SALUS UNIVERSITY

College of Education and Rehabilitation

Department of Speech-Language Pathology

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Effective: Fall, 2019

Mission of the Department:

The mission of the Department of Speech-Language Pathology is to enhance and train graduate-level students to become exemplary professionals in speech-language pathology who provide excellence in service delivery to individuals with communication and swallowing disorders, and who engage in and promote interprofessional education and practice, lifelong learning and prevention of communication and swallowing disorders.

Mission of the College:

The mission of the College of Education and Rehabilitation is to develop and offer graduate programs preparing highly qualified professionals to support individuals who have, or are at risk for, disabilities through the education and rehabilitation process, by creating an interprofessional environment of practitioners committed to lifelong learning, critical thinking, and dedication to the individuals and communities they serve.

Mission of the University:

Salus University leads in innovative education, research and service to enhance health.

SLP Supervisor Handbook

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SUPERVISOR HANDBOOK

This handbook is intended to serve as a guide concerning the policies and procedures of the clinical training program in Speech-Language Pathology within the College of Education and Rehabilitation at Salus University. Explanations and examples of requirements, formats, and information pertinent to the student's successful completion of practicum are included. If, at any time, a supervisor is uncertain about clinic policies or procedures, or finds requirements unclear, he/she is strongly encouraged to seek clarification from the clinical director or department chair.

Should any change or update in this handbook be required, the clinical director will provide it as an addendum.

SLP Supervisor Handbook

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SLP Supervisor Handbook

Welcome to the Salus University!

The faculty and staff of the Department of Speech-Language Pathology in the College of Education and Rehabilitation at Salus University are so pleased that you will be joining us to supervise our graduate students! Working with you allows us to provide our students with a high-quality learning experience that exposes them to the depth and breadth of the profession across a variety of settings.

The purpose of the handbook is to support you in supervising students during their clinical education of the Master's program. The faculty has developed this handbook as a resource containing the guidelines relevant to the clinical supervision. You will find information about the policies and procedures associated with clinical education, along with professional resources from the American Speech-Language Hearing Association.

So, please look through the handbook carefully and become familiar with its content.

A successful clinical practicum will be one where both you and the student gain from the experience. We are certain that the student you supervise will learn new clinical skills in diagnostic, treatment and administrative work. In addition, we hope that you learn something about your professional skills and supervision style.

Your dedication and willingness to participate in the education of new professional is truly appreciated!

OVERVIEW

Salus University's curriculum in speech-language pathology provides its students with the education and training required for the practice of speech-language pathology, providing future practitioners with the knowledge and skills to work with clients across the lifespan who demonstrate a variety of communication disorders. The curriculum requires five semesters to complete, including a summer semester in between the first and second years of the program. Students who successfully complete the curriculum achieve a Master of Science degree in Speech-Language Pathology and meet the academic and clinical requirements for the Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP) through the American Speech Language Hearing Association (ASHA). Graduates will also meet state licensure requirements for the practice of speech-language pathology in Pennsylvania and for Pennsylvania Department of Education's certification as an educational specialist in speech-language pathology.

The master's program in speech-language pathology at Salus University has been granted candidacy status by the Council of Academic Accreditation (CAA) of ASHA and complies with all standards set forth by the Council.

The on and off-campus clinical experiences are an integral part of the program and are vital to the advancement of skill acquisition. These experiences provide students with opportunities to apply information learned in a classroom to service delivery in real educational and health care settings. Students complete placements during all semesters of study in a variety of settings such as the Salus University Speech-Language Institute, schools, hospitals, rehabilitation centers, skilled nursing facilities, assisted living facilities, community clinics and private practices. In each of these settings, students benefit from guided learning that fosters improved clinical competency and progressive independence.

The student who has been placed at a particular site will remain at that site for the agreed time period as stated in the contract letter. The contract letter also contains information concerning roles and responsibilities for supervisors/students, dates when specific forms/grades are due and the university's calendar.

Students may earn clock hours only for the portion of time they are actively participating in service delivery to clients. To meet clinical program requirements, students must accrue diagnostic and treatment hours during their placements and must be actively supervised by an ASHA-certified professional in accordance with standards of ASHA. ASHA standards require at least 25 percent supervision of all therapy sessions and 50 percent supervision of all diagnostic sessions. This time should be adjusted depending on the severity of the clients on the caseload and the experience of the student. The clinical supervisor's signature verifies successful completion of clinical clock hours.

PURPOSES OF CLINICAL EDUCATION

For Students:

• To provide a continuing series of practical experiences, adapted to students' levels of expertise, that provide opportunities for application of principles, knowledge and skills previously acquired in classes and clinical practica.
• To learn how to assume professional roles in clinical settings while becoming accustomed to a variety of organization structures, working relationships and job expectations.
• To develop a professional identify as a speech-language pathologist.
• To gain experiences in the role of a team member when working with other professionals and families in the treatment process.

For Clinical Sites/Supervisors:

• To provide opportunities for input in the development of the university program, thereby sharing in the education of future speech-language pathologists.
• To serve as a catalyst for growth for participating speech-language pathologists through interaction with students.
• To provide participating sites an opportunity to recruit new employees.

For the University:

• To establish a measure of students' abilities to function ethically, efficiently and effectively as speech-language pathologists.
• To facilitate continuous evaluation of the curriculum's relevance and effectiveness, leading to modifications when necessary.
• To provide diverse clinical experiences for students.

GOALS OF THE PROGRAM

A basic goal of the Department of Speech-Language Pathology is to assure that students are clinically exposed to individuals who have or are at risk for communication disorders across the depth and breadth of the scope of practice in speech-language pathology. In order to accomplish this goal, the Salus University Speech-Language Institute and off-campus externship sites will:

- provide diagnostic and treatment services commensurate with the qualifications of its staff and the limits of its facilities
- refer clients for diagnostic, treatment and consultation services, which it cannot provide within the staff and time limitations of its clinic service
- use only supervisors who are clinically certified by ASHA and are in good standing with ASHA
- assign each client to a clinically certified supervisor
- follow the standards set by ASHA for supervision
- protect the confidentiality of the client
- adhere to the Code of Ethics and the Scope of Practice.

ROLE OF THE SUPERVISORS

Role of the University Supervisor
A clinical supervisor from the Department of Speech-Language Pathology maintains his/her CCC-SLP and state licensure and is assigned to each student completing a practicum. This supervisor will communicate with the Clinical Director and will observe the student in action, and will discuss on-going progress with the student and faculty, at the on-site clinic. The supervisor, working with the faculty, will ensure that the student has met the requirements to complete the practicum. University Supervisor requirements include:

- Maintenance of the CCC-SLP and state licensure at initiation of and throughout the practicum
- Provision of on-site supervision throughout the practicum.
- Regular communication with the Clinic Director.
- Participation in student advisement and other clinic projects/meetings
- Completion of documentation required by the Department of Speech-Language Pathology including signing the student clinician's clock hour logs.

Role of the Externship Supervisor
Externship supervisors are Speech-Language Pathologists with at least their master's degree, maintain their Certificate in Clinical Competency in Speech-Language Pathology (CCC-SLP) and state licensure and work in a variety of practice settings. The individual differences of the settings and personal styles of organizing and managing programs are respected. The externship supervisor requirements include:

- Agreement to the placement as it is arranged by Salus University and the placement.
- Maintenance of the CCC-SLP and state licensure at initiation of, and throughout the externship experience.
- Provision of on-site supervision throughout the externship.
- Regular communication with the Clinic Director (or designee).
- Completion of documentation required by the Department of Speech-Language Pathology including signing the student clinician's clock hour logs.

Role of the Academic Advisor
The academic advisor will be responsible for advising the student in both didactic and clinical education. The advisor will provide support to the student, the clinical educator and other supervisors during the student's practicum experience.

Role of the Clinical Director
The Clinical Director will schedule supervisory meetings during the on-campus clinical experience and site visit(s) during the externship during which he/she will review any records or assignments that the student has completed, observe the student doing therapy/diagnostic work, meet with the student individually, meet with the supervisor individually, and then meet with both to discuss requirements, paperwork, etc. The Clinical Director should be contacted if any questions or concerns arise at any time during the externship. The Clinical Director will complete a final evaluation based on 1) the mid-term & final evaluations completed by the supervisor, 2) the ongoing input received from the supervisor, and 3) direct observation and evaluation of the student's work.

EXPECTATIONS OF CLINICAL EXPERIENCES

The following are experiences in which graduate students will participate:

1. Observation of a speech-language pathology program.

2. Evaluation and diagnosis of communication and swallowing disorders.

3. Scheduling of treatment sessions.

4. Familiarization with forms and other types of documentation used by clinics and school systems in reporting record keeping, billing, etc.

5. Familiarization with reimbursement procedures in a variety of health care and educational settings.

6. Treatment, both individual and group, with a variety of communication and swallowing disorders.

7. Writing treatment/lesson plans that include appropriate goals, logical task sequences, clear conditions and criteria for achieving goals, types and amounts of reinforcement and appropriate selection of materials and activities.

8. Conferences with practicioners, family members and other professionals.

9. Proficient use of a variety of materials and equipment.

10. In-service education programs for clinicians.

11. Attendance at IFSP/IEP meetings, staffings, interpretive conferences and other professional meetings.

12. Observations of special programs in hospitals, rehabilitation centers, skilled nursing facilities, school systems and other settings.

SITE SELECTION

The Clinical Director will select all clinical education sites for students in the Department of Speech-Language Pathology. The sites represent a wide variety of settings and experiences, including public schools, private practices, skilled nursing facilities, medical centers and specialized programs. The Clinic Director will consider the following characteristics when selecting new sites:

- Breadth and depth of clinical population.
- Site supervisors' interests and experiences in clinical education.
- Positive climate for clinical education.
- Availability of appropriate diagnostic, treatment and related opportunities.

STUDENT ORIENTATION

One of the first responsibilities of clinical supervisors is to orient the student to the physical facilities and policies/procedures of the clinical site. Students must know:

- Organization and structure of the facility.
- Protocols followed at the facility, including dress requirements, hours of work, use of the phone and other pertinent information.
- Availability of materials and equipment for use in diagnostics and therapy.
- Forms required by the clinical site.
- Introductions to other staff members with an explanation of their roles.
- Requirements for the setting, including in-service training, immunizations needed and presentations to staff.
- Duties and competencies expected of student clinicians.

The Department of Speech-Language Pathology provides all students with the SLP Student Handbook, which specifies information regarding the clinical policies and procedures. Off-campus sites may also provide written information for the student's review.

ATTENDANCE

Attendance is mandatory for all scheduled activities for the practicum courses. Student absences must be reported to the clinical educator or site supervisor and the clinical director. Students will be required to offer make-up sessions for any sessions missed while they were out.

SUPERVISOR ABSENCES

Supervisors, because of illness or other responsibilities, occasionally must be absent for all or a part of a therapy session. In these instances, another supervisor will be designated to be responsible for the student and the clients. If additional supervisors are not available, sessions should be cancelled.

CLINICAL CLOCK HOURS

Students need to accumulate 400 clinical clock hours across the lifespan for a variety of communication disorders. This is only a minimum requirement and most students usually earn more hours during their graduate program. Specific clinical education needs of students, maintaining the welfare of clients, and completion of externship responsibilities at particular sites are all important considerations in site assignments. The duration of students' clinical experience will be determined by the quality of their performance and meeting competencies, not by the completion of the minimum requirement for clinical clock hours or acquiring well-over the required hours.

Students are expected to be competent in the knowledge and skills of prevention, evaluation and treatment of the following nine disorders areas:

- Articulation
- Fluency
- Voice and resonance
- Receptive and expressive language
- Hearing
- Swallowing disorders
- Cognitive aspects of communication
- Social aspects of communication
- Communication modalities

Additionally, students must have knowledge regarding standards of ethical conduct, principles of evidenced-base practice, contemporary professional issues and credentialing process.

RECORDING OF CLINICAL CLOCK HOURS

Students are expected to maintain complete and accurate clinical clock hour records. During the semester, students maintain a running record of clinical clock hours using the Clinical Assessment of Learning Inventory of Performance Streamlined Office Operations (CALIPSO). Verification of completion of clinical clock hours requires students to obtain the signature and ASHA account number of each supervisor. Clinical clock hours will not be accepted unless properly signed. Once students submit the clinical clock hours and have their total verified by the Clinical Director or Department Chair, they will receive a grade for the practicum experience. Supervisors should advise students to make copies of their signed and original externship clinical clock hours.

CALIPSO

The Department of Speech-Language Pathology has adopted the Clinical Assessment of Learning Inventory of Performance Streamlined Office Operations (CALIPSO), a competency based application that manages student clinical learning. To access Salus' CALIPSO website, go to the CALIPSO login page.

Registration

To gain access to the CALIPSO system, the supervisor will be emailed a one-time PIN number by the clinical director. With the PIN number, the supervisor will receive step-by-step instructions for using the system.

Instructions for CALIPSO

Supervisors will find instructions for verifying clock hours and submitting students' midterm and final evaluations on the CALIPSO website. Students must enter and supervisors must approval all clinical clock hours prior to the end of each semester.

CALIPSO Scoring

CALIPSO scoring is a competency-based program and adheres to the standards set forth by the Council on Academic Accreditation (CAA), and the Council for Clinical Certification (CFCC). This means that students have to demonstrate specified clinical competencies by program graduation. Competency on a standard is considered to be met when a student's average on the standard reaches at least a "3" on the Cumulative Evaluation.

Competency-Based Scores:

1. Absent – supervisor modeling and intervention needed
2. Emerging – supervisor intervention needed
3. Evident – with supervisor support and feedback
4. Independent – given occasional feedback
5. Clinical Fellowship (CF)-ready - consultation with supervisor

The purpose of the rating system is to provide feedback on specific clinical competency areas and guide decisions in which students need practice or support. The supervisor will evaluate and grade the practicum or externship student's performance at midterm and at the end of the placement.

A pass in a practicum course indicates that the student has met at least minimum requirements to count clinical clock hours. Students will be evaluated across three major domains: (1) Evaluation, (2) Intervention and (3) Preparedness, Interaction and Personal Qualities. In order to receive a passing grade for the practicum, the student must have a minimum average competency score of 3 in each domain. Students may not count clinical hours towards the minimum required hours for graduation during a term when a failing grade is received.

PRACTICUM GRADING

Satisfactory clinical performance is an integral part of the Department's expectation of them. As part of the assessment process, students will be required to reflect on and write about their clinical experiences, including their self-perceived strengths and areas for improvement. These reflections will be discussed with the clinical supervisor. The student's assessments will be compared with the supervisor's rating scale at mid-term and within the final two or three weeks of their clinical placement. The self-reflections will also be discussed during formal advising sessions. The clinical supervisor and academic advisor will communicate as needed regarding the student's performance.

At the midterm point of the semester, the clinical supervisor will provide formal assessment to strengthen or improve observed areas of weakness and reinforce the student's strengths.

At the close of the semester, the clinical supervisor provides summative assessment information to strengthen or improve observed areas of weakness and reinforce the student's strengths. This exchange occurs during the final conference between the student and the clinical supervisor. A grade is assigned for the student's work during the semester.

Satisfactory clinical performance (i.e., direct client care) is an integral part of the Department's expectation of students. Students who receive a practicum grade below B in any clinical assignment will be placed on clinical probation and a remediation plan will be developed. Failure

in clinical performance will result in failure of the course.

ACADEMIC AND CLINICAL SUPPORT

Students will meet with their academic advisors at least once a semester to share and obtain feedback on their progression, both didactically and clinically. If a student is exhibiting academic or clinical difficulties, the student and relevant faculty and/or clinical educators will jointly develop a remediation plan. This plan will be carried out by the student while being monitored by the academic advisor.

Clinical Remediation Plans

If a student has difficulty achieving student learning outcomes, the clinical educator, clinical director, and/or department chair will formally meet with the student to identify the area of knowledge or skill that is deficient. The supervisor, in consultation with the student, and supported by the clinical director will design a written remediation plan with specific tasks, outcomes, and timelines. The student's knowledge and/or skills will be re-evaluated at the completion of the remediation plan by the supervisor and clinical director as needed. (Refer to the Program Plan for Student Remediation found in Appendix H.)

Plans for clinical remediation may include one or more of the following:

- additional opportunities to observe clinical sessions
- additional readings or assignments
- faculty advisement on subject matter
- role-playing with peers/actors
- computer simulated patients
- evaluation of recorded sessions
- co-treatment with supervisor and/or clinical director

Selection of the above activities will be individualized to the needs of the students and determined by the supervisor and the clinical director to guide the student to successful completion of the plan. The remediation plan will be written, approved and signed by the student, clinical director and/or department chair and copied for the student's file. Regular meetings with the supervisor and student, facilitated by the clinical director or designee, will be held to evaluate student progress until (a) the remediation plan is successfully completed and the student functions under the practicum's expectation or (b), during the course of the plan, it is determined that the only action is to dismiss the student from the site and then having the student repeat the practicum before continuing with more advanced clinical placements.

Students who do not successfully complete a remediation plan will be required to repeat the clinical experience during the following semester. Students who elect to not repeat the practicum will not be allowed to register for didactic courses until they have registered for the practicum to be repeated.

DISMISSAL FROM CLINICAL EDUCATION

Occasionally, students may have difficulty with a particular site or placement. In the unlikely event that students are unable to cope with the requirements of a site or engage in behavior that substantially disrupts a program or poses a risk of injury to clients, other students, or staff, the supervisor should contact the Clinic Director immediately. Disruptive behavior may result in dismissal from the site.
The Clinic Director and supervisor will be responsible for meeting with the student and explaining the reason(s) for dismissal.

COUNCIL ON ACADEMIC ACCREDITATION CONTACT

Concerns and questions relative to the academic and clinical training issues of the Department of Speech-Language Pathology's accredited program should be directed to the Department Chair. Students may also contact the Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA).

Complaints Against Programs

The CAA will address concerns via the complaint process that are clearly related to a program's compliance with accreditation standards. The CAA cannot intervene in disputes between individuals and programs, and cannot affect outcomes such as grade changes, reinstatement to the graduate program, employment, etc., as part of this complaint process.

Before filing a complaint, it is strongly recommended that you read Chapter XIII: Complaints in the *Accreditation Handbook.*

Criteria

Complaints about programs must meet all of the following criteria:

- Be against an accredited graduate education program or program in candidacy status in audiology or speech-language pathology
- Relate to the Standards for Accreditation of Entry-Level Graduate Education Programs in Audiology and Speech-Language Pathology in effect at the time that the conduct for the complaint occurred, including the relationship of the complaint to the accreditation standards
- Be clearly described, including the specific nature of the charge and the data to support the charge
- Be within the timelines specified below:
    - If the complaint is being filed by a graduate or former student, or a former faculty or staff member, the complaint must be filed within one year of separation* from the program, even if the conduct occurred more than 4 years prior to the date of filing the complaint
    - If the complaint is being filed by a current student or faculty member, the complaint must be filed as soon as possible, but no longer than 4 years after the date the conduct occurred
    - If the complaint is being filed by other complainants, the conduct must have occurred at least in part within 4 years prior to the date the complaint is filed

**Note: For graduates, former students, or former faculty or staff filing a complaint, the date of separation should be the date on which the individual was no longer considered a student in or employee of the graduate program (i.e., graduation, resignation, official notice of withdrawal or termination), and after any institutional grievance or other review processes have been concluded.*

Submission Requirements

- Complaints against a program must be filed in writing using the CAA's official Complaint Form [DOC]. The Complaint Form must be completed in its entirety. The CAA does not accept complaints over the phone.
- The complainant's name, address, and telephone contact information and the complainant's relationship to the program must be included in order for the Accreditation Office staff to verify the source of the information. The CAA does not accept anonymous complaints.
- The complaint must include verification, if the complaint is from a student or faculty/staff member, that the complainant exhausted all pertinent institutional grievance and review mechanisms before submitting a complaint to the CAA.
- Documented evidence in support of the complaint must be appended, including as appropriate relevant policies/procedures, relevant correspondence (including email), timelines of referenced events, etc. **Do not** enclose entire documents, such as a handbook or catalog; only the specific pages should be included that present content germane to the complaint. Page numbers to these appendices should be referenced in the complaint. Materials may be returned to the complainant if not properly organized to support the complaint.
- All complaints and supporting evidence must be submitted in English, consistent with the business practices of the CAA.
- The complaint form must be signed and submitted with any relevant appendices via U.S. mail, overnight courier, or hand delivery—not via e-mail or as a facsimile—to:
  Chair, Council on Academic Accreditation in Audiology and Speech-Language Pathology
  American Speech-Language-Hearing Association
  2200 Research Boulevard, #310
  Rockville, MD 20850

The complainant's burden of proof is a preponderance, or greater weight, of the evidence. It is expected that the complaint includes all relevant documentation at the time of submission.

Copies of the CAA's complaint procedures, relevant Standards for Accreditation, and the Complaint Form are available in paper form by contacting the Accreditation Office at accreditation@asha.org or 800-498-2071. All complaint materials (completed and signed complaint form and relevant appendices) must be typewritten or printed from a computer.

Additional information can be located at: http://www.asha.org/academic/accreditation/

SUGGESTED GUIDELINES FOR CLINICAL PRACTICUM EXPERIENCES

The following are suggested guidelines based upon a field assignment of 3 - 5 days per week for 10 or more weeks. Individual students and supervisors should proceed at "their own pace". *These guidelines are adapted from guidelines used at Temple University.*

Check off and date when completed.

Week One:

_____1. Program Site Orientation

_____2. Review of Policy and Procedures, Student Orientation Manual, if available.

_____3. Observation of Supervisor

_____4. Observations of other Speech-Language Pathologists (as possible)

_____5. Discuss the agency/clinicians' philosophy and standard of practice

_____6. Review of Client Charts:

_____Log/File/Progress Notes

_____Initial/subsequent evaluations

_____Case/Medical History

_____7. Become familiar with working conditions, manipulatives, literature for families, therapy materials, and tests (where kept, philosophy of delivery)

_____8. Discussion of appropriate dress and professional behavior

_____9. Knowledge and Sensitivity to cultural and/or linguistic diversity

_____10. Other: _____

_____

_____

Week Two:

_____1. Active observation of supervisor (e.g. collection and analysis of language sample, written oral discussion)

_____2. Become familiar with evaluation procedures and tests

_____3. Establish frequency of supervisory meetings to provide student clinician with performance feedback, review student self -monitoring (e.g., what's going right, what needs to change, what can I do to get more out of this.)

_____4. Other: _____

_____

_____

Week Three:

_____1. Initiate at least one therapy task with 3-4 cases

_____2. Document client performance during treatment session by writing in the daily note and discussing with supervisor

_____3. Conduct 50% of initial evaluation with guidance from supervisor (formal or informal) and write a shadow report

_____4. Demonstrate rudimentary mastery of paperwork procedures and case management time lines

_____ 5. Keep daily log of ASHA hours

_____6. Supervisory meeting

_____7. Select, read and discuss relevant articles as needed or suggested by Supervisor

_____8. Other: _____

_____

_____

Week Four:

_____1. Plan and implement treatment sessions for 4-5 clients.

_____2. Demonstrate ability to provide evaluative feedback to client

_____3. Write therapy notes for those individuals being followed with moderate supervision

_____4. Supervisory meeting

_____5. Conduct a full evaluation with developing naturalness, flexibility and accuracy

_____ 6. Other: _____

_____

_____

Weeks Five, Six, Seven, Eight: (Mid-Term):

_____ 1. Assume responsibility for an increasing amount of the caseload at the discretion of the supervisor (including documentation and collaboration with staff)

_____ 2. Mid-term evaluation (CALIPSO) and visit is completed (especially important to have student conduct a self- monitoring check, e.g., what's going right; what needs to change; what can I do to get more out of this)

_____ 3. Present in-service topic to supervisor for approval (optional)

_____ 4. Weekly supervisory meeting

_____ 5. Family Contact: Discussion of therapeutic progress and/or diagnostic results

_____ 6. Observation and participation in an interdisciplinary consult or client discussion

_____ 7. Other: _____

_____

_____

Weeks Nine-Thirteen:

_____ 1. Assume responsibility for increasing caseload

_____ 2. Present a 30 minute in-service to agency staff (optional)

_____ 3. Weekly supervisory meeting

_____ 4. Prepare for final week/completion of practicum (review CALIPSO, progress notes)

_____ 5. Other: _____

_____

_____

Last Week:

_____1. Complete final evaluation with supervisor and Clinic Director

_____2. Complete clinical clock hours and request supervisor to sign all required Documentation

_____3. Completion of evaluations of practicum by student, field supervisor, and university supervisor

_____4. Gather samples of documentation and record experiences in student portfolio

_____5. Other: _____

_____

_____

Appendix A.

SEQUENCE OF CLINICAL EDUCATION EXPERIENCES

Fall Semester Year I

CER-SLP-5000-AA (3) Neuroscience
CER-SLP-5001-AA (2) Counseling Foundations in Communication Sciences & Disorders
CER-SLP-5100-AA (3) Articulation and Phonological Disorders
CER-SLP-5130-AA (2) Prevention, Assessment & Treatment of Communication Disorders in the Children: Zero to Five
CER-SLP-5230-AA (2) Adult Language Disorders 1: Aphasia and Right Hemisphere Damage
CER-SLP-5555-AA (1) Interprofessional Evidence Based Practice Course
CER-SLP-6000-AA (2) Clinical Foundations

Spring Semester Year I

CER-SLP-5002-AA (2) Applied Integrative Anatomy for Speech-Language Pathology
CER-SLP-5005-AA (1) Cleft Palate and Craniofacial Anomalies
CER-SLP-5131-AA (2) Prevention, Assessment, & Treatment of Communication Disorders in School-Aged Children: Six to Twenty-One
CER-SLP-5231-AA (3) Adult Language Disorders 2: Traumatic Brain Injury and the Dementias
CER-SLP-5400-AA (2) Research Design and Application of Evidence Based Practice in Speech-Language Pathology (includes students identifying Capstone Project Topic)
CER-SLP-5401-AA (3) Dysphagia
CER-SLP-6030-AA (2) Clinical Management and Practicum 1

Summer Semester Year I

CER-SLP-5003-AA (2) Communication Disorders in Culturally and Linguistically Diverse Populations
CER-SLP-5300-AA (2) Motor Speech Disorders
CER-SLP-5301-AA (2) Autism Spectrum Disorders
CER-SLP-5302-AA (2) Fluency Disorders
CER-SLP-5303-AA (2) Voice Disorders
CER-SLP-6031-AA (2) Clinical Management and Practicum 2

Fall Semester Year II

CER-SLP-5030-AA (2) Special Topics Seminar 1
CER-SLP-5304-AA (2) Technology in Speech-Language Pathology: Augmentative and Alternative Communication and Computer Applications
CER-SLP-5500-AA (2) Aural Habilitation/Rehabilitation
CER-SLP-6031-AA (3) Clinical Management and Practicum 3

Spring Semester Year II

CER-SLP-5004-AA (2) Professional Issues and Ethics in Speech-Language Pathology
CER-SLP-5031-AA (2) Special Topics Seminar 2

CER-SLP-5402-AA (2) Capstone Project in Speech-Language Pathology
CER-SLP-6033-AA (4) Clinical Management and Practicum 4

Appendix B.

COURSE DESCRIPTIONS

CER-SLP-5000-AA Neuroscience
(3 credits)

An overview of the anatomy and physiology (structure and function) of the central nervous system (CNS) and the peripheral nervous system (PNS). Special emphasis is placed on how these structures support the production of speech, language, cognition, voice and swallowing. Communication and swallowing disorders associated with pathophysiology of the CNS and PNS are also presented.

CER-SLP-5001-AA Counseling Foundations in Communication Disorders
(2 credits)

An introduction to counseling skills needed by speech-language pathologists in their daily interactions with clients/patients and their families. A broad overview of counseling theories and techniques will be provided, with an emphasis throughout the course on "positive psychology" and a mind-body wellness perspective. Discussion and practice of effective communication techniques, including verbal, nonverbal, and interpersonal communication is presented. Students will understand the emotional needs of individuals with communication disorders and their families, and how communication disorders affect the family system. Counseling needs of individuals with specific communication disorders will be discussed, including those with fluency disorders, autism spectrum disorders, hearing loss, acquired/adult language and cognitive disorders, dysphagia and congenital disorders.

CER-SLP-5002-AA Applied Integrative Anatomy for SLP
(2 credits)

Lecture and lab provide students with a background in gross human anatomy using body parts of cadavers. Emphasis is on body structures supporting the speech, voice and swallowing mechanisms, including anatomical structures associated with respiration, phonation, articulation/resonance and mechanics of swallowing using upper and lower digestive systems.

CER-SLP-5003-AA Communication Disorders in Culturally and Linguistically Diverse Populations
(2 credits)

Foundational issues involved in serving culturally and linguistically diverse populations with a focus on developing and exhibiting cultural competence when conducting interviews, patient/family education and counseling. Investigates how to collect data on relevant cultural and linguistic background and incorporate this information into the therapeutic process. Consideration is given to reliability and validity of standardized assessment tools based on those culturally distinct populations that were used by authors of the examinations to obtain normative data. Treatment approaches that respect and incorporate the cultural-linguistic background of the patient and family members will also be discussed.

CER-SLP-5004-AA Professional Issues and Ethics in Speech-Language Pathology (2 credits)

Issues related to employment settings, job exploration/preparation, credentialing and licensure application and acquisition, trends in service delivery, ethics, legal considerations and professional advocacy including state, national and international politics and laws associated with speech-language pathology. Course content parallels guidelines associated with the American Speech-Language-Hearing Association (ASHA) Scope of Practice, Code of Ethics, Preferred Practice Patterns and credentialing guidelines established by the ASHA Council for Clinical Certification. Professional leadership, ASHA, state associations and community volunteerism, including patient/client advocacy will be discussed and encouraged**.**

CER-SLP-5005-AA Cleft Palate and Craniofacial Anomalies (1 credit)

A comprehensive study of the definitions, characteristics, classifications, epidemiology, pathophysiology, etiologies, and differential diagnosis of cleft palate and other craniofacial anomalies. Formal and informal assessment tools and intervention strategies will be presented.

CER-SLP-5030-AA Special Topics Seminar 1 (2 credits)

Topics of current interest to the profession of speech-language pathology. Guest lecturers and research literature related to speech, language, voice, swallowing and contemporary professional issues will be incorporated. The intent of this seminar is to expand upon the overall understanding of the discipline of speech-language pathology by presenting topics not routinely covered in a standard speech-language pathology curriculum. Topics may vary from year-to-year depending on the current state-of-the art or 'hot topics' being discussed at the state, national and international levels.

CER-SLP-5031-AA Special Topics Seminar 2 (2 credits)

Continuation of topics of current interest to the profession of speech-language pathology using guest lecturers and research literature to discuss speech, language, voice, swallowing and contemporary professional issues.

CER-SLP-5100-AA Articulation and Phonological Disorders (3 credits)

Articulatory phonetics, phonological processes and backward and forward co-articulation are presented. Contemporary assessment and intervention tools for articulatory and phonological delays and disorders, including specific remediation procedures are demonstrated.

CER-SLP-5130-AA Prevention, Assessment and Treatment of Communication Disorders in Children: Zero to Five (2 Credits)

Etiologies, risk factors, inter-disciplinary assessment and analysis of language disorders in infants, toddlers, and preschool aged children using formal and informal measures. Language

facilitation and intervention strategies are presented. Includes practice in the self-directed hand based and computerized analysis of child speech and language samples.

CER-SLP-5131-AA Prevention, Assessment and Treatment of Communication Disorders in School-Aged Children: 6-21
(2 credits)

A comprehensive study of children's phonologic, morphemic, syntactic, semantic, pragmatic and emerging literacy impairments with focus on etiologies, characteristics, and associated risk factors. Formal and informal assessment methods, service delivery models (i.e., classroom interactions between the teacher and speech-language pathologist) and intervention strategies in our culturally and linguistically diverse population are presented. The role of the speech-language pathologist in assisting with the development of Individualized Education Plans (IEPs) is discussed.

CER-SLP-5230-AA Adult Language Disorders 1: Aphasia and Right Hemisphere Damage
(2 credits)

Definitions, characteristics, classifications, epidemiology, pathophysiology, etiologies, differential diagnosis of aphasia and cognitive-linguistic disorders associated with right brain hemisphere syndrome. Formal and informal assessment tools and intervention strategies will be presented.

CER-SLP-5231-AA Adult Language Disorders 2: Traumatic Brain Injury and the Dementias
(3 credits)

Definitions, characteristics, classifications, epidemiology, pathophysiology, etiologies, differential diagnosis of cognitive-linguistic disorders associated with traumatic brain injury, Alzheimer's disease and other dementias. Formal and informal assessment tools and intervention strategies are presented.

CER-SLP-5300-AA Motor Speech Disorders
(2 credits)

An overview of pathophysiology and the symptomatology of the dysarthrias and apraxia of speech. Assessment, differential diagnosis and treatment of developmental and acquired apraxia of speech and the dysarthrias are discussed. Classification schemes will be presented as will diagnostic and intervention strategies using evidence-based practice research. Both perceptual and objective measures of dysarthric and apraxic speech will be examined.

CER-SLP-5301-AA Autism Spectrum Disorders
(2 credits)

Current research on the epidemiology, etiologies and characteristics associated with various clients along the autism continuum. Assessment and clinical management strategies for pediatric and adult populations with autism are discussed. Client and family education and community intervention approaches and supportive resources are presented.

CER-SLP-5302-AA Fluency Disorders
(2 credits)

Etiologies, epidemiology characteristics and classifications of persons with fluency disorders are presented. Diagnosis and therapeutic intervention for both pediatric and adult populations who exhibit stuttering and cluttering behaviors are discussed.

CER-SLP-5303-AA Voice Disorders
(2 credits)

Study of normal laryngeal physiology, vocal hyperfunction and vocal pathophysiology ranging from vocal nodules and polyps to vocal cord paralysis and cancer of the larynx are presented, including functional/behavioral, organic and neurogenic etiologies of voice disorders. Perceptual and objective diagnostic measures and specific intervention techniques are presented. Research studies examining evidence-based practice, care of the professional voice and prevention of voice disorders will also be incorporated as part of the course.

CER-SLP-5304-AA Technology in Speech-Language Pathology: Augmentative and Alternative Communication and Computer Applications
(2 credits)

Assessment strategies and AAC systems ranging from simple communication picture and alpha-numeric boards to highly technical and sophisticated electronic speaking boards using artificial voices to improve the communication skills of individuals with limited or nonfunctional speech-language production will be discussed, demonstrated and used. Students will also be introduced to hardware and software computer applications in speech-language pathology that can be incorporated in the diagnostic and therapeutic process.

CER-SLP-5400-AA Research Design and Application of Evidenced Based Practice in Speech-Language Pathology
(2 credits)

Strategies and methodology in the design and analysis of research in communication sciences and disorders. Includes a module on how to find and identify the most efficacious and efficient evidence for clinical application in the diagnosis and treatment of communication disorders. Students will also identify a research topic that will be used throughout the remainder of their studies as their Capstone Project topic.

CER-SLP-5401-AA Dysphagia
(3 credits)

Normal anatomy and physiology of mastication and deglutition (chewing and swallowing) as well as disrupted stages of feeding and swallow are presented for pediatric, adult and elderly patients. Discussion of etiologies and characteristics of swallowing disorders are presented. Interprofessional education and inter-collaborative service models are described in the diagnosis and treatment of dysphagia along with current research indicative of best practices.

CER-SLP-5402-AA Capstone Project in Speech-Language Pathology
(2 credits)

Culmination of a research, special clinical service delivery and/or community education and service project that is student directed. Projects are mentored into fruition by faculty in the Department of Speech-Language Pathology. Student presentations (poster and oral) to the faculty, student peers within the department and fellow students and faculty across the university.

CER-SLP-5500-AA Aural Habilitation/Rehabilitation
(2 credits)

Application of methods and procedures for management of the individual with a hearing impairment and the role of the speech-language pathologist. Includes language, speech, auditory training, speech-reading, and subject-matter tutoring.

CER-SLP-5555-AA Interprofessional Evidence Based Practice Course
(1 credit)

A highly interactive, interprofessional course taught across all of the health sciences academic programs at the University. Helps students understand how evidence based practice tools are applied to clinical training, clinical problem solving and most importantly, clinical practice.

CER-SLP-6000-AA Clinical Foundations
(2 credits)

An introduction to clinical policies, procedures and processes including: development and recording a case history; conducting patient and family/caregiver interviews; basic principles of assessment; differential diagnosis; report writing including long- and short-term goals; development of clinical lesson plans; generating patient progress notations (e.g., SOAP notes, computerized progress checklists, narrative notes), and use of effective communication strategies (verbal, non-verbal and interpersonal 'soft' skills) when interacting with the patient and family members. Clinical problem solving cases using SimuCase and/or actors who mimic various communication disorders are included for individual and small group analysis. Also includes actively engaged student observations and analysis of diagnostic and therapeutic techniques and settings (videotaped and/or real-time) by trained, certified (CCC-SLP) speech-language pathologists.

CER-SLP-6030-AA Clinical Management and Practicum 1
(2 credits)

Development of clinical decision-making skills and applying those skills to evaluate and treat pediatric, adult and elderly clients with various communication disorders. Includes the use of appropriate interview and counseling techniques with clients and family members from various cultural and linguistic backgrounds. Student-generated long- and short-term goal setting, diagnostic and treatment lesson planning, clinical session preparation of materials and reinforcement award systems for patient motivation and active participation; establishing measureable outcome data and incorporating clinical techniques used and resulting outcome data measures for progress notation and report writing under the close supervision of on-

campus clinical educators. Clinical session planning and implementation will involve students working in pairs and individually at the Salus University on-campus clinic.

CER-SLP-6031-AA Clinical Management and Practicum 2
(2 credits)

Self-directed student-generated evaluation and treatment of children, adults and the elderly with communication disorders at the Salus University on-campus clinic under the supervision of ASHA certified faculty and clinical educators. Real-life application of clinic foundational knowledge, skills and materials while earning clinic hours under the supervision of ASHA-certified (CCC-SLP) and Pennsylvania state-licensed speech-language pathologists. More independent student clinicians who demonstrate expected didactic knowledge and clinical competencies at this stage will be placed in their first off-campus external placement site under certified and licensed speech-language pathologists who will serve as externship clinical supervisors.

CER-SLP-6032-AA Clinical Management and Practicum 3
(3 credits)

External clinical placement site involving hospital, rehabilitation, private and public schools, pre-schools, skilled nursing facilities, home-based and private practice clinical settings. Students are supervised by a certified and licensed external placement site speech-language pathologist. Adaptation of time-schedule for service delivery, workload requirements as well as the particulars involving report writing, individual education plans (IEPs) progress notation, billing procedures, interprofessional team patient care management using a case manager (usually a nurse or social worker), work related policies and procedures and other duties as assigned are experienced by the student clinician.

CER-SLP-6033-AA Clinical Management and Practicum 4
(3 credits)

Full-time evaluation and treatment of pediatric, adult and/or elderly patients with communication disorders or dysphagia in an external clinical setting under supervision of an external site certified and licensed speech-language pathologist.

Appendix C.

Standards for Accreditation of Graduate Education Programs in Audiology and Speech-Language Pathology

Approved February 2016 | Last Updated October 2017
Effective August 1, 2017

Introduction
The Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA) of the American Speech-Language-Hearing Association (ASHA) accredits graduate programs that prepare individuals to enter professional practice in audiology or speech-language pathology. The CAA and its predecessors were established by ASHA, which authorized the CAA to function autonomously in setting and implementing standards and awarding accreditation. The CAA is recognized by the Council for Higher Education Accreditation (CHEA) and by the U.S. Secretary of Education as the accrediting body for the accreditation and pre-accreditation (accreditation candidate) of education programs leading to the first professional or clinical degree at the master's or doctoral level and for the accreditation of these programs offered via distance education, throughout the United States.

Accreditation by the CAA indicates that a program is committed to excellence and ongoing quality improvement so that students and the public are assured that graduates are prepared to meet the challenges they will face when entering the workforce.

The accreditation standards have been written to address six essential components. The standards are designed to ensure that, when programs are in full compliance, their graduate students are prepared to function in the complex and ever-changing service provision (or delivery) arenas.

Professional Practice Competencies (3.1.1B)
The program must provide content and opportunities for students to learn so that each student can demonstrate the following attributes and abilities and demonstrate those attributes and abilities in the manners identified.

Accountability

- Practice in a manner that is consistent with the professional code of ethics and the scope of practice documents for the profession of speech-language pathology.
- Adhere to federal, state, and institutional regulations and policies that are related to services provided by speech-language pathologists.
- Understand the fiduciary responsibility for each individual served.
- Understand the various models of delivery of speech-language pathology services (e.g., hospital, private practice, education, etc.).
- Use self-reflection to understand the effects of his/her actions and makes changes accordingly.
- Understand the health care and education landscape and how to facilitate access to services.
- Understand how to work on interprofessional teams to maintain a climate of mutual respect and shared values.

Integrity

- Use the highest level of clinical integrity with each individual served, family members, caregivers, other service providers, students, other consumers, and payers; and
- Understand and use best professional practices related to maintenance of confidentiality for all individuals in accordance with HIPAA and FERPA requirements.

Effective Communication Skills

- Use all forms of expressive communication—including written, spoken, and nonverbal communication—with individuals served, family members, caregivers, and any others involved in the interaction to ensure the highest quality of care that is delivered in a culturally competent manner.
- Communicate—with patients, families, communities, and interprofessional team colleagues and other professionals caring for individuals in a responsive and responsible manner that supports a team approach to maximize care outcomes.

Clinical Reasoning

- Use valid scientific and clinical evidence in decision-making regarding assessment and intervention.
- Apply current knowledge, theory, and sound professional judgment in approaches to intervention and management of individuals served.
- Use clinical judgment and self-reflection to enhance clinical reasoning.

Evidence-Based Practice

- Access sources of information to support clinical decisions regarding assessment and intervention/management,
- Critically evaluate information sources and applies that information to appropriate
- populations, and
- Integrate evidence in provision of speech-language pathology services.

Concern for Individuals Served

- Show evidence of care, compassion, and appropriate empathy during interactions with each individual served, family members, caregivers, and any others involved in care; and
- Encourage active involvement of the individual served in his or her own care.

Cultural Competence

- Understand the impact of his or her own set of cultural and linguistic variables on delivery of effective care. These include, but are not limited to, variables such as age, ethnicity, linguistic background, national origin, race, religion, gender, and sexual orientation.
- Understand the impact of the cultural and linguistic variables of the individuals served on delivery of care. These include but are not limited to variables such as age, ethnicity, linguistic background, national origin, race, religion, gender, and sexual orientation.
- Understand the interaction of cultural and linguistic variables between the caregivers and the individuals served in order to maximize service delivery.
- Understand the characteristics of the individuals served (e.g., age, demographics, cultural and linguistic diversity, educational history and status, medical history and

status, cognitive status, and physical and sensory abilities) and how these characteristics relate to clinical services.

Professional Duty

- Engage in self-assessment to improve his or her effectiveness in the delivery of services.
- Understand the roles and importance of professional organizations in advocating for rights to access to speech-language pathology services.
- Understand the role of clinical teaching and clinical modeling as well as supervision of students and other support personnel.
- Understand the roles and importance of interdisciplinary/interprofessional assessment and intervention and be able to interact and coordinate care effectively with other disciplines and community resources.
- Understand and practice the principles of universal precautions to prevent the spread of infectious and contagious diseases.
- Understand and use the knowledge of one's own role and those of other professions to appropriately assess and address the needs of the individuals and populations served.

Collaborative Practice

- Understand how to apply values and principles of interprofessional team dynamics.
- Understand how to perform effectively in different interprofessional team roles to plan and deliver care centered on the individual served that is safe, timely, efficient, effective, and equitable.

Foundations of Speech-Language Pathology Practice (3.1.2B)
The program must include content and opportunities to learn so that each student can demonstrate knowledge of the:

- discipline of human communication sciences and disorders;
- basic human communication and swallowing processes, including the appropriate biological, neurological, acoustic, psychological, developmental, and linguistic and cultural bases;
- ability to integrate information pertaining to normal and abnormal human development across the life span;
- nature of communication and swallowing processes
    - elements
        - articulation;
        - fluency;
        - voice and resonance, including respiration and phonation;
        - receptive and expressive language (phonology, morphology, syntax, semantics, pragmatics, prelinguistic communication, and paralinguistic communication) in speaking, listening, reading, writing, and manual modalities;
        - hearing, including the impact on speech and language;
        - swallowing (oral, pharyngeal, esophageal, and related functions, including oral function for feeding; orofacial myology);
        - cognitive aspects of communication (e.g., attention, memory, sequencing, problem solving, executive functioning);

        - social aspects of communication (e.g., behavioral and social skills affecting communication);
        - augmentative and alternative communication.
    - knowledge of the above elements includes each of the following:
        - etiology of the disorders or differences,
        - characteristics of the disorders or differences,
        - underlying anatomical and physiological characteristics of the disorders or differences,
        - acoustic characteristics of the disorders or differences (where applicable),
        - psychological characteristics associated with the disorders or differences,
        - developmental nature of the disorders or differences,
        - linguistic characteristics of the disorders or differences (where applicable),
        - cultural characteristics of the disorders or differences.

Identification and Prevention of Speech, Language, and Swallowing Disorders and Differences (3.1.3B)
The program must include content and opportunities to learn so that each student can demonstrate knowledge of

- principles and methods of identification of communication and swallowing disorders and differences,
- principles and methods of prevention of communication and swallowing disorders.

Evaluation of Speech, Language, and Swallowing Disorders and Differences (3.1.4B)
The program must include content and opportunities to learn so that each student can demonstrate knowledge and skills in assessment across the lifespan for disorders and differences associated with

- articulation;
- fluency;
- voice and resonance, including respiration and phonation;
- receptive and expressive language (phonology, morphology, syntax, semantics, pragmatics, prelinguistic communication, and paralinguistic communication) in speaking, listening, reading, writing, and manual modalities;
- hearing, including the impact on speech and language;
- swallowing (oral, pharyngeal, esophageal, and related functions, including oral function for feeding; orofacial myology);
- cognitive aspects of communication (e.g., attention, memory, sequencing, problem solving, executive functioning);
- social aspects of communication (e.g., behavioral and social skills affecting communication); and
- augmentative and alternative communication needs.

Intervention to Minimize the Effects of Changes in the Speech, Language, and Swallowing Mechanisms (3.1.5B)

The program must include content and opportunities to learn so that each student can demonstrate knowledge and skills in

- intervention for communication and swallowing differences with individuals
- across the lifespan to minimize the effect of those disorders and differences on
- the ability to participate as fully as possible in the environment.
- intervention for disorders and differences of
    - articulation;
    - fluency;
    - voice and resonance, including respiration and phonation;
    - receptive and expressive language (phonology, morphology, syntax, semantics, pragmatics, prelinguistic communication, and paralinguistic communication) in speaking, listening, reading, writing, and manual modalities;
    - hearing, including the impact on speech and language;
    - swallowing (oral, pharyngeal, esophageal, and related functions, including oral function for feeding; orofacial myology);
    - cognitive aspects of communication (e.g., attention, memory, sequencing, problem solving, executive functioning);
    - social aspects of communication (e.g., behavioral and social skills affecting communication);
    - augmentative and alternative communication needs.

General Knowledge and Skills Applicable to Professional Practice (3.1.6B)
The program must include content and opportunities to learn so that each student acquires knowledge and skills in working with individuals with the aforementioned communication and swallowing disorders across the lifespan and by demonstration of

- ethical conduct;
- integration and application of knowledge of the interdependence of speech, language, and hearing;
- engagement in contemporary professional issues and advocacy;
- processes of clinical education and supervision;
- professionalism and professional behavior in keeping with the expectations for a speech-language pathologist;
- interaction skills and personal qualities, including counseling and collaboration;
- self-evaluation of effectiveness of practice.

Council on Academic Accreditation in Audiology and Speech-Language Pathology. (2017). Standards for accreditation of graduate education programs in audiology and speech-language pathology (2017). Retrieved 12/27/2018 from http://caa.asha.org/wpcontent/uploads/Accreditation-Standards-for-Graduate-Programs.pdf

Appendix D.

2014 Standards and Implementation Procedures for the Certificate of Clinical Competence in Speech-Language Pathology

Effective Date: September 1, 2014
Revised Date: March 1, 2016

Introduction

The Council for Clinical Certification in Audiology and Speech-Language Pathology (CFCC) is a semi-autonomous credentialing body of the American Speech-Language-Hearing Association. The charges to the CFCC are: to define the standards for clinical certification; to apply those standards in granting certification to individuals; to have final authority to withdraw certification in cases where certification has been granted on the basis of inaccurate information; and to administer the certification maintenance program.

A Practice and Curriculum Analysis of the Profession of Speech-Language Pathology was conducted in 2009 under the auspices of the Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA) and the CFCC. The survey analysis was reviewed by the CFCC, and the following standards were developed to better fit current practice models.

The 2014 standards and implementation procedures for the Certificate of Clinical Competence in Speech-Language Pathology are now in effect as of September 1, 2014. View the SLP Standards Crosswalk [PDF] for more specific information on how the standards have changed.

Citation
cite as: Council for Clinical Certification in Audiology and Speech-Language Pathology of the American Speech-Language-Hearing Association. (2013). 2014 Standards for the Certificate of Clinical Competence in Speech-Language Pathology. Retrieved [date] from http://www.asha.org/Certification/2014-Speech-Language-Pathology-Certification-Standards/.

Standard I: Degree

The applicant for certification must have a master's, doctoral, or other recognized post-baccalaureate degree.

Implementation: The Council for Clinical Certification in Audiology and Speech-Language Pathology (CFCC) has the authority to determine eligibility of all applicants for certification.

Standard II: Education Program

All graduate course work and graduate clinical experience required in speech-language pathology must have been initiated and completed in a speech-language pathology program accredited by the Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA).

Implementation: If the graduate program of study is initiated and completed in a CAA-accredited program or in a program that held candidacy status for CAA accreditation, and if the program director or official designee verifies that all knowledge and skills required at the time of application have been met, approval of academic course work and practicum is automatic. Applicants eligible for automatic approval must submit an official graduate transcript or a letter from the registrar that verifies the date the graduate degree was awarded. The official graduate transcript or letter from the registrar must be received by the National Office no later than 1 year from the date the application was received. Verification of the graduate degree is required of the applicant before the certificate is awarded.

Individuals educated outside the United States or its territories must submit documentation that course work was completed in an institution of higher education that is regionally accredited or recognized by the appropriate regulatory authority for that country. In addition, applicants outside the United States or its territories must meet each of the standards that follow.

Standard III: Program of Study

The applicant for certification must have completed a program of study (a minimum of 36 semester credit hours at the graduate level) that includes academic course work and supervised clinical experience sufficient in depth and breadth to achieve the specified knowledge and skills outcomes stipulated in Standard IV-A through IV-G and Standard V-A through V-C.

Implementation: The minimum of 36 graduate semester credit hours must have been earned in a program that addresses the knowledge and skills pertinent to the ASHA Scope of Practice in Speech-Language Pathology.

Standard IV: Knowledge Outcomes

Standard IV-A

The applicant must have demonstrated knowledge of the biological sciences, physical sciences, statistics, and the social/behavioral sciences.

Implementation: Acceptable courses in biological sciences should emphasize a content area related to human or animal sciences (e.g., biology, human anatomy and physiology, neuroanatomy and neurophysiology, human genetics, veterinary science). Acceptable courses in physical sciences should include physics or chemistry. Acceptable courses in social/behavioral sciences should include psychology, sociology, anthropology, or public health. A stand-alone course in statistics is required. Research methodology courses in communication sciences and disorders (CSD) may not be used to satisfy the statistics requirement. A course in biological and physical sciences specifically related to CSD may not be applied for certification purposes to this category unless the course fulfills a university requirement in one of these areas.

Academic advisors are strongly encouraged to enroll students in courses in the biological, physical, and the social/behavioral sciences in content areas that will assist students in acquiring the basic principles in social, cultural, cognitive, behavioral, physical, physiological, and anatomical areas useful to understanding the communication/linguistic sciences and disorders.

Standard IV-B

The applicant must have demonstrated knowledge of basic human communication and swallowing processes, including the appropriate biological, neurological, acoustic, psychological, developmental, and linguistic and cultural bases. The applicant must have demonstrated the ability to integrate information pertaining to normal and abnormal human development across the life span.

Standard IV-C

The applicant must have demonstrated knowledge of communication and swallowing disorders and differences, including the appropriate etiologies, characteristics, anatomical/physiological, acoustic, psychological, developmental, and linguistic and cultural correlates in the following areas:

- articulation;
- fluency;
- voice and resonance, including respiration and phonation;
- receptive and expressive language (phonology, morphology, syntax, semantics, pragmatics, prelinguistic communication and paralinguistic communication) in speaking, listening, reading, writing;
- hearing, including the impact on speech and language;
- swallowing (oral, pharyngeal, esophageal, and related functions, including oral function for feeding, orofacial myology);
- cognitive aspects of communication (attention, memory, sequencing, problem-solving, executive functioning);
- social aspects of communication (including challenging behavior, ineffective social skills, and lack of communication opportunities);
- augmentative and alternative communication modalities.

Implementation: It is expected that course work addressing the professional knowledge specified in Standard IV-C will occur primarily at the graduate level.

Standard IV-D

For each of the areas specified in Standard IV-C, the applicant must have demonstrated current knowledge of the principles and methods of prevention, assessment, and intervention for people with communication and swallowing disorders, including consideration of anatomical/physiological, psychological, developmental, and linguistic and cultural correlates.

Standard IV-E

The applicant must have demonstrated knowledge of standards of ethical conduct.

Implementation: The applicant must have demonstrated knowledge of the principles and rules of the current ASHA Code of Ethics.

Standard IV-F

The applicant must have demonstrated knowledge of processes used in research and of the integration of research principles into evidence-based clinical practice.

Implementation: The applicant must have demonstrated knowledge of the principles of basic and applied research and research design. In addition, the applicant must have demonstrated knowledge of how to access sources of research information and have demonstrated the ability to relate research to clinical practice.

Standard IV-G

The applicant must have demonstrated knowledge of contemporary professional issues.

Implementation: The applicant must have demonstrated knowledge of professional issues that affect speech-language pathology. Issues typically include trends in professional practice, academic program accreditation standards, ASHA practice policies and guidelines, and reimbursement procedures.

Standard IV-H

The applicant must have demonstrated knowledge of entry level and advanced certifications, licensure, and other relevant professional credentials, as well as local, state, and national regulations and policies relevant to professional practice.

Standard V: Skills Outcomes

Standard V-A

The applicant must have demonstrated skills in oral and written or other forms of communication sufficient for entry into professional practice.

Implementation: Individuals are eligible to apply for certification once they have completed all graduate-level academic course work and clinical practicum and been judged by the graduate program as having acquired all of the knowledge and skills mandated by the current standards.

The applicant must have demonstrated communication skills sufficient to achieve effective clinical and professional interaction with clients/patients and relevant others. For oral communication, the applicant must have demonstrated speech and language skills in English, which, at a minimum, are consistent with ASHA's current position statement on students and professionals who speak English with accents and nonstandard dialects. In addition, the applicant must have demonstrated the ability to write and comprehend technical reports, diagnostic and treatment reports, treatment plans, and professional correspondence in English.

Standard V-B

The applicant for certification must have completed a program of study that included experiences sufficient in breadth and depth to achieve the following skills outcomes:

1. Evaluation
    a. Conduct screening and prevention procedures (including prevention activities).
    b. Collect case history information and integrate information from clients/patients, family, caregivers, teachers, and relevant others, including other professionals.
    c. Select and administer appropriate evaluation procedures, such as behavioral observations, nonstandardized and standardized tests, and instrumental procedures.
    d. Adapt evaluation procedures to meet client/patient needs.
    e. Interpret, integrate, and synthesize all information to develop diagnoses and make appropriate recommendations for intervention.
    f. Complete administrative and reporting functions necessary to support evaluation.
    g. Refer clients/patients for appropriate services.

2. Intervention
    a. Develop setting-appropriate intervention plans with measurable and achievable goals that meet clients'/patients' needs. Collaborate with clients/patients and relevant others in the planning process.
    b. Implement intervention plans (involve clients/patients and relevant others in the intervention process).
    c. Select or develop and use appropriate materials and instrumentation for prevention and intervention.
    d. Measure and evaluate clients'/patients' performance and progress.
    e. Modify intervention plans, strategies, materials, or instrumentation as appropriate to meet the needs of clients/patients.
    f. Complete administrative and reporting functions necessary to support intervention.
    g. Identify and refer clients/patients for services as appropriate.

3. Interaction and Personal Qualities
    a. Communicate effectively, recognizing the needs, values, preferred mode of communication, and cultural/linguistic background of the client/patient, family, caregivers, and relevant others.
    b. Collaborate with other professionals in case management.
    c. Provide counseling regarding communication and swallowing disorders to clients/patients, family, caregivers, and relevant others.
    d. Adhere to the ASHA Code of Ethics and behave professionally.

Implementation: The applicant must have acquired the skills referred to in this standard applicable across the nine major areas listed in Standard IV-C. Skills may be developed and demonstrated by direct client/patient contact in clinical experiences, academic course work, labs, simulations, examinations, and completion of independent projects.

The applicant must have obtained a sufficient variety of supervised clinical experiences in different work settings and with different populations so that he or she can demonstrate skills across the ASHA Scope of Practice in Speech-Language Pathology. Supervised clinical experience is defined as clinical services (i.e., assessment/diagnosis/evaluation, screening, treatment, report writing, family/client consultation, and/or counseling) related to the management of populations that fit within the ASHA Scope of Practice in Speech-Language Pathology.

These experiences should allow students to:

- interpret, integrate, and synthesize core concepts and knowledge;
- demonstrate appropriate professional and clinical skills; and
- incorporate critical thinking and decision-making skills while engaged in identification, evaluation, diagnosis, planning, implementation, and/or intervention.

Alternative clinical experiences may include the use of standardized patients and simulation technologies (e.g., standardized patients, virtual patients, digitized mannequins, immersive reality, task trainers, computer-based interactive).

Supervisors of clinical experiences must hold a current ASHA Certificate of Clinical Competence in the appropriate area of practice during the time of supervision. The supervised activities must be within the ASHA Scope of Practice in Speech-Language Pathology to count toward certification.

Standard V-C

The applicant for certification in speech-language pathology must complete a minimum of 400 clock hours of supervised clinical experience in the practice of speech-language pathology. Twenty-five hours must be spent in clinical observation, and 375 hours must be spent in direct client/patient contact.

Implementation: Guided observation hours generally precede direct contact with clients/patients. The observation and direct client/patient contact hours must be within the ASHA Scope of Practice in Speech-Language Pathology and must be under the supervision of a qualified professional who holds current ASHA certification in the appropriate practice area. Such supervision may occur simultaneously with the student's observation or afterwards through review and approval of written reports or summaries submitted by the student. Students may use video recordings of client services for observation purposes.

Applicants should be assigned practicum only after they have acquired sufficient knowledge bases to qualify for such experience. Only direct contact with the client or the client's family in assessment, intervention, and/or counseling can be counted toward practicum. Up to 20% (i.e., 75 hours) of direct contact hours may be obtained through clinical simulation (CS) methods. Only the time spent in active engagement with the CS may be counted. CS may include the use of standardized patients and simulation technologies (e.g., standardized patients, virtual patients, digitized mannequins, immersive reality, task trainers, computer-based interactive). Debriefing activities may not be included. Although several students may observe a clinical session at one time, clinical practicum hours should be assigned only to the student who provides direct services to the client or client's family. Typically, only one student should be working with a given client at a time in order to count the practicum hours. It is possible for several students working as a team to receive credit for the same session, depending on the specific responsibilities each student is assigned. The applicant must maintain documentation of time spent in supervised practicum, verified by the program in accordance with Standards III and IV.

Standard V-D

At least 325 of the 400 clock hours must be completed while the applicant is engaged in

graduate study in a program accredited in speech-language pathology by the Council on Academic Accreditation in Audiology and Speech-Language Pathology.
Implementation: A minimum of 325 clock hours of clinical practicum must be completed at the graduate level. At the discretion of the graduate program, hours obtained at the undergraduate level may be used to satisfy the remainder of the requirement.

Standard V-E

Supervision must be provided by individuals who hold the Certificate of Clinical Competence in the appropriate profession. The amount of direct supervision must be commensurate with the student's knowledge, skills, and experience, must not be less than 25% of the student's total contact with each client/patient, and must take place periodically throughout the practicum. Supervision must be sufficient to ensure the welfare of the client/patient.

Implementation: Direct supervision must be in real time. A supervisor must be available to consult with a student providing clinical services to the supervisor's client. Supervision of clinical practicum is intended to provide guidance and feedback and to facilitate the student's acquisition of essential clinical skills. The amount of direct supervision must be commensurate with the student's knowledge, skills, and experience, must not be less than 25% of the student's total contact with each client/patient, and must take place periodically throughout the practicum. Supervision must be sufficient to ensure the welfare of the client/patient.

Standard V-F

Supervised practicum must include experience with client/patient populations across the life span and from culturally/linguistically diverse backgrounds. Practicum must include experience with client/patient populations with various types and severities of communication and/or related disorders, differences, and disabilities.
Implementation: The applicant must demonstrate direct client/patient clinical experiences in both assessment and intervention with both children and adults from the range of disorders and differences named in Standard IV-C.

Standard VI: Assessment

The applicant must have passed the national examination adopted by ASHA for purposes of certification in speech-language pathology.

Implementation: Results of the Praxis Examination in Speech-Language Pathology must be submitted directly to ASHA from ETS. The certification standards require that a passing exam score must be earned no earlier than 5 years prior to the submission of the application and no later than 2 years following receipt of the application. If the exam is not successfully passed and reported within the 2-year application period, the applicant's certification file will be closed. If the exam is passed or reported at a later date, the individual will be required to reapply for certification under the standards in effect at that time.

Standard VII: Speech-Language Pathology Clinical Fellowship

The applicant must successfully complete a Speech-Language Pathology Clinical Fellowship (CF).

Implementation: The CF may be initiated only after completion of all academic course work and clinical experiences required to meet the knowledge and skills delineated in Standards IV and V. The CF experience must be initiated within 24 months of the date the application is received. Once the CF has been initiated, it must be completed within 48 months. For applicants completing multiple CFs, all CF experiences related to the application must be completed within 48 months of the date the first CF was initiated. Applications will be closed for a CF/CFs that is/are not completed within the 48-month timeframe or that is/are not reported to ASHA within 90 days after the 48-month timeframe. The Clinical Fellow will be required to reapply for certification and must meet the Standards in effect at the time of re-application. CF experiences older than 5 years at the time of application will not be accepted.

The CF must have been completed under the mentorship of an individual who held the ASHA Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP) throughout the duration of the CF. It is the Clinical Fellow's responsibility to identify a mentoring speech-language pathologist (SLP) who holds an active Certificate of Clinical Competence in Speech-Language Pathology. Should the certification status of the mentoring SLP change during the CF experience, the Clinical Fellow will be awarded credit only for that portion of time during which the mentoring SLP held certification. It, therefore, is incumbent on the CF to verify the mentoring SLP's status periodically throughout the CF experience. A family member or individual related in any way to the Clinical Fellow may not serve as a mentoring SLP.

Standard VII-A: Clinical Fellowship Experience

The Clinical Fellowship must have consisted of clinical service activities that foster the continued growth and integration of knowledge, skills, and tasks of clinical practice in speech-language pathology consistent with ASHA's current Scope of Practice in Speech-Language Pathology. The Clinical Fellowship must have consisted of no less than 36 weeks of full-time professional experience or its part-time equivalent.

Implementation: No less than 80% of the Fellow's major responsibilities during the CF experience must have been in direct client/patient contact (e.g., assessment, diagnosis, evaluation, screening, treatment, clinical research activities, family/client consultations, recordkeeping, report writing, and/or counseling) related to the management process for individuals who exhibit communication and/or swallowing disabilities.

Full-time professional experience is defined as 35 hours per week, culminating in a minimum of 1,260 hours. Part-time experience of less than 5 hours per week will not meet the CF requirement and will not be counted toward completion of the experience. Similarly, work in excess of the 35 hours per week cannot be used to shorten the CF to less than 36 weeks.

Standard VII-B: Clinical Fellowship Mentorship

The Clinical Fellow must have received ongoing mentoring and formal evaluations by the CF mentor.

Implementation: Mentoring must have included on-site observations and other monitoring activities. These activities may have been executed by correspondence, review of video and/or audio recordings, evaluation of written reports, telephone conferences with the Fellow, and evaluations by professional colleagues with whom the Fellow works. The CF mentor and Clinical Fellow must have participated in regularly scheduled formal evaluations of the Fellow's

progress during the CF experience. The Clinical Fellow must receive ongoing mentoring and formal evaluations by the CF Mentor.

The mentoring SLP must engage in no fewer than 36 supervisory activities during the clinical fellowship experience. This supervision must include 18 on-site observations of direct client contact at the Clinical Fellow's work site (1 hour = 1 on-site observation; a maximum of six on-site observations may be accrued in 1 day). At least six on-site observations must be conducted during each third of the CF experience. On-site observations must consist of the Clinical Fellow engaged in screening, evaluation, assessment, and/or habilitation/rehabilitation activities. Use of real-time, interactive video and audio conferencing technology is permitted as a form of on-site observation, for which pre-approval must be obtained.

Additionally, supervision must also include 18 other monitoring activities. At least six other monitoring activities must be conducted during each third of the CF experience. Other monitoring activities are defined as evaluation of reports written by the Clinical Fellow, conferences between the mentoring SLP and the Clinical Fellow, discussions with professional colleagues of the Fellow, etc., and may be executed by correspondence, telephone, or reviewing of video and/or audio tapes.

On rare occasions, the CFCC may allow the supervisory process to be conducted in other ways. However, a request for other supervisory mechanisms must be submitted in written form to the CFCC, and co-signed by the CF mentor, before the CF is initiated. The request must include the reason for the alternative supervision and a description of the supervision that would be provided. At a minimum, such a request must outline the type, length, and frequency of the supervision that would be provided.

A CF mentor intending to supervise a Clinical Fellow located in another state may be required to also hold licensure in that state; it is up to the CF mentor and the Clinical Fellow to make this determination before proceeding with a supervision arrangement.

Standard VII-C: Clinical Fellowship Outcomes

The Clinical Fellow must have demonstrated knowledge and skills consistent with the ability to practice independently.

Implementation: At the completion of the CF experience, the applicant will have acquired and demonstrated the ability to

- integrate and apply theoretical knowledge,
- evaluate his or her strengths and identify his or her limitations,
- refine clinical skills within the Scope of Practice in Speech-Language Pathology,
- apply the ASHA Code of Ethics to independent professional practice.

In addition, upon completion of the CF, the applicant must have demonstrated the ability to perform clinical activities accurately, consistently, and independently and to seek guidance as necessary.

The CF mentor must submit the Clinical Fellowship Report and Rating Form, which includes the Clinical Fellowship Skills Inventory (CFSI), as soon as the CF successfully completes the CF experience. This report must be signed by both the Clinical Fellow and mentoring SLP.

Standard VIII: Maintenance of Certification

Certificate holders must demonstrate continued professional development for maintenance of the Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP).

Implementation: Individuals who hold the Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP) must accumulate 30 certification maintenance hours of professional development during every 3-year maintenance interval. Intervals are continuous and begin January 1 of the year following award of initial certification or reinstatement of certification. A random audit of compliance will be conducted.

Accrual of professional development hours, adherence to the ASHA Code of Ethics, submission of certification maintenance compliance documentation, and payment of annual dues and/or certification fees are required for maintenance of certification.

If renewal of certification is not accomplished within the 3-year period, certification will expire. Individuals wishing to regain certification must submit a reinstatement application and meet the standards in effect at the time the reinstatement application is submitted.

Council for Clinical Certification in Audiology and Speech-Language Pathology of the American Speech-Language-Hearing Association. (2013). 2014 Standards and Implementation Procedures for the Certificate of Clinical Competence in Speech-Language Pathology. Retrieved 12/27/2018 from http://www.asha.org/Certification/2014-Speech-Language-Pathology-Certification-Standards/

Appendix E.

Scope of Practice for Speech-Language Pathology

Ad Hoc Committee on the Scope of Practice in Speech-Language Pathology

About this Document

This scope of practice document is an official policy of the American Speech-Language-Hearing Association (ASHA) defining the breadth of practice within the profession of speech-language pathology. This document was developed by the ASHA Ad Hoc Committee on the Scope of Practice in Speech-Language Pathology. Committee members were Mark DeRuiter (chair), Michael Campbell, Craig Coleman, Charlette Green, Diane Kendall, Judith Montgomery, Bernard Rousseau, Nancy Swigert, Sandra Gillam (board liaison), and Lemmietta McNeilly (ex officio). This document was approved by the ASHA Board of Directors on February 4, 2016 (BOD 01-2016). The BOD approved a revision in the prevention of hearing section of the document on May 9, 2016 (Motion 07-2016).

Introduction

The *Scope of Practice in Speech-Language Pathology* of the American Speech-Language-Hearing Association (ASHA) includes the following: a statement of purpose, definitions of *speech-language pathologist* and *speech-language pathology*, a framework for speech-language pathology practice, a description of the domains of speech-language pathology service delivery, delineation of speech-language pathology service delivery areas, domains of professional practice, references, and resources.

The *speech-language pathologist* (*SLP*) is defined as the professional who engages in professional practice in the areas of communication and swallowing across the life span. *Communication* and *swallowing* are broad terms encompassing many facets of function. *Communication* includes speech production and fluency, language, cognition, voice, resonance, and hearing. *Swallowing* includes all aspects of swallowing, including related feeding behaviors. Throughout this document, the terms *communication* and *swallowing* are used to reflect all areas. This document is a guide for SLPs across all clinical and educational settings to promote best practice. The term *individuals* is used throughout the document to refer to students, clients, and patients who are served by the SLP.

As part of the review process for updating the *Scope of Practice in Speech-Language Pathology*, the committee revised the previous scope of practice document to reflect recent advances in knowledge and research in the discipline. One of the biggest changes to the document includes the delineation of practice areas in the context of eight domains of speech-language pathology service delivery: collaboration; counseling; prevention and wellness; screening; assessment; treatment; modalities, technology, and instrumentation; and population and systems. In addition, five domains of professional practice are delineated: advocacy and outreach, supervision, education, research and administration/leadership.

Service delivery areas include all aspects of communication and swallowing and related areas that impact communication and swallowing: speech production, fluency, language, cognition, voice, resonance, feeding, swallowing, and hearing. The practice of speech-language pathology continually evolves. SLPs play critical roles in health literacy; screening, diagnosis, and treatment of autism spectrum disorder; and use of the *International Classification of Functioning,*

Disability and Health (ICF; World Health Organization [WHO], 2014) to develop functional goals and collaborative practice. As technology and science advance, the areas of assessment and intervention related to communication and swallowing disorders grow accordingly. Clinicians should stay current with advances in speech-language pathology practice by regularly reviewing the research literature, consulting the Practice Management section of the ASHA website, including the Practice Portal, and regularly participating in continuing education to supplement advances in the profession and information in the scope of practice.

Statement of Purpose

The purpose of this document is to define the *Scope of Practice in Speech-Language Pathology* to

1. delineate areas of professional practice;
2. inform others (e.g., health care providers, educators, consumers, payers, regulators, and the general public) about professional roles and responsibilities of qualified providers;
3. support SLPs in the provision of high-quality, evidence-based services to individuals with communication, feeding, and/or swallowing concerns;
4. support SLPs in the conduct and dissemination of research; and
5. guide the educational preparation and professional development of SLPs to provide safe and effective services.

The scope of practice outlines the breadth of professional services offered within the profession of speech-language pathology. Levels of education, experience, skill, and proficiency in each practice area identified within this scope will vary among providers. An SLP typically does not practice in all areas of clinical service delivery across the life cycle. As the ASHA Code of Ethics specifies, professionals may practice only in areas in which they are competent, based on their education, training, and experience.

This scope of practice document describes evolving areas of practice. These include interdisciplinary work in both health care and educational settings, collaborative service delivery wherever appropriate, and telehealth/telepractice that are effective for the general public.

Speech-language pathology is a dynamic profession, and the overlapping of scopes of practice is a reality in rapidly changing health care, education, and other environments. Hence, SLPs in various settings work collaboratively with other school or health care professionals to make sound decisions for the benefit of individuals with communication and swallowing disorders. This *interprofessional collaborative practice* is defined as "members or students of two or more professions associated with health or social care, engaged in learning with, from and about each other" (Craddock, O'Halloran, Borthwick, & McPherson, 2006, p. 237). Similarly, "interprofessional education provides an ability to share skills and knowledge between professions and allows for a better understanding, shared values, and respect for the roles of other healthcare professionals" (Bridges et al., 2011, para. 5).

This scope of practice does not supersede existing state licensure laws or affect the interpretation or implementation of such laws. However, it may serve as a model for the development or modification of licensure laws. Finally, in addition to this scope of practice document, other ASHA professional resources outline practice areas and address issues related to public protection (e.g., A guide to disability rights law and the Practice Portal). The highest standards of integrity and ethical conduct are held paramount in this profession.

Definitions of Speech-Language Pathologist and Speech-Language Pathology

Speech-language pathologists, as defined by ASHA, are professionals who hold the ASHA Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP), which requires a master's, doctoral, or other recognized postbaccalaureate degree. ASHA-certified SLPs complete a supervised postgraduate professional experience and pass a national examination as described in the ASHA certification standards, (2014). Demonstration of continued professional development is mandated for the maintenance of the CCC-SLP. SLPs hold other required credentials where applicable (e.g., state licensure, teaching certification, specialty certification).

Each practitioner evaluates his or her own experiences with preservice education, practice, mentorship and supervision, and continuing professional development. As a whole, these experiences define the scope of competence for each individual. The SLP should engage in only those aspects of the profession that are within her or his professional competence.

SLPs are autonomous professionals who are the primary care providers of speech-language pathology services. Speech-language pathology services are not prescribed or supervised by another professional. Additional requirements may dictate that speech-language pathology services are prescribed and required to meet specific eligibility criteria in certain work settings, or as required by certain payers. SLPs use professional judgment to determine if additional requirements are indicated. Individuals with communication and/or swallowing disorders benefit from services that include collaboration by SLPs with other professionals.

The profession of speech-language pathology contains a broad area of speech-language pathology practice that includes both speech-language pathology service delivery and professional practice domains. These domains are defined in subsequent sections of this document and are represented schematically in **Figure 1**.

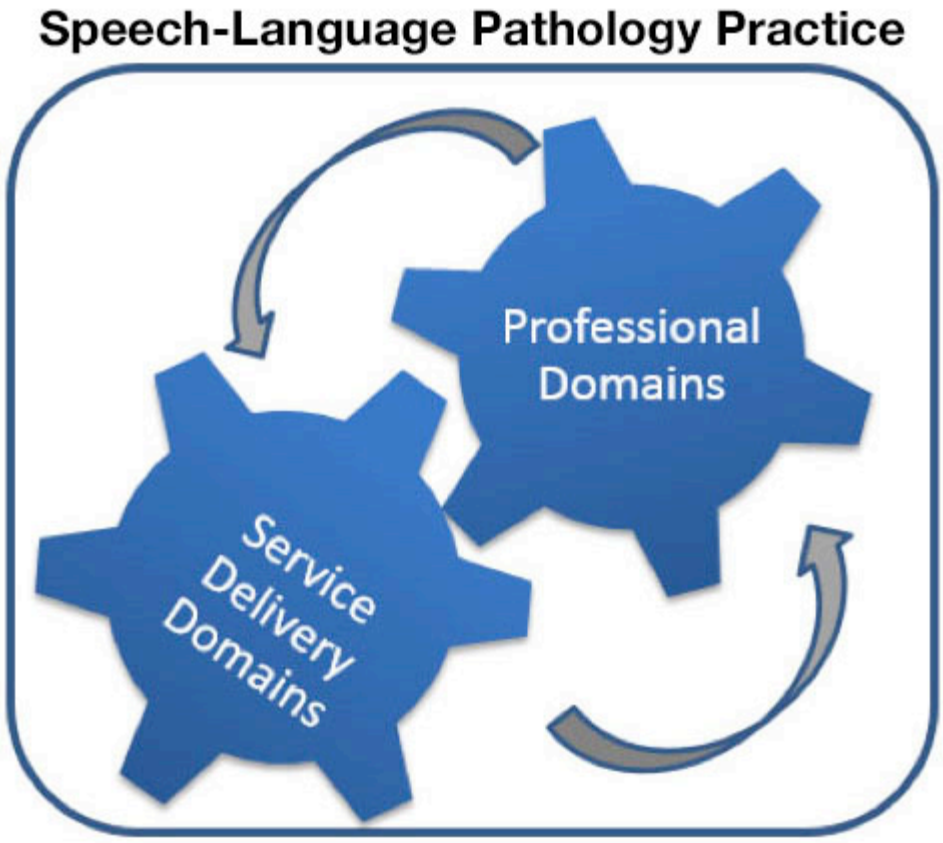

Figure 1. Schematic representation of speech-language pathology practice, including both service delivery and professional domains.

Framework for Speech-Language Pathology Practice

The overall objective of speech-language pathology services is to optimize individuals' abilities to communicate and to swallow, thereby improving quality of life. As the population of the United States continues to become increasingly diverse, SLPs are committed to the provision of culturally and linguistically appropriate services and to the consideration of diversity in scientific investigations of human communication and swallowing.

An important characteristic of the practice of speech-language pathology is that, to the extent possible, decisions are based on best available evidence. ASHA defines *evidence-based practice* in speech-language pathology as an approach in which current, high-quality research evidence is integrated with practitioner expertise, along with the client's values and preferences (ASHA, 2005). A high-quality basic and applied research base in communication sciences and disorders and related disciplines is essential to providing evidence-based practice and high-quality services. Increased national and international interchange of professional knowledge, information, and education in communication sciences and disorders is a means to strengthen research collaboration and improve services. ASHA has provided a resource for evidence-based research via the Practice Portal.

The scope of practice in speech-language pathology comprises five domains of professional practice and eight domains of service delivery.

Professional practice domains:

- advocacy and outreach
- supervision
- education
- administration/leadership
- research

Service delivery domains

- Collaboration
- Counseling
- Prevention and Wellness
- Screening
- Assessment
- Treatment
- Modalities, Technology, and Instrumentation
- Population and Systems

SLPs provide services to individuals with a wide variety of speech, language, and swallowing differences and disorders within the above-mentioned domains that range in function from completely intact to completely compromised. The diagnostic categories in the speech-language pathology scope of practice are consistent with relevant diagnostic categories under the WHO's (2014) *ICF ,* the American Psychiatric Association's (2013) *Diagnostic and Statistical Manual of Mental Disorders*, the categories of disability under the Individuals with Disabilities Education Act of 2004 (see also U.S. Department of Education, 2004), and those defined by two semiautonomous bodies of ASHA: the Council on Academic Accreditation in Audiology and Speech-Language Pathology and the Council for Clinical Certification in Audiology and Speech-Language Pathology.

The domains of speech-language pathology service delivery complement the *ICF,* the WHO's multipurpose health classification system (WHO, 2014). The classification system provides a standard language and framework for the description of functioning and health. The ICF framework is useful in describing the breadth of the role of the SLP in the prevention, assessment, and habilitation/rehabilitation of communication and swallowing disorders and the enhancement and scientific investigation of those functions. The framework consists of two components: health conditions and contextual factors.

Health Conditions

Body Functions and Structures: These involve the anatomy and physiology of the human body. Relevant examples in speech-language pathology include craniofacial anomaly, vocal fold paralysis, cerebral palsy, stuttering, and language impairment.

Activity and Participation: *Activity* refers to the execution of a task or action. *Participation* is the involvement in a life situation. Relevant examples in speech-language pathology include difficulties with swallowing safely for independent feeding, participating actively in class, understanding a medical prescription, and accessing the general education curriculum.

Contextual Factors

Environmental Factors: These make up the physical, social, and attitudinal environments in which people live and conduct their lives. Relevant examples in speech-language pathology include the role of the communication partner in augmentative and alternative communication (AAC), the influence of classroom acoustics on communication, and the impact of institutional dining environments on individuals' ability to safely maintain nutrition and hydration.

Personal Factors: These are the internal influences on an individual's functioning and disability and are not part of the health condition. Personal factors may include, but are not limited to, age, gender, ethnicity, educational level, social background, and profession. Relevant examples in speech-language pathology might include an individual's background or culture, if one or both influence his or her reaction to communication or swallowing.

The framework in speech-language pathology encompasses these health conditions and contextual factors across individuals and populations. **Figure 2** illustrates the interaction of the various components of the ICF. The health condition component is expressed on a continuum of functioning. On one end of the continuum is intact functioning; at the opposite end of the continuum is completely compromised function. The contextual factors interact with each other and with the health conditions and may serve as facilitators or barriers to functioning. SLPs influence contextual factors through education and advocacy efforts at local, state, and national levels.

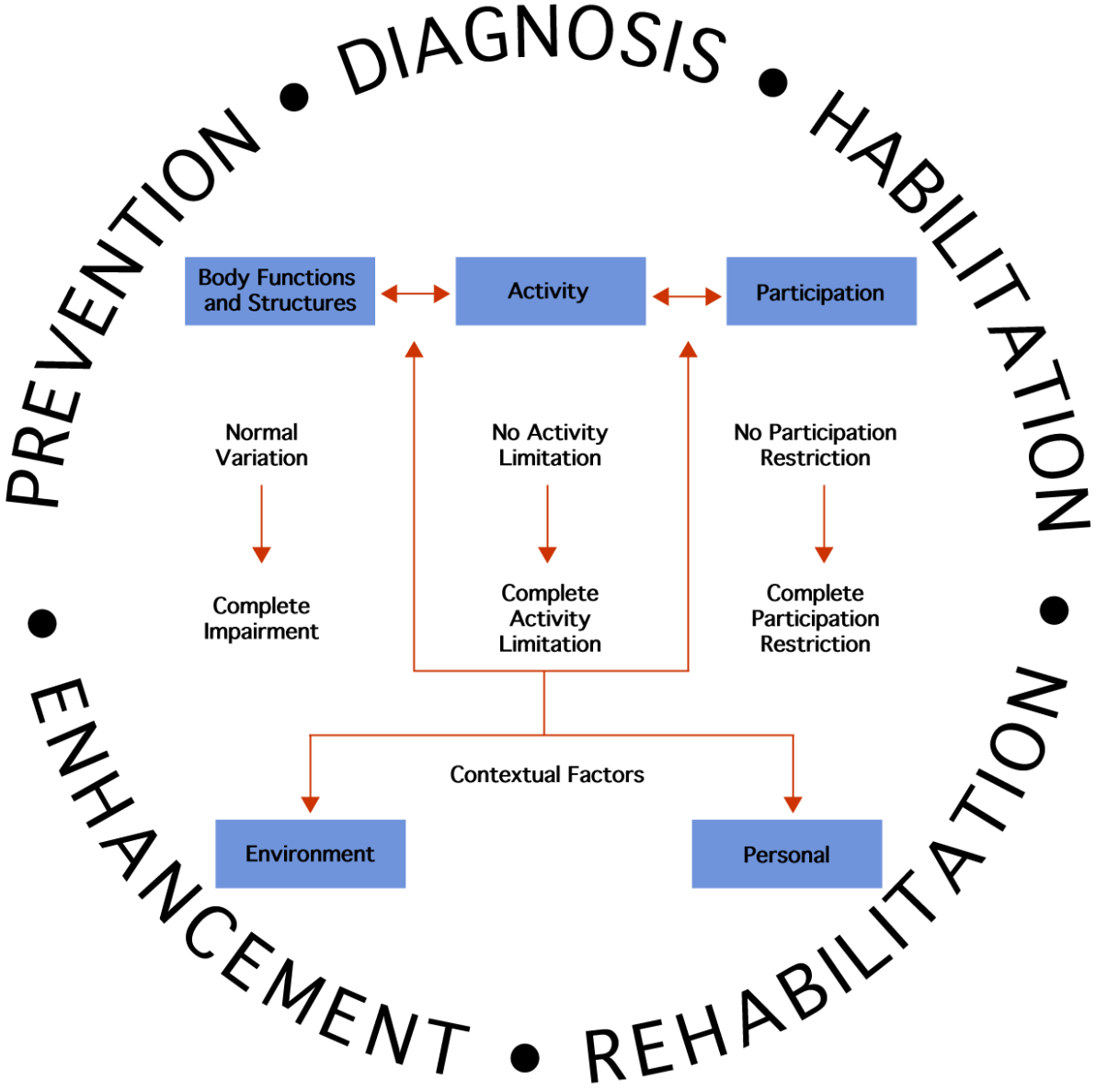

Figure 2. Interaction of the various components of the ICF model. This model applies to individuals or groups.

Domains of Speech-Language Pathology Service Delivery

The eight domains of speech-language pathology service delivery are collaboration; counseling; prevention and wellness; screening; assessment; treatment; modalities, technology, and instrumentation; and population and systems.

Collaboration

SLPs share responsibility with other professionals for creating a collaborative culture. Collaboration requires joint communication and shared decision making among all members of

the team, including the individual and family, to accomplish improved service delivery and functional outcomes for the individuals served. When discussing specific roles of team members, professionals are ethically and legally obligated to determine whether they have the knowledge and skills necessary to perform such services. Collaboration occurs across all speech-language pathology practice domains.

As our global society is becoming more connected, integrated, and interdependent, SLPs have access to a variety of resources, information technology, diverse perspectives and influences (see, e.g., Lipinsky, Lombardo, Dominy, & Feeney, 1997). Increased national and international interchange of professional knowledge, information, and education in communication sciences and disorders is a means to strengthen research collaboration and improve services. SLPs

- educate stakeholders regarding interprofessional education (IPE) and interprofessional practice (IPP) (ASHA, 2014) principles and competencies;
- partner with other professions/organizations to enhance the value of speech-language pathology services;
- share responsibilities to achieve functional outcomes;
- consult with other professionals to meet the needs of individuals with communication and swallowing disorders;
- serve as case managers, service delivery coordinators, members of collaborative and patient care conference teams; and
- serve on early intervention and school pre-referral and intervention teams to assist with the development and implementation of individualized family service plans (IFSPs) and individualized education programs (IEPs).

Counseling

SLPs counsel by providing education, guidance, and support. Individuals, their families and their caregivers are counseled regarding acceptance, adaptation, and decision making about communication, feeding and swallowing, and related disorders. The role of the SLP in the counseling process includes interactions related to emotional reactions, thoughts, feelings, and behaviors that result from living with the communication disorder, feeding and swallowing disorder, or related disorders.

SLPs engage in the following activities in counseling persons with communication and feeding and swallowing disorders and their families:

- empower the individual and family to make informed decisions related to communication or feeding and swallowing issues.
- educate the individual, family, and related community members about communication or feeding and swallowing disorders.
- provide support and/or peer-to-peer groups for individuals with disorders and their families.
- provide individuals and families with skills that enable them to become self-advocates.
- discuss, evaluate, and address negative emotions and thoughts related to communication or feeding and swallowing disorders.
- refer individuals with disorders to other professionals when counseling needs fall outside of those related to (a) communication and (b) feeding and swallowing.

Prevention and Wellness

SLPs are involved in prevention and wellness activities that are geared toward reducing the incidence of a new disorder or disease, identifying disorders at an early stage, and decreasing the severity or impact of a disability associated with an existing disorder or disease. Involvement is directed toward individuals who are vulnerable or at risk for limited participation in communication, hearing, feeding and swallowing, and related abilities. Activities are directed toward enhancing or improving general well-being and quality of life. Education efforts focus on identifying and increasing awareness of risk behaviors that lead to communication disorders and feeding and swallowing problems. SLPs promote programs to increase public awareness, which are aimed at positively changing behaviors or attitudes.

Effective prevention programs are often community based and enable the SLP to help reduce the incidence of spoken and written communication and swallowing disorders as a public health and public education concern.

Examples of prevention and wellness programs include, but are not limited to, the following:

- *Language impairment:* Educate parents, teachers and other school-based professionals about the clinical markers of language impairment and the ways in which these impairments can impact a student's reading and writing skills to facilitate early referral for evaluation and assessment services.
- *Language-based literacy disorders:* Educate parents, school personnel, and health care providers about the SLP's role in addressing the semantic, syntactic, morphological, and phonological aspects of literacy disorders across the lifespan.
- *Feeding:* Educate parents of infants at risk for feeding problems about techniques to minimize long-term feeding challenges.
- *Stroke prevention:* Educate individuals about risk factors associated with stroke
- *Serve on teams:* Participate on multitiered systems of support (MTSS)/response to intervention (RTI) teams to help students successfully communicate within academic, classroom, and social settings.
- *Fluency:* Educate parents about risk factors associated with early stuttering.
- *Early childhood:* Encourage parents to participate in early screening and to collaborate with physicians, educators, child care providers, and others to recognize warning signs of developmental disorders during routine wellness checks and to promote healthy communication development practices.
- *Prenatal care:* Educate parents to decrease the incidence of speech, hearing, feeding and swallowing, and related disorders due to problems during pregnancy.
- *Genetic counseling:* Refer individuals to appropriate professionals and professional services if there is a concern or need for genetic counseling.
- *Environmental change:* Modify environments to decrease the risk of occurrence (e.g., decrease noise exposure).
- *Vocal hygiene:* Target prevention of voice disorders (e.g., encourage activities that minimize phonotrauma and the development of benign vocal fold pathology and that curb the use of smoking and smokeless tobacco products).
- *Hearing:* Educate individuals about risk factors associated with noise-induced hearing loss and preventive measures that may help to decrease the risk.
- *Concussion /traumatic brain injury awareness:* Educate parents of children involved in contact sports about the risk of concussion.
- *Accent/dialect modification:* Address sound pronunciation, stress, rhythm, and intonation of speech to enhance effective communication.

- *Transgender (TG) and transsexual (TS) voice and communication:* Educate and treat individuals about appropriate verbal, nonverbal, and voice characteristics (feminization or masculinization) that are congruent with their targeted gender identity.
- *Business communication:* Educate individuals about the importance of effective business communication, including oral, written, and interpersonal communication.
- *Swallowing:* Educate individuals who are at risk for aspiration about oral hygiene techniques.

Screening

SLPs are experts at screening individuals for possible communication, hearing, and/or feeding and swallowing disorders. SLPs have the knowledge of-and skills to treat-these disorders; they can design and implement effective screening programs and make appropriate referrals. These screenings facilitate referral for appropriate follow-up in a timely and cost-effective manner. SLPs

- select and use appropriate screening instrumentation;
- develop screening procedures and tools based on existing evidence;
- coordinate and conduct screening programs in a wide variety of educational, community, and health care settings;
- participate in public school MTSS/RTI team meetings to review data and recommend interventions to satisfy federal and state requirements (e.g., Individuals with Disabilities Education Improvement Act of 2004 [IDEIA] and Section 504 of the Rehabilitation Act of 1973);
- review and analyze records (e.g., educational, medical);
- review, analyze, and make appropriate referrals based on results of screenings;
- consult with others about the results of screenings conducted by other professionals; and
- utilize data to inform decisions about the health of populations.

Assessment

Speech-language pathologists have expertise in the differential diagnosis of disorders of communication and swallowing. Communication, speech, language, and swallowing disorders can occur developmentally, as part of a medical condition, or in isolation, without an apparent underlying medical condition. Competent SLPs can diagnose communication and swallowing disorders but do not differentially diagnose medical conditions. The assessment process utilizes the *ICF* framework, which includes evaluation of body function, structure, activity and participation, within the context of environmental and personal factors. The assessment process can include, but is not limited to, culturally and linguistically appropriate behavioral observation and standardized and/or criterion-referenced tools; use of instrumentation; review of records, case history, and prior test results; and interview of the individual and/or family to guide decision making. The assessment process can be carried out in collaboration with other professionals. SLPs

- administer standardized and/or criterion-referenced tools to compare individuals with their peers;
- review medical records to determine relevant health, medical, and pharmacological information;
- interview individuals and/or family to obtain case history to determine specific concerns;

- utilize culturally and linguistically appropriate assessment protocols;
- engage in behavioral observation to determine the individual's skills in a naturalistic setting/context;
- diagnose communication and swallowing disorders;
- use endoscopy, videofluoroscopy, and other instrumentation to assess aspects of voice, resonance, velopharyngeal function and swallowing;
- document assessment and trial results for selecting AAC interventions and technology, including speech-generating devices (SGDs);
- participate in meetings adhering to required federal and state laws and regulations (e.g., IDEIA [2004] and Section 504 of the Rehabilitation Act of 1973).
- document assessment results, including discharge planning;
- formulate impressions to develop a plan of treatment and recommendations; and
- discuss eligibility and criteria for dismissal from early intervention and school-based services.

Treatment

Speech-language services are designed to optimize individuals' ability to communicate and swallow, thereby improving quality of life. SLPs develop and implement treatment to address the presenting symptoms or concerns of a communication or swallowing problem or related functional issue. Treatment establishes a new skill or ability or remediates or restores an impaired skill or ability. The ultimate goal of therapy is to improve an individual's functional outcomes. To this end, SLPs

- design, implement, and document delivery of service in accordance with best available practice appropriate to the practice setting;
- provide culturally and linguistically appropriate services;
- integrate the highest quality available research evidence with practitioner expertise and individual preferences and values in establishing treatment goals;
- utilize treatment data to guide decisions and determine effectiveness of services;
- integrate academic materials and goals into treatment;
- deliver the appropriate frequency and intensity of treatment utilizing best available practice;
- engage in treatment activities that are within the scope of the professional's competence;
- utilize AAC performance data to guide clinical decisions and determine the effectiveness of treatment; and
- collaborate with other professionals in the delivery of services.

Modalities, Technology, and Instrumentation

SLPs use advanced instrumentation and technologies in the evaluation, management, and care of individuals with communication, feeding and swallowing, and related disorders. SLPs are also involved in the research and development of emerging technologies and apply their knowledge in the use of advanced instrumentation and technologies to enhance the quality of the services provided. Some examples of services that SLPs offer in this domain include, but are not limited to, the use of

- the full range of AAC technologies to help individuals who have impaired ability to communicate verbally on a consistent basis-AAC devices make it possible for many individuals to successfully communicate within their environment and community;

- endoscopy, videofluoroscopy, fiber-optic evaluation of swallowing (voice, velopharyngeal function, swallowing) and other instrumentation to assess aspects of voice, resonance, and swallowing;
- telehealth/telepractice to provide individuals with access to services or to provide access to a specialist;
- ultrasound and other biofeedback systems for individuals with speech sound production, voice, or swallowing disorders; and
- other modalities (e.g., American Sign Language), where appropriate.

Population and Systems

In addition to direct care responsibilities, SLPs have a role in (a) managing populations to improve overall health and education, (b) improving the experience of the individuals served, and, in some circumstances, (c) reducing the cost of care. SLPs also have a role in improving the efficiency and effectiveness of service delivery. SLPs serve in roles designed to meet the demands and expectations of a changing work environment. SLPs

- use plain language to facilitate clear communication for improved health and educationally relevant outcomes;
- collaborate with other professionals about improving communication with individuals who have communication challenges;
- improve the experience of care by analyzing and improving communication environments;
- reduce the cost of care by designing and implementing case management strategies that focus on function and by helping individuals reach their goals through a combination of direct intervention, supervision of and collaboration with other service providers, and engagement of the individual and family in self-management strategies;
- serve in roles designed to meet the demands and expectations of a changing work environment;
- contribute to the management of specific populations by enhancing communication between professionals and individuals served;
- coach families and early intervention providers about strategies and supports for facilitating prelinguistic and linguistic communication skills of infants and toddlers; and
- support and collaborate with classroom teachers to implement strategies for supporting student access to the curriculum.

Speech-Language Pathology Service Delivery Areas

This list of practice areas and the bulleted examples are not comprehensive. Current areas of practice, such as literacy, have continued to evolve, whereas other new areas of practice are emerging. Please refer to the ASHA Practice Portal for a more extensive list of practice areas.

Fluency

- Stuttering
- Cluttering

Speech Production

- Motor planning and execution

- Articulation
- Phonological

Language- Spoken and written language (listening, processing, speaking, reading, writing, pragmatics)

- Phonology
- Morphology
- Syntax
- Semantics
- Pragmatics (language use and social aspects of communication)
- Prelinguistic communication (e.g., joint attention, intentionality, communicative signaling)
- Paralinguistic communication (e.g., gestures, signs, body language)
- Literacy (reading, writing, spelling)

Cognition

- Attention
- Memory
- Problem solving
- Executive functioning

Voice

- Phonation quality
- Pitch
- Loudness
- Alaryngeal voice

Resonance

- Hypernasality
- Hyponasality
- Cul-de-sac resonance
- Forward focus

Feeding and Swallowing

- Oral phase
- Pharyngeal phase
- Esophageal phase
- Atypical eating (e.g., food selectivity/refusal, negative physiologic response)

Auditory Habilitation/Rehabilitation

- Speech, language, communication, and listening skills impacted by hearing loss, deafness
- Auditory processing

Potential etiologies of communication and swallowing disorders include

- neonatal problems (e.g., prematurity, low birth weight, substance exposure);
- developmental disabilities (e.g., specific language impairment, autism spectrum disorder, dyslexia, learning disabilities, attention-deficit disorder, intellectual disabilities, unspecified neurodevelopmental disorders);
- disorders of aerodigestive tract function (e.g., irritable larynx, chronic cough, abnormal respiratory patterns or airway protection, paradoxical vocal fold motion, tracheostomy);
- oral anomalies (e.g., cleft lip/palate, dental malocclusion, macroglossia, oral motor dysfunction);
- respiratory patterns and compromise (e.g., bronchopulmonary dysplasia, chronic obstructive pulmonary disease);
- pharyngeal anomalies (e.g., upper airway obstruction, velopharyngeal insufficiency/incompetence);
- laryngeal anomalies (e.g., vocal fold pathology, tracheal stenosis);
- neurological disease/dysfunction (e.g., traumatic brain injury, cerebral palsy, cerebrovascular accident, dementia, Parkinson's disease, and amyotrophic lateral sclerosis);
- psychiatric disorder (e.g., psychosis, schizophrenia);
- genetic disorders (e.g., Down syndrome, fragile X syndrome, Rett syndrome, velocardiofacial syndrome); and
- Orofacial myofunctional disorders (e.g., habitual open-mouth posture/nasal breathing, orofacial habits, tethered oral tissues, chewing and chewing muscles, lips and tongue resting position).

This list of etiologies is not comprehensive.

Elective services include

- Transgender communication (e.g., voice, verbal and nonverbal communication);
- Preventive vocal hygiene;
- Business communication;
- Accent/dialect modification; and
- Professional voice use.

This list of elective services is not comprehensive.

Domains of Professional Practice

This section delineates the domains of professional practice-that is, a set of skills and knowledge that goes beyond clinical practice. The domains of professional practice include advocacy and outreach, supervision, education, research, and administration and leadership.

Advocacy and Outreach

SLPs advocate for the discipline and for individuals through a variety of mechanisms, including community awareness, prevention activities, health literacy, academic literacy, education, political action, and training programs. Advocacy promotes and facilitates access to communication, including the reduction of societal, cultural, and linguistic barriers. SLPs perform a variety of activities, including the following:

- Advise regulatory and legislative agencies about the continuum of care. Examples of service delivery options across the continuum of care include telehealth/telepractice, the use of technology, the use of support personnel, and practicing at the top of the license.
- Engage decision makers at the local, state, and national levels for improved administrative and governmental policies affecting access to services and funding for communication and swallowing issues.
- Advocate at the local, state, and national levels for funding for services, education, and research.
- Participate in associations and organizations to advance the speech-language pathology profession.
- Promote and market professional services.
- Help to recruit and retain SLPs with diverse backgrounds and interests.
- Collaborate on advocacy objectives with other professionals/colleagues regarding mutual goals.
- Serve as expert witnesses, when appropriate.
- Educate consumers about communication disorders and speech-language pathology services.
- Advocate for fair and equitable services for all individuals, especially the most vulnerable.
- Inform state education agencies and local school districts about the various roles and responsibilities of school-based SLPs, including direct service, IEP development, Medicaid billing, planning and delivery of assessment and therapy, consultation with other team members, and attendance at required meetings.

Supervision

Supervision is a distinct area of practice; is the responsibility of SLPs; and crosses clinical, administrative, and technical spheres. SLPs are responsible for supervising Clinical Fellows, graduate externs, trainees, speech-language pathology assistants, and other personnel (e.g., clerical, technical, and other administrative support staff). SLPs may also supervise colleagues and peers. SLPs acknowledge that supervision is integral in the delivery of communication and swallowing services and advances the discipline. Supervision involves education, mentorship, encouragement, counseling, and support across all supervisory roles. SLPs

- possess service delivery and professional practice skills necessary to guide the supervisee;
- apply the art and science of supervision to all stakeholders (i.e., those supervising and being supervised), recognizing that supervision contributes to efficiency in the workplace;
- seek advanced knowledge in the practice of effective supervision;
- establish supervisory relationships that are collegial in nature;
- support supervisees as they learn to handle emotional reactions that may affect the therapeutic process; and
- establish a supervisory relationship that promotes growth and independence while providing support and guidance.

Education

SLPs serve as educators, teaching students in academic institutions and teaching professionals through continuing education in professional development formats. This more formal teaching is in addition to the education that SLPs provide to individuals, families, caregivers, decision makers, and policy makers, which is described in other domains. SLPs

- serve as faculty at institutions of higher education, teaching courses at the undergraduate, graduate, and postgraduate levels;
- mentor students who are completing academic programs at all levels;
- provide academic training to students in related disciplines and students who are training to become speech-language pathology assistants; and
- provide continuing professional education to SLPs and to professionals in related disciplines.

Research

SLPs conduct and participate in basic and applied/translational research related to cognition, verbal and nonverbal communication, pragmatics, literacy (reading, writing and spelling), and feeding and swallowing. This research may be undertaken as a facility-specific effort or may be coordinated across multiple settings. SLPs engage in activities to ensure compliance with Institutional Review Boards and international laws pertaining to research. SLPs also collaborate with other researchers and may pursue research funding through grants.

Administration and Leadership

SLPs administer programs in education, higher education, schools, health care, private practice, and other settings. In this capacity, they are responsible for making administrative decisions related to fiscal and personnel management; leadership; program design; program growth and innovation; professional development; compliance with laws and regulations; and cooperation with outside agencies in education and healthcare. Their administrative roles are not limited to speech-language pathology, as they may administer programs across departments and at different levels within an institution. In addition, SLPs promote effective and manageable workloads in school settings, provide appropriate services under IDEIA (2004), and engage in program design and development.

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Appendix F.

ASHA Code of Ethics

PREAMBLE

The American Speech-Language-Hearing Association (ASHA; hereafter, also known as "The Association") has been committed to a framework of common principles and standards of practice since ASHA's inception in 1925. This commitment was formalized in 1952 as the Association's first Code of Ethics. This Code has been modified and adapted as society and the professions have changed. The Code of Ethics reflects what we value as professionals and establishes expectations for our scientific and clinical practice based on principles of duty, accountability, fairness, and responsibility. The ASHA Code of Ethics is intended to ensure the welfare of the consumer and to protect the reputation and integrity of the professions.

The ASHA Code of Ethics is a framework and focused guide for professionals in support of day-to-day decision making related to professional conduct. The Code is partly obligatory and disciplinary and partly aspirational and descriptive in that it defines the professional's role. The Code educates professionals in the discipline, as well as students, other professionals, and the public, regarding ethical principles and standards that direct professional conduct.

The preservation of the highest standards of integrity and ethical principles is vital to the responsible discharge of obligations by audiologists, speech-language pathologists, and speech, language, and hearing scientists who serve as clinicians, educators, mentors, researchers, supervisors, and administrators. This Code of Ethics sets forth the fundamental principles and rules considered essential to this purpose and is applicable to the following individuals:

- a member of the American Speech-Language-Hearing Association holding the Certificate of Clinical Competence (CCC)
- a member of the Association not holding the Certificate of Clinical Competence (CCC)
- a nonmember of the Association holding the Certificate of Clinical Competence (CCC)
- an applicant for certification, or for membership and certification

By holding ASHA certification or membership, or through application for such, all individuals are automatically subject to the jurisdiction of the Board of Ethics for ethics complaint adjudication. Individuals who provide clinical services and who also desire membership in the Association must hold the CCC.

The fundamentals of ethical conduct are described by Principles of Ethics and by Rules of Ethics. The four Principles of Ethics form the underlying philosophical basis for the Code of Ethics and are reflected in the following areas: (I) responsibility to persons served professionally and to research participants, both human and animal; (II) responsibility for one's professional competence; (III) responsibility to the public; and (IV) responsibility for professional relationships. Individuals shall honor and abide by these Principles as affirmative obligations under all conditions of applicable professional activity. Rules of Ethics are specific statements of minimally acceptable as well as unacceptable professional conduct.

The Code is designed to provide guidance to members, applicants, and certified individuals as they make professional decisions. Because the Code is not intended to address specific situations and is not inclusive of all possible ethical dilemmas, professionals are expected to follow the written provisions and to uphold the spirit and purpose of the Code. Adherence to the Code of Ethics and its enforcement results in respect for the professions and positive outcomes for individuals who benefit from the work of audiologists, speech-language pathologists, and speech, language, and hearing scientists.

Terminology

ASHA Standards and Ethics
The mailing address for self-reporting in writing is American Speech-Language-Hearing Association, Standards and Ethics, 2200 Research Blvd., #313, Rockville, MD 20850.

advertising
Any form of communication with the public about services, therapies, products, or publications.

conflict of interest
An opposition between the private interests and the official or professional responsibilities of a person in a position of trust, power, and/or authority.

crime
Any felony; or any misdemeanor involving dishonesty, physical harm to the person or property of another, or a threat of physical harm to the person or property of another. For more details, see the "Disclosure Information" section of applications for ASHA certification found on www.asha.org/certification/AudCertification/ and www.asha.org/certification/SLPCertification/.

diminished decision-making ability
Any condition that renders a person unable to form the specific intent necessary to determine a reasonable course of action.

fraud
Any act, expression, omission, or concealment—the intent of which is either actual or constructive—calculated to deceive others to their disadvantage.

impaired practitioner
An individual whose professional practice is adversely affected by addiction, substance abuse, or health-related and/or mental health–related conditions.

individuals
Members and/or certificate holders, including applicants for certification.

informed consent
May be verbal, unless written consent is required; constitutes consent by persons served, research participants engaged, or parents and/or guardians of persons served to a proposed course of action after the communication of adequate information regarding expected outcomes and potential risks.

jurisdiction
The "personal jurisdiction" and authority of the ASHA Board of Ethics over an individual holding

ASHA certification and/or membership, regardless of the individual's geographic location.

know, known, or knowingly
Having or reflecting knowledge.

may vs. shall
May denotes an allowance for discretion; shall denotes no discretion.

misrepresentation
Any statement by words or other conduct that, under the circumstances, amounts to an assertion that is false or erroneous (i.e., not in accordance with the facts); any statement made with conscious ignorance or a reckless disregard for the truth.

negligence
Breaching of a duty owed to another, which occurs because of a failure to conform to a requirement, and this failure has caused harm to another individual, which led to damages to this person(s); failure to exercise the care toward others that a reasonable or prudent person would take in the circumstances, or taking actions that such a reasonable person would not.

nolo contendere
No contest.

plagiarism
False representation of another person's idea, research, presentation, result, or product as one's own through irresponsible citation, attribution, or paraphrasing; ethical misconduct does not include honest error or differences of opinion.

publicly sanctioned
A formal disciplinary action of public record, excluding actions due to insufficient continuing education, checks returned for insufficient funds, or late payment of fees not resulting in unlicensed practice.

reasonable or reasonably
Supported or justified by fact or circumstance and being in accordance with reason, fairness, duty, or prudence.

self-report
A professional obligation of self-disclosure that requires (a) notifying ASHA Standards and Ethics and (b) mailing a hard copy of a certified document to ASHA Standards and Ethics (see term above). All self-reports are subject to a separate ASHA Certification review process, which, depending on the seriousness of the self-reported information, takes additional processing time.

shall vs. may
Shall denotes no discretion; may denotes an allowance for discretion.

support personnel
Those providing support to audiologists, speech-language pathologists, or speech, language, and hearing scientists (e.g., technician, paraprofessional, aide, or assistant in audiology, speech-language pathology, or communication sciences and disorders). For more information, read the Issues in Ethics Statements on Audiology Assistants and/or Speech-Language

Pathology Assistants.

telepractice, teletherapy
Application of telecommunications technology to the delivery of audiology and speech-language pathology professional services at a distance by linking clinician to client/patient or clinician to clinician for assessment, intervention, and/or consultation. The quality of the service should be equivalent to in-person service. For more information, see the telepractice section on the ASHA Practice Portal.

written
Encompasses both electronic and hard-copy writings or communications.

Principle of Ethics I

Individuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally or who are participants in research and scholarly activities, and they shall treat animals involved in research in a humane manner.

Rules of Ethics

A. Individuals shall provide all clinical services and scientific activities competently.

B. Individuals shall use every resource, including referral and/or interprofessional collaboration when appropriate, to ensure that quality service is provided.

C. Individuals shall not discriminate in the delivery of professional services or in the conduct of research and scholarly activities on the basis of race, ethnicity, sex, gender identity/gender expression, sexual orientation, age, religion, national origin, disability, culture, language, or dialect.

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

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

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

G. Individuals who hold the Certificate of Clinical Competence may delegate to students tasks related to the provision of clinical services that require the unique skills, knowledge, and judgment that are within the scope of practice of their profession only if those students are adequately prepared and are appropriately supervised. The

responsibility for the welfare of those being served remains with the certified individual.

H. Individuals shall obtain informed consent from the persons they serve about the nature and possible risks and effects of services provided, technology employed, and products dispensed. This obligation also includes informing persons served about possible effects of not engaging in treatment or not following clinical recommendations. If diminished decision-making ability of persons served is suspected, individuals should seek appropriate authorization for services, such as authorization from a spouse, other family member, or legally authorized/appointed representative.

I. Individuals shall enroll and include persons as participants in research or teaching demonstrations only if participation is voluntary, without coercion, and with informed consent.

J. Individuals shall accurately represent the intended purpose of a service, product, or research endeavor and shall abide by established guidelines for clinical practice and the responsible conduct of research.

K. Individuals who hold the Certificate of Clinical Competence shall evaluate the effectiveness of services provided, technology employed, and products dispensed, and they shall provide services or dispense products only when benefit can reasonably be expected.

L. Individuals may make a reasonable statement of prognosis, but they shall not guarantee—directly or by implication—the results of any treatment or procedure.

M. Individuals who hold the Certificate of Clinical Competence shall use independent and evidence-based clinical judgment, keeping paramount the best interests of those being served.

N. Individuals who hold the Certificate of Clinical Competence shall not provide clinical services solely by correspondence, but may provide services via telepractice consistent with professional standards and state and federal regulations.

O. Individuals shall protect the confidentiality and security of records of professional services provided, research and scholarly activities conducted, and products dispensed. Access to these records shall be allowed only when doing so is necessary to protect the welfare of the person or of the community, is legally authorized, or is otherwise required by law.

P. Individuals shall protect the confidentiality of any professional or personal information about persons served professionally or participants involved in research and scholarly activities and may disclose confidential information only when doing so is necessary to protect the welfare of the person or of the community, is legally authorized, or is otherwise required by law.

Q. Individuals shall maintain timely records and accurately record and bill for services provided and products dispensed and shall not misrepresent services provided, products dispensed, or research and scholarly activities conducted.

R. Individuals whose professional practice is adversely affected by substance abuse, addiction, or other health-related conditions are impaired practitioners and shall seek professional assistance and, where appropriate, withdraw from the affected areas of practice.

S. Individuals who have knowledge that a colleague is unable to provide professional services with reasonable skill and safety shall report this information to the appropriate authority, internally if a mechanism exists and, otherwise, externally.

T. Individuals shall provide reasonable notice and information about alternatives for obtaining care in the event that they can no longer provide professional services.

Principle of Ethics II

Individuals shall honor their responsibility to achieve and maintain the highest level of professional competence and performance.

Rules of Ethics

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

B. Members who do not hold the Certificate of Clinical Competence may not engage in the provision of clinical services; however, individuals who are in the certification application process may engage in the provision of clinical services consistent with current local and state laws and regulations and with ASHA certification requirements.

C. Individuals who engage in research shall comply with all institutional, state, and federal regulations that address any aspects of research, including those that involve human participants and animals.

D. Individuals shall enhance and refine their professional competence and expertise through engagement in lifelong learning applicable to their professional activities and skills.

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

F. Individuals in administrative or supervisory roles shall not require or permit their professional staff to provide services or conduct clinical activities that compromise the staff member's independent and objective professional judgment.

G. Individuals shall make use of technology and instrumentation consistent with accepted professional guidelines in their areas of practice. When such technology is not available, an appropriate referral may be made.

H. Individuals shall ensure that all technology and instrumentation used to provide services or to conduct research and scholarly activities are in proper working order and are

properly calibrated.

Principle of Ethics III

Individuals shall honor their responsibility to the public when advocating for the unmet communication and swallowing needs of the public and shall provide accurate information involving any aspect of the professions.

Rules of Ethics

A. Individuals shall not misrepresent their credentials, competence, education, training, experience, and scholarly contributions.

B. Individuals shall avoid engaging in conflicts of interest whereby personal, financial, or other considerations have the potential to influence or compromise professional judgment and objectivity.

C. Individuals shall not misrepresent research and scholarly activities, diagnostic information, services provided, results of services provided, products dispensed, or the effects of products dispensed.

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

E. Individuals' statements to the public shall provide accurate and complete information about the nature and management of communication disorders, about the professions, about professional services, about products for sale, and about research and scholarly activities.

F. Individuals' statements to the public shall adhere to prevailing professional norms and shall not contain misrepresentations when advertising, announcing, and promoting their professional services and products and when reporting research results.

G. Individuals shall not knowingly make false financial or nonfinancial statements and shall complete all materials honestly and without omission.

Principle of Ethics IV

Individuals shall uphold the dignity and autonomy of the professions, maintain collaborative and harmonious interprofessional and intraprofessional relationships, and accept the professions' self-imposed standards.

Rules of Ethics

A. Individuals shall work collaboratively, when appropriate, with members of one's own profession and/or members of other professions to deliver the highest quality of care.

B. Individuals shall exercise independent professional judgment in recommending and providing professional services when an administrative mandate, referral source, or

prescription prevents keeping the welfare of persons served paramount.

C. Individuals' statements to colleagues about professional services, research results, and products shall adhere to prevailing professional standards and shall contain no misrepresentations.

D. Individuals shall not engage in any form of conduct that adversely reflects on the professions or on the individual's fitness to serve persons professionally.

E. Individuals shall not engage in dishonesty, negligence, fraud, deceit, or misrepresentation.

F. Applicants for certification or membership, and individuals making disclosures, shall not knowingly make false statements and shall complete all application and disclosure materials honestly and without omission.

G. Individuals shall not engage in any form of harassment, power abuse, or sexual harassment.

H. Individuals shall not engage in sexual activities with individuals (other than a spouse or other individual with whom a prior consensual relationship exists) over whom they exercise professional authority or power, including persons receiving services, assistants, students, or research participants.

I. Individuals shall not knowingly allow anyone under their supervision to engage in any practice that violates the Code of Ethics.

J. Individuals shall assign credit only to those who have contributed to a publication, presentation, process, or product. Credit shall be assigned in proportion to the contribution and only with the contributor's consent.

K. Individuals shall reference the source when using other persons' ideas, research, presentations, results, or products in written, oral, or any other media presentation or summary. To do otherwise constitutes plagiarism.

L. Individuals shall not discriminate in their relationships with colleagues, assistants, students, support personnel, and members of other professions and disciplines on the basis of race, ethnicity, sex, gender identity/gender expression, sexual orientation, age, religion, national origin, disability, culture, language, dialect, or socioeconomic status.

M. Individuals with evidence that the Code of Ethics may have been violated have the responsibility to work collaboratively to resolve the situation where possible or to inform the Board of Ethics through its established procedures.

N. Individuals shall report members of other professions who they know have violated standards of care to the appropriate professional licensing authority or board, other professional regulatory body, or professional association when such violation compromises the welfare of persons served and/or research participants.

O. Individuals shall not file or encourage others to file complaints that disregard or ignore

facts that would disprove the allegation; the Code of Ethics shall not be used for personal reprisal, as a means of addressing personal animosity, or as a vehicle for retaliation.

P. Individuals making and responding to complaints shall comply fully with the policies of the Board of Ethics in its consideration, adjudication, and resolution of complaints of alleged violations of the Code of Ethics.

Q. Individuals involved in ethics complaints shall not knowingly make false statements of fact or withhold relevant facts necessary to fairly adjudicate the complaints.

R. Individuals shall comply with local, state, and federal laws and regulations applicable to professional practice, research ethics, and the responsible conduct of research.

S. Individuals who have been convicted; been found guilty; or entered a plea of guilty or nolo contendere to (1) any misdemeanor involving dishonesty, physical harm—or the threat of physical harm—to the person or property of another, or (2) any felony, shall self-report by notifying ASHA Standards and Ethics (see Terminology for mailing address) in writing within 30 days of the conviction, plea, or finding of guilt. Individuals shall also provide a certified copy of the conviction, plea, nolo contendere record, or docket entry to ASHA Standards and Ethics within 30 days of self-reporting.

T. Individuals who have been publicly sanctioned or denied a license or a professional credential by any professional association, professional licensing authority or board, or other professional regulatory body shall self-report by notifying ASHA Standards and Ethics (see Terminology for mailing address) in writing within 30 days of the final action or disposition. Individuals shall also provide a certified copy of the final action, sanction, or disposition to ASHA Standards and Ethics within 30 days of self-reporting.

Appendix G.

Clinical Supervision in Speech-Language Pathology and Audiology

Position Statement
Committee on Supervision

About this Document:

The following position paper, developed by the Committee on Supervision, was adopted by the American Speech-Language-Hearing Association through its Legislative Council in November 1984 (LC 8-84). Members of the Committee included Elaine Brown-Grant, Patricia Casey, Bonnie Cleveland, Charles Diggs (ex officio), Richard Forcucci, Noel Matkin, George Purvis, Kathryn Smith, Peggy Williams (ex officio), Edward Wills, and Sandra Ulrich, Chair. Also contributing were the NSSLHA representatives Mary Kawell and Sheran Landis. The committee was under the guidance of Marianna Newton, Vice President for Professional and Governmental Affairs.

Contributions of members of the ASHA Committee on Supervision for the years 1976–1982 are acknowledged. Members of the 1978–1981 Subcommittee on Supervision (Noel Matkin, Chair) of the Council on Professional Standards in Speech-Language Pathology and Audiology are also acknowledged for their work from which the competencies presented herein were adapted.

Resolution:

WHEREAS, the American Speech-Language-Hearing Association (ASHA) needs a clear position on clinical supervision, and

WHEREAS, the necessity for having such a position for use in student training and in professional, legal, and governmental contexts has been recognized, and

WHEREAS, the Committee on Supervision in Speech-Language Pathology and Audiology has been charged to recommend guidelines for the roles and responsibilities of supervisors in various settings (LC 14-74), and

WHEREAS, a position statement on clinical supervision now has been developed, disseminated for both select and widespread peer review, and revised; therefore

RESOLVED, that the American Speech-Language-Hearing Association adopts “Clinical Supervision in Speech-Language Pathology and Audiology” as the recognized position of the Association.

Introduction:

Clinical supervision is a part of the earliest history of the American Speech-Language-Hearing Association (ASHA). It is an integral part of the initial training of speech-language pathologists and audiologists, as well as their continued professional development at all levels and in all work settings.

ASHA has recognized the importance of supervision by specifying certain aspects of supervision in its requirements for the Certificates of Clinical Competence (CCC) and the Clinical Fellowship Year (CFY) (ASHA, 1982). Further, supervisory requirements are specified by the Council on Professional Standards in its standards and guidelines for both educational and professional services programs (Educational Standards Board, ASHA, 1980; Professional Services Board, ASHA, 1983). State laws for licensing and school certification consistently include requirements for supervision of practicum experiences and initial work performance. In addition, other regulatory and accrediting bodies (e.g., Joint Commission on Accreditation of Hospitals, Commission on Accreditation of Rehabilitation Facilities) require a mechanism for ongoing supervision throughout professional careers.

It is important to note that the term **clinical supervision**, as used in this document, refers to the tasks and skills of clinical teaching related to the interaction between a clinician and client. In its 1978 report, the Committee on Supervision in Speech-Language Pathology and Audiology differentiated between the two major roles of persons identified as supervisors: clinical teaching aspects and program management tasks. The Committee emphasized that although program management tasks relating to administration or coordination of programs may be a part of the person's job duties, the term **supervisor** referred to “individuals who engaged in clinical teaching through observation, conferences, review of records, and other procedures, and which is related to the interaction between a clinician and a client and the evaluation or management of communication skills” (*Asha*, 1978, p. 479). The Committee continues to recognize this distinction between tasks of administration or program management and those of clinical teaching, which is its central concern.

The importance of supervision to preparation of students and to assurance of quality clinical service has been assumed for some time. It is only recently, however, that the tasks of supervision have been well-defined, and that the special skills and competencies judged to be necessary for their effective application have been identified. This Position Paper addresses the following areas:

- tasks of supervision
- competencies for effective clinical supervision
- preparation of clinical supervisors

Tasks of Supervision:

A central premise of supervision is that effective clinical teaching involves, in a fundamental way, the development of self-analysis, self-evaluation, and problem-solving skills on the part of the individual being supervised. The success of clinical teaching rests largely on the achievement of this goal. Further, the demonstration of quality clinical skills in supervisors is generally accepted as a prerequisite to supervision of students, as well as of those in the Clinical Fellowship Year or employed as certified speech-language pathologists or audiologists.

Outlined in this paper are 13 tasks basic to effective clinical teaching and constituting the distinct area of practice which comprises clinical supervision in communication disorders. The committee stresses that the level of preparation and experience of the supervisee, the particular work setting of the supervisor and supervisee, and client variables will influence the relative emphasis of each task in actual practice.

The tasks of supervision discussed above follow:

1. establishing and maintaining an effective working relationship with the supervisee;
2. assisting the supervisee in developing clinical goals and objectives;
3. assisting the supervisee in developing and refining assessment skills;
4. assisting the supervisee in developing and refining clinical management skills;
5. demonstrating for and participating with the supervisee in the clinical process;
6. assisting the supervisee in observing and analyzing assessment and treatment sessions;
7. assisting the supervisee in the development and maintenance of clinical and supervisory records;
8. interacting with the supervisee in planning, executing, and analyzing supervisory conferences;
9. assisting the supervisee in evaluation of clinical performance;
10. assisting the supervisee in developing skills of verbal reporting, writing, and editing;
11. sharing information regarding ethical, legal, regulatory, and reimbursement aspects of professional practice;
12. modeling and facilitating professional conduct; and
13. demonstrating research skills in the clinical or supervisory processes.

Competencies for Effective Clinical Supervision:

Although the competencies are listed separately according to task, each competency may be needed to perform a number of supervisor tasks.

1.0 Task: Establishing and maintaining an effective working relationship with the supervisee. Competencies required:

1.1 Ability to facilitate an understanding of the clinical and supervisory processes.
1.2 Ability to organize and provide information regarding the logical sequences of supervisory interaction, that is, joint setting of goals and objectives, data collection and analysis, evaluation.
1.3 Ability to interact from a contemporary perspective with the supervisee in both the clinical and supervisory process.
1.4 Ability to apply learning principles in the supervisory process.
1.5 Ability to apply skills of interpersonal communication in the supervisory process.
1.6 Ability to facilitate independent thinking and problem solving by the supervisee.
1.7 Ability to maintain a professional and supportive relationship that allows supervisor and supervisee growth.
1.8 Ability to interact with the supervisee objectively.
1.9 Ability to establish joint communications regarding expectations and responsibilities in the clinical and supervisory processes.
1.10 Ability to evaluate, with the supervisee, the effectiveness of the ongoing supervisory relationship.

2.0 Task: Assisting the supervisee in developing clinical goals and objectives.
Competencies required:

2.1 Ability to assist the supervisee in planning effective client goals and objectives.
2.2 Ability to plan, with the supervisee, effective goals and objectives for clinical and professional growth.
2.3 Ability to assist the supervisee in using observation and assessment in preparation of client goals and objectives.
2.4 Ability to assist the supervisee in using self-analysis and previous evaluation in preparation of goals and objectives for professional growth.
2.5 Ability to assist the supervisee in assigning priorities to clinical goals and objectives.
2.6 Ability to assist the supervisee in assigning priorities to goals and objectives for professional growth.

3.0 Task: Assisting the supervisee in developing and refining assessment skills.
Competencies required:

3.1 Ability to share current research findings and evaluation procedures in communication disorders.
3.2 Ability to facilitate an integration of research findings in client assessment.
3.3 Ability to assist the supervisee in providing rationale for assessment procedures.
3.4 Ability to assist supervisee in communicating assessment procedures and rationales.
3.5 Ability to assist the supervisee in integrating findings and observations to make appropriate recommendations.
3.6 Ability to facilitate the supervisee's independent planning of assessment.

4.0 Task: Assisting the supervisee in developing and refining management skills.
Competencies required:

4.1 Ability to share current research findings and management procedures in communication disorders.
4.2 Ability to facilitate an integration of research findings in client management.
4.3 Ability to assist the supervisee in providing rationale for treatment procedures.
4.4 Ability to assist the supervisee in identifying appropriate sequences for client change.
4.5 Ability to assist the supervisee in adjusting steps in the progression toward a goal.
4.6 Ability to assist the supervisee in the description and measurement of client and clinician change.
4.7 Ability to assist the supervisee in documenting client and clinician change.
4.8 Ability to assist the supervisee in integrating documented client and clinician change to evaluate progress and specify future recommendations.

5.0 Task: Demonstrating for and participating with the supervisee in the clinical process.
Competencies required:

5.1 Ability to determine jointly when demonstration is appropriate.
5.2 Ability to demonstrate or participate in an effective client-clinician relationship.
5.3 Ability to demonstrate a variety of clinical techniques and participate with the supervisee in clinical management.
5.4 Ability to demonstrate or use jointly the specific materials and equipment of the profession.

5.5 Ability to demonstrate or participate jointly in counseling of clients or family/ guardians of clients.

6.0 Task: Assisting the supervisee in observing and analyzing assessment and treatment sessions.
Competencies required:

6.1 Ability to assist the supervisee in learning a variety of data collection procedures.
6.2 Ability to assist the supervisee in selecting and executing data collection procedures.
6.3 Ability to assist the supervisee in accurately recording data.
6.4 Ability to assist the supervisee in analyzing and interpreting data objectively.
6.5 Ability to assist the supervisee in revising plans for client management based on data obtained.

7.0 Task: Assisting the supervisee in development and maintenance of clinical and supervisory records.
Competencies required:

7.1 Ability to assist the supervisee in applying record- keeping systems to supervisory and clinical processes.
7.2 Ability to assist the supervisee in effectively documenting supervisory and clinically related interactions.
7.3 Ability to assist the supervisee in organizing records to facilitate easy retrieval of information concerning clinical and supervisory interactions.
7.4 Ability to assist the supervisee in establishing and following policies and procedures to protect the confidentiality of clinical and supervisory records.
7.5 Ability to share information regarding documentation requirements of various accrediting and regulatory agencies and third-party funding sources.

8.0 Task: Interacting with the supervisee in planning, executing, and analyzing supervisory conferences.
Competencies required:

8.1 Ability to determine with the supervisee when a conference should be scheduled.
8.2 Ability to assist the supervisee in planning a supervisory conference agenda.
8.3 Ability to involve the supervisee in jointly establishing a conference agenda.
8.4 Ability to involve the supervisee in joint discussion of previously identified clinical or supervisory data or issues.
8.5 Ability to interact with the supervisee in a manner that facilitates the supervisee's self-exploration and problem solving.
8.6 Ability to adjust conference content based on the supervisee's level of training and experience.
8.7 Ability to encourage and maintain supervisee motivation for continuing self-growth.
8.8 Ability to assist the supervisee in making commitments for changes in clinical behavior.
8.9 Ability to involve the supervisee in ongoing analysis of supervisory interactions.

9.0 Task: Assisting the supervisee in evaluation of clinical performance.
Competencies required:

9.1 Ability to assist the supervisee in the use of clinical evaluation tools.

9.2 Ability to assist the supervisee in the description and measurement of his/her progress and achievement.
9.3 Ability to assist the supervisee in developing skills of self-evaluation.
9.4 Ability to evaluate clinical skills with the supervisee for purposes of grade assignment, completion of Clinical Fellowship Year, professional advancement, and so on.

10.0 Task: Assisting the supervisee in developing skills of verbal reporting, writing, and editing.
Competencies required:

10.1 Ability to assist the supervisee in identifying appropriate information to be included in a verbal or written report.
10.2 Ability to assist the supervisee in presenting information in a logical, concise, and sequential manner.
10.3 Ability to assist the supervisee in using appropriate professional terminology and style in verbal and written reporting.
10.4 Ability to assist the supervisee in adapting verbal and written reports to the work environment and communication situation.
10.5 Ability to alter and edit a report as appropriate while preserving the supervisee's writing style.

11.0 Task: Sharing information regarding ethical, legal, regulatory, and reimbursement aspects of the profession.
Competencies required:

11.1 Ability to communicate to the supervisee a knowledge of professional codes of ethics (e.g., ASHA, state licensing boards, and so on).
11.2 Ability to communicate to the supervisee an understanding of legal and regulatory documents and their impact on the practice of the profession (licensure, PL 94-142, Medicare, Medicaid, and so on).
11.3 Ability to communicate to the supervisee an understanding of reimbursement policies and procedures of the work setting.
11.4 Ability to communicate knowledge of supervisee rights and appeal procedures specific to the work setting.

12.0 Task: Modeling and facilitating professional conduct.
Competencies required:

12.1 Ability to assume responsibility.
12.2 Ability to analyze, evaluate, and modify own behavior.
12.3 Ability to demonstrate ethical and legal conduct.
12.4 Ability to meet and respect deadlines.
12.5 Ability to maintain professional protocols (respect for confidentiality, etc.)
12.6 Ability to provide current information regarding professional standards (PSB, ESB, licensure, teacher certification, etc.).
12.7 Ability to communicate information regarding fees, billing procedures, and third-party reimbursement.
12.8 Ability to demonstrate familiarity with professional issues.
12.9 Ability to demonstrate continued professional growth.

13.0 Task: Demonstrating research skills in the clinical or supervisory processes.

Competencies required:

13.1 Ability to read, interprets, and apply clinical and supervisory research.
13.2 Ability to formulate clinical or supervisory research questions.
13.3 Ability to investigate clinical or supervisory research questions.
13.4 Ability to support and refute clinical or supervisory research findings.
13.5 Ability to report results of clinical or supervisory research and disseminate as appropriate (e.g., in-service, conferences, publications).

Preparation of Supervisors:

The special skills and competencies for effective clinical supervision may be acquired through special training which may include, but is not limited to, the following:

1. Specific curricular offerings from graduate programs; examples include doctoral programs emphasizing supervision, other postgraduate preparation, and specified graduate courses.
2. Continuing educational experiences specific to the supervisory process (e.g., conferences, workshops, self-study).
3. Research-directed activities that provide insight in the supervisory process.

The major goal of training in supervision is mastery of the "Competencies for Effective Clinical Supervision." Since competence in clinical services and work experience sufficient to provide a broad clinical perspective are considered essential to achieving competence in supervision, it is apparent that most preparation in supervision will occur following the preservice level. Even so, positive effects of preservice introduction to supervision preparation have been described by both Anderson (1981) and Rassi (1983). Hence, the presentation of basic material about the supervisory process may enhance students' performance as supervisees, as well as provide them with a framework for later study.

The steadily increasing numbers of publications concerning supervision and the supervisory process indicate that basic information concerning supervision now is becoming more accessible in print to all speech-language pathologists and audiologists, regardless of geographical location and personal circumstances. In addition, conferences, workshops, and convention presentations concerning supervision in communication disorders are more widely available than ever before, and both coursework and supervisory practicum experiences are emerging in college and university educational programs. Further, although preparation in the supervisory process specific to communication disorders should be the major content, the commonality in principles of supervision across the teaching, counseling, social work, business, and health care professions suggests additional resources for those who desire to increase their supervisory knowledge and skills.

To meet the needs of persons who wish to prepare themselves as clinical supervisors, additional coursework, continuing education opportunities, and other programs in the supervisory process should be developed both within and outside graduate education programs. As noted in an earlier report on the status of supervision (ASHA, 1978), supervisors themselves expressed a strong desire for training in supervision. Further, systematic study and investigation of the supervisory process is seen as necessary to expansion of the data base from which increased knowledge about supervision and the supervisory process will emerge.

The “Tasks of Supervision” and “Competencies for Effective Clinical Supervision” are intended to serve as the basis for content and outcome in preparation of supervisors. The tasks and competencies will be particularly useful to supervisors for self-study and self-evaluation, as well as to the consumers of supervisory activity, that is, supervisees and employers.

A repeated concern by the ASHA membership is that implementation of any suggestions for qualifications of supervisors will lead to additional standards or credentialing. At this time, preparation in supervision is a viable area of specialized study. The competencies for effective supervision can be achieved and implemented by supervisors and employers.

Summary:

Clinical supervision in speech-language pathology and audiology is a distinct area of expertise and practice. This paper defines the area of supervision, outlines the special tasks of which it is comprised, and describes the competencies for each task. The competencies are developed by special preparation, which may take at least three avenues of implementation. Additional coursework, continuing education opportunities and other programs in the supervisory process should be developed both within and outside of graduate education programs. At this time, preparation in supervision is a viable area for specialized study, with competence achieved and implemented by supervisors and employers.

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Appendix H.

Clinical Supervision in Speech-Language Pathology

Position Statement
Ad Hoc Committee on Supervision in Speech-Language Pathology

About this Document

This position statement is an official policy of the American Speech-Language-Hearing Association. It was developed by the Ad Hoc Committee on Supervision in Speech-Language Pathology. Members of the committee were Lisa O'Connor (chair), Christine Baron, Thalia Coleman, Barbara Conrad, Wren Newman, Kathy Panther, and Janet E. Brown (ex officio). Brian B. Shulman, vice president for professional practices in speech-language pathology (2006–2008), served as the monitoring officer. This document was approved by the Board of Directors on March 12, 2008.

Position Statement

The position statement Clinical Supervision in Speech-Language Pathology and Audiology was approved in 1985. This new position statement updates that document with respect to the profession of speech-language pathology. Although the principles of supervision are common to both professions, this position statement addresses only speech-language pathology because of differences in pre-service education and practice between the two professions.

It is the position of the American Speech-Language-Hearing Association that clinical supervision (also called clinical teaching or clinical education) is a distinct area of practice in speech-language pathology and that it is an essential component in the education of students and the continual professional growth of speech-language pathologists. The supervisory process consists of a variety of activities and behaviors specific to the needs, competencies, and expectations of the supervisor and supervisee, and the requirements of the practice setting. The highly complex nature of supervision makes it critically important that supervisors obtain education in the supervisory process. Engaging in ongoing self-analysis and self-evaluation to facilitate the continuous development of supervisory skills and behaviors is fundamental to this process. Effective supervision facilitates the development of clinical competence in supervisees at all levels of practice, from students to certified clinicians. Clinical supervision is a collaborative process with shared responsibility for many of the activities involved in the supervisory experience. The supervisory relationship should be based on a foundation of mutual respect and effective interpersonal communication. Clinical supervisors have an obligation to fulfill the legal requirements and ethical responsibilities associated with state, national, and professional standards for supervision.

Index terms: supervision

Reference this material as: American Speech-Language-Hearing Association. (2008). Clinical supervision in speech-language pathology [Position Statement]. Available from www.asha.org/policy.

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Appendix H.

Clinical Supervision in Speech-Language Pathology

Technical Report
Ad Hoc Committee on Supervision in Speech-Language Pathology

About this Document

This technical report was developed by the Ad Hoc Committee on Supervision in Speech-Language Pathology of the American Speech-Language-Hearing Association (ASHA). Members of the committee were Lisa O'Connor (chair), Christine Baron, Thalia Coleman, Barbara Conrad, Wren Newman, Kathy Panther, and Janet E. Brown (ex officio). Brian B. Shulman, vice president for professional practices in speech-language pathology (2006–2008), served as the monitoring officer. This document was approved by the Board of Directors on March 12, 2008.

Introduction

Because of increasing amounts of data from studies on supervision, advances in technology, and a greater understanding of the value of interpersonal factors in the supervisory process, there was a need to update ASHA's 1985 position statement *Clinical Supervision in Speech-Language Pathology and Audiology* (ASHA, 1985b). This 2008 technical report accompanies an updated position statement and knowledge and skills document for the profession of speech-language pathology (ASHA 2008a, 2008b). Although the principles of supervision (also called clinical teaching or clinical education) are common to both professions, the updated documents address only speech-language pathology because of differences in pre-service education and practice between the two professions.

The 1985 position statement identified specified competencies for supervisors, with an emphasis on clinical supervision of students. This 2008 technical report addresses supervision across the spectrum of supervisees, with the exception of speech-language pathology assistants. Professionals looking for guidance in supervising support personnel should refer to the ASHA position statement, guidelines, and knowledge and skills documents on this topic (ASHA, 2002, 2004b, 2004e).

As stated in ASHA's position statement on clinical supervision in speech-language pathology (ASHA, 2008a), “clinical supervision (also called clinical teaching or clinical education) is a distinct area of practice in speech-language pathology and ... is an essential component in the education of students and the continual professional growth of speech-language pathologists” (p. 1). Clinical supervision is also a collaborative process, with shared responsibility for many of the activities throughout the supervisory experience.

At some point in their career, many speech-language pathologists (SLPs) will be involved in a role that involves supervising students, clinical fellows, practicing SLPs, and/or paraprofessionals. Many of these SLPs do not have formal training or preparation in supervision. Recognizing the importance and complexity involved in the supervisory process, it is critical that increased focus be devoted to knowledge of the issues and skills in providing clinical supervision across the spectrum of a professional career in speech-language pathology.

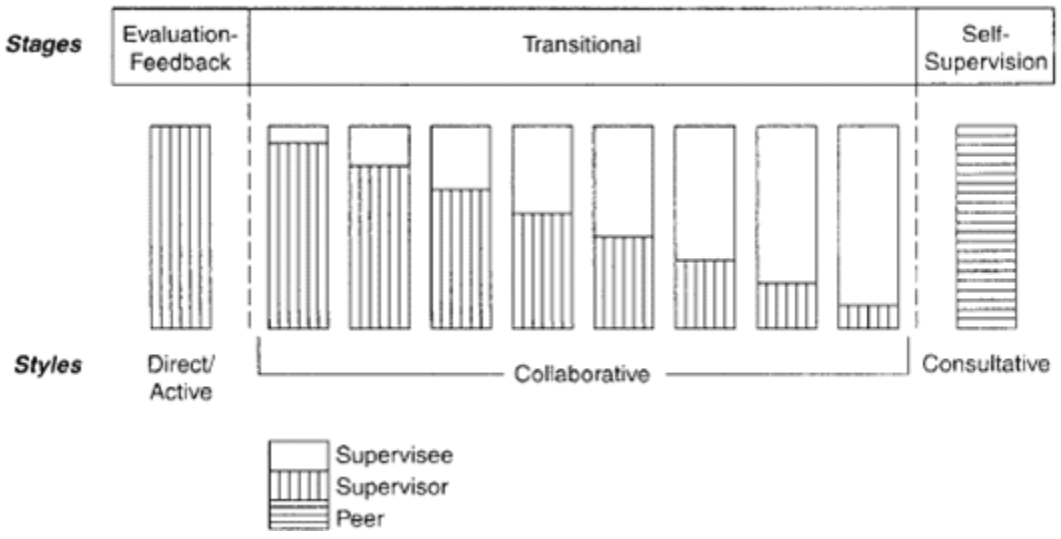
The purpose of this technical report is to highlight key principles and issues that reflect the importance and the highly skilled nature of providing exemplary supervision. It is not intended to provide a comprehensive text on how to become a supervisor. The companion document *Knowledge and Skills Needed by Speech-Language Pathologists Providing Clinical Supervision* (ASHA, 2008b) delineates areas of competence, and the position statement *Clinical Supervision in Speech-Language Pathology* (ASHA, 2008a) affirms the role of supervision within the profession.

Background Information

In 1978, the ASHA Committee on Supervision indicated that there was little knowledge of the critical factors in supervision methodology (American Speech and Hearing Association, 1978). During the three decades since that report was written, a body of work has been published that has helped to identify some of the critical factors in supervision methodology and their relationship to the effectiveness of supervision.

Jean Anderson's *The Supervisory Process in Speech-Language Pathology and Audiology* (1988) played a significant role in helping professionals understand the critical factors in supervision methodology and their contribution to the effectiveness of supervision. Her continuum of supervision is the most widely recognized supervision model in speech-language pathology (see Figure 1). This model is based on a developmental continuum that spans a professional career.

Figure 1. Continuum of supervision. From *The Supervisory Process in Speech-Language Pathology and Audiology* (p. 25), by E. S. McCrea and J. A. Brasseur, 2003, Boston: Allyn and Bacon. Copyright © 2003 by Pearson Education. Reprinted by permission of the publisher.



The continuum mandates a change over time in the amount and type of involvement of both the supervisor and the supervisee in the supervisory process. As the amount of direction by the supervisor decreases, the amount of participation by the supervisee increases across the continuum (J. L. Anderson, 1988). The stages (evaluation-feedback, transitional, self-supervision) should not be viewed as time-bound, as any individual supervisee may be found at any point on the continuum depending on situational variables as well as the knowledge and

skill of the supervisee. The model stresses the importance of modifying the supervisor's style in response to the needs, knowledge, and skills of the supervisee at each stage of clinical development. This model also fosters professional growth on the part of both the supervisor and the supervisee.

In addition to the publications from acknowledged experts in the profession, ASHA has provided guidance in the area of supervision through standards, the Code of Ethics, and Issues in Ethics statements. These documents are described below in the sections *Standards, Regulations, and Legal Issues and Ethical Considerations in Supervision*.

Research on Supervision

As the profession of speech-language pathology has advanced, evidence-based knowledge about practice in clinical disorders has developed through experimental and descriptive research. However, there is little empirical evidence in the area of supervision (Spence, Wilson, Kavanagh, Strong, & Worrall, 2001), especially as it relates to client outcomes. Knowledge about supervision in speech-language pathology has primarily come from descriptive studies documented in texts by acknowledged experts, conference proceedings, and personal and shared experience. The results of descriptive studies have led to the identification of some of the behaviors that supervisors need to modify in order to be less directive and to facilitate high levels of critical thinking in supervisees (Dowling, 1995; Strike-Roussos, 1988, 1995, as cited in McCrea and Brasseur, 2003). Another major source of information about supervision comes from the research literature from other professions. McCrea and Brasseur (2003) examined the work of Rogers (1951), Carkhuff (1967, 1969), Leddick and Barnard (1980), and Hart (1982) in psychology; Fiedler (1967) in business management; Kagan (1970) in social work; and Cogan (1973) and Goldhammer (1969; Goldhammer, Anderson, & Kajewski, 1980) in education to show the extent to which other disciplines have contributed to our knowledge of effective supervision, and to emphasize the shared core principles of supervision reagardless of the discipline and/or service delivery setting (Dowling, 2001).

Definition of Supervision

In 1988 Jean Anderson offered the following definition of the supervisory process:

> *Supervision is a process that consists of a variety of patterns of behavior, the appropriateness of which depends on the needs, competencies, expectations and philosophies of the supervisor and the supervisee and the specifics of the situation (tasks, client, setting and other variables). The goals of the supervisory process are the professional growth and development of the supervisee and the supervisor, which it is assumed will result ultimately in optimal service to clients. (p. 12)*

Anderson's definition is still consistent with the goals of the process but needs some expansion. ASHA's position statement (1985b) noted that “effective clinical teaching” involves the development of self-analysis, self-evaluation, and problem-solving skills on the part of the individual being supervised. Self-analysis and self-evaluation are important activities for the supervisor as well. Therefore, Anderson's definition may be expanded to include the following:

> *Professional growth and development of the supervisee and the supervisor are enhanced when supervision or clinical teaching involves self-analysis and self-*

evaluation. Effective clinical teaching also promotes the use of critical thinking and problem-solving skills on the part of the individual being supervised.

Critical thinking is based on building hypotheses, collecting data, and analyzing outcomes. A supervisor can facilitate the critical thinking abilities of supervisees through collecting data and facilitating problem solving. Engaging in this process will also help supervisees assess the quality of their service delivery. The *Data Collection in Supervision* section that follows provides further information on this topic.

The following sections discuss key issues that affect supervision or influence the supervisory process.

Supervision Across Settings

Professional, clinical, and operational demands across practice settings vary; however, the supervisory process can be viewed as basically the same wherever speech-language pathology services are delivered. Client populations as well as equipment, tools, and techniques used to provide clinical services can differ across the practice settings. Nevertheless, the dynamics of the supervisory relationship and the components of the supervisory process are similar regardless of work setting.

Often the supervisor is also responsible for day-to-day operations and program management. These supervisors with management responsibilities are accountable to multiple stakeholders (e.g., administrators, regulatory agencies, consumers, employees, and payers). These supervisors also have an obligation to provide clinical teaching to supervisees at all levels of their career. Clinical education may be managed directly by the supervisor, facilitated as a collaborative activity by the supervisor, or delivered in peer training formats (e.g., through literature review and discussion, or continuing education). Methods may vary according to the needs of the clinical population, developmental level of the supervisee, supervisor and supervisee teaching/learning styles and preferences, economics, and practice setting. The basic objective of professional growth and development for both the supervisor and supervisee remains at the core of the supervisory process.

Technology in Supervision

Although technology is not a new concept in supervision, the ways in which technology may be used have changed immensely. It can allow one message to be received by many at one time (through an e-mail list) or it can provide support to just one supervisee through the use of two-way videoconferencing (i.e., “e-supervision”). Through the use of technology, information can be delivered at a distance in real time or be archived for users to retrieve at their convenience. Many forms of technology can be used to support communication and clinical teaching, particularly the Internet, which facilitates the use of e-mail, e-mail lists, instant messaging, Web sites/pages, videoconferencing, video software, Weblogs (or “blogs”), and podcasting. The Appendix provides examples of current uses of technology for supervision. When one uses technology in supervision (e.g., videoconferencing) it is important to be aware of and follow regulatory guidelines involving confidentiality.

The Influence of Power in Supervision

Power has been defined as the ability of one party to change or control the behavior, attitudes, opinions, objectives, needs, and values of another party (Rahim, 1989). Although different models and descriptions of power are described in the literature, some researchers have acknowledged the importance of modifying supervisees' behavior using social and interpersonal influence processes. One form of social influence is power (Wagner & Hess, 1999). According to Robyak, Goodyear, and Prange (1987), supervisors' power influences trainees to change their clinical behaviors. Other disciplines have extensively investigated social power because of the influence that power has on subordinates' compliance, motivation, satisfaction, task commitment, job performance, and interpersonal conflicts (Wagner & Hess, 1999).

Understanding the influence of social power on the supervisory relationship is important. Supervisors hold the power of grading, signing off on clinical hours, conducting performance evaluations, and making promotion decisions. Lack of awareness of the influence of power can result in intimidation and a reluctance on the part of the supervisee to participate actively in the supervisory experience.

Individuals from diverse cultural and/or linguistic backgrounds may respond differently to the power dynamic (e.g., to people they perceive to be in roles of authority). They may behave in ways that may be interpreted as inappropriate by those who are unfamiliar with their culture and/or background (Coleman, 2000). Therefore, it is important for supervisors to know when to consult someone who can serve as a cultural mediator or advisor concerning effective strategies for culturally appropriate interactions with individuals (clients and supervisees) from specific backgrounds.

Mentoring in Supervision

The terms *mentoring* and *supervision* are not synonymous but are often used interchangeably (Urish, 2004). Mentoring is typically defined as a relationship between two people in which one person (the mentor) is dedicated to the personal and professional growth of the other (the mentee) (Robertson, 1992). While this definition may sound similar to the relationship of the supervisor and the supervisee, the primary focus of supervision is accountability for the supervisee's performance (e.g., providing grades or conducting performance evaluations; documenting professional behavior and clinical performance). In contrast, mentoring focuses on creating effective ways to build skills, influence attitudes, and cultivate aspirations. Mentors advise, tutor, sponsor, and instill a professional identity in mentees. Mentoring is an intense interaction between two people, where the mentor has authority and power based on experience. To highlight the importance of the mentoring role, the 2005 ASHA Standards for Clinical Certification references mentoring. In some sections the terminology has been changed from *supervision* to *mentoring* and from *clinical fellowship supervisor* to *clinical fellowship mentor* (Council for Clinical Certification in Audiology and Speech-Language Pathology [CFCC], 2005).

Some aspect of mentoring should be involved in all supervisory relationships, the degree being dependent on supervisory style, the amount of experience and skill level of the supervisee, and factors associated with the practice setting. Supervisors who maintain a “direct-active” style of supervision as described by J. L. Anderson (1988) are less likely to address the mentoring aspect of supervision. The “direct-active” style focuses mainly on growth in performance rather

than on the personal growth of the supervisee. “Collaborative” or “consultative” styles, as described by J. L. Anderson (1988), better facilitate the ability to address the mentoring aspect of supervision. Mentoring is most appropriate when supervisees have moved into the advanced level of the “transitional stage” and/or the self-supervision stage on the Anderson continuum.

Training in Supervision

Many professionals are thrust into the role of supervisor or clinical educator without adequate preparation or training (J. L. Anderson, 1988; Dowling, 2001; McCrea & Brasseur, 2003; Spence et al., 2001). They become “overnight supervisors” and are forced to draw on their own past experiences as supervisees, positive or negative, as a source for their own techniques and methodologies. Supervisors in all practice settings may also have unrealistic expectations concerning the academic and clinical preparation of supervisees, particularly students.

Dowling (2001) and McCrea and Brasseur (2003) discussed research in speech-language pathology by Culatta and Seltzer (1976), Irwin (1975, 1976), McCrea (1980), Roberts and Smith (1982), and Strike-Roussos (1988, 1995) indicating that supervisors who engage in supervisory conferences/meetings without formal supervisory training tend to dominate talk time, problem solving, and strategy development. These supervisors tend to use the same direct style of supervision with all supervisees regardless of their knowledge or skill levels, and without regard for the supervisee's learning style, which can lead to passive supervisee involvement and dependence on the supervisor (J. L. Anderson, 1988). Further, a direct style of supervision diminishes the need for the supervisee to use critical thinking and problem-solving skills. Supervisors should seek training on the supervisory process so that they can learn about differing supervisory styles and develop competence in supervision. This will help ensure the use of strategies and behaviors that promote supervisee learning and development. ASHA's *Knowledge and Skills Needed by Speech-Language Pathologists Providing Clinical Supervision* (ASHA, 2008b) lists competencies for effective supervision. Training in supervision can be obtained through course work, continuing education programs, self-study, peer mentoring, and resources from ASHA (e.g., products and/or continuing education offerings) and from Special Interest Division 11, Administration and Supervision.

Supervisor Accountability

Quite often, the effectiveness of a supervisor is determined by asking the supervisee to evaluate the clinical instructor. While such evaluations do have some importance, few supervisees have sufficient understanding of the supervisory process to know what to expect of a supervisor. Further, unless complete anonymity is ensured, the likelihood of receiving honest feedback may be questioned. Therefore, supervisors should also evaluate their own behaviors relative to the supervisory process. Given the lack of validated guidelines for accomplishing such self-evaluation, supervisors must devise their own methods of data collection (McCrea & Brasseur, 2003) or turn to resources from other fields. Casey (1985) and colleagues (Casey, Smith, & Ulrich, 1988) developed a self-assessment guide to assist supervisors in determining their effectiveness in acquiring the 13 tasks and 81 associated competencies contained in the 1985 position statement (ASHA, 1985b). Analyzing the results allows the supervisor to identify supervisory objectives, decide on certain procedures, and determine whether goals were accomplished.

Studying the supervisory process in relation to one's own behavior is an opportunity for the supervisor to develop a personalized quality assurance mechanism, and a way to ensure accountability. Making a decision to improve as a supervisor also promotes job satisfaction, self-fulfillment, and ethical behavior, and prevents burnout (Dowling, 2001).

Data Collection in Supervision

Objective data about the supervisee's performance adds credibility and facilitates the supervisory process (J. L. Anderson, 1988; Shapiro, 1994). According to J. L. Anderson (1988) and Shapiro (1994), data collection methods can include rating scales, tallying behaviors, verbatim recording, interaction analysis, and individually designed methods. A number of tools have also been developed for analysis of behaviors and self-assessment (J. L. Anderson, 1988; Casey et al., 1988; Dowling, 2001; McCrea & Brasseur, 2003; Shapiro, 1994). Results from the analysis of this data can be applied both to the supervisee's clinical interactions with clients as well as to behaviors of the supervisor and supervisee during supervisory conferences. Analysis of both the supervisee and supervisor's behaviors during supervisory conferences can yield valuable insights to improve the interactions and outcomes of the supervisory experience for both individuals.

To be effective at their job, supervisors must be concerned about their own learning and development. Studying one's own behavior in supervisory process not only facilitates accountability in clinical teaching, but also is an opportunity for supervisors to examine their own behavior in order to improve their effectiveness in supervision.

Communication Skills in Supervision

Although supervisors may collect data and analyze the behaviors of supervisees, success in facilitating a supervisee's development may ultimately rest on the supervisor's skill in communicating effectively about these behaviors. While there are many resources that discuss interpersonal communication, McCrea and Brasseur (2003) briefly reviewed the literature in speech-language pathology on the interpersonal aspects of the supervisory process, citing Pickering (1979, 1984, 1987, 1990), Caracciolo and colleagues (1978), Crago (1987), Hagler, Casey, and DesRochers (1989), McCrea (1980), McCready and colleagues (1987, 1996), and Ghitter (1987). All of these researchers found a relationship between the interpersonal skills of supervisors and the clinical effectiveness of the supervisees. In their review of the literature, McCrea and Brasseur noted the importance of a supervisor's skill in communication. Adopting an effective communication style for each supervisee was shown to affect the supervisees' willingness to participate in conferences, share ideas and feelings, and positively change clinical behaviors. Ghitter (1987, as cited in McCrea & Brasseur, 2003) reported that when supervisees perceive high levels of unconditional positive regard, genuineness, empathic understanding, and concreteness, their clinical behaviors change in positive directions.

The ability to communicate effectively is viewed by many as an aptitude or an innate skill that people possess without any training. However, many professionals operate at a level of effectiveness far below their potential (Adler, Rosenfeld, & Proctor, 2001). There are also potential barriers to clear and accurate communication (e.g., age, gender, social and economic status, and cultural/linguistic background). Further information addressing such barriers is included in the sections *Generational Differences* and *Cultural and Linguistic Considerations in Supervision*). Training in interpersonal communication is an important component of supervisory

training. Growth in the interpersonal domain will enhance supervisors' proficiencies in interacting with clinicians in a helpful manner.

Standards, Regulations, and Legal Issues

Various external groups provide guidance for or regulation of supervision in speech-language pathology, particularly with respect to students and clinical fellows. ASHA's standards for certification and accreditation, state licensure laws, and federal/state reimbursement programs set minimum standards for the amount of supervision provided to individuals who are not certified SLPs.

At the preprofessional level, the *Standards for Accreditation of Graduate Education Programs in Audiology and Speech-Language Pathology* (Council on Academic Accreditation in Audiology and Speech-Language Pathology [CAA], 2004) require competent and ethical conduct of faculty, including on-site and off-site faculty. The standards also require programs to demonstrate that “Clinical supervision is commensurate with the clinical knowledge and skills of each student…” (Standard 3.5B; CAA, 2004).

Standards and Implementation Procedures for the Certificate of Clinical Competence address the requirements for direct and indirect supervision of students (CFCC, 2005). The standards require that student supervision be provided by a certified SLP, and that at least 25% of a student's total contact with each client be directly observed. The amount of supervision “should be adjusted upward if the student's level of knowledge, experience, and competence warrants” (CFCC, 2005). Standards for clinical fellows require 36 mentoring activities, including 18 hours of on-site direct client contact observation. Both sets of standards may be updated periodically. Regulation by state licensure boards is separate from ASHA requirements; therefore, all students, clinical fellows, and certified clinical practitioners must be aware of and adhere to ASHA certification requirements as well as their state's requirements. Licensure laws regulate the provision of SLP services within the state; for SLPs practicing in schools, different or additional standards may also be required. States' requirements for student supervision may in some cases exceed ASHA's requirements.

Supervisors also must be aware of regulations for student supervision issued by payers such as the Centers for Medicare and Medicaid Services (CMS). For services delivered to Medicare beneficiaries under Part B, Medicare guidance explicitly states that the qualified SLP must be in the room at all times and be actively engaged in directing the treatment provided by the student (CMS, 2003, chapter 15, section 230B.1). There is an exception for services to Part A beneficiaries residing in a skilled nursing facility where “line of sight” supervision of the student by the qualified SLP is required instead of “in the room.”

The nature of the supervisory relationship includes a vicarious liability for the actions of the supervisee. Supervisors hold full responsibility for the behavior, clinical services, and documentation of the student clinician. For their own protection as well as to foster the growth of students and protect the welfare of clients, supervisors must be fully involved and aware of the performance of the student and address any issues that could affect patient outcomes or satisfaction.

Ethical Considerations in Supervision

ASHA's Code of Ethics (2003) provides a framework for ethical behavior of supervisors across supervisory responsibilities. Principle of Ethics I states that client welfare must always be held paramount. Accordingly, the supervisor must provide appropriate supervision and adjust the amount and type of supervision based on the supervisee's performance. The supervisor ensures that the supervisee fulfills professional responsibilities such as maintaining confidentiality of client information, documenting client records in an accurate and timely manner, and completing other professional activities. In addition, the supervisor has an obligation to inform the client of the name and credentials of individuals (such as students) involved in their treatment.

Principle of Ethics II addresses issues of professional competence, and its rules state that professionals should only engage in those aspects of the profession that are within their scope of competence. Accordingly, supervisors should seek training in the area of effective supervisory practices to develop their competence in this area. Supervisors also have the responsibility to ensure that client services are provided competently by supervisees whether they are students, clinical fellows, or practicing clinicians. In addition, the rules state that treatment delegated to clinical fellows, students, and other nonprofessionals must be supervised by a certified speech-language pathologist.

Principle of Ethics IV addresses the ethical responsibility to maintain “harmonious interprofessional and intraprofessional relationships” and not abuse their authority over students (ASHA, 2003). See the section *The Influence of Power in Supervision* for further discussion of this issue.

Issues in Ethics statements are developed by ASHA's Board of Ethics to provide guidance on specific issues of ethical conduct. Statements related to supervision include *Fees for Clinical Service Provided by Students and Clinical Fellows* (ASHA, 2004a), *Supervision of Student Clinicians* (ASHA, 2004d), and *Responsibilities of Individuals Who Mentor Clinical Fellows* (2007).

Supervisors should also be cognizant of the problems that may arise from developing a social relationship with a supervisee in addition to their supervisory relationship. Although working together may provide opportunities for socialization beyond professional activities, supervisors must be comfortable in addressing a supervisee's performance without being influenced by their relationship outside the work setting.

King (2003) identified situations where ethical misconduct in the area of supervision may occur. Although King's comments were directed to the supervision of students, these concerns can be applied to all supervisory relationships. According to King, situations of potential misconduct can include, but are not limited to, failure to provide a sufficient amount of supervision based on the performance of the supervisee, failure to educate and monitor the supervisee's protection of patient confidentiality, failure to verify appropriate competencies before delegating tasks to supervisees, failure to demonstrate benefit to the patient based on outcomes, and failure to provide self-assessment tools and opportunities to supervisees.

Supervision by Other Professionals

Increasingly, ASHA-certified SLPs and clinical fellows may work in settings where their direct supervisor may be an administrator or an individual from another profession. Evaluation of clinical skills by that individual is not appropriate, according to ASHA's position statement on *Professional Performance Appraisal by Individuals Outside the Professions of Speech-Language Pathology and Audiology* (ASHA, 1993). Peer appraisal and/or self-evaluation are recommended as alternatives. In addition, guidelines on the *Professional Performance Review Process for the School-Based Speech-Language Pathologist* (ASHA, 2006) were recently developed to help address this frequently occurring situation in schools.

Access to Clinical Externships

Practicing SLPs participate in the training and development of those who are entering the profession. However, pressures within the workplace have created challenges to students gaining access to externship sites (McAllister, 2005). Students are considered by some clinicians and administrators to be a drain on existing resources. The pace of the work, productivity demands, complexity of clients, and program specialization can limit an organization's willingness to embrace the task of student training (McAllister, 2005). In some cases, an externship supervisor's expectations of a student's knowledge and skills may be unrealistic and/or not met. Requirements for specified levels of supervision imposed by regulatory agencies (e.g., CMS) have also been identified as barriers to accepting students.

Staffing shortages can also limit student placement opportunities. Student training is often one of the casualties of inadequate staffing in the workplace. Veteran SLPs have much to offer students and other supervisees, but these individuals may work on a part-time or as-needed basis. Organizations that implement flexible work schedules to retain seasoned employees may refuse student placements because they believe they cannot accommodate the students' scheduling needs (McAllister, 2005). An unfortunate irony exists because sites that do not offer student externship placements are less likely to successfully recruit qualified SLPs.

McAllister (2005) posited the need for innovative solutions in the following areas. A shift in training models may be necessary in some cases to provide more opportunities for student placements. Ingenuity and collaboration between universities and work sites can ultimately produce innovative scheduling, supervisory incentives, and exploration of new supervisory models that may allow for excellent training opportunities. Cooperative partnerships between the universities, work sites, and clinicians are needed to develop collaborative training models appropriate to work site demands and pressures. Universities can play a key role in assisting work sites in experimenting with and evaluating innovative training models and in educating potential and existing supervisors on best practices in clinical education.

Cultural and Linguistic Considerations in Supervision

The population of the United States is becoming increasingly diverse. Supervisors will interact more frequently with individuals from backgrounds that are different from their own. As they interact with others, supervisors will have to take into account culturally based behaviors, values, and belief systems to be successful in their interactions. No universal communication, learning, or behavioral style is used by all people. Many cultural values have a significant impact on how and when individuals choose to communicate, how they behave in various settings, and

how they prefer to learn. Differences in cultural values have an impact on the nature and effectiveness of all aspects of clinical interactions, including supervisor-supervisee relationships. Supervisors must take into consideration culturally based behaviors and learning styles of supervisees if their interactions with them are to be successful (Coleman, 2000).

Shapiro, Ogletree, and Brotherton (2002) reported research findings that most faculty were viewed as not being prepared for engaging in the supervisory process even with students from mainstream backgrounds. This problem is even more widespread in view of previous findings that most SLPs do not believe they are prepared to work effectively with clients from culturally and linguistically diverse backgrounds (ASHA, 1985a; Carey, 1992; Coleman & Lieberman, 1995; Keough, 1990). The lack of understanding and/or appreciation for culturally and linguistically diverse clients could also have a significant impact on the nature of interactions these professionals have with other nontraditional students, such as older students or returning students (McAllister, 2005).

Supervisors who supervise individuals from culturally and linguistically diverse backgrounds should develop competencies that will help them engage in appropriate clinical education practices (ASHA, 1998a, 1998b, 2004c, 2005). Many researchers across disciplines have addressed the issue of culturally appropriate clinical intervention strategies (Adler, 1993; N. B. Anderson, 1992, Battle, 1993, Cheng, 1987, Langdon & Cheng, 1992). One of the first suggestions in most of these sources is that the service provider conduct a self-inventory of his or her cultural awareness and sensitivity. Resources for cultural competence awareness assessment may be obtained through ASHA and/or literature review. Recognizing that behavior may be influenced by culture allows supervisors to develop a better understanding of variations among people.

Generational Differences

The coexistence of multiple generations in the workforce presents unique challenges in supervision. Differences in values and expectations of one generation versus another can result in misinterpretations and misunderstandings during supervisor–supervisee interactions. McCready (2007) noted that various authors (Kersten, 2002; Lancaster & Stillman, 2002; and Raines, 2002, 2003) have mentioned that the disparities among generations today are deeper and more complex than in the past. According to Lancaster and Stillman (2002), there are four separate and distinct generations working together today: the Traditionalists (born between 1900 and 1945), the Baby Boomers (born 1946–1964), the Generation Xers (born 1965–1980), and the Millennials (1981–1999). People, places, events, and symbols not only define each of these generational cohorts but profoundly influence their values and expectations. Supervisors therefore need to be prepared to understand and accommodate attitudes and behaviors that may differ from their own.

McCready (2007) described ways in which supervisors across work settings can bridge the generation gap and facilitate improved communication. One suggestion is to form study groups to investigate the research in this area; the group could then present their findings to a larger group within the work setting (McCready, 2007). The supervisor can also engage in discussions about the generations represented in the work setting and how generational characteristics may and may not apply to specific individuals (McCready, 2007). Such discussion might include generational characteristics that can lead to miscommunication and misunderstandings in interactions with clients and supervisors.

Supervising Challenging Supervisees

Students who are admitted to graduate programs in communication sciences and disorders have successfully passed through a very competitive screening process using a variety of selection criteria such as Graduate Record Examination scores, undergraduate grade point averages, and letters of recommendation. Most of these students perform well in their academic courses and clinical assignments. However, most training programs periodically encounter students who present special challenges during the supervisory process (Shapiro et al., 2002) and are often referred to as “marginal” students. Dowling (1985, as cited in Dowling, 2001) described marginal students as individuals who “cannot work independently, are unable to formulate goals and procedures, have basic gaps in conceptual understanding, and cannot follow through with suggestions” (p. 162). Given the impact on students, programs, clients, and the professions, working effectively with marginal students deserves serious and systematic consideration (Shapiro et al., 2002). These same issues may apply to supervisees of varying experience levels and in all practice settings.

One characteristic that is frequently reported about these challenging supervisees is their lack of ability to accurately evaluate their skill level (Kruger & Dunning, 1999, as cited in McCrea & Brasseur, 2003). Using the supervisory conference/meeting can be critically important in assisting them in evaluating their own performance (Dowling, 2001). During these meetings, supervisors need to give specific feedback based on data collected about the supervisee's performance and provide concrete assistance in planning and strategy development (Dowling, 2001). Eventually, however, the supervisee must learn to engage in self-analysis and self-evaluation to develop an understanding of his or her own performance.

Summary

This document defines supervision and highlights key issues that reflect the complexity of providing exemplary supervision. Acquiring competency as a supervisor is essential to developing supervisory behaviors and activities that are critical to the training of professionals. Such supervisory training may not be provided as part of graduate education programs; therefore, SLPs must look to continuing education opportunities, peer learning and mentoring, and self-study using literature that focuses on the supervisory process (J. L. Anderson, 1988; Casey et al., 1988; Dowling, 2001; McCrea & Brasseur, 2003; Shapiro, 1994; Shapiro & Anderson, 1989). Although there may be opportunities to learn from other disciplines that also use supervisory practices, preparation in the supervisory process specific to speech-language pathology is critically important. McCrea and Brasseur (2003) and Dowling (2001) discussed ways in which preparation in the supervisory process can be implemented. The models discussed in these texts range from inclusion of information in early clinical management courses to doctoral level preparation. Training that is included as part of academic and clinical training of professionals and extended to supervisors at off-campus practicum sites will enhance the supervisors' effectiveness (Dowling, 1992; and Dowling, 1993, 1994, as cited in McCrea & Brasseur, 2003). ASHA's *Knowledge and Skills Needed by Speech-Language Pathologists Providing Clinical Supervision* (ASHA, 2008b) delineates specific areas of competence deemed necessary to the provision of effective supervision.

Research Directions

Systematic study and investigation of the supervisory process is necessary to expand the evidence base from which increased knowledge about supervision and the supervisory process will emerge. Topics for further research may include the following:

- exploring different supervisory approaches that promote problem solving, self-analysis, and self-evaluation to develop clinical effectiveness;
- identifying essential components of training effective supervisors;
- examining the efficacy of supervisory training on supervisor/supervisee satisfaction and competence;
- identifying the basic behaviors/skills that supervisors should use in their interactions with supervisees that are essential to an effective working relationship;
- examining how supervisory style affects the development of clinical competence;
- examining different methods to develop more efficient models of supervision;
- examining supervisor behaviors that enhance supervisee growth (e.g., examining the process for negotiating and mutually agreeing on targets for change and measuring the impact that supervisor change has on the supervisee's professional growth) or training supervisors to use specific interpersonal skills (e.g., empathy, active listening) and then measuring how such skills enhance supervisee growth (McCrea & Brasseur, 2003);
- examining the effectiveness and efficiency of technology in delivering supervision;
- examining the impact of supervision on client outcomes;
- examining supervisory approaches and communication styles with supervisees in consideration of gender, age, cultural, and linguistic diversity;
- examining aspects of the supervisory process (i.e., understanding, planning, observing, analyzing, and integrating) and the relationship of each to the success of the supervisory experience (McCrea & Brasseur, 2003).

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Appendix

Uses of Current Technology for Supervision

E-mail with attachments: The primary benefit of using electronic mail is the speed of delivery versus traditional mail. If contacting the supervisor by phone is difficult, an e-mail message may be sent instead. With e-mail, the supervisor has the option of responding at his or her convenience rather than trying to schedule a phone call or a face-to-face meeting with the supervisee when only a short response may be required. Lesson plans, sample individualized education program goals, diagnostic reports, and so on may be attached and submitted to the supervisor for his or her review and comment.

E-mail lists: Sending messages via e-mail to a closed list of supervisees. Each supervisee has the opportunity to ask questions, pose problems, or ask for suggested resources from peers. This can be extremely powerful in learning from each other's experiences and sharing innovative ideas or tried-and-true therapy techniques.

Instant messaging: The individual can see which other individuals are available at their computer through “buddy” icons and contact them through instant messaging. A group can communicate in an instant messaging conference, or the SLP can converse with his or her supervisor instantly rather than waiting for the supervisor to check e-mail.

Web sites/Web pages: Information pertinent to supervisees (such as frequently asked questions on licensure renewal, guidelines on service delivery options, or frequently used forms) is placed on the supervisor's Web site. The supervisees can access the information when needed. Supervisees can suggest what materials, links, or resources they would find helpful to have uploaded to the supervisor's site.

E-supervision: Using two-way videoconferencing to supervise graduate students in a public school setting is one example of electronic supervision according to Dudding and Justice (2004). The equipment costs of videoconferencing are offset by the productivity in clinical instruction. Dudding and Justice reported that electronic supervision allows for more flexibility in scheduling and a reduction in travel costs while also increasing the student's knowledge and appreciation for technology.

Video software: Embedding a visual message within an e-mail or on a Web site provides access to information when it is needed, and the message can be archived for later reference as well. With the use of video software, the supervisor can easily video record a message while also embedding photos or graphics into the message. The software requires a simple mounted camera on the computer to video record the supervisor's message. The message can be an update on therapy techniques or a short training on the use of new forms, for example. Once recorded, it can be embedded into an e-mail and sent out to all of the supervisees or archived on a Web site to be accessed when needed. This expedites the training process by only recording and delivering the message one time and makes the information available when the supervisee has time to retrieve the information, which can differ for all involved.

Weblogs: Journal entries displayed in reverse chronological order. The supervisor and others can leave comments or statements of support for the supervisee in this interactive format.

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Appendix I.

Knowledge and Skills Needed by Speech-Language Pathologists Providing Clinical Supervision

Knowledge and Skills
Ad Hoc Committee on Supervision in Speech-Language Pathology

About this Document

This knowledge and skills document is an official statement of the American Speech-Language-Hearing Association (ASHA). This knowledge and skills statement was developed by the Ad Hoc Committee on Supervision. Members of the committee were Lisa O'Connor (chair), Christine Baron, Thalia Coleman, Barbara Conrad, Wren Newman, Kathy Panther, and Janet E. Brown (ex officio). Brian B. Shulman, vice president for professional practices in speech-language pathology (2006–2008), served as the monitoring officer. This document was approved by the Board of Directors on March 12, 2008.

Knowledge and Skills

This document accompanies ASHA's policy documents Clinical Supervision in Speech-Language Pathology: Position Statement and Technical Report (ASHA, 2008a, 2008b). ASHA's position statement affirms that clinical supervision (also called clinical teaching or clinical education) is a distinct area of expertise and practice, and that it is critically important that individuals who engage in supervision obtain education in the supervisory process. The role of supervisor may include administrative responsibilities in some settings, and, should this be the case, the supervisor will have two major responsibilities: clinical teaching and program management tasks. However, the knowledge and skills addressed in this document are focused on the essential elements of being a clinical educator in any service delivery setting with students, clinical fellows, and professionals.

Professionals looking for guidance in supervising support personnel should refer to the ASHA position statement and knowledge and skills documents on that topic (ASHA, 2002, 2004a, 2004b).

ASHA's technical report on clinical supervision in speech-language pathology (2008b) cites Jean Anderson's (1988) definition of supervision:

> Supervision is a process that consists of a variety of patterns of behavior, the appropriateness of which depends on the needs, competencies, expectations and philosophies of the supervisor and the supervisee and the specifics of the situation (tasks, client, setting and other variables). The goals of the supervisory process are the professional growth and development of the supervisee and the supervisor, which it is assumed will result ultimately in optimal service to clients. (p. 12)

The ASHA technical report (2008b) adds the following elements to the above definition:

> Professional growth and development of the supervisee and the supervisor are enhanced when supervision or clinical teaching involves self-analysis and self-evaluation. Effective clinical teaching also promotes the use of critical thinking and problem-solving skills on the part of the individual being supervised. (p. 3)

This expanded definition was used as a basis for the following knowledge and skills statements.

Developing Knowledge and Skills

All certified SLPs have received supervision during their student practica and clinical fellowship; however, this by itself does not ensure competence as a supervisor. Furthermore, achieving clinical competence does not imply that one has the special skills required to be an effective supervisor. ASHA does not have specific requirements for coursework or credentials to serve as a supervisor; however, some states or settings may require coursework and/or years of experience to serve as a supervisor. Knowledge and skills may be developed in a variety of ways: participating in courses or workshops on supervision, engaging in self-study, participating in Division 11 (Administration and Supervision), and gaining mentored experiences under the guidance of an experienced clinical educator.

The following 11 items represent core areas of knowledge and skills. The supervisee is an essential partner in the supervisory process; however, these areas are presented from the perspective of knowledge and skills that should be acquired by the supervisor.

I. Preparation for the Supervisory Experience

A. Knowledge Required

1. Be familiar with the literature on supervision and the impact of supervisor behaviors on the growth and development of the supervisee.
2. Recognize that planning and goal setting are critical components of the supervisory process both for the clinical care provided to the client by the supervisee and for the professional growth of the supervisee.
3. Understand the value of different observation formats to benefit supervisee growth and development.
4. Understand the importance of implementing a supervisory style that corresponds to the knowledge and skill level of the supervisee.
5. Understand the basic principles and dynamics of effective collaboration.
6. Be familiar with data collection methods and tools for analysis of clinical behaviors.
7. Understand types and uses of technology and their application in supervision.

B. Skills Required

1. Facilitate an understanding of the supervisory process that includes the objectives of supervision, the roles of the participants, the components of the supervisory process, and a clear description of the assigned tasks and responsibilities.
2. Assist the supervisee in formulating goals for the clinical and supervisory processes, as needed.
3. Assess the supervisee's knowledge, skills, and prior experiences in relationship to the clients served.

4. Adapt or develop observational formats that facilitate objective data collection.
5. Be able to select and apply a supervisory style based on the needs of the clients served, and the knowledge and skill of the supervisee.
6. Model effective collaboration and communication skills in interdisciplinary teams.
7. Be able to analyze the data collected to facilitate the supervisee's clinical skill development and professional growth.
8. Use technology as appropriate to enhance communication effectiveness and efficiency in the supervisory process.

II. Interpersonal Communication and the Supervisor-Supervisee Relationship

A. Knowledge Required

1. Understand the basic principles and dynamics of effective interpersonal communication.
2. Understand different learning styles and how to work most effectively with each style in the supervisory relationship.
3. Understand how differences in age, gender, culture, social roles, and self-concept can present challenges to effective interpersonal communication.
4. Understand the importance of effective listening skills.
5. Understand differences in communication styles, including cultural/linguistic, generational, and gender differences, and how this may have an impact on the working relationship with the supervisee.
6. Be familiar with research on supervision in terms of developing supervisory relationships and in analyzing supervisor and supervisee behaviors.
7. Understand key principles of conflict resolution.

B. Skills Required

1. Demonstrate the use of effective interpersonal skills.
2. Facilitate the supervisee's use of interpersonal communication skills that will maximize communication effectiveness.
3. Recognize and accommodate differences in learning styles as part of the supervisory process.
4. Recognize and be able to address the challenges to successful communication interactions (e.g., generational and/or gender differences and cultural/linguistic factors).
5. Recognize and accommodate differences in communication styles.
6. Demonstrate behaviors that facilitate effective listening (e.g., silent listening, questioning, paraphrasing, empathizing, and supporting).
7. Maintain a professional and supportive relationship that allows for both supervisee and supervisor growth.
8. Apply research on supervision in developing supervisory relationships and in analyzing supervisor and supervisee behaviors.
9. Conduct a supervisor self-assessment to identify strengths as well as areas that need improvement (e.g., interpersonal communication).
10. Use appropriate conflict resolution strategies.

III. Development of the Supervisee's Critical Thinking and Problem-Solving Skills

A. Knowledge Required

1. Understand methods of collecting data to analyze the clinical and supervisory processes.
2. Understand how data can be used to facilitate change in client, clinician, and/or supervisory behaviors.
3. Understand how communication style influences the supervisee's development of critical thinking and problem-solving skills.
4. Understand the use of self-evaluation to promote supervisee growth.

B. Skills Required

1. Assist the supervisee in using a variety of data collection procedures.
2. Assist the supervisee in objectively analyzing and interpreting the data obtained and in understanding how to use it for modification of intervention plans.
3. Assist the supervisee in identifying salient patterns in either clinician or client behavior that facilitate or hinder learning.
4. Use language that fosters independent thinking and assists the supervisee in recognizing and defining problems, and in developing solutions.
5. Assist the supervisee in determining whether the objectives for the client and/or the supervisory experience have been met.

IV. Development of the Supervisee's Clinical Competence in Assessment

A. Knowledge Required

1. Understand and demonstrate best practices, including the application of current research in speech-language pathology, for assessing clients with specific communication and swallowing disorders.
2. Understand principles and techniques for establishing an effective client–clinician relationship.
3. Understand assessment tools and techniques specific to the clients served.
4. Understand the principles of counseling when providing assessment results.
5. Understand and demonstrate alternative assessment procedures for linguistically diverse clients, including the use of interpreters and culture brokers.

B. Skills Required

1. Facilitate the supervisee's use of best practices in assessment, including the application of current research to the assessment process.
2. Facilitate the supervisee's use of verbal and nonverbal behaviors to establish an effective client–clinician relationship.
3. Assist the supervisee in selecting and using assessment tools and techniques specific to the clients served.
4. Assist the supervisee in providing rationales for the selected procedures.
5. Demonstrate how to integrate assessment findings and observations to diagnose and develop appropriate recommendations for intervention and/or management.
6. Provide instruction, modeling, and/or feedback in counseling clients and/or caregivers about assessment results and recommendations in a respectful and sensitive manner.
7. Facilitate the supervisee's ability to use alternative assessment procedures for linguistically diverse clients.

V. Development of the Supervisee's Clinical Competence in Intervention

A. Knowledge Required

1. Understand best practices, including the application of current research in speech-language pathology, for developing a treatment plan for and providing intervention to clients with specific communication and swallowing disorders.
2. Be familiar with intervention materials, procedures, and techniques that are evidence based.
3. Be familiar with methods of data collection to analyze client behaviors and performance.
4. Understand the role of counseling in the therapeutic process.
5. Know when and how to identify and use resources for intervention with linguistically diverse clients.

B. Skills Required

1. Assist the supervisee in developing and prioritizing appropriate treatment goals.
2. Facilitate the supervisee's consideration of evidence in selecting materials, procedures, and techniques, and in providing a rationale for their use.
3. Assist the supervisee in selecting and using a variety of clinical materials and techniques appropriate to the clients served, and in providing a rationale for their use.
4. Demonstrate the use of a variety of data collection procedures appropriate to the specific clinical situation.
5. Assist the supervisee in analyzing the data collected in order to reformulate goals, treatment plans, procedures, and techniques.
6. Facilitate supervisee's effective use of counseling to promote and facilitate change in client and/or caregiver behavior.
7. Facilitate the supervisee's use of alternative intervention materials or techniques for linguistically diverse clients.

VI. Supervisory Conferences or Meetings of Clinical Teaching Teams

A. Knowledge Required

1. Understand the importance of scheduling regular supervisory conferences and/or team meetings.
2. Understand the use of supervisory conferences to address salient issues relevant to the professional growth of both the supervisor and the supervisee.
3. Understand the need to involve the supervisee in jointly establishing the conference agenda (e.g., purpose, content, timing, and rationale).
4. Understand how to facilitate a joint discussion of clinical or supervisory issues.
5. Understand the characteristics of constructive feedback and the strategies for providing such feedback.
6. Understand the importance of data collection and analysis for evaluating the effectiveness of conferences and/or team meetings.
7. Demonstrate collaborative behaviors when functioning as part of a service delivery team.

B. Skills Required

1. Regularly schedule supervisory conferences and/or team meetings.
2. Facilitate planning of supervisory conference agendas in collaboration with the supervisee.

3. Select items for the conference based on saliency, accessibility of patterns for treatment, and the use of data that are appropriate for measuring the accomplishment of clinical and supervisory objectives.
4. Use active listening as well as verbal and nonverbal response behaviors that facilitate the supervisee's active participation in the conference.
5. Ability to use the type of questions that stimulate thinking and promote problem solving by the supervisee.
6. Provide feedback that is descriptive and objective rather than evaluative.
7. Use data collection to analyze the extent to which the content and dynamics of the conference are facilitating goal achievement, desired outcomes, and planned changes.
8. Assist the supervisee in collaborating and functioning effectively as a member of a service delivery team.

VII. Evaluating the Growth of the Supervisee Both as a Clinician and as a Professional

A. Knowledge Required

1. Recognize the significance of the supervisory role in clinical accountability to the clients served and to the growth of the supervisee.
2. Understand the evaluation process as a collaborative activity and facilitate the involvement of the supervisee in this process.
3. Understand the purposes and use of evaluation tools to measure the clinical and professional growth of the supervisee.
4. Understand the differences between subjective and objective aspects of evaluation.
5. Understand strategies that foster self-evaluation.

B. Skills Required

1. Use data collection methods that will assist in analyzing the relationship between client/supervisee behaviors and specific clinical outcomes.
2. Identify and/or develop and appropriately use evaluation tools that measure the clinical and professional growth of the supervisee.
3. Analyze data collected prior to formulating conclusions and evaluating the supervisee's clinical skills.
4. Provide verbal and written feedback that is descriptive and objective in a timely manner.
5. Assist the supervisee in describing and measuring his or her own progress and achievement.

VIII. Diversity (Ability, Race, Ethnicity, Gender, Age, Culture, Language, Class, Experience, and Education)

A. Knowledge Required

1. Understand how differences (e.g., race, culture, gender, age) may influence learning and behavioral styles and how to adjust supervisory style to meet the supervisee's needs.
2. Understand the role culture plays in the way individuals interact with those in positions of authority.
3. Consider cross-cultural differences in determining appropriate feedback mechanisms and modes.
4. Understand impact of assimilation and/or acculturation processes on a person's behavioral response style.

5. Understand impact of culture and language differences on clinician interactions with clients and/or family members.

B. Skills Required

1. Create a learning and work environment that uses the strengths and expertise of all participants.
2. Demonstrate empathy and concern for others as evidenced by behaviors such as active listening, asking questions, and facilitating open and honest communication.
3. Apply culturally appropriate methods for providing feedback to supervisees.
4. Know when to consult someone who can serve as a cultural mediator or advisor concerning effective strategies for culturally appropriate interactions with individuals (clients and supervisees) from specific backgrounds.
5. Demonstrate the effective use of interpreters, translators, and/or culture brokers as appropriate for clients from diverse backgrounds.

IX. The Development and Maintenance of Clinical and Supervisory Documentation

A. Knowledge Required

1. Understand the value of accurate and timely documentation.
2. Understand effective record-keeping systems and practices for clinically related interactions.
3. Understand current regulatory requirements for clinical documentation in different settings (e.g., health care, schools).
4. Be familiar with documentation formats used in different settings.

B. Skills Required

1. Facilitate the supervisee's ability to complete clinical documentation accurately and effectively, and in compliance with accrediting and regulatory agencies and third party funding sources.
2. Assist the supervisee in sharing information collaboratively while adhering to requirements for confidentiality (e.g., HIPAA, FERPA).
3. Assist the supervisee in maintaining documentation regarding supervisory interactions (e.g., Clinical Fellowship requirements).

X. Ethical, Regulatory, and Legal Requirements

A. Knowledge Required

1. Understand current standards for student supervision (Council on Academic Accreditation in Audiology and Speech-Language Pathology, 2004)
2. Understand current standards for mentoring clinical fellows (Council for Clinical Certification in Audiology and Speech-Language Pathology, 2005).
3. Understand current ASHA Code of Ethics rules, particularly regarding supervision, competence, delegation, representation of credentials, and interprofessional and intraprofessional relationships.
4. Understand current state licensure board requirements for supervision.
5. Understand state, national, and setting-specific requirements for confidentiality and privacy, billing, and documentation policies.

B. Skills Required

1. Adhere to all ASHA, state, and facility standards, regulations, and requirements for supervision.
2. Assist the supervisee in adhering to standards, regulations, and setting-specific requirements for documentation, billing, and protection of privacy and confidentiality.
3. Demonstrate ethical behaviors in both interprofessional and intraprofessional relationships.
4. Assist the supervisee in conforming with standards and regulations for professional conduct.
5. Assist the supervisee in developing strategies to remain current with standards and regulations throughout their professional careers.

XI. Principles of Mentoring

A. Knowledge Required

1. Understand the similarities and differences between supervision and mentoring.
2. Understand how the skill level of the supervisee influences the mentoring process (e.g., mentoring is more appropriate with individuals who are approaching the self-supervision stage).
3. Understand how to facilitate the professional and personal growth of supervisees.
4. Understand the key aspects of mentoring, including educating, modeling, consulting, coaching, encouraging, supporting, and counseling.

B. Skills Required

1. Model professional and personal behaviors necessary for maintenance and life-long development of professional competency.
2. Foster a mutually trusting relationship with the supervisee.
3. Communicate in a manner that provides support and encouragement.
4. Provide professional growth opportunities to the supervisee.

References

Anderson, J. L. (1988). The supervisory process in speech-language pathology and audiology. Austin, TX: Pro-Ed.

American Speech-Language-Hearing Association. (2002). Knowledge and skills for supervisors of speech-language pathology assistants. Available from www.asha.org/policy.

American Speech-Language-Hearing Association. (2004a). Guidelines for the training, use, and supervision of speech-language pathology assistants. Available from www.asha.org/policy.

American Speech-Language-Hearing Association. (2004b). Training, use, and supervision of support personnel in speech-language pathology [Position Statement]. Available from www.asha.org/policy.

American Speech-Language-Hearing Association. (2008a). Clinical supervision in speech-language pathology [Position Statement]. Available from www.asha.org/policy.

American Speech-Langauge Hearing Association. (2008b). Clinical supervision in speech-language pathology [Technical Report]. Available from www.asha.org/policy.

Council for Clinical Certification in Audiology and Speech-Language Pathology 2005 Membership and certification handbook of the American Speech-Language-Hearing Association. Retrieved December 28, 2007, from www.asha.org/certification/slp_standards/.

Council on Academic Accreditation in Audiology and Speech-Language Pathology. (2004). Standards for accreditation of graduate education programs in audiology and speech-language pathology programs. Available from www.asha.org/policy.

Reference this material as: American Speech-Language-Hearing Association. (2008). *Knowledge and skills needed by speech-language pathologists providing clinical supervision* [Knowledge and Skills]. Available from www.asha.org/policy.

Appendix J.

Supervision and the Professions: Resources for Supervision

By Cheryl Gunter, PhD, CCC-SLP

Perhaps you are someone who has supervised clinical practice for several decades (or, in contrast, for several days). Perhaps you are someone who has supervised in a diverse assortment of clinical contexts (or, in contrast, in one focused situation). Perhaps you have supervised clinicians across the experience continuum (or, in contrast, only undergraduate or graduate students or only post-CFY clinicians). Perhaps you are someone who has achieved a considerable level of competence and comfort in supervision tasks. Or, in contrast, you are someone who has identified areas for substantial professional development in supervision. Whatever your circumstances, welcome to this compilation of resources, courtesy of Special Interest Group 11 (Administration and Supervision), to enhance your effectiveness as a supervisor. We hope that this list of electronic and print items is valuable.

ASHA Standards for Supervision

Effective supervision starts with an awareness of the ethical bases of clinical practice, as well as of the competencies and expectations for supervisors. These documents, available via the ASHA web site, articulate this information.

- ASHA Code of Ethics
- Issues in Ethics Statements: Supervision of Student Clinicians
- Issues in Ethics Statements: Responsibilities of Individuals Who Mentor Clinical Fellows in Speech-Language Pathology
- Position Statement: Clinical Supervision in Speech-Language Pathology and Audiology

ASHA Special Interest Group 11, Administration and Supervision

Specific Special Interest Group 11 resources can be of value to supervisors. In particular, the publication of the SIG introduces readers to current issues in supervision, as well as to practical solutions and resources.

Texts for Clinical Supervision in Communication Disorders

Several classic texts are available that overview philosophical and practical aspects of supervision in speech-language pathology and audiology. The reference lists within these texts capture the state of the supervision literature at the time of their publication and serve as a valuable resource for supervisors who wish to consult data-based research, access practical tools, solve clinical problems, and observe the evolution of clinical supervision perspectives within the discipline over time.

- *Clinical Education in Speech-Language Pathology: Professional Growth for Students and Clinical Educators.* Authors: L. McCallister & M. Lincoln. Publication Date: 2004. Publisher: Whurr Publishers. ISBN: 1861563108.
- *Handbook of Supervision: A Cognitive Behavioral System.* Authors: W. R. Leith, E. M. McNiece, & B. B. Fusilier. Publication Date: 1989. Publisher: Pro-Ed. ISBN: 0316520349.

- *Implementing the Supervisory Process: Theory and Practice.* Author: S. Dowling. Publication Date: 1991. Publisher: Prentice-Hall. ISBN: 0138757259.
- *Introduction to Clinical Supervision in Speech Pathology.* Author: G. W. Schubert. Publication Date: 1978. Publisher: W. H. Green. ISBN: 0875271626.
- *Self-Supervision: A Career Tool for Audiologists and Speech-Language Pathologists.* Authors: P. L. Casey, K. J. Smith, & S. R. Ulrich. Publication Date: 1988. Publisher: National Student Speech-Language-Hearing Association. ISBN: 0887-6584.
- *Supervision in Communication Disorders.* Authors: S. S. Farmer & J. L. Farmer. Publication Date: 1989. Publisher: Merrill. ISBN: 0675209633.
- *Supervision in Human Communication Disorders: Perspectives on a Process.* Authors: M. B. Crago & M. Pickering. Publication Date: 1987. Publisher: Taylor & Frances Books. ISBN: 0850666759.
- *Supervision: Strategies for Successful Outcomes and Productivity.* Author: S. Dowling. Publication Date: 2000. Publisher: Allyn & Bacon. ISBN: 0205315070.
- *The Supervisory Process in Speech-Language Pathology and Audiology.* Author: J. Anderson. Publication Date: 1988. Publisher: College-Hill Press. ISBN: 0316039594.
- *The Supervisory Process in Speech-Language Pathology and Audiology.* Authors: E. McCrea & J. Brasseur. Publication Date: 2002. Publisher: Allyn & Bacon. ISBN: 0205336620.

Perspectives on Supervision from Related Disciplines

While not specific to the disciplines of Audiology and Speech-Language Pathology, these reference texts from related disciplines nonetheless provide valuable philosophical and practical perspectives on clinical supervision. The diverse views on the nature of clinical supervision will help you assess your own framework for your own supervision principles and practices.

General Clinical Supervision

- *Clinical Supervision: A Handbook for Practitioners.* Authors: M. Fall & J. Sutton. Publication Date: 2003. Publisher: Allyn & Bacon. ISBN: 0205408516.
- *Clinical Supervision in the Helping Professions: A Practical Guide.* Authors: R. Haynes, G. Corey, & P. Moulton. Publication Date: 2002. Publisher: Wadsworth. ISBN: 0534563139.
- *Clinical Supervision Made Easy: The 3-Step Method.* Author: E. Van Ooijen. Publication Date: 2003. Publisher: Churchill Livingstone. ISBN: 0443072426.
- *Clinical Supervision: What to do and How to Do It.* Author: R. I. Cohen: Publication Date: 2003. Publisher: Wadsworth. ISBN: 0534630278.
- *Essentials of Clinical Supervision.* Author: J. M. Campbell. Publication Date: 2005. Publisher: Wiley. ISBN: 0471233048.
- *Fundamental Themes in Clinical Supervision.* Editors: J. R. Cutcliffe, T. Butterworth, & B. Proctor. Publication Date: 2001. Publisher: Routledge. ISBN: 0415228875.
- *Fundamentals of Clinical Supervision (3rd Ed.).* Authors: J. M. Bernard, R. K. Goodyear, & J. M. Bernard. Publication Date: 2003. Publisher: Allyn & Bacon. ISBN: 0205388736.

Clinical Supervision from a Mentor and Coach Perspective

- *Coaching, Counseling, and Mentoring.* Author: F. M. Stone. Publication Date: 1998. Publisher: American Management Association. ISBN: 0-8144-0416-2.

- *Effective Supervision: A Guidebook for Supervisors, Team Leaders, and Work Coaches.* Author: D. L. Goetsch. Publication Date: 2001. Publisher: Prentice Hall. ISBN: 0130315834.
- *Mentoring, Preceptorship, and Clinical Supervision: A Guide to Professional Roles in Clinical Practice.* Author: A. Morton-Cooper & A. Palmer. Publication Date: 2000. Publisher: Blackwell. ISBN: 0632049677.
- *The Elements of Mentoring.* Authors: W. B. Johnson & C. R. Ridley. Publication Date: 2004. Publisher: Palgrave Macmillan. ISBN: 1403964017.
- *The Team Coach.* Author: D. Deeprose. Publication Date: 1994. Publisher: American Management Association. ISBN: 0-8144-7859-X.
- *The Truth about Supervision: Coaching, Teamwork, Interviewing, Appraisals, 360 Degree Assessments, and Recognition.* Author: A. O'Brien. Publication Date: 2004. Publisher: Charles C. Thomas. ISBN: 0398074704.
- *Transforming Practice through Clinical Education, Professional Supervision, and Mentoring.* Authors: M. Rose & D. Best. Publication Date: 2005. Publisher: Churchill Livingstone. ISBN: 0443074542.

Clinical Supervision from a Human Resources Perspective

- *2005 State by State Guide to Human Resources Law.* Editors: J. F. Buckley & R. M. Green. Publication Date: 2005. Publisher: Aspen Publishers. ISBN: 0735548846.
- *Managing Clinical Supervision: Ethical Practice and Legal Risk Management.* Author: J. E. Falvey. Publication Date: 2001. Publisher: Wadsworth. ISBN: 0534530745.
- *Managing Human Resources in the Human Services: Supervisory Challenges.* Authors: F. D. Perlmutter, D. Bailey, & E. Netting. Publication Date: 2000. Publisher: Oxford University Press. ISBN: 0195120272.
- *Principles of Human Resource Development.* Authors: J. W. Gilley, S. A. Eggland, & A. M. Gilley. Publication Date: 2002. Publisher: Perseus Books. ISBN: 0738206040.
- *Supervision: Concepts and Practices of Management.* Authors: E. C. Leonard & R. L. Hilgert. Publication Date: 2003. Publisher: South Western College Publishers. ISBN: 0324178816.
- *The Complete Guide to Human Resources and the Law: 2005 Edition.* Author: D. Shilling. Publication Date: 2004. Publisher: Aspen Publishers. ISBN: 073554736X.
- *The HR Answer Book: An Indispensable Guide for Managers and Human Resources Professionals.* Authors: S. A. Smith & R. A. Mazin. Publication Date: 2004. Publisher: Amacom. ISBN: 0814472230.
- *The Human Resource Problem-Solver's Handbook.* Author: J. D. Levesque. Publication Date: 1992. Publisher: McGraw-Hill. ISBN: 0070375313.

Clinical Supervision from a Reflective Practice Perspective

- *Educating the Reflective Practitioner: Toward a New Design for Teaching and Learning in the Professions.* Author: D. A. Schon. Publication Date: 1990. Publisher: Jossey-Bass. ISBN: 1555422209.
- *Effective Clinical Supervision: The Role of Reflection.* Authors: T. Ghayle, S. Lillyman, & D. Rawstone. Publication Date: 2000. Publisher: Quay Books. ISBN: 1856421252.
- *Learning Journals and Critical Incidents: Reflective Practice for Health Care Professionals.* Authors: S. Lillyman & T. Ghave. Publication Date: 1997. Publisher: Quay Books. ISBN: 1856421538.

- *Reflection in Action: Developing Reflective Practice in Health and Social Services.* Author: B. Redmond. Publication Date: 2004. Publisher: Ashgate. ISBN: 075463356X.
- *Reflection: Principles and Practices for Health Care Professionals.* Authors: T. Ghayle & S. Lillyman. Publication Date: 2000. Publisher: Quay Books. ISBN: 1856421112.
- *Thinking about Management: A Reflective Practice Approach.* Editors: D. Golding & D. Currie. Publication Date: 2000. Publisher: Routledge. ISBN: 0415202760.

Clinical Supervision from Various Theoretical Perspectives

- *Clinical Supervision: A Competency-Based Approach.* Authors: C. A. Falender & E. P. Shafraske. Publication Date: 2004. Publisher: American Psychological Association. ISBN: 1591471192.
- *Clinical Supervision: A Four-Stage Process of Growth and Discovery.* Publication Date: 1995. Publisher: Families International. ISBH: 0873042816.
- *Clinical Supervision: A Practical Approach.* Authors: E. Van Ooijen & E. Van Ooijen. Publication Date: 2000. Publisher: Churchill Livingstone. ISBN: 0443058423.
- *Clinical Supervision: A Systems Approach.* Author: E. L. Holloway. Publication Date: 1995. Publisher: Sage Publications. ISBN: 0803942249.
- *Collaborative Clinical Education: The Foundation of Effective Health Care.* Author: J. Westberg. Publication Date: 2004. Publisher: Springer. ISBN: 0826180310.
- *Supervision: A Skill-Building Approach (2nd Ed.).* Author: R. N. Lussier. Publication Date: 1994. Publisher: Richard D. Irwin. ISBN: 0256090505.

Practical Supervision Aids

- Sometimes new supervisors find their comfort and confidence levels enhanced by the presence of very practical tools. These references provide real-life solutions to real-life supervision dilemmas and serve as a basis for the continued development of problem-solving strategies.
- *First-Time Supervisors Survival Guide.* Author: G. Fuller. Publication Date: 1994. Publisher: Prentice-Hall. ISBN: 0133114325.
- *Supervisor's Portable Answer Book.* Author: G. Fuller. Publication Date: 1989. Publisher: Prentice-Hall. ISBN: 0138765901.
- *The Manager's Question and Answer Book.* Author: F. M. Stone. Publication Date: 2003. Publisher: American Management Association. ISBN: 0-8144-0758-7.
- *The New Supervisor's Survival Manual.* Author: W. A. Salmon. Publication Date: 1998. Publisher: American Management Association. ISBN: 0814470270.

Clinical Research and Supervision

These resources link scholarly activity to clinical practice. For the supervisor who wishes to incorporate basic, applied, conceptual, and instructional research into his/her daily activity, these resources present varied useful perspectives on the relationship between the philosophical and the practical.

- *Real World Research: A Resource for Social Scientists and Practitioner-Researchers.* Author: C. Robson: Publication Date: 1993. Publisher: Blackwell. ISBN: 0631176896.

- *Scholarship Assessed.* Author: C. E. Glassick, M. T. Huber, & G. I. Maeroff. Publication Date: 1997. Publisher: John Wiley & Sons. ISBN: 0-7879-1091-0.
- *Scholarship Reconsidered.* Author: E. L. Boyer. Publication Date: 1990. Publisher: Carnegie Foundation. ISBN: 0-7879-4069-0.
- *The Scientist Practitioner: Research and Accountability in the Age of Managed Care (2nd Ed.).*Authors: S. C. Hayes, D. H. Barlow, & R. O. Nelson-Gray. Publication Date: 1999. Publisher: Allyn & Bacon. ISBN: 0205280981.

Appendix K.

Tips for First-Time Supervisors of Graduate Student Clinicians

Administrative considerations prior to graduate student placement:

- Obtain any necessary approvals for serving as a clinical educator and placement site from your facility. Your director or human resources office is a good place to start.
- Review the agreement that your facility has established with the university. If your facility has never before accepted a graduate student, be sure to establish an agreement in writing that has been reviewed and approved by the legal department of both your facility and the university.
- Contact your Human Resources department about their requirements and orientation process for graduate students.
    - Do they need ID badges, background checks, and other paperwork to complete?
    - What facility-wide orientation needs to be done in advance, and what is done in the first day on the job?
    - What kind of department orientation do graduate students receive?
- Determine the type of office or treatment space that will be made available to the graduate student(s).
- Complete any necessary paperwork attesting to your professional credentials (ASHA certification, state licensure, and/or state teacher certification) as this may be necessary for the graduate student to document their supervised clinical experiences when they make application for their own professional credentials.
- Clarify expectations about the amount of time the student will spend at your site (e.g, 3 or 5 days a week, number of hours, number of weeks).
- Contact the university placement coordinator to ask questions about communication between you and the university program once the graduate student is placed, including:
    - type and frequency of contact;
    - number of site visits by university coordinator;
    - systems for addressing any problems;
    - benchmarks and assessment for student progress.
- Inquire if the university offers or requires supervisors to have taken university or professional development courses on supervision or specific clinical topics. If not, ask the university if such coursework is available to supervisors.

Educational considerations prior to graduate student placement:

- Clearly communicate to the university information about the site, nature of cases seen, depth and breadth of clinical experiences and knowledge and skills likely to be learned at your site. Update this information annually.
- Determine if your department or your facility requires an interview or specific coursework prior to accepting the graduate student.
- Find out what types of clinical experiences the graduate student has acquired.
- Consider interviewing students who are candidates for placement at your facility in order to ascertain a "good fit" for placement at your site.
- Determine the type of evaluation of the graduate student's performance that the university requires (frequency and format).

- Consider how you plan to assess and teach clinical skills.
- Determine how you will assign cases and manage your caseload accordingly.
- Determine graduate student assessment measures.

Educational considerations after graduate student placement:

- When working with the graduate student, consider the following:
  - Set up regular times for conferences.
  - Encourage the graduate student to be an active participant in establishing mutually agreed upon educational goals for the placement, which take into consideration the student's level of experience and the nature of the clinical opportunities available at the site.
  - Clearly state your expectations for the graduate student over the course of the practicum-hours, responsibilities (clients, assigned projects or readings), and facility policies -- and how the student will be evaluated.
  - Be cognizant of the graduate student's learning style and how they respond to feedback.
  - Avoid attempting to expose the graduate student to every type of patient and disorder. Periodically revisit the goals for placement and student learning objectives.
  - Maintain communication with the university regarding the student's progress.

Resources available to you as a supervisor:

- Contact the university's clinic director and/or coordinator with questions or concerns regarding your graduate student.
- Consider joining Special Interest Group 11: Administration and Supervision. You can post questions and learn from other clinical educators once you join the division email list.

Appendix L.

Frequently Asked Questions about Student Supervision

General

For individuals that seek the Certificate of Clinical Competence (CCC) in Speech-Language Pathology, the certification standards provide guidance on:

- Qualifications for service as a supervisor to allow student clinicians to count clinical hours towards their CCC applications
- Basics about observation and practicum hours required for the CCC by the student
- Guidelines for critical aspects of supervision

Are there requirements to supervise student clinicians?

Yes. Supervisors should have established competency in any area of practice in which the supervisor or student may engage (e.g., supervisors without experience and competency working with pediatric populations should not supervise a student who is working with a child). The Issues in Ethics Statement on Supervision of Student Clinicians includes further discussion of this issue.

To meet ASHA's Standards for the Certificate of Clinical Competence (CCC), student clinicians must be supervised by an individual who holds the CCC in the appropriate area of practice (see Standard IV-E of speech-language pathology standards). University programs also may require the supervisor to hold the necessary state credential to practice in their setting, i.e. license and/or teacher certification.

Is there a requirement about the number of years one needs to be ASHA-certified before supervising a graduate student?

No. However, the supervisor should have acquired sufficient knowledge and experience to mentor a student and provide appropriate clinical education. Obtaining knowledge and skills related to principles of student assessment and pedagogy of clinical education is encouraged

Is there special "training" you need?

As with any area of practice, SLPs who are clinical educators should have established competency in supervision. There are a number of ways one can establish and maintain competency in this area. ASHA's position statement on clinical supervision outlines the competencies needed and training options.

How do I find an academic program that will send me student clinicians to supervise?

A list of graduate programs in speech-language pathology is available on ASHA's Web site. You can speak with the department chair, graduate program director, or clinic director for further information.

How much of the practicum has to be directly supervised?

According to Standard IV-E of the SLP Certification Handbook:

"Direct supervision must be in real time and must never be less than 25% of the student's total contact with each client/patient and must take place periodically throughout the practicum. These are minimum requirements that should be adjusted upward if the student's level of knowledge, experience, and competence warrants."

The implementation language further states that "The amount of supervision must be appropriate to the student's level of knowledge, experience, and competence. Supervision must be sufficient to ensure the welfare of the client/patient."

Also see the ASHA document, Quality Indicators for Professional Service Programs in Audiology and Speech-Language Pathology, which includes information about supervision.

In addition, facilities, payers, and other regulatory agencies may have requirements regarding supervising student clinicians that may impact the amount of supervision provided.

Can I supervise more than one student at a time?

Yes. Supervisors often find that they are called upon to supervise more than one student at a time. There is no language within the standards that specifies the number of students that can be supervised by one person.

Do I have to be on-site when the student is on-site? Is it okay to have other SLPs on-site?

As noted in the question above, the amount of direct supervision provided must be appropriate to the student's needs and ensure the welfare of the client. If the primary supervisor cannot be on site, another clinician may supervise the student, if needed. It is important to note that all persons who take on supervisory responsibilities must hold the appropriate CCC in the professional area in which the clinical hours are being obtained in order for the graduate student clinician to apply those supervised clinical hours towards their own CCC application.

To learn more about payer requirements for reimbursement of services provided by student clinicians and how this may influence the issue of on-site supervision in health care settings, see the first question in the Health care section below.

Am I liable for the treatment provided by the student under my supervision?

As a supervisor, you are responsible for any actions taken by the student while under your supervision. You should ensure that the amount of supervision provided is appropriate to the needs of the client/patient and for the graduate student's experience and skill.

Do I have to co-sign all notes, such as treatment plans and IEPs, written by the student? Can anyone else sign the student's notes?

The supervisor of record for the case would be expected to sign all treatment documentation, in accordance with the facility's policies.

How many minutes are in a clinical practicum hour?

The Council For Clinical Certification defines one (1) clinical practicum hour as equal to 60 minutes. When counting clinical practicum hours for purposes of ASHA certification, experiences/sessions that total less than 60 minutes (e.g., 45 minutes or 50 minutes) cannot be rounded up to count as 1 hour.

Health Care

Can I bill for services provided by a graduate student clinician?

In the ASHA Issues in Ethics statement, Ethical Issues Related to Clinical Services Provided by Audiology and Speech-Language Students (2013), it states that "the ASHA Code of Ethics [2010] recognizes the professional acceptability of appropriately supervised clinical practice by students; hence, there is no basis for suggesting or requiring that fees charged for services delivered by students differ in any way from the fees typically charged for services provided by certified audiologists or speech-language pathologists." Therefore, billing for such services is allowable, provided those services meet or exceed professional standards of supervision.

Payers differ in their regulations regarding paying for services provided by student clinicians. Medicare coverage of student clinicians differs depending on setting and whether the person is a Part A or Part B beneficiary. To find out the requirements for private payers, it is best to contact them directly as each will differ and may or may not follow Medicare's regulations.

Do I need to supervise the student more for swallowing cases than other disorders?

Supervision requirements do not differ based on disorder or patient population. The amount of supervision provided should meet or exceed minimum requirements and should be based on the individual needs of the student and the welfare of the client/patient being treated. Many student clinicians will come to the facility with minimal experience in swallowing, simply because swallowing disorders are not commonly seen in the university clinic setting. These student clinicians may require additional supervision to develop competencies in this area.

Are criminal background checks required for student clinicians?

The need to conduct a criminal background check depends on state law and the facility's policy. Part of this decision is whether or not the state law specifies student clinicians as a category of personnel who are required to have a background check. The Joint Commission on Accreditation of Health Care Organizations expects background checks to be done in accordance with such laws.

Under HIPAA, can I share personal health information with a student or do I need to get authorization from the patient or family?

HIPAA regulations were designed so as not to impede the provision of normal health care operations. "Health care operations," as defined in regulation, includes "conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers." (retrieved from http://www.hhs.gov/hipaafaq/limited/209/ on June 18, 2007).

Student clinicians will need to learn about HIPAA regulations and should be introduced to the facility's HIPAA policies and procedures. Facilities may require that student clinicians receive HIPAA training as part of their orientation. Student clinicians are expected to abide by the privacy rule regulations just as any employee in the facility.

Do I need to have the patient or family sign a consent form to allow the student to work with them?

Most health care facilities that allow for student trainees include a statement in their consent forms that services may be provided by a student clinician under the supervision of a qualified professional. The inclusion and wording of such statements will be influenced by relevant state laws and facility policies.

The ASHA Code of Ethics stipulates that "individuals shall not misrepresent their credentials, competence, education, training, experience, or scholarly or research contributions (Principle of Ethics III, Rule A [2010])." Student clinicians and supervisors should identify themselves appropriately to patients and families at all times. See the Issues in Ethics statement, Ethical Issues Related to Clinical Services Provided by Audiology and Speech-Language Students (2013), for more information.

How do I convince my administration to allow me to supervise student clinicians? What are the cost benefits of supervising student clinicians?

ASHA developed Frequently Asked Questions on What Administrators Need to Know [PDF] that can be used to frame discussions with health care administrators about supervising student clinicians.

The main issues have to do with personnel shortages and staff development. If a student is exposed to speech-language pathology services in hospitals, clinics, nursing homes, home care, or private practice, they may become part of the pool of appropriately-trained, qualified professionals from which facilities can recruit when they have open positions. In 2007, ASHA conducted a focus group with SLPs on the topic of externship supervision. Participants generally agreed that externships influenced a student's thinking about job choice and that graduate education programs can be used as a recruiting tool.

Supervising student clinicians also benefits the supervising SLP in a number of ways, including:

- Keeping up with current information in the field
- Sharpening clinical skills by teaching others
- Stronger relationships with university programs
- A sense of "giving back" to the profession

In speech-language pathology, as in any field, it is as important to keep good employees as it is to find new ones. While there may be some impact on the SLP's productivity and the facility's bottom line for speech services when the SLP supervises a graduate student clinician, it is unlikely that the impact will cost as much as recruiting and hiring new staff. Estimates on the cost of personnel turnover run as high as 1/3 of a new hire's annual salary to replace an employee (U.S. Department of Labor, retrieved June 18, 2007). Happy employees tend to stay with an employer. Giving SLPs the opportunity to grow professionally and personally by supervising a student clinician is one way of improving morale and ultimately retaining that SLP.

School Settings

Can I bill Medicaid for services provided by a graduate student?

In the ASHA Issues in Ethics statement, Ethical Issues Related to Clinical Services Provided by Audiology and Speech-Language Students (2013), it states that "the ASHA Code of Ethics [2010] recognizes the professional acceptability of appropriately supervised clinical practice by students; hence, there is no basis for suggesting or requiring that fees charged for services delivered by students differ in any way from the fees typically charged for services provided by certified audiologists or speech-language pathologists." Therefore, billing for such services is allowable, provided those services meet or exceed professional standards of supervision.

Do I need to supervise the student more for swallowing cases than other disorders?

Supervision requirements do not differ based on disorder or patient population. The amount of supervision provided should meet or exceed minimum requirements and should be based on the individual needs of the student and the welfare of the client/patient being treated. Many student clinicians will come to the facility with minimal experience in swallowing, simply because swallowing disorders are not commonly seen in the university clinic setting. These student clinicians may require additional supervision to develop competencies in this area.

Are criminal background checks required for student clinicians?

The need to conduct a criminal background check depends on state law and organization policy. Part of this decision is whether or not the state law specifies student clinicians as a category of personnel who are required to have a background check. Check with your administrator or contact the State Education agency.

Under The Family Rights and Education Privacy Act (FERPA), can I share student health and education records with a graduate student being supervised by me or do I need to get authorization from the family?

A graduate student being supervised by you may generally be considered a "school official" with a "legitimate educational interest" and, as such, may be provided access to students' education records under FERPA. FERPA requires that schools specify the criteria for determining which parties are school official and what the school considers to be a legitimate educational interest.

However, graduate students should be made aware of their responsibilities under FERPA not to disclose personally identifiable information from education records, unless authorized to do so, either with parental consent or under one of the conditions in FERPA permitting disclosure without consent.

Appendix M.

Focus Group Report: Externship Supervision

ASHA Health Care Conference
Bethesda, Maryland
March 31, 2007
Gail Ghazzawi
Surveys & Information Team
April 25, 2007

Purpose of Focus Group

ASHA conducted a focus group to gain insight into the feelings, opinions, and perspectives of ASHA members on the topic of externship supervision. It was moderated by an ASHA staff member who works in the Association's Research Issues and Activities Cluster.

The focus group was held on Saturday, March 31, 2007 at the ASHA Health Care Conference in Bethesda, Maryland. It lasted for approximately ninety minutes.

The focus group moderator led participants in a structured discussion of the following sub-topics:

- Memories of focus group participants' externships
- Preparedness of today's students for externships
- Importance of externships to health care facility and university administrations
- Strengths and rewards of externships
- Barriers to/challenges of externships
- ASHA's role in facilitating access to externships

Composition of Focus Group

The focus group consisted of nine ASHA members. All are female. Three of the members represented universities; six represented health care facilities. All were knowledgeable about the topic of interest.

Disclaimer

Focus groups allow for the collection of qualitative data that shed light on a topic of interest. They do not allow for the development of numerical data that is generalizable to a larger population.

Executive Summary

Memories of Focus Group Participants' Externships
Overall, the focus group participants described more positive than negative aspects of their experiences as students in extern programs. Even those who described the more negative parts of their experiences continue to see the benefits of extern programs generally.

Preparedness of Today's Students for Externships
The participants emphasized the positive feedback that they'd received from students in extern programs more than the negative feedback that they'd received. Some of the negative feedback that they'd received (e.g., that students felt overwhelmed) is understandable and perhaps even unavoidable.

The participants generally agreed that externships influence students' thinking about job choice. Sometimes they confirm students' current interests; sometimes they lessen them. Sometimes they lead students down new career paths altogether.

The participants agreed that some students are more prepared than others for their externships. They had different perspectives, though, on how prepared students should be.

Importance of Externships to Health Care Facility and University Administrations
One participant indicated that her health care facility administration provides structured support for their extern program. Other participants indicated that their administration provides less structured support.

The participants in health care facilities indicated that they did not receive tangible benefits, such as money, comp. time, etc. from their administration for supervising. They do, however, reap other types of benefits (e.g., knowing that they've helped someone else.)

The participants generally agreed that health care facility administrators recognize that extern programs are vehicles for recruiting future staff. Some use them as recruitment tools, though, more than others. A number of participants indicated that their administrators feel compelled to place greater priority on meeting high productivity requirements than on taking on students (who can be burdensome in the short-term.)

A number of participants in universities indicated that their administration supports their extern program by providing supervisors with continuing education opportunities at either no or a reduced cost.

Strengths and Rewards and Barriers to/Challenges of Externships
The participants in health care facilities described many strengths and rewards of extern programs. They also described a number of barriers to/challenges of such programs. They focused on one challenge in particular – the lack of formal training for extern supervisors.

The participants in universities indicated that they facilitate successful externships by routinely communicating with students and supervisors.

The participants in universities described a number of barriers to/challenges of extern programs. These include liability issues and scheduling difficulties.

The participants indicated that communication between health care facilities and universities varies for a wide variety of reasons.

ASHA's Role in Facilitating Access to Externships
The participants suggested a number of ways that ASHA could facilitate students' access to extern programs. These include offering continuing education units for supervising, offering a formal course on supervision, encouraging research on the topic of supervision (research that

could be published in journals and shared at national conferences,) and making grants available to speech therapists who wish to supervise students.

I. Memories of Focus Group Participants' Externships

Think back to when you were a student being supervised in a health care placement. Describe some of the positive and negative aspects of that experience.

Many of the focus group participants described the positive aspects of their student externships. They emphasized that they'd learned a lot. One participant stated that her externships had supported her coursework (i.e., they'd made the abstract concrete.) One participant stated that her externship had supplemented her coursework. (Through her externship, she'd learned about pediatric dysphagia. A course on that subject was not offered at her university at the time.) Two participants mentioned that their externships had been helpful in part because they'd "matched" their chosen specialty area (voice.)

A number of the participants stated that their hospital placements, including one at a Veteran's Affairs hospital, had been beneficial. For one participant, her placement had solidified her desire to work in a hospital following graduation.

A couple of participants mentioned that they'd had "wonderful" supervisors. One participant stated that through her externship, she'd built mentored relationships with two supervisors that had been retained over the years.

One participant stated that her externship had been valuable – that sometimes her colleagues have to travel to conferences (at a cost) in order to obtain the information that she'd obtained through her externship. In her words, following her externship, she'd felt "ahead of the game."

Some of the focus group participants also described the negative aspects of their student externships. A number of the participants indicated that they'd been dissatisfied with their facilities. One participant said that she'd been disappointed with the (limited) number of hours that she'd been given. One participant recalled being left alone in a private pediatric practice for ten hours and being expected to see patients. A number of participants indicated that they'd been unhappy with their supervisors. They said that their supervisors had conducted themselves poorly/treated students badly.

Interestingly, a couple of the participants stated that they'd benefited from the negative aspects of their student externships. Those negative aspects motivated them to ultimately become good supervisors and to make students a big part of their professional lives.

II. Preparedness of Today's Students for Externships

What feedback have you received from students in externships about their experience?

On the more positive side, one focus group participant said that their students learn a lot; they have a greater knowledge and skill base which increases their confidence. She also said that their students come back feeling excited, enthusiastic, and positive.

One participant said that through externships, their students obtain a set of core clinical skills that can be used across work settings. She also said that students learn to "problem solve" and think in a logical fashion.

One participant emphasized that through externships, students are provided the opportunity to work with different therapists who have different styles, different patient caseloads, etc. She said that her students feel "safe" coming to her and to the other therapists to talk, share concerns, etc.
On the more negative side, a number of participants indicated that the students are initially overwhelmed. They sometimes cry. The students aren't prepared to have contact with patients in hospitals who are so sick, who may be on ventilators, have trachs, etc. One mentioned a student who'd passed out in the Intensive Care Unit.

Another participant noted that students struggled with the fast-pace of the work and the necessary documentation. She also noted that it's difficult to simultaneously take classes and participate in an externship. (That's a heavy workload.)

How supported did the students feel by both the university and the health care facility?

One focus group participant said that she supports her students by setting short- and long-term goals for them. She said that it's helpful to students to have structure, and to know what's expected of them. She said that her students have given her positive feedback on this form of support. She also said that the clinical staff of Rush University interviews and rates supervisors (including her.) She said that she appreciates their doing that in support of their students.

One participant said that Temple University uses an "Expectations Form" which they encourage students and supervisors to complete during their first week together. It's a tool that the university uses to ensure that the expectations of both the students and supervisors are met. Faculty members from Temple University also meet with supervisors, have telephone conversations with them, etc. as a way to support both students and supervisors.

How do you think externships influence students' thinking about job choice?

The focus group participants agreed that externships influence (sometimes dramatically) student job choices. One participant said that she specifically looks for students with an interest in her own specialty area (voice.) This not only facilitates successful externships, it also helps to confirm students' interests.

One participant said that meeting her supervisor "changed the course of her career." (Prior to meeting her supervisor, this participant never thought she'd pursue a career in pediatrics/pediatric swallowing.) She said that she thinks that sort of thing "happens all the time

One participant recalled a first-year graduate student who was certain that she wanted to pursue a career in adult neurologic disorders. Following her placements, she chose to work in a school treating children.

One participant said that sometimes her students decide that a career in private practice is not for them, at least not right out of school. (They see that she sometimes has to work very long hours and complete a lot of paperwork in order to be paid by insurance companies.) She thinks that's a good choice – they need to explore their options.

One participant brought up a unique situation (limited to New York.) She said that sometimes her students really like the facility they're in but they've already committed to working for the Board of Education for a period of time following graduation. (The Board will pay for their education if they do so.) So sometimes her students feel torn. They've found a facility in which they might like to work but the opportunity to have their education paid for is also appealing.

One participant said that sometimes supervisors ask her students if they're more interested in working with children or adults. She said that she coaches her students to answer that question in an "open-ended" way.

How prepared do you think the students were to have successful externships?

A number of focus group participants said that some students were more prepared than others – it depended on the university. One participant said that students from "University A" – who'd completed their coursework and had only their externship left to do, and possibly a thesis, were far better prepared than students from "University B" – who'd completed only part of their coursework and were taking classes/participating in an externship simultaneously. She said that taking on unprepared students is a problem that she "runs into time and time again."

One participant said that she's frustrated with universities that "turn their students out." She said that she very carefully attempts to match students to supervisors and settings in order to facilitate successful externships.

One participant said that when she was a supervisor, she wondered why the universities weren't teaching the students X and Y. Now that she's a faculty member, she sees that they are teaching them X and Y! She also said that she doesn't think that it's her job to teach her students everything. She wants to help prepare them to make "connections." She wants to help develop students who will take the initiative to study their textbooks, review their notes, and ask questions.

The participants spent much time discussing whether or not the students should be well prepared for their externships. There were strong differences of opinion on this topic. One participant, as noted above, said it's problematic for her if her students aren't well prepared for their externships.

Two participants said that they understood the "frustration" felt by (burdened, very busy) supervisors who take on students who aren't as prepared as they'd like them to be. One of these participants also said, though, that "It's a Catch 22. You can't get the training until you have the experience but you can't have the experience without the training."

One participant said that, at a minimum, she wants students who understand "basic neurology." She said she thinks that's what's essential. Another participant agreed.

One participant said that she thought it was "good to get them (the students) out early," even if they couldn't assist much or help in a hands-on way. She said that the exposure and opportunities for observation and learning were beneficial. Another participant agreed. She said that it's important for students to have opportunities to "marry" text-based information with clinical information. She said that she doesn't expect her students "to know everything" when they walk through her door.

III. Importance of Externship to Health Care Facility and University Administrations

A question for folks in health care facilities: to what extent does your administration become involved in or support the student externship program?

One participant said that her facility has a structured program for speech-language pathology, occupational therapy, and physical therapy students. The program manager has a meeting for all of the students every other week. The students are expected to bring a "wrap-up form" that they've completed along with their supervisor. The form summarizes what the student's been doing, what they've learned, etc. The meetings provide students with an opportunity to share, receive feedback, prepare for what's ahead, etc.

One participant responded, "That's really cool!" She said that her facility doesn't have any type of program for students. In her words, it's "very, very loose." She said that if someone wants to take on a student, they seek permission from a manger who'll typically give him or her the "ok." A senior therapist will take care of the interviewing, paperwork, etc. She said that she and her colleagues would really like to take on a student every semester – and that their administration would support them – but that they're too busy/that it's too difficult logistically.

Another participant said that her facility didn't have a structured program, either. She said that she, too, liked the idea of having one, though.

What incentives (e.g., money, comp. time, reduced productivity levels) does the administration provide for employees who supervise externships?

The focus group participants laughed when the moderator asked them if their administration reimbursed them for supervising! They emphasized that they, as well as other supervisors, are caring professionals who give back because they want to. They're rewarded in non-financial ways for doing so (e.g., knowing that students have been observing, listening, and learning!)

One participant said that, as a form of compensation, she's allowed to take courses (in any field) for academic credit at a university in New York. She's responsible for paying the course registration fee. She greatly appreciates this form of compensation.

Does the administration recognize the externship program as a way to recruit Clinical Fellows and future employees?

One participant said "yes," her administration definitely recognizes the externship program as an excellent vehicle for recruiting future employees. She said that sometimes, though, their students are treated more like employees than students. (They're expected to "hit the ground running.") She emphasized that it's important for administrators to remember that the students aren't employees yet – that they're still in a learning period.

One participant (representing a university) said that it's her impression that rehabilitation companies are better than hospitals at using their extern programs to recruit future staff. She said that they'll work with whomever because they know that "the payoff" is potentially there.

One participant said "no," because her administration is not looking to expand its speech and hearing clinic.

One participant said that she thinks her administration understands that their externship program could be a valuable tool for recruiting future staff. In the short-term, though, they've had to focus on meeting high productivity levels. She said that recruitment of students, though, may become more of a priority in the near future. Her facility is struggling to recruit staff as it's based in an area in which housing costs are high.

Another participant (representing a university) said that hospital administrators in the Washington, D.C. area tell her that they're too short-staffed and too busy to take on students; that their productivity demands are too high. But she's concerned that if they don't take on students for training, if no one's "in the pipeline," that the pool of qualified job applicants for hospital positions will ultimately "dry up."

A question for folks in universities: To what extent does your university administration become involved in or support your student externship? Does it cultivate relationships with health care facilities? Does it offer incentives to the extern site supervisors?

One participant said that her university offers a continuing education event for supervisors every year. Supervisors are invited to attend the event and earn free continuing education units. Another participant said that supervisors can attend – for free or at a reduced cost – any of the continuing education programs that her university sponsors.

One participant said that her administration doesn't do a lot to support its student extern program even though they rely so heavily on it. She said that they're appreciative, and that they say "thank you" and make telephone calls. She recognizes that she and others in her administration need to provide more support for their extern program.

One participant (representing a health care facility) said that a university looking for a supervisor who was bilingual recently contacted her to see if she'd take on a student if they paid her and sent that student to her/her clinic (i.e., she wouldn't have to go to the university to supervise.) She's considering that offer – it might be "worth her time and effort" – but she has to consider many factors first (insurance contracts, etc.)

IV. Strengths and Rewards and Barriers to/Challenges of Externships

To the health care facility people: Talk a little about the challenges and rewards – or strengths and barriers – of having an extern program.

A number of the focus group participants talked about the strengths and rewards of having an extern program. One participant said that working with students helps her to grow professionally. She obtains new information from students and improves skills-wise. She also said that she benefits socially. Another participant agreed that working with students prompts her to "keep up" with new information.

One participant said that she enjoys "giving back." She also said that it's important to "armor" students for the workforce. Externships allow for that.

One participant said that she likes having control over what students are learning. She also said that her relationships with students are "symbiotic" and "wonderful."

One participant (representing a university) described extern programs as “an integral part of the education” process. She said that students learn “the basics” at their universities and “the advanced-level parts” at their extern programs.

One participant said that their extern program strengthened her relationship with a local university generally – a relationship that she values very much.

A number of the participants talked about the barriers to/ challenges of having an extern program. One participant emphasized that it’s very time consuming.

One participant said that supervising some students is more challenging than supervising other students (due to personality differences, etc.)

One participant said that there’s a lack of formal training for supervisors. The mention of this “barrier” or “challenge” prompted a fairly lengthy discussion among participants about the availability/non-availability of formal training for supervisors.

One participant responded that she was required to take a class on supervision at a university prior to supervising.

One participant said that the topic of supervision is discussed at her university’s annual continuing education event for supervisors. (At that event, there are sessions for both new and seasoned supervisors.)

Two participants commented on a voluntary, two-day class on supervision that’s offered by the American Physical Therapy Association. The intent of the class is to prepare physical therapists to become supervisors. One of the participants said that the class might become mandatory for those who wish to supervise.

One participant (representing a university) said that she belongs to ASHA’s Special Interest Division 11 (Administration and Supervision.) She said that belonging to the Division has been a “wonderful experience” and that she’s received much support from her fellow Division members.

To the university people: What do you do (or see others do) to facilitate the success of your externship program? What factors affect success?

One focus group participant said that she tries to prepare her students for their interviews. She also said that she puts together a “pretty substantial packet of information” about the university for supervisors. She, too, stays in touch with supervisors (by phone) and students (by face-to-face meetings) to gain their perspectives on how the externship is going. Sometimes the perspectives of the supervisors and students are quite different!

One participant said that she does those things, too. She also reminds supervisors that they shouldn’t try to “create a finished product” by the end of the semester. They need to “meet their students wherever they happen to be” at that point in their training.

One participant (representing a health care facility) said that she interviews her students two months prior to the start of their externships in order to learn about their coursework, expectations, etc. She said that the interview serves to relieve some of the students’ anxiety. Another participant said that she asks her students to provide her with a resume.

To the university people: Talk a little about the barriers to/challenges of having an extern program.

One focus group participant said that liability issues present challenges to having an extern program. She said that on the one hand, hospital attorneys are very interested in liability issues. On the other hand, universities, particularly state universities, don't want to be "Big Brother" and won't sign contracts that obligate them to ensure student behavior.

One participant said that scheduling coursework and externships is challenging. In her words, "There's no magic that works for everybody." One participant said that her university continues to follow the older ASHA guidelines that require students to get their "20-20-20" in different disorders. Consequently, their students aren't always available for externships.

How well do the universities and the health care facilities communicate and meet one another's expectations?

One focus group participant said that she's in constant communication – by phone or email – with university staff, primarily to "cover" herself. She's "constantly worried" that students will misinterpret what she's said and so she takes great care to explain her words/teachings to university staff.

One participant said that there's constant open communication between university and health care facility staff. She made a point of saying that this communication is "very time consuming."

One participant said that university staff had been "condescending" and hadn't been clear about why they'd wanted to visit. (She'd suspected that they were "nervous," as she was a first-time supervisor, but hadn't been certain.) She found their lack of communication "frustrating."

A number of participants said that the communication between university and hospital staff varies for a number of reasons. One participant said that she'd prefer to set up externships with a program coordinator (like the one at Temple University) rather than with students. She also said that, unless there's a problem, she might not communicate with university staff until there's a week or so left in the extern program.

One participant said that she's established a great with rapport with staff at one university but not with another – primarily because of a lack of time.

One participant said that after a while, you get to know people and places very well and that site visits become less necessary. (They can even be disruptive.) She said that she'll make a site visit, though, if she thinks a student will have a "rough learning curve."

One participant said that she's new to her position and is trying to establish a good rapport with health care facility staff. She thinks it will come in time, but it's challenging, as the staff had grown accustomed to working with her predecessor, who'd been in the position for eleven to twelve years.

V. ASHA's Role in Facilitating Access to Externships

What could ASHA do to facilitate students' having access to health care externships?

One participant asked if ASHA could provide continuing education units (or some other form of "credit") for supervising.

One participant recommended that ASHA offer a course on supervision, as the American Physical Therapy Association does. She thinks that such a course would increase the confidence of supervisors, help them to become "educators" as opposed to "supervisors," and ultimately improve the quality of training received by students in externships.

One participant said that it would be in the profession's best interest to teach the "basic skills of supervision"– skills that would be applicable across work settings.

One participant said that the field doesn't have research on supervision. She also said that even if someone's interested in doing research on supervision, it won't necessarily be easy to get it published in journals or accepted at national conferences. (That's important for tenure.) She emphasized that being a supervisor is not the same as being a clinician.

One participant said that ASHA should strive to attain greater respect for the field, particularly at the "legislative level" and with Medicare. She said that she isn't always recognized for her medical knowledge and the clinical experience that she has – she's treated as more of a "para-professional" or "technician." This hampers her desire to take on students and the burdens that come with doing so.

One participant suggested that ASHA help students with various housing needs.

One participant suggested that ASHA make grants available to therapists who wish to supervise students.

VI. Wrap-up

I'd like to go around the room and ask you to make one last comment about supervision. You may either emphasize one point you made earlier or add something you didn't have the opportunity to say.

One focus group participant said that externships allow staff to "get a good perspective on the student's developmental stage." She also said that an externship is work, "if you're doing it right!" She emphasized, though, that midway through the externship, there should be less work – that the student should be helping instead of hindering. For that reason, sometimes longer externships are better than shorter ones. She ended by saying that they'd all gotten supervision as graduate students and that it's important to give back.

One participant emphasized that university staff are very appreciative of supervisors, especially given the high productivity demands placed on them.

One participant emphasized the importance of supervision skills and the field's need for research on supervision.

One participant said that we could learn a lot from OT and PT – they do a lot with their externships and a lot generally.

One participant said that she'd like to be invited to speak at a university to provide students insight into what it's like to be a speech therapist. Another participant agreed, saying she thinks it's important for students to see that "this is what I'm going to grow up to be."

One participant said that too much emphasis is placed on diagnostics and not enough emphasis is placed on treatment. That had made her uncomfortable as a student. She'd prefer to see a greater balance.

One participant said that she'd "love" to be invited to speak at a university. She also emphasized the importance of supervisory skills (which are different from other types of skills) and the need for training or a competency in that area. She also said that she'd feel more confident as a supervisor if there were research on supervision or some sort of protocol on goal setting for students in externships.

One participant said that she speaks at a university every year and for NSSLHA and that it "really, really renews" her. She also said that she lobbies and takes students with her to the Capitol, to meet members of Congress, etc. She reminds them that "in therapy, we need advocates."

Appendix N.

Quality Indicators for Professional Service Programs in Audiology and Speech-Language Pathology

Standards/Quality Indicators
Working Group on Quality Indicators

Background

Since 1959, the American Speech-Language-Hearing Association (ASHA) has ensured the provision of quality services to persons with communication disorders by establishing a standards program for the accreditation of professional service programs. Standards were developed by the Council on Professional Standards in Speech-Language Pathology and Audiology (Standards Council). The Professional Services Board (PSB) was responsible for implementing the standards and overseeing the professional services accreditation program. In 2001, ASHA's Council on Professional Services Accreditation in Audiology and Speech-Language Pathology (CPSA) replaced the PSB and became responsible for setting standards for professional service programs and for monitoring compliance with those standards through the accreditation process. The most recent version of the standards—approved by the Standards Council in 2000—became effective January 2002.

At its spring 2001 meeting, ASHA's Legislative Council (LC) passed a resolution to eliminate the accreditation of professional services programs and the CPSA, via a 3-year phase-out period, effective December 31, 2001 (LC 9-2001). Also, as part of the Association's commitment to quality services for consumers, the LC passed another resolution (LC 10-2001) to develop and disseminate quality indicators by January 2005 that will serve as a resource for professional service programs.

The purposes of this resource document are to:

- identify and describe indicators of quality;
- assist programs in self-evaluation activities;
- provide a guide for the development of policies and procedures that will facilitate the provision of quality professional service.

The principles that underlie this document reflect accepted best practices and include many of the components covered in the 2002 Standards. Whereas the Standards were developed for use in the accreditation of professional service programs and provided necessary and minimum requirements in a variety of areas, the guidance provided in this document is intended to specify components that are typically present in quality clinical service programs but do not constitute requirements. The document is intended to be self-explanatory. It can be used to provide a framework for programs in the development stages as well as to assist in establishing a means of documenting progress toward improving quality of service provisions by audiologists and speech-language pathologists. Some of the functions of the quality indicators are to:

- help professionals seeking to improve quality of service delivery;

- inform other professions, accrediting bodies, funding sources, and other regulatory agencies of the essential elements of quality in programs that provide speech-language pathology and audiology services;
- guide the development of new clinical service programs;
- provide a basic framework for self-evaluation, program modification, and future planning in existing programs;
- demonstrate to facility administrators and governing bodies the goals to be achieved in developing and operating quality clinical service programs;
- enable programs to generate a detailed written report of quality service provision that might be used to fulfill requirements of accrediting and regulatory agencies;
- help students and practicing professionals understand the components involved in providing quality care;
- educate consumers and the general public about the important indicators of quality clinical service programs in audiology and speech-language pathology.

A working group was charged with the task of developing quality indicators to be available to disseminate to members and others by January 1, 2005. Members of the Working Group on Quality Indicators included Susan Bartlett, Jaynee Handelsman (Chair), Dianne Meyer, John Tonkovich, Marilyn Dunham Wark, and Kelly Appler (ex officio). Sue T. Hale, VP for Quality of Service in Speech-Language Pathology, served as the monitoring officer. In the development of the indicators, the working group considered the contents of the 2002 Standards as well as other ASHA resource documents and input from key stakeholders.

Key Features

The quality indicators emphasize the currency, appropriateness, and effectiveness of service delivery in the practice of audiology and speech-language pathology. Concepts of individualization of services to the needs of the persons served, consideration of various service delivery models, interdisciplinary team participation, age and area specific staff competencies, and data driven decision making are featured. Indicators reflect the need to consider all aspects of communication by both speech-language pathologists and audiologists. They emphasize the ongoing nature of program evaluation and performance improvement. While the two professions of audiology and speech-language pathology are guided by their scope of practice statements, individual programs may deliver some or all services from those scopes of practice. Intrinsic to these indicators is the assumption that every aspect of a program is driven by its individual stated purpose and scope of services.

The quality indicators cover five topic areas, each of which applies to professional service programs in speech-language pathology and audiology in any setting (e.g. school based, health care, and private practice):

- purpose and scope of services
- service delivery
- program operations
- program evaluation and performance improvement
- ethics

For each of these, there is a statement of the underlying principle followed by key components of the application of the principle. A question-and-answer format has been used to assist programs in thinking about the application of the components to their specific needs and the

needs of the persons they serve. The topic areas are discussed sequentially, in that they build upon one another, similar to a pyramid. For example, since all aspects of a program are based upon the definition of its clients and the services to be provided, the first task for a program is to define the purpose and scope of services. Similarly, for program evaluation and performance improvement to be meaningful, the components of service delivery and program operations must first be specified. Finally, ethical practices of the program and its staff apply to all areas of program operations.

When used as a tool for program self-assessment, these indicators provide a framework for generating a quality report. A written narrative summary of the self-assessment findings, according to this framework, might be used to document the program's voluntary adherence to these quality indicators to administrators, payers, accrediting agencies, and other stakeholders.

Quality Indicators

I. Purpose and Scope of Services

The program articulates its purpose and identifies the populations it serves.

- **The program has a written statement that describes its purpose.**

What is the written purpose of the program?
Some programs define their purposes through the use of a mission statement, vision statements, and/or organization values. The purpose typically is developed by gathering input from staff at all levels of the program.

- **The scope of program services is clearly defined with respect to population, disorders, and types of services provided.**

What is the program's scope of services?
A program's scope of service is part of the broader scope of practice. It is defined by taking into account the characteristics (e.g., age, impairment, activity limitation, cultural and linguistic background, demographics) of persons served, communication disorders or communication variations (e.g., accented English, corporate communication, professional voice), and types of services.

- **The program demonstrates how its purpose and scope are integrated within the purpose of the overall institution.**

How does the program's written purpose relate to the purpose of the institution?
A program may be part of a larger institution, in which case its statement of purpose and scope reflects the overall purpose of that larger institution. This particular guideline does not apply to programs that are not a part of a larger institution.

- **Information concerning program purpose and scope of services is made available to the public.**

How does the program disseminate information about its purpose and scope of services?

The public has access to information about the purpose and scope of services of the program. Information about a program's purpose and scope of services is made available to the public and may be disseminated through means such as brochures, public service announcements, Web sites, conferences, workshops, and direct mail.

- **The program has attainable goals and measurable objectives that are consistent with its purpose and scope of services and that are directed toward the provision of quality services.**

What are the program's goals and objectives?
Goals and objectives typically are formulated by gathering and analyzing information from a variety of sources (e.g., staff, persons served, other stakeholders, management reports, program outcomes). Goals are broad in scope: for example, “the program will better serve a designated clinical population that is currently underserved.” Objectives are more focused and are measurable. A sample objective might be “The program will increase the number of ‘outstanding’ ratings on patient satisfaction surveys by 10%.” Attainable goals are relevant, realistic, and achievable based on current or expected market conditions and resources (e.g., human, financial, physical facility). Goals and objectives may be set within a long-term strategic plan or may be short-term, focused issues. In addition, programs may set annual business goals as well as service provision goals. A program's goals and objectives relate to its purpose and scope of services.

What impact do the program's goals and objectives have on its delivery of quality services?
It is evident that there is an improvement in the quality of services if the goals and objectives are appropriately formulated, measured, and achieved.

II. Service Delivery

Within its defined scope of services, the program delivers services appropriate to the needs of the persons served and consistent with the current knowledge and skills related to the practices of audiology and speech-language pathology.

- **The program follows established practices for initiation and termination of service, and follow-up.**

What criteria are used to determine initiation and termination of service?
Programs develop initiation and termination criteria based on factors such as preferred practices, empirical evidence, medical status, diagnosis, staff knowledge and skills, prognosis, acuity, outcome of treatment, participation of persons served, organization policies, finances, and legal mandates and regulations.

What follow-up procedures are in place?
Programs develop follow-up procedures to assess factors such as maintenance of outcomes, satisfaction of the persons served and other relevant stakeholders (e.g., referral sources, payers, classroom teachers, employers), and follow through on recommendations made at the time of termination of service.

- **The program has developed diagnostic guidelines that are based on sound scientific principles and evidence, consistent with its scope of services, and appropriate to the needs of the persons served.**

What are the program's diagnostic guidelines and how were they developed?
Programs develop diagnostic guidelines by considering factors such as empirical evidence, preferred practices, staff knowledge and skills, cultural and linguistic variables, as well as the program's scope of services. In addition, the guidelines relate to the needs of the persons served (see ASHA's 2004 Technical report, *Evidence-Based Practice in Communication Disorders: An Introduction.*)

- **The program has developed treatment guidelines that are based on sound scientific principles and evidence, that are consistent with its scope of services, and that are appropriate to the needs of the persons served.**

What are the program's treatment guidelines and how were they developed?
Programs develop treatment guidelines by considering factors such as empirical evidence, preferred practices, staff knowledge and skills, cultural and linguistic variables, as well as the program's scope of services. In addition, the guidelines relate to the needs of the persons served (see ASHA's 2004 Technical report, *Evidence-Based Practice in Communication Disorders: An Introduction*).

- **Diagnostic and treatment practices are individualized to meet specific needs of persons served, including**
  - **age and developmental status**
  - **gender**
  - **cognitive ability**
  - **learning style**
  - **cultural and language background**
  - **impairments**
  - **activity limitations**
  - **participation restrictions**
  - **environment**
  - **family/caregiver/spouse**
  - **federal, state, and local regulations and/or policies.**

How are diagnostic and treatment practices individualized to meet the needs of persons served?
One way a program might choose to individualize diagnostic practices is to allow additional time for persons requiring interpreters or translators. Another example of individualization is to adapt the treatment modality to enable a child with physical limitations to participate in an outdoor group activity.

- **The program's professional staff considers a variety of service delivery models and selects**
  an appropriate model for persons served.

How does the program's professional staff determine what service delivery model is best for persons served?

A variety of service delivery models are available. These include, but are not limited to, care that is team based, classroom based, pull out, individual, group, collaborative, home and community based, family centered, and consultative. Professional staff considers the needs and preferences of persons served with sensitivity to culture, linguistic background, and gender in selecting diagnostic and treatment materials and service delivery models.

- **The program uses established policies for referring persons served to other sites or programs when the needs of persons served exceed the program's scope or availability of services.**

What are the program's policies when the needs of persons served exceed the scope or availability of services?
The program has written policies for managing persons served when it cannot meet their needs. Policies include criteria for referral to other providers and a process for decision making.

- **Within their respective scopes of practice, audiologists address speech-language issues and speech-language pathologists address hearing issues.**

How do audiologists address speech-language pathology issues and/or how do speech-language pathologists address hearing issues?
There is documentation that audiology evaluations consider the communication status of the persons served and that speech, language, communication, and swallowing evaluations consider the hearing status of the persons served in order to determine if referral to the other profession is necessary.

- **For each person served, the program maintains accurate, legible, and complete records that are protected with respect to confidentiality and that comply with legal mandates and regulations.**

How does the program assure that records are accurate and complete?
Written policies exist that define “accurate and complete” records. These include items such as identification data and case history; referral information; pertinent correspondence; applicable legal forms; signed and dated reports; and documentation of follow-up activities. Records are legible and systematically organized.

How is confidentiality of the records guaranteed?
Written policies exist that describe procedures used to ensure protection of patient and staff records. Those policies are consistent with applicable legal mandates and regulations. All staff members within the program are trained regarding confidentiality of records. Persons served are also informed about the policies regarding protection of their records.

- **Persons served participate in determining their plans of care.**

In what way do the persons served participate in determining the plan of care?
Professional staff members within the program solicit and consider input from persons served as part of the process in establishing a plan of care. Documentation of the plans reflects this process.

III. Program Operations

A. Administration

The structure and function of program administration assure effective and efficient program operation.

- **The program has established policies and procedures that reflect the program's purpose and scope of services, which are communicated to program personnel and followed.**

How are policies and procedures established to reflect the program's purpose and scope of services?
Policies and procedures are written by administrators and/or a committee of knowledgeable individuals in the organization. Ideally, professional staff members are included in the development process. Care is taken to reflect the purpose and scope of services in the policies and procedures. All policies and procedures are reviewed and updated on a regular basis.

How are policies and procedures communicated to the program's personnel and how does the program determine if the policies and procedures are applied consistently?
The program's policies and procedures are published in a resource manual and disseminated to all personnel or, at the least, located in an area that is accessible to all. Personnel are informed of revisions to the manual, and methods exist to determine if the policies and procedures are followed.

- **Administrative structures indicate clear lines of authority and responsibility.**

What are the program's lines of authority and responsibility?
Organizational charts can clearly represent the lines of authority in a program. Job descriptions outline the levels of authority and responsibility and are available to staff.

- **The knowledge and skills of program administrators are consistent with job responsibilities and level of decision-making authority.**

How does the program determine that the knowledge and skills of the program administrator(s) are consistent with the responsibilities of the job and the level of authority to make decisions?
Qualifications, responsibilities, and authority of the designated professional are shown in a written job description. If the program director is not an audiologist or speech-language pathologist, it is recommended that a credentialed professional is designated to represent the professional staff when decisions regarding clinical services are being made.

- **Administrators lead staff in formulating attainable program goals and measurable objectives.**

How does the leadership of the program work with the staff to formulate attainable program goals and measurable objectives?
Program goals and objectives are developed in collaboration with qualified and credentialed professional staff representing the clinical services offered. Staff members and/or leadership typically review goals and objectives regularly, modifying and updating as needed.

- **Program operations are in compliance with applicable legal mandates and regulations.**

What are the legal mandates and regulations the program is required to follow, and where are the reference materials located?
Administrators and professional staff members are knowledgeable about all applicable legal mandates and regulations at the federal, state, corporate, and facility levels. Copies of these mandates/regulations are easily accessible for review. Written policies and procedures describe how the program will comply with the applicable legal mandates and regulations.

B. Human Resources

The program has the human resources necessary to fulfill its purpose and scope of services and to achieve its goals.

- **Professional staff providing clinical services has appropriate qualifications and valid credentials to provide those services.**

What qualifications and credentials are required for audiologists and/or speech-language pathologists working within the program?
Minimal criteria for speech-language pathologists and audiologists are specified by a number of groups, including professional organizations, departments of education, and licensure boards. Program policies indicate the education, experience, skills, and other credentials needed for staff that independently provide clinical services, taking into account the current requirements of all appropriate groups. Programs can refer to the ASHA policy documents for information regarding clinical certification requirements and to government regulatory agencies for guidance.

How does the program monitor the currency of the credentials of professional staff members once they are employed by the program?
Programs typically maintain a personnel file for each employee, which includes copies of credentials such as ASHA certification, state license, registration, specialty certifications, and continuing education records. Professional staff members submit documentation of the currency of their credentials on an annual basis.

How does the program make certain that nonlicensed and noncertified staff providing clinical services (including students) are appropriately supervised?
The amount and type of supervision needed for nonlicensed and noncertified staff are designated by program policies and are consistent with legal mandates, accreditation and certification standards, and other pertinent directives. Typically, programs maintain logs that document the amount and type of supervision. In addition, programs provide periodic performance assessments of such staff and students.

- **All program personnel are in compliance with applicable legal mandates and regulations pertinent to the performance of their job responsibilities.**

What are the program's policies and procedures for making certain that staff meet legal mandates and regulations?
Some legal mandates and regulations (e.g., licensure, certification, or registration) apply only to specified staff. Other legal and regulatory directives (e.g., privacy, health precautions, or

corporate compliance issues) apply to all staff. Programs provide staff with information needed to meet legal requirements. Usually, programs monitor staff compliance through training and assessment programs and by documenting credentials.

- **Assignments are made in accord with staff members' professional qualifications and specific competencies.**

How does the assignment of caseload take into account each professional's qualifications and specific competencies?
The knowledge and skills required of clinical staff are considered foremost when making assignments; these may include, but are not limited to, specialized skills in working with persons across the age span, expertise with specific communication disorders and differences, and procedural competencies. The clinician's qualifications and areas of expertise are consistent with clinical assignments.

- **For each of the areas of clinical practice represented in the program's scope of services, someone on the staff maintains competence. There is a mechanism in place to make certain that these competencies are established and maintained.**

How are the skills and competencies needed by clinical staff established?
Programs have processes for determining the skills and competencies needed across staff to provide their scope of services. Clinical practice statements and ASHA guidelines are good resources for identifying needed skills and competencies. This information is reviewed periodically and is available to all staff.

How are the skills and competencies needed by clinical staff maintained?
Maintenance of skills and competencies can be addressed in a number of ways, such as continuing education, mentoring, in-services, and providing a minimum number of services or procedures. It is important that programs provide ways for staff to maintain skills and competencies as well as to develop new ones when needed.

- **The program assumes responsibility for providing opportunities for continued professional growth and development for staff at all levels of the organization.**

How does the program provide for continued professional growth and development of staff?
Providing high quality clinical services requires continued professional learning. Programs can support continued learning by providing financial support, release time, on-site training, mentoring or sharing of clinical expertise, journal clubs, client staffings, in-services, and other activities and materials that result in the acquisition or refinement of knowledge and skills. A variety of educational resources and learning opportunities are available for staff, taking into account individual learning styles and needs. Programs usually maintain annual records of staff continuing education activities.

- **Written personnel policies and records are maintained and updated on a periodic basis.**

How are the program's personnel policies established?
Programs that are part of a larger organization typically have personnel policies and procedures that have been developed by the institution, while independent programs develop policies and procedures appropriate to their setting and needs. In both cases, personnel policies address

issues including, but not limited to, position descriptions, vacation and sick time, benefits, personnel records, grievances, and leaves of absence. Personnel records include evidence of current licensure, continuing education, certification, or other requirements. Policies provide for periodic staff performance appraisals.

What procedures are in place for maintaining and updating personnel records?
The content of personnel records and the individual's access to the records are specified by personnel policies. Each employee's personnel file may include items such as hiring documents (e.g., curriculum vita, contract, position description), copies of credentials (e.g., ASHA certification, state license, and continuing education records), salary information, individual staff member goals, and documentation and results of periodic reviews. The personnel file includes records of changes or updates for these items.

- **Individual staff workloads are adjusted to achieve a balance between program needs and**
  available staffing without compromising the quality of service delivery.

What are the procedures to make certain that each staff member has adequate time for fulfilling all job responsibilities noted in the position description?
Staff schedules reflect that each staff member has sufficient time for planning, record keeping, supervision, follow up, equipment maintenance, and other job-related activities. Staffing policies and procedures discriminate between workload and caseload, and they ensure that quality service delivery is not compromised by workload fluctuations.

How does the program manage client caseload and other program activities relative to available staff?
Programs have policies and procedures for managing fluctuations in caseload and other work activities. These policies may include staffing needs (both professional and support staff), waiting list policies, initiation and termination of service criteria, staff recruitment, and staff productivity and absences.

- **Program support services are adequate for the volume and scope of program activities.**

How does the program address the need for adequate support services?
Inadequate support services may impact the quality and viability of clinical services. Programs assess their needs for support services, including clerical and administrative assistance, technical support, access to office machines and technology, business staff, and professional assistants. Support services must be adequate for the volume and scope of program services. Resources allocated for support services (e.g., salaries, space, and equipment) are consistent with the need.

C. Financial Resources and Management

The program's financial resources and their management are appropriate for program operations.

- **The program has financial resources that are sufficient to provide appropriate services with a reasonable expectation of continuity.**

How does the program determine if the financial resources are sufficient to support the operations of the program?
Resources provide adequate financial support for personnel, space, equipment, materials, and supplies to provide services continually across the designated scope of service. Staff member requests are considered when developing the budget.

- **The program's financial management is conducted in accordance with established policies and procedures, including those related to determining fees, using acceptable accounting procedures, budgeting, and maintaining accountability to relevant groups.**

How does the program manage its finances in accordance with the policies and procedures established?
The program has an identifiable process for budget development that shows expenses and revenues consistent with the program's goals and scope of services. There are written procedures for monitoring the program's expenditures, billing, collection of fees for services and/or products, and donations received.

- **The program's financial management complies with legal mandates and regulations.**

How does the program document that its financial management complies with legal mandates and regulations?
The program maintains written documents that specify policies and procedures addressing the applicable laws and regulations regarding all financial matters of operation. These mandates and regulations may include, but are not limited to, those of third-party payers and the state and federal governments.

D. Physical Facilities, Equipment, and Program Environment

The program has a physical plant and suitable environment to conduct program activities and to provide for the safety and welfare of persons served.

The equipment, materials, and supplies of the program are current and adequate to meet program needs.

- **The program's physical facilities are adequate for conducting activities that meet the program's purpose and scope of services and comply with applicable building and safety codes.**

How does the program's physical plant support its purpose and meet the needs of persons served?
Programs have facilities that are clean, of adequate size and design, and treated to achieve noise abatement. The facility's climate control system is maintained regularly to make certain that all work and storage areas are appropriately ventilated, heated, and cooled.

How does the program monitor its compliance with safety codes?
There is evidence that safety inspections are conducted regularly and that the facility meets applicable local, state, and federal safety codes for fire protection, mechanical lifts, lighting, and

electrical systems. An emergency evacuation plan exists, and regular evacuation drills are conducted in accordance with the appropriate authority's regulations for safety.

- **The program's physical facilities and services are accessible to persons with activity limitations in compliance with applicable legal mandates and regulations.**

How does the program safeguard that the physical facility is accessible to all persons served, including its personnel?
Standards established by the Americans with Disabilities Act (1990 and all updates) provide guidance for programs to develop and implement procedures for ensuring accessibility. Information contained in Section 4.0 of Part 36 ("Nondiscrimination on the basis of disability by public access and commercial facilities") specifies standards for accessible design.

How does the program make certain that its compliance with applicable mandates and regulations is current?
Plans are made to conduct routine inspections of the facility, to check currency of compliance, and to take any action necessary for addressing inconsistencies.

- **The program's physical facilities and service environment are designed to minimize communication barriers for persons served.**

How has the program considered the communication limitations of persons served in the design of their physical facilities and service environments?
Programs may use signs and emergency signaling systems that accommodate individuals with all types of communication limitations. Administrators and professional and support staff are instructed on how to communicate with persons who have a range of disorders (e.g., hearing loss, aphasia, laryngectomy) and communication differences (English language learners). The program's services are adapted to meet the preferences and needs of persons served, with sensitivity to the persons' culture.

- **The program establishes and maintains an environment that protects the health and safety of persons served and program personnel by implementing policies that address universal precautions, infection control, risk management, radiation exposure, and emergency preparedness.**

How does the program protect the health and safety of all persons served?
Written policies and procedures that focus on risk management address those circumstances that potentially endanger health and safety. These include, but are not restricted to, infection control, medical emergencies, equipment safety, radiation exposure, weather emergencies, natural disasters, and physical plant catastrophes (power failure, radiation leaks, evacuations, etc.).

How does the program implement its health and safety procedures?
Contingency plans are necessary for managing events that may endanger the health and safety of persons served. When a risk management program is conducted, it is necessary to post universal precautions for implementing infection control measures in areas that are at risk for health and safety violations. Signage that illustrates proper hand washing is situated throughout the facility. Training is regularly provided to staff regarding health and safety procedures.

How does the program prepare its facility to implement its health and safety precautions?
Administrators and professional and support staffs are trained to recognize and respond to emergency situations. These may include, but are not restricted to, CPR training, incident reporting procedures, and evacuation procedures. Structural barriers are eliminated and all areas of the program's facilities are easily accessible by all persons. Policies and procedures for maintaining a safe and healthy environment are reviewed at least annually for currency.

- **Non-facility-based services are delivered in environments that are suitable for conducting program activities and that minimize risk to the persons served.**

What criteria does the program apply to determine that non-facility-based environments are safe and appropriate for persons served, including personnel?
When services are delivered in non-facility-based environments, the program develops and applies guidelines for determining the suitability of such sites. Criteria may include accessibility (such as lack of barriers), safety, structural stability, compliance with prevailing building codes, proximity, availability of equipment, materials and supplies, standards of clinical practice, support personnel, and security for all persons served, including the individuals who provide services. Programs approve non-facility-based sites according to the criteria prior to the delivery of services.

- **Equipment, materials, and supplies available are consistent with state of the art practices and reflect preferred practice patterns, best available empirical data, and professional consensus.**

How does the program select and implement equipment, materials, and supplies that will be used in diagnostic and treatment activities?
Using a range of criteria, the program's administrators and professional staff select materials, equipment, and supplies to meet the needs of persons served. These criteria may include validity and reliability of particular test instruments, treatment materials or protocols, theoretical bases underlying their development and use, robustness of the results from empirical studies, practicality, usefulness, cost, format, availability, product reviews in professional and trade journals, and applicability to the communication disorders served by the program.

How are materials, equipment, and supplies monitored?
An inventory of materials is maintained and updated at least annually; materials, equipment, and supplies that are outdated, broken, or unsuitable are removed from the inventory and discarded.

- **All equipment is maintained in safe and effective working order.**

What steps does the program take to make certain that equipment, materials, and supplies are maintained appropriately and that they are up-to-date, safe, and in working order?
Policies and procedures exist that cite the care and maintenance of the program's equipment, materials, and supplies. They also specify the frequency, schedules, and persons responsible for carrying out routine safety and maintenance. Routine maintenance is documented and reviewed regularly. When equipment does not meet safety standards or is not in working order, it is repaired or removed from inventory.

- **Equipment that requires periodic calibration is maintained and checked in accordance with current industry standards and benchmarks.**

How does the program meet industry standards and benchmarks for calibration of equipment?
Calibration is conducted using guidelines from the American National Standards Institute (ANSI) and equipment manufacturers. Calibration procedures (including electrical, acoustical, and mechanical) are established at the time of equipment installation, and regularly scheduled calibration checks are conducted and documented. Daily biologic checks are performed and all calibration activities are logged, documented, and reviewed on a regular basis. Policies and procedures specify what happens when equipment is out of calibration.

- **Hearing testing services are offered in a sound-treated test environment that meets the standards of ANSI and that is of sufficient size to accommodate procedures appropriate to the services offered.**

How does the program show evidence that its test environment meets ANSI standards and that it is an adequate size to meet the needs of persons served?
Records of calibration of audiometric equipment provide evidence of compliance with universal standards for noise levels. The amount of ambient noise in sound-treated test environments is documented through frequent and systematic measures that are conducted according to ANSI guidelines. Sound-treated rooms/suites comply with industry standards related to electromagnetic, acoustic, and fire suppression qualities.

What is "sufficient" size?
The size of the test environment depends on: 1) the nature of the services provided; 2) the size and type of equipment, furnishings, and materials; and, 3) the mobility status of the persons served.

IV. Program Evaluation and Performance Improvement

The quality of services provided is evaluated and documented on a systematic and continuing basis, and results are used to make program modifications or improvements. These quality evaluations address both program and client outcomes.

- **The program has a written plan and process for evaluating the effectiveness and efficiency of its performance.**

What is the program's process for evaluating the effectiveness and efficiency of its performance?
A written plan describing the process for evaluating a program's effectiveness and efficiency is developed and implemented. On a periodic and systematic basis, program outcomes are reviewed to determine the effectiveness of the services provided and the efficiency of the program's operations in terms of resources used.

- **The plan provides for data collection from relevant stakeholders, the program's operations, and clinical outcomes.**

How are data collected from relevant stakeholders?
The program's plan for evaluating effectiveness and efficiency includes a mechanism for obtaining data from relevant stakeholders. Patient satisfaction surveys, surveys that elicit satisfaction information from referral sources and payers, and data obtained from focus groups are some ways in which programs might collect data from relevant stakeholders. These data are periodically reviewed and compared with relevant or previously established benchmarks.

How are data from the program's operations collected?
Relevant information from a program's operations is included in the assessment of the program's effectiveness and efficiency. Budgetary reports, expense reports, revenue reports, variance reports, capital expenditures, and other reports that summarize resource utilization are some examples of data that might be used from the program's operations. These data are periodically reviewed and compared to relevant or previously established benchmarks.

How are data from clinical outcomes collected?
A program may collect data from clinical outcomes in a number of ways. These might include the use of nationally recognized outcome measures, the percentage of goals achieved by persons served, the average length of stay or duration of services provided, and the volume of persons served. These data are periodically reviewed and compared to relevant or previously established benchmarks.

- **The program's performance improvement process includes periodic and systematic reviews of clinical service delivery, including**
  - **outcomes of persons served**
  - **clinical guidelines**
  - **staffing, staff competence, and staff development**
  - **clinical records.**

How does the program's performance improvement process address pertinent aspects of clinical service delivery?
The program periodically and systematically reviews information about its clinical service delivery. Specifically, the program may review data from

  - outcomes of persons served that relate to goals achieved and/or satisfaction with services delivered;
  - clinical guidelines for the delivery of services that might include initiation and termination of service criteria, clinical protocols, and clinical pathways;
  - the level of staffing needed to accomplish the program's clinical service delivery goals, staff competencies in delivering the clinical services, and areas of staff development necessary for delivering the clinical services.

As a result of these periodic reviews, the program makes modifications in its clinical service delivery as necessary in an effort to improve program performance.

- **The program's performance improvement process reflects evidence-based practice and includes periodic and systematic reviews of program operations, including**
  - **purpose**
  - **scope of services**
  - **attainable program goals and measurable objectives**
  - **administration/leadership**
  - **financial operations**
  - **physical facilities and environment**
  - **equipment and materials**
  - **safety procedures and emergency preparedness**
  - **ethical conduct**
  - **compliance with legal mandates and regulations**

How does the program's performance improvement process address pertinent aspects of program operations?
The program periodically and systematically reviews information about its operations. The program's purpose and scope of services are reviewed on an ongoing basis to ascertain that they continue to be relevant to the clinical services delivered. The program's measurable objectives are reviewed to determine the extent to which program goals have been achieved. The budget is reviewed periodically throughout the year and compared with actual income and expenses as a means of measuring ongoing stability of financial operations. The program's administration/leadership, physical facilities and environment, and equipment and materials are reviewed to determine the extent to which they continue to meet the needs of the program's clinical service delivery. The program's safety procedures and emergency preparedness plans are reviewed to determine the extent to which they are current and relevant. Ethical conduct policies and practices are reviewed to make certain that they meet the needs of the program and the persons it serves. Program compliance with legal mandates and regulations is also periodically reviewed. As a result of each of these periodic reviews, the program makes modifications in its operations as necessary in an effort to improve performance.

- **Data from the program performance reviews are documented, analyzed, and used to modify clinical service delivery and program operations.**

How are data from the program performance reviews documented and analyzed?
Programs prepare a written report of performance reviews that documents and analyzes data from clinical service delivery and program operations. These reports or a synopsis of them are typically made available to staff members at all levels of an organization.
How are data used to modify clinical service delivery and program operations?
Programs demonstrate the changes in service delivery or operations that have resulted from performance improvement reviews. For instance, programs might demonstrate specific clinical service delivery options that have been created, eliminated, or modified as a result of data identified in performance improvement reviews. Similarly, changes in program operations that have resulted from factors identified in the program's performance improvement activities also would be identified.

V. Ethics

Programs have policies that promote the adherence to ethical principles and rules of conduct. Ethical policies are infused into all aspects of service delivery and program operations and upheld by staff at all levels of the organization.

- **The program does not discriminate in its services and employment practices on the basis of race or ethnicity, gender, age, religion, national origin, sexual orientation, impairment, or activity limitation.**

What are the program's written policies regarding nondiscrimination?
Programs draft policy statements regarding nondiscrimination that apply to people seeking employment within the program as well as to people seeking professional services from the program. The statements are made available to consumers and are understood by all staff.

How does the program monitor compliance with its policies of nondiscrimination?
Various monitoring options exist, including periodic review of recruitment and hiring data, as well as review of referral, initiation, and termination of service data.

- **Policies relating to clinical decisions in audiology are made by appropriately credentialed audiologists; policies relating to clinical decisions in speech-language pathology are made by appropriately credentialed speech-language pathologists.**

How do clinical decisions made within the program relate to staff members' credentials?
The program's written guidelines specify that all clinical decisions regarding the provision of clinical speech-language pathology services are made by speech-language pathologists and clinical decisions regarding the provision of services in audiology are made by audiologists. Note: Refer to the Human Resources section of this document for information regarding credentials for speech-language pathologists and audiologists.

- **Appropriately credentialed audiologists and speech-language pathologists must supervise persons engaging in any aspect of clinical service delivery who do not have appropriate credentials. The nature, amount, and accessibility of supervision are commensurate with the knowledge and skills of the supervisee and other legal mandates and regulations.**

Does the program use non-credentialed persons in the delivery of clinical services?
In many programs, support personnel are used in some aspect of the provision of clinical services. When that happens, the program has written guidelines regarding the specific nature of the tasks that are within the purview of non-credentialed staff as well as clearly defined supervision requirements. Furthermore, the program's written guidelines specify the educational and experiential qualifications of each type of support person employed in the program.

What are the program's written policies regarding the supervision of non-credentialed staff in clinical service delivery?
Written policies exist regarding the amount and type of supervision provided to non-credentialed staff as well as the relationship between qualifications, competence, job task, and degree and type of supervision provided. Program personnel are encouraged to refer to existing ASHA policy documents when drafting their own guidelines for supervision. In addition, program guidelines for supervision conform to legal mandates, as well as agency and school district regulations.

How does the program assess whether supervision is appropriate for non-credentialed personnel?
Evaluation of the appropriateness of supervision could include things such as comparing logs of supervision against established guidelines for supervision, obtaining feedback from persons supervised as well as from supervisors, and evaluating clinical outcomes of persons served. Modifications of supervision guidelines are data driven and are assessed on a periodic and systematic basis.

- **The program has a written code of conduct for the ethical behavior of its staff.**

What is the program's code of conduct, and how was it developed?
A program might be part of a larger organization that has established institutional codes of conduct, in which case the program might adapt the more general code to reflect criteria that are specific to its purpose and scope of services. Speech-language pathologists and audiologists are bound by the code of ethics of the professional organizations to which they belong, in addition to any ethical codes established by other applicable regulatory bodies (e.g.,

state licensure boards, Department of Education policies). Non-credentialed staff might also be bound by ethical codes of other parent organizations. The code of conduct for individual programs typically reflects standards for behavior that are in concert with other ethical codes and that are general enough to apply to all staff within the program.

How are staff informed about the code of conduct?
Program staff members are typically informed about the code of conduct at the time of hire. In addition, staff members might participate in periodic review of the code.

- **The program has a written process for managing complaints.**

What is the program's complaint process?
A program may be part of a larger institution, in which case it has a complaint process that uses established guidelines of the larger institution. For programs that are not part of a larger institution, program personnel develop a procedure for addressing complaints from program staff and from consumers of the program. The procedure may include how a complaint can be made, how it will be investigated, how a resolution will be decided, and how the complainant will be notified of the outcome.

Appendix A: Glossary

Activity limitations: See activity/participation limitations and restrictions. The World Health Organization (2001) combined the terms “activity limitations” and “participation restrictions.” Previously, activity limitations were defined as “difficulties an individual may have in executing activities” and replaced terminology of “disability.”

Activity/participation limitations and restrictions: Combined terminology to refer to “an associated reduction in the ability of an individual to execute tasks in different settings both in a clinic and the patient's real life environment.”

Acuity: As used in this document, refers to time post-onset.

Appropriately credentialed: Refers to licenses and/or certificates required for practice by various administrative units (e.g., professional associations, boards of health, boards of education).

Currency: State of the art.

Diagnostic: Term that is defined as assessment, individual evaluation.

Disability: According to ICF, this is a general term that includes impairments, activity limitations, and participation restrictions.

Empirical evidence: The use of experimental data to support a specific strategy or clinical method.

Environment: Setting.

Facility-based programs: Refers to those programs that are typically housed in the site where they are administered (e.g., educational settings, hospitals, rehabilitation centers, private practice offices).

Goals: Broad areas identified to be accomplished in a designated time frame.

Impairments: Defined by ICF as “problems in body function or structure such as a significant deviation or loss.”

Institution: Organization within which the program resides (e.g., hospital, university).

Job description: A written document describing specific duties, responsibilities, and job-related tasks. Also known as a position description, functional statements, or qualification standards.

Legal mandates: Legal directions or instructions from a group in authority.

Legal regulations: State or federal laws.

Maintenance of outcomes: Over a prolonged period of time. Also referred to as durability of outcomes.

Medical status: Severity of illness.

Mission statement: Overarching defining principle of an organization or agency.

Objectives: Specific steps identified to achieve the broader goal.

Participation restrictions: See activity/participation limitations and restrictions. Previously, participation restrictions were defined as “problems an individual may experience in involvement in life situations” and replaced terminology of “handicap.”

Patient/client: See *Persons served*.

Performance improvement process: A systematic and organized approach designed to identify, change, and evaluate areas of functioning within a program or of an individual's contribution to it. Also known as “quality improvement,” “quality assurance,” “continuous quality improvement.”

Persons served: Any individual or group who is affected by the delivery of services. This may include clients, families, caregivers, and others directly affected such as educational, medical, and rehabilitation personnel.

Policies and procedures: A policy is a guiding principle created by a governing body that is used to influence and determine decisions and actions. Procedures are the ways in which the policies are to be carried out.

Preferred Practices: Covers ASHA Preferred Practice Patterns, clinical practice guidelines, and best practices. Preferred Practice Patterns define universally applicable characteristics of activities directed toward individual patient/clients, and that address structural requisites of the practice, processes to be carried out, and intended outcomes. Clinical Practice Guidelines are a

recommended set of procedures for a specific area of practice, based on research findings and current practice, that details the knowledge, skills, and/or competencies needed to perform the procedures appropriately (*ASHA Desk Reference*, Volume 1).

Program: The entity that provides speech-language pathology and/or audiology services.

Protected health information: According to the Health Insurance Portability and Accountability Act (1996), "PHI" comprises any information that may identify an individual through his or her health records. This includes, but is not limited to, an individual's name, birth date, social security number,
address, identification number, and medical record number.

Protocols: Clinical practice patterns customized to specific setting and program.

Purpose: Specific aims of the program (vision).

Scope of practice: ASHA policies for the practices of speech-language pathology and audiology. Two separate documents serve to describe services, to provide resource information, and to identify those activities that require ASHA certification.

Scope of services: Those portions of the scope of practice that are included in a program. Scope of services includes definitions of clinical populations.

Screening: An initial probe to determine if further evaluation is warranted.

Supervisee: Any individual who is being supervised; this may include student clinicians, noncredentialed employees in a program, technicians, and others who may require any amount of supervision.

Values: See purpose.

Vision: See purpose.

World Health Organization (WHO): The United Nations specialty agency established in 1948 whose objective is for all persons to attain complete physical and mental health and social well being. Among its many responsibilities, WHO issues the "ICD" (International Statistical Classification of Diseases and Related Health Problems) and "ICF" (International Classification of Function, Disability, and Health) regulations and standards.

Workload: All activities subsumed under a position (e.g., administrative, teaching, research, mentoring, clinical).

Appendix B. Additional Resources

The following policy statements, guidelines, articles, and saleable products from the American Speech-Language-Hearing Association (ASHA) are included as related resources to professional programs providing audiology and/or speech-language pathology services. This list is not meant to be exhaustive or limiting; rather, it should serve as a starting point to assist programs in all settings in development, self-assessment, and improvement.

American Speech-Language-Hearing Association. (2004). Admission/discharge criteria in speech-language pathology. *ASHA Supplement, 24*, 65–70.

American Speech-Language-Hearing Association. (2003). Appropriate school facilities for students with speech-language-hearing disorders: Technical report. *ASHA Supplement 23*, 83–86.

American Speech-Language-Hearing Association. (1985, June). Clinical management of communicatively handicapped minority language populations. *Asha, 27* (6).

American Speech-Language-Hearing Association. (1985, June). Clinical supervision in speech-language pathology and audiology. *Asha, 27*, 57–60.

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American Speech-Language-Hearing Association. (1991). Considerations for establishing a private practice in audiology and/or speech-language pathology: Technical report. *Asha, 33*(Suppl. 3), 10–21.

American Speech-Language-Hearing Association. (2002). Cultural Competence Checklists. Available from www.asha.org/practice/multicultural/self/.

American Speech-Language-Hearing Association. (2004). Evidence-based practice in communication disorders: An introduction [Technical report]. Available from http://www.asha.org/policy.

American Speech-Language-Hearing Association. (2004). *Guidelines for the training, use, and supervision of speech-language pathology assistants*. Rockville, MD: Author.

American Speech-Language-Hearing Association. Issues in Ethics Statements. Available from http://www.asha.org/policy.

American Speech-Language-Hearing Association. (2004). Knowledge and skills needed by speech-language pathologists and audiologists to provide culturally and linguistically appropriate services. *ASHA Supplement 24*, 152–158.

American Speech-Language-Hearing Association. (1990, April). Major issues affecting delivery of services in hospital settings: Recommendations and strategies: Technical report. *Asha, 32*, 67–70.

American Speech-Language-Hearing Association. (1997, Spring). Multiskilled personnel: Technical report. *Asha, 39*(Suppl. 17), 13.

American Speech-Language-Hearing Association. (1993). National health policy: Back to the future: Technical report. *Asha, 35*(Suppl. 10), 2–10.

American Speech-Language-Hearing Association. (1997). *Preferred practice patterns for the profession of audiology*. Rockville, MD: Author.

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American Speech-Language-Hearing Association. (1999). *Practical tools and forms for supervising speech-language pathology assistants*. Rockville, MD: Author.

American Speech-Language-Hearing Association. (1987, March). Private practice. *Asha, 29*, 35.

American Speech-Language-Hearing Association. (1994). Professional liability and risk management for the audiology and speech-language pathology professions: Technical report. *Asha, 36*(Suppl. 12), 25–38.

American Speech-Language-Hearing Association. (1993, March). Professional performance appraisal by individuals outside the professions of speech language pathology and audiology: Technical report. *Asha, 35*(Suppl. 10), 11–13.

American Speech-Language-Hearing Association. (2004). Scope of practice in audiology. *ASHA Supplement, 24*, 27–35.

American Speech-Language-Hearing Association. (2001). *Scope of practice in speech-language pathology*. Rockville, MD: Author.

American Speech-Language-Hearing Association. (1983, September). Social dialects. *Asha, 25*, 23–27.

American Speech-Language-Hearing Association. (2004). Support personnel. Available from http://www.asha.org/policy.

American Speech-Language-Hearing Association. (2003). Technical Report: American English Dialects in press. *Asha Supplement 23*.

American Speech-Language-Hearing Association. (2004). *The training, use, and supervision of support personnel in speech-language pathology: Position statement*. Rockville, MD: Author.

American Speech-Language-Hearing Association. (2000). *Working with speech-language pathology assistants in school settings*. Rockville, MD: Author.

Council for Clinical Certification in Audiology and Speech-Language Pathology. (1997). Standards and implementations for the certificate of clinical competence of practice in speech-language pathology. In Rockville, MD: Author. Available from http://www.asha.org/policy/.

Council for Clinical Certification in Audiology and Speech-Language Pathology. (1997). Standards and implementations for the certificate of clinical competence in audiology. In Rockville, MD: Author. Available from http://www.asha.org/policy/.

Council on Academic Accreditation in Audiology and Speech-Language Pathology. (2004). Standards for accreditation of graduate education programs in audiology and speech-language pathology. Available from http://www.asha.org/policy.

National Joint Committee for the Communication Needs of Persons with Severe Disabilities. (2003a). Position statement on access to communication services and supports: Concerns regarding the application of restrictive “eligibility” policies. *ASHA Supplement, 23*, 19–20.
National Joint Committee for the Communication Needs of Persons with Severe Disabilities. (2003b). Supporting documentation for the position statement on access to communication services and supports: Concerns regarding the application of restrictive “eligibility” policies. *ASHA Supplement, 23*, 73–81.

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World Health Organization. (2001). *International classification of functioning, disability and health (ICF)*. Geneva, Switzerland: Author.

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Appendix O.

Evidence-Based Practice in Communication Disorders

Position Statement
Joint Coordinating Committee on Evidence-Based Practice

About this Document

This position statement was developed by the American Speech-Language-Hearing Association (ASHA) Joint Coordinating Committee on Evidence-Based Practice. Members of the committee included Randall R. Robey (chair); Kenn Apel; Christine A. Dollaghan; Wendy Ellmo; Nancy E. Hall; Thomas M. Helfer; Mary Pat Moeller; Travis T. Threats; Celia R. Hooper, 2003–2005 vice president for professional practices in speech-language pathology; Raymond D. Kent, 2004–2006 vice president for research and technology; Janet Brown (ex officio); and Brenda L. Lonsbury-Martin (ASHA staff consultant).
This position statement is an official policy document of the American Speech-Language-Hearing Association (ASHA).

It is the position of the American Speech-Language-Hearing Association that audiologists and speech-language pathologists incorporate the principles of evidence-based practice in clinical decision making to provide high quality clinical care. The term *evidence-based practice* refers to an approach in which current, high-quality research evidence is integrated with practitioner expertise and client preferences and values into the process of making clinical decisions.

In making clinical practice evidence-based, audiologists and speech-language pathologists—

- recognize the needs, abilities, values, preferences, and interests of individuals and families to whom they provide clinical services, and integrate those factors along with best current research evidence and their clinical expertise in making clinical decisions;
- acquire and maintain the knowledge and skills that are necessary to provide high quality professional services, including knowledge and skills related to evidence-based practice;
- evaluate prevention, screening, and diagnostic procedures, protocols, and measures to identify maximally informative and cost-effective diagnostic and screening tools, using recognized appraisal criteria described in the evidence-based practice literature;
- evaluate the efficacy, effectiveness, and efficiency of clinical protocols for prevention, treatment, and enhancement using criteria recognized in the evidence-based practice literature;
- evaluate the quality of evidence appearing in any source or format, including journal articles, textbooks, continuing education offerings, newsletters, advertising, and Web-based products, prior to incorporating such evidence into clinical decision making; and
- monitor and incorporate new and high quality research evidence having implications for clinical practice.

Technical Report
Research and Scientific Affairs Committee

About this Document

This technical report was developed by the The Research and Scientific Affairs Committee of the American Speech-Language-Hearing Association (ASHA) and approved by ASHA's Executive Board on August 20, 2004. Members of the Committee included Christine A. Dollaghan (chair), Raquel T. Anderson, M. Patrick Feeney, John H. Grose, Peggy B. Nelson, D. Kimbrough Oller, Elena Plante, C. Melanie Schuele, Linda M. Thibodeau, Sharon E. Moss (ex officio), and Brenda L. Lonsbury-Martin (monitoring officer).

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Definition of Topic

Evidence-based practice (EBP) is a perspective on clinical decision-making that originated in evidence based medicine, and has been defined as "… the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients … [by] integrating individual clinical expertise with the best available external clinical evidence from systematic research" (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, p. 71). Recent discussions of EBP (e.g., Guyatt et al., 2000; Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000) have emphasized the need to integrate patient values and preferences along with best current research evidence and clinical expertise in making clinical decisions.

The EBP orientation has the potential to improve the quality of the evidence base supporting clinical practice in speech-language pathology and audiology, and ultimately to improve the quality of clinical services to patients with speech, language, and hearing disorders. Accordingly, this technical report has four purposes: (a) to provide an overview of some of the principles and procedures of EBP; (b) to describe the relevance of EBP to current clinical issues in speech-language pathology and audiology; (c) to raise awareness of the importance of EBP research as one component of the research mission of the American Speech-Language-Hearing Association; and (d) to recommend potential steps toward increasing the quantity of credible evidence to support clinical activities in the professions. It is not possible to include or address all of the issues and information concerning EBP within the scope of this report; the final section provides a list of sources for individuals interested in learning more about EBP.

Overview of Evidence-Based Practice

An important impetus for the EBP orientation has been the growing awareness of the limitations of expert opinion as the sole basis for clinical decision making.

As noted by Sackett, Haynes, Guyatt, & Tugwell (1991), the history of medicine includes a number of cases in which the recommendations of respected authorities have turned out to be wrong or harmful when subjected to scientific investigation. These cases range from William Osler's 19th century recommendation that opium be used to treat diabetes (Sackett, Haynes, Guyatt, & Tugwell, 1991) to the 1940s-era “best practice” of oxygenating premature infants to prevent retrolental fibroplasia, a condition that careful research eventually showed to be caused, not cured, by this treatment (Meehl, 1997). More recent examples are easy to find (e.g., Barrett-Connor, 2002). At the time they were made, all of these recommendations were consistent with current clinical thinking; only when they were evaluated by rigorous scientific tests were they discounted (Sackett et al., 1991). For this reason, the EBP orientation accords greater weight to evidence from high-quality studies than to the beliefs and opinions of experts.

In the EBP framework, explicit criteria are used to evaluate the quality of evidence available to support clinical decisions. Some of these criteria are common to all scientific investigations, but others are specific to studies of clinical activities. Many systems for ranking the credibility of evidence have been proposed; in some cases evidence “grades” are then assigned to clinical recommendations according to the strength of their supporting evidence. The criteria for evaluating evidence differ somewhat according to whether the evidence concerns screening, prevention, diagnosis, therapy, prognosis, or healthcare economics; the Oxford Centre for Evidence-based Medicine (http://cebm.jr2.ox.ac.uk/docs/levels) describes a set of criteria relevant to each type of clinical question. Table 1 shows a system specifically designed for rating evidence from studies of treatment efficacy; other criteria are needed to rank evidence from studies of other questions, such as those concerning treatment effectiveness or diagnostic accuracy. However, regardless of the particular question being addressed, five common themes appear to contribute to ratings of evidence quality in the EBP literature. Each of these is described briefly in the following section.

Table 1. Levels of evidence for studies of treatment efficacy, ranked according to quality and credibility from highest/most credible (Ia) to lowest/least credible (IV) (adapted from the Scottish Intercollegiate Guideline Network, www.sign.ac.uk).

Level	Description
Ia	Well-designed meta-analysis of >1 randomized controlled trial
Ib	Well-designed randomized controlled study
IIa	Well-designed controlled study without randomization
IIb	Well-designed quasi-experimental study
III	Well-designed nonexperimental studies, i.e., correlational and case studies
IV	Expert committee report, consensus conference, clinical experience of respected authorities

Five Themes in Evidence Ratings

1. Independent confirmation and converging evidence

It is extremely rare for a single study to provide the definitive answer to a scientific or clinical question, but a body of evidence comprising high quality investigations can be synthesized to approach a definitive answer even when, as is likely, results vary across studies. When the question concerns treatment efficacy, the highest evidence ranking goes to well-designed meta-analyses that summarize results across a number of scientifically rigorous studies. In many cases, results are expressed using both summary statistics and a graphic representation of the direction, size and precision of findings from individual studies. This level of evidence remains relatively rare even in medicine, but a growing number of studies of treatment efficacy are eligible for meta-analysis and meta-analyses are beginning to appear in the communication disorders literature (e.g., Casby, 2001; Robey, 1998). A number of organizations sponsor reviews of evidence according to explicit and stringent criteria; these include the U. S. Department of Health and Human Service's Agency for Healthcare Research and Quality (http://www.ahrq.gov), the Cochrane Collaboration (www.cochrane.org), and the Scottish Intercollegiate Guideline Network (www.sign.ac.uk). A single meta-analysis or systematic review of evidence may not yield results that are so uniform as to preclude disagreement and debate, especially if the number of high quality studies available for inclusion is relatively small. However, the principle of seeking converging evidence from multiple strong studies is inextricably linked to the EBP orientation.

2. Experimental control

The design features of individual studies also influence ratings of evidence quality. In the EBP framework, evidence from studies that are controlled (i.e., that contrast an experimental group with a control group) and that employ prospective designs (in which patients are recruited and assigned to conditions before the study begins) is rated more highly than evidence from retrospective studies in which previously collected data are analyzed, because the reliability and accuracy of many measures are difficult or impossible to ensure post hoc. In addition, group comparison studies are rated more highly when patients are randomly assigned to groups than when they are not, because random assignment reduces the chance that groups might differ systematically in some unanticipated or unrecognized ways other than the experimental factor being investigated.

Lower evidence ratings generally are assigned to quasi-experimental studies, including cohort studies in which patients with and without a variable of interest are followed forward in time to compare their outcomes, and case-control designs in which patients with and without an outcome are identified and compared for their previous exposure to a variable of interest. Evidence from quasi-experimental studies ranks lower than evidence from controlled studies because only through random assignment can the risk of differences due to unknown biases be minimized. Evidence from non-experimental designs such as correlational studies, case studies (N = 1), and case series is rated even lower due to the lack of a control group, but even evidence from non-experimental study designs outranks statements of belief and opinion in EBP rating schemes.

It is worth emphasizing that experimental control is only one of the themes important to rating evidence quality; regardless of its design, every study addressing a clinical question also must be evaluated with respect to such factors as the potential for subjectivity and bias, the

importance of its results, and its relevance and feasibility. Especially when they are designed so as to maximize experimental control and to minimize bias, quasi- and non-experimental studies can provide evidence that is crucially important to the early stages of investigation into a phenomenon and can lay the necessary groundwork for studies with larger samples, random assignment, and strict experimental control. For example, investigators can provide some evidence of experimental control in single-subject studies by comparing treated and control goals in a multiple-baseline design or by randomly assigning treatment and control conditions to different time periods in a multiple crossover or alternating treatments design. In addition, as noted by Sackett et al. (2000), well-designed single-subject studies can be extremely helpful in assessing the effectiveness of treatment for an individual patient. Thus, carefully conducted single-subject studies should be recognized as having an important role to play in EBP although their results will always require confirmation via stronger designs.

3. Avoidance of subjectivity and bias

An important criterion for credible evidence is that observers, investigators, statisticians, others involved with patients, and if possible the patients themselves, be kept unaware of information that could potentially influence, or bias, the results of a study. This tactic is known as blinding, concealment, or masking. Blinding addresses a particular threat to the validity of patient-oriented evidence: the seemingly inescapable bias that clinicians have toward believing that their efforts are beneficial. George Pickering (1964; cited in Barrett Connor, 2002) observed that belief in the value of one's efforts is a pre-requisite to clinical practice, but such belief is at odds with the objectivity that is fundamental to the scientific method (Meehl, 1997). There is persuasive empirical evidence of the need for blinding in studies of medical treatment; one analysis showed that estimates of treatment effects from studies without blinding were substantially larger than those from studies in which treatment conditions were concealed (Schulz, Chalmers, Hayes, & Altman, 1995). Observer expectations have been shown to influence even such seemingly objective measurements as recording fetal heart rates from monitors (Sackett et al., 1991). The fact that relatively few studies in speech-language pathology and audiology employ strategies to ensure adequate blinding may be one reason literature on communication disorders is underrepresented in evidence-based reviews. Complete blinding of patients and clinicians may be impossible in some studies, especially for behavioral treatments for which a placebo condition cannot be constructed. However, even in such studies a number of steps can be taken to minimize the potential for bias, such as ensuring that treatment effects (positive or negative) are measured not by the clinician, the investigator, or a family member but rather by independent examiners who rate patients without knowing their treatment assignments. Similarly, examiners can rate unlabeled, randomly ordered recordings from different stages in the course of intervention (e.g., pre-, intra- and post-treatment) to minimize the potential influence of their expectations about treatment effects.

Another important control for potential bias that influences evidence ratings is the requirement that outcomes be reported for every patient originally enrolled in a study, not just for the patients who complete it. This ensures that patients who did not complete the study as planned are taken into account in analyzing effects, avoiding the understandable tendency to focus only on patients who have positive outcomes. In randomized trials this approach, known as the “intention-to-treat” analysis, means that patients must be analyzed as part of the treatment group to which they were originally assigned even if they did not actually receive the treatment as planned (e.g., Moher, Schulz, Altman, et al. 2001; Sackett et al., 2000).

4. Effect sizes and confidence intervals

The EBP orientation emphasizes that studies of clinical questions should specify and justify the size of effect that is deemed clinically important and should provide evidence that statistical power is adequate to detecting an effect of this magnitude. Appreciation of the need to consider not just statistical significance (i.e., the probability that differences or effects were not chance events), but also practical significance (i.e., the magnitude of differences or effects, usually in the form of a standardized metric such as *d* or omega-squared) has been growing for at least 25 years, culminating in the mandate that information on effect sizes and statistical power be included in every published study (Wilkinson & APA Task Force on Statistical Inference, 1999). A variety of effect size indices exist (e.g., Huberty, 2002); according to Cohen (1990, p. 1310) the important point is to convey "… the magnitude of the phenomenon of interest appropriate to the research context."

The EBP orientation also emphasizes the need for investigators to report the confidence interval (CI) associated with an experimental effect. CIs reflect the precision of the estimated difference or effect, specifying a range of values within which the "true" value is expected to occur with a given probability for a certain level of Type I error. Narrower CIs offer stronger (i.e., more precise and interpretable) evidence than wider CIs; studies in which samples are large and measurement error is small yield narrower CIs. This fact explains why, all else being equal, evidence from studies with large samples is likely to be ranked higher than evidence from studies involving smaller samples. It is increasingly common for investigators to provide CIs in published reports of their studies. Sackett et al. (2000; Appendix 1) provide a helpful review of the interpretation of CIs as well as procedures for calculating CIs for various types of diagnostic and treatment studies.

5. Relevance and feasibility

Relevance and feasibility are also considered frequently in rating the quality of patient-oriented evidence. Relevance of evidence is considered highest when the patients studied are typical of those commonly seen in clinical practice (Ebell, 1998), and/or when the clinical decision being studied is one that is difficult to make. Feasibility or applicability (Scottish Intercollegiate Guidelines Network, 2002) is high when the screening, diagnostic, or treatment activity being investigated is one that could reasonably be applied or used by practitioners in real-world settings. For example, some conditions can be diagnosed as accurately by interview as by time-consuming and expensive tests; the former would accordingly out-rank the latter on feasibility. It may not be possible to provide evidence of relevance and feasibility for results from studies at the early stages of investigation into a clinical question, but these factors must ultimately be included in evaluating the strength of evidence as a line of inquiry progresses.

EBP and Current Issues in Speech-Language Pathology and Audiology

The EBP orientation has obvious relevance for many aspects of clinical practice in speech-language pathology and audiology. The growing number of randomized controlled clinical trials in the communication disorders literature, as well as efforts such as those undertaken by the Academy of Neurologic Communication Disorders and Sciences (ANCDS; Yorkston et al., 2001a, 2001b) to develop practice guidelines based on systematic evidence reviews, are encouraging developments. However, there is an enormous need for additional work aimed at applying EBP principles to communication disorders. Studies designed and conducted in accordance with EBP criteria could help to resolve questions about the nature and defining

characteristics of controversial diagnostic categories such as childhood apraxia of speech, auditory processing disorder, nonverbal learning disability, and many others. Evaluating diagnostic procedures and measures according to EBP criteria would provide a rational basis for selecting the maximally informative and cost-effective diagnostic protocols from among the hundreds of diagnostic tools that are reported or advertised each year. There is a critical need for evidence concerning the effectiveness of efforts aimed at preventing and remediating communication disorders. EBP offers criteria and approaches for tackling these difficult questions.

A vivid example of the need for increased use of EBP principles in studies of communication disorders can be found in an evidence summary prepared for the U. S. Preventive Services Task Force. The review panel concluded that due to design flaws in existing studies, "…the evidence is insufficient to recommend for or against routine screening of newborns for hearing loss during the postpartum hospitalization" (Helfand et al., 2001, p. 1). Specifically, the panel reported an absence of high-quality evidence that children whose hearing losses were detected by newborn screening had better language outcomes at age 3 years than did infants whose hearing losses were identified later in infancy. Designing studies so that they meet the EBP appraisal criteria will result in stronger evidence concerning not just universal newborn hearing screening but virtually all other activities aimed at improving outcomes for clients with communication disorders.

Of course, EBP is not a panacea. Several analysts have discussed real and potential limitations of the EBP framework and have noted that the question of whether EBP has positive effects on clinical care itself should be studied empirically (Cohen, Stavri & Hersh, 2004; Sackett et al., 1996, 2000). Some studies of the impact of evidence on medical practice are beginning to appear (Majumdar, McAlister, & Soumerai, 2003). In addition, some of the EBP criteria and procedures may need to be adapted to meet the particular challenges of studying complex behavioral conditions such as communication disorders. However, the potential benefits of EBP appear to far outweigh the potential harms (Woolf et al., 1999). Awareness of the principles of EBP by researchers and practitioners in speech-language pathology and audiology seems likely to improve substantially the quality of evidence available to support clinical decisions, one step in ongoing efforts to provide optimal care to people with communication disorders.

EBP Research as a Key Component of the Research Mission of the Association

Basic research aimed at understanding the fundamental mechanisms and processes of normal and abnormal functioning is extremely important. However, it is unwarranted to assume that findings from such studies are necessarily relevant to clinical practice. Speculation about the clinical implications of basic research findings, being based on opinion rather than research, ranks low on the evidence quality scale. Accordingly, the distinction between basic research and research designed to provide credible evidence on clinical issues should be acknowledged, and both types of endeavor should be encouraged and valued equally within the research mission of the Association. The EBP literature shows that research into clinical questions demands not only the scientific acumen needed for more theoretically oriented investigations, but also additional expertise specific to designing, conducting, and analyzing data from patients and clinicians. Ensuring that investigators in communication disorders have the knowledge and skills needed to conduct high-quality studies of clinical activities should have a prominent place on the research agenda of the Association over the coming years.

Potential Steps Toward Increasing the Quantity of Credible Evidence to Support Clinical Activities in the Professions

1. Make educational offerings concerning EBP widely available to Association members, to increase their knowledge and skills with respect to the principles, processes, and uses of EBP in their clinical and scholarly pursuits. Raise awareness of the potential contributions of EBP to increasing accountability to other health care providers and to funding agencies. Publicize the wealth of free information on EBP that is readily available on the Internet and assist members in accessing it, for example by including links to information sources on the Association's Web site.
2. Assist university programs in including information on EBP in their curricula by sponsoring conference sessions aimed at current and future faculty members and by supporting Internet-based instruction and sharing of course materials.
3. Ensure that editors, reviewers, and authors of publications in ASHA journals are familiar with recommendations made by the CONSORT (Moher, Schulz, & Altman, for the CONSORT Group, 2001) and STARD (Bossuyt et al., for the STARD Group, 2003) groups for improving the quality of published reports concerning studies of treatment and diagnosis, respectively. Discourage speculation about the clinical implications of studies not explicitly designed to address clinical questions in ASHA publications.
4. Highlight exemplary uses of EBP principles by researchers and clinicians, both on the Association's Web site and at the annual Convention.
5. Support the creation of an independent, broadly representative EBP task force including researchers, clinicians, members of related professions, and consumers. This group initially would be charged with identifying and prioritizing clinical questions in communication disorders and with recommending a process by which evidence reviews on these questions could be conducted. Allocate resources to publicize this effort broadly, seeking collaborative relationships with other professional organizations to plan, conduct, and disseminate results from evidence reviews.
6. Recognize that full-fledged systematic evidence reviews require a great deal of time, resources, and training, and that impartiality is crucial to their credibility. The Scottish Intercollegiate Guideline Network (SIGN, www.sign.ac.uk) publications provide a detailed description of the process. According to these investigators, 24 months is a reasonable estimate of the minimal time required to go from identifying a clinical question worthy of review to the point at which evidence ratings can be disseminated. SIGN also describes costs and sources of potential funding support for such efforts.

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Additional Resources

Note: The amount of information on evidence-based practice in healthcare and other fields is expanding rapidly. An Internet search on the topic will yield many resources and sites; the list below provides an entrée to some of the oldest and most widely used sites, but it is far from exhaustive.

- http://www.cebm.utoronto.ca: The Centre for Evidence-Based Medicine at the University of Toronto Health Network; provides teaching suggestions, an excellent glossary, and a comprehensive list of other EBP resources, with descriptions and links.
- http://www.cebm.net: Oxford Centre for Evidence-Based Medicine; provides excellent resources such as an EBM toolbox, practice problems, and links to many other EBP sites and journals.
- http://bmj.com/collections: British Medical Journal site; includes a section listing resources and collections concerning EBP as well as a compilation of disease-specific information; also links to the new evidence-based mental health journal at http://ebmh.bmjjournals.com
- http://www.poems.msu.edu/InfoMastery: This site, copyrighted by Mark H. Ebell, MD (Department of Family Practice, Michigan State University) in 1998 and 1999 includes self-tutorials on EBP, with separate instructional modules addressing how to evaluate articles about diagnosis, prevention, therapy, prognosis, metaanalysis, and decision analysis.
- www.ahrq.gov: Agency for Healthcare Research and Quality site; allows investigators to search for evidence about a large number of health conditions with direct links to studies as well as summary statements and funding opportunities.
- www.guideline.gov: National Guideline Clearinghouse site (also accessible via AHRQ), allows searches for evidence according to condition, disease or treatment; interested investigators can receive free weekly guideline updates by e-mail.

Reference this material as: American Speech-Language-Hearing Association. (2004). *Evidence-based practice in communication disorders: an introduction* [Technical Report]. Available from www.asha.org/policy.

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Appendix P.

Students and Professionals Who Speak English with Accents and Nonstandard Dialects: Issues and Recommendations

Position Statement
ASHA Joint Subcommittee of the Executive Board on English Language Proficiency

Position Statement

It is the position of the American Speech-Language-Hearing Association (ASHA) that students and professionals in communication sciences and disorders who speak with accents and/or dialects can effectively provide speech, language, and audiological services to persons with communication disorders as long as they have the expected level of knowledge in normal and disordered communication, the expected level of diagnostic and clinical case management skills, and if modeling is necessary, are able to model the target phoneme, grammatical feature, or other aspect of speech and language that characterizes the client's particular problem. All individuals speak with an accent and/or dialect; thus, the nonacceptance of individuals into higher education programs or into the professions solely on the basis of the presence of an accent or dialect is discriminatory. Members of ASHA must not discriminate against persons who speak with an accent and/or dialect in educational programs, employment, or service delivery, and should encourage an understanding of linguistic differences among consumers and the general population.

Technical Report
ASHA Joint Subcommittee of the Executive Board on English Language Proficiency

About this Document

This technical report was prepared by the American Speech-Language-Hearing Association (ASHA) Joint Subcommittee of the Executive Board on English Language Proficiency. Committee members responsible for this report include two members from the Multicultural Issues Board, Hortencia Kayser and Lynda Campbell; the monitoring officer for the Multicultural Issues Board, Vic Gladstone; two members from the Council on Professional Standards, Julie Atwood and Patricia Kricos; and was chaired by Nancy Swigert with Diane Scott as ex officio. Special advice was rendered by Charlena Seymour and Toya Wyatt. To stimulate discussion and generate other recommendations, this report was circulated for select peer review to the Multicultural Issues Board; the Academic Affairs Board; Special Interest Division 11-Administration and Supervision; Special Interest Division 14-Communication Sciences and Disorders in Culturally and Linguistically Diverse Populations; related professional organizations such as the Council of Supervisors in Speech-Language Pathology and Audiology (CSSPA), the National Black Association for Speech-Language and Hearing (NBASLH), L'GASP, the Hispanic Caucus, the Asian/Pacific Islander Caucus, the Native American Caucus, and the Council on Professional Standards in Speech-Language Pathology and Audiology.

Introduction

In accordance with ASHA's Code of Ethics, speech-language pathologists and audiologists must not discriminate in the delivery of professional services. Audiologists and speech-language pathologists should educate clients, parents, and other professionals about the acceptance of linguistic and cultural diversity. That same nondiscriminatory behavior is expected of speech-language pathologists and audiologists in their interactions with colleagues and student clinicians.

However, general practice in many communication sciences and disorders education programs and by some employers is typically reflective of a monocultural perspective regarding linguistic diversity. Many educational programs have discouraged speakers of certain nonstandard linguistic varieties from majoring in communication sciences and disorders. Other programs have not permitted or have restricted clinical practicum experiences for students who speak [certain] nonstandard linguistic varieties of English. Still others have required student enrollment as a client at the university clinic to eradicate accents or dialects, or reassigned such students based solely on negative attitudes and prejudices of clients and clinical supervisors. In many of these cases, the ability of students with accents or dialects to provide clinical services or write clinical reports have been called into question. Similar negative practices have been demonstrated by some employers. All of the aforementioned behaviors are contrary to fostering and celebrating the cultural diversity that enhances the professions.

Members of the professions of speech-language pathology and audiology and the consumers they serve all speak with accents and/or dialects that reflect when, where, how, and with whom and from whom they learned language. An accent refers to a phonetic trait from a person's original language (L1) that is carried over a second language (L2); whereas, a dialect refers to sets of differences, wherever they may occur, that make one English speaker's speech different from another's (Wolfram & Fasold, 1974). Each dialect has distinguishing linguistic characteristics (phonological, morphological, and grammatical), although the majority of linguistic features of the (American) English language are common to each of the varieties of (American) English. The presence of an accent and/or dialect may make a person vulnerable to stereotypical judgments, prejudices, and sometimes discrimination because some accents or dialects are deemed more acceptable than others. Members of ASHA, in the conduct of their professional activities, are urged not to discriminate against persons who speak with an accent or dialect.

Background Information

In December 1994 a joint subcommittee of the Executive Board was formed and charged with addressing issues related to linguistic competence of speakers of English as a second language and individuals who speak with an accent or dialect. After several revisions, this technical paper addresses only those issues related to individuals who speak with accents and dialects, and not those who are in the process of acquiring English as a second language. Thus, allowing for a thorough and targeted approach to addressing specific concerns.

This technical paper will:

- identify the differences between speakers of accents and dialects and those who are limited English proficient speakers.

- identify considerations necessary for the provision of clinical services by individuals who speak with accents and dialects.
- define the extent to which clinical report writing may be influenced by the use of accents and dialects.
- provide recommendations for decreasing discriminatory behavior and providing resources for students and professionals who speak with accents and dialects.

Distinguishing Among Accents, Dialects, and Limited English Proficiency

In the United States, speakers of English may be categorized into one of three basic groups on the basis of accent or dialect. The first group consists of persons who were **born in another country and learned their first language (s) before they acquired English.** Their English may be accented by their first language(s). This group could include persons born in other countries where students learn English while in school. The second group consists of persons **born in the United States who learned their first language(s) before they acquired English.** This group could include children born of parents who speak a language or languages other than English in the home and whose children then learn English in school, or children who are learning multiple languages, including English, simultaneously. The third group consists of persons **born in the United States or other countries whose only language is English.** Their development of English is affected by region, status, style, ethnicity, age, gender, life experiences, and communication models among other factors, resulting in their use of a nonstandard dialect of English. Examples of this third group would include, but are not limited to, individuals who speak Appalachian English, one of the New York dialects, African American English, standard English, British dialect, southern English, and English influenced by some other non-English languages such as Spanish. In reality, all speakers then have accents and dialects.

There is a fourth group of individuals whose use of English may differ from native English speakers. This group consists of persons **who learned their first language(s) and are in the process of learning English as a second language, but who have not yet acquired proficiency in English.** This group includes those persons who have moved to the United States permanently or temporarily, such as to attend college. This technical report addresses the three groups described above but does not address the concerns of limited English proficient speakers.

Considerations Necessary for the Provision of Clinical Services by Accent or Dialect Speakers

There is no research to support the belief that audiologists and speech-language pathologists who speak a nonstandard dialect or who speak with an accent are unable to make appropriate diagnostic decisions or achieve appropriate treatment outcomes. When working with students who speak a nonstandard dialect or speak with an accent, clinical supervisors and faculty should be asking such questions as:

- Does the individual have the expected level of knowledge in normal and disordered communication?
- Does the individual have the expected level of diagnostic and clinical case management skills?

- If modeling is necessary, is the individual able to model the target phoneme, grammatical feature, or other aspect of speech and language that characterizes the client's particular problem?

Clinical Report Writing Skills

The subcommittee agreed that students' inadequate writing skills are not directly linked to their culturally and linguistically diverse backgrounds. Although inadequate writing skills are pervasive and problematic among the student population, they exist irrespective of student background. In fact, to specifically relate difficulty with writing skills to the culturally and linguistically diverse backgrounds of students may be prejudicial. It is recommended that all students have access to resources for improving writing skills. Although clinical report writing skills and competencies are critical to effective documentation, standards need not be altered for students who speak with dialects or with accents.

Recommendations

Demographic changes anticipated in the near future indicate a need for increasing numbers of professionals with the linguistic diversity to provide services to those individuals with communication disorders from culturally and linguistically diverse populations. ASHA's position papers on Social Dialects (1983) and the Clinical Management of Communicatively Handicapped Minority Language Populations (1985) provide ASHA members with the necessary policy and guidelines for providing services to individuals who speak with accents/dialects and outlines the competencies necessary to provide such service. Many speakers with accents and dialects also have these competencies and it is critical that we allow their full participation in the professions. It is also of paramount concern to educate employers of audiologists and speech-language pathologists about the benefits/advantages of hiring personnel from culturally and linguistically diverse backgrounds.

The subcommittee offers the following recommendations as additional actions for minimizing the discriminatory behavior that may be evident in educational programs and employment settings, as well as to provide enhanced resources to professionals and students with accents and dialects.

1. Develop separate position statements on Accents and Dialects, and English Language Proficiency that would address the inclusion of students who are from culturally and linguistically diverse backgrounds in communication sciences and disorders. ASHA's *Social Dialects Position Paper* (ASHA, 1983) states that dialects are not to be considered as disordered speech and language among our clients. The same inclusiveness and acceptance of diversity should be extended to practitioners and students from culturally and linguistically diverse populations who may not speak standard English.
2. Provide information to students who speak with accents and dialects about strategies they might use to improve their use of standard English. Lists of contacts and addresses for the various Caucuses and allied and related professional organizations dealing with diversity also can be provided to students. The subcommittee wishes to emphasize that it should be the responsibility of educational programs to counsel exiting students regarding their strengths and weaknesses in standard English, and how these might affect employers' perceptions or impact their ability to perform in various work settings.

3. Develop resource materials for clinical supervisors (university based and at externship sites) to assist them in assigning clients to students based on clinical skills, without inappropriate consideration of the students' use of an accent or dialect. A list of university supervisors who routinely supervise students from diverse backgrounds could be compiled to serve as resources and mentors for supervisors with less experience in working with students from culturally and linguistically diverse backgrounds. Additionally, sensitivity and awareness training on cultural and linguistic differences and the advantages of diversity would be beneficial for faculty and supervisors.
4. Develop and disseminate resources for graduate programs that describe different strategies for helping students succeed who are from culturally and linguistically diverse backgrounds and who speak a nonstandard dialect or speak with accents. The curriculum guidelines outlined in *Multicultural Professional Education in Communication Disorders: Curriculum Approaches* (ASHA, 1987) focus on models for teaching multicultural information and provide some information concerning practicum for students from culturally and linguistically diverse backgrounds. These could be more widely distributed.
5. Explore avenues for employer education concerning multicultural sensitivity. Encourage employers to establish policies and procedures that prohibit discrimination against professionals with accents and dialects by clients and caregivers.
6. Encourage university education programs to obtain input from experienced clinicians with different areas of expertise to better prepare students to meet the real challenges of the work setting. Furthermore, mentor/protégé relationships between these clinicians and students should be encouraged. These clinicians may include persons with the same linguistic backgrounds and similar experiences as the students. These relationships should provide opportunities to share strategies and resources that enhance the communication skills expected in the work setting.

Final Note

It is suggested that the following groups might address some of the recommendations: Multicultural Issues Board, Academic Affairs Board, Special Interest Division 11 (Administration and Supervision), Special Interest Division 14 (Communication Sciences and Disorders in Culturally and Linguistically Diverse Populations), related professional organizations such as Council of Supervisors in Speech-Language Pathology and Audiology (CSSPA), National Black Association for Speech-Language and Hearing (NBASLH), Hispanic Caucus, Asian/Pacific Islander Caucus and Native American Caucus.

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Appendix Q.

White Paper:
Preparation of Speech-Language Pathology Clinical Educators

COUNCIL OF ACADEMIC PROGRAMS IN COMMUNICATION SCIENCES AND DISORDERS
April, 2013

Background Information

The CAPCSD Board of Directors approved the formation of a working group on the Preparation of Clinical Educators during the summer of 2011. This committee was formed in response to a resolution submitted to CAPCSD from the Northeast Council of Clinic Directors in Communication Sciences and Disorders which identified the need to develop a framework for training and learning outcomes for preparation of clinical educators. CAPCSD's charge to this committee was "to develop a white paper on evidence-based guidelines for individuals to acquire the knowledge and skills necessary for effective clinical supervision and education." The committee was formed with representatives from public and private universities and from all geographic regions of the country. The first conference call was held in November 2011; the committee's work has been conducted via conference calls, e-mails and one face-to-face meeting at the CAPCSD conference in 2012.

The committee members are as follows:

Melissa Bruce; University of Houston, Houston, TX.
Elizabeth Gavett: Boston University, Boston, MA
Pamela Klick: Saint Xavier University, Chicago, IL
Marcella McCollum: San Jose State University, San Jose, CA
Ruth Peaper-Fillyaw: University of New Hampshire, Durham, NH, Committee Chair
Lee Robinson: Brigham Young University, Provo, UT
Lisa Scott: Florida State University, Tallahassee, FL
Michael Flahive: Saint Xavier University, CAPCSD monitoring Vice President.

Introduction

Clinical supervision has been an integral part of the profession of speech-language pathology since its inception. In ASHA's 1985 Position Statement on Clinical Supervision in Speech-Language Pathology and Audiology, preparation in supervision was identified as "a viable area of specialized study" and clinical supervision as a "distinct area of expertise and practice" (ASHA, 1985). These beliefs were reiterated in the updated 2008 ASHA Position Statement on Clinical Supervision (ASHA, 2008a). The term "clinical supervision" has historically referred to the supervision of graduate or undergraduate students assigned to clinical practicum within a course of study at an institution of higher learning; however, it is important to acknowledge that clinical supervision is practiced in a variety of arenas and with a wide array of supervisees. These supervisees may include speech-language pathologists during their Clinical Fellow experience, speech-language pathology assistants, colleagues in a workplace environment, or

professionals in other healthcare fields. Over the span of a career in Communication Sciences and Disorders, all speech-language pathologists will have been a recipient of supervision and many will likely be providers of supervision as well.

Historically, the primary requirement in the professions of Speech-Language Pathology and Audiology for individuals to provide supervision has been to hold the Certificate of Clinical Competence. This requirement implicitly suggests that an individual who is competent to provide clinical services is also competent to provide clinical supervision. More recently, many professions, including our own, emphasize the importance of demonstrating specific knowledge and skills prior to performing any service. The 2008 ASHA supervision documents delineated the specific knowledge and skills required to competently perform the role of clinical supervisor and furthermore stated that "the highly complex nature of supervision makes it critically important that supervisors obtain education in the supervisory process."(ASHA, 2008a) ASHA's Special Interest Group 11: Administration and Supervision (SIG 11) has also strongly recommended that persons involved in clinical supervision complete some form of training specific to this distinct area of practice. Although ASHA and SIG 11 have indicated the need for training, requirements for the amount of training or the type of training have yet to be developed.

A recent ASHA document: Speech-Language Pathology Assistant Scope of Practice (ASHA, 2013) is the first to include a statement requiring supervisory training. This document specifies that the supervising SLP must have completed or be currently enrolled in at least one course or workshop in supervision for at least 1.0 CEUs (10 clock hours). This requirement applies only to supervisors of Speech-Language Pathology Assistants The Council of Academic Programs in Communication Sciences and Disorders (CAPCSD) also recognizes the need for clinical supervisors of students to have the requisite knowledge and skills in this distinct area of expertise and practice, as evidenced by the inclusion of numerous presentations about supervision issues at the annual conference (Duthie, 2010; Maxwell, (2009); McCrea & Newman (2008); Reuler et al, (2008). The academic community further acknowledges that "clinical supervisor" may not be the most appropriate descriptor for this role; clinical supervision involves much more than "overseeing" the supervisee, which is often the lay interpretation of this term. Effective supervision requires individuals to teach specific skills, clarify conceptual knowledge, facilitate critical thinking, role model professional behavior, develop professional writing, etc., in order for the student to provide proficient speech and language services and to be prepared to enter the workforce. Currently, many professionals involved in the supervisory process recognize that "clinical supervisor" may be an outdated label and have begun referring to this role as "clinical educator/instructor." This label more accurately reflects what clinical supervisors actually do, particularly in the academic setting.

Although this change in terminology is relatively new, literature examining supervisory models and processes is not. The model most commonly referenced in Communication Sciences and Disorders and referenced in the 2008 ASHA documents is Anderson's Continuum Model (Anderson, 1988). The practice of clinical supervision should be based on a solid theoretical foundation, just as is required in clinical practice. It is important that preparation in supervision be broad enough in scope to address models/frameworks that prepare individuals to supervise persons with varying levels of clinical experience and expertise. For example, one would expect there to be differences between the supervisory expectations required for a novice clinician with little or no experience working in a university clinic and a second-year graduate student clinician with over 350 hours participating in his/her second externship at a hospital rehabilitation unit, or between a speech-language pathology assistant and a Clinical Fellow. Preparation should also accommodate the focus supervisory duties play in one's job. University clinical educators

generally view supervision and clinical teaching as all or part of their primary role at the university, so these individuals may benefit from advanced preparation. In contrast, the supervisors of students in externship settings view supervision as an ancillary duty and introductory preparation may be better suited for this group. These differences in the relationship of supervision to one's primary responsibilities, suggest the need for different levels of supervisory preparation.

Furthermore, other professions, including physical therapy, occupational therapy, and athletic training, have acknowledged the need for supervisory training and education and have subsequently developed and implemented more formal programs and requirements for professional preparation of individuals in their fields assuming a supervisory role. Various states have also considered requirements for training in supervision prior to assuming the role of supervisor. Currently, only a small number of states have actually mandated such training for speech-language pathologists; however, it seems likely that other states may be considering requirements for this area of practice. As previously stated, it is very probable that many speech-language pathologists will assume a supervisory role at some point in their careers. Based on the information cited above, it is becoming increasingly clear that required training for current and future speech-language pathologists and audiologists in the area of clinical supervision is a necessary step to prepare those in the profession who will assume the supervisory role. ASHA's Board of Directors has recently assembled a committee to identify more specific guidelines regarding the clinical preparation of supervisors in a variety of settings, which is further indication of this need.

In summary, supervision practices should be rooted in theory, they should address the already identified knowledge and skills delineated in 2008 by ASHA, and they should be applied differentially for varying levels of supervisees. It is critical to explore ways in which educational programs for supervisors can be developed and made accessible to professionals. Prior to assuming the role of supervisor, all clinical supervisors/clinical educators should have adequate preparation in this area of practice. Additionally, there is a need to identify appropriate means of delivering this training. Finally, given the critical role of clinical supervision in the field of speech language pathology and given the expected requirements for clinical educators, it is also important that graduate programs consider the inclusion of professional preparation for this area of practice.

This paper will address the following key issues:

1) Review current evidence describing preparation of clinical supervisors in Communication Sciences and Disorders.
2) Identify and differentiate between knowledge and skills needed for developmental levels of clinical educators.
3) Present data regarding state requirements for professional preparation of supervisors.
4) Identify the current regulations and preparation programs for clinical educators in related professions.
5) Recommend possible "next steps" in order to move toward the goal of developing accessible and appropriate preparation in the supervisory process.

Preparation of Clinical Supervisors: Available Evidence

In 2008, the Northeast Council of Clinic Directors in Communication Sciences and Disorders conducted a study of the perceptions and practices in the supervisory process (Peaper-Fillyaw

et al., 2008). A questionnaire was sent to supervisors in on- and off-campus settings used by member institutions with 447 completed surveys returned. Respondents were asked how they had acquired supervisory skills; 31.5% reported they had used self-guided instruction, 26% were mentored in the workplace, 11.2 % had attended professional workshops and 4% had taken graduate coursework or a post-master's course.

Also in 2008, Klick & Schmitt conducted a pilot study that examined how universities prepared clinical faculty who provided clinical supervision for graduate students in Communication Sciences & Disorders Programs. A total of 1000 surveys were randomly distributed to professionals involved in clinical supervision at the university level via graduate program directors; 176 surveys were returned. Results revealed that most speech-language pathologists involved in the supervision of graduate students had little or no formal education in supervision. Supervisors tended to heavily rely on information gleaned from personal experiences during their own education and/or engage in self-teaching. Results affirmed the need for formal preparation in clinical supervision as well as a need for the development of new training tools and strategies to support this preparation. The research also suggested the need to investigate how supervisors in other practice settings are prepared prior to assuming this role.

In 2010, ASHA's Special Interest Group on Administration and Supervision (SIG 11) sent an e-mail invitation to 1051 affiliates to respond to a "Supervisor Credential" survey; 406 surveys were returned. The following results were obtained when asked: "What kind of training have you received in supervision?" Respondents were asked to check all that applied.

None 1.5%
Informal Networking 65. 0%
Self-study/readings 85.0 %
Workshops/conferences 75.6%
On the job training 76.8%
College or university courses 18.7%
Other 9.6%

The SIG 11 Survey found a much higher percentage of respondents who had attended some formal workshop, conference or course on supervision than did the Northeast Council/survey. This may be explained by the fact that the SIG 11 members completing that survey had supervision as an area of interest by virtue of their membership in this ASHA SIG and may have been more committed to seeking formal training.

The SIG 11 survey sought input about the importance of formal training in supervision. Respondents were asked: "How important is formal training in supervision?" Responses were as follows:

Very Important 67.6%
Somewhat important 29.5%
Minimally important 2.0%
Not at all important 0.2%
Do not know/no opinion 0.7%

Other relevant findings from the SIG 11 survey included input about the type of supervisor training in which respondents would participate. Respondents indicated they would participate in the following:

None 1.0%
Self-study/readings 83.9%
Workshops/conferences 96.0%
College or university course for credit 40.1%
Other 11.9%

Respondents were also asked about their potential interest in pursuing a credential in supervision through the question: “If a course of study existed in the area of supervision leading to a credential, how likely is it that you would participate?”

Very likely 53.3%
More likely than unlikely 33.7%
More unlikely than likely 4.5%
Very unlikely 5.5%
Do not know/no opinion 3.0%

This evidence supports our contention that those in supervisory roles often have little preparation for assuming the responsibilities inherent in this role. Additionally, the surveys show that supervisors are interested in more formal preparation and education in the supervisory process.

Knowledge and Skills in Supervision

The Knowledge and Skills Needed by Speech-Language Pathologists Providing Clinical Supervision (ASHA, 2008c) lists 125 separate items reflecting knowledge and skills that clinical educators practicing in the area of speech-language pathology should possess when interacting with students or SLP-As. The items, however, are not classified as introductory, intermediate, or advanced skills.

Although clinical educator training is available via mechanisms such as the ASHA Conventions, state conferences, university-sponsored events, the Special Interest Group 11 (Administration and Supervision) Perspectives, and various on-line offerings, the courses vary widely in content and instructional level. It is unknown how closely content of these trainings relates to the knowledge and skills described in the 2008 supervision knowledge and skills document. Additionally, the items listed in the supervision “KASA” document are not categorized as introductory, intermediate, or advanced. Because of the increased attention on clinical educator preparation, it is anticipated that proposals may be developed calling for some sort of standardized, introductory-level training. Therefore, if ASHA or another group were to propose such a voluntary standardized clinical educator training, it would be difficult to know which skills to address in a basic training workshop.

This CAPCSD working group conducted a pilot study (Scott, Bruce, Gavett, Klick, McCollum, Peaper-Fillyaw, & Robinson, 2012), asking 15 experienced clinical educators from a variety of work environments to categorize each skill listed on the supervision KASA as *introductory, intermediate*, or *advanced*. Because of the nominal nature of the data, Cohen’s Kappa was used to determine the strength of agreement among the categorizations made. Analysis revealed a Kappa value of .44, which represents moderate agreement after chance agreement has been removed.

Inspection of the raw data revealed that 50 items had 100% agreement as being *Introductory* level. [Refer to Appendix A for a listing of these items.] Of the remaining 75 items, only 2 had 100% agreement as *Intermediate* level skills and none had 100% agreement as *Advanced* level skills. In fact, only 20 of the 125 items were categorized even once as *Advanced*. Although preliminary, these data seem to indicate that there is a fundamental skill set that should be addressed in the development of any uniform supervisory training. Certainly, further exploration of the items and their instructional levels is needed. Attempting to address 125 different aspects of supervision as part of any training would be a daunting task, and a single training course is unlikely to meet the needs of all participants. Thus, creating tiers of learning outcomes would better facilitate course design and offer participants opportunities to advance their skills through multiple courses once they've achieved those that are most basic. Given the small ample size, however, further exploration of the knowledge and skills warranted in speech language pathology supervision is needed to determine whether the initial 50 skills unanimously identified as Introductory would still be viewed as such by a larger pool of experienced clinical supervisors.

State Data on Current Requirement for Supervision Preparation

The CAPCSD working group on the Preparation of Speech-Language Pathology Clinical Educators surveyed clinic directors and department chairs throughout the country to determine which states currently have training requirements imposed by individual state agencies for supervisors of students, clinical fellows (CF), speech-language pathology assistants (SLPA), and those seeking licensure. The following were the findings:

- 41 states currently have no requirements or recommendations for supervision training.
- 13 states have requirements clearly indicated for supervisors (i.e., mandated years of experience, etc.) of non-licensed clinicians (SLPAs, students, CF, etc.)
- 3 states have regulations from their departments of public instruction mandating some sort of requirement (license, training, etc.)
- 9 states require proof of continuing education in the area of supervision
- An increasing number of states are recommending training in the area of supervision

Of those findings, the breakdown in terms of requirements was weighted toward supervisors of SLPAs.

- 2 states require 2+years of clinical experience for supervision of those seeking licensure versus 11 states that required 2+ years of clinical experience for those supervising SLPAs
- 3 states required training/coursework in supervision for those supervising temporary license holders/CFs/students versus 6 states for those supervising SLPAs

In surveying representatives of the various states, it is evident that there is a growing move toward requiring or strongly recommending some sort of training for those responsible for supervising students, clinicians, and SLPAs. In particular, states are increasing their regulation of supervisors of SLPAs.

State-by-state specific requirements are available for review in Appendix B.

Preparation of Clinical Educators in Related Professions

The committee surveyed clinical educator preparation in several related professions. Representatives from Physical Therapy, Occupational Therapy, Athletic Training, Audiology, Nursing, Psychology, Social Work and Therapeutic Recreation were interviewed and asked about preparation of clinical educators. The results are presented in the following table.

Clinical Educator Instruction by Profession

Profession	Standardized Clinical Instructor Education Available	Required/ Voluntary	Provider	Length of Training	Online vs. Live	Credential Offered
Physical Therapy	YES	Voluntary	APTA	2 day Basic training; Advanced training also available	Live	Yes
Occupational Therapy	YES	Voluntary	AOTA	2 days	Live	Yes
Athletic Training	NO	Required	University Clinical Ed Programs	Variable	Both	No
Speech/Language Pathology	NO					
Audiology	NO					
Nursing	NO					
Psychology	NO					
Social Work	NO					
Therapeutic Recreation	NO					

As noted in the table, Physical Therapy and Occupational Therapy offer formal training programs for clinical educators. Both training programs are managed by the professional association and culminate in a Clinical Instructor credential. Although the OT and PT training is not mandated by the respective professional association, individual university and/or clinical programs may impose a requirement that supervisors of their students and/or professional staff hold the Clinical Instructor credential. The Physical Therapy credential has been offered since 1996 with over 35,000 attending the two-day trainings. In response to demand, the American Physical Therapy Association now offers an Advanced Clinical Instructor Training.

Formal preparation for supervisors is required in Athletic Training but unlike Physical Therapy and Occupational Therapy, the training is developed and managed by each academic program rather than by the professional association. Prior to July 2012, individuals who completed the training earned an Approved Clinical Instructor credential. Currently, the title has been changed to Preceptor and no formal credential is offered. Details about the clinical educator preparation programs for the professions of Physical Therapy, Occupational Therapy and Athletic Training, where training is offered or required, are provided in Appendix C.

Recommendations

1. Formal training/preparation of clinical educators is necessary and should be required. Quality clinical experiences supported by clinical educators knowledgeable about the supervisory process are crucial for supervisees at any level. The 2008 ASHA Position Statement: Clinical Supervision in Speech-Language Pathology (ASHA, 2008a) stated, “The highly complex nature of supervision makes it critically important that supervisors obtain education in the supervisory process,” but stopped short of making this a requirement. The recently released Speech-Language Pathology Assistant Scope of Practice (ASHA, 2013) is the first ASHA document to require training for supervisors, but this is limited to supervisors of speech-language pathology assistants.

A mandate for training in supervision is supported by the ASHA Code of Ethics (ASHA, 2010): Principle I, Rule A. “Individuals shall provide all services competently.” And Principle II, Rule B. “Individuals shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their level of education, training and experience.” ASHA’s Code of Ethics expects that clinicians are adequately prepared to treat clients competently. This expectation should also apply to those who provide the professional service of supervision.
Training for supervisors of certain supervisees has already been mandated by some state license boards and state departments of education, yet there is no national standard. The time has come to require formal education in the supervisory process to ensure that supervisors are prepared to assume this demanding, complex and important role in our profession.

2. In order to ensure consistency of supervisor preparation, the required clinical educator training should follow a standard curriculum with primary focus on the supervisory process which can be adapted to meet the needs of supervisees at all levels. Training content should be structured around the Knowledge and Skills Needed by Speech Language Pathologists Providing Clinical Supervision (2008c) described in the ASHA document which may include:

- Establishing an effective relationship with the supervisee
- Utilizing effective interpersonal communication
- Structuring learning experiences to assure supervisees will develop critical thinking skills and clinical decision making skills appropriate for their level
- Using questions to develop clinical reasoning skills
- Using objective observation techniques and sharing feedback with supervisees
- Understanding the impact on diversity of supervisory interactions

The training programs developed should be at basic and intermediate/advanced levels. The basic training curriculum would be required of all supervisors with an optional advanced curriculum for clinical educators for whom supervision is their primary professional role or for whom this is an area of high interest. Individual employers could decide whether the advanced training is required for their setting.

3. Criteria for those who present the training workshops must be developed. Trainers should be experienced supervisors with expertise in the supervisory process.

4. The required training workshops must be widely available to supervisors nationwide. Possible hybrid models of face-to-face workshops complemented with an on-line component should be explored.

5. There should be a reasonable phase-in period before the training requirement takes effect. Supervisors will need time to obtain the training. Additionally, college/university programs and employers will need time to plan for and implement the changes imposed by this requirement.

6. This paper described successful Clinical Instructor credential programs that have been implemented by related disciplines. While we believe the Clinical Instructor credential has merit, we recognize the logistics of developing and maintaining a credentialing program are significant and could delay implementing the training requirement. The focus should be in making sure that supervisors receive needed training; the focus should not be on earning a credential. However, the development of a Clinical Educator Credential in Speech-Language Pathology seems a reasonable long-term goal. As supervisors receive and recognize the value of education about the process, it is likely they would support a credentialing program to acknowledge their skills in this area.

7. Given the likelihood that Speech-Language Pathology students will assume supervisory roles at some point in their careers, students would benefit from an introduction to the supervisory process while in their graduate program.

8. CAPCSD should play a key role in supporting excellence in clinical education as it is a crucial component of any academic program preparing speech-language pathologists. This may include:

- Continued inclusion of clinical education topics at the annual national CAPCSD conference
- Monitoring and supporting standards for formal preparation of clinical educators
- Including explicit language in responsibilities of a CAPCSD vice president to assume responsibility for monitoring clinical education issues
- Consideration to fund research in clinical education

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Appendix A: Knowledge and Skills

Supervisory knowledge and skills rated with 100% agreement, organized by item number from the
Knowledge and Skills Needed by Speech-Language Pathologists Providing Clinical Supervision (ASHA, 2008c) document.

ITEM	TEXT
IA2	Recognize that planning and goal setting are critical components of the supervisory process both for the clinical care provided to the client by the supervisee and for the professional growth of the supervisee.
IA4	Understand the importance of implementing a supervisory style that corresponds to the knowledge and skill level of the supervisee.
IA6	Be familiar with data collection methods and tools for analysis of clinical behaviors.
IB1	Facilitate an understanding of the supervisory process that includes the objectives of supervision, the roles of the participants, the components of the supervisory process, and a clear description of the assigned tasks and responsibilities.
IB2	Assist the supervisee in formulating goals for the clinical and supervisory processes, as needed.
IB3	Assess the supervisee's knowledge, skills, and prior experiences in relationship to the clients served.
IB4	Adapt or develop observational formats that facilitate objective data collection.
IB5	Be able to select and apply a supervisory style based on the needs of the clients served, and the knowledge and skill of the supervisee.
IB7	Be able to analyze the data collected to facilitate the supervisee's clinical skill development and professional growth.
IIA1	Understand the basic principles and dynamics of effective interpersonal communication.
IIA4	Understand the importance of effective listening skills.
IIB1	Demonstrate the use of effective interpersonal skills.
IIB6	Demonstrate behaviors that facilitate effective listening (e.g., silent listening, questioning, paraphrasing, empathizing, and supporting).
IIIA4	Understand the use of self-evaluation to promote supervisee growth.
IIIB2	Assist the supervisee in objectively analyzing and interpreting the data obtained and in understanding how to use it for modification of intervention plans.
IIIB3	Assist the supervisee in identifying salient patterns in either clinician or client behavior that facilitate or hinder learning.
IVA1	Understand and demonstrate best practices, including the application of current research in speech-language pathology, for assessing clients with specific communication and swallowing disorders.
IVA3	Understand assessment tools and techniques specific to the clients served.
IVB1	Facilitate the supervisee's use of best practices in assessment, including the application of current research to the assessment process.
IVB2	Facilitate the supervisee's use of verbal and nonverbal behaviors to establish an effective client–clinician relationship.
IVB3	Assist the supervisee in selecting and using assessment tools and techniques specific to the clients served.
IVB4	Assist the supervisee in providing rationales for the selected procedures.

IVB5	Demonstrate how to integrate assessment findings and observations to diagnose and develop appropriate recommendations for intervention and/or management.
VA1	Understand best practices, including the application of current research in speech-language pathology, for developing a treatment plan for and providing intervention to clients with specific communication and swallowing disorders.
VA2	Be familiar with intervention materials, procedures, and techniques that are evidence based.
VA3	Be familiar with methods of data collection to analyze client behaviors and performance.
VB1	Assist the supervisee in developing and prioritizing appropriate treatment goals.
VB2	Facilitate the supervisee's consideration of evidence in selecting materials, procedures, and techniques, and in providing a rationale for their use.
VB3	Assist the supervisee in selecting and using a variety of clinical materials and techniques appropriate to the clients served, and in providing a rationale for their use.
VB5	Assist the supervisee in analyzing the data collected in order to reformulate goals, treatment plans, procedures, and techniques.
VIA1	Understand the importance of scheduling regular supervisory conferences and/or team meetings.
ITEM	TEXT
VIB1	Regularly schedule supervisory conferences and/or team meetings.
VIIA1	Recognize the significance of the supervisory role in clinical accountability to the clients served and to the growth of the supervisee.
VIIB4	Provide verbal and written feedback that is descriptive and objective in a timely manner.
VIIIB1	Create a learning and work environment that uses the strengths and expertise of all participants.
VIIIB2	Demonstrate empathy and concern for others as evidenced by behaviors such as active listening, asking questions, and facilitating open and honest communication.
IXA1	Understand the value of accurate and timely documentation.
IXA2	Understand effective record-keeping systems and practices for clinically related interactions.
IXB1	Facilitate the supervisee's ability to complete clinical documentation accurately and effectively, and in compliance with accrediting and regulatory agencies and third party funding sources.
IXB2	Assist the supervisee in sharing information collaboratively while adhering to requirements for confidentiality (e.g., HIPAA, FERPA).
XA1	Understand current standards for student supervision (Council on Academic Accreditation in Audiology and Speech-Language Pathology, 2004).
XA3	Understand current ASHA Code of Ethics rules, particularly regarding supervision, competence, delegation, representation of credentials, and inter-professional and intra-professional relationships.
XA4	Understand current state licensure board requirements for supervision.
XB1	Adhere to all ASHA, state, and facility standards, regulations, and requirements for supervision.
XB2	Assist the supervisee in adhering to standards, regulations, and setting-specific requirements for documentation, billing, and protection of privacy and confidentiality.
XB3	Demonstrate ethical behaviors in both inter-professional and intra-professional relationships.
XB4	Assist the supervisee in conforming with standards and regulations for professional conduct.
XIB1	Model professional and personal behaviors necessary for maintenance and life-long development of professional competency.
XIB2	Foster a mutually trusting relationship with the supervisee.
XIB3	Communicate in a manner that provides support and encouragement.

Appendix B: State by State Data

http://www.capcsd.org/documents/Preparation%20of%20Clinical%20Educators-White%20Paper.pdf

Appendix C: Clinical Educator Preparation in Related Disciplines

Profession:	Physical Therapy
Program:	APTA Clinical Instructor Education Certification Program
Outcome:	Basic and Advanced credentials offered
Required:	The APTA does not require this preparation of supervisors although many university programs require supervisors of their students to have completed the program.
Program Initiated:	1996
Number Trained:	Training: 35,000 for basic credential, 700 for advanced as of 11/2011
Format of Training:	Live 2 day workshops

Program Development

The initial training materials grew out of a program initiated by the New England Consortium of PT Clinical Education Coordinators. This New England group had designed a supervision training program and was offering this to their own clinical educators. The APTA wanted to develop a similar national offering and offered a RFP which was awarded to three members of the New England Consortium.

Award was for $25,000 in 1994-1996 and covered the time for the principal investigators and support staff needed to assist with project, material development and pilot testing of the assessment component of the program

Goals for the project:

- Easily accessible across the country (reason they have multiple trainers)
- Affordable
- Valued by profession, recognized as a new skill set by administrators
- Result in "credential" - not just a CE product

Currently the training is only available in live workshops. They have discussed on-line offerings, but feel the group learning activities at the workshops and the sharing of information by participants are important components of the live workshops. There have been recent discussions about offering a hybrid model where workshop participants could complete some initial on-line modules and then come together for a live meeting and group activities but no decision about this change have occurred yet.

APTA also offers Advanced Clinical Educator training in response to demand from members.

How Program is Organized and Supported (as of 11/2011)
The individual courses are arranged by a local sponsor who makes all of the logistical arrangements. There is a set fee charged by the APTA ($90 for members), but local sponsors can increase the registration fee to cover additional expenses (room rental, meals,

transportation for speakers, honorariums). The APTA does not impose a cap as to what the local sponsor may charge.

Trainers may receive an honorarium of up to $600 for the 2-day workshop. Some trainers will present for less or waive the honorarium as a way of offering service to their profession and/or university or employment facility.

Support provided at the national level by the APTA for the fee charged:

- Course Manuals
- Maintain schedule of courses offered nationally
- Maintain database of certified CIs
- Print and send out certificates
- Certify CEU completion

APTA offers trainer workshops every 2 years. Individuals interested in becoming trainers apply (extensive criteria to be considered as a trainer is posted on APTA website and reviewed by committee). If approved, they are invited to attend the trainer workshop. Demand and the geographical distribution of trainers may influence who to invite to new trainings. For example, the state of California requires the training for anyone working with a PT who has been trained in a foreign country, so there is a high demand in that state. The fee to attend the 2012 trainer workshop is $400.

While the local trainings are supported by the fees charged, the APTA budget does support the staff who manages the CIECP program, marketing, database, printing and other operating expenses.

The CIECP curriculum is reviewed every 5 years and modifications made as needed. The review is conducted by APTA staff as well as by experienced trainers who are recruited to perform this review.

APTA Program Curriculum

As noted above, the APTA CIECP training takes place over two days in a live workshop format. The format includes lecture as well as small group activities and covers the following content:

Section I: The Clinician as Clinical Educator
Roles and Responsibilities
Clinical Instructor Self-Assessment
APTA Guidelines for Clinical Instructors

Section II: Readiness to Learn
Learning Styles
Stages of Learning
Writing Behavioral Objectives for student clinicians
Characteristics of Adult Learners
Educational Objectives Taxonomy

Section III: Facilitating Learning in the Clinical Environment
Expectations of Students

Teaching Methods to Structure Effective Learning Experiences
Teaching/Supervisory Techniques
Guidelines for Providing Feedback

Section IV: Performance Assessment – The Clinical Environment
Formative and Summative Assessments
Anecdotal Record
Critical Incident Report
APTA Clinical Performance Instrument – This is an evaluation tool used by most APTA DPT programs to assess student clinical performance. Practical exercises addressing how to use this instrument are included in the workshop.

Section V: Legal, Regulatory and ADA Issues in Clinical Education
Clinical Affiliation Agreements
Student Dismissal
Students with Disabilities
Student Supervision and Medicare

Section VI: Managing the Exception Student and the Student with Problems in Clinical Education
Identification of the Exceptional Student
Negotiation/Confrontation Form
Learning Contract

Section VII: Answer Keys and Recommended Resources

Profession:	Occupational Therapy
Program:	American Occupational Therapy Association, Inc. (AOTA) Fieldwork Educator Certificate Workshops
Outcome:	15 hours of CE credit toward licensure renewal and a Clinical Instructor credential upon successful completion of the training
Required:	No
Training Workshops:	Minimum of 20 participants enrolled in each 2-day workshop
Format of Training:	Live 2-day workshop

Program Description

The clinical (aka. fieldwork) educator training is conducted only in live workshops. The trainers who conduct the workshops have each participated in a 3-day course. The trainer team is composed of one clinician and one fieldwork coordinator from a university OT program. The AOTA determines the frequency of the trainer course based on regional need for training. For example, if the CE 2-day workshops are oversubscribed, plans to offer another trainer course are considered. There have been 3 trainer courses conducted since the AOTA began offering trainer courses approximately five years ago. The fee for the trainer course is approximately $295 for AOTA members and $395 for nonmembers. Trainers sign a contract agreeing to conduct three 2-day workshops over three years. Trainers receive $750 for conducting the 2-day workshop and the host facility receives a $500 stipend for hosting, plus two free seats in the workshop. The curriculum for the 2-day workshop has undergone revision once in the past 5 years.

Goals of the 2-day training for fieldwork educators and academic placement coordinators

- Deeper understanding of the role of fieldwork educator
- Effective strategies to integrate learning theories and supervision models
- Increased skills to provide high-quality educational opportunities during fieldwork experiences
- Interaction with trainers through dialogue and reflections about fieldwork
- Engagement in 4 curricular modules: administration, education, supervision, and evaluation
- Analysis of strategies to support best practice in fieldwork education
- Continuing education credit (15 contact hours) toward licensure renewal

The AOTA offers a Self-Assessment Tool for Fieldwork Educator Competency. This document identifies the skills necessary to be an effective fieldwork educator (i.e., Clinical Educator in an off-site setting) “whose role is to facilitate the progression from student to entry-level practitioner.” This tool enables OTs in the field to assess their own level of competence and identify areas for development/ improvement of their mentoring skills. The use of this tool guides self-reflection for professional growth.

How Program is Organized and Supported

The CE training across the United States is set up by geographic region. For example, Texas/Oklahoma is one region. Qualified trainer teams are designated to serve a given region. The individual 2-day workshops are arranged by a local sponsor at a fieldwork site with a minimum enrollment of 20 participants. Clinical Instructors, OTs, OTAs and Field Work Coordinators are the target registrants. The training is voluntary, but highly recommended by the association. Some settings, such as Methodist Hospital in Houston, encourage all OTs to

become certified as fieldwork clinical educators. Following successful completion of the 2-day on-site training, an OT fieldwork clinical educator credential is awarded. The fee for these 2-day workshops ranges from $202.50 to $323.10, depending on whether the registrant is an AOTA member or nonmember, and the number of OTs from the same facility who are registering for the workshop.

Workshop participants receive a fieldwork clinical educator manual that provides extensive detail and guidance regarding such topics as how to establish a student clinical education program in the facility that meets certification requirements, OT student performance expectations, student evaluation procedures, ADA accommodations, various models of supervision and implementation, how to manage challenging students, and how to communicate with university program coordinators.

Profession:	Athletic Training
Program:	Administered by each educational institution
Outcome:	Preceptor
Program Initiated:	Early 2000's
Number trained:	Over 300 accredited programs in Athletic Training, most at Baccalaureate level
Format of training:	Program autonomy to develop training and evaluation methods

Program Development

Old Standards (effective until July 1, 2012): Accreditation standards for Athletic Training programs require academic programs to develop and deliver preparation in clinical education to all preceptors used in clinical practicum assignments. Programs are free to develop their own training modules; individuals who complete this training are awarded Approved Clinical Instructor (ACI) recognition. ACI's are required to renew/attend another training every 3 years. Required content includes information on learning styles, specifics about a program's curriculum, etc. Training may be online, live or a combination of both. Programs are given flexibility in developing these trainings; training programs are reviewed as part of the accreditation site visit process.

New Standards (effective July 1, 2012): Accreditation Standards for Athletic Training programs continue to require academic programs to develop and deliver preparation in clinical education to preceptors used in clinical practicum assignments; however, some changes have been made to provide programs with greater flexibility. There is no longer an awarding of the credential of Approved Clinical Instructor. The general guidelines for training content in the previous standards have been eliminated, giving programs maximum flexibility to develop training modules specific to the objectives of their program. The requirement to have preceptors (formerly ACIs) attend training every 3 years has been removed. Programs may now send a student to work with a preceptor who has not attended training but this preceptor serves only in a supervisory capacity and is not allowed to assess the student for the purposes of meeting program requirements. This flexibility allows programs to send students to specific sites for a very limited experience (e.g., student health service, emergency room).

Appendix R.

FORMS

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Clinical Reflection Tool

Graduate Student: _____ Supervisor: _____

Date of Observation: _____ Date of Conference: _____

Semester/Year: _____ Location: _____

What Happened?	The goals/objectives were:
Positive Feedback	Questions for Discussion

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Student Self-Reflection of Evaluation Session

Rate your own performance on a 1 to 5 scale:
5=strongly agree; 4=agree; 3=neither agree nor disagree; 2=disagree; 1=strongly disagree; NA=not applicable

	1	2	3	4	5	NA
1. I am well prepared.						
2. My clients have made positive changes.						
3. I am willing to accept suggestions and constructive criticism.						
4. I can formulate appropriate long term behavioral objectives and goals for my clients.						
5. I can formulate appropriate daily lesson plans.						
6. I can effectively execute lesson plans.						
7. I can relate effectively to other professionals.						
8. I can put forth initiative and effort.						
9. I have a positive attitude towards my clients and therapy in general.						
10. I am flexible and can adapt my therapy and materials to meet the needs of my clients.						
11. I can appropriately use therapy materials.						
12. My language usage is appropriate for the level of my clients.						
13. My nonverbal behavior matches my verbal behavior.						
14. I am in control of therapy situations even when inappropriate behaviors of my clients occur.						
15. I use appropriate reinforcements for my clients.						
16. I am able to observe client behaviors effectively.						
17. I can record client behaviors effectively.						
18. I can record clinical data accurately.						
19. I am punctual for therapy sessions.						
20. I keep all of my lesson plans, evaluations, and logs up to date.						
21. My written language on lesson plans, reports and evaluations is appropriate and in keeping with the language used in my profession.						
22. My reports are turned in on time.						

Rate your own performance on the following scale 1 to 5 scale:
Scale: 5=excellent; 4=good enough; 3=average; 2=below average; 1=disappointing

I judge the extent of my contribution and quality of my work to be_____.

As applicable, I judge the extent of contribution and quality of my co-clinician's work as follows_____.

Name:_____ Client's Initials: _____

Constructive Comments:

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Student Self-Reflection of Treatment Session

Rate your own performance on the following scale 1 to 5 scale:
5=strongly agree; 4=agree; 3=neither agree nor disagree; 2=disagree; 1=strongly disagree; NA=not applicable

	1	**2**	**3**	**4**	**5**	NA
1. I am well prepared.						
2. I am willing to accept suggestions and constructive criticism.						
3. I can relate effectively to other professionals.						
4. I put forth initiative and effort.						
5. I have a positive attitude toward my clients.						
6. I am flexible and can adapt my materials to meet the needs of each client.						
7. My language usage is appropriate for the level of my clients.						
8. My nonverbal behavior matches my verbal behavior.						
9. I am in control of diagnostic situations even when inappropriate behaviors of my clients occur.						
10. I am able to observe client behaviors effectively.						
11. I can record client behaviors effectively.						
12. I can record clinical data accurately.						
13. I am punctual for diagnostic appointments.						
14. I keep all of my logs up to date.						
15. My written language on therapy plans, reports and evaluations is appropriate and in keeping with the language used in my performance.						
16. My reports are turned in on time.						

Rate your own performance on the following scale 1 to 5 scale:
Scale: 5=excellent; 4=good enough; 3=average; 2=below average; 1=disappointing

I judge the extent of my contribution and quality of my work to be_____.

As applicable, I judge the extent of contribution and quality of my co-clinician's work as follows _____.

Name: _____ Client's Initials: _____

Constructive Comments:

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SESSION OBSERVATION FORM

Clinician:_____ Client:_____ Date: _____

Observation Codes

+ Exceeds expectation level ☐ Consistent with clinician **N** Needs development **N/A** Not Applicable

Objectives	**Code**	**Comments**
Behaviorally written		
Includes prompts/cues, if applicable		
Includes stimulus		
Includes appropriate criteria		
Appropriate to client's needs		
Professional terminology is used		
Materials		
Age-appropriate		
Listed and/or discussed as to use		
Activities		
Introduction/logical progression of activity		
Presentation of stimulus materials included		
Age-appropriate		
Activity corresponds with objective		
Data/Assessment/Session Evaluation		
Data is quantified according to objective		
Data includes types of cues, if applicable		
Session reflection form is completed		
Subjective/Comments		
Appropriately represents client/session		
Management/Organization		
Instructional techniques are effective		
Client has sufficient time to respond		
Use of modeling/prompts/cues is effective		
Reinforcement is varied/ appropriate/effective		
Appropriate use of time		
Modifies procedures as necessary		
Client behaviors are managed effectively		
Elicits maximum responses		

Additional Comments:_____

_____

_____

Time Observed: _____

Clinical Supervisor: _____ Date: _____

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Description of Observation Experience

Student Name: _____

Date of Observation: _____ Time: _____

☐ Course Requirement (Course Number: _____) ☐ Remediation Activity

Client's Initials: _____ Supervisor: _____

Location: _____

Client Age: ☐ Infant ☐ Pre-school ☐ School-aged ☐ Adult

☐ Evaluation/Re-evaluation ☐ Treatment ☐ Group Session

Disorder/Need/Focus: _____

Narrative Description:

Impressions/Reactions:

Signature: _____ Supervisor's Initials: _____

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PROGRAM PLAN FOR STUDENT REMEDIATION

Student Name: _____ Semester: _____

Course/Clinic Title: _____

Reason for Remediation:

Remediation Objective(s):

Remediation Activities:

Time Frame for Completion: _____

Acknowledgement of Program Plan for Remediation:

Faculty Signature _____ Date _____

Student Signature _____ Date _____

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Student Name: _____ Semester: _____

COMPLETION OF REMEDIATION PLAN

Outcome(s):

Remediation Complete ☐

_____ _____

Course/Clinic Instructor Signature Date

If the student fails to complete remediation by agreed date, the student will be required to repeat the clinic or class the next time it is offered.

Faculty will complete this form in presence of student and print three copies:

1. Keep the signed original for yourself
2. Give one copy to student
3. Place one copy in student's file
4. When remediation is complete, the signed original is placed in the student's file

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CLINICAL PRACTICUM PROGRESS LOG

Name of Student: _____ Semester: _____

Date & Time:	Comments:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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Site Orientation Checklist

Daily Schedule: Arrival:_____ Leave: _____

Supervisor Vacation/Days Off: _____

Protocol for notification of absence(s) or inclement weather:

- Who is the person to be notified?_____
- How should the notification be made? _____
- Phone number or email address to be used? _____
- By what time should notification be made? _____

Dress code:

- Lab coat? YES / NO
- Scrubs? YES / NO
- General Attire: _____
  _____
  _____

Cell Phone Policy: _____

Down time procedures:_____
_____
_____

Procedures for scheduling meetings/client reviews:_____
_____
_____

Important office policies:_____
_____
_____

Site/department orientation completed (dates): _____
Observations completed (dates): _____

Office personnel (name/title/contact information):

- _____
- _____
- _____

Student Name Printed: _____ Date Reviewed & Signed:_____

Student Signature: _____ Supervisor Signature:_____

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Supervisor's Evaluation of the Department of Speech-Language Pathology

Site: _____ Date: _____

Site Supervisor's Name_____

For the purpose of this evaluation, please compare the Department of Speech-Language Pathology at Salus University to either: a) other programs you have worked with, or b) programs that you are familiar.

Thanks in advance for your feedback!

Please evaluate your experience by checking your response and sharing any additional comments regarding the following items. Please be sure to complete both sides of this form.

Rating Scale:

- **Excellent** = Program provides consistent evidence of excellence in student training.
- **Above Average** = Provides evidence of above average skills in the competency.
- **Average** = Provides evidence of average skills in the competency.
- **Below Average** = Provides evidence of below average skills in the competency.

	Excellent	**Above Average**	**Average**	Below Average	**Not Applicable**
1. The program demonstrates an awareness of ethical guidelines, and confidentiality. *Comments:*					
2. The program seeks to understand agency's policy, legal issues, and interacts courteously and respectively with agency personnel. *Comments:*					
3. The program complies with agency policies. *Comments:*					
4. The program collaborates effectively with agency in providing services that address the academic, personal, social, and career development needs of its students. *Comments:*					
5. The program demonstrates effective relationships, establishes and builds rapport with students, demonstrates sensitivity to cultural/linguistic differences, of its students and the agency. *Comments:*					

	Excellent	**Above Average**	**Average**	Below Average	**Not Applicable**
6. The program demonstrates the ability to integrate interprofessional education as evidenced by the student's ability to consult effectively with colleagues, staff, and the school. *Comments:*					
7. The program uses supervision feedback well. Program actively seeks input when necessary, is receptive to feedback about its students and suggestions from agency. *Comments:*					
8. The program demonstrates accountability of its students. *Comments:*					
9. The program demonstrates a commitment to professional leadership. *Comments:*					
10. The program responds to the agency's needs and requests in a timely manner. *Comments:*					

11. What were the positive aspects of the practicum for you and/or your organization?

12. What were the challenges of the practicum for you and/or your organization?

13. Are there any areas of our student's educational background that you feel could be added to, improved, or made more complete? What are these?

Any additional comments with regard to how the program is functioning as it educates the next generation of SLPs.

Communication Proficiency Screener

The Communication Proficiency Screener is administered to all matriculated graduate students in the program, during the week of orientation, by a state licensed and ASHA certified speech-language pathologist from the Department of Speech-Language Pathology. The specific results of each component of the screener will be discussed with the student via their academic advisor.

Students who require follow-up in one or more areas of the screening tool will be counseled about their options to seek further assistance, including:

1. Self-correction/monitoring activities;
2. Seeking assistance for the communication disorder via private consultation with an external speech-language pathologist;
3. Participating in additional diagnostic and treatment activities through the Department of Speech-Language Pathology on-campus clinic.

Acknowledgement Statement

I have read the SLP Supervisor Handbook. I understand that I must abide by the policies set herein. I certify that I have had ample time to discuss the Handbook and its contents with the Clinical Director and I fully understand its contents.

I acknowledge that I am licensed/certified by the State to practice Speech-Language Pathology and hold the Certificate of Clinical Competence in Speech-0Lnaguage Pathology (CCC-SLP) from the American Speech-Language Hearing Association (ASHA). I also agree to maintain these credential current throughout the duration of the supervisory experience. Should anything change in my licensure or certification status, I will immediately contact the Clinical Director and/or Department Chair.

With this knowledge, I accept the policies outlined herein as a condition of accepting the duties of supervision in the graduate program.

Supervisor's Signature	Date
Faculty's Signature	Date