AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

Ad Hoc Committee on AuD Education Summit

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Executive Summary

2016 AuD Education Summit

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2016 AuD Education Summit
Executive Summary

On October 27–28, 2016, the American Speech-Language-Hearing Association (ASHA) hosted a summit on audiology education titled "AuD Education Summit 2016" (hereafter, "the Summit"). Attendees included representatives from all 75 AuD education programs in the United States as well as from related professional organizations and accreditation bodies. Bob Devlin of Transformation Strategies, Inc., facilitated the Summit. A complete list of attendees and their affiliations can be found in Appendix A.

The focus of the Summit was determined following the 2014 report of the Academic Affairs Board (AAB) that identified major challenges to the existing model of AuD education. The overarching question was, "Is a 4-year post-bachelor's training model that incorporates an externship as part of the AuD degree still the optimal model for AuD education?" Summit participants discussed the challenges associated with the current model of clinical education, learned about alternative models from other doctoral professions, and identified strategies for improvement. A major consideration was whether transitioning the 4th-year externship to a residency model would address five identified challenges in clinical education, including

1. lack of standardization of the externship process;
2. quality control for externship sites;
3. qualifications and skills of preceptors;
4. student debt; and
5. ensuring student readiness, both for the externship and at graduation.

DAY 1

The first day began with informing attendees of the planning committee's charge to implement an audiology education summit to examine the pros and cons of current and alternative models of AuD education so that future directions for audiology can be identified and advanced.

Day 1—Round 1 of Discussions

Following a historical overview of the development of the AuD by Dr. Fred Bess and a summary of pre-meeting survey data provided by academic programs, preceptors and AuD students, the first round of table discussions was held. Participants were asked to discuss

- their concerns with respect to the five challenges listed above;
- which of those items they found most challenging (or as the facilitator put it, "caused the most pain"); and, conversely,
- which of those challenges present as the areas of greatest opportunity.

Outcomes of those discussions indicated that the majority of respondents were satisfied with the issues listed above. Some overarching concerns included standardization of

the externship process and the content of the externship itself. Discussions also reiterated the need for evaluation of outcomes from the externship or "clinical immersion" experience. Note that 10%–15% of programs do not report any problems with the current externship model; attendees noted that these programs had some unique resources for clinical training available to them that could likely not be replicated on a nationwide basis.

Day 1—Presentations From Medicine, Optometry, and Physical Therapy

Presentations about residencies were provided by experts in clinical training from medicine, physical therapy, and optometry. Each representative presented an overview of their profession's residency programs in order to better inform our discussions regarding whether the profession of audiology would benefit from having a residency model. We learned that, of the three professions (i.e., medicine, optometry, and physical therapy), a residency is required only for medicine. Both optometry and physical therapy have voluntary residency programs, and these programs are focused on expanded training in a specialty area. All three professions include a clinical immersion experience of at least 7 months as part of their degree program. After intensive discussion and careful deliberation, the conference participants determined that **the audiology profession was not prepared for a residency model and voted overwhelmingly not to pursue the model at this time.**

Day 1—Round 2 of Discussions

The participants then turned their attention to addressing the challenges associated with the current model. Table discussions at this juncture focused on the need for quality control and standardization of the externship application process, clinical sites, core competencies to be gained throughout the AuD (years 1–3 and the externship), and "outcomes-based" versus "hours-based" standards.

DAY 2

The second day began with asking participants to reflect on what stood out from the previous day's discussions and presentations. Reflections reiterated themes of standardization across all aspects of AuD training, outcomes-based instead of hours-based training requirements, the need for an externship clearinghouse, and the need for a consensus on what is best for the future of the profession and for recipients of audiology services.

Summit participants requested further information from those programs that deliver the AuD program (including an externship) within a 3-year time period. Representatives from Arizona State University, Grand Valley State University, Indiana University, Northwestern University, Pacific University, University of the Pacific, and Wichita State University provided brief overviews of their 3-year programs.

Bob Devlin of Transformation Strategies reviewed key elements of the Kotter change model, including building a sense of urgency, forming a powerful guiding coalition,

creating a vision, communicating the vision, and empowering others to act on that vision.

Day 2—Testing and Building Consensus

Attendees used real-time polling to determine the level of consensus on key issues and strategies for improvement.

Table 1. Results of poll on key issues and strategies for improvement.

Question	Results
1. What is the urgency of creating a national database of clinical externship sites?	76% = *very or somewhat urgent* 23% = *not urgent* 1% = *not important*
2. What is the urgency in standardizing the application process (including application deadlines) for clinical externship sites?	87% = *very or somewhat urgent* 13% = *not urgent* 0% = *not important*
3. Should we explore mandatory preceptor training (yes/no)?	54% = *yes* 46% = *no*
4. Are you in favor of exploration of a residency model or other postgraduate training (yes/no)?	34% = *yes* 66% = *no*
5. What is the urgency of moving toward a residency model or other postgraduate education?	17% = *very or somewhat urgent* 42% = *not urgent* 41% = *not important*
6. In keeping with a "skate-to-the-puck" metaphor, are we ready, as a profession, to plot our course for the next 10, 15, 20 years?	28% = *strongly agree* or *agree* 53% = *disagree* 19% = *strongly disagree*

Day 2—Round 3 of Discussions

Participants were asked to attend table discussions (continued from Rounds 1 and 2 on Day 1) on the following 11 topics to generate strategies to propel audiology education forward. A leader at each table facilitated these discussions. Participants could attend more than one discussion during this period. The 11 topics were as follows:

1. Standardization of the externship process, including the application process for externship
2. Quality control of externship sites
3. Preceptor qualifications
4. Student debt and return on investment
5. Student training/readiness
6. Mandatory preceptor training
7. Explore residency or other postgraduate training
8. Vision for the future —"skate to the puck"
9. Best practices for current competency assessment
10. Shortening programs without sacrificing quality
11. Guiding coalition

A final poll was taken after these 11 discussion groups reported their outcomes (these outcomes are detailed in Appendix B). Participants were asked to respond to the following questions:

As an outcome measure of clinical training, we should move toward…

Competency-based evaluations – 64%
Hours-based evaluation – 1%
Combination of competency-based and hours-based evaluation – 34%

What is the urgency of expanding our scope of practice to accommodate the changing demands of our health care system?

Very urgent – 44%
Somewhat urgent – 37%
Not urgent – 13%
Not important – 6%

From the list of 11 discussion topics above, which would have the most impact on the profession? (Participants voted for their top three.)

The attendees deemed the following top four priorities to have the most impact (by vote):

- Priority #1: [Establishing a] vision for the profession (58 votes)[1]
- Priority #2: Standardization of externship process and national database of clinical externship sites (48 votes)
- Priority #3: Ensuring student training/readiness for clinical immersion/externship (43 votes)
- Priority #4: Measuring outcomes in terminal competency [i.e., program completion] and best practices for competency assessment (33 votes)

Participants were asked to indicate their willingness to continue the discussion on these points and to work on various committees that would address these specific issues. Attendees offered an impressive amount of engagement, with 90 people signing up to work on specific topics.

Final Comments From Participants

The Transformation Strategies report (see Appendix B) provides nearly five pages of extemporaneous comments from the participants; we collected these comments during this open microphone session. Some themes from these comments include the following:

- Issues related to standardization, competencies, and outcomes of AuD education may best be addressed by accreditation bodies with input from the audiology community.

[1] Note that polling earlier in the day indicated that 72% of participants did not believe that we were ready to "plot a course for the future." This later result appears to indicate that attendees perceive further discussion about the future of audiology as having significant impact—perhaps as preparation for plotting that course for the future.

- Highlight exemplary AuD programs and externship sites for others to emulate.
- Recognize that other groups, such as the Council of AuD Programs (CAuDP) and the Council of Academic Programs in Communication Sciences and Disorders (CAPSCD) may help to identify and/or further develop standards for evaluation of outcomes and/or externship processes.
- For change to occur, audiology professional organizations must work together.

Participants were overwhelmingly positive about the Summit and its outcomes as determined from the results of a post meeting survey.

Recommendations

A debriefing session was held immediately after the Summit. Also, a 1-hour meeting was held with several ad-hoc committee members who attended the ASHA Convention in Philadelphia. From these discussions and further consideration of the Transformation Strategies report (see Appendix B), we propose the following recommendations as next steps (listed in order of what could be accomplished in the near to medium term).

1. **By January 2018, establish a task force of audiology organizations—to include the American Speech-Language-Hearing Association, the American Academy of Audiology, the Council on Academic Accreditation, the Accreditation Commission for Audiology Education, the Council for Clinical Certification, the American Board of Audiology, the Council of AuD Program Directors, and the Council of Academic Programs in Communication Sciences and Disorders—that would be charged with developing an action plan to achieve the following goals:**

    a. Provide a mechanism for establishing Summit working groups to further pursue strategies for addressing the identified challenges.

    b. Provide frameworks and mechanisms for standardization of the AuD externship.
        i. Collect data on externship training capacity, including how many externships are available from year to year; their location; the types of experiences offered (e.g., pediatric, geriatric, hearing aid dispensing, aural rehabilitation, electrophysiology, vestibular evaluation and treatment, school- or hospital based); stipend available; and availability of Certificate of Clinical Competence-Audiology (CCC-A) supervision.
        ii. From data collected above, determine the requirements for externship training sites.
        iii. Pursue preceptor training requirements.[2]
        iv. Explore the feasibility of developing a common application system similar to the Communication Sciences and Disorders Common Application System (CSDCAS) for providing standardization of the externship application process.

[2] Note that polling indicated only a 54% majority in favor of this.

c. Provide frameworks and mechanisms for evaluating student readiness and outcome measures.
    i. Determine what tools—of those currently available for evaluation of student readiness/student competency for the externship—could be made available to all programs.
    ii. Measure outcomes after the externship addressing theoretical and applied knowledge and assessing clinical skills.

2. **Provide this Executive Summary of the AuD Education Summit 2016—along with any outcomes from these recommendations—to accreditation bodies and other standards-setting bodies as a resource to inform the setting and maintaining of standards for academic and clinical AuD education.**

3. **The Board of Directors track the progress of recommendation #1 (a,b,c) on an annual basis, and within three years report on that progress and make recommendations as to the timing of the next summit "Audiology in 2040" that would take place prior to the year 2025 and would utilize the leadership at ASHA along with the leadership of other audiology professional organizations.**

Appendix A: List of Participants
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Appendix B: Transformation Strategies Report Summary

AuD EDUCATION SUMMIT

OCT. 27-OCT28 2016

This document is a written account of presentations, Q&As, & conversations that occurred as part of the AuD Education Summit 2016. The document is chronologically arranged and integrates verbatim participant feedback & poll results alongside notes taken during presentations & table discussion report outs.

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AUD EDUCATION SUMMIT: DAY 1

OPENING REMARKS | 8:30-8:45

Welcome | Barbara Cone

This summit has been three years in the making. The process began with Academic Affairs Board (AAB) members' research, review, and discussion of materials from the first 20 years of AuD education. Together, members worked to prepare a report for the ASHA Board of Directors (BOD). In the report, the AAB identified nine critical issues for exploration and developed a justification for a summit to discuss audiology education. The BOD accepted the report and its recommendation for a Summit. The primary questions they raised had to do with the model of AuD education, asking:

Is this four-year model still the optimal model?
Does the inclusion of a one-year externship prior to graduation need to be revised?

In order to develop a summit, ASHA formed an ad hoc committee in the fall of 2015 to plan the summit

Purpose of Summit | Ruth Bentler

This committee has worked incredibly hard to put this summit together. Our charge as a committee was to structure and implement an audiology education summit to examine the pros and cons of current and alternative models of AuD education so that future directions for audiology can be identified and advanced. Our intention over the next two days is to bring together the stakeholders in this conversation to have a discussion among our profession; we don't know what the outcome will be at the end of these two days. Our only agenda is conversation that might lead to recommendations and conclusions that we can act on.
The summit is focused on addressing issues identified by the AAB members' report and further informed by surveys done of all 75 AuD programs. In particular, this summit aims to address 5 clear issues:

- *Standardization of the externship process*
- *Quality control of externship sites*
- *Preceptor qualifications*
- *Student debt/ROI*
- *Student training/readiness*

By coming together as a profession to discuss our common interests and shared future we hope to educate ourselves on the issues at hand. The outcome of these discussions is not predetermined. What is said here is the voice of this committee, not ASHA or any other group.

There is a vast amount of territory under consideration, thus it is important to stay focused on the questions before us. This summit is **not** about:

- *Accreditation process (or bodies)*
- *Outcomes of the current academic programs*
- *Certification versus Licensure*

Rather, it is about conversation within the profession and generating recommendations and conclusions we can act on.

Framing the Conversation | Bob Devlin

My role is to facilitate conversation among members of the audiology profession in service of the outcomes we're looking to achieve. We want to leave with a shared picture, but how sharp will it be? We don't know yet— it's up to us, over the next two days, to see what the resolution of that picture is. We don't yet know what will come out of this conversation. We're here to figure out two primary things:

Where is this conversation today?
Where will we go from here?

This summit is about ***thought leadership for the future of the profession*** in this domain. Each participant brings his/her own interest, but at the same time each person is involved in the larger context of the profession as a whole. Our goal here is for everyone to bring their own individual thinking to our conversations while also listening to and acknowledging the concerns of others and the profession as a whole.
As a following note, I want to mention that this is being live-streamed. Welcome to our online participants!

TABLE INTRODUCTIONS

Table members introduce themselves to one another by stating their name, institution, and role, and speaking briefly about why they are here today... They finish by adding a fun fact about themselves, or a particular interest/focus in their work relevant to why they are here.

SETTING THE STAGE FOR MEANINGFUL CONVERSATION | 8:45-9:15

The Dynamics of Change | Bob Devlin

We're here in this room because we are thinking about change. There is both excitement and fear in change: both of which may come up in our discussions today. We are here together to create a compelling future, address challenges that we care about, and find new ways forward. Inherent in this process is loss of the status quo, fear of an unknown path ahead, fear of potential mess and failure, and getting caught in the details.
As we think about change, there are two major questions that arise:

WHAT *do we want to do?*
WHY *would it make sense to do that?*

Another question that could easily come into these discussions is:

- **how?**

It's too soon to ask this question. The road from here to there is not simple—but we don't want to let the winding road get in the way of doing what is right. Let's not let our conversations these next two days get caught in the how!

To move forward we need committed leadership, clear focus, and energy in the system: all of which are present in this room today!

Discussion Guidelines | Ruth Bentler

Bring what is important to you to the discussion. At the same time, listen to others' concerns and pay attention to the larger picture within the profession. Be succinct, work to draw others out, and most importantly, be kind.

HISTORY OF AuD | 9:15-10

Fred Bess, Ph.D. | Introduced by Anne Marie Tharpe

Fred Bess is a pioneer in the profession of audiology. In the 1960s he started the Audiology Department at Central Michigan University, in the 1970s he served as Department Chair in Hearing and Speech Sciences, and in the 1980s he became a founding member of AAA. He is here today to provide history and context for our conversations.

The AuD. Degree: A Retrospective | Fred Bess

For detailed slides regarding seminal events in the evolution of the AuD see Appendix B: Power-point Presentations

There were many challenges to creating the AuD Encountering these obstacles at the time, they seemed almost insurmountable. But it was the collaboration among numerous critical stakeholders that eventually pushed us forward and helped the AuD movement go further.

The presence and prestige of audiology in the health-care community has been significantly enhanced by the AuD We owe a debt of gratitude to those pioneers in our field who pushed the AuD forward. The profession is best served when all stake holders cooperate for the collective interest.

The AuD Model Today | Ruth Bentler

*Ruth Bentler's briefing was streamed live on Facebook with a total of **4083** views*

For complete viewership data see Appendix 5

As Fred Bess just detailed, the AuD model was first proposed and rejected 50 years ago. Twenty-five years ago we said: "Ok lets go for it," and now, finally we have something in place everywhere. I say this as a forewarning: we might decide in the next few days that we need to make some changes—but change doesn't happen over-night—it takes time, particularly if that change is good for us.

In preparation for this summit, the ad hoc committee surveyed every program, including AuD students and preceptors. We read everything related to the AuD educational model, specifically related to themes from the AAB report. We met face–to-face and via conference call for the past 12 months to brainstorm **what** and **how** to address the most critical programs.

The questions we asked were open ended. We had determined what the questions would be, but we wanted you to tell us the answers that were true for you. We wanted to know:

HOW *ARE YOU doing with the AuD program?*
WHAT *are some of the issues that you're facing?*

The following slides will show examples of the survey questions and the compilations of participants' answers.

For detailed slides containing data from the Spring 2016 surveys of programs, students, and preceptors see the Appendix B: Powerpoint Presentations

The major themes we found in our surveys determined the focus of the summit. We found that there is a lot of concern about the "externship" itself (or whatever each institution calls the clinical training portion of the program)—the surveys identified that the standardization of that process leaves something to be desired. All the data collected identified a lack of quality control standards and preceptor qualification standards. Another critical issue identified was student debt and return on investment. Our final major theme identified was student training and readiness. These are the five major themes that we will focus on over the next two days. After a short break we will break out into tables and begin to discuss these issues before us.

BREAK | 10-10:30

TABLE CONVERSATIONS | 10:30-12

Setting Up the Discussion | Bob Devlin

Up until now we've been providing history and context. Now it's time to move this conversation forward; here, today, we have the space to talk amongst ourselves and get into the conversation. The following questions can help orient us in the discussions.

- Reactions to what has been said so far
- Your main concerns with respect to the issues presented
- What areas cause the most pain? Where are the greatest opportunities?

Table Conversations | Report Outs

Table #	Verbatim transcriptions of flip charts generated during table discussions	Summaries of table report outs
Table 1	1) What is our goal with AuD? -Ready to practice -Programs are responsible -Across scope of practice at graduation? 2) Preceptor training -Opportunity	Backing up: what is our goal with AuD? We talked about graduating students ready to practice (a topic we actually didn't get consensus on at our table). We decided that programs need to be responsible for student readiness, and that students need to be ready to practice across the scope of the practice at graduation. We also concluded that preceptor training is critical no matter how you look at the model.
Table 2	Most pain Externships Biggest fear Preparedness of students if moved to optional residency: academic & clinical diversity of skills Opportunity Fast-track/undergrad. Degree to shorten total training time Need to develop true	We looked at what is best for the profession, which we think comes down to what will best prepare students to be practitioners upon graduation. Standardization would be very helpful. We need to think about: what level of preparation do students need to become certified practitioners? In regards to student debt: what could be done to streamline the process? We discussed fast-track models, which prepare the best and the brightest for

Table #	Verbatim transcriptions of flip charts generated during table discussions	Summaries of table report outs
		early program application. Finally, we discussed the need to develop true outcome measures to determine whether a student has developed competencies before an externship.
Table 3	Top Two Consistent quality of externship including process Educational value of externship not equal to "cost" Opportunity Preceptor training Relational model "Trust the Audiologist that	At our table there was a strong distaste for how the current 4th year model is working. We discussed a lot of alternative models, and no consensus was reached on any one in particular. Because students are relied on at the sights for low-level technician work, they are not given relevant training at the sites—hence, the educational value is not equal to the "cost" of the externship. There is an opportunity for preceptor training when we think about the externship experience: rather than developing a transactional relationship, we should be cultivating relational models—either with individual preceptors or with the facility at large. In this way we can start building more opportunities for preceptors. "Trust the audiologist that teaches."
Table 4	1) Lack of standardization in years 1-3 impacting year 4 (externship) No student skills metric to determine outcomes 2) Student debt/ROI 3) Quality control of externships/preceptors	We talked about what precedes the 4th year. We think that there is a lack of standardization in years 1-3 that needs to be addressed. The front end of the degree process needs more preparation and standardization. We discussed quality control— in the sense of competency being the goal rather than a number of hours achieved. In regards to student debt/ROI we believe that we should strive to make debt be relative to the beginning salary of newly graduated practitioners. We discussed quality control of externship and preceptors. We like the idea of a screening sheet to give to 4th year sites. We need to find some reasonable way to have quality control in externship sites and among preceptors.
Table 5	1) Post graduate model/standardization 2) Financial issues/debt/ tuition/reimbursement/control	There was consensus at our table that the externship should be post graduate. This would lead to some standardization of preparedness in training, which leads right into the financial issues we discussed. This would reduce costs for students and the programs themselves, and allow for a terminal degree.
Table 6	4th year externship 1) Universal application deadline (process issue!) 2) Quality of sites	We discussed issues relating to both process and quality. In terms of process, we need universal application deadlines. Relating to quality, there needs to be a standard quality of

Table #	Verbatim transcriptions of flip charts generated during table discussions	Summaries of table report outs
	3) Preceptor training 4) Consistency across experiences and evaluation of students (e.g. forms)	sites and preceptor training, consistency across externship experiences, and standardization in student evaluation.
Table 7	Greatest concern Stress-$, time, competition Greatest opportunity Standardized process incorporating matching, deadlines, stipends, some individualized aspects (student centered), evaluation, focused on competency based education (not clock hours)	Our greatest opportunity is to come to consensus. We talked about using a computer algorithm to help standardize the program.
Table 8	1) No consensus on externship in or outside graduate programs 2) Standardizing guidelines for acceptable internship sites	We did not reach a consensus in our discussions about whether the externship should be in or out of the degree process. We did agree that there should be standardizing guidelines for acceptable externship sites ensuring the quality of sites for externship. We discussed the negative connotations with some private practices dispensing hearing aids only, and the positive connotations with medical establishments.
Table 9	1) Can we provide skills needed to practice within 3 years? What does that do to expectations? 2) Can we agree on the required components of a residency? Who would accredit/set the standards?	We talked about the 4th year externship. We wondered: if we moved to a 3 year model, would a residency be required or optional? There was concern at our table about whether or not we could adequately prepare students to be prepared for residency in 3 years—would knowledge and skills be adequate? Could we agree on the elements we want to have in a residency? Could we agree on a set of standards for residency?
Table 10	1) Student Debt -Financial management taught -Accurate info re: cost & related factors 2) Clinical Education -Begin earlier in program -Initial 3-year preparedness in clinical training prior to 4th -Clinical judgement: develop as a goal	We talked about the 4th year externship. We wondered: if we moved to a 3 year model, would a residency be required or optional? There was concern at our table about whether or not we could adequately prepare students to be prepared for residency in 3 years—would knowledge and skills be adequate? Could we agree on the elements we want to have in a residency? Could we agree on a set of standards for residency?
Table 11	What we need: Standardization (wish list) 1) Of application process for the 4th year 2) Clinical training prior to the 4th year 3) Sites—Accredit them	As a group we weren't sure whether we wanted to go toward a residency model and abandon the current model, but we did agree on the need for standardization. We need to work towards consistency and uniformity of the

Table #	Verbatim transcriptions of flip charts generated during table discussions	Summaries of table report outs
	*DPT Model for residency sites (res. not feq.???) ~$3700 to get accredited + $500 annually →Good recruitment tool → May lose sites →Res. has curriculum standard components exams Two Big Items 1) Consistency & Uniformity of 4th year process 2) Student readiness—i.e. clinical & academic training prior to 4th year. How is readiness determined?	4th year process. We discussed student readiness, i.e. measuring the outcomes of clinical and academic training before the 4th year. How do we know students are ready for residency?
Table 12	What are obstacles: 1) Standardization of process 1-Application 2-Database of site visit date 3-Database of site visit date 4-CAPSCD? As an entity to provide infrastructure for standardization 2) Assessment of outcome of externship Differences in expectations from sites	We concluded that standardization of process is a big goal. What are the obstacles to standardization? We discussed the need to standardize the application and application process, create a database of externship sites and a database of site visit data. Additionally, in assessing outcomes of the externship, we need standardization of expectations. We need to figure out how to assess the value and value added of an externship.
Table 13	1) Standardization of externship process (timelines, quality, expectations) 2) Student financial burden 3) National stance on CC-A requirement for supervision (to NOT require them)	**13.** We discussed standardizing the externship process, in particular developing timelines and standards of quality. We also discussed the need to decrease the student financial burden. Finally, we think there should be a national stance on CC-A requirement

LUNCH | 12-1

PRESENTATIONS ON THREE DIFFERENT RESIDENCY MODELS | 1-2

Panelist Introductions | Radhika Aravamudhan

*These presentations on residency models from other professions were streamed live on Facebook with a total of **2679** views.*
For complete viewership data see Appendix 5

We have invited three speakers to present on different approaches to residency. First, Donald Brady will present on the residency process in Medicine, followed by a presentation on residency in the Optometry model by Susan C. Oleszewski. Finally, William Boissonnault will give a presentation on Physical Therapy's approach to residency. Following a quick break, we will bring back our panel for advice going forward and a Q&A.
We've invited these speakers here today because we want to hear their various approaches to clinical education.

How are other professions managing their clinical training?

Medical Model | Donald Brady, MD

For detailed slides on the Medical residency model see Appendix B: Powerpoint Presentations

Is residency required in the medical profession? Technically you do not have to do a residency to be a doctor—however, there is no state in the country that would allow a graduate to practice without at least one year of residency. In my experience with the medical residency model, having standardization of the residency program benefits the residents and the programs themselves. Currently, accreditation models in medicine are shifting away from a focus on the process of the residency and toward a focus on the outcomes of residency. Your opportunity to affect "the system" has never been greater. Where will the healthcare system be 20 years from now? We have no idea. Today, your challenge is not only to think about the issues facing your professions now, but also to consider how the changing healthcare system will affect where the audiology profession will be 5, 10, 20 years from now.

Optometry Model | Susan C. Oleszewski, OD, MA, FAAO

For detailed slides on the residency model in Optometry see Appendix B: Powerpoint Presentations

Residency is optional in Optometry. In my profession, residency programs are for advanced topics in Optometry—not entry level skills. Residencies are generally one year in duration, and do provide some professional advantages depending on an individual's career goals. Due to a lack of residency sites, there are only residencies available for about 25% of optometry graduates. Even without a mandatory residency, graduates are very well trained clinically upon graduation and have the skills to take care of the public after 4 years of training.

Physical Therapy Model | William Boissonnault, PT, DPT, DHSc, FAAOMPT, FAPTA

For detailed slides on the Physical Therapy residency model see Appendix B: Powerpoint Presentations

In the physical therapy education model there is a high level of standardization in the didactic component, but no standardization in the clinical training portion. Students across different institutions are at different levels of training. Residency is not required in the physical therapy professions. The goal of residency education in physical therapy is to "produce physical

therapists who demonstrate superior post-professional skills and advanced knowledge in specified areas of practice." Some challenges we face in regards to residency are: inconsistency among program reviews, acceptance of varying program models/approaches, unclear residency/fellowship program distinction, ineffective integration of technology in the accreditation process, scalability of current model, and a shortage of residency programs to serve all physical therapy graduates. The physical therapy community has gone through similar processes to the audiology community in regards to clinical training. We can learn from each other.

BREAK | 2-3:30

Q & A | 10-10:30

Advice Going Forward | Panelists

Oleszewski (OD)
This conversation today feels like Déjà vu—a similar conversations happened in the Optometry profession when we were developing the residency model. In order for the conversation to move forward the audiology community—leadership especially—needs to be on the same page.

Boissonnault (PT)
My advice would be to take your "program" hat off and put your "profession" hat on. What is best for the profession? Issues described with student debt, preceptor and site quality, etc. are not going away. Its important not to be thinking in terms of "Band-Aids" and "quick fixes." Sometimes you need to put the cart in front of the horse and let the horse catch up.

Brady (MD)
Firstly, it is important to keep the patient in the front of your minds in this conversation. Secondly, there are three levels on which you need to be focused at the same time: there are requirements and regulations on the state and federal level that need to be incorporated, there are the outcome requirements of the residency/clinical training itself, and then there is the need for standards in the "incoming product," i.e. a minimum competency requirement for incoming residents. As a final piece of advice I will reiterate that this is about where the field is going: to be—not now—but in the next, 10, 15, 20 years. Its important to think about: how will you organize training for the profession of the future?

PANEL Q & A

For a full list of questions submitted by participants see Appendix 3

1. ***What are the sources of funding for the residency programs?***

   PT: Funding comes from academic centers and the residents themselves (residents pay for their training program, with less than 10% coming from paid stipends/low wages/housing)

   OD: Funding comes from the sponsor of the residency. Residents have salaries and benefits.

   MD: Funding comes from the clinical margin for the enterprise. Not only are residents learning, but they are also providing a level of work that someone would have to do if they weren't there. Residents work for lower wages than a Nurse Practitioner, plus they work longer hours and less desirable shifts.

2. ***Do you have a matching program—and do all students who want a residency program get one?***

   OD: Yes there is a matching program, but not all residency applicants get a residency. There are only residency slots for about 25% of Optometry graduates.

   MD: To get a residency you have to go through a matching program. Everyone could get a position who wants one, but that won't always be the case moving forward.

   PT: There is no matching system in physical therapy. We usually get around 80% of our residency slots filled.

3. ***If residency is optional, how much clinical training is obtained in the program? Is this determined by hours or competency?***

   OD: A Resident's progress is tracked by the number of patients, diagnosis, and involvement in care. Outcomes are reported to accrediting group to prove that the goal of training a specialty provider has been met. The last year of training is divided into clinical quarters. Students undergo four full-time clinical rotations in different categories. There is a minimum of 35 hours of clinical care per week, but most rotations are more (~50 hours/week).

   PT: Students have 30-31 weeks minimum clinical training upon graduation.

   MD: There are requirements for clinical training prior to residency. We have clear clinical standards that must be met before students become residents.

4. ***Question for PT: Are graduates who chose not to pursue a residency sufficiently educated to perform competently in the entire scope of the practice?***

   PT: We are charged to graduate a generalist, but no—a graduate will not be competently trained across all areas of PT without a specific residency.

5. ***Question for MD: How did different professional organizations (D.O., M.D.) finally come together to agree to ONE accrediting body/one set of standards?***

   MD: There was a push to come together into an evolving partnership. As a profession, we saw the need to take more control of self-regulation. We knew that if we didn't do it, someone else would.

6. ***Question for PT and OD: This question has to do with salary expectations: what is the differential between those that are residency trained and those that are not?***

   OD: Graduates who choose to do residencies are doing it because they believe that their skill set will be improved. It is true that there are employers who are specifically looking for residency trained optometrists. Generally speaking, residency leads to a little bit better compensation due to an extra year of rigorous training.

PT: Residency does not guarantee a higher salary. However, residency makes specialization more streamlined and makes graduates more marketable—often former residents go on to leadership positions.

7. ***The starting salary for those professions shared today are significantly higher than audiology, which makes student ROI significantly less of a burden. How do we go about improving our current situation?***

   Its important to emphasize the value that audiology brings, and how it fits into overall health care. Educate, and then legislate: make sure to convince the legislative bodies that you are doing work that needs to be done. Looking at future trends, it is more likely that medical salaries will come down rather than audiology salaries going up. Be disruptive in thinking about how you train: do you really need 3 years? Could there be a common curriculum that doesn't need class-time? Think disruptively in order to fix that.

8. ***How many residencies are available in private practice environments?***

   OD: Not a lot—small percentage

   PT: 1/3 to ½. Private practices really drove the residency model.

   MD: 2/3 of Medical sponsors are not academic enterprises.

9. ***Question for PT and OD: What are possible limitations to not making residency required? Any benefits to not requiring it?***

   PT: If we require residency we would have to take the option of just taking the exam away. We have a good accreditation process in place and really good sites—our challenge is to connect these pieces in an efficient way.

   OD: We have made the decision that were not going to make residency mandatory. Graduates are very well trained (clinically) upon graduation, and have the skills to take care of the public after 4 years of training. Given the number of graduates and number of sites, the challenge of coming up with another 1000 residency slots to meet the demand of all our graduates is not really feasible at this time.

10. ***Question for PT and OD: What undergraduate degree do you require as prerequisite for the professional degree? And what is your clinical training sequence in your graduate program?***

    OD: We mostly get Biology or Chemistry undergraduate students. Students begin to observe in a clinic in year one. They begin to see patients in January of their second year and they have to begin going on external rotations in the latter half of their 3rd year.

    PT: We get students from Kinesiology, Biology, Chemistry. In terms of sequencing of clinical training, we have an integrated model. Early on in their first year students begin seeing patients, with clinical work increasing throughout the program.

11. ***Question for MD: Are smaller or more rural clinics able to sustain residency programs, and how are they able to sustain the programs?***

    MD: Smaller and more rural clinics are not easy to sustain financially. However, there is state and Federal funding to help underserved areas—both inner city and rural areas. These programs are usually smaller and often very innovative.

12. Who established the outcomes of residency programs and who assesses/measures the outcomes?

MD: There are two levels at which residency outcomes are assessed/measured: each program itself has its own accreditation standards, and there is also a post-graduate examination process in the professional boards exam.

PT: Programs have assessment tools in place as part of the accreditation process. Clinical examinations are happening at the program level as residency is not required for the board exam.

OD: Program objectives are set by the program. Residents are already licensed to practice—each program has to make sure what they say they are doing is actually happening.

13. What is in it for the residency sites?

OD: They are getting a well-trained provider being paid less than what a non-resident would be paid. Is the student or resident getting what they need from an educational standpoint? If so, then its ok that in some regards the resident is a well-trained set of hands for low wages.

PT: Some residency sites develop programs altruistically, some develop programs to help with recruitment and others to help with senior staff retention. There are opportunities for mentorship that would not be there without residents. There is a level of in-house professional development that happens with residents.

MD: There is an advantage—over time—for prestige that comes with having a residency program. There is an advantage to having a "care team," which includes residents as extra eyes, ears, hands. One potential downside with residents, is that they are employees as well as students, and employment law is very different than issues with students (a challenge to think about).

14. Do we need externship/residency in audiology, in your view?

OD: The core program has to be on very solid ground in terms of consistency and standards before you can go to residency standards. With the developments of core consistency—especially clinical experiences—it might be found that residency programs are not needed.

PT: Residency is the best way to produce a specialty practitioner. Much of the teaching and learning occurs over patient care.

MD: There are certain things that having a degree allows you to do that you just don't let students do (example: writing prescriptions). Residency allows for gradual independence. Over time over the residency program, residents are allowed gradual autonomy. The advantage of having a residency program as a post-graduate program is the allowance for gradual autonomy. It is important to design some training program to give trainees gradual autonomy still with some level of supervision—its way to guarantee the safest level of individual practitioner when they are done.

STRETCH BREAK | 3:45-4

POST-PANEL TABLE DISCUSSIONS | 4-4:45

HOW might these residency models help address some of the challenges we face?
WHAT might we adopt from the models presented?
WHAT would be the benefits?

Table Conversations | Report Out

Table #	Verbatim transcriptions of flip charts generated during table discussions	Summaries of table report outs
Table 1	1) Enforcement of consistent standards—strict 2) Models presented do not address #1 (core issue)	**1.** One of the problems is consistent standards across programs. The models presented don't address the problems. We might need to create a disruption to the model we use now.
Table 2	1) *Accreditation of residency sites. Would they enter the process to become accredited? How about an <u>oversight</u> process?* 2) *Can we accomplish the acquisition of sufficient clinical skills w/o the residency/externship as a part of the training program? Is it possible?*	**2.** In the first place, would sites be amenable to an accreditation process? We need at least the possibility of an oversight process—so at least we could be working toward consistency. If we didn't have the final year of residency as part of our training program, how would we then do everything that is necessary to prepare our students to be independent service providers in 3 years?
Table 3	AuD program= 3 y (min) <u>Competency</u>-based Clinical rotations interspersed *optimal (optional?) residency	We went back to our roots, asking: why did we start with an AuD process in the first place? A minimum of 3 years with clinical interspersed should be folded into an AuD degree. Outcome measurements should be competency based. We should have an in-training exam as a future goal. Residency should be an optional specialty, not as a method of finishing what the training program didn't accomplish.
Table 4	**1)** Discussion of the models helped us focus on <u>standardizing</u> the first three years of AuD. i.e. define "core" competencies 2) Residency model is NOT the solution to the "4th year problem."	Discussion of these three residency models helped us come to the belief that a residency model is not the solution to the 4th year problem.
Table 5	*Excited about the idea of a "gradient of supervision" in a residency model (<u>POST</u> GRADUATION) *Minimum standards for: 1) Education 2) Residency 3) Licensure/regulatory control	We were excited about the idea coming from the MD model where there is a gradation of supervision in a residency model (Post-Grad). We need minimum standards for education (milestone measures as students progress), residency, and licensure/regulatory control.
Table 6	1) Not ready for post-graduate residencies! 2) More info on how 3 year programs operate?	We agreed with the theme that we are not yet ready to adopt the residency. We currently have a handful of 3 year programs represented here—why not hear about their outcomes?
Table 7	Adopt the following: 1) One accrediting body 2) Re-visit competencies Generalist vs. Specialist Knowledge vs. Practical/Skills 3) Develop standardization process for externship sites	If medicine can do it, we can do it. We need one independent accrediting body!

Table #	Verbatim transcriptions of flip charts generated during table discussions	Summaries of table report outs
Table 8	*Primary care provider (PCP) for hearing health care *Strong science base in undergraduate education to support doctoral (AuD, Ph.D.) training. *autonomy we enjoy clinically is based on our foundation of science.	Our table identified most with the optometry model—but we are now where they were in 1970. We are advocating to think about what will change our training models.
Table 9	1. Everything should be about outcomes rather than duration or # hours 2. If we had a 3+1, no consensus about optional vs. mandatory	We believe residency should be about outcome not a number of hours. We discussed interspersing clinical practicum with didactic sections. We did not reach a consensus about mandatory/optional 4th year.
Table 10	1. Re-evaluation of core *Patient/public quality 2. What does competency mean? -Breadth/depth balance for preparation in independent practice -Hours vs. skills	What is the breadth and depth of competency? What are our expectations in terms of standards? Is there consensus about this?
Table 11	Hear from 3 yr programs 1. Eval of 3 vs 4 yr programs -students -faculty -preceptors, esp. 4th yr 2. Collaboration between/among non-physician health professions to deal w/ residency applications/programs 3. Standardize "in house" (clinical education prior to 4th year) clinic expectations. Agree on competence, etc. 4. Standard of care needed	We need to look at 3 vs. 4 year programs in terms of student and faculty precepts and outcomes. We need to collaborate with other non-physician health professions across other fields of practice to deal with standardizing residency application processes and programs. Finally, we need a standard of care document.
Table 12	1) Systematic clinical training within degree 2) What is the outcome for audiology in 5, 10, 15 yrs.? 3) CUBS	The other professions presented have systematic clinical training within the degree. What do we want the outcome to be in 5 years? We need to think toward the future.
Table 13	* Post-graduate residency addresses student debt and work issues * Need to re-evaluate 1-3 years (competence vs. hours) THINK DISRUPTIVELY	Having residency be post graduate could address issues with student debt. We need to reevaluate years 1-3; if we are going to do something with year 4, we need to have standardization in years 1-3. We like the phrase "think disruptively."

CONCLUDING THE DAY | 4:45-5

Closing Remarks | Ruth Bentler

Tomorrow we will take the threads we've pulled out today and take them farther. Overnight we will figure out the right directions for our conversations to go tomorrow.

AUD EDUCATION SUMMIT: DAY 2

OPENING REMARKS | 8:30-9:15

Overnight Thoughts | Ruth Bentler

I wanted to start today by reminding us why we're here: we are having, in our profession and in many of our programs, challenges achieving the quality of clinical education agendas that we have intended. We are coming to this conversation because of responses collected from you all. Upon review of the challenges as collected in the data, it's clear that we do have issues that we need to address in our profession.
Yesterday we heard from 3 other professions who have different residency models, and I think we learned that we might not be ready for a residency model—today or ever—but we do have a lot of challenges to deal with nonetheless. We are here to fix the things we have identified as problems with our training models. Maybe what we need more of is strengthening our clinical models—wherever that falls—inside or outside of our degree. We still have a lot of things to do! Let's hope that the conversations today are equally as productive as yesterday!

Today's Agenda | Bob Devlin

You have an amazing opportunity today to do something remarkable in your profession. The goal is to bring the brain trust of this group together around the things you care about and develop strategies for accomplishing your goals.

There are two ways the outcomes of this summit will take effect. The first way is sort of a "wholesale" model, where we ask: what is the will of this group? Are there things that we collectively want to do? Together, we can form committees, find funding, and make structural changes. The second way the outcomes will be implemented could be seen as a "retail" model, where each individual program/institution takes what we accomplished here and implements it back home. We need both.
Last night in the committee meeting we came up with some questions for polling today based on conversations and questions committee members heard happening yesterday. Later this morning we will be polling to gauge the feelings in the room and gather some data. But first we will be hearing from 3-year programs. Next, we'll move into the notion of building our consensus, where we will poll the group. Then we'll move to breakout groups where we'll work on some of the topics—including information gathered by the polls—and issues raised by you. There is flexibility in topics. During your conversations today please think about: what role do you want to play in the next steps? There will be space for generating groups and leadership on certain topics.

Brief Table Conversations | Report Out

TOPIC

What stands out from yesterday? (15 minutes)

- We talked about the need for data: we don't have great data in terms of being able to assess some of these things.
- We talked about standardizing programs: what would a core curriculum be?
- We settled on the idea of eliminating the hour requirement. How to assess student competency in a better way?
- We need to obtain an externship clearing house that would work for making 4th year process more standardized.

- We reached a consensus in that we do not believe we are ready, as a profession for a residency model. We cannot afford to blow our existing system up and start over. There will be millions of people each year needing our help going forward: our plan is to train as many generalists as quickly as possible to serve the healthcare needs of the future and then work on training specialists.
- Put politics aside and put patients first is our general consensus.
- We are not ready yet for the residency model but we want to think about it for the future. Strengthen what we are doing now.
- How we could move toward something like a cast? We really need to focus on years 1-3 first instead of on the 4th year.
- We talked about the concept of "liability" in healthcare today. Why do we repeat audiograms done in other centers so much? Because we don't trust each other. That is an indictment of our education system. We need to focus on reliability and being able to measure outcomes.
- We talked about standardization—specifically, that when you start to develop standards with as much diversity as we have they can get watered down. We need to remember that as we move forward.

Kotter Change Model | Bob Devlin

*Bob Devlin's talk about focusing and mobilizing energy for change was streamed live on Facebook with a total of **3679** views.*

For complete viewership data see Appendix 5

What we are doing here is **thought leadership for the profession**. Yet everyone here also has individual local interests. We need to focus on both our local interests and our collective needs. If we stay at the local level we can't get "where the puck needs to be." We need to think about the profession as a whole.

Where does the puck need to be?

John Kotter's research focused on highly effective change efforts. Over the course of his research he generated a huge amount of data from highly successful change efforts. He wanted to find out if there were any patterns or sequencing that might guide others toward successful change.

He found that there are 8 steps to successful change, the first and most important being establishing a sense of urgency. What is your **sense of urgency** with the issues you are discussing? If there isn't enough of a sense of urgency, there will not be enough momentum to move forward. We need urgency in order to act. The second most important factor for successful change is forming a powerful **guiding coalition**. Who should be part of this coalition? Is there an organization that should lead this, or that should be formed to lead this? Who needs to be involved to ensure that your plans are thoughtful, thorough and comprehensive? Next, its important to create a **vision**. What is your vision for the future of AuD education with respect to the immersion experience? There were elements of "vision" that came out of the overnight thoughts—those can help guide you. How can you make the vision work for all? What is right to do for the profession? Tied to this idea is Kotter's step of **communicating the vision**. What mechanisms do you need to communicate? Kotter also detailed the need to **empower others to act on the vision**. How should the guiding coalition engage the broader community that will be impacted? What role should existing organizations or bodies have in this process?

Think about these elements as you consider what stakes you want to put in the ground today. What is the will in this group to do something? What can you get behind? Kotter found that change relies on truly connecting to the hearts and minds of those involved in the change. For change to occur its necessary to find a way to connect to the hearts and minds of stakeholders in ways that shift behavior.

HEARING FROM 3-YEAR PROGRAMS | 9:15-10

Presentations on Three-Year Training Models | Participant Speakers

Participants from 3-year programs present on the pros and cons of a 3-year model for addressing the issues we face as a profession.

NORTHWESTERN UNIVERSITY | SUMITRAJIT DAHR

Didactic Required: 82 semester hours
Clinical Achieved: 600 semester hours; including internship**:** 1800 hours

We have been operating on a 3-Year model for the last 13 years. The program focuses on didactic materials without sacrificing clinical skills. Our focus is making sure that every student has reached the required threshold of knowledge and skills by graduation. One major challenge we face is time management. We operate on a quarter system so that helps because we can pack a lot in. For us didactic hours and clinical hours are a thing of the past—we have to move into outcomes.

WICHITA STATE UNIVERSITY | RAY HULL

Didactic Required: 87 semester hours
Clinical Achieved: 600 hours; including residency: 2300 hours

Looking at the other doctoral programs within our institution, we realized that they are preparing their students well in a 3-year time period. We looked critically at our 4-year program and realized we were wasting time. During year 1 our students were shadowing in the clinic, but they weren't really engaged. We began to think about an accelerated program, including introducing students to hands-on clinical work in year 1. Undergraduate students are often already introduced to clinical work. There is a 100% pass rate on praxis exam. Students do well on their residencies. We are happy with it.

UNIVERSITY OF THE PACIFIC (CALIFORNIA) | JACQUELYN GEORGESON AND ROBERT HANYAK

Didactic Required: 84 semester hours
Clinical Achieved: 700-800 hours; including residency: 2600 hours

Georgeson: We started out as a 4-year program and moved to a 3-year program for practical reasons. We have accelerated what we feel is the knowledge needed to succeed.
Hanyak: We did not have an option of creating a 4-year program at our institution. We are the only 3-year accredited dental program in the US, and other 3-year programs in the healthcare profession. Our provost said: if you want an AuD program it must be done in 3 years. What is so special about Audiology that it needs more than 3 years?

ARIZONA STATE UNIVERSITY | ANDREA PITTMAN

Didactic Required: 70 hours
Clinical Achieved: 16 clinical credits; 4th year externship: 3 optional credit hours

We are transitioning to 3-year program for practical reasons: we need to cut costs. Our program has increased in cost 177% since we began (for instate students) while the median income of audiologists has only gone down. In our program the 4th year is optional. The optional 4th year 1 credit per semester---most students do it because it only costs 3 credits—but students can graduate any time after 3 years,

INDIANA UNIVERSITY | CAROLYN GARNER

Didactic Required: 70 hours
Clinical Achieved: 850-900 hours; including residency: 2000 hours

I am an externship coordinator and clinic supervisor in our program. We are doing a great job as a 3-year program. We are currently looking at financial impact for students.

PACIFIC UNIVERSITY (OREGON) | WENDY HANKS

Didactic Required: 84 hours
Clinical Achieved: 800 hours; including residency: 1820 hours

Our program is in its 5th year of existence. We started our program from scratch and it has followed other models from other healthcare professions. The first year, the didactic/clinical ratio is 90/10; by the second year it is 50/50, and by the 3rd year it is 90/10. In the education mode that we follow, students take only one topic at a time for 2 week blocks, each building on the block before. On the days students are not in class, they are in lab or clinic. Every 3 students have a complete audiological set up—they spend a lot of time in lab integrating what is going on in the classroom. Students must have excellent time management skills. Students do a fulltime internship for 9 weeks, and then the 4th year is externship with online classes to support the externship.

GRAND VALLEY STATE UNIVERSITY | DAN HALLING

Total hours: 86
Didactic/Clinical ratio: 66/20
*program is still in design phase

We are in the process of proposing a 3-year program. In designing the program, we have found that a huge factor is finances.

Questions & Comments | Participants

- It seems like we aren't thinking about 3 year programs for the sake of Audiology but rather for the sake of economics.
- It seems like we should be talking to preceptors about what they need from students upon graduation.
- How many students are admitted per class? Do your students get any funding
  Northwestern: 15 students, financial aid given
  Pacific California: 20-27 students. There are scholarships mainly for minority applicants. With the time commitment to class and clinic there is not much time for research assisting positions etc.
  Pacific Oregon: 25
  Wichita: 8 students. All out of state students are on graduate assistantships
- Please tell me how you figure out if a student has good time management skills?

It's important to look at what else did the applicant did besides going to class as an undergraduate.

- Is there data that looks at cost comparison between 3 and 4 year programs?
  ASU- Old model: $62,000 (instate) -$132,000 (out of state)
  New Model $10,000-20,000 less
  University of the Pacific & Northwestern: Adjusted to be competitive with other programs
- It seems like 3-year programs eliminate research at any level.
  Northwestern—Not true for us. On average 35-40 percent of each class publishes their research in peer review journals. Labs plug students into ongoing research. We have to come up with creative ways of working with what we've got
- It seems like students are graduating with a very wide difference in number of hours. How many hours do students need?

BREAK | 10-10:30

TESTING & BUILDING OUR CONSENSUS | 10:30-11

Poll questions | Ruth Bentler

Why are we giving you these poll questions? These questions are coming directly from conversations we heard happening yesterday. There is a need to take the pulse of the room in terms of topics raised yesterday.

Poll Results | Participant Generated

Polls answered by text from participants' own personal devices. Final poll results were displayed on screens in real-time.
For unformatted Poll Results See Appendix 1

What is the urgency in creating a national data base of clinical externship sites?

1 - Very Urgent **48%**
2 - Somewhat Urgent **28%**
3 - Not Urgent **23%**
4 - Not Important **1%**

What is the urgency in standardizing the application process (including application deadlines) for clinical externship sites?

1 - Very Urgent **56%**
2 - Somewhat Urgent **31%**
3 - Not Urgent **13%**
4 - Not Important **0%%**

Should we explore mandatory preceptor training?

1 - Yes **54%**
2 – No **46%**

Are you in favor of exploration of a residency model or other postgraduate training?

1 - Yes **34%**
2 – No **66%**

What is the urgency of moving toward a residency model or other post-graduate education?

17% indicated very urgent or somewhat urgent
42% not urgent
41% not important

Keeping with the "skate to the puck metaphor," we are ready, as a profession, to plot our course for the next 10, 15, 20 years?

1 – Strongly Agree **10%**
2 - Agree **18%**
3 - Disagree **53%**
4 – Strongly Disagree **19%**

TABLE CONVERSATIONS | 11-12

Breakout Group Table Conversations | Bob Devlin

TABLE TOPICS | PARTICIPANT GENERATED

What are the big issues?
What are the strategies we should use moving forward?

Table number(s)	Topic	Facilitator
Tables 1, 6, & 7	Standardization of externship process including application process for externship	Radhika
Table 2	Quality control of externship sites	Neil
Table 3	Preceptor qualifications	Vishaka
Table 4:	Student debt/ROI	Andrea
Table 5	Student training/readiness	Martha
Table 8	Mandatory Preceptor Training	Bob
Table 9	Explore residency or other post grad training	Tammy
Table 10	Vision for the future—'Skate to the Puck'	Sherri
Tables 11 & 12	Best practices for current competency assessment	Joan
Table 13	Shortening programs without sacrificing quality	Janie
Table 14	Guiding coalition	Jill

LUNCH | 12-1

FINAL DISCUSSIONS & REPORTS | 1-2

Generating Strategies Report Out | Participant Speakers

Table #	Verbatim transcriptions of flip charts generated during table discussions	Summaries of table report outs
Table 1, 6, & 7 ***Standardization of the Externship Process***	-Centralized application system ~CSDCAS • Application deadlines-window • Acceptance timelines -Buy in from preceptors/sites • Focus Group @AAA/ASHA/ADA – CAPCSD -When the database of sites is available, should we establish quality standard for sites	To streamline our externship process we need a centralized application system (CSDCAS). To be meet our goals preceptors/sites have to be a part of this especially in terms of acceptance timelines. Focus groups can work with preceptors to establish timelines that work for everyone.
Table 2 ***Quality Control of Externship Sites***	1. Sites should demonstrate they meet established guidelines to qualify as an immersion site. 2. Ad Hoc committee needs to be established to determine these guidelines.	We talked about a future vision for a standardization process of sites. Initially, we determined we would establish guidelines for externship/immersion sites. What is it a site should have? Who would oversee that? Eventually programs would be asked to follow guidelines. -Do your preceptors have preceptor training? -Are your clinical procedures best practices? Why would a site want to do this? Sites would want to be training sites—prestige. To be successful this can't happen immediately; we need guidelines before "standards."
Table 3 ***Qualifications for Preceptors***	*Survey preceptors 1. Master's or Doctorate in Audiology 2. At minimum, 2+ years of experience post degree 3. Willingness of mentors hip model (How?) using evidence based practice 4. Ongoing clinical load @ site (full-time) to support # of students 5. Willingness to perform outcome measures/competency measures 6. Certification/licensure requirements?? Follows code of ethics	**.** We believe a preceptor should possess a Masters or Doctoral degree in Audiology and have had at least 2 years-experience post graduate school. Further, preceptors should be willing to follow a mentorship model, where there is a gradient of supervision and practice is evidence based. Sites should have an ongoing clinical role to support ongoing students. Preceptors should be willing to perform an outcome/competency measure for students. Finally, we think there should be some sort of certification/licensure requirement which adheres preceptors to a code of ethics.
Table 4 ***Responsible Program Advising***	1. Know the cost of your 4 yr. program 2. Advise student move out-of-state	We don't have any data to bring to the conversation right now so this was a challenge. That said, we recommend program directors know the cost of their 4-year program for

Table #	Verbatim transcriptions of flip charts generated during table discussions	Summaries of table report outs
	3. Advise incoming students 4. Communicate income-to-debt ratio through undergrad organizations STUDENT DEBT Andrea Pittman	current students. Take this numbers to your faculty. Predict ahead for students that came in this year. Then you can advise students better. Advise undergraduate students who are considering going out of state to do the math. Advise incoming students coming from out of state to make sure they recognize the cost. Do students have a plan? Find some way to keep students in state. Communicate this income to debt issue through the associations. Educate our undergraduate students about future income vs. debt.
Table 5 Student Readiness for Immersion	- Expectations for Immersion Experience (IEx) 1. Students that need supported repetition in an area or 'polish' - Develop a universal <u>blunt</u> summary of skills based upon 'general clinical areas' as determined by recent CAuDP survey - Important to continue to emphasize IEx is part of education training – not 'cheap labor' - Full Disclosure • Program to Sites re K&S time with populations • Sites to Program <u>What</u> they can provide - Rec: Subsequent work on this >> • Task Force via CAuDP	We want to create practicing clinicians that can practice a broad scope. Immersion experience is part of the training. The relationship between the program and the externship site has to be a two-way street and has to include some knowledge sharing. We must move toward fuller disclosure— programs should provide info about students (their clinical experience, their preparedness level), and what is needed from preceptors. Fuller disclosure should be required by everyone (could also help with information gathering in helping to establish standards going forward).
Table 8 *Mandatory Preceptor Education*	*easy access on line* *CEU's* **Current Option** - CH-AP APSA: 4 Modules -ends in a certificate - CAPCSD Preceptor Education -late 2016; Dept. Chair will receive code: 2 modules for 3 years **Guidance for preceptors** -SELF LEARNING -Baseline of skills – foundation "Reward" to preceptor – "perk" Transferable skills for preceptor Tangible – the plaque Generational issues	We have two tools available that were never available before: CAPCSD and the American Board of Audiology. Preceptors are not here today, but they do want to elevate their skill set. We need to give them easy access to training. We need to provide CEUS and also other guidance for preceptors. How long should you be an audiologist before you're a preceptor? Mandatory training might allow for some self-training. We need to offer rewards to preceptors: what can we do to enhance the prestige associated with being a teaching institution? We should explore making preceptor trainings a transferable skill—could these trainings benefit preceptors in other areas of their work? We should think about

Table #	Verbatim transcriptions of flip charts generated during table discussions	Summaries of table report outs
	Involve Students Mandatory? 54% in favor; 46% opposed Licensure-taking care in how this is implemented *Learning Styles Generational* *Other Options:* *Training w/ program* *Standard case* *Student training*	tangible prestige: perhaps preceptors should get a certificate or plaque. This would enhance the ability of the preceptor in eyes of patients. Could preceptor training be a part of the AuD training? What do we mean by mandatory? Mandatory from program, practice, institution?
Table 9 ***Exploring residency/ post grad training***	Key Considerations: - Mandatory vs optional o this decision would need to depend on Y1-Y3 education - Opportunity for specialization? o could be pursued immediately after graduation or at a later date - If they can do it in 3 yrs, why can't we? o we certainly could increase efficiencies in didactic instruction and early clinical training Next Steps: -Accrediting issues -National competency exam? -Input from preceptors -Take a good look @ Y1-Y3... • work to transition to competency based model (no more beans to count!) Strategies: -Registry for residency positions • 1 organization manages this for different health professions (e.g., DT, Aud, etc. - Have a clearly defined foundation for Y1-Y3	Would residency be mandatory or optional? The decision would really depend on the quality of education in years 1-3. If optional: puts pressure on programs to educate students really well so they are good candidates in applying to residency programs. Provides an opportunity to specialize—could be pursued immediately after years 1-3, or at a later date. If other health care professions can do a doctoral degree in 3 years, why can't we? We can increase efficiencies in our program to decrease the amount of time. We must create a registry of residency positions, handled by one organization. In Medicine there is one organization that organizes residencies—could we do this in other healthcare professions? Next steps: input from preceptors. Where are students at? Where do they need to be? Take a look at years 1-3 and focus on competency model
Table 10 ***Visioning the Puck***	(Lots of discussion occurred)	We tried not to get too involved in the how. We reached a consensus on the reality of change with diagnosis and treatment systems

Table #	Verbatim transcriptions of flip charts generated during table discussions	Summaries of table report outs
	1. Current Diagnostics and Treatment Strategies will change dramatically. Examples: a) online HA's, disposable HA's b) Molecular and pharmacological intervention for SNHL c) preventive interventions 2. Set a Bold Vision. Example: - Audiologists are the primary care porviders for hearing, balance, and tinnitus care 3. What we need. Examples: a. examine other models of VG/Grad Program b. get data, accreditor drives change c. professional orgs band together d. be Fearless!	in the next 25 years—we don't know how, but they will change dramatically. Given those changes, we thought we should set a bold vision for Audiology. Example: Audiologists are the PCPs for hearing health care. This statement will drive improvements in education, patient care. Accrediting bodies need to embrace this vision and be the bold leaders. In the example of Medicine, accreditation bodies drove the profession forward. We want to examine other models for undergraduate and graduate prep. Professional organizations could band together in ways to support each other (maybe merge together as one????) We need to be fearless in order to get where we want to go.
Table 11 & 12 ***Best practices for current competency assessment***	Large variety of assessment tools available that are local Concern: Reliance on assessment of students by volunteers Creates: Issues of reliability and validity **Sense of urgency: Develop a mechanism to define and then assess competency *No need to reinvent the wheel, use our collective knowledge and experience to build and address <u>urgent need</u>*	There is a large variety of assessment tools that people use. Our concern is on reliance on students as volunteers. We need to develop a mechanism to define and then assess competency. We also don't need to reinvent the wheel: why not use models already available? Develop Task force/ad hoc committee: find out what is available and merge together so everyone has access to it.
Table 13 ***Shortening Program***	- Some administrations are wanting to shorten programs to 3 years - Needs to be more standardization to make it work (curriculum) - Needs to be a 'guiding light' - Rethink curriculum – does everything need to be there/a full semester class? - Would 3-year program attract more applicants? - Written and clinical comps after the 1st year - What are students getting from program during 4th year?	There would need to be more standardization in place to make this work. We need to work on developing core curriculum components. We need a guiding light to make this happen. We need to re-think the curriculum: does everything in there need to be there—especially considering evolving technology? Could outdated subjects be eliminated/shortened? Would 3-year programs attract more qualified applications? One of the current 3-year programs has written and clinical exams after 1st and 2nd year. What are students getting from their program during 4th year to justify paying tuition? What is happening at the state level that would affect making changes to curriculum?

Table #	Verbatim transcriptions of flip charts generated during table discussions	Summaries of table report outs
	- What barriers at university or state level?	
Table 14 ***Guiding Coalition for Audiology Education***	3 Voices – so can't move forward Try to find commonality for greater good 3 organs need to come together Accreditation is part of this – waster of effort and $ to continue this Fewer difference than commonalities Pool resources – all about $$$ Start a new organization *audiology education and externships Funding fr/ASHA+AAA+ADA if consensus then move ahead Leaders of 3 orgs need to sit down and discuss operationalizing outcomes of this summit and ** continue the discussion** Need to be able to carry out what table 10 decides _____ Undercurrent is not good _____ CCC-A issue- requiring preceptor for 4th yr to have CCC-A is not approp. _____ Licensure laws are all different _____ Figure out the model for AuD Educ. That we want – expect licensure will follow _____ Consensus on outcomes is most critical/urgent _____ Need to agree on how to measure competencies _____ Final outcome measure - Board Certification? - State Board Exam? - Praxis? Low cost way to "add enhance to Praxis" _____	Creating a new coalition is another stepping stone to bringing professional organizations to common ground. We need to create a coalition for audiology education. The fact that we have all these people in this room proves that we have come a long way! We need a new coalition: a group to continue these discussions and operationalize them. This group wouldn't be a group to dictate what programs would look like, but rather to assess the outcomes of the training. Perhaps this could be a group would implement outcome assessments. We won't come up with one model of education, but hopefully we will come up with one national model to assess outcomes. Our group is very fiscally conscious. How can we do this? We need to work with praxis, perhaps that could be used to measure outcomes. One way to measure clinical competency would be to create standardized patients. We could write standardized patient cases that could be video-taped and assessed on a national level. For those that don't have standardized patients, these could be done remotely.

Table #	Verbatim transcriptions of flip charts generated during table discussions	Summaries of table report outs
	PRECEPTORS INVOLVED, NEED COMMITTEE TO CREATE CASES AND BENCHMARKS ASSESS VIA > TELEMEDICINE? DO @ INSTITUTIONS?	

FURTHER CONSENSUS | 2-2:15

Final Polls | Participant Generated

The following poll questions were generated by ad hoc committee members in response to major issues raised and to the previous poll results.

POLL RESULTS | PARTICIPANT GENERATED

Polls answered by text message from participants' personal devices. Final poll results were displayed on the screens in real-time.

For unformatted Poll Results See Appendix 2

1. As an outcome measure for clinical training, should we move towards…

   A – Competency-based evaluations **64%**
   B – Hours-based student evaluations **1%**
   C – Combination of competency-based and hours based-evaluations **34%**

2. What is the urgency of expanding our scope of practice to accommodate the changing demands of our healthcare system?

   A - Very Urgent **44%**
   B - Somewhat Urgent **37%**
   C - Not Urgent **13%**
   D - Not Important **6%**

3. Action on which topic would have the most impact on the profession?

This poll was conducted as a multi-vote where each participant voted for their three top priorities. Final Tally numbers below

Option	N
A: Standardization of externship process and training	13
B: Quality control of externship sites	22
C: Preceptor qualifications	8
D: Student debt/ROI	12
E: Student training/readiness	43
F: Mandatory preceptor training	5
G: Explore residency or other post-graduate national database of clinical national database of clinical externship sites	46
H: Vision—"Skate to the puck"	58
I: Measuring outcomes in terminal competency and best practices for competency assessment	33
J: Shortening programs w/o sacrificing quality	18
K: Guiding coalition	21

Impact Ranking | Participant Polling

MOST IMPACT	-Vision -Standardization of externship process and national database of clinical externship sites -Student training/readiness -Measuring outcomes in terminal competency and best practices for competency assessment
IMPACT	Quality control of externship sites -Guiding coalition -Shortening programs w/o sacrificing quality
LEAST IMPACT	-Explore residency or other post-graduate training -Student debt/ROI -Preceptor qualifications -Mandatory preceptor training

FINAL COMMENTS | 2:15-3:25

Open Mic | Participant Speakers

For the sake of time and efficiency participants were urged to keep comments brisk and deep.

- We need to get preceptors involved, but why haven't we been talking about getting students involved? Students are foundations of the future of Audiology so we need to include them in the discussion.
- Related to the first poll question:
- Those of you who are for competency only, would you be ok with having 0 hours? Competency outweighs hours, but if you completely ignore hours…there must be a minimum. People have different definitions of what partially competent means.
- Competency far outweighs hours. If we focus on process rather than the outcome, we risk falling short. If we stay focused on the outcome and leave the processes to the programs, we could find better ways of meeting outcomes while also meeting individual needs.
- We need independent evaluation of competency.
- I trust my colleagues that no one would ever equate 0 hours, 1 patient, 2 patients with competency…if we don't trust our colleagues, then we must assign a number of hours.
- How you define and measure competency is very important. Educator preparation is defining and measuring competencies. what is competency, how do we measure it, what are the tools used to assess the competency, is there independent assessment of competency?
- Before we throw out counting hours, we need to really define what we're talking about.
- There have been examples of students who have a huge number of hours but no experience in certain areas. If we move toward a competency based model we could better assess competency in many different areas.
- "Cases" would be a better measure…minimum number of cases. Competency should include number of hours or cases.
- As a preceptor: A lot of this is just needing full disclosure. Preceptors need the data so that they can prepare for what areas students need to gain competency in. Students are often good at measuring their own competency—their own strengths and weaknesses.

- Can a student see the patient through from beginning to end including interpreting the data and counseling the patient. It takes real competency to interpret data and go to the next step. This needs to be an outcome that were striving for.
- Student should do self-evaluations, asking themselves questions like: do I need supervision with technical abilities? Do I need help interpreting?
- Two levels of competency:
  1)Technical level: can you hook a patient to an ABR unit, etc.
  2) Now that you've got the information what are you going to do it? The knowledge of how you handle information for interpretive decision making
- **Q:** Speaking to the standardization of externship process including application: for those that didn't think this is a priority, please explain your reasoning.
  A:
  - I want to see the process; I need to see the model.
  - A good idea in terms of standardization would be to standardize the earliest dates rather than final deadlines.
  - Academic programs are all on different calendars…from a pragmatic perspective, how could a standardized application process work?
  - If we are going to standardize the process the first thing we need to do is standardize schedules, but we also need to decide if they are going to be paid or not, because it's not an even playing field.
  - Standardizing the externship is not super urgent because we haven't really defined what the outcome we are trying to achieve is.
  - We have so much to figure out in terms of the vision of where we want to go in improving education, it seemed like a band aid solution.
  - If we do anything, I'd like to see us fix the affiliation problem.
  - When you talk about standardization, as an externship site, we respect that institutions are on different academic calendars—we'd love to work on a common timeline. If you're thinking about standardization think about all the forms and deadlines on the preceptor end. It's equally as important in the standardization conversation.
  - As training programs it isn't our place to insist on standardization.
  - Externship is a very inequitable experience for students across country. It's a real disservice to students. But standardization isn't necessarily going to resolve these inequities.
- These same issues were discussed in 2009; we are no closer today than we were. What are the obstacles, from your program's perspectives, to achieving standardization?
  - People/programs do not want to give up their individual forms. We are very stubborn about changing that type of thing.
  - The first step is standardizing the first 3 years—then we can work to standardize externships.
  - The biggest barrier is that we have abdicated ¼ of our degrees to volunteers. Energy should not be put into preserving the externship as it is now. Energy should be: is a student competent to be an Audiologist? How to work toward that.
- What will the profession look like in 25 years? Looking at models of optometry, dentistry, etc.
- We should be looking at more of an aural rehabilitation or a medical model.
- Vision:
  Training that we give students in first 3 years
- If we want to expand the scope of our practice, we need to expand undergraduate training. Are the students that were bringing into the graduate program the best for the program?

- We fear rigor! If we are going to work toward competency, why are we trusting people in the field (volunteers/preceptors) to graduate our students? It should be OUR responsibility to graduate our students.
- Who chooses audiology depends on more than what we can decide in this room: it's not an easy answer.
- One of the ways we can achieve more consistency among programs is to have fewer AuD programs. optometry and dentistry have significantly fewer programs. We are spreading our resources so thin that it is affecting the competency of Audiology students.
- We are a very small profession, but there is something to be said for looking at a consortium model. A way to regulate and provide a more standardized experience.
- We need to be going into stem programs in high schools and talking about audiology as a viable option for students considering health care. A great majority had never heard of audiology before. Find ways to pull into high schoolers so that, in turn, we can get more undergraduates interested. Build awareness of what we do throughout scope of the practice earlier.
- If we are thinking about a vision, comparing ourselves to optometry and dentistry, are we really preparing students for where the profession is going? In all the programs around the country? Do we have the curriculums in place?
- We need to define where the future is going in all different areas. We need to ask experts in each area from the associations (ASHA, AAA, etc.) to talk about the future of the field.
- There is a downward pressure on reimbursement. Research shows that how good you are as a practitioner is measured by what impact you had on the quality of life of the individual patient. We will have to improve our outcomes based on quality of life improvements—it's what we will be judged on. We practice according to how we are paid. Our ability to thrive and grow as a profession will be determined on what we bring to the table.
- We need to be involved in Bundling plans, where healthcare packages are put together. Not everyone is positioned in a medical center, but we do need to think about that—we want to be part of a cochlear implant bundle, a heading loss bundle, etc. We need to be in those conversations.
- In regards to conflicts between organizations: the truth is, we do a lot together and think a lot alike. We work hard together. We may see conflict, but I have been very impressed by the lack of conflict in what we've been doing. Props. We do a lot of good together. Thanks to ASHA for organizing this—it moves us all forward.
- I don't know what the next steps are. We have an hour left, and we are still not moving forward. We need to figure out WHO are the drivers of these changes. Accreditation bodies? Associations? If we don't move beyond identifying the problems we have wasted a lot of time and money to get nowhere. It is incumbent on all the academic programs here to give a little—you must figure out how to give a little in all these areas in order to move into the future together and achieve our goals. I don't want to be in the same meeting in 5 years. Please—on behalf of our profession—make that change, make that commitment.

A Call to Lead | Bob Devlin

This is a time for someone to step up to lead on these key issues. If not somebody from this room, then who? If not now, then when? The challenges/problems should not keep us from doing what is right. I invite anyone who feels so moved to step forward and take charge. Leaders make things happen that wouldn't happen otherwise. You are the leaders of the profession.

Final Conversations | Open Mic

- This is all about accreditation. Those are the bodies that should be setting the standard. It's great that people are signing up, but to me it is vague. We have bodies that are set up to do this, and something

has failed—this is the elephant in the room—this all goes back to appropriate rigorous accreditation processes.

- One of the issues is that the accreditation standards are written in such a way to give programs a lot of flexibility for setting standards. Do we, as a profession, have an appetite to ratchet things down with regards to programs? If we don't, we're not going to get there.
- In many ways we have a room full of people here who have all been leaders in many capacities—it has to go beyond here, it has to be the entire audiology community! It can't be the same people all the time, because people lose fire. It's the same people who are always leading, but it could be everyone. We need to find ways to light the fire under our whole community.
- Challenge and invitation to other west coast institutions from Barbara Cone to form a West Coast Coalition!
- In regards to the standardizing committee: programs must agree to follow committee's recommendations in regards to: timeline, database, matching process, forms.
- We need support from Accrediting agencies—they need to follow standardizations at the evaluation level. Now we have 75 different evaluation forms.
- We can't all have the same processes to get there, but we can have the same outcomes.
- While we are all different, any of us that are doing placements face the same challenges. We are already united on a lot of levels. I think we can do this. It must come from a higher body—that's how you're going to get the off campus sites to buy into it.
- We need a group to develop a standardizing assessment tool for student competence.
- Suggestion: lets identify 3-4 programs as exemplars, 3-4 externship sites as exemplars—diverse ways of doing things with good outcomes.
    - Make sure we have a diversity of what those programs are. For example, urban vs. rural—we need regional diversity. Not all our programs have the same problems/concerns.
- We are all in the same room today: we need a commitment from national organizations here to consider a coalition for addressing the issue of the standardization process that we've been talking about. It will take members of many groups—must be an inter-organizational group.
- As a starting point, CAuDP can work on standardizing student evaluation forms.
- We have two accreditation bodies that should get this together! We, the academic programs, cannot fix this! We need to get the accrediting bodies together and get this done!! We need rigorous accreditation that holds everyone to the standard—if you can't reach the standard, then you don't get the accreditation.
- It is our responsibility to make the accreditation process better. We need to serve on the accreditation boards and visit sites.
- We still haven't defined competency. Until we define that, then accreditors can't define that either. If we don't do it the right way, the federal government will intervene. We need to have standards, but we need to have some ability to define what we're looking for.
- Ending on a positive note: we are close. We are moving in a good, positive direction!

CLOSING REMARKS | 3:28-3:30

Thanks and Farewell | Ruth Bentler

Our discussion guidelines have been met! Especially in terms of being kind. Those of you who put your names down for committee work, you will be called upon! Thanks to ASHA for sponsoring the summit!

APPENDICES

Appendix 1 | Poll 1 Results

1. What is the urgency in creating a national data base of clinical externship site?
    1 - Very Urgent: 48%
    2 - Somewhat Urgent: 28%
    3 - Not Urgent: 23%
    4 - Not Important: 1%
2. What is the urgency in creating national database for clinical externship sites
    1. Very Urgent: 49%
    2. Somewhat Urgent: 27%
    3. Not Urgent: 23%
    4. Not important:
3. Should we explore mandatory preceptor training?
    1 - Yes: 54%
    2 – No: 46%
4. Are you in favor of exploration of a residency model or other postgraduate training?
    1 – Yes: 34%
    2 – No: 66%
5. What is the urgency in standardizing the application process (including application deadlines) for clinical externship sites?
    1. Very urgent: 56%
    2. Somewhat urgent: 31%
    3. Not Urgent: 13%
    4. Not important: 0%
6. Keeping with the "skate to the puck metaphor", we are ready, as a profession, to plot our course for the next 10, 15, 20 years?
    1 - Strongly Agree: 10%
    2 - Agree: 19%
    3 – Disagree: 53%
    4 - Strongly Disagree: 19%

Appendix 2 | Poll 2 Results

1. As a outcome measure for clinical training should we move towards…

Option	Responses
Competency-based student evaluations	59
Hours-based student evaluations	1
Combination of competency-based and hour-based evaluations	30

2. What is the urgency of expanding our scope of practice to accommodate the changing demands of our healthcare system?

   1 – Very Urgent: 40
   2 - Somewhat Urgent: 33
   3 –Not Urgent: 12
   4 – Not Important: 5

Option	Responses
Standardization of the externship process (including application) and national database of clinical externship sites	28, 11, 9 **(48)**
Quality control of externship sites	5, 11, 6 **(22)**
Preceptor qualifications	2, 1, 5 **(8)**
Student debt/ROI	5, 4, 3 **(12)**
Student training/readiness	12, 16, 12 **(40)**
Mandatory preceptor training	1, 2, 2 **(5)**
Explore residency or other post graduate training	4, 5, 4 **(13)**
Vision-"Skate to the Puck"	24, 22, 8 **(54)**
Measuring outcomes, terminal competency and best practices for competency assessment	4, 10, 19 (**33)**
Shortening programs w/o sacrificing quality	4, 4, 10 **(18)**
Guiding coalition	3, 6,12 **(21)**
Student recruitment, retention, satisfaction	0, 0, 4 **(4)**

Appendix 3 | Panel Questions, Complete List

1.What are the sources of funding for residency programs?
2.Do you have a matching program—and do all students who want a residency program get one?
3. If residency is optional, how much clinical training is obtained in the program? Is this determined by hours or competency?
4. Q for PT: Are graduates who choose not to pursue a residency sufficiently educated to perform competently in their entire scope of practice?
5. Q for MD: How did different professional organizations (D.O., M.D.) Finally come together to agree to ONE accrediting body/one set of standards?
6. PT & OD: Salary Expectations: What is the income differential between those that are residency trained and those that are not?
7. The starting salary for those professions shared today are significantly higher than audiology, which makes student ROI significantly less of a burden. How do we go about improving our current situation?
8. OD & PT: How many residencies are available in private practice environments?
9. OD & PT: What are possible limitations to not making residency required? Any benefits to not requiring it?

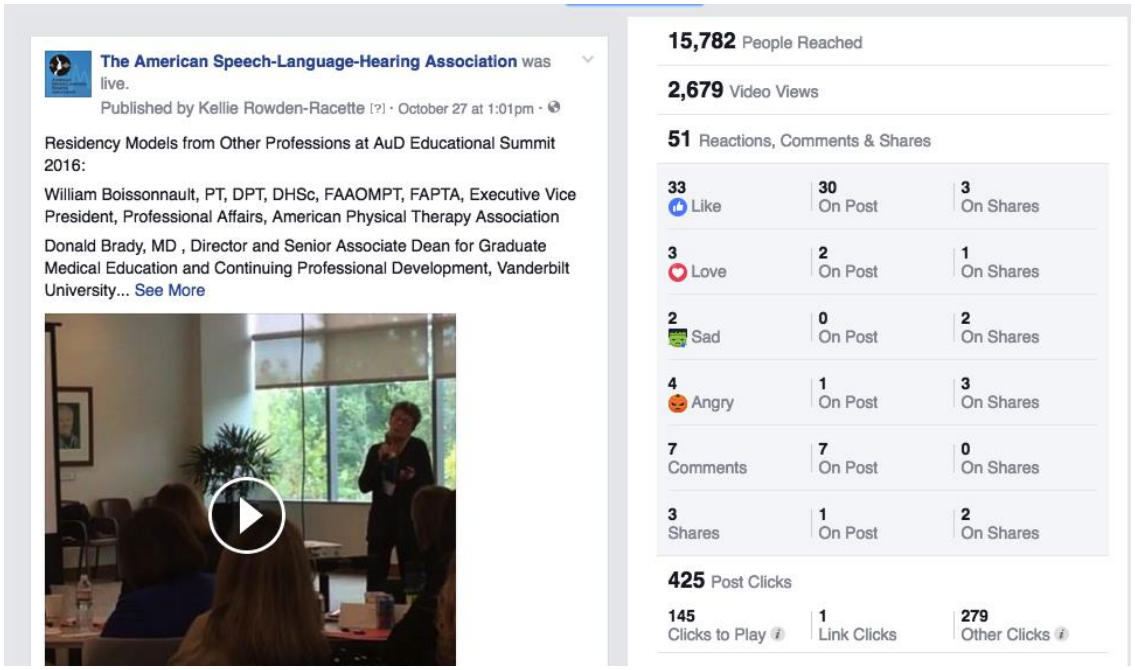
10. PT & OD: What undergraduate degree do you require as prerequisite for the professional degree? And what is your clinical training sequence in your graduate program?
11. MD: Are smaller or more rural clinics able to sustain residency programs, and how are they able to sustain the programs?
12. Who established the outcomes of residency programs and who assesses/measures the outcomes?
13. What is in it for the residency sites?
14. OD: If a student doesn't get accepted into the residency program initially, can they apply the next year?
15. Hospitals are paid to take residents so of course they sign on, go through accreditation, etc. This is a "how" issue but is it a deal breaker in setting up a "residency" and expecting sites to go through an accreditation (standards) process?
16. Is there a relationship between the accrediting bodies: residency site and training site?
17. PT: Do you have any evidence that people who complete advance training have better patient outcomes?
18. How much hands-on clinical experience do Optometry students get prior to graduation?
19. PT: The application process for PT residency status is time consuming and costly, especially for single individual practices. Why do they participate? What is in it for them?
20. MD: What is the percentage of MDs that do not complete residency—and if not complete, is it more likely to be by life choices or because they don't get in?
21. OD: With 80+ graduates per class, how do you find placements for all those students?
22. PT: What is the general/average number of faculty at universities with PT degrees? Did this number change with the implementation of the doctorate?
23. What is the difference between residency and fellowship?

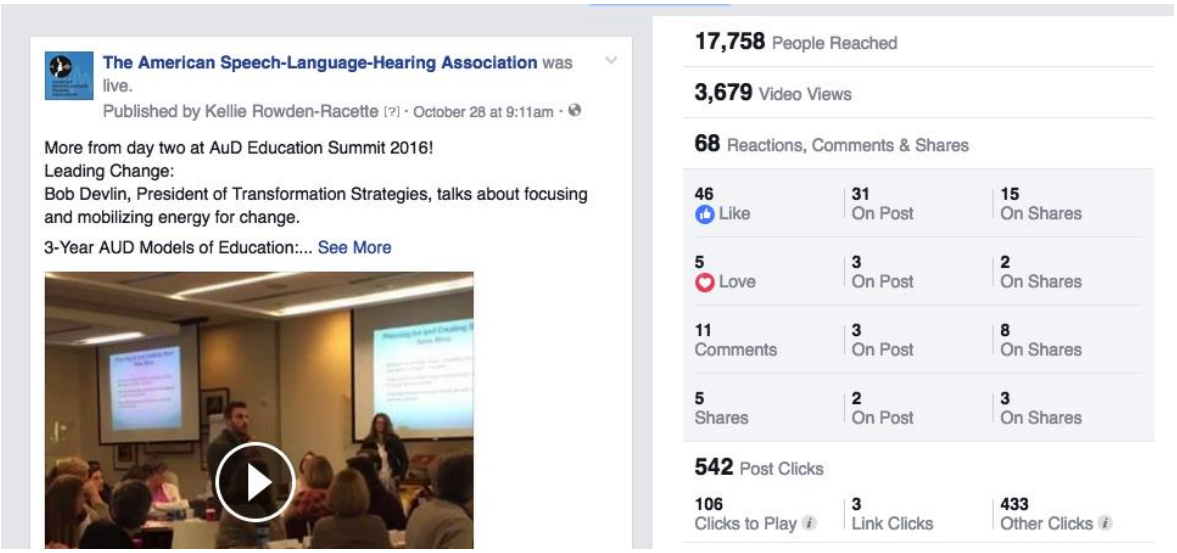
Appendix 4 | Complete Notes from Visioning Group

- Be primary care providers for hearing, balance, and tinnitus care – what do we need to know to be that?
- Speaks to different model of education
- Perhaps more like optometry – increase basic sciences at UG and grad level
- Need to understand difference between CSD and other
- Potential UG models of curriculum
- HA Model for audiology my disappear
- Sell your services – not a product
- Take control of profession
- Expand scope of practice
- Are there different kinds of audiologist – diagnostic vs. therapeutic
- Look to Psych, look to Dentistry
- Generalist vs. specialists
- Visions aligned – PCP vs. intervention
- Online Has. Dementia, aural rehab
- To meet the need of hearing loss, can we produce enough generalists?
- Audiometrics and HA relegated to technicians
- Audiologists may prescribe, , myringotomy, etc.
- Is there a way to protect turf in HA's?
- What is our role in health care? We are experts in hearing.
- In 25 years, will be implantables, molecular therapy, pharmaceuticals
- Our current model will disappear
- Value is understanding brain function and prescribe system
- Like optometry, we will prescribe
- >50% don't know enough about where will go
- 5 things that we need to do in 5 years
- Greater technology applications
- Prescribing systems (tech & systems & meds)
- Simple surgeries, management (tinnitus, balance, etc.)
- PA/Audiologist model perhaps
- Are we willing to expand scope of practice to meet the needs of health care
- Barriers to expand scope of practice
    - State licensure
    - Physicians
    - Major ally could be insurance
    - Current education model
    - Reimbursement – state by state
    - Medicare
    - # of audiologists to others
    - 3 orgs need to come together
- Launching outcomes measurement system (ASHA)
- Need more audiologists
- Profession need to remain attractive
- Be fearless about changes that need to be made
- Address reimbursement
- Public awareness
- Where we recruit, timing of recruitment
- Survey @ UG and Grad requirement for other professions (dentist, optometry for example)
- Look at costs of other models
- All 3 orgs band together
- Training to support expanded scope of practice
- Talk to optometry and dental orgs for strategic partnerships

- Accreditors need to be drivers of change
- One singular voice of accreditation
- Firmly establish the vision – need a group to do this
- Set objectives and goals
- Orgs- publicize how well they work together – could we merge ever?

Appendix 5 | Facebook Live Viewership Data




The American Speech-Language-Hearing Association was live.
Published by Kellie Rowden-Racette [?] · October 28 at 9:11am ·
More from day two at AuD Education Summit 2016!
Leading Change:
Bob Devlin, President of Transformation Strategies, talks about focusing and mobilizing energy for change.
3-Year AUD Models of Education:... See More
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68 Reactions, Comments & Shares
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31 On Post
15 On Shares
5 Love
3 On Post
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8 On Shares
5 Shares
2 On Post
3 On Shares
542 Post Clicks
106 Clicks to Play
3 Link Clicks
433 Other Clicks