



AMERICAN  
SPEECH-LANGUAGE-  
HEARING  
ASSOCIATION

# SLP Health Care SURVEY 2017

## Practice Issues

For additional information, please contact  
Jeanette Janota, Surveys & Analysis  
American Speech-Language-Hearing Association  
Rockville, MD 20850  
800-498-2071, ext. 8738  
[jjanota@asha.org](mailto:jjanota@asha.org)

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## Executive Summary

The American Speech-Language-Hearing Association (ASHA) conducted a survey of speech-language pathologists (SLPs) in the spring of 2017. The survey was designed to provide information about health care–based service delivery and to update and expand information gathered during previous SLP Health Care Surveys. The results are presented in a series of reports.

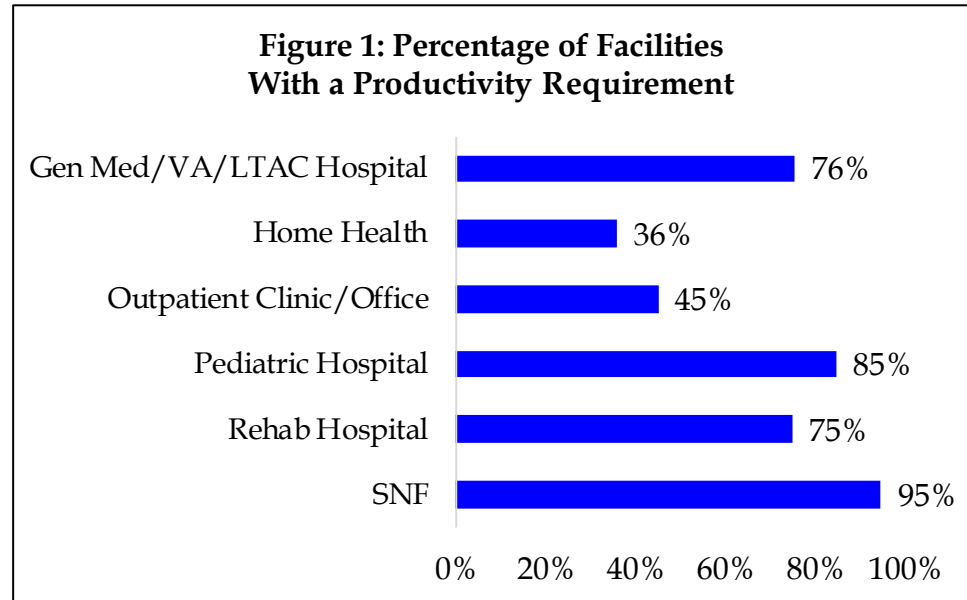
This report addresses only questions on the survey pertaining to practice issues. Data are drawn from six types of health care facilities: general medical, Veterans Affairs (VA), and long-term acute care (LTAC) hospitals; rehabilitation (rehab) hospitals; pediatric hospitals; skilled nursing facilities (SNFs); home health agencies or clients' homes; and outpatient clinics or offices.

### *Highlights*

- ◆ More than 80% of SLPs in SNFs (95%) and pediatric hospitals (85%) had productivity requirements.
- ◆ The average productivity requirement was 79%, ranging from 69% in pediatric hospitals to 85% in SNFs.
- ◆ 41% said that meeting the productivity requirement was very important at their jobs.
- ◆ 43% usually or always completed documentation at point of service.
- ◆ 27% of hourly SLPs typically performed “off-the-clock” work daily.
- ◆ 80% used electronic medical records for clinical documentation.
- ◆ 48% used an interpreter or cultural broker during the past 12 months.
- ◆ 9% needed to request funding for interpreter or translator services during the past 12 months.

## Productivity Requirement

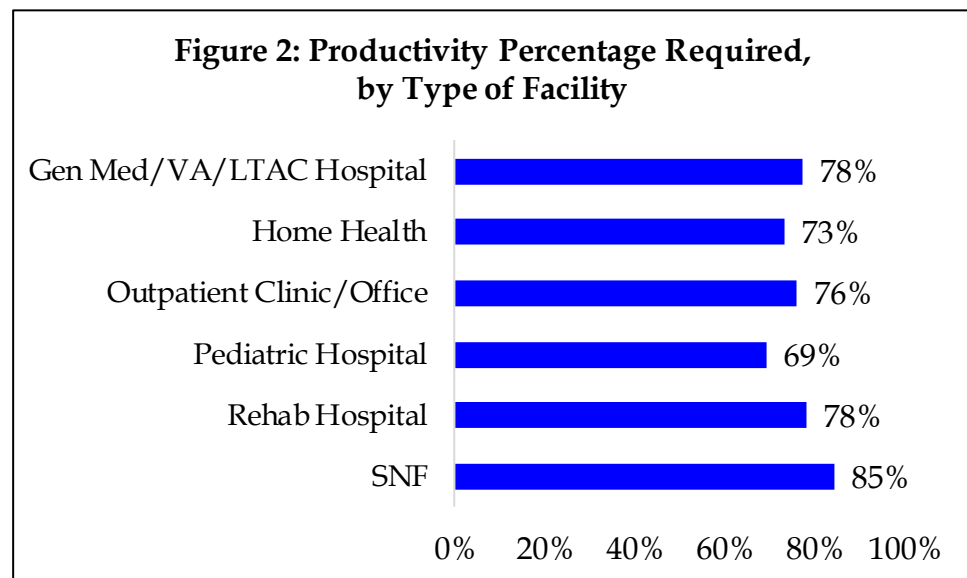
Productivity requirements were more common in SNFs and pediatric hospitals than in other facilities ( $p = .000$ ; see Figure 1).



Note.  $n = 1,550$ .

## Productivity Percentage

The average (mean) productivity requirement was 79%, ranging from a low of 69% in pediatric hospitals to a high of 85% in SNFs ( $p = .000$ ; see Figure 2).



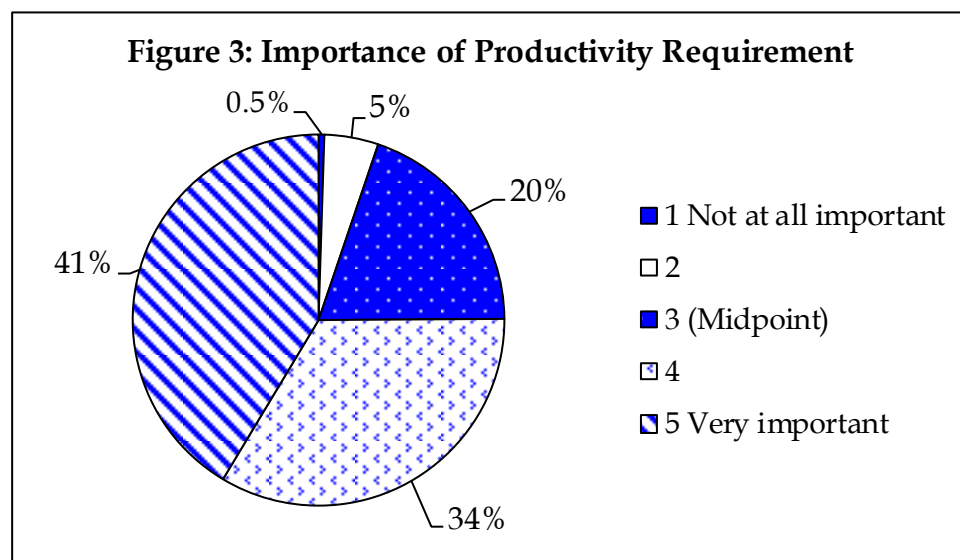
Note.  $n = 927$ .

Combining data from the two previous figures, 45% of SLPs in outpatient clinics or offices, for example, had a productivity requirement (see Figure 1), and the average productivity requirement for that group was 76% (see Figure 2).

## Productivity Importance

SLPs who had a productivity requirement were asked to use a 5-point scale to rate how important the productivity requirement was at their job. The mean rating given was 4.1, and the median was 4.0, where 1 meant *not at all important* and 5 meant *very important*.

Three-fourths of the respondents indicated that it was of high importance by selecting 4 or 5. Fewer than 1% selected *not at all important* (see Figure 3).



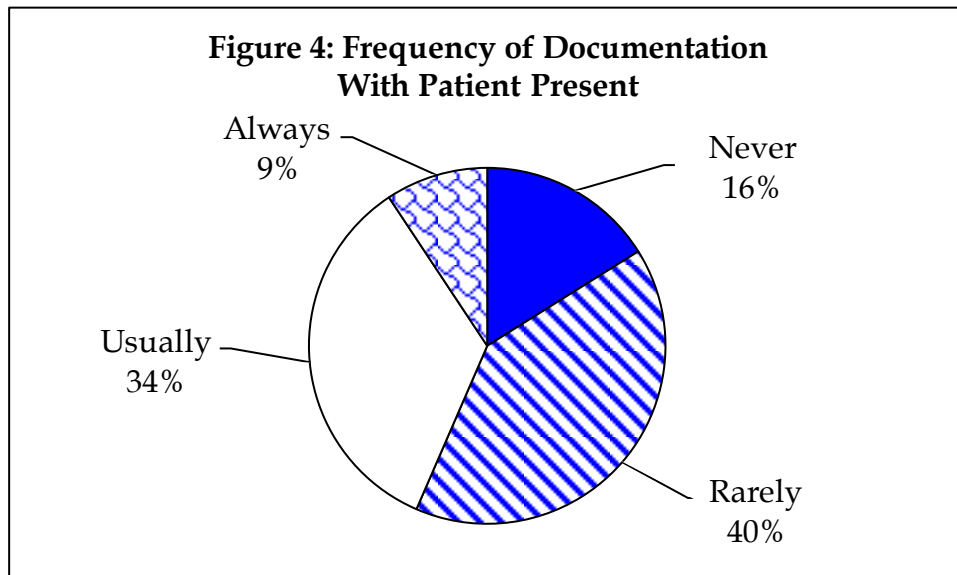
Note.  $n = 1,004$ . Values of 5%, 20%, and 34% were rounded up.

## Productivity Activities

SLPs with a productivity requirement were asked to select which of five activities counted toward their productivity calculation when patients were not present. Note that 68% said that nothing counted when patients were not present.

- The option *clinical team meetings* (16%) was selected by more respondents than any of the other activities. The range was from 10% of SLPs in SNFs to 31% in home health agencies or clients' homes ( $p = .000$ ).
- The option *in-services or informal staff training sessions* was selected by 15%. The range was from 8% of SLPs in SNFs to 28% in home health agencies or clients' homes ( $p = .000$ ).
- Of the SLPs with a productivity requirement, 13% said that *documentation* counted toward their productivity calculation when patients were not present.
- *Care coordination activities* counted toward their productivity calculation when patients were not present according to 11% of the SLPs with a productivity requirement.
- Five percent of the SLPs said that *other activities* counted. The range was from 3% of SLPs in SNFs to 10% of those in home health agencies or clients' homes ( $p = .013$ ).

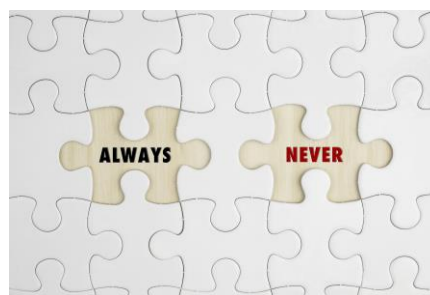
The SLPs who had a productivity requirement were also asked how often they complete documentation at point of service (i.e., with the patient present). The most common response was *rarely*, given by 40% of the respondents (see Figure 4).



Note.  $n = 1,000$ .

The type of facility, region of the country, and population density where SLPs were employed each had an effect on their response ( $p = .000$ ). For example:

- Responses of *never* ranged from 7% of the SLPs in SNFs to 35% in pediatric hospitals.
- Of the SLPs in the Midwest, 11% elected *never*, as did 13% of those in the South, 22% in the Northeast, and 24% in the West.
- Of the SLPs in rural areas, 10% selected *never*, as did 11% of those in suburban areas and 22% in city or urban areas.



## “Off-the-Clock” Work

Hourly employees were asked if they ever performed “off the clock” work. More than one quarter (27%) said that they typically did this daily, 19% a few times a week, 23% a few times a month, and 31% never. The type of facility in which they worked had an effect on their responses ( $p = .000$ ), but neither geographic area ( $p = .562$ ) nor population density ( $p = .234$ ) did.

- More of the SLPs in general medical, VA, and LTAC hospitals (51%), rehab hospitals (38%), and SNFs (34%) selected *never* than any other response.
- More of the SLPs in home health agencies or clients’ homes (47%) and in outpatient clinics or offices (33%) selected *daily* than any other response.
- Responses from SLPs in pediatric hospitals were more widely distributed, with 32% selecting *never* and 32% selecting *a few times a month*.

## Pressure From Employers or Supervisors

When participants in the survey were asked whether they had been pressured by their employers or supervisors to engage in any of five types of activities, 69% said that they had not been pressured. This response ranged from 47% in SNFs to 79% in outpatient clinics or offices ( $p = .000$ ).

The type of facility in which they worked was related to four of the five activities, and SLPs in SNFs were the most likely group to have felt pressured with regard to each of those four activities.

- Overall, 16% felt pressured to provide inappropriate frequency or intensity of services. The range was from 7% in outpatient clinics or offices to 32% in SNFs ( $p = .000$ ).
- Overall, 15% said they had been pressured to discharge inappropriately (e.g., early or delayed). The range was from 6% in general medical, VA, and LTAC hospitals and outpatient clinics or offices to 37% in SNFs ( $p = .000$ ).
- Overall, 11% felt pressured to provide evaluation and treatment that were not clinically appropriate. The range was from 4% in outpatient clinics or offices and pediatric hospitals to 23% in SNFs ( $p = .000$ ).
- Overall, 7% felt pressured to provide services for which they had inadequate training and/or experience. Facility did not have an effect on their responses ( $p = .478$ ).
- Overall, 6% felt pressured to alter documentation for reimbursement. The range was from 2% in pediatric hospitals to 10% in SNFs ( $p = .001$ ).



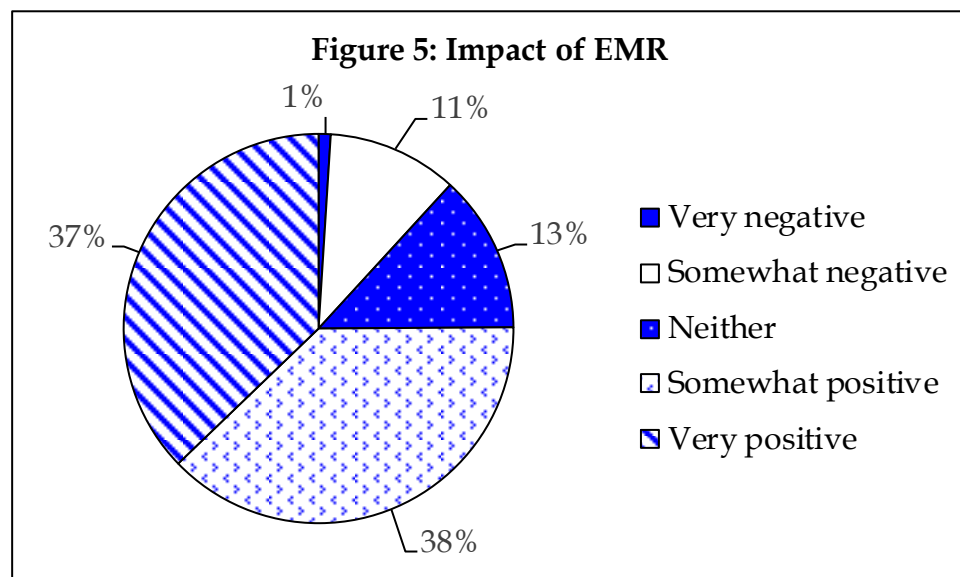
## Electronic Medical Records

The survey respondents were asked to answer questions about two aspects of electronic medical records (EMR): their purpose and their impact.

Of the SLPs who were employed full time or part time, 14% said that they did not use EMR. However, most did, including 80% who use EMR for clinical documentation, 72% who use it for billing, and 57% who use it for scheduling. The type of facility in which they were employed had an effect on each of their responses ( $p = .000$ ), but it is notable that the SLPs who work in home health or clients' homes were the least likely to use EMR for any purpose (see Appendix, Table 1).

- Between 3% of the SLPs in general medical, VA, and LTAC hospitals and 27% in home health or clients' homes did not use EMR.
- Between 64% of the SLPs in home health or clients' homes and 95% in pediatric hospitals and general medical, VA, or LTAC hospitals used EMR for clinical documentation.
- Between 50% of the SLPs in home health or clients' homes and 90% in pediatric hospitals used EMR for billing.
- Between 43% of the SLPs in home health or clients' homes and 86% in pediatric hospitals used EMR for scheduling.

Three-fourths of the SLPs said that using EMR had a very or somewhat positive impact on their clinical or administrative work (see Figure 5).



Note.  $n = 1,614$ .

## Cultural and Linguistic Diversity

The SLPs who were clinical service providers were asked three questions about cultural and linguistic diversity. The first question asked them to select which of six clinical approaches they had used during the past 12 months to address cultural and linguistic influences on communication. The type of facility in which they worked was related to each of their responses (see Appendix, Table 2).

- Overall, nearly half (48%) used an interpreter or cultural broker. The range was from 30% in SNFs to 81% in pediatric hospitals ( $p = .000$ ).
- More than one third (35%) modified assessment strategies or procedures, ranging from 27% of the SLPs in home health or clients' homes to 47% in pediatric hospitals ( $p = .000$ ).
- Slightly more than one quarter (28%) acquired translated materials. The range was from 20% of the SLPs in outpatient clinics or offices to 53% in pediatric hospitals ( $p = .000$ ).
- One in five (20%) translated therapy tools. SLPs in home health or clients' homes and in outpatient clinics or offices were the least likely to select this response (14%), compared with 40% of those in rehab hospitals ( $p = .000$ ).
- Overall, 19% of the SLPs translated written materials, including consumer information. This response was lowest in outpatient clinics or offices (13%) and highest in pediatric hospitals (40%;  $p = .000$ ).
- Nineteen percent of the SLPs referred to bilingual service providers. The range was from 8% of the SLPs in SNFs to 41% in pediatric hospitals ( $p = .000$ ).
- Finally, 28% of the SLPs said that they had not used any of the six approaches. This response was selected by 9% of the SLPs in pediatric hospitals; 11% in rehab hospitals; 14% in general medical, VA, or LTAC hospitals; 31% in outpatient clinics or offices; 35% in home health or clients' homes; and 37% in SNFs ( $p = .000$ ).

When asked whether they had needed to request funding for interpreter or translator services during the past 12 months, 9% ( $n = 139$ ) of the clinical service providers said that they had.

This small group that had requested funding was asked if funding had been reduced or denied and the reason. The most common reasons given were *family members provided interpreter or translator services* (37%), *referral was made to a bilingual service provider* (22%), and *the budget was insufficient to cover services* (15%).

## Alternative Payment Models

When they were presented with a list of three alternative payment models, 54% of the SLPs said that they did not know if they or their practice delivered services using any of the three models, and 23% said that none of the three models were used. However,

- 15% used the bundled payment/episode of care model;
- 2% used the accountable care organization (ACO) model; and
- 1% used the patient-centered medical home (PCMH) model.

## Survey Notes and Methodology

The *ASHA SLP Health Care Survey* has been fielded in odd-numbered years since 2005 to gather information of interest to the profession. Members, volunteer leaders, and staff rely on data from the survey to better understand the priorities and needs of SLPs.

The survey was fielded in February 2017 to a random sample of 4,000 ASHA-certified SLPs who were employed in health care settings in the United States. From this group, 1,500 SLPs were assigned to a control group to receive surveys via postal mail. They also received an electronic “be-on-the-lookout-for” message at the time of the first mailing. Second (March) and third (April) postal mailings followed, at approximately 3- or 4-week intervals, and a Survey Monkey invitation was sent in May to those who had not yet responded. The 2,500 members of the experimental group were sent a total of four Survey Monkey invitations between February and May as well as two postal invitations in March and April.

The sample was a random sample, stratified by type of facility and by private practice. Small groups, such as pediatric hospitals, were oversampled. Weighting was used when presenting data to reflect the actual distribution of SLPs in each type of facility within ASHA.

## Response Rate

Of the original 4,000 SLPs in the sample, 11 were retired, 7 had incorrect addresses, 94 were employed in other types of facilities, 13 were not employed in the field, and 3 were ineligible for other reasons, leaving 3,872 possible respondents. The actual number of respondents was 2,019, resulting in a **52.1%** response rate. The results presented in this report are based on responses from those 2,019 individuals.

## Suggested Citation

American Speech-Language-Hearing Association. (2017). *ASHA 2017 SLP Health Care Survey: Practice issues*. Available from [www.asha.org](http://www.asha.org).

## Survey Reports

Results from the *ASHA 2017 SLP Health Care Survey* are presented in a series of reports:

- Survey Summary
- Workforce
- Practice Issues
- Caseload Characteristics
- Annual Salaries
- Hourly and Per Home-Visit Wages
- Survey Methodology, Respondent Demographics, and Glossary

## Supplemental Resources

American Speech-Language-Hearing Association. (n.d.-a). Documentation. Available from [www.asha.org/Practice-Portal/Professional-Issues/Documentation-in-Health-Care/](http://www.asha.org/Practice-Portal/Professional-Issues/Documentation-in-Health-Care/)

American Speech-Language-Hearing Association. (n.d.-b). Health care resources. Available from [www.asha.org/slp/healthcare](http://www.asha.org/slp/healthcare)

American Speech-Language-Hearing Association. (2016). Code of ethics. Available from [www.asha.org/policy/ET2016-00342/](http://www.asha.org/policy/ET2016-00342/)

## Additional Information

For additional information regarding the *ASHA 2017 SLP Health Care Survey*, please contact Gennith Johnson, associate director, Health Care Services, at 800-498-2071, ext. 5681, or [gjohnson@asha.org](mailto:gjohnson@asha.org); Monica Sampson, associate director, Health Care Services, ext. 5686, or [msampson@asha.org](mailto:msampson@asha.org); or Janet Brown, director, Health Care Services, ext. 5679, or [jbrown@asha.org](mailto:jbrown@asha.org).

## Thank You

ASHA would like to thank the SLPs who completed the *ASHA 2017 Health Care Survey*. Reports like this one are possible only because people like *you* participate.

## **Appendix: State Listings and Data Tables**

*Regions of the Country*

Northeast

- ◆ Middle Atlantic
  - New Jersey
  - New York
  - Pennsylvania
- ◆ New England
  - Connecticut
  - Maine
  - Massachusetts
  - New Hampshire
  - Rhode Island
  - Vermont

South

- ◆ East South Central
  - Alabama
  - Kentucky
  - Mississippi
  - Tennessee
- ◆ South Atlantic
  - Delaware
  - District of Columbia
  - Florida
  - Georgia
  - Maryland
  - North Carolina
  - South Carolina
  - Virginia
  - West Virginia
- ◆ West South Central
  - Arkansas
  - Louisiana
  - Oklahoma
  - Texas

Midwest

- ◆ East North Central
  - Illinois
  - Indiana
  - Michigan
  - Ohio
  - Wisconsin
- ◆ West North Central
  - Iowa
  - Kansas
  - Minnesota
  - Missouri
  - Nebraska
  - North Dakota
  - South Dakota

West

- ◆ Mountain
  - Arizona
  - Colorado
  - Idaho
  - Montana
  - Nevada
  - New Mexico
  - Utah
  - Wyoming
- ◆ Pacific
  - Alaska
  - California
  - Hawaii
  - Oregon
  - Washington

Table 1: Use of Electronic Medical Records (EMR)

Q.5. For what purpose do you use electronic medical records (EMR) in your primary place of employment? <i>Select all that apply.</i> (Percentages; order of responses was changed from alphabetic to descending order of frequencies.) Analyses limited to respondents who met the following criteria: ❖ CCC-SLP ❖ Employed full time or part time							
Pressure	Facility Type						
	All Facility Types (n = 1,896)	General Medical/VA/LTAC Hospital (n ≥ 281)	Home Health/Client's Home (n ≥ 347)	Outpatient Clinic/Office (n = 534)	Pediatric Hospital (n ≥ 78)	Rehab Hospital (n ≥ 129)	Skilled Nursing Facility (n = 459)
Clinical documentation	80.4	95.4	64.4	68.0	94.9	89.2	93.9
		Statistical significance: $\chi^2(5) = 221.0$ , $p = .000$ , Cramer's V = .348 <u>Conclusion:</u> There is adequate evidence from the data to say that the responses vary by type of facility.					
Billing	71.9	82.9	49.6	67.0	89.9	82.9	83.0
		Statistical significance: $\chi^2(5) = 158.4$ , $p = .000$ , Cramer's V = .294 <u>Conclusion:</u> There is adequate evidence from the data to say that the responses vary by type of facility.					
Scheduling	57.2	55.0	42.7	62.5	85.9	52.7	60.6
		Statistical significance: $\chi^2(5) = 66.3$ , $p = .000$ , Cramer's V = .190 <u>Conclusion:</u> There is adequate evidence from the data to say that the responses vary by type of facility.					
Do not use EMR (SKIP to Q. 7.)	13.8	2.5	27.4	21.7	3.8	6.2	4.6
		Statistical significance: $\chi^2(5) = 159.1$ , $p = .000$ , Cramer's V = .295 <u>Conclusion:</u> There is adequate evidence from the data to say that the responses vary by type of facility.					

Table 2: Service Delivery to Address Cultural and Linguistic Influences

Q.30. In the past 12 months, which clinical approaches have you used in service delivery to address cultural and linguistic influences on communication? *Select all that apply.* (Percentages; order of responses was changed from alphabetic to descending order of frequencies.)

Analyses limited to respondents who met the following criteria:

- ❖ CCC-SLP
- ❖ Primarily clinical service provider

Clinical Approaches	Facility Type						
	All Facility Types (n = 1,655)	General Medical/VA/LTAC Hospital (n ≥ 259)	Home Health/Client's Home (n ≥ 319)	Outpatient Clinic/Office (n = 454)	Pediatric Hospital (n = 68)	Rehab Hospital (n ≥ 114)	Skilled Nursing Facility (n = 396)
Used interpreter/cultural broker	48.3	76.5	41.3	42.7	80.9	71.1	30.3
		Statistical significance: $\chi^2(5) = 198.9$ , $p = .000$ , Cramer's V = .351 <u>Conclusion:</u> There is adequate evidence from the data to say that the means vary by type of facility.					
Modified assessment strategies/procedures	34.5	39.8	27.2	31.9	47.1	46.1	35.9
		Statistical significance: $\chi^2(5) = 23.8$ , $p = .000$ , Cramer's V = .121 <u>Conclusion:</u> There is adequate evidence from the data to say that the means vary by type of facility.					
Acquired translated materials	27.5	39.2	21.9	20.0	52.9	43.5	25.3
		Statistical significance: $\chi^2(5) = 72.8$ , $p = .000$ , Cramer's V = .213 <u>Conclusion:</u> There is adequate evidence from the data to say that the means vary by type of facility.					

(Question 30 continues on next page.)



Q.30. (cont'd) In the past 12 months, which clinical approaches have you used in service delivery to address cultural and linguistic influences on communication? *Select all that apply.* (Percentages; order of responses was changed from alphabetic to descending order of frequencies.)

Analyses limited to respondents who met the following criteria:

- ❖ CCC-SLP
- ❖ Primarily clinical service provider

Clinical Approaches	Facility Type						
	All Facility Types (n = 1,655)	General Medical/VA/ LTAC Hospital (n ≥ 259)	Home Health/ Client's Home (n ≥ 319)	Outpatient Clinic/Office (n = 454)	Pediatric Hospital (n = 68)	Rehab Hospital (n ≥ 114)	Skilled Nursing Facility (n = 396)
Translated therapy tools	20.0	25.1	14.1	14.1	20.6	40.0	22.2
		Statistical significance: $\chi^2(5) = 51.0$ , $p = .000$ , Cramer's V = .178 <u>Conclusion</u> : There is adequate evidence from the data to say that the means vary by type of facility.					
Translated written materials, including consumer information	19.1	22.3	16.9	13.4	39.7	30.7	18.9
		Statistical significance: $\chi^2(5) = 40.5$ , $p = .000$ , Cramer's V = .159 <u>Conclusion</u> : There is adequate evidence from the data to say that the means vary by type of facility.					
Referral to bilingual service providers	19.0	16.9	16.3	27.1	41.2	26.1	7.6
		Statistical significance: $\chi^2(5) = 80.5$ , $p = .000$ , Cramer's V = .223 <u>Conclusion</u> : There is adequate evidence from the data to say that the means vary by type of facility.					
None of the above	28.3	13.8	35.4	30.8	8.8	11.3	36.6
		Statistical significance: $\chi^2(5) = 79.0$ , $p = .000$ , Cramer's V = .221 <u>Conclusion</u> : There is adequate evidence from the data to say that the means vary by type of facility.					