



**Final Report  
Ad Hoc Committee on Graduate  
Education for Speech-Language  
Pathologists**

**March 2020**

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## Executive Summary

By resolution (BOD 23-2018), the Ad Hoc Committee on Graduate Education for Speech-Language Pathologists was established in 2018 and submitted the final report in March 2020. The Committee had three over-arching questions that they were charged with addressing, which are listed below along with the Committee's major conclusions regarding each of these questions.

**Question #1** – What are the rationale and data indicating whether optional, post-entry-level clinical doctoral programs in speech-language pathology in the United States should be accredited? (See Section IV.)

Relative to Question #1, the Committee concluded that the number and gravity of the risks associated with not accrediting optional, post-entry-level clinical doctoral programs in speech-language pathology far outweigh the benefits of continuing without accreditation. The targeted revenue-to-expense ratio of 40% for the CAA could be achieved initially if 12-14 programs applied for and were later granted accreditation. With eight extant optional, post-entry-level clinical doctoral programs in speech-language pathology and another five implementing a plan to begin offering the degree in the 2020-2021 academic year and another seven the year after, it is imperative that we act soon. Accreditation is needed to ensure the adoption of standards and promote continuous quality improvement in these programs, and to align the educational outcomes so that it is clear what knowledge domains, skills and competencies these graduates have acquired—and what, in general, they are prepared to do. Working now on accrediting optional, post-entry-level clinical doctoral programs in speech-language pathology will stave off having to align a greater number of potentially even more diverse programs in the future.

**Question #2** – What are the rationale and data indicating what is needed to adequately prepare future speech-language pathologists (SLPs) to enter the profession? (See Section V.)

Relative to Question #2, the Committee concluded there is much need to reexamine the current model of entry-level education for SLPs. The master's degree became the entry-level degree in 1963. Since then, the scope of practice has changed significantly, but the educational model has not. Based on analyses of the surveys and focus groups reported in this document, there appears to be widespread concern that students may not be consistently prepared to enter practice nor to deliver services across the full scope of practice across the lifespan. In 2013, 33% of master's programs in speech-language pathology reported that faculty have concerns about the department's capacity to teach across the full scope of practice; in 2019, that percentage increased to 47% of master's programs. In 2013 and 2019, the curricular areas for which master's programs reported having limited faculty expertise included all of the "Big Nine" areas listed in the [\*2020 Standards for Certificate of Clinical Competence in SLP\*](#) for which demonstrated current knowledge of the principles and methods of prevention, assessment, and intervention is required for certification. Securing enough quality clinical placements is another pressing challenge facing many academic programs. The Committee identified six areas that would be key targets to reexamine to improve educational outcomes, including: (a) content and pedagogy of degree programs; (b) competency-based models; (c) clinical experiential component; (d) role of the undergraduate degree; (e) variability across academic programs and clinical placements; and (f) need to instill lifelong learning and better

preparation in evidence-based practice and other areas critical to the future of work. These factors compel further consideration of how entry-level education for SLPs can be improved in the future.

**Question #3** – What input do ASHA members and other key stakeholders have regarding (a) which aspects of the current model of entry-level education for speech-language pathology in the United States are serving the profession and the public adequately now, and in the near future, and (b) which aspects are not? (See Section VI.)

Relative to Question #3, the Committee documented that there are aspects of the current model of entry-level education for speech-language pathology that multiple stakeholders identified as serving the profession and the public well and others that are not adequately serving the profession nor the public. Several challenges were identified and multiple areas were suggested to be in need of improvement by the many stakeholders who participated in focus groups or responded to surveys fielded on behalf of this Committee. As indicated by the evidence reviewed in this report, changes are indicated, but first, more input is needed from a larger group of stakeholders to determine which changes are needed to address current challenges and improve entry-level education for SLPs. As research and deliberation about this topic continue, it will be important to anticipate how educational preparation could be adjusted to better align with the future of learning and the future of work.

**The Committee made three recommendations** (see Section II).

**Recommendation #1** – The Committee recommends that the ASHA Board of Directors request that the CAA undertake deliberation of accrediting optional, post-entry-level clinical doctoral programs in speech-language pathology (see rationale in Section IV).

**Recommendation #2** – The Committee recommends that the ASHA Board of Directors appoint a planning committee charged with advising the ASHA BOD about how the questions posed in Recommendation #3 should continue to be addressed. The Committee recommends that these efforts continue to focus on how the future of learning and work could impact the education of entry-level SLPs in the future.

**Recommendation #3** – The Committee recommends that work continue with a larger number of stakeholders, including representatives from the CFCC, CAA, the National Student Speech-Language-Hearing Association (NSSLHA), and CAPCSD, to further address the following questions:

- What is needed to adequately prepare future SLPs to enter the profession?
- What competencies are needed to enter speech-language pathology practice, and how should they be acquired and evaluated?
- Which aspects of the current model of entry-level education for speech-language pathology in the United States are serving the profession and the public adequately now, and in the near future, and which aspects are not?
- Are there changes to the current model of entry-level education that would likely help to address challenges, gaps or unmet needs that have been identified?

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# **Ad Hoc Committee on Graduate Education for Speech-Language Pathologists — Report to the ASHA Board of Directors**

**Submitted to the Board of Directors on March 31, 2020**

## **I. Introduction**

By resolution (BOD 23-2018), the Ad Hoc Committee on Graduate Education for Speech-Language Pathologists was established, partly in response to the Council of Academic Programs in Communication Sciences and Disorders (CAPCSD) 2017 resolution, which was forwarded to ASHA’s Vice President for Academic Affairs in Speech-Language Pathology, Lynn Williams, in October 2017. The CAPCSD resolution requested that ASHA examine whether ASHA and the Council of Academic Accreditation in Audiology and Speech-Language Pathology (CAA) should consider setting educational standards and establishing an accreditation program for optional, post-entry-level clinical doctoral programs in speech-language pathology. In response to the CAPCSD resolution, ASHA 2017 President Gail Richard requested that Lynn Williams convene a call with key stakeholders to begin a preliminary discussion and to recommend next steps.

The call occurred on December 13, 2017, and included the following stakeholders: Elizabeth Crais (2019-2021 Vice President for Academic Affairs in Speech-Language Pathology), Marie Ireland (2018-2020 Vice President for Speech-Language Pathology Practices), Annette Hurley (2017 Chair of the CAA), Jennifer Friberg (2018 Chair of the CAA), Vivian Sisskin (2017 Chair of the Council for Clinical Certification in Audiology and Speech-Language Pathology [CFCC]), Lynn Flahive (2018 Chair of the CFCC), Lynne Hewitt (2017 Chair of the Academic Affairs Board), Glen Tellis (2018 Chair of the Academic Affairs Board), Loretta Nunez (ASHA Director of Academic Affairs and Research Education), Patti Tice (ASHA Director of Accreditation in 2017), Todd Philbrick (ASHA Director of Certification), Lemmietta McNeilly (Chief Staff Officer for Speech-Language Pathology), and Margaret Rogers (Chief Staff Officer for Science and Research).

In addition to considering the CAPCSD resolution, these participants discussed what would happen if the entry-level degree for speech-language pathology shifted to the clinical doctorate in the future and what the implications might be relative to the question of whether an accreditation program for optional, post-entry-level clinical doctoral programs in speech-language pathology should be developed. The consensus of those on the call—and from subsequent discussions with the CAA (February 2018), the Speech-Language Pathology Advisory Council (March 2018), and the CAPCSD Board of Directors (April 2018)—was that these questions should be addressed in tandem because accreditation of entry-level versus post-entry-level degree programs could entail significantly different kinds of efforts and deliverables.

## I.A. Charge Framing the Committee's Work

In May 2018, the ASHA Board of Directors authorized the formation of the Ad Hoc Committee on Graduate Education for Speech-Language Pathologists (AHC-GESLP) and charged this committee with gathering data and synthesizing information on the following questions.

**Question #1** – What are the rationale and data indicating whether optional, post-entry-level clinical doctoral programs in speech-language pathology in the United States should be accredited?

**1a** – What are the risks to the profession of speech-language pathology and/or the public if post-entry-level clinical doctoral programs in speech-language pathology continue to be unaccredited, and what would be the benefits of accrediting these programs?

**1b** – What are the human and financial resources that might be needed to establish an accreditation program for optional, post-entry-level clinical doctoral programs in speech-language pathology—and, also, to conduct ongoing monitoring of such programs?

**1c** – How could the clinical doctorate in speech-language pathology best align with other degrees in the continuum of service delivery?

**Question #2** – What are the rationale and data indicating what is needed to adequately prepare future speech-language pathologists (SLPs) to enter the profession?

**2a** – Which aspects of the current model of entry-level education for speech-language pathology in the United States are serving the profession and the public adequately now, and in the near future, and which aspects are not?

**2b** – Are there changes to the current model of entry-level education that would likely help to address any gaps or unmet needs that have been identified?

**2c** – What are the benefits and risks to the profession of speech-language pathology and/or the public if the current model of entry-level education for SLPs remains unchanged in the near future?

**2d** – What are the benefits and risks to the profession of speech-language pathology and/or the public if the current model of entry-level education for SLPs (or some aspects of the current model) is changed in the near future?

**Question #3** – What input do ASHA members and other key stakeholders have regarding (a) which aspects of the current model of entry-level education for speech-language pathology in the United States are serving the profession and the public adequately now, and in the near future, and (b) which aspects are not? The perspectives of ASHA-certified SLPs will be sought from those who work in

- school settings;
- preschool and early intervention settings;
- private practice settings;
- health care settings; and
- universities.

The perspectives of other key stakeholders who are not necessarily ASHA-certified SLPs will be sought—in particular, those stakeholders from

- university academic and clinical faculty and program directors in communication sciences and disorders (CSD) departments;
- administrators (e.g., deans, provosts) in university settings;
- administrators and supervisors from practice settings in which ASHA members work; and
- students enrolled in speech-language pathology master’s degree programs, clinical doctoral programs in speech-language pathology, and undergraduate CSD programs.

Furthermore, the ASHA Board of Directors charged the AHC-GESLP with addressing any other questions that they deem important, summarizing the data gathered about the current and alternative models of graduate education for preparing SLPs and outlining possible next steps in a report to be submitted to the ASHA Board of Directors (BOD).

## I.B. The Committee’s Work

The AHC-GESLP met in-person in September 2018 and in June 2019. The Committee also worked via conference calls to address the questions posed in the charge. The Committee started by reviewing three prior ASHA committee reports on the optional, post-entry-level clinical doctorate in SLP. These are summarized in Section III. The AHC-GESLP reviewed related survey and focus group reports collected between 2012 and 2019. To assist the AHC-GESLP in accomplishing their charge, five surveys were fielded, five focus groups were conducted, and supplemental questions were added to the 2018-2019 *CSD Education Survey*. Additional information was distilled from data and open-ended responses obtained through the 2020 *Public Policy Survey*, 2017 *Health Care Survey* and the 2018 *Schools Survey*.



The AHC-GESLP identified six areas that needed in-depth exploration and focused work plans to help the committee accomplish its charge. Accordingly, the work was divided, and six subcommittees were formed: Educational Models; Competency Models; Challenges with the Current Educational Model for SLPs; Surveys and Data; Certification; and Accreditation. Each subcommittee was responsible for identifying the questions to be addressed, additional data needed to address those questions, and work plans. Monthly conference calls were held during the formulation and implementation stages so that the full AHC-GESLP could stay informed and collectively help to advance the work of each subcommittee. Each of the six subcommittees prepared a report. These were made available to the full AHC-GESLP prior to the second in-person meeting so that deliberations could be informed by relevant information, data, and considerations of regulatory policies, educational models in other disciplines, and stakeholders' perceptions about challenges with the current educational model for preparing entry-level SLPs. Information from these subcommittees has been integrated into this final report and each of the six subcommittee reports are appended (see Appendices A-F).

Appendix A - Educational Models Subcommittee Report

Appendix B - Competency Subcommittee Report

Appendix C - Challenges with the Current Educational Model Subcommittee Report

Appendix D - Surveys and Data Subcommittee Report

Appendix E - Certification Subcommittee Report

Appendix F - Accreditation Subcommittee Report

This final report provides an overview of key data, stakeholder perspectives, information about the regulatory and educational landscape, and the conclusions and recommendations formed by the AHC-GESLP. The Committee's recommendations are presented first in Section II. Then, in Section III, an overview is provided of the three prior ASHA committee reports on the clinical doctorate in speech-language pathology. In Sections IV, V, and VI, data syntheses, financial modeling of an accreditation program, and the conclusions of the AHC-GESLP are organized relative to each of the three superordinate questions posed in the Committee's charge (see Section I.A.). Section VII provides a summary of the conclusions drawn regarding the current model of entry-level education in speech-language pathology.

## II. Recommendations

The AHC-GESLP reviewed extant data and reports and obtained new information from several surveys and focus groups that were conducted to elucidate how certified SLPs, faculty, CF supervisors, students, administrators, and employers view issues related to the questions of (a) accreditation for optional, post-entry-level clinical doctoral programs in speech-language pathology, (b) how well the current model of entry-education for SLPs is serving the profession and the public; and (c) what is needed to adequately prepare future SLPs to enter the profession. In formulating the following recommendations, the Committee focused on the strengths of the current educational model for SLPs as well as on emerging and longstanding threats to the quality of entry-level education and the future viability of the profession. The AHC-GESLP makes three recommendations, which are introduced below to lay a foundation for scaffolding the considerable amount of information contained in this report.

**Recommendation #1** – The Committee recommends that the ASHA Board of Directors request that the CAA undertake deliberation of accrediting optional, post-entry-level clinical doctoral programs in speech-language pathology (see rationale in Section IV).

**Recommendation #2** – The Committee recommends that the ASHA Board of Directors appoint a planning committee charged with advising the ASHA BOD about how the questions posed in Recommendation #3 should continue to be addressed. The Committee recommends that these efforts continue to focus on how the future of learning and work could impact the education of entry-level SLPs in the future.

**Recommendation #3** – The Committee recommends that work continue with a larger number of stakeholders, including representatives from the CFCC, CAA, the National Student Speech-Language-Hearing Association (NSSLHA), and CAPCSD, to address the following questions:

- What is needed to adequately prepare future SLPs to enter the profession?
- What competencies are needed to enter speech-language pathology practice, and how should they be acquired and evaluated?
- Which aspects of the current model of entry-level education for speech-language pathology in the United States are serving the profession and the public adequately now, and in the near future, and which aspects are not?
- Are there changes to the current model of entry-level education that would likely help to address challenges, gaps or unmet needs that have been identified?

### III. Overview of Past Committee Reports

Since 2010, there have been three ASHA committees previously charged with making recommendations regarding the accreditation of optional, post-entry-level clinical doctoral programs in speech-language pathology. Their three prior reports informed and framed the work of the current AHC-GESLP. Building upon the work of these prior committees, consistent themes emerge, including the fact that there is much need for—and potential benefit to be derived from—clinical doctoral degree programs in speech-language pathology, especially with respect to (a) making a positive difference in the quality of clinical education and clinical service delivery and (b) enhancing the professional autonomy and reputation of speech-language pathology. However, the actual impact that the emergence of the optional, post-entry-level clinical doctorate in speech-language pathology will have on the profession, and on those whom we teach and serve, depends in large part on the answer to the primary question posed to this Committee—namely, “Should optional, post-entry-level clinical doctoral degree programs in speech-language pathology be accredited by the CAA?”

The AHC-GESLP agrees with the conclusion of these three prior committees that standards should be established for optional, post-entry-level clinical doctoral programs in speech-language pathology. The work completed and recommendations made by each of these prior committees are summarized below.

#### III.A. Academic Affairs Board Report on the Clinical Doctorate in Speech-Language Pathology ([Report](#) Accepted in October 2012)

At the request of the 2010 ASHA BOD, the Academic Affairs Board (AAB) prepared a landscape report on the optional, post-entry-level clinical doctorate in speech-language pathology by examining the following:

- National and global trends regarding clinical and professional doctorates
- Description of clinical doctorates across professions
- Intended outcomes of optional, post-entry-level clinical doctoral programs in speech-language pathology
- Factors driving the emergence of optional, post-entry-level clinical doctoral programs in speech-language pathology
- Current status and projected future development of optional, post-entry-level clinical doctoral programs in speech-language pathology
- Potential threats posed by the optional, post-entry-level clinical doctorate in speech-language pathology
- Potential impact of the optional, post-entry-level clinical doctorate in speech-language pathology on the research pipeline
- Perceived value of and need for accreditation of optional, post-entry-level clinical doctoral programs in speech-language pathology

- Potential risks posed by the current lack of standards and accreditation for optional, post-entry-level clinical doctoral programs in speech-language pathology in the United States

The AAB reported that there is widespread interest in and perceived need for this degree and for an accreditation program for this degree. Their conclusions included the following:

- There is a high degree of agreement across survey and focus group respondents that there is a substantial need for and interest in post-entry-level clinical doctoral degrees in speech-language pathology among academic faculty and master’s-level speech-language pathology practitioners across school and health care settings.
- The need for the clinical doctoral degree in speech-language pathology was primarily attributable to the following:
  - The need for advanced clinical skills and specialization in speech-language pathology
  - The need for career advancement tracks in speech-language pathology
  - The need for parity with other professions
- There is a strong perceived need for accreditation of post-entry-level clinical doctoral degree programs in speech-language pathology among academic faculty and master’s-level speech-language pathology practitioners across school and health care settings.

The AAB recommended in the 2012 report that the ASHA BOD establish an ad hoc committee to conduct a feasibility study in collaboration with the CAA regarding accreditation of post-entry-level clinical doctoral degree programs in speech-language pathology. A feasibility study was recommended so that the ASHA BOD and CAA could make informed decisions about the advisability of the CAA accrediting optional, post-entry-level clinical doctoral degree programs in speech-language pathology.

### III.B. Ad Hoc Committee on the Feasibility of Standards for the Clinical Doctorate in Speech-Language Pathology ([Report](#) Accepted in November 2013)

By resolution (BOD-29-2013), the Ad Hoc Committee on the Feasibility of Standards for the Clinical Doctorate in Speech-Language Pathology (hereafter, “the Ad Hoc Committee on the Feasibility of Standards”) was established. They developed a financial model that estimated the expenses and revenue relative to establishing and maintaining an accreditation program for optional, post-entry-level clinical doctoral programs in speech-language pathology. They also reported the following information:

- Across employers, clinicians, and students, greater than 50% of respondents reported that the post-entry-level clinical doctorate in speech-language pathology would have a positive impact in these seven areas:
  - 1) Clinical service delivery
  - 2) Leadership
  - 3) Respect from clients, consumers, and other health care providers
  - 4) Specialized training
  - 5) Application of evidence-based practice as well as increased knowledge and skills
  - 6) Enhancement of prestige of the profession
  - 7) Promotion of autonomy

The Ad Hoc Committee on the Feasibility of Standards made the following recommendations:

- That ASHA initiate the development of guidelines for academic programs offering the optional, post-entry-level clinical doctorate in speech-language pathology.
- That ASHA and CAPCSD, through the *CSD Education Survey*, monitor the rate of development of such clinical doctoral programs, including the number of programs and the number of students enrolled and graduated.
- That ASHA monitor the success of guidelines use, growth of programs, financial variables, and relevant risk factors to determine when or if accreditation is warranted.

### III.C. Ad Hoc Committee on Guidelines for the Clinical Doctorate in Speech-Language Pathology (Report Accepted in August 2015; Guidelines Posted to ASHA Website in 2015)

By resolution (BOD-02-2014), the Ad Hoc Committee on Guidelines for the Clinical Doctorate in Speech-Language Pathology (hereafter, “the Ad Hoc Committee on Guidelines”) was established and charged with developing guidelines for optional, post-entry-level clinical doctoral programs in speech-language pathology. Their activities and deliverables included the following:

- In 2014, ASHA fielded an online survey on behalf of the Ad Hoc Committee on Guidelines for the Clinical Doctorate in Speech-Language Pathology to approximately 8,000 individuals—including master’s- and doctoral-level speech-language pathologists in school and health care settings, academic program directors, clinic directors (both university-based and non-university-based),

communication sciences and disorders (CSD) speech-language pathology faculty, current speech-language pathology PhD students, and speech-language pathology clinical doctorate holders.

- It was explicitly stated in the survey invitation and instrument that the survey was not collecting data to consider changing the entry-level degree requirement from a master's to a clinical doctorate but rather to obtain information about the optional, post-entry-level clinical doctorate in speech-language pathology.
- The purpose of the survey was to collect perspectives on a set of proposed knowledge and skill statements so that the most important elements of a clinical doctorate in speech-language pathology could be identified.
- After the most important knowledge and skill statements were identified, they were organized into six domains and proposed as guidelines. These draft guidelines underwent widespread peer review, which was open to the full ASHA membership. The results were incorporated into the final version.
- The ASHA BOD approved the [\*Guidelines for the Clinical Doctorate in Speech-Language Pathology\*](#) (hereafter, “the Guidelines”) as an official ASHA policy in August 2015.

## **Guidelines**

- The Guidelines cover six domains that should be addressed by all clinical doctoral programs in speech-language pathology. For each of the following components, guidelines were identified to assist programs in addressing the intended purpose of the degree. These components include:
  - *Administrative Structure and Governance*
  - *Academic and Clinical Faculty*
  - *Students*
  - *Assessment*
  - *Program Resources*
  - *Curriculum*
- Under the first component, *Administrative Structure and Governance*, the Committee concluded that “Institutions offering the degree—Speech-language pathology clinical doctoral degree programs should be housed in institutions with existing master’s in speech-language pathology programs—accredited by the Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA)—or PhD programs that serve speech-language pathologists (SLPs) in clinical research settings” (p. 2).

- Under *Students*, the Committee concluded that “Students eligible for admission to the clinical doctoral program should hold or qualify for the Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP) or the accepted credential in the country of practice. Rationale: Holding the CCC-SLP identifies the individual as ready for advanced clinical education and able to mentor others; otherwise, distinction between the master’s and doctorate is blurred” (p. 3).
- Under *Curriculum*, the essential components of the curriculum were developed based on a set of ten educational outcome domains that were identified from the survey responses to the series of knowledge and skill statements. These 10 domains were divided into two tiers (see Figure 1).
  - Tier I includes four curricular domains, which are shown in the inner circle in Figure 1. The knowledge and skills in Tier I domains are essential for the quality of the program, and all should be addressed in the curriculum.
    1. Depth of knowledge and advanced skill development in select areas of clinical practice
    2. Critical thinking and clinical problem-solving
    3. Clinical education, teaching, supervision, and mentorship
    4. Expertise in interpreting and applying clinical research
  - Tier II includes six curricular domains, which are shown in the outer rectangles in Figure 1. The knowledge and skills in Tier II domains should also be addressed in the curriculum; however, the individual knowledge and skills within each Tier II domain may be tailored to meet the strengths of individual programs and the needs of students.
    5. Professionalism and ethical decision-making
    6. Oral and written communication about the clinical enterprise
    7. Advocacy and leadership
    8. Interprofessional practice
    9. Regulatory and reimbursement expertise
    10. Service delivery in a multicultural society
  - All 10 curricular domains were deemed highly important knowledge and skills areas and key educational outcomes for the optional, post-entry-level clinical doctorate in speech-language pathology.

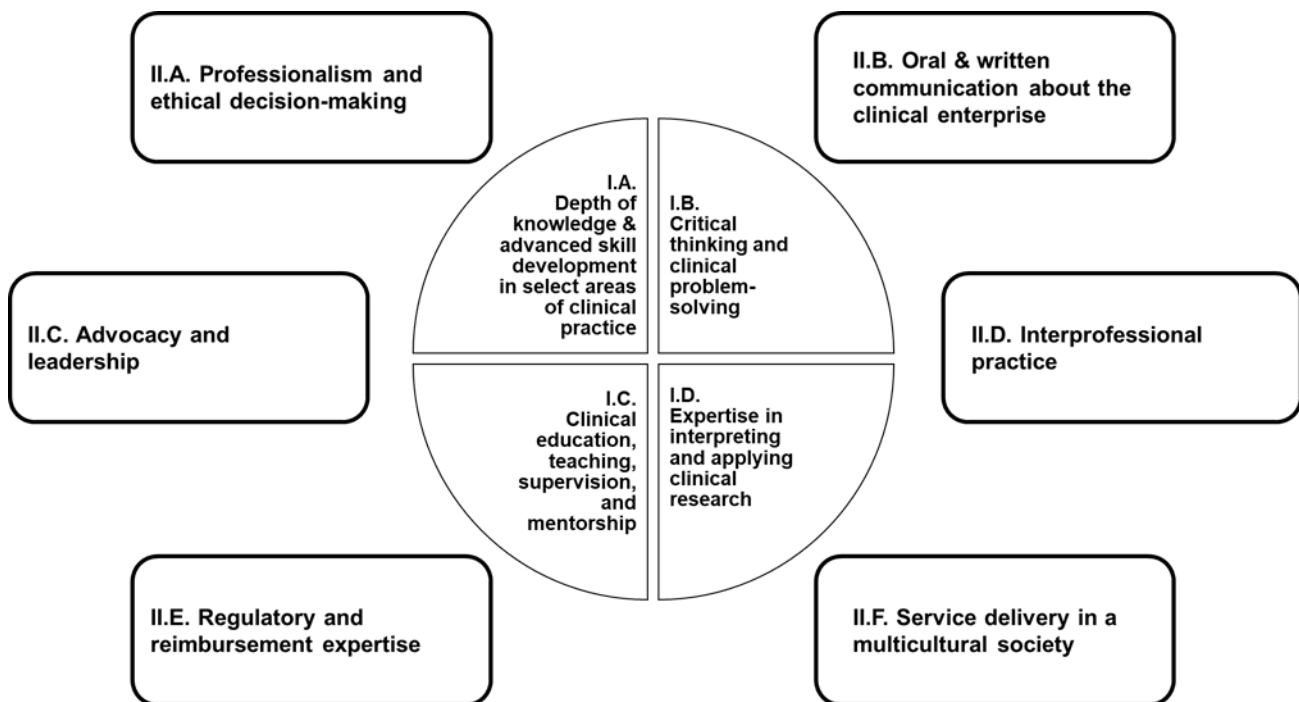


Figure 1: The 10 essential curricular components of optional, post-entry-level clinical doctoral programs in speech-language pathology, as outlined in the [ASHA Guidelines for the Clinical Doctorate in Speech-Language Pathology](#), are organized into 10 knowledge and skills domains. The four Tier I domains in the inner circle are essential, central components of the curriculum, whereas the six Tier II domains in the outer rectangles, while essential, may be tailored to meet the strengths of individual programs and the needs of students.



#### **IV. What are the rationale and data indicating whether optional, post-entry-level clinical doctoral programs in speech-language pathology in the United States should be accredited?**

The primary question posed to the AHC-GESLP and by CAPCSD in 2017 concerns whether accreditation standards should be set for optional, post-entry-level clinical doctoral degree programs in speech-language pathology. This question is addressed in the following three sections, which are organized in terms of: (IV.A.) the risks and benefits associated with accrediting and not accrediting this optional degree; (IV.B.) the human and financial resources needed for establishing and maintaining an accreditation program; and (IV.C.) how this optional degree aligns with other degrees in the continuum of service delivery. The primary points of consideration that formed the Committee's conclusions are explicated within each of these sections.

##### **IV.A. What are the risks to the profession of speech-language pathology and/or the public if post-entry-level clinical doctoral programs in speech-language pathology continue to be unaccredited, and what would be the benefits of accrediting these programs?**

To address this question, the AHC-GESLP reviewed information about extant programs offering an optional, post-entry-level clinical doctorate in speech-language pathology. Surveys were fielded to ASHA members working across a variety of settings and to faculty and students in both master's and clinical doctoral programs in speech-language pathology. Administrators and employers were also surveyed. Several focus groups, each with 9-12 participants, were conducted with clinic directors at universities and department chairs at the 2019 CAPCSD Conference and with SLPs practicing in a variety of settings at the 2018 ASHA Convention. In some cases, similar data had been collected in 2012 and 2013 and, where possible, trends were examined. These data were analyzed to ascertain what the perceived risks and benefits might be to establish an accreditation program for optional, post-entry-level clinical doctoral programs in speech-language pathology. These risks and benefits of accreditation for optional, post-entry-level clinical doctoral programs in speech-language pathology are presented in this section along with some additional considerations that were highly relevant but did not clearly represent either risks or benefits.

**Conclusion:** The number and gravity of the risks associated with not accrediting optional, post-entry-level clinical doctoral programs in speech-language pathology far outweigh the benefits of continuing without accreditation. Without accreditation, there is no mechanism by which to evaluate the quality of these programs. As new programs are established, without accreditation, variability will likely increase regarding degree requirements, length of program, curriculum, whether there is a focus on advancing knowledge and skill development in select areas of clinical practice, or whether there is a focus on preparing these graduates to provide clinical education. The lack of alignment among extant clinical doctoral programs in speech-language pathology with respect to the ten essential educational outcomes outlined in ASHA’s [Guidelines](#) (see Figure 1), already threatens the formation of a clear identity for this degree. As the number of new master’s programs grows (see Figure 4) but the number of PhDs conferred annually continue to be around 110 in speech-language pathology and speech-language science (see Figure 3), graduates of clinical doctoral programs in speech-language pathology are playing important roles (see Figure 5) in contributing to the viability of the profession by helping to fill the 20-35% of open faculty positions that might otherwise remain unfilled (see Figure 2). Accreditation is needed to align which knowledge domains, skills, and competencies these graduates have acquired—and what, in general, they are prepared to do. Working now on accrediting the post-entry-level clinical doctorate degree will stave off having to align a greater number of potentially even more diverse programs in the future. These conclusions are supported by the following considerations of the risks and benefits associated with accreditation of optional, post-entry-level clinical doctoral programs in speech-language pathology.

**Growth in the number of clinical doctoral programs** — An increasing number of clinical doctoral programs in speech-language pathology are likely to be established over the next ten years.

- In 2013, there were three clinical doctoral programs in speech-language pathology in the United States; in 2019, there were eight.
- According to the 2018–2019 *CSD Education Survey* (CAPCSD & ASHA, 2020), 247 students were enrolled in post-entry-level clinical doctoral programs in speech-language pathology.
- As of December 2019, there were 311 ASHA members who indicated that they have a clinical doctorate in speech-language pathology. Whereas in 2013, there were fewer than 100 (data retrieved from NetForum, ASHA’s member database, for the 2019 Year-End Counts).

- An analysis of supplemental questions posed in the 2018–2019 *CSD Education Survey* (see *Supplemental Question Report* in Appendix G) indicated that there are 46 U.S.-based programs that are planning or considering offering the post-entry-level clinical doctoral degree in speech-language pathology.

<b>Universities Offering Clinical Doctoral Degrees in 2019</b>	<b>Credits</b>	<b>Target Class Size</b>	<b>Average Time to Degree</b>	<b>Degree Offered Online</b>
University of Kansas	30	5	3 Semesters	No
Kean University of New Jersey	33	10	6 Semesters	No
Rocky Mountain University of Health Professions	39	56	7 Semesters	Limited Residency
Northwestern University	48	25	7 Quarters	Limited Residency
Loma Linda University	51	5	10 Semesters	No
Nova Southeastern University	53	15	9 Semesters	Limited Residency
Valdosta State University	56	No info	9 Semesters	No
University of Pittsburgh	99	No info	11 Semesters	No

Table 1: Information about the eight programs in the United States offering optional, post-entry-level clinical doctoral degrees in speech-language pathology as of December 2019. Information was retrieved from [EdFind](#) on January 26, 2020, except the information on [Rocky Mountain University of Health Professions](#), which was retrieved from EdFind and their website (retrieved January 26, 2020).

## **Risks**

1. **Inconsistency across programs** — Currently, there are eight programs that offer optional, post-entry-level clinical doctorates in speech-language pathology in the United States. These programs are shown in Table 1 with information about the required number of credits, target class size, average time to degree, and whether the degree is offered online (i.e., limited residency).

The inconsistency across these eight programs is exemplified by the following:

- a. An average of 50 semester credits is required for degree completion by these eight pioneering programs, ranging from 30 credits to 99 credits with a standard deviation of 20 credits.
- b. Two degree designators have been adopted thus far by these eight programs—seven use the “Speech-Language Pathology Doctorate (SLPD),” and one confers the “Doctor of Clinical Science (CScD).”
- c. In 2019, a survey was fielded that included 228 ASHA-certified SLPs who reported holding or expecting a clinical doctorate in speech-language pathology (see Appendix D). A total of 108 individuals completed the survey for an overall response rate of 47.4%. These respondents reported working across a variety of settings including schools (33%), home health (3.7%), college/university (24.1%), health care facility (16.7%), private practice (13.9%) and other (7.4%). There were responses from graduates of all eight of the extant clinical doctoral programs in speech-language pathology. Their responses to the following questions indicate a lack of consistency across these programs.
  1. Did you have a focus or major for your clinical doctorate?
    - Yes – 63 (60.6%)
    - No – 41 (39.4%)
  2. Did your program have a clinical component?
    - Yes – 44 (45.4%)
    - No – 53 (54.6%)
  3. Was your program “in-residence,” on-line, or a hybrid?
    - In-residence – 21 (21.9%)
    - On-line – 10 (10.4%)
    - Hybrid – 65 (67.7%)
- d. Some programs have a clinical component; others do not.
- e. Programs vary in degree requirements, methods of teaching, length of program, curriculum, whether there is a focus on deepening knowledge and advanced skill development in select areas of clinical practice, supervision, pedagogy, and in other curricular areas. The programs’ goals with respect to student learning outcomes are also variable to the extent that they are known.
- f. The number of faculty full-time equivalents (FTEs) available within these programs to teach and mentor clinical doctoral students in speech-language pathology is unknown.

- g. Despite recommendations made in ASHA's [Guidelines](#), not all clinical doctoral programs in speech-language pathology have been developed "in institutions with existing master's in speech-language pathology programs accredited by the Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA) or with PhD programs that serve speech-language pathologists (SLPs) in clinical research settings." (p. 3).
  - h. The wide variability that characterizes the current cohort of programs does not help to establish a clear identity for the degree. Inconsistency across educational programs may dilute the meaning of the degree, and a lack of a clear identity can cause confusion for potential applicants, employers, other professionals, and those for whom we provide services.
2. **Lack of quality control** — Presumably, the public and other professionals will have higher expectations for practitioners who have advanced degrees, such as the clinical doctorate—yet, without programmatic accreditation, quality control can neither be assured nor monitored.
- a. Because these degree holders would likely be regarded as "Master Clinicians" and leaders in their clinical settings and sub-specialties, it is important that these current and emerging programs graduate professionals who have truly advanced the depth of their knowledge and acquired advanced clinical skills.
  - b. If clinical doctoral programs in speech-language pathology are not aligned and evaluated by a common set of standards, then it is possible that the entire profession may suffer the consequences of a diminished reputation caused by a subset of inconsistently trained graduates who are presumably "advanced" professionals.
  - c. Without an accreditation program for optional, post-entry-level clinical doctoral programs in speech-language pathology, there is no mechanism of quality control and thus, there will continue to be a risk that low-quality programs will be established. This risk threatens the reputation not only of other clinical doctoral degree programs in speech-language pathology and their graduates but also of the profession more generally.
3. **Impact on enrollment** — Without an accreditation program for optional, post-entry-level clinical doctoral programs in speech-language pathology, students and

practicing SLPs report that they are less likely to enroll in clinical doctoral programs in speech-language pathology.

- a. According to the *Academic Affairs Board Report on the Clinical Doctorate in Speech-Language Pathology* (ASHA, 2012), 71% of practicing SLPs indicated that they would consider enrolling in a clinical doctoral program only if it was accredited.
- b. In Table 2, the results of surveys that were fielded on behalf of the AHC-GESLP in 2019 to three groups are shown. They were asked - “What impact would accreditation have on your decision to pursue an optional, post-entry-level clinical doctoral degree in SLP?”. Between 72.0 to 82.7% of respondents indicated that they “would only consider an accredited optional, post-entry-level clinical doctoral program in speech-language pathology.”

<b>Practicing SLPs</b>	Percent	Number
I would only consider an accredited optional, post-entry-level clinical doctoral degree program in speech-language pathology.	72.0%	780
I would consider both accredited and non-accredited optional, post-entry-level clinical doctoral degree programs.	8.4%	91
Uncertain	19.7%	213
<b>2019 Speech-Language Pathology Advisory Council Members</b>	Percent	Number
I would only consider an accredited optional, post-entry-level clinical doctoral degree program in speech-language pathology.	81.3%	26
I would consider both accredited and non-accredited optional, post-entry-level clinical doctoral degree programs.	9.4%	3
Uncertain	9.4%	3
<b>National Student Speech-Language-Hearing Association Members</b>	Percent	Number
I would only consider an accredited optional, post-entry-level clinical doctoral degree program in speech-language pathology.	82.7%	483
I would consider both accredited and non-accredited optional, post-entry-level clinical doctoral degree programs.	9.1%	53
Uncertain	8.2%	48

Table 2: Responses from three stakeholder groups about the role accreditation would play in their decision to pursue a post-entry-level clinical doctorate. Responses to the question - “What impact would accreditation have on your decision to pursue an optional, post-entry-level clinical doctoral degree program in speech-language pathology?” are displayed. Source: Graduate Education in Speech-Language Pathology, 2019 (see Appendix D).

- c. Additionally, there is some concern that without accreditation, some students may not be able to get loans to pay tuition, which may dissuade them from enrolling in a clinical doctoral program.

## **Benefits**

1. **Alignment** – Though not the purpose of accreditation, it would help improve clarity about what the degree means within and outside the discipline if programs largely adhered to a set of recognized standards. Accrediting optional, post-entry-level clinical doctoral programs in speech-language pathology is critical to establishing consistency and a clear identity within the profession. And it is likely that a clear identity is key to positively influencing perceptions about the value of the degree in the minds of people—including (a) professionals from related disciplines, (b) employers, (c) potential students, (d) SLPs, and (e) consumers. The public, employers, and other professionals are likely to have higher expectations for practitioners with clinical doctorates, as compared to master’s level professionals. Yet without accreditation, there is no quality control mechanism to ensure that clinical doctoral programs graduate well-trained and truly advanced professionals. Additionally, without an accreditation program, there is no mechanism to determine what competencies and learning outcomes these graduates should have in common nor to facilitate alignment across programs.
2. **Stakeholders’ desire for accreditation** – All of the stakeholder groups surveyed in 2012, 2013 and 2019 affirm that they place a high value on accreditation.
  - a. ASHA conducted multiple surveys to advance the work of the Ad Hoc Committee on the Feasibility of Standards (2013). Multiple stakeholder groups were asked, “Do you think an optional, post-master’s clinical doctoral program should have oversight by an accrediting body (accreditation)?” Respondents used a 5-point scale (1 = *not important*; 5 = *critically important*) to rate the importance of accreditation.
    - i. The accreditation of optional, post-entry-level clinical doctoral programs in speech-language pathology was perceived as critically important by employers (84%) and by clinicians (85%).
    - ii. Additionally, students (78%) and clinicians (71%) agreed that oversight was essential for their consideration of applying to an optional, post-entry-level clinical doctoral program in speech-language pathology.

- b. In 2019, several stakeholder groups were surveyed about their perceptions concerning accreditation of optional, post-entry-level clinical doctoral programs in speech-language pathology (see Appendix D). They were all asked – “Do you think an optional, post-entry-level clinical doctoral degree program (in speech-language pathology) should have oversight by an accrediting body (accreditation)?” Table 3 shows the number and percent of respondents who indicated *Yes*, *No*, or *Uncertain*.
- i. Between 76.2% to 93.9% of respondents affirmed that optional, post-entry-level clinical doctoral degree programs in speech-language pathology should have oversight by an accrediting body.
  - ii. Between 3.0% to 8.3% of respondents indicated that optional, post-entry-level clinical doctoral degree programs in speech-language pathology should not have oversight by an accrediting body.
  - iii. Between 3.0% to 15.5% of respondents were uncertain.

<b>Stakeholder Group</b>	<b>Yes</b>	<b>Percent Yes</b>	<b>No</b>	<b>Percent No</b>	<b>Uncertain</b>	<b>Percent Uncertain</b>
Practicing SLPs	928	84.7%	36	3.3%	132	12.0%
ASHA 2019 SLP Advisory Council	31	93.9%	1	3.0%	1	3.0%
Clinical Doctorate Graduates	64	76.2%	7	8.3%	13	15.5%
Employers	971	83.2%	68	5.8%	128	11.0%
NSSLHA Students	521	87.7%	19	3.2%	54	9.1%

Table 3: Responses from five stakeholder groups about whether post-entry-level clinical doctoral programs should be accredited. Responses to the question – “Do you think an optional, post-entry-level clinical doctoral degree program (in speech-language pathology) should have oversight by an accrediting body (accreditation)?” are displayed (see Appendix D).



3. **Downstream effects on clinical education** – Graduates of post-entry-level clinical doctoral programs in speech-language pathology are filling instructional positions at universities. This trend has potential to produce exceedingly positive downstream effects on the next generation of practitioners—but that largely depends on how well they are trained to provide clinical education and the depth of their expertise in one or more specific clinical areas. If the educational outcomes for an accreditation program are similar to what has been proposed in the ASHA Guidelines (see Figure 1), then accreditation would help to ensure that graduates of optional, post-entry-level clinical doctoral programs in speech-language pathology are well-prepared in areas such as educational instruction, supervision and pedagogy, and that they have advanced mastery in one or more clinical areas.
- a. The percent of open full-time research doctorate faculty positions that remain unfilled annually is shown in Figure 2 for the 2012-2013 through the 2018-2019 academic years ([ASHA Report on Communication Sciences and Disorders Education Trend Data, 2010-2011 to 2018-2019](#), ASHA 2020). The percent of open full-time research doctorate faculty positions remaining unfilled averaged 25% over the last seven academic years. It is notable that the percent of open research doctorate faculty positions remaining unfilled increased 10-15% increase in the 2018-2019 academic year relative to the percentages reported from the prior six academic years.
    - i. From the 2012–2013 academic year through to the 2018-2019 academic year, between 20-35% of open research doctorate faculty positions in speech-language pathology/ speech-language science went unfilled.
    - ii. In 2018–2019, 35% of research doctorate faculty positions in speech-language pathology/ speech-language science went unfilled.
    - iii. The number of open research doctorate faculty positions in speech-language pathology/ speech-language science being filled by individuals with clinical doctoral degrees in speech-language pathology averaged 2% (40/1,856 positions) over the last seven academic years, ranging from 1.0% in 2012-2013 and 2015-2015 to 5% in 2014-2015.

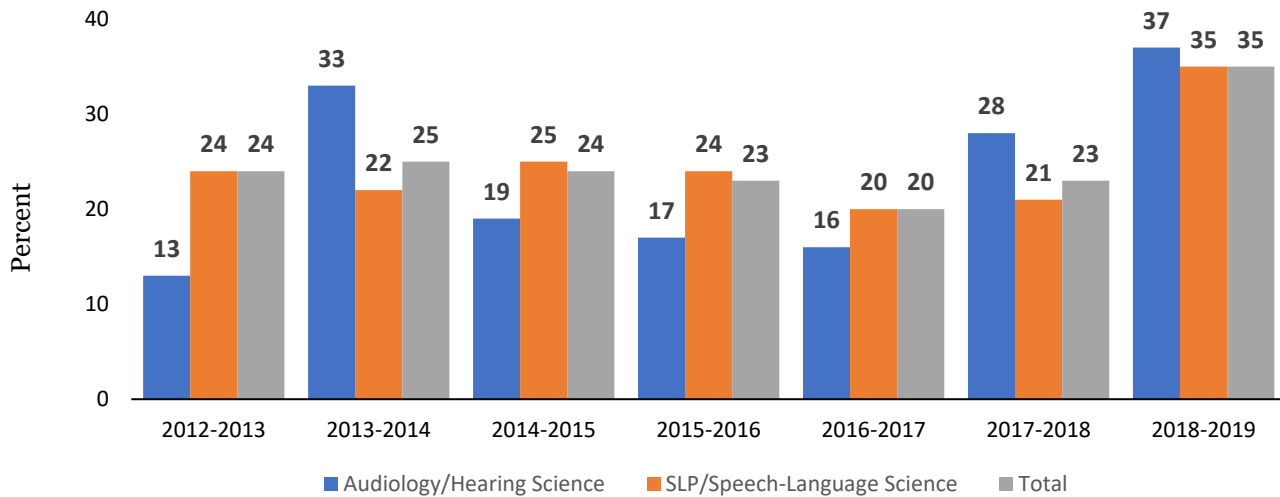


Figure 2: Percent of full-time research doctorate faculty positions unfilled annually. The percent of research doctorate faculty positions left unfilled averaged 25% over the last seven academic years, including all audiology/ hearing science and speech-language pathology/ speech-language science positions. Source: [ASHA Report on Communication Sciences and Disorders Education Trend Data, 2010-2011 to 2018-2019](#), ASHA 2020.

- b. The number of research doctoral degrees in speech-language pathology and speech-language science conferred has remained fairly constant since the 2012-2013 academic year ([ASHA Report on Communication Sciences and Disorders Education Trend Data, 2010-2011 to 2018-2019](#), ASHA 2020). These data are shown in Figure 3.
  - i. The average number of research doctoral degrees in speech-language pathology and speech-language science conferred over the past seven years is 110/year.
  - ii. In 2012–2013, 100 new research doctoral degrees in speech-language pathology and speech-language science were granted.
  - iii. In 2018–2019, 94 new research doctoral degrees in speech-language pathology and speech-language science were granted.

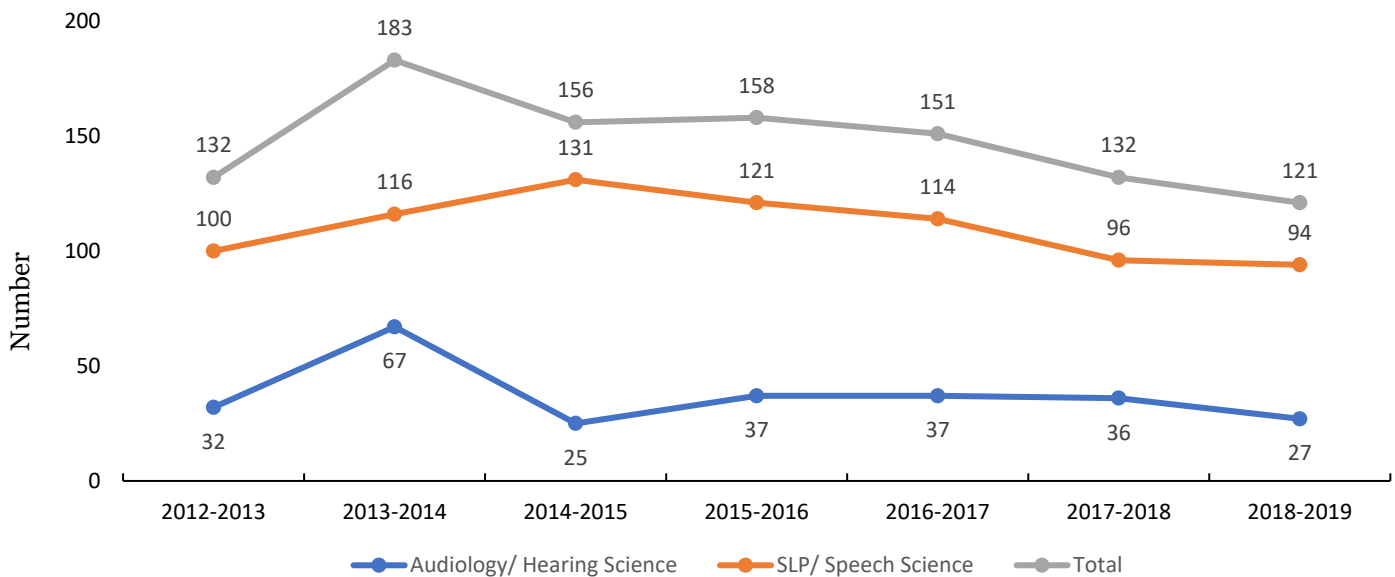


Figure 3: Number of research doctoral degrees granted annually. From 2012-2013 through 2018-2019, the number of research doctoral degrees granted annually averaged 148; 39 for audiology/ hearing science and 110 for speech-language pathology/ speech-language science. Source: [ASHA Report on Communication Sciences and Disorders Education Trend Data, 2010-2011 to 2018-2019](#), ASHA 2020.

- c. The number of new master’s programs in speech-language pathology being accredited by the CAA has grown substantially over the past decade and this trend is predicted to continue. Figure 4 shows that 27 new master’s programs in speech-language pathology have been accredited since 2009. With seven new master’s programs in speech-language pathology scheduled for Candidacy site visits in 2020, six undergoing Readiness Reviews, and ten more that have submitted letters of intent to apply for Candidacy in 2020, this trend does not appear to be temporary. Although not all of these programs may end up applying or becoming accredited, these data do indicate that the number of new master’s programs in speech-language pathology may be escalating.

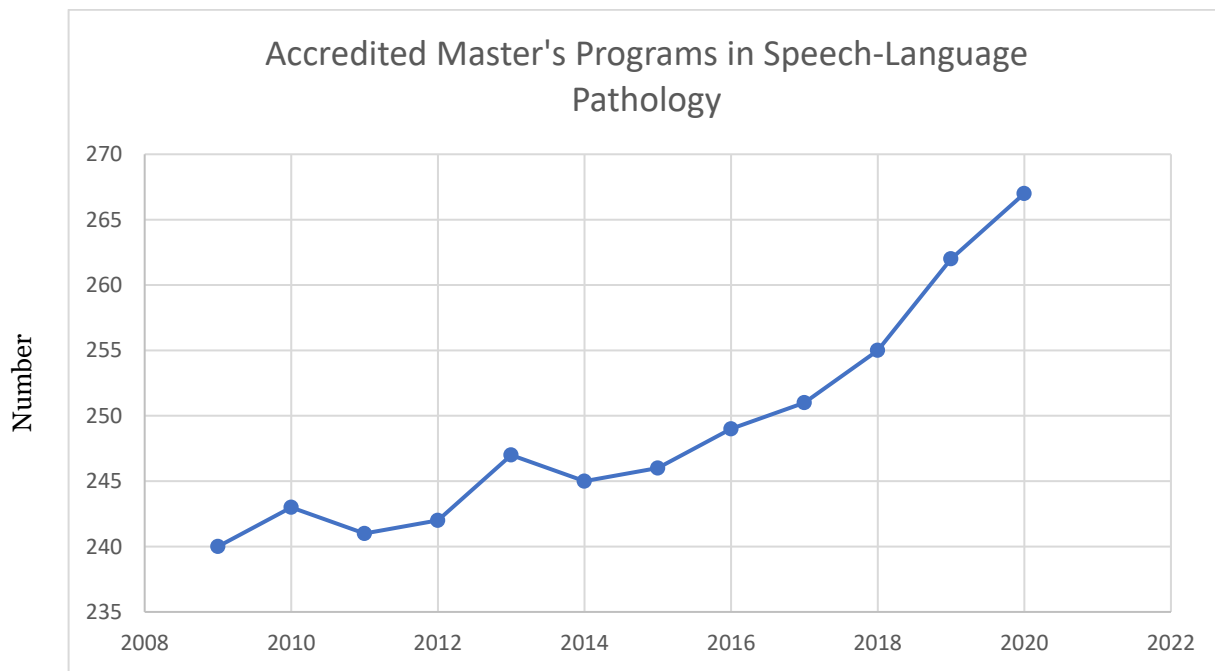


Figure 4: Number of accredited master’s programs in speech-language pathology. Data from the Council on Academic Accreditation in Audiology and Speech-Language Pathology shows that between 2009 and 2020, 27 new master’s programs in speech-language pathology were accredited.

- d. Individuals with clinical doctorates in speech-language pathology are already supporting the didactic teaching and supervision needs of master’s programs in speech-language pathology. According to supplemental questions posed on the 2018–2019 *CSD Education Survey* (see Appendix G):
  - i. There are 81 individuals with a clinical doctorate in speech-language pathology on faculty across the 264 master’s-level speech-language pathology programs that responded to the 2018–2019 *CSD Education Survey* (CAPCSD & ASHA, 2020).
  - ii. There are 50 master’s-level speech-language pathology programs in the U.S. that employ faculty with a clinical doctorate in speech-language pathology. Of these, 33 programs reported having only one such individual on faculty and 15 programs reported having more than one.
  - iii. Figure 5 shows the roles and responsibilities of faculty members with clinical doctorates in speech-language pathology. These data were collected from responses to a supplemental question included in the 2018-2019 *CSD Education Survey* (see *Supplemental Question Report* in Appendix G). All 50 programs that reported employing faculty with a clinical doctorate in speech-language pathology responded to this question about their roles.

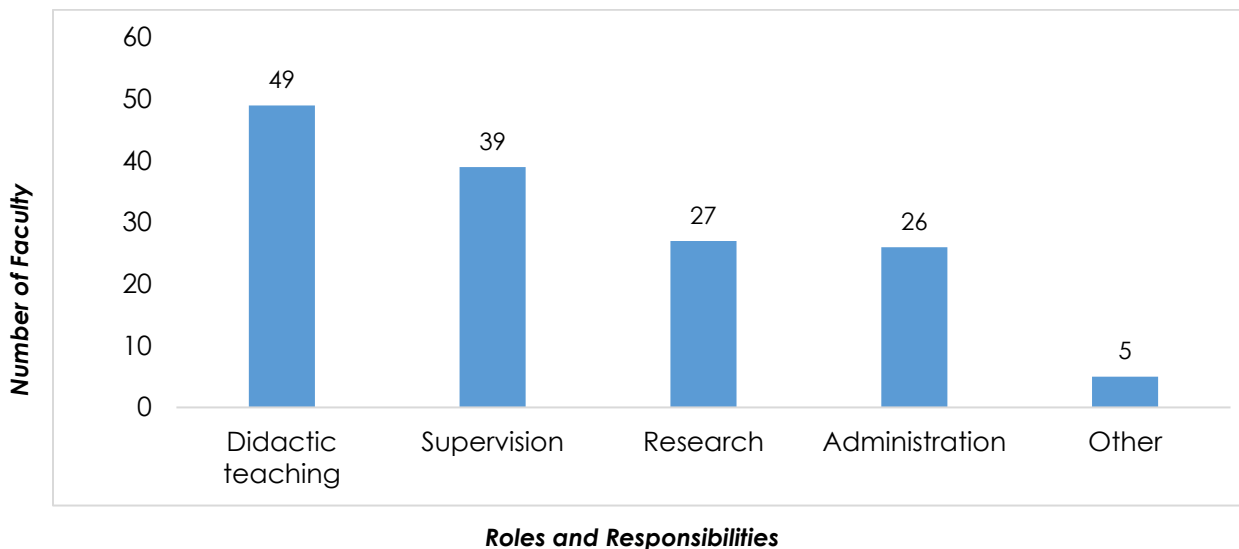


Figure 5: Roles and responsibilities of faculty members who have a post-entry-level clinical doctorate in speech-language pathology. *Note:* 264 (94%) of 281 master’s speech-language pathology programs completed the 2018-2019 *CSD Education Survey*. All 50 programs that reported employing faculty with a clinical doctorate in speech-language pathology responded to this question about their roles.

### **Additional Considerations**

The items below do not clearly represent risks or benefits but nonetheless, were relevant to the Committee’s deliberations.

1. The CAA is charged with accreditation of specific clinical degrees (i.e., master’s in speech-language pathology and the clinical doctorate in audiology [AuD]). Changes to the CAA bylaws may be needed if the decision is made to accredit optional, post-entry-level clinical doctoral programs in speech-language pathology.
2. Should the ASHA BOD and CAA decide to accredit the optional, post-entry-level clinical programs in speech-language pathology, the CAA would need to request to the Council on Higher Education (CHEA) and U.S. Department of Education (USDE) to expand its scope of recognition. The expansion request would need to include but is not limited to the following: a rationale for the proposed changes in scope; an independent comprehensive curriculum study; a justification for differences of accreditation standards between the current master’s degree and optional, post entry clinical doctorate standards; and evidence of the CAA’s capacity and competency to carry out accreditation reviews under the proposed scope. At a time when the USDE has identified concerns around credential inflation for entry-level degrees, the CAA’s request would need to emphasize the value of the degree and that the clinical doctorate is an optional, post-entry-level degree in speech-language pathology.

3. The CAA is currently recognized by the Secretary of USDE as an accrediting agency. At the time of this report concerns about the relationship between professional accreditors and their professional associations have been highlighted during discussions for the current reauthorization of the Higher Education Act. However, should language come forward that includes the stipulation that accreditors must be separate and independent from related professional associations or societies, then the CAA would have the option of complying and remaining recognized, or not complying and foregoing recognition. Either decision could have a significant impact. To relinquish recognition could have potential impacts most notably, but not limited to, state licensure eligibility for graduates as many laws reference graduation from a program accredited by an agency recognized by the USDE as a contingency of licensure. Maintaining recognition as an autonomous accreditor would necessitate change in the operational infrastructure of CAA. A self-sustaining financial model for the CAA could have a significant impact on the operational cost of accreditation for academic programs.
4. As elaborated upon in Section IV.B., there would be additional expenses associated with a new accreditation program that ASHA and the CAA would incur. Accreditation of optional, post-entry-level clinical doctoral programs in speech-language pathology would also generate revenue from application and annual fees.
  - a. ASHA's Accreditation unit would have to establish an accreditation program for optional, post-entry-level clinical doctoral programs in speech-language pathology. An additional 0.5 full-time equivalent (FTE) staff would be needed in the Accreditation unit—and, as more programs apply for accreditation, the FTE allocation to that unit might need to increase further. The CAA would need additional volunteers to address the work of the Council.
  - b. Academic programs offering clinical doctoral degrees in speech-language pathology would have to pay application fees to the CAA if they decide to apply for accreditation, site visit fees, and annual accreditation fees if they are approved. Also, academic programs might incur additional expenses to meet the accreditation standards.
5. There are no regulations or laws that would compel academic programs offering clinical doctoral degrees in speech-language pathology to apply for accreditation; accreditation of optional degrees is voluntary. However, 74% of existing clinical doctoral programs in speech-language pathology and those considering or planning to offer this degree rated accreditation as important or very important (see Appendix G). Accreditation is voluntary; however, accreditation signifies to prospective applicants, employers, related professionals, and to the public that the program meets or exceeds established educational standards.

6. Several factors go into seeking accreditation beyond interest including need, cost, institutional support, availability of resources including faculty and clinical sites, and other factors, which may be idiosyncratic to each university. Thus, it may be the case that not all of the clinical doctoral programs in speech-language pathology that are interested in becoming accredited will all be able to meet the readiness standards to be considered for accreditation.
7. Development of accreditation standards for optional, post-entry-level clinical doctoral degree does not preclude the CAA from developing accreditation standards for an entry-level clinical doctoral degree in the future or revising the existing standards for the entry-level master's degree in speech-language pathology.
8. As occurred for audiology when they transitioned to the clinical doctorate as the entry-level degree, if a decision is made at some time in the future to move to an entry-level clinical doctorate for speech-language pathology, there would likely remain a need for post-entry-level clinical doctoral programs in speech-language pathology. For audiology, these post-entry-level clinical doctoral programs served to provide additional education for those with a master's degree in audiology who wanted to earn a clinical doctorate. There was concern within the audiology community about the quality of some of the post-entry-level degree programs after the entry-level degree shifted to the clinical doctorate but, there wasn't an accreditation program for them. Similarly, post-entry-level degree programs in speech-language pathology would continue to provide additional education for SLPs already credentialed to practice with a master's degree if the entry-level degree shifted to a clinical doctorate at some point in the future. Having an accreditation program for optional, post-entry-level clinical doctoral programs in speech-language pathology might become even more important to potential students and future employers even if the entry-level degree someday became the clinical doctorate.
9. It is self-evident that accreditation of optional, post-entry-level clinical doctoral programs in speech-language pathology would help to protect the public by ensuring the adoption of standards and promoting continuous quality improvement, as these are the primary functions of accreditation.
  - a. The *CAA Handbook* (CAA, 2020, p. 1) describes the value of accreditation in the following manner.

“ASHA’s interest in accreditation is based upon the belief that all professions that provide services to the public have an obligation to ensure, as far as possible, that services provided by its members are of high professional quality. One effective way in which this obligation can be met is by

establishing appropriate standards of educational quality and by identifying publicly those education programs that meet or exceed these standards. Accreditation is intended to protect the interests of students, benefit the public, and improve the quality of teaching, learning, research, and professional practice. Through its accreditation standards, the accrediting body encourages institutional freedom, ongoing improvement of institutions of higher education and graduate education programs, sound educational experimentation, and constructive innovation.”

- b. As stated in Part 4 of the *CAA Handbook* (CAA, 2020, p. 75), “the purposes of accreditation standards are to
  - promote excellence in preparing students to enter the professions of audiology and speech-language pathology,
  - protect and inform the public by recognizing programs that meet or exceed accreditation standards, and
  - stimulate improvement of programs’ educational activities by means of self-study and evaluation.”
- c. Although consistency may be enhanced with accreditation, it is important to note that CAA’s existing accreditation models do allow for considerable flexibility relative to what each program states as their mission. As per best practices in quality assurance and expectations from CHEA, which is one of the CAA’s recognition entities, this flexibility allows the CAA to promote innovation in programs to enable them to address the changing needs of the professions. Should the current model of entry-level education for speech-language pathology change, but without a change in the entry-level degree designator, the CAA’s existing accreditation model may support that with adjustments to the current standards and requirements for review.
- d. Under the current Accreditation Standards, specifically 2.3, “the program must demonstrate that the majority of academic content is taught by doctoral faculty who hold the appropriate terminal academic degree (PhD, EdD).” Currently, faculty who hold a clinical doctorate contribute to a range of roles in academic programs, however; they do not contribute to this requirement.



#### IV.B. What are the human and financial resources that might be needed to establish an accreditation program for optional, post-entry-level clinical doctoral speech-language pathology?

The AHC-GESLP reexamined and updated the financial model of an accreditation program for optional, post-entry-level clinical doctoral programs in speech-language pathology that had been originally developed by the [Ad Hoc Committee on the Feasibility of Standards](#). The human and financial resources needed to establish and maintain such an accreditation program were estimated from information provided by three ASHA units (Accreditation, Finance and Accounting, and Human Resources). To estimate revenue, the number of programs planning or considering offering the degree was collected from supplemental questions asked on the 2018–2019 *CSD Education Survey* (see Appendix G). As dates were needed to develop a financial model, hypothetical dates were selected for (a) when a decision would be made to accredit post-entry-level clinical doctoral programs (2021), (b) when work would commence (2022), and (c) when accreditation applications would first be accepted from optional, post-entry-level clinical doctoral programs in speech-language pathology (2025). (The financial model is based on the CAA’s current USDE recognition status (as noted in #3 under “Additional Considerations”), or the CAA’s willingness to forego USDE recognition.)

**Conclusion:** The results of the financial modeling of an accreditation program for optional, post-entry-level clinical doctoral programs in speech-language pathology performed in 2019 for this report are consistent with the results of the financial modeling conducted by the [Ad Hoc Committee on the Feasibility of Standards](#), (2013, p. 68). The model depicted in that earlier report suggested that the targeted revenue-to-expense ratio of 40% for the CAA could be achieved if 12-14 programs applied for and were later granted accreditation. The modeling done for this report in 2019 replicated that finding and supported these additional conclusions:

- Financial support from ASHA would be needed to cover 100% of the costs associated with developing an accreditation program. It would likely take 3 years to develop an accreditation program before applications could be accepted. The estimated annual expense for these first 3-years ranges from \$86,000 to \$105,000 per year, with a total of \$260,627 across all 3 years.
- During the subsequent 3 years, the revenue-to-expense ratio might fall short of the targeted 40% for the CAA (i.e., the CAA targets covering 40% of expenses from application and annual fees). This shortfall is estimated to be approximately 10% per year (i.e., a 30% revenue-to-expense ratio is likely to be achieved during the three years in which candidacy applications are accepted).
- Thereafter, an accreditation program for post-entry-level clinical doctoral programs in speech-language pathology is likely to meet or exceed the 40% revenue-to-expense ratio.

**Factors used to estimate the revenue-to-cost ratio of accreditation**

1. **Number of programs likely to apply for accreditation** – To model potential revenue, the number of programs likely to seek accreditation was estimated for the period from 2022 to 2032 from data obtained through the 2018-2019 *CSD Education Survey*. There are currently eight clinical doctoral programs in speech-language pathology in the United States (see Table 1). The *Supplemental Question Report* from the 2018–2019 *CSD Education Survey* (see Appendix G) summarizes programs’ responses to the survey question that asked them about their plans to offer a clinical doctorate in speech-language pathology. These data are presented in Table 4.
  - a. Of the 217 programs that responded to the supplemental questions on the 2018–2019 *CSD Education Survey* asking them about their plans to offer a clinical doctorate in speech-language pathology, 54 programs (20%) reported that they are
    - i. already offering the clinical doctoral degree in speech-language pathology (8 programs), or
    - ii. implementing a plan in 2020-2021 or are engaged in planning to offer this degree by the 2022-2023 academic year (12 programs), or
    - iii. considering offering the degree at some point (34 programs).

<b>Current Status</b>	<b>Count</b>	<b>Percent</b>
Currently offer the post-entry clinical doctorate in SLP	8	3.0%
Implementing a plan to offer an optional, post-entry clinical doctorate in SLP in the 2020-2021 academic year	5	1.8%
Planning to begin offering an optional, post-entry clinical doctorate in SLP sometime between the academic years 2021-2022 and 2023-2024	7	2.6%
Considering offering an optional, post-entry clinical doctorate in SLP (but not far enough along to identify an anticipated timeline)	34	12.5%
None of the above	217	80.1%

Table 4: Academic program responses to the supplemental question asked on the 2018–2019 *CSD Education Survey* (see Appendix G) about their plans to offer a clinical doctorate in speech-language pathology. *Note:* 271 of 281 Master’s programs in speech-language pathology that completed the 2018-2019 *CSD Education Survey* responded to this question.

- b. Of the 12 programs that are planning to offer this degree by the 2023-2024 academic year and of the 34 programs that are considering offering this degree at some yet-to-be-determined date, 74% indicated that accreditation is important or very important.
  - c. Although 54 programs reported that they already offer the degree, are planning to offer the degree, or are considering offering the degree, the number of programs projected to apply for accreditation between 2025 and 2032 was only 40 programs (74%).in accordance with the number of these programs that deemed accreditation important. By projecting that only 74% of 54 programs would apply for accreditation helps to account for the possibility that not all of these programs may end up offering this degree.
- 2. Growth function for clinical doctoral programs in speech-language pathology** – In Figure 6, the growth of clinical doctoral programs in speech-language pathology that might apply for accreditation is modeled. In this model, the first year that programs could apply for candidacy is 2025.
- a. Of these 54 programs in Table 4, the model assumes that only 74% (40 programs) would apply for accreditation by 2032.
  - b. Of the 20 programs (8 already offering + 5 implementing in 2020-2021 +7 planning to offer by 2023-2024) that are likely to have been established by 2025, the model assumes that only 12 programs (60%) will actually apply for accreditation in 2025.
  - c. As there are no data currently available to inform how many programs would apply in a given year, the application rate for the remaining 28 programs that are projected to apply after 2025 is evenly distributed in the model by adding 4 programs annually, starting in 2026 and ending in 2032.
  - d. The model ends with a total of 40 programs becoming accredited by 2032, which is only 74% of the programs that currently offer, are planning to offer, or are considering offering this degree.

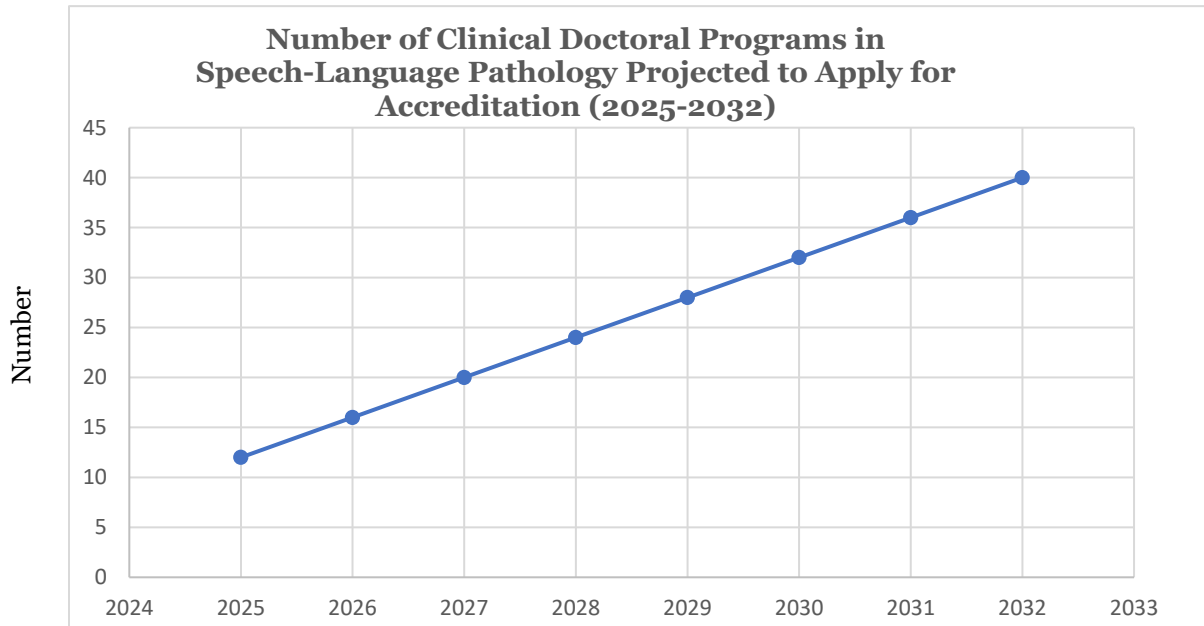


Figure 6: Growth in the number of clinical doctoral programs modeled to apply for accreditation between 2025 and 2032.

3. **Expenses** – There are seven expense categories associated with developing and maintaining an accreditation program for post-entry-level clinical doctoral programs in speech-language pathology. The categories are described below, and the projected expenses from 2022 through 2032 are displayed in Table 5.

**Category 1: Personnel** – It was estimated that the number of FTEs needed in the Accreditation unit would be 0.5 starting in 2022 and would move to 1.0 in 2025 (assuming that the decision to accredit post-entry-level clinical doctoral degree programs in speech-language pathology is made in 2021 and that work commences in 2022).

**Category 2: Professional Development Costs** – This cost is to support the professional development (e.g., attending a conference, external training) of the staff member assigned to work on this program.

**Category 3: CAA Board and Other Associated Costs** – These costs reflect the expansion of the CAA to include three additional members who would attend three in-person meetings of the CAA annually starting in Year 1, which is 2022 in this model.

**Category 4: Candidacy Visits** – In the financial model, candidacy visit costs for the initial 12 programs are split between years 4 and 5, so that the 12 site visits would be conducted over a 2-year period. In the following years, four candidacy visits are modeled annually.

**Category 5: Initial Accreditation Visits** – In the financial model, initial accreditation site visits would begin in Year 8 (2029).

**Category 6: Indirect Costs** – ASHA applies a 10% charge to all programs at ASHA to support operational costs, such as facilities, utilities, and technology expenses.

**Category 7: Practice Analysis** – Practice analyses are conducted every 5 years. Three practice analyses are planned between 2022 and 2032. The projected expenses for the practice analyses are \$25,000 in 2022, \$26,000 in 2027, and \$27,000 in 2032.

Expense Category	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
Accred. Personnel	\$56,438	\$58,695	\$61,043	\$124,528	\$129,509	\$134,689	\$140,077	\$145,680	\$151,507	\$157,567	\$163,870
Prof Devel.	\$750	\$750	\$750	\$1,500	\$1,560	\$1,622	\$1,687	\$1,755	\$1,825	\$1,898	\$1,974
CAA Board	\$13,467	\$14,006	\$14,566	\$15,149	\$15,754	\$16,385	\$17,040	\$17,722	\$18,431	\$13,467	\$14,006
Other CAA Costs	\$2,244	\$2,334	\$2,427	\$2,524	\$2,625	\$2,730	\$2,839	\$2,953	\$3,071	\$3,194	\$3,322
Candidacy Visits	\$0	\$0	\$0	\$27,720	\$28,829	\$19,216	\$19,985	\$20,784	\$21,615	\$22,480	\$23,379
Initial Accred. Visits	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$27,720	\$27,720	\$9,240	\$9,610
Indirect Costs	\$7,290	\$7,578	\$7,879	\$17,148	\$17,834	\$17,471	\$18,170	\$21,668	\$22,424	\$20,792	\$21,624
Practice Analysis	\$25,000	\$0	\$0	\$0	\$0	\$26,000	\$0	\$0	\$0	\$0	\$27,040
<b>Total Costs</b>	<b>\$105,188</b>	<b>\$83,363</b>	<b>\$86,665</b>	<b>\$188,562</b>	<b>\$196,105</b>	<b>\$218,106</b>	<b>\$199,791</b>	<b>\$238,274</b>	<b>\$246,586</b>	<b>\$228,631</b>	<b>\$264,816</b>

Table 5: Projected expenses to establish and maintain an accreditation program. Estimates of the total expenses entailed to develop and maintain an accreditation program for optional, post-entry-level clinical doctoral programs in speech-language pathology are shown in the bottom row of this table. The costs associated with each expense source are shown in the rows above the total cost.

**4. Revenue** – There are three sources of revenue: Candidacy Application Fees (~\$8,000 per program), Initial Accreditation Fees (~\$6,000 per program), and Annual Fees (~\$2,500 per program). The candidacy fee is due upon application. The initial application fee is paid by academic programs in the fourth year of their candidacy cycle. Annual fees are paid every year thereafter for the 8-year accreditation cycle. Table 6 shows the projected fee revenue from 2022 to 2032. In Table 6, Candidacy and Initial Application Fees are combined and are listed together as “Application Fee Revenue”. A 5% fee increase every third year is typical for the CAA and was applied to the model.

Programs	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
# of Programs	0	0	0	12	16	20	24	28	32	36	40
# New Programs	0	0	0	0	4	4	4	4	4	4	4
Application Fee Revenue	\$0	\$0	\$0	\$96,000	\$32,000	\$32,000	\$105,600	\$57,600	\$57,600	\$60,480	\$60,480
Annual Fees Revenue	\$0	\$0	\$0	\$0	\$29,172	\$38,896	\$48,620	\$61,261	\$71,471	\$81,682	\$96,486
<b>Total Revenue</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$96,000</b>	<b>\$61,172</b>	<b>\$70,896</b>	<b>\$154,220</b>	<b>\$118,861</b>	<b>\$129,071</b>	<b>\$142,162</b>	<b>\$156,966</b>

Table 6: Projected revenue from application and accreditation fees. In the top two rows of this table, the number of clinical doctoral programs in speech-language pathology projected to apply for accreditation is shown from 2022 to 2032. In the bottom three rows of this table, the projected revenue from application and annual fees and the total revenue for the same time period is displayed. *Note:* Application fees are the sum of the projected Candidacy Fees and Initial Application Fees.

**5. Expense-to-Revenue Ratio** – In the first 3 years of the accreditation program being modeled (2022–2024), there would be only expenses and no revenue generated because applications for accreditation would not be accepted until 2025. These costs, shown in the bottom row of Table 5, are estimated to be \$100,251 in Year 1 (2022); \$78,228 in Year 2 (2023); and \$82,149 in Year 3 (2024). The total funding needed to develop an accreditation program during the first 3 years is estimated to be \$260,627. Projected expenses and revenue and the corresponding expense-to-revenue ratios for the period 2022–2032 are shown in Table 7 and graphically displayed in Figure 7. In Year 4, the expense-to-revenue ratio is estimated to be 52%, which is 12% more than the 40% expense-to-revenue ratio that the CAA targets. Over the next two years (2026 and 2027), the expense-to-revenue ratio dips to approximately 31%, in part because another Practice Analysis would be needed. Thereafter, the ratio remains well above the targeted ratio of 40%.

Expenses & Revenue	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
Total Expenses	\$105,188	\$83,363	\$86,665	\$188,628	\$196,173	\$218,178	\$199,865	\$238,352	\$246,666	\$228,714	\$264,903
Total Revenue	\$0	\$0	\$0	\$96,000	\$61,172	\$70,896	\$154,220	\$118,861	\$129,071	\$142,162	\$156,966
Expense-to-Revenue Ratio	<b>0</b>	<b>0</b>	<b>0</b>	<b>51%</b>	<b>31%</b>	<b>32%</b>	<b>77%</b>	<b>50%</b>	<b>52%</b>	<b>62%</b>	<b>59%</b>

Table 7: Projected expenses and revenue and expense-to-revenue ratio for an accreditation program. The financial resources needed to develop and maintain an accreditation program for post-entry-level clinical doctoral degree programs in speech-language pathology for the period 2022–2032 are shown, along with the projected revenue. The total expenses and total revenue projections are shown in the top two rows, and the corresponding expense-to-revenue ratio is shown in the bottom row.

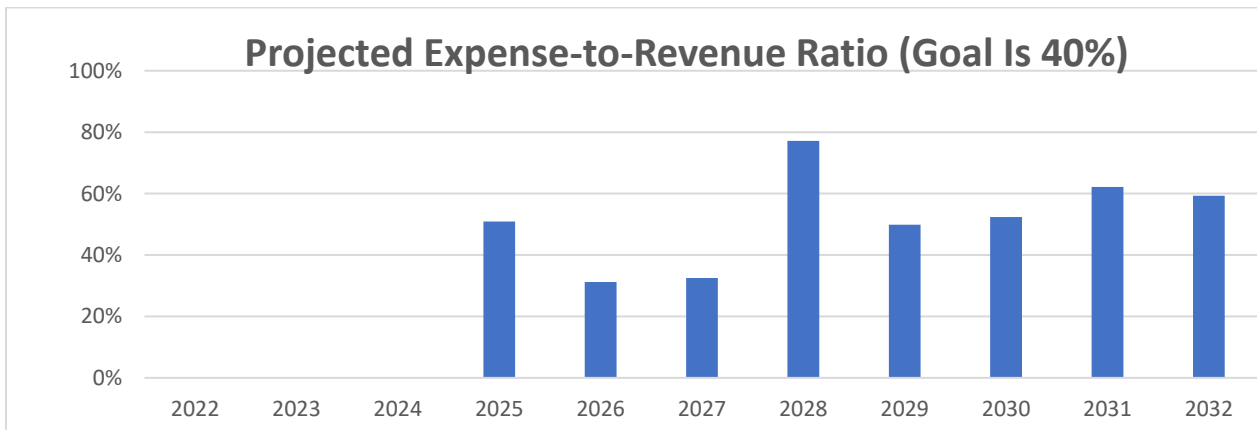


Figure 7: Expense-to-Revenue Ratio for an accreditation program. The expense-to-revenue ratio estimated for establishing and maintaining an accreditation program for post-entry-level clinical doctoral programs in speech-language pathology is plotted for the 11 years modeled (2022–2032).

#### IV.C. How could the clinical doctorate in speech-language pathology best align with other degrees in the continuum of service delivery?

**Conclusion:** The optional, post-entry-level clinical doctorate in speech-language pathology fulfills the need for advanced clinical skills and specialization in speech-language pathology, satisfies the demand for career advancement tracks, avails an opportunity for parity with other professions, and supports the development of leadership that is the lifeblood of any discipline. Individuals with clinical doctorates in speech-language pathology are contributing to the didactic teaching, supervision, research, and administrative needs of academic programs in speech-language pathology. A well-trained workforce in speech-language pathology with advanced instructional, supervision and clinical skills fulfills essential needs in higher education and across practice settings. If SLPs with clinical doctorates develop expertise in interpreting and applying clinical research (see quadrant I.D in Figure 1), then they will likely have a meaningful impact on advancing evidence-based practice in the profession. The answers to questions such as - “*How well will the clinical doctorate align with the other degrees in the profession?*” and “*How much benefit will the clinical doctorate bring to the profession?*”, are highly dependent on whether the educational outcomes of clinical doctoral programs can be aligned. If all of the clinical doctoral programs foster the development of the ten knowledge and skill domains described in the Guidelines for the Clinical Doctorate in Speech-Language Pathology (see Figure 1), then these graduates will fulfill mission-critical roles across both practice and academic settings for which there are significant and longstanding needs with no other potential solutions in sight.

According to the 2018–2019 *CSD Education Survey*, the following information is relevant to this question:

- There are 81 individuals with a clinical doctorate in speech-language pathology who serve on faculty across 50 master’s speech-language pathology programs in the United States.
- The roles and responsibilities of faculty members with clinical doctorates in speech-language pathology include didactic teaching, supervision, research, and administration (see Figure 4).

According to the [ASHA Report on Communication Sciences and Disorders Education Trend Data, 2010-2011 to 2018-2019](#), (ASHA 2020), and based on longitudinal data from the CAA, the following information is relevant to this question:



- The number of newly earned PhDs in speech-language pathology/ speech science has remained fairly constant over the past seven years (~110/year; see Figure 3) and the number of master’s programs is steadily growing (27 new programs accredited since 2009; see Figure 4).
- As the need for faculty increases but the supply remains constant, it is predictable that the percent of open faculty positions remaining unfilled every year will continue to increase (from 2012-2019, 25% remained unfilled; in 2018-2019, 35% remained unfilled; see Figure 2).

Individuals with clinical doctorates in speech-language pathology are currently helping 50 academic programs fulfill their clinical teaching mission and this trend is likely to grow. On page 9 of the [Academic Affairs Board Report on the Clinical Doctorate in Speech-Language Pathology](#) (ASHA, 2012), it states that:

“Academic programs have always hired individuals to provide clinical teaching and supervision who may not necessarily have PhDs. Given that there is an extensive amount of clinical teaching required to educate SLPs, the discipline could benefit greatly from the contribution that master clinicians with clinical doctoral degrees could make to the clinical teaching mission, especially because clinical pedagogy is a likely focus of this advanced degree.”

The [Ad Hoc Committee on the Feasibility of Standards](#) (2013) reported that, across employers, clinicians, and students, greater than 50% of respondents reported that the clinical doctorate in speech-language pathology would have a positive impact on clinical service delivery, leadership, specialized training, application of evidence-based practice, increased clinical knowledge and skills, enhancement of respect for the profession from clients, consumers, and other providers, and promotion of professional autonomy.

The post-entry-level clinical doctorate in speech-language pathology is an advanced degree that aligns well with the need for career advancement, leadership development opportunities, and clinical specialization in the profession. Individuals with this degree can serve as “Master Clinicians”, clinical educators, and lead teams of SLPs and related professionals. These individuals, if well-trained in the translation and implementation of evidence-based practices, would have a widespread and highly positive impact on advancing clinical practice across settings. They are also helping to fill faculty shortages, which appear to be increasing with the recent expansion of master’s programs in speech-language pathology. In the 2019-2020 academic year, more than 80 SLPs with clinical doctorates in speech-language pathology provided didactic teaching, supervision, research assistance, and administrative functions (CAPCSD & ASHA, 2020). However, the value that each of these potential benefits might bring to the profession depends, in large part, on the focus and quality of each program. Aligning educational outcomes and establishing program quality indicators are key to optimizing the impact of the degree but these factors cannot be influenced without an accreditation program.

**V. What are the rationale and data indicating what is needed to adequately prepare future speech-language pathologists (SLPs) to enter the profession?**

V.A. Which aspects of the current model of entry-level education for speech-language pathology in the United States are serving the profession and the public adequately now, and in the near future, and which aspects are not?

**Conclusion:** There are many aspects of the current model of entry-level education for speech-language pathology that multiple stakeholders identified as serving the profession and the public well and others that are not adequately serving the profession and the public. The master's degree became the entry-level degree in 1963. Since then, the scope of practice has changed significantly, but the educational model has not. Based on analyses of the surveys and focus groups reported in this document, there appears to be widespread concern that students may not be consistently prepared to enter practice nor to deliver services across the full scope of practice and across the lifespan. The breadth of topics that are now central to the speech-language pathology profession limits students being able to delve deeply or develop areas of specialization in their entry-level program. The limited number of specialists in areas such as voice, fluency, augmentative and alternative communication (AAC), and dysphagia were frequently mentioned. Securing a sufficient number of quality clinical placements is another pressing challenge facing many academic programs. There is also concern that practicing clinicians transitioning across settings may not be adequately prepared to do so and may require additional professional development and mentoring for a successful transition, which is not a requirement currently. There is concern among SLPs across educational and health care settings about professional parity and encroachment by other related disciplines. These factors compel further consideration of how the future of entry-level education for SLPs can be improved.

The AHC-GESLP reviewed multiple survey and focus group reports and read through hundreds of open-ended responses provided by ASHA members, CSD academic faculty, students (undergraduate, master's, and clinical doctoral students in speech-language pathology), and employers to ascertain which aspects of the current entry-level education model are serving the profession and public adequately and which are not. Members of AHC-GESLP also solicited input from ASHA's School Issues Advisory Board, the State Education Agencies Communications Disability Council (SEACDC), and the Speech-Language Pathology Advisory Council members during the 2-years that the committee worked on the charge (2018 & 2019).

- a. A synopsis of the themes about how adequately the **profession** is being served by the current educational model is displayed in Table 8.

<b>The current model of entry-level education for speech-language pathology is . . .</b>	
<b>. . . serving the <u>profession</u> well.</b>	<b>. . . not serving the <u>profession</u> well.</b>
Lifespan preparation enables flexibility to transition across settings.	Students may not be consistently prepared in many areas, nor consistently prepared to work across settings.
Students are well-prepared in some areas.	Students may not be consistently prepared even in some of the “Big Nine” areas.
There are outstanding applicants.	There is insufficient student diversity (e.g., under-represented minorities, males).
There is a plethora of applicants.	A large number of undergraduate majors cannot get into graduate school in speech-language pathology.
Academic programs have freedom to design and deliver the curriculum flexibly to meet the standards.	The current model lacks a competency framework to guide educational preparation and evaluation of student readiness for entry into practice.
The use of simulation enhances learning.	There is an over-reliance on volunteer professionals for outplacements and variable quality across these experiences.
There is high career satisfaction among speech-language pathologists.	There is a scarcity of outplacements and supervisors who are willing and able to offer clinical placements.
There is a high graduation rate.	There is high variability in what academic programs offer for student placements.
There are high pass rates on the PRAXIS.®	There is a lack of alternative models for accessing graduate education in speech-language pathology part time.
There is a high employment rate.	There may not be enough momentum or capacity in universities to prepare for the future of learning and work.
There is a high demand for SLPs in the workforce across schools, health care, home health, early intervention, and private practice settings.	Not enough programs are preparing undergraduate majors to become assistants, nor enough graduate programs preparing future SLPs to work with assistants.
Maintaining the 2-year master’s degree educational model in speech-language pathology helps control student debt load.	Trying to fit the full scope of practice across the lifespan into a 2-year master’s program is counterproductive to achieving educational outcomes and overly stressful for students.

Table 8: Themes about how adequately the profession is being served by the current educational model. These themes were derived from multiple surveys and focus groups to the question posed in V.A. about how well the current model of entry-level education is serving.

- b. A synopsis of the themes about how adequately the **public** is being served by the current educational model is displayed in Table 9.

<b>The current model of entry-level education for speech-language pathology is . . .</b>	
<b>. . . serving the public well.</b>	<b>. . . not serving the public well.</b>
Lifespan preparation enables speech-language pathologists (SLPs) to work across settings and with all age groups.	SLPs may not be consistently prepared to work across many settings nor are they consistently prepared in regulatory matters.
SLPs are well-prepared in some areas, and they have access to continuing education and resources to learn more about other areas.	SLPs may not be consistently well-prepared in all areas of practice, not even across all of the “Big Nine” areas.
Most SLPs are highly dedicated and capable individuals.	There is insufficient diversity among SLPs (e.g., under-represented minorities, males).
Academic accreditation helps to maintain the quality of academic programs.	There are shortages of SLPs in most states and in many settings.
The Certification of Clinical Competence in Speech-Language Pathology (CCC-SLP) is viewed as being highly valuable.	The current model lacks a competency framework to guide educational preparation and self-evaluation of readiness for specific areas of practice.
SLPs can provide services across the full spectrum of communication disorders.	There is a scarcity of SLPs specializing in areas such as fluency disorders, voice disorders, alternative and augmentative communication (AAC), and dysphagia.
Speech-language pathology services are reimbursed by private insurance, Medicare, Medicaid, and so forth, because state licensure includes educational requirements that are consistent with the CCC-SLP.	There are concerns about SLPs’ knowledge of billing and reimbursement, documentation, regulations, ethics, interprofessional collaborative practice, evidence-based practice, and cultural competence.

Table 9: Themes about how adequately the public is being served by the current educational model. These themes were derived from multiple surveys and focus groups to the question posed in V.A. about how well the current model of entry-level education is serving.

- On the *2013 Higher Education Survey* (CAPCSD & ASHA, 2014), 114 of 257 master’s programs (44.4%) reported facing challenges teaching across the full scope of practice because (a) faculty hired to teach may not have the depth of expertise needed to do it well; (b) there is insufficient time in the program to fit it all into the curriculum; and (c) there are insufficient practicum experiences available across practice settings.

3. In 2013 and again in 2019, a supplemental question was included in the *CSD Education Survey*. Respondents were asked, “Are there curricular topics for which the program has limited faculty expertise that would benefit from access to shared expert-level instructional resources? If so, what areas?”
  - a. In 2013, 85 of 257 programs (33%) reported areas for which they had limited faculty expertise. These are displayed in Figure 8.

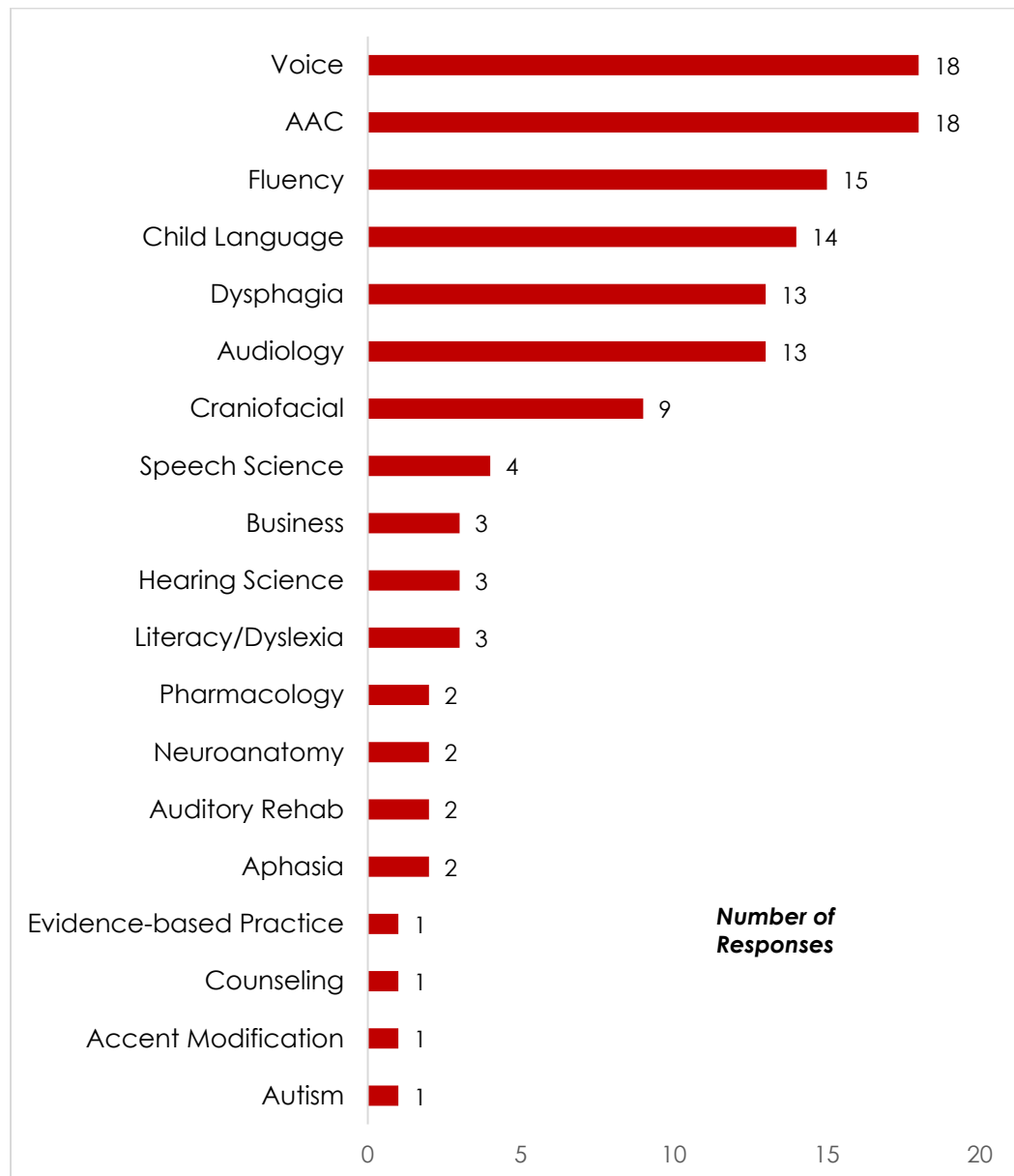


Figure 8: Responses to the supplemental question included in the *2013 Higher Education Survey* that asked, “Are there curricular topics for which the program has limited faculty expertise that would benefit from access to shared expert level instructional resources? If so, what areas?” *Note:* 236 (92%) of 257 master’s speech-language pathology programs completed the *2013 Higher Education Survey*, and 85 programs responded to this question.

- b. In 2019, 125 of 264 programs (47%) reported areas for which they had limited faculty expertise. These are displayed in Figure 9.

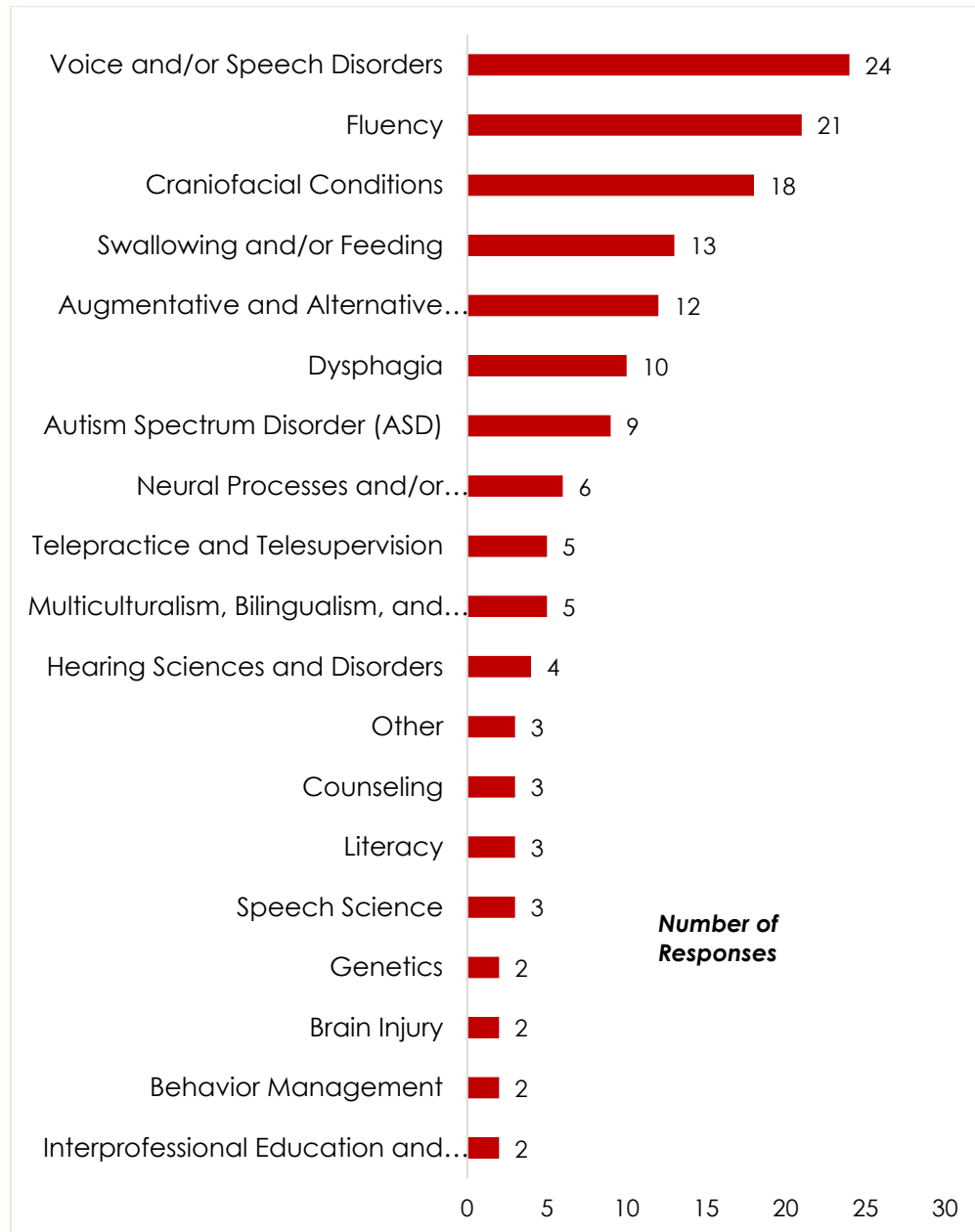


Figure 9: Responses to the supplemental question included in the *2018-2019 CSD Education Survey* that asked, “Are there curricular topics for which the program has limited faculty expertise that would benefit from access to shared expert level instructional resources? If so, what areas?” *Note:* 264 (94%) of 281 master’s speech-language pathology programs completed the *2019 CSD Education Survey*, and 125 programs responded to this question.

- c. In 2019, programs were also asked about “faculty concern about the department’s capacity to teach across the full scope of practice across the life span in speech-language pathology.” As shown in Figure 10, of the 257 master’s programs in speech-language pathology that responded to this question, nearly half (47%) indicated that faculty had concerns about the department’s capacity to teach across the full scope of practice across the life span.

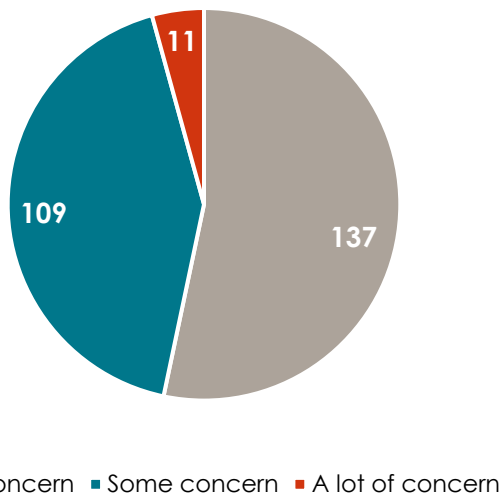


Figure 10: Responses to a supplemental question included in the *2018-2019 CSD Education Survey* about “faculty concern about the department’s capacity to teach across the full scope of practice across the life span in speech-language pathology.” *Note:* 264 (94%) of 281 master’s speech-language pathology programs completed the *2018-2019 CSD Education Survey*, and 257 programs responded to this question.

4. The curricular topics identified by academic programs in response to the question about having “limited faculty expertise” in 2013 and in 2019 include all of the “Big Nine” areas for which “demonstrated current knowledge of the principles and methods of prevention, assessment, and intervention” is required for certification (see Standard IV-C and IV-D of the [2020 Standards for Certificate of Clinical Competence in SLP](#)). The “Big Nine” areas are as follows:
- Speech sound production, to encompass articulation, motor planning and execution, phonology, and accent modification
  - Fluency and fluency disorders
  - Voice and resonance, including respiration and phonation

- d. Receptive and expressive language, including phonology, morphology, syntax, semantics, pragmatics (i.e., language use and social aspects of communication), prelinguistic communication, paralinguistic communication (e.g., gestures, signs, body language), and literacy in speaking, listening, reading, and writing
  - e. Hearing, including the impact on speech and language
  - f. Swallowing/feeding, including (i) structure and function of orofacial myology and (ii) oral, pharyngeal, laryngeal, pulmonary, esophageal, gastrointestinal, and related functions across the life span
  - g. Cognitive aspects of communication, including attention, memory, sequencing, problem solving, and executive functioning
  - h. Social aspects of communication, including challenging behavior, ineffective social skills, and lack of communication opportunities
  - i. AAC modalities
5. Focus group participants from the 2019 CAPCSD Conference (see Appendix D) reported that:
- a. There are not enough faculty in their department to teach across the full scope of practice.
  - b. There is not enough time in the program to fit everything into the curriculum.
  - c. There are not enough externship sites available across practice settings.
6. Focus group participants from the 2019 CAPCSD Conference also reported that most graduating students, including those demonstrating academic excellence, are not prepared to work in all settings and sometimes had limited experience in their first CF setting. Some areas were identified as being especially challenging to secure placements and prepare students adequately—such as neonatal intensive care units, craniofacial clinics, voice clinics, acute care, private practices with an emphasis on fluency disorders, and preschool autism programs.



V.B. Are there changes to the current model of entry-level education that would likely help to address any gaps or unmet needs that have been identified?

1. The AHC-GESLP discussed what changes to the current model of entry-level education might help to address the gaps and unmet needs that have been identified. Committee members identified six areas, listed below, that would be key targets to reexamine to improve educational—and, thus, clinical outcomes. The Committee did not determine exactly what changes should or could be made; rather, the AHC-GESLP identified the following six areas, primarily to provide a starting point for future efforts, which ideally will include a larger number of stakeholders and the development of a work plan dedicated solely to addressing this pressing, all important question.
  - a. **Content and pedagogy of degree programs:** There is concern that the full scope of speech-language pathology practice—and many of the professional competencies required for practice across increasingly complex practice settings—cannot be adequately covered in the current educational model. Also, there is concern that current pedagogical methods need to be more aligned with the future of learning (e.g., McMurtrie, 2018) and the content adjusted to better prepare students for the future of work (e.g., Carlson, 2017).
  - b. **Competency-based model:** The AHC-GESLP identified a need for a competency-based model to enhance educational preparation and evaluation of graduate for entry-level practice in speech-language pathology. These competencies might address areas within the “Big Nine” but importantly, competencies should be considered for areas such as critical thinking, problem-solving skills, professional responsibilities, ethics, cultural competence, interprofessional collaborative practice, evidence-based practice, and both oral and written communication skills.
  - c. **Clinical experiential component:** The AHC-GESLP also identified a need to reevaluate how well the current model of providing clinical experiences is working in general and specifically relative to the challenges associated with securing clinical placements. The dependency on and, in some cases, the scarcity of clinical placements are challenges that the AHC-GESLP identified as critical based on the input received by multiple stakeholder groups.
    - i. According to Table 21 in the [Communication Sciences and Disorders \(CSD\) Education Survey National Aggregate Data Report for the 2018–2019 Academic Year](#), (p. 45), “insufficient clinical placements” was the top factor impacting enrollment across speech-language pathology master’s level programs. Almost half (45.7%) of the 264 master’s

programs that responded to the survey reported “insufficient clinical placements” as either a moderate (24.2%) or major (21.5%) factor impacting enrollment in master’s degree programs in speech-language pathology.

- ii. According to the supplemental question posed on the 2018-2019 *CSD Education Survey* (see *Supplemental Question Report* in Appendix G) that asked respondents whether, in their program, “speech-language pathology faculty and clinical extern coordinators were concerned about challenges finding external clinical placements that provide needed experiences across a range of populations?”, 76 (29%) indicated “a lot of concern”, 127 (49%) indicated “some concern”, and 58 (22%) indicated “no concern.” As shown in Figure 11, more than three-quarters (78%) of the master’s programs in speech-language pathology indicated that faculty and clinical extern coordinators were concerned about challenges finding external clinical placements.

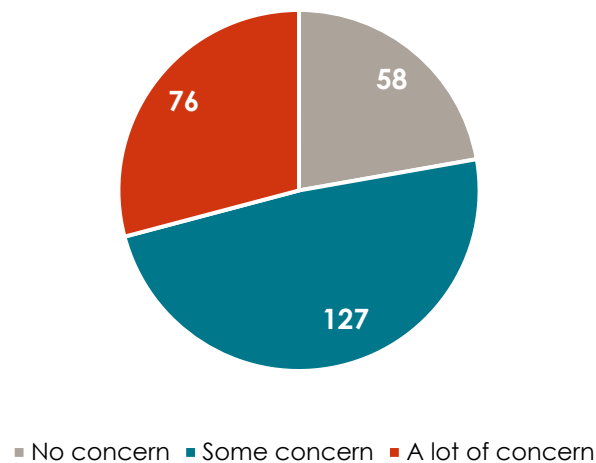


Figure 11: Responses to a supplemental question included in the 2018-2019 *CSD Education Survey* about “speech-language pathology faculty and clinical extern coordinators concern about challenges finding external clinical placements that provide needed experiences across a range of populations.” *Note:* 264 (94%) of 281 master’s speech-language pathology programs completed the 2019 *CSD Education Survey*, and 261 programs responded to this question.

- d. **Role of the undergraduate degree:** The perceived need for more time devoted to entry-level education could be accomplished by dedicating a greater proportion of the undergraduate degree to meet the certification standards and to develop student competencies in areas such as billing and reimbursement, documentation, regulations, ethics, interprofessional

collaborative practice, evidence-based practice, cultural competence, and perhaps others. This approach could help to cover more without increasing student debt.

- e. **Variability across programs and clinical placements:** Variability across programs, outplacement and internship sites, and quality of supervision all lead to inconsistencies in educational preparation and student readiness for entry-level practice. This issue was identified by the ACH-GESLP as a challenge in the current educational model—and one that deserves greater attention.
  - f. **Need to instill commitment to lifelong learning and better preparation in evidence-based practice:** There is a perceived need to do more to instill critical thinking, evidence-based practice, and lifelong learning. Incorporating alternative teaching methods, such as problem-based learning, offering practica with diverse populations and collaboration with other professionals, and providing clinical experiences that teach and incorporate evidence-based practice were all suggestions the AHC-GESLP members agreed would move the profession in a more positive direction.
2. Three alternative models of entry-level education were considered by the ACH-GESLP as having the potential to mitigate some of the challenges listed above and in section VI, to improve educational outcomes, and perhaps reduce some of the stress that the current model is placing on many academic programs and their students. These models were considered by two focus groups, which were held at the 2019 CAPCSD Conference. University clinic directors and department chairs were asked to provide opinions about each of the three alternative educational models that are briefly described below.
- a. **The Life Span model** is the current educational model, except that more than 2 years would be required to complete the degree to avail more time to teach across the full scope of practice, enable students to gain greater depth of knowledge in one or more clinical areas, and provide a greater diversity of clinical experiences. The Life Span model was described to focus group participants as “one program and one certification for all SLPs covering the full scope of practice across the life span—only the time to degree would be extended beyond 2-years.”
  - b. **The Track model** was described to focus group participants as “two tracks with separate programs for adult/medical and child/schools, plus a required core curriculum that all students in all tracks would receive. Certification

would no longer apply across the full scope of practice but rather by child/schools and adult/medical subdivisions.”

- c. The Modular model** was described to focus group participants as “a re-organization of the current curriculum into modules (e.g., 12 modules), plus a required core curriculum that all students in all programs would receive. Programs would offer the core curriculum plus those modules that they choose, but at least as many as would be required for graduation and initial certification (e.g., six modules). SLPs would be certified to provide services in only those areas for which they have completed the educational requirements and passed the qualifying exam. After graduation, SLPs could expand the areas in which they are qualified to practice by completing the educational requirements and presumably, by passing a qualifying exam for that module.
- d.** The themes that emerged about these three models from the two focus groups held at the 2019 CAPCSD Conference are described below.

  - i. For both focus groups, most participants preferred the Life Span model, which explicitly included an extended program duration relative to the current model and relative to both the Track and the Modular models. The Life Span model was perceived as the most feasible to implement because this educational model would not be all that different from what they are currently offering, just longer.
  - ii. Most focus group participants liked the notion of extending the program’s duration for the Life Span model by dedicating portions of the undergraduate degree (i.e., the senior year), into the entry-level degree as opposed to adding another year of graduate school (primarily due to sensitivities around increasing student debt).
  - iii. The Modular model was viewed as a creative approach and several participants expressed interest in that concept being furthered explored. They liked that students would have the opportunity to gain more depth of knowledge and develop clinical acumen in specific areas based upon the modules being offered. They also liked the notion that departments could “play to their strengths” and “not have to cover it all.”
  - iv. There were risks perceived with the Track and Modular models—primarily in terms of how the models might affect faculty lines and how students might find it difficult to decide so early in their career which track or modules they want. Participants expressed concern that many

students may not be ready to choose a track or specialty area until they have sampled them all.

- v. The alignment among educational standards, credentialing standards, and licensure and reimbursement policies is an intricate one. The focus group participants discussed how these three models might differentially affect this alignment. The importance and complexity of that question was generally acknowledged but no conclusions were drawn.
- vi. The focus group participants expressed concern that without change, there is an increased risk of encroachment, of missing the mark with respect to clinical excellence, and risk to the reputation of the profession. There was concern expressed that, without change, SLPs may lose ground in terms of protecting the scope of practice and professional parity and respect. Concern was expressed that, without change, the risk of being viewed as *technicians* rather than as *professionals* will only increase.

### V.C. What are the benefits and risks to the profession of speech-language pathology and/or the public if the current model of entry-level education for SLPs remains unchanged in the near future?

1. The AHC-GESLP reviewed multiple survey and focus group reports and read through hundreds of open-ended responses provided by ASHA members; certified SLPs, CSD academic faculty and undergraduate, master's, and clinical doctoral students in SLP, and recent graduates of master's and clinical doctoral programs in speech-language pathology.
2. The Committee members also read reports from previous committees to ascertain what the potential benefits and risks to the speech-language pathology profession and the public might be if entry-level education for SLPs remains unchanged.
3. The AHC-GESLP considered and discussed all these perspectives to distill the most salient and frequently mentioned points. A synopsis of the benefits and risks if the current model of entry-level education remains unchanged is displayed in Table 10.

<b>If the current model of entry-level education <u>remains unchanged</u> . . .</b>	
<b>Benefits</b>	<b>Risks</b>
No changes to student debt load.	Inadequately preparing students.
No effect on current entry-level programs or those being established.	Continued encroachment, especially in dysphagia, cognition, language, voice, autism, reading, and pediatric feeding.
No negative effect on the current pipeline of SLPs.	Loss of professional autonomy, professional equity, and respect.
No changes to employer financial obligation (e.g., step increases).	Prospective students may choose a different profession.
No associated changes needed to accreditation and certification standards.	Employers may have to accept increased responsibility to educate entry-level SLPs due to gaps in knowledge and skills, including professional responsibilities.
No changes to the work, time, costs to academic programs to change.	Continued shortages of practitioners qualified to practice in specialty areas (e.g., voice, fluency, autism, and AAC).
No changes to accreditation and certification standards.	Those who we serve may not be receiving adequate care as consistently as needed.

Table 10: A synopsis of the benefits and risks to the profession of speech-language pathology and/or the public if the current model of entry-level education remains unchanged. AAC = augmentative and alternative communication.

V.D. What are the benefits and risks to the profession of speech-language pathology and/or the public if the current model of entry-level education for SLPs, or some aspects of the current model, is changed in the near future?

1. The AHC-GESLP reviewed multiple survey and focus group reports that included ASHA members; certified SLPs, CSD academic faculty and undergraduate, master’s, and clinical doctoral students in SLP, and recent graduates of master’s and clinical doctoral programs in speech-language pathology.

2. The Committee members read reports from previous committees to ascertain what the potential benefits and risks to the speech-language pathology profession and the public might be if entry-level education for SLPs were changed.
3. The AHC-GESLP considered and discussed all these perspectives to distill the most salient and frequently mentioned points. A synopsis of the benefits and risks if the current model of entry-level education is changed is displayed in Table 11.

<b>If the current model of entry-level education is <u>changed</u>...</b>	
<b>Benefits</b>	<b>Risks</b>
Better prepared and more competent entry-level practitioners.	Some programs may close if the changes require a change in the degree designator.
Those who receive SLP services may be more likely to receive adequate care more consistently.	Risk to the pipeline if some programs close, as then there might be fewer graduates and they might be less diverse.
Mitigate loss of professional autonomy and loss of professional equity.	Employers may not notice changes unless there is a change in degree designator.
Ward off encroachment by other disciplines.	There may be substantial work and increased cost to academic programs if major changes are planned.
Decreased cost and time for employers to onboard entry-level practitioners.	There may be substantial work and increased cost for accreditation and certification programs if major changes are planned.
Increase availability of practitioners qualified to practice in specialty areas (e.g., voice, fluency, autism, dysphagia).	If the debt load is increased by the changes, then prospective students may choose a different profession with fewer educational requirements for entry to avoid incurring more debt.

Table 11: A synopsis of the benefits and risks to the profession of speech-language pathology and/or the public if the current model of entry-level education is changed.

## **VI. What input do ASHA members and other key stakeholders have regarding (a) which aspects of the current model of entry-level education for speech-language pathology in the United States are serving the profession and the public adequately now, and in the near future, and (b) which aspects are not?**

The AHC-GESLP sought the perspectives of ASHA-certified SLPs who work in school, health care, early intervention, and private practice settings. Perspectives were solicited from certified SLPs with more than eight years of experience as well as from recently certified SLPs. The Committee also gathered perspectives on this question from department chairs, clinical directors, and other faculty teaching in master's programs in speech-language pathology. The AHC-GESLP also incorporated input on this question from large numbers of ASHA members through three ASHA surveys: 2019 *Public Policy Agenda*, 2018 *Schools Survey*, and 2017 *Health Care Survey*. The themes that emerged are described below and include perspectives from the following stakeholder groups:

- CF supervisors
- Recently certified SLPs
- Certified SLPs with more than 8 years of experience
- University clinic directors
- University department chairs
- Respondents to ASHA's
  - 2019 *Public Policy Agenda*,
  - 2018 *Schools Survey*, and
  - 2019 and 2017 *Health Care Survey*.



**Conclusion:** Four aspects of the [\*2020 Standards for Certificate of Clinical Competence in Speech-Language Pathology\*](#) were frequently mentioned as challenges by respondents across stakeholder groups when asked how well the current model of entry-level education for SLPs is serving the profession and the public now, and in the near future.

1. **Full Scope of Practice in SLP:** Applicants for certification in speech-language pathology must have demonstrated knowledge of communication and swallowing disorders and differences—including the appropriate etiologies, characteristics, and anatomical/physiological, acoustic, psychological, developmental, and linguistic and cultural correlates in nine areas. (Standard IV-C)
2. **Clock Hours:** Applicants for certification in SLP must complete a minimum of 400 clock hours of supervised clinical experience in the practice of speech-language pathology. (Standard V-C)
3. **Across the Life Span:** Supervised practicum must include experience with individuals across the life span and from culturally/linguistically diverse backgrounds. (Standard V-F)
4. **Clinical Fellowship:** Applicants for certification in speech-language pathology must successfully complete a Clinical Fellowship. (Standard VII)

a. **CF Supervisors** participated in a focus group conducted at the Boston Convention in 2018. Their responses revealed the following:

1. Most of the participants said that the clinical fellows that they had supervised were adequately prepared to begin their CF. However, they also indicated that there would have been a problem if their clinical fellows had been eligible for certification and licensure immediately following graduate school and had come to work as an SLP instead of as a clinical fellow.
2. The following areas were identified in response to the question, “Of the clinical fellows you have supervised, were there professional responsibilities or areas of practice for which the clinical fellows were not well prepared? If so, what were they?”:
  - Swallowing
  - Physiology related to underlying diagnoses
  - Cognition and dementia
  - Rehab in general
  - Behavioral challenges
  - Counseling skills

- Pediatric feeding
  - Developmental norms
  - Goals and carrying out the goals
  - Reimbursement codes and billing practices
  - Insurance
  - Regulatory information
  - Documentation
  - Clinical writing
  - Synthesizing case histories and medical charts
3. Respondents were unanimous in their conviction that the CF should continue to be a requirement for certification.
  4. Focus group participants suggested the following as possible changes to the current model of graduate education: seminars on specialty topics, more opportunities for externships, giving undergraduates clinical experience, and awarding different degrees or certifications for different tracks.
  5. Some focus group participants shared concerns about online-only programs and wanted to eliminate discrepancies among master's programs in speech-language pathology.
  6. The participants were asked, "If you could design a program to prepare individuals to become SLPs, what would the program look like? How would it differ from the current model?" In response to this question, they thought that a third year would help to better prepare students. They discussed a 3-year program with a required curriculum, followed by a CF that would last at least 12 months. They also suggested that mini-placements be scattered throughout the first 2 years.

b. **Recently Certified SLPs** participated in a focus group conducted at the Boston Convention in 2018. Their responses revealed the following:

1. They all described themselves as having been adequately prepared when they started their CFs.
2. Areas of practice for which they would have liked more training included dysphagia, cognitive evaluation, and working in medical settings.
3. The list of professional responsibilities for which they would have liked more training included preparing individualized education programs (IEP), paperwork; electronic medical records; varying dosage/frequency of treatment for Medicare Part

A and Part B patients; collaborating with physical therapists and occupational therapists; familiarity with medical terminology and abbreviations; knowing how to call a code; and meeting productivity requirements.

4. Currently, 400 clinical clock hours are completed within the confines of a graduate school program, but these focus group members questioned whether that is enough. They questioned whether competencies should be developed, as opposed to simply gathering clinical clock hours?
5. All participants in this focus group were in favor of maintaining the CF requirement.
6. Perceived strengths of the CF included that the experience provides an opportunity to obtain on-the-job training with real clients/patients under the guidance of a seasoned mentor if the experience is designed and monitored appropriately.
7. The fact that the CF is a paid experience was viewed as a critical component.
8. These focus group participants noted that it is frequently challenging to find a placement in one's targeted specialty area, and geography can compound that difficulty.
9. Another challenge noted is that the CF experience varies greatly, depending on the setting and mentoring styles vary greatly. Although mentors only have to observe the Clinical Fellow for 6 hours per segment (420 hours), some clinical fellows state that they cannot get in touch with their mentor or that the mentor is not providing the level of supervision that they feel they need.
10. The participants valued the framework of the CF and did not believe that new graduates could benefit as much from an employer-based mentorship program as from a CF.
11. Specialty tracks were recommended, but they did not want to give up flexibility, so they preferred that SLPs are trained across the full scope of practice and across the life span. Increased costs to programs and to students were perceived as the biggest barrier to developing programs to better prepare students.
12. They all agreed that the scope of practice is so broad that it is necessary to increase the time to degree in academic programs that prepare SLPs to enter practice and to add more practica, but they did not want to increase costs. Several participants recommended embedding course-related practica within each course.

c. **ASHA-Certified SLPs with more than 8 Years of Experience** participated in a focus group conducted at the Orlando Convention in 2019. Their responses revealed the following:

1. Areas where they wished they had received more training included legal issues, ethics, dysphagia, and treating individuals with laryngectomies. Most wished they had received more hands-on experience prior to their CFs.
2. The breadth of material that current students are required to learn was viewed as both a strength and a weakness. Current clinical fellows begin with a lot of book knowledge but do not have a specialty area and are lacking in clinical experience. In addition, CF positions can be difficult to find and secure, particularly in one's chosen setting.
3. Suggested changes to the current model included: (a) in-house clinical practicum in undergraduate programs; (b) more semester-long placements; (c) more networking opportunities; (d) more focus on Interprofessional Education/ Interprofessional Collaborative Practice; (e) increased hours in assessment; (f) more diversity training; (g) greater standardization across programs; (h) more psychology classes; and (i) increased ethics offerings and requirements for graduation and/or certification.

d. **University clinic directors** participated in a focus group conducted at the 2019 CAPCSD Conference in San Diego. Their responses revealed the following:

1. Clinic directors indicated that they were challenged to find external placements, by the ever-expanding scope of practice, by having insufficient faculty to teach across the scope of practice, and by the allowance of time in the curriculum to adequately prepare entry-level clinicians. They said that their best students would be prepared for clinical practice upon graduation, although they noted that expectations of clinical fellows' competencies may be unrealistically high. Students with typical performance may succeed, but they would likely need more careful mentoring and support during their CF than would students with excellent performance, and they may not be ready to work in some types of facilities.
2. Clinic directors suggested changes to the current model that included expanding to a 3-plus-3 or a 5-year program, returning courses on disorders to the undergraduate level, incorporating clinicians with specialized skills from the community more often into the faculty, adding distance learning and incorporating more online learning, modernizing programs to reflect the current health care and education fields, and reconsidering the number of required practicum hours and/or how they are obtained.

- e. **University department chairs** participated in a focus group conducted at the 2019 CAPCSD Conference in San Diego. Their responses revealed the following:
1. Department chairs indicated that they were challenged by time, money, availability of practicum experiences, and faculty expertise to teach across the full scope of practice. Despite this, their best students would be prepared for clinical practice upon graduation because, in addition to knowledge, they had self-efficacy and critical thinking skills and had likely volunteered for experiential learning projects. Their typical students might also be ready to practice, but they noted that student expectations and supervisor expectations were often unaligned.
  2. Department chairs suggested changes to the current model that included adding more requirements to the CF to increase accountability and revising the model of externship supervision similarly. They suggested that it's time to reexamine what it is we believe students need to be able to do (i.e., competencies) and not so much what they need to know (i.e., knowledge and skills). Not having a sufficient number of clinical placements and externship sites was viewed as the major barrier to accepting more students.
  3. Department chairs concluded that if there were more external clinical sites for placements, then there could be more students; if there were more students, then there could be more faculty; and if there were more faculty, then it would be more possible to teach and adequately prepare students across the full scope of practice.
- f. **2020 Public Policy Agenda (PPA) Survey:** Data and open-ended comments from the 2,573 individuals who responded to the *2020 PPA Survey* (ASHA, 2019) included many concerns about the adequacy of the clinical education that entry-level clinicians receive and the competency of practicing clinicians.
1. **Scope of practice** was identified by the 2020 PPA survey respondents as being among the top three priorities.
    - 92.9% of all respondents rated Scope of Practice as “very” or “somewhat” important to address.
    - 93.1% of all SLP respondents rated Scope of Practice as “very” or “somewhat” important to address.
    - 91.1% of SLP respondents working in school settings rated Scope of Practice as “very” or “somewhat” important to address.
    - 94.1% of SLP respondents working in health care settings rated Scope of Practice as “very” or “somewhat” important to address.

2. **Encroachment** was a major issue cited in the open-ended comments by many of the 2,573 individuals who responded to the *2020 PPA Survey*. The data indicated that ASHA members from all work settings are concerned that the current approach to entry-level education for SLPs is not adequately preparing our future clinicians and may be hampering the profession’s ability to hold onto its current scope of practice (i.e., concerns about encroachment).
  3. **Inadequacy of the clinical education for speech-language pathology students to enter medical settings** was also frequently mentioned by many of the 2,573 individuals who responded to the *2020 PPA Survey*.
  4. **Lack of skills and competency of practicing clinicians** to practice in several areas—that included feeding and swallowing, AAC, autism, voice, and others—were viewed as a result of the rapidly expanding scope of practice and as a contributing factor to encroachment by many of the 2,573 individuals who responded to the *2020 PPA Survey*.
- g. **2019 and 2017 Health Care Survey and 2018 Schools Survey:** The 1,894 SLPs working in health care settings and the 1,620 SLPs working in school settings who responded to the *2017 Health Care Survey* and the *2018 Schools Survey*, respectively, frequently cited encroachment and lack of skills as top concerns in the provision of their clinical services. These respondents had concerns about the adequacy of clinical education for speech-language pathology students—and that other professionals were beginning to take a primary role in communication and swallowing services. They mentioned scope of practice infringements in several areas, including aphasia, dysphagia, autism, developmental language disorders, and cognitive-communication disorders.
1. More than a quarter of 2017 SLP Health Care Survey respondents providing early intervention (EI) services indicated “other professionals taking primary role in communication or swallowing services” as a top issue affecting their work, as did 8.2% of respondents to the 2018 Schools Survey.
  2. Of the 2,174 respondents to the 2019 Health Care Survey, 8.2% felt pressured to provide services for which they had inadequate training and/or experience, up from 7.4% in 2017. In addition, 9.4% of the 2017 Health Care Survey respondents providing EI services indicated that “serving as primary provider in areas outside my scope” was an issue that affected their work. One fifth (20.5%) of the 2,170 respondents to the 2018 Schools Survey indicated “lack of training to work with specific disorders or special populations” as one of their greatest challenges.

#### **h. Summary of stakeholder perceptions about the current model of entry-level education for SLPs**

There are many aspects of the current model of entry-level education for speech-language pathology that multiple stakeholders identified as serving the profession and the public well and other aspects of the current model that may not be adequately serving the profession and the public. The master's degree became the entry-level degree in 1963. Since then, the scope of practice has changed significantly, but the educational model has not. Based on analyses of the surveys and focus groups reported in this document, there appears to be widespread concern that students may not be consistently prepared to enter practice nor to deliver services across the full scope of practice across the lifespan. Additionally, the baseline requirement of 400 clinical clock hours remains in place, yet there is growing awareness of the need to transition to a competency-based educational model to better support the preparation and evaluation of future SLPs. There is concern that practicing clinicians transitioning across settings may not be adequately prepared to do so and may require additional professional development and mentoring for a successful transition. There is also concern about professional parity and encroachment by other related disciplines. The breadth of topics that are now central to the speech-language pathology profession limits students being able to delve deeply or develop areas of specialization in their entry-level program. The limited number of specialists in areas such as voice, fluency, AAC, and dysphagia were frequently mentioned. The expanding scope of practice is challenging for academic programs and students given the time allotted for entry-level education in speech-language pathology. Securing a sufficient number of quality clinical placements is another pressing challenge facing many academic programs. These factors compel further consideration of how entry-level education for SLPs can be improved. As indicated by the data reviewed in this report, changes are needed, but additional input is required from a larger group of stakeholders to determine which changes are needed to address current challenges, to improve entry-level education for SLPs, and to anticipate how educational preparation could be adjusted to better align with the future of learning and the future of work.

## VII. Final Conclusions

In response to the request made in the 2017 CAPCSD resolution, the AHC-GESLP reviewed pertinent information about the need for accreditation of optional, post-entry clinical doctoral programs in speech-language pathology. The variability among the eight extant programs was examined and many inconsistencies were identified across programs. As new programs are established, without accreditation, variability will likely increase regarding degree requirements, length of program, curriculum, whether there is a focus on advancing knowledge and skill development in select areas of clinical practice, or whether there is a focus on preparing these graduates to provide clinical education. Because these degree holders would likely be regarded as “Master Clinicians” and as leaders in their clinical settings and sub-specialties, and be hired by academic programs to teach the next generation of SLPs, it is imperative that these current and emerging programs graduate professionals who have truly advanced the depth of their knowledge and acquired advanced clinical skills. Without accreditation, there is no mechanism by which to evaluate the quality of these programs. If clinical doctoral programs in speech-language pathology are not aligned and evaluated by a common set of standards, then it is possible that the entire profession may suffer the consequences of a diminished reputation caused by a subset of inconsistently trained graduates who are presumably “advanced” professionals. With 27 new master’s programs becoming accredited by the CAA over the past 10 years and many additional programs in the application pipeline, but with no major increase in the number of PhDs conferred, the faculty shortage appears to be increasing. In the 2018-2019 academic year, more than 80 individuals with clinical doctorates in speech-language pathology contributed to the didactic teaching, supervision, research, and administrative needs of 50 academic programs in speech-language pathology. It appears clear that a well-trained workforce in speech-language pathology with advanced instructional, supervision and clinical skills fulfills essential needs in higher education and across practice settings.

As elaborated upon in Section IV.B., there would be additional expenses that ASHA and the CAA would incur to establish and maintain an accreditation program for optional, post-entry-level clinical doctoral programs in speech-language pathology. Accreditation of these programs would also generate revenue from application and annual fees. The financial model described in Section IV.B. indicates that the targeted revenue-to-expense ratio of 40% for the CAA could be achieved if 12-14 programs applied for and were later granted accreditation. With eight extant clinical doctoral programs in speech-language pathology, another five programs planning to begin offering the degree in the 2020-2021 academic year, and another seven the year after, it appears likely that 12-14 programs would be interested in applying for accreditation by 2025, especially because 74% of these programs have already indicated their interest in becoming accredited. In light of this finding and the compelling need for accreditation, the AHC-GESLP recommends that the ASHA Board of Directors and the CAA undertake deliberation of accrediting optional, post-entry-level clinical doctoral programs in speech-language pathology.



The AHC-GESLP also addressed the question of “What are the rationale and data indicating what is needed to adequately prepare future speech-language pathologists (SLPs) to enter the profession?” After reviewing extant data, prior reports and collecting new information, the Committee concluded there is much need to reexamine the current model of entry-level education for SLPs. The master’s degree became the entry-level degree in 1963. Since then, the scope of practice has changed significantly, but the educational model has not. Based on analyses of the surveys and focus groups reported in this document, there appears to be widespread concern that students may not be consistently prepared to enter practice nor to deliver services across the full scope of practice across the lifespan. In 2013, 33% of master’s programs in speech-language pathology reported that faculty have concerns about the department’s capacity to teach across the full scope of practice; in 2019, that percentage increased to 47% of master’s programs. In 2013 and 2019, the curricular areas for which master’s programs reported having limited faculty expertise included all of the “Big Nine” areas listed in the [\*2020 Standards for Certificate of Clinical Competence in SLP\*](#) for which demonstrated current knowledge of the principles and methods of prevention, assessment, and intervention is required for certification. Securing enough quality clinical placements is another pressing challenge facing many academic programs. The Committee identified six areas that would be key targets to reexamine to improve educational outcomes, including: (a) content and pedagogy of degree programs; (b) competency-based models; (c) clinical experiential component; (d) role of the undergraduate degree; (e) variability across academic programs and clinical placements; and (f) need to instill lifelong learning and better preparation in evidence-based practice and other areas critical to the future of work. These factors compel further consideration of how entry-level education for SLPs can be improved in the future.

The AHC-GESLP also addressed the question of “What input do ASHA members and other key stakeholders have regarding (a) which aspects of the current model of entry-level education for speech-language pathology in the United States are serving the profession and the public adequately now, and in the near future, and (b) which aspects are not?” The Committee concluded that there are aspects of the current model of entry-level education for speech-language pathology that multiple stakeholders identified as serving the profession and the public well and others that are not adequately serving the profession nor the public. Several challenges were identified and multiple areas were suggested to be in need of improvement by the many stakeholders who participated in focus groups or responded to surveys fielded on behalf of this Committee. As indicated by the data reviewed in this report, changes are needed, but additional input is required from a larger group of stakeholders to determine which changes are needed to address current challenges and improve entry-level education for SLPs. As research and deliberation about this topic continue, the Committee emphasized that it will be important to anticipate how educational preparation could be adjusted to better align with the future of learning and the future of work.

Accordingly, the AHC-GESLP recommends that the ASHA Board of Directors appoint a planning committee charged with advising the ASHA BOD about how the four questions posed below should continue to be addressed. The Committee recommends that these efforts continue to focus on how the future of learning and work could impact the education of entry-level SLPs in the future.

The Committee also recommends that work continue with a larger number of stakeholders, including representatives from the CFCC, CAA, the National Student Speech-Language-Hearing Association (NSSLHA), and CAPCSD, to address the following questions:

1. What is needed to adequately prepare future SLPs to enter the profession?
2. What competencies are needed to enter speech-language pathology practice, and how should they be acquired and evaluated?
3. Which aspects of the current model of entry-level education for speech-language pathology in the United States are serving the profession and the public adequately now, and in the near future, and which aspects are not?
4. Are there changes to the current model of entry-level education that would likely help to address challenges, gaps or unmet needs that have been identified?

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## Appendix A: AHC-GESLP Educational Models Subcommittee Report

### 1. Overview of professions included in the review of educational models in related disciplines

- Criteria for inclusion in the original selection of professions for the Subcommittee’s review were:
  - Health or education profession that requires a license or certification to practice.
  - Entry-level education of at least a bachelor’s degree.
- The Subcommittee identified 43 related professions in Health and Education that were included in the initial information gathering. The list was shared with full AHC-GESLP to ensure that it was complete and that all relevant related professions were identified; they affirmed the list.
- Based on a subsequent call with the Competency Models Subcommittee, it was suggested that we select the top 20 professions for this information gathering effort.
- From that, the Educational Models Subcommittee made recommendations for removing some professions (10), parking some professions as a second-tier group (6), and combining some professions (8 professions were combined to make 4). All candidate and selected professions are listed in Table 1.

Professions Reviewed		Professions Combined (4 Health / 4 Educ)	Professions Parked (5 Health / 1 Educ)	Professions Removed (8 Health / 2 Educ)	
Health	Education				
Athletic Trainer	School Counselor	<b>Nurse (2)</b> <ul style="list-style-type: none"> <li>• Nurse</li> <li>• Nurse Anesthetist</li> </ul>	Art Therapist	Occupational Health Specialist	
Audiologist	<b>Psychologist (1)</b>	<b>Psychology (3)</b> <ul style="list-style-type: none"> <li>• Education</li> <li>• Neuropsychology</li> <li>• Health Psych</li> </ul>	Healthcare Administrator	Naturopath	
Chiropractor	<b>Special Educators (3)</b>	<b>Special Educators (3)</b> <ul style="list-style-type: none"> <li>• Learning Disabilities Specialist</li> <li>• Reading Specialist</li> <li>• Special Ed Teacher</li> </ul>	Music Therapist	All associate degree professions: <ul style="list-style-type: none"> <li>• Dental Hygienist</li> <li>• Rad Technician</li> <li>• Respiratory Therapist</li> </ul>	
Dentist (DDS/DMD)	Teachers of the Deaf/Hard of Hearing		Veterinarian	Public Health Specialist	
Physical Therapist			Orientation/Mobility Specialist	Visual Rehabilitation	
Genetic Counselor			Child Development Specialist	Assistive Therapy	
<b>Nurse (2)</b>					Interpreter/Translator
Nutritionist					General Education Teacher
Occupational Therapist					
Optometrist					

Pharmacist				
Exercise Physiologist				
Physician (MD & DO)				
Physician Assistant				
<b>Psychologist (2)</b>				
Prosthetist/Orthotist				
Recreation Therapist				
Rehab Counselor				
Social Worker				
<i>N</i> = 19 (22)	<i>N</i> = 4 (6)			

Table 1. Professions considered and professions selected for review by the Educational Models Subcommittee.

**2. The education and health professions selected include 18 that have not transitioned to a clinical doctorate as the entry-level degree.**

Nine of these require a master’s degree at the entry-level; nine require a bachelor’s degree. Table 2 shows the distribution of entry-level degree requirements of these professions.

<b>Bachelor’s Entry-Level Professions</b>	<b>Master’s Entry-Level Professions</b>
BSW (Social Worker)	Athletic Trainer (in 2022)
BSRN (Nurse)	Prosthetics & Orthotics
Exercise Physiologist	Rehab Counselor
Nutritionist	Genetic Counselor
Recreation Therapist	School Counselor
Teachers of the Deaf/Hard of Hearing	Educational Psychologist
Learning Disabilities Specialist	Physician Assistant
Reading Specialist	Health Psychologist
Special Education Teacher	Occupational Therapist (dual entry)

Table 2. Health and education professions reviewed that have not transitioned to a clinical doctorate as the entry-level degree. Nine require a bachelor’s degree; nine at master’s degree.

**3. There are nine professions included in the Subcommittee review that have transitioned to the clinical doctorate as the entry-level degree.**

These professions are listed in Table 3 along with information about what motivated each profession to transition to the clinical doctorate as the entry-level degree, what is the educational model for each profession, how the undergraduate degree is incorporated, the number of years to degree completion and the number of credits. The data displayed in Table 3 address the following five questions.

- Which professions have transitioned to the clinical doctorate as the entry-level degree or that plan to transition in the near future?
- Why did they decide to transition?
- What is their educational model, and specifically does education span all ages of human life?
- How have they incorporated the undergraduate (UG) degree work?
- How many years to graduation and credits are required?

<b>Ten professions that transitioned to clinical doctorate as entry-level degree.</b>	<b>Motivation for transitioning</b>	<b>Educational model</b>	<b>How is UG incorporated?</b>	<b>Number of years/ credits</b>
Audiology (AuD)	Scope of practice; expansion of knowledge & skills	Lifespan	N/A	3–4 years / ~ 100 credits
Pharmacy (PharmD)	Scope of practice; expansion of knowledge & skills	Lifespan	N/A	3–4 years / ~ 135 credits
Physical Therapy (DPT)	Primarily driven by desire to <i>have a seat at the table</i> in medical settings	Lifespan	N/A	3 years / 110 credits
Nurse Practitioner (DNP) (and nurse anesthetists in 2022)	Scope of practice; expansion of knowledge & skills; AACN adopted DNP as appropriate level of education for advanced practice	Life span	BSRN + 1 year experience in acute setting	2–3 years
Neuropsychology (PsyD/PhD)	Scope of practice; expansion of knowledge & skills	Life span	N/A	5 years / ~ 100 credits
Chiropractor (DCP)	Scope of practice; expansion of knowledge & skills	Life span	N/A	4 years / 90 credits
Dentistry (DDS/DMD)	Scope of practice; expansion of knowledge & skills	Life span	N/A	4 years
Medical (MD) and Osteopathy (DO)	Scope of practice; expansion of knowledge & skills	Life span	N/A	4 years / ~ 100 credits
Optometry (OD)	Scope of practice; expansion of knowledge & skills	Life span	N/A	4 years / ~ 160 credits
Occupational Therapy* (OTD)	Primarily driven by desire to <i>have a seat at the table</i> in medical settings	Life span	N/A	2 years / ~ 100 credits

Table 3. Data is displayed about nine professions that transitioned to the clinical doctorate as the entry-level degree. The factors that motivated the transition to the clinical doctorate as the entry-level degree, the educational model for each profession, how the undergraduate degree is incorporated, the number of years to degree completion and the number of credits are shown. \*Dual entry-level degree. \*\*OT is, and will remain, a dual entry-level degree (MOT/OTD).

**5. The Subcommittee on Educational Models examined 28 professions.**

There were nine professions reviewed that require a bachelor’s degree at the entry-level, nine that require a master’s degree; and ten that require a clinical doctorate or PhD. All 28 of these professions are listed in Table 4 organized according to their entry-level degree requirements.

<b>Bachelor’s</b>	<b>Master’s</b>	<b>Clinical Doctorate</b>
Social Work*	Athletic Trainer (in 2022)	Audiologist
Nurse*	Prosthetics and Orthotics	Pharmacist
Exercise Physiologist	Rehab Counselor	Physical Therapist
Nutritionist*	Genetic Counselor	Nurse Practitioner (and nurse anesthetist in 2022)
Recreation Therapist	School Counselor	Neuropsychologist
Teacher of the Deaf/Hard of Hearing	Education Psychologist*	Chiropractor
Learning Disabilities Specialist	Physician Assistant	Medical Doctor and Doctor of Osteopathy
Reading Specialist	Health Psychologist*	Dentist
Special Education Teacher	Occupational Therapist**	Optometrist

Table 4. Summary of entry-level degree requirements across the 28 professions reviewed by the Subcommittee on Educational Models. Note: \*Dual entry-level degree. \*\*Occupational Therapy is, and will remain, a dual entry-level degree (MOT/OTD).

**7. The full continuum of degrees was considered by the Subcommittee, including how assistants are being trained and the role of the undergraduate degree.**

Table 5 shows the 16 professions that have a continuum of degrees from associate to master’s or doctorate. The distribution of these 16 professions that have a continuum of degrees from associate to master’s or doctorate is also shown graphically in Figure 1.

<b>Associate → Doctorate</b>	<b>BS → Doctorate</b>	<b>BS → MS</b>	<b>MS → Doctorate</b>
Nurse	Athletic Trainer	Recreation Therapist	Genetic Counselor
	Exercise Physiologist	Teacher of the Deaf/Hard of Hearing	Health Psychologist
	Social Worker	Learning Disabilities Specialist	Occupational Therapist (OT)
	Nutritionist	Reading Specialist	Physician Assistant (PA)
		Special Education Teacher	Rehab Counselor
			Educational Psychologist
			School Counselor

Table 5. Degree continuum of the 16 professions reviewed with a continuum of degrees.

- Of 28 health and education professions reviewed, 16 have multiple degrees and entry points.
  - Only 5 of 22 allied health related professions and 4 education professions have entry-level practice with a bachelor’s degree in the discipline-specific curriculum.
  - All of these health and education professions, however, have master’s degrees, which—for many—are required for more advanced or specialized practice.
  - Professions that have a continuum of degrees from associate to master’s or doctorate typically restrict entry level with an associate degree to assistants who have a limited scope of practice in comparison with fully trained practitioners at the master’s or doctoral level.
  - Licensure or certification is required in most states to work at the assistant level. In addition, a number of professions are considering the transition to requiring a bachelor’s degree for certification at the assistant level.



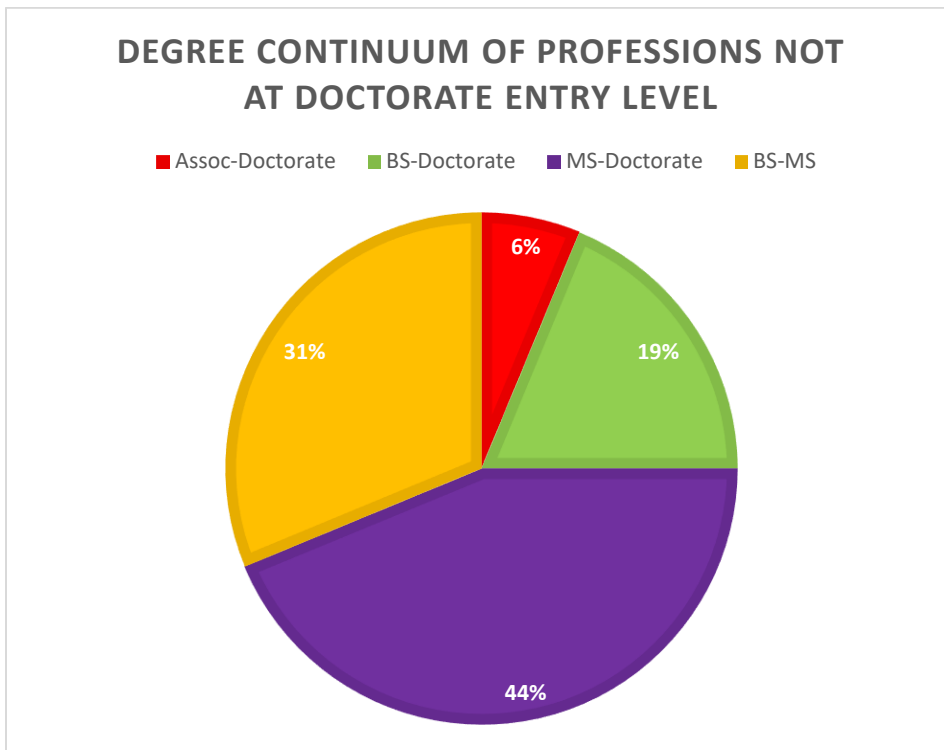


Figure 1. Degree continuum of the 16 professions that do not require a doctorate at the entry-level.

8. What do graduates do with a bachelor's degrees in the 10 professions shown in Table 5 that have a scope of practice to work with an UG degree? (See first 3 columns in Table 5.)

**Health Professions:** The following 6 health professions recognize the bachelor's degree as entry level (but note that the profession of athletic trainer is about to transition to master's entry level as of 2022):

- **Nurse:** A bachelor's degree in nursing (BSN) provides additional training beyond an associate degree in nursing (ADN) and is becoming recognized as the preferred entry-level credential by many employers. Many individuals with an associate degree must complete a BSN, often through an RN-to-BSN program in a specified time period upon employment. The increased value of the BSN is that the curriculum includes additional coursework covering areas such as evidence-based practice, leadership, and the profession of nursing.
- **Nutritionist:** The bachelor's degree is considered entry level, although a nutritionist license can be obtained with an associate degree. Most individuals obtain a master's degree, and area of specialty distinguishes the various entry levels.

- **Social Worker:** A non-clinical position, such as a mental health assistant, can be obtained with a bachelor's degree in social work (BSW); however, for clinical practice, an MSW is required.
- **Exercise Physiologist:** A bachelor's degree qualifies an individual for employment as a personal trainer. Three certifications are offered by the American College of Sports Medicine, each requiring passing of an exam, CPR certification, and completion of continuing education requirements every 3 years.
- **Recreation Therapist:** A bachelor's degree is required for certification through a national exam; specialty certification in five areas is also available. Degree programs range from associate to master's.
- **Athletic Trainer:** A bachelor's degree is currently considered entry level and qualifies an individual for clinical trainer positions; however, note that this profession is transitioning to master's entry level (2022).

**Education Professions:** The following 4 of 6 educational professions recognize the bachelor's degree as entry level; school counselors and school psychologists recognize the master's degree.

- **Teacher of the Deaf or Hard of Hearing (HoH):** The bachelor's degree in deaf education is considered entry level and provides eligibility for certification to practice. Requirements can vary from state to state. A master's degree is required for further employment advancement.
- **Reading Specialist:** A bachelor's degree in reading or literacy is considered entry level, but progression to a master's degree allows eligibility for increased employment opportunities and salary.
- **Learning Disabilities Specialist:** A bachelor's degree in reading or literacy is considered entry level, but progression to a master's degree allows eligibility for increased employment opportunities and salary.
- **Special Education Teacher:** A bachelor's degree that meets state special education certification requirements is considered entry level. This degree can be obtained through programs that vary from 4 to 5 years, depending on the state. A master's degree is required for further employment advancement.

## 9. What are the models for a residency or fellowship across professions?

- Of the 28 professions considered, our research indicated that only 9 have a fellowship or residency associated with them.
  - Most of these residency/fellowships occur post-graduation.
  - In a few cases (audiology, physician assistant, educational psychologist, and health psychologist), there is a full-time, hands-on experience prior to degree completion.
  - For audiology and educational psychology, a residency/fellowship is required; for the other two, it depends upon the particular university.
  - In all cases (typically described as *internships* except for audiology, which uses the term *externship*), this experience is 9–12 months in duration and occurs at the end of the curriculum.
- Five other professions (dentistry, optometry, pharmacy, general medicine (physician), and physical therapy) have post-graduate residency opportunities.
  - It should be noted that, in audiology, some people have expressed interest in a post-graduate residency option, but at this time, there is only one known residency available. Thus, audiology residencies are not currently common practice.
  - Physical therapy also has an optional, 1-year, post-graduate residency available for training in an advanced clinical specialty.
  - Dentistry requires a 2- to 4-year residency for specialties but no post-graduate training for general dentistry.
  - Optometry has optional, 1-year residencies available for specialty training.
  - Pharmacy has a 1- to 2-year required residency (clinical or research).
  - General medicine has required residencies that vary in length from 3 to 7 years, depending upon the specialty area.

In summary, only pharmacy appears to require a post-graduate residency; however, almost all physicians complete residencies in their area of specialization. In the other professional areas where residencies are offered, they are optional. The Subcommittee did not research what percentage of individuals elect to complete optional residencies.

## 10. What requirements do related professions have for a final exam?

- All 28 of the professions considered require individuals to pass a national exam to obtain a license and/or certification.
  - Pharmacists must pass two separate exams—the North American Pharmacist Licensure Exam and the Multi-State Pharmacy Jurisprudence exam.
  - Three professions include both written and practical examinations—chiropractic, dentistry, and general medicine (physician).
    - Chiropractors must pass a four-part exam, of which one part is practical.
    - Likewise, dentists must pass a practical and a written board exam, and physicians take the United States Medical Licensing Examination

(USMLE), which has four parts, one of which is a practical exam and the other three of which are written.

**11. What have other related professions done to move to a competency model? What is the role of simulation in their competency models of education? Where are competencies being demonstrated (i.e., in clinic or classroom; live or simulated)?**

- A review of 28 related professions examined the approach that educational programs took to establish criteria for entry-level practice.
- Essentially, all professions used competency as a measure of readiness to practice in each field. Although the specific details of competencies used varied across each field, several general categories/themes were common for each.
- Dentistry is a representative example of a profession that has described the types of desired competencies. They measure competency in the following areas:
  - Critical Thinking
  - Professionalism
  - Communication and Interpersonal Skills
  - Health Promotion
  - Practice Management and Informatics
  - Patient Care
  - Assessment, Diagnosis, and Treatment Planning
- Nursing has long used competency assessment to measure ability to move into practice. Previously, competencies were recognized to be a set of technical skills that were essential to nursing practice. More recently, nursing has moved toward a more holistic and integrated approach that acknowledges the role of knowledge and skills but also incorporates personal characteristics, professional attitudes, and values. Across the 28 professions reviewed, this was a clear trend.
- Simulation is used in many fields. Simulation ranges across professions from relatively modest simulations (e.g., problem-based learning) to advanced simulations (e.g., high-fidelity simulations, mannikins, and standardized patients). In many fields, an increase in the use of simulation has been strongly encouraged; authors of some articles in nursing have recommended that up to 50% of clinical hours (for BSN) occur in simulation. Dentistry strongly encourages simulation (via medium- to high-fidelity mannikins) to develop performance of procedures.
  - Competency assessment occurs across a range of environments. Standardized testing occurs in many professions (e.g., dentistry, pharmacy, nursing, medicine). For most professions, satisfactory completion of core coursework (classroom settings) denotes competency. Finally, competency assessment occurs in

simulation (typically in initial learning phases) and then is evaluated in live, clinical settings.

## **12. Can two entry-level degrees coexist and work? What would the clear lines be to distinguish these degrees?**

- There are health and education professions where two different entry-level degrees coexist and work operationally for entry-level practice. Often, clear lines—such as scope of practice, work setting, area of specialty, and clinical versus research positions—distinguish these degrees.
- Based on a review of 28 professions, 7 professions (i.e., 6 health professions and 1 education profession) require multiple entry-level degrees in order to enter practice.
- Health professions with two or more coexisting entry-level degrees include the following:
  - **Nurse** – As long as graduates get licensed, RN entry-level positions can be obtained with an associate degree, bachelor's degree, or hospital diploma. A master's degree in nursing is required to be a Clinical Nurse Specialist (CNS). A Doctor of Nursing Practice (DNP) degree is recommended for advanced practice, and a PhD degree is recommended for research.
  - **Nutritionist** – An associate degree can qualify you for a nutritionist license, which can be achieved in 2 years or less. Most nutritionists have master's degrees, although the bachelor's degree is considered entry level in the nutrition field. The multiple levels are distinguished by the area of specialty.
  - **Educational Psychologist** – A master's degree may be sufficient for school and industrial organizational positions, but clinical psychologists, counseling psychologists, and research psychologists need doctorates. Psychological assistants hold a master's degree and work under the supervision of a doctoral-level psychologist. The requisite entry-level degree is determined by what position is desired after graduation.
  - **Health Psychologist** – A PhD in psychology is a research degree and requires a dissertation. The PsyD is a clinical degree and requires more practical work and exams. A master's degree could be sufficient for those seeking to work in school and industrial organizational positions or as psychological assistants in clinical, counseling, or research settings. A research or clinical focus differentiates the degrees.
  - **Rehabilitation Counselor** – A master's degree is required in order to be credentialed as a rehabilitation counselor and to provide a full range of services in the scope of work. A person who possesses a bachelor's degree in rehabilitation and disability studies cannot offer the full range of services that a counselor with a master's degree in rehabilitation counseling can offer.
  - **Social Worker** – A social worker needs to have either a bachelor's degree or a master's degree. Clinical positions require master's degrees. Degree requirements also depends on the specialty chosen.

- Education professions with two or more coexisting entry-level degrees include the following:
  - **School Counselor** – A master’s degree is required. Entry level degree requirements may vary based on different areas of counseling or the type of position.
- Other health or education professions have one requisite degree for entry into the profession but may require subsequent levels of education based on the position held or employer requirements. For example:
  - **Recreational Therapist** – A bachelor’s degree prepares someone to be a certified recreational therapist. A master’s degree focuses on administration and management aspects of various forms of therapy. An associate degree is required for jobs such as recreational therapy assistant, rehabilitation activity director, special recreation program leader, adult activity coordinator, and assisted living program service coordinator.
  - **Special Education Teacher** – A bachelor’s degree is required to become a special education teacher. One may also earn a master’s degree and a doctoral degree. An associate degree prepares paraprofessionals and students continuing on to higher education. The varying levels of education necessary for different positions is based on the employer and/or position. Teachers get a raise in pay with higher degrees—for example, a teacher with a master’s degree in special education (or relevant field) gets paid more than a teacher who has completed only their undergraduate degree.
  - **Athletic Trainer** – a 4-year undergraduate degree is required for entry into the profession, but a master’s degree is required for a management position (this profession is transitioning to a master’s entry-level degree in 2022).

### 13. What are the trends in each of those professions, and what were the drivers of change?

Of the professions that have two or more coexisting entry-level degrees, only nursing provides hard data and information about the drivers of change to retain multiple entry-level degrees.

- **Nursing** – For a discussion of trends that impact multiple entry-level degrees in nursing, see the *Inside Higher Ed* article titled “[Debate Continues on Nursing Degrees](#)” by Ashley Smith (December 22, 2017).
  - More associate degree nursing graduates receive state licenses than those who have gone the bachelor’s-degree route. The associate degree route is seen as an important and affordable entry into the field. Associate degree nursing programs have played a historical role in bringing new recruits into the field, especially as university programs have struggled to expand their capacities to meet the demand for more health care professionals.

- In 2010, the National Academy of Medicine published a report recommending that the percentage of registered nurses with a **BSN** increase to 80% by 2020. An American Association of Critical-Care Nurses (AACN) position paper found that 72% of nursing directors identified differences in practice between BSN-prepared registered nurses and those with an associate degree or hospital diploma. The paper also cited research that BSN-prepared nurses had better patient outcomes. Registered nurses entering the profession with a bachelor’s degree see “faster salary growth and higher lifetime earnings over the course of their careers. They also have greater opportunities for employment.”  
<https://www.insidehighered.com/news/2017/12/22/battle-over-entry-level-degree-nursing-continues>
- AACN adopted the **Doctor of Nursing Practice (DNP)** degree as the appropriate level of education for advanced practice (AACN, 2006). (*Note: The profession of Nurse Anesthetist is transitioning to the DNP in 2022.*)
- **Nutritionists** – see the [Academy of Nutrition and Dietetics website](#).
  - All registered dietitians are nutritionists—but not all nutritionists are registered dietitians. The credentials for Registered Dietitian (RD) and Registered Dietitian Nutritionist (RDN) have identical meanings.
  - Nutritionist careers have been in place for more than 100 years. There are accredited bachelor’s and master’s degree programs that prepare individuals to qualify for the RDN credential. Three educational pathways to the RDN include the following:
    - Graduate level – competency-based dietitian nutritionist program that integrates coursework and experiential learning for RDN eligibility.
    - Bachelor’s and graduate level – dietitian coursework and supervised practice for RDN eligibility (combined program).
    - Bachelor’s and graduate level – dietitian coursework only (must be completed before the dietetic internship that is required for RDN eligibility).
- **Educational Psychologist** – see the [American Psychological Association \(APA\) website](#).
  - **National Certification**– A master’s degree is required for the Nationally Certified School Psychologist (NCSP) credential. School PhD programs in psychology, as well as clinical PhD programs in psychology, are accredited by the American Psychological Association (APA).
  - **School Psychology** – School psychology is a general practice and health service provider specialty of professional psychology that is concerned with the science and practice of psychology as it relates to (a) children, youth, families; (b) learners of all ages; and (c) the schooling process. The basic education and training of school psychologists prepares them to provide a range of services—including psychological diagnosis, assessment, intervention, prevention, health promotion, and program development and evaluation—with a special focus on the developmental processes of children and youth within the context of schools, families, and other systems.
  - **Educational Psychology** – Psychologists working in education study the social, emotional, and cognitive processes involved in learning and apply their

findings to improve the learning process. Some specialize in the educational development of a specific group of people such as children, adolescents, or adults, whereas others focus on specific learning challenges such as attention-deficit/hyperactivity disorder (ADHD) or dyslexia.

- **Health Psychologist** – see the [American Psychological Association \(APA\) website](#).
  - Health psychologists study how patients handle illness, why some people don't follow medical advice, and the most effective ways to control pain or change poor health habits. They also develop health care strategies that foster emotional and physical well-being.
  - Although a bachelor's degree is the foundation for a career in health psychology, most careers require a doctoral degree.
  - The career path for someone with a master's degree often includes positions such as a research assistant or behavior specialist. Typically, they work under the supervision of a licensed psychologist.
  - Those with doctoral degrees have the most options; they are able to work independently and will often supervise research or clinical teams, including those working in the areas of managing weight and preventing obesity, pain management, helping individuals cope with genetic diseases, preventing rehospitalization of patients, and planning walkable communities to encourage physical activity.
  
- **Rehabilitation Counselor**
  - A master's degree is the minimum degree required for this career path because it allows for a deeper, more specialized understanding of issues and treatment options. Unlike the coursework for a bachelor's degree, master's degree coursework focuses solely on the subject at hand, with no general education requirements. Those who pursue a doctorate can teach in a university setting and can generally earn greater income over time.
  - A master's degree in rehabilitation counseling must be accredited by the Council for Accreditation of Counseling & Related Educational Programs (CACREP).
  - Beyond the degree requirements, all 50 states require professionals to earn certifications or apply for licensing. Licensing requirements vary, but students usually must possess an applicable degree, pass an exam, and accrue a certain number of supervised work hours.
  
- **Social Worker**
  - Bachelor of Social Work (BSW) programs prepare students for entry-level, professional, generalist social work practice and for graduate social work education. Once you receive your BSW, you will be eligible to begin working as a social worker.
  - If you are interested in clinical social work, you must obtain a Master's of Social Work (MSW) and then become licensed in your state.
  - If you are interested in moving to a supervisory role and advancing in your social work career, then you should consider obtaining an MSW. Increasingly,



employers are seeking master’s-level social workers for any position above entry-level. Even those searching for entry-level positions are likely to find that an MSW opens more doors than a BSW.

- **School Counselor**

- Every state requires its school counselors to earn a master’s degree in order to qualify for licensure. A master’s program includes learning and practical experience in a classroom setting.
- There are no specific undergraduate degrees for school counseling. Students who wish to become a counselor usually major in psychology, sociology, or counseling. Other majors are possible, but those students will need some sort of strong background in the practical and theoretical underpinnings of counseling in order to successfully get accepted into a master’s program.
- There are several doctoral level programs available, including a PhD in Counseling Psychology, an EdD in Counseling Psychology, and a PhD in Marriage and Family—General Family Therapy.

#### 14. Summary Points

- a. All of the **HEALTH** professions—with the exception of Prosthetics & Orthotics—offer a clinical doctorate and/or PhD.
  - i. Typically, the value-added is as follows:
    - advanced clinical practice areas/specialization
    - research
    - higher education
    - administration/leadership
  - ii. The educational model for all of the health professions examined is the life span model, wherein students are educated to work with people of all ages.
- b. Of the **EDUCATION** professions, only Educational Psychology and School Counseling offer the clinical doctorate and/or the PhD.
  - i. Typically, the value-added is as follows:
    - research
    - higher education
    - administration/leadership
- c. Of the 28 professions, 6 have dual entry-level degrees (social worker, nutritionist, educational psychologist, health psychologist, occupational therapist, and nurses).
- d. Figure 1 and Table 5 show the degree continuum breakdown for professions that do not require a clinical doctorate at the entry-level and offer a continuum of degrees from associate to master’s or doctorate.
- e. In Table 6, additional data collected by the Subcommittee is shown regarding professions with entry-level degrees that are not at doctoral Level.
- f. In Table 7, additional data collected by the Subcommittee is shown regarding the scope of practice and licensing distinctions across the degree continuum is shown for the of 12 professions.

Table 6. Data about professions with entry-level degrees that are not at Clinical Doctorate Level.

Professional Title: Entry-Level Degree, NOT Doctorate	Entry-Level Degree	Dual Entry-Level Degree?	Differentiation of Dual Entry-Level Degrees	Associate Degree (or Lowest Degree)	Highest Degree Awarded	Value Added of Highest Degree
<b>HEALTH PROFESSIONS</b>						
Athletic Trainer (AT)	BS (but moving to MS in 2022)	No		Bachelor's	Doctorate in AT (very few universities offer); PhD in Kinesiology (AT)	Career in higher education
Exercise Physiologist	Bachelor's	No		Bachelor's	PhD in Exercise Physiology	Advanced clinical practice areas; research, administration
Genetic Counselor	Master's	No		Master's	PhD in Human Genetics	Conduct original research
Health Psychologist	Master's	Master's/PsyD	Research or clinical focus differentiates the degrees,	Master's	PsyD; Health Psychology PhD	Higher education, research, administrative roles
Nurse	Bachelor's	Assoc/BSRN/MSRN/DNP	<ul style="list-style-type: none"> <li>• RN entry can be obtained with an associate's degree, bachelor's degree, or diploma</li> <li>• Master's degree required to be clinical nurse specialist</li> <li>• DNP recommended for advanced practice</li> </ul>	Associate	DNP	Career flexibility (research, teaching, administration)
Nutritionist	Bachelor's	Assoc/BS/MS	Multiple levels, distinguished by area of specialty.	Associate	Doctorate in Clinical Nutrition	Advanced clinical practice areas; research, leadership roles

<b>Professional Title: Entry-Level Degree, NOT Doctorate</b>	<b>Entry-Level Degree</b>	<b>Dual Entry-Level Degree?</b>	<b>Differentiation of Dual Entry-Level Degrees</b>	<b>Associate Degree (or Lowest Degree)</b>	<b>Highest Degree Awarded</b>	<b>Value Added of Highest Degree</b>
Occupational Therapist	Master's	MOT/OTD		Master's	OTD	Advanced clinical practice areas; leadership
Physician Assistant	Master's	No		Master's	PA Doctorate; Doctor of Medical Sciences	To adapt to needs for advanced degrees among clinicians in other related health professions (e.g., DPT, AuD, Nursing, OT); open doors, seats at table; expand knowledge of topics not stressed in master's program
Prosthetics & Orthotics (CPO)	Master's	No		Master's	Master's	
Recreation Therapist	Bachelor's	No		Bachelor's	Master's (PhD in Parks, Recreation, and Tourism Management)	Adjunct faculty (higher education, research)
Rehab Counselor	Master's	No	Can have bachelor's degree in rehab/disability studies, but can't offer full range of services.	Master's	PhD in Rehab Counseling	Teaching, research, leadership
Social Worker	Bachelor's	BSW/MSW	Clinical positions require MSW; degree requirement also depends on specialty chosen.	Bachelor's	Doctor of Social Work (DSW); PhD in Social Work	DSW: Advanced training in a professional area of practice  PhD: Research degree

<b>EDUCATION PROFESSIONS</b>						
<b>Professional Title: Entry-Level Degree, NOT Doctorate</b>	<b>Entry-Level Degree</b>	<b>Dual Entry-Level Degree?</b>	<b>Differentiation of Dual Entry-Level Degrees</b>	<b>Associate Degree (or Lowest Degree)</b>	<b>Highest Degree Awarded</b>	<b>Value Added of Highest Degree</b>
Deaf/HoH Teacher	Bachelor's	No		Bachelor's	Master's	Greater specialization (technology, CLD populations)
Educational Psychologist	Master's	Master's/PsyD	Clinical, counseling, and research psychologists need doctorates.	Master's	PsyD; PhD in Educational Psychology	Higher education, research
Learning Disabilities Specialist	Bachelor's	No		Bachelor's	Master's	Greater specialization, focus on evidence-based pedagogy
Reading Specialist	Bachelor's	No		Bachelor's	Master's	Greater specialization, flexibility (research institutions, government agencies, postsecondary institutions)
School Counselor	Master's	No		Master's	Doctorate in School Counseling	Higher education, research, administrative roles
Special Education Teacher	Bachelor's	No		Bachelor's	Master's	Concentration areas (e.g., visual impairment, ASD); work with large range of children with special needs, families, and educational staff; teach students with special needs at all levels; prepare students for licensure, which is required by all 50 states

Table 7. Scope of Practice/Licensing Distinctions across the Educational Continuum.  
 (NOTE: Entry-level degrees appear in **boldface**.)

HEALTH PROFESSIONS						
Professional Title	Degree Continuum	Bachelor's	Master's	Doctorate	Dual-Entry	Distinction
Athletic Trainer	BS → <b>MS</b> → DAT (PhD in Kinesiology)	<ul style="list-style-type: none"> <li>• Certified Athletic Trainer</li> <li>• Moving to MS as entry-level degree in 2022.</li> </ul>	<ul style="list-style-type: none"> <li>• Certified Athletic Trainer</li> <li>• Work in different practice settings (health, education, sports, occupational/ industrial)</li> <li>• Meet 2022 standard</li> <li>• Specialize</li> <li>• Combine training + research</li> <li>• Expand career options</li> </ul>	<ul style="list-style-type: none"> <li>• Collaborate with physicians to provide exercises to prevent injuries, assist in rehab/ therapeutic intervention</li> <li>• More doctorates are desired by employers</li> <li>• Are academic and clinical leaders</li> </ul>	No	Scope of practice Practice settings
Exercise Physiologist	<b>BS</b> → MS → PhD in Exercise Physiology	<ul style="list-style-type: none"> <li>• Certified Clinical Exercise Physiologist</li> <li>• Considered “stepping stone” degree</li> <li>• Personal trainer</li> <li>• Limited options</li> </ul>	<ul style="list-style-type: none"> <li>• Certified Clinical Exercise Physiologist</li> <li>• Clinical specialization (e.g., cardiac rehab); participate in research</li> <li>• National certification</li> </ul>	Teaching, research, advocacy, clinical practice	No	Scope of practice Career options Research
Genetic Counselor	<b>MS</b> → PhD in Human Genetics	Typically get BS in biology then receive specialized training.	Licensed Genetic Counselor	Academic focus (teaching and research)	No	Clinical: MS Academic/ Research: PhD
Health Psychologist	<b>Master's</b> → PsyD	Earn bachelor's degree from accredited university	<ul style="list-style-type: none"> <li>• American Board of Clinical Health Psychology certifies clinical health psychologists</li> <li>• Different types of health psychology (clinical health, community health, occupational health, public health)</li> </ul>	<ul style="list-style-type: none"> <li>• For licensing in independent practice, must have doctorate</li> <li>• Clinical specialization</li> <li>• Higher education (teaching, research)</li> <li>• Leadership and administration</li> </ul>	No	Most health psychologists have PhD or PsyD

Professional Title	Degree Continuum	Bachelor's	Master's	Doctorate	Dual-Entry	Distinction
Nurse	<b>Assoc</b> → <b>BS</b> → MS-DNP	Registered Nurse (BSRN)	<ul style="list-style-type: none"> <li>MSRN</li> <li>Expand career options (nursing consultant, research nurse, nurse educator, nurse administrator, advanced nurse practitioner, clinical nurse specialist)</li> </ul>	<ul style="list-style-type: none"> <li>Leadership</li> <li>Clinical specialization</li> <li>Higher education (teaching, research)</li> </ul>	Yes	Career options Leadership Higher education
Nutritionist	<b>Assoc</b> → <b>BS</b> → <b>MS</b> → DNP	BS is entry degree, but associate degree might work as weight loss counselors, food technologists, or nutrition assistants.  Bachelor's degree: <ul style="list-style-type: none"> <li>Registered Dietician</li> <li>Licensed Nutritionist</li> </ul>	<ul style="list-style-type: none"> <li>Registered Dietician/ Licensed Nutritionist</li> <li>Can teach in undergraduate programs</li> </ul>	<ul style="list-style-type: none"> <li>Academic positions (teaching, research)</li> <li>Expand career options in public health, consulting and pharmaceuticals</li> </ul>	Yes	Career options Research Higher education
Occupational Therapist	OTA → <b>MOT</b> → <b>OTD</b>	MOT is entry-level degree, but can get associates or bachelor's degree (OTA).	Registered OT	<ul style="list-style-type: none"> <li>Leadership</li> <li>Clinical specialization</li> <li>Higher education (teaching, research)</li> </ul>	Yes	Clinical specialization Leadership
Physician Assistant	<b>Master's</b> → PA → Doctorate or <b>Master's</b> → PA → Doctor of Medical Sciences	Complete a bachelor's degree in science or healthcare-related major.	<ul style="list-style-type: none"> <li>Physician Assistant–Certified (PA-C)</li> <li>Clinical or hospital practice from primary care to emergency service and psychiatry</li> </ul>	<ul style="list-style-type: none"> <li>Address expanding knowledge and skills of scope of practice</li> <li>Adapt to needs for advanced degrees among clinicians in other related health professions (e.g., DPT, AuD, DNP); open doors, get seats at table</li> </ul>	No	Clinical specialization Leadership

Professional Title	Degree Continuum	Bachelor's	Master's	Doctorate	Dual-Entry	Distinction
Prosthetics & Orthotics (CPO)	COT → CPT → CPOT (Orthotist or Prosthetist Technician)  CO → CP → CPO → <b>Master's</b>	Often, will major in engineering, biology, or kinesiology—but must have prerequisite courses (biology w/ lab, chemistry w/ lab, physics w/ lab, psychology, statistics, and human anatomy and physiology)	<ul style="list-style-type: none"> <li>• Certified Prosthetist (CP); Certified Orthotist (CO); Certified Prosthetist &amp; Orthotist (CPO)</li> <li>• Must complete 12-month residency (for either Prosthetics or Orthotics) <b>or</b> 18-month residency (in P&amp;O) to become: <ul style="list-style-type: none"> <li>○ CO</li> <li>○ CP</li> <li>○ CPO</li> </ul> </li> </ul>	N/A	No	Technicians assist CPO in fabrication and some fitting
Recreation Therapist	<b>BS</b> → MS	Certified Therapeutic Recreation Specialist	Certified Therapeutic Recreation Specialist with advanced skills	N/A	No	Advanced skills
Rehab Counselor	<b>Master's</b> → PhD in Rehab Counseling	Generally, they earn a bachelor's degree in counseling, psych, or related field.	Certified Rehabilitative Counselor	<ul style="list-style-type: none"> <li>• Specialization areas</li> <li>• Leadership and administration</li> <li>• Research</li> <li>• Higher education</li> </ul>	No	Specialization  Different career options
Social Worker	<b>BSW</b> → <b>MSW</b> → DSW	Many states require master's degree to be social worker <ul style="list-style-type: none"> <li>• BSW is not required for MSW.</li> </ul>	MSW is required for someone to become a Licensed Clinical Social Worker (LCSW).	<ul style="list-style-type: none"> <li>• Advanced skills</li> <li>• Used for leadership and management positions</li> </ul>	Yes	MSW is required for LCSW; also, MSW has greater specialization than BSW.  DSW is often completed for leadership or administrative roles in social work.

EDUCATION PROFESSIONS						
Professional Title	Degree Continuum	Bachelor's	Master's	Doctorate	Dual-Entry	Distinction
Deaf/HoH Teacher	<b>Bachelor's</b> → Masters	Teacher certification for Deaf/HoH	Teacher Certification for Deaf/HoH	N/A	No	Greater specialization (technology, populations)
Educational Psychologist	<b>Master's</b> → <b>PsyD</b> → PhD in Educ Psych	Bachelor's degree in psychology	Certified Educational Psychologist	Those with a PhD in Educational Psychology can work as psychometricians, school administrators, or university faculty or administrators.	Masters / PsyD	Higher education, Administrative roles, Research, More career options
Learning Disabilities Specialist	<b>Bachelor's</b> → Master's	Special education teacher license and certification	Special Education Teacher License and Certification	N/A	No	Greater specialization, focus on evidence-based pedagogy
Reading Specialist	<b>Bachelor's</b> → Master's	Certified Reading Specialist	Certified Reading Specialist	N/A	No	Greater specialization, flexibility (research institutions, government agencies, postsecondary institutions)
School Counselor	<b>Master's</b> → Doctorate in School Counseling	Bachelor's degree in counseling, education, or psych	Certified School Counselor	Doctorate in School Counseling	No	Higher education, Research, Administrative roles
Special Education Teacher	<b>Bachelor's</b> → Master's	Certified Special Education Teacher	Certified Special Education Teacher	N/A	No	Concentration areas; work with children with special needs, families, and educational staff; teach students with special needs at all levels; prepare students for licensure, which is required by all 50 states.



## Appendix B: AHC-GESLP Competency Subcommittee Report

### Question #1: What did other professions do to transition to a competency model (e.g., physical therapy)?

Almost all the professions that the Competency Subcommittee reviewed (allied health professions, physicians, chiropractors, pharmacists, dentists, psychologists, genetic counselors, and certified registered nurse anesthetists [CRNA]s) established practice domains and core competencies developed through organizational efforts that varied in resources and time to establish the frameworks. These domains and competencies are mostly in the following range: 5–6 domains, and then 20+ associated competencies or elements within each domain.

#### EXAMPLE

The medical profession first adopted the following six core competencies in 1999, led by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS).

- 1. Practice-Based Learning and Improvement:** Show an ability to investigate and evaluate patient care practices, appraise and assimilate scientific evidence, and improve the practice of medicine.
- 2. Patient Care and Procedural Skills:** Provide care that is compassionate, appropriate, and effective treatment for health problems and to promote health.
- 3. Systems-Based Practice:** Demonstrate awareness of and responsibility to the larger context and systems of health care. Be able to call on system resources to provide optimal care (e.g. coordinating care across sites or serving as the primary case manager when care involves multiple specialties, professions or sites).
- 4. Medical Knowledge:** Demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and their application in patient care.
- 5. Interpersonal and Communication Skills:** Demonstrate skills that result in effective information exchange and teaming with patients, their families and professional associates (e.g. fostering a therapeutic relationship that is ethically sound, uses effective listening skills with non-verbal and verbal communication; working as both a team member and at times as a leader).
- 6. Professionalism:** Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to diverse patient populations.

For more information, see <https://www.abms.org/board-certification/a-trusted-credential/based-on-core-competencies/>.

The medical profession has extensive literature describing a 50-year history of work to define *competency*, followed by ongoing efforts to establish a framework for defining, measuring, and improving the practitioner’s skills—many other professions have adopted a similar definition of *competency*, as follows (Carraccio et al., 2002, p. 2):

*“A complex set of behaviors built on the components of knowledge, skills, attitudes, and ‘competence’ as personal ability.”*

Multiple articles and studies describe the medical profession’s systematic and methodical process of coming to agreement on what the competencies should be—continuing efforts in 2013 were described as follows:

The authors used the Accreditation Council for Graduate Medical Education (ACGME)/American Board of Medical Specialties (ABMS) six domains of competence and 36 competencies delineated by the ACGME as their foundational reference list. They added two domains described by other groups after the original six domains were introduced: Interprofessional Collaboration (four competencies) and Personal and Professional Development (eight competencies). They compared the expanded reference list (48 competencies within eight domains) with 153 competency lists from across the medical education continuum, physician specialties and subspecialties, countries, and health care professions. Comparison analysis led them to add 13 “new” competencies and to conflate six competencies into three to eliminate redundancy. (Englander et al., 2013)

The Speech Pathology Association of Australia (SPA) created a competency-based, computer-assisted tool to validly assess the performance of speech-language pathologists in their clinical placements. It is based on educational principles and was psychometrically validated as a result of a 4-year national collaborative research program. SPA has developed a tool for entry-level clinicians, called the Competency-Based Occupational Standards for Speech Pathologists (CBOS), that describes the minimum skills, knowledge base, and professional standards required for entry-level practice in speech pathology in Australia. The tool spells out explicit performance criteria as well as “cues” for the different elements (i.e., competencies).

On its website, SPA states the following:

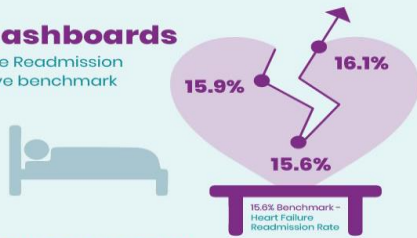
The profession identified generic professional competencies (see McAllister et al., 2006) and confirmed them through research to define an underlying variable of competency. They are detailed in “COMPASS®: Competency Assessment in Speech Pathology” and form one aspect of the competency assessment used widely by universities in Australia in the clinical assessment of speech pathology students. For more information, see [https://www.speechpathologyaustralia.org.au/SPAweb/Resources\\_For\\_Speech\\_Pathologists/CBOS/spaweb/Resources\\_for\\_Speech\\_Pathologists/CBOS/CBOS.aspx?hkey=d82f4c40-683c-438e-8ef3-f8614db09478](https://www.speechpathologyaustralia.org.au/SPAweb/Resources_For_Speech_Pathologists/CBOS/spaweb/Resources_for_Speech_Pathologists/CBOS/CBOS.aspx?hkey=d82f4c40-683c-438e-8ef3-f8614db09478).

Organizations such as Knowledge to Practice (K2P) help the medical profession and are expanding to other professions to help make “the connection between quality metrics and clinical knowledge.” See the infographic below in Figure 1. For more information on K2P, see <https://knowledgetopractice.com/>.

# THE CONNECTION BETWEEN QUALITY METRICS AND CLINICAL KNOWLEDGE

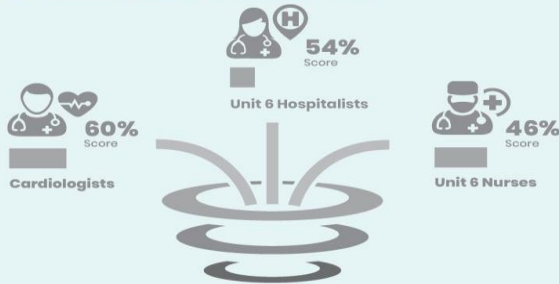
## Quality Dashboards

show Heart Failure Readmission consistently above benchmark



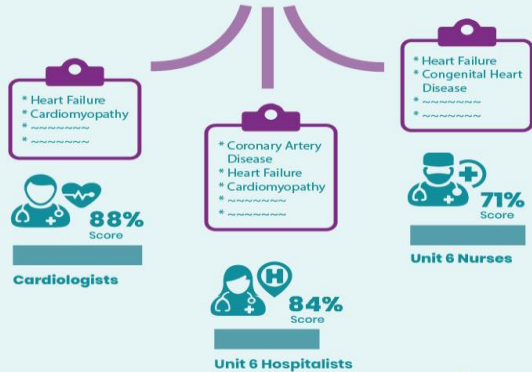
## K2P Pre-Assessment

scores show cardiology teams need more knowledge in cardiovascular medicine



## Personalized, Competency-Based LEARNING PLAN

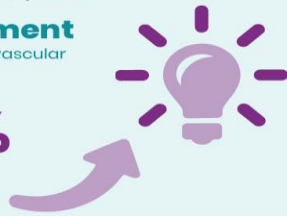
focuses learning on areas individuals haven't mastered



## K2P Post-Assessment

increase in knowledge in cardiovascular medicine across unit

**25-30% Increase in Knowledge**



Learn how improving clinical knowledge has helped leading healthcare providers impact their quality metrics.

[www.knowledgetopractice.com](http://www.knowledgetopractice.com)

**K2P** Knowledge to Practice

Figure 1. Infographic from Knowledge to Practice (K2P), an organization that helps connect quality metrics with clinical knowledge (<https://knowledgetopractice.com/>).

## **Question #2: How would competencies be measured in graduate education? (Not clock hours.)**

Competencies would be measured as exhibited across the scope of practice:

- knowledge
- comprehension
- skills
- values

Observations would be done by the clinical preceptor of the individual providing services.

Services would be as follows:

- 1:1, group
- Home, classroom, clinic
- Training family members, assistants, extenders
- **Question #3: How would competencies be determined for entry into the profession for educational and medical settings?**

Agreement on the standards for competencies across the scope of practice for entry to practice is needed. Input about the competencies needed to practice would be provided by practitioners via the practice analysis process.

The purpose of *competency-based standards* is to define the minimum skill level and areas of competence that the public has a right to expect of an entry-level speech-language pathologist.

They also

- inform candidates for entry to the profession of the standards and range of competencies that they must achieve prior to acquiring the certificate of clinical competence;
- inform and guide the assessment and re-education of anyone wishing to re-enter the profession; inform the profession of areas relevant for professional development;
- inform the institutions responsible for the education of speech-language pathologists of the competency required of an entry-level speech pathologist;
- inform entry-level speech-language pathologists and employers of the range and standard of independent practice expected of an entry-level speech-language pathologist; and
- inform government and policy makers of the range and standard of practice of an entry-level speech-language pathologist.

### **DEFINITION OF *ENTRY-LEVEL***

- The point equivalent to graduation with a graduate degree in speech-language pathology from a CAA-accredited university. Currently, graduates may enter the profession with a master's degree. Regardless of degree, graduates must meet a minimum set of requirements.

- The minimum requirements to be met before employment as a speech-language pathologist in the United States.
- The first 9 months of practice as a speech-language pathologist.

### **ENTRY-LEVEL CONSIDERATIONS**

It is unrealistic to expect that an entry-level speech-language pathologist will be competent in all areas of speech-language pathology practice without access to supervision, guidance, and support from a senior member of the profession.

An entry-level speech-language pathologist needs to have professional support and clinical supervision as well as managerial supervision. This is particularly important for entry-level speech-language pathologists employed in remote contexts or in any practice where they are the sole speech-language pathologist.

Some areas of practice, in particular, will require more input from an experienced speech-language pathologist.

### **COMPETENCY-BASED PROFESSIONAL STANDARDS FOR SPEECH-LANGUAGE PATHOLOGISTS**

Employers need to familiarize themselves with the expected competency of entry-level speech-language pathologists, and they need to consider how to provide the professional support necessary to enable speech-language pathologists to perform competently.

Who would do this? The Council for Clinical Certification in Audiology and Speech-Language Pathology (CFCC).

The standards also would have to address simulated learning in clinical training. Resources developed for the Simulation-Based Learning Program are provided below for use by other organizations looking to embed simulation into their programs. These resources are licensed under a Creative Commons Attribution-Noncommercial 4.0 International License. Organizations are free to copy, communicate, and adapt the work for noncommercial purposes, provided that they credit the authors of the work, attribute Speech Pathology Australia (SPA), and comply with other notice requirements set out under the license. The appropriate citation for the resources is available on the inside front page of each resource.

The Simulation-Based Learning Program was designed as a 5-day learning program. The program can be conducted over consecutive or nonconsecutive days. Although the program was designed to build student competency in an integrated manner over the 5 days, individual simulations can be used as discrete components, and the program's delivery can be customized to suit an organization's needs.

Resources were developed to assist implementation for all components of the program, including student and clinical educator workbooks, clinical educator and simulated patient training guides, a simulated learning environment set-up guide, and administrative guides for university faculty. All resources are available below.

Clinical educator workbooks are available on Speech Pathology Australia's website at <https://www.speechpathologyaustralia.org.au/>.

### ***Speech Pathology Australia Resources***

Speech Pathology Australia designed the Competency-Based Assessment Tool (COMPASS®) to validly assess the performance of speech-language pathology students in their placements. It is based on educational principles and psychometrically validated as a result of a 4-year national collaborative research program. It is an online tool that yields both qualitative and quantitative information regarding a student's performance as rated by the clinical educators supervising clinical placements in their work settings. The tool is delivered via the Internet and is also available in a paper-based version. It is accessible only to universities that have signed a formal license agreement with Speech Pathology Australia. For more information, see <https://www.speechpathologyaustralia.org.au/>.

### ***COMPASS® and CBOS***

The Competency-Based Occupational Standards for Speech Pathologists (CBOS)—Entry Level describes the minimum skills, knowledge base, and professional standards that are required for speech pathology to enter practice in Australia. The CBOS is updated as the profession and evidence base for practice evolves. It was revised in 2011 and was updated in 2017. This is a useful tool for reviewing as we consider modifications to assessing competence for entry-level speech-language pathology practice in the United States.

For more information on COMPASS®, see

[https://www.speechpathologyaustralia.org.au/SPAweb/Resources\\_For\\_Speech\\_Pathologists/COMPASS/SPAweb/Resources\\_for\\_Speech\\_Pathologists/COMPASS/COMPASS.aspx?hkey=b3f7f01e-5e73-4026-9ec5-3eb546a2d18a](https://www.speechpathologyaustralia.org.au/SPAweb/Resources_For_Speech_Pathologists/COMPASS/SPAweb/Resources_for_Speech_Pathologists/COMPASS/COMPASS.aspx?hkey=b3f7f01e-5e73-4026-9ec5-3eb546a2d18a). For more information on CBOS, see <https://www.speechpathologyaustralia.org.au/>.

For more information on CBOS, see

[https://www.speechpathologyaustralia.org.au/SPAweb/Resources\\_For\\_Speech\\_Pathologists/CBOS/SPAweb/Resources\\_for\\_Speech\\_Pathologists/CBOS/CBOS.aspx?hkey=c1509605-c754-4aa8-bc10-b099c1211d4d](https://www.speechpathologyaustralia.org.au/SPAweb/Resources_For_Speech_Pathologists/CBOS/SPAweb/Resources_for_Speech_Pathologists/CBOS/CBOS.aspx?hkey=c1509605-c754-4aa8-bc10-b099c1211d4d).

### **Question #4: How would competencies be determined for entry into the profession for educational and medical settings? Who would do this—the CFCC?**

- a. The speech-language pathology profession must have clearly articulated CORE COMPETENCIES and PRACTICE DOMAINS; the CFCC would likely establish these.
- b. These core competencies and practice domains would be supported by foundational knowledge and skills—in behavioral, social, linguistic, educational, medical, and ethical science—that are essential for independent and unsupervised performance as an entry-level clinician (see, e.g., what is being done in the dentistry profession). Would this be done by CAA?

\*(Review “Competency Assessment Toolkit for Professional Psychology” for more information.)

- c. Include BENCHMARK COMPETENCIES, which are aligned to

- practicum readiness for internship and
- readiness for entry to practice.

**Question #5: How would competencies be determined for “expert” status? Who would do this—the CFCC and the CSCB?**

- Distinguish between *general scope of practice* (entry-level) and *advanced scope of practice* (expert).
- For *advanced scope of practice*, complete a residency (see DCP): A *residency* is defined as a postdoctoral educational program that is centered on the clinical training and development of advanced clinical skill sets (minimum duration of 12 months).
- The CSCB would likely do this.

**Question #6: How might the competency model affect what is assessed on the PRAXIS exam? How do related clinical service professions assess knowledge and skills (i.e., board exams)?**

- Like the development of competencies, most of the professions that were reviewed had similar practices when it comes to exams (whether for entry-level or for board specialties).
- Most had national-level written exams, and some included hands-on practical assessments through direct examiner and patient model interaction in a clinical environment.
- Most also incorporate periodic exams to maintain licensure.
- For references and source materials on this topic, see Avi-Itzhak and Krauss (2014), Blachman et al. (2017), Dolan (2003), Nickbakht et al. (2013), and Torres-Narvaez et al. (2018).
- The Association of American Medical Colleges (AAMC) published guidelines in May 2014 to provide expectations for both learners and teachers that include 13 activities that all medical students should be able to perform upon entering residency, regardless of their future career specialty. See the guidelines here: <https://students-residents.aamc.org/training-residency-fellowship/managing-your-medical-career/tools-success-during-residency/>.
- Dental schools change their curricula and assessments often to meet the needs of a constantly changing population but make concerted efforts to keep this change constant across all the schools.
- In social work, many states require applicants to take standardized examinations administered by the Association of Social Work Boards (ASWB) via an external link, although some states require their own examinations in addition to or in place of ASWB examinations. For more information, see <https://www.aswb.org/exam-candidates/about-the-exams/>.
- In genetic counseling, to achieve American Board of Genetic Counseling (ABGC) certification, applicants must pass the Certified Genetic Counselor® Examination during the period of their Active Candidate Status. Candidates have three attempts to become certified within 5 years of graduation from an ACGC-accredited program. States issuing a genetic counselor license require genetic counselors to sit and pass the ABGC certification exam. For more information, see <https://www.abgc.net/becoming-certified/exam-preparation-materials/>.

## Question #7: How might the competency model affect supervision?

Over the course of our review of numerous health care and allied health care professions, we have discovered limited published information regarding the *preparation* of clinical supervisors/clinical educators when developing, implementing, and/or assessing students' clinical performance in the context of a competency-based clinical profession. The field of psychology appears to have the most robust information and resources related to competency-based education and its impact on supervision.

In the field of psychology, the establishment of supervisor competencies in a developmental process (New Zealand Psychologists Board, 2013; Psychology Board of Australia, 2013; Roberts et al., 2005; Roth & Pilling, 2007). The American Psychological Association (APA) has recently laid the foundation for a competence model for **supervision with** guidelines from both the APA (2014) and the Association of State and Provincial Psychology Boards (ASPPB). These guidelines are reportedly the “defining parameters for clinical **supervision** and the requisite supervisor **competencies**” (APA, 2014, p. 12). APA offers several academic program resources for faculty who are developing and preparing to implement a competency-based program, including APA's valuable *Competency Assessment Toolkit for Professional Psychology* (Kaslow et al., 2009). This guide does not specifically address clinical supervision; however, it does provide a template to consider how faculty would use a particular teaching approach (i.e., group discussion, case presentation, etc.) to support and assess areas of competence.

In an article titled “Clinical Supervision: The Missing Ingredient,” Falender (2018) proposed “that clinical supervision training follow the shift to the competence movement that has occurred in psychology education, training, and regulation generally and embrace a systematic and intentional competence model” (p. 1240).

Across many related professions, there was reference to having a “qualified” supervisor or mentor; however, those qualifications are relatively broad in definition. In speech-language pathology, Liz McCrea and Judy Brasseur (2003) have provided a compilation of supervisory guidelines and self-assessment tools that may serve as a valuable resource for the development of clinical educator competencies. In physical therapy, O'Connor et al. (2017) states, “Educators must be committed to using valid assessment tools that measure their students' performance in their clinical areas objectively, accurately, and consistently in terms of the prioritization of core clinical duties on a day-to-day basis. In the 2016 Standards from the Council for Accreditation of Counseling and Related Educational Programs (CACREP), which addresses School Counselors, ‘the CACREP standards speak directly to required counseling practicum and internship experiences, including requisite direct and indirect contact hours, individual and group supervision hours, and faculty and site supervisor qualifications’ (p. 5).”

Based on our review across professions to date, the following information regarding the question, “How might a speech-language pathology competency model affect supervision?” is speculative. For the purpose of this summary, we have considered the most recent examination of clinical educator preparation completed through the Council of Academic Programs in Communication Sciences and Disorders (CAPCSD). In April 2013, CAPCSD published a white paper titled *Preparation of Speech-*



*Language Pathology Clinical Educators* that was prepared by CAPCSD’s Working Group on the Preparation of Speech-Language Pathology Clinical Educators. A request had come forward in 2011 from clinical educators in CAPCSD member academic programs “to develop a framework for training and learning outcomes for preparation of clinical educators” (p. 3). CAPCSD established the working group and charged the committee “to develop a white paper on evidence-based guidelines for individuals to acquire the knowledge and skills necessary for effective clinical supervision and education.”

At the outset, the working group reported that “historically, the primary requirement in the professions of speech-language pathology and audiology for individuals to provide supervision has been to hold the Certificate of Clinical Competence. This requirement implicitly suggests that an individual who is competent to provide clinical services is also competent to provide clinical supervision” (CAPCSD, 2013, p. 4). They went on to report that within the past decade, “many professions, including our own, [now] emphasize the importance of demonstrating specific knowledge and skills prior to performing any service” (p. 4). In their introduction, they referenced the 2008 ASHA supervision documents delineating “specific knowledge and skills required to competently perform the role of clinical supervisor” (ASHA, 2008a, p.3) and furthermore stated that “the highly complex nature of supervision makes it critically important that supervisors obtain education in the supervisory process” (p. 4).

As was the case in 2013, today the speech-language pathology profession has “guidelines” for the knowledge and skills of clinical supervision. During the past decade, the professions of audiology and speech-language pathology have begun officially to recognize the importance of clinical educator education and preparation. However, the methods of assessing graduate student clinical knowledge and skills acquisition (i.e., clinical competencies) continues to be highly variable across degree programs—and across clinical educators.

If the speech-language pathology profession were to move to a competency-based model, the following elements would need to be addressed:

- Develop a set of clinical competencies across the scope of practice that would define the “entry-ready” level practitioner, which would include foundational competencies and which might include competencies for areas of specialization.
- Determine the expectations for delivery of these competencies within an academic program by asking the following questions:
  - Would the responsibility for the delivery of clinical competencies rest primarily with clinical educators?
  - Would the responsibility for measuring clinical competence rest primarily with clinical educators?
  - Would programs provide/address foundational or “core” competencies, **or** would programs decide which competencies they would address in their degree program (i.e., tracks)? And, therefore, would clinical educators need to have knowledge and skills in foundational competencies as well as in areas of specialization or tracks?
  - Examine the methods of clinical instruction and measurement to address validity and reliability (Nickbakht et al., 2013).

- Develop mechanisms to address consistency of delivery during the education process and consistency in measuring clinical competency performance, which would include the following:
  - Training of the foundational competencies and calibration of measurement tools.
  - Training toward reliability across multiple supervisors in house and in the community (i.e., off-site supervision in practica and intern/externship). This would also mean “establishment of valid and reliable methods of observation and evaluation” (Roberts et al., 2005, p. 356).
  - Development of “trainers” to train the clinical educators. This would also mean the development of clinical education materials.
  - Access to training for in-house/program supervisors **and** off-site supervisors.
- Develop a universal outcomes competency measurement tool that would be used across programs to enable consistency and reliability in the assessment tool(s).
- Consider the development of core competency standards for clinical educators (New Zealand Psychologists Board, 2013; Psychology Board of Australia, 2013; Roth & Pilling, 2007; Roberts et al., 2005).
- Consider accreditation/certification of clinical educators (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2016).

Specific to the question of the impact of clinical competency on supervision/clinical education, these elements and questions would warrant direction from front-line clinical educators as well as from other stakeholders.

**Question #8: Would an apprentice model be more relevant in a competency model than a CF?**

Unfortunately, the question regarding “an apprentice model being more relevant in a competency model than a clinical fellowship” provides an **either/or** discussion. The relevant questions could be as follows:

- a. Is there a need for the speech-language pathology clinical fellowship postgraduation?
- b. Are there comparable and/or alternate models of postgraduate support or transition as the new graduate enters the profession?
- c. What would be the impact of a competency model on the postgraduate employee?

The *Speech-Language Pathology Certification Standards* have recently been revised and adopted with an implementation date of January 1, 2020. For background regarding the recently adopted changes to the speech-language pathology clinical fellowship, one should refer to the *2020 Standards and Implementation Procedures for the Certificate of Clinical Competence in Speech-Language Pathology* (ASHA, 2020), which include specific changes and anticipated improvements to the clinical fellowship. “A practice analysis and curriculum study for the profession of speech-language pathology was conducted in 2017. The [Council for Clinical Certification \(CFCC\)](#) and the [Council on Academic Accreditation \(CAA\)](#) partnered with ASHA to develop and conduct this study, last completed in 2009. A subject-matter expert panel, which included a broad representation of expertise and practice settings, was established to develop the survey. The survey underwent a pilot review, and minor modifications were made to the instrument based on the feedback received. The survey was fielded to a widespread audience representative of the profession of speech-language pathology. The results of this study . . . . [informed] the CAA and CFCC on academic and clinical standards for the profession of speech-language

pathology, as well as the content and weighting of the national Praxis® examination. One of the outcomes of the 2017 analysis [was] to ensure that the scope and level of academic and clinical education [was] consistent with the current scope of practice for the profession” (p. 7). Currently, it is not possible to know the impact of upcoming changes to the clinical fellowship experience for new graduates, as well as for clinical fellowship supervisors. The CFCC anticipates monitoring the impact of the new clinical fellowship model process.

Alternate models to the clinical fellowship could include the following:

- Entry-level practice without specific mentoring in the work setting
- A mentoring program during a specified period of employment and referred to as one of the following:
  - residency
  - apprenticeship
  - fellowship
  - other title—not specified

These models of postgraduate mentoring have not been fully explored for this exercise. However, the Audiology Summit did examine alternate models to the fourth-year externship and should be reviewed in this discussion.

Should the speech-language pathology profession move to a competency-based model, the following elements would need to be addressed relative to the clinical fellowship (postgraduate) process. As indicated in Question #7, many of the same conclusions, questions, and topics of interest would apply:

- Develop a set of clinical competencies across the scope of practice that would define the “entry-ready” level practitioner, which would include foundational competencies and might include competencies for areas of specialization.
- Determine the expectations for delivery of these competencies upon entry into the profession.
- Develop mechanisms to address consistency in measuring clinical competency performance during the defined period of postgraduate supervision or mentorship.
  - Training of the competencies and calibration of measurement tools.
  - Training toward reliability across multiple supervisors in the community. This would also mean “establishment of valid and reliable methods of observation and evaluation” (Roberts et al., 2005, p. 358).
  - Development of “trainers” to train the post graduate clinical educators. This would also mean the development of clinical education materials.
  - Access to training for postgraduate supervisors.
- Develop a universal outcomes competency measurement tool that would be used across employment sites and settings to enable consistency and reliability in the assessment tool(s).
- Consider the development of core competency standards for clinical educators (New Zealand Psychologists Board, 2013; Psychology Board of Australia, 2013; Roth & Pilling, 2007)
- Consider accreditation/certification of clinical educators (e.g., CACREP, 2106).
- Consider accreditation of the postgraduate employment sites

Additional questions should be considered regarding employment entry:

- a. What data/evidence from the practice analysis support a change in the speech-language pathology clinical fellowship process?
- b. What data/evidence support a change in certification and/or academic accreditation standards regarding the entry-level requirements?
- c. Would a change in the postgraduate requirement have an impact on state regulations that are currently in place?
- d. Would a change in the postgraduate requirements have an impact on job openings?
- e. Would a change in the postgraduate requirements have an impact on the application requirements and process for international candidates?

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### **Competency Subcommittee**

#### **Synthesis Table: Comparisons Across Professions**

<b>Professions</b>	<b>Competency Definition</b>	<b>Measurement (hours/other)</b>	<b>Clinical Pedagogy</b>	<b>Exams</b>	<b>Timing/ Benchmarks</b>	<b>Models for Advanced Practice</b>	<b>Supervisor</b>
-Athletic Trainers -AuD -Exercise Phys -OT -PT -P&O -Rehab Counselors	All described knowledge and skills typically within Core Competencies and Practice Domains	5/7 specified a minimum # of clinic hours; 2 specified time-based requirements (e.g., PT 30 weeks; P&O – 1-year residency)	Didactic + clinic and 4/7 included simulations	National exams (P&O specified that the exam includes written simulation and Clinical patient management (hands-on practical assessments through direct examiner and patient model interaction in a clinical environment)	2–3 years coursework + 5/7 include an externship	2/7 include residencies ; 4/7 have specialty certification	Generally, a professional within the discipline (6/7), although Exercise Physiology had an unspecified model post bachelor's degree PT and AuD can have a licensed practitioner within their discipline OT Level I Fieldwork can have other related professions supervise
-School Counselor/ Counselor (not just	Focus on large content areas such as knowledge, abilities, skills	credits, hours, competency evaluations at various points in the program	Traditional approaches including observation ,	Summative and formative was a theme	A remarkable example of the depth and breadth of work that the	Nothing out of the ordinary for these professions	Recommendation for qualified teachers, supervisors,

<p>specific to Schools)  -Deaf/Hard - of -Hearing Teacher  -Psychology, Psychologist:  Educational Psychologist:  -Neuropsych Psychologist:  Health Special Educators: - Learning Disabilities Specialist  -Reading Specialist  -Special Education Teacher</p>	<p>and then some "soft skills" related to professional practice (i.e., attitudes, values, etc.</p>		<p>practicum, internship or externship, and some select approaches : simulation, standardized patient, teaching demonstration, self-reflections, 360-assessment . However, a valuable "Competency Assessment Toolkit for Professional Psychology " provides a nice template to consider how one could assess the way in which they would use a particular teaching approach (group discussion, case presentation, etc.) to support areas of competence.</p>		<p>APA has done on examining and implementing mechanisms to help degree programs achieve their goals. Benchmark includes competencies aligned to: READINESS FOR PRACTICUM READINESS FOR INTERNSHIP and READINESS FOR ENTRY TO PRACTICE.</p>		<p>mentors. Unique in APA of "accreditation of the post-graduate employment site"!</p>
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Special note: 2012 Guide notes two approaches to implementing competency base program: start from the point of asking faculty to look at all of its curriculum and build one based on the desired competencies. OR ask faculty to think about the established curriculum of their program in terms of how it would manifest itself in trainee competencies.

Professions	Competency Definition	Measurement (hours/other)	Clinical Pedagogy	Exams	Timing/ Benchmarks	Models for Advanced Practice	Supervisor
-Physicians -Nurse Anesthetists (CRNAs) -Chiropractors (DCPs) -Pharmacists	The medical profession has long history of attempting to define competency - see research and white papers dating back to the 1960's. They consistently define <i>competency</i> as: "A complex set of behaviors built on the components of knowledge, skills, attitudes, and 'competence' as personal ability." Other professions reviewed do not specifically define competency but universally use competencies in manner consistent with the medical profession definition.	Professions reviewed have a combination of hours and explicit associated behaviors tied to defined competencies. For example, the DCP curriculum = minimum of 4,200 instructional hours. The didactic and clinical education components of the curriculum are structured and integrate required meta-competencies with measurable behavioral outcomes. CRNAs are required to log 2,500 clinical hours and administer 850 anesthetics prior to certification. The following competencies are measured: technical skills, critical thinking, interpersonal skills. These "methods" are used to measure: observation of daily work, return demonstrations, peer review, case studies, simulation, self-	The professions use a combination of didactic and supervised clinical practice: instructional hours are accomplished in a patient care setting and involve the direct delivery of patient care. In medical school, coursework —through classroom, clinical, and community experiences —covers science, problem-solving and communication skills, prevention and care, professionalism and medical ethics. In pharmacist programs, years three and four are transitional, combining intensive curriculum with clinical orientation and	All professions require a series of exams starting with admittance exams (e.g., MCAT), to licensing exams and then periodic exams to maintain licensure. Pharmacists: must pass the PCAT - the Pharmacy College Admissions Test. A license is required in all 50 states and to get the license you must pass the NAPLEX (North American Pharmacist Licensure Examination). To enter medical school students must score well on the MCAT	The professions reviewed have established paths that in most cases begin in the early college years and are prescribed through maintenance of certification during the working life. The CRNA path is representative : a minimum of seven years postsecondary education and experience to become a certified registered nurse anesthetist (CRNA): 1. Complete a BSN 2. Gain license as an RN 3. Practice one year as an acute care nurse 4. Get into an accredited program 5. Graduate from the program 6. Pass the National Certification Examination or NBCRNA: computer exam with 100 to 170 questions 7.	The DCP is representative of the models for advanced practice: A residency is a post-doctoral, educational program centered on clinical training and development of <i>advanced clinical skill sets</i> that results in the resident's attainment of an advanced level of clinical knowledge. Specific to the area of training, the residency expands and builds on the entry-level competencies attained through completion of the Doctor of Chiropractic degree through a comprehensive clinical education program. A	All the professions reviewed rely on senior clinicians to help supervise, mentor and evaluate the clinicians. Pharmacy students additionally keep accurate and complete clinical experience logs that are reviewed by program faculty on a regular basis. All newly-registered pharmacists will work under the direct or indirect supervision of a more experienced pharmacist, whether through the supervising and superintendent pharmacist structure or other senior managing colleagues, experienced clinicians, preceptors,



		assessments, etc.	supervised pharmacy rotations. According to the Pharmacy Curriculum Outcomes Assessment programs use contact or credit hours of structured simulation in the IPPE experience: medium and high-fidelity manikins, computer simulations, standardized patients, role playing, OSCEs (objective structured clinical examination).	(typically taken in college) Prior to starting residency after med school: The American Association of Medical Colleges (AAMC) published new guidelines in May 2014 to provide expectations for both learners and teachers that include 13 <u>activities</u> that all medical students <u>should be able to perform upon entering residency</u> , regardless of their future career specialty.	Practice as entry-level CRNA: Some employers seek individuals who can work among several major departments, whereas others seek CRNAs with more specialized qualifications and experience to work in specific departments such as obstetrics, pediatrics, or endoscopy. 8. Maintain certification: Nurse anesthetists must recertify through the NBCRNA every two years. CREDENTIALING: Before practicing the CRNA has to complete the credentialing process, which can take 90-120 days to complete. This includes 1. Passing board exams 2. Completing credentialing paperwork 3. Gaining hospital privileges 4. Having a face-to-face introductory meeting with	residency is a program with a minimum duration of 12 months. The duration of the residency must be appropriate for the intended outcome as postgraduate training leading to specialty certification or qualification.	clinical Faculty.
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Professions	Competency Definition	Measurement (hours/other)	Clinical Pedagogy	Exams	Timing/ Benchmarks	Models for Advanced Practice	Supervisor
-Dentistry	Competency: a complex behavior or ability essential for the general dentist to begin independent, unsupervised dental practice; it assumes that all behaviors and skills are performed with a degree of quality consistent with patient well-being and that the general dentist can self-evaluate treatment effectiveness.	The evaluation of competence is an ongoing process that requires a variety of assessments that can measure not only the acquisition of knowledge and skills, but also assess the process and procedures which will be necessary for entry level practice.	<p>Most of their training outside of the core classes in the first two years involves practicing procedures on models of the mouth and teeth. Both simulations and direct patient contact.</p> <p>In competency-based dental education, what students learn is based upon clearly articulated competencies and further assumes that all behaviors/abilities are supported by foundation knowledge and psychomotor skills in biomedical, behavioral, ethical, clinical dental science and informatics</p>	<p>The last two years of dental school mostly involve clinical study (direct patient care) and some practice management instruction. Students will learn to care for chronically ill, disabled, special care and geriatric patients as well as children to ensure they have a wide variety of experience caring for all types of people.</p> <p>At many schools, students often rotate through various clinics, hospitals and other off-campus communities</p>	<p>the hospital board</p> <p>American Dental Association has developed ethically-based, voluntary practice management guidelines to help your practice succeed. Guidelines for Practice Success™ (GPS™) have been developed via a consensus-driven process that includes dental practice management consultants and content authorities.</p>	<p>Students also often learn about how to care for a diverse array of populations and may interact with patients to provide very basic oral health care. Most of their training outside of the core classes in the first two years involves practicing procedures on models of the mouth and teeth.</p> <p>The foundation of these Standards is a competency-based model of education through which students acquire the level of competence needed to begin the unsupervised practice</p>	At many schools, students often rotate through various clinics, hospitals and other off-campus community settings, and work under the supervision of a clinical instructor.

			<p>areas that are essential for independent and unsupervised performance as an entry-level general dentist. In creating curricula, dental faculty must consider the competencies to be developed through the educational process, the learning experiences that will lead to the development of these competencies, and ways to assess or measure the attainment of competencies.</p>	<p>y settings, and work under the supervision of a clinical instructor.</p> <p>This gives students the opportunity to work closely with other health professionals and health professions students, giving them the appreciation of a team approach to health care delivery. Dental schools change their curriculums often to meet the needs of a constantly changing population, but the general outline tends to stay the same across all schools.</p>		<p>of general dentistry.</p> <p>Professional competence is the habitual and judicious use of communication, knowledge, critical appraisal, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individuals and communities served. Accordingly, learning experiences help students blend the various dimensions of competency into an integrated performance for the benefit of the patient, while the assessment process focuses on measuring the student's overall capacity to function as an entry-level, beginning</p>	
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						general dentist rather than measuring individual skills in isolation.	
-Social Work	<p>Competence in social work is the product of knowledge, skills and values. ... acquired and applied knowledge. reflected upon and analyzed their practice. transferred knowledge, skills and values in practice.</p> <p>Social work supervisors should be competent and participate in ongoing continuing education and certification programs in supervision. Supervisors should be aware of growth and development in social work practice and be able to implement evidence-based practice into the supervisory process. Supervisors should also be aware of their limitations and operate within the</p>	<ol style="list-style-type: none"> <li>1. Identify as a professional social worker and conduct oneself accordingly.</li> <li>2. Apply social work ethical principles to guide professional practice.</li> <li>3. Apply critical thinking to inform and communicate professional judgments.</li> <li>4. Engage diversity and difference in practice.</li> <li>5. Advance human rights and social and economic justice.</li> <li>6. Engage in research-informed practice and practice-informed research.</li> <li>7. Apply knowledge of human behavior and the social environment.</li> <li>8. Engage in policy practice to advance social and economic well-being and to deliver effective social work services.</li> <li>9. Respond to contexts that shape practice.</li> </ol>	Supervisors and supervisees should also sign a written contract that outlines the parameters of the supervisory relationship. Frequent written progress reports prepared by the supervisor should be required and, if appropriate, meet the ongoing standards established by jurisdictions and agency requirements.	Many states require applicants to take standardized examinations administered by the Association of Social Work Boards (ASWB) External link, though some states require their own examinations in addition to or in place of ASWB examinations.	A Bachelor of Social Work is usually the minimum educational requirement for beginning your career as a social worker. Some entry-level positions may also accept candidates with a bachelor's degree in psychology, sociology, or other related fields. Undergraduate Social Work Education: States require that social workers hold a Bachelor of Social Work (BSW) from a school approved by the Council on Social Work Education (CSWE) External link. Graduate Social Work Education: States often require that social workers obtain a Masters in Social Work or a relevant doctoral degree before applying for advanced	Supervised Experience : Documented professional experience under the supervision of a qualified LCSW for approximately two years is often a requirement for licensure beyond initial licensure, though some states require professional experience for all types of licensure. There are several main types of social work licensure, including licensure for social workers with a bachelor's degree, licensure for social workers with a master's	There are many definitions of social work supervision. Generally, supervision is defined as a professional relationship between a supervisor and a social worker in which the supervisor provides evaluation and direction of the social worker's services to clients to promote competence and ethics fostering ongoing development of the social worker's knowledge and application of professional social work skills and values. While your manager may serve as a supervisor, the role of manager or employer is distinct

	<p>scope of their competence. When specialty practice areas are unfamiliar, supervisors should obtain assistance or refer supervisees to an appropriate source for consultation in the desired area.</p>	<p>10. Engage, assess, intervene, and evaluate with individuals, families, groups, organizations, and communities.</p>			<p>social work licensure. There are also options for pursuing your Master of Social Work online.</p>	<p>degree and licensure for clinical social workers. Within these fields, social workers can also apply for additional credentials and certifications through the National Association of Social Workers (NASW) External link.</p> <p>Initial License: States often require first-time social workers to become licensed as bachelor- or associate-level social workers, often referred to as Licensed Baccalaureate Social Workers (LBSW). Upon receiving this type of licensure, social workers in most states will be required to work under the</p>	<p>from the role of supervisor. Supervision allows for consultation on current services and issues as they arise and debriefing on past practice. Supervision is often a structured time designed to enhance knowledge and skills through practice, discuss pertinent research, develop greater self-awareness, and internalize professional ethics. Supervisors regularly analyze supervisees' decisions and judgments, alternative options to be considered, and lessons learned in individual and group sessions. Group sessions allow for supervised social workers to learn from each other</p>
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						<p>supervision of an approved Licensed Clinical Social Worker (LCSW). Master License: Social workers holding an initial license and a graduate degree in social work may become licensed as master- or graduate-level social workers, often referred to as Licensed Master Social Workers (LMSW). This type of licensure often requires both field experience and the successful completion of a standardized exam.</p> <p>Clinical License: A clinical license is a full professional license to practice social work. Social workers holding a current</p>	<p>as well as their supervisor while individual sessions often address more personal topics such as managing biases, ethical dilemmas in the field, and practicing self-care. Each state defines the number of hours and the type of supervision necessary to receive varying levels of social work licenses. Even if you are not working toward an advanced license, supervision can be very helpful for new social workers. Supervision may also be recommended if you are taking over a new role or learning a new skill and may be required as a result of disciplinary action.</p> <p>With the increasing</p>
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						license and a graduate degree in social work may become licensed as a clinical-level social worker, often referred to as Licensed Clinical Social Workers (LCSW) External link. This type of licensure often requires years of professional experience, in addition to the successful completion of a standardized exam.	focus on interdisciplinary practice in recent years, social workers may be supervised by a professional of a different discipline.
-Genetic Counselors	The profession developed a set of competencies for all practitioners that encompasses five different domains: Genetics Expertise and Analysis; Interpersonal, Psychosocial and Counseling Skills; Education; and Professional Development and Practice.	Clinical Rotation and Clinical Practicum The genetic counseling practicum allows students to practice components of the genetic counseling session in a safe environment. During this quarter, students will practice more advanced counseling skills and the first-year students will observe.	Genetic counseling provides a great blend of science, critical thinking and personal interactions. Some genetic counseling tasks include: <ul style="list-style-type: none"> <li>• Interpreting family medical history and genetic test results to assess the</li> </ul>	Certification in genetic counseling is offered by the American Board of Genetic Counseling (ABGC) through an examination administered twice per year. Certification, while not required everywhere,	A master's degree in genetic counseling usually is required for genetic counselor positions. These programs typically provide coursework in human genetics, lab work, counseling, and research. Students develop the skills needed to research, counsel, and	Entry-level positions allow genetic counselors to work under supervision, assessing patients, and providing counseling. More advanced positions allow genetic counselors to work independently at these duties, in	The JHU program faculty provide students with one-on-one supervision for an hour each week throughout their graduate studies. These sessions offer students feedback based on audiotaped sessions with clients and on

	<p>The Practice Based Competencies for Genetic Counselors provide guidance for the training of genetic counselors and an assessment of competency for practicing genetic counselors.</p> <p>The Practice Based Competencies define and describe the 22 practice-based competencies that an entry-level provider must demonstrate to successfully practice as a genetic counselor. It provides guidance for the training of genetic counselors and an assessment for maintenance of competency of practicing genetic counselors. The didactic and experiential components of a genetic counseling training curriculum and maintenance of competency for providers must support</p>		<p>chance of disease.</p> <ul style="list-style-type: none"> <li>• Educating about inheritance, genetic testing, management, prevention and resources.</li> <li>• Counseling to promote informed choices about and adaptation to health risks or conditions.</li> </ul> <p>The 21-month, full-time program provides students with a unique blend of didactic and skills-based coursework in genetics/genomics, patient-centered communication, public health, and research. Given our philosophy that students learn best by observing and doing, clinical rotations and field experiences will begin in the second semester and</p>	<p>demonstrates that the individual has met the standards necessary to provide competent genetic counseling .</p> <p>To achieve ABGC certification, applicants must pass the Certified Genetic Counselor® Examination during the period of their Active Candidate Status. Candidates have three attempts within five years of graduation from an ACGC accredited program to become certified. ABGC certification is required by almost half of all 50 states as part of the requirements to qualify for a license</p>	<p>consult with patients, their families, and members of the healthcare community to provide information on genetic conditions. Admission requirements usually include a bachelor's degree with credits in genetics, biochemistry, and statistics. Some schools require applicants to have performed some type of counseling work. The American Board of Genetic Counselors (ABGC) offers a certification program. This certification is technically voluntary; however, some states require it for licensing, and some employers prefer it. In addition, some states require genetic counselors to become licensed before performing work with the public. Certification requirements include</p>	<p>addition to performing research and providing education to the public and healthcare professionals. The National Society of Genetic Counselors (NSGC) provides individuals with online education resources and opportunities to network with other members of the field. Courses go over self-marketing, mentoring, and instructional guides on starting a clinic.</p>	<p>interventions consistent with development of counseling expertise.</p> <p>Preceptors evaluate each student's performance and students are asked to complete a self-evaluation of their progress. Additionally, students are asked to provide feedback to the clinical supervisor(s).</p> <p>Most of the preceptors for clinical rotations are board-certified genetic counselors. Those who are not (e.g., medical social workers, nurse practitioners, physicians, etc.) enhance the students' clinical training by exposing them to a variety of disciplines. The American</p>
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	<p>the development of competencies categorized in the following domains: (I) Genetics Expertise and Analysis; (II) Interpersonal Psychosocial and Counseling Skills; (III) Education; and (IV) Professional Development &amp; Practice. These domains describe the minimal skill set of a genetic counselor, which should be applied across practice settings.</p>		<p>continue throughout the program. The public health training provides students with invaluable opportunities as genetics becomes infused into more aspects of health care, as service delivery models evolve, and as we learn more about the complex interactions between genetic, environmental and behavioral risk factors.</p>	<p>to practice as a genetic counselor, and practices in exempt states often require certification regardless. States issuing a genetic counselor license require genetic counselors to sit and pass the ABGC certification exam.</p>	<p>completion of a graduate degree program in genetic counseling through an ABGC-accredited program and passage of a written exam. ABGC certification can serve as proof of competency and give job candidates an edge in employment.</p>		<p>Board of Genetic Counseling endorses this type of broad experience.</p>
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### Additional Questions

Professions	Competency Definition	Measurement (hours/other)	Clinical Pedagogy	Exams	Timing/Benchmarks	Models for Advanced Practice	Supervisor
<p>Can we define competencies across all areas of our scope of practice? Next, would we want to look at the APA and other professions that have "readiness" models to address</p>	<p>How would our professional standards move away from a # of clock hours to a competency-based model with defined criteria levels of achievement (or similar wording)? Is this a question to CFCC to</p>	<p>Should we have dedicated examination of "how we teach" in speech-language pathology? Are we delivering our programs in an evidenced-based manner for the students of today (and the next X # of years)?</p>	<p>Should our profession require programs to incorporate into the curriculum standardized computer simulations, standardized patients and OSCEs (objective structured clinical</p>	<p>Should the speech-language pathology licensing exam (currently the PRAXIS) have additional component(s) that include measurable observed activity of</p>	<p>Can speech-language pathology programs really teach and expect competencies to be achieved in the current 2-year timeframe?</p>	<p>Should we model from many other professions that have differentiated between a general scope of practice and advanced practice?</p>	<p>Is there a stakeholder question here: would accreditation of the "CF site" bridge the transition to high-demand settings (i.e., med centers)? Ask this of degree programs,</p>

<p>competencies on a continuum as a student progresses through their program?</p>	<p>start? Would that include allowing a set # of programs to pilot a competency-based program? What might that pilot look like?</p>		<p>examination )?</p>	<p>explicit behaviors tied to competencies? Should we consider an exam to measure skills PRIOR to a CFY (or “residency”)?</p>		<p>and ask this of medical speech-language pathologists and admin.</p>
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## Appendix C: AHC-GESLP Challenges with the Current Educational Model Subcommittee Report

### Subcommittee Questions

Question 1: Synthesize the available information from survey and focus group on what stakeholders (as listed in the charge) perceive as challenges.

Question 2: What have other professions perceived as challenges that fueled their transition to a clinical doctorate as the entry-level degree?

Question 3: What are the gaps and unmet needs in the current educational model to prepare entry-level clinicians to be competent across the full scope of practice?

Question 4: Feasibility and Packaging Perspective: How can we package teaching [for every student] the full scope of practice so that it is reasonable to assume that newly certified clinicians are well-prepared to enter practice in the area in which they choose to work? What is needed to enter practice (include extenders)?

Question 5: How are we teaching? What is the pedagogical model of training SLPs? How can we better develop critical thinking skills?

**Question 1: Synthesize the available information from survey and focus group on what stakeholders perceive as challenges.**

### **Clinical Fellowship (CF) Supervisors Focus Group (Conducted at the 2018 ASHA Convention)**

1. Most of the participants said that the clinical fellows they had supervised were adequately prepared to function independently in clinical practice.
2. Areas of practice where they could have been better prepared included swallowing, pediatric feeding, understanding the physiology related to underlying diagnoses, cognition and dementia, rehab in general, behavioral challenges, counseling skills, developmental norms, and carrying out goals.
3. Professional responsibilities in need of better preparation included billing, insurance, Current Procedural Terminology® (CPT) codes, documentation, clinical writing, and synthesizing case histories.
4. Everyone agreed that there would have been a problem if their clinical fellows had been eligible for certification and licensure immediately following graduate school and had come to work as an SLP instead of as a clinical fellow.
5. It was unanimous among the participants: Keep the CF.
6. Seminars on specialty topics, more opportunities for externships, giving undergrads clinical experience, and awarding different degrees or certifications for different tracks were suggested as possible changes to the current model of graduate education.

7. The group disparaged online programs and wanted to eliminate discrepancies between programs.
8. They designed a 3-year program with a required curriculum, followed by a CF that would last at least 12 months. Mini-placements would be scattered throughout the first 2 years.

### **Recently Certified SLPs Focus Group** (Conducted at the 2018 ASHA Convention)

1. They all described themselves as having been adequately prepared when they started their CF.
2. Areas of practice for which they would have liked more training included dysphagia, cognitive evaluations, and medical settings.
3. The list of professional responsibilities for which they would have liked more training was longer—paperwork; electronic medical records software; varying dosage/frequency of treatment for Medicare Part A, Part B, and skilled nursing facilities (SNFs); collaborating with physical therapists (PTs) and occupational therapists (OTs); familiarity with medical terminology and abbreviations; knowing how to call a code; and meeting productivity requirements.
4. All participants were in favor of CFs.
5. One challenge with having a required CF is finding one. It is frequently challenging to find one in your specialty area, and geography can compound that difficulty.
6. The participants valued the framework of the CF and did not believe that new graduates could benefit as much from an employer-based mentorship as from a CF. Without CFs, it would become “like the wild, wild west.”
7. Specialty tracks were recommended, although one participant argued both sides of this issue, not wanting to give up flexibility. Cost was the biggest barrier as participants developed a program to better prepare students. They recommended specialty certifications, but not if they had to pay ASHA to maintain them.
8. The scope of practice is so broad that it is necessary to increase the length of academic programs and practicums—but, again, they did not want to increase costs. Several participants recommended embedding applied practica within each course.

### ***Perceived Challenges of the CF***

Experience varies greatly depending upon the setting. Mentoring styles vary greatly. Mentors have the authorization to see the CF in direct clinical contact for only 6 hours of direct observation per segment (420 hours). Many CFs contact ASHA stating that they can't get in touch with their mentor or that the mentor is not providing the level of supervision that they feel they need.

- Clinical doctorate programs for PT, OT, and the doctoral degree in audiology (AuD) require an extra semester with a capstone project. Candidates are reporting difficulties finding sites and mentors to complete these projects, as well as difficulty finding supervisors.
- Currently, 400 clinical practicum hours are completed within the confines of a graduate school program, but is that enough? Should competencies be developed as opposed to meeting a minimum number of clinical hours?
- We need data to determine if other models have proved to be efficient and/or to work.

### ***Strengths of the CF***

The CF provides an opportunity to obtain on-the-job training with real clients/patients under the guidance of a seasoned mentor.

- If a mentorship is designed and monitored appropriately, then having a mentor work with you for 9 months could prevent a majority of mistakes from happening, and when it comes to health care, a mentorship protects our clients/patients, which is paramount.
- The CF is a paid experience.

### **Question 2: What have other professions perceived as challenges that fueled their transition to a clinical doctorate as the entry-level degree?**

#### ***The Pursuit of Professional Autonomy***

In many ways, the challenges that fueled other health care professions to adopt a clinical doctorate parallel the challenges currently being discussed as our own profession debates and weighs its best way forward. To better understand the context of our own professions' motivations for change, let us briefly turn to a sampling of related professions and their journeys to the clinical doctorate.

Occupational therapy mandated a master's degree as the mandatory entry-level degree starting in 2007 (Brown et al., 2015). Just 7 years later, the American Occupational Therapy Association (AOTA) Board of Directors published a position statement (AOTA, 2014) supporting an iterative move to adopting a clinical doctorate as the entry-level degree by 2025 (Brown et al., 2015). Perceived challenges fueling this plan, as per AOTA's 2014 position statement, included the following: (a) to improve graduates' preparedness with an ever-growing scope of practice and (b) to improve their graduates' ability to implement evidence-based practice—and, thereby, improve graduates' professional autonomy. "Additional factors included reducing confusion with two entry-level degrees and remaining competitive when seated next to other related professions who have already adopted a clinical doctorate as their entry-level degree" (Brown et al., 2015, p. 2). As of April 10, 2019, the AOTA's Representative Assembly stepped back this plan, publishing a statement saying that occupational therapists can enter the profession with either a master's or a doctorate degree and that students will now be accepted to programs at each of these levels (AOTA, 2019).

The profession of audiology adopted a clinical doctorate as its entry-level degree in 2007 (Cosby et al., 2008). Factors fueling this transition included (a) an ever-growing graduate curriculum that was seen to be "bursting at the seams" (Goldstein, 1989, p. 33) due to a growing scope of practice and professional literature and (b) students arriving to the program without adequate basic education in the sciences. By better preparing clinicians through a well-developed clinical doctorate program, it was also thought that those pursuing a PhD in audiology would be more uniformly interested in pursuing relevant clinical research (Goldstein, 1989). Similarly, the profession had hoped to achieve improved autonomy and respect by producing graduates who were knowledgeable in the literature and who were capable of consuming and applying research literature (American Academy of Audiology, 1991; Brown-Benedict, 2008). In other words, the audiology profession sought to raise the standards of the profession and to help audiology earn greater respect. "Audiology is a doctoring profession. It needs and deserves its own doctor's degree" (Goldstein, 1989, p. 35).

The first clinical pharmacy degree (PharmD) debuted in the 1950s at the University of Southern California, with several more programs opening at other universities in the 1960s. At the time, the entry-level degree to practice as a pharmacist was a bachelor's degree. Initially, the PharmD was separate from the entry-level bachelor's degree but later developed into a streamlined single degree program at most universities (Pierce & Peyton, 1999). As of 2000, the PharmD became the entry-level pharmacy degree, based on a model with 2 years of pharmacy-specific education at the undergraduate level and 4 years of postgraduate studies—oftentimes with only one terminal/all-or-nothing degree awarded at the end (American Association of Colleges of Pharmacy, 2017; Brown-Benedict, 2008). Factors fueling this transition to the doctoral degree included the following: (a) the challenge of teaching an ever-expanding scope and depth of practice, (b) the desire to improve the quality of clinical practice, and (c) the hope to elevate the profession and thereby improve professional autonomy (Brown-Benedict, 2008; Pierce & Peyton, 1999).

The first doctor of physical therapy (DPT) program opened in 1992 at the University of Southern California and was originally geared toward the needs of clinical faculty (Pierce & Peyton, 1999). The American Physical Therapy Association (APTA) set out to adopt DPT as the entry-level degree for physical therapy by 2020 (Johanson, 2005), but the goal was reached ahead of schedule, and now, all accredited physical therapy degree programs run at the doctoral level (Commission on Accreditation in Physical Therapy Education [CAPTE], 2019). Reasons for transitioning to the DPT included (a) the need to accommodate an increasing breadth and depth of practice, with the need for greater opportunities to practice clinically prior to entering the profession (including the need to better develop students' interaction skills); (b) the need to further the profession by graduating students with more buy-in to clinical education and research; and (c) the need to attract stronger candidates (Mathur, 2011). Additional motivating factors that fit under the umbrella of “the pursuit of professional autonomy” included supporting the aim of physical therapy becoming “fully professionalized” and a “doctoring profession” (Johanson, 2005, p. 7) to (a) support the goal of achieving direct patient access to physical therapists without the need for physician referral, (b) improve recognition from other professions and the public, and (c) help the profession achieve improved recognition of what physical therapists already offer by applying the doctoral label (Mathur, 2011).

Nursing offers the doctor of nursing practice (DNP) degree as a post professional degree. Although nursing's clinical doctorate is by no means the entry-level degree in the profession, it provides an outlet to educate clinical leaders in nursing (Brown-Benedict, 2008). Those who earn a DNP are better able to work *with* (versus *under*) other professions and are better able to help elevate the public, clinical, and internal views of nursing (Clinton & Sperhac, 2006). In other words, “the DNP supports the goal of improving the autonomy of the nursing profession” (Brown-Benedict, 2008, p. 453).

### ***Other Professions***

“The doctorate is the entry-level degree in the following fields: medicine, dentistry, osteopathy, clinical psychology, chiropractic, optometry, podiatry, pharmacy, physical therapy, audiology, and advanced practice nursing” (Brown et al., 2015, p. 3).

## **Take-Aways**

- In many ways, the challenges that fueled other health care professions to adopt a clinical doctorate parallel the challenges currently being discussed as our own profession debates and weighs its best way forward.
- Audiology adopted an entry-level clinical doctorate in 2007. Physical therapy has already reached its planned 2020 adoption of an entry-level clinical doctorate. Occupational therapy plans to adopt an entry-level clinical doctorate by 2025.
- Key motivating factors for advancing entry-level education to practice in these examples of health care professions included the need to (a) accommodate an ever-growing scope of practice within the curriculum, (b) improve graduates' ability to implement evidence-based practice, (c) improve the quality of clinical practice, (d) improve professional autonomy, and (e) improve recognition within the greater health care community.  
Speech-language pathology is not currently competitive with audiology, occupational therapy, or physical therapy regarding minimum academic requirements to enter clinical practice.

### **Question 3: What are the gaps and unmet needs in the current educational model to prepare entry-level clinicians to be competent across the full scope of practice?**

Exploration of unmet needs and challenges included the gathering of information from a variety of subgroups, including (a) ASHA's School Issues Advisory Board (SIAB), (b) the ASHA Speech-Language Pathology Advisory Council, and (c) focus groups representing new graduates and those who supervise new graduates at the 2018 ASHA Annual Convention. Additional feedback and comments were provided after SIAB and Advisory Council members sought input from professionals in their networks.

The subcommittee examined the preparedness of entry-level school-based SLPs and entry-level health care-based SLPs—the latter representing settings of outpatient care, acute care, inpatient rehab, home health, and SNFs. The following questions were posed to the various groups mentioned above:

- Are students adequately prepared to enter their various work settings?
- What are the gaps and unmet needs in the current educational model to prepare entry-level clinicians to be competent across the full scope of practice?

These questions are discussed in the subsections below.

#### **Are students adequately prepared to enter their various work settings?**

Feedback on this question highlighted the variability in graduate training programs, clinical experiences, and individual student skills. Overall, new graduates participating in the focus groups reported feeling adequately prepared while mentioning specific topics or experiences that may have been a factor of their clinical experiences. One new graduate highlighted the need for critical thinking and hands-on practice during graduate training by sharing the following:

“During my grad school years, they taught us via lectures/videos/presentations/research with as much hands-on experience as possible. To me, the more hands-on experiences we can get, the better. Critical thinking skills are truly put to the test when you are immersed into the situation and having to think/do/make decisions right then and there.”

Those who were hiring and supervising new graduates—and who were serving in focus groups, SIAB, and the SLP Advisory Council—reported that the preparedness of new graduates varied by their training program, clinical placement, and unique skill set and personality. Some comments included a lack of diverse clients in university clinics and the need for expanding clinical placements so that students could have experiences with a variety of (a) populations, (b) service delivery models, and (c) documentation and regulatory systems.

When asked to provide specific information on gaps, unmet needs, or their perceived challenges for entry-level clinicians, the range of topics shared by both schools and health care and clinical providers included significant overlap. This reinforced that the historical view of professional practice being divided by practice setting (i.e., schools and health care) is no longer relevant in today’s practice settings. If a need arises for segmenting the scope of practice of educational programs, a pediatric and adult model may be more appropriate. School-based providers are increasingly serving medically complex and fragile students and desire the same knowledge and skills as do health care and clinic professionals in order to serve their students safely and effectively.

The following topics were more frequently identified as gaps or unmet needs in the current educational model:

1. Complex Health Care Needs
2. Dysphagia
3. Second Language Learners
4. Cultural Competencies
5. Dialectal Differences and Language Variation
6. Interprofessional Teams, Interprofessional Collaborative Practice
7. Traumatic Brain Injury (TBI)
8. Awareness of Laws and Regulations (e.g., IDEA, ESSA, Medicare)
9. Clinical Placement in a Variety of Settings for Exposure to Content and Various Clients
10. Augmentative and Alternative Communication (AAC) Evaluation and Device Selection
11. Supervision of Speech-Language Pathology Assistants (SLPAs) and Extenders
12. Documentation



**Question 4: Feasibility and Packaging Perspective: How can we package teaching [for every student] the full scope of practice so that it is reasonable to assume that newly certified clinicians are well-prepared to enter practice in the area in which they choose to work? What is needed to enter practice (include extenders)?**

Current accreditation mandates dictate that SLPs should be prepared to serve patients across the lifespan. In turn, this means that each professional must exit an accredited program competent in the area in which they will serve—and across all areas of professional practice (all ages, all settings, all populations). For SLPs, this means having to be competent in nine major areas and knowing the comparative differences between multiple work settings. This report contains further information regarding what is needed to enter practice and the feasibility of teaching the full scope of practice to adequately prepare new clinicians.

To obtain more information regarding the number of SLPs who made the shift between medical and education settings, we analyzed ASHA Year End Count data between 1999 and 2014. During this time period, there was a mean of 3.5% of SLPs who changed from schools to health care, and there was a mean of 6.6% of SLPs who changed from health care to schools. Therefore, this identifies a need for SLPs to be adequately prepared in all areas to meet the demands of the profession.

Based on data from recently certified SLPs at 2018 ASHA focus groups (ASHA, 2018a, 2018b, 2019a, 2019b)—that is, they had obtained their Certificate of Clinical Competence in Speech-Language Pathology [CCC-SLP]—we identified a need for more medical setting exposure, as participants stated multiple areas within which they wished they were more familiar (i.e., dysphagia and cognitive evaluations). CF supervisors felt that there is not enough time in a 2-year period to meet the requirements to graduate students who are competent in all of the nine areas in which an SLP is supposed to be competent.

According to ASHA's *2013 CSD Higher Education Survey*, 114 programs acknowledged the fact that they face challenges when it comes to teaching across the full scope of practice. Some noted that these challenges included limited expertise among faculty members, inadequate time in the curriculum, and scarce practicum experiences. The vast majority of program chairs indicated that they are indeed facing these challenges when it comes to teaching the full scope of practice. Participants from the clinic director group also mentioned similar challenges, including the students, extern placements, expanding scope, insufficient faculty to teach across the scope of practice, and time in the curriculum.

Some proposed changes to the current educational model in order to increase competency in new graduates included the option of adding a year (or two) to the current educational model to allow for more clinical experiences and more time for coursework. It was also suggested that undergraduates be given more experiences and exposure, and graduate school would build on this foundation (ASHA, 2018). This idea was also stated during program chair and clinic director focus groups. The pros and cons of the Lifespan Model, the Track Model, and the Modular Model were also examined during this focus group discussion. Throughout the discussion of the different models, the fact was mentioned again that it is likely that clinicians will experience changes during a career, which includes a change in settings. Given the data regarding SLPs who change settings in their careers, it would be critical for

SLPs to be trained in the full scope of practice in order to prevent clinicians from doing anything unethical.

The majority of health care professions shadow—or are similar to—the medical model for professional preparation, but with reduced intensity and fewer required clinical hours than a physician. Clinical doctorates have become the new educational standard among most health care professions, with perceived benefits being an increase in professional opportunities and an increase in salary. Although there are benefits, the “cons” to this transition are that research training, research productivity, diversity, and professional debt burden have been adversely affected by this shift.

Health care professions requiring more than a bachelor’s degree and more than a 2-year master’s degree for entry level included audiologist, pharmacist, chiropractor, dentist, physician’s assistant (2–3 years of a master’s degree), medical doctor, neuropsychologist, health psychologist, and physical therapist. In education settings, the majority of entry-level degrees are bachelor’s degrees or 2-year master’s degrees.

For medical students, coursework during the first 3 years is taught through classroom, clinical, and community experiences and covers (a) science, (b) problem-solving and communication skills, (c) prevention and care, and (d) professionalism and medical ethics. In their fourth year, students choose a specialty area based on personal interests, clinical experiences, and so forth, and apply to residency programs. Upon completion of the program, students complete a 3- to 7-year residency. The residency is required to be licensed and board certified and includes supervised, hands-on training to develop independent clinical skills. During this residency, they experience a variety of settings. After the residency, they have the option to undergo a fellowship program, which adds on 1–2 years of study in a specialty area (Association of American Medical Colleges, n.d.).

Audiology students complete a 4-year clinical doctorate (AuD). The focus of the AuD is “on the development of clinical proficiency” (American Academy of Audiology, 1991, para. 4). In this 4-year clinical doctorate, AuD students begin with both clinical experience and academic coursework, and as the program progresses, the focus shifts more to clinical experience—with the 4th year being all clinical experience. In order to become certified clinicians, students in an AuD program must obtain at least 1,820 hours of clinical experience.

The entry-level degree for pharmacy students is a 4-year clinical doctorate degree. Because of this change in entry-level degree, schools of pharmacy were able to meet the challenges that they were facing due to an expanded role in health care. Changes to the PharmD educational model included a 3-calendar-year curriculum, a 2-plus-2 curricula, and more team-based instruction, problem-based learning, and service learning. Because of the change in educational model/entry-level degree, standards for pharmacy education were also revised to include more interprofessional instruction; more use of active-learning techniques; greater curriculum emphasis on medication safety, cultural competence, professionalism, research principles, improved preparation for graduates to be educators, assessors of student competence, and innovators; and more student involvement in program/college operations, such as committees (Vlasses, 2010).

Like audiology and pharmacy, the entry-level degree for physical therapy is also a 4-year clinical doctorate degree. The change to the clinical doctorate degree was deemed necessary to accommodate

a broader scope of practice and to meet the need for greater opportunities for clinical practice prior to entrance into the profession; this includes the need to improve students' collaboration and communication skills (Threlkeld et al., 1999; Mathur, 2011).

With a growing scope of practice, the feasibility of teaching the entire scope of speech-language pathology within a short time frame is becoming more and more difficult. Based on the data and information provided above, adjustments to the current educational model should be considered in order to train highly qualified professionals who are prepared to practice across all areas of the profession and who are prepared to meet the demands of current employers in the discipline.

### **Question 5: How are we teaching? What is the pedagogical model of training SLPs? How can we better develop critical thinking skills?**

#### **A. How are we teaching?**

Currently, *pedagogy* is viewed as both an art and a science. Most academicians identify pedagogy as an applied science, much like medicine and other practice-based fields (Vellas, n.d.). Given the historical model for higher education that included primarily a lecture from the instructor and a response from the students, the communication sciences and disorders (CSD) discipline has moved over time to a more interactive form of education. Over time, strategies that emphasize small-group activity, case studies, role plays, and use of video footage of patients/clients/students with various disorders began to appear in CSD classrooms. Today's pedagogy has taken another turn toward additional interactive and transformative strategies that include flipped classrooms<sup>1</sup>, greater use of technology, and more student-led activities.

#### **B. What is the pedagogical model of training SLPs?**

CSD education also represents a range of models, including those that "front-load" academic and clinical coursework followed by clinical work; other programs interweave academic coursework and clinical practica throughout their program. An example of the latter is when, within a semester/quarter, a program has students spend a few days a week taking courses and spend the other days participating in practica (e.g., coursework on Tuesdays and Thursdays; practica on Mondays, Wednesdays, and Fridays). In contrast, some use a blocking system (much like occupational or physical therapy), where students are in a semester- or quarter-long class with a 1- or 2-week practicum inserted one or more times in between class sessions. In addition, some programs have their students begin clinic their first semester, whereas others use the first semester for preparatory activities such as guided observations, Simucase practice, and online modules. Some programs offer survey-like courses during the first semester (e.g., adult vs. child communication), covering the "Big Nine" courses required by the Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA) in an overview manner to minimally prepare students for clinic.

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<sup>1</sup> A *flipped classroom*, as defined on Wikipedia, is "an instructional strategy and a type of blended learning focused on student engagement and active learning, giving the instructor a better opportunity to deal with mixed levels, student difficulties, and differentiated learning styles during in-class time. It moves activities, including those that may have traditionally been considered homework, into the classroom. In a flipped classroom, students watch online lectures, collaborate in online discussions, or carry out research at home while engaging in concepts in the classroom with the guidance of a mentor." For more information, see [https://en.wikipedia.org/wiki/Flipped\\_classroom](https://en.wikipedia.org/wiki/Flipped_classroom)

There are also program variations in the location of clinical work—some programs have their students complete all clinical activity in an in-house clinic, whereas others require their students to do all clinical activities in the community because the university program does not have a clinic. Further, other programs require a mix of in-house and community-based practicum experiences. Still other programs require students to do a full-time internship their last semester, either in the local area or a farther distance from the program (e.g., out of state).

In terms of coursework, there is also a good deal of variation. Some programs require all students to take the same set of courses in the same sequence; others have a few electives available for some student choice. Still others have emphasis areas (e.g., child, adult, or lifespan), thus allowing students to have more choice in elective courses, where all students take a basic set of courses and then choose electives in a particular emphasis area (or across the spectrum with a lifespan approach). Some programs offer coursework in all the Big Nine areas as well as coursework in more specialized disorders that are newer to the profession (e.g., fluency, voice, dysphagia, AAC, autism). Other programs offer online modules or mini-courses for some of these courses. Programs also vary in terms of who teaches academic and clinical courses. For some programs, only PhD-level tenure-track faculty teach academic courses, whereas clinical staff teach clinical courses. Other programs utilize both academic and clinical faculty to teach academic courses. The degree of use of adjunct faculty also varies across programs—as does the proportion of overall courses taught by adjuncts.

Thus, across CSD programs, there is a wide range of models used to prepare students. Unfortunately, our discipline does not have a strong body of scholarship of teaching and learning data to identify the effectiveness of the various models used by CSD programs. Some might look at (a) output variables such as pass rates and/or scores on the CSD Praxis® exam, (b) program completion rates, and/or (c) honors received by students; however, these static measures are only one means to extrapolate the effectiveness of a program or model of CSD education. Much research in this area is needed across CSD programs to help determine policy and to make informed suggestions of recommended practices in CSD education.

### **C. How can we better develop critical thinking skills?**

This question may be best guided by first asking, “What are critical thinking skills?”

Study.com<sup>2</sup> defines *critical thinking* as follows:

*Critical thinking* means making reasoned judgments that are logical and well-thought-out. It is a way of thinking in which you don't simply accept all arguments and conclusions you are exposed to but rather have an attitude involving questioning such arguments and conclusions. It requires wanting to see what evidence is involved to support a particular argument or conclusion. People who use critical thinking are the ones who say things such as, “How do you know that? Is this conclusion based on evidence or gut feelings?” and “Are there alternative possibilities when given new pieces of information?”

Additionally, critical thinking can be divided into the following three core skills:

1. *Curiosity* is the desire to learn more information and seek evidence as well as being open to new ideas.
2. *Skepticism* involves having a healthy questioning attitude about new information that you are exposed to and not blindly believing everything everyone tells you.

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<sup>2</sup> Source: <https://study.com/academy/lesson/what-is-critical-thinking-definition-skills-meaning.html>

3. Finally, *humility* is the ability to admit that your opinions and ideas are wrong when faced with new convincing evidence that states otherwise.

The University of Greenwich in London<sup>3</sup> defines *critical thinking* in the following way:

Being *critical* requires you to not only gather appropriate data and information but to examine it carefully and question its reliability and authority. *Critical thinking* involves looking beyond the obvious surface issues, asking questions about motivation and purpose. Being critical requires you to not only gather appropriate data and information but to examine it carefully and question its reliability and authority. One way of helping to focus your critical thinking is by considering the 6 Ws, which are:

1. **Who by?** Who has produced a piece of information is a crucial issue. Everyone has a perspective, a point of view, that can't be avoided. Being aware of a person's point of view, background, and even prejudices helps us to interpret their work and better understand why they are saying what they are saying.
2. **Why?** Why something has been written or said is a very important critical issue. We are bombarded by information these days, and each piece is presented to serve a particular purpose. Knowing why something has been written will help in identifying the underlying motivation of the writer or producer and thus help us decide whether the information is valuable to us or not.
3. **What?** What evidence is the information based upon? In reading a book or watching the TV or listening to teachers, it is important to ask questions about the basis for what is being said. It is important not to believe something just because somebody says so; we need to know why they are saying what they are saying. Otherwise, it is simply gossip.
4. **When?** The period in history when a piece of information was presented is very important, especially in fields such as IT, where there is rapid development. There is little use writing an essay about the current state of mobile phone technology based upon a book written in the 1980s.
5. **Where?** Geographical location is often an important critical factor. Where something was produced will often make a difference to the kind of information being presented and the way it is presented. Health care issues, for example, will differ widely between developed and developing countries. Attitudes toward law, religion, and society vary a great deal from country to country.
6. **Who for?** The target audience for a presentation of information will be an important issue when critically evaluating its value and significance. Writers can aim their work very specifically at the young or the old, male or female, different political groups, different social groups, and so on. Some writings or media productions are aimed at the general public; others are aimed at a small section. Some information is packaged for easy consumption by people with limited education; some is tailored to the needs of students, teachers, and experts. It is important when studying to ask whether your source material is pitched at the appropriate level—the “Ladybird Book of Policemen” would not, for example, be an appropriate textbook for an undergraduate essay on criminality and policing in the United Kingdom.

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<sup>3</sup> Source: <https://www.gre.ac.uk/articles/academicskills/critical-thinking>

Thinking critically is a skill that is taught at school and university, BUT its main purpose is to better equip you to understand the world, to make more sense of the vast amount of information that is available to us, and to avoid being manipulated. It is a life skill.

We all act critically in our everyday lives. We don't simply accept gossip and random information, and we certainly shouldn't accept everything we see on TV or in the media as true and authoritative. It is vital in our everyday lives to be able to question why people are saying things to us—be it the government, our friends, or the advertising industry. If we accepted everything we heard and read and saw, without question, we would be open to constant abuse and manipulation. To buy what we really need, to vote for who we really support, and to befriend those who truly care for us, we have to think critically.

#### **D. Are CSD programs clear and intentional about how they go about building critical thinking skills?**

Most programs would likely respond that they use practice-based opportunities to build their students' critical thinking skills. Methods such as case studies, role plays, grand rounds, small- and large-group discussions, evidence-based reviews, and IPE activities are commonly used. Programs also very likely encourage the use of evidence-based practices and the process for identifying the quality of the evidence for particular assessment, policy, or treatment approaches. However, as noted in many arenas, educators find the evaluation/measurement of these skills difficult.

The following are trends in higher education that need to be considered in examining current and future teaching and learning practices:

- Use of online modules and materials.
- Use of case studies, simulated cases, and/or Simucase.
- Adherence to adult learning principles.
- Increased use of active learning strategies.
- A move toward flipped classrooms.
- Increased use of technology (e.g., quizzes, clickers, polls) that allows for data collection on student use, learning, application, and web views and for lecture capture (for later viewing).
- Increased resources from Centers of Teaching and Learning.
- Increased interest in the science of learning (within CSD programs, too).
- Demands for increases in program size.
- Increases in the amount of content to cover.
- Increases in student mental health issues.
- Increased focus on student autonomy, self-guided study, and competency-based education.
- Increased availability of comparison resources such as the College Scorecard Data website (<https://collegescorecard.ed.gov/data/>) to compare undergraduate programs. According to its website, "The College Scorecard is designed to increase transparency, putting the power in the hands of the public—from those choosing colleges to those improving college quality—to see how well different schools are serving their students."
- Other organizations have recently launched efforts to collect more accurate data on college completion, remedial education, and workforce outcomes (see, e.g., Selingo, 2016).

- Greater focus on return on investment (ROI). “*The Economist*, *Money* magazine, and LinkedIn all released their own college rankings based on the earnings and job placement rates of graduates. Seven states—Arkansas, Colorado, Minnesota, Tennessee, Texas, Virginia, and Washington—now match statewide salary data from unemployment insurance records with graduates from colleges and universities within the state, allowing consumers to compare the ROI of both institutions and majors” (Selingo, 2016, p. 6).
- Rising costs of education and student debt.
- Achievement gaps among different ethnic and racial groups.
- Overuse of part-time or adjunct faculty members (therefore, this means lower pay and significant cost savings for the program).
- Changing demographics of students (pipeline issues that the CSD discipline is facing nationally; see, e.g., Selingo, 2016).
- Supply-and-demand issue for PhD-level faculty.
- Some predictions that state funding for higher education will continue to decline to the point of nonexistence (see, e.g., Selingo, 2016).
- Aging and increasingly expensive faculty.
- Growing interest in some fields for a two-track faculty system: teaching and research. This could reduce the need for adjuncts, reduce hierarchy among faculty, and provide a pathway for graduate students interested in teaching. A recent survey documented that “50 percent of tenured faculty and 70 percent of full-time, non-tenured faculty said they found the idea of customized pathways in a particular area of practice attractive. So, too, did 68 percent of deans and 74 percent of accreditors” (Kezar et al., 2015, p. 29).
- Suggestions for a three-tiered teaching model (professor, instructor/preceptor, and teaching assistant) for large classes. This “results in improved retention and graduation rates. At the University of Delaware, which uses the preceptor model in introductory biology courses, class attendance has gone up and the dropout rate among STEM majors who have preceptors has fallen” (Kezar et al., 2015, as cited from Harker, 2013, p. 30).
- Team-based, “design–build approach” (faculty and an instructional designer create courses on campuses).
- Move toward the adoption of a broader definition of *scholarship* (see Boyer, 1990).
- Increased need to enhance learning. “In 2010, the National Research Council released a report describing the broad skills students need to succeed when facing the future challenges of the workplace. Often described as ‘21st Century Skills,’ these include a mix of **cognitive**, **intrapersonal**, and **interpersonal** attributes such as collaboration and teamwork, creativity and imagination, critical thinking, and problem solving” (Selingo, 2016, p. 34, citing work from Pellegrino & Hilton, 2010).
- Increased focus on the “T-shaped professional” as the cornerstone of the undergraduate education experience. As explained in the 2026 report, “The vertical bar of the T represents a person’s deep understanding of one subject matter—history, for example—as well as one industry, perhaps energy or health care. The horizontal stroke of T-shaped people is the ability to work across a variety of complex subject areas with ease and confidence, which is encouraged by the classic liberal arts” (Selingo, 2016, p. 34).
- BA/BS+ (the bachelor’s degree with added certifications, badges, and/or extended transcript earned while in the program or after completing the program).

- Degree + boot camp options after completing the degree. “Such partnerships might form the basis of a university for life, where traditional higher-education institutions curate channels of content from various providers and then push it out to their students and alumni . . . such content . . . will provide students and alumni more value for their money by giving them access to learning platforms when they need them throughout their lifetimes” (Selingo, 2016, p. 38).

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## Appendix D: AHC-GESLP Surveys and Data Subcommittee – Summary of Data

### I. 2019 Survey results about the optional, post-entry-level clinical doctorate in SLP

#### A. Five Surveys fielded September 17, 2019 with reminders Sept 24 and Oct 1, closed out on Oct 8.

- SLP Practitioners (24% response rate; n= 1130 individuals)
- Members of SLP AC (69% response rate; n=35 individuals)
- In or graduates of Clinical Doc in SLP (47% response rate; n=108)
- Employers of SLP (25% response rate; n=1206)
- NSSLHA Students (30% response rate; n=620)

#### B. SLP Practitioners (42% were early career professionals)

- Responses about whether the Clinical Doctorate be of value and would you pursue it, were similar to the 2012 results
  - Half of 2019 48% of 2012 sample answered “Yes” that there is value to the profession to have this degree available
  - In 2019, 56% in HC settings and 47% in school-based settings said the degree is valuable to the profession
  - In 2019, 31% school; 39% in HC thought that there would be value to them professionally (33% across all respondents)
  - When asked if they would pursue this degree: Overall 24% said “Yes” [25% in 2012]
    - 21% schools in 2019 said they would pursue it; [22% in schools in 2012]
    - 31% in HC in 2019 said they would pursue it; [19% in HC in 2012]
  - Do you think this optional degree should have oversight by an accrediting body
    - Overall, 85% responded “Yes” in 2012 and in 2019 across all employment facilities
    - 82% in schools and 90% in HC in 2019 said “Yes”
  - Open-ended comments
    - Negative comments about the added cost
    - Negative value in having this degree in the schools (not much value-added)
    - Lots of comments about how this degree would give the profession added and needed value

#### C. SLP Advisory Council (n=35)

- Only 3% had been practicing less than 10-years (whereas 42% have been practicing less than 10-years in the practitioners’ results)
- 94% indicated that clinical doctoral programs in SLP should be accredited

#### D. SLPs in a clinical doctorate program or who hold a clinical doctorate in SLP (47% response rate; n=108)

- 43% indicated they had or were attending Nova Southeastern, Northwestern 14%, Rocky Mountain 9%, KU 7%, Kean 6%, the rest ~1%)
- 76% indicated that the clinical doctorate should be 75% indicated that lack of accreditation did not concern them

- Comments were focused on prestige of the institution (trust the reputation of the University)
- Some thought their program was already accredited (there may be some confusion with regional accreditation)
- 72% said their program met their expectations
  - i. Some felt that they should have gone for a PhD/EdD as they want to work at Universities

**E. Employer survey** (n=1206 in 2019; n=2109 in 2012); sample pulled based on data in NetForum

- 36% indicated that they were clinical service providers (and not administrators)
- Is there a value for the profession to have this degree – 52% said “Yes” [48% said there was a need for this degree in 2012]
- Is there value for individuals in your work setting [41% said “Yes” in 2019]; question not asked in 2012
- Should there be oversight by an accrediting body [83% in 2019; 84% in 2012]
- When asked “What impact would an accredited clinical doctorate degree have in hiring?”, 50% would only consider those from an accredited program in 2019, [up from 44% in 2012]

**F. Students** (n=620 NSSLHA students currently enrolled in Master’s program)

- In 2012, 42% were undergraduates and 54% Masters level students or graduates
- Value of this degree for the profession 60% said “Yes” in 2019 [43% said there was a need for this degree in 2012]
- Value of the degree personally 51% in 2019 (33% practitioners in 2019) [question not asked in 2012]
- In 2019, 88% of students thought that the degree would require oversight [question not asked in 2012]
- In 2019, 83% would only consider accredited program [78% in 2012]
- Even distribution when asked if they would pursue this degree (39% yes, 30% no, 31% uncertain) [38% yes, 23% no, 37% uncertain in 2012]
- Members are realistic that this degree won’t likely have much of an impact on salaries

**G. 2018 Focus Group at the Boston Convention**

**B. CF Supervisors**

- In response to the question “Of the CFs you have supervised , were there professional responsibilities or areas of practice for which the CFs were not well prepared? If so, what were they?”
  - Swallowing
  - Physiology related to underlying diagnoses
  - Cognition and dementia
  - Rehab in general
  - Behavioral challenges
  - Counseling skills

- Pediatric feeding
- Developmental norms
- Goals and carrying out the goals
- Billing
- Insurance
- CPT codes; ICD 10 codes
- Documentation
- Clinical writing
- Synthesizing case histories and medical charts

## II. Summary of Surveys and Focus Groups Key Data (2012-2019)

- A. Which aspects of the current model of entry-level education for speech-language pathology in the United States **are serving the profession and the public adequately** now, and in the near future?
- Potential models proposed along with elements of change to gather reactions. Three alternative models were posed to the 2019 CAPCSD Focus Group participants (Lifespan, Track, and Modular models) They unanimously preferred the current Lifespan model.
    - Almost all preferred the Lifespan model which extended the program duration over the Track model and the Modular model.
    - Almost all preferred the Lifespan model and the notion of extending the program's duration by incorporating portions of the undergraduate degree, like the senior year, into the degree rather than adding another year of graduate school (primarily due to sensitivities around increasing student debt loads).
    - Participants believe that students are not ready to choose a Track or Specialty area until they have sampled it all.
  - Pathways that programs could take to adjust to potential changes
    - The Lifespan model was perceived as the most feasible to implement because it isn't all that different from what they are currently doing.
    - There were perceived risks to the other two models primarily in terms of how it might affect faculty lines and how it might be difficult for students to decide so early in their career what areas or settings they want to work.
- B. And which aspects of the current model of entry-level education for speech-language pathology **are not serving the profession and the public adequately** now, and in the near future? (2019 CAPCSD Focus Group participants responses below.)
- On the 2013 Higher Education Survey, 114 Masters-level programs reported that they had challenges teaching across the full scope of practice because: (a) they don't have the expertise needed to teach on their faculty; (b) there is insufficient time in the program to fit it all into the curriculum; and (c) there are insufficient practicum experiences available across practice settings.
  - On the 2013 Higher Education Survey, 114 Masters-level programs reported that they were especially challenged to teach the following areas:

<b>Area</b>	<b>Number of Programs</b>
AAC	18
Voice	18
Fluency	15
Child Language	14
Audiology	13
Dysphagia	13
Craniofacial	9
Speech Science	4
Literacy/Dyslexia	3
Hearing Science	3
Business	3
Aphasia	2
Auditory Rehabilitation	2
Neuroanatomy	2
Pharmacology	2
Autism	1
Accent Modification	1
Counseling	1
Evidence-based Practice	1

- Focus group participants from the 2019 CAPCSD meeting reported that: (a) there are not enough faculty in their department to teach across the full scope of practice; (b) there is not enough time in the program to fit everything into the curriculum; and (c) there are not enough externship sites available across practice settings.
- Focus group participants from the 2019 CAPCSD meeting reported that: (a) most graduating students, including the excellent ones, are not prepared to work in all settings, and sometimes have limited experience in the first setting that they work as a CF. Some areas are especially challenging to prepare students adequately such as NICU, craniofacial clinics, voice clinics, acute care, private practices with an emphasis on fluency, and preschool autism programs.
- Without the clinical doc, there is an increased risk of encroachment (e.g. OTs with clinical docs will be increasingly looked to for dysphagia and administrative roles) that may minimize what SLPs do; we may lose ground in terms of respect from other health care providers; makes us susceptible to encroachment and decreases respect for the SLP profession and of SLP professionals

- C. Are there changes to the current model of entry-level education that would likely help to address any gaps or unmet needs that have been identified? Focus group participants from the 2019 CAPCSD meeting responded that alternative models could:
- Better prepare students across the full scope (breadth)
  - Better prepare students for specialized areas of practice or specific practice settings (depth)
  - Better prepare students for evidence-based practice. Better prepare students for lifelong learning by instilling that learning should continue across your lifetime, and that it does not end with graduate school.
  - Better satisfy employer demands.
  - Lead to better outcomes for the patients, clients, and students that SLPs serve.
  - Help mitigate threats of encroachment from other professions if speech-language pathology moves to the clinical doctorate as the entry-level degree.
  - Create potential opportunities for University programs to supplement their budgets by offering certificate programs in specialty areas to practicing clinicians.
  - Promote the development of certificate programs, which could be helpful to clinicians who intend on transitioning to new settings and to clinicians who want to increase their knowledge and competencies to work in a specific setting or with a specific population.
  - Create collaborative environments, like a shared resourcing, for University programs to form consortiums so that expertise in specific areas could be shared and more students could benefit from the faculty expertise that exist across Universities.
- D. Perceived barriers to change across stakeholders?
- 2019 CAPCSD Focus Groups addressed implications for University programs
    - Pressure from administration and legislators to “get’m in – get’m out” as fast as possible.
    - Pressures to reduce any extra charges to students and against increasing credit hours required for graduation.
    - Can’t place any more burdens on external placement sites to prepare students
    - Shared perceptions that student debt load should not be increased
- E. Perceptions of school-based practitioners and educators
- School-based perception that change will mean “more” from them – what are the benefits for them? “Advance Licensure”, pay scale, different responsibility scale? Psychologists in schools?
  - Would a change in entry-level degree worsen shortages in schools? (Do shortages persist?)
  - Would a change in entry-level degree affect applications to graduate programs?
  - Would a change in entry-level degree affect where graduates choose to work?
  - Added costs of clinical doctorates need to be factored into how it went for Audiology.
- F. Possibilities for Change
- Potential models proposed along with elements of change to gather reactions. Three alternative models were posed to the 2019 CAPCSD Focus Group participants (Lifespan, Track, and Modular models).

- Almost all preferred the Lifespan model which extended the program duration over the Track model and the Modular model.
- Almost all preferred the Lifespan model and the notion of extending the program's duration by incorporating portions of the undergraduate degree, like the senior year, into the degree rather than adding another year of graduate school (primarily due to sensitivities around increasing student debt loads).
- Participants believe that students are not ready to choose a Track or Specialty area until they have sampled it all.

#### G. Pathways that programs could take to adjust to potential changes

- The Lifespan model was perceived as the most feasible to implement because it isn't all that different from what they are currently doing.
- There were perceived risks to the other two models primarily in terms of how it might affect faculty lines and how it might be difficult for students to decide so early in their career what areas or settings they want to work.

#### H. Role of certificates

- There was consensus that there is a need and great value to certificate programs. Such programs could: (a) offer excellent opportunities for focused continuing education; (b) create additional revenue streams for academic programs; and (c) help SLPs to gain specialty expertise and to transition to new settings.
- The notion of "stackable credentials" was viewed as a viable alternative to the Modular model that would be more feasible for University programs to offer.



## Appendix E: AHC-GESLP Certification Subcommittee Report

### **1. What are the strengths/challenges of an apprenticeship model, and what do related professions look like?**

#### ***Clinical Fellowship Strengths***

- Provides an opportunity to obtain on-the-job training with real clients/patients under the guidance of a seasoned mentor.
- If designed and monitored appropriately, having a mentor work with you for 9 months could prevent a majority of mistakes from happening, and when it comes to health care, it protects our clients/patients, which is paramount.
- The Clinical Fellowship is a paid experience, and Clinical Fellowships are not incurring additional student loan debt.

#### ***Clinical Fellowship Challenges***

- Experience varies greatly depending upon the setting, mentoring styles vary greatly, mentors have the requirement to only see the Clinical Fellowship in direct clinical contact for 6 hours of direct observation per segment (420 hours), many Clinical Fellows (CFs) contact ASHA stating that they can't get in touch with their mentor or that the mentor is not providing the level of supervision that they feel they need.
  - It is difficult for most practice settings to provide real-world experiences that mirror the full scope of practice and patient populations.
- Clinical doctorate programs for physical therapy, occupational therapy, and the doctorate in audiology (AuD) require extended clinical time and, in some instances, Capstone projects. These externships meet the extended clinical time required for full skill and competency development. Although this experience is not prescribed by the CAA or CFCC, the majority of programs have adopted a 10- to 12-month model. This means that students apply for competitive positions and may move across the country to complete the experience. This poses its own challenges with quality control, management of students who are not selected by their chosen sites, and a myriad of administrative issues.
- Capstones in audiology have traditionally been research-based experiences where students are completing literature reviews, collecting data, and writing extensive documents. This process can be shaped by a university to be very rigorous (much like the dissertation for the Doctor of Philosophy degree [PhD]). Candidates are reporting difficulties finding sites and mentors to complete these projects, as well as research mentors.
- Currently, 400 clinical practicum hours are completed within the confines of a graduate school program, but is that enough? Should competencies be developed as opposed to clinical hours? Yes, the focus should be on demonstration of competencies observed by a

knowledgeable observer. The number of clinical hours required to acquire competence varies.

- We need data to determine if other models have proven to be efficient.

## **2. What is the CFCC already doing to improve the Clinical Fellowship?**

- The CFCC completed a revalidation study in 2018 with a consultant. A group of subject matter experts (SMEs) gathered at the ASHA National Office and developed the new **Clinical Fellowship Skills Inventory (CFSI)**. The new CFSI contains a 3-point rating scale with 21 objectives. A new rating scale was developed that includes: 3 = *Exceeds Expectations*; 2 = *Meets Expectations*; 1 = *Does Not Meet Expectations*. CFs must receive a rating of a 2 (*Meets Expectations*) for all 21 objectives in order to successfully complete the Clinical Fellowship experience. All 21 skills are considered to be “core” skills. There is no longer an “N/A” option.
- The SMEs developed scenarios for the CFSI. The CF in each scenario was then assessed by various speech-language pathologist (SLP) CF mentors using the new CFSI. In all but one case, strong interrater reliability was determined for each scenario, and in all cases, the raters stated a preference for the new CFSI.
- CFs and CF mentors who are currently in the process of completing a Clinical Fellowship were identified to pilot the new CFSI in conjunction with the current rating scale. CFCC received overwhelming support in favor of the new CFSI form and format.
- CFCC developed guidelines for CF mentors completing the new CFSI. This included a description of the CFSI, directions for use, rating tips, submitting the CFSI, and a template for tracking supervisory activities. These may all be found on the ASHA webpage titled “[A Guide to the ASHA Clinical Fellowship Experience](#).”
- Micro-learning tools are being developed for case studies in assisting CF mentors completing the CFSI.
- On January 1, 2020, the CFSI was implemented for all new CFs beginning on or after that date. The current CFSI was sunsetted on December 31, 2019, and is no longer available. Those in the process of completing their Clinical Fellowship experience under the current CFSI will be allowed to complete the Clinical Fellowship experience under the current CFSI. All others will be required to use the [new CFSI](#) as of January 1, 2020.
- CFCC implemented an [online application process](#) for the CF experience.

## **3. Do we need the CF experience? Does it need to be modified?**

- Yes, but not in the current structure. Due to the wide range of students and patients we serve, some sort of mentorship training needs to be in place.
- With the rollout of the CFSI, CFCC will need to collect data to determine the CFSI’s effectiveness and ASHA’s efficiency in training our CFs.

#### **4. How would clinical performance be measured (hours vs. competency)—overlapping with the work of the Competency Models subcommittee?**

- Should we do away with clinical hours and develop competencies? Yes.
- Do we need both? No.
- Recommend minimum number of hours to provide consistency, which is the current process.
- Need competencies to demonstrate skills acquisition.
- Need to teach skills to students in programs.
- Rather than a set number of hours, have a variety of experiences with a variety of clients in various settings.
- Observe live interactions with actual clients.
- Assess skills demonstrated in simulation and with live clients in real time.

#### ***Using Dental Education as a Model***

The dental education model is a good example of assessing competence. In competency-based dental education, what students learn is based upon clearly articulated competencies and further assumes that all behaviors/abilities are supported by foundational knowledge and psychomotor skills in the areas of biomedics, behavior, ethics, clinical dental science, and informatics—areas that are essential for independent and unsupervised performance as an entry-level general dentist. In creating curricula, dental faculty considers the competencies developed through the educational process, the learning experiences that will lead to the development of these competencies, and ways to assess or measure the attainment of such competencies.

#### ***Professional Competence***

The foundation of these standards is a competency-based model of education through which students acquire the level of competence needed to begin the unsupervised practice. *Professional competence* is the habitual and judicious use of communication, knowledge, critical appraisal, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individuals and communities served.

#### **5. How would currently certified SLPs practice if the entry-level degree were to change?**

#### ***Considering the Future: Licensure and Certification***

The committee discussed challenges and opportunities with a model change to an entry-level doctoral degree relative to certification (ASHA Certificate of Clinical Competence [CCC]) and licensure requirements. It is important to note that issues with licensure are always more unpredictable than possible scenarios with the CCC because of ASHA's control over the CCC credential. In Tables 1 and 2, we have included issues regarding a potential entry-level degree requirement in the context of licensure and the CCC credential. The tables are broken into the

two main credential types and then list each type of potential change—with possible changes, threats, and opportunities, from left to right.

**Table 1.** Considerations for the ASHA Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP) should the entry-level degree requirement become a doctoral-level degree requirement.

<b>Certificate of Clinical Competence (CCC)</b>			
<b><i>Type of Change</i></b>	<b><i>Possible Changes</i></b>	<b><i>Threats</i></b>	<b><i>Opportunities</i></b>
<ul style="list-style-type: none"> <li>▪ No certification change.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Status quo.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Only usual threats.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Usual opportunities for growth and change.</li> </ul>
<ul style="list-style-type: none"> <li>▪ Certification change with grandmothereing.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Temporary status quo.               <ul style="list-style-type: none"> <li>– Credential could be changed for “new” applicants as of the effective change date.</li> </ul> </li> <li>▪ Issues arise with supervision. Audiology model allowed for CCC credential to “count,” regardless of degree held by preceptor.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Students may express concern. Potential credibility concerns for the larger discipline               <ul style="list-style-type: none"> <li>– Pipeline issues: Not all CAA programs can grant doctoral degrees; students may be discouraged due to projected student loans.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▪ Changes are rolled out over time, and certificate holders have time to comply with typical changes in certification (ethics). Demonstrates acknowledgment of elevation of the profession.</li> </ul>
<ul style="list-style-type: none"> <li>▪ Certificate change with no grandmothereing.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Degree is required for ongoing CCC status.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Pipeline issues—from both an employment and a supervision standpoint.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Elevates profession.</li> <li>▪ Benefits CE providers.</li> </ul>
<ul style="list-style-type: none"> <li>▪ Degree change with partial grandmothereing.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Certified practitioners are required to meet some form of credentialing requirement (dossier review, continuing education review, etc.) on a timeline clearly delineated by ASHA.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Pipeline issues.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Elevates the profession.</li> <li>▪ SLPs have a known timeline.</li> <li>▪ Could benefit CE providers.</li> </ul>

*Note.* Within the table, we use the term *grandmothereing* to refer to exemptions that might be made for those who hold current credentials in the discipline.

**Table 2.** Considerations for the state licensure in speech-language pathology should the entry-level degree requirement become a doctoral-level degree requirement.

<b>Licensure</b>			
<b><i>Type of Change</i></b>	<b><i>Possible Changes</i></b>	<b><i>Threats</i></b>	<b><i>Opportunities</i></b>
<ul style="list-style-type: none"> <li>▪ No degree change.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Status quo.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Only the usual issues (e.g., scope).</li> </ul>	<ul style="list-style-type: none"> <li>▪ None.</li> </ul>
<ul style="list-style-type: none"> <li>▪ Degree change with grandmothering.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Temporary status quo—credential could be changed for “new” applicants as of the effective change date. This happened in some states for audiology.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Challenges with licensure reciprocity and those who move across states—it is possible that a degree might be required if a practitioner changes states.</li> <li>▪ Those who let a license lapse may need to meet new requirements.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Regional compacts.</li> </ul>
<ul style="list-style-type: none"> <li>▪ Degree change with no grandmothering.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Licensure boards may need to work immediately to recognize change, dependent upon language. Could “open up” regulation.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Pipeline issues.</li> </ul>	<ul style="list-style-type: none"> <li>▪ All providers are at the highest level.</li> <li>▪ Significant opportunities for higher education; however, they (providers) may not be able to meet the demand.</li> </ul>
<ul style="list-style-type: none"> <li>▪ Degree change with partial grandmothering.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Licensed practitioners are required to meet some form of credentialing requirement (dossier review, continuing education review, etc.) on a timeline clearly delineated by states (likely with guidance from ASHA).</li> </ul>	<ul style="list-style-type: none"> <li>▪ Pipeline issues.</li> <li>▪ Two levels of providers—how are we certain that someone with a master’s degree and CCC-SLP has the same knowledge as someone with a doctoral degree?</li> </ul>	<ul style="list-style-type: none"> <li>▪ All providers are at the highest level.</li> <li>▪ Significant opportunities for higher education and for other CE providers; however, they (providers) may not be able to meet the demand.</li> </ul>

*Note.* Within the table, we use the term *grandmothering* to refer to exemptions that might be made for those who hold current credentials in the discipline.

## ***The Certificate of Clinical Competence (CCC)***

The impact of *grandmothering*<sup>4</sup> can be considered for the CCC. For instance, if the entry-level degree were to change to a clinical doctorate, there may be a grandmothering process relative to the CCC credential—similar to what happened in the transition to the AuD. With full grandmothering, master’s-level certificate holders would be able to hold the CCC credential with no additional requirements as long as they maintained the certificate by

- maintaining their continuing education,
- abiding by the ASHA Code of Ethics, and
- paying membership dues in a timely manner.

If a certificate holder allowed their certification to lapse, there could be a variety of scenarios. One scenario could be to pass the Praxis® examination at the time of re-certification (assuming that the exam would be restructured for doctoral-level practice), as well as meeting any other knowledge and skill requirements. A more stringent requirement could be that those who allow the certificate to expire could be required to meet the new entry-level degree requirements.

If there were no grandmothering, all currently certified ASHA SLPs who do not hold a clinical doctorate would be required to earn a doctorate in speech-language pathology (SLPD) or equivalent. With partial grandmothering, there could be a temporary status quo while the certificate holder worked to acquire additional required knowledge and skill to maintain the certificate. For instance, it could be determined that all current certificate holders gain knowledge and skill in a specific area of practice in order to maintain the CCC credential at the level required of new SLPD applicants.

Nested within the conversation regarding the CCC status is the topic of student clinical experiences should an entry-level degree requirement change to the doctoral level. Again, the profession of audiology has set an example for the profession of speech-language pathology. Master’s-level audiologists who are appropriately credentialed have been allowed to offer clinical education experiences for those earning a clinical doctorate degree in audiology. Without this exception, significant pipeline issues would be created because there would not be an adequate number of preceptors available for students if there were a requirement that the preceptor hold the same, or higher, degree.

## ***Licensure***

Licensure issues are more complicated. It is difficult to predict how different states might respond to changes in requirements in licensure in both medical and health arenas. We have witnessed several states have licensure challenged for SLP even without proposed changes (Michigan, Texas, and Iowa serve as some recent examples). One broad area that the committees discussed were potential pipeline issues should licensure regulations change in some way that do not fit potential changes in the entry-level degree. This could occur in situations where other interest groups influence change. We are aware that in many parts of

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<sup>4</sup> *Grandmothering* refers to exemptions that might be made for those who hold current credentials in the discipline.

the country there are not enough clinicians. Therefore, it is wise to be extremely thoughtful should any change in the entry-level degree occur.

### ***Opportunities and Threats***

Overall, there are a variety of opportunities and threats with a model change. The largest benefit may be future elevation of the profession of speech-language pathology. On the contrary, the threats to a model change are significant. Here, pipeline issues are a considerable concern. These pipeline challenges involve graduating enough clinicians, providing the necessary clinical experiences for these new graduates with appropriate-credentialed providers, and potential pipeline barriers in higher education.

### **6. If there was a change in the entry-level degree, how would one navigate supervision of the clinical doctorate when most clinicians have the master's as the entry-level degree?**

- Audiologists and physical therapists do this currently. Supervision is based on years of experience and skills of the supervisor.

### ***Additional Issues for Discussion***

- How would the CFCC handle the certification of international applicants when no international programs offer a clinical doctorate program?

## Appendix F: AHC-GESLP Accreditation Subcommittee Report

### 1. What is accreditation?

For an orientation to and overview of accreditation, see the excerpts below from the [Council on Academic Accreditation of Audiology and Speech Language Pathology \(CAA\) Handbook](#).

#### “A. Role and Value of Accreditation in the Professions

ASHA’s interest in accreditation is based upon the belief that all professions that provide services to the public have an obligation to ensure, as far as possible, that services provided by its members are of high professional quality. One effective way in which this obligation can be met is by establishing appropriate standards of educational quality and by identifying publicly those education programs that meet or exceed these standards. Accreditation is intended to protect the interests of students, benefit the public, and improve the quality of teaching, learning, research, and professional practice. Through its accreditation standards, the accrediting body encourages institutional freedom, ongoing improvement of institutions of higher education and graduate education programs, sound educational experimentation, and constructive innovation.

The accreditation process involves evaluating programs in light of their own mission, goals and education models—judging the degree to which a program has achieved those goals and objectives. Therefore, the CAA does not explicitly prescribe the processes by which the program’s outcomes should be reached; rather, it evaluates a program’s success in achieving outcomes and goals that are consistent with its stated mission (including religious mission, if relevant). If a program’s goals and education model are clearly and accurately described, the different “publics” served by this program should be able to make intelligent and informed decisions about the quality of the program and the qualifications of the students it educates.

#### B. Benefits of CAA Accreditation

The public is assured that accredited programs in audiology and in speech-language pathology are evaluated extensively and conform to standards established by the professions. Students can identify those education programs that meet their chosen profession's standards for a high quality education. Accreditation offers students the assurance that the academic and clinical education provided by the graduate education program will prepare them for entry into the professions. For example, the ASHA Standards and Implementation Procedures for the Certificate of Clinical Competence (CCC) in audiology and in speech-language pathology require that applicants obtain a graduate degree from a CAA-accredited program, which automatically satisfies the academic and clinical practicum requirements for the CCC. Similarly, graduates from CAA-accredited programs will be prepared to meet state licensing and/or state teacher certification requirements, if these elements are included in the program goals.

Colleges and universities benefit from the stimulus for self-evaluation and self-directed improvement that the accreditation process provides. The professions benefit from their members’ vital input into the standards established for the graduate education of future professionals.”

*CAA Accreditation Handbook – p. 1*



### C. History of ASHA's Accreditation Bodies

"ASHA established the American Board of Examiners in Speech Pathology and Audiology (ABESPA) in 1959 to foster the purposes of the Association and ensure the provision of quality services to persons with communication disorders. ABESPA designated the Educational Training Board (ETB), later named the Educational Standards Board (ESB), to evaluate programs that offered master's degrees in audiology and in speech language pathology and that voluntarily submitted applications for accreditation. Association Bylaws were amended to replace ABESPA with the Council on Professional Standards in Speech-Language Pathology and Audiology (Standards Council), effective January 1, 1980. The Standards Council, a semi-autonomous body established by ASHA's Legislative Council, was responsible for establishing and monitoring all standards programs of ASHA. The standards were implemented by three operating boards: the Educational Standards Board, the Professional Services Board (for professional services facility accreditation), and the Clinical Certification Board (for individual's professional certification). The Standards Council also arbitrated appeals of decisions rendered by the operating boards (LC 59-78, LC 54-79, and LC 12-84).

In September 1993, ASHA and the Council of Graduate Programs in Communication Sciences and Disorders (CGPCSD) formed an Ad Hoc Joint Committee on Academic Accreditation Issues. This Joint Committee, comprising members from each organization, was charged to examine and study issues related to accreditation of education programs in response to internal and external influences, prepare analyses of these influences on the process of standards setting and implementation and related matters, and make recommendations for action. The committee's report, published in 1994, resulted in a set of accreditation principles and a recommended structure for a new accrediting body." *CAA Accreditation Handbook – p. 2*

### D. Council on Academic Accreditation in Audiology and Speech-Language Pathology

"Effective January 1, 1996, the Educational Standards Board was replaced by the Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA), having responsibility for oversight of the accreditation of graduate education programs that prepare entry-level professionals in audiology and in speech-language pathology (LC 25-94, LC 26-94, LC 27-94, and LC 28-96). The CAA is charged with establishing, defining, monitoring, and implementing accreditation of graduate education programs. "Graduate" refers to post-baccalaureate programs leading to a master's or doctoral degree, whether offered through graduate or professional schools.

The charge to the CAA by act of the Legislative Council (LC 26-94) is to:

- formulate standards for the accreditation of graduate education programs that provide entry level professional preparation in audiology or speech-language pathology,
- evaluate programs that voluntarily apply for accreditation,
- grant certificates and recognize those programs deemed to have fulfilled requirements for accreditation,
- maintain a registry of holders of such certificates,
- prepare and furnish to appropriate persons and agencies lists of accredited programs."

*CAA Accreditation Handbook – p. 3*

Additional background information on the purpose of accreditation can be found on the Association of Specialized and Professional Accreditors (ASPA) website (“What Is Accreditation?”): <https://www.aspa-usa.org/about-accreditation/>. CAA is an active member of ASPA.

**2. What is the current cost of accreditation to academic programs?**

“The CAA is autonomous in the development of accreditation standards, in the establishment and implementation of policies and procedures, and in making its accreditation decisions. As required in the criteria for external recognition of the CAA as an accrediting agency, . . . the CAA must maintain appropriate separation from any entity in conducting the accreditation program activities. However, [the CAA] does receive support from ASHA and the academic program community. Through agreements with ASHA, checks and balances are built into the CAA’s processes (e.g., ex officio members, ASHA board liaisons, observers, widespread peer review, etc.) in order to provide appropriate stakeholder input and to ensure consistency with ASHA’s mission” (CAA, 2019, p. 3).

CAA maintains a “semi-autonomous” relationship with ASHA with regard to operational infrastructure. Operational costs for the Council include a memorandum of agreement (MOA) with ASHA. Through fees collected from pre-accreditation or maintaining accreditation, CAA covers approximately 40% of its operational budget—with the remaining 60% covered by ASHA. This MOA was updated in 2018.

The most recent *Audited Financial Statement of the CAA Budget (2017)* included the following:

○ Total revenue (annual fees, application fees, and site visit fees)	\$682,950
○ Total expenses (personnel, site visit expenses, CAA Board operations, volunteer and staff travel, space/equipment, etc.)	\$1,499,939

ASHA National Office and CAA staff have explored voluntary accreditation of speech-language pathology clinical doctoral programs and its financial impact. This study included examining a set of assumptions regarding the addition of the speech-language pathology doctorate. The exploration outlined the potential impact regarding CAA scope, infrastructure, academic program fees, staffing, standards revisions or expansion including a practice analysis to inform standards, and volunteer recruitment and training for financial modeling.

*Note:* CAA currently has a waiver from the U.S. Department of Education that allows CAA to maintain the semi-autonomous relationship with ASHA. At the time of this report, concerns for the relationship between accreditors and their professional associations have been reflected in the proposed language developed for the reauthorization of the Higher Education Act. However, that current language stands. Should language come forward that includes a separate and independent requirement without the opportunity to seek a waiver, the CAA would have the option of complying and remain recognized, or not complying and forego recognition. Either decision could have significant impact. To relinquish recognition could have potential impacts most notably, but not limited to, state licensure eligibility for graduates as many laws reference graduation from an

accredited institution or program as a contingency of licensure. Maintaining recognition as an *autonomous accreditor* would necessitate change in the operational infrastructure of CAA. A self-sustaining financial model in CAA would have significant impact on the operational cost of accreditation for academic programs.

### 3. What are the different models of accreditation across other professions?

- *Do they accredit different degree levels?*
- *Do they accredit/recognize different tracks?*
- *Do they have different accreditations or separate programs, or different standards for differing degree levels/tracks?*
- *How do other agencies handle different degree levels?*
- *Are there multiple entry points to the profession?*

CAA is a member of the [Association of Specialized and Professional Accreditors](#) (ASPA). ASPA members set “national educational standards for entry into more than 100 specialized disciplines or defined professions.” ASPA is a 501(c)(3) association that “works with higher education and government officials to enhance education and accreditation and functions as the only national voice for this important constituency” (ASPA, n.d.). To explore different models of accreditation, the following questions and resulting data were gathered and synthesized from an informal query to ASPA members on behalf of CAA:

A. “Do you accredit different degree levels within the same profession?”

Yes = 19 (73%)

No = 6 (23%)

Not usually = 1 (4%)

B. “Do you accredit or recognize different tracks within the same profession?”

Yes = 13 (50%)

No = 12 (46%)

Yes, some disciplines have concentrations which can be accredited separately if desired = 1 (4%)

C. “If yes to #3A or #3B above, do you have different accreditations, or separate programs, or different standards for differing degree levels or tracks?”

Yes = 10 (42%)

No = 14 (58%)

D. “If yes to #1 or #2 above, how do you handle/manage accreditation of different degree levels within the same profession? What is the impact, if any, on your recognition—if so recognized by USDE or CHEA?”

Every accreditor and profession has unique ways of handling accreditation of different degree levels.

E. “Are there multiple entry points in your accredited programs for the profession?”

Responses were deemed to be inconclusive because the majority of accreditors misunderstood the question.

4. **If the CAA were to accredit portions of the undergraduate degree** (and/or optional, post-entry-level clinical doctoral degree programs), how would this impact CAA’s recognition with the [United States Department of Education](#) (USDE) and the [Council on Higher Education Accreditation](#) (CHEA)?

The following information will begin to address this question:

- an overview of CAA’s external recognitions
- additional background regarding CHEA and USDE
- a review of CAA processes for considering revisions to the accreditation standards
- a review of CAA’s capacity to carry out activities under new scope of accreditation

## 5. Accreditation External Recognition

### Background

The CAA is recognized as an accrediting agency for audiology and speech-language pathology graduate education programs by CHEA and by the USDE. Recognition by these agencies is an external validation of the CAA’s adherence to best practices in accreditation” (CAA, 2019). The benefits of national recognition include the following:

- Opportunity for a comprehensive self-assessment by the CAA and external reviews of its accreditation process against specific standards, as both CHEA and ED require agencies to participate in scheduled reviews every 5–10 years to maintain recognition.
- Affirmation for the public that the CAA has standards and processes that advance academic quality in higher education; ensure accountability through consistent, clear, and coherent communication to the public and the higher education community; and encourage institutions or programs to plan for purposeful change and needed improvement.
- Eligibility for the CAA’s accredited programs to receive certain federal funding, such as grants.

### CHEA

The CAA and its predecessors have been [recognized continuously by CHEA](#) since 1964. CAA’s recognized scope under CHEA is for the accreditation and pre-accreditation (Accreditation Candidate) throughout the United States of education programs in audiology and speech-language pathology leading to the first professional or clinical degree at the master’s or doctoral level, and the accreditation of these programs offered via distance education.

During 2012–2013, CAA participated in eligibility and continued recognition reviews by CHEA. CAA met eligibility conditions in September 2012 and completed the recognition component in November 2013 that resulted in CHEA awarding CAA its [maximum 10-year recognition period](#). The scope of recognition, as listed above, was approved in March 2014.

## USDE

“The CAA and its predecessors have been [recognized continuously by ED](#) since 1967. The CAA’s scope of recognition under ED is for the accreditation and pre-accreditation (Accreditation Candidate) throughout the United States of education programs in audiology and speech-language pathology leading to the first professional or clinical degree at the master’s or doctoral level, and the accreditation of these programs offered via distance education” (CAA, n.d.).

“Postsecondary accreditation is a voluntary process in that a college or university need not be accredited in order to provide instruction or confer academic degrees; generally, the permission to operate as a degree-granting institution comes from states. Because colleges and universities may not participate in Federal Student Aid (Title IV) programs unless they are accredited; however, institutions are rarely able to compete for students without this seal of approval. Moreover, even among institutions with endowments sufficient to cover the full cost of education, accreditation is increasingly critical to ensuring that employers and other institutions recognize their degrees and that graduates can continue their education and pursue additional credentials at other institutions” (U.S. Department of Education, 2018, p. 2).

“The ED recognition also enables CAA-accredited programs to establish eligibility to participate in federal programs authorized under the National Institutes of Health (NIH), Academic Research Enhancement Award (AREA), Section III; and the U.S. Public Health Service Act, as amended by the Health Professions Education Partnership Act of 1998, Public Law 105-392, Sec. 739” (CAA, n.d.).

During 2015, the CAA prepared, submitted, and defended its petition for continued recognition with the Secretary of Education. As a result, USDE awarded continued recognition to the CAA in March 2016 for the maximum term of 5 years.

### **Standards Changes**

CAA has experienced changes to the scope of its accreditation programs in audiology and speech-language pathology (i.e., change in the entry-level degree for audiology, distance education modality). In order to maintain CHEA and ED recognition, a change in the scope of CAA accreditation would require in part an application process, a data-driven rationale, and include evidence to warrant the proposed change, as well as evidence of the council’s ability to meet the proposed change(s) in scope.

Additionally, as part of the CAA processes, a proposed change in the standards requires widespread peer review. The Council conducts a formal, comprehensive review of the Accreditation Standards every 5 to 8 years. This formal review may or may not result in revisions of the standards. In addition, the CAA may conduct interim or focused reviews of standards before the formal comprehensive review is due. When revisions to accreditation standards are identified through either a comprehensive or an interim review, the CAA will initiate action within twelve months to make the changes and complete that process within the following 2-year period. The CAA will follow the process outlined below to conduct a widespread peer review:

- Proposed standards or standards revisions are published in appropriate ASHA publications and on the website, with a request for comments by a specified date. A typical peer review comment period is between 60 and 90 days.
- The CAA conducts a comprehensive widespread peer review by distributing proposed standards to all of its stakeholders for comment through its normal distribution methods. This includes a survey to stakeholders that would include the following, as appropriate:
  - Graduate and undergraduate program directors and faculty
  - Deans/administrators of accredited graduate programs
  - CAA site visitors
  - Students (National Student Speech-Language-Hearing Association [NSSLHA] and Student Academy of Audiology [SAA])
  - Relevant ASHA committees and boards
  - ASHA Advisory Councils
  - ASHA Board of Directors
  - ASHA general membership
  - Council of Academic Programs in Communication Sciences and Disorders (CAPCSD)
  - Clinical supervisors
  - State education agencies
  - State regulatory boards (including National Council of State Boards)
  - ASHA Special Interest Groups
  - Consumer groups
  - Allied and Related Professional Organizations (e.g., AAA, ADA, AFA, ARA)
  - Council of Colleges of Arts and Sciences
  - Council of Graduate Schools
  - Association of Schools of Allied Health Professions
  - Other accrediting organizations (ASPA, USDE, CHEA)
- Academic program directors are asked to communicate proposed standards to appropriate university administrators in their respective institutions.
- The Council may hold open forums at appropriate professional meetings to review the proposed standards and obtain stakeholder comment.
- The CAA will review all comments submitted on the proposed standards and will make modifications as determined appropriate, including withdrawal of the proposed standards revision. The proposed standards revision document may be sent out again for widespread peer review depending upon stakeholder comments and council review. That would initiate the same review process described above.
- When all comments have been considered and the CAA has approved the final language for the standards document, the approved standard(s) are distributed to all academic programs and published in multiple venues with the effective date prominently noted.
- *Note:* At least 6 months must elapse between the date of the CAA publication and the effective date of the new standard(s). A longer implementation period may occur to ensure programs have adequate time to address a standards change.

In December 2018, the ED published *Rethinking Higher Education: Accreditation Reform*. A cautionary statement regarding the relationship between professional associations and

programmatic accrediting bodies highlighted the need for data-driven, evidence-based decision making when addressing changes in credentialing:

At the same time, there has been little attention paid to the troubling trend of credential inflation in certain fields, which often is the result of agreements between programmatic or specialized accreditors and professional associations or licensing boards. There is a natural inclination for groups of occupational professionals or practitioners to implement standards and requirements that reduce competition in the field and increase prestige, but accreditors should not enable unnecessary credential inflation simply because licensing boards or professional organizations demand it. Instead, programmatic accreditors must find new ways to engage employers to determine if better results can be achieved through short-term credentialing or alternative pathways that are more affordable and accessible and avoid costly credential inflation. (U.S. Department of Education, 2018, p. 9).

#### **6. If there is a change in accreditation model:**

- *What might be impact on academic programs?*
- *What might be the cost to academic programs?*

The Institute of Medicine (2003) referenced the challenges in academia when faced with change, stating the following:

When change happens in health professions education, it does not happen overnight. Multiyear processes are required to develop, review, and achieve consensus on new requirements or methods before they can be implemented (Batalden et al., 2002). For example, to implement new accreditation standards, accreditors need to go through a lengthy process of development that may take 2 years or longer and requires substantive input and discussion. The standards must be tested to see whether they achieve the stated objective (Gelmon, 1996). Once the standards have been finalized, they must be phased in over a 3-year period or longer. Within institutions, changing course requirements in response to new accreditation requirements may take many years, and often involves a highly charged political conflict within and across departments and disciplines. (Institute of Medicine, 2003, pp. 135–136)

In the context of changing the current accreditation model, the subcommittee began to explore the impact of moving to a “1 + 2 + CF” degree model (i.e., 1 year of the undergraduate degree, plus 2-years at the graduate level, plus the Clinical Fellowship), with a culminating clinical doctorate in speech-language pathology. The following points are for consideration and for further data collection and examination:

- Programs would need to anticipate
  - curricular changes to meet the program content, outcomes, and so forth;
  - adapting the degree program to meet new standards;
  - the resulting changes in faculty sufficiency to meet the rigor of this higher degree; and
  - meeting clinical education needs at or above the clinical doctorate.

- It will be valuable to look at the employment setting data on the approximate 300 SLPs who currently hold clinical doctorates in speech-language pathology. Those individuals would be able to supervise and provide clinical education at the clinical doctorate level. However, under the current CAA accreditation standards, *faculty sufficiency* is defined as the majority of faculty holding a PhD or EdD. Examination of alternative ways in which to achieve faculty sufficiency standards and clinical education requirements may be needed. This could include exploring online delivery of course content across institutions, having centralized faculty supporting areas of content need across programs and institutions, and incentivizing current faculty to elevate their master’s degree to the clinical doctorate level.
- It would be valuable to review data on the programs that could or could not offer a clinical doctorate, specifically, keeping in mind the following questions:
  - What types of institutions could begin offering this clinical doctorate (i.e., public vs. private)? Are there differences from institution to institution in terms of their ability to offer the clinical doctorate?
  - What external limiters could affect implementation: state regulators, academic accrediting agency requirements? What are the requirements in the institution and at the state or accrediting agency level?
  - How were audiology programs successful in making the change? What lessons could be learned? *Note:* For programs with an existing AuD program, institutional support for a clinical doctorate in SLP may or may not occur. An institutional or granting authority approval may be required.

Sources of data could include surveying CAPCSD member programs and possibly adding a question to the *Higher Education Survey*. However, the Subcommittee concluded that the question could raise undue concern without sufficient context. The CAA may be able to query accredited programs via the annual report, asking for “the highest degree your program could confer” as part of the institutional accrediting question under “Program Demographics.” The *CSD Survey* data may be an additional source by collating AuD and PhD programs to identify the number of existing programs that might currently be able to offer a clinical doctorate. It would be important to know what the impact might be on enrollment capacity, cohort size, and student tuition if, at some point in the future, consideration is given to transitioning the entry-level degree in speech-language pathology to the clinical doctorate.

## 7. What is the difference between accrediting an academic program versus certifying an individual?

Accreditation offered through CAA maintains standards and accredits the degree program (not the department, the institution, or the individual). Certification through the Council for Clinical Certification in Audiology and Speech-Language Pathology (CFCC) maintains standards and certifies the individual in their area of professional preparation and practice.



**8. What additional data about outcomes and satisfaction is available related to accreditation?**

The following are areas of outcome and satisfaction survey data related to accreditation. With specific questions in mind, a review of the data may yield valuable information as well as prompt the need for additional data.

- a. Regarding CAA program “Student Outcomes Data:” Program completion rate, employment rate 1 year post program completions, and Praxis® Scores are reported by each accredited program annually and at the time of their application for reaccreditation.
- b. The CAA provides opportunities for programs to submit satisfaction feedback regarding standards and CAA accreditation report process and experiences.
- c. The CAA completed an expansive *2017 Customer Feedback Survey*.
- d. The CFCC completed a *2017 SLP Practice Analysis*. Appendices L and M focus on where and when knowledge and skills should be or are acquired (i.e., they are acquired via the graduate program, during the Clinical Fellowship, or post certification).

\*\*\*\*\*

Five additional questions were brought forth from the Accreditation Subcommittee’s original charge:

**9. How might the faculty shortage impact adoption of other educational models?**

Response: This is a question for the Education Model Subcommittee.

**10. If recommendations are formulated to change the existing educational model, then how would the CAA develop a process for transitioning . . .**

- a. . . . to a competency model?
- b. . . . to incorporate some part of the undergraduate degree into the entry-level degree?
- c. . . . to more than one degree designator to enter practice (MS + SLPD)?
- d. . . . to a clinical doctorate for all?

Response: See above text under DOE and CHEA recognition and peer review process.

**11. If the AHC recommends one degree designator for all, but different educational offerings are recommended to prepare students for educational settings and medical settings (or birth-18 years vs. adults) such that a given university could offer just one or both tracks, then how would the CAA accredit these different tracks?**

- Would the CAA have different standards for programs focusing on one track or the other (i.e., education vs. medical tracks or birth-18 years vs. adults)?

Response: The opportunity for this currently exists, as long as programs meet accreditation standards.

**12. If the AHC recommends two degree designators—one to prepare students for educational settings (or birth to 18 years) and one for medical settings (or adults), such that a given university could offer just one track or both—then how would the CAA accredit these different tracks with different degree designators?**

Response: This would be part of the information gathering step, mentioned in Question #10 above.

**13. What would the costs and timeline be to accredit optional, post-entry-level clinical doctoral programs, should that recommendation be accepted by the CAA?**

Response: At the time of this report, current financial modeling is not available. However, this will be essential prior to finalizing the AHC report.

**References: Accreditation Subcommittee Report**

1. Association of Specialized and Professional Accreditors. (2019). What is accreditation? <https://www.aspa-usa.org/about-accreditation/>
2. Council on Academic Accreditation in Audiology and Speech-Language Pathology (n.d.). CAA Handbook. <http://caa.asha.org/wp-content/uploads/Accreditation-Handbook.pdf>.
3. Institute of Medicine. (2003). *Health professions education: A bridge to quality*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/10681>
4. U. S. Department of Education. (2018). *Rethinking higher education accreditation reform*. <https://www2.ed.gov/admins/finaid/accred/rethinking-higher-education-accreditation-reform.pdf>

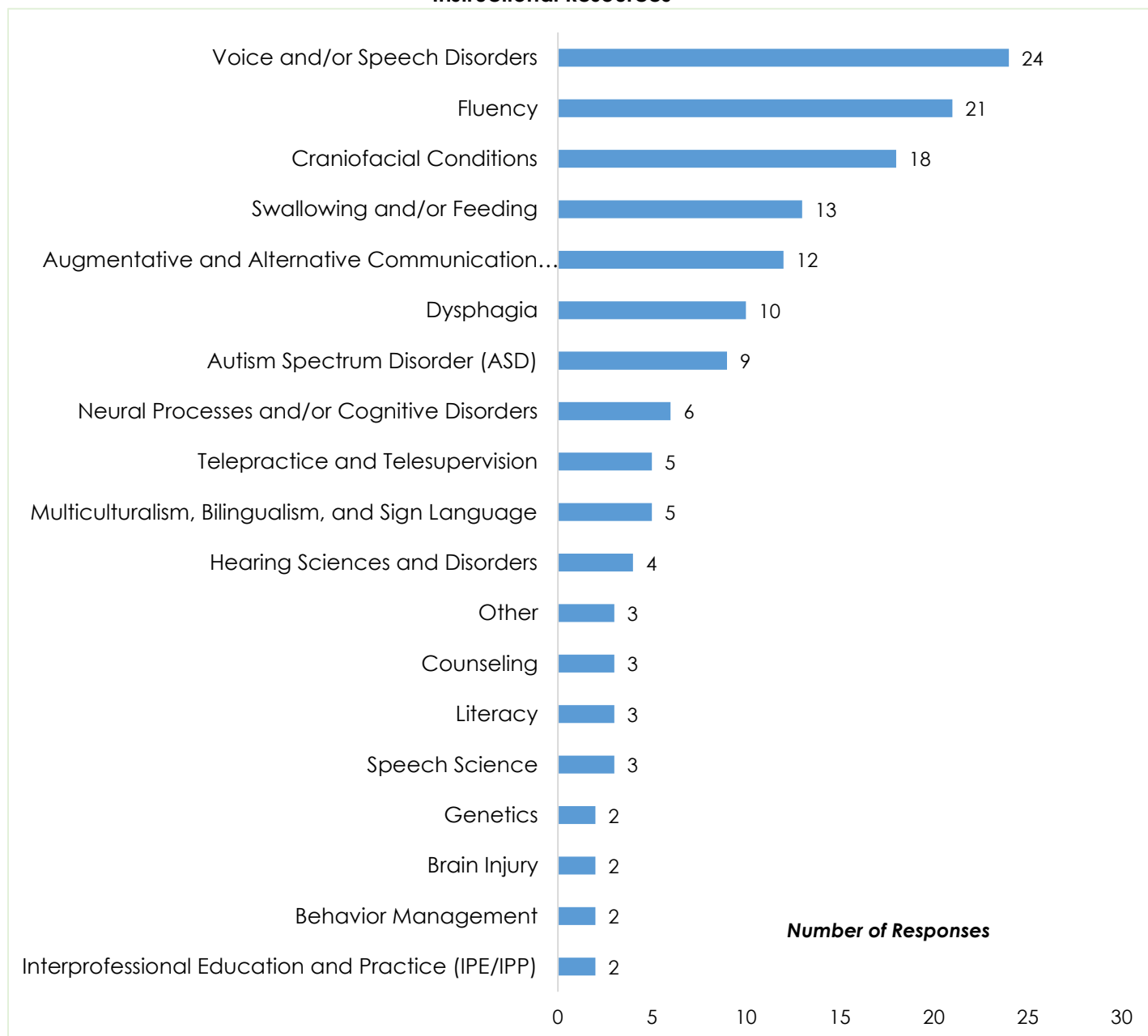
## Appendix G: Supplemental Question Report from the CSD Survey (2018-2019)



### Ad Hoc Report: Master's SLP Scope of Practice

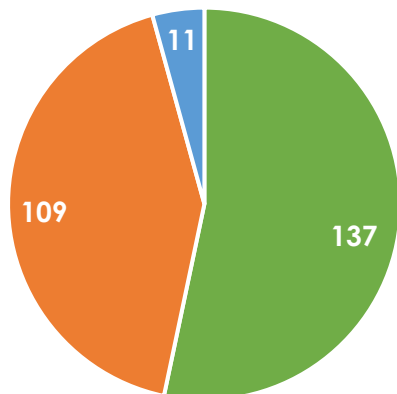
2019 CSD Education Survey for Academic Year 2018-2019

#### Curricular Topics with Limited Faculty Expertise that Would Benefit from Access to Shared Expert Level Instructional Resources



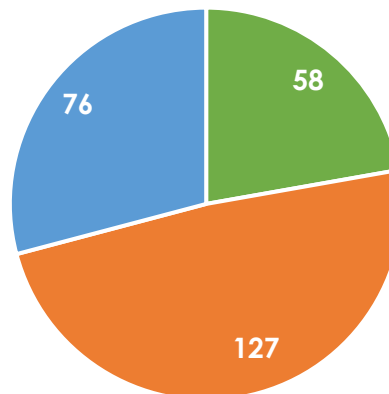
**Note:** 264 (94%) of 281 Master's SLP programs completed the 2019 CSD Education Survey. 125 programs responded to this question.

**Faculty Concern about the Department's Capacity to Teach Across the Full Scope of Practice Across the Lifespan in Speech-Language Pathology in the Current Educational Model**



■ No concern ■ Some concern ■ A lot of concern  
N = 257

**Speech-Language Pathology Faculty and Clinical Extern Coordinator Concern about Challenges Finding External Clinical Placements that Provide Needed Experiences Across a Range of Populations**



■ No concern ■ Some concern ■ A lot of concern  
N = 261

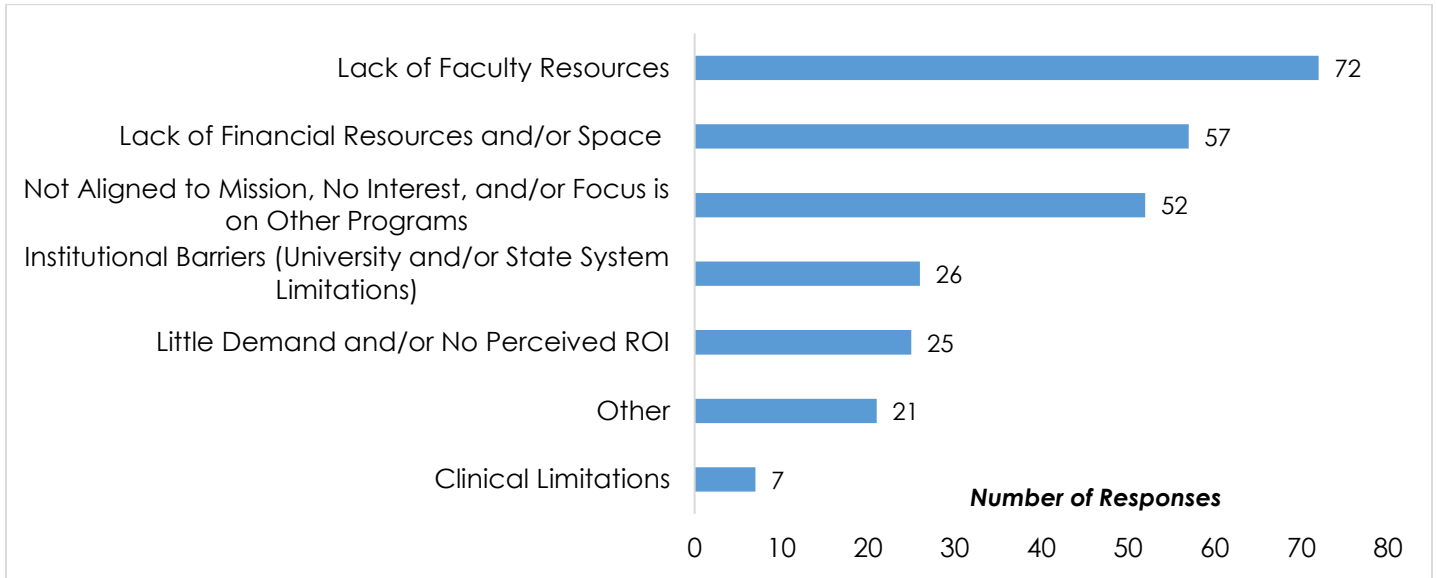
**Note:** 264 (94%) of 281 Master's SLP programs completed the 2019 CSD Education Survey.

**Programs' Current Post-Entry SLP Doctorate Status**

Current Status	Count	Percent
Offering the post-entry clinical doctorate in SLP	8	3.0%
Implementing a plan to offer an optional, post-entry clinical doctorate in SLP in the 2020-2021 academic year	5	1.8%
Planning to begin offering an optional, post-entry clinical doctorate in SLP sometime between the academic years 2021-2022 and 2023-2024	7	2.6%
Considering offering an optional, post-entry clinical doctorate in SLP (but not far enough along to identify an anticipated timeline)	34	12.5%
None of the above	217	80.1%

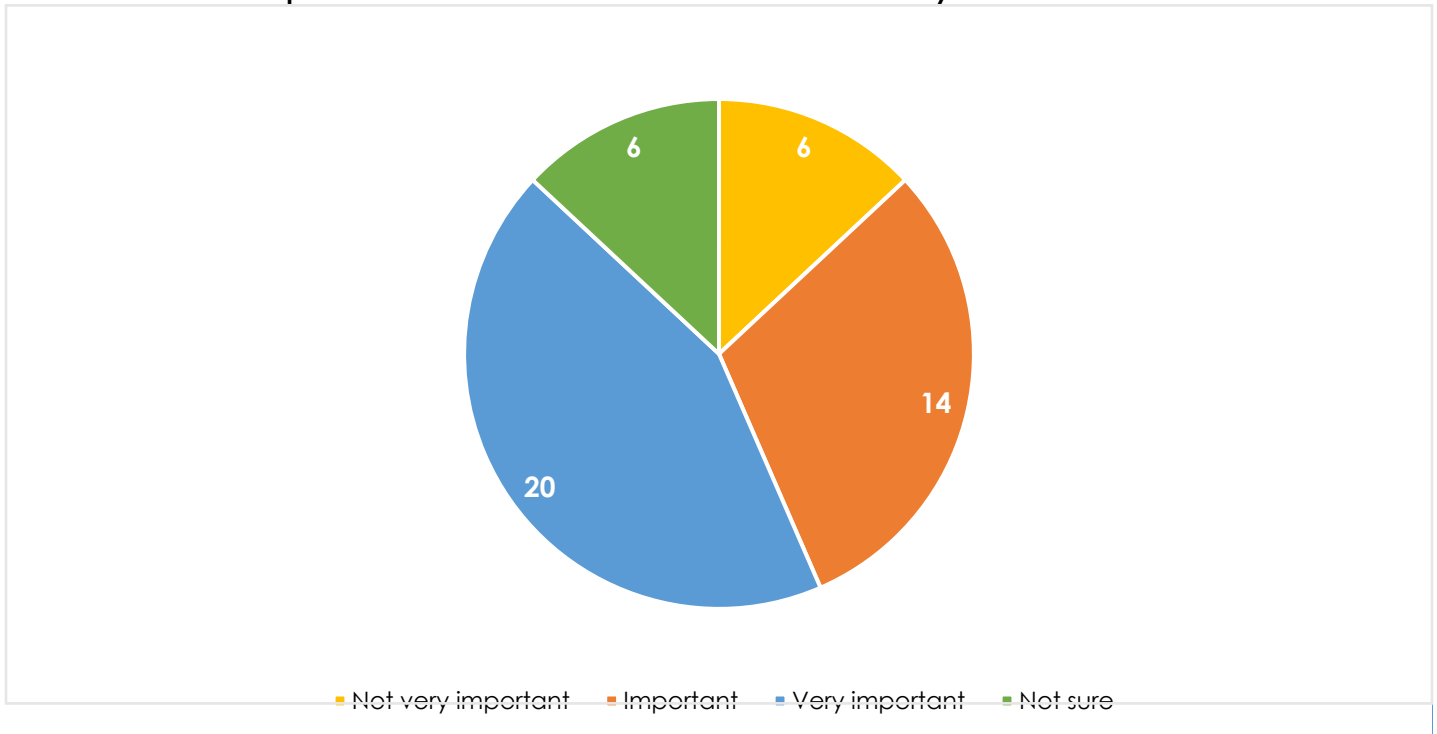
**Note:** 264 (94%) of 281 Master's SLP programs completed the 2019 CSD Education Survey. 271 programs responded to this question or reported offering a post-entry clinical doctorate.

### Factors Impacting Decision Not to Offer an Optional, Post-Entry Clinical SLP Doctorate



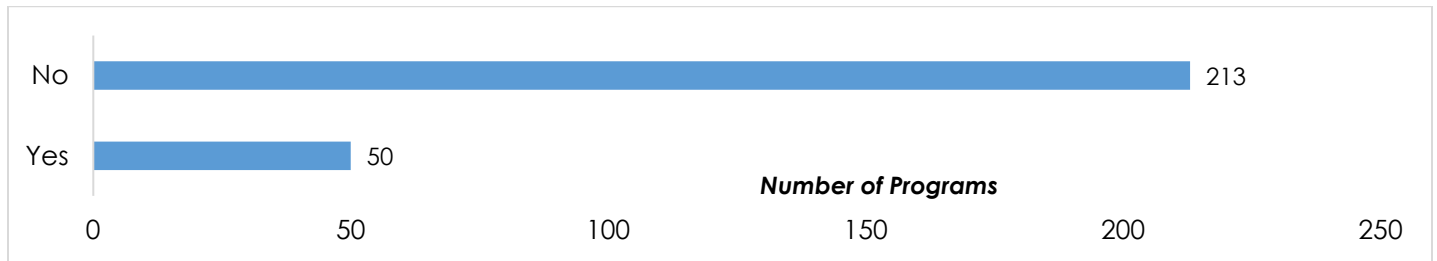
**Note:** 264 (94%) of 281 Master's SLP programs completed the 2019 CSD Education Survey. 215 programs responded to this question.

### Perceived Importance of the CAA Accreditation of the Post-Entry Clinical SLP Doctorate



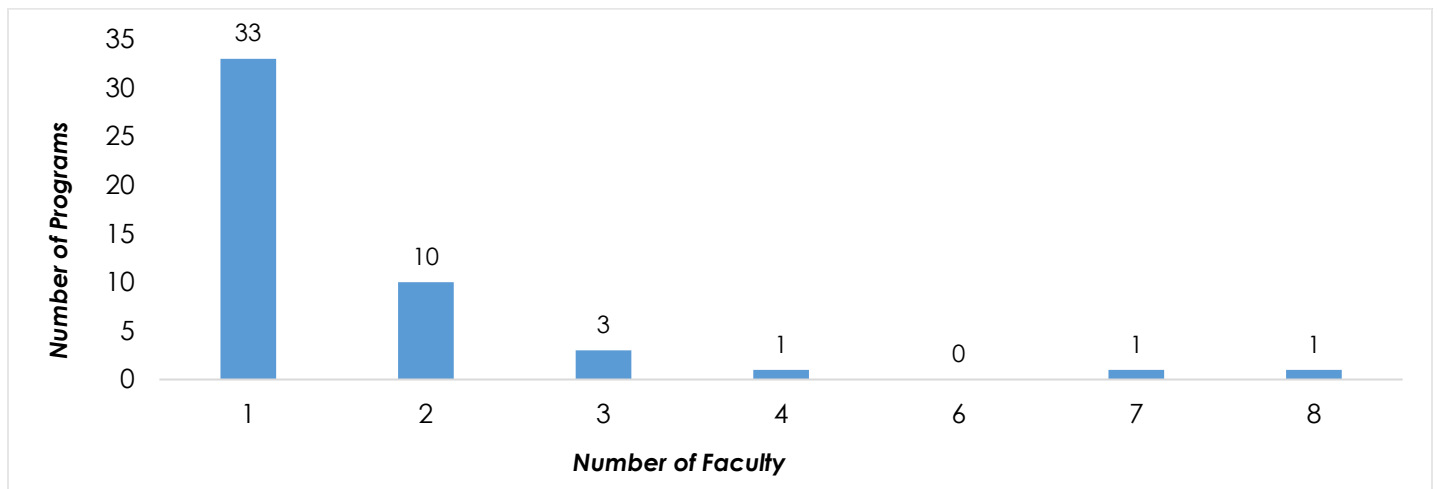
**Note:** 264 (94%) of 281 Master's SLP programs completed the 2019 CSD Education Survey. 46 programs responded to this question.

### Number of Programs with Faculty that Have a Post-Entry Clinical SLP Doctorate



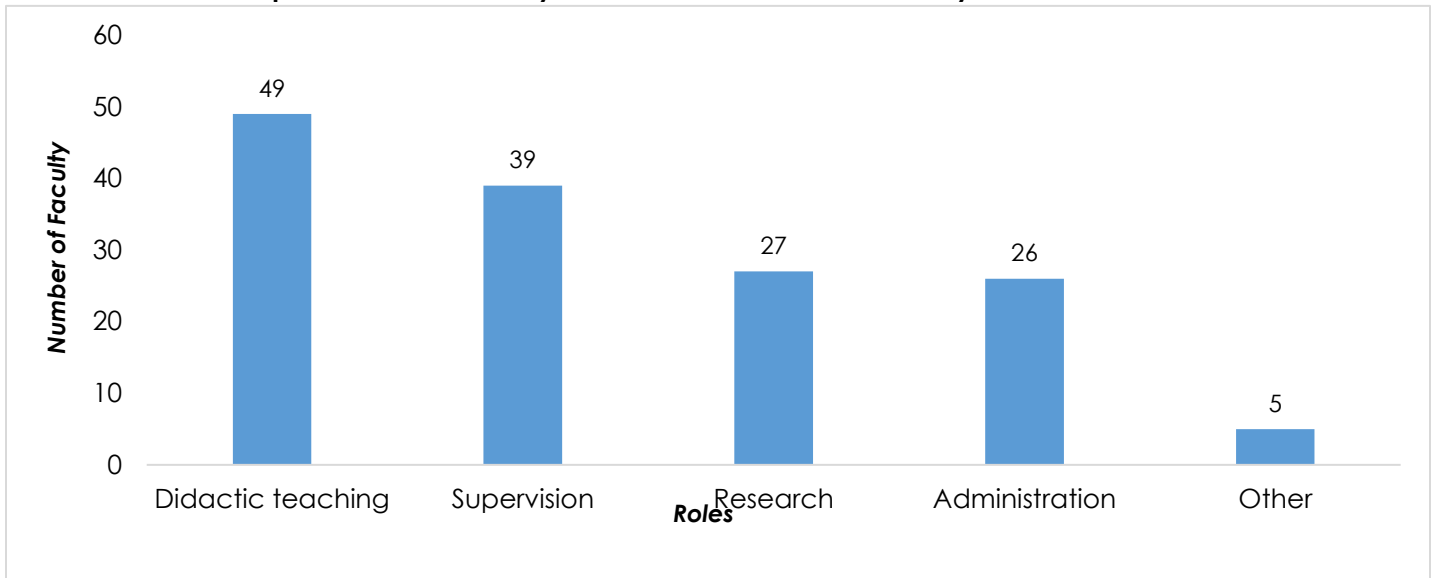
**Note:** 264 (94%) of 281 Master's SLP programs completed the 2019 CSD Education Survey. 263 programs responded to this question.

### Number of Faculty that Have a Post-Entry Clinical SLP Doctorate



**Note:** 264 (94%) of 281 Master's SLP programs completed the 2019 CSD Education Survey. 49 programs responded to this question. 81 total faculty members with a post-entry clinical SLP doctorate are employed across all SLP programs.

### Roles and Responsibilities of Faculty Members that Have a Post-Entry Clinical SLP Doctorate



**Note:** 264 (94%) of 281 Master's SLP programs completed the 2019 CSD Education Survey. 50 programs responded to this question. 81 total faculty members with a post-entry clinical SLP doctorate are employed across all SLP programs.