If wearing the face covering causes</li> </ol>	

<sup>58</sup>PPS & PSNM. (2020). Joint Statement on the use of Face Shield for Newborns during the SARS-COVID-2 Pandemic, 22 April 2020.

		the child to increase risk of getting exposed to the virus because they are touching their face more frequently. <sup>59</sup>	
	OLDER CHILDREN, Clients and Companions	Whenever possible, all clients/patients (who are comfortable wearing masks) and their companions are to wear masks. If surgical masks are unavailable, the use of cloth face coverings/masks are recommended.	
	Adults, Elderly and Companions	All adult clients/patients and their companions are to wear masks. If surgical masks are unavailable, cloth face coverings/ masks are to be used.	
SLP/Personnel		Do NOT wear long sleeves. Remove any hand or arm accessories (jewelry, watch, bracelet, rings), and maintain clean nails (short, no nail polish, no gel nails). Clinicians are recommended to maintain neatly combed, tied-up hair and ensure that hair does not touch the face.	
<b>PREVENTION</b>			
SLP/Personnel		Apply standard, droplet, and contact precautions when seeing clients/patients. Given that asymptomatic and presymptomatic transmissions of COVID-19 are possible, SLPs may benefit from applying droplet and contact precautions since close contact is typically required when handling clients /patients.	
SLP/Personnel	Clients/Patients	Maintain at least 1 meter distance from the client/patient to make visual and perceptual observations.	
SLP/Personnel	Clients/Patients	Sit/stand beside the client/patient rather than across and maintain a safe distance. Utilize a large, wall-mounted mirror if the center/room has such provisions.	
SLP/Personnel		If possible, use augmentative and alternative communication (AAC) approaches for evaluating specific skills to limit contact with virus droplets and possible aerosol (from client's/patient's sneeze, yell, or cough). Visual representations and communication boards may be used.	

<sup>59</sup> AAP. (2020). Masks and Children During COVID-19, 04 April 2020,

SLP/Personnel		Private/school-based centers are to designate personnel/staff or the building's security guard to check the client's/patient's temperature for signs and symptoms upon entry.	Defer acceptance to therapy once signs and symptoms of COVID-19 are observed.
	Parents/ Guardians	Parents are requested to check their child's/guardian's health status prior to their visit to the center. Guardians and caregivers are required to go through the same procedure.	

#### F. IPC Precautions for High-Risk Patients in the Hospital-Based Setting

This section is applicable only to SLPs in hospital-based settings who will be seeing patients identified as **high risk** for infection.

IPC Precautions for HIGH RISK Patients			
Hospital Setting			
Target group		Activity	Procedure
Clinician	Patients and Companions		
PREVENTION			
SLP		Standard, contact, and droplet precautions must be strictly observed when handling these patients, in addition to the other basic infection control measures (e.g., hand hygiene, social distancing, etc.).	
SLP		Airborne precautions must be strictly observed when doing procedures that may result in the production of aerosols (i.e., aerosol-generating procedures or AGPs). AGPs typically result from face-to-face contact or direct physical contact with respiratory, oral, or aerodigestive tract secretions from high-risk patients.	



SLP		<p>Avoid or minimize AGPs as much as possible to reduce potential aerosolization of SARS-CoV-2. Some AGPs that may be relevant for SLPs working in hospitals include the following:</p> <ol style="list-style-type: none"> <li>1) tracheostomy care (e.g., speaking valve trials, etc.)</li> <li>2) laryngectomy care and management (e.g., open stoma inspection, voice prosthesis fitting/replacement)</li> <li>3) suctioning of oral or tracheal secretions</li> <li>4) induction of volitional or reflexive coughing during dysphagia assessments<sup>60</sup> or oral-motor examination</li> <li>5) high-intensity voice production<sup>61</sup></li> <li>6) cardiopulmonary resuscitation (CPR)</li> <li>7) flexible endoscopic evaluation of swallowing (FEES)</li> <li>8) videofluoroscopic swallowing studies (VFSS)</li> <li>9) swallowing rehabilitation or oral-motor exercises that involves cough training</li> <li>10)swallowing or communication assessment for COVID patients on non-invasive ventilation (NIV), high-flow nasal oxygen (HFNO)</li> </ol>	
<b>PERSONAL PROTECTIVE EQUIPMENT</b>			
SLP		<p>Provided by the hospital or clinician</p>	<ol style="list-style-type: none"> <li>(1) clean, non-sterile, disposable gown</li> <li>(2) shoe covers</li> <li>(3) N95 / FFP2 masks or equivalent</li> <li>(4) goggles/ protective glasses</li> <li>(5) face shield</li> <li>(6) single-use gloves</li> </ol>
		<p>Wear, remove, and replace PPE according to hospital protocol.</p>	

## VI. SCREENING

### A. Managing Referrals and Scheduling Sessions

1. Determine the clinical necessity and urgency of the procedure to be undertaken by consulting with the medical team and reviewing the patient’s/client’s records. Give priority to cases that may affect the individual’s respiratory, nutritional and cognitive status (i.e. acute stroke dysphagia, pneumonia).

<sup>60</sup> RCSLT. (2020). Aerosol generating procedures, dysphagia assessment and COVID-19, 22 April 2020.

<sup>61</sup> Anfinrud P, et al. (2020). *N Eng J Med*

2. Determine if the procedure can be safely and effectively done through telepractice.
  - a. Assess the client's/patient's eligibility for participating in telepractice (i.e., appropriate level of attention, technical requirements)
  - b. Establish proper informed consent with the patient/family/caregivers regarding the features of this mode of service delivery as well as its benefits and associated risks
  - c. Conduct consultation, intake, initial interview through alternative platforms (i.e., call, video conference, etc)
  - d. Provide instructions through appropriate, accessible and available platforms (e.g., text messaging, call, etc.)
  - e. Assure patient/family/caregivers that quality of service provided is not compromised regardless of the mode of service delivery (e.g., use of evidence - based practice, complete documentation)
3. Postpone face-to-face consultations for routine and non-urgent appointments (e.g. chronic speech and language disorders) to limit the chances of infection of patients/clients or healthcare workers in the facility. Length of postponement will depend on prevailing institutional regulations.
4. Conduct a screening process for COVID-19 symptoms prior to a scheduled appointment.
  - a. Contact the primary caregivers through text messages or calls and consult with the attending physician and respective medical professionals prior to the consultation.
  - b. Perform symptom screening by phone or text for clients/patients receiving outpatient or home-based services, including their companions, on the day of their scheduled appointment. Refer to the appropriate triaging process when necessary.
    - i. Defer the procedure if the client/patient and/or companion presents COVID-19 symptoms.
    - ii. Advise the client/patient to monitor symptoms for the next two weeks.

- iii. Recommend consultation with a medical professional if symptoms appear to worsen.
  - c. A maximum of one (1) companion is allowed per client/patient during the session.
  - d. Inform all clients/patients and their families/companions regarding early recognition of symptoms and the standard precautions implemented in the hospital/therapy center to ensure healthcare workers' safety.
5. Schedule the client/patient for a consultation once the assessment of the procedures' necessity has been established and an initial screening has been done.
6. When seeing clients/patients in person, provide strategies to alleviate his/her potential anxiety towards certain protocols (e.g., explain the rationale for using PPE and for physical distancing, use visual cues or augmentative-alternative communication).
7. Schedule sessions such that clients/patients with the same risk classification may be seen under the same time window. As much as possible
  - a. for hospital-based centers: whether in- or out-patients, see low-risk patients first and high-risk patients last.
  - b. for private pediatric centers: defer high-risk patients

## **VII. ASSESSMENT CONSIDERATIONS**

Assessments may be carried out in conventional in-person sessions at the therapy center, in-person by way of home care/home visit, or via telepractice which are conducted virtually in the center or at the clinician's residence and delivered to the client in their residence.

Speech-language pathologists are urged to utilize their expertise and clinical judgment in advising, guiding and informing their clients/patients and their families regarding the benefits and risks of each service delivery mode in order to facilitate decision-making given the present circumstances.

### **A. Specific Guidelines for In-Person Assessments At Hospital-Based Centers and Home Care / Home Visit**

#### **1. Swallowing Assessment and Voice Assessment**

- a. General Precautions for Patients Referred for Swallowing and Voice Assessment
- i. For **high risk** patients: Complete assessment while keeping direct patient contact time to a minimum (maximum of 15 minutes)
  - ii. Assessment is to be done at least within 1 m distance, **UNLESS** patient is **high risk** (*see item IV and V below*)
  - iii. **only** assess patients who are/have:
    1. fully awake
    2. conscious
    3. stable respiratory status
    4. optimal oxygen saturation
    5. able to follow instructions
  - iv. The following are the only **URGENT** procedures allowed for clinical assessment:
    1. Risk of complication (e.g. malnutrition, pneumonia, etc.)
    2. Dysphagia of unknown origin with underlying disease requiring treatment (e.g. tumors, bilateral vocal fold paralysis, etc.)
  - v. Perform the following swallowing assessment procedures upon given clearance by, and in close consultation with AMD, and with the appropriate PPE (*Refer to IPC Precautions for High-Risk Patients*):
    1. water swallow test (patient at risk of coughing)
    2. intraoral examination (OPM assessment cough reflex/ voluntary cough testing)
    3. gag reflex testing
    4. cervical auscultation
    5. phonatory tasks for vocal intensity, pitch, quality
    6. perform suctioning procedures
  - vi. Perform assessment procedures upon given clearance by, and in close consultation with AMD, and with the appropriate PPE (*Refer to IPC Precautions for High-Risk Patients*) with clients who manifest difficulties in saliva control or who exhibit distress by yelling/crying.
  - vii. **DO** indirect assessment (i.e., performing assessments without making direct contact with the patient, usually with the help of the nurse or other hospital staff), **NO** direct assessment needed if possible.
  - viii. Use dedicated materials (e.g., food, utensils such measuring cups/ spoon, medicine cups, stethoscope, sphygmomanometer) to avoid

sharing between patients. These are to be prepared by the patient's caregiver or family prior to consultation.

- ix. Instrumental assessments are to be avoided as much as possible as they are associated with an increased risk of aerosol production. However, if an instrumental assessment is deemed absolutely necessary to guide the management of the patient's current swallowing and/or voice difficulties, coordinate closely with the referring physician and other members of the multidisciplinary team.

**b. Droplet Precautions:** Determine if there is an increased risk of droplet emission in the following procedures:

- i. Consider if the procedure to be undertaken is essential to the management of the patient (e.g. oral-peripheral mechanism examination, dysphagia assessment).
- ii. Determine the risks that may be involved in conducting oral trials as part of a swallowing assessment (clinical swallowing examination [CSE], videostroboscopic study or videofluoroscopic swallowing study [VFSS]).

**c. Airborne Precautions**

- i. Avoid any procedures that involve inspecting stoma or managing tracheoesophageal puncture (this includes the use of catheter or voice prosthesis).
- ii. Do not undertake any procedures that also involve inspection or contact with tracheostomy (this includes the pilot balloon (connected to the cuff), tracheal suctioning, inner cannula, above-cuff devices, and/or speaking valves, without the use of appropriate PPE).
- iii. Delay the use of speaking valves and leak speech for clients who are COVID-19 positive, where possible, until over acute infection and the risk of transmission is minimized.

**B. General Assessment Guidelines for Hospital-Based Centers and Private / School-Based Centers**

**1. In-Person Assessment in the Therapy Center**

Speech-language pathologists may provide in-person assessment in the therapy center for clients/patients who:

- a. Need immediate, medically-necessary and urgent assessment as deemed necessary by his/her medical team
- b. Passed the initial client screening for low-risk infection transmission

2. In-Person Assessment through Home Care/Home Visit

- a. Clients/patients can have the option to avail of communication and/or swallowing assessments through home care/home visit (refer to home care/home visit guidelines).
- b. Clients/patients who may be considered for this mode of service delivery include those who:
  - i. have acute respiratory illness that place them at high-risk
  - ii. possess a severe medical condition rendering exposure and movement to other settings as a health risk
  - iii. are infants and are deemed too young, hence, vulnerable to exposure
  - iv. are part of the family's decision to remain at home for their safety and are willing to abide by IPC protocols for home care/home visit

3. Assessment through Telepractice

- a. Clients/patients are to be given the option to avail of and access communication and/or swallowing assessments through telepractice (refer to section on **Telepractice Guidelines**). This form of assessment may be carried out through a combination of avenues such as--but are not limited to--the following:
  - i. videoconferencing
  - ii. telephone interview
  - iii. emailing
  - iv. messaging through text messaging/app messaging
  - v. video recording
  - vi. audio recording
- b. To lessen and--to a certain extent--mitigate infection and spread of the virus, centers are encouraged to explore telepractice assessment as a viable option and carry out most, if not all, of the evaluation procedures online.
- c. Clients/patients who qualify for this kind of assessment include those who:

- i. have the requisite and adequate testing behavior that make online assessment feasible
  - ii. have families who can assist in the evaluation process
  - iii. have access to telecommunication in the convenience of their homes
- d. Innovations regarding mode and methods of assessment for telepractice are encouraged and necessary given the current situation.

#### 4. Combination of Assessments

- a. Cognizant of the different variables that are at play in the therapeutic setting, hospital-based centers and private therapy centers may opt for a combination of services whilst still aiming for prevention and mitigation. A client/patient, for example, can be evaluated through telepractice and via in-person (whether in the center or at home). Accommodations can be enforced such as implementing as many evaluation procedures (e.g. case history, assessing communication functions through video files of the client) via telepractice so that less time will be spent on completing the assessment in-person.
- b. Combining in-person assessment in the center and at home is strongly discouraged as this further increases possibility and range of infection.

#### 5. Conduct of Assessment

- a. Avoid or delay aerosol-generating procedures like direct oral motor function assessment, bedside dysphagia assessment, instrumental swallowing evaluations, cough reflex testing, gag reflex testing, laryngectomy care and management, tracheostomy care and management, assessment of clients needing ventilators/high flow nasal oxygen/respiratory support via nasal cannula, and assessment of clients with poor saliva control and/or under distress unless doing so will put the client's health and well-being at great risk.
- b. If oral peripheral mechanism assessment is necessary and urgent, alternative means instead of direct contact oral assessment is recommended (i.e. videotaping the client's skills or letting the caregiver/guardian carry out parts of the assessment with direct supervision from the SLP).
- c. If swallowing assessment is necessary and urgent, alternative means instead of direct contact oral assessment is recommended (i.e. videotaping the client's skills or letting the caregiver/guardian carry out selected parts of the assessment with direct supervision of the SLP). These alternative means are

to be approached with much prudence and caution, though, given the sensitive nature of this kind of assessment.

- d. Complete in-person assessment in 1 session and within an hour (or less). Continuing assessments or scheduling succeeding sessions is strongly discouraged.
- e. Disseminate assessment results and recommendations as well as reports via email, video conferencing or calls, ensuring the data privacy of the patient and clinician.



## VIII. TREATMENT CONSIDERATIONS

### A. Treatment Procedures In Hospital-Based Centers and Home Visit

#### 1. Swallowing

- a. Non-COVID case:
  - i. Continue with previously recommended treatments, with main goals being:
    1. to restore to optimal nutritional status
    2. to establish safe nutritional status
    3. to improve quality of life
- b. Confirmed/Suspected/Probable case:
  - i. Telepractice is recommended if the patient is eligible.
    1. Provide recorded videos of exercises via tablet or other applicable devices.
    2. Ask clients/patients to do a return demo via synchronous or asynchronous means (recorded video).
    3. Provide copy of the procedure-specific treatment program to address identified concerns.
  - ii. Utilize AAC (i.e. communication boards, visual representations) to bridge gaps in communication between clients/patients and clinicians. Consider cognitive, motor and linguistic status, as well as the willingness of patients to use such means.
    1. Introduce appropriate means to clients/patients with compromised speech (i.e. on NGT, with oral-motor problems).
    2. Use when providing directions/explanations to improve clarity and efficiency (such as when affected by the worn PPE).
  - iii. May do compensatory strategies such as:
    1. Postural adjustments/ techniques
    2. 80-90 degrees inclination on the upper back. **Avoid** head-neck extension.
    3. Chin-tuck maneuver, if applicable
    4. Texture/ consistency modifications (IDDSI 3, 4, 5)
    5. Temperature modifications
    6. Environmental adjustments/ modification
  - iv. May do rehabilitative strategies that **DO NOT** generate aerosol production
  - v. **AVOID** maneuvers/ strategies that require any the following:
    1. cough training

2. expiratory muscle strength training
  3. vocal adduction exercises
  4. supraglottic and super-supraglottic swallow maneuver
- vi. **AVOID** the following:
1. Neuromuscular electrical stimulation (NMES)
  2. Thermal-tactile stimulation
  3. Oral care by healthcare professional, **SELF-CARE** instructions are to be provided
- vii. Recommend **DEFERRAL** of PEG tube insertion.
- viii. Consider **NGT feeding**. DO NOT mix oral and NGT feeding to minimize risk of aspiration.
- ix. Defer oral trials with cough training, unless instructed by and in close consultation with AMD.
- x. Limit oral trials to observation on **IDDSI 3, 4, 5 ONLY**

## 2. Language and Communication Disorders

- a. Non-COVID case:
- i. Continue with previously recommended treatments, with main goals being to optimize speech, language, cognitive-communication skills
  - ii. Telepractice as an option is encouraged, especially among clients who are candidates for this mode of service delivery.
- b. Confirmed/Suspected/Probable case:
- i. Telepractice is **HIGHLY** recommended.
    1. Ascertain that actual start of teletherapy is preceded by training the client's/patient's caregiver to be a facilitator who will be present with the client/patient at all teletherapy sessions.
    2. Provide recorded video of exercises via tablet or other applicable devices.
    3. With the facilitator's help, ask the client/patient to do a return demo via synchronous or asynchronous means (recorded video).
    4. Provide copies of procedure-specific treatment programs.
  - ii. For in-person sessions, maintain at least 1 meter distance from the client/patient during in-person sessions.
  - iii. Sit/stand beside the patient rather than across from the patient and maintain a safe distance.

- iv. Allot specific equipment and materials for the sole use of the client/patient. Dispose, replace, and disinfect as necessary (see IPC Precautions).
- v. A caregiver may accompany the patient during therapy only when deemed clinically necessary. Only one caregiver may accompany the patient during the session. Physical distancing measures are to be followed during session observations. Clinicians in hospital-based centers are advised to start and end sessions promptly, and minimize waiting times typically associated with chart-writing and verbal feedback. It is recommended that feedback be given via phone calls / electronic messaging, and documentation be done towards the end of the workday to minimize contamination by way of paper and writing instruments. Homevisit SLPs may utilize electronic documentation in lieu of notebooks.

### 3. Voice Disorders

- a. Non-COVID case:

Continue with typical treatments employing appropriate infection control procedures before, during and after the treatment sessions. Previously recommended treatments may continue, with main goals being:

  - i. to restore voice to a functional level necessary for verbal communication
  - ii. to facilitate the uptake of good vocal behaviors
  - iii. to improve communication quality of life
- b. Confirmed/Suspected/Probable case:
  - i. Telepractice is recommended if the patient is eligible.
    - 1. provide recorded videos of exercises via tablet or other applicable devices.
    - 2. ask patients to do a return demo via synchronous or asynchronous means (recorded video).
    - 3. provide copy of the procedure-specific treatment program to address identified concerns.
  - ii. Utilize AAC (i.e. communication boards, visual representations) to bridge gaps in communication between patients and clinicians. Consider cognitive, motor and linguistic status, as well as the willingness of patients to use such means.
    - 1. Introduce appropriate means to patients with compromised speech intelligibility (i.e. with neurological conditions)

- Use when providing directions/explanations to improve clarity and efficiency (such as when affected by the worn PPE)
  - May do rehabilitative strategies that **DO NOT** generate aerosol production such as use of confidential voice, resonant voice that does not require increased vocal intensity
2. Avoid treatment tasks that will result to possible aerosol generation
- prolonged phonation tasks
  - voice amplification
  - isometric exercises
  - phonation and breathing exercises
  - tasks that require singing, changing voice pitch
- iii. For alaryngeal patients, consider deferring the use of mechanical devices such as pneumatic aids, electronic aids (neck aids such as electrolarynx, oral aids, etc.)
- iv. For tracheostomy patients, consider deferring the use of tracheoesophageal speech exercises and phonation trials unless given clearance by referring physician and with appropriate PPE (Refer to IPC Precautions for High-Risk Patients).

#### **4. Oral Motor Disorders**

- a. Continue with typical treatments employing appropriate infection control procedures before, during and after treatment sessions. Should hands-on, tactile kinesthetic input is needed, wear single-gloves, face mask and face shield or goggles during in-person sessions.
- b. If possible, consider telepractice as a means of service delivery to minimize risks of transmission and infection.

## **IX. DEFERMENT AND POSTPONEMENT OF ASSESSMENT AND TREATMENT**

1. Defer or postpone assessment/treatment through telepractice due to problems with access to telecommunication and/or technical difficulties caused by equipment failure, power outage, service provider outage.
2. Defer or postpone in-person sessions if the client/patient, his/her immediate family, and/or primary caregiver, companion/housemate present COVID-19 symptoms. In such instances, the family is advised to monitor symptoms for the next two (2) weeks. Recommendation to consult with a medical professional should likewise be proffered.
3. Defer in-person sessions for the following reasons:
  - a. False declaration of the client's/patient's, guardians' and housemates' medical and travel history
  - b. Absence of necessary PPE (in the center or at home)
  - c. Client/patient presents behaviors like yelling, crying, hitting, and/or poor saliva control that increase risk for infection by way of droplets
  - d. SLP exhibits COVID-19 symptoms or had tested positive but is asymptomatic
  - e. Center has been compromised due to a COVID-19 case
  - f. Non-compliance of the center to safety guidelines provided by the DTI-DOLE
4. Notify the family regarding the decision and the reason/s behind the decisions made. Proper coordination regarding the next steps specific to rescheduling are to be done.
5. Monitor and track deferred clients/patients. Once they have been cleared via symptom screening, then they can finally be scheduled for the preferred service/s.

## **X. DOCUMENTATION**

1. Make a complete written record of all procedures undertaken during the session. Enumerate infection control protocol procedures completed, modifications or variations done (if any) during the session, the outcomes noted and any adverse events within the session.
2. Feedback to caregivers may be done through text messaging or calls, email, and/or video calls after completing out-patient sessions to reduce contact. Ensure the data privacy of the client/patient depending on the existing institution protocol.
3. Include recommendations for the conduct of the next treatment sessions (e.g. change of mode of service delivery, environmental modification).

4. Specify modifications done during the session as part of the risk management approach to COVID-19 pandemic.
5. Disseminate electronic medical records such as clinical abstract, referral forms, assessment reports via email, video conferencing or calls, ensuring the data privacy of the patient and depending on the existing institution protocol.

## XI. TELEPRACTICE

On April 07, 2020, the Department of Health and National Privacy Commission have released a draft version of the “Guidelines on the Use of Telemedicine in COVID-19 Response”, which enables the health care providers to communicate with their clients/patients who are at home and provide telehealth services through communication technologies.<sup>62</sup> Telemedicine aims to deliver healthcare services through online or mobile platforms and concurrently reduce the risk of patient traffic in health facilities, implement community quarantine, and guarantee efficient and safe use of telecommunications technology except for patients with severe conditions, have emergency cases, or have COVID-19 related issues that require face-to-face assessment and immediate treatment. The implementation of telemedicine should adhere to the principles of ethics, legal standards, and guiding principles of human rights as dictated by the Philippine law and other relevant international standards and policies.<sup>63</sup>

The American Speech-Language-Hearing Association adopted the term *telepractice* instead of the frequently used telemedicine or telehealth to avoid misperception that these services are used only in health care services.<sup>64</sup> Teleaudiology, telespeech, and speech teletherapy are terms used by others to pertain to telepractice as well. The service delivery of speech-language pathologists are included in the broader generic term telerehabilitation (American Telemedicine Association, 2010).<sup>65</sup>

Telepractice is seen as a critical response to the ongoing public health emergency by staying relevant to the practice and ensuring the patients and their families access to the services. In compliance with the Department of Health’s (2020) guidelines, PASP recommends that outcome measures of telepractice are to be equivalent to or if not better than in-person services. There are various types of telepractice that the clinician may use in providing services. *Synchronous telepractice*, also referred to as client interactive, is done by utilising audio-visual means in order to simulate in-person sessions done in the clinic or hospital setup. *Asynchronous telepractice*, also described as store-and-forward, is conducted through the use of images or data that are captured and

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<sup>62</sup>Department of Health—National Privacy Commission (DOH-NPC) (2020) Guidelines on the Use of Telemedicine in COVID-19 Response.

<sup>63</sup>*Ibid.*

<sup>64</sup>American Speech-Language Hearing Association. Telepractice: An Overview. (n.d.).

<sup>65</sup>*Ibid.*

transmitted for viewing or interpretation by a clinician. Examples include transmission of voice clips, audiologic testing results, or outcomes of independent client practice.<sup>66</sup>

The clinician evaluates a client's qualification for telepractice by looking at the following factors:

- a. availability of devices and internet connection in the client's working environment
- b. baseline technical skills of client and/or family to operate and access the device
- c. environmental barriers and facilitators
- d. speech, language, and communication skills

The clinician trains e-helpers or facilitators, which refer to individual/s assisting the clients during teletherapy sessions (Schlaak, 2018),<sup>67</sup> on patient handling, data security and confidentiality, technical skills, and communication skills. The clinician is also recommended to collaborate with the family on goals for prioritization before the start of intervention availed through telepractice. Efficiency of telepractice must be evaluated by both parties, the clinician and the family; hence, consistent monitoring of outcomes is to be implemented.

Edwards et al (2012) and Houston (2011) recommended the following conditions, which can benefit from telepractice:

- a. speech and language delays/disorders
- b. articulation and phonological disorders
- c. non-verbal
- d. traumatic brain injury
- e. auditory-verbal therapy/ parent coaching
- f. adult aural rehabilitation
- g. aphasia
- h. fluency disorders
- i. apraxia
- j. dysarthria
- k. voice disorders<sup>68,69</sup>

Just as with regular, in-person sessions, members of PASP are expected to adhere to the Association's Code of Ethics and Standards of Practice even as they utilize telepractice and teletherapy as a mode of service delivery. Informed consent is to be secured from each client. Clinic owners, as well as individual practitioners, should ensure that all data and teleconferencing platforms are secure, and compliant with R.A. 10173, otherwise known as the Data Privacy Act of 2012 (<https://www.privacy.gov.ph/data-privacy-act>),<sup>70</sup> Health Insurance Portability and

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<sup>66</sup>*Ibid.*

<sup>67</sup>Schlaak, H. M. (2018). Professional Competencies for E-helpers: A Telepractice Resource.

<sup>68</sup>Edwards, M., Stredler-Brown, A., & Houston, K. T. (2012). Expanding Use of Telepractice in Speech-Language Pathology and Audiology.

<sup>69</sup>Houston, K. T. (2011). TeleIntervention: Improving service delivery to young children with hearing loss and their families through telepractice.

<sup>70</sup>National Privacy Commission (NPC) Republic Act 10173 – Data Privacy Act of 2012. (2016, July 19).

Accountability Act (HIPAA),<sup>71</sup> and Business Associate Agreement (BAA)<sup>72</sup> for international clients.

\*Clinicians are urged to refer to PASP'S Clinical Practice Guidelines on Telepractice for additional details.

## **XII. Home Visits / Home Care**

### **A. Referral System and Scheduling Sessions**

1. Determine the clinical necessity and urgency of home care visit to be undertaken. Give priority to cases that may affect the individual's respiratory, nutritional and cognitive status (e.g. dysphagia, stroke, developmental regression in ASD).
2. Conduct consultations if the procedures can be effectively achieved through telerehabilitation.
3. Conduct an initial screening which includes--but is not limited to--consultation with the patient's attending physician and other respective medical professionals (e.g. physical therapist, occupational therapist, dietitian, nurses, etc.) and history of possible symptoms suggestive of COVID-19. Refer to the appropriate triaging process when necessary.
4. Accomplish and co-sign the necessary and appropriate consent forms between the patient/caregivers and the clinician regarding the expectations and responsibilities of each party regarding the use and/or provision of PPE as well as the observance and implementation of home infection control procedures.
5. Provide instructions on the patient's/family's preparations prior to conducting the assessment via appropriate, accessible and available platforms (e.g. text messaging, phone or video calls, etc.).
6. Schedule the patient for assessment once the procedures' necessity have been established and an initial screening has been done.
7. Schedule session of visits. Ascertain that PPEs are utilized and IPC measures are implemented each time, pre- and post-visit.

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<sup>71</sup>HHS Office of the Secretary, Office for Civil Rights, & Ocr. (2013, July 26). Summary of the HIPAA Privacy Rule.

<sup>72</sup>HHS Office of the Secretary, Office for Civil Rights, & Ocr. (2019, May 24). Business Associates.



8. Defer a patient who is COVID-19 positive or when any member of the household is COVID-19 positive.

## **B. PPE Guidelines**

1. Appropriate PPE must be used during AGPs or droplet exposure during face-to-face assessment or treatment management. It is recommended that for infection control purposes, the homevisit patient's family is to provide the PPEs and IPC materials for the clinician's use. Modification in PPE usage may occur as a consequence of limited supplies and availability and resource allocation on the part of the clinician and patient/caregiver. These modifications are acceptable for as long as these do not compromise the safety of neither the clinician nor the patient/caregivers. In scenarios like these, the clinician is expected to exercise prudence in clinical decision-making, prioritizing the safety and welfare of all individuals involved in all sessions.
2. If the patient's family is unable to provide the clinician the appropriate PPE and the patient/caregivers still express willingness to avail the services, the SLP is to provide for their own PPEs. A written, signed agreement between the patient/caregiver and clinician must be accomplished. Such written agreements may include--but are not limited to--types of PPE to be used, IPC procedures to be made, the rationale behind their usage, and the possible risks if protocols are not observed.
3. Family members and/or caregivers are to use PPEs, engage in physical distancing, and implement IPC measures when interacting with the clinician and client/patient all throughout each homevisit session including home instruction dissemination.
4. Pediatric clients are also expected to wear PPEs. As similarly indicated in Section VI, B-3 to B-4, children are not to be forced to wear masks, and the wearing of such is forbidden for infants and toddlers. The clinician however must wear the appropriate PPE and determine ways to acclimatize the client/patient in his/her use of these.
5. Utmost care must be given to adults and children who may have cognitive, nutritional, and/or respiratory impairments. Consider special precautions when making them wear masks during AGP procedures.

## **C. Infection Control Procedures**

1. Avoid assessment and treatment tasks that will result in possible aerosol generation (see section on AGPs among High Risk Patients).

2. Heightened IPC measures are to be followed by the clinician before and after home visit. Knowledge and training on appropriate procedures reduce the risk of infection transmission to patients and other people. Refer to the IPC measures.
3. Prescribed house disinfection and infection control measures must be done at home before and after home visit. These include--but are not limited to--using a foot bath / stomp mat, leaving shoes outside the main door and donning indoor slippers (provided in-house), utilizing the house's restroom for clothes change and/or proper donning/doffing of PPE, implementing thorough hand hygiene procedures, leaving bag outside of patient's room, surface cleaning and disinfection, etc.
4. Physical distancing is practiced at all times among individuals that do not require close contact. This is to be modified only when being near the patient is absolutely necessary, on a case-to-case basis.
5. Limit the number of caregivers or family members present during the clinical assessment and treatment sessions whenever possible.

**D. Assessment Considerations (see Section VII)**

**E. Treatment Considerations (see Section VIII)**

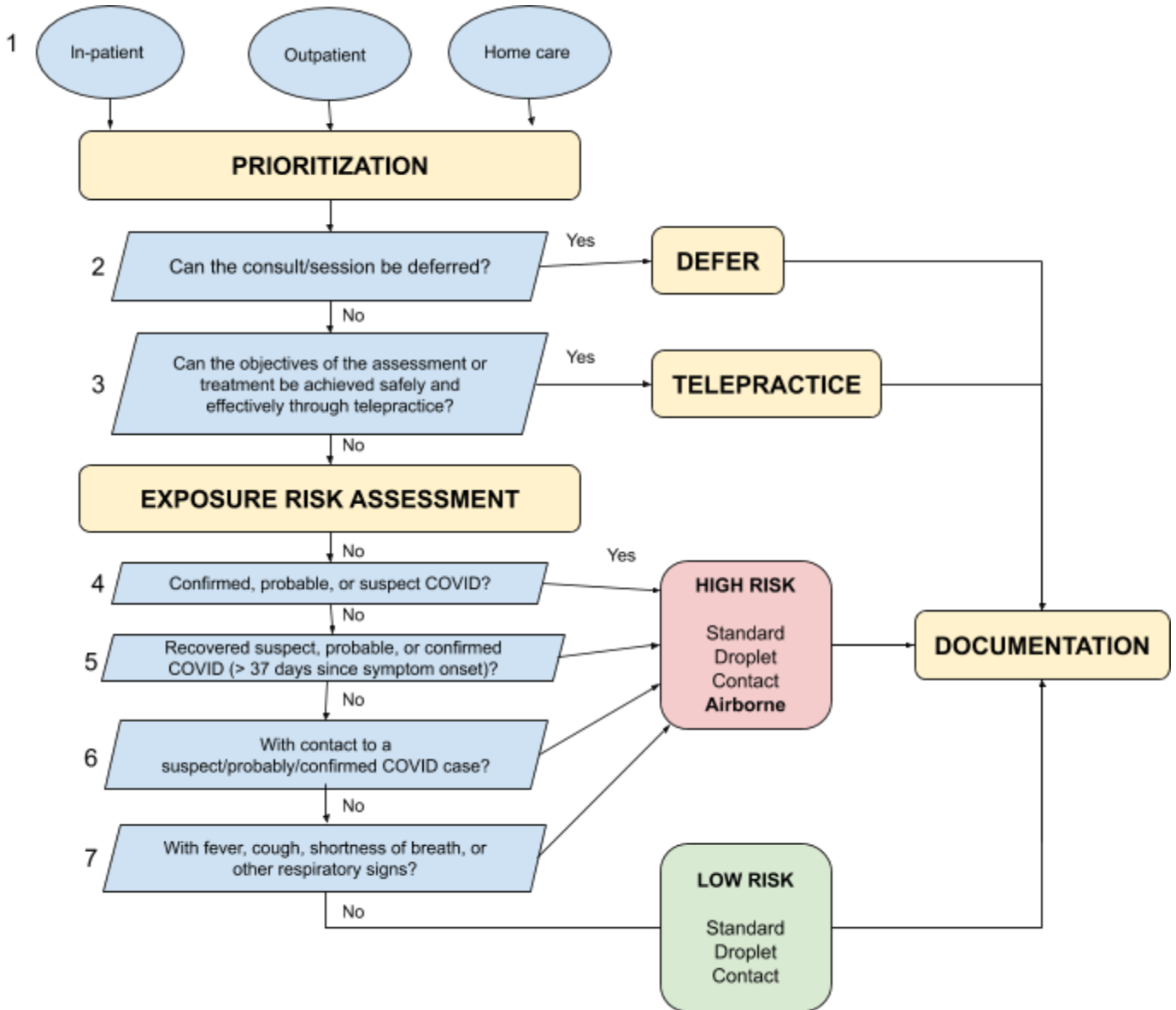
**F. Home Instructions**

1. Synchronous or asynchronous telepractice is highly recommended to cut down frequency of in-person visits.
2. Recommendations for the next treatment session, follow-up program, or patient-caregiver education are deemed necessary.

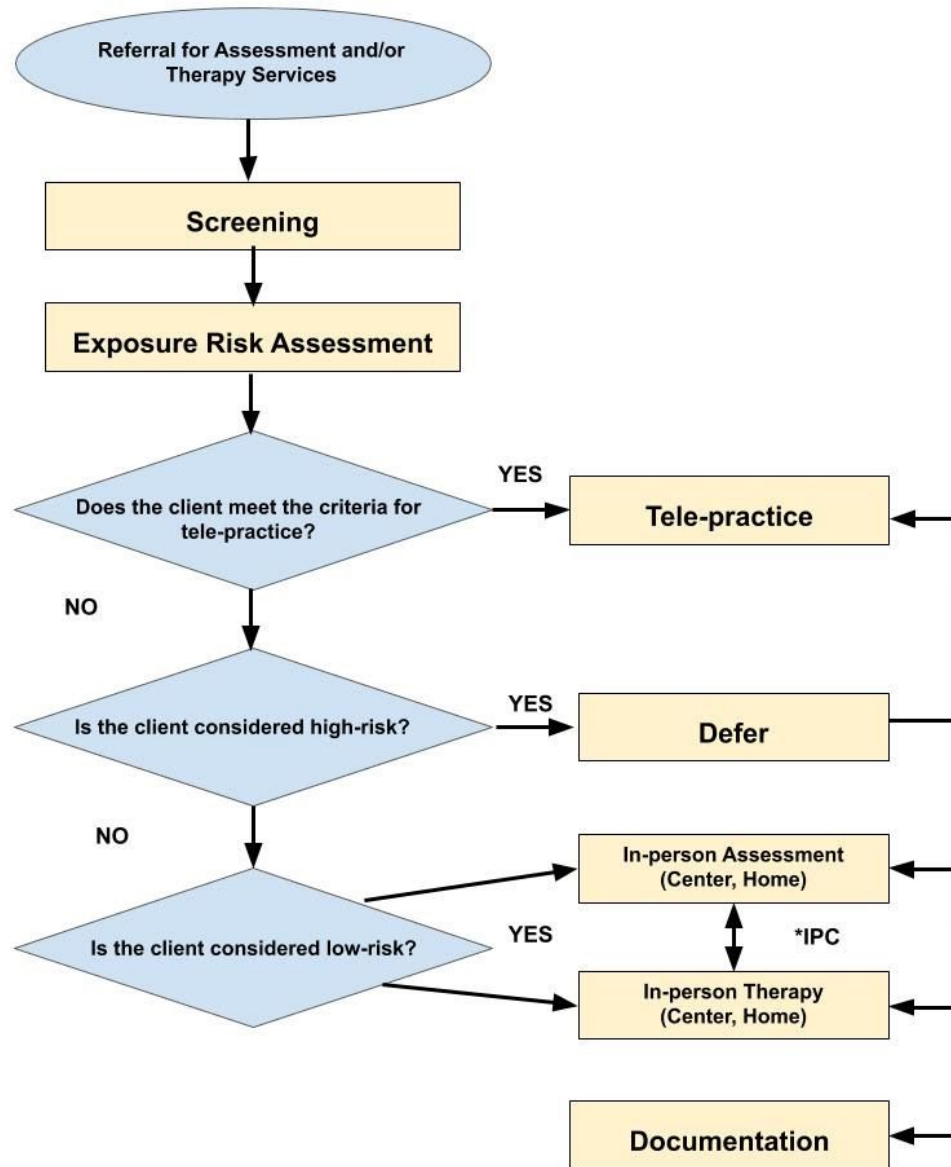
**G. Documentation (see Section IX)**

### XIII. ALGORITHM

#### A. ALGORITHM OF SERVICES IN HOSPITAL AND HOME CARE SETTINGS DURING THE PANDEMIC





**B. ALGORITHM OF SERVICES IN PRIVATE / SCHOOL-BASED THERAPY CENTERS DURING THE PANDEMIC**





\*Infection Prevention Control

**XIV. APPENDICES**

**Infection Prevention and Control Recommendations for SLPs During the COVID-19**

<b>IPC MEASURES</b>	<b>LOW RISK</b> (non-COVID OR recovered COVID-cases) <b>Standard + Contact + Droplet</b>
<p><b>Basic Precautions</b></p> <ul style="list-style-type: none"> <li>● Physical distancing</li> <li>● Cough etiquette</li> <li>● Do NOT touch face</li> <li>● Wash hands 20 sec</li> <li>● 5 Moments of Hand Hygiene</li> </ul>	
<p><b>PPE Required</b></p> <ul style="list-style-type: none"> <li>● Surgical mask / (clear window type mask)</li> <li>● Goggles/protective glasses OR face shield</li> <li>● Single-use gloves</li> </ul>	

<b>IPC MEASURES</b>	<b>HIGH RISK</b> (suspect, probable, confirmed COVID cases) <b>Standard + Contact + Droplet + Airborne</b>
<p><b>Basic Precautions</b></p> <ul style="list-style-type: none"> <li>● Physical distancing</li> <li>● Cough etiquette</li> <li>● Do NOT touch face</li> <li>● Wash hands 20 sec</li> <li>● 5 Moments of Hand Hygiene</li> </ul>	
<p><b>PPE Required</b></p> <ul style="list-style-type: none"> <li>● Disposable gown</li> <li>● Shoe covers</li> <li>● N95 / FFP2 mask</li> <li>● Goggles/protective glasses</li> <li>● Face shield</li> <li>● Single-use gloves</li> </ul>	

**IMPORTANT REMINDERS**

1. PPE must be changed between use and for each different client.
2. Dispose single-use PPE in a waste bin with a lid and wash your hands thoroughly.
3. Anything single-use cannot be reused or sterilized!
4. Do a seal check for N95 masks. Remove facial hair to ensure a tight seal.
5. Do NOT touch your eyes, nose or mouth with gloves or bare hands until proper hand hygiene has been performed.
6. Assess exposure risk before and after each client/patient interaction. If exposure risk is high, or if you start developing symptoms, stop client/patient care, and seek medical care ASAP.

**PRIVATE CENTERS (ENGLISH VERSION)**

**HEALTH CONDITION DECLARATION FORM**

Pursuant to Republic Act 11332, you are required to provide truthful information about your health condition and possible exposure.

**Dear Parents/Guardians,**

To ensure both our safety during and after assessment or therapy of your child in our clinic. Kindly check (/) the appropriate boxes below.

QUESTIONS	YES	NO
Do you and/or your child have the following?		
fever? (37.6 C above)		
sore throat?		
is experiencing coughs & colds?		
shortness of breath or difficulty of breathing?		
experiencing headaches?		
feel that your body is weak?		
diarrhea?		
Do you and/or your child consult a medical doctor for the above mentioned signs and symptoms?		
Do you and/or your child have a history of travel within 14 days? If yes, where _____ and when _____?		
Have you and/or your child travelled to or live in local areas outside the Philippines where there are reported cases of COVID-19?		
Do you and/or your child have contact or exposure to someone who travelled in areas with local transmission?		
Have you and/or your child been exposed to a person with a suspected / probable/positive case of COVID-19?		
Do you or anyone in the household have any of the above mentioned signs and symptoms or pending COVID-19 test results?		
Do you and/ your child have the following conditions: lung disease (including asthma), cardiovascular disease, immunosuppression, severe obesity (body mass index [BMI]≥40), diabetes, chronic kidney disease on dialysis or liver disease?  (If your answer is yes, kindly encircle the medical condition/s that you and/your child have.)		

I hereby certify that the above given information is true, correct and complete. I understand that I will be held criminally liable for failure to give right of information or intentionally providing misinformation.

\_\_\_\_\_  
Client's Name

\_\_\_\_\_  
Parent's/ Guardian's Signature over Printed Name/ Date

*(Adapted from Asian Hospital & Medical Center, Department of Pediatrics)*

## PRIVATE CENTERS (FILIPINO VERSION)

### HEALTH CONDITION DECLARATION FORM

Alinsunod sa *Republic Act 11332*, kinakailangan ninyong makapagbigay ng totoong impormasyon ukol sa inyong kalusugan at posibleng pagkahawa sa COVID -19.

**Minamahal naming Magulang at mga Tagapangalaga,**

Para masiguro ang kaligtasan ng lahat bago, habang at pagkatapos ng *assessment o therapy* ng inyong anak sa aming center, makikisagutan ang mga katanungan sa ibaba. Pakilagyan ng *check mark (/)* ang inyong sagot.

MGA KATANUNGAN	OO	HINDI
Mayroon ka ba at/ ang iyong anak ng mga alinman sa sumusunod?		
lagnat (37.6 C pataas)?		
pamamaga o pananakit ng lalamunan (sore throat)?		
inuubo at / sinisipon?		
hinahapo o nahihirapan sa paghinga?		
masakit ang ulo?		
pakiramdam ng paghina ng katawan? matamlay?		
pagtatae?		
Nakapagpatingin ba kayo at/ ang iyong anak sa doktor tungkol sa mga nasabing palatandaan o sintomas?		
Naglakbay ba kayo at/ang iyong anak sa loob ng 14 araw bago pumunta sa aming tanggapan? Kung oo, saan _____ at kailan _____?		
Naglakbay ba kayo at/ang iyong anak o nakatira sa labas ng Pilipinas kung saan may naitalang mga kaso ng COVID-19? Kung oo, saan _____ at kailan _____?		
Mayroon ba kayo at/ang iyong anak na nakasalamuha o nakasama na galing sa mga lugar na may lokal na transmission?		
Mayroon ba kayo at/ ang iyong anak na kasama na maaaring pinaghihinalaan, posible, positibo sa COVID-19?		
Mayroon ba kayo o sa inyong mga kasama sa bahay ng mga nasabing palatandaan o sintomas o hinihintay na resulta ng COVID-19 test?		
Mayroon ba kayo at/ ang iyong anak ng mga sumusunod na kondisyon: sakit sa baga (kasama ang asthma), sakit sa puso, immunosuppression, severe obesity (body mass index [BMI]≥40), diabetes, sakit sa bato o (chronic kidney disease on dialysis) o sakit sa atay? (Kung OO ang inyong sagot, pakibilugan ang mga kondisyong medikal na mayroon ka at/ ang iyong anak?)		

Ito ang nagpapatunay na ang aking mga ibinigay na impormasyon sa itaas ay totoo, tama at kumpleto. Naiintindihan ko na mananagot ako sa batas na may pananagutan sa kabiguang magbigay ng karapatan ng impormasyon o sadyang magbigay ng maling impormasyon.

\_\_\_\_\_

Pangalan ng Kliyente

\_\_\_\_\_

Lagda ng Magulang/Tagapangalaga sa Itaas ng Pangalan/ Petsa

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