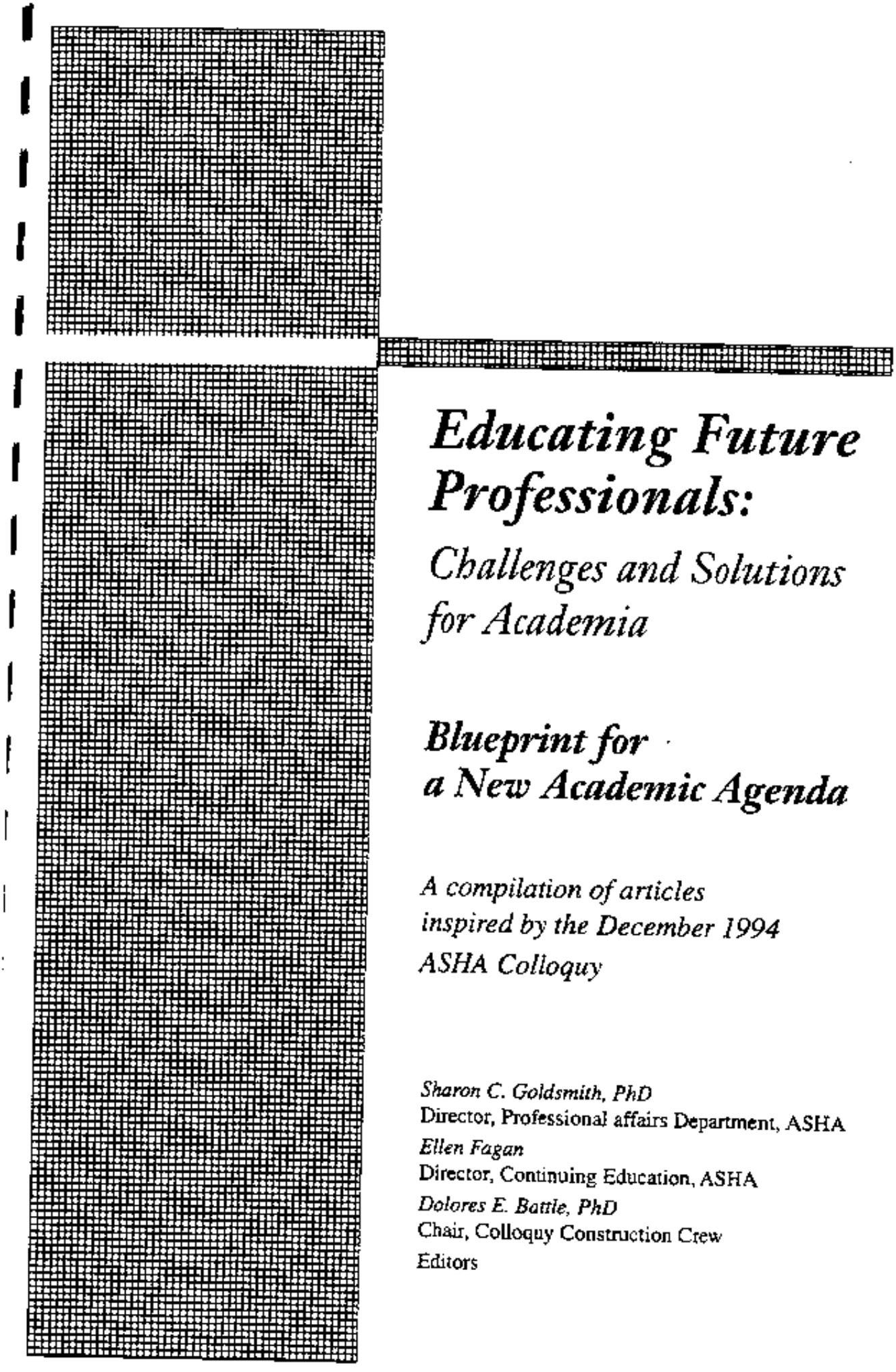

Educating Future Professionals:

Challenges and Solutions for Academia

Blueprint for a New Academic Agenda

A compilation of articles inspired by the December 1994 ASHA Colloquy

Sharon C. Goldsmith, PhD
Director, Professional affairs Department, ASHA
Ellen Fagan
Director, Continuing Education, ASHA
Dolores E. Battle, PhD
Chair, Colloquy Construction Crew
Editors

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Blueprint for a New Academic Agenda: A compilation of articles inspired by the December 1994 ASHA Colloquy

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American Speech-Language-Hearing Association
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(301) 897-5700

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Preface

Why a colloquy? Colloquy, according to Webster's New Collegiate Dictionary (1981) is defined as "a conversation, dialogue, a high level serious discussion." And that is exactly what occurred. And why one on educating future professionals? Because never before have so many challenges faced academia, challenges which are profoundly influencing higher education structures, funding, and accountability mechanisms. Additionally, our professions, audiology and speech-language pathology, are facing rapid changes in scope of practice, client populations served, technologies utilized, diagnostic and treatment protocols; in short, the practice of the professions.

The colloquy provided a forum where representatives from both professions and a variety of practice settings could discuss with representatives of the academic community, the internal and external influences on professional environments, the ways services are provided and ultimately, the ways in which future practitioners will need to be educated.

The colloquy incorporated formal presentations along with these discussions. Outcomes of the colloquy were designed to include a working document, crafted by colloquy participants which would contain recommendations for directions of change within academia and suggested strategies administrators and faculty could use for managing change.

Additionally, it was hoped that a critical outcome of the event would be an action plan, a blueprint for change which would chart:

- what changes are necessary?
- who should be responsible for them?
- what resources are needed? and
- (assuming the availability of resources), what time lines are feasible?

Such a blueprint for a new academic agenda would provide guidance to ASHA, to institutions of higher education and to programs in communication sciences and disorders, as new priorities are formulated, programs are developed, and resources are allocated.

This document is a compilation of articles based on the colloquy presentations as well as a summary of the issues raised and the action plan developed. As I hope the document demonstrates, the colloquy surpassed all expectations. The volume of information presented and the quality and comprehensive- ness of the issues and action plan reflects the considerable expertise and commitment of the colloquy participants.

This document is organized to reflect the order of events at the colloquy. Introductory material is presented by Gloria Kellum and Jeri Logemann. Gloria Kellum, is Professor, Communicative Disorders and Co-Chair of the Sesquicentennial at the University of Mississippi in Oxford. At the time the colloquy was conducted, she was Vice President of Academic Affairs for the American Speech-Language-Hearing Association and was the leading force in conceptualizing, planning and implementing this colloquy. This document is testimony to her leadership and her vision.

Jeri Logemann is Chair of the Department of Communication Disorders at Northwestern University, Evanston, Illinois, and an internationally recognized authority in the practice of speech-language pathology, specifically, dysphagia, an area of practice which perhaps more than any other, has experienced major change within the past few years. At the time of colloquy, Dr. Logemann was President of the American Speech-Language-Hearing Association, and provided the support necessary in multiple ways to make the colloquy a reality.

The article, by Julia Davis entitled, *Looking at the Big Picture: Changing Fiscal, Policy, Demographic, and Technological Environments in Higher Education*, addresses the internal influences on academia. Julia Davis is Professor and Dean of the College of Liberal Arts, University of Minnesota. At the time of the colloquy, and currently, Dr. Davis is the Chair of the Academic Affairs Board of the American Speech-Language-Hearing Association. The Academic Affairs Board, working with the blueprint contained in this document, will be transforming written words into actions.

Frederick Spahr, Executive Director of the American Speech-Language-Hearing Association, presents the big picture view of *The Impact of External Forces on the Education of Audiologists and Speech-Language Pathologists*.

The following two articles address some of the external forces on the professions. Glen Markus, in his article *Educating Future Professionals: The Purchaser's Viewpoint*, speaks from the perspective of a principal at a consulting firm in the Washington, DC area. This firm, Health Policy Alternatives,

provides guidance to many corporations and professional associations (including ASHA) on issues regarding federal and state health care reform initiatives.

These are followed by three articles on how profession specific changes will affect academia. Jim Jerger, author of the first article in this section, is Department Chair and Professor of Audiology, Baylor College of Medicine, Houston, Texas. Dr. Jerger started the first Au.D. program in the country at Baylor College of Medicine and is world-renowned for his basic and applied research in diagnostic audiology. His article, *Audiology: A Perspective on Future Development*, provides an analysis of future trends in the practice of audiology.

A companion article, by Jeri Logemann, entitled *Changes in Practice Patterns in Speech-Language Pathology*, provides an analysis of future trends for the practice of Speech-Language Pathology.

The third article entitled *Innovations in Academic Preparation* focuses on future trends specific to the education of audiologists and speech-language pathologists. Its author, Arthur Guilford, is Chair of the Communication Sciences and Disorders Department at the University of South Florida, and is a nationally known resource in the profession on innovations in higher education, especially the use of distance learning.

An excellent analysis and synthesis of all the complex issues is provided by Jeri Logemann in her article *Potential Changes in Graduate Programs: Where Do We Go From Here?*

The last section of this document addresses the next steps and provides a summary of five major issues identified by colloquy participants as relevant to academia and professional preparation. These issues are summarized by participants in the colloquy who agreed to be part of a colloquy "construction crew," an informal group appointed to disseminate information regarding the colloquy and help move the blueprint along.

The construction crew is headed by Dolores Battle, who developed the format for and edited these summaries. Dr. Battle is Professor in the Speech-Language Pathology and Audiology Department at State University College-Buffalo, Buffalo, New York. At the time of the colloquy, she was Chair of the Council on Professional Standards and continues to play a major leadership role in the American Speech-Language-Hearing Association as a member of the Legislative Council. She summarizes the discussions related to issues in Certification and Accreditation.

The discussion on faculty development is summarized by John Ferraro, Chair of the Department of Hearing and Speech at the University of Kansas Medical Center. Dr. Ferraro is past president of the Council of Graduate Programs in Communication Sciences and Disorders.

The discussion on *Educational Structures* is summarized by Terry Thies, a consultant from Duarte, California.

The *Managing Change* discussion is summarized by Juanita Sims Doty, Associate Professor and Director of the Speech and Hearing Center, Department of Speech and Dramatic Art at Jackson State University, Jackson, Mississippi.

The discussion on *Curriculum and Instruction* is summarized by Michael J. Flahive, Professor, Department of Speech, Program in Communication Sciences and Disorders at St. Xavier University, and a past president of the Academy of Pre-Professional Programs.

Ranking of Issues, and *Working Group Action Plans (Appendix A)* was edited by Ellen Fagan, Director of the Continuing Education Division at the American Speech-Language-Hearing Association. Ms. Fagan also was instrumental in organizing the colloquy, facilitating the progress of the discussion groups and of course, in serving as co-editor of this document.

Many thanks are owed to the many people for this *Educating Future Professionals: Challenges and Solutions for Academia*. First of all to Gloria Kellum and Jeri Logemann who "visioned" the colloquy; to the co-editors, Dolores Battle and Ellen Fagan; to all the contributing authors and to the ASHA staff who produced it: CB Wohl, production coordinator; Tarja Carter, graphics; Pat Becker, word processing; Mary Sirleaf, departmental assistant.

Thank you as well to Donna Geffner, 1995 Vice President of Academic Affairs for the American Speech-Language-Hearing Association, whose support and leadership helped move this project off my desk and on to all of yours.

Overview

Gloria D. Kellum, PhD
University of Mississippi

Times are changing! Faculty and academic institutions are often accused of poking along at our own pace while the "real world" passes us by. Those of us who had the good fortune to attend the Academic Colloquy sponsored by the American Speech-Language-Hearing Association (ASHA) are acutely aware of the energy, the interest, and the dedication of a unique group of academics and practitioners who spent three intense days working to assure that our educational programs are "real world." This gathering provided an opportunity for valuable interchange among ASHA members (Audiologists, Speech-Language Pathologists and Speech, Language, and Hearing Scientists) from various practice settings and universities.

This colloquy was an outgrowth of years of interest and activity. The need for a forum to further address issues of academic and clinical education in the Communication Sciences and Disorders became apparent as the ASHA Legislative Council established the Academic Affairs Board in November of 1993. In addition, the establishment by the ASHA Executive Board of an Ad Hoc Committee on Academic Accreditation Issues in order to study the growing concerns over accreditation marked another milestone toward change. The actions by the Legislative Council and the study underway by the Council of Professional Standards in Speech-Language Pathology and Audiology regarding the Audiology Doctorate were indications of change as well. The ASHA Executive Board working meetings with the Executive Board of the Council of Graduate Programs

in Communication Sciences and Disorders resulted in common goals of the two associations to find methods to address the rapid changes in the academic arena.

On the first day of the colloquy, participants heard and interacted with speakers who presented information relevant to higher education and the academic climate. On day two, participants identified issues that needed to be addressed related to academia and the professional preparation of students. The list of issues was grouped into five major categories of concern:

- faculty development issues,
- educational structures, mission and evaluation,
- managing change,
- accreditation and certification, and
- curriculum and instruction.

Colloquy participants then self-selected to participate in one of five working groups to further address the major categories outlined above. Working groups (a) identified and prioritized the major issues in each category, (b) identified barriers to improvement or change, and (c) developed strategies for addressing the issues. Each group presented their plans to the entire colloquy group on the last day of the colloquy. As the information was presented, each major issue identified by the working group was listed on flip charts. At the end of the presentations fourteen (14) issues had been identified by the five groups. Each participant was given five "votes" to indicate the issues they felt were the priority. The top five issues identified by the Colloquy participants were improving instruction, evaluating new models of education, positioning faculty for the next century, redefining practicum, and creating more flexibility in accreditation. These and the other important issues are discussed within this report.

As in any endeavor, we are indebted to our colleagues. A special thank you to the 1994 ASHA Executive Board, the National Office staff (particularly Sharon Goldsmith and Ellen Fagan) and the presenters and participants for a well organized, challenging, and intensely interesting Colloquy.

We hope that the information from this Colloquy will help provide support to our academic programs and our professions as we all work together in the formidable task of preparing professionals for the 21st century.

Welcome and Introduction to the Colloquy

Jeri A. Logemann, PhD
Northwestern University

Welcome to the Colloquy on Educating Future Professionals in Audiology and Speech-Language Pathology: Challenges and Solutions for Academia. We have brought together a group of academic program directors, faculty, working professionals from a variety of practice settings, including medical and educational, to provide perspectives on ways we can improve the education of audiologists and speech-language pathologists. I would like to take this opportunity to review the various forces that are currently affecting our academic programs. Some of these forces are external and are threatening to significantly affect how we educate our professionals.

First, the expectations of employers have changed regarding their employees, particularly in health care. Employers expect audiologists and speech-language pathologists, whether new graduates or experienced professionals, to enter a work site ready to interact effectively with patients/clients and other professionals. They will no longer tolerate a period of learning by the new professional, since the employer can no longer afford to devote time to educating new graduates. Working professionals in many work sites are being pressured not to provide supervision to students in training because it takes time away from direct patient/client care and billable hours. It is thus becoming more difficult for academic programs to place students in external practica and for

students to attain a clinical fellowship position in which they can spend time learning on the job. Employers are pressuring academic programs to better prepare students for the work place. Various groups working for health care reform are carefully examining the education of speech and hearing professionals. The Pew Health Professions Commission, funded by a private family foundation, is suggesting reducing the educational requirements for health care professionals as a way to lower costs. The Allied Health Commission, established by Congress under the Bush administration and appointed under the Clinton administration, is carefully examining educational requirements for various professions classified in allied health. The American Hospital Association and the Pew Commission are promoting the concept of the multiskilled professional, trained on the job rather than in academic institutions, or trained in a partnership between academic institutions and employers. Managed care is significantly changing the ways in which health care is delivered, and is reducing the role of specialists within the health care system.

Education reform is cutting costs within various educational settings. Rapidly changing practice patterns are often forcing clinicians to work in the classroom, rather than in the one-to-one clinical arena. Health care is also moving into the schools, changing the population base for school-based Clinicians.

In higher education, cost containment is a major initiative. We are continually asked to do more with less and cuts in budgets have and are continuing to affect many programs in the Communication Sciences and Disorders. Universities are also functioning in a climate of reduced respect for higher education and the perception on the part of the public that professors ignore teaching and waste too much time on research.

Given these pressures to produce a clinician ready to work with no on-the-job training, and to cut costs at the level of higher education and in the settings where our graduates work, it is critical that we examine how we are educating our clinicians and collect data on outcomes of various models of education. Unfortunately, as in many professions in both health and education, we have no existing data to indicate that our current programs are the optimal way to educate audiologists and speech-language pathologists.

This is a difficult time, with pressures coming from both within and outside of academic institutions, from employers, government bodies, and the general cost containment environment. We can look at this time as an opportunity to build, grow stronger, and construct truly effective academic programs. Or we can view this as a time of destruction and ignore the forces that are attempting to change how we educate our practitioners.

Throughout the next several days, we will hear more details about these various forces and we will spend time examining our academic programs and defining ways to improve education in the

Communication Sciences and Disorders. I challenge us to make this an opportunity to strengthen our educational programs and our professions.

Looking at the Big Picture: Changing Fiscal, Policy, Demographic, and Technological Environments in Higher Education

Julia M. Davis, PhD
University of Minnesota

The current widespread anxiety among individuals who are employed in institutions of higher education is unique in my experience and in the experience of most of my colleagues who have been associated with higher education for two or more decades. Bluntly stated, higher education is under attack and it is not defending itself well. This situation is influencing the environment in universities in significant ways that will affect all of us and our educational programs over the next decade or more.

Although higher education has been the target of numerous reform movements and public concerns in the past, these concerns were, for the most part, reasonably localized. From time to time, states have chided institutions for not taking seriously enough the needs of state or local communities. In the case of some states, legislatures have tried to micromanage universities by dictating how certain portions of the support provided by the state should be used. These attempts had little lasting effect on higher education; if they had, perhaps we would not be facing the level of criticism that exists today.

The really serious attacks on higher education in general began in the late 1980's, probably as a result of several factors. Fears about the economy, concern over being able to get a job even after finishing college, and the rising costs of a college education certainly contributed to growing public unrest. It would be foolish to discount the public's amazement and intolerance for some of the most interesting and highly-publicized accounts of political correctness on campuses as another contributor to the situation we face today. This factor has become a focal point in the conservative movement that has flourished in recent years. When he was president, George Bush delivered a scathing attack on political correctness during a commencement address at a leading university. Few took note of this fact, but it coincided with a new wave of criticism that is still in force.

The fact that K-12 education has experienced some very serious problems for the last 20 years or so, resulting in a population of young people who are unprepared for either college or the workplace, has also contributed to a general level of concern among the public. Even so, it is not the public that is the source of the anger currently directed against higher education. Polls and surveys conducted by the American Council on Education and other organizations reveal that although the public, in general, is concerned about the rising costs associated with education and the possibility of reduced access, it nevertheless favors increased support of education as a means of solving those problems.

The rising tide of criticism leveled at colleges and universities comes primarily from those who are responsible for higher education's funding. Robert Zemsky, Senior Editor of *Policy Perspectives*, the publication of the Pew Higher Education Roundtable, states the situation bluntly:

> The real anger at higher education comes principally from the makers and shapers of public policy—governors, legislators, regulators, heads of public agencies, and surprisingly, an increasing number from the world of private philanthropy. Certainly not all, but clearly too many, of those responsible for higher education's funding believe that colleges and universities have become too isolated from the economic pressures that are forcing most other American enterprises to rethink purpose and mission, to reduce scope by scaling back the size of their operations. As the instinct to impose punitive regulation has grown, so too has the impulse to teach higher education a lesson, to make it less smug and less insular. (1994)

Policy makers are also angry at what they perceive to be elitism on the part of universities. Faculty are accused of being self-centered, disdainful of public opinion, uninterested in students and teaching, and dedicated only to advancement of their own careers. Data used by policy makers to support these contentions do not take into account the differences among the missions of research institutions, comprehensive institutions, community colleges, and 4-year liberal arts colleges. These data indicate that teaching loads have been reduced and greater emphasis placed on research, to the

detriment of teaching. The data are correct; the interpretation of these data is flawed. Because information from all kinds of institutions has been combined, it is impossible to determine which institutions have actually undergone change and which have not. In fact, research universities have not decreased teaching loads significantly except in certain disciplines, whereas many newer and smaller universities have tried to become research institutions by placing more emphasis on research and less on teaching.

Subjecting all kinds of institutions to the same criticism and proposing a single solution for all will result in much more damage to research universities than to those whose original mission was teaching and service. Let me state emphatically, however, that requiring all institutions to be more responsive to the needs of their students is appropriate and long overdue, and would result in improvements in the educational experiences of many students.

Both state and federal legislators seem prepared to propose specific solutions to the problems they perceive. These include increasing faculty teaching loads, reducing emphasis on research, questioning the value of tenure and sabbaticals, and requiring a high level of accountability from university administrators. This willingness to dictate change in academic institutions is exemplified by the federal legislation that establishes State Postsecondary Review Entities (SPREs), which constitute regulatory agencies designed to examine the activities of institutions, including their financial management. Among other issues, SPREs can determine whether or not the tuition and fees being charged at an institution are sufficiently related to the earnings of those who graduate from it! These agencies then make recommendations to state legislatures regarding educational policy and funding patterns.

One of the requirements associated with increased regulation by state and federal bodies is the development of accountability measures that provide a means of assessing the efficiency and effectiveness of university programs. The trend toward establishing performance measures (such as graduation rates, diversity, and costs per student) that can be compared across programs and institutions is not, in itself, unreasonable. However, additions to these benchmarks are already being demanded, and the new ones include measures of value added. For our profession, that may not be difficult to achieve through certification requirements and national examination scores. For some liberal arts majors, however, there may be no clear-cut measure that can be applied at the time of graduation.

The major threat, however, has been and will continue to be the reduction of financial support to institutions of higher education. We are being told to get smaller, more efficient, and more concerned about solving society's problems than advancing our own reputations and careers. To ensure that we carry out these directives, public support for institutions is being reduced. Although already firmly established, the practice of reducing funding to higher education is about to accelerate. The Democratic Study Group of the U.S. House of Representatives (1994) has

summarized the proposals included in the recently revealed Republican "Contract with America" that will affect higher education directly. These include reducing the overhead rate on federally sponsored university research; reducing Medicare payments to hospitals for the indirect costs of teaching programs; eliminating the ability to have the interest on student loans "forgiven" and requiring accrual of interest over the duration of the loan; eliminating student aid programs such as supplemental grants, work-study, and Perkins loan programs; limiting the rate of growth of the National Science Foundation; eliminating the Advanced Technology Program by which universities enter into consortia with businesses to develop and make available the latest technology; and reducing funding to the arts and humanities. Have they left out anything?

There was a time in the recent past when education, including higher education, was a top priority for many states and a high priority for the federal government. Even under the best of circumstances, this would not be possible today. The rising costs of health care and the need to address the problems associated with crime have relegated education to a third-place priority at best. This has resulted in a decrease in the proportion of the Minnesota state budget allocated for higher education from a high of more than 15% in 1987 to a little over 12% in 1994. Although the state budget has grown during this period of time, its investment in higher education has not kept pace. The University of Minnesota alone has experienced budget cuts of more than $80 million in the last few years. Furthermore, in most states, the need to reform K-12 education takes precedence over funding for colleges and universities. Federal regulations regarding special education, which we as a profession support strongly, are particularly costly to schools, creating budget woes for many school districts.

As state legislatures have reduced the funding available, institutions have sought to replace lost revenues by raising tuition and seeking more external funding. What they have not done is take seriously the demand that they restructure themselves and become smaller and more efficient. There are many ways to accomplish this, but none of them is in widespread use. Lazerson and Wagener (1994) have proposed three simple steps that faculty members and administrators can take to bring their activities more in line with public expectations. These are: reconceptualize the curriculum and reduce course offerings by 20 to 30%; have faculty reassume responsibility for academic advising; and make everyone in the academic community aware of the costs involved each time a department or college faculty makes a decision. The last point is a very important one. Most faculty members who have not served in an administrative capacity have little knowledge about the costs associated with such items as fringe benefits, reductions in class size, introduction of new requirements for students, and limiting enrollment in popular majors.

Although advances in technology have provided very strong teaching and administrative tools that could improve teaching and result in less costly teaching efforts, there have been few attempts to introduce the technology into the average classroom. I believe there are three reasons for this. First, the equipment is expensive and requires an initial investment that many institutions cannot

afford. Second, a significant commitment of time and expertise is required in order to make maximum use of the technology that is available, at least initially. Third, most institutions have not taken seriously the need to provide a different type of teaching, both on campus and at a distance, that would be enhanced by telecommunication technology (Zemsky, 1994). Although institutions are aware of some of the advantages of using technology to enhance teaching, the lack of equipment and support staff have hindered its widespread use. For the most part, faculty members have not yet had the opportunity to change their instructional methods to take advantage of the new equipment and expertise now available. We are rapidly reaching a point, however, when profound change is inevitable and can no longer be postponed or ignored.

Unfortunately, at the same time that institutions are being required to cut back on their programs, they are being urged to increase public access to education. Not only are universities expected to accept more students (demographic factors are in favor of increasing undergraduate enrollments, because the number of high school graduates is on the rise after a period of reduction), they are also being urged to diversify their student bodies, both in terms of the age of students (more and more older students are seeking retraining or additional coursework for purposes of advancing their careers) and their racial and cultural heritage. In St. Paul, Minnesota, for example, almost 60% of the public school population are students of color. Universities are under pressure to offer programs that will appeal to a changing population of students and to ensure an environment that will be welcoming and affirming to them. Most institutions have not been able to attract the critical mass of minority faculty that would contribute to such an environment. As a consequence, universities often find themselves in a bidding war for faculty of color, as well as for highly qualified students who are members of underrepresented classes. These activities require scholarship money, handsome salary packages, and other perquisites that are quite costly. Many institutions have set numerical goals for the proportion of the student body and faculty that should consist of people of color, but achieving those goals is extraordinarily difficult in many parts of the country.

The way universities deliver education to students who arrive as freshmen to seek degrees and those who enroll periodically in order to meet specific educational goals must differ, if we are to meet the needs of these two different populations. This has been a fact of life for urban institutions for many years, but more traditional institutions are now faced with the necessity of continuing to provide the usual type of programming for new high school graduates who want to seek undergraduate degrees as preparation for careers, graduate school, and/or life itself, and providing access to those students who require either a special set of courses or a schedule that will allow them to continue to work while taking courses.

Most institutions are designed for the former set of students and feel comfortable and capable of serving them. Only a few institutions have used the available technology to educate students either at a distance or according to a unique schedule unlike the one to which most of us are accustomed.

Those who have taken seriously the need to provide distance education are now positioned to provide that education in many geographic locations, a fact that is just now becoming evident to institutions that have not considered distance education to be an important part of their mission. The widespread availability of telecommunication courses and interactive video presentations will have an effect on the enrollments and tuition revenue of universities whose area is targeted by another educational institution. For example, we now have the Graduate School of America, located in Bloomington, Minnesota; it offers PhD degrees in a wide variety of fields, but has no faculty associated with it on a full-time basis.

I have concentrated primarily on the changes in institutional environments related to fiscal policy and reality. The reason for this is simple: Institutions no longer have the resources to continue to function as they have in the past, and every decision that is made in this context is influenced as much by financial reality as by intellectual goals. As unfortunate as this situation is, and as much as it is deplored and derided by faculty members, it is a fact of life for those of us who must administer programs and meet public expectations for our institutions. In an effort to reduce costs without dictating the nature of substantial changes that must be made, many institutions have adopted concepts and practices from the corporate world, including Total Quality Management (or, in softer and more academic terms, Total Quality Improvement) and Responsibility Centered Management (RCM). The latter has as its mantra, "each tub on its own bottom." Inelegant use of language aside, faculty and administrators would be wise to understand the ramifications of the concept of RCM.

The goals of RCM are to decentralize responsibility for the costs involved in education and to provide incentives for units to become more efficient. Although the exact manner in which RCM is carried out in institutions varies, in general it works like this: Instructional units (usually colleges) are allowed to retain all income generated by their components. This would include tuition revenue, indirect cost income, fees, continuing education, and so on. Non-instructional units, such as the graduate school, admissions office, and others, are supported by taxing the instructional units according to the proportion of non-instructional services they receive. This is often based on student head count; for example, if a college had 40% of the undergraduates on campus, it might be expected to provide 40% of the support for the undergraduate admissions office.

Colleges would also pay for the <u>costs</u> associated with the buildings they occupy, as well as any other expenses incurred. The more income the unit generates, the more it can spend. The more it spends on non-income-producing activities, the more income it will need to generate in order to pay for its non-revenue-producing activities. The ramifications of the adoption of RCM are clear: Interest in generating income, which usually involves serving large numbers of students, becomes a major consideration when decisions are made about adding programs, revising curricula, hiring personnel, and supporting research and service activities. Academic units that serve many students, either in service courses or because of a large number of majors, will be well-positioned to thrive under

RCM. Programs that serve a small number of students may be supported, but even they will be expected to achieve efficiencies that are anathema to most academicians. They will almost surely be asked to develop service courses, to increase class sizes, to reduce the amount of one-on-one teaching that goes on, and to consider other cost-saving measures.

Critics of RCM point to the disadvantages of having to take into account non-intellectual factors when decisions are made about academic programs, as well as the possible effects of RCM on small, but central programs such as classical studies, ethnic studies, and the like. Proponents of RCM refer to the decentralization of decision-making, the clarification of the true costs of education, and the contribution that RCM makes to the need for multi-year planning.

Under these circumstances, it would not surprise me if the number of educational programs in speech-language pathology and audiology is reduced significantly over the next few years. The degree to which this occurs may depend on the location of the program within the university. If the program is central to the mission of the collegiate unit, as would be the case in a College of Health Related Professions, then its quality would probably be the most relevant factor involved in decisions about its survival. Programs that reside in Colleges of Liberal Arts or Arts and Sciences will come under increasing scrutiny. Programs are most likely to be retained if they can show that they meet a local or state need, are in high demand among students, are willing to reduce costs wherever possible, and are highly regarded in professional circles. In the short run, we may see our educational programs shifted out of liberal arts colleges and into more professionally based units.

I have come to believe strongly that these factors must be taken into consideration by any professional group that accredits or sets standards for its educational programs. I have not yet heard criticism from other administrators about the accreditating requirements under which ASHA operates, but there is widespread harsh criticism of other accrediting regulations. There is now a serious movement among institutions to examine the accreditation requirements of several programs and to move away from automatically seeking accreditation for eligible programs. Do not be surprised if you encounter resistance on the part of deans and provosts when you propose an accreditation visit or review. This is less problematic for professions such as ours, in which protection of the public is a primary objective, than for programs such as journalism or dance. Nevertheless, any increase in the requirements for accreditation that entail the necessity for additional resources will be met with dismay and resistance by many institutions. This fact must be considered seriously by professional organizations such as ASHA before changes in accreditation requirements are proposed. The development of new programs, such as the AuD, should be negotiated carefully and thoroughly with university administrators, whose ability to provide adequate financial support or to justify such support in the context of shrinking budgets may be limited.

The environment in higher education is changing quite rapidly. In order for programs to survive, let alone flourish, in the current atmosphere, there must be strong leadership that is willing to propose and carry out changes that have been resisted strongly in the past. Hunkering down and waiting until we "get back to normal" has been a widespread response to the events of the last decade. Institutions that emerge as strong ones in the future will be those that recognize the directions in which higher education is moving and manage to get there first. Strategic planners have known this for years, and they have warned institutions of the need to carve out a niche for the future that is likely to be far different from that of the past. So far, most of us have not heeded that warning, and our attempts to carry on business as usual have placed us in an increasingly vulnerable position. We have not reduced the size of our curricula, eliminated marginal programs, nor examined closely the costs involved in the traditional ways of going about our jobs. We have not taken advantage of the technology that would enable us to cooperate with other institutions to offer a varied curriculum when we cannot afford to offer it in a single university.

When administrators propose these cost-cutting measures, they are met with resistance, anger, and plummeting morale. Somehow, those of us who are responsible for providing academic leadership have failed to communicate the seriousness of the situation in such a way as to gain support of faculty and staff. Unfortunately, what we have not done for ourselves will soon be done for us, perhaps to the distinct disadvantage of our students, faculties, and the public good.

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Educating Future Professionals: The Purchaser Viewpoint

Glenn R. Markus
Health Policy Alternatives

The real clients of health providers, and of those who educate them, are no longer the people served, but rather those who pay for and who control access to services.

For years, most employers, employee health/welfare funds, even governments, were "passive" participants in determining when health and rehabilitation services were provided, by whom, for how long, under what conditions, and with what outcomes. They were "payers," bankers asked to finance services, but had little responsibility for imposing themselves between employees and family members—as patients—and the health providers who served patients' interests. Most employers (and many labor unions) have taken steps to move from being "payers" of health care services, that is, covering the bills as submitted, to being prudent purchasers. They are now taking a much more active and aggressive role in designing health benefit programs and in selecting which insurance carriers and managed care organizations will act as their agents in dealing with providers of services.

The marketplace is increasingly treating health care as a purchasing function in which business considerations, most notably cost, are dominant. "Smart purchasing" mimics the procurement

practices of business itself. Employers or health fund managers make decisions through a competitive bidding process that is initiated by setting out specifications for a well-defined product or service. Quality is then measured against such specifications; and, if quality cannot be defined, or more importantly, even measured, then cost becomes the dominating concern for the purchaser. Supplier assertions about quality in the health care field are assumed to be just assertions unless substantiated by real evidence. Cost effectiveness has become a more important consideration than unsubstantiated claims from health professionals about the clinical effectiveness or benefits of their intervention.

Quality assessment, in the past, has been based on the assumption that each procedure, each service was necessary. This assumed that quality could be determined through evaluating structure, process, and outcome. The necessity for any intervention at all was rarely, if ever, questioned. But purchasers are now collecting their own data, and have examined other data that reveal enormous variations in the practice styles of individual practitioners. They have discovered that professional literature often provides little, if any, information about the relative effectiveness and appropriateness of various treatment alternatives. Moreover, they have learned, even where such information has been developed, that the recommendations contained in the literature or learned through experiences in the classroom or clinics is not always reflected in the behavior of practitioners or in their practice styles.

Smart purchasers of health care are focusing first on the matter of defining quality, and they start with the business bias that high quality and low cost are not inconsistent goals. More is not always better, but it is almost certainly more costly. These businesses understand that they must compete in a world that demands such a standard for their products and services. Why should health care be seen in any different light?

If quality cannot be defined, it is impossible for those who provide services to fill the request for quality. Definitions of quality must not only be defined, but also shared with providers, insurers, and the purchasers to explore the implications of such specifications. Purchasers often begin by consulting the work of the educators of health professionals. After all, certainly they must have some idea, based on demonstrable evidence, about what works, how well, in what circumstances, and at what cost.

Most purchasers, however, are disappointed by what they learn about the education process and standards of practice involved in health professions training. They do not see a focus on the "quality model" with which they are especially concerned. The "quality model" focuses on providing the right service the first time. Many providers either are not learning this approach from their educational experiences or they are failing to adopt this model after leaving the academic and training environment. So many purchasers are taking a new approach to defining quality and cost effectiveness.

Various trade-offs must occur:

- Providers must accept more stringent quality and utilization management monitoring, accept competitively priced services and more controls over resource use. Professional independence, as it has been known in the past, is neither acceptable, nor even very desirable from the purchaser's point of view.

- Consumers must accept that freedom to choose their providers in an oversupplied marketplace will be restricted to assure access to services at an affordable price.

- Insurers and other agents of payers must learn to share responsibility for promoting cost management, if they expect to play a future role in the health care field.

- Employers must realize that keeping health care costs in line with other production costs will require much more restrictive health benefits, in terms both of access and scope of services.

There are several implicaitons for specialty and advanced training programs:

- In an era of great concern about cost, and about the use of "gatekeepers" to constrain access to all kinds of specialist services, payers are especially skeptical about the claimed benefits of specialty certification and advanced training programs.

- It is the underlying economics of certification and advanced training that are at the core of payer concerns. Precisely what "value-added" should be expected of such programs, and who should finance their costs and marketplace impact?

- Critics of the health professions note, in an era of constraint, that professionals often seek to create demands for the highest levels of trained personnel, in order that such persons can meet nearly every possible need for their professional services from the moment they enter practice. But the purchasers of care take a different view toward organizing the use of high cost resources in an era of constraint.

- Payers focus on trying to get the work done by the least trained people qualified to complete most of the tasks. In other words, they try to employ or contract with a mix of trained individuals to do the work, and not engage only the most educated or even the most experienced.

- Proposals to extend education and training in an era of restraint without demonstrable benefits for the consumer is almost certain to lead payers to seek arrangements with other types of personnel to compete with the most highly trained individuals.

- In today's and tomorrow's health care marketplace, workforce specialization that adds costs without significantly adding to quality or efficiency is likely to lead to secondary fragmentation of professionals' services, or even worse.

There are also several issues specific to clinical training centers which educators must be aware of:

- In the battle for the rapidly expanding number of managed care patients, and in vigorous competition with nonacademic providers of services, many education centers, and their clinics, are being forced to negotiate "bargain basement" rates of payment—in some cases, even agreeing to below-cost rates to gain access to patients.

- Although teaching center programs are now competing with managed care plans, their missions are obviously quite different. Managed care plans, particularly those owned by investors, are required only to apply existing knowledge to routine patient care. Academic centers often create new knowledge, develop and assess new technologies, evaluate new treatments, train students, and care for many of the sickest patients. The costs of the training programs may be as much as 30 to 40% more expensive than care provided in nonacademic settings. And because most training centers cannot compete with nonacademic institutions in price, they are used as little as possible by managed care organizations. Although some clinics are jammed with patients that serve training objectives, they may in fact be generating little or no income for sponsoring institutions and may suddenly be at considerable risk for the future.

- Some educators involved in clinical training have concerns about the quality of care being provided in an increasingly competitive environment. Faculty members may actually worry that even their own programs might eventually be staffed, at least in part, by practitioners that are not up to their standards. Many practitioners who are not faculty members, however, are convinced that academic practitioners use unnecessary resources to provide care resources that could not be sustained in the so-called real world of modern competitive health care delivery.

Health professions education and training has grown steadily over the last several decades, except with respect to some important changes in state- funded support. But perhaps it is time to ask the question that virtually every industry has had to ask itself, whether it is time to reconsider how the education and training goals for audiology, speech, and language should be accomplished. Questions educational programs need to ask include:

- What can be done to reduce the costs of training?
- Is decentralization of the training function indicated?
- What about outcomes research—what does the profession really know about what works and what doesn't? And what are the relative cost benefits of different treatment modalities?
- Do you know where your young people are going after leaving your educational programs?
- How are they faring? Must they relearn many things in order to survive in the "real" world?
- How do purchasers look at them? Are they prepared, or must a substantial amount of additional training take place to prepare them for productive roles as clinicians?
- What is the workforce situation regarding clinicians? Are the estimates of future workforce needs derived from professional or market-based assumptions?
- There is widespread concern about the overuse of treatment services in both the private sector and in government circles. Do those of you in education have a role to play regarding utilization decision making by your students?
- What can you tell purchasers about treatment services? What is good care and bad care? How can you help purchasers measure the differences? After all, if you can't define the standards, then most assuredly others, who pay the tab, will.

The Impact of External Forces on the Education of Audiologists and Speech-Language Pathologists

Frederick T. Spahr, PhD
American Speech-Language-Hearing Association

My presentation will focus on those societal forces at work today that will have an impact on education and training in audiology and speech-language pathology. First, I will identify and discuss those outside forces; then, I will show how these forces affect not only education and training in general, but also the way we provide instruction to our future professionals in audiology and speech-language pathology.

Eternal Forces Influencing Academic Programs

The first major force changing how we operate in the world at large is COST CONTAINMENT. A focus on cost containment is occurring in all work sites. In the past, the way to handle mounting costs was to find sources of additional revenue. The paradigm has shifted in today's workplace. The current paradigm reduces costs, in other words, do the same or more, with less. The next phase will be doing less with less.

Fewer dollars results in changes in the way we conduct our operations. This is particularly true for audiologists and speech-language pathologists. Because approximately 80% of all audiologists and speech-language pathologists are engaged in the delivery or supervision of clinical services in schools or health care settings, cost containment has a profound effect on the way services are delivered. Fewer dollars places emphasis on efficiency, best use of personnel, fewer personnel, less expensive personnel, and removal of barriers in the delivery of services. Efficiency means doing things right, as contrasted to doing the right things, which relates to effectiveness. Efficiency is time management, doing things more quickly with less process. A physical therapist colleague of mine in a visiting nurses agency in the Northeast told me that the kind of patient she was seeing in the recovery room 5 years ago she is now seeing in the home. Hospitals are drastically paring down the lengths of stays of patients.

Best use of personnel could be summed up by looking at the added value that each employee brings to the employer beyond the specific discipline in which that employee is educated and trained. In other words, the employer is looking for a speech-language pathologist who can go beyond tongues and an audiologist who can go beyond ears.

What added value do our professionals bring to the work force is a question that educators in our institutions of higher learning must ask. Currently, there is emphasis on the multiskilled, the multifunctional, and the cross-trained. The definitions for these three terms vary depending upon the speaker or author. Let me provide an operational framework. The multiskilled relates to the professional who has a scope of practice that is broad and flexible rather than narrow and strictly defined. Audiologists and speech-language pathologists indeed have adapted smoothly to changes in the kinds of service that we deliver. Look, for example, to dysphagia and augmentative communication in speech-language pathology and to interoperative monitoring and otoacoustic emissions in audiology. The scopes of practice for our professions are wide and readily adaptable to new forms and services delivered. Likewise, many of our professionals are multifunctional and they can do more than provide audiology services or speech-language pathology services. They can contribute in the area of quality assurance and data-based management, and they can offer other talents and skills that add value to the workplace.

Certainly cost containment means fewer personnel and less expensive personnel. There is currently a shortage of speech-language pathologists (and to some degree audiologists) in our work force (particularly in the schools). This has caused our education and training programs to be filled to capacity. However, I believe that the workforce in audiology and speech-language pathology will shrink as a result of what is occurring in health care reform. We already are seeing signs of workforce shrinkage in health care institutions. Middle managers are being eliminated in hospitals and rehabilitation facilities. As a representative from a large health care corporation told me, "Why should we have a department of speech-language pathology, a

department of occupational therapy, and a department of physical therapy, with three department directors, when we could have one department of rehabilitation with one department director?"

Hiring less expensive personnel is always on the mind of an employer. But as professionals, we need to ask ourselves whether what we are doing, in part, can be done by others who are less educated and trained than we. The ASHA Task Force on Support Personnel has been hard at work developing guidelines for a speech-language pathology assistant that clearly delineate the tasks, levels of training, and degree of supervision for a support personnel category in speech-language pathology. These guidelines are currently under modification and will be presented again to the Legislative Council in 1995.

Employers are pressuring for the removal of barriers to the efficient and efficacious delivery of clinical services. The major barriers from the perspective of employers include credentialing, in other words, licensure, certification, and accreditation. To the employers, licensure is professionally not publicly owned. Licensure exists to protect the guilds (audiology and speech-language pathology being considered as guilds) rather than to serve the public. Certification is viewed as self-serving, with the end of promoting the interests of the professions and not the interests of the public. Accreditation is perceived as a tool for blackmail by administrators, a tool which adds unnecessary costs and stifles change. With respect to the latter concern, the argument goes something like this: College and university curricula are based on the standards for accreditation; because accreditation standards change slowly, the curricula in colleges and universities are even slower to change. Therefore, if we eliminate accreditation as it now exists, then colleges and universities not only will have more flexibility in changing their curricula, but also will be more responsive to pressure from employers to produce the kinds of products that employers want.

There are agents at work outside the higher education institutions that are dedicated to changing our educational structure and content. These outside change agents include the Pew Health Professions Commission, the American Hospital Association, and employers (primarily the conglomerates that have clout). I was invited to participate in two symposia by the U.S. Bureau of Health Professions and the Pew Health Professions Commission held in August and October of 1994. The first symposium focused on the future of the workforce in allied health and the second on the education and training of the health care worker of the future. Many of my present remarks come from the information that I received in these symposia as well as my own analysis of what's happening. The Pew Health Professions Commission is funded by the Pew Charitable Trusts, a family-owned foundation dedicated to examining issues in health care, education and the arts. This Commission has the education and training of the health care worker high on its agenda. The American Hospital Association is likewise placing pressure on the way our health care professionals are being educated.

Let me digress a little to indicate that I have focused many of my remarks on outside forces related to health care. Our professionals in the schools should recognize that there exists as well those who desire to bring changes in the way services are delivered in the schools and the way that the future audiologists and speech-language pathologists who will work in the schools are educated. One reason is that health care services are being provided in the schools through the use of Medicaid funds. Another is the placement of students in the schools who are very sick and have severe disabilities. Certainly, the Council of Administrators in Special Education (CASE) and the National Association for the State Directors of Special Education (NASDE) are unremitting in their desire to lower the educational standard for audiologists and speech-language pathologists to a bachelor's entry level degree rather than the master's degree.

Let me articulate the issues that these change agents are addressing. Employers and payers want assurance from academic programs that the products produced, in other words, the employees, possess the knowledge, skills, and attributes to do the job for which they are hired. If the academic programs cannot produce students whose education and training is directly relevant to the workplace, then employers will do that education and training. This is not an idle threat. Many of the large conglomerates already educate and train their work forces; some are seeking approval from the state higher education authorities to grant degrees. In fact, there is already one degree-granting program in speech-language pathology located in a service delivery facility. I suspect more will come about if our academic programs are not responsive to the needs and desires of employers.

Another concern of the outside change agents is professional proliferation. In other words, professions beget professions. As a particular specialty forms within a profession, that specialty spins off to form a profession of its own. The new profession wants to emulate its parent by having its own multilayering (e.g., the professional, the assistant, the aide, etc.), its own accreditation, its own certification, and its own licensure.

"Degree creep" is another issue outside change agents are addressing. We know today that, in the health care arena, the trend is away from specialization and toward generalization. Although professional specialization may be an important direction for a profession to pursue (and I believe it *is* for audiology and speech-language pathology), we should not make the mistake of believing that our professional services will be worth more in the marketplace as a result of specialization. Specialization may be the right thing to do professionally but it will not increase the compensation base for the professional. However, we need to recognize that an outsider's perception of specialization is that the professions want to upgrade academic qualifications for entry into that profession in order to promote the image of the profession and increase the compensation to the professionals. The outside change agents often believe that each profession should be downsized to one level per profession and the lowest common denominator used for academic preparation. The outside agents believe that many professions can compress the education and training into

fewer years so that costs for that education can be reduced as can the costs of employing less educated professionals.

We also must not forget our federal and state legislatures as change agents. Our recent elections will have a profound impact on the way services are delivered and who will deliver those services both in our schools and in our health care facilities. When I was watching the election results on November 8, 1994, one television station showed vignettes of the acceptance speeches from the winning candidates. All acceptance speeches reflected three major themes: lower taxes, no funding for new initiatives, and get the government out of people's lives.

Positioning our Academic Programs for the Future

Our academic education and training programs can and must be responsive to the world at large. Our programs cannot exist by and for themselves, but must exist for the purpose of contributing professionals capable of delivering services to meet the needs of today's consumers (patients, students, clients) of our services. As I see it, our academic programs are faced with the following challenges:

First, our programs need to develop and evaluate educational models. The first step might be to define the goals of the educational program. Do our departments and faculty know what outcomes they are attempting to achieve? Are they able to measure educational outcomes against these goals? Are employers involved in the development of these goals? Is the program looking at different ways of providing instruction? What steps is the program taking to determine what is needed in the product (student) of that program in the future?

There is a need for most audiology and speech-language pathology graduate programs to reshape, recast, and redo their curricula. First, focus needs to be placed on developing competency-based curricula, that is, curricula which teaches the knowledge, skills, and attributes needed at the point of entry into the profession and provides assurance that each student graduated possesses those sets of knowledge, skills, and attributes. Remember that the focus is not on the number of courses, not on the degrees, not on the credentials, but on the performance and the ability of the student to perform on the job. Education for today's and tomorrow's marketplace does not preclude education that focuses on building critical thinking skills, developing good problem-solving attributes, and so on. Let's put to rest the argument whether our professional academic programs train for the job or educate for life...we can and should do both.

We need to prepare school-based and health care professionals first and disciplinary experts second. Employers want value-added professionals. They want professionals whose scopes of practice are wide and flexible. We need to teach our students how to be multifunctional and multiskilled. We need to provide our students with competency-related technology, interpersonal

skills (teaming), communication skills (both oral and written), and skills in managing diversity. We must go beyond human communication disorders in preparation of our professionals. And we must do so using outcomes rather than inputs.

Our education and training programs must ensure the relevance of course instruction and practicum to the workplace. In other words, do the goals for the academic program reflect the changing delivery systems in our schools and health care facilities? We may provide excellent instruction to our student audiologist in the use of tuning forks and we may have even progressed to developing competency-based criteria for the measurement of knowledge and skills attained in the proficient use of tuning forks, yet the program's course of instruction may be wholly out of date in a workplace where tuning forks are no longer used. Are we teaching our students how to collect outcome and cost-effectiveness data? Are we teaching our students how to work as part of interdisciplinary teams?

It is my belief that our education and training programs need to continue (and in some instances, as sad it may be, begin) to instill science as a base for clinical practice. This tenet is not bowing to the altar of science as some clinical practitioners would have it; nor is this tenet of instilling science as the base for clinical practice acquiescing to "applied research" as some scientists would have it. Rather, a science base focuses on understanding the "why" in the delivery of clinical services. In other words, science is the basis for our professional judgments and clinical decision making. When one looks at the practice of medicine, the basis for the length of education and training is not for the technical skills required to practice medicine. Performing an appendectomy is not a difficult technical procedure; nor does it require much else other than good eye-hand coordination. Indeed, the technical skills involved in suturing are at a very basic level. The length of education and training is for the decision making concerning the patient's condition and the handling of complex and difficult procedures that require mature judgment.

Lastly, we need to improve the teaching and advocacy skills of our faculties. I do not envy the role of chairs of academic and training programs in audiology and speech-language pathology. They are constantly between a rock and a hard place, between the administration to whom they report and the faculty. Unlike in the corporate world and even the nonprofit association world such as ASHA, academic department directors do not "control" their faculty. It is as if each faculty member can go his or her own way as each chooses. The job of the department director is to cajole, encourage, and try to pressure the faculty member to understand that the world is changing and faculties must change with it. Faculty should be leading the charge of change; all too often, however, faculty, kicking and screaming, are following the change that is occurring. There are mechanisms that should be implemented that hold faculty accountable for their students' learning. Further, there are all manner of ways that the skills of the teaching faculty can be enhanced. All of us can improve what we do and how we do it, no less should be expected of our educators.

Although I've articulated a number of changes occurring in our society that will cause our academic preparation of professionals to change, these changes should be viewed as challenges to us all. Denial of these changes will be detrimental (perhaps professionally suicidal); resistance to some of the changes not only will be difficult but also not fruitful. The first step to the resolution of any difficult situation is to own it. I believe that our academic programs are ready to make changes (many are already altering their programs radically and substantially). The American Speech-Language-Hearing Association through this colloquy, as well as the Academic Affairs Board and the Expanding Educational Opportunities Ad Hoc Committee stands ready to encourage and assist our academic colleagues in making the changes necessary for our professions' futures.

Audiology: A Perspective on Future Development

James F. Jerger, PhD
Baylor College of Medicine

Two converging developments will set the course of audiology for the next decade.

One is the current revolution in the health care delivery system. This inexorable trend will affect audiology in two important ways. First, there will be continued pressure to minimize the costs to consumers in the delivery of our services. Second is the issue of accountability: There will be continued pressure to justify our actions--for example, the aids we dispense, the recommendations we make.

The second converging development is the slow but steady move toward the professional doctorate as the definition of minimal competence to practice the profession. This trend will also affect audiology in two ways. First, there will be growing pressure on the existing educational establishment to phase out master's degree programs in audiology, and to replace them with doctoral training programs. Second, there will be growing pressure to move toward a two-tiered model for the delivery of our services, a model in which the audiologist is assisted by technicians trained at a lower level.

It is up to us whether these two developments lead to better audiological services for persons with hearing loss or whether they lead to audiological chaos.

All present indicators suggest that we, like virtually all other providers of health care services, are going to have to accommodate to downsizing. We are going to have to provide the present level of services with fewer personnel. This can only be accomplished by changing the model under which we have traditionally provided audiological services. That model is essentially one-on-one, an audiologist for every client. When a client, for example, comes to the audiology service in our hospital in Houston, a licensed, certified audiologist greets the client, takes the history, administers all necessary tests, counsels the client and the significant others, takes earmold impressions, fits and dispenses amplification systems, and prepares a report. In the case of children, parts of this scenario may even require two certified, licensed audiologists.

This kind of service is a luxury we cannot afford much longer. Imagine, for example, what health care would cost if a highly paid physician or surgeon were involved in every aspect of the processing of every patient evaluated for a medical problem. But that is not how the system works. Most of the preliminary testing and evaluation is carried out by less expensive personnel such as nurses and technicians in radiology, EEG, and pathology.

In order to survive financially, we must adopt such a multitiered model. In order to factor a relatively expensive doctoral-level audiologist into the model and still save on cost to the consumer we must be able to take advantage of the cost savings provided by the use of relatively less expensive technicians. But this will require a realistic dedication to the concept of a two-tiered system, and a commitment to undertake the onerous but important task of creating training programs for audiometric technicians.

People close to trends in national health care have been warning us for decades about the need for better accountability. We have paid lip service to the concept, but we haven't done very much of substance. Consider the example of amplification systems. Hearing aids, especially those involving advanced digital technology, have become very expensive. A binaural fitting, for example, may involve an expenditure of $2,000 to $3,000. If we ever expect third-party payors to reimburse for such an expense, we are going to have to demonstrate, in some convincing way, that the expenditure is justified by the client's disorder and the extent to which the device(s) ameliorate(s) that handicap.

But we have done little to standardize measures of handicap beyond the pure-tone average, and almost nothing to quantify the extent to which hearing aids actually help people. According to a recent survey by Fred Martin, published in the *American Journal of Audiology* (3, 1994), audiologists employ a bewildering array of different approaches to hearing aid evaluation. Indeed, some still evaluate hearing aid performance according to the system invented by Ray

Carhart more than 50 years ago. And those who have moved into the modern arena of real-ear measurement of frequency response cannot even agree on what gain rule to follow.

We are in desperate need of a multi-institutional task force determined to thrash out methods and techniques designed to answer, at the individual rather than the group level, two straightforward questions: How much trouble does this client have in the course of daily living because of the +hearing impairment?, and How much does an amplification system help? Only when such tools are available can we truly address the issue of accountability.

Changes in Practice Patterns in Speech-Language Pathology

Jeri A. Logemann, PhD
Northwestern University

Over the past decade, there has been significant change in practice patterns in speech-language pathology. We are seeing increasing diversity in practice sites and in client populations that receive speech-language pathology services, changing expectations of employers regarding speech-language pathologists, increasing use of instrumentation, including invasive instrumentation, increasing interest in specialty areas of practice, and decreasing time for service delivery with increasing emphasis on outcomes and cost.

Increasing Diversity in Practice Sites

Speech-language pathologists have significantly increased the sites where they provide diagnostic and treatment services. Traditionally, services have been provided at schools. In recent years, however, speech-language pathologists have expanded into private practice, acute care hospitals, rehabilitation centers, intermediate care facilities, skilled nursing facilities, and patients' homes. Each of these practice sites requires some degree of special skills in interacting with a variety of professionals on behalf of the patient as well as the patient's family or significant other. In the

future, it is likely that a significant part of a speech-language pathologist's services will be delivered in the patient's home, the least expensive care site.

Changing Patient Populations

The patient populations receiving speech-language pathology services have broadened over the last 10 years. We are now seeing patients from birth through old age, particularly as the life span increases and infant mortality decreases. We are seeing more patients with head injuries, HIV, and other previously rare or unknown medical disorders and patients with more medically complex and multiple disorders. We are also seeing an increased multicultural representation that requires knowledge of cultural differences, especially cultural differences in communication patterns and reactions and interactions with health care providers and educators in order for the speech-language pathologist to evaluate and treat the patient effectively.

Expectations of Employers

Expectations of employers have changed dramatically over the last 3 years. Clinicians are expected to work better and faster, to see more patients and to do it in the most cost-effective manner. Audiologists and speech-language pathologists are expected to be knowledgeable in interacting with a multi-disciplinary team, to provide team care, and to develop the care plan. Employers no longer wish to participate in the education of clinicians and want to see graduates of our programs in audiology and speech-language pathology who require little or no on-the-job training. The scope of practice of speech-language pathologists has expanded and in some cases employers are pressing clinicians to further expand their scopes of practice to include such things as respiratory care.

Increasing Instrumentation and Invasiveness

Speech-language pathologists are increasingly using imaging technology to examine the oral cavity, pharynx, and larynx during speech, voice, and swallowing. Frequently, speech-language pathologists are required to suction a patient and in some cases to provide simple respiratory care. Clinicians are expected to be knowledgeable in augmentative and alternative communication devices and ways to evaluate patients regarding the type of device they can most optimally use. Clinicians are sometimes using electromyography to provide biofeedback for patients. Students in speech-language pathology need to gain knowledge and skills in these procedures during their educational programs, not on the job.

Increasing Interest in Specialty Areas

Speech-language pathologists frequently practice a specialty or emphasize a particular area in their practice. Many clinicians work in the area of dysphagia and spend a significant amount of their time treating patients with swallowing disorders. Augmentative and alternative communication is another area where clinicians may spend a significant amount of their clinical care time. Multicultural issues are becoming increasingly important as the population in the United States changes. It is anticipated that by the year 2050, approximately half of the U.S. population will be other than white. Some clinicians specialize in multicultural communication disorders. As services have expanded across the age range, some clinicians specialize in the 0 to 3 population whereas others specialize in geriatric care. Each of these areas has a special body of knowledge and skills that need to be provided in our academic programs.

Increasing Time for Service Delivery with Emphasis on Outcome/Cost

Speech-language pathology practice patterns and employers are increasingly emphasizing more service delivery for lowest cost with demonstrable outcomes. Clinicians are asked repeatedly to show the impact of their clinical care, that is, its effect on patients' function. Students need increased expertise in clinical areas, management skills to allow them to participate in supervisory activities, ways to measure outcomes and costs of their work, interpersonal and team skills, and advocacy skills. These need to be introduced in university course work and further developed in clinical practica. In order to provide our graduate students with the necessary knowledge and skills to work in the increasingly high-pressured work place, our academic programs need to expand the breadth and depth of course work, potentially moving more course work to the undergraduate curriculum. Some academic programs may need to specialize in either the health care environment or the education setting. Increased supervision is needed to ensure that students are gaining the knowledge and skills needed to enter the work place as fully qualified and educated clinicians. Clinical practicum experiences need to be broadened and students provided with a range of opportunities to work with widely variable patient populations and disorder groups. Academic programs may wish to develop liaisons with employers to share this educational burden.

Speech-language pathology is a dynamic profession that requires students to have developed the knowledge and skills needed to enter the work force fully ready to provide effective clinical services.

Innovations in Academic Preparation: A Function of Leadership

Arthur M. Guilford, PhD
University of South Florida

There are no simple solutions to the problems facing us in academe. We are confronted with dwindling numbers who are ready to enter the professorate, increasing demands for enrollment in both our undergraduate and graduate programs, all in the face of declines in state and federal funding to support our academic programs. These concerns, both external and internal, force us to review and formulate new operational paradigms for our academic programs. We have developed a fixed pattern of professional and educational goals, plans, perspectives, judgments, and approaches for our educational programs and at times, we are reluctant to move forward or shift from our long-held beliefs and self-imposed academic constraints. All is not bleak, however. Universities can reinvent themselves. We can modify what we are doing, while preserving the best aspects of our programs and throwing out the worst.

It is probably unrealistic to believe that we can and should continue to do things in precisely the same way that we have been doing them. In April, 1994, at the annual meeting of the Council of Graduate Programs in Communication Sciences and Disorders, I presented a model of practice that addressed the need for change in both the educational and practice (career options) parameters of the professions. This model recognized the changing face of the professions of

audiology and speech-language pathology and the growing need to accommodate quality undergraduate students graduating from our programs. Since that time, the ASHA Legislative Council (November, 1994) approved a position statement on speech assistants, providing even greater credibility to this model and redefining the entry level into the profession. This entry level may be redefined again, as we look at other actions of this 1994 Council that included the approval of voluntary specialty recognition. The future may evolve in such ways that we will evaluate multiple entry levels relative to scopes of practice, service delivery systems, and work sites.

We have begun to look at our professions as multitiered, thus providing more room for practitioners at a variety of levels. Personnel shortages have had their advantages in the sense that they have elevated starting salaries in many areas of practice. There is currently speculation that when health care reform comes (as it will eventually) we may not find employment for as many providers of speech and language services due to changes in reimbursement policies and numbers of treatment sessions allowed. Treatment efficacy studies are finally underway and are due, in large part, to the need to establish our worth as health care providers and to save our position within the health care arena. It is true that health care reform will make differences, but these may be overshadowed by the continuous growth in many states of the at-risk populations that we serve. These populations, once considered quite small, will no longer be insignificant (Work, 1991). We may see a decline or shift in the numbers of professionals needed to serve in health care, but there is no indication that the number of children needing our services will decline. Passage of PL 99-457, Part H, has assured services for children in the birth to 3-year age group. We must consider nontraditional service delivery models to meet this challenge (Work, 1991).

The ASHA Task Force on Health Care (1993) cited five primary issues that must be considered if we are to meet our challenges and facilitate practice applications across all work sites. In order of importance they were:

1. The need for treatment outcome and efficacy data.
2. The need for changes in clinical and academic preparation of entry-level practitioners.
3. The lack of inclusion or use of services for communication and related disorders in public and private health care programs.
4. The need for greater professional autonomy within the health care system (*Asha*, September, 1993, p. 54).

Stratification of responsibility, allied with expected or established client needs, represents a reasonable direction for our reconsideration of academic programs. Combined impact of federal laws, education, health care, and client needs, supported by rapidly accumulating data for

efficacy of treatment, suggest that it is time to revisit the roles of undergraduate, graduate, and post-graduate programs and those of students who elect the various levels of study.

Meeting Challenges and Creating Partnerships

What are universities willing to do to meet new challenges? Can we accept a shift in our paradigm? We can change, and we have certainly done so in the past. In order to do so now, however, we must look at our funding base, our programmatic outcomes, and the skill and breadth of performance of our graduates.

In these times in which the base of funding for academic programs has declined, we are going to have to look to ways to diversify what we are doing and find innovative ways to increase our resources in order to educate students effectively (*The Economist*, December 25, 1993.) For many years, Colleges of Engineering and Fine Arts, and Departments of Marketing, Accounting, and Geology have actively marketed their faculty's and students' skills to the public and private sector. These marketing efforts have created real-world educational and practical training opportunities for students, while increasing the earning potential for faculty, students, and academic units. Some might call this a sellout to the market. I call it entrepreneurial and a way to survive. As local and federal grant-supported resources have declined, there have not often been other effective ways to equip our theaters, art galleries, and laboratories.

Departments of Communication Sciences and Disorders have not traditionally marketed themselves aggressively. There has been a certain resistance to embrace new technologies and partnerships. Now may be the time to do this.

Now may be the time to formulate partnerships with both the public and private markets. Henri's survey (*Asha*, January, 1994) revealed that the marketplace is not thoroughly enamored with the education and practical training of our graduates. For example, in speech-language pathology, skills and knowledge related to prevention, clinical research, public relations and marketing, business and legal aspects, were all ranked as only fair to poor in our graduates. Preparation of the speech-language pathology graduate in areas of alternative/augmentative communication, central auditory processing, dysphagia, and multicultural issues was also rated fair to poor. It may be of interest that three of the four areas directly relate to the use and knowledge of technology. Deficits in the fourth area (multicultural knowledge) may be related to the fact that many of our university programs are still located in relatively white enclaves in middle-America and exposure of our students to other students and clients of color is minimal. Henri also notes that many of our graduate-level clinicians have never had opportunities to observe treatment performed by a master clinician.

How can we begin to address some of these shortcomings in our graduate education programs? One way to meet both resource needs and, ultimately, student needs is to form partnerships between the university and public and private markets, hospitals and rehabilitation centers, school systems, and other universities. If we are to form partnerships successfully we must be willing to shift paradigms. Faculty in universities will need to admit that there are others in the work force and at other universities who can effectively participate in the education of our students beyond routine assignments to in-the-field practicum experiences. Are we going to be willing to give up total and complete ownership and still feel that we have maintained our integrity? I hope so.

Cooperative efforts between universities, rural and urban school personnel, community service providers, and student participants will greatly influence the face of academia while more effectively providing for quality service delivery within the university. The anticipated impact of cooperative partnerships would be an increase in the number of qualified professionals, unique opportunities for career development, and a support system for educators seeking adaptive, relevant career development. Therefore, we must

1. Recruit graduate students from underqualified personnel who are currently serving school children with speech-language disorders and who wish to meet the entry requirements for fully certified professional work.
2. Implement a curriculum that will address the need to expand educational opportunities to current and potential practitioners in rural settings through distance-learning opportunities.
3. Identify distance-learning technologies that will deliver the curriculum effectively.
4. Identify and recruit faculty who have demonstrated expertise in course delivery through various distance-learning approaches (e.g., ITFS, interactive computer technology, e-mail, tape delay, independent study, and field-based clinical practicum modules).
5. Expand opportunities to participate in these technologies and innovative teaching techniques to all other programs within our state university systems.

Distance-Learning Initiatives

We have seen changes in the overall student profile since many of us began our work in the university. Students are no longer content to have only one method of instruction; they are use to multimedia entertainment that is far more action-filled than most of us can easily achieve within our classrooms. Our societal values have changed to the point that in many urban settings, students are no longer living on a closed campus, but are commuting to classes from their homes and apartments off-campus. Many students, for example, are no longer content to commute long distances to sit in a classroom and listen to a talking head hour after hour.

Baby boomers (77 million strong) have grown up with television and accept it as a viable means of acquiring entertainment and information. This group is thus a natural recipient for televised

distance learning. Furthermore, distance learning is cost-effective when one considers the amount of commuting time that can be saved for students who are able to participate in course work closer to their homes.

Increasing numbers of mid-career students have decided to change and work in the professions of audiology or speech-language pathology. Many of these students have already been successful in one field and now are interested in working in another. Furthermore, they are use to earning an income, and they do not wish to be without one for long periods of time. Distance learning can provide effective alternatives for study that will allow many individuals to remain in their home environment while concomitantly participating in classroom instruction.

More students from diverse minorities are entering universities and there have been documented differences in their learning styles. What we have been doing for years in our classrooms tends to emphasize an exclusively Eurocentric learning style and may not be appropriate for all of our students. Interactive distance-learning formats and course/practicum modules that provide opportunities for interactive learning may be more appropriate for many minority groups.

Distance learning is cost-effective. It saves natural resources. It does not encourage the duplication of programs at a time when few if any of the existing programs may be adequately supported. It even provides a sense of belonging in the cohort of students at the distant receive site. With access to professional curricula through distance learning, many persons unable to seek a degree due to geographical barriers, and financial and time constraints will be afforded the opportunity for professional advancement.

Summary

Programs for academic preparation in communication sciences and disorders need to change on a number of fronts. For example, Massy, Wilger, and Colbeck (1994) reported that lack of communication among faculty members is a significant problem across all disciplines. These authors identified five major elements responsible for it: desire for autonomy, specialization, lack of civility, generational splits, and personal politics. Developing a common goal and becoming more program- or task-oriented in attempting to solve collective problems has not been easy for many university personnel. Therefore, change and acceptance of new technologies, ways of problem solving and cooperation with other programs have not been easy tasks.

Collegiality has been a mainstay of the academy. Yet, in many respects collegiality as demonstrated by many faculties does not lead to the substantial discussions necessary to improve or change the educational process. This form of collegiality has been defined by Massy, Wilger, and Colbeck (1994) as "hollowed" or "superficial" because it actually impedes decision making and problem solving. However, despite this, there still remains some semblance of the

"community of scholars." It is this notion that compelled many of us to enter the academy in the first place.

In an ideal world, collegiality would probably be sufficient to provide an effective education. "That the professors' chairs were turned inward—that they talked mainly among themselves—mattered little since faculty were in close touch with the needs of students and their patrons. But today's world requires that at least some of the chairs be turned outward some of the time; our funders, tasks—and especially our student bodies are so much different" (Massy et al., 1994, p. 19).

We have been reluctant to change, but can no longer be so. We must look at new and innovative ways to improve the educational process while maintaining our integrity and our standards. We must not say "It will not work" before we evaluate all possible processes in which a proposed method might work. We must turn to ourselves, our colleagues, and to our Association to find ways in which we can provide innovations in academic preparation without sacrificing our integrity, beliefs, and commitment to quality. If we are true leaders, we must evoke a fresh and compelling vision for our departments if we are to meet future academic challenges.

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Potential Changes in Academic Programs: Where Do We Go From Here?

Summary

Jeri A. Logemann, PhD
Northwestern University

We have heard presentations that defined the various forces affecting our educational programs, including national health care reform, the changing fiscal policy, demographic and technological advancements in higher education, changes in professional practice in audiology and speech-language pathology and federal activity affecting higher education. Now we need to ask ourselves some questions relative to our academic programs:

- Can we reduce the cost of our educational programs by repackaging course work or perhaps moving some course work to the undergraduate level?

- Do distance learning, other technologies, or use of part time/adjunct faculty assist us in cost containment and budget management?

- With the change in employers' expectations for new employees and the reduced time allowed for supervision of students, can educational programs pay for student practicum?

- In light of the various organizations active in health care reform, all of whom are pushing us toward educating our audiologists and speech-language pathologists more cheaply and faster, can we reduce the cost of education?

- With reform occurring in both education and health care, can we produce a well-trained student who is ready to enter the work force with little or no on-the-job training?

- Do we have data supporting our educational model as the best way to prepare clinicians?

- Is there a better (faster and cheaper) way?

- What data/research can we or should we initiate in order to evaluate our educational models?

- Should we initiate research to define the value of the level of education (B.A. vs. M.A.) relative to specific disorder management?

- Should we and how do we expand the skills of our professionals in the areas of respiratory care, vital signs monitoring, multi-disciplinary communication, management skills, outcome measures, quality measures, use of technology, advocacy skills?

- Should we and how do we build varying models to meet varying preparation needs, such as those of varying work sites?

- How can we integrate practitioners and employers in our educational programs?

- How can we improve the efficiency of our educational programs?

- Can we use technology to teach clinical decision making?

- How do we overcome any barriers to our developing partnerships with public and private markets; sharing course work across universities; using distance learning;

developing contracts with hospitals and rehabilitation centers; and developing partnerships with other universities?

- How do we assist our faculties to update regularly and to improve teaching skills?
- Have we defined our educational goals in the context of the reality of the work world?
- Should we or how do we help faculties understand the forces at work and the urgency of the need to change in a context of so many students; distance learning; technology; practice changes?
- How do we educate our publics, that is, academic consumers such as deans and vice chairs about the role of communication sciences and disorders programs?
- What organizations should we work with to improve our situation?
- How do we or should we assist program chairs and organizations that aid program chairs with advocacy, management, cost cutting procedures, and faculty management?

All of these questions are worthy of significant debate and discussion. As we examine the variety of issues affecting our academic programs, we need to address these questions to assist us in constructing the optimum models for academic training in communication sciences and disorders.

Blueprint For A New Academic Agenda

On the second day of the Colloquy, participants identified issues relevant to academia and student preparation that they felt needed to be addressed. The issues were grouped into five categories:

- accreditation and certification;
- faculty development;
- educational structures, mission, and evaluation;
- managing change; and
- curriculum and instruction.

Colloquy participants then chose a category of interest and broke up into five working groups to address the issues. On the last day of the Colloquy, the findings of each group were presented to the participants at large who voted and chose the following five issues to be of most importance:

1. Develop flexibility in accreditation standards, which will encourage programs to be innovative and creative in meeting changes in the workplace and in higher education.
2. Improve instruction. All levels and stages of instruction should be competency-based, integrated, and should be relevant to current needs in the workplace. To improve cost-effectiveness, technology must be infused throughout the curriculum, regardless of the instructional environment, including classroom, laboratory, and practicum sites.
3. Position faculty for a changing world. Educate faculty about internal and external factors affecting the future of academia and the profession.
4. Develop and evaluate models of education.
5. Redefine practica so that they are readiness- and competency-driven.

Following is a summary of the recommendations developed regarding each issue.

Accreditation and Certification

Dolores E. Battle, PhD
State University College at Buffalo

Issue 1. Develop flexibility in accreditation standards which will encourage programs to be innovative and creative in meeting changes in the workplace and in higher education.

The standards for academic program accreditation are too restrictive. They limit the ability of academic programs to develop new models of education, and to develop specialties in academic programs and/or clinical practicums. While program accreditation does not alone restrict development in this area, the linkage between program accreditation and clinical certification restricts programs from developing new program models according to the strengths of their individual faculty and their resources. In addition, because of perceived restrictions dictated by the certification standards, academic programs are not able to change quickly or develop new areas to meet the demands of professional practice.

The present system of credentialing academic programs is labor intensive, both on the part of the current board for accreditation (Educational Standards Board) and the ASHA staff. Unless there is a change in the accreditation process with the Council on Academic Accreditation, there will be no change in the workload placed on the accreditation body.

Change to the Council on Academic Accreditation in 1996 may allow some flexibility in the standards to develop, however, the standards will continue to be subject to regulations imposed by internal structures such as the standards for clinical certification and external structures imposed by the Commission on Recognition of Postsecondary Accreditation (CORPA) and the Department of Education.

Possible Barriers

The current system of academic accreditation is process oriented with evaluation being based on quantifiable variables rather than true indicators of quality. Although there is a perceived need to affect some changes in the accreditation system, there is a lack of outcomes data to support the need for change vs. the need to maintain the status quo, nor is there any universal agreement of the specific changes that need to be made. Existing state licensure laws and requirements of the Department of Education and the Commission on Recognition of Postsecondary Accreditation restrict the flexibility of academic programs to be innovative and creative.

Recommended Actions

- Council on Academic Accreditation should review the implementation statements associated with the current standards for academic accreditation to allow more flexibility in meeting the standards.

- Council on Academic Accreditation should allow academic programs to try pre-approved experimental approaches to academic education by allowing "creative implementation of the accreditation standards."

- The Council on Academic Accreditation should develop a system to collect data to validate both traditional approaches to education and the innovative, creative programs that may be developed.

- The Council on Academic Accreditation should develop outcome measures for the accreditation of educational programs.

- The linkage between academic accreditation and clinical certification should be removed.

Issue 2. Develop standards which will encourage and allow programs to be creative in meeting changes in the workplace and higher education environments.

The standards for clinical certification are also too restrictive and often are not consistent with marketplace expectations. The concepts of lifetime certification may be inappropriate for a rapidly changing profession. Concepts related to base level certification with endorsements or specialization need to be explored and developed. Clinical certification requirements should include core information, e.g., human communication processes, basic science, ethics, attributes of disorders, normal vs. abnormal communication processes, as well as problem solving and creative thinking in the assessment and intervention process. There also should be some identification of knowledge and skills necessary for preservice education as well as an identification of knowledge, skills, and attributes to be obtained through in-service or post-certification education.

Potential Barriers

The current certification standards and most existing state licensure laws are based on ASHA "historical precedents" rather than current and future demands of the profession. There is little if any data available to validate the current standards. The Department of Education regulations restrict program flexibility in education. There is a lack of data to support the need for change as well as a lack of universal agreement to change. Marketplace expectations may indicate the need to change preparation for certification. The concept of lifetime certification needs to be explored.

Recommended Actions

- The Council on Professional Standards should reevaluate the appropriateness of the current assumptions concerning the knowledge, skills, and attributes required for independent practice, renewal of clinical certification, and the role of the clinical fellowship in the preparation of competent clinicians.

- The Council on Professional Standards should reduce numerical-specific requirements for clinical certification, e.g., courses, credit hours, and age and disorder categories.

- Council on Professional Standards should develop standards that focus on functional outcomes rather than process.

- The Clinical Certification Board and state licensure boards should investigate systems for developing and evaluating alternative models for demonstrating clinical competence.

- The Council on Professional Standards should consider base level certificates with endorsements.

- Council on Professional Standards should consider identification of core information in science, ethics, normal processes, problem solving, and identification.

- Council on Professional Standards should consider pre-service and in-service knowledge, skills, and attributes.

Resources Needed

The action plans could be implemented with current resources within the structure provided by the Council on Academic Accreditation, the Council on Professional Standards, and the Clinical Certification Board. Depending on the nature of the tasks, however, additional resources may be necessary to support additional meeting days and additional National Office staff time to complete specific tasks.

Faculty Development

John A. Ferraro, PhD
University of Kansas

Issue 1. Improving Instruction

All levels and stages of instruction in our educational programs should be competency based, integrated (re: theory and practice/classroom and clinic), and relevant to current needs in the workplace. To improve cost-effectiveness, technology must be infused throughout curricula, regardless of instructional environment (i.e., classroom, laboratory and practicum sites).

Barriers

Barriers to improving instruction include the costs associated with developing technology and instructional materials. In addition, current certification and accreditation standards may not be flexible enough to support the use of innovative instructional approaches. There also is a lack of administrative and financial support for faculty/staff to integrate new technology into their instruction. Data supporting the effectiveness of either traditional or alternate models of instruction are lacking, as are formal preparation programs in instructional effectiveness for individuals who provide instruction. General "resistance to change" is a major barrier to improving instruction. For example, a barrier to implementing integrated classroom-clinic

curricula is the resistance to altering the traditional instructional approach of dichotomizing classroom and clinic teaching.

Action Steps

Eight action steps were proposed to accomplish the general goal of improving instruction:

1. Explore the use of case- and problem-based learning.
2. Promote the use of interactive technologies for various instructional experiences.
3. Develop instructional packages that address issues ranging from specific tasks to complete courses.
4. Conduct a search for innovative instructional models and materials across disciplines.
5. Establish a national clearinghouse for innovative instructional models and materials.
6. Identify/promote more cost-effective models of supervision, such as sequential, layered, team and distance supervision.
7. Develop a national data base relative to the efficacy of alternate practicum experiences through interactive technologies as an alternative to face-to-face supervision.
8. Develop functional outcome measures of classroom instruction, supervision, and curriculum relative to competencies of graduate.

Resources

Development of case based learning could be assigned to the ASHA Academic Affairs Board and/or Special Interest Division #11 who could collect, analyze and disseminate information. The development of interactive technologies and instructional packages would necessitate the identification/use of experts in the subject matter and access to technology, and the support of future program committees for the annual Convention as well as the ASHA Scientific and Professional Programs Board. The ASHA Continuing Education Board, with collaboration with the Council of Supervisors in Speech-Language Pathology and Audiology could establish a clearinghouse of innovative instructional models and materials for supervision and instruction.

Issue 2. Position Faculty for a Changing World

The need exists to educate faculty about internal and external factors affecting the future of academia and the profession. At present, however, no group or individual is taking responsibility for collecting and disseminating information addressing knowledge gaps. In addition, faculty are already overburdened with other duties/information.

Four action steps were identified to accomplish the goal of educating faculty for a changing world:

1. Coordinate, collect and disseminate information about the internal and external factors affecting the profession.

2. Frame and communicate a focused message about issues impacting academia that are customized around the types of institutions offering educational programs.

3. Use continuing education to teach faculty how to advocate, network and manage diversity.

4. Develop an Internet bulletin board and/or e-mail system to provide avenues for communication among academics. Provide avenues for communication among academics.

Resources

ASHA should publish directories of retired practitioners and faculty to aid in faculty mentoring, short-term faculty positions, and assistance in recruitment. In addition, ASHA should maintain a directory of clinicians who are seeking short-term or faculty positions. These activities could be coordinated with the Academic Affairs Board, Multicultural Issues Board in collaboration with the Council of Graduate Programs in Communication Sciences and Disorders.

Educational Structures: Mission and Evaluation

Terry L. Thies, Ph.D.
Consultant

Issue 1. Encourage and promote flexible program models that create quality speech-language pathology practitioners and scholars.

In spite of major changes in scope of practice, consumer characteristics, service delivery systems and available technologies for delivering instruction, there has been relatively little change in academic and clinical training models in communication disorders. The Association must encourage and promote flexible program models that result in quality speech-language pathology and audiology practitioners and scholars.

Potential Barriers

Accreditation and certification standards as well as licensure and legislative mandates tend to preserve the status quo. Programs do not currently have cost analysis instruments to adequately evaluate alternative program models. Similarly, there is a dearth of efficacy studies for academic and clinical education in communication disorders. Clinical education models are similar

throughout the country. Innovation is frequently discouraged so as not to be out of step with other programs. Inertia exists both with respect to institutions as well as faculty. There seems to be a prevailing attitude "We're already good; and we don't need to look outside the professions." In spite of the technological revolution affecting all levels of instruction, many faculty persevere in a shroud of technophobia. Those faculty who are willing and able to incorporate new technologies into their instruction are thwarted by lack of rewards and recognition.

Recommended Actions

- The Council on Academic Accreditation, Educational Standards Board, and Professional Standards Board need to modify current standards to accommodate more flexible program models. A two year timeline is recommended.

- Incentives need to be provided for innovative program models. Such incentives might be provided through ASHA Convention committees, universities, CGPSCD, ASHA, SPPB, NAPPA, and CUSPA. It is recommended that ESB and CAA coordinate this incentive effort.

- All levels of academic and clinical instruction need to be examined with respect to the use of technology to improve both effectiveness and efficiency of instruction. The AAB, CAA, Practitioner RPOs, CGPSCD and university programs share responsibility for ensuring optimal use of technology in training programs.

- The Association needs to encourage efficacy studies for academic and clinical training models. The role and value of partnerships needs to be considered in this endeavor.

Issue 2. Establish competencies for entry into clinical practice across the practice continuum.

A prerequisite for evaluating the cost effectiveness of instructional models is a clear definition of minimum competencies. The Association has recently undertaken an effort to define minimum competencies required by audiologists. It is important to establish competencies for entry into clinical practice across the practice continuum.

Potential Barriers

There are numerous problems in defining level of educational preparation and nature of competency. Many are uncomfortable with the required analytic approach and have fear of becoming too prescriptive. There is a lack of consensus regarding practitioner outcomes and resistance within the profession to acknowledge need for multiple practice levels. There is a lack of well established training program models at levels for entry other than the master level. Many

state agencies and other groups are already defining competencies for purposes of credentialing. There is a move towards multi-skilled practitioner models and a need for fluidity with respect to scope of practice. There is no efficacy data concerning competencies across practice. There are limited rewards for creative technology involvement. There is a lack of speech-language pathology and audiology collaboration (proprietary focus).

Recommended Actions

- Develop competencies across entry level practice levels for speech-language pathology, audiology, and support personnel. Audiology entry level is already slated for completion by 1996. Support personnel/speech-language pathology competencies should be determined by 1997 and entry level competencies for speech-language pathology should be completed by 1998.

- Standards need to be modified to be in synchrony with entry level competencies.

- Efficacy studies need to be completed for various educational models as part of the competency development.

- The Association needs to assist programs to identify and seek funding for competency development and efficacy studies.

- The Academic Affairs Board should collate and disseminate data concerning state level practice patterns, e.g. speech assistants and their training and certification by state education boards. This is envisioned as an ongoing activity of the Board with a first report disseminated as soon as possible.

Issue 3. Invigorate research base of the professions.

With renewed attention being focused on clinical practice, it is important that the research base of the professions not be forgotten. The Association needs to develop a strategic plan to invigorate the research base of speech-language pathology and audiology.

Potential Barriers

There is currently a shortage of researchers and too few students going into research. There are limited postdoctoral opportunities and a lack of financial incentives for research careers. Research funds are drying up and the future forecast for government sponsored research efforts is bleak. There is a renewed focus on teaching in higher education which is further limiting the number going into research. There is an increase in the number of junior faculty members.

Traditional teaching models and curricular sequences do not have enough emphasis upon research at undergraduate and graduate levels.

Recommended Actions

- Universities should develop honors programs to recognize research achievements.

- Universities should encourage flexibility in tracking of students to identify capable, interested students early.

- There should be a concerted effort among universities, NAPP, CGPCSD, ASHA, ASHF, and NSSLHA to develop more student research rewards. Outside funds from outside agencies, corporations and other sponsors should be tapped to support such awards. Tuition waivers or travel funds from universities could be awards as well as alumni scholarships. State funds could also be sought for undergraduate research awards.

- ASHA should assist universities with identification of corporate partnerships for research. ASHA personnel could identify possible sources and disseminate this information. ASHA and Graduate Council could present model programs.

- Academic Affairs Board should develop incentives for graduate students to finish dissertation prior to leaving institution. This might be done through mentoring efforts with ASHA assisting with networking efforts among mentors. A bulletin board or LISTSERV for Ph.D. students could be established.

- Academic Affairs Board and CGPCSD should review and follow up on documents from NIH research training needs conference of 1994. AAB, CGPCSD and MAO should collaborate with this review and spearhead implementation.

Managing Change

Juanita Sims Doty, EdD
Jackson State University

In order for ASHA to continue to grow, change must occur. Change is inevitable. Change should be positive and proactive, therefore, we must plan for it and effectively manage it.

Issue 1A. Maintain clinical contacts in the real world: Involvement.

There is need to make individuals in academic settings aware, in a continuously updated fashion, of issues, trends, and factors which impact on higher education and/or professional preparation in audiology and speech-language pathology. Many professionals outside of higher education, including some students, think that faculty members sit in their "ivory towers" (university settings), oblivious to what is going on around them in the real world. Therefore, in an effort to manage change effectively, there is need for individuals in academic settings to be aware, in a continuously updated fashion, of the news, trends, and factors which have an impact on higher education and/or professional preparation in audiology and speech-language pathology.

Recommended Actions

- Publish articles describing the issues and providing a proactive challenge to engage in changes.

- Publish summary of solutions from the Academic Colloquy.

- Disseminate article and Colloquy Summary to Council of Graduate Programs and ASHA members in academic settings.

- Offer modules on current issues affecting academia to Council of Graduate Programs, Council of State Association Presidents, ASHA's Directors Conference, and the ASHA Convention.

- Establish an e-mail update network or bulletin board for academic institutions and faculty.

Needed Resources

The Academic Affairs Board and the ASHA staff should provide outcome measures and assessment tools related to individual assessment and programs assessment. It should explore sources for funds to provide increased communication and telecommunications networking.

Issue 1B. Maintaining clinical contact in the real world: Information.

In order to manage change effectively, it is important that faculty members maintain contact within the clinical environment, outside the university. It is important to be aware of the factors affecting our field in assessment, service delivery, and outcome measures.

Possible Barriers

Maintaining contact with the real world is difficult. Many faculty members are comfortable with and committed to the status quo. There is difficulty in keeping track of diverse and fast-paced issues. Barriers to maintaining clinical contact outside the university include difficulty finding outside clinical opportunities, limited recent clinical experience; issues related to licensure and liability; and departmental responsibilities that restrict outside activities. The constructs of the department or university may be such that each faculty member has his or her assigned responsibilities, which do not include maintaining clinical contacts in the community.

Recommended Actions

- Faculty should identify existing placement sites and look at employment patterns and trends of recent graduates.

- Establish partnerships between the university and sites that would offer expertise and training in the clinical areas.

- Explore sites where program graduates are securing employment as possible practicum sites.

Necessary Resources

Academic Affairs Board should communicate these strategies to faculty and staff.

Issue 2. Involvement in the legislative process: Marketing and advocacy.

In order to manage change effectively, it is important for faculty to become involved in the legislative process. Faculty should also be involved in marketing, and in advocacy for their programs, facilities, students, and the population needing their services. Marketing and advocacy should take place within the university first, then at the local, state, and national levels.

Possible Barriers

Faculty perceive that they lack the know-how in legislative advocacy and that there are too many other demands on their time. There is the feeling that someone else is doing this job and that faculty cannot make a difference.

Recommended Actions

- Collaborate with state associations, legislative committees, and ASHA's governmental affairs to educate staff and students about the political process and current political issues.

- Incorporate relevant political information into classroom instruction.

- Develop a political consciousness among students, and encourage them to get involved in the political process.

- Market the department and program within the institution in a proactive rather than a reactive manner.

- Develop an awareness of and encourage participation in the Task Force on Treatment Outcomes activities.

- Lobby and contribute money to the ASHA Political Action Committee.

Necessary Resources

In order to accomplish these tasks, it is necessary to cooperate and exchange information between academic programs, ASHA, and the ASHA Political Action Committee. Increased cooperation and increased communication between institutions and the Academic Affairs Board are necessary for this to be successful.

Issue 3. Recruitment and retention of minority and nontraditional students.

ASHA's Long Term Strategic Plan addresses the need to increase the number of minorities within the professions to mirror the percentage of minorities within the U.S. population. There is a critical need to reinforce this initiative as some minority groups are showing a decrease in numbers as compared to the overall Association membership. With the changing face of the United States, more nontraditional students will be entering our programs.

The cultural climate of the institutions and departments are integral factors in the recruitment and retention of minority students. This climate creates a feeling of concern and lack of acceptance of those students from different cultural backgrounds. In recent years, complaints of discrimination from students at various universities have been brought to the attention of the Ethical Practice Board of the American Speech-Language-Hearing Association.

There is a lack of minority faculty role models. The recruitment, retention and graduation of minority doctoral students will create a larger pool of faculty role models from which to choose faculty and role models.

Potential Barriers

Among the major barriers to progress in this issue is the lack of support services for minority and nontraditional students. In addition, financial constraints hinder disadvantaged students from progressing through programs to completion. There is also a lack of minority role models and a lack of sensitivity to, and understanding and awareness of cultural differences that affect student's approach to learning.

Recommended Actions

- Review accreditation and certification standards to determine if there are ways to educate students faster and with less expense.

- Develop and disseminate a resource manual for funding which includes a list of programs with funding for minority and nontraditional students in addition to a list of funding sources at the federal level.

- Explore distance learning concepts to link diverse faculty to students at universities without minority faculty.

- Infuse multicultural issues, including sensitivity training into the curriculums of state and national professional meetings, the Council of Graduate Programs in Communication Sciences and Disorders meetings.

- Educate students and faculty about procedures for complaints of discrimination.

Necessary Resources

Activities related to the retention and recruitment of minority and nontraditional students into the profession should be coordinated between the Office of Minority Affairs, Multicultural Issues Board, National Black Association for Speech, Language and Hearing, The Hispanic, Native-American, and Asian-Pacific Islander Caucuses, the Council on Professional Standards in Speech-Language Pathology and Audiology, the Council on Academic Accreditation, and the Academic Affairs Board.

Curriculum and Instruction

Michael J. Flahive, PhD
Valparaiso University

Issue 1. Develop and evaluate models of education.

The need to develop and evaluate new models of education is among the most important issues among academics. There is considerable frustration at the pressure to be responsive to issues on the academic work setting. External pressure on academic curriculum include societal components in health care reform and educational system configuring. Internal pressure include increased information pool, changing workplaces, expectations for more sophisticated graduates, and poor funding. There is also concern for the value of research and scholarly activity among all members of the professions. A key concern in developing education models is flexibility.

Clinical service providers are concerned about the capability of graduates entering the field to move into different work settings. Concerns include exposure to theoretical constructs, specific content, and adequate practical experience with the many and diverse clients seen across work settings in practice today. There is need for new graduates to "hit the ground running" as competent to begin practice. These challenges and expectations are great. However, there is a willingness among academics to assist in problem-solving with respect to educational practices and alternative models.

Action Plans

- Establish an incentive program to support the examination of innovative, alternative models of preparation. This could involve the development of a competition for funds directed to academic programs.

- Explore alternative educational models that take into account innovations impacting other sectors of higher education, including applications of distance learning and other technology-based methods.

Barriers

There are several barriers to the development and evaluation of alternative educational models. A major barrier is reluctance to break with tradition, resistance to change, and lack of "buy-in," both from faculty members as well as university administration that are satisfied with the status quo. Additional concerns include cost of developing faculty and curriculum and access to technology. Other barriers include territoriality and a lack of expertise in model modification. A final barrier is the present accreditation standards which put constraints on thinking and limit possibilities.

Issue 2. Redefine practicum so that it is readiness and competency driven.

A number of forces are driving the needs for restructuring clinical education. These include societal demographic changes, expansion in health care, and educational reform efforts, the continuing increase in the professional informational base, and a number of changes in service delivery settings. Service delivery issues involve changes to more consumer-oriented approaches, the "do more for less" alterations to funding sources, increased need for competence with diverse populations, varied modes of service delivery and others.

Action Plans

- Develop a set of competency guidelines for beginning level practitioners on speech-language pathology as is being done for audiology.

- Modify clinical education certification standards so that they are competency, nor hourly, driven. This would involve combining didactic and practical components of coursework where a goal of courses would include not only expansion of a knowledge base, but also clinical skills in that content area. This would involve the formation of partnerships with supervisors, both internal and external, and other groups involved in the clinical education.

- Abolish the clinical fellowship year. If cooperative partnerships with internal and external supervisors are developed and didactic and practicum components are competency driven, it may be possible to eliminate the clinical fellowship year.

Barriers

Barriers to redefining practicum are both ideological and pragmatic. Resistance to change from conventional practices is a major barrier. Alternative approaches would be harder to evaluate and more difficult to administer. This is due, in part, because there are not adequate links between competence-based coursework and practicum. This model might place a burden on clinical supervisors as well as general question concerning the ASHA Code of Ethics. A final concern is the objective measurement of competency and the issue of grade inflation that appears to exist presently in clinical education.

Issue 3. Address recruitment/shortage of doctoral students.

There is need to recruit more persons into doctoral programs to alleviate shortages of faculty and researchers.

Action Plan

No plan was developed.

Identified By Academic Colloquy Working Groups Ranking of Issues:

Ellen C. Fagan, MS
American Speech-Language-Hearing Association

Fourteen issues were identified by the working groups. The following is a listing of how the issues were ranked by the entire colloquy followed by number of votes each issue received.

1. Develop flexibility in accreditation standards which will encourage programs to be innovative and creative in meeting changes in the workplace and in higher education.
   (31)

2. Improve instruction. All levels and stages of instruction should be competency-based, integrated, and should be relevant to current needs in the work place. To improved cost-effectiveness, technology must be infused throughout the curriculum, regardless of the instructional environment, including classroom, laboratory, and practicum sites.
   (28)

3. Position faculty for a changing world. Educate faculty about internal and external factors affecting the future of academia and the profession. (27)

4. Develop and evaluate models of education. (26)

5. Redefine practicum so that it is readiness- and competency-driven. (24)

6. Develop flexibility in certification (develop standards which encourage/allow programs to be creative in meeting changes in the workplace and higher education environments). (20)

7. Recruit minority and non-traditional students.
   ASHA's Long Range Strategic Plan addresses the need to increase the number of minorities within the professions to mirror the percentages of minorities within the U.S. population. With the changing face of the U.S., more non-traditional students will be entering our programs. (16)

8. Invigorate research base of the profession(s). (14)

9. Encourage and promote flexible program models that create quality speech-language pathology and audiology practitioners and scholars. (12)

10. Establish competencies for entry into clinical practice across the practice continuum.
    (12)

11. Maintain clinical contact in the real world: Involvement
    There is a need to make individuals in academic settings aware in a continuously updated fashion, of news, trends, and futures which have impact on higher education and/or professional preparation in audiology and/or speech-language pathology.

    Maintain clinical contact in the real world: Information
    In order to manage change effectively, it is important that faculty members maintain contact within the clinical environment outside the university to be

aware of the factors affecting our field in assessment, services delivery and outcome measures. (2)

12. Involve faculty in the legislative process: Marketing and advocacy
    In order to manage change effectively, it is important for faculty to become involved in the legislative process, in marketing, and in advocacy for their program, facilities, students and the population needing their services

13. Decrease faculty shortages. (3)

14. Address recruitment/shortage of doctoral students. (2)

Appendix A: Working Group Action Plans

Group # 1 **Group Name: FACULTY DEVELOPMENT ISSUES**

Issue #1 Improve instruction.

All levels and stages of instruction should be competency based, integrated, and should be relevant to current needs in the work place. To improve cost-effectiveness, technology must be infused throughout the curriculum, regardless of the instructional environment, including classroom, laboratory, and practicum sites.

Barriers:

Cost of technology and the development of instructional materials.
Current certification and accreditation standards may not support the use of innovative instructional approaches.
Lack of administrative and financial support for faculty and staff to integrate new technology into their instruction.
Traditional instructional approaches dichotomize classroom and clinic teaching.
Resistance to change by individuals.
There is a lack of data to support the effectiveness of either traditional or alternate models of instruction.
There is a lack of formal preparation in instructional effectiveness for individuals who provide instruction.

Solutions:

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
1. Explore use of case-based and problem-based learning.	Academic Affairs Board Special Interest Division #11	1/1/96	Personnel to collect, analyze and disseminate information-(volunteers, staff).	
2. Promote use of interactive technologies for various instructional experiences (i.e., levels and types).	Experts in subject matter and access to the technology	1/1/96, ongoing	Support of convention program committee and Scientific and Professional Programs Board for 1995, 1996 and 1997 technology programs	

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
3. Develop instructional packages that address issues ranging from specific tasks to complete courses.	Experts in subject matter and the technology; coordinating committee of the Vice President for Research and Technology.	6/1/95	Consider RFP development ($100,000) of two instructional packages - one emphasizing speech-language pathology and one emphasizing audiology.	Explore external funding
4. Conduct search for innovative instructional models and materials across disciplines.	National Office staff	6/1/95	Personnel to collect, analyze, and disseminate information -(volunteers, staff)	
5. Establish national clearing house for innovative instructional models and materials.	Continuing Education Board, National Office staff, Computer Users in Speech and Hearing	1/1/96		
6. Identify and promote more cost-effective models of supervision, such as sequential, layered, team, distance supervision.	CSSPA, Special Interest Division #11	1/1/96, on-going	Support of Council on Professional Standards	Support of Council on Professional Ethics

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
7. Develop a national data base relative to the efficacy of alternate practicum experiences through interactive technologies as an alternative to face-to-face supervision.	Ad hoc committee, task force, ASHA Research Department	6/1/95	Consider RFP development ($100,000)	Explore external funding
8. Develop functional outcome measures of classroom instruction, supervision, and curriculum relative to competencies of graduates.	Standards Council, Academic Affairs Board	As soon as possible	$75,000	

Group # 1 Group Name: FACULTY DEVELOPMENT ISSUES

Issue #2 Position faculty for a changing world.

Educate faculty about internal and external factors affecting the future of academia and the professions.

Barriers:

Currently, no group or individual is taking responsibility for collecting and disseminating information addressing knowledge gaps. Faculty overburdened.

Solutions:

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
1. ASHA should take responsibility for coordinating, collecting, and disseminating information about internal & external factors.	National Office staff, Division Director for Academic Affairs	1/1/95	$60,000	Person will be key to implementing action plans developed related to academic affairs.
2. Frame and communicate focused message about issues impacting academia customized around types of institutions.	Director of Academic Affairs, Academic Affairs Board; Vice President for Academic Affairs	1/1/95	$10,000 (second meeting of Academic Affairs Board in 1995)	

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
3. Teach faculty how to advocate, network, and manage diversity.	Scientific and Professional Programs Board, Continuing Education Board, Convention Program, Director of Academic Affairs, VP of Academic Affairs, & Coordinating committee	12/95		
4. Provide avenue for communication among academics (e.g. maintain Internet bulletin board, develop E-mail directly for academics).	Director of Academic Affairs Division	3/1/95	$2,000	

Group # 1 **Group Name: FACULTY DEVELOPMENT ISSUES**

Issue #3 Decrease faculty shortages

Barriers:

Lack of applicants.
University restrictions on adding positions.
Difficulty attaining tenure.
Downsizing at university level.
Salary limitations.
Competition from higher paying employers.
Overall decrease in student enrollment.

Solutions:

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
1. Recruit faculty from clinical area.	ASHA	1996	Directory of clinicians ($10,000)	
2. Use retired practitioners as faculty (to deal on short-term basis w/shortage).	ASHA	1996	Directory of retired practitioners and faculty. Directory of positions available on short term. ($5,000)	
3. Long term recruiting of best students into academia.	ASHA ad hoc committee,	1995	a. Develop a plan for obtaining cooperation from academic administrations.	Reduce teaching and credit loads
	Graduate Council, Academic Affairs Board	1996	b. Develop a private practice plan.	Work w/ASHA on dissemination

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
4. Find ways to make salaries competitive.	ASHA ad hoc committee	1995	a. Develop a plan for obtaining cooperation from academic administration. b. Obtain additional funding sources. c. Develop a plan for obtaining cooperative partnership with business/industry for sponsorship of faculty to work in teaching, consulting, and research supported by the business/industry.	Work w/ASHA on dissemination
5. Consolidate institutions.	Council on Graduate Programs/AASB	1995-1996	Develop a plan on how to establish regional consortia. ($5,000)	
6. Recruit and promote and retain faculty of underrepresented groups.	Academic Affairs Board Multicultural Issues Board	1995	Develop a plan for mentorship.	Develop mentorship programs using faculty from throughout the university.
7. Address shortage of researchers.	Research and Scientific Affairs Committee, Vice President for Research and Technology, ASHA Research Department	1995-1996	a. Directory of researchers ($5,000). b. Detain additional funding sources other than tuition. c. Develop a plan for obtaining cooperative partnership with business/industry for sponsorship of faculty to work in teaching, consulting, and research supported by the business/industry.	

Group # 2 Group Name: EDUCATIONAL STRUCTURES AND MISSION AND EVALUATION

Issue #1 Encourage and promote flexible program models that result in quality speech-language pathology and audiology practitioners and scholars.

Barriers:

Programs need cost analysis instruments.
Accreditation, licensure, certification, standards, and legislative mandates.
Lack of efficacy studies for academic and clinical education in communication disorders.
Similarities of clinical education models across programs.
Innovation discouraged.
Institutional inertia.
Faculty inertia.
Attitude within profession that: "We're already good; and we don't need to look outside the professions."
Technophobia.
Limited rewards for creative technology involvement.

Solutions:

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
1. Modify standards.	Council on Academic Accreditation (resources approved), Educational Standards Board, Professional Standards Board	1997	Additional resources for peer review may be needed (see ASHA data vis a vis standards change cost analysis).	
2. Provide incentives for innovative program models.	ASHA Convention Committees, Universities, CGPSCD, ASHA, SPPB, NAPPA, CUSPA	Agenda item for next ESB and CAA	Training and equipment costs will vary across institutions.	

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
3. Technology.	AAB, CAA, Practitioner RPOs, CGPSCD, Universities	1/1/97	Communication and dissemination.	
4. Encourage practitioner involvement in defining program outcomes and approaches.	See Issue 2			
5. Define competencies for program graduates.	Refer to Group 5			
6. Encourage efficacy studies for academic and clinical training models (including role and value of partnerships).				

Group # 2 **Group Name: EDUCATIONAL STRUCTURES AND MISSION AND EVALUATION**

Issue #2 Establish competencies for entry into clinical practice across the practice continuum.

Barriers:

Fear of becoming too prescriptive.
Problems in defining level of educational preparation.
Difficulty defining the nature of competency.
Lack of consensus regarding practitioner outcomes.
Lack of well established training program models at levels for entry other than the masters level.
State agencies and other groups are already defining competencies and credentialing.
Resistance within the profession to acknowledge need for multiple practice levels.
Impact of move toward multi-skilled practitioner model.
No efficacy data concerning competencies across practice.
Limited rewards for creative technology involvement.
Lack of speech-language pathology and audiology collaboration (proprietary focus).

Solutions:

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
1. Develop competency across entry level practice levels.	Audiology, Speech Language Pathology	Audiology entry level-1996, support personnel to be determined. Speech-Language Pathology entry level 1998, support personnel 1997.	Costs for entry level Speech-Language Pathology will be similar to Audiology study already underway. Support personnel for Speech-Language Pathology underway. Support personnel for Audiology unknown.	
2. Flexibility in standards.				
3. Efficacy studies for educational models to develop competencies.				

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
4. To assist educational programs to identify and seek funding for 1 and 3.				
5. To collate and disseminate data concerning state level practice patterns (e.g. speech assistants and their training and certification by state education boards).	Academic Affairs Board	July 1995	Per ASHA formula	

Group # 2 Group Name: EDUCATIONAL STRUCTURES AND MISSION AND EVALUATION

Issue #3 Need to invigorate research base of the professions.

Barriers:

Shortage of researchers.
External forces directing our attention away from research training (towards clinical).
Limited post doc opportunities.
Not enough students going into research.
Lack of financial incentives.
Drying up of research funds.
Renewed focus on teaching in higher education.
Junior faculty.
Not enough emphasis upon research in curriculum at undergraduate and graduate level.
Traditional teaching models and curricular sequences.

Solutions:

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
1. Develop honors programs.	Universities	1995	Faculty time and commitment to honors program.	
2. Encourage flexibility in tracking of students to identify capable, interested students early.	Universities	1995	Faculty time and commitment to identifying students.	

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
3. Develop more student research rewards.	Universities, NAPP, CGPCSD, ASHA, ASHA Foundation, NSSLHA	1995	Outside funds from outside agencies, corporations, sponsors, etc. to support cash awards. Tuition waivers or travel funds from universities could be awards. Alumni scholarships. State funds for undergraduate research awards.	
4. Explore possibility of corporate partnerships for research.	Universities (ASHA could identify)	1995	ASHA personnel to identify possible sources & dissemination of this information. ASHA & Graduate Council meetings could present model programs.	
5. Develop incentives to finish dissertation prior to leaving institution.	Mentoring, encouragement through networking so students do not exit prematurely or without doctorate. Academic Affairs Board. Bulletin boards for Ph.D students.	1995	ASHA network of possible mentors. Faculty time and interest.	
6. Academic Affairs and CGPCSD review and follow up on documents from NIH research training needs conference of 1994.	Academic Affairs Board of ASHA, CGPCSD, MAO.	Should be on agendas for 1995 or 1996.	ASHA Academic Affairs Board, Graduate Council, and MAO to review and spearhead implementation.	

Group # 3 **Group Name: MANAGING CHANGE**

Issue #1A Maintain clinical contacts in the real world: Involvement.

There is a need to make individuals in academic settings aware, in a continuously updated fashion, of issues, trends, and factors that have impact on higher education and/or professional preparation in Audiology and/or Speech-Language Pathology.

Barriers:

Difficult to track diverse and fast paced issues.
Some individuals are comfortable with and committed to the status quo.
Feedback received may reinforce the status quo.

Solutions:

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
1. Article describing the issues, and providing a proactive challenge to engage in changes (include summary of solutions from Academic Colloquy).	Academic Affairs Board	Spring 1995		Outcome measures Assessment tools 1. Individual assessment -benefits gained -three things learned -three things to do differently 2. Program assessment -changes made
2. Send reprints of article to Council of Graduate Programs, ASHA members in academic settings.	ASHA staff	Spring 1995	+$3,000	

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
3. Offer sessions/modules based on above information and report to: Council of Graduate Programs, Council of State Association Presidents, Director's Conference, 1995 ASHA Convention.	Academic Affairs Board, ASHA Health Services Division	1995		
4. Set up an e-mail update network.	Academic Affairs Board	Spring 1995	Need to be determined	

Group # 3 Group Name: MANAGING CHANGE

Issue #1B Maintaining clinical contact in the real world: Information.

In order to manage change effectively, it is important that faculty members maintain contact within the clinical environment, outside the university, to be aware of the factors affecting our field in assessment, services delivery, and outcome measures.

Barriers:

May be committed to or comfortable with the status quo.
Difficulty in finding opportunities.
Economic, regulatory issues, etc. (licensure, liability).
Limited recent clinical experience.
Lack of shared values between faculty and practitioners.
The constructs of the department or university may be such that each faculty member has his/her assigned activities, and this is not part of his/her responsibilities.

Solutions:

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
1. Identify existing placement sites/affiliations and utilization patterns.	Academic Affairs Board should communicate this strategy to faculty and staff via wake up call letter, etc.	Spring 1995		
2. Look at employment patterns and trends of recent graduates.				
3. Determine the match between #1 and #2 (above).				

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
4. Develop ongoing, interactive partnerships with sites as needed.				
5. Explore possibilities for faculty/staff to provide services at sites.				

Group # 3 Group Name: MANAGING CHANGE

Issue #3 Recruit and retention of minority and non-traditional students.

ASHA's Long Range Strategic Plan addresses the need to increase the number of minorities within the professions to mirror the percentages of minorities within the U.S. population. With the changing face of the U.S., more non-traditional students will be entering our programs.

Barriers:

Lack of support services for minority and non-traditional students.
Financial constraints.
Lack of faculty role models.
Lack of sensitivity, understanding, and awareness of cultural differences.

Solutions:

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
1. Review accreditation standards (are there ways to educate students faster and cheaper??).	ESB	March 1996		
2. Explore distance learning to link diverse faculty and/or student populations.	ESB	December 1995		
3. Develop a list of programs with funding for minority/non-traditional students.	MIB, OMA	March 1995		
4. Develop a list of funding sources at the federal level.	OMA	March 1995		
5. Develop a resource manual for program chairs to tap funding resources.	OMA	March 1995		

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
6. Infuse multicultural issues in curriculum (train faculty) via Sea Island, CGP and State Association Meetings; explore external funding to support wider attendance.	AAT, OMA, CSAP, CGP	December 1995		
7. Educate students and faculty about procedures for complaints of discrimination from students: -ASHA Convention -Council of Graduate Programs -NSSLHA -All minority organizations and caucus meetings.	EPB, NBASLH Caucus: Hispanic, Native American, Asian-Pacific Island	January-December 1995		

Group # 3 **Group Name: MANAGING CHANGE**

Issue #2 Involvement in the legislative process: Marketing and advocacy.

In order to manage change effectively, it is important for faculty to become involved in the legislative process, in marketing, and in advocacy for their programs, facilities, students, and the population needing their services.

Barriers:

Too many other demands on time.
Perceived lack of know-how.
Feeling that someone else is doing it.
Sense that they cannot make a difference.

Solutions:

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
1. Take on as a department task in collaboration with—	state associations' legislative committees, ASHA PAC/Governmental Affairs, Department members, Faculty/students, NSSLHA	1995-1996 academic year	Liaison with ASHA Political Action Committee.	
2. Educate staff and students regarding political process.	Department members	1995-1996 academic year	Focused mailing.	
3. Lobby/encourage students to get involved in the political process.	Faculty, staff, students	1995-1996 academic year	Exchange information with academic programs, ASHA, PAC.	
4. Contribute money.	Everyone	ASAP		

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
5. Devise means of incorporating relevant political information for classroom dissemination.	Faculty members	Immediately, as needed	Cooperation	
6. Develop a political consciousness among students.	Faculty members	1995-1996 academic year		
7. Awareness of and participation in Task Force on Treatment Outcomes.				
8. Explore possibility of faculty participation in advocacy module.	Vice President for Governmental Affairs			
9. Marketing the department within the institution.	Program at ASHA- (Academic Affairs Board)	1995 Convention		Marketing our department in a proactive vs a reactive manner.

Group # 4 Group Name: ACCREDITATION AND CERTIFICATION

Issue #1 Develop flexibility in accreditation standards which will encourage programs to be innovative and creative in meeting changes in the workplace and in higher education.

Barriers:

Existing state licensure laws.
Current standards.
ASHA "historical precedents."
Workload of current boards and ASHA staff.
Department of Education and Commission on Recognition of Postsecondary Accreditation regulations.
Lack of data to support changes.
Lack of universal agreement to change.

Solutions:

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
1. Review implementation of current standards to increase flexibility of meeting the standards.	ESB	1995-96	Current resources	
2. Allow programs to try pre-approved experimental approaches to educate students by: a. "creative" implementation of ESB standards and b. eventually "creative" implementation of CCC requirements.	Standards Council, ESB, and selected academic programs. Standards Council and CCB	1995-96 1995-96	Add 3 additional meeting days per year to the Boards involved. Additional meeting days.	

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
3. Develop a system to collect data to validate the approaches.	EB with Standards Council; CCB and ESB would develop an RFP	1995	Additional meeting days. Literature searches and consultants.	
4. Develop outcome measures for accreditation of educational programs.	ESB and CAA	1995-96	Literature searches and consultants.	
5. Unbundle accreditation and certification.	Standards Council and CCB	1995-96	Additional meeting days.	

[redacted]

Group # 4 **Group Name: ACCREDITATION AND CERTIFICATION**

Issue #2 Develop flexibility in certification.

Develop standards that encourage/allow programs to be creative in meeting changes in the work place and higher education environments.

Barriers:

Existing state licensure laws.
Current standards.
ASHA "historical precedents."
Workload of current boards and ASHA staff.
Department of Education regulations.
Lack of data to support changes.
Lack of universal agreement to change.
Marketplace expectations.
Prevailing attitude of lifetime certification.

Solutions:

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
1. Re-evaluate the appropriateness of the current assumptions concerning: • knowledge, skills and attributes required for independent practice, • renewal mechanisms, • audiologists/speech-language pathologists-same/different, • general, i.e., audiologists and speech-language pathologists combined, • role of clinical fellowship.	Task Force	1995-96	Meeting expenses	

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
2. Develop and evaluate appropriate outcome measures for certification.	Standards Council Develop RFP	1996-97	Literature searches, consultants, meeting expenses	
3. Reduce numerical/specific requirements, e.g., courses, hours, categories (ages, disorders).	Standards Council, state licensing boards, and Clinical Certification Board	1996-97	Meeting expenses	
4. Include system for trying and evaluating alternative models.	Clinical Certification Board, state licensure boards, and educational programs.	1996-97		
5. Consider the following possibilities: • base level certificates with endorsements, • core information, e.g., science, ethics, attributes, normal process vs abnormal, problem solving, identification, etc. • identification of pre-service and inservice knowledge, skills, attributes.				

Group # 5 **Group Name: CURRICULUM AND INSTRUCTION**

Issue #1 Develop and evaluate models of education.

Barriers:

Lack of availability.
Current accreditation guidelines.
Lack of faculty buy-in.
Development costs (including faculty, technology, etc.).
Funding.
Who comprises and monitors review panel.
Breaks the status quo.
Timeframe.
Access to technology.
Institutional priorities.
Territoriality.
Lack of expertise.
Resistance to change.

Solutions:

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
1. Develop an RFP for innovative models of education for comparison to existing models.	Educational institutions/units preparing practitioners for entry level professionals.	Month #1 - announce RFP. Month #2 - letter of intent, brief description of project, projected costs.	$150,000 to $300,000 (excluding funding agency overhead) depending on number of awards.	Proposal must show evidence of cost containment. Respondents required to meet at onset and develop common outcome measures.

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
Continued— 1. Develop an RFP for innovative models of education for comparison to existing models.		Month #4 - screening completed. Month #7 - detailed descriptions for those selected from screening process. Month #11 - funding to begin.		Proposals involving multiple funding from other sources are encouraged. Proposal should show evidence of science and technology. To be overseen and monitored by the Academic Affairs Board. Review panel comprised of individuals with appropriate expertise for reviewing models of education.

Group # 5 **Group Name: CURRICULUM AND INSTRUCTION**

Issue #2 Redefine practicum so that it is readiness-and competency-driven.

Barriers:

Resistance to change.
Harder to evaluate.
Lack of competency based criteria.
Harder to administer.
Lack of adequate linkage to competency based coursework.
Current accreditation standards (for example, clock hours).
Places greater burden on supervisors.
Current grade inflation in practicum.
ASHA Code of Ethics.

Solutions:

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
1. Modify practicum requirements so that they are competency - vs hourly-driven. Mechanism to do this would be to combine didactic and practical components in all coursework. This would involve forming partnerships with supervisors, both internal and external, and other groups involved in the clinical training of our students.	Academic Affairs Board in consultation with the Standards Counsel/ESB.	To begin by January 1995	None	Creativity, open mindedness, and flexibility.

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
Continued— 1. The goals then of our courses would include not only expanding the knowledge base of a particular area but also preparing students to become practitioners in that area. If this is accomplished, we would be able to abolish the Clinical Fellowship experience.				
2. Develop a set of competency guidelines for beginning level practitioners in speech-language pathology along the lines of what is currently being developed for audiologists.				
3. Develop and implement competency - versus hourly-based standards for the CCC.				

Group # 5 Group Name: CURRICULUM AND INSTRUCTION

Issue #3 Address recruitment/shortage of doctoral students.

Barriers:

Solutions:

WHAT	WHO	WHEN	RESOURCES NEEDED	OTHER
1. Address recruitment and shortage of doctoral students.	Academic Affairs Board	As soon as possible.		

Appendix B: Colloquy Agenda

AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

Educating Future Professionals: A Colloquy on Challenges and Solutions for Academia

December 9 - 11, 1994

National Office
American Speech-Language-Hearing Association
Rockville, Maryland

Anticipated Outcomes of the Colloquy

1. **Participants will develop an awareness of the external and internal influences that are changing our professional environment and the way we provide services, and influencing the way we educate future practitioners.**

2. **Participants will develop strategies to incorporate the expanding scope of practice into the curriculum.**

3. **Participants will explore strategies and action plans to promote new models of preparation--including identifying barriers to development of models and exploring the roles professional organizations play in promoting the development of new models.**

4. **Participants will explore strategies to enable faculty to respond to the changing environment and incorporate "change" strategies into their environment.**

5. **At the end of the colloquy, the group will have developed recommendations and an action plan for methods of dissemination to all constituencies in the academic community and practice community involved in and effected by academic preparation.**

6. **Participants will develop strategies for forming alliances in the changing financial environments that will result in shared information, realistic educational programming and clinical experience for future practitioners.**

7. **Participants will develop a list of priority topics in addition to those addressed at the conference for future consideration.**

10801 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852 301-897-5700 VOICE OR TDD FAX 301-571-0457

Educating Future Professionals:
A Colloquy on Challenges and Solutions for Academia

Program Agenda

Friday, December 9, 1994

9:30 - 9:45	**Welcome and Introduction to Colloquy** Jeri Logemann, PhD, President American Speech-Language-Hearing Association
9:45 - 10:15	**Looking at the Big Picture - Changing Fiscal, Policy, Demographic, and Technological Environments in Higher Education** Julia Davis, PhD, Chair ASHA Academic Affairs Board
10:15 - 10:30	**Questions and Answers**
10:30 - 11:00	**National Healthcare Reform Issues: The Changing Face of Healthcare as It Impacts on the Preparation of Students** Frederick Spahr, PhD, Executive Director American Speech-Language-Hearing Association
11:00 - 11:15	**Questions and Answers**
11:15 - 11:30	**BREAK**
11:30 - 12:00	**Educating Future Professionals: The Purchaser's Perspective** Glenn Markus Principal Health Policy Alternatives
12:00 - 12:15	**Questions and Answers**

12:15 - 1:15	**Lunch**
1:15 - 1:45	**Changes in Professional Practice in Audiology and Speech-Language Pathology** James Jerger, PhD Director of Audiology Services Baylor College of Medicine Jeri Logemann, PhD President American Speech-Language-Hearing Association
1:45 - 2:00	**Questions and Answers**
2:00 - 2:30	**Innovative Preparation Models** Arthur Guilford, PhD, Chair Department of Communication Sciences and Disorders University of South Florida
2:30 - 2:45	**Questions and Answers**
2:45 - 3:00	**BREAK**
3:00 - 3:30	**Federal Activity Affecting Higher Education** Mary Ann Phelps, PhD, Chief of Staff Office of Post-Secondary Education United States Department of Education
3:30 - 3:45	**Questions and Answers**
3:45 - 4:45	**Conversation With the Presenters** (Panel of all Presenters)

Saturday, December 10, 1994

9:00 - 10:00	**Summary of Forces Impacting Education and Potential Changes in Education** Jeri Logemann, PhD, President American Speech-Language-Hearing Association
10:00 - 11:30	**Brainstorming on Issues for Academia** Gloria Kellum, PhD Vice President for Academic Affairs American Speech-Language-Hearing Association
11:30 - 12:00	**Identify Issues to be Addressed in Five Action Groups** **Discuss Goals and Procedures for Action Groups** Gloria Kellum
12:00 - 1:15	**Lunch (Sign Up for Action Groups)**
1:15 - 3:30	**Small Group Discussions**
3:30 - 3:45	**BREAK**
3:45 - 4:15	**Small Group Discussions - Continued**
4:15 - 5:00	**Preliminary Reporting of Small Groups in General Session**

Sunday, December 11, 1994

9:00 - 10:00	**Responses to Group Reports of Previous Day** Gloria Kellum-facilitator
10:00 - 12:00	**Continued Small Group Discussions**
12:00 - 1:00	**Lunch**
1:00 - 1:30	**Report of Group 1**
1:30 - 2:00	**Report of Group 2**
2:00 - 2:30	**Report of Group 3**
2:30 - 3:00	**Report of Group 4**
3:00 - 3:30	**Report of Group 5**
3:30 - 3:45	**BREAK**
3:45 - 4:30	**Summary and Development of Comprehensive Action Plan** Jeri Logemann

Appendix C: Colloquy Participants

Educating Future Professionals:
A Colloquy on Challenges and Solutions for Academia

PARTICIPANTS

Dolores Battle
John Bernthal
Celeste Bilodeau
Jean Blosser
Patrick Carney
Donald Counihan
Nancy Creaghead
Juanita Doty
John Ferraro
Michael Flahive
Tanya Gallagher
Donna Geffner
Vic Gladstone
Larry Higdon
Hortencia Kayser
Noel Matkin
Maurice Mendel
Janice Monk
James Naas
Marilyn Newhoff
Debra Osborn
Thomas O'Toole
Harold Powell
Judith Rassi
Danielle Ripich
Tommie Robinson
Barbara Samuels
Barbara Shadden
Barbara Sonies
Ida Stockman
Richard Talbott
Terry Thies
Daniel Tullos
Sandra Ulrich
John Wegener

FACULTY

Julia Davis
Art Guilford
James Jerger
Gloria Kellum
Jeri Logemann
Glenn Markus
Mary Ann Phelps
Fred Spahr

STAFF

Zenobia Bagli
Karen Beverly-Ducker
Dorise Blatt
Patty Brown
Ellen Fagan
Barbi Ferguson
Kathy Fisher
Sharon Goldsmith
Diane Hambright
Iola Jones
Diane Paul-Brown
Kay Payne
Arlene Pietranton
Gail Smith
Donna Vernon
Laurie Wilson
Denise Wynter

Appendix D: ASHA Executive Board

ASHA Executive Board

1994

Jeri A. Logemann, PhD
President
Northwestern University
Evanston, IL

Judith K. Montgomery, PhD
President-Elect
Chapman University
Orange, CA

Crystal S. Cooper
Vice President for Professional Practices
Tuscaloosa City Schools
Tuscaloosa, AL

Tanya M. Gallagher
Vice President for Research and Technology
McGill University
Montreal, Quebec, Canada

Vic S. Gladstone
Vice President for Administration and Planning
Towson State University
Baltimore, MD

Gloria D. Kellum
Vice President for Academic Affairs
University of Mississippi
University, MS

Thomas J. O'Toole, PhD
Past President
JCT, Incorporated
Gaithersburg, MD

Frederick T. Spahr, PhD
Executive Director

Nancy B. Swigert
Vice President for Governmental and
Social Policies
Swigert and Associates, Inc.
Lexington, KY

Sandra R. Ulrich
Vice President for Quality of Service
University of Connecticut
Storrs, CT

1995

Judith K. Montgomery
President
Chapman University
Orange, CA

Katharine G. Butler
President-Elect
Butler Associates
Monterey, CA

Crystal S. Cooper
Vice President for Professional Practices
in Speech-Language Pathology
Tuscaloosa City Schools
Tuscaloosa, AL

Donna Geffner
Vice President for Academic Affairs
St. John's University
Jamaica, NY

Vic S. Gladstone
Vice President for Administration and Planning
Towson State University
Baltimore, MD

Lawrence W. Higdon
Vice President for Professional Practices
in Audiology
AudioLabs/Sound Advice
Austin, TX

David P. Kuehn
Vice President for Research and Technology
University of Illinois
Champaign, IL

Jeri A. Logemann
Past President
Northwestern University
Evanston, IL

Frederick T. Spahr
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Nancy B. Swigert
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and Social Policies
Swigert and Associates, Inc.
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Sandra Ulrich
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University of Connecticut
Storrs, CT

Appendix E: Academic Colloquy Follow-Up

Academic Colloquy Follow-Up

Colloquy proceedings will continue to be marketed and distributed at no cost. The Academic Affairs Board will determine which activities, based on the Colloquy Blueprint, they will assume in 1996. National Office staff will continue to search for external funds to support follow-up colloquy activities, including another conference for the academic community based on the model approved by the Executive Board in 1995.