



**Final Report of the
Ad Hoc Committee to Plan Next Steps to
Redesign Entry-Level Education for
Speech-Language Pathologists
December 2023**

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Executive Summary

The Ad Hoc Committee to Plan Next Steps to Redesign Entry-Level Education for Speech-Language Pathologists (“Next Steps Committee”) explored six topics that are pivotal to transforming education in speech-language pathology. This exploratory effort was directed towards identifying solutions to address longstanding problems, threats to sustaining the profession, and to meet evolving demands. Brief summaries and recommendations for each topic are provided in this section and are elaborated upon in Sections III–VIII. This executive summary was composed by humans with the assistance of Claude.ai.

Future of Learning, Work, and Teaching: Summary

- Advances like artificial intelligence (AI), telepractice, and big data are changing education and health care delivery, necessitating digital literacy and adaptability from clinicians and educators.
- Workplace needs are shifting to prioritize “21st century skills” like critical thinking, collaboration, and empathy over disciplinary knowledge. These transferable competencies need to be formally cultivated.
- Graduates need to be ready to enter the workforce career-ready with broad discipline-specific knowledge and well-cultivated clinical and 21st century skills. Moreover, they need to be equipped with a set of skills, habits, and attitudes that can help them adapt to evolving demands and disruption throughout their careers.
- The role that 21st century skills play in helping one keep pace with change throughout one’s career intersects with (a) the ability to adapt to new technologies and (b) information and research literacy. Students must become adept at learning and applying new tools and approaches, be skilled at finding and distinguishing trustworthy information from misinformation and be practiced at using trustworthy information to solve complex problems.
- Pedagogy must align with the science of learning and the scholarship of teaching and learning to promote expertise in learning, critical and reflective thinking, and growth mindsets to support essential lifelong learning.
- Academic programs need to foster an inclusive culture and incorporate culturally responsive teaching to prepare students for working in a diverse society.
- Efforts to expand accessibility, support student well-being, and nurture community are imperative for learner success.

Future of Learning (Work and Teaching): Recommendations

1. Cultivate and evaluate 21st century skills like critical thinking and cultural responsiveness.
2. Align pedagogy with science of learning to promote deep learning and foster expert learner skills.
3. Expand access to education through online/hybrid delivery.
4. Enhance support for learners with diverse backgrounds.
5. Promote the mindset that collaboration and lifelong learning are central to our personal and professional identities.

Alternative Educational Models: Summary

- Concerns voiced by faculty and employers about the future of the profession stem primarily from the dilemma that 2-year programs cannot adequately cover the expanded scope of practice in speech-

language pathology. Upon graduating, students often lack entry-level competencies in key areas like dysphagia, autism, augmentative and alternative communication (AAC), and medical settings. These longstanding concerns are compounded by the mounting reimbursement and workplace policies and pressures that constrain the availability and time of external supervisors who might otherwise be able to help students fill key gaps and cultivate important workplace competencies.

- **Alternative educational models** that could help address these challenges were considered, including the following:
 - **New Lifespan Model:** Extending master’s to more than two years to allow entry-level mastery across the full scope of practice and lifespan.
 - **Track Model:** Separate adult and pediatric concentrations with a shared common core curriculum. Practica are geared towards track specialization in the second year.
 - **Modular Model:** Customize required competencies based on a subdivision (e.g., 12) of the clinical areas in speech-language pathology, wherein graduates are not expected to master all areas, maybe half, but later can add areas through professional development.
 - **Educational Stages:** Changes at the undergraduate, clinical fellowship, and post-graduate stages may also improve preparation as well as promote critical thinking and lifelong learning.
 - **Competency-Based Education:** Competency-based frameworks outlining skills and milestone levels could facilitate personalized, self-directed learning and could provide methods of self-evaluation, gap detection, and connection of learners with targeted resources.
- Currently, there is no consensus about whether it is wise to proceed with any of the alternative educational models described above. Based on the aggregate survey results, 96% of 137 respondents indicated that it is “very” or “somewhat” critical “to reconsider the educational model for preparing speech-language pathologists to enter practice” (see Question #9, Appendix A). Although viewpoints on specific solutions differed, participants agreed that sustaining the profession will require embracing change and being adaptable.

Alternative Educational Models: Recommendations

1. Consider extending the entry-level degree program’s duration to enable entry-level mastery across the scope of practice across the lifespan **or** restructuring the curriculum into tracks or modules to improve students’ educational outcomes and readiness for practice.
2. Develop both collaborative and self-directed learning opportunities based on a competency-based educational framework to enable personalized pacing tailored to the learner’s needs at any stage.
3. Promote further consideration of how the undergraduate program, clinical fellowship, and professional development opportunities could help shore up acquisition of entry-level competencies.

4. Create a grant mechanism to support educational programs to conduct demonstration projects and research that aims to address how academic programs can better prepare SLPs for the future of work.

Competency-Based Education: Summary

- Competency-based education (CBE) focuses on demonstrated mastery of competencies rather than simply the completion of required clock hours. It promotes self-paced, personalized learning trajectories tailored to strengths and developmental needs.
- A CBE framework could be instrumental in addressing gaps in entry-level preparation.
- A CBE framework could help SLPs evaluate their own knowledge, skills, and competencies. Professional development content structured within a CBE framework would facilitate access to customized learning opportunities, which would help learners to easily find resources to address competency gaps and to transition into new areas of practice.
- A CBE framework could provide greater transparency about the areas in which a speech-language pathologist (SLP) is sufficiently qualified to practice or has advanced levels of expertise.
- CBE could strengthen preparation for professional practice and lifelong learning, cultivation of essential 21st century skills, and support for career transitions and professional development.
- Implementation challenges would likely include (a) paradigm shifts in higher education, health care, and school-based practice settings; (b) the risk of inconsistent implementation across programs; (c) complexities in competency measurement; (d) implementation of student progression policies; and (e) cost management.
- Redesigning education for SLPs within a CBE framework could provide the granularity and flexibility needed for the profession to meet evolving demands and adapt to future challenges and opportunities.

Competency-Based Education (CBE): Recommendations

1. Research the perspectives of stakeholders in higher education, health care, and school-based practice settings—and with standards-setting bodies—to develop a CBE implementation plan.
2. Collaborate with those communities who would be most directly involved and affected to identify risks, to gain insights about barriers to adoption, to engineer for feasible implementation, and to benefit from their partnership through every stage from inception to widespread national adoption.
3. Determine methods to work with clinical and academic stakeholders to (a) inventory clinical area-specific and practice setting-specific competencies and (b) identify cross-cutting competencies needed at the entry level across practice settings.

4. Create competency standards that distinguish entry level from advanced practice.
5. Provide extensive training, tools, and community support to assist programs in transitioning to CBE.
6. Develop policies and other supports to mitigate risks related to student progression and program inconsistencies.
7. Develop a specialty credentialing system that encompasses areas of clinical and professional competencies with tiers to signal levels of expertise and to guide professional development.

Faculty Sufficiency and Development: Summary

- Shortages of PhD-trained faculty pose major threats to programs' capacity to (a) fully cover the scope of practice, especially in specialty areas like dysphagia, autism, and AAC and (b) work in medical settings. This challenge is exacerbated by limited PhD faculty pipelines coupled with significant growth in the number of graduate programs in speech-language pathology over the past decade.
- Creative solutions are needed—for example, competency-based credentialing of clinical experts, alternative terminal degree pathways, shared online resources, cross-institutional consortia, and advocacy efforts that target policies, funding, and support for diverse faculty.
- Enhanced pedagogical preparation in PhD and clinical doctoral programs in speech-language pathology are needed, as is ongoing professional development to strengthen teaching excellence. Efforts to recruit, retain, and support diverse faculty are vital.
- Teaching, supervision, leadership, and research productivity in the science of teaching and learning (SoTL) should be more valued in hiring, promotion, and tenure processes.

Faculty Sufficiency and Development: Recommendations

1. Expand funding and create alternative pathways to increase not only the pipeline of PhD students but also the diversity of students within that pipeline.
2. Intentionally prepare and engage SLPs with clinical doctorates as teachers and supervisors. Explore ways to support training in pedagogy for clinical doctoral students.
3. Offer pedagogical preparation for PhD students and students in clinical doctoral programs in speech-language pathology and incentivize ongoing professional development for faculty related to pedagogy.
4. Develop a specialty credentialing system that encompasses areas of clinical and professional competencies that include teaching and supervision as professional competency areas.
5. Offer stackable digital badges and micro-credentials in key skill areas (e.g., competency-based assessment, problem-based learning, culturally responsive teaching).
6. Create a portal with information geared to the academic community—including an open-access database of communication sciences and disorders (CSD) teaching and supervision resources.
7. Explore team teaching, cross-institutional consortia, and other shared faculty models to leverage limited resources and faculty capacity.
8. Advocate for policies that value—and a culture that values—teaching excellence.

Student Diversity: Summary

- Diversifying the field is critical, but programs face interrelated barriers that hinder recruitment of underrepresented students, including
 - minimal awareness of the speech-language pathology career field among underrepresented communities;
 - traditional admissions practices that disadvantage these applicants;
 - underrepresentation of diversity in the current workforce; and
 - educational costs.
- Factors that threaten retention include
 - lack of role models and mentoring,
 - financial constraints,
 - clinical placement concerns,
 - inflexible matriculation requirements, and
 - departmental cultures that are not sufficiently inclusive.
- Solutions require improving
 - awareness of the speech-language pathology career field within underrepresented communities,
 - holistic admissions for graduate school,
 - mentoring and support systems,
 - flexible pacing,
 - cultural awareness education, and
 - purposeful cultivation of a culture of inclusivity in which programs embrace diversity.

Student Diversity: Recommendations

1. Conduct outreach showcasing careers and provide hands-on learning opportunities to high school students from underrepresented communities.
2. Promote holistic admissions and tailored support systems for underrepresented students.
3. Provide cultural humility and implicit bias education for faculty, staff, and students.
4. Offer proactive advising, mentoring, counseling, and other support customized to the needs of first-generation, underrepresented, and other diverse students that can aid retention and promote success.
5. Encourage inclusive teaching by providing faculty development around how to structure classes equitably and communicate expectations for diverse learners.
6. Cultivate a culture of inclusivity in programs—one that embraces diversity.

Clinical Experiential Learning: Summary

- The paucity of high-quality placements across settings that can take students was the most critical concern of the 151 respondents to the Next Steps survey (see Question #10, Appendix A). The scarcity of medical outplacements has reached critical levels of concern.

- The degree of burden on, and lack of incentives for, outplacement supervisors pose challenges to the sustainability of an educational model that relies so heavily on volunteers.
- High productivity requirements and high workloads and caseloads make it difficult for SLPs to take on students.
- Taking on students is discouraged due to employer restrictions and other reasons.
- Gaps between academic and real-world clinical realities make outplacement experiences a big adjustment for students and contribute to the administrative burden required to onboard students in external placements.
- Typically, there are minimal training requirements to be a clinical educator or supervisor—and no formal means of evaluating and improving skills in these areas.
- Students often lack essential professional and clinical skills upon graduating—in large part because entry-level competencies across the scope of practice are difficult for students to obtain under the current educational model.
- Transitioning to a CBE framework with clear standards and milestones is recommended but will require extensive research, collaboration, coordination, and training to successfully implement at the national level.
- Improved integration of didactic and clinical learning and the use of innovative models like simulations, interprofessional labs, problem-based learning, and community partnerships are options that can enrich learning and preparation at the local level.

Clinical Experiential Learning: Recommendations

1. Integrate simulations, case studies, role play, interprofessional education activities, and problem-based learning into coursework to provide more opportunities to cultivate 21st century skills and basic clinical competencies early on. These opportunities also help students learn how to bridge theory and research to clinical practice.
2. Create virtual opportunities to connect students with specialized clinicians and a variety of practice settings.
3. Increase communication between academic and clinical faculty to align training. Jointly develop shared lectures, grand rounds, and problem-solving groups with academic and clinical faculty.
4. Provide support for new supervisors to ensure quality mentoring.
5. Provide classroom and lab experiences that scaffold clinical skills in areas like treatment planning, report writing, data collection, and cultivation of 21st century skills.
6. Develop and nurture relationships with community clinics, shelters, day programs, and others to expand external placements.
7. Create a shared vision of competency milestones among academic and clinical faculty and external clinical sites.

Cross-Cutting Recommendations

Ten recommendations that address cross-cutting needs across the six topic areas are as follows:

1. Develop national competency standards distinguishing entry versus advanced skill levels to guide education and credentialing.
2. Promote competency-based, personalized instructional models tailored to students' strengths and their individual developmental arcs.
3. Create a resource library with information geared to the academic community, including an open-access database of CSD teaching, supervision, and research resources.
4. Promote holistic admissions emphasizing 21st century skills.
5. Advance cultural responsiveness, inclusive cultures within academic programs, and implicit bias education.
6. Develop and promote interprofessional educational activities.
7. Expand early clinical experience via simulations, observations, and assistant roles.
8. Enhance faculty development in pedagogy, technology integration, and support of diverse learners.
9. Develop micro-credentials and stackable certificates for specializations across clinical and professional domains, which could culminate in specialty certification.
10. Advocate for funding, policies, and partnerships to mitigate barriers to recommended changes.

Key Recommendations for ASHA

The Future of Work, Learning, and Teaching

- ASHA could synthesize guidance from the science of teaching and learning (SoTL) to help programs implement pedagogical approaches that strengthen student engagement, critical thinking, and information and research literacy skills.
- ASHA could identify and disseminate pedagogical approaches and experiential learning activities that help cultivate 21st century skills.
- ASHA could work with the Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA) and the Council for Clinical Certification in Audiology and Speech-Language Pathology (CFCC) to incorporate 21st century skills into standards and with the Council of Academic Programs in Communication Sciences and Disorders (CAPCSD) to help foster alignment across academic programs regarding implementation.
- ASHA could curate and disseminate resources on culturally responsive approaches to teaching and guidance on nurturing an inclusive culture of learning.

Alternative Educational Models

- ASHA can provide technical assistance to academic programs considering alternative models of entry-level education, holistic admissions, and other innovative approaches.
- ASHA can create a grant mechanism to fund innovative educational demonstration projects and research on SoTL.

- ASHA can create a *CSD Education Innovation Community* site for sharing ideas, new models, resources, and reflections about ideas and pilot projects.
- ASHA can develop micro-credentials and stackable certificates across clinical and professional domains to guide professional development, improve clarity and transparency about the specific competencies needed for areas of practice, and perhaps to support pathways to specialty certification.

Competency-Based Education (CBE)

- ASHA can support the development of competency-based standards by gathering information from various people—stakeholders in educational programs, SLPs working in various practice settings, employers, state licensure boards, accreditation and certification bodies, and others—to develop a competency inventory across clinical areas and settings.
- ASHA can coordinate research to inform the development of a CBE framework and, later, to provide data to inform quality improvement efforts.
- ASHA can support the development of CBE and work with the CAA and CFCC to include competency-based components in accreditation and certification standards.
- ASHA can provide implementation support through toolkits, training, and communities of practice to help programs transition to CBE.

Faculty Sufficiency and Development

- ASHA can advocate for policies that support student loan and loan forgiveness programs.
- ASHA can provide professional development opportunities and resources tailored to CSD faculty needs.
- ASHA can create a resource library—including an open-access database of CSD teaching, supervision, and research resources and other information geared to support the academic community and to help to advance recommendations made within this report.
- ASHA can advocate for policies that support educational innovation and exploration of ways to strengthen the workforce supporting higher education in CSD.

Student Diversity

- ASHA can provide funding, conduct research, and advocate for best practices and standards around equity and inclusion.
- ASHA can curate resources and develop training materials for faculty and practicing SLPs to promote equity and inclusion.
- ASHA can facilitate networking and community building.
- ASHA can showcase innovators and innovative programs.

Clinical Experiential Learning

- ASHA can address the scarcity of medical outplacement opportunities by facilitating discussions with medical SLPs, health care administrators, clinical externship coordinators, and others in academic programs to identify what can be done to reduce burden and provide better incentives SLPs in medical settings to take on student clinicians.
- ASHA can advocate with insurers and decision makers to support policies that accommodate student internships in health care settings.

- ASHA can create toolkits and training materials to help programs shift their clinical education to competency-driven models.

This executive summary highlights the key insights and recommendations from the full report, with the goal of transforming graduate education in speech-language pathology through competency-based, research-informed, and student-centered approaches. Successfully transforming CSD education requires a multipronged, coordinated strategy across stakeholders. Although individual groups can drive change through their respective roles, collective impact will arise from interdependent efforts aligned around common goals. Widespread changes are needed to address evolving demands and will require strategic collaborations and phased implementation planning to chart an attainable path forward. This report is written to help those who take up the charge to know what challenges, concerns, and opportunities have been identified by stakeholders and what potential solutions have been suggested.

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Report of the Ad Hoc Committee to Plan Next Steps to Redesign Entry-Level Education for Speech-Language Pathologists

I. Introduction

Charge

By resolution (BOD 9-2021), the Ad Hoc Committee to Plan Next Steps to Redesign Entry-Level Education for Speech-Language Pathologists (hereafter, “Next Steps Committee”) was established with the following goal:

Advance discussion and planning to redesign entry-level education for SLPs and formulate recommendations for the ASHA Board of Directors (BOD) about how comprehensive input might be obtained from a large group of stakeholders to advance entry-level education for SLPs.

The Next Steps Committee should take into consideration the report of the Ad Hoc Committee on Graduate Education for Speech-Language Pathologists (AHC-GESLP) in its planning, especially with respect to the following four questions:

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

Committee Composition

The 22 volunteer committee members, 10 ASHA staff consultants, and two co–ex officios are listed on page 1. The committee included (a) nine speech-language pathologists (SLPs) representing academic administration, persons with a clinical doctorate in speech-language pathology, board-certified specialists, persons with teaching and supervision experience, researchers, SLPs with experience working in schools and in health care; (b) the Vice Presidents for Academic Affairs in Speech-Language Pathology; (c) the Vice President for Practices in Speech-Language Pathology; and (d) the Vice-President for Standards and Ethics in Speech-Language Pathology.

Stakeholder committee members included representatives from ASHA’s Academic Affairs Board, the Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA), the Council for Clinical Certification in Audiology and Speech-Language Pathology (CFCC), the National Student Speech Language Hearing Association (NSSLHA), ASHA’s Specialty Certification Board, Special Interest Groups (SIGs) 10 and 11, and the Council for Academic Programs in Communication Sciences and Disorders (CAPCSD).

Methods

The Next Steps Committee held several meetings in 2021 and 2022, all remotely, to determine how best to gain more stakeholder input on specific issues so that recommendations could be formulated for what next steps could be taken to address the challenges and identify opportunities to advance education in speech-language pathology. Given that there are many challenges and opportunities, the Next Steps Committee decided that the most efficient path forward would be to subdivide into working groups on six broad topics. These topics, and the Working Group members who contributed to the work on each topic, are listed in Table 1 below.

Topics and Working Groups

Table 1. Participants in each Next Steps Working Group are shown in alphabetical order with the Working Group lead member listed first.

1. **Future of Learning**
Margaret Rogers
Meher Banajee
Jennifer Friberg
Kendrea Garand
Donna Smiley
2. **Alternative Educational Models**
Margaret Rogers
Andrea Bertone
Marnie Kershner
Carol Koch
Todd Philbrick
Sonja Pruitt-Lord
Patti Solomon-Rice
3. **Competency-Based Education**
Lemmietta McNeilly
Meher Banajee
Monica Ferguson
Kendrea Garand
Stacy Kaplan
Kimberlee Moore
Patti Solomon-Rice
Barbara Zucker
4. **Faculty Sufficiency and Development**
Ann Tyler
Jennifer Friberg
Stacey Kaplan
Loretta Nunez
Sonja Pruitt-Lord
Jennifer Richard
Linda Rosa-Lugo
5. **Student Diversity**
Lemmietta McNeilly
Melanie Alcala
Kyomi Gregory
Shubha Kashinath
Carol Koch
Sharon Moss
6. **Clinical Experiential Learning**
Ann Tyler
Melanie Alcala
Andrea Bertone
Amanda Gallagher
Shubha Kashinath
Nola Radford
Barbara Zucker

Webinars and Breakout Group Discussions

The Next Steps Committee planned the *Next Steps Summer Webinar Series* in 2022 to gather stakeholder input on each of the six topics listed in Table 1. Each Working Group hosted one or two webinars between June and August in 2022. A major effort was made to get widespread awareness of the *Next Steps Summer Webinar Series* in 2022 and to draw in stakeholders across employment settings, and anyone was welcome to register for these free information sharing webinars. Announcements were made to the general ASHA membership throughout the spring and summer of 2022 through most of ASHA’s communication channels—including social media, online communities for all SIGs and ASHA committees, *ASHA Now*, *The ASHA Leader*, and banners posted on the ASHA.org homepage. To ensure that people in the Midwest and on the West Coast of the United States could participate conveniently, two sessions of each webinar were held so that people could join at 5:30 p.m. on either coast. Recordings of the webinars were made available after the live webinar so that people could listen to them at any time.

Each Working Group met remotely for several months prior to hosting the webinars to determine which information within their topic area was most relevant and important for stakeholders to know about and discuss. Each Working Group developed a PowerPoint presentation to introduce their topic to the webinar participants. This introductory information was conveyed in approximately 30 minutes at the beginning of each webinar. After that, three to eight participants were placed into a Zoom breakout room, and they were allotted at least 1 hour for their discussion. Each Working Group developed a few questions that served as discussion prompts for these breakout groups.

The introductory presentations aimed to create a common understanding of the terms, concepts, critical issues, and extant efforts related to that topic. It was hoped that by “getting everyone on the same page” during the first part of the webinar, the ensuing breakout group discussions would focus more on potential solutions than on rehashing the problems. This introductory information is shared in the sections of this report devoted to each of the six Working Group topics (Sections III-VIII).

The breakout group discussions were recorded, and the participants had been informed about this in advance. The recordings were later transcribed, and any personally identifying information was removed. The Working Group members then analyzed the transcripts to identify themes related to challenges, opportunities, and potential solutions or recommendations.

The transcripts were also analyzed using Claude.ai, an artificial intelligence (AI) assistant created by Anthropic. Claude analyzed the raw breakout group transcripts and synthesized the key points into organized summaries. The Working Group lead for each topic reviewed and edited the detailed summaries of the breakout group conversations prepared by Claude. Each The AI-generated summaries were cross-checked to make sure that the themes identified by the Working Groups were included in the AI-generated summary—and that the final version captured the most important points accurately.¹

¹ *AI Disclaimer:* The AI-generated summaries on the breakout group discussions contained in this report were prepared by the AI assistant Claude.ai, created by Anthropic. Claude analyzed the raw breakout group transcripts and synthesized the key points into organized summaries. Although AI tools can help efficiently process large amounts of qualitative data, Claude’s summaries reflect an artificial intelligence’s interpretation of the transcripts. Each Working Group lead reviewed and edited each summary.

In Sections III-VIII of this report, an overview is provided of each Working Group topic, followed by the topic-specific survey results and a summary of the breakout group discussions. In each of these sections, an AI-generated summary of the breakout group discussion, created by Claude.ai and edited by humans, is shared. These summaries were extensively reviewed and edited by the lead member of each Working Group and others. Each lead member used the qualitative analyses generated by each Working Group to cross-check the AI-generated summary. The challenges, opportunities, and recommendations contained in the breakout group transcripts were captured exceedingly well by Claude.ai, and those few items that the Working Group identified as themes but that did not receive mention in the AI-generated summary were added to the final version of the summary by the Working Group lead.

This new process of (1) delivering a presentation via a webinar to set the stage for a focused discussion among stakeholders, (2) simultaneously recording, and later transcribing, several breakout group discussions, and (3) using AI to help summarize the results proved to be a successful proof-of-concept demonstration for ASHA. It provides an innovative way to gather and interpret detailed, open-ended input from many stakeholders. This method enabled the Next Steps Committee to gather and interpret detailed, open-ended input from more than 100 stakeholders, relatively more efficiently and easily than would have been possible even a year earlier.

Next Steps Surveys

The Next Steps Committee created a survey for each Working Group topic that was fielded to all webinar participants—regardless of whether they had participated in the live event or watched remotely. Eleven questions were included that were asked in all surveys. An additional two to five topic-specific questions were also included that were specific to the topic of a given webinar. At the end of every webinar, participants were asked to respond to a survey that included these topic-specific questions and the eleven common questions. People who watched the webinar remotely also had an opportunity to respond to the surveys, which remained open throughout the summer of 2022.

The aggregated results of the eleven common questions included on all of the surveys are shown in the *Aggregate Survey Report*, which appears in Appendix A. In Section II of this report, labeled “Aggregate Survey Summary,” a brief overview is provided of the results from the eleven common questions, which included six demographic questions and five general questions asking about the perceived state of education in speech-language pathology. A selection of representative responses to the two open-ended questions that were fielded on every survey are also shared in Section II of this report. These two questions asked about what’s working well and what’s not working well with the current educational model.²

A brief overview of the responses to the topic-specific survey questions appears in each Working Group section of this current document, under the heading “Stakeholder Input.” The full survey reports for each of the six Working Groups appear in Appendices B–G.

² The term “current educational model” is used numerous times in this report, and it was frequently used during the *Next Steps Summer Webinar Series* and on the surveys. This term was described simply to webinar participants using the following language: “The current educational model to prepare speech-language pathologists to enter practice is a master’s degree (approximately 2 years) comprised of academic and clinical educational experiences covering the full scope of practice across the lifespan.”

II. Aggregate Survey Summary

Next Steps Survey

Throughout the summer of 2022, a series of surveys were fielded as part of the *Next Steps Summer Webinar Series*. Individuals who participated in the live webinars, as well as those who viewed the recorded sessions, had the opportunity to complete a survey by August 30. Each survey included a set of eleven questions that were common across surveys, plus an additional set of two to five topic-specific questions that were asked only in relation to a specific webinar topic. The results of the eleven common questions are summarized in this section. Six of the common questions gathered demographic information about the respondents. The other five questions asked: (a) how well the current model is working; (b) what is working well (open-ended); (c) what is not working well (open-ended); (d) how critical is the need for change; and (e) how critical the need for change is across ten specific areas. A total of 151 individuals responded to the survey, 145 from the live webinars and six who viewed a recorded session. (Note that individuals may have completed the survey more than once if they participated in and/or viewed multiple webinars and, therefore, some individuals' responses may be included several times in the aggregate survey report.)

Demographic Overview of the Respondents

Demographic information was asked, including questions about certification, years of employment, primary employment setting, and primary employment function. In aggregate:

- A total of 151 individuals responded to the survey.
 - 91.4% were certified SLPs, and 5.3% were certified audiologists.
- Most (64.2%) had been employed in the professions for 21 or more years. The remaining respondents reported their employment as follows:
 - 13.2% for 16–20 years
 - 11.9% for 11–15 years
 - 10.6% for fewer than 10 years
- College/university was the primary employment setting for 85.0% of respondents. The remaining respondents reported primary employment setting as follows:
 - 7.5% in hospitals, residential and nonresidential health care facility
 - 1.4% in schools
 - 5.1% in “other”
- Faculty was the primary employment function for 90% of respondents. (They could check all that apply.) The remaining respondents reported primary employment function as follows:
 - 20.1% indicated chair/department head/manager.
 - 4.4% indicated supervisor.
 - 13.7% indicated clinical service provider.
 - 9.4% indicated other director/supervisor.
 - 7.2% indicated researcher.

Aggregate Responses to Five Common Questions

The aggregated responses to the three common questions with fixed response options that were included on every webinar survey across topics are presented below in Figures 1A-1C.

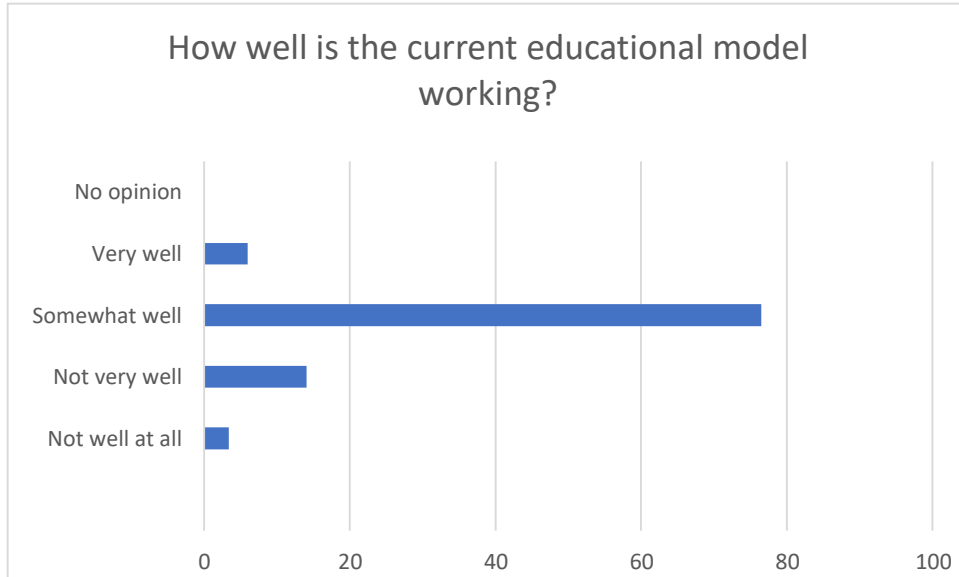


Figure 1A. Shows the aggregated responses (n = 149) to Question #7: How well is the current educational model working to prepare speech-language pathologists to enter practice?

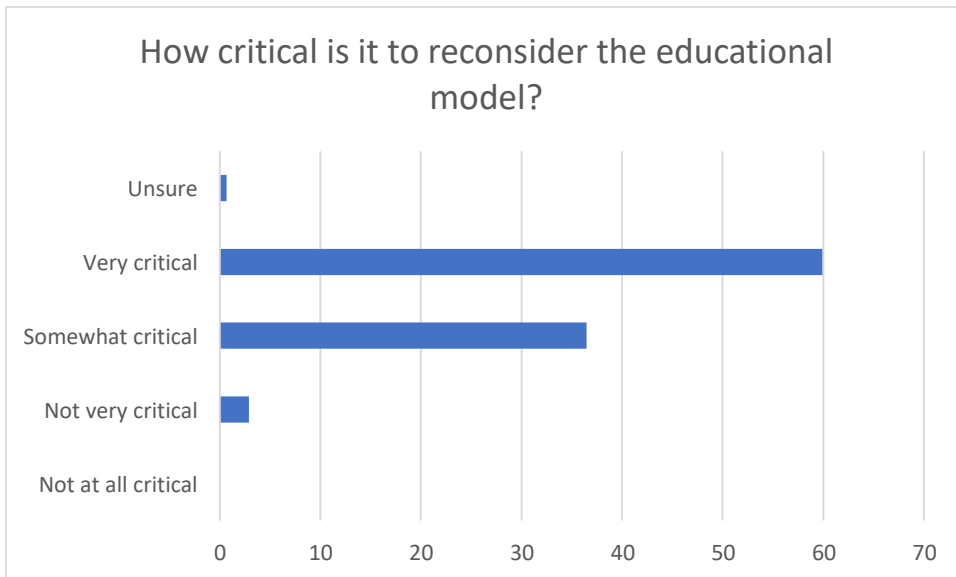


Figure1B. Shows the aggregated responses (n = 137) to Question #10: How critical is it to reconsider the educational model for preparing speech-language pathologists to enter practice?

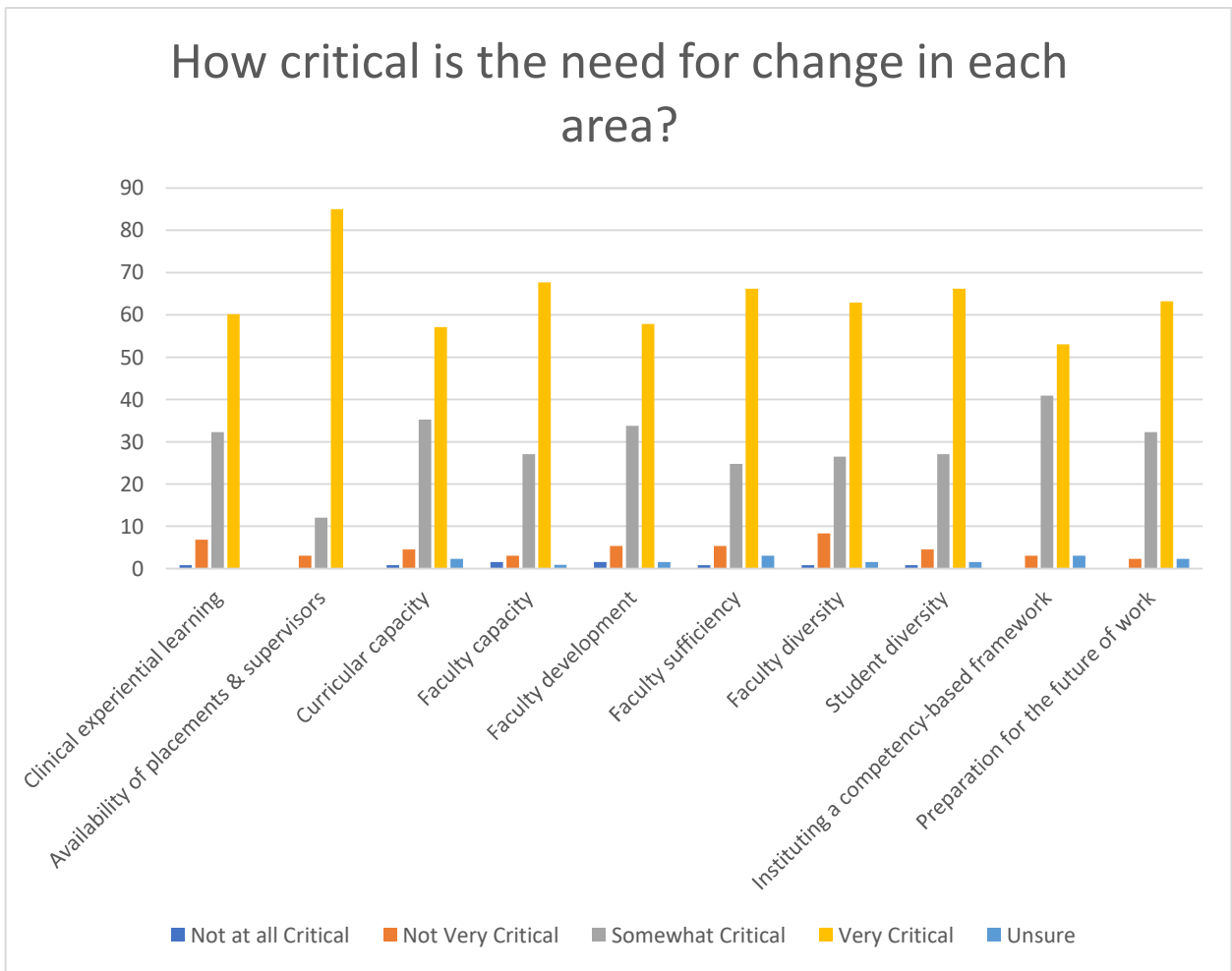


Figure 1C. Shows the aggregated responses (n = 131) to Question #10: How critical is the need for

Figure1C. Shows the aggregated responses (n = 131) to Question #11: How critical is the need for change in each of the following areas?

Comparison of What’s Working Well and Not Well

Responses to the two open-ended questions that were asked on every survey about how well and not well the current educational model is working are summarized below. These questions asked respondents to list up to three aspects of the current educational model that they consider to be working well (Question 8) and up to three that they consider to not be working well (Question 9). The nine themes below are syntheses of the participants responses. It is notable that participants generated both positive and negative comments about most of the themes, indicating that many aspects of the current model are viewed as having both positive and negative effects and attributes. There were two exceptions to this finding in that no participant listed anything as going well relative to undergraduate preparedness nor faculty sufficiency and capacity. Representative comments for each of the nine themes below are included to illustrate both the positive (when mentioned) and negative aspects of the current educational model.

1. [Degree length and scope of practice](#)
2. [Breadth and depth](#)
3. [Adequacy of entry-level preparation](#)
4. [Academic–clinic cohesion](#)
5. [Diversity and multiculturalism](#)
6. [21st century skills](#)
7. [Clinical educational model](#)
8. [Undergraduate preparedness](#)
9. [Faculty sufficiency and capacity](#)

Degree Length and Scope of Practice

Working Well

- 2-year degree controls student debt.
- Two years is a competitive length compared to other master's degree programs in and outside of our field.
- Students prepare/complete the program in a reasonable timeframe.
- Length of time isn't excessive.
- Able to cover scope fairly well in terms of classes and clinic.
- Coursework covers the lifespan.
- Students do get information across all areas.
- Exposure across the big nine.

Not Working Well

- 2-year degrees are very stressful for students.
- The graduate workload is PACKED.
- Too little time to cover everything that is required in standards.
- Not enough time to cover all the content and skills that students will need.
- Students don't have enough time to be ready for entry-level practice.
- Impossible to cover the full scope of practice.
- Full scope of practice is not covered or is covered insufficiently.
- Not achieving entry-level competence in all big nine areas.
- Lack of consistent preparation across the big nine areas.
- Not adequately covering all areas in the scope of practice.

Breadth and Depth

Working Well

- Ability to start general and specialize later.
- Breadth of clinical experience and academic knowledge acquisition.
- Generalist training allows clinicians to be flexible in their career.
- Students are generally able to get some opportunity to learn some areas in-depth.

Not Working Well

- Broad generalists with limited specialization.
- Students learn surface level.
- Lack of ability, resources, and opportunities for specialization.
- Our educational model creates a lack of "experts" in our field and also decreases confidence clients and other providers have in an SLPs ability to adequately treat specific disorders.
- Clinicians should be able to practice "at the top of their license" by providing excellent care in their specialized areas of expertise.

Adequacy of Entry-level Preparation

Working Well

- Students pass the praxis and earn employment.
- Students report feeling well-prepared in many areas in post-graduation surveys.
- Students are successful in their first employment settings.
- Workforce SLPs report excellent student preparedness.
- The current model "introduces" students to medical SLP.
- The current model prepares students to work in the schools. School CFYs are very prepared.
- Students receive a variety of clinical experiences.
- Students are prepared for basic clinical skills.
- Provides a general academic and clinical overview of the field.
- Generally strong clinical preparation.
- Students get foundational knowledge and skills.

Not Working Well

- Students leaving programs unprepared to practice.
- Clinicians lacking basic clinical and soft skills upon graduation.
- Significant challenge finding clinical placements, particularly in medical areas, that prepare students for entry-level medical work.
- Difficult to prepare students in competency in dysphagia if there is no medical university attached to the academic program.
- Dysphagia is minimally addressed in many academic programs.
- I'm a CAA site visitor, I'm in disbelief that almost all programs I've visited over 11 years are not providing clinical experiences and training in a skill set that is as life threatening as swallowing.
- Most students are NOT adequately prepared to work in medical settings.
- Students are generally not prepared to begin work in health care environments, requiring mentoring that employers frequently decline to provide on the understanding that the graduate has a degree and license, and it is assumed they are prepared to function independently.
- Medical sites are often unwilling to hire CFs stating that they need people who are ready to jump in with both feet with less mentoring than what they currently need Lack of preparation from undergraduate CSD programs.

Academic–Clinic Cohesion

Working Well

- Class-to-clinic connections.
- Collaboration between clinical and academic faculty.
- Students show some integration of clinic and classroom learning.
- Combining clinical practicum with academic learning.
- Academic learning is paired with clinical learning to develop students' ability to apply knowledge.

Not Working Well

- Coordination of courses with practica.
- Disconnect between academic theory/evidence and clinical application.
- Fragmented cohesion between academic and clinical learning.
- Moving EBP [evidence-based practice] from classroom teaching into clinical experiences.
- Lack of ability to align clinical experiences with academic curriculum.
- Coursework and clinic are not always connected.

Diversity and Multiculturalism

Working Well

- Increased use of hybrid education models and [the] embracing of telehealth practices have increased access for students to participate in degree programs.
- Current emphasis on multiculturalism and diversity.
- CLD [Cultural Linguistic Diversity] infused across the curriculum.

Not Working Well

- The diversity of both faculty and students is low.
- The full-time 2-year model is financially exclusionary for many people—[this] results in less diversity of backgrounds and experience.
- Increasing [the] diversity of faculty.
- Increasing [the] diversity of student body.
- Teaching cultural humility and culturally responsive practices.

21st Century Skills

Working Well

- Emphasis on evidence in clinical service.
- Students begin to learn how to interact with clients as professionals.
- Newer focus on DEI [diversity, equity, and inclusion] and IPE [interprofessional education] has been emphasized in many programs.
- Interprofessional practice opportunities are occurring.
- Increased awareness of need for EBP [evidence-based practice] in education; infusing EBP.
- Critical thinking skills.
- Application of problem-based learning.

Not Working Well

- Insufficient preparation in interprofessional education, cultural responsiveness, critical thinking.
- Development of problem-solving and critical thinking skills.
- Education is not meeting [the] shift in practice from memorizing all to knowing how to think critically and problem solve with available digital resources.
- Lack of general professional skills.

Clinical Educational Model

Working Well

- The requirement for the 450 clock hours.
- Theoretical knowledge.
- Clinical placements.
- Knowledgeable faculty.

Not Working Well

- Clinical clock-hour model is not a good model for comprehensive clinical skill development.
- Dependence on volunteers to provide clinical supervision and unrealistic expectations of external supervisors.
- Difficult to get external placements; [low] number of quality outplacement supervisors especially in medical settings.

Undergraduate Preparedness

Working Well

- No comments.

Not Working Well

- Graduate programs are having to spend 20% of class time covering UG [undergraduate] content.
- Students are coming to graduate school lacking in writing skills.
- I think UG [undergraduate] courses at most universities are not doing their job—students are ill-prepared when they enter graduate school, so we have to teach everything over again.
- Lack of preparation from undergraduate CSD [communication sciences and disorders] programs.

Faculty Sufficiency and Capacity

Working Well

- No comments.

Not Working Well

- Faculty burnout.
- The great number of new programs and lack of enrollment caps are putting a huge strain on clinical placements in the community. Some programs have nearly 1,000 online students.

- The PhD shortage plays a major role in the preparation of future speech-language pathologists. Smaller programs, including those at teaching-focused universities, often struggle to recruit and hire PhD-level faculty.
- Not enough faculty.
- Faculty capacity to create new programs, approaches, and instructional techniques is limited. It was [so] before the pandemic and is even more so now.
- Due to the rigidity of standards and prescriptive nature of program requirements, it is difficult for programs and educators to innovate and try something new. I think it would be beneficial to design and pilot some innovative models and allow selected universities to pilot them and report back.
- Nearly all programs will have some faculty teaching a course or two outside their primary area of expertise. Creating some open educational resources on needed topics would support those faculty.

Summary of Open-Ended Comments

Both the survey data and the open-ended comments indicate that it is critical to take the following actions:

- Address the challenge of **insufficient clinical placements and insufficient clinical educators/supervisors**—and the training, mentoring, and other supports needed to sustain this critical component of the current educational model.
- Address the **faculty sufficiency and capacity problem**, and support faculty development.
- Improve the adequacy and consistency of entry-level education to **better prepare graduates to enter practice in health care settings**.
- Improve **diversity, equity, inclusion, and access to graduate education** in speech-language pathology.
- Develop a **competency-based educational framework** with pathways to acquire, assess, and recognize (or signal) specific clinical and professional competencies in speech-language pathology.
- Develop framework and infrastructure to support **lifelong learning** and **clinical and professional specialization**.
- Optimize use of the **undergraduate degree** to help students develop 21st century skills, expand the bandwidth in graduate programs to cover the full scope of practice, and provide opportunities for in-depth learning more adequately.

III. The Future of Learning, Work, and Teaching

The ability to change, adapt, and evolve is essential to the survival of humans, disciplines, and systems. Adaptability, resilience, and lifelong learning are more essential than ever to survive and succeed in our rapidly changing world. Many factors contribute to this rapid pace of change and influence the future of learning, work, and teaching. The factors that are most relevant to the future of the communication sciences and disorders (CSD) discipline and the profession of speech-language pathology are addressed in this third section. Key factors include the digital revolution; the competency-based hiring movement, along with the value it places on 21st century skills; rapidly advancing technologies; living in a diverse society; and applying findings from the science of learning and the science of teaching and learning (SoTL) to advance pedagogy and clinical experiential learning.

The Future of Work

Digital Revolution

One of the most important factors influencing the future of work, including in the speech-language pathology profession, is the digital revolution. The impact of the digital revolution on the future of work is pervasive, transformational, and evolving at an exceedingly rapid pace. The digital revolution has already changed how SLPs practice and how they are educated. The implications of the digital revolution for the future of work, teaching, and learning in speech-language pathology include the following needs and realities:

- The workforce needs to be prepared to work with expanding technologies—such as artificial intelligence (AI) and wearable sensors—and need to be able to adapt to fast-paced changes in information technology.
- The use of telemedicine and telepractice is increasing, and the profession of speech-language pathology is no exception. Graduate programs need to make sure that students are well-prepared to provide services in remote practice settings.
- The use of digital applications (apps)—and, increasingly, apps supported by AI—in the delivery of services is growing. AI is already being applied in clinical settings for assessment, monitoring, and intervention purposes in speech-language pathology. The efficiency and intelligence afforded by applications of this technology offer great potential to advance evidence-based practice and improve the outcomes of the services that SLPs provide.
- The use of big data, outcomes reporting, and point-of-care tools in clinical decision making—and in clinical practice more generally—is growing. And these trends are central to the transition from the *fee-for-service* model to the *value-based purchasing* model in health care.
- Continuous lifelong learning has become more important than ever so that professionals can stay current and well-informed. This need is supported by and associated with the emerging prominence of online degrees and stackable credentials (badges, certificates, micro-credentials).

Competency-Based Hiring Movement

The *competency-based hiring movement* is another important factor influencing the future of work, teaching, and learning.

- The competency-based hiring movement is more focused on 21st century skills than on discipline- or system-specific competencies.
- Some of the 21st century skills listed in Table 2 below have also been referred to as “soft skills” and “noncognitive skills.” However, throughout this report, the diverse skills listed in Table 2 is referred to as *21st century skills*—ASHA’s preferred term.
- This set of 21st century skills can be compartmentalized into four domains: learning skills, life skills, literacy skills, and civic skills.

Table 2. The set of 21st century skills are displayed in four categories pertaining to learning skills, life skills, literacy skills, and civic skills.

21st Century Skills	
Learning Skills	
Critical and Analytical Thinking	Collaboration and Communication
Reflective Thinking	Creativity and Innovation
Life Skills	
Flexibility and Adaptiveness	Social and Relationship Skills
Initiative and Self-Direction	Leadership
Professionalism	Productivity
Problem-Solving Skills	Growth Mindset
Self-Awareness	Perseverance and Resilience
Literacy Skills	
Information Literacy	Technology and Digital Literacy
Research Literacy	Media Literacy
Civic Skills	
Social Responsibility	Global Awareness
Empathy and Compassion	Cultural Humility

- Based on a Burning Glass Technologies report (2015), of the 1.8 million job postings reviewed that required advanced graduate degrees, 21st century skills were mentioned and valued much more frequently than discipline-specific knowledge or system-specific competencies.
- Discipline-specific knowledge, like the big nine in speech-language pathology, is viewed as necessary for employment but not sufficient for successful job performance. As is true of mastering discipline-specific content, students need opportunities and guidance to develop 21st century skills—skills such as adaptability, teamwork, managing stress, and thinking creatively about challenges.
- 21st century skills are considered *boundary-crossing competencies* because they are not grounded in a specific knowledge base related to one’s discipline or in one specific system; rather, the 21st century

skills listed in Table 2 are the boundary-crossing competencies that are not tied to any one discipline, profession, or system.

- 21st century skills have been associated with the term “life ready” because they are fundamental to succeeding in most careers and to achieving real-world success.
- Unfortunately, despite the criticality of these 21st century skills, teaching and evaluation in education have, by and large, paid little attention to cultivating these skills in students.
- Even in speech-language pathology, these skills are not systematically nor consistently evaluated and targeted in graduate education, nor are they an explicit requirement for graduation.

The World Health Organization (WHO) has identified [five fundamental life skills](#) “that are crucial to cultivate and learn to have a better and more productive life . . . regardless of culture, education, or background” (Davis, 2019). These five life skills are as follows:

1. Decision-Making and Problem-Solving
2. Creative Thinking and Critical Thinking
3. Communication and Interpersonal Skills
4. Self-Awareness and Empathy
5. Coping With Emotions and Coping with Stress

This resource also addresses, in a preliminary manner, how to cultivate growth and learning in these domains, and the point is made that cultivation of any of one of these five capabilities can support and feed into improvements in other life skills. For example, improved communication can decrease sources of stress, and gains made in critical thinking skills can be reflected in better decision-making.

The importance of 21st century skills and life skills to the future of work is now well-recognized by employers, educators, and students alike, but this widespread recognition has not yet translated into a more concerted focus on the cultivation and evaluation of these skills in higher education.

Some of the obstacles to putting cultivation of 21st century skills at the top of the list in speech-language pathology education include the following three realities:

- There may not be sufficient time or space to add more to the curriculum, especially given the challenges that programs already face trying to cover the breadth of discipline-specific knowledge and skills.
- These skills are not typically included in the requirements for accreditation or graduation.
- Faculty and clinical educators may not have sufficient time or information about how to evaluate and cultivate 21st century skills—nor about which tools would be useful to employ.

Despite these obstacles, 21st century skills need to become more of a central focus in educating SLPs because the future of work is forever a rapidly changing landscape in which the ability to think critically and creatively, to adapt and be resilient, and to collaborate with empathy and self-awareness will be the key drivers of success. It is not clear how, when, or where these skills should be cultivated, but the current situation is not tenable—primarily because we lack tools, frameworks, and mandates to improve cultivation of 21st century skills. Inclusion of 21st century skills in a competency-based educational framework would help advance cultivation and evaluation of these skills. If 21st century skills were to be included in a competency-based educational framework, then tools and resources could be developed to help guide and align the cultivation and evaluation

of these skills for SLPs in academic programs and external clinical sites. The need is urgent for greater attention, more action, and rapid improvements to better support students in developing these critical skills. (This topic is addressed in greater depth in Section V on Competency-Based Education.)

The Future of Learning and Teaching

In our rapidly changing world, educators recognize that students need to be prepared for jobs and responsibilities that might not yet exist. *Career readiness* is a term that conveys graduates are ready to enter the workforce. In addition, graduates need to be equipped with a set of skills, habits, and attitudes that can prepare them for the unknown throughout their careers—growth mindset, lifelong learning habits, critical and reflective thinking, and more. Mastering discipline-specific knowledge is not sufficient, by itself, for an individual to become an effective SLP—and we have known this for a long time. The role that 21st century skills play in helping one keep pace with change throughout one’s career intersects with having the ability to adapt to new technologies and maintaining information and research literacy. **SLPs must know how to find, critically appraise, and apply new knowledge throughout their careers.** If students have not learned how to distinguish trustworthy information from misinformation by the time they graduate, it is likely that **misinformation** will continue to inform their practice throughout their careers. It is critical that students become adept at learning and applying new tools and approaches, become skilled at finding and identifying **trustworthy information**, and be ready to solve complex problems so that they carry these skills with them throughout their careers.

Technology

Many changes and factors influence the future of learning and teaching, including how technology has helped, and can continue to help, advance teaching and clinical practice. The examples below are already being tried and, to varying extents, are being adopted by academic programs in speech-language pathology—in part due to the acceleration of technological solutions for teaching associated with the COVID-19 pandemic.

- Virtual clinical experiences, simulation, and the use of standardized patients can help to provide varied clinical experiences across the lifespan, across practice settings, and with diverse populations.
- Hybrid and fully online academic programs have the potential
 - to open greater access to diverse students and increase access to services for clients, which is of great benefit to those living in rural areas and those with mobility challenges;
 - to facilitate self-directed learning, interprofessional education, and problem-based learning; and
 - to reduce geographical constraints for students and expand academic programs’ ability to engage scholars outside of local geographical areas in their teaching mission.
- Cross-institutional collaboratives supported by technology have the potential to facilitate the sharing of faculty expertise and mentoring across programs. Scaling up collaborative, cross-institutional approaches could provide some much-needed relief to many programs that struggle year after year to fill faculty positions and teach across the full scope of practice.

Living in a Diverse Society

Our increasingly diverse society is another important factor influencing the future of learning, work, and teaching. According to a report by William Frey (2021) from the Brookings Institute, 2020 census data substantiates that racial, cultural, and linguistic diversity is increasing in the United States and has been for quite some time.

- Currently, more than 40% of Americans identify as one or more racial and ethnic groups and less than 50% of first graders in the United States are White non-Hispanic.
- Southern states will contribute much of the student population growth in next decade, with an associated change in student demographics.
- Due to the “hollowing out” of the middle class, lower family incomes, and less academically prepared undergraduates, universities are being called upon to create pipelines through college to better support students from varying backgrounds and levels of educational readiness.

Graduate programs in speech-language pathology also need to better serve and support students from varying backgrounds and levels of educational readiness. A lot of research and discussion has occurred regarding what it means to learn, teach, and practice in a diverse society. *Culturally responsive teaching and learning* is an important growth area for educators, with the end goal of ensuring that all students can be well-supported and well-prepared to work effectively with all people—regardless of race, ethnicity, culture, disability status, or sexual and gender identity. To help meet the need of faculty and others who are seeking more culturally responsive ways to approach teaching, ASHA developed a resource on the topic of [Culturally Responsive Teaching and Learning](#) that is a curated collection of resources vetted by ASHA’s Academic Affairs Board with contributions from members of the following SIGs: SIG 10 – Issues in Higher Education; SIG 11 – Administration and Supervision; and SIG 14 – Cultural and Linguistic Diversity. (The topic of diversity in education is addressed in greater depth in Section VII on Student Diversity.)

The Science of Learning and the Scholarship of Teaching and Learning

The future of learning and teaching is being influenced by research from two critical areas: the *science of learning* and the *scholarship of teaching and learning* (SoTL). This research is helping to inform pivotal questions such as:

- How can generalization of knowledge and lifelong learning be cultivated?
- How can integrative and critical thinking be cultivated, especially when attention spans are getting shorter, and distractions are becoming more abundant?

When coupled with SoTL research, it has become clear that educators need to help students learn content in deep, complex ways—because research indicates that when this happens, students are better able to successfully generalize and apply what they’ve learned to novel situations and problems. To provide experiences that lead to deep learning, the science of learning literature supports the need for students to actively engage in critical thinking and problem solving in addition to learning content.

Research on learning has demonstrated that novice and veteran learners learn and acquire competency very differently. For example, Ambrose et al. (2010) investigated how novice learners (shown in the top row of Figure 2) make connections. They are predictably categorical and linear in their approach. Whereas expert learners (shown in the bottom row of Figure 2) make complicated networks of connections.

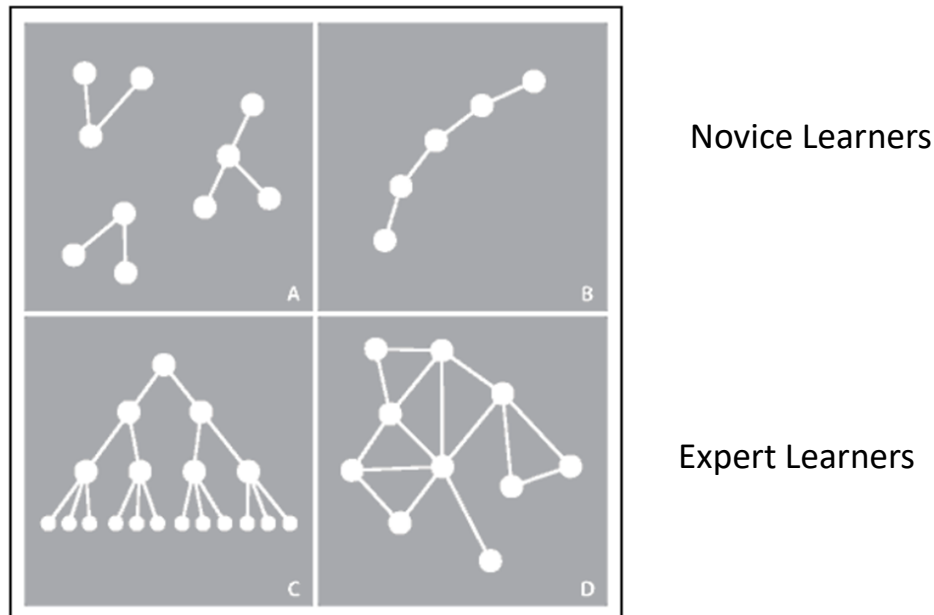


Figure 2. Graphical depictions of learning by novice and expert learners. From Ambrose et al., 2010.

The *science of learning* is changing the why, what, how, where, and when of learning, especially in terms of how educators can support students as they do the following tasks:

- Make important connections to grow professional and clinical competency (Ambrose et al., 2010)
- Develop successful study habits (Dunlosky et al., 2013)
- Learn to reflect as metacognitive thinkers (Tanner, 2012)
- Establish and grow relationships (Lambert & Felten, 2020)
- Learn across their lifespan (Brown, Roediger, & McDaniel, 2014)

There is widespread recognition that **deep learning is necessary** for the development of professional competencies and 21st century skills. It is the job of educators to help novice learners progress to expert levels of learning. To prepare future SLPs most effectively, we must help our students become expert learners. Students need to develop **complicated networks of connections**—because a deep understanding of the **complicated knowledge ontology underlying CSD** is essential in order for SLPs to practice effectively. Students need to delve deeply into a small set of topics to become expert learners who can then think critically and creatively about a wider array of topics in a field. Educators can help learners build complicated networks of connections by requiring activities, such as completing capstone projects and writing papers, that support deep learning and reflective thinking.

It is also the job of educators to challenge students to think about their own learning and to become reflective thinkers. A growth mindset and lifelong learning can be cultivated by pedagogies that encourage **reflective**

thinking—wherein a person thinks about their own learning by intentionally considering questions such as these:

- What have I learned, and what do I have yet to learn?
- How can I apply this information across various situations?
- Might others have a different point of view?
- How does this new information relate to what I already know?
- How does this new information change the way I think about the topic?

As the science of learning has demonstrated, students need to learn some content deeply to develop complicated networks of connections and to cultivate key 21st century skills such as critical and reflective thinking. And, considering that critical and reflective thinking are essential to lifelong learning, cultivation of these skills is of paramount importance for professional development. Unfortunately, strain on faculty capacity and the broad scope of practice in the profession of speech-language pathology has left little room for students to learn deeply and has left little time for faculty to help them cultivate 21st century skills like critical and reflective thinking.

- Based on faculty concerns about critical thinking skills, the Researcher-Academic Town Meeting at the 2019 ASHA Convention focused on this topic: [It's Critical! The Assessment and Development of Critical Thinking](#).
- Cultivation of critical and reflective thinking skills will remain a challenge if we cannot provide more opportunities for students to learn some content more deeply.

Opportunities Afforded by the Future of Work, Learning, and Teaching

Advances in **problem-based learning** and **simulation** in graduate education are proving to be effective in promoting integrative and critical thinking, in addition to gaining a deeper understanding of the content area. Pedagogical approaches that entail **self-directed learning** and **reflective thinking** can help to instill a growth mindset, which is key to developing lifelong learning skills and habits. Teaching the tools of **information, media,** and **research literacy** are also key to this objective. As most graduates enter practice with many knowledge and skill gaps, it is important to help students learn how to continually assess their knowledge and skills and how to pursue continuous improvement.

The future of learning recognizes the importance of having a **culture of learning**, which is **relationship-based**, so it is important that **mentoring, partnering,** and **peer-to-peer learning** be integrated into educational programs along with learning opportunities that entail **teamwork** and **collaborative learning** (e.g., journal clubs, learning communities). Successful preparation of *career-ready* SLPs includes cultivating the mindset that collaboration and lifelong learning are central to our personal and professional identities.

The **science of learning** and **SoTL** will continue to produce valuable research about the efficacy of pedagogical approaches that promote deep learning and valuable guidance about how to evaluate and cultivate 21st century skills.

- Academic programs, faculty, and clinical educators can implement this valuable knowledge to better align pedagogy and clinical experiential learning with the future of learning and the adequate preparation of students for the future of work. Approaches such as problem-based learning further deep learning and critical thinking. Cultivating a culture of learning with peer-to-peer, relationship-based learning activities promotes student engagement.

- Cultivation of 21st century skills could be integrated within and across all didactic and clinical experiences. Ideally, 21st century skills could be progressively cultivated throughout the student’s program, with periodic feedback directed about growth goals. The use of simulations is proving especially effective in helping beginning students practice these skills, and later, in stretching the abilities of more advanced students.
- A focus on cultivating 21st century skills should play a central role in this educational transformation. These competencies have already been integrated into competency-based educational frameworks in speech-language pathology (e.g., COMPASS [Competency Assessment in Speech Pathology]) and into the certification standards for SLPs in Australia.
- It is recommended that standard-setting bodies, such as the CFCC and the CAA, consider how 21st century skills could be explicitly recognized by their standards. Inclusion of 21st century skills in the standards, perhaps nested in a competency-based educational framework, would accelerate adoption of these recommendations and foster alignment across academic programs regarding how these standards and expectations related to 21st century skills are implemented.

The Next Steps Committee deemed it very important to consider the factors that are influencing the future of work, learning, and teaching to help formulate recommendations that could address some of the longstanding problems and provide guidance about how education in speech-language pathology should be transformed. A synopsis of these recommendations is provided after each of the five questions below—with each question focusing on a longstanding problem—to highlight where more attention, effort, and innovation are needed. These recommendations are based primarily on the opportunities afforded by the future of work, learning, and teaching.

- **Question 1: How can the breadth and depth of the knowledge, skills, and clinical competencies attained by entry-level SLPs be increased?**
 - By incorporating guidance from the science of learning and SoTL to develop and implement pedagogical approaches aimed at strengthening student engagement, critical thinking, problem solving, and information literacy skills. Use of **problem-based learning and simulation** can deepen students’ understanding, skills, and engagement. These pedagogical approaches can (a) provide deeper learning experiences and (b) prepare students to work in different settings and adapt in a continually changing workplace. Methods that promote **self-directed and self-paced learning** could help address some of the educational challenges relative to teaching the full scope of practice across practice settings and across the lifespan. (See also Section VI on Faculty Sufficiency and Development.)

- **Question 2: How can 21st century skills and other professional competencies be better cultivated so that students are well-prepared for the future of work and are *career ready*?**
 - By exploring pedagogical approaches (e.g., **problem-based learning**) and experiential learning activities (e.g., **simulation** and **interprofessional education**), 21st century skills can be cultivated to improve career readiness for entry-level practice. These skills need to be evaluated and, where needed, targeted as growth opportunities. Students need mentoring and feedback—and they need opportunities to practice, fail, and try again. Simulation provides opportunities for trial-and-error learning that help students strengthen their 21st century skills. Progress in making 21st century skill development a priority could be accelerated, and implementation would be better aligned across academic programs, if the standard-setting entities for speech-language pathology incorporated 21st century skills into a **competency-based educational framework** and thereby include them in the standards. (See also Section V on Competency-Based Education.)

- **Question 3: How can the CSD workforce be more diverse and better prepared to work in a diverse society?**
 - By better supporting students from diverse backgrounds and from underrepresented racial and ethnic communities to enter and thrive within the CSD discipline, the CSD workforce will become more diverse. It is also important that **culturally responsive teaching and learning** practices become widely adopted across academic programs so that future SLPs are better prepared to work effectively in our diverse society. (See also Section VII on Student Diversity.)

- **Question 4: How can the CSD workforce learn to adapt to continually emerging technologies and maintain information, media, and research literacy?**
 - While teaching discipline-specific knowledge, evidence-based practice, and strategies for incorporating new knowledge into practice, students can simultaneously acquire information, media, and research literacy skills and habits. **Formal instruction on how to find and evaluate information** is important to developing this critical skillset. Students must be able to determine whether a source is **trustworthy** and to distinguish factual and scientifically grounded information from misinformation.

- **Question 5: How can lifelong learning be cultivated and supported?**
 - By helping students develop their ability to become **critical and reflective thinkers**, and by creating collaborative learning and self-directed learning opportunities, CSD professionals can cultivate a growth mindset. **Relationship-based learning opportunities** can increase engagement in lifelong learning, as can workplaces that value a **culture of learning**. Relationship-based learning opportunities—like collaborative learning, simulation, community forums, and journal clubs—also function to **cultivate the mindset that collaboration and lifelong learning are central to our personal and professional identities**.

In our rapidly changing world, there is no doubt that the ability to continually learn and adapt will be essential for professional success. The factors influencing the future of work, learning, and teaching should not be viewed as challenges to overcome; rather, these changes are creating opportunities that have great potential to enhance the educational preparation of SLPs and to lessen the impact of some of the profession's longstanding critical problems, which are described in greater detail in Section IV on Alternative Educational Models.

Stakeholder Input: Future of Learning Survey Summary

Participants of the 2022 *Next Steps Summer Webinar Series* were asked to complete an online survey. The survey was designed to gather information on general topics and on a subset of questions specific to the Future of Learning topic. The full *Future of Learning Survey Report* is available in Appendix B.

Demographic Overview of the Respondents

- A total of 46 individuals responded to the survey.
 - 91% were certified SLPs.
 - 4% were certified audiologists.
 - 2% were Clinical Fellows.
 - 2% were “other.”
- Most (70%) had been employed in the professions for 21 or more years.
 - 17% for 16–20 years
 - 9% for 11–15 years
 - 4% for fewer than 10 years
- College/university was the primary employment setting for 84%.
 - 9% reported that they worked in a hospital.
 - 2% reported that they worked in a nonresidential health care facility.
 - 2% reported that they worked in a school.
 - 2% reported their primary employment setting as “other.”

Topic-Specific Questions

After the Future of Learning webinar, two topic-specific questions were asked only of those participants who indicated that their primary employment setting was “college/university.” As shown in Figure 3, most respondents somewhat or strongly agreed that “*My educational program aligns teaching with the science of learning.*”

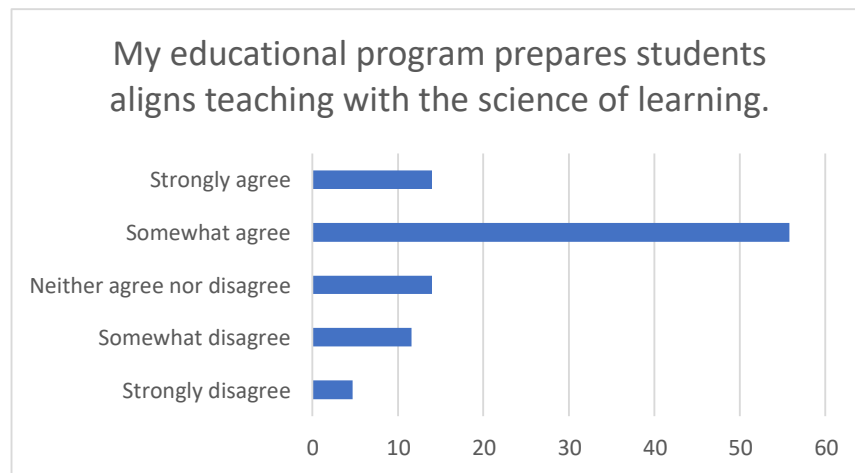


Figure 3: The distribution of responses to Question #12 on the Future of Learning is shown. Indicate the degree to which you agree/disagree with the following statement: *My educational program aligns teaching with the science of learning.* [Excluded respondents who are not in a college/university setting.]

As shown below in Figure 4, most respondents indicated that their academic program is already preparing *students to work in a diverse society; to nurture 21st century skills; to develop technological competency; and to instill lifelong learning.*”

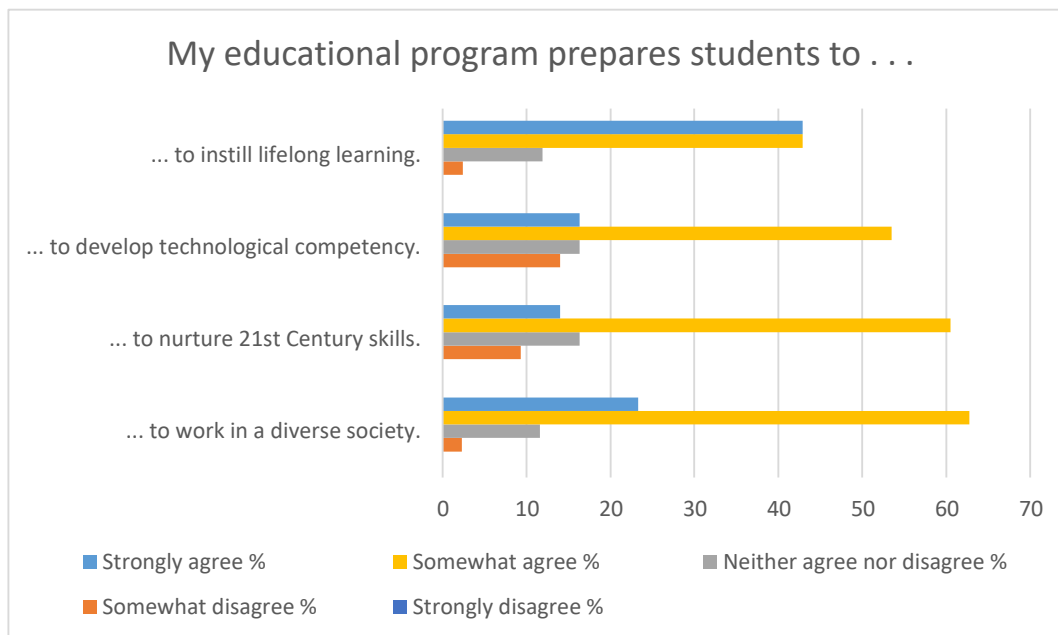


Figure 4: The distribution of responses to Question #13 on the Future of Learning Survey is shown. Indicate the degree to which you agree/disagree with the following statement: My educational program prepares students . . . [Excluded respondents who are not in a college/university setting.]

Most survey respondents indicated that their educational programs are already doing the following:

- **70%** indicated that their *educational program aligns teaching with the science of learning.*
- **86%** indicated that their *educational program prepares students to work in a diverse society.*
- **75%** indicated that their *educational program prepares students to nurture 21st century skills.*
- **70%** indicated that their *educational program prepares students to develop technological competency.*
- **86%** indicated that their *educational program prepares students to instill lifelong learning.*

Although the data are not representative of all academic programs nor faculty across rank and years of experience, they do indicate that some academic programs are already taking steps to address these needs.

Future of Learning Webinar Breakout Group Summary

This summary was generated by Claude.ai and edited by humans.

Key Points

The Next Steps Committee planned the *Next Steps Summer Webinar Series* in 2022 to gather stakeholder input using the procedures described in the Introduction, under Methods. The Future of Learning webinar participants' discussions centered on two key questions:

1. How might future trends change professional practice in speech-language pathology?
2. What changes should be made to advance educational preparation of SLPs?

Several consistent themes and recommendations emerged across the groups.

- There was strong consensus that the mental health crisis among both students and faculty needs to be addressed. Heavy workloads, financial pressures, lack of work–life balance, and isolation have contributed to high stress, anxiety, depression, and burnout. Programs need to reduce unnecessary stressors, provide more flexible pacing options to students, integrate resilience training, enhance counseling services, and support faculty in handling student mental health issues.
- Diversity, equity, and inclusion were also central topics. Making programs more accessible and flexible is vital to attracting diverse students. Holistic admissions practices should replace over-reliance on test scores. More funding and support services are imperative to attract, support, and retain students from underrepresented backgrounds. Admissions offices should emphasize competencies over test scores and grade-point averages (GPAs). Diversity and cultural responsiveness must be integrated throughout curricula and throughout the admissions and recruitment processes.
- In terms of specific educational preparation changes, increased flexibility and accessibility through part-time, online, and modular content delivery is needed so that students can balance other responsibilities. Assessments should focus on demonstration of skills versus time-based clinical hour requirements. Diversity, advocacy, and interprofessional education need integration across curricula. Open educational resources and stronger academic–outplacement site partnerships should be fostered.
- Generational differences in learning must be embraced by providing more experiential, interactive pedagogies that are focused on developing critical thinking and using applied skills versus encouraging and relying upon rote content memorization. Well-designed technology integration is key, and faculty need support in effectively leveraging online tools. The webinar participants discussed the need to reconsider accreditation standards to expand instructor pools beyond the 50% PhD target. Advanced practitioners, like those with clinical doctorates in speech-language pathology, enhance clinical education and could bolster faculty capacity.
- Although proposed solutions varied, participants agreed that advancing the field requires willingness to reexamine longstanding policies and practices, curriculum models, and clinical training methods with an aim toward using a more student-centered, competency-focused lens. Participants recommended specific innovations that include (a) leveraging technology for heightening student engagement and flexible learning, (b) promoting interprofessional education and use of simulations, (c) taking a holistic

approach to admissions, (d) developing stackable credentialing options, and (e) prioritizing student well-being and work–life balance.

In conclusion, the breakout group’s discussion highlighted critical challenges but also presented innovative opportunities to evolve speech-language pathology education and practice to meet changing societal needs. Supporting student and faculty well-being, emphasizing competency-based flexible learning, integrating technology effectively, fostering interdisciplinary collaboration, enhancing diversity, and aligning training with real-world demands emerged as six key priorities for the future. Embracing change and flexibility will be imperative.

Breakout Group Discussions

1. How might factors influencing the future of learning, work, and teaching change professional practice in speech-language pathology?
2. What changes should be made to advance the educational preparation of SLPs?

Professional Preparation

- **Mental Health and Well-Being:** Participants emphasized the growing mental health crisis among students, citing high levels of stress, anxiety, and depression. Contributing factors include large workloads, financial pressures, social isolation, and generational differences. There are calls for programs to reduce student stress while still meeting all competency requirements. Suggestions include offering more flexible program delivery, providing part-time options, offering hybrid/online formats, and addressing student well-being. Faculty burnout is also increasing, so the mental health needs of faculty should also be supported.
- **Diversity, Equity, and Inclusion:** Programs need to increase accessibility and flexibility to attract more diverse students. Admissions should take a more holistic approach focused on competencies rather than just test scores and grades. More funding and support services are imperative to attract, support, and retain students from underrepresented backgrounds. Diversity and cultural responsiveness must be integrated throughout the curriculum to create welcoming environments. Definitions of *professionalism* may need reexamination to ensure that standards are inclusive.
- **Generational Differences:** Pedagogical approaches should evolve to align with how current students learn best. More emphasis on visual, interactive, and experiential learning can make content engaging and applied. Programs can embrace technology while teaching its appropriate use. Critical thinking, problem solving, and clinical skills should be prioritized, and efforts should be made to evaluate and cultivate 21st century skills.
- **Interprofessional Education:** Simulations and interprofessional training with other health and education fields are valuable but need more standardization and oversight on quality. Programs can collaborate to share resources and ideas.
- **Faculty Development:** Many faculty members lack formal training in teaching and supervision. More professional development is needed on instructional approaches, technology integration, culturally responsive teaching and learning, and student mental health needs. Adjunct and practitioner faculty should be utilized more to expand instructor pools. Alternative models like team teaching and cross-institutional consortia could help address faculty shortages.

Educational Preparation

- **Program Delivery:** The most common suggestion was increasing accessibility and flexibility through part-time, online/hybrid, and alternative scheduling options. This allows students to balance work and life responsibilities. Learning would be enhanced if some content could be delivered in more bite-sized or modular approaches.
- **Admissions Policy:** Move toward competency-based admissions, taking a holistic view that considers more factors beyond just test scores and grades. This expands access for diverse and nontraditional students. Provide more funding and support services for students from underrepresented backgrounds.
- **Curriculum Integration:** Integrate diversity, equity, inclusion, and cultural responsiveness at all levels. Teach students how to be effective advocates and serve diverse populations. Infuse more opportunities for critical thinking, clinical applications, and interprofessional education.
- **Assessment Approach:** Shift toward competency-based assessment models that focus on applied skills and performance rather than on time-based clinical hour requirements. Develop better measures for 21st century skills like cultural responsiveness and critical thinking.
- **Faculty Composition:** Utilize more practitioner faculty and expand instructor pools beyond PhDs. Allow flexibility in graduate teaching requirements and offer more professional development to faculty. Explore alternative models like team teaching.
- **Resource Availability:** Provide more open educational resources from ASHA and other sources. Create an ASHA teaching journal. Develop high-quality simulation cases for common use.
- **Academic–Outplacement Alignment:** Foster stronger partnerships between academic programs and clinical sites. Collaborate with SLP outplacement supervisors to ensure that the training experience aligns well with the needs of the student.

There was consensus that programs need to take a more student-centered approach and reexamine longstanding policies and practices, curriculum models, and clinical training methods to meet the needs of students and society in the 21st century. Although viewpoints on specific solutions differed, most agreed that sustaining the profession will require embracing change and being adaptable.

Concerns and Recommendations

Student Mental Health

Concerns

- High levels of stress, anxiety, and depression due to factors like heavy workloads, finances, and isolation.
- Difficulty handling constructive feedback.
- Faculty unequipped to handle mental health issues; inadequate counseling.

Recommendations

- Reduce non-essential program requirements to lower stress.
- Provide flexible pacing options.
- Integrate education on coping skills, resilience, and advocacy into the curriculum.

- Enhance availability of counseling services and connect students to those services.

Faculty Preparation

Concerns

- Faculty capacity is maxed out—both at the individual level and collectively.
- Stress and burnout are significant concerns, especially because it is difficult to be creative and embrace change in such a state.
- Many faculty members lack sufficient training in pedagogy, supervision, technology, and culturally responsive teaching and learning.
- Shortages of PhD faculty lead to heavy workloads and burnout.

Recommendations

- Expand instructor pools to allow more faculty members who are practitioners.
- Offer alternative teaching models to address shortages (e.g., team-based teaching, consortia).
- Provide training on instruction, technology, cultural responsiveness, implicit bias, and mental health.
- Recognize time spent on pedagogy, mentoring in career advancement, and tenure.

Accessibility and Diversity

Concerns

- High program cost and pace limit access for working students, students from underrepresented backgrounds, students from lower socioeconomic status.
- Traditional admissions criteria introduce disadvantages and lack diversity.
- Students are uncomfortable addressing diversity, equity, inclusion, and cultural competence.

Recommendations

- Take a holistic admissions approach that focuses on competencies rather than on test scores.
- Provide funding and support services.
- Actively recruit and retain diverse students, faculty, and staff.
- Train search committees to recognize and avoid implicit bias.
- Infuse diversity and cultural responsiveness throughout the curriculum.
- Create safe spaces for open dialogue.

Curriculum Challenges

Concerns

- Broad base of knowledge and competencies covered in a short time frame.
- Content often lacks integration across courses.
- Application of critical thinking skills is not emphasized enough compared with content memorization.
- Limited interprofessional and simulation opportunities; lack of standardization and guidance.

Recommendations

- Prioritize applied learning, clinical skills, critical thinking over memorization.
- Increase interprofessional simulations and the diversity of outplacement experiences.
- Partner with sites to align training with the realities of that practice setting.
- Allow more flexible delivery models like online/hybrid courses, modules, and tracks.
- Provide open-access teaching resources and evidence-based practices.
- Infuse more opportunities for applied learning and critical thinking.

Opportunities and Recommendations

Leverage Technology

Opportunities

- Use technology to increase engagement, provide flexible learning, and align with student preferences.
- Incorporate more interactive media, videos, simulations, and telepractice.
- Offer online/hybrid courses and modular learning options.
- Provide mobile-friendly, readily accessible resources and content.

Recommendations

- Increase use of pedagogical approaches that advance online learning to help students prepare to be actively engaged in interactive, in-person learning, such as “flipped” classrooms—with students previewing content online and practicing skills and problem-solving issues in class.
- Develop a centralized repository of high-quality instructional videos and simulation cases and other resources that faculty can use to accelerate and strengthen student learning and cultivation of 21st century skills, especially critical and reflective thinking.
- Train faculty on effective online teaching practices and use of technology as teaching tools.
- Provide telepractice experiences for more advanced students.
- Teach students appropriate use of social media and skills to identify and question misinformation.
- Teach students information, media, and research literacy skills to promote evidence-based practice and decrease their susceptibility to misinformation.

Foster Interprofessional Collaboration

Opportunities

- Promote interprofessional education to enhance teamwork and learning.
- Increase simulation experiences with other health fields.
- Improve partnerships between academic programs and outplacement sites.

Recommendations

- Require interprofessional education learning activities across health science departments.
- Develop simulations where students work in interprofessional groups.
- Create opportunities for students to learn clinical skills alongside students in other programs.
- Engage alumni, employers, and other professionals to provide interprofessional education and mentorship.

Rethink Admissions

Opportunities

- Take a more holistic, equitable approach to admissions.
- Diversify the student body and profession.
- Address shortage of PhD faculty from diverse backgrounds in the long term.

Recommendations

- Base admission decisions more on competencies and skills versus test scores and GPAs.
- Actively recruit and retain students from underrepresented groups.
- Give more weight in making admissions decisions to credentials like speech-language pathology assistant (SLPA) and bilingual/multilingual skills.
- Expand instructor credentials beyond PhDs to include more practitioner faculty with clinical doctorates in speech-language pathology.

Enrich Curriculum

Opportunities

- Graduate well-rounded clinicians who are skilled in technology, research, and advocacy.
- Emphasize applied learning, clinical thinking, and problem solving.
- Integrate cultural responsiveness and advocacy training into the curriculum.

Recommendations

- Add more hands-on applied learning activities into coursework.
- Develop capstone experiences that integrate clinical and critical thinking skills (e.g., Grand Rounds courses).
- Incorporate cultural humility, equity, anti-racism, and social justice issues throughout the curriculum.
- Include ethics, leadership, and self-care in the program.

Support Student Well-Being

Opportunities

- Address growing student mental health needs.
- Teach coping skills and resilience earlier.
- Reduce non-essential stressors.
- Promote student self-care and work–life balance.

Recommendations

- Integrate stress management, mindfulness, and counseling into the curriculum.
- Adjust program requirements to allow more flexibility.
- Provide hybrid/online options for better work–life balance.
- Train faculty to recognize and respond to mental health issues.
- Partner with counseling centers to meet student demand.

This summary highlighted areas of opportunity identified by the breakout group participants along with their suggestions for how academic programs can capitalize on them through local policy changes, revised practices, resource development, and innovation. Their recommendations reflect a student-centered approach focused on leveraging technology, fostering collaboration, diversifying the field, enriching curriculum, and supporting overall well-being. The breakout group participants also recommended that ASHA catalyze innovation in CSD higher education, which is described in next.

Program Recommendation: Catalyze Innovation in CSD Education

Program Title: ***Catalyze Innovation in CSD Education***

Goal: *Catalyze Innovation in CSD Education* aims to accelerate transformational change through collaboration, innovation, and knowledge sharing.

Key Initiatives

Launch a CSD Education Innovation Community

- Create a community site where CSD faculty can share ideas, new models, resources, and reflections about ideas and pilot projects.
- Organize working groups to tackle topics like competency-based assessment, mental health, and creating greater diversity of professionals within the CSD discipline.
- Convene stakeholders to write reports synthesizing knowledge on “what works” in transforming CSD education.
- Host webinars and member discussion forums on educational technology tools, virtual learning best practices, pedagogy, and more.

Develop a Teaching–Learning–Research Hub

- Create a portal that serves as a centralized hub of information geared to the academic community, and design resources therein that support faculty, supervisors, and others in teaching, learning, and research.
- Create a database of open-access CSD teaching resources contributed by ASHA staff and committees, members of the academic community, and others.
- Publish articles about what programs are doing to improve CSD education.
- Offer funding to support the development of new virtual learning resources.

Host Conferences and Webinar Series on Key Topics to Advance CSD Education

- Develop webinars and hands-on training workshops on key topics to advance education (e.g., competency-based education, interprofessional education, case-based teaching, simulation, holistic admissions, cultivating 21st century skills).
- Host regional train-the-trainer conferences in different geographic regions each year.
- Cultivate local expertise that members can bring back to their programs.
- Provide online opportunities for discussion (e.g., breakout groups) and online community forums to promote relationship-based learning among faculty, clinical educators, and SLPs supervising in clinical placements.

Promote Knowledge Dissemination on Key Topics to Advance CSD Education

- Disseminate information about webinars, conference presentations, and publications to share findings and resources.
- Showcase examples of CSD programs leading successful transformation efforts.
- Keep the key topics in front of members for a prolonged period through many channels.

Create a CSD Educator Micro-Credentialing Program

- Offer stackable digital badges/micro-credentials in key skill areas (e.g., competency-based assessment, problem-based learning, culturally responsive teaching).
- Provide credentialing at low or no cost to members.

- Recognize CSD professionals for micro-credentials earned—to incentivize professional development.

Catalyze Innovation in CSD Education is a multipronged approach that focuses on stakeholders collaborating, sharing knowledge, and collectively, shifting the culture to transform education for SLPs. To promote positive change and to realize the full magnitude and scope of these recommendations, the ideas and spread of expertise must come from within the CSD education community itself, but ASHA has critical roles to play.

ASHA's Roles

ASHA will need to initiate and support the implementation of this transformational program in at least the following 12 ways.

1. Create the *CSD Education Innovation Community* site on ASHA's member engagement platform.
2. Continue to support asset development for ASHA's *Teaching–Learning–Research Hub*, which is a centralized, open-access library of resources on pedagogy, teaching CSD topics, academic-research careers, conducting research, and associated tools of value to faculty and others.
3. Establish and maintain mechanisms to regularly monitor the educational landscape and identify areas of need or topics for the program to address.
4. Host regional train-the-trainer conferences, or perhaps partner with state associations.
5. Promote the program's initiatives, training opportunities, and resources to the academic community and to the ASHA membership at large.
6. Formally recognize or endorse the micro-credentials earned through the proposed new micro-credentialing program.
7. Showcase the program's work through ASHA publications, conferences, and communications.
8. Connect the program to other ASHA initiatives or resources that could provide synergies.
9. Conduct research evaluating the program's effectiveness and impact on CSD education.
10. Advocate for policies that support educational innovation in CSD.
11. Provide technical assistance to academic programs as they consider making changes.
12. Maintain an advisory committee to assist the program on a volunteer basis by providing feedback and guidance.

IV. Alternative Educational Models

Background

Similar to the Next Steps Committee, the prior Ad Hoc Committee on Graduate Education for Speech-Language Pathologists (GESLP; hereafter, “the GESLP Committee”) had been charged with the following tasks:

- Identifying which aspects of the current entry-level educational model are serving the profession and the public well, versus which aspects are falling short, to adequately prepare SLPs across practice settings.
- Gathering stakeholder input on the question of whether there are changes to the current model of entry-level education that would address gaps or unmet needs.

Read the [Ad Hoc Committee on Graduate Education for Speech-Language Pathologists Final Report](#), or access it from this QR code. (This report is hereafter referred to as the “GESLP Final Report”).

The Alternative Educational Models Working Group of the Next Steps Committee focused primarily on whether there are changes to the current model of entry-level education that would help address the unmet needs and critical problems facing the field of speech-language pathology. Member input was gathered on how alternative models of entry-level education might help mitigate some of the longstanding educational challenges and how the undergraduate, graduate, and Clinical Fellowship experiences could be better leveraged. Because the *GESLP Final Report* thoroughly outlined the critical problems threatening the viability and sustainability of the current educational model for SLPs, the Alternative Educational Models Working Group was able to use this information as a springboard that allowed us to shift our focus more on the potential solutions. This set of critical problems identified in the *GESLP Final Report* is summarized below and is listed in Table 3.



Critical Problems

From the *GESLP Final Report*, a detailed landscape emerges of the educational challenges facing the speech-language pathology field—and their impact on the profession and on those we serve. Although there are many aspects of the current educational model that were identified as serving the profession and public well (see pages 43–44 of the *GESLP Final Report*), many more were judged to be falling short. The weight of the data suggests a beleaguered faculty and supervisory workforce whose collective mission has been made nearly impossible by the expanded scope of practice and the dwindling availability of clinical outplacements. The growth in the number of new academic programs competing for the same limited pool of PhD-level faculty, combined with pressures in higher education to expand graduate enrollment, is exacerbating what was already a tenuous situation. The shortcomings of the current approach for preparing SLPs—especially to work in medical settings and in specialized areas (e.g., autism, augmentative and alternative communication)—may be hampering the profession’s ability to retain its current scope of practice (i.e., due to encroachment). The *GESLP Final Report* raises significant concerns about the downstream effects on the quality of services and the profession’s reputation in the eyes of our colleagues, the public, and decision makers. Based on input from a variety of stakeholders, there is widespread recognition of the most critical problems threatening the viability and sustainability of the current educational model in speech-language pathology. The following section provides a snapshot of stakeholder input from surveys and focus groups that contributed to the list of critical problems identified by the GESLP Committee.

Survey and Focus Group Data from the *GESLP Final Report*

The *GESLP Final Report* cites data from the general ASHA membership and data gathered from SLPs working in school, health care, and university settings. Illustrative examples from the *GESLP Final Report* reflect why they concluded that there is widespread concern about the current educational model.

On page 62 of the *GESLP Final Report*, data are reported from the *2020 Public Policy Survey*, which is fielded to the **entire ASHA membership**.

- “Encroachment was a major issue cited in the open-ended comments by many of the 2,573 individuals who responded to the 2020 PPA Survey. The data indicated that ASHA members from all work settings are concerned that the current approach to entry-level education for SLPs is not adequately preparing our future clinicians and may be hampering the profession’s ability to hold onto its current scope of practice (i.e., concerns about encroachment).
- The inadequacy of the clinical education for speech-language pathology students to enter medical settings was also frequently mentioned by many of the 2,573 individuals who responded to the 2020 PPA Survey.
- Lack of skills and competency of practicing clinicians to practice in several areas—that included feeding and swallowing, AAC, autism, voice, and others—were viewed as a result of the rapidly expanding scope of practice and as a key contributing factor to encroachment by many of the 2,573 individuals who responded to the 2020 PPA Survey.”

On pages 45–47, data obtained from the **academic community** contributed to the GESLP Committee’s conclusion that students need to learn too much information and acquire too many skills in the limited time available under the current educational model. For example, on multiple *CSD Education Surveys* fielded to academic programs between 2013 and 2019, faculty expressed concern that academic programs are struggling to teach across the full scope of practice, leaving students unprepared to enter practice in settings that commonly employ SLPs and to deliver speech-language pathology services across the lifespan.

- “In 2013: 33% of speech-language pathology master’s degree programs reported concerns about capacity to teach across the full scope of practice.
- In 2019, 78% of master’s degree programs reported being concerned about limited faculty capacity to cover all big nine curricular areas.”

On page 48, focus group results are shared from the 2019 CAPCSD annual conference. ASHA conducted these focus groups to get input from **department chairs and clinical directors**. Across both stakeholder groups, there was consensus that . . .

- “There is not enough faculty capacity to teach across the full scope of practice.
- There is not enough time in a 2-year program to fit the full scope of practice across the lifespan into the curriculum.
- There are not enough externship sites available across practice settings for many programs.
- Most graduating students, including those demonstrating academic excellence, are not sufficiently prepared to enter practice and often have limited experience in their first Clinical Fellowship setting.”

On page 65, the GESLP Committee concluded that . . .

- “After reviewing extant data, prior reports and collecting new information, there is much **need to reexamine the current model** of entry-level education for SLPs.
- Based on analyses of the surveys and focus groups reported in this document, there appears to be **widespread concern that students may not be consistently prepared** to enter practice.

- As indicated by the data reviewed in this report, changes are needed, but additional input is required from a **larger group of stakeholders** to determine which changes are needed to address current challenges and improve entry-level education for SLPs.”

The *GESLP Final Report* provides a clear picture of the most critical problems threatening the viability and sustainability of the current educational model. These ten critical problems are listed in Table 3.

Table 3. Critical Problems Associated With the Current Educational Model for Speech-Language Pathology (synthesized from the [GESLP Final Report](#)).

- | | |
|---|--|
| <ul style="list-style-type: none"> • Students are not consistently prepared to enter practice across work settings that commonly employ SLPs. • There is a growing scarcity of outplacements and supervisors and an overreliance on volunteers for supervision. • There is insufficient student and faculty diversity, and challenges with recruitment, admission, and retention of people from underrepresented backgrounds. • There are not enough SLPs specializing in key clinical areas, and there is not a robust system of recognition/certification options for signaling specialized expertise in many key areas, like autism and voice. • There is unequal training across speech-language pathology programs and insufficient guidance about evaluating whether SLPs have the necessary entry-level competencies for a given setting, especially in medical settings. | <ul style="list-style-type: none"> • Trying to fit the full scope of practice across the lifespan into a 2-year master’s program has become impossible. • There is not sufficient faculty capacity in most academic programs to teach all topic areas within the big nine. • Access to graduate education is limited due to the predominance of our “full-time residency” model. • Students are not consistently prepared to work with diverse populations, and cultivation of critical thinking and other 21st century skills is not sufficiently prioritized. • The current model lacks a competency-based educational framework to guide preparation and self-evaluation of one’s readiness for specific areas of clinical practice and 21st century skills. |
|---|--|
-

Unmet Needs

The critical problems listed in Table 3 can also be conceptualized in terms of the following needs.

- The need to increase
 - the number of faculty,
 - the number of SLPs, and
 - student and faculty diversity.
- The need for expanded opportunities for students to

- improve their readiness to enter practice,
- effectively deliver services to diverse populations with cultural humility,
- better cultivate critical and analytical thinking skills,
- develop stronger oral and written communication skills,
- master information and research literacy skills and the ability to implement evidence-based practices, and
- instill a growth mindset to support lifelong learning.
- The need for innovation to develop
 - a competency-based educational framework with pathways to learn, evaluate, and recognize (or signal) specific competencies and
 - new pedagogies and curricular goals to better prepare students for the future of work.

Conclusions from the *GESLP Final Report*

The upshot of the GESLP Committee’s conclusion is that students need to learn too much information and acquire too many skills given the limited available time and faculty capacity to consistently achieve entry-level competency across all of the big nine areas and to enter work in the settings that commonly employ SLPs (i.e., schools, private practice, hospital and non-residential health care facilities, and early intervention). The ASHA Code of Ethics requires that “Individuals who hold the Certificate of Clinical Competence shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their certification status, education, training, and experience” ([ASHA Code of Ethics](#), Principle IIA). Despite this guardrail, there is no mechanism or framework in speech-language pathology by which an individual can evaluate their own level of readiness to competently provide services in specific areas and practice settings. The problem is even more concerning from the perspective of employers and consumers, who have the challenging task of having to make informed decisions about someone’s competency to provide services in specific areas of practice. In this respect, the current models of education, certification, and specialty certification are not serving the profession or public very well.

Three Models of Entry-Level Education

The GESLP Educational Models Subcommittee reviewed the educational models of 27 education and health disciplines (see Appendix A, *GESLP Educational Models Subcommittee Report*, pages 68–88, in the [GESLP Final Report](#)). Based on their analyses of other disciplines’ educational models, they proposed three alternative models of entry-level education: (1) the lifespan model, (2) the track model, and (3) the modular model (all are discussed in greater detail in the subsections below). These three models were given further consideration by the individuals who participated in the *Next Steps Summer Series Webinar* on Alternative Educational Models in 2022. These three models were selected because they all have the potential to

- mitigate some of the critical problems listed in [Table 3](#);
- improve educational outcomes for students in speech-language pathology;

- reduce some of the stress that the current model is placing on many academic programs and their faculty and students; and
- enable the profession to evolve in a sustainable manner as the scope of practice continues to grow and as the field adapts to the changes described in Section III on the Future of Learning.

New Lifespan Model

The first to be considered is the *new lifespan model*, which is an extension of the current educational model except that, to make room for students to better develop entry-level competencies across the entire scope of practice and lifespan, more than 2 years would be required to complete the degree. This new lifespan model would continue the tradition of having only one type of entry-level degree, one set of graduate program requirements to prepare entry-level SLPs, and one certification for all of speech-language pathology. The Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP) would continue to certify that certificate holders “have the knowledge, skills, and expertise to provide high-quality clinical services” (see ASHA webpage, [General Information About ASHA Certification](#)). The major difference between the current model and the new lifespan model is time to degree, which would need to be extended beyond 2 years.

Adoption of a new lifespan model in which more credits and time are added to the entry-level graduate degree programs in speech-language pathology could

- make it more feasible for students to gain entry-level competency across the full scope of practice, lifespan, and practice settings that commonly employ SLPs;
- enable students to gain greater depth of knowledge in one or more clinical areas;
- provide more time and opportunity for students to cultivate their critical thinking and other 21st century skills; and
- maintain the flexibility that SLPs currently have to transition across settings without having to satisfy requirements for an additional credential or certificate.

Track Model

The *track model* consists of two tracks for preparing SLPs, each with a different course of study and different set of clinical experiences, to prepare students to work with either adult or pediatric populations (or to work in educational or medical settings, as shown in this screenshot of the track program in the [University of Washington’s Speech and Hearing Sciences Department](#)). The track model requires that students from both tracks take a common core curriculum (e.g., in Year 1) and then take a separate set of courses based on the track that they select to pursue (e.g., in Year 2). Clinical experiential learning is tailored to the track selected. The track model would not necessitate a change in the number of credits or time required to complete the degree. Under a track model, academic programs would not necessarily need to offer both tracks.

MASTER OF SCIENCE IN SPEECH-LANGUAGE PATHOLOGY

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Educational Speech-Language Pathology

For students who want to practice in school or educational settings

EXPLORE EDSLP >



Medical Speech-Language Pathology

For students who want to practice in medical or health care settings

EXPLORE MEDSLP >

Because generalist training is still part of the curriculum in a track model due to the common core curriculum, graduates are qualified to receive the CCC-SLP after successful completion of their Clinical Fellowship. However, if track models were to be implemented nationwide, then it would be important to address the question of whether certification should continue to apply to the full scope of practice because competency in the *track not followed* cannot be assured or assumed. To authentically link certification to competency in a track model, two certification programs might be needed to accommodate the pediatric (or educational) and adult (or medical) subdivision of the clinical competencies in speech-language pathology. Because subdividing certification might usher in the need for associated changes in state licensure across 50 states—which would be a monumental task—the relationship between the educational model and the certification model would need to be carefully considered. In lieu of a major overhaul of the certification program, frameworks and tools could be developed by which an individual could evaluate their own level of readiness to competently provide services in specific areas and practice settings. Such tools would be immensely helpful to ameliorate the current situation wherein SLPs, employers, and consumers have no reliable way of evaluating a clinician’s competency to provide services in specific areas. Such tools would also be helpful to SLPs who might decide after graduation that they would like to become qualified to practice in the other track.

Adoption of a track model for entry-level education in speech-language pathology could

- enable students to gain greater depth of knowledge in one or more clinical areas;
- provide more opportunities for students to cultivate critical thinking and other 21st century skills;
- make it more feasible for students to gain entry-level competencies in the specific areas that are important to working with their chosen segment of the population or practice setting;
- improve the likelihood that outplacement supervisors and settings would agree to take students because the students would be better prepared for work in that setting; and
- provide relief to academic programs that do not have sufficient faculty capacity to teach all topic areas or that do not have medical settings close by or available for student outplacements.

Modular Model

The *modular model* would entail a reorganization of the current curriculum into modules (e.g., 12 modules), plus a required core curriculum that all students in all programs would receive. Under a modular model, academic programs would not necessarily offer all modules. Academic programs would offer a core curriculum plus those modules that they choose to offer, but at least as many as would be required for graduation and initial certification (e.g., six modules). The modular model would not necessitate a change in the number of credits or time required to complete the degree. In theory, SLPs would be ethically bound to provide services in only those modular areas for which they have completed the educational requirements, demonstrated entry-level competency, and passed a qualifying exam. After graduation, SLPs could expand the modular areas in which they are qualified to practice by completing the educational requirements, demonstrating competency, and passing a qualifying exam for that module.

Many of the same benefits and challenges that applied to the track model apply also to the modular model. However, because the field would be divided into many more subsections in the modular model, gaining knowledge and skills to become competent in a new module would likely be more feasible than trying to acquire all of the entry-level competencies needed to be prepared for practice in the other half of the field. As generalist training is still part of the curriculum in a modular model due to the common core curriculum, graduates in a modular model would still be qualified to receive the CCC-SLP, in its current form, after successfully completing their Clinical Fellowship.

If the entire field moved to a modular model, then the CCC-SLP certification could continue as the basic level of certification signaling competency in the generalist knowledge and skills associated with being an SLP—much like the “MD” degree designates broad medical knowledge but not specialization. A single certification in isolation does not serve a profession well to reflect advanced competencies. Implementation of a modular model would best be supported by multiple specialized certifications or certificates being developed, perhaps one for each module, which would be “on top of” the overarching certification (i.e., the CCC-SLP). But importantly, it would have to be well-established and understood that not every SLP is competent to practice in every area of the field, which is currently the de facto reality anyway. Other mechanisms could be created to (a) help employers and the public better discern in which of the modular areas a given SLP is competent to practice and (b) help them find SLPs who are competent in the specific area for which they are seeking services. In a modular model, being certified would convey all that it does now—except that the areas in which an SLP is competent to practice (or not) would need to be more identifiable and discoverable – transparent.

Adoption of a modular model for entry-level education in speech-language pathology could

- enable students to gain greater depth of knowledge in the modular areas they complete;
- provide more opportunities for students to cultivate their critical thinking and other 21st century skills;
- afford students the opportunity to gain more experience in graduate school with the populations and practice settings associated with the modules they are learning;
- make it more feasible for students to gain entry-level competency in a select number of modular areas;
- support clinicians to expand their expertise by making the learning pathway and competency requirements clearer;
- improve the likelihood that outplacement supervisors and settings would agree to take students because the students would be better prepared for work in that setting;
- provide relief to academic programs that do not have sufficient faculty capacity to teach all topic areas across the scope of practice, lifespan and practice settings;
- provide relief to academic programs that cannot adequately prepare students to work in medical settings because there is not a medical setting close by or available for student outplacements;
- afford students the opportunity to gain more experience in graduate school with the populations and practice settings that are associated with the modules that they are learning;
- support the development of frameworks and tools by which an individual could evaluate their own level of readiness to competently provide services in specific modular areas; and

- increase transparency about the areas in which an SLP is competent to practice.

Four Stages of Education

Options to modify the current model at four stages of education were also considered.

- Stage 1: Before students enter graduate programs at the **pre-entry-level** stage
- Stage 2: During the **entry-level** degree program
- Stage 3: During the **Clinical Fellowship**
- Stage 4: After individuals are certified at the **post-entry-level** stage

Options at the Pre-Entry-Level Stage

Approaches to better leveraging the undergraduate degree to mitigate some of the critical problems (listed in [Table 3](#)) associated with the current educational model were considered. The options at the pre-entry-level stage are as follows:

- In the past, the inclusion of more clinical practica in the undergraduate degree was common; however, this practice was discouraged when the master's degree became the entry-level degree in 1963. The certification standards that limit the number of clinical clock hours from the undergraduate degree that can be counted toward certification could be reconsidered. It might be preferable to encourage more clinical experience in undergraduate programs that could count toward certification because it would give students more time to develop clinical and 21st century skills, and it could help to alleviate some of the pressures that academic programs face providing enough clock hours in the entry-level degree program.
- Formally incorporating the last year of one's undergraduate education into the entry-level degree (i.e., a 1+2 model) could create opportunities to more consistently prepare SLPs who are ready to enter practice. Mechanisms by which a portion of the undergraduate degree could be included in the accreditation standards would need to be considered.
- Standards driving the curricula across undergraduate (or leveling programs) and the entry-level degree could be reconsidered to include greater emphasis on foundational sciences, especially in the areas of neuroscience, language science, speech science, and swallowing physiology and biomechanics.
- If a competency-based framework were in place that could help guide students through portions of the curriculum at their own pace, perhaps the knowledge components could be learned more efficiently. With the clarity that a competency-based framework would provide about what competencies are needed for practice in a specific area, learning activities and resources could be developed to guide self-paced learning of some of the core curriculum. Then, undergraduates could proceed through the curriculum at their own pace so that they could advance more quickly and focus more on cultivating their clinical and 21st century skills in graduate school.

Options at the Entry-Level Stage

As described previously, alternative models of entry-level education could help sustain the profession as the scope expands and as changes associated with the future of work unfold. The options at the entry-level stage are as follows:

- The new lifespan model entails adding credits to the current entry-level degree requirements. The generalist model would be preserved but would avail more time than the current model for the student to learn and cultivate skills.
- The track model entails splitting the field into two tracks—adult and pediatric—with a core curriculum that would be taken by all students. The time spent in graduate school would remain the same, but students could be better prepared to work with the specific populations and in the settings associated with their selected track.
- The modular model would also include a core curriculum, and then a select number of modules corresponding to specific clinical areas would be required for graduation and certification. Because not every area across the scope of practice and lifespan would be mastered in the entry-level program, SLPs could add competencies in a new modular area through professional development at any point in their career.
- Competency-based assessment could be a useful way for instructors and students to identify knowledge and skills for which additional education is needed to achieve entry-level competency in a specific area. Use of a competency-based framework could result in increased efficiencies because once students demonstrate entry-level competency in a given area, they could move on to learning more in another area for which knowledge and skill development are still needed.
- Self-directed learning grounded within a competency-based framework could help to augment coursework. There could be self-paced learning programs wherein students could assess their knowledge and competencies in a given area and then deepen their learning at their own pace.
- A self-directed learning approach would benefit from area-specific competency assessments and would serve as a way for employers and consumers to better understand and recognize advanced competencies.

Options at the Clinical Fellowship Stage

Approaches to better leveraging the Clinical Fellowship to strengthen and develop additional competencies were also considered. The options at the Clinical Fellowship stage are as follows:

- More structure in Clinical Fellowship experiences might be needed to help Clinical Fellowship supervisors facilitate and support continued learning in specific areas during the Clinical Fellowship.
- More structure and formalized expectations for employers to better support continuing education for these early career professionals would also be helpful.
- More professional development opportunities focused on areas that employers and clinical fellows have identified as common gaps or information generally needed by entry-level SLPs.
- Community sites, hosted by ASHA, Universities, or others, for clinical fellows to communicate, ideally with mentors and seasoned clinicians, about their experiences and to ask questions.

Options at the Post-Entry-Level Stage

Options for certified SLPs to excel at lifelong learning include cultivating a growth mindset, regularly engaging in critical and reflective thinking, and having mechanisms that promote and recognize advanced competencies.

Opportunities at the post-entry-level stage include:

- Pathways to specialized credentials (and differentiated levels of expertise);
- Micro- and stackable credentials that collectively signal advanced levels of competency;
- Certificates and advanced credentials that incentivize lifelong learning; and
- A competency assessment mechanism, in which SLPs could assess their own competencies.

Webinar breakout group participants discussed how the three alternative educational models that were presented—and the options at each of the four stages—could produce transformational changes to improve the viability and sustainability of the profession of speech-language pathology. Their input and ideas are summarized next.

Stakeholder Input: Alternative Educational Models Survey Summary

Participants of the 2022 *Next Steps Summer Webinar Series* were asked to complete an online survey. The survey was designed to gather information on general topics and on a subset of questions specific to the Alternative Educational Models topic. The full *Alternative Educational Models Survey Report* is available in Appendix C.

Demographic Overview of the Respondents

- A total of 33 individuals responded to the survey.
 - 94% were certified SLPs.
 - 6% were certified audiologists.
- Most (70%) had been employed in the professions for 21 or more years.
 - 6% for 16–20 years
 - 15% for 11–15 years
 - 9% for fewer than 10 years
- College/university was the primary employment setting for 85%.
 - 6% in hospitals
 - 3% in schools
 - 6% in “other”

Topic-Specific Questions

After the Alternative Educational Models webinar, five topic-specific questions were asked of the participants. These five topic-specific questions were covered in Questions #13 (three parts), #14, and #15.

Question #13 had three parts and asked about survey respondents’ level of agreement with changes to the current educational model. The three parts of Question #13 were as follows:

Figure 5A: “The current educational model in speech-language pathology should be maintained **but the duration of graduate programs should be extended beyond 2-years...**”

Figure 5B: “The current educational model in speech-language pathology should be maintained **but more content should be moved into the undergraduate degree...**”

Figure 5C: “The current educational model in speech-language pathology should be maintained **and should be left unchanged because students are consistently being prepared...**”

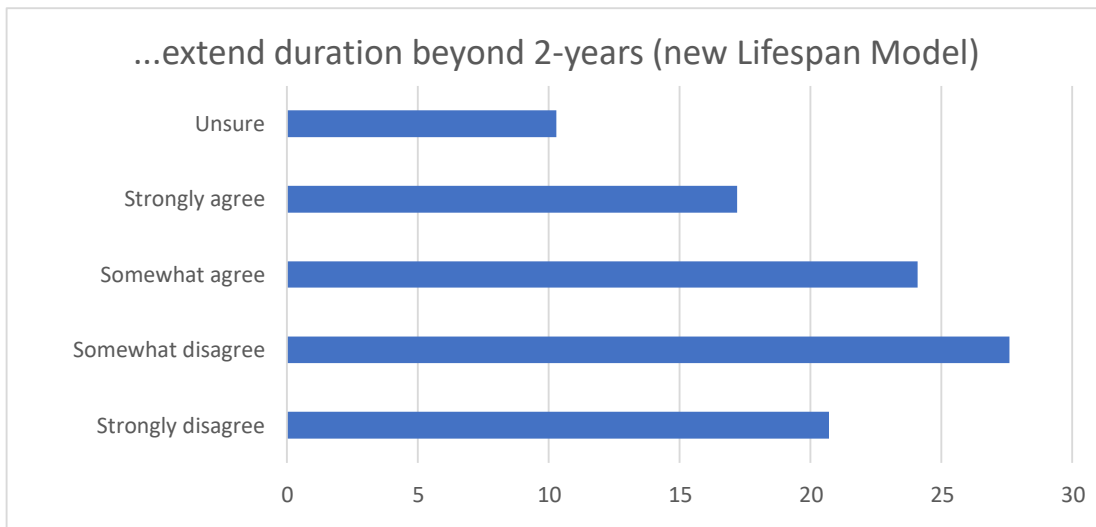


Figure 5A. The distribution of responses to the first part Question #13 on the Alternative Educational Models Survey are shown. Respondents were asked to indicate their agreement with the following: The current educational model in speech-language pathology should be maintained . . . **but the duration of graduate programs should be extended beyond 2-years** to enable delivery of the full curriculum and adequate time for students to fully develop the clinical competencies needed for entry into clinical practice.

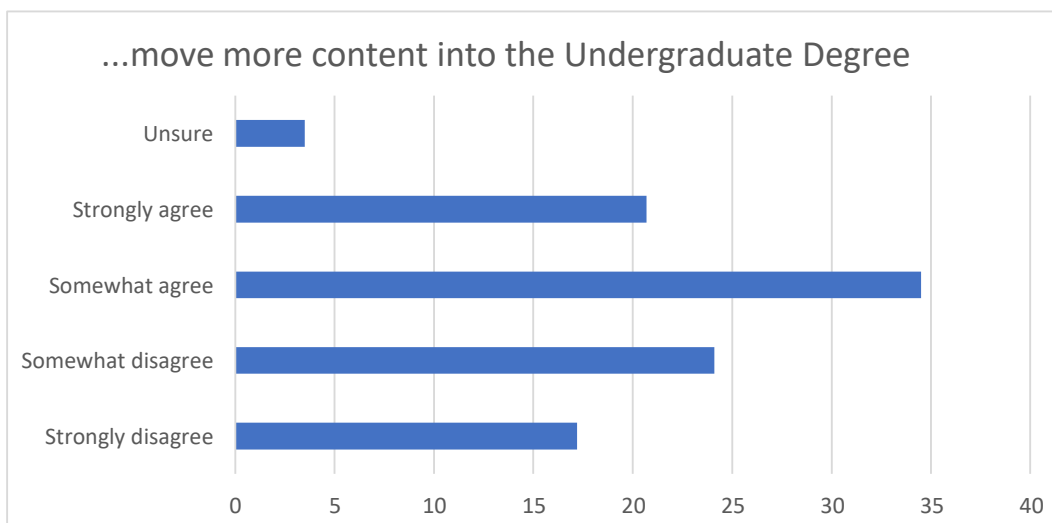


Figure 5B. The distribution of responses to the second part of Question #13 on the Alternative Educational Models Survey are shown. Respondents were asked to indicate their agreement with the following: *The current educational model in speech-language pathology should be maintained . . . **but more content should be moved into the undergraduate degree** so that undergraduates are able to complete coursework and clinical practica required for the graduate degree and for clinical certification in speech-language pathology.*

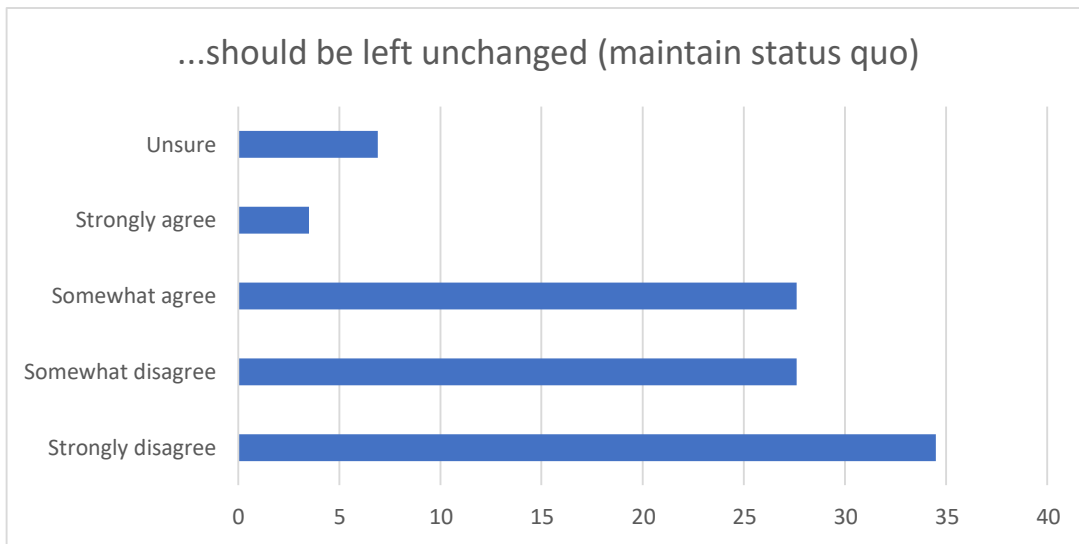


Figure 5C. The distribution of responses to the third part of Question #13 on the Alternative Educational Models Survey are shown. Respondents were asked to indicate their agreement with the following: *The current educational model in speech-language pathology should be maintained . . . and should be left unchanged because students are consistently being prepared* for entry-level practice across the big nine areas and to work with individuals across the lifespan and practice settings.

Question #14 asked survey respondents to indicate their level of support for further considering **Track Models** (Figure 6), and, in Question #15, about their level of support to further considering **Modular Models** (Figure 7).

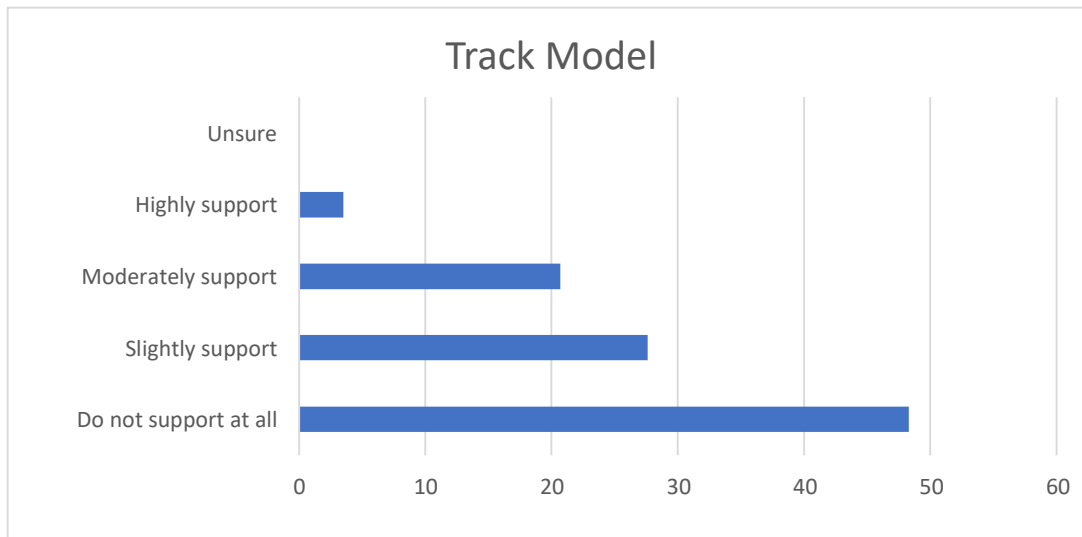


Figure 6. The distribution of responses to Question #14 of the Alternative Educational Models Survey are shown. Respondents were asked: To what degree do you support **further consideration of Track Models** for speech-language pathology, wherein graduate students prepare to work with either pediatric or adult populations after completing a common core curriculum?

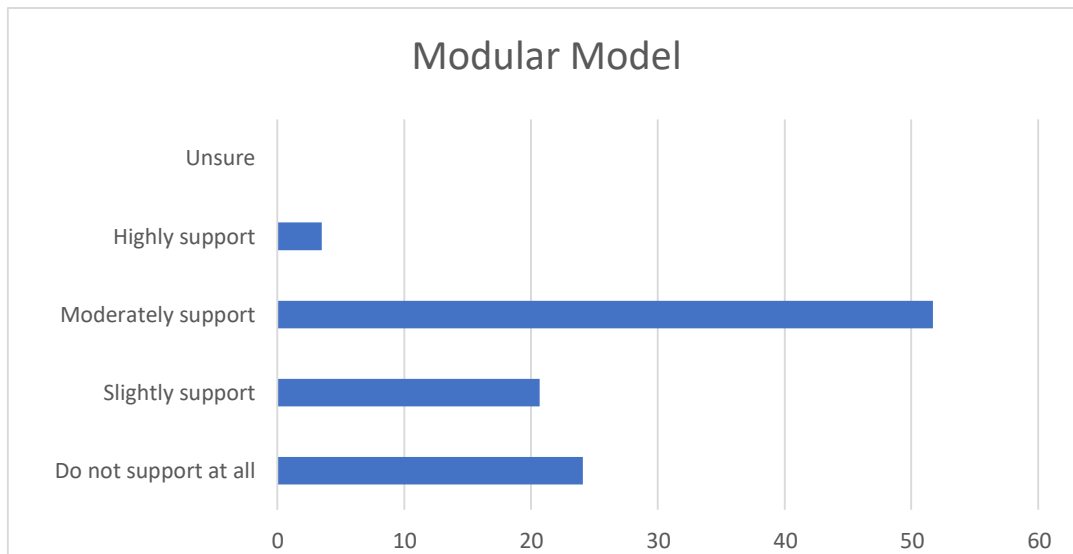


Figure 7. The distribution of responses to Question #15 of the Alternative Educational Models Survey are shown. Respondents were asked: *To what degree do you support further consideration of Modular Models for speech-language pathology, wherein graduate students prepare to work in a subset of clinical areas after completing a core curriculum (with pathways available to acquire additional competencies in other clinical areas throughout one’s career)?*

These results indicate a lack of consensus about any of the models considered, including maintaining the status quo.

- As can be seen in Figure 5A, 48% of respondents indicated that they “strongly disagreed” or “somewhat disagreed” with further consideration of a new Lifespan Model in which more time and credits would be added to the entry-level degree program.
- As can be seen in Figure 5B, 41% of respondents indicated that they “strongly disagreed” or “somewhat disagreed” with further consideration of moving more content into the undergraduate degree.
- As can be seen in Figure 5C, 62% of respondents indicated that they “strongly disagreed” or “somewhat disagreed” with the statement that “the current educational model in speech-language pathology should be maintained and should be left unchanged because students are consistently being prepared for entry-level practice across the big nine areas and to work with individuals across the lifespan and practice settings.”
- As can be seen in Figures 6 and 7, 48% of respondents did “not support at all” further consideration of Track Models (Figure 6), and 24% did “not support at all” further consideration of Modular Models (Figure 7).

With approximately half of the respondents indicating no or low support for any of the alternatives explored, challenges associated with gaining buy-in are likely to be significant if any of these proposed solutions move forward. However, the sample size is small and may not be fully representative of faculty across rank nor of SLPs across practice settings and years of experience—thus, more research and further exploration of alternative educational models is warranted.

Alternative Educational Models Webinar Breakout Group Summary

This summary was generated by Claude.ai and edited by humans.

Key Points

The Next Steps Committee planned the *Next Steps Summer Webinar Series* in 2022 to gather stakeholder input using the procedures described in the Methods section of this document. There was discussion around the different models presented (New Lifespan, Track, Modular) and the pros and cons of each. There were differing opinions on which model seems best.

- The lifespan model seems most like the current model but with more time added, which could be challenging for some programs and students, and it would be more costly than the current 2-year new lifespan model.
- The track model allows for specialization but may pigeonhole students too much and too early.
- The modular model allows flexibility but could be confusing for employers.

A major theme centered around (a) the preparedness of students entering graduate programs across the big nine areas and (b) gaps in critical thinking, research skills, writing skills, and other essential 21st century skills.

- Suggestions included adding more prerequisites in research methods, statistics courses, and information and research literacy skills; incorporating more hands-on learning and simulation; and strengthening the undergraduate CSD curriculum.
- Extending the entry-level program from two years to three or four years in duration came up as an option, but there were concerns around increasing costs for students, whether extending program length would increase extant shortages of SLPs, and how that lengthening might affect students from underrepresented backgrounds.
- Another major topic centered around the disconnect between classroom learning and clinical practice.
- Suggestions included balancing coursework more evenly between the first and second year.
- Suggestions also included incorporating more simulation, case-based learning, standardized patient cases, and other ways to emphasize application more often into courses.

There was discussion around the over-reliance on volunteer externship supervisors, reimbursement issues exacerbating outplacement scarcities, and the need to better support outplacement supervisors given their high caseloads and productivity demands.

Other topics included generational differences, the role of technology and social media in learning, interprofessional training, and the need for more consistent teaching across programs.

Breakout Group Discussions

The following discussion prompts were posed to the participants during the breakout group sessions:

1. Of the models presented, which is your preference, and why?

The groups had mixed preferences on the models. Some liked aspects of the new Lifespan Model because it was like the current model, but they disliked the added time. Others felt that the Track Model allowed for specialization but was too limiting. The Modular Model was seen as flexible and would address many problems but might be confusing for some employers and consumers. Overall, there was no consensus on a preferred model, but all seemed worthy of further exploration.

2. Do you have any suggestions about other models that haven't been discussed that could help to improve the entry-level preparation of SLPs?

Suggestions included incorporating more hands-on learning, simulation, and clinical experience earlier on in the program. Some brought up following a medical school model with core foundations and rotations followed by specialization and board certification. Others suggested boosting the undergraduate CSD curriculum and prerequisites.

In summary, the groups discussed pros and cons of the proposed models but did not seem to prefer one model strongly over the others. There were many thoughtful suggestions around improving preparation through (a) changes to curriculum and to prerequisites and (b) incorporation of simulation, case-based learning, and clinical experience. Looking for solutions across all four stages—from undergraduate program to post-certification employment—was viewed as a necessary part of the effort to improve quality and specialization. There was support for the idea of a more formal system of stackable credentials for professional development so that practicing clinicians could add skills in a manner that could signal advanced competencies to employers and consumers. Although no new models were proposed as alternatives to the three that were presented, the use of cross-institutional consortium models for creating partnerships across academic programs was viewed as an appealing avenue to reduce strain on faculty capacity and to improve teaching in areas in which some departments may lack sufficient faculty expertise. Other suggestions about improving preparation are listed below.

Suggestions About Improving the Education of SLPs

Curriculum

- Incorporate more interprofessional education experiences.
- Include more foundational knowledge related to working in health care settings.
- Add more prerequisites on research methods and statistics, and graduate course requirements that get fulfilled at the beginning of the program.
- Strengthen writing and critical thinking skills development.
- Balance coursework more evenly between the first and second year.
- Incorporate more application and hands-on learning into courses.
- Include more simulations and clinical methods in classes.
- Develop consistent competencies—and methods for demonstrating them.

Prerequisites

- Consider requiring research methods, statistics, and writing prerequisites.
- Standardize and strengthen undergraduate CSD curriculum as foundation.

Simulation

- Increase use of simulation to provide more opportunities for students to apply knowledge.
- Use simulation early on to provide opportunities to evaluate 21st century skills.
- Use simulation and standardized patients throughout the student's program to provide opportunities to cultivate 21st century skills.
- Use simulation to provide students with experiences across a broader range of disorders, ages, and cultures.

Clinical Experience

- Add more clinical experiences earlier in undergraduate and graduate programs.
- Develop competency-based assessments for clinical skills and 21st century skills.
- Partner with community providers to broaden clinical experiences.
- Identify ways that outplacement supervision could be incentivized and better supported.

V. Competency-Based Education

Competency-based education (CBE) is defined as an “approach [that] allows students to advance based on their ability to master a skill or competency at their own pace regardless of environment. [CBE Definition - Gettingsmart.com](#)

Competency-based learning is an approach to education that focuses on the student’s demonstration of desired learning outcomes as central to the learning process. [Competency-Based Learning – Teachthought.com](#)

CBE contains three key features: competencies, assessment, and flexibility.

- Competencies emphasize knowledge, skills, and attitudes that are measured through real tasks. Competencies are definable, measurable, explicit, transferable outcomes, and they provide multiple opportunities for success.
- Assessments are formative and summative; students complete self-assessments, and the supervisor/mentor completes assessments.
- Flexibility is the third core feature, in which learning and progression are personalized and independent of time.

Competencies—including knowledge, comprehension, skills, and values—must be observable and assessed across the scope of practice. Clinical mentors should observe student clinicians and varied settings and types of services—including sessions with individuals, with groups, in homes, in schools, in clinics, and with varied service providers. CBE differs from the current educational model by being more learner centric. Table 4 shows a comparison of the current (traditional) and CBE models.

Table 4. Conceptual differences between the current educational model and competency-based education.

Current Model	Competency-Based Education Model
Defined clinical hours	Variable clinical hours
Prescribed assessment schedule	Fluid assessment data points
Common pathway to program completion	Customized trajectory to program completion
Student learning is the responsibility of the instructor	Student learning is the shared responsibility of learner and instructor

Competency-Based Standards for SLPs

Competency-based standards should define the minimum skill levels for an entry-level SLP. How could a competency-based educational framework improve the development and assessment of SLP-specific clinical competencies and other 21st century skills?

Competency-based standards should

- inform readiness for entry into the profession,
- guide assessment and re-education for someone wanting to re-enter practice,
- inform academic institutions of the competencies expected of entry-level SLPs,
- inform SLPs and employers of the standards for independent practice, and
- inform policymakers about the range and standards of practice for an entry-level SLP.

The final report of the GESLP Committee (pages 92-3) provides a definition of *entry-level knowledge and skills*, as well as consideration of competency-based professional standards for SLPs. It highlights the CFCC's responsibilities in determining the competencies for entering practice in health care and education.

Standards play a significant role in restructuring graduate education for speech-language pathology. The CAA and CFCC are critical in this process. Accreditation and certification bodies are responsible for providing the structure of standards. Developed through a peer-review process, these standards are designed to ensure entry-level quality and allow for flexibility in implementation. The timeline for revising standards is slow and deliberate. Engagement of stakeholders is necessary because multiple ad hoc committees and practice analyses are essential components of the process.

Further consideration of competency-based models of education in speech-language pathology would benefit from detailed examples of how curricula, syllabi, simulations, evaluations, and clinical experiences could be framed to support a CBE approach. Fortunately, there are pioneers within our discipline from other countries and from other disciplines whose efforts and achievements can help provide examples and guidance. These pioneers and examples follow in the subsections below.

COMPASS®

Speech-language pathology programs in Australia, New Zealand, Hong Kong, and Singapore use the Competency Assessment in Speech Pathology (**COMPASS**®). COMPASS is a competency-based, computer-assisted assessment tool designed to validly assess the performance of speech pathology students in their placements. These countries have used COMPASS since 1993. Speech Pathology Australia recently revised COMPASS and mapped it to the [World Health Organization \(WHO\) Rehabilitation Competency Framework](#) (WHO, 2021).

CBOS

The Competency Based Occupational Standards for Speech Pathologists (CBOS) is a document that describes the minimum skills, knowledge, and professional standards required for speech pathologists to enter practice in Australia (Speech Pathology Australia, 2023). The CBOS is also used in New Zealand, Hong Kong, and Singapore.

CBE Adoption in Related Health Professions

Some health professionals that use CBE models include physicians, nurses, dentists, genetic counselors, physical therapists, occupational therapists, and pharmacists. The organizations for each profession established frameworks centered around the major practice domains within the profession's framework—and, within each practice domain, a set of core competencies. The domains and competencies are mostly in the following range: five to six domains, and more than 20 competencies within each domain.

In 1999, the American Medical Association (AMA) adopted [six core competencies](#) led by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS). (For more information, see <https://www.abms.org/board-certification/a-trusted-credential/based-on-core-competencies/>).

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

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

For example, Knowledge to Practice (K2P) offers [competency-based learning experiences](#) to facilitate top-of-the-license practice in a rapidly changing health care environment.

Advantages to CBE

CBE frameworks increase accountability through the identification of standards of practice, measurement of competency and skills, and maintenance of clinical competence for communication and swallowing disorders in varied populations.

There are several advantages of implementing a CBE model:

- Ensures entry-level competence across core areas of practice.
- Ensures consistent knowledge, skills, and professional behaviors in students across programs.
- Develops appropriate self-assuredness in entry-level practitioners.
- Prepares graduates to adapt and be flexible in response to changes in scope of practice and settings.
- Disconnects entry-level education from the concept of “clinical hours.”

Challenges to CBE

Some of the challenges associated with establishing a CBE framework for speech-language pathology in the United States include:

- The limited number of faculty with CBE knowledge.
- The infrastructure variability and varying constraints across universities.
- The complexity of identifying competencies across the big nine areas, practice settings, 21st century skills, and distinguishing between entry-level and more advanced competency levels.
- The lack of clarity concerning how the large range of varying competencies mentioned above is to be acquired, assessed, and recognized.

Several challenges with the current speech-language pathology educational model have been identified (see [Table 3](#) for the list of Critical Problems). Graduates are inadequately trained across the full scope of practice—with significant gaps in particular topic areas (e.g., voice, dysphagia, autism). Most academic programs are challenged to provide education and training across the full scope of practice across the lifespan. For others, despite having sufficient expertise to teach across the big nine topic areas in the scope of practice, they lack the faculty capacity needed to do so. The depth and breadth of knowledge and skills is unequal among graduates, and no framework is currently in place by which competency gaps can be clearly identified.

Development of a competency-based framework for speech-language pathology in the United States is a multi-staged endeavor. To begin, an inventory of competencies in specific areas of practice is needed. The experimental methods used by the Next Steps Committee to gather stakeholder input could be applied to gather detailed information across many SLPs working in a variety of settings and with a variety of populations. By taking a qualitative approach—either through interviews or focus group discussions—information about the full range of competencies needed in their area of practice could be collected with a sufficient level of granularity to inform the development of a competency-based framework. With the assistance of generative AI, a large corpus of spoken and written language could be analyzed efficiently to describe the competencies needed in specific areas of practice. Expert panels could then review the list and make the final determination of which competencies should be included for a given area of practice. The development of competency inventories will guide the transformation of the current educational model and secure a clearer path by which SLPs can expand their competencies to advance in their current practice setting or transition to a new one.

The process of restructuring education in speech-language pathology using a CBE framework entails several elements. First, more research is needed to determine the potential impact of CBE on academic programs, faculty, clinical educators, and certification and accreditation standards. Additionally, the infrastructure needs and potential cost to ASHA and other stakeholders should be estimated. Information about the potential benefits, costs and risks will be invaluable to those making decisions about CBE. If transitioning to a CBE framework appears feasible and the benefits out-weigh the risks, then efforts to identify the core competencies and measurable benchmarks for an entry-level SLP will be needed across the scope of practice, practice settings, and 21st century skills. Identification of core competencies for clinical educators and for expert speech-language pathology practice will need to follow. A substantial amount of time, effort and cost by many institutions and stakeholders would be needed to incorporate CBE into the educational model and the accreditation and certification standards for speech-language pathology in the United States. Thus, it is imperative to conduct the research needed to determine the potential impact of CBE on academic programs, faculty, clinical educators, certification and accreditation standards, the infrastructure needs, and the potential benefits, risks and costs to ASHA and other stakeholders before committing to the journey.

Stakeholder Input: CBE Survey Summary

Participants of the 2022 *Next Steps Summer Webinar Series* were asked to complete an online survey. The survey was designed to gather information on general topics and on a subset of questions specific to the CBE topic. The full *Competency-Based Education Survey Report* is available in Appendix D.

Demographic Overview of the Respondents

- A total of 25 individuals responded to the survey.
 - 96% were certified SLPs.
 - 4% were certified audiologists.
- Most (60%) had been employed in the professions for 21 or more years.
 - 8% for 16–20 years
 - 24% for 11–15 years
 - 8% for fewer than 10 years
- College/university was the primary employment setting for 92%.
 - 4% in agency/organization or research facility
 - 4% in “other”

Topic-Specific Questions

After the CBE webinar, three topic-specific questions were asked on the CBE Survey to better understand the participants own readiness for, interest in, and knowledge of CBE.

- The first, Question #14, asked, “What is your level of readiness to change to a competency-based education model?” Responses to Question #14 are shown in Figure 8.
- The second, Question #15, asked, “What is your level of interest in moving to a competency-based education model for graduate training in SLP?” Responses to Question #15 are shown in Figure 9.
- The third, Question #16, asked, “How knowledgeable are you about competency-based education?” Responses to Question #16 are shown in Figure 10.



Figure 8. The distribution of responses to Question #14, which asked, “What is your **level of readiness** to change to a competency-based education model?”

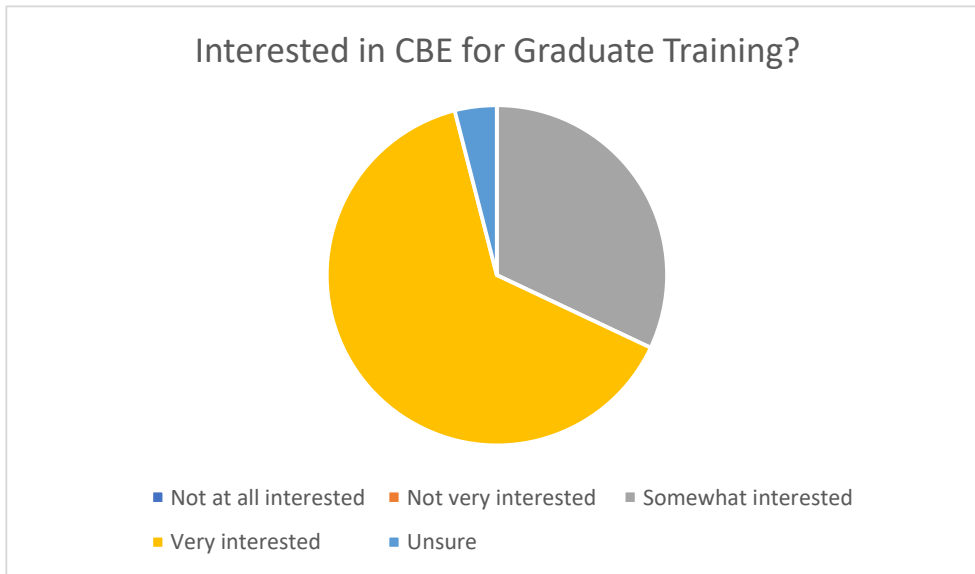


Figure 9. The distribution of responses to Question #15, which asked “What is your **level of interest** in moving to a competency-based education model for graduate training in SLP?” (Note: None of the respondents selected the "Unsure" or "Not at all interested" response options.)

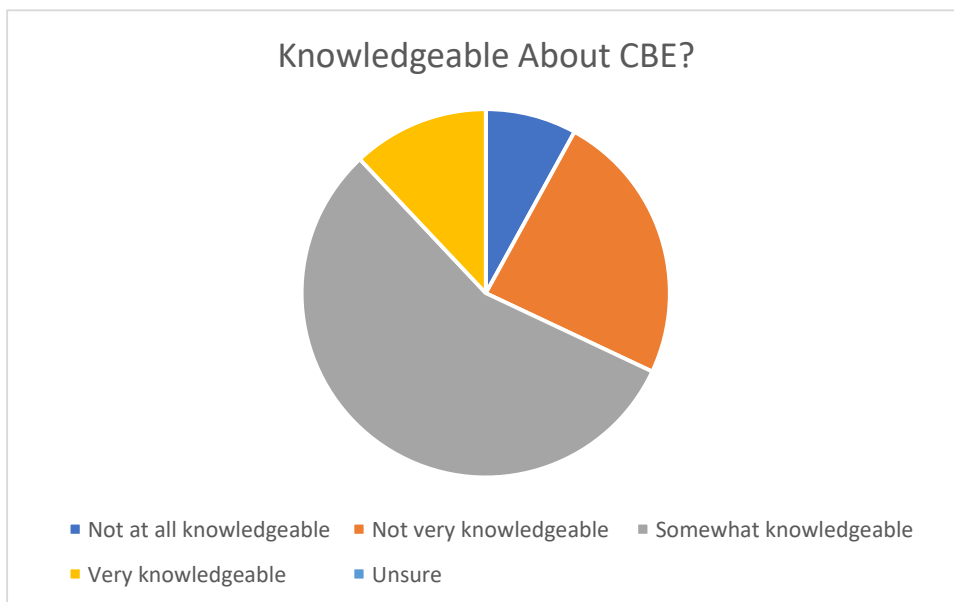


Figure 10. The distribution of responses to Question #16, which asked, “How **knowledgeable** are you about competency-based education?” (Note: None of the respondents selected the “Unsure” response option.)

CBE Webinar Breakout Group Summary

This summary was generated by Claude.ai and edited by humans.

Key Points

The Next Steps Committee planned the *Next Steps Summer Webinar Series* in 2022 to gather stakeholder perspectives on transitioning to CBE in graduate programs. Six virtual sessions were held, with approximately 8–10 participants per group using the procedures described in the Introduction, under the Methods section. This summary synthesizes the key themes, concerns, opportunities, and recommendations that emerged across the breakout group discussions.

The following major themes emerged from the CBE webinar breakout group discussions:

- *Strong support for CBE—but concerns about execution.* There was consensus on the need to move toward competency-based models to strengthen preparation of practice-ready clinicians. However, the scale of change that is required gives pause and brings forth fears of inconsistent implementation across hundreds of programs.
- *Call for a balance between structure and flexibility.* Participants desire a structured framework from ASHA—with tools, benchmarks, and training to support CBE. But programs also need latitude to customize competencies and enable implementation in their contexts.
- *Emphasis on competencies beyond technical skills.* Heavy focus on building critical thinking, problem solving, communication, cultural responsiveness, and other essential 21st century skills to fulfill workplace demands.
- *New assessment models are critical for success.* Validated tools and benchmarks are needed to gauge competencies reliably across diverse settings. Training for clinical supervisors is vital.
- *Focus on interprofessional education and shared core competencies.* Developing some shared foundational competencies jointly with other health care fields can promote collaboration and smooth transitions.
- *Paradigm shift requires extensive support.* Transforming well-entrenched conventional models of teaching and learning demands significant guidance, resources, and phased timelines.

Breakout Group Discussions

The breakout groups responded to the following three discussion prompts. The responses touched on a variety of common themes, which are detailed in the bullets below.

1. What other information about CBE would you like to provide to the Next Steps Committee?
2. What is the most critical thing that the Next Steps Committee needs to know to implement CBE?
3. What other information do you want to share with the Next Steps Committee about CBE?

Common Themes

Several common themes emerged from the breakout groups in response to the three discussion prompts.

1. What other information do you want to share with the Next Steps Committee about CBE?

- There was strong support for moving toward CBE to better prepare students for diverse, real-world, clinical situations and to reduce reliance on checkboxes for clock hours. However, participants emphasized the need for a shared understanding and framework for implementing CBE successfully.
 - Participants discussed the challenges of shifting mindsets and models—within higher education institutions—that are still largely based on time and number of credits. There was a call for support in transitioning and adapting a CBE model within current systems and constraints.
 - Several groups highlighted the need for more integration between academic knowledge and clinical skills/application throughout the curriculum, rather than siloed courses. There was support for concepts like just-in-time education and learning of knowledge concurrently with clinical experiences.
 - Evaluating competencies was discussed extensively including setting clear benchmarks, gauging 21st century skills, and training clinical supervisors on consistent assessment. Also discussed was the focus on lifelong learning skills rather than just technical competencies.
 - Concerns were raised about variability across programs, settings, and supervisors, and the resulting inconsistencies in education and measurement of competencies. Participants expressed a desire for more standardization across the field in implementing CBE.
 - Emphasizing competencies that enable lifelong learning and growth mindsets, not just technical skills.
 - Considering post–Clinical Fellowship expectations and defining the developmental arcs in acquiring specific competencies.
 - Educating employers on competency progression and supporting new clinicians. Getting input on any needed improvements.
 - Focusing on issues around student motivation and engagement with the process. Avoiding an over-reliance on extrinsic benchmarks.
2. What is the most critical thing that the Next Steps Committee needs to know in order to implement CBE?
- Many participants expressed the need for a clear operational framework and guidelines from ASHA, which would allow programs to successfully transition to CBE. This includes defining key terms, deciding upon required components, coming up with reliable examples, and allowing for flexibility within a structured model.
 - Participants emphasized that CBE requires a major paradigm shift in how programs educate students and in how faculty teach. There are implications for workload, and there is a need for promoting buy-in, overcoming resistance, and obtaining extensive training and support.
 - Several groups discussed the challenges of mapping competencies across diverse settings, disorders, age groups, and stages of clinical training. Guidance is needed on breaking down and scaffolding competencies.
 - Consistent assessment tools, benchmarks, and checkpoints are critical for measuring competencies. Training is needed for clinical supervisors on expectations and evaluation methods. Avoiding too much variability across programs and systems is recommended.
 - Participants raised concerns about student progression timelines, attrition policies, and preparedness for Clinical Fellowships with a self-paced model. Guardrails are needed to uphold standards.
3. What other information do you want to share with the Next Steps Committee about CBE?
- Look at expectations for entry-level versus post-graduate competencies to set realistic goals. Many settings have unrealistic views of new clinicians' skills.

- Consider specialization tracks, resident programs, and supplemental certificates, such as micro- and stackable credentials to deepen knowledge and fill training gaps as needed. Avoid a one-size-fits-all model.
- Examine potential financial impacts on students and barriers to completing competencies. Avoid added burdens and ensure equitable opportunities.
- Partner with employers to understand priority competencies and to assess successes and shortcomings of current educational models. Get employers' input on improvements needed.
- Look at creative solutions to provide competency-building opportunities and incentives for clinical preceptors/supervisors to expand available placements.
- Start introducing competency measures and active learning pedagogy at the undergraduate level to lay foundations and to prepare students for the graduate program shift.

In summary, these breakout groups reflected enthusiasm for moving toward CBE to strengthen preparation of students for clinical practice. However, extensive work is needed to create structured frameworks, address paradigm shifts, provide training and support, set realistic competency expectations at each stage, and mitigate potential barriers to effective implementation across diverse programs and settings. Leveraging models both within and beyond CSD will help guide this transition.

Concerns and Challenges

The CBE webinar breakout group brought forth the following concerns and challenges during the discussion:

- Major mindset shifts for faculty and institutions accustomed to time- and credit-based models, which are perhaps easier to objectively measure. Significant training and change management strategies are needed.
- Risk of inconsistencies and inability to uphold standards with highly decentralized execution across hundreds of programs and clinical sites.
- Difficulty accommodating self-paced progression timelines within rigid academic calendars and funding constraints at every level. Need innovative solutions, which may surface as higher education undergoes significant transformation.
- Already insufficient clinical placements could be further strained with unpredictable student timelines.
- Employers have unrealistic expectations of entry-level competencies. They lack understanding of the developmental arc.
- Increased workload burden on programs and supervisors for frequent student competency assessment using new tools.
- There is no field-wide consensus yet on how to define, classify, and measure competencies. Varying interpretations exist.

Key Opportunities

The CBE webinar breakout group identified the following key opportunities:

- Strengthen preparation for real clinical environments through authentic, experiential learning.
- Enable more personalized learning paths tailored to students' strengths, interests, and developmental needs.

- Build critical 21st century skills demanded by employers—skills like communication, cultural responsiveness, and teamwork.
- Promote interprofessional education and development of shared core competencies with other fields.
- Enhance career-long learning and smooth role transitions via competency augmentation and through stackable and micro-credentials.

Recommendations

To capitalize on CBE opportunities while addressing concerns, breakout group participants provided the following recommendations:

- Develop structured but adaptable competency-based frameworks outlining core components and flexible aspects.
- Provide extensive training, resources, and communities of practice to support faculty and site transitions.
- Partner with clinical sites to (a) integrate students at varying competency levels and (b) provide rich learning experiences early on.
- Use simulation, lab-based, adaptive, and online learning to expand access and to supplement workplace training.
- Align competency expectations with employers, faculty, and students to realistic developmental arcs from graduation to independent practice.
- Educate employers on competency progression and the need for mentoring of new clinicians.
- Offer micro-credentials and stackable certificates for specializations, and bridge competency gaps across diverse settings.
- Leverage technology to facilitate personalized instruction, practice opportunities, and competency measurement.
- Validate assessment tools and rubrics that minimize the training and scoring burden while still upholding standards.
- Build interprofessional education through joint simulations and the mapping of complementary competencies.
- Develop policies and support mechanisms to mitigate increased costs and access barriers that are likely to occur if this shift to CBE warrants extended timelines to degree completion.

In addition, the breakout group participants recommended gathering perspectives from programs that have implemented a CBE model (e.g., medicine, nursing, international speech-language pathology programs, and other stakeholders). Ongoing input and co-design with academic and other stakeholders will be key for an effective and sustainable transition of this magnitude.

Next Steps

This stakeholder feedback provides invaluable insights to inform continued efforts. Key next steps include the following:

- Researching potential effects and stakeholder perspectives concerning the adoption and potential implementation of a CBE framework for educating SLPs, and weighing the pros, cons, benefits, costs, and risks to make a go/no-go decision. If decisions are made to proceed with CBE, then the following next steps would be warranted:
- Developing a competency-based framework that distinguishes foundational, intermediate, and advanced competencies.
- Mapping competencies to clinical practice and workplace requirements using research and technical expert panels.
- Designing professional development programs to assist faculty and supervisors with reorienting instruction and assessment approaches.
- Conducting trials of rubrics and assessment tools to gauge competencies reliably and feasibly across diverse programs and settings.
- Engaging institutions, employers, and partners in the co-creation of resources, solutions, and policies supporting CBE adoption.
- Creating guidance documents, tools, and templates to assist programs in redesigning curricula, assessments, and learning experiences aligned to a CBE model.
- Exploring potential accreditation implications and advocating for necessary reforms in higher education systems, funding, and policies.
- Developing communications campaigns and change management strategies promoting buy-in and showcasing the benefits of transitioning to CBE.
- Developing a specialty credentialing system that encompasses areas of clinical and professional competencies with tiered levels to signal expertise and professional growth throughout one's career.

By proceeding thoughtfully with a focus on stakeholder needs, research, and collaborative solutions, the promise of CBE to transform education in speech-language pathology can be realized. A competency framework would benefit the public and the profession by helping us to be better prepared to serve our clients, students, and patients. Redesigning education for SLPs within a competency-based framework will provide the granularity and flexibility that the field needs to meet evolving demands and to adapt in the future.

Recommendations

The CBE webinar breakout group provided recommendations to address the following nine concerns raised during the CBE breakout group discussions.

1. [Paradigm Shift and Resistance to Change](#)
2. [Variability Across Programs and Settings](#)
3. [Student Progression and Attrition Policies](#)
4. [Cost and Access Barriers](#)
5. [Shortage of Clinical Placements](#)
6. [Employer Engagement and Expectations](#)
7. [Assessment Burden on Programs and Supervisors](#)
8. [Defining and Measuring Competencies](#)
9. [Inconsistencies in Competency Measurement](#)

Paradigm Shift and Resistance to Change

Concern

CBE represents a major shift in mindset, teaching methods, program structure, and workload that many faculty and institutions will find difficult to adapt to. The magnitude of this shift could generate resistance, skepticism, and initiative fatigue. This risk should be considered a top concern.

Recommendations

- Provide extensive training, support, and examples to help faculty transition to CBE principles and pedagogy.
- Partner with faculty and supervisors at every stage, and support grassroots efforts in academic and clinical programs.
- Highlight the benefits of the CBE model in producing more practice-ready clinicians.
- Incrementally phase in the implementation of CBE to allow time for adoption.
- Incentivize adoption of CBE and provide resources to alleviate the workload burden of redesigning curricula and other implementation efforts.

Variability Across Programs and Settings

Concern

With decentralization and increased flexibility in CBE, there are risks of inconsistent competency expectations and assessment methods across programs, supervisors, and work settings.

Recommendations

- Develop guidelines and benchmarks for core competencies at each stage, while allowing customization.
- Create validated tools for measurement of competencies and standardize evaluation methods and criteria.
- Provide access to training for faculty, clinical supervisors, and employers on competency assessment.
- Facilitate sharing of best practices across institutions to promote consistency.

Student Progression and Attrition Policies

Concern

Self-paced progression in CBE could lead to variable timeline completion, bottlenecks, and questions about policies for students unable to achieve competencies.

Recommendations

- Provide guidance on reasonable program duration and gateways for competency achievement.
- Develop clear policies and guardrails for remediation and attrition that uphold standards.

- Consider competency integration into Clinical Fellowships to support transition to independent practice.
- Explore stacking certificates or micro-credentials for attaining competencies beyond entry level.

Costs and Access Barriers

Concern

Students could face increased financial burdens and tuition costs if CBE extends the time required to graduate. This could disadvantage students from lower socioeconomic backgrounds.

Recommendations

- Advocate for reforms in higher education funding models to align with the CBE approach.
- Provide scholarships, grants, and support to assist students.
- Develop lower-cost online modules, resources, and training programs to supplement campus learning.
- Partner with employers to offer apprenticeships and tuition assistance programs.

Shortage of Clinical Placements

Concern

Programs already struggle to secure sufficient quality clinical placements. This struggle could be exacerbated if CBE increases students' time to completion.

Recommendations

- Expand simulation training and experiential labs to complement workplace learning.
- Offer incentives like continuing education credits to preceptors.
- Structure rotations to support competency development from novice to mastery levels.
- Collaborate with placement sites to integrate students at various competency stages.

Employer Engagement and Expectations

Concern

Employers often have unrealistic expectations of entry-level clinicians' abilities. Lack of understanding of the CBE model and competency progression stages could exacerbate this issue.

Recommendations

- Align competency expectations to the typical developmental arc from graduation to independent practice.
- Educate employers on integrating CBE-trained clinicians and supporting their mentored growth.

- Collaborate with employers to map competencies to job requirements and provide workplace training opportunities.
- Engage advisory boards and partners to promote employer buy-in to CBE.

Assessment Burden on Programs and Supervisors

Concern

Frequent assessment of competencies could substantially increase workloads for programs and clinical supervisors.

Recommendations

- Provide validated rubrics and efficient assessment tools to minimize added workload.
- Implement competency-sampling methods rather than assessing every competency continually.
- Structure assessments across competency levels and milestones to ease tracking.
- Offer training and support for evaluators on competency-based assessment methods.

Defining and Measuring Competencies

Concern

There is a lack of consensus on how to define, classify, scaffold, and measure competencies. This can impact consistency and quality of CBE.

Recommendations

- Develop a competency framework with standard taxonomy, categories, and milestones.
- Provide rubrics, benchmarks, and learning objective examples for key competency domains.
- Research and validate new assessment tools purpose-built for competency evaluation.
- Leverage competency mapping that accreditation bodies and licensing boards can utilize.

Inconsistencies in Competency Measurement

Concern

With the decentralization and flexibility of CBE, there are risks of inconsistent expectations and assessment methods for competencies across university programs, supervisors, and work settings. This could lead to gaps or inadequacies in training.

Recommendations

- Develop detailed frameworks and rubrics to standardize evaluation criteria and methods nationally, while allowing for some customization.

- Provide extensive training for clinical supervisors and employers on competency assessment principles and practices.
- Use sampling approaches for competency demonstration instead of assessing every competency continually.
- Require regular calibration exercises among supervisors to promote consistent scoring.
- Facilitate sharing of best practices in competency mapping and measurement across institutions.
- Leverage technology—such as simulations and virtual patients—to provide standardized assessment opportunities.

In summary, these are among the most pressing concerns and barriers raised by breakout group participants regarding the transition to CBE. They provided a wide range of constructive recommendations to proactively address these challenges. By considering these insights and advice from stakeholders within the CSD community, ASHA can refine its approach to implementing CBE in ways that maximize benefits and minimize risks. This will help ensure a thoughtful, evidence-based transition that meets the needs of students, programs, employers, and the profession.

Opportunities and Recommendations

CBE opens many opportunities to improve the education of SLPs, six of which are listed below.

1. [Strengthening Clinical Preparation](#)
2. [Promoting Student-Centered Learning](#)
3. [Cultivating Essential 21st Century Skills](#)
4. [Supporting Interprofessional Education](#)
5. [Enhancing Career Mobility and Lifelong Learning](#)
6. [Leveraging Technology and Innovation](#)

Strengthening Clinical Preparation

Opportunity

CBE allows a focus on developing skills that are critical for practice readiness rather than emphasizing time-based requirements. This can enhance preparation for diverse, real-world, clinical situations.

Recommendations

- Map competencies to workplace requirements and high-impact skills needed for practice.
- Integrate knowledge and hands-on application throughout curricula.
- Provide experiential learning opportunities through simulation, labs, and clinical placements.
- Have checkpoints for competency attainment at different stages.
- Use simulations and standardized patients as opportunities for practice and evaluation.
- Consider extensions to the length of graduate programs.

Promoting Student-Centered Learning

Opportunity

CBE facilitates more personalized, self-directed learning—with flexibility in pacing and customization based on interests and strengths.

Recommendations

- Develop customized competency roadmaps for each student.
- Implement formative and summative assessments to support self-monitoring.
- Provide coaching and resources to nurture self-efficacy and self-directed learning.

Cultivating Essential 21st Century Skills

Opportunity

CBE facilitates and emphasizes critical thinking, problem solving, teamwork, communication, and other essential 21st century skills demanded by employers.

Recommendations

- Incorporate 21st century skills explicitly into competency standards across settings and stages.
- Develop simulations and tools to practice and evaluate 21st century skill application.
- Partner with employers to understand the priority skills needed for success.

Supporting Interprofessional Education

Opportunity

CBE opens doors for increased interprofessional education and greater collaboration across disciplines.

Recommendations

- Map complementary competencies across professions to identify opportunities for co-training.
- Implement interprofessional simulations and experiential projects.
- Develop shared core competencies in areas like teamwork, ethics, evidence-based practice, and so forth.

Enhancing Career Mobility and Lifelong Learning

Opportunity

CBE facilitates continuous development across diverse settings and a changing scope of practice throughout one's career.

Recommendations

- Articulate competency expectations across various specializations and settings.

- Develop micro-credentials and certificates for ongoing education in new areas.
- Cultivate a growth mindset focused on continual improvement beyond graduation.
- Focus on smoothing career transitions and bridging competency gaps via micro-credentials and stackable certificates.

Leveraging Technology and Innovation

Opportunity

CBE enables integration of new instructional approaches and technologies like adaptive learning, virtual simulation, and online modules.

Recommendations

- Curate online learning resources related to diverse competency domains that promote accessibility.
- Develop virtual tools for personalized instruction, practice, and competency assessment.
- Provide training in instructional design and edtech applications for teaching faculty.
- Incorporating more simulation, lab-based, and online learning.

In summary, CBE presents exciting opportunities to transform CSD education in student-centered, clinically relevant, and innovative ways. These insights provide a strong foundation for programs to capitalize on these opportunities through thoughtful implementation guided by stakeholder needs.

Program Recommendation: Establishing a CBE Framework

Transitioning to a CBE framework represents a major opportunity for the field to transform graduate education and improve practice readiness of SLPs. However, it also presents formidable challenges for university programs and faculty accustomed to using conventional time- and credit-based approaches.

The Next Steps Committee recommends that ASHA continue to explore how CBE might work in the United States across the diverse array of academic institutions that educate SLPs and to further consider the relative benefits and risks of this transformational change. These deliberations need to include those who would be most involved in transitioning to a CBE model (e.g., the academic community, clinicians who supervise students and Clinical Fellows, students, employers, Academic Affairs Board, CAA, CFCC, CAPCSD) in these deliberations. Should the decision then be made to transition to a CBE model, the following recommendations are offered.

The proposed CBE program framework outlined below identifies key components of a CBE model that provide structure and consistency while allowing flexibility for contextualization. A phased rollout is proposed to enable iterative refinement and gather ongoing stakeholder input to maximize buy-in.

Proposed CBE Program Framework

Competency Framework with Three Tiers

- **Foundational Competencies:** Knowledge and skills expected at entry level for generalized practice. Aligned to current standards.
- **Specialization Competencies:** Deeper skills and knowledge for specific settings (e.g., schools), populations (e.g., geriatrics), or techniques (e.g., AAC) built through electives, placements, and supplemental credentials.
- **Advanced Competencies:** Higher-level skills such as differential diagnosis, clinical teaching, and evidence-based practice. Developed in the Clinical Fellowship or via residencies or micro-credentials.

Flexible Timelines with Milestones

- Minimum time-based requirements at institution and state licensing levels.
- Self-paced progression monitored via formative assessments, and milestones mapped to competency development arc from novice to mastery.
- Required summative assessments to verify competency attainment for advancement—with options to remediate or extend training if milestones are not met.

Integrated Learning

- An interweaving of knowledge, hands-on skills practice, and clinical experience throughout the curriculum rather than an offering of siloed courses.
- Authentic activities like simulation, role play, and problem-based learning cases that integrate competencies from multiple domains.
- A set of core competencies and interprofessional education opportunities that are shared with nursing, physical therapy, occupational therapy, medicine, and other fields.

Coaching and Supports

- Individualized learning plans mapping the required foundational, specialized (if any), and transitional competencies from Clinical Fellowship into first job.
- Academic and clinical advisors guiding students in managing competency progression with tools like online portfolios documenting achievements.
- Support services being expanded to assist students who are navigating challenges and who need extended timelines.
- Programs could provide coaching on growth mindset, self-efficacy, and metacognition.
- Students having regular reflection exercises and portfolio reviews.
- Programs using strengths-based language that emphasizes mastery instead of focusing solely on scores.

Validated Assessments

- Field-tested rubrics and tools benchmarked nationally to evaluate competencies consistently while allowing program customization.
- Training for faculty and clinical educators on competency assessment principles and practices.

- A sampling approach where subsets of foundational competencies are assessed each term rather than evaluating all competencies continually.
- Use of frequent formative feedback—including peer assessment and self-assessment—supplemented by summative assessments each semester tracking developmental progress.
- Tools that aim to minimize training and scoring burden on programs and supervisors.

Resource Exchange

- Online repositories to share assessment tools, learning activities, rubrics, interprofessional modules, adaptive learning resources, and other materials.
- Faculty communities to exchange best practices in instruction, competency mapping, student support, and partnership building.
- Toolkits and training programs on topics like change leadership, assessment design, instructional methods, core competencies, program–site partnership cultivation, and more.

Phased Implementation Approach

Year 1

- Form working groups to develop the competency framework, assessments, and toolkits.
- Pilot the components at volunteer programs and sites and gather feedback.
- Provide extensive training for pilot participants—with an ongoing support system.
- Develop consortia for sharing resources and collaborating across institutions.
- Conduct research on competency mapping, assessment validity, pedagogical transitions that may be needed, and integration models.

Years 2–5

- Provide training and resources to aid additional programs in transition.
- Expand consortia and resource exchange communities.
- Continue to research and modify tools based on data and stakeholder input.
- Update accreditation standards and processes to support CBE integration.
- Address policy barriers related to funding, graduation timelines, licensing requirements, and so forth.

Ongoing

- Maintain robust training, resources, and support systems for new adopters.
- Facilitate continued knowledge exchange among CBE programs to promote consistency and share evolving best practices.

This proposed CBE program framework aligns with the breakout group recommendations for a structured but flexible approach customized to different settings. It balances standardization in competency expectations and assessment methods with latitude for programs to innovate within a framework.

Gradual, iterative implementation would enable adaptation in response to emerging evidence, stakeholder feedback, and lessons learned by early adopters. Ongoing input from students, programs, employers, and other stakeholders should be gathered to help define and refine the model.

ASHA's Role

ASHA plays a central role in implementing the proposed competency-based hybrid educational model in at least the following ways, as outlined below.

1. *Research*: ASHA should coordinate multi-site research on the potential impact of competency-based education across institutions and disseminate its findings to inform decisions, and refinement of the model and practices if adopted.
2. *Convene stakeholders*: ASHA should bring together representatives from academic programs, employers, state licensure boards, accreditation bodies, and other critical groups to continue to explore and research the benefits and risks and to collaboratively develop competency-based frameworks and standardize requirements should the decision be made to adopt a CBE framework to educate SLPs.
3. *Competency development*: ASHA should use its existing resources and expertise to facilitate a robust, inclusive process of defining essential competencies across the scope of practice, drawing from proven models like COMPASS® in Australia.
4. *Assessment alignment*: ASHA should help coordinate efforts to ensure that assessments at each educational stage accurately measure attainment of priority competencies. This includes licensure exams.
5. *Educator support*: ASHA should create professional development resources, communities of practice, and training programs to help facilitate faculty adoption of competency-based methods and pedagogical improvements.
6. *Advocacy*: ASHA should advocate for policy reforms to graduate program requirements, credentialing, reimbursement, and funding streams to enable implementation of the model.
7. *Implementation guidance*: ASHA should develop guides, tools, templates, and other resources to help graduate programs and other stakeholders implement components of the model.
8. *Model curriculum*: ASHA should collaborate with faculty to develop and share sample competency-based course syllabi, learning activities, assessments, and clinical teaching approaches to exemplify the CBE model.
9. *Technology facilitation*: ASHA should help build out shared repositories of simulations, virtual patients, and other instructional technologies to support programs in implementing the CBE model.

Conclusion

CBE holds tremendous potential to strengthen graduate training and practice readiness. This subsection on ASHA Recommendations related to CBE describes key elements of a CBE program and recommends effective transition strategies to help marshal the expertise and energy of the CSD discipline in seizing this opportunity. Through collaboration, evidence-based design, and a commitment to continuous quality improvement, an adaptable CBE model can be built that can then be integrated throughout the field. Importantly, this work will lay the foundation upon which future changes to the speech-language pathology scope of practice—and practice demands—can be accommodated.

VI. Faculty Sufficiency and Development

The Working Group on Faculty Sufficiency and Development developed two webinars—one on **Faculty Growth and Sufficiency** and another on **Faculty Development**.

Faculty Growth and Sufficiency

The Working Group gathered data on research doctoral graduates to understand the research doctoral pipeline for faculty to staff academic speech-language pathology master’s degree programs. The trend data shown in Figure 11 was obtained from the *CSD Education Survey* from the past 10 years. The solid line in Figure 11 shows the number of doctoral degrees conferred in the United States annually and the dotted line depicts the derived linear function, which shows a downward trend in the number of research doctoral degrees granted since the 2012–2013 fielding. The average number of research speech-language pathology and speech science doctoral degrees conferred was 107.2 per year over the 10-year period, with a range of 92–131. In that same 10-year period, 20%–45% of open speech-language pathology / speech science research doctoral faculty positions went unfilled. There has been a steady proliferation of new speech-language pathology master’s degree programs over the past decade. As of July 2022, there were 276 accredited programs—with an additional 25 candidacy programs in the continued monitoring phase and another 12 in the early application/decision phase of candidacy. In addition, 20 programs are scheduled for an application cohort from July 2023 to July 2025. Unfortunately, the projected need for research doctoral faculty is outpacing the growth of research doctoral graduates. Too few faculty with appropriate terminal academic degrees in the discipline poses a major threat to the education of SLPs, the profession, and to sustaining the science of the discipline.

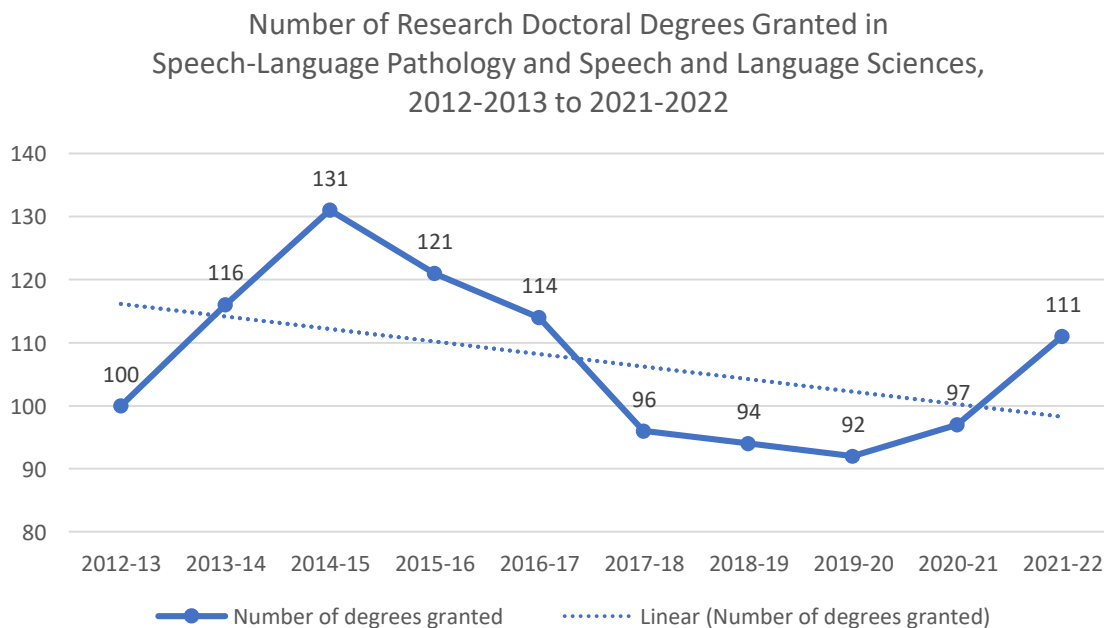


Figure 11. Number of research doctoral degrees conferred in speech-language pathology or in speech or language science in the United States is displayed from 2012–2013 through 2021–2022. The dotted line depicts the derived linear function, which shows a downward trend in the number of research doctoral degrees granted since the 2012–2013 fielding.

Graduation and enrollment in research doctoral programs are a direct measure of the pipeline of new speech-language pathology faculty. Thus, the linear trend shown in Figure 11, indicating a downward trajectory, is a disturbing predictor of the discipline's viability, especially considering the rampant growth in new academic programs in speech-language pathology. The following key data points from the 2020–2021 *CSD Education Survey* are worrisome:

- Capacity for new doctoral students in research doctoral programs was only 43% filled, leaving more than half the slots empty.
- Across all research doctoral programs, the biggest impact on enrollment has been insufficient student funding and an insufficient number of qualified applicants.

However, the following key data points from the same survey offer some hope for the future of the professions:

- Of the 267 offers of admission made, 89.5% of these were made with funding.
- Of those students enrolled in research doctoral programs, the percentage from underrepresented racial and ethnic groups has increased almost 42% in the past 10 years. The proportion of those enrolled was highest this past year at 18%.

Additional data from the 2021–2022 *CSD Education Survey* on the “number of professorial searches and positions filled by area of study” show the following results:

- 45 (32%) of the 141 faculty searches in speech-language pathology went unfilled;
- SLPs with clinical doctorates are contributing to the didactic teaching, clinical education, and administrative needs of approximately 50 academic programs;
- 7 of the 96 speech-language pathology searches were filled by individuals with a clinical doctorate in speech-language pathology; and
- more than 80 individuals with clinical doctorates in speech-language pathology are teaching in academic programs in the United States.

Indicators that address the question of whether there will continue to be sufficient PhD-level faculty in speech-language pathology to support the number of current and future programs have suggested a less-than-promising answer.

The Working Group on Faculty Development and Sufficiency also explored variables that affect recruitment and retention of research doctoral students. Data concerning what prospective research doctoral students are looking for in a PhD program are important factors to consider (Tucker, Compton, Ellen, et al., 2020). From a variety of sources, we know that prospective students are looking for programs with a part-time option, online components in program delivery, and flexibility. Barriers that prospective students cite include time to degree completion, the requirement for applicants to re-locate, and sufficient funding.

Mentoring is another important variable (Cassuto & Weisbuch, 2021), which ideally includes:

- a focus on “fit” to recruit and retain students;
- the provision of timely and continuous mentoring (e.g., early and often);
- clear, documented metrics for program completion with timely progress monitoring and feedback;
- adequate preparation of students for the roles and responsibilities of academic life, which for example, might include
 - providing a positive but realistic view of obtaining a PhD and working in academe; and
 - providing different opportunities to students seeking academic careers at different institutions.

With respect to best practices in mentoring, ASHA’s Academic Affairs Board (AAB) suggested, in their November 2016 Final Report, PhD Programs in Communication Sciences and Disorders: Innovative Models and Practices, that “if we can act as a collective community to improve PhD CSD education, we can increase enrollment and completion, increase the number of graduates who choose academic positions, and add to the research and scientific base in our discipline” (p. 24). In that report from seven years ago, the AAB made recommendations to increase the PhD pipeline in CSD.

ASHA’s Academic and Research Mentoring Network

ASHA has established many educational and mentoring programs within the [Academic and Research Mentoring \(ARM\) Network](#) with the goal of increasing the number of PhD faculty and advancing the generation of research needed to support evidence-based practice. These programs provide educational, networking, and mentoring opportunities for students, post-doctoral fellows, and faculty who are considering, launching, or advancing an academic-research career. [ARM Network Program Participant Outcomes Data](#) is collected annually on key scholarly accomplishments of Network participants by measuring short and long-term participant-reported outcomes at 3 years and at 6 years following their participation. These programs are associated with positive effects on the career development of participants who were **considering**, **launching**, or **advancing** their academic-research career at the time of their participation. For example:

- More than 90% of participants who were **considering** a PhD at the time of their participation continue to engage in one or more research activities 6 years later.
- For those who were **launching** their academic-research careers when they participated, 93% had subsequently published at least one peer-reviewed manuscript 3 years later and 69% had been awarded research funding. After 6 years, 79% had been awarded research funding.
- For those who were **advancing** their academic-research career when they participated, within 3 years, 84% were awarded research funding and, within 6 years, 91% were awarded research funding. After 6 years, all continued to hold academic appointments.

While these programs are yielding promising results, there is still an urgent need to expand and improve PhD education, especially given that approximately one third of PhD graduates in CSD do not remain in the academic-research career pipeline. According to the 2021–2022 *CSD Education Survey*, 34.8% of PhD graduates accepted faculty positions. Another 28% went on to do a post-doc. The remaining third (~37.2%) sought employment in clinical or industry settings.

Barriers and Challenges to Expanding the Academic-Research Pipeline

It is important to consider possible barriers to pursuing academic employment. Some of these barriers cited across several ASHA survey and focus group reports include stagnant salaries, stress related to multiple responsibilities, lack of teaching experience, and the threat of not being tenured.

ARM Network Programs

- Promoting the Next Generation of Researchers (PROGENY)
- Students Preparing for Academic Research Careers (SPARC)
- Audiology/Hearing Science Research Travel Award (ARTA)
- Research Mentoring-Pair Travel Award (RMPTA)
- Mentoring Academic-Research Careers (MARC)
- Pathways
- Lessons for Success (LFS)
- Advancing Academic-Research Careers (AARC)
- Grant Review and Reviewer Training (GRRT)
- Clinical Practice Research Institute (CPRI)
- Dissemination and Implementation Science Travel Award (DISTAnce)

To increase enrollment and graduation of PhD students, the following should be considered:

- focusing on student-centered practices to innovate research doctoral programs;
- using best practices in mentoring to increase retention in the research student pipeline; and
- implementing or refining innovative programming such as combined degree programs (“bridge” master’s-to-PhD programs), part-time options, or cross-institutional consortia wherein students attend classes at multiple universities.

Related to our challenges in growth of the professoriate is the challenge that not all speech-language pathology master’s degree programs consistently possess the departmental capacity to cover teaching across the full scope of practice and across the lifespan with their faculty expertise. When asked about their departmental capacity to cover the full scope of practice, responses to the 2020-2021 *CSD Education Survey* (ASHA, 2021) indicated that 47% of program faculty had concerns about their department’s capacity to teach across the full scope of practice and across the lifespan. Further, curricular areas for which programs reported having limited faculty expertise included all of the big nine areas.

One of the longstanding challenges is how programs balance teaching needs with the high priority to support faculty who are engaged in research that is advancing the discipline’s knowledge in strategic areas and whose research informs education of the next generation of SLPs. When anticipating future research needs in regard to basic science and clinical research in normal and disordered communication processes, it is important to consider the [strategic plans](#) established by the National Institute on Deafness and Other Communication Disorders (NIDCD) <https://www.nidcd.nih.gov/about/strategic-plan/2023-2027-nidcd-strategic-plan>. It is also important to know that the CAA’s [Standards for Accreditation of Graduate Education Programs in Audiology and Speech-Language Pathology include](#) prioritize the research mission of academic programs.

From Section 2.1:

“The number and composition of the program faculty (academic doctoral, clinical doctoral, other) are sufficient to deliver a program of study that:

- 2.1.1 allows students to acquire the knowledge and skills required in Standard 3,
- 2.1.2 allows students to acquire the scientific and research fundamentals of the discipline . . . ”

From Section 2.3:

“The program must demonstrate that the majority of academic content is taught by doctoral faculty who hold the appropriate terminal academic degree (PhD, EdD).”

Possible solutions to the challenges faculty report in trying to cover the full scope of practice in the speech-language pathology curriculum include hiring more PhD graduates from interdisciplinary health sciences degree programs and other related disciplines. In addition, graduates of clinical doctoral programs in speech-language pathology need to be more consistently and reliably prepared for careers as clinical educators. Unfortunately, there are no accreditation standards established for clinical doctoral programs in speech-language pathology nor are there specialty certification or other credentialing programs that could provide assurance that these graduates have developed essential teaching competencies needed to assume faculty positions focused on clinical education.

Opportunities may also exist for academic programs and institutions to share coursework or form cross-institutional consortia. Innovative collaborations often arise through responses to grant announcements. For example, San Diego State University (SDSU) has two Office of Special Education Programs (OSEP) grants. One of

them, [Project MAINSAIL](#)³, is an interdisciplinary education program for 16 students enrolled in the early childhood special educator program and 16 students enrolled in the speech-language pathology program with a focus on children with significant autism who are dual language learners. The other OSEP-funded program at SDSU, the [iPUEDE! Project](#), focuses on service delivery for dual language and English learners. It prepares 36 fully qualified bilingual school psychologists and SLPs skilled at interdisciplinary collaboration in assessment, interventions, and consultation for dual and English learner students with high-intensity needs.

Another example is the University of Central Florida's [Project SPEECH](#)⁴, which is an innovative OSEP-funded project designed to prepare professionals to work with children with high-intensity needs. The project provides funding for courses leading to either a Master of Education (M.Ed.) in Exceptional Student Education or a Master of Arts (MA) in Speech-Language Pathology. Additionally, scholars who participate in Project SPEECH earn a graduate certificate in [Interdisciplinary Language and Literacy Intervention](#).

Programs within different types of institutions have unique needs and challenges in covering the full curricula within their various budgetary and hiring constraints. There are certainly many constraints and barriers to programs collaborating across universities, but the need to provide the full depth and breadth of the expanded scope of practice across the lifespan in speech-language pathology compel further exploration of this option.

Faculty Development

In the current post-pandemic context, higher education institutions have been increasingly adopting not only hybrid and online delivery models but also alternative methodologies such as simulation. There has been widespread recognition of the need to retool and educate faculty as the expectations for teaching and learning environments have been rapidly changing. This context presents unique challenges for faculty development in the CSD discipline. First, there is a need to better prepare and retain faculty for current and future teaching and learning environments. Second, faculty within the CSD discipline currently face limited professional learning opportunities.

To address this challenge, we ask, "How can synergies be created across professional development educators who sponsor specialized educational opportunities intentionally designed for CSD faculty?" Opportunities for CSD faculty should help them develop the knowledge base in teaching and learning for the professions. Several groups offer professional development opportunities—for example, ASHA sponsors a Faculty Development Institute. Also, in 2021, ASHA sponsored a Teaching Symposium focused on foundational CSD science courses. CAPCSD offers a webinar series, including a variety of topics of interest to faculty. ASHA SIGs and Specialty Boards also offer faculty-focused educational opportunities. SIG 10 (Issues in Higher Education) and SIG 11 (Administration and Supervision) focus specifically on professionals working in higher education and in educator and administrator roles. ASHA's Specialty Boards offer professional development opportunities in their specific content areas already. Ideally, ASHA would institute a coordinated effort or implement a curated site or dashboard that shows all of the various discipline-specific offerings.

The expansion of faculty development opportunities on topics related to the science of learning and SoTL is repeatedly identified as an area of primary need. As noted in this document's Future of Learning Section, these two areas of science are informing best practices in teaching and learning that higher education institutions can implement and refine in order to advance education for SLPs. The research and its deliverables could address:

³ MAINSAIL = M.A. degree Interdisciplinary preparation N for Speech-language And early Intervention Leaders)

⁴ SPEECH = Speech-Language Pathologists and Exceptional Educators Collaboration for Children with High-Intensity Needs

- inclusive pedagogy with culturally responsive practices;
- high-impact evidence-based methods for teaching across modalities (e.g., in-person, online, blended);
- competency-based framework and assessment;
- instruction in new modalities such as virtual patients, digitized mannequins, immersive reality, task trainers, and so forth;
- incorporation of best practices in pedagogy—including team-based learning, active learning, interprofessional education, and problem-based learning; and
- reflective teaching and learning.

Challenges include (a) how to intentionally support faculty involvement in professional development opportunities about teaching and learning and (b) how to develop and infuse SoTL in research agendas and scholarly expectations. One solution lies in intentional development and mentoring for faculty retention. To begin, the collective faculty of a unit should appraise its diversity, equity, and inclusion discourse and commitments to dismantling systemic inequities. Mentoring that is specific to faculty members' research agendas is another important feature of support for faculty retention.

As mentioned previously, ASHA's [ARM Network](#) offers a variety of research support opportunities at every stage. Increasingly, colleges and departments are developing their own mentoring programs. The [National Center for Faculty Development and Diversity](#) at the University of Maryland Baltimore County (UMBC) provides a variety of programs for faculty at different career stages. Also, two recent forums in ASHA's *American Journal of Speech-Language Pathology* (AJSLP) address the need for increasing diversity in the CSD workforce (ASHA, 2021a, 2021b): See [Part 1](#) (September 2021) and [Part 2](#) (November 2021) of this AJSLP forum. The use of mentoring to support faculty retention is an important element needed to increase diversity in the CSD workforce. Another is a culture shift that (a) creates structures and support for professional development needs and (b) results in environments that foster retention of faculty from diverse groups.

Entry-level faculty have unique professional development needs. PhD programs can play an important role in bolstering the readiness of new doctoral graduates for careers focused on teaching and scholarship in our shifting academic landscape wherein many roles and expectations are changing. Both clinical and research doctoral programs should require teaching experience and the development of teaching portfolios for their doctoral candidates. Programs can intentionally introduce doctoral students to SoTL as a knowledge base to guide their approach to teaching and pedagogical development. As SoTL is a recognized science, academic programs should embrace the opportunity to increase research productivity by including SoTL among the program's research priorities.

Entry-level faculty should also be encouraged to identify pathways for further clinical specialization or certification. Solutions need to recognize the shifting professional development needs in the academic life cycle of CSD faculty—including doctoral students, clinical educators, and early-career, mid-career, and senior faculty. The professional development needs of those who transition into faculty roles as a second career also need to be considered.

To summarize, doctoral education and ongoing faculty development in pedagogy should be a priority to prepare this workforce for the future of teaching and learning. This includes becoming knowledgeable about the science of learning and SoTL, especially pedagogies that promote critical and reflective thinking and other 21st century skills, such as cultural responsiveness, information and research literacy, and adaptiveness. Programs need to place greater emphasis on the importance of learning how to teach effectively by being able to navigate continually changing technology with the aims of achieving measurable outcomes—not only with respect to students learning discipline-specific content and completing courses but also with respect to students needing to learn how to think deeply about the content—and, later, to apply that knowledge.

Stakeholder Input: Faculty Growth, Sufficiency and Development Survey Summaries

Participants of the 2022 *Next Steps Summer Webinar Series* were asked to complete an online survey. Two surveys were designed to gather information about Faculty Growth and Sufficiency and about Faculty Development. The *Faculty Growth and Sufficiency Survey Report* is available in Appendix E. The *Faculty Development Survey Report* is available in Appendix F.

Demographic Overview of the Respondents

- A total of 24 individuals responded to these two surveys.
 - For the *Faculty Growth and Sufficiency Survey*, 79% were certified SLPs, and 14% were certified audiologists.
 - For the *Faculty Development Survey*, 100% were certified SLPs.
- More than 60% had been employed in the professions for 21 or more years across both surveys.
- “College/university” was the primary employment setting for . . .
 - 92% in the *Faculty Growth and Sufficiency Survey* and
 - 78% in the *Faculty Development Survey*.
- Additionally, for the *Faculty Growth and Sufficiency Survey*, 7.7% reported working in hospitals, and 0.0% reported working in “other” employment settings.
- For the *Faculty Development Survey*, 22.2% reported working in hospitals, and 0.0% reported working in “other” employment settings.

Topic-Specific Survey Questions

For the **Faculty Growth and Sufficiency** webinar, two topic-specific survey questions were asked of the participants.

In response to Question #12 (“If you are at a research institution that offers a research doctoral degree, what student-centered practices does your doctoral program implement?”), all respondents selected the following four options:

- Flexibility (e.g., able to work outside the program)
- Part-time option
- Remote options
- Strong mentoring (e.g., recognize individual and professional interests, have regular conversations with faculty advisors, work together to create a development plan)

In response to Question #13 (“Which of the following approaches does your university/program use to meet master’s SLP curricular needs across the full scope of practice?”), the respondents provided the following top three responses:

- Simulations, standardized patients
- Courses taught by off-campus experts (local or remotely based)
- Institutional collaborations or partnerships

For the **Faculty Development** webinar, two topic-specific questions were asked of the participants.

The respondents provided the following answers to Question #12 (“Describe ways that SoTL is supported and implemented by your department/program.”):

- Opportunities through the [Association of Colleges and Universities](#) (ACUE) and through the university system.
- Discussion and sharing of ideas for how to assess/organize/teach courses, including review of teaching objectives and outcomes.
- General encouragement to engage in SoTL and for improving student teaching and learning.
- Grant funding for SoTL research. Travel funding for CEUs and/or presentation of SoTL.
- Journal clubs, professional development funds.
- Learning across disciplines; interprofessional education and collaborative practice.
- University colloquium. University learning opportunities and support.
- Updating course(s) as one item toward tenure.

In response to Question #13 (“Does your institution recognize scholarly contributions in teaching and learning for promotion and tenure decisions?”), 100% of respondents selected, “Yes.”

Faculty Growth and Sufficiency Breakout Group Summary

This summary was generated by Claude.ai and edited by humans.

Key Points

The Next Steps Committee planned the *Next Steps Summer Webinar Series* in 2022 to gather stakeholder input using the procedures described in the Introduction Section of this report, under Methods. The Next Steps Committee conducted several breakout group sessions primarily with faculty members from CSD programs across the country. The goal was to discuss challenges around faculty growth, sufficiency, and sustainability in covering the full scope of practice across the lifespan. Participants shared insights on barriers and opportunities from their experiences. This summary highlights the key themes and takeaways.

Shortage of PhD Faculty

The most prominent concern was the shortage of PhD faculty across programs and the difficulties that programs face in filling open positions. Reasons cited included

- low stipends and lack of funding support for PhD students;
- high cost of PhD programs compared with earning potential;
- inflexibility of many traditional programs requiring relocation and full-time study;
- programs denying applicants who are perceived as being too focused on teaching; and
- insufficient support around issues disproportionately affecting female faculty.

This shortage significantly impacts programs’ ability to adequately cover all specialty areas and the full scope of practice across the lifespan. There was strong consensus on the need for expanded funding and more flexible PhD pathways to incentivize teaching-focused students, working professionals, women with families, and other groups to pursue faculty careers.

Need for Creative, Collaborative Solutions

Given constrained resources faced by individual programs, participants highlighted the need for creative solutions and collaborative models that allow programs to share expertise. Suggestions included cross-institutional consortia; centralized modules/courses in specialty topics; and cross-utilization of faculty between programs, enabled by online platforms. But barriers exist around logistics, territorial attitudes, rigid program requirements, and financial constraints.

Need to Valuing the Full Range of Expertise

A repeated theme was participants' concern that narrow definitions of the phrase "qualified faculty" have led to under recognition of the value of educators who possess deep clinical expertise but who have less traditional research backgrounds. There was a sense that credentials like clinical doctorates and specialty certifications should be able to count toward requirements—and that the field needs to develop systems to formally credential clinical experts as faculty.

Need to Support Teaching Development

Many participants felt that future PhD faculty need more grounding in pedagogy and teaching methods—not just content knowledge. Programs that are specifically focused on developing teaching skills and SoTL could help attract those who are interested in faculty careers centering on teaching and less on intensive research.

Changing Systemic Barriers

Participants noted wider systemic barriers that constrain programs' responses—including university policies around promotion and tenure, attitudes of higher administration, competition between programs, and accreditation requirements. Addressing these factors likely requires advocacy and policy changes at state and national levels.

Recommendations

Based on the discussions, the following recommendations could help in addressing the faculty shortage and the challenges that programs face teaching the full scope of practice across the lifespan.

- *Increase funding for PhD students* through more paid positions, stipends, training grants, and scholarships to offset costs and debt burdens.
- *Develop hybrid and online PhD programs* that allow for remote and/or part-time completion, providing flexibility while maintaining academic rigor.
- *Actively recruit diverse PhD students* starting at the undergraduate level by highlighting a range of research careers and providing support around issues like work–life balance.
- *Rethink faculty credential requirements* to allow clinical doctorates and specialty certifications to count toward PhD percentage requirements. Develop systems to formally credential clinical experts and supervisors.
- *Create faculty sharing systems* through online modules, cross-appointments, and cross-institutional consortia to share expertise, especially in specialty areas.
- *Advocate for changes* in state and national policies around program funding, support for diverse faculty, alternative pathways, and addressing wider systemic barriers.
- *Promote faculty development*, teaching excellence, and expanded research models to elevate the status of teaching faculty and to recognize diverse forms of impactful scholarship.

Next Steps

Addressing the faculty shortage and challenges teaching across the scope of practice in CSD programs will require commitment and collaboration among multiple stakeholders. These conversations represent an important step in outlining tangible solutions. Key next steps include sharing these findings with the wider community, identifying effective models and pilot opportunities, and building coalitions to advocate for supportive policies and resources. With creativity and partnerships, the field can work to sustainably strengthen its faculty capacity.

The following discussion prompts were posed to the breakout group participants:

1. How do we best maximize, utilize, and sustain existing faculty resources?
2. Have we covered the relevant issues with regard to program capacity to teach across the full scope of practice from your perspective? Are there other issues?

Responses to Question #1: Strategies to Maximize, Utilize, and Sustain Existing Faculty Resources

- **Interdepartmental collaborations:** Bringing in faculty from other departments (e.g., linguistics, psychology) to teach courses can help fill gaps, but they [faculty members] may lack clinical knowledge. Need to ensure that they are supported to learn about CSD field and integrate knowledge bases.
- **Shared courses:** Sharing courses between programs through consortium models could expand offerings, especially in specialty areas like fluency, voice, [and] AAC. But [this is] logistically challenging to set up and manage. Requires buy-in at all levels.
- **Role of SLPs with clinical doctorates:** Clinical doctorates do not currently count toward required PhD percentage standard set by the CAA, but they have valuable clinical knowledge. Could advocate for changing this ratio.
- **Preparation of SLPs with clinical doctorates:** The need to prepare SLPs with clinical doctorates to teach and take on other roles in academe was discussed. Establishing an accreditation program for clinical doctoral programs in speech-language pathology could help ensure that these individuals are prepared to be an effective part of efforts to address critical problem such as insufficient faculty capacity and challenges bridging classroom-to-clinic and science-to-practice.
- **Online/distance learning:** Allows bringing in remote experts and sharing faculty more easily. But some areas like research training still benefit from in-person [learning].
- **Non-tenure-track positions:** Can provide good options for clinically focused faculty. But it is important that positions are respected/valued by administration.
- **“Grow your own” approach:** Hire staff with requirement to obtain PhD. Provides job while getting degree part-time. Risk of overspecialization if [staff members who are getting PhD] stay at same university [after graduating].
- **Alternative/flexible PhD options:** Programs that allow part-time, distance, consortium model could expand access. But research training may suffer if [learning is] not in person.
- **Funding PhD students:** More funding [is] needed via stipends and scholarships to offset cost. Loan forgiveness could incentivize careers in academia.
- **Recruit early:** Spark interest in research careers starting at undergrad level. But because many students are more motivated by clinical work, spark their interest in applied, clinical practice research projects.
- **Value teaching in PhD program:** Some programs deny applicants who are too focused on teaching, but the field needs educators. Allow teaching tracks.
- **Support women’s issues:** Must address policies around childcare and work/life balance, which disproportionately impact speech-language pathology as a female-dominated field.

Responses to Question #2: Covering the Full Scope of Practice Across the Lifespan

- **Relying more on adjuncts:** Engage more alumni and local experts but note that overuse of adjuncts instead of core faculty could pose threats to quality.
- **Persistent shortage areas:** Specialties like fluency, voice, AAC, and dysphagia remain difficult for programs to cover fully with in-house experts.

- **Changing curricula:** Condense and combine courses, thread topics across curriculum. But traditions persist, and it is challenging to rework the curriculum.
- **Faculty rotations:** Can rotate dedicated courses between faculty to share load in specialty areas. But rotating could lead to inconsistencies across cohorts.
- **Recognize breadth of expertise:** Faculty can develop depth and breadth through continuing education and collaborations.
- **Consortium model:** Programs sharing faculty expertise across universities could significantly expand offerings in specialty areas. Major logistical barriers—but consortia could greatly help address the field’s faculty shortages and teaching challenges.
- **Count clinical doctorates:** Those who have earned clinical doctorates might have expertise to teach clinical courses. These individuals could engage in professional development and be mentored to excel at teaching.
- **Modularize training:** With consortium and online options, content could be “plugged into” existing programs. Attention needs to be given to integration and oversight to ensure that these options work.
- **Development of teaching modules:** ASHA and other organizations can provide optional modules in specialty areas. Case studies should be developed to accompany these modules to deepen discussion in a “flipped classroom” manner.
- **Interprofessional education collaborations:** Partnering on shared courses across health disciplines, like research methods, could maximize resources. Scheduling difficulties can be a challenge.

Overall, the discussions highlighted creative solutions that programs have developed to maximize existing faculty, but the discussions also shone a light on the persistent challenges and shortages, especially in covering specialty areas. Key themes included the need for (a) flexibility, (b) collaboration, and (c) valuing the breadth of expertise that both clinical faculty and research faculty provide. The shortage of PhD-trained faculty appears likely to worsen as the number of graduate programs increases and the number of PhD graduates remains flat or declines. Significant changes are needed to address barriers like program inflexibility (e.g., part-time options, online components, re-location requirements), insufficient student funding, stagnant faculty salaries, and more support for student and faculty diversity.

Concerns and Recommendations

The breakout groups identified four major concerns and recommendations to address each of them.

Shortage of PhD Faculty

Concern

There is a shortage of PhD-level faculty to fill open positions, resulting in unfilled roles across CSD programs. This was attributed to issues like low pay when compared with clinical jobs, inflexibility of PhD programs, lack of funding, and insufficient support for student diversity.

Recommendations

- Increase stipends/scholarships to offset PhD costs.
- Develop hybrid/online/consortium PhD programs.
- Advocate for loan forgiveness for careers in academia.
- Spark early interest in research careers among students—starting as undergraduates.
- Provide support around women’s issues and work–life balance.

Covering Specialty Practice Areas

Concern

With limited faculty, programs struggle to fully cover specialty practice areas such as fluency, voice, AAC, and dysphagia. This limitation leads to overreliance on adjunct faculty or gaps in training.

Recommendations

- Allow clinical doctorates to count toward the 50% PhD requirement.
- Develop a system to credential clinical experts as qualified instructors.
- Create mechanisms to share faculty expertise between programs.
- Provide optional online teaching modules in specialty areas.

Valuing Breadth of Expertise

Concern

Concerns that narrow definitions of “qualified faculty” fail to recognize the value of instructors with deep clinical—but less research—expertise.

Recommendations

- Reassess credential requirements to better value and create more clinical specialty certifications.
- Develop a system to credential clinical experts as qualified instructors.

Lack of Pedagogical Training

Concern

Future PhD faculty need more training in teaching methods—not just content knowledge.

Recommendations

- Develop teaching-focused components within doctoral programs.
- Develop modules for doctoral students that focus on pedagogical training.

Opportunities and Recommendations

The breakout groups identified the following five opportunities as well as recommendations to assess and implement those opportunities.

Increase Funding for PhD Students

Opportunity

There is an opportunity to provide more funding support for PhD students to offset the costs and debt burdens. This could help incentivize students to pursue doctoral degrees and careers in academia.

Recommendations

- Increase stipends and scholarships to offset PhD costs.
- Advocate for loan forgiveness programs for PhD graduates that pursue faculty positions.

Develop Flexible PhD Program Models

Opportunity

There is an opportunity to create more flexible PhD program options besides the traditional on-campus, full-time model. This increased flexibility could expand access for non-traditional students.

Recommendations

- Establish hybrid/online/consortium PhD programs.
- Allow for part-time and distance completion while maintaining rigor.
- Highlight these flexible options to recruit working, place-bound students.

Recruit and Support Diverse PhD Students

Opportunity

There is an opportunity to proactively recruit and provide support to PhD students from diverse backgrounds and experiences.

Recommendations

- Spark interest in research careers starting at the undergraduate level.
- Provide mentoring and support around women's issues, diversity issues, and work-life balance.
- Actively recruit clinical entry-level students who are focused on teaching and research careers.

Rethink Faculty Credential Requirements

Opportunity

There is an opportunity to reassess the required credentials to teach in CSD programs, valuing clinical expertise alongside research background.

Recommendations

- Consider allowing clinical doctorates to count toward the 50% PhD requirement.
- Recognize clinical specialty certifications as qualifications for adjunct faculty members.
- Develop a system to credential clinical experts as educators and supervisors.

Share Faculty Expertise Between Programs

Opportunity

There is an opportunity to share faculty expertise through online resources, cross-appointments, consortia, and other collaborations. This would help to fill specialty gaps in teaching.

Recommendations

- Create online teaching modules that programs can utilize, especially in specialty areas.
- Develop formal systems for sharing faculty between local and regional programs.
- Partner with other health disciplines to offer interprofessional courses.

Program Recommendation: Strengthen Teaching Capacity and Pedagogy

The Next Steps Committee recommends that ASHA develop a program to strengthen teaching capacity and pedagogy, enhance faculty and PhD student support, establish a collaborative resource-sharing program, and develop a credentialing program for clinical educators.

This program would focus on leveraging technology, alternative credentialing pathways, resource sharing, and collaborative models to maximize existing faculty resources and build capacity to fully cover specialty practice areas in speech-language pathology.

The program would include the following five core components:

- *Online Teaching Library*: The *Teaching–Learning–Research Hub* (TLR Hub) that ASHA is already developing will serve as a centralized library of video-based online modules and modules in CSD specialty topics. The TLR Hub will be available for programs to utilize and “plug into” their curriculum.
- *Clinical Educator Credentialing*: A national certification system to qualify clinical experts without PhDs as sanctioned CSD educators based on rigorous examination, continuing education, and standards.
- *Shared Faculty Registry*: A database of PhD and credentialed clinical faculty interested in teaching across programs. Programs could identify and collaborate with additional faculty as needed.
- *Consortium Models*: Development of cross-institutional consortia to share development of online content and credentialed educators, providing economies of scale.
- *Enhanced PhD Support*: Expanded PhD funding, hybrid program options, and recruitment initiatives focused on student diversity and teaching preparation.

This collaborative program would help address key challenges around faculty shortages and scope-of-practice gaps in an efficient, cost-effective manner.

- The *TLR Hub* will provide online resources to fill specialty gaps without each program reinventing the wheel, especially in low-incidence areas.
- Clinical educator credentialing would allow programs to formally recognize the expertise of seasoned clinical Educators in filling teaching and supervision needs.
- A shared faculty registry could facilitate efficient specialized instructor sharing between programs regionally or nationally.
- Cross-institutional consortia would allow joint development of resources and the negotiating of access to a pool of instructors.
- Enhancing PhD support would help to expand the faculty pipeline.

The *Strengthen Teaching Capacity and Pedagogy* program incorporates ideas of content modularization, cross-institutional collaboration, alternative credentialing pathways, and online education to creatively maximize expertise. It provides the infrastructure and incentives for programs, instructors, and professional organizations to participate in strengthening faculty capacity.

Development and Launch

- A CSD Teaching Task Force would be needed to flesh out details and begin developing content, policies, and infrastructure.
- An ASHA workforce, including instructional designers, would need to be hired (or identified) to develop teaching modules and other related resources (e.g., case-based learning assets, learner outcomes, assessments, teaching guides).
- A few specialty topic modules would be used to pilot the concept and technology approaches.
- The full program would launch sometime later, allowing time for awareness building and structuring of consortiums.

Key Challenges

- Ensuring buy-in and participation from programs, faculty, and professional organizations may require a gradual culture shift and implementation of change-management strategies.
- Developing high-quality online content and instructor certification standards that support positive learning outcomes.
- Administering and sustaining the program long-term and providing ongoing tech support.
- Balancing elements of centralization for quality and efficiency with local program customization and oversight.

By proactively addressing these challenges and concerns, ASHA can forge a path to implementing creative solutions to the pressing needs around faculty resources and teaching across the full scope of practice. This collaborative program provides a model for maximizing assets through technology, credentialing, partnerships, and peer sharing. With dedication and cooperation, a more sustainable training infrastructure can be established that benefits future SLPs and the patients, students, and clients whom they serve.

ASHA's Role

ASHA needs to play a central part in implementing this program. Various roles of ASHA would include the following:

- *Convene Stakeholders*: Bring together a diverse task force of faculty and other stakeholders to design and flesh out the program.
- *Awareness Building*: Use ASHA's communication channels and platforms to promote the program; once launched, build buy-in among various audiences.
- *Advocacy*: Advocate with certification and accreditation bodies to support alternative credentialing pathways and other components to strengthen teaching capacity and pedagogy such as accreditation standards for clinical doctoral programs in speech-language pathology.
- *Infrastructure*: Develop and host the online teaching library (TLR Hub) resources and facilitate the shared faculty registry database.
- *Consortia Support*: Provide resources and guidance to facilitate the formation of program consortia for collaboration.
- *Ongoing Research*: Conduct research on the program's efficacy and outcomes to support continuous improvement and shared learning.
- *Sustainability Planning*: Explore ongoing needs to support the program long-term, such as participating fees, grants, and donations.

By leveraging ASHA's expertise, network, platforms, and reputation, it can play an integral role in catalyzing this collaborative solution to faculty capacity and scope challenges. As a respected leader in the field, ASHA can rally stakeholders and drive adoption of creative approaches to strengthen training capacity.

Faculty Development Breakout Group Summary

This summary was generated by Claude.ai and edited by humans.

Key Points

The Next Steps Committee planned the *Next Steps Summer Webinar Series* in 2022 to gather stakeholder input using the procedures described in the Introduction Section of this report, under Methods. The Next Steps Committee conducted several breakout group sessions primarily with faculty members from CSD programs across the country. The goal of the Faculty Development breakout group sessions was to discuss the need, challenges, and recommendations to improve pedagogy. Participants shared insights on barriers and opportunities from their experiences. This summary highlights the key themes and takeaways.

Several consistent themes emerged around gaps, opportunities, concerns, and recommendations to strengthen pedagogical capacity in CSD higher education programs.

Preparation of PhD Students

There was resounding consensus that CSD PhD programs need to place more emphasis on pedagogical preparation—not just content and research expertise. Partnerships with campus teaching and learning centers were lauded as providing critical expertise and assistance. All of the following strategies could better equip PhD graduates for faculty roles:

- requiring courses in evidence-based teaching practices
- providing teaching mentorships and hands-on experiences
- developing comprehensive teaching portfolios

Ongoing Faculty Development

Once PhD graduates have secured faculty roles, they need ongoing professional development focused specifically on honing teaching skills. This can be achieved through sabbaticals, continuing education, conferences, and on-campus instructional support. Development related to high-priority areas such as online teaching, inclusive pedagogy, interprofessional education, and mentoring students from underrepresented backgrounds rose to the top. Webinar attendees recommended opportunities to collaborate in learning communities and to engage in SoTL.

Alternative Pathways

Mid-career CSD professionals seeking to transition into faculty roles face barriers entering traditional full-time residential PhD programs. The development of alternative pathways—such as online, hybrid, and clinically focused doctoral programs—could expand access to the terminal credentials required for faculty positions.

Valuing the Full Portfolio

Attendees engaged in robust discussion around the need to elevate the value of teaching excellence in tangible ways. An individual's research productivity is often prioritized over their teaching skills and experience—at all stages of the educational journey, from graduate program admissions to faculty hiring, promotion, tenure, and merit-based decisions. The following changes could help create a culture that recognizes teaching and learning as equally important to research and service:

- updated guidelines
- equitable evaluation processes
- broadened opportunities to allow faculty to contribute their full range of skills

Effective Development Models

No single development model meets all faculty needs. A multifaceted ecosystem provides choice and flexibility. Recommendations included

- intensive regional workshops,
- online repositories of training materials and modules,
- campus teaching centers for observations and microteaching,
- individual learning paths, and
- cohort models.

Collaborative partnerships among organizations such as ASHA, CAPCSD, CAA, and CFCC are critical for strategy development, research, early implementation, and later, wide-scale adoption that can be tailored to work in local contexts across academic institutions in the United States.

Recommendations

The Next Steps webinar attendees made the following key recommendations:

- Make pedagogical preparation central to PhD programs through requiring coursework on evidence-based teaching practices and learning theories, providing teaching mentorship/apprenticeships, ensuring supervised independent teaching experiences, and encouraging teaching portfolios.
- Incentivize continuing education in university teaching and development of a teaching philosophy/portfolio for faculty.
- Develop flexible terminal degree pathways such as online, hybrid, and clinically focused doctoral programs.
- Advocate for clinical doctoral degrees to be valued in accreditation standards similarly to the PhD and EdD.
- Update policies, guidelines, and evaluation processes to value the full scope of faculty skills and accomplishments.
- Support multifaceted teaching development opportunities at the individual, program, institutional, state, and national levels.

In summary, strengthening pedagogical expertise requires a systemic approach to prepare, develop, and value educators across the career span. Targeted investments and collaborations are needed to evolve CSD programs into cultures that actively cultivate teaching excellence with equity.

Breakout Group Discussions

The following two discussion prompts were posed:

1. What professional learning opportunities would you recommend for faculty in our discipline in order to prepare and retain them for current and future teaching and learning environments?
2. How would you envision that these professional learning opportunities be provided?

Their responses are summarized next.

Preparation of PhD Students

- Attendees expressed strong agreement that PhD programs need to provide more pedagogical training and teaching experiences for doctoral students who will become faculty members. Only about one third of PhD programs currently require students to teach an entire course independently.
- Pedagogical preparation should be just as valued as research training in CSD PhD programs. Suggestions along these lines included
 - requiring a course on evidence-based teaching practices and learning theories,
 - providing teaching mentorship/apprenticeships, and
 - ensuring supervised independent teaching experiences.
- Participants felt that, in addition to receiving teaching skills, future faculty members should receive training on curriculum design, program administration, clinical supervision/education, and leadership.

Ongoing Faculty Development

- Pedagogical skills should be an ongoing area of development for CSD faculty—not just a one-time training experience. By requiring continuing education in teaching and learning, university programs could help retain and strengthen educators over time.
- Faculty should have opportunities to continually improve their knowledge of evidence-based teaching strategies such as the following:
 - active learning

- experiential learning
 - inclusive practices
 - online pedagogy
 - interprofessional education
- Development opportunities focused on the following areas were highlighted as particularly important needs:
 - mentoring students from underrepresented backgrounds
 - implementing inclusive curricula
 - teaching in ways that promote equity and cultural responsiveness
 - Administrators and institutions should incentivize pedagogical development by counting it fully toward promotion, tenure, and merit-based decisions.

Alternative Pathways

- Participants expressed a strong desire for more alternative pathways to terminal degrees that provide the necessary preparation for teaching-focused careers.
- Part-time, online, and clinically focused doctoral programs could expand access for mid-career professionals who cannot pursue traditional, full-time, residential PhDs.
- CSD programs should consider partnering with education, instructional design, or clinical doctorate programs to develop tailored options for current educators seeking advanced preparation in teaching and learning.

Delivery Methods

- Programs need a multifaceted approach, including both individual and collaborative development opportunities that are accessible online and in-person. Attendees provided the following suggestions:
 - online modules, courses, and resources that allow self-paced learning
 - mentorship programs with seasoned teaching mentors
 - master teacher certification programs
 - intensive teaching institutes and workshops at conferences
 - journal clubs and/or learning communities to discuss pedagogical research
 - campus teaching centers and opportunities to observe expert instructors
- State associations and ASHA should partner to provide learning opportunities at conferences, through webinars/modules, training videos, and so forth.
- Institutions should provide funding and incentives for faculty to engage in pedagogical development and communities of practice.

Changing Culture and Values

- Elevating the status of teaching would require cultural and structural changes in programs—and in the field of speech-language pathology overall. Faculty roles, promotion guidelines, and merit evaluation processes tend to prioritize research over teaching.
- Programs need to value the “full portfolio” of skills that faculty employ, including teaching, clinical work, leadership, advocacy, assessment, and SoTL.

In summary, these breakout groups emphasized the need for

- stronger pedagogical preparation in PhD programs,
- ongoing faculty development opportunities focused on teaching and learning,

- alternative pathways to terminal degrees,
- multifaceted and flexible delivery methods, and
- elevating the culture and values around teaching in the CSD discipline.

Implementing these recommendations would require commitment and collaboration among multiple stakeholders.

Conclusion

CSD higher education faces an urgent need to maximize and sustain teaching capacity across the full scope of practice. Doing so requires multifaceted initiatives tailored to diverse faculty backgrounds, experience levels, and learning preferences. A coordinated effort uniting stakeholders from across the educational ecosystem can enhance pedagogical preparation, expand alternative pathways to academic-research careers, incentivize professional development related to pedagogy and SoTL, and elevate the culture to place more value on teaching excellence. Given pressing needs for innovation and access, the time is now to invest in the teaching workforce.

ASHA's Role

ASHA could play the following key roles in implementing this comprehensive program for strengthening pedagogical capacity in CSD higher education:

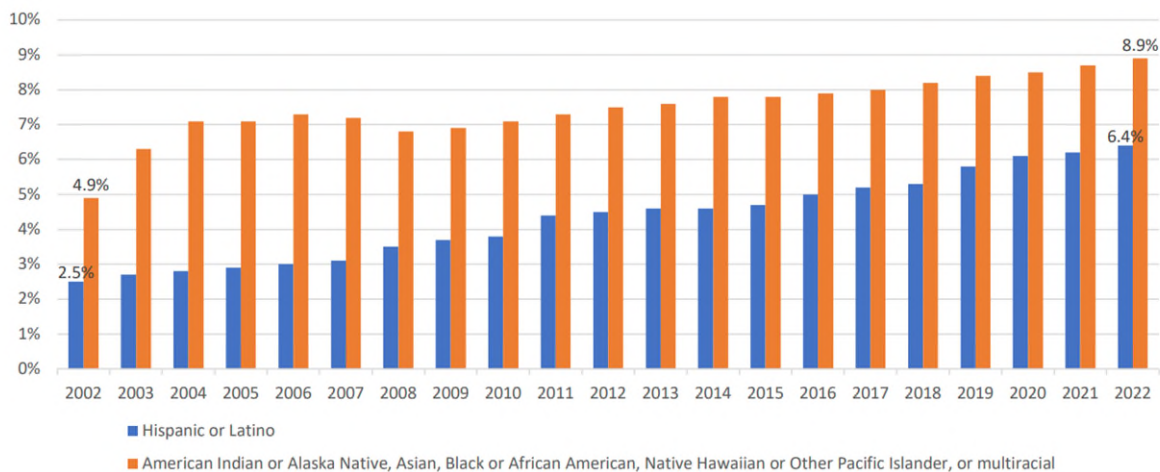
- *Funding*: ASHA could provide seed funding and personnel support to develop, coordinate, and launch new initiatives like the Teaching Institute, Teaching Excellence Academy, and Faculty Working Groups. Ongoing funding partnerships could be established.
- *Advocacy*: ASHA could advocate to the CAA to recognize alternative credentials like the SLPD and CScD, which would enable students on these alternative tracks to meet the "50%" accreditation requirements.
- *Collaboration*: ASHA's relationships with graduate programs, state associations, and other related organizations would allow them to facilitate collaboration of a Teaching Apprenticeship Network and recruitment for a Teaching Excellence Academy.
- *Content Development*: ASHA's educational and clinical resources and faculty expertise could be leveraged to develop online courses, training materials, standards documents, and publications that could be centrally housed in ASHA's TLR Hub.
- *Dissemination*: ASHA has broad engagement with the CSD community and with mechanisms such as websites, journals, newsletters, conferences, and social media. Thus, ASHA could effectively disseminate information about new programs to a wide-reaching audience.
- *Credentialing*: ASHA could potentially develop credentialing or certificate programs around teaching excellence, clinical supervision, or leadership development that faculty could pursue through other components of the program such as the Teaching Institute.
- *Program Evaluation*: With its research arm, ASHA could conduct program evaluation activities to ensure that initiatives like the Teaching Institute and the CSD Teaching Task Force achieve their goals and support continuous improvement.

In summary, ASHA's existing resources and reach position the Association well to play a driving role in coordinating, launching, sustaining, disseminating, and evaluating efforts to strengthen pedagogical capacity through this proposed multifaceted program. CAPCSD also could contribute to these efforts, given that their mission aligns well with these goals.

VII. Student Diversity

SLPs serve populations that consist of people from diverse backgrounds and cultures; service providers should reflect that diversity. Unfortunately, there is a predominance of white females in the profession of speech-language pathology—and an underrepresentation of SLPs from underrepresented backgrounds.

In 2022, 91.8% of ASHA constituents self-identified as White, and 96.4% self-identified as female ([ASHA Member and Affiliate Profile, 2022a](#)). The ASHA constituency has comprised primarily White women for most of the time that speech-language pathology has been a profession. ASHA, academic programs, and others have long recognized the need to diversify—and ASHA has tracked demographic data for the CSD discipline for more than 30 years. In Figure 12, demographic trend data from 2002 to 2022 from the ASHA Member and Affiliate Profile Trends are displayed ([ASHA, 2022b](#)). In 2022, 6.4% of ASHA constituents self-identified as Hispanic or Latino—up from 2.5% in 2002—and 8.9% self-identified as American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, or multiracial—up from 4.9% in 2002. Although these increases indicate positive trends, we in the CSD discipline need to do more work to reduce barriers to entry and to ensure retention.



Note. These data are from the 2002–2022 ASHA Member & Affiliate Profiles. They exclude National NSSLHA members. ASHA collects and presents ethnicity and race data separately, in accordance with federal guidelines.

Figure 12. Percentage of ASHA constituents who self-identify as Hispanic or Latino and who self-identify as American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, or multiracial, 2002–2022. Note: These data do not include members of NSSLHA [National Student Speech Language Hearing Association].

Source: [ASHA Member & Affiliate Profile 2002–2022 \(ASHA, 2022b\)](#).

Need for Diversity

There is a dire need to increase the number of speech-language pathology faculty members and SLPs from underrepresented backgrounds. The importance of (a) recruiting students from diverse backgrounds and (b) intentionally selecting individuals across a variety of lived experiences into graduate programs cannot be understated: Doing so would help ASHA achieve its goal of service providers and members better reflecting the diverse ethnic, racial, and cultural backgrounds of those we serve.

Individuals are more comfortable working with professionals who share similar cultural experiences—and, presumably, the efficacy of the services provided is thereby enhanced. The need for academic programs to expand opportunities for students to serve people from diverse backgrounds is also imperative to support the cultivation of cultural humility, empathy, and other 21st century skills. Doing so will improve student readiness for work in varied practice settings and in communities with diverse populations.

Challenges to Increasing Student Diversity

Several factors hinder the recruitment and retention of students from diverse backgrounds and slow the growth of a diverse workforce in speech-language pathology including gatekeeping and multiple barriers to entry and graduation.

Gatekeeping describes the activity of controlling access to something, such as filtering information for dissemination in media, communications, or management contexts. Practitioners and speech-language pathology professionals now use this concept more broadly to convey that, due to limited time, space, or resources, they must make decisions that inevitably will enable opportunity for some people and limit it for others. In relation to higher education, gatekeeping impacts recruitment, retention, and graduation rates of students from diverse backgrounds—and may reflect intentional or unintentional bias.

Barriers to entry include factors that hinder recruitment and admission of students from diverse backgrounds into graduate school.

- In some target communities, there is limited awareness of the speech-language pathology profession due, in part, to a general lack of diversity in the current workforce.
- Among some target audiences—such as high school counselors, STEM leaders in middle and high schools, undergraduate advisors, admissions counselors, and faculty in related disciplines—there is limited knowledge of the profession and of the educational requirements to qualify for admission into entry-level graduate programs.
- Many students from diverse backgrounds are first-generation college graduates who may face barriers such as:
 - having a limited understanding of how to get into graduate school;
 - lacking access to mentors who can assist them with the mechanics of getting into graduate school, such as filling out applications, navigating financial aid, and other opportunities and requirements specific to a given university; and
 - high educational costs.
- An over-reliance on standardized tests, such as the GRE[®], in the admissions process has disadvantaged students from underrepresented backgrounds yet continues to be used—despite the lack of evidence of predictive validity in the field of speech-language pathology.

Barriers to graduation include factors that hinder program completion for students from diverse backgrounds who are in graduate school.

- Often, there is an insufficient number of faculty that come from underrepresented cultures and backgrounds or who can skillfully engage with students from a wide array of cultures.
- Mentoring and support systems tend to be insufficiently tailored for students from underrepresented backgrounds.
- Faculty may have limited knowledge about the needs of students with underrepresented backgrounds, especially when it comes to knowledge about factors that disproportionately impact first-generation college students' success.

- Students from underrepresented backgrounds may encounter micro-aggressions and other forms of bias and may even be excluded from some clinical placements.
- Matriculation requirements, such as requiring full-time enrollment, may create barriers for some graduate students who must juggle multiple responsibilities (e.g., parenting, employment) and who may face barriers due to the need for relocation.

Recommended Strategies to Increase Student Diversity

Strategies that academic programs can use to recruit students from diverse backgrounds—and ensure that they graduate—include

- engaging in holistic admissions;
- practicing transparent teaching methods;
- educating faculty on implicit bias and cultural responsiveness;
- purposefully cultivating inclusive program cultures;
- implementing tailored support systems for first-generation students and for students from diverse backgrounds;
- flexibly rethinking rigid GPA score cutoffs and relaxing GPA-related requirements;
- explicitly valuing a diversity of perspectives in the classroom and in the profession;
- targeting outreach to systemically connect with students from diverse backgrounds; and
- prioritizing the development of a more diverse student and faculty pipeline in admissions and hiring practices.

Stakeholder Input: Student Diversity Survey Summary

Participants of the *Next Steps 2022 Summer Webinar Series* were asked to complete an online survey. The survey was designed to gather information on general topics and on four questions specific to the Student Diversity topic. The full *Student Diversity Survey Report* is available in Appendix G.

Demographic Overview of the Respondents

- A total of 13 individuals responded to the survey.
 - 77% were certified SLPs.
 - 8% were certified audiologists.
 - 8% were Clinical Fellows.
 - 0% selected “other.”
- Most (62%) had been employed in the professions for 21 or more years.
 - 15% for 16–20 years
 - 0% for 11–15 years
 - 8% for 6–10 years
 - 16% for 0–5 years
- College/university was the primary employment setting for 83% of survey respondents.
 - 8% in residential health care facility
 - 0% in schools
 - 8% in industry
 - 0% in “other”

Topic-Specific Questions

After the Student Diversity webinar, participants were asked to answer four topic-specific questions. Their responses are shown after each question below (Questions #13, #14, #15, and #16 from the *Student Diversity Survey Report* in Appendix G).

Question #13: What retention strategies are successful for students from underrepresented backgrounds?

- Access to appropriate financial support
- Access to social, cultural networks (build community and engagement)
- Easy access to departmental/institutional programs that support diverse students
- Peer mentoring (formal or informal)
- Access to qualified, approachable academic advisors
- Establishment of measurable goals
- Access to mental health support
- Inclusive teaching strategies

Question #14: What do students need to feel included, and what do graduates need to be prepared to be SLPs who deliver culturally affirming services?

- Culturally responsive coursework
- Mentorship (i.e., faculty, peer)
- A variety of experiences with clients from varying backgrounds during clinical rotations
- Financial resources
- Being involved with an organization
- Supportive faculty and clinical supervisors who are supportive mentors

Question #15: What are some outreach strategies that have led to the successful recruitment of students from diverse backgrounds?

- Career days at high schools and community colleges
- Health care fairs at high schools and community colleges
- Open houses and information sessions for interested students
- On-campus summer programs for high school students
- Graduate School Fair at the ASHA Convention
- Promotion at events for incoming college freshmen and transfer students
- Networking at the National Black Association for Speech-Language and Hearing (NBASLH)
- Social media posts about degree programs
- Visits to programs at Historically Black Colleges and Universities (HBCUs) and Hispanic Serving Institutions (HSIs)
- A faculty body that represents greater diversity

Question #16: What information, resources, or strategies do faculty need to effectively advise students from different cultures?

- Cultural humility and responsiveness training
- Collaboration with programs that have greater student and faculty diversity

Student Diversity Breakout Group Summary

This summary was generated by Claude.ai and edited by humans.

Key Points

The Next Steps Committee planned the *Next Steps Summer Webinar Series* in 2022 to gather stakeholder input using the procedures described in the Introduction Section of this report, under Methods. Several of breakout group sessions were conducted on challenges and strategies related to diversifying the field's student and faculty pipeline.

The conversations focused on

- interrelated barriers tied to insufficient early exposure to the field,
- inequitable and disadvantaging admissions policies,
- lack of workforce diversity,
- misperceptions about the field, and
- insufficient support systems for students from underrepresented backgrounds.

Stakeholders advised that programs use targeted outreach, holistic admissions, faculty development, and proactive retention practices to develop a more representative student and faculty pipeline.

The following two discussion prompts were posed:

1. What barriers are programs experiencing in their recruitment efforts of diverse students for the graduate speech-language pathology programs?
2. What retention strategies are successful for diverse students?

Barriers, Opportunities, and Recommendations for Academic Programs

Recruitment Barriers and Recommendations

The breakout group members extensively discussed the barriers to recruit graduate students from diverse backgrounds. Major barriers that group members highlighted included minimal awareness of the speech-language pathology career field among underrepresented communities, traditional admissions practices that disadvantage applicants from diverse backgrounds, underrepresentation of diversity in the current workforce, educational costs, potential exclusion faced during clinical placements, and enduring perceptions that speech-language pathology is for White, affluent women. The interrelated barriers that hinder recruitment of graduate students from diverse backgrounds include the following:

- **Lack of career awareness.** Many communities have little exposure to speech-language pathology as a potential career path, especially in under resourced school districts and communities. Guidance counselors may steer students toward more familiar options—and minimal visible diversity in the field also perpetuates the perception that speech-language pathology is not an option for students from underrepresented backgrounds. We need targeted outreach to spread awareness.

Recommendation: Coordinate outreach programs at high schools, colleges, and community centers to expose more students from diverse backgrounds to the field of speech-language pathology.

- **Homogenous demographics.** The group members noted that there is not a lot of diversity among current SLPs and academic faculty members; this is a barrier to the goal of increasing diversity in the field of speech-language pathology. This lack of representation among professionals and professors in the field may deter students who are from underrepresented backgrounds from envisioning themselves in these roles. If the faculty and student populations do not show visible diversity, then it may signal an unwelcoming culture to students from underrepresented backgrounds.

Recommendation: Fund more diversity-focused graduate slots, and recruit faculty from diverse backgrounds to increase representation in the field of speech-language pathology.

- **Financial constraints.** From tuition to test prep to unpaid experiences that are highly valued in applications, the path to a CSD graduate program is increasingly expensive, group members said. These financial hurdles disproportionately affect applicants from underrepresented backgrounds.

Recommendation: Review and address costs of tuition, materials, and test fees through scholarships, and improve access through other funding mechanisms.

- **Stereotypes.** Even with ample interest and aptitude, students from underrepresented backgrounds may self-select out of pursuing a field that is seen as better suited for those of higher socioeconomic status and those who are members of the predominant culture/ethnicity. The perception that speech-language pathology is for “rich White girls” may be a deterrent keeping some undergraduate students from envisioning themselves as future SLPs.

Recommendation: Use targeted marketing and outreach to reshape the public’s ideas of who can become SLPs.

Admission and Retention Barriers and Recommendations

To admit and retain students from diverse backgrounds, the group members emphasized the need for (a) using holistic, transparent teaching methods; (b) educating faculty on implicit bias and cultural responsiveness; (c) purposefully cultivating inclusive program cultures; (d) tailoring support systems for first-generation students and for students from diverse backgrounds; (e) engaging in a flexible rethinking of rigid GPA cutoffs; and (f) explicitly valuing diversity of perspectives in the classroom and profession. The discussion on increasing the number of graduate students from diverse backgrounds highlighted these practices:

- **Problematic admissions practices.** Many promising applicants from diverse backgrounds face disadvantages such as a heavy reliance on GPA cutoffs, standardized test scores, and bias in traditional admissions criteria. Extant admissions criteria reflect existing inequities and fail to capture skills and traits that predict strong clinicians, especially among applicants from underrepresented backgrounds.

Recommendation: Reduce overreliance on GPA cutoffs, standardized tests, and narrow criteria by adopting holistic, more equitable processes. Adopt holistic admissions rather than using

ranking or cutoffs. The group advocated viewing any GPA that falls above minimum thresholds as acceptable to mitigate past inequities. Similarly, the group members touted the use of *holistic processes*—that is, those that (a) consider each applicant as a unique individual and (b) examine multiple facets of that applicant—as a more equitable admissions strategy. The key strategies centered on admissions policies that look beyond narrow, biased criteria and focus more on purposeful development of support systems, education, and inclusive cultures that are optimized for learners from diverse backgrounds.

- **Tailored support systems.** Proactive support systems can aid retention and success. Examples might include advising, mentorships, counseling, and other strategies that are customized to the needs of first-generation, underrepresented, and other students from diverse backgrounds.

Recommendation: Develop specialized orientation, peer groups, advising, and mental health services to support the needs of students from diverse backgrounds as well as first-generation students.

- **Inclusive program culture.** Group members emphasized fostering a program ecosystem where different types of students feel welcomed. Group members also suggested training faculty members on implicit bias. Participants recommended specialized mentoring and support tailored to the needs of students from diverse backgrounds; they also recommended purposeful cultivation of inclusive program cultures. Suggestions on an institutional level included the use of cluster-hiring initiatives to rapidly enhance faculty diversity.

Recommendation: Provide faculty development around (a) structuring classes equitably for learners from diverse backgrounds and (b) clearly communicating expectations. Offer education on implicit bias and cultural responsiveness to faculty and externship supervisors.

- **Transparent teaching practices.** Clearly communicated expectations, rationales, and supports benefit learners from diverse backgrounds. Explicitly orient faculty and externship supervisors on implicit bias and cultural responsiveness. For example, faculty should not assume that students of color are not able to successfully pass courses. Programs should offer a variety of ways to assess knowledge and application of course content.

Recommendation: Implement regular implicit bias and cultural awareness education for all faculty and clinical supervisors and engage them in cultural responsiveness education.

- **Clinical placements.** Another barrier cited was the location and culture of clinical placements, especially in less diverse communities. Some students may encounter and confront discriminatory attitudes or lack of cultural understanding—and that can lead to those students not receiving clinical placements. Some students may express nervousness about (a) potentially confronting discriminatory attitudes and (b) potentially experiencing a lack of cultural understanding by supervisors in clinical placements.

Recommendation: Carefully assess placement sites, allow students to express concerns without fear of academic repercussions, and provide options for alternative placements.

- **Valuing diverse perspectives.** Finally, the group members stressed the need for programs to recognize diverse backgrounds and ways of thinking as true assets that enrich class discussions and that only serve to improve the field of speech-language pathology.

Recommendation: Facilitate activities and spaces for hosting open dialogue and facilitating community-building among students from diverse backgrounds.

The breakout groups discussed the following opportunities and made recommendations for academic programs.

Leverage Existing Community Resources

Opportunity: Schools, hospitals, clinics, youth programs, and other community resources could help expose students from diverse backgrounds to the field of speech-language pathology.

Recommendations:

- Set up informational booths and activities at high school career fairs and community health fairs.
- Collaborate with children’s hospitals and speech-language clinics serving people in underrepresented communities.
- Partner with youth enrichment and development programs to present on speech-language pathology careers.
- Work with guidance counselors to incorporate information on CSD careers into planning.
- Participate in community intervention events to showcase the field.

Create Experiential Learning Initiatives

Opportunity: Hands-on learning initiatives could generate interest and dispel misperceptions about the field among students from diverse backgrounds.

Recommendations:

- Host career exploration events allowing high school students to shadow SLPs.
- Develop and participate in summer camps and programs to engage youth in experiencing various aspects of the field.
- Sponsor events where students get hands-on experience doing things like transcribing their names in the International Phonetic Alphabet (IPA) or creating messages with AAC devices.
- Leverage opportunities for experiential learning credits in an effort to expose more students to clinical experiences in speech-language pathology at the undergraduate level.

Improve Graduate Program Recruitment Practices

Opportunity: By engaging in proactive recruiting efforts, graduate programs could increase applications from—and admission of—students from underrepresented backgrounds.

Recommendations:

- Build relationships with HBCUs and HSIs to encourage graduate applications.
- Work with undergraduate programs on 4+1 accelerated degree options.
- Increase recruitment advertising and outreach aimed at students from diverse backgrounds.
- Partner with affinity professional groups to extend program reach.
- Offer application/interview workshops to support applicants from diverse backgrounds.

Enhance Faculty Knowledge and Tools

Opportunity: Equipping faculty with skills and knowledge on the topic of diversity and inclusion could improve retention.

Recommendations:

- Provide ongoing training in the topic areas of implicit bias, cultural responsiveness, and inclusive pedagogy.
- Support instructor mentoring circles for sharing retention challenges and strategies.
- Create teaching resources on working with a wide variety of learning styles, engaging in transparent instruction, and advising students from underrepresented backgrounds.
- Highlight as models those faculty members who are implementing innovative inclusion practices.
- Incentivize the development of more equitable teaching practices.

The group members also recommended capitalizing on community resources and experiential learning to increase early exposure to the CSD discipline by students from diverse backgrounds. The group members also proposed improvements in graduate program recruiting and suggested the use of tools to help faculty foster more inclusive educational environments in order to realize the opportunities for enhancing diversity within CSD programs.

Recruitment

- **Outreach Coordinators.** Create opportunities to conduct culturally responsive outreach about CSD careers at high schools, colleges, and community organizations in geographic areas that contain a high proportion of individuals from underrepresented cultures and backgrounds. People who are involved in these outreach efforts could share information about careers in speech-language pathology, lead hands-on activities, and identify specific promising students that they would then guide through the pipeline.
- **Marketing Campaign.** Launch a digital marketing campaign using social media, websites, and apps to promote CSD among people in underrepresented communities. Use images, stories, and influencers from a wide range of backgrounds and cultures to reshape society's ideas of who can become an SLP (with the answer being "anybody!").
- **Application Workshops.** Host application and interview workshops to demystify the application process and help applicants from underrepresented backgrounds present themselves effectively and authentically. Provide fee waivers or offer these workshops at no charge.
- **Admissions Overhaul.** Implement holistic, bias-mitigating admissions practices, such as interviews, that downplay reliance on GPA or GRE scores and that instead emphasize individual experiences and traits.

Retention

- **First Generation ("First Gen") Programming.** Develop specialized orientation, mentoring, networking, and other support for first-generation college students to help them adapt and thrive.
- **Faculty and Supervisor Training.** Require and incentivize regular education regarding bias and cultural responsiveness for all faculty and staff. Share resources on inclusive teaching strategies.
- **Diverse Student Groups.** Facilitate student-led discussions groups, online forums, and activities that create a sense of community, collective voice, and mutual support for students from diverse backgrounds and cultures.
- **Mental Health Counselors.** Identify, engage, or hire counselors specializing in the needs of students from diverse backgrounds, and make services easily accessible.

Implementation of these recommendations in a coordinated manner would likely (a) help attract more students from underrepresented backgrounds—who may not envision themselves pursuing CSD careers due to lack of exposure—and (b) also help retain them in the pipeline. Holistic, workshop-supported admissions would contribute to increasing accessibility and representation. Academic programs should consider strategies such as first-gen programming, education, counseling, and peer groups. By using such strategies, academic programs would then equip students from diverse backgrounds who are admitted into the program with the resources and environment that they need to succeed. In so doing, the academic programs would also gain cultural capital and play a formative role in shaping the CSD field of the future—one that is inclusive and culturally responsive.

Intended Outcomes

- Increased racial/ethnic, socioeconomic, and first-gen diversity among CSD graduate students and faculty
- Higher retention and graduation rates for students from diverse backgrounds
- Expanded inclusion of culturally aware and bias-mitigated practices within academic programs
- Greater sense of belonging, voice, and empowerment among students from diverse backgrounds
- Expanded ideas of who can excel as SLPs among faculty and practitioners
- Growth of a more diverse CSD workforce and an increased capacity to provide culturally responsive care throughout the field

With data tracking and iterative improvements, this comprehensive effort—combining targeted outreach, admissions changes, and multifaceted support—could significantly diversify and strengthen the CSD pipeline.

ASHA's Role

ASHA could provide invaluable support and resources toward implementing this diversity pipeline program in several ways:

- **Funding.** ASHA could offer grants, scholarships, and other financial incentives to help launch and sustain elements such as outreach coordinators and first-gen student supports.
- **Research.** ASHA could promote and share research on best practices for increasing diversity in CSD, helping to inform program design and modifications with evidence-based approaches.
- **Advocacy.** ASHA could use its platform and influence to advocate for more institutional focus and priority on recruiting diverse talent into the CSD field.
- **Standards.** ASHA and the CAA could establish standards, competencies, and guidelines around equity, inclusion, and cultural responsiveness for graduate CSD programs.
- **Professional Development.** ASHA could curate and develop more resources and workshops on topics like implicit bias, transparent teaching practices, and the advising of students from diverse backgrounds. Academic programs could then use these materials and workshops to educate faculty and staff.
- **Networking.** ASHA could facilitate networking, knowledge sharing, and mentorship connections between programs wanting to improve diversity, so successes can spread.
- **Showcasing.** ASHA could highlight innovative programs as case studies and models while celebrating the achievements of students and faculty members from diverse backgrounds—as a way to inspire other programs.
- **Job Board.** ASHA could expand recruitment advertising options and outreach to candidates from underrepresented backgrounds—as a way to increase applicant diversity.

ASHA—with its expertise, influence, network, and resources—could play a powerful role in guiding, supporting, and accelerating the adoption of best practices in diversity, equity, and inclusion across the graduate education

landscape. Collaborations among ASHA, CAPCSD, NSSLHA, and individual academic programs could amplify the impact of these recommendations.

NSSLHA's Role

NSSLHA could be a valuable partner in implementing this diversity recruitment and retention program in the following ways:

1. **Student Perspectives.** NSSLHA could organize focus groups and surveys to (a) gather direct insights from CSD students of diverse backgrounds on needs, challenges, and opportunities and (b) share ideas about how academic programs could improve components of the academic experience could be improved in order to increase diversity. This would help ensure that academic programs tailor their initiatives to improve the experience and address the needs of students from diverse backgrounds.
2. **Peer Mentorship.** NSSLHA could help develop and facilitate peer-to-peer mentorship initiatives connecting incoming students from diverse backgrounds with those students who are farther along in their programs—for guidance and mutual support.
3. **Ambassador Outreach.** NSSLHA members could be trained as ambassadors who return to their high schools and communities to conduct outreach about CSD careers. Their passion could help inspire others.
4. **Volunteering.** NSSLHA chapters could provide volunteers to assist with program elements like application workshops, orientation events for first-gen students, and faculty development initiatives.
5. **Virtual Hubs.** NSSLHA could leverage online platforms, like Discord, to create virtual hubs. These hubs would facilitate connections and community-building program-wide for students from diverse backgrounds.
6. **Showcasing Diversity.** NSSLHA could use their platforms and activities to (a) intentionally highlight and celebrate diversity within the CSD discipline and (b) challenge stereotypes.
7. **Advocacy.** With their collective student voice, NSSLHA could influence academic institutions, ASHA, and policymakers for needed reforms around equity and inclusion.

As the main association for speech-language pathology students, NSSLHA brings valuable grassroots and youthful perspectives to ASHA and the NSSLHA member's own academic program. The organization's networking capabilities could greatly strengthen recruitment and retention efforts aimed at having SLPs reflect the diversity of those they serve. NSSLHA's partnership could be tremendously beneficial.

VIII. Clinical Experiential Learning

A significant challenge in the current Clinical Experiential Learning model is the large variability in how a student obtains clinical hours. Further, the accumulation of hours does not ensure that students are prepared to enter practice (a) across the full scope of practice and lifespan and (b) in different practice settings. Our current clinical, educational model has a direct-contact clock-hour requirement of 400 hours. Of those hours, a student may apply 75 clinical clock-hours accumulated during an undergraduate program toward that requirement. Students must obtain the remainder of the required clock-hours at the graduate level. Graduate programs use different models of clinical experiences to help students satisfy clock-hour accumulation as well as required external placements. Some programs provide students with both on-campus and off-campus clinical experiences, whereas others rely more heavily on off-campus placements to provide these experiences.

The *2020 CSD Education Survey* data show that an average of 115 clock hours per student are accumulated in on-campus clinical experiences (ASHA, 2020). However, the greater proportion of clock-hour accumulation occurs off-campus, with an average of 321 hours per student being accumulated there, typically in two different settings. The overreliance on volunteers to supervise students in outplacement settings, and the growing shortage of outplacement supervisors willing to take students, is one of the critical problems listed in [Table 3](#). Additionally, this problem was the top area in *critical need of change* according to the Next Steps webinar survey respondents, as shown in [Figure 1C](#).

The growing scarcity of outplacements and supervisors—and an overreliance on volunteers for supervision—is an area of top concern for the current educational model. Breakout group members identified many barriers to securing more outplacement sites and recruiting more certified SLPs to supervise in outplacement settings. These barriers include the following:

- minimal training to be a clinical educator and supervisor
- no extrinsic rewards or incentives
- high productivity requirements—and high workloads and caseloads
- employer restrictions on student participation
- discouragement from employers
- administrative burden of onboarding students
- gap between academic and real-world clinical realities
- insufficient capacity of understaffed settings
- scarcity of medical outplacements

When considering what is needed to adequately prepare SLPs to enter the profession, the question of how a clock-hour model can ensure that graduates have acquired the full range of entry-level competencies they need to enter practice is puzzling. The accumulation of hours may not be enough to ensure competency.

With a goal of helping graduates across programs more consistently achieve entry-level competencies, the previous GESLP Committee received feedback that students need

- longer and more varied clinical experiences;
- increased focus on cultivating critical thinking and independence in clinical decision-making; and
- more robust clinical experiences across populations, settings, and lifespan.

As described in the scope of practice, there are also the Professional Practice Competencies of advocacy and outreach, supervision, education, research, administration, and leadership. And these transcend all the Domains of SLP Service Delivery, which include the big nine categories of communicative and swallowing disorders.

Service delivery domains involve patient-centered activities such as collaboration, counseling, prevention and wellness, screening, assessment, treatment, modalities, technology, and instrumentation for populations and systems. Finally, we have competencies sought by employers and viewed as desirable in workforce-ready candidates. These competencies include professional responsibility, communication skills, problem-solving, cultural humility and competency, and interprofessional collaborative practice.

Further, as the scope of speech-language pathology practice has expanded, we have witnessed reports of a lack of competency and concerns about encroachment in certain areas. The most frequently cited areas include

- swallowing and feeding,
- AAC,
- autism,
- cognitive-communication impairments,
- voice, and
- developmental language disorders.

As the Next Steps Committee explored these challenges, they sought creative opportunities that reflect our value that programs should have the autonomy to make decisions for themselves, as there is no “one-size-fits-all” solution. The Next Steps Committee also recognized that many programs may already be implementing some of the suggestions provided. Nonetheless, there is widespread recognition of the need to advocate for greater consistency across programs. The primary reason is to ensure that students enter practice ready to meet the needs of their patients, students, and clients. There is also a critical need for mechanisms to more realistically and transparently signal the specific areas in which an SLP is competent to practice.

- The clinical experiential pathway could begin with encouraging undergraduate clinical experiences through face-to-face and alternative modalities such as simulation. If guided observation hours were required to represent the breadth of communicative disorders, then students would begin to develop competency with different populations across the lifespan.
- Academic programs can also use alternative pedagogical models to bridge learning from the classroom to the clinic. Case-based and problem-based learning strategies strengthen a student’s critical thinking skills.
- If the competency-based education model is advanced, then academic programs could (a) develop performance criteria and evaluation rubrics to improve the outcomes of clinical education and (b) provide guidance that would allow a student to advance and expand clinical competencies throughout their career.

Clinical experiential learning is contextualized within broader programmatic opportunities and constraints. We recognize that academic and clinical curricula are interdependent; therefore, program administrators should consider both components when developing program modifications. Program changes should support sufficient clinical learning and competency while maintaining a generalist degree. We must embrace lifelong learning through shared expectations for continued professional development and competency. To achieve this, we must provide opportunities for advanced training and specialization—for example, clinical skills, program administration, and supervision—in the professions. Professional training in advocacy or leadership that is received in the workplace, for example, could also be recognized.

Another challenge with our current clinical learning model is its broad variability in the rigor and quality of clinical placements and in clinical educator expertise and expectations, and for many programs, an insufficient

number of placements. Concerning the last item (insufficiency of clinical placements): In a supplemental question to the *CSD 2019–2020 Education Survey* (ASHA, 2020), faculty and extern coordinators in more than three-quarters of master’s degree programs expressed “some or a lot of” concern about finding clinical placements for experience across the full range of populations and lifespan. Faculty and external coordinators further indicated that placements limit enrollment—programs cannot increase cohorts’ size due to insufficient clinical placements. Some factors affecting the variability of externship supervision and the quality of clinical placements include

- high variability in the supervision practices of clinical educators;
- different program models and expectations for clinical educators; and
- limited resources and incentives to recruit, orient, and retain clinical educators.

The Next Steps Committee identified various opportunities to increase the rigor and quality of clinical placements across populations and lifespan.

First, we need to increase the clinical educator workforce and the consistency of its preparation. Consistency in the rigor and quality of clinical education should align with the priorities and resources available to a given college or university. One path to elevating the importance of the clinical educator role is through messaging from ASHA. For instance:

- ASHA could encourage all certified SLPs to engage in continuing professional development related to clinical education.
- These educators could also be provided with resources and recognition.
- We could advance the goal of increasing the number of professionals who participate in clinical education by incentivizing clinical education through the short-term availability of free hours of continuing education units.
- It may also be advantageous to establish a clinical educator mentoring program, for example, as a path in ASHA’s Students to Empowered Professional (S.T.E.P.) mentoring program. Such incentives may inspire clinicians to contribute to the professions in this role.

Second, there are opportunities to increase consistency in the rigor and quality of clinical placements through speech-language pathology programs’ onboarding of clinical educators. Programs can require their clinical educators to implement best practices in setting expectations, communicating feedback, evaluating students, and teaching students to use evidence-based practice through mechanisms such as

- providing a resource manual detailing how to foster clinical reasoning, communication techniques, and other clinical skills;
- providing an orientation that includes the use of templates and evaluation tools to facilitate consistency in both on- and off-campus clinical supervision; and
- supporting the exchange of knowledge and experiences between clinical educators and program faculty.

Some programs already are implementing many of the above practices.

Third, there are opportunities to (a) foster communication between programs and the clinical sites at which students are placed and (b) elevate the value of educating graduate student clinicians. Academic programs should be encouraged to become actively involved in the placement of students at external sites, including selection and continued monitoring of the site and the students placed there throughout the placement. Employers need help understanding the importance of having their SLPs educate graduate students. This might be accomplished by investing in the orientation and education of new hires. Advocacy efforts, specifically ones

that describe the benefits of taking graduate students and the value of clinical education, could be developed for different types of setting. For example, employers could incentivize the role of clinical education by establishing an annual award for an employee who fulfills this role.

Stakeholder Input: Clinical Experiential Learning Survey Summary

Participants of the *Next Steps Summer Webinar Series* in 2022 were asked to complete an online survey. The survey was designed to gather information on general topics and on a subset of questions specific to the Clinical Experiential Learning topic. The full *Clinical Experiential Learning Survey Report* is available in Appendix H.

Demographic Overview of the Respondents

- A total of 10 individuals responded to the survey.
 - 100% were certified SLPs.
- 40% had been employed in the professions for 21 or more years.
 - 20% for 16–20 years
 - 20% for 11–15 years
 - 20% for fewer than 10 years
- “College/university” was the primary employment setting for 70% of respondents.
 - 10% worked in hospitals.
 - 0% worked in schools.
 - 20% specified “other.”

Topic-Specific Questions

Four topic-specific questions were asked of the participants in the Clinical Experiential Learning webinar.

Question #12 asked, “Does your program use any of the following alternative pedagogical methods for clinical experiential learning—in particular, those involving simulation?” Respondents could check all that applied. The results are shown in Figure 13.

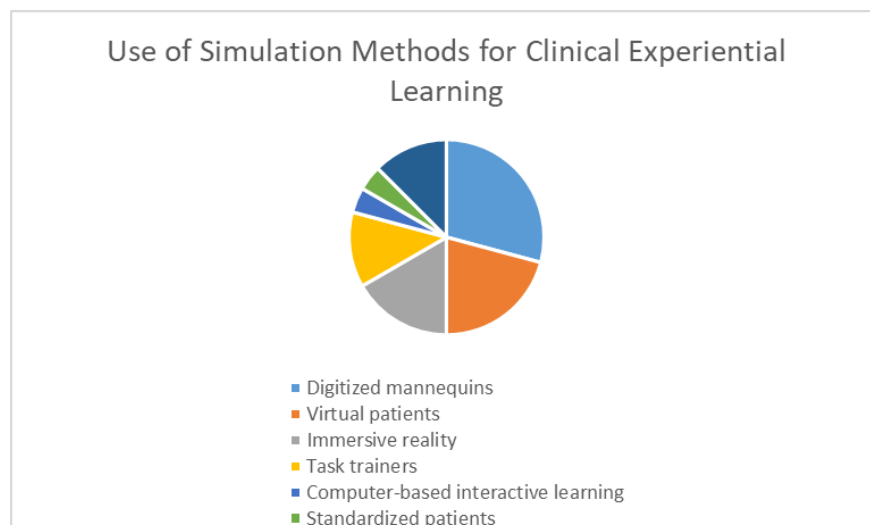


Figure 13. The distribution of responses to Question #12, “Does your program use any of the following alternative pedagogical methods for clinical experiential learning—in particular, those involving simulation?”

Question #14 asked, “In which of the following clinical professional skills are graduating students most lacking competency?”, and respondents could check all that apply. The results are shown in Figure 14.

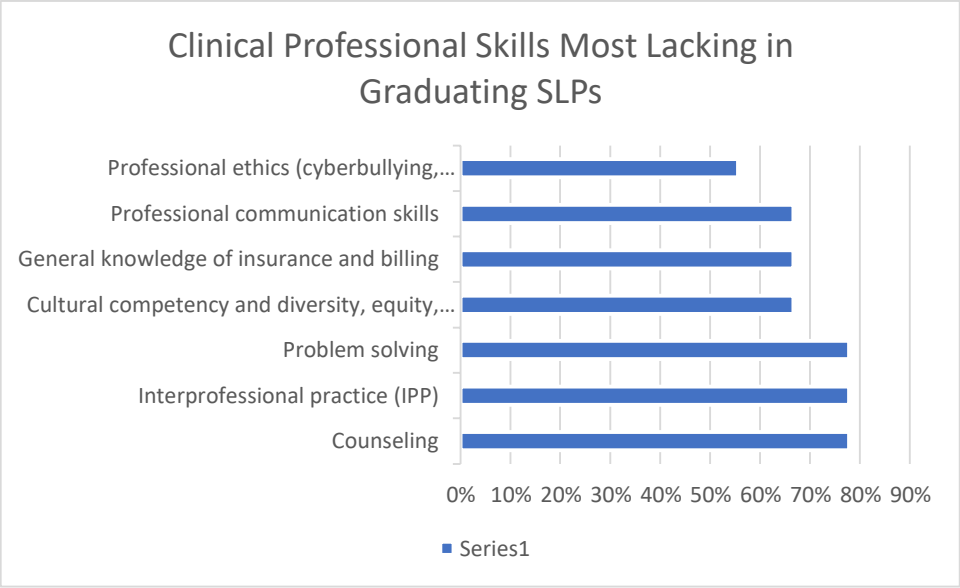


Figure 14. The distribution of responses to Question #14, “In which of the following clinical professional skills are graduating students most lacking competency?”

In Question #15, which asked, “Does your program require students to complete both one externship in a pediatric setting and one externship in an adult setting?”, 86% of respondents indicated “Yes.”

In Question #16, which asked, “How long is each externship?”, the mean was 15 weeks, with an average of 30 hours over 4 days per week spent at the site for both adult and pediatric settings.

In Question #17, which asked, “How many externship experiences beyond on-campus or initial clinical experiences does your program require?”, the median response was 2.

The responses to these latter three questions are in agreement with data obtained from prior surveys. Use of simulation is growing, but students continue to graduate lacking the fundamental clinical and professional skills needed by SLPs in every practice setting.

Clinical Experiential Learning Webinar Breakout Group Summary

This summary was generated by Claude.ai and edited by humans.

The second way in which we sought stakeholder input was through breakout groups conducted during the Next Steps Summer Webinar Series in 2022.

Key Points

The Next Steps Committee planned the 2022 Next Steps Summer Webinar Series with the purpose of gathering stakeholder input using the procedures described in the Introduction Section, under Methods. Discussion focused on ways to enhance clinical education and competency development for students preparing to enter the field. Participants included university faculty, clinical educators, medical SLPs, school SLPs, and others.

Thoughtful discussions ensued around the opportunities and challenges in clinical training, competency-based assessment, and student readiness for practice. Although perspectives sometimes differed based on context, several consistent themes and suggestions emerged.

Key Themes and Discussion Points

The following key themes and discussion points emerged from the Next Steps webinar:

- Acquiring enough quality placements and supervision is a systemic challenge—creative solutions are needed to expand student experiences. Competencies, not just placement hours, must be the focus.
- Classroom learning has limits in instilling competencies without adequate clinical practice. Finding the right balance and integration is crucial.
- Competencies and supervision expectations are not consistently defined or applied across settings. Standards with flexibility are needed.
- Students often lack the professional skills, critical thinking, and experience needed to thrive in clinical environments, especially medical and collaborative settings.
- Resources—including funding, personnel, community partnerships, and technology—restrict training capacity for many programs.
- SLPs supervising in outplacements are often ill-prepared and undertrained. They need ongoing support to deliver quality mentoring focused on competency development.
- Traditional models struggle to provide integrated training across diverse populations and settings. Innovative hybrid approaches should be explored.
- Moving to competency-based assessment and promoting experiential learning in classrooms, simulations, and in the community can enrich development.
- IPE and academic–clinical faculty collaborations are critical to advance training and address evolving demands.

When synthesized, these discussions highlight a few key priorities for strengthening clinical preparation and entry-level competencies.

Key Priorities

1. Adopt a Competency-Based Mentality and Assessment
 - Transition focus from clock-hours to defined competencies that are collaboratively developed by educators, clinicians, accreditors, and other stakeholders. Apply these standards flexibly within programs.
 - Clarify expectations for competency stages, maintain minimum hours, and increase quality control.
 - Develop tools to evaluate knowledge, skills, and mindsets.
 - Promote regular assessment dialogues.
2. Prioritize Quality Clinical Mentoring
 - Expand supervisor pools through partnerships and recognition. Offer training incentives such as free continuing education units.

- Calibrate supervisor expectations via joint onboarding and continuing education.
 - Integrate supervisor feedback into classroom training and competency plans.
3. Bridge Classroom and Clinic Through Experience
 - Make curricula clinically relevant via simulations, role plays, case studies, and debriefs.
 - Connect classroom to clinic through discussing classroom content in relation to clinical observation experiences.
 - Create progressive responsibilities—from screening to evaluating to treatment planning to providing treatment.
 - Partner with community organizations for service-learning opportunities.
 4. Align Training with Interprofessional Education
 - Pursue interprofessional education, joint placements, case conferences, and staff exchanges.
 - Educate students on professional roles, care frameworks, terminology, regulations, and ethics.
 - Develop collaborative mindsets, knowledge, and skills.
 5. Support Creativity and Innovation
 - Pilot and study novel approaches such as simulations, community labs, and co-treatment models.
 - Showcase emerging solutions at conferences and in publications.
 - Advocate to remove policy and resource barriers.

Applying these priorities requires commitment, dialogue, and resources from programs, educators, students, clinicians, associations, and policymakers. However, advancing clinical education should be an urgent priority, given its vital impact on client care. Although solutions may differ across contexts, the overall trajectory is clear: Academic programs need competency-based, collaborative, experiential, and clinically integrated training in order to meet evolving demands. The recommended priorities can help guide strategic investments and innovations to strengthen the path to practice.

Questions Asked of Breakout Group Members

1. How might students gain more robust clinical experiences and competencies across populations, settings, and the lifespan to be better prepared to enter the field?
2. Have we covered the relevant issues around clinical education and entry-level competency from your perspective? Are there others?

The breakout groups discussed ways in which students could gain more robust clinical experiences and competencies across populations, settings, and the lifespan so that they become better prepared to enter the field. The breakout groups also covered issues related to clinical education and entry-level competency.

Gaining More Robust Clinical Experiences

- **Placements and Hours.** A major theme was the difficulty of securing enough quality placements and hours for students across settings and populations. Solutions included more placements at private practices and in underserved/diverse areas, partnerships with community organizations, simulations, and telepractice. However, placements alone may not lead to competency without proper supervision and training.
- **Supervision.** Participants emphasized the need for high-quality supervision from experienced clinicians during placements. Challenges exist in finding willing, qualified supervisors. Suggestions included training supervisors, recognizing their contributions, and requiring more clinical education hours.
- **Competency Versus Hours.** Some group members advocated moving from an hours-based model to a competency-based one. However, defining competencies across settings is complex. Some group

members proposed a hybrid model, wherein some standard competencies are required, but other competencies programs could adapt to the context of their specific setting.

- **Academic–Clinical Integration.** Better integrating academic and clinical learning was seen as important for competency. Ideas included joint development of competencies, classroom simulations, alignment of placements with coursework, and communication between academic and clinical faculty.
- **Exposure and Experience.** Experiences that are not necessarily clinical (e.g., observations, assistant roles) can expose students to diverse populations and settings and can have value in helping to build competencies and readiness for clinical work.
- **Post-Graduate Training.** Students may gain some competencies during their Clinical Fellowship or on the job. Programs should focus on foundations, critical thinking, and learning skills so that graduates can develop further competencies.
- **Barriers.** Breakout group members identified the following barriers to clinical placements:
 - restrictions on billing/insurance
 - supervisor availability
 - placements saturated with competitors
 - costs/productivity pressures

Clinical Education and Entry-Level Competencies

- **Defining Competencies.** Many group members agreed that competencies should replace hours as the focus, but defining standardized competencies across diverse settings is challenging. ASHA could provide guidance and support.
- **Supervision Training.** Training for clinical educators is lacking but needed to improve student competencies. Options include instituting required CE, implementing training incentives, and partnering academic supervisors with external clinical supervisors.
- **Interprofessional Education and Collaboration.** Engaging in interprofessional education and training students to collaborate with professionals in other fields was seen as increasingly important for holistic, ethical, client-centered care.
- **Medical/Health Care Exposure.** Those in medical settings felt that students needed more medical knowledge, health care experience, and understanding of roles/ethics before entering clinical work.
- **Real-World Experience.** Some people argue that classroom learning has limitations for competency: Real-world clinical experience is essential. Placements should increase in complexity and independence.
- **Student Readiness.** Expectations between programs and outplacement sites may be misaligned regarding student readiness and the level of supervision needed. Clearer expectations and communication are needed.
- **Resource Limitations.** Shortages of time, willing supervisors, faculty positions, community partnerships, and funding limit the clinical experiences that programs can offer to build competency in their students.
- **Standardization Versus Flexibility.** Programs should have some flexibility to tailor competencies and experiences to their context, resources, and community while meeting overall standards.
- **Regulations and Accreditation.** CAA requirements regarding placements and hours constrain programs. Group members suggested advocating for more flexible models.

Overall, the breakout groups highlighted the complexity of defining and assessing competencies amid diverse settings, populations, and learning needs. Although standardization has its merits, flexibility and creativity are

also required to build competencies, especially given programs' unique constraints and resources. Collaboration between academic programs, students, clinicians, professional organizations, and policymakers was seen as key to addressing the challenges raised.

Concerns and Recommendations

The breakout groups expressed concerns and provided recommendations related to the following five topic areas:

- shortage of clinical placements and quality supervision
- clock-hours versus competencies
- gaps between classroom and clinical learning
- student readiness for medical and health care settings
- supervisor expectations versus student readiness

The subsections below provide more details on each of these areas of concern and some recommendations.

Shortage of Clinical Placements and Quality Supervision

Concerns

- There is a shortage of quality clinical placements across settings and populations to meet student volume. Competition between programs for clinical placements is increasing.
- Many clinicians are unwilling or unable to supervise students due to productivity pressures, lack of incentives, and perceived burden.

Recommendations

- Build partnerships with community organizations, private practices, and facilities focused on underserved areas to expand placement opportunities and breadth of clinical experiences.
- Implement screening and support for new supervisors—to ensure quality mentoring.
- Increase placement availability through simulations, telepractice, and academic–clinical faculty partnerships.
- Provide incentives for supervision through recognition, discounted ASHA fees, reduced conference rates, and free CE.
- Educate employers on student supervision needs, benefits of mentorship, and impact on the profession.
- Advocate for supervision and training requirements—to ensure dedicated time for students.

Clock-Hours Versus Competencies

Concerns

- The emphasis on clock-hours does not necessarily equate to competency upon graduation.
- Clock-hours are difficult to attain, and an emphasis on them restricts opportunities.
- Competencies are not well-defined across diverse settings and populations. Programs have flexibility in interpretation.

Recommendations

- Shift to a competency-based model with defined standards co-created by educators, clinicians, and ASHA.
- Maintain reasonable clock-hour minimums for competency development paired with milestone assessments.
- Increase quality control through clear expectations, supervisor training, and student evaluations.

- Allow for contextual application of competencies that can vary across settings but is unified in assessment.
- Provide resources to help programs integrate competencies into curriculum and clinical learning.

Gaps Between Classroom and Clinical Learning

Concerns

- Classroom instruction does not always adequately prepare students for the realities of clinical work. Faculty may be detached from clinical practice.
- Clinical supervisors assume foundational skills that students lack from coursework.

Recommendations

- Increase communication between academic and clinical faculty to align training.
- Integrate case studies, role play, simulations, and so forth, into coursework—in order to bridge theory and practice.
- Develop joint competencies, shared lectures, and problem-solving groups with academic and clinical faculty.
- Provide classroom and lab experiences that scaffold clinical skills in areas like writing, data collection, and professionalism.
- Create a shared vision of competency milestones between academia and clinical sites.
- Maintain reasonable clock-hour minimums to allow integration and application of classroom knowledge.

Student Readiness for Medical and Health Care Settings

Concern

- Students often lack health care experience, medical knowledge, ethics training, and an understanding of professional roles prior to medical placements.

Recommendations

- Offer interprofessional labs, simulations, observations, and assistant roles to expose students to health care environments.
- Provide coursework and practical experiences in topics like medical terminology, electronic records, HIPAA [[Health Insurance Portability and Accountability Act of 1996](#)], ethics, and so forth.
- Educate students on scope of practice, advocacy, and regulations for ethical and collaborative health care practice.
- Forge training relationships with nursing and medical schools for shared practical learning.
- Partner with health care employers to inform classroom training and competency expectations.

Supervisor Expectations Versus Student Readiness

Concern

- Expectations are sometimes misaligned between programs and outplacement sites regarding a student's preparation level and supervision needed.

Recommendations

- Set clear expectations and milestones for competency development at each stage of training.
- Provide tools that enable programs and supervisors to regularly assess progress and readiness.
- Maintain open communication channels between programs and supervisors regarding student performance.
- Educate supervisors on principles of adult learning, the scoping of supervision to learner needs, and the role of mentoring.

- Offer joint preceptor training with program faculty and site supervisors, so they can calibrate expectations.
- Encourage supervisors to share expertise and inform training priorities based on expectations from the speech-language pathology field.

The breakout group discussions brought up meaningful concerns regarding the availability, quality, and relevance of clinical experiences for competency development. Although complex, the movement toward competency-based assessment, improved supervisor training, stronger academic–clinical integration, and flexible, collaborative solutions can help address these pressing issues.

Opportunities and Recommendations

The breakout groups discussed the following opportunities and made recommendations, which are detailed in the subsections below (broken down by topic area).

Leverage Technology and Simulations

Opportunity

- Simulations and virtual platforms allow broader training opportunities and increased access to patients and experts.

Recommendations

- Integrate telepractice, simulations, videos, and so forth, into coursework for exposure before placements.
- Create virtual opportunities to connect students with specialized clinicians and settings.
- Use technology—such as electronic medical records (EMR) trainers and interactive case studies—to teach clinical documentation and clinical decision-making.
- Offer simulations of interprofessional collaboration for health care role training.
- Pursue recognition of quality simulations as partial credit toward clinical hours.

Community-Engaged Learning

Opportunity

- Community partnerships can provide experiences with diverse populations and can also increase access to services for underserved groups. Such community partnerships can also help students better understand—and plan care based on—factors influencing the social determinants of health.

Recommendations

- Develop relationships with community clinics, shelters, day programs, and other organizations to create rotational placements.
- Collaborate on free clinics, advocacy projects, health fairs, and other service-learning initiatives.
- Create liaison roles and advisory boards to align training with community needs.
- Use community engagement resources and networks to facilitate connections.
- Through community immersion, educate students on issues like health literacy, cultural responsiveness, and barriers to access.

Interprofessional Education

Opportunity

- Interprofessional education develops holistic mindsets, ethics, communication skills, and team-based care—all of which are needed in collaborative practice.

Recommendations

- Create interprofessional simulations and experiential learning with programs such as nursing, counseling, and medicine.
- Pursue shared placements, case conferences, rounds, and problem-solving groups across disciplines.
- Develop joint competencies and curricula integrating CSD knowledge and skills with the skillsets of complementary fields.
- Model interprofessional simulations through teams that have diverse expertise.
- Expose students to roles, ethics, and care frameworks in related fields.

Next Generation Academic–Clinical Models

Opportunity:

- Innovative models—such as faculty-supervised community rotations, site-based faculty labs, and joint appointments between clinical sites and academic programs—hold promise.
- Remote options for classroom-to-clinic connections should be explored.

Recommendations

- Pilot some promising models—such as site-based faculty labs and paired preceptors—to validate the benefits.
- Support faculty and preceptors who are co-treating patients and co-supervising placements.
- Develop hybrid educator roles to reward clinical teaching and to maintain practice knowledge.
- Evaluate outcomes compared with traditional models and disseminate best practices.
- Showcase successful innovations at conferences and via publications.

The breakout group discussions highlighted exciting opportunities to enrich training and to better prepare students for collaborative practice. Capitalizing on technology, community partnerships, interprofessional training, and emergent academic–clinical models can strengthen competency development in the field.

Program Recommendation: Competency-Based Experiential Learning Model

Background

As evidenced by the breakout group discussions, there is a pressing need to enhance clinical education and competency development in entry-level programs for SLPs. Students require integrated knowledge, critical thinking abilities, professional skills, and diverse experiences to meet evolving demands across settings and populations. To address current gaps, it is proposed that ASHA develop and collaborate with academic programs to develop and implement a *Competency-Driven Experiential Learning Model*.

Model Overview

The Competency-Driven Experiential Learning Model aims to enrich competencies through clinical classroom learning strategies, simulations, community immersion, and clinical experiential learning.

Goals

The goals of this Competency-Driven Experiential Learning Model are as follows:

- Provide robust experiences with diverse populations and settings.
- Bridge didactic and clinical learning.
- Instill collaborative practice capabilities.
- Assess milestone competency achievement.

- Equip students for career responsibilities.

By pursuing an integrative approach, students can build competencies aligned with industry needs, emerging practices, and their specific career trajectories.

Key Program Elements

The six key program elements of this Competency-Driven Experiential Learning Model consist of (1) competency-based framework, (2) didactic alignment, (3) experiential learning, (4) competency assessments, (5) preceptor development, and (6) interprofessional training.

Competency-Based Framework

- Develop a competency-based framework, mapping the knowledge, skills, and abilities needed for holistic practice.
- Include competencies for assessment, intervention, advocacy, ethics, collaboration, 21st century skills, and more.
- Distinguish milestones from “novice” to “expert” for each competency.

Didactic Alignment

- Tailor curricula to competencies using simulations, case studies, lectures, projects, and problem-based learning.
- Require analysis and application, to deepen learning.
- Integrate clinical partners into course design and delivery.

Experiential Learning

- Begin immersive training via observations, screenings, and assistant roles as early as possible in the students’ program.
- Provide telehealth, simulation, and role-play experiences.
- Offer rotations through diverse settings—schools, hospitals, nursing homes, community shelters.
- Include rural, urban, multilingual, and underserved populations.
- Partner with community organizations on service initiatives.

Competency Assessments

- Gauge competencies throughout the program via rubrics, observations, and portfolios.
- Require self-evaluations, supervisor reviews, and plan creation.
- Customize milestone goals based on specializations and career goals.
- Use simulations and objective structured clinical exams.

Preceptor Development

- Provide ongoing training on supervision, coaching, and assessment.
- Calibrate expectations and tools through joint onboarding.
- Recognize contributions through financial incentives and status.
- Maintain open communication channels with programs.

Interprofessional Education

- Engage students in interprofessional simulations, case conferences, and debriefs.
- Learn health care terminology, regulations, ethics, and care models.
- Train in collaborative teaming, shared decision-making, and family education.
- Understand scope of practice across roles.

By pursuing this integrative approach under a defined competency-based framework, students can gain the robust experiences they need to deliver ethical, collaborative, and evidence-based care to diverse populations. This Competency-Driven Experiential Learning Model is applicable across settings and is flexible to allow for contextual customization.

Implementation Recommendations

To implement this program, the following considerations are provided:

- Pursue collaborations with critical industry and community partners.
- Secure buy-in and input from faculty and administration to shape design.
- Phase in the various components incrementally to allow testing and refinement of new elements.
- Provide faculty development and resources to support experiential instruction.
- Develop comprehensive program review processes to monitor outcomes.
- Create toolkits of competencies, rubrics, cases, and other materials for standardization.
- Consider regulatory and accreditation policies that may require advocacy for change.
- Identify funding mechanisms such as government grants, internal funding mechanisms, and philanthropic sources.

The proposed program offers an ambitious transformational vision for speech-language pathology education that is aligned with the concerns and ideas voiced by breakout group participants. Although the process will be demanding, incremental steps can chart an attainable path forward. Overall, the framework provides student-centered, competency-driven preparation that is enriched through experiential learning in the classroom and community. This integrative approach can produce practice-ready graduates who are equipped to meet diverse needs and collaborate across specializations. By comprehensively aligning learning opportunities with defined competencies and career trajectories, CSD programs can strengthen the path from classroom to clinic.

ASHA's Role

ASHA can support the development and implementation of competency-driven experiential learning programs in the following 10 ways.

1. *Develop competency standards.* Lead collaborative efforts to define (a) core competencies for the field and (b) milestone progressions. Provide guidance to programs.
2. *Shape accreditation requirements.* Advocate for CAA to (a) include competency-based components into accreditation standards and (b) reconsider the clinical experiential requirements.
3. *Provide implementation support.* Develop toolkits, rubrics, cases, and other materials to assist programs in shifting to competency-driven models. Offer training opportunities on all aspects.
4. *Facilitate partnerships.* Use ASHA's platform to connect academic programs with health care partners, community organizations, and preceptors.
5. *Recognize contributions.* Expand honors—such as ASHA's Awards for Continuing Education (ACE)—to recognize clinical supervisors, mentors, and partner organizations contributing to clinical experiential training.
6. *Share innovations.* Feature promising experiential learning models in publications, at conferences, and on the website to accelerate adoption.
7. *Fund demonstration projects and research.* Provide seed grants to pilot innovative approaches. Fund research on competency-based educational models of student outcomes.
8. *Advocate for policy change.* Lobby accreditors, regulators, and funding sources to allow and incentivize competency-based experiential education, where needed.
9. *Raise public awareness.* Communicate how clinician competencies translate into quality care to elevate the profile and value of the profession.

10. *Lead interprofessional initiatives.* Build partnerships across health care fields to co-create training programs that advance team-based, collaborative care capabilities.

With its leadership role, public presence, networks, and resources, ASHA is well-positioned to play a catalytic role in enabling competency-driven reforms. A coordinated effort engaging ASHA's expertise, influence, and constituencies can help actualize the recommended changes to improve clinical preparation and to better prepare students for the future of work.

IX. Conclusions

This report covered critical factors influencing the future of learning, work, and teaching in speech-language pathology, exploration of alternative educational models to address longstanding challenges and the potential of competency-based education. The Next Steps Committee also examined the challenges and opportunities associated with improving Faculty Growth and Sufficiency, Faculty Development, Student Diversity, and Clinical Experiential Learning. Several consistent themes and recommendations emerged across these topics.

Prepare for Future of Learning, Work and Teaching

The Future of Learning, Work and Teaching section emphasizes that adaptability, resilience, and lifelong learning are essential for professionals to keep pace with rapid changes. Key influences include the digital revolution, competency-based hiring valuing 21st century skills, advancing technologies, diversity in society, and research on learning and teaching. Recommendations focused on leveraging technology to increase engagement and flexibility, promoting interprofessional collaborations in teaching and practice, changing admissions practices to attract more professionals with diverse backgrounds, integrating advocacy and cultural responsiveness training throughout curricula, and better supporting student mental health and well-being. Opportunities exist to reexamine policies, curriculum models, and clinical training methods using a competency-based, student-centered lens aimed at meeting evolving societal needs. It is recommended that ASHA establishes the following initiative to create a structured program to coordinate the many disparate efforts required to transform education for SLPs.

Catalyze Innovation in CSD Education

A programmatic focus on innovation in CSD education is needed and should include the following components.

- Create communities to share ideas and resources on improving preparation.
- Develop conferences and webinars focused on key strategies like competency-based assessment, holistic admissions, and interprofessional training.
- Showcase examples of successful program transformation.
- Provide tools and training to support adoption of student-centered, flexible, clinically relevant models.
- Integrate digital learning strategies like simulations, adaptive learning platforms, and virtual patients.
- Pursue stackable micro-credentials aligned to competencies to signal capabilities.
- Provide faculty development on online and alternative pedagogies, educational technologies, inclusive teaching practices, and learning science.
- Develop shared curricular assets like modular courseware, case libraries, assessments to reduce duplication.

Further Consider Alternative Educational Models

The section on Alternative Educational Models examines options to address critical problems with current preparation of SLPs, including inconsistent quality and depth of preparation for medical and health care settings that employ SLPs, insufficient student and faculty diversity, overloaded curricula, unequal training across programs, and lack of a competency-based frameworks. Three proposed alternative models are:

- 1) New lifespan model extending degree requirements beyond 2 years to enable competency development across the full scope of practice

2) Track model with separate adult and pediatric tracks to enable greater specialization aligned with selected track

3) Modular model organizing curriculum into modules that programs can selectively offer to focus training and recognize specific competencies

Modifying undergraduate preparation, entry-level training, clinical fellowship, and post-entry-level professional development could also help strengthen competencies and signal specialized expertise.

Other areas that are considered essential for transforming education of SLPs include reevaluating admissions and graduation policies and practices, leveraging technology, emphasizing competencies, supporting well-being, increasing flexibility, fostering interprofessional collaboration, and enhancing diversity. The two recommendations below could help transform SLP education to address challenges and better prepare professionals for evolving health, education, and social needs.

Support Student and Faculty Wellbeing

The mental health crisis cannot be ignored. Programs need to reduce nonessential stressors and integrate resilience training while enhancing counseling services. Faculty workload and burnout must also be addressed through greater work-life balance, flexibility, and support.

Align Training with Practice Demands

Foster strong academic-clinical partnerships to bridge competency gaps. Increase interprofessional education and use of simulations and experiential learning focused on applied skills over content memorization. Integrate technology effectively while teaching appropriate use. Include cultural responsiveness, ethics, leadership, and advocacy in curricula.

Adopt Competency-Based Educational and Competency-Driven Experiential Models

Transition to competency-based education to focus more on applied knowledge and clinical thinking versus time-based requirements. Integrate competency-driven, personalized learning paths tailored to competency levels and interests throughout students' experiential learning opportunities. Develop micro-credentials to signal specializations and promote lifelong learning. Allow part-time, online, and modular options to increase accessibility.

Increase Accessibility and Diversity

Make programs more flexible and affordable to attract diverse students who balance other responsibilities. Take a competency-focused, holistic approach to admissions. Actively recruit and fund students from minority backgrounds, expanding the diversity of the field. Diversifying the field is critical, but programs face interrelated barriers that hinder recruitment and retention of underrepresented students. The following recommendations are considered key to change.

- Conduct culturally responsive outreach to expose more students to the field.
- Provide application/interview workshops to aid diverse applicants.
- Overhaul admissions practices to be holistic and mitigate bias.
- Develop specialized orientation, advising, peer groups for diverse students.
- Educate faculty/supervisors on cultural competence and implicit bias.
- Facilitate student-led groups and activities for underrepresented students.
- Increase faculty diversity.

Increase Faculty Growth and Sufficiency

Despite many efforts over the past two decades, the shortage of PhD-level faculty in the discipline continues to be a major challenge. With many new programs in the accreditation pipeline, the situation is likely to worsen. The following suggestions may help to provide mitigations.

- Increase PhD funding via stipends and scholarships to incentivize academia.
- Offer hybrid/online and part-time PhD programs for flexibility and access.
- Advocate for alternative credential pathways to count toward faculty requirements.
- Develop clinical educator credentialing programs.
- Create faculty-sharing systems via online modules and cross-appointments.
- Form academic consortiums for resource and curriculum sharing.

Support Faculty Development

The need for faculty to engage in faculty development focused on pedagogy is an important component of improving and sustaining the speech-language pathology field. Many faculty need training on instructional approaches, technology integration, culturally responsive teaching, clinical supervision, and addressing student mental health crises. Workloads are unsustainable and the faculty shortages may get worse, so the discipline needs to consider how to better utilize practitioner faculty, alternative staffing models, and team approaches to augment instructor pools.

- Prioritize pedagogical preparation in PhD programs via required courses, mentored teaching experiences, and portfolios.
- Incentivize continuing pedagogical professional development for faculty.
- Develop online terminal degree pathways tailored to teaching careers.
- Recognize clinical doctorates like SLPD for faculty roles.
- Update policies and processes to value teaching accomplishments equitably.
- Support teaching development opportunities at multiple levels.
- Provide interprofessional simulations focused on teamwork, communication, and ethics.
- Create opportunities for collaborative field experiences and learning.
- Develop shared case studies drawing connections across disciplines.
- Educate students on professional roles, care models, regulations, and scope across fields.
- Model interprofessional collaboration through classroom teaching teams.

Improve Clinical Experiential Learning

The paucity of high-quality placements across settings that can take students and the scarcity of medical outplacements are the top concerns that require immediate attention. The following recommendations are essential to improving clinical experiential learning.

- Reduce the gap between academic and real-world clinical realities.
- Lessen the administrative burden of SLPs who take students in external placements.
- Shift focus from hours to defined competencies and quality supervision.
- Make curricula clinically relevant via simulations, cases, and debriefs.
- Create progressive clinical responsibilities across settings/populations.
- Expose students early via observations, screenings, assistant roles.
- Offer interprofessional labs, simulations, and practical health care experiences.

In summary, the field of speech-language pathology must be willing to rethink assumptions and practices. Findings confirm that change is imperative to sustain the profession and produce practice-ready clinicians. Supporting wellness, increasing diversity, evolving pedagogy, adopting competency-driven curricula, and catalyzing innovation in partnership with stakeholders represent top priorities. Embracing more student-centered, flexible, and clinically relevant preparation guided by a competency-based educational framework can propel necessary transformation. Enhancing graduate education in speech-language pathology requires commitment across stakeholders to strengthen pedagogy, diversify the pipeline, enrich clinical preparation, support faculty, and foster interprofessional capabilities and 21st century skill development. ASHA can play a vital role through convening partners, providing resources and platforms, recognizing contributions, advocating for policy changes, and accelerating adoption of promising models. Collective dedication to raising standards can help ensure that practice-ready graduates are equipped to enter practice across the settings in which SLPs commonly work. Successfully transforming education in speech-language pathology to address longstanding challenges and meet evolving demands will require a thoughtful, coordinated strategy across stakeholders. While individual groups can drive change through their respective roles, collective impact arises from interdependent efforts aligned around common goals, which ASHA must facilitate.

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XI. Appendices

Appendix A: Aggregate Survey Results

Ad Hoc Committee to Plan Next Steps to Redesign Entry-Level Education for Speech-Language Pathologists' Next Steps 2022 Summer Webinar Series

Introduction

Beginning June 7, 2022, a survey was made available as part of the Ad Hoc Committee to Plan Next Steps to Redesign Entry-Level Education for Speech-Language Pathologists' Next Steps 2022 Summer Webinar Series. Individuals who participated in the live webinars, as well as those who viewed the recorded sessions, had the opportunity to complete the survey by August 30.

A total of 151 individuals responded to the survey, 145 from the live webinars and six who viewed a recorded session. Results for questions common to all seven webinar topic surveys, except state of residence, follow. Responses are presented for all respondents combined, as well as for each webinar topic. Note that individuals may have completed the survey more than once if they participated in and/or viewed multiple webinars, and therefore, may be counted numerous times in the results in this report. Comments have been lightly edited for spelling and grammar. This report was prepared by ASHA's Surveys and Analysis unit.

Results

1. Which of the following best describes your current ASHA affiliation status? (Check one.)

Response	All Respondents	Future of Learning	Competency-Based Education	Alternative Educational Models	Faculty Growth and Sufficiency	Clinical Experiential Learning	Faculty Development	Student Diversity
	<i>n</i> = 151	<i>n</i> = 46	<i>n</i> = 25	<i>n</i> = 33	<i>n</i> = 14	<i>n</i> = 10	<i>n</i> = 10	<i>n</i> = 13
ASHA-certified in audiology	5.3	4.4	4.0	6.1	14.3	0.0	0.0	7.7
ASHA-certified in speech-language pathology	91.4	91.3	96.0	93.9	78.6	100.0	100.0	76.9
ASHA-certified in both audiology and speech-language pathology	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Noncertified member	0.7	0.0	0.0	0.0	0.0	0.0	0.0	7.7
Clinical Fellow	2.0	2.2	0.0	0.0	7.1	0.0	0.0	7.7
International affiliate	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Speech-language pathology or audiology assistant	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Student (undergraduate, graduate or research doctoral)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other (Provided in webinar-specific reports.)	0.7	2.2	0.0	0.0	0.0	0.0	0.0	0.0

2. How many years have you been employed? (Check 0 if none.)

Response	All Respondents	Future of Learning	Competency-Based Education	Alternative Educational Models	Faculty Growth and Sufficiency	Clinical Experiential Learning	Faculty Development	Student Diversity
	<i>n</i> = 151	<i>n</i> = 46	<i>n</i> = 25	<i>n</i> = 33	<i>n</i> = 14	<i>n</i> = 10	<i>n</i> = 10	<i>n</i> = 13
0	2.0	2.2	0.0	0.0	7.1	0.0	0.0	7.7
1-5	1.3	0.0	0.0	0.0	7.1	0.0	0.0	7.7
6-10	7.3	2.2	8.0	9.1	7.1	20.0	10.0	7.7
11-15	11.9	8.7	24.0	15.2	0.0	20.0	10.0	0.0
16-20	13.2	17.4	8.0	6.1	14.3	20.0	20.0	15.4
21 or more	64.2	69.6	60.0	69.7	64.3	40.0	60.0	61.5

3. Which of the following best describes your current primary employment setting? (Check one.)

Response	All Respondents	Future of Learning	Competency-Based Education	Alternative Educational Models	Faculty Growth and Sufficiency	Clinical Experiential Learning	Faculty Development	Student Diversity
	<i>n</i> = 147	<i>n</i> = 45	<i>n</i> = 25	<i>n</i> = 33	<i>n</i> = 13	<i>n</i> = 10	<i>n</i> = 9	<i>n</i> = 12
Early intervention/ pediatric home health	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
School (preschool, elementary, etc.)	1.4	2.2	0.0	3.0	0.0	0.0	0.0	0.0
College/university	85.0	84.4	92.0	84.9	92.3	70.0	77.8	83.3
Hospital (all types, inpatient and outpatient)	6.1	8.9	0.0	3.0	7.7	10.0	22.2	0.0
Nonresidential health care facility (clinic, physician's office, etc.)	0.7	2.2	0.0	0.0	0.0	0.0	0.0	0.0
Residential health care facility (skilled nursing facility, etc.)	0.7	0.0	0.0	0.0	0.0	0.0	0.0	8.3
Adult home health	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Private practice	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Agency, organization, or research facility	0.7	0.0	4.0	0.0	0.0	0.0	0.0	0.0
Industry	1.4	0.0	0.0	3.0	0.0	0.0	0.0	8.3
In audiology externship and/or clinical practicum	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Not employed (student, retired, on leave of absence, etc.)	0.7	0.0	0.0	3.0	0.0	0.0	0.0	0.0
Other (Provided in webinar-specific reports.)	3.4	2.2	4.0	3.0	0.0	20.0	0.0	0.0

4. What is your current primary employment function? (Check all that apply.)

Response	All Respondents	Future of Learning	Competency-Based Education	Alternative Educational Models	Faculty Growth and Sufficiency	Clinical Experiential Learning	Faculty Development	Student Diversity
	<i>n</i> = 139	<i>n</i> = 45	<i>n</i> = 25	<i>n</i> = 32	<i>n</i> = 13	<i>n</i> = 10	<i>n</i> = 9	<i>n</i> = 12
Clinical service provider (i.e., audiologist or speech-language pathologist)	13.7	13.3	12.0	9.4	7.7	30.0	22.2	8.3
College/university academic faculty	58.3	55.6	56.0	53.1	69.2	50.0	55.6	50.0
College/university clinical faculty	31.7	26.7	32.0	34.4	30.8	40.0	22.2	25.0
Researcher	7.2	6.7	0.0	9.4	15.4	0.0	22.2	0.0
Consultant	2.2	2.2	4.0	3.1	0.0	0.0	0.0	0.0
Administrator/executive officer	3.6	2.2	4.0	6.3	7.7	0.0	0.0	0.0
Chair/department head/manager	20.1	17.8	16.0	12.5	30.8	10.0	44.4	25.0
Supervisor of clinical activity	14.4	6.7	16.0	18.8	15.4	20.0	11.1	16.7
Other director/supervisor	9.4	6.7	20.0	12.5	7.7	0.0	0.0	0.0
Other (Provided in webinar-specific reports.)	6.5	8.9	4.0	6.3	0.0	10.0	0.0	8.3

Note. Only individuals who selected “college/ university academic faculty” or “college/university clinical faculty” moved on to question 5. All other respondents were automatically skipped to question 6.

5. What is your current faculty rank? (Check one.)

Response	All Respondents	Future of Learning	Competency-Based Education	Alternative Educational Models	Faculty Growth and Sufficiency	Clinical Experiential Learning	Faculty Development	Student Diversity
	<i>n</i> = 97	<i>n</i> = 30	<i>n</i> = 17	<i>n</i> = 23	<i>n</i> = 9	<i>n</i> = 5	<i>n</i> = 5	<i>n</i> = 8
Lecturer	4.1	6.7	0.0	4.4	0.0	20.0	0.0	0.0
Assistant professor	17.5	23.3	17.7	13.0	22.2	0.0	20.0	12.5
Associate professor	42.3	30.0	52.9	34.8	22.2	80.0	60.0	75.0
Full professor	22.7	23.3	11.8	34.8	33.3	0.0	20.0	12.5
Other (Provided in webinar-specific reports.)	13.4	16.7	17.7	13.0	22.2	0.0	0.0	0.0

6. The current educational model to prepare speech-language pathologists to enter practice is a master's degree (approx. 2 yrs.) comprised of academic and clinical educational experiences covering the full scope of practice across the lifespan. How well is the current educational model working to prepare speech-language pathologists to enter practice?

Response	All Respondents	Future of Learning	Competency-Based Education	Alternative Educational Models	Faculty Growth and Sufficiency	Clinical Experiential Learning	Faculty Development	Student Diversity
	<i>n</i> = 149	<i>n</i> = 46	<i>n</i> = 25	<i>n</i> = 33	<i>n</i> = 13	<i>n</i> = 10	<i>n</i> = 9	<i>n</i> = 13
Not well at all	3.4	0.0	8.0	0.0	7.7	10.0	0.0	7.7
Not very well	14.1	13.0	12.0	15.2	15.4	10.0	22.2	15.4
Somewhat well	76.5	82.6	72.0	78.8	69.2	80.0	66.7	69.2
Very well	6.0	4.4	8.0	6.1	7.7	0.0	11.1	7.7
No opinion	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

7. What is working well? List up to three aspects, each on a separate line. Leave blank if none.

See Sub-Appendix A

8. What is not working well? List up to three aspects, each on a separate line. Leave blank if none.

See Sub-Appendix B

9. How critical is it to reconsider the educational model for preparing speech-language pathologists to enter practice?

Response	All Respondents	Future of Learning	Competency-Based Education	Alternative Educational Models	Faculty Growth and Sufficiency	Clinical Experiential Learning	Faculty Development	Student Diversity
	<i>n</i> = 137	<i>n</i> = 44	<i>n</i> = 24	<i>n</i> = 29	<i>n</i> = 12	<i>n</i> = 9	<i>n</i> = 9	<i>n</i> = 10
Not at all critical	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Not very critical	2.9	13.0	0.0	6.9	0.0	0.0	11.1	0.0
Somewhat critical	36.5	82.6	54.2	44.8	50.0	44.4	33.3	30.0
Very critical	59.9	4.4	45.8	48.3	41.7	55.6	55.6	70.0
Unsure	0.7	0.0	0.0	0.0	8.3	0.0	0.0	0.0

10. How critical is the need for change in each of the following areas?

All Respondents (<i>n</i> ≥ 131)	Not at Critical	Not Very Critical	Somewhat Critical	Very Critical	Unsure
Clinical experiential learning	0.8	6.8	32.3	60.2	0.0
Availability of clinical placements and supervisors	0.0	3.0	12.0	85.0	0.0
Curricular capacity	0.8	4.5	35.3	57.1	2.3
Faculty capacity	1.5	3.0	27.1	67.7	0.9
Faculty development	1.5	5.3	33.8	57.9	1.5

Faculty sufficiency	0.8	5.3	24.8	66.2	3.0
Faculty diversity	0.8	8.3	26.5	62.9	1.5
Student diversity	0.8	4.5	27.1	66.2	1.5
Instituting a competency-based framework	0.0	3.0	40.9	53.0	3.0
Preparation for the future of work	0.0	2.3	32.3	63.2	2.3

	Not at Critical	Not Very Critical	Somewhat Critical	Very Critical	Unsure
Future of Learning, Work, and Teaching (<i>n</i> = 44)					
Clinical experiential learning	0.0	6.8	25.0	68.2	0.0
Availability of clinical placements and supervisors	0.0	2.3	18.2	79.6	0.0
Curricular capacity	0.0	2.3	40.9	54.6	2.3
Faculty capacity	0.0	0.0	31.8	68.2	0.0
Faculty development	0.0	0.0	45.5	54.6	0.0
Faculty sufficiency	0.0	4.6	29.6	63.6	2.3
Faculty diversity	0.0	2.3	29.6	65.9	2.3
Student diversity	0.0	2.3	22.7	72.7	2.3
Instituting a competency-based framework	0.0	4.6	31.8	61.4	2.3
Preparation for the future of work	0.0	2.3	36.4	56.8	4.6

	Not at Critical	Not Very Critical	Somewhat Critical	Very Critical	Unsure
Competency-Based Education (<i>n</i> ≥ 23)					
Clinical experiential learning	0.0	4.2	37.5	58.3	0.0
Availability of clinical placements and supervisors	0.0	4.2	4.2	91.7	0.0
Curricular capacity	0.0	8.3	29.2	58.3	4.2
Faculty capacity	0.0	4.2	25.0	70.8	0.0
Faculty development	0.0	4.2	29.2	66.7	0.0
Faculty sufficiency	0.0	0.0	20.8	79.2	0.0
Faculty diversity	0.0	8.7	21.7	69.6	0.0
Student diversity	0.0	4.2	25.0	70.8	0.0
Instituting a competency-based framework	0.0	0.0	41.7	50.0	8.3
Preparation for the future of work	0.0	0.0	20.8	79.2	0.0

	Not at Critical	Not Very Critical	Somewhat Critical	Very Critical	Unsure
Alternative Educational Models (<i>n</i> = 28)					
Clinical experiential learning	3.6	10.7	28.6	57.1	0.0
Availability of clinical placements and supervisors	0.0	3.6	7.1	89.3	0.0
Curricular capacity	0.0	7.1	32.1	57.1	3.6
Faculty capacity	3.6	3.6	32.1	60.7	0.0
Faculty development	3.6	3.6	39.3	50.0	3.6
Faculty sufficiency	3.6	7.1	28.6	53.6	7.1
Faculty diversity	3.6	10.7	39.3	46.4	0.0
Student diversity	3.6	7.1	35.7	53.6	0.0
Instituting a competency-based framework	0.0	0.0	46.4	50.0	3.6
Preparation for the future of work	0.0	0.0	32.1	67.9	0.0

	Not at Critical	Not Very Critical	Somewhat Critical	Very Critical	Unsure
Faculty Growth and Sufficiency ($n \geq 10$)					
Clinical experiential learning	0.0	9.1	54.6	36.4	0.0
Availability of clinical placements and supervisors	0.0	9.1	18.2	72.7	0.0
Curricular capacity	9.1	0.0	27.3	63.6	0.0
Faculty capacity	9.1	0.0	0.0	81.8	9.1
Faculty development	9.1	18.2	0.0	63.6	9.1
Faculty sufficiency	0.0	9.1	9.1	72.7	9.1
Faculty diversity	0.0	18.2	9.1	63.6	9.1
Student diversity	0.0	18.2	27.3	45.5	9.1
Instituting a competency-based framework	0.0	10.0	40.0	50.0	0.0
Preparation for the future of work	0.0	9.1	36.4	54.6	0.0

	Not at Critical	Not Very Critical	Somewhat Critical	Very Critical	Unsure
Clinical Experiential Learning ($n = 9$)					
Clinical experiential learning	0.0	0.0	33.3	66.7	0.0
Availability of clinical placements and supervisors	0.0	0.0	11.1	88.9	0.0
Curricular capacity	0.0	11.1	33.3	55.6	0.0
Faculty capacity	0.0	11.1	22.2	66.7	0.0
Faculty development	0.0	22.2	22.2	55.6	0.0
Faculty sufficiency	0.0	11.1	33.3	55.6	0.0
Faculty diversity	0.0	22.2	33.3	44.4	0.0
Student diversity	0.0	0.0	44.4	55.6	0.0
Instituting a competency-based framework	0.0	0.0	44.4	55.6	0.0
Preparation for the future of work	0.0	0.0	44.4	55.6	0.0

	Not at Critical	Not Very Critical	Somewhat Critical	Very Critical	Unsure
Faculty Development ($n = 7$)					
Clinical experiential learning	0.0	0.0	28.6	71.4	0.0
Availability of clinical placements and supervisors	0.0	0.0	0.0	100.0	0.0
Curricular capacity	0.0	0.0	42.9	57.1	0.0
Faculty capacity	0.0	0.0	14.3	85.7	0.0
Faculty development	0.0	0.0	28.6	71.4	0.0
Faculty sufficiency	0.0	0.0	14.3	85.7	0.0
Faculty diversity	0.0	14.3	28.6	57.1	0.0
Student diversity	0.0	0.0	42.9	57.1	0.0
Instituting a competency-based framework	0.0	0.0	57.1	42.9	0.0
Preparation for the future of work	0.0	0.0	42.9	57.1	0.0

	Not at Critical	Not Very Critical	Somewhat Critical	Very Critical	Unsure
Student Diversity ($n = 10$)					
Clinical experiential learning	0.0	10.0	40.0	50.0	0.0

Availability of clinical placements and supervisors	0.0	0.0	20.0	80.0	0.0
Curricular capacity	0.0	0.0	40.0	60.0	0.0
Faculty capacity	0.0	10.0	40.0	50.0	0.0
Faculty development	0.0	10.0	30.0	60.0	0.0
Faculty sufficiency	0.0	10.0	20.0	70.0	0.0
Faculty diversity	0.0	0.0	0.0	100.0	0.0
Student diversity	0.0	0.0	0.0	100.0	0.0
Instituting a competency-based framework	0.0	10.0	50.0	40.0	0.0
Preparation for the future of work	0.0	10.0	20.0	60.0	10.0

Other responses [and criticality]:

Very Critical

- Address the pressure students are perceiving to improve their mental health and well-being.
- Being viewed as "equals" compared to other rehabilitation professionals and comparative disciplines (e.g., PT, OT, AuD, MD, LSSP, etc.)
- Change in the thinking about the SLPD. Need to move to doctoral level education.
- Demands of accreditation bodies (e.g., SACS), buy-in from stakeholder (e.g., future employers, payer sources, state licensing variability)
- Examining the purpose and role of the undergraduate degree. Are pre-requisites and a graduate model a better match? Should undergrad focus be on advocacy and promoting equity for people with CD?
- Faculty competency for clinical training vs. academic training; having a terminal degree does not make you more qualified to teach a course than a highly-competent clinician.
- Gosh. I was listening to the conversation and the whole time I was thinking about how different my university is compared to the others. Or how different my students are versus what it sounds like theirs are. My administration is different. My rural community is different. I don't know that ASHA can really do a whole lot to fix this because all of us in terms of universities are so different. A lot of what is tying my hands right now is my administration, as in my dean and my Provost. The process of changing curriculum. The pressure to admit greater numbers of students for the money. I keep hearing more and more people talking about the solutions and then I'm thinking, my dean won't go for that. We need more than just the faculty at this table. If you want to find solutions, you have to bring in all the stakeholders.
- Hands on experience in an interdisciplinary environment. Move away from simulation, students need work with REAL patients and clients! Even if it incorporates telepractice which is better than Simucase. Simucase is ok for first semester students, after which students need to go live!
- I do think that there is a need for blended program of academics and CBE.
- I have heard discussions about changes to make (alternative delivery model webinar) to graduate education. I would like this group and ASHA to also consider changes to undergraduate education. The undergraduate degree in communication sciences and disorders is not preparing many students for a graduate program and changes also need to happen there.
- Many of the skills addressed in the webinar are life skills that young people need in general. I would like to see problem solving, team work, inquiry, addressed at the UG level so that a foundation is there to build discipline specific knowledge on top.

- Meaningful and safe mechanisms for student input into programmatic decisions and feedback regarding experiences
- Require different tracks or more education to compete and improve competency in health care settings
- Restructure clinical learning- different model and learning opportunities needed.
- Thank you for caring!
- The discussion in this series targeted alternative education at the graduate level. Any of these discussions need to also address changes to UG experience. The two must be discussed in combination. The one directly impacts the other.
- There needs to be clinical professors who also work in clinical settings to teach PRACTICE and EBP application.
- Undergraduate teaching model. undergraduate CSD students should come out with the ability to work in the field. Additionally, the overinflated GPAs coming from the "worthless" undergraduate CSD have created a false baseline for competency entering the graduate level. A person who may have many more and varied experiences in a more rigorous major is unable to compete financially and academically with someone who is not challenged in the undergraduate CSD coursework. The overemphasis on the CSD undergrad has created a homogenous group of people applying for graduate SLP programs. If this is investigated further, most of the undergrads are predominantly "rich, white women" with the means to be able to focus on school amongst other things, compared to those with other backgrounds.
- We need more faculty so there are more SLPs so caseloads and workloads are manageable. We need more advocacy for better salaries for SLPs who work in schools.

Somewhat Critical

- I would like to see more research done and clearer definitions of competency-based education prior to adopting it in our programs.
- Many programs are trying to implement competency-based approaches but doing so within the traditional academic structure is not easy.
- Our professions already have a competency-based framework, but the way it is implemented may discourage or stigmatize students who take longer to master an area.
- To some degree, programs are trying to fit competency assessment into their traditional course models.

11. Have we addressed the most critical issues—specific to this webinar topic—from your perspective?

Response	All Respondents	Future of Learning	Competency-Based Education	Alternative Educational Models	Faculty Growth and Sufficiency	Clinical Experiential Learning	Faculty Development	Student Diversity
	<i>n</i> = 138	<i>n</i> = 44	<i>n</i> = 25	<i>n</i> = 29	<i>n</i> = 13	<i>n</i> = 9	<i>n</i> = 8	<i>n</i> = 10
Yes	65.9	90.9	68.0	44.8	53.9	77.8	50.0	30.0
No	34.1	9.1	32.0	55.2	46.2	22.2	50.0	70.0

12. Please provide any other comments that you would like to share with the Ad Hoc Committee to Plan Next Steps to Redesign Entry Level Education for SLPs.

See Sub-Appendix C

Sub-Appendix A

What is working well? List up to three aspects, each on a separate line. Leave blank if none.

- 2-year degree controls student debt
- Ability to start general and specialize later
- Able to cover scope fairly well in terms of classes / clinic
- Academic coverage of 9 main areas
- Academic knowledge acquisition
- Academic learning is paired with clinical learning to develop students' ability to apply knowledge
- Accepting students with majors other than CSD - majors that may have more focus on writing and critical thinking skills development
- Accreditation helps keep programs meeting the same standards but allows for flexibility in how that is accomplished.
- Accreditation processes maintain standards
- Adapting to telepractice and using virtual platforms
- Addition of electives
- Admissions/applicant numbers
- All SLPs hypothetically have same core training, easier for employers
- Allowing students to try things they don't think they will like
- Aphasia introduction
- Application of knowledge in externships
- Application of problem-based learning
- ASHA acknowledges the need for growth mindsets and infusion of cultural humility
- Attracting strong students
- Availability
- Because students cannot be exposed to EVERY client and EVERY clinical situation, emphasis is on critical thinking and integration
- Breadth of clinical experience
- Breadth of clinical experience
- Breadth of content
- Breadth of content facilitates flexibility in practice settings
- Breadth of experiences
- Breadth of knowledge in the big nine
- Broad clinical knowledge base
- Broad exposure to depth and breadth of scope of practice
- Broad exposure to different aspects of the field
- Builds relationships between students and supervisor
- CAA accreditation
- Can cover basic content
- Case-based learning
- Certified at end of CFY
- CFY
- Child language development/disorders
- Class to clinic connections

- CLD infused across the curriculum
- Clinic practice opportunities
- Clinical and didactic courses in curriculum
- Clinical experience
- Clinical experience in schools and medically based setting
- Clinical experience on campus for 3 semesters
- Clinical experiences must be diverse
- Clinical experiences often result in IPE/IPP experiences
- Clinical externships
- Clinical Fellowship
- Clinical hands on experience
- Clinical hours required
- Clinical placements
- Clinical placements
- Clinical practice
- Clinical preparation
- Clinical simulation
- Clinical supervision
- Clinical supervision training puts out great clinicians
- Clinical training in a broad range of areas
- Clinicals
- Cohort models where students feel part of a community
- Collaboration between academic and clinic faculty
- Collaboration between clinical and academic faculty
- Combination of clinical and academic experiences.
- Combination of didactic and clinical experiences
- Combining clinical practicum with academic learning
- Competency in knowledge and clinical skills
- Comprehensive examinations
- Consideration of clinical pedagogy
- Content covered
- Content knowledge through classes
- Core coursework in big nine areas
- Core required knowledge and skills ensure that students are starting from at least a minimum level of competence
- Course then clinic
- Coursework covers the Big 9
- Coursework covers the lifespan
- Covering everything that we have in the scope of practice
- Critical thinking skills
- Culminating experience
- Current emphasis on multiculturalism and diversity
- Curriculum content
- Dedicated faculty to teach across areas
- Dependent on the university program and student preparation
- Diverse opportunities for learning
- Documentation

- Dysphagia prep is much stronger than when I went through my Master's program
- Educational setting preparation
- Educational standards for speech-language pathologists are well established in the different areas of practice
- Emphasis on evidence in clinical service
- Employers report that they are pleased to hire our graduates
- Employers tell us that our students are well prepared.
- Employment rates
- Engaged and dedicated faculty (clinical and academic)
- Enough time for students to participate in coursework across Big 9 areas
- Entry level clinicians are prepared across the scope of practice for choice in work settings.
- Entry level practice
- Experiences and education across the scope of practice
- Exposes students to different settings
- Exposes students to diverse students across age span
- Exposure
- Exposure across the big nine
- Exposure across the lifespan
- Exposure to depth and breadth of fundamental skills
- Exposure to primary, fundamental concepts
- Exposure to the types of diagnoses we encounter
- Firm understanding of all 9 areas of practice
- Flexibility
- Flexibility in actual practicum experiences
- Flexibility in definition of "competency"
- Flexibility in means to assess competency
- Flexibility in skill exposure and acquisition
- Focus on Big 9
- Focus on foundational skills
- Focus on functional application of fundamental skills
- Focus on fundamental/foundational knowledge
- Focus on generalist skills
- For our setting, we interview students in advance - that works well for a pediatric medical center and clinics
- For us, going back to in-person classes has helped the students bond, support each other and lower anxiety.
- Foundation
- Foundational knowledge
- Foundational skills
- Front loading with simulation
- Full time internships versus doing internships while also doing classes
- General coverage of Big 9
- General Praxis prep
- Generalist degree with experiences across lifespan
- Generalist training allows clinicians to be flexible in their career
- Generally strong clinical preparation
- Generally strong entry-level knowledge base

- Having a broad knowledge of treatment of disorders across the lifespan allows for flexibility in future employment settings.
- Having two 10- to 12-week full time internships
- High demand for SLPs
- High employment rate
- High graduation and certification rates
- High graduation and certification rates
- High Praxis rate so students are learning the material
- High Praxis scores
- Hours are easy to track
- Hours requirement
- In built clinical experiences
- Increased awareness for education of clinical educators
- Increased awareness of need for EBP in education
- Increased used of hybrid education models and embracing of telehealth practices have increased access for students to participate in degree programs.
- Individualized meetings with students for clinical
- Infusing EBP
- Integrated coursework and clinic
- Interacting with people with communication disorders
- Interprofessional education
- Interprofessional practice opportunities ae occurring
- I've answered this question 5-6 times before :)
- Knowledge that addresses development and acquired, educational and medical components
- Knowledgeable faculty
- Language development
- Length of time isn't excessive
- Lifespan approach enables flexibility
- Master's graduates are broadly prepared
- Most students are introduced to ethics, EBP, scope of practice, etc.
- Most students gain experiences working with a variety of clinical populations.
- Most students graduate with basic knowledge in the "Big 9"
- Most university programs have some form of online learning as COVID winded down
- Nearly all students complete our program
- Need for improvement in clinical education has been recognized by increased number of position postings for clinical faculty
- Newer focus on DEI and IPE has been emphasized in many programs
- Numerous professional development opportunities to take a master-level trained person with an interest in a specialty to gain knowledge and experience to then teach graduate course in that area of specialty
- Obtaining knowledge about different conditions/diagnoses
- On campus clinical experience
- On-campus clinics and clinical practicum experiences are the best avenue for students to gain functional skills for immediate application upon entering the workforce.
- Opportunities
- Opportunities to explore the profession
- Our past graduates report being well-prepared in most areas to enter clinical practice.

- Our program clinical supervisor spends more time than ASHA requires with student - as a result they are better prepared
- Our students find medical externship placements, although it is difficult sometimes
- Our students find placements in school settings, although it is difficult sometimes
- Pass Praxis
- Passionate learners
- People are coming out still passionate
- Piques the interest of students
- Practicums in both age populations- pediatrics and adult
- Praxis
- Praxis
- Praxis pass rates
- Preparation as generalist
- Preparing generalists
- Problem based learning
- Program is completed within reasonable number of semesters
- Programs have flexibility to design processes, tracks, etc. that support new professional success
- Provides a framework for us to target
- Provides a general academic overview of the field
- Provides a general clinical overview of the field
- Provides a structure about which we can talk with students
- Providing book knowledge
- Providing experience in SOME areas of SLP
- Providing students with generalist training that allows students to pursue careers in medical or school settings - many skills do serve as a foundation for both settings and across disorder areas and ages
- Recruitment
- Related to faculty sufficiency, several of our recent graduates have completed or are in PhD programs
- Related to this topic, ASHA appears to be making great efforts here
- Required courses cover the Big 9
- Requirement for variety in clinical placements and lifespan
- Research opportunities
- Running sessions
- Scaffolded and spiraled clinical curriculum
- School CFYs are very prepared
- Sequencing of academic courses
- Shift to accept simulation
- Simucase
- Simulations
- SLPS change lives
- Some clinical experiences
- Some of the big 9 areas
- Streamlined education minimizes faculty advising/variability
- Strong emphasis on clinical experiences
- Students acquire a broad clinical experience, ensuring they have opportunities to learn about what they want to do or not want to do as a clinician
- Students appreciate widespan of learning.
- Students are able to find employment after graduation.

- Students are able to get clinical experience in a variety of settings and with many different populations
- Students are able to have formative experiences during grad school without having to select a population preference before they have completed any clinical work
- Students are broadly prepared to work in a variety of settings.
- Students are finding employment in the settings of their choice.
- Students are introduced to various professional work environments
- Students ARE leaving programs able to practice
- Students are passing the Praxis, indicating some level of basic competency across the nine areas
- Students are prepared academically across the Big 9.
- Students are prepared across the lifespan; thus, SLPs have at least some background knowledge and skills across areas within the scope of practice.
- Students are prepared for basic clinical skills
- Students are receiving broad exposure to many aspects of the discipline.
- Students are receiving preparation for school setting.
- Students are required to complete varied clinical experiences
- Students are required to develop competencies
- Students are successful in their first employment settings
- Students are supported by the CF experience as they continue to learn by practicing
- Students basically don't need an UG degree to enter the masters
- Students begin to learn how to interact with clients as a professional.
- Students begin to learn their professional work responsibilities for some work environments.
- Students currently get a lot of theoretical knowledge in academic classes.
- Students demonstrate growth and skills across the program
- Students do get information across all areas
- Students gain considerable knowledge and skills in the discipline
- Students gain knowledge on the theory behind the assessment and treatment of communication disorders across the lifespan
- Students generally get some opportunity to learn some areas in-depth
- Students get academic and clinical experiences across disorder areas and across the lifespan
- Students get experience across the Big 9
- Students get to learn details/nuts and bolts of settings with full-time placements
- Students have broad exposure to the full scope of practice
- Students have hands-on clinical learning experiences
- Students have opportunities to develop broad knowledge and clinical skills
- Students learn about disorders, assessment, and treatment across the Big 9 areas
- Students learn theoretical foundations
- Students must meet competencies not linked to course grades
- Students participate in several clinical experiences, become generalists in field, pre-CF ready
- Students pass Praxis
- Students pass Praxis
- Students pass the praxis and earn employment
- Students prepare/complete the program in a reasonable timeframe
- Students receive a variety of clinical experiences across the two-year program
- Students report feeling well-prepared in many areas in post-graduation surveys
- Students show readiness for work settings
- Students show some integration of clinic and classroom learning
- Teaching clinical thought processes

- Teaching foundations of all areas
- Telepractice
- Telepractice experience
- The CF provides an additional layer of support and mentorship, which is essential for entry-level clinicians
- The clinical fellowship
- The clinical fellowship provides the support and depth of training for particular work settings rather than focusing on that at the master's level.
- The current model “introduces” students to medical SLP
- The current model prepares students to work in the schools.
- The knowledge and skills students acquire in graduate school prepare them for a clinical fellowship and lifelong learning.
- The pool for master’s level is good
- The requirement for the 450 clock hours
- Theoretical knowledge
- Theories surrounding CSD and audiology are taught very well
- Therapists are graduating with some knowledge.
- There are many different program options
- There are some programs that excel
- There is continued interest in the field
- There is more information about the profession than ever before
- They know how to evaluate
- They know how to treat
- Time for clinical training
- Time to graduation and employment
- Training in assessment and treatment
- Training in scope of practice
- Transition from in-program clinic to externships to CF provides a good level of support as students become more independent
- Two years is a competitive length compared to other master’s degree programs in and outside of our field
- University faculty are doing the best they can with additional requirements being put on them and all of the constraints that the university puts on them
- University run clinics do a nice job of preparing students early on.
- Use of clinical staff
- Varied clinical experiences
- Varied clinical opportunities with sufficient hours
- Variety in disorders and coursework
- Variety of experiences
- We are getting students out to the job force
- We are recognizing a need for post-education learning
- We focus heavily on clinical education
- We have a clinical coordinator who connects on a regular basis with the university coordinator.
- We have a full year of internships which allows a student to experience adult and child real world, full time experience
- We have an on campus clinic, so our students are able to get clock hours before they leave campus

- We have PT, OT, Audiology, Sports, and SLP in our program both inpatient and outpatient. This allows for a big picture look at a pediatric medical placement
- We require students to be at the setting at least 20 hours a week in no more than 3 days to simulate real life work setting
- Wide array of settings
- Workforce SLPs report excellent student preparedness

Sub-Appendix B

What is not working well? List up to three aspects, each on a separate line. Leave blank if none.

- 2-year degrees are very stressful for students
- 400 hour requirements
- 5 semester programs, instead of 6, resulting in deletion of important disordered coursework
- A large focus on school-based services still
- Academia continue to demonstrate limited knowledge about the job responsibilities of working SLPs
- Academic preparation is widely varied for students.
- Academic professors need to open their eyes to what is going on in the field of SLP
- Accreditation and certification standards add new requirements without eliminating any
- Accumulating hours does not equal ensuring quality experiences- either the educator, diversity, etc.
- Add courses to align to standards
- Adequately covering all areas of scope of practice
- An opportunity might be to better support students from theory to practice.
- Any and all training for dysphagia management--we are not preparing our students well to work in any medical settings
- Anyone can supervise based on continuing education rather than experience teaching
- Applicant pools for faculty positions are very small
- ASHA doesn't hold programs accountable for teaching critical content, so student knowledge is varied
- Assigning clients in a university clinic to students who have not yet taken disorder coursework yet
- Balancing programs across the lifespan with diversity
- Because of the 'hours' requirement, students may miss out on other valuable experiences in settings like team meetings, working with families, etc.
- Broad generalists with limited specialization
- Broad scope of practice to gain knowledge across all
- Cannot always hire in specific areas of expertise
- Cannot cover any one of the Big 9 in depth
- Cannot fit all the information into the program
- Class sizes becoming too large
- Clinical clock hour model is not a good model for comprehensive clinical skill development
- Clinical documentation- hard to teach in a way that works across settings
- Clinical education has become more about collecting clock hours than developing competency
- Clinical education model
- Clinical education models
- Clinical educator mentorship varies greatly
- Clinical instructor/preceptor attitudes
- Clinical placements not linked to academic coursework
- Clinical proficiency based on clock hours rather than clinical competencies
- Clinicians lacking basic clinical and soft skills upon graduation
- Clock hour requirements
- Clock hours are restrictive
- Clock hours do not equate to competency
- Consider clinical doctorate as doctoral level

- Content continuously added to the curriculum
- Coordination of courses with practica
- Cost
- Cost of education for students is increasing and already burdensome
- Cost of the education
- Coursework and clinic are not always connected
- Covering content areas leaves little room for critical thinking
- Covering skills and knowledge of nine disorders across the life span and addressing personal and professional identity growth including mental health in students.
- Critical thinking
- Critical thinking across disorders
- Deeper knowledge in content areas
- Demand of 400 hours without any adjustments has been tough
- Demands of higher education hinder relationship-rich education
- Dependence on volunteers to provide clinical supervision in clinical placements
- Depth of coverage in all areas
- Depth of experiences
- Desire to teach beyond entry level
- Development of problem solving
- Development of soft skills needed for success (e.g. critical thinking, etc.)
- Different expectations on competent
- Difficult to cram material into an academic program
- Difficult to experience all in our broad scope of practice
- Difficult to get clinical externships
- Difficult to get external placements
- Difficult to prepare students in competency in dysphagia if there is no medical university attached to the academic program
- Difficulty finding clinical placements
- Disagreement about best practices and established competency among practicing SLPs
- Disconnect between academic theory/evidence and clinical application
- Disconnects between academic theory and clinical practice
- District starting salaries are low
- Diversity of both faculty and students is low
- Dominance of pediatric-based topics
- Dysphagia is minimally addressed in many academic programs though it is the first and primary modality treated in the healthcare setting.
- Each university has its own clinical evaluation tool versus a standardized, consistent tool for all SLP graduate students.
- Education for employers on what to expect
- Education not quite meeting shift in practice from memorizing all to knowing how to think critically and problem solve with available digital resources.
- Employers are often not willing to hire CFs as they are looking for employees who are better prepared to jump in and work with minimal support
- Enrollment
- Ensuring cooperating clinicians understand, utilize and teach best practices
- Ensuring students have depth in knowledge across the Big 9
- Entry level competence in all Big 9 areas

- Equal supervision for easy and hard skills
- Equitable clinical instruction- some students might need more hours in certain areas than others
- Expectations to cover information on all Big 9 areas in specific depth
- Experience with low-incidence disorders and diagnostics across all areas
- Faculty
- Faculty burnout
- Faculty diversity
- Faculty diversity
- Faculty diversity
- Faculty must have PhD
- Faculty need more support!
- Faculty numbers
- Faculty recruitment for scope of practice
- Faculty support to teach and serve various roles (chair, director, etc.)
- Faculty with fixed mindsets and chairs who say, this is how we always done it.
- Finding externships is a challenge
- Focus on 400 clinical hours/difficult finding placements
- Focus on amount of hours rather than quality of such
- Focus on clock hours, less on competencies/skills
- Focus on quantity of hours rather than quality
- Focus or emphasis that some areas are “better” than others (e.g., swallowing is more important than speech sounds)
- For some students, may take longer to demonstrate competencies
- For students who come into the profession knowing what they want to do, they have to spend a lot of time learning about things they are unlikely to need/use
- Fragmented cohesion between academic and clinical learning
- Full scope of practice is not being consistently covered
- Full scope of practice is not covered, or is covered insufficiently
- Generalizing skills across clients and settings
- Getting all students in a program comparable, comprehensive experiences
- Graduate students report high levels of stress.
- Hard for students to grasp all content equally well
- Hard to provide enough experiences across the Big 9 areas
- Hesitancy of SLPs to take students
- I don't think we faculty demonstrate or teach the balance between life and work.
- I think the student is changing, and we need to understand them better
- I think UG courses at most universities are not doing their job - students are ill prepared when they enter graduate school so we have to teach everything over again
- I'm a CAA site visitor, I'm in disbelief that almost all programs I've visited over 11 years are not providing clinical experiences and training in a skill set that is as life threatening as swallowing.
- Important experiences such as coaching parents or teachers don't count towards clock hours
- Impossible to adequately cover scope of practice in appropriate breadth and depth in two years
- Impossible to cover the full scope of practice
- Inability to discuss or focus on relevant clinical issues (e.g., billing, writing for reimbursement versus an academic assignment)
- Inadequate confidence or lack of confidence
- Inconsistency in breadth and depth of programs

- Increasing diversity of faculty
- Increasing diversity of student body
- Individualized education is limited in lock-step model
- Inefficient use of credit hour system - three hours for everything
- Inexperience in ALL areas of SLP
- Insufficient preparation in IPE, cultural competence, critical thinking, billing, ethics
- Interpretation of entry level competency is broad and largely left up to the university; it's not consistent
- It is a really terrible idea to divide coursework into adult vs children, there are plenty of adults with developmental disorders and plenty of children with acquired impairments - we have created a false dichotomy and any move towards codifying that in practice is a bad idea
- It is challenging as an educator to incorporate all of the professional issues (such as IPP, counseling, etc.) that need to be addressed in addition to academic content in coursework.
- It is challenging to encourage thinking across courses/integration of knowledge
- It is difficult for students to apply foundational knowledge to clinical settings
- It is difficult for students to develop depth of knowledge in any area.
- It is impossible to obtain clinical experiences in all of the Big 9 in externships alone.
- It is nearly impossible to cover the scope of practice across settings and ages in a 2-year program
- It is SO challenging to find places that will accept students, particularly in medical settings.
- I've answered this question 5-6 times before :)
- Lack of ability to align clinical experiences with academic curriculum
- Lack of ability to specialize even by age prevents adequate prep in any area
- Lack of ability, resources and opportunities for specialization. This creates a lack of "experts" in our field and also decreases confidence clients and other providers have in an SLPs ability to adequately treat specific disorders. Clinicians should be able to practice "at the top of their license" by providing excellent care in their areas of expertise, however, because we are encouraged/forced to have a basic competency across all of the Big 9 that does not allow for growth or specialization in specific areas.
- Lack of clinical knowledge
- Lack of clinical placements
- Lack of clinical supervision/extern locations
- Lack of clinical tracing sites with growing number of programs
- Lack of consistent preparation across the Big 9 areas
- Lack of early practical experience connecting theory and application
- Lack of education re: science, culture, arts, and humanities
- Lack of faculty who are BOTH clinically and academically competent
- Lack of flexibility for students
- Lack of general professional skills
- Lack of integrated academics with clinicals
- Lack of medical clinical placements
- Lack of medical placements
- Lack of overlap in Big 9
- Lack of oversight in what is taught in some courses at the graduate level
- Lack of practicum sites
- Lack of preparation from undergraduate CSD programs
- Lack of qualified faculty to meet ASHA desire of over 50%
- Lack of recognition of integrated content
- Lack of specialization
- Lack of standardization for clinical educator training

- Lack of standardization to “entry level”
- Lack of sufficient supervision training
- Lack of supervisors
- Lack of time
- Lack of time for faculty to serve as IT, administrators, etc. while also responsible for teaching, grading
- Lack of transition from undergrad to grad resulting in students needing a semester to shift approach to learning
- Lack of willingness for medical settings to take students for outplacements
- Large class sizes
- Learning all aspects of the scope of practice is nearly impossible in a two-year time frame
- Length of program with expanding scope of practice
- Liberal arts requirements affect earlier introduction of core SLP coursework
- Limited clinical placements
- Limited critical thinking
- Limited diagnostic opportunities
- Many 'academic' professors haven't practiced clinically in years; huge disconnect between knowledge and clinical practice or skills
- Many newbies go with contract companies which are more expensive for school districts but pay newbies better
- Many students leave graduate school feeling incompetent/underprepared in some service areas.
- Many students not demonstrating cultural humility
- Medical sites are often unwilling to hire CFs stating that they need people who are ready to jump in with both feet with less mentoring than what they currently need
- Mentoring
- Minimal externship placement opportunities are burdensome to university programs scrambling to find appropriate externship experiences for their students. This can result in a sub-par learning experience if students are not learning from clinicians best qualified to teach them in the settings needed to ensure preparation for future employment.
- More places to get clock hours or what can count as clock hours
- More recent students (since COVID especially) are overwhelmed with the amount of learning in the 2-year program.
- Moving EBP from classroom teaching into clinical experiences
- Need competency based assessment of student skills not just knowledge
- Need for more than 50% doctoral level
- No agreement on what determines readiness to enter the field
- No incentive
- No standard measure of learning from undergraduate pre-requisite courses thus students enter master’s program with varying background knowledge
- No support from university to grow own PhD faculty
- Not enough access for rural students or those who cannot afford to move to a program - also a financial barrier.
- Not enough advocacy
- Not enough coursework for specialty area
- Not enough depth of knowledge.
- Not enough faculty
- Not enough faculty
- Not enough faculty

- Not enough knee to knee experience
- Not enough new resources on combining the academic and clinical skill areas
- Not enough placements
- Not enough SLP graduate programs
- Not enough spaces in programs
- Not enough time for all 9 areas
- Not enough time to cover all the content and skills that students will need
- Not enough time to focus on specific disorders
- Not enough time to really train skills and competencies
- Not prepared for medical settings
- Not sure if all students are getting similar experiences across programs
- Number of quality outplacement supervisors especially in medical settings
- Numbers are going up slightly (student data) but not sure if actually certified SLPs is meaningfully moving
- Online education
- Opportunities for direct clinical experience in some areas is limited.
- Our 'curriculum' organization is so dated -- our classes are set up in the Big 9 which is how it was taught when I was a student.
- Outdated curriculum
- People don't understand what holistic admissions ACTUALLY is ... and how it works
- Percent of PhD required on staff
- Perception that some skills or domains are more important than others
- Perceptions of entry-level skills upon graduation from other disciplines
- Poor integration of research into clinical practice
- Poor research support
- Poor salaries to support extra education
- Poor salary
- Praxis exam. Almost 100% of our students pass on the first attempt. I know our program is good, but every student in our program isn't that good. We need a higher bar for the national exam.
- Pressure to obtain, secure clinical placements in the community or in your university to help students demonstrate skills across the Big 9
- Professional communication
- Programs aren't sufficiently teaching students - if we address it in adults, we address it in children (and vice versa) - I have so many say well we don't work on executive function in kids - there are a lot of people out there who pretend that the scope of practice is only for one age group. I also have plenty of people who will not address language-learning abilities in adults.
- Recruitment
- Reduced availability of internship / externship sites and supervisors
- Related to faculty growth and sufficiency, the PhD shortage plays a major role in the preparation of future speech-language pathologists. Smaller programs, including those at teaching-focused universities often struggle to recruit and hire PhD-level faculty.
- Reliance on clinicians to volunteer time to support students (with little to no reward or recognition for such)
- Reliance on unpaid community supervisors to take students- can be hard for academic programs to find and guarantee placements to students
- Removing silos of education and understanding complex clients
- Requiring PhD to teach masters level
- Retention
- Rigor and time commitment in courses impact on student mental health

- Salaries are too low to justify a longer educational program
- Scope of practice is too broad to cover in 2 years
- Scope too broad to teach well in a program
- Separating expected development from disordered or different development
- Should all the material be at a master's level
- Should not take longer than 5-6 semesters to obtain master's degree
- Significant challenge finding clinical placements, particularly in medical areas, that prepare students for entry level acute medical work
- Silo approach to 'communication disorders'
- Siloed within a narrow academic home
- Skill silo
- SLP graduate students frequently report feeling highly stressed
- SLP graduate students have heavy course loads to fit everything into their program of study.
- Some faculty believe students leave graduate school under/unprepared in some service areas.
- Some programs minimally cover some of the Big 9 areas, i.e., lectures within a class vs. an entire class on the topic.
- Some students do not have professional accountability.
- Some students graduate feeling like a jack of all trades, master of none. This can leave them feeling unconfident or incompetent in different areas of practice.
- Sometimes difficult to find experiences in all nine areas
- Sometimes difficult to get the students to full competency
- Standard format lecture class
- Student and faculty diversity
- Student anxiety is at an all-time high.
- Student diversity
- Student diversity
- Student diversity
- Student funding
- Student generalization across Big 9
- Student readiness is somewhat subjective
- Student's aren't adequately prepared to work with limited English or no English speaking individuals.
- Students and CFs are not adequately prepared to work in medical settings, lacking knowledge in medical practices (vitals, respiration, and SLP practice as it relates to swallow and how we function.
- Students are coming to graduate school lacking in writing skills.
- Students are extremely stressed and overwhelmed
- Students are generally not prepared to begin work in healthcare environments, requiring mentoring that employers frequently decline to provide on the understanding that the graduate has a degree and license and it is assumed they are prepared to function independently.
- Students are less prepared for the expanded rigor of the profession- this causes much anxiety
- Students are not academically prepared for the placement.
- Students are NOT adequately prepared to work in a medical field. This results in the need for extensive self-study and reliance for ongoing education beyond the degree to obtain the knowledge needed to be an effective clinician in these settings.
- Students are not equipped to document about evidence based practice.
- Students are not generalizing skills/knowledge from the Big 9 post-graduation.
- Students are not prepared for medical settings.
- Students are not prepared to evaluate and treat dysphagia.

- Students are not typically very prepared to navigate the billing side of practice or understand advocacy.
- Students are not well prepared for professionalism in a clinical setting.
- Students can still graduate with no clinical experience in some areas
- Students cannot always get training in specialized areas of practice, even if they would like training in those areas
- Students do not receive the same clinical experiences across universities
- Students don't have enough time to be ready for entry level practice
- Students graduating with poor critical thinking or soft skills
- Students have difficulty when there's not a clear-cut or black and white answer to a clinical case
- Students having difficulty applying critical thinking and clinical decision-making
- Students in class/clinic all day every day
- Students in our program report feeling considerable stress because of the workload.
- Students lack knowledge about the physician's role and documentation for reimbursement.
- Students lack of time and limited flexibility in the program result in poor learning practices (e.g., do it to get it done; memorization; survival!)
- Students lack understanding about others' roles and responsibilities (inter professional practice)
- Students learn surface level
- Students leaving programs unprepared to practice
- Students may have heavy academic requirements alongside of the clinical placements
- Students not confident in their ability to apply theory to clinical settings
- Students not learning at the same rate as others go on remediation plans
- Students often come in not knowing which setting or population or age group they want to work with, which is an appeal of our profession; narrowing that in some way may discourage some students from our field
- Students receive different levels of instruction across universities
- Students report considerable stress throughout their graduate studies
- Students semester credit hours are at the maximum our university allows
- Students so focused on 400 hours rather than becoming competent
- Students sometimes take AP Stats as high school juniors and then are unprepared for stats at the Master's level
- Students struggle to integrate information between the Big 9 because we teach in that way and then students
- Students tendency to look for answers (e.g. internet search) over creating their own plans/ideas
- Students that apply and begin work in my state and local work environments are unable to function as a medical SLP and complete the work responsibilities expected of employers, insurance companies, and physician referrals. One example is the ability to research and apply evidence based practice to their diagnostics and treatments.
- Students understanding the professional demands of various workplaces
- Students worried about grades over competency
- Terminal degree being masters, where no specialty is able to be developed / honed
- The clinical clock hour is overly prescriptive and the guidelines seem arbitrary at times for "what counts"
- The cost of graduate school is very high, which may limit programs from adding credits for fear of driving people away due to economic concerns
- The discipline is becoming increasingly female and in some cohorts we have not males.
- The full time two-year model is financially exclusionary for many people- results in less diversity of backgrounds and experience.
- The graduate workload is PACKED

- The great number of new programs and lack of enrollment caps is putting a huge strain on clinical placements in the community. Some programs have nearly 1,000 online students.
- The role of simulation (e.g., online or standardized patients) and the provision of services via telepractice are not well defined or provided to students.
- The scope of practice is a mismatch for a 2-year (typically) degree
- The scope of practice is far too large to cover adequately in two years
- The scope of practice of speech-language pathologists is too broad to learn about in depth in a two-year program, especially if clinical skills are also being emphasized
- The separation between academics and clinicals is not conducive to experiential/ hands on learning that our other allied health professionals receive during lab components in their programs
- The students are not prepared for the medical model in SLP
- The students don't understand their role and responsibilities among peers in an interdisciplinary setting
- The transition from theory to practice is difficult and not always well supported by clinical master's programs
- There are too many knowledge and skill standard to address in each disorder area for a two-year program.
- There is a huge amount of content to cover in a small amount of time.
- This is going to be hard to solve with different administrations and communities
- Time
- Time to integrate added knowledge requirements into program and courses
- Time to teach methods
- Too little exposure to all domains/settings
- Too little time in each domain/emphasis/work setting
- Too little time to cover everything that is required in standards, by university programs, and desired by students
- Too many hours in one domain or one age group or one setting
- Too many new graduate SLP programs being accredited
- Too much content
- Too much emphasis on just our scope of practice/discipline
- Too much information in too short of a time
- Too much redundancy across academic courses
- Traditional lecture methods are not effective with all learners.
- Training students to be generalists in a two-year program is not feasible. Having tracks or an entry level SLPD would be better.
- Two years is too short a time to cover all aspects and make students competent
- Unclear expectations for what entry level is
- Undergraduate preparedness - graduate programs are having to spend 20% of class time covering UG content
- Unevenness of clinical supervision and clinical fellowship supervision
- Unrealistic expectations of external supervisors
- Use of more effective pedagogy
- Variability in student success in graduate school as well as in their future employment
- Vast differences in clinical externship and CF experiences leading to different levels of preparation
- We have people getting trained but not having confidence to practice.
- We have some students from diverse backgrounds in our program, but not nearly enough.
- We need students to have baseline fundamentals in all areas of Big 9
- Wide range/focus

Sub-Appendix C

Please provide any other comments that you would like to share with the Ad Hoc Committee to Plan Next Steps to Redesign Entry Level Education for SLPs.

- Allow for pediatric/adult or medical/educational tracks
- Allow student members to vote in ASHA elections.
- As said in the breakout room for this session, I feel there are multiple levels of disconnect. I feel there are still SLPs in certain settings who could care less about the profession as a whole, but want to pretend that because they work in a certain setting, the majority of new graduates and current clinicians are incompetent. I also feel that clinical sites and universities do not communicate with one another. Universities are going to be restricted by resources and other components of the infrastructure. Hospitals and schools have their restrictions per state laws and reimbursement. I don't think we realize always that we cannot be accountable for everything for everyone. I think we should consider rounds for SLPs, increased simulations, case studies, and more time in the degree plan (yes, meaning a clinical doctorate even though "it's not in the charge) to truly teach students knowledge and skills.
- Competency based education and clinicals
- Consider work groups that include academia AND supervisor/lead, seasoned practitioners in the field in EQUAL numbers to obtain better input from group discussions.
- Create ASHA-mandated anonymous course feedback forms to track faculty/program performance in areas of DEI
- Due to the rigidity of standards and prescriptive nature of program requirements, it is difficult for programs and educators to innovate and try something new. I think it would be beneficial to design and pilot some innovative models and allow selected universities to pilot them and report back. I would be willing to be a pilot program!
- Exposure to variety of work settings for graduates.
- Faculty capacity to create new programs, approaches, and instructional techniques is limited. It was before the pandemic and is even more so now.
- Global skills are more important than highly specific skills. I can teach social communication in general and it applies to those with autism, those with executive function disorders, those with acquired disorders, those with developmental disorders. If I just teach autism it is much harder to have the generalized skills that are truly an SLPs strengths. Siloed classes are not a good idea and long term will leave even larger gaps in care.
- I am fearful for the graduate students of the move towards tracks and modules and person's enjoyment in the field and thus staying in the field. There is quantitative and qualitative data that graduate SLP students change their areas of interest / degree of interest based on the courses they take and their internships. Asking a graduate student to select if they want to be a pediatric or medical SLP is unfair to that graduate student in light of this data. The courses and internships with children and adults is crucial to helping them make that choice. This also reduces the employment opportunities for new graduates. A new graduate that completed a medical track has fewer opportunities for employment and that is a thought they might not be able to fully process / appreciate when being asked to make this decision. For many SLP professionals the ability to move from one setting to another is what keeps us in the field and having a high level of positive satisfaction in the field. What about the SLP who wants to work in a medical setting with children. Does that SLP go the medical route or the school route? Courses that

might be in a medical route or a school route - how do you separate those? Is dysphagia medical or school?

- I am sorry to say but I felt the presentation on this topic was rather empty. It would have been nice to have something to work with rather than a flash of resources that were considered...considered in what way, how do you apply these?
- I am very concerned that doctoral level education is not an option. I understand that CAA does not feel that accrediting SLPD programs is not within their scope. That is not a reason to abandon doctoral discussion. I would encourage the development of more doctoral programs and that is the place to include a track model. ASHA should work with doctoral programs on improving curriculum and goals for doctoral learning. Hold workshops and seminars on doctoral issues. I believe without doctoral programs we are doing a disservice to master's graduates who are now competing with doctoral level health care workers (OT, PT, nursing) in healthcare settings. I think we need to think 10-20 years down the line to see the implications. Can you see any of these professions treading on our scope of practice? How will SLPs move up a career ladder to administrative positions if others hold the doctoral degree? What if regulatory agencies reconsider the type of payment we receive based on level of education and training when compared to other professions? I would gather data on existing SLPD programs to see how these programs affected the graduates. How did their careers improve or not improve? What more did they learn that they hadn't learned at a master's level? I think these stakeholders may be an untapped source of information.
- I believe we need to examine all levels of education -- pre-entry level, entry-level, CF, and post-entry. Different models for the different levels. For example, lifespan for pre-entry and entry levels; track for CF; and modular for post-entry specialty certification (e.g., residency models)
- I disagree that this is not related to college degree decisions.
- I feel like we've had some of these conversations before. It seems that the "old guard" within the broader membership stopped discussions of a shift in clinical education models. So - is this really something the membership at large decides? I feel like once the scope of practice is outlined, then CAA, CFCC and the programs themselves should make final determination of the "how to's".
- I feel that there needs to be more consensus and agreement about teaching in our disciplines (SLP and AuD). First, we need to acknowledge that clinical instruction is not "clinical supervision." There needs to be more realistic opportunities as well as expectations for clinical educators who take students to teach and train these soon-to-be graduates rather than just "throw them to the wolves" or "sink or swim." We need to provide resources to these individuals. Also, I think that there needs to be more of an understanding that not everyone is supposed to be a teacher or faculty member. Again: it is a separate skill set. I think that PhD programs should incorporate more pedagogy based courses and balance those with research/methods courses. I am not too sure that we shouldn't start "teaching how to teach" to our students in graduate school. Other disciplines (e.g., nursing) have specific sub disciplines that they can specialize in order to train future professionals. Could we do something similar? I think that it is imperative that ASHA strive to inform and educate that teaching and faculty is not "just the next step" in an important clinical career.
- I feel these two comments are critical. 1. SLP is a health science, but the teaching and training is inadequate for a health device major. 2. The "pathology" part of our title indicates we study diseases and disorders. Better faculty and student education and training is needed to maintain such title or it should be officially changed to therapist or tech, otherwise we are misrepresenting ourselves as a profession.
- I hope this doesn't lead us further down a specialization path.
- I personally think there is value in extended, intense time in a placement. I wonder, however, if our traditional 'hours' are the most important metric (vs. competency and/or period of days/weeks, etc.). Also think there should be increased value on quality simulation to get experiences; you can learn and

reason through a bedside in simulation with a well-prepared clinical educator than a less prepared, overworked, stressed, and busy externship supervisor. Who do we value teaching these skills more?

- I suggest that SLP learn from the somewhat failed model of the AuD to better address entry-level education without making it unsustainable for students or programs.
- I think a focus on ungrading / competency-based education is really important
- I think it would behoove the Next Steps Committee to research even more models of education. For example, could we move to more of a medical school model? I know that several individuals are concerned about the student debt and DEI issues associated with a clinical doctorate. That said, in medical education, only certain pre-requisites are required for admission. There are several doctors who only have their MDs; they do not always have bachelor level degrees. This might help enhance the quality of education and the models while also allaying some of the difficulties that might come with an "advanced" degree. Also, has anyone consulted on how audiology has changed their model? So often, I feel we do not speak to our sister profession and there's a lot we can learn from them. Also, what about more of a case-based/grand rounds model? Would a business/MBA type model work? I feel that there were very limited models provided. I am not in support of the track model. This will only cause more divide in the profession. No longer is there really a difference between a school SLP and a medical SLP. Some individuals just have a chip on their shoulder and a superiority complex. I think that tracks might also lead to other professions taking us less seriously. I like the idea of a lifespan model but only if 1) instructors (both clinical and academic) understand the importance of teaching and learning for ENTRY-level proficiency as well as alternative forms of teaching; and 2) we move to a clinical doctorate. I think that the modular model is interesting; however, I would like more details before completely endorsing it. Again, I think that the modular model could be more like a medical school model. That said, I have trouble motivating my students enough as it is. I also think that being certified in ONLY certain areas has some benefits but also may create problems in areas of need (e.g., rural communities, public schools). Ultimately, I am glad that we are having these conversations for the future of our students, patients, and professions.
- I think that it is important that we have this discussion. I think our profession is great; however, I think we are still in a rut of wanting to be health care but have the flexibility of education. Should we or should we not expect persons entering the profession to be competent? We should; however, our current model does not promote that for any setting or specific skill. I am not arguing that there aren't some benefits from the logistic side of things about our current model. I also am not implying that one setting is better or more difficult than others (e.g., medical versus school). I am, however, suggesting that competencies need to be better defined as well as given some thought about how to assess these for entry-level professionals rather than those with 5 to 10 years' experience.
- I think these talks are so interesting and beneficial. Our field has to change. To be frank, I feel that the DEI movement has masked other major concerns about our field. The fact that we are not paid like other rehabilitation specialists, sometimes purely due to the letters behind our names (master's versus doctorate) as well as the old "pumps and pearls" stereotypes that SLP is not a real health care profession but one in which educated women (and a few men) can be the hybrid of a teacher and a health worker but never have the responsibility of either. The problem is that our profession has changed so much in the past 30 years. Per this webinar series, we have done next to nothing to change with the times in almost 60 years. That is a problem. Kudos to this committee and thanks for their hard work. I will argue that SLPs and their organizations are going to have to decide: do we want what is best for our students, our patients, and our profession? I promise you: no one is asking "Oh, we have to worry about student debt," or "Life is so hard for young adults now" in the law schools or medical schools. Why should we be any different? I am all for more of a professional school model (such as medicine, pharmacy, nursing, business) rather than the current one. I also recognize as a minority and first-generation student that there have to be more students supports without compromising integrity and rigor. Not everyone who

wants something should achieve it. I'm not saying that these are simple solutions and with every change, different problems arise. I am arguing, however, that as the AHC assesses and analyzes these trends towards the Next Steps, they also advocate for realistic change and rigorous change. This is at the student, faculty, and registration/licensure/credentialing levels. I am sometimes surprised: for our profession to be the experts in communication, have we even reached out to other professions to know what might work for us in the future?

- I think this transition is necessary but very big in scale to achieve.
- I was worried this webinar would be focused on the SLP-D as an entry level requirement. I'm glad to know that other options are being considered since requiring a further degree could only compound our current problems.
- I would love to see more student opinions on what worked well and what didn't in their graduate program.
- I would propose starting with observations in grad school (and do away with the undergrad degree). Maybe then incorporate rounds then incorporate more individual clinical experiences.
- In my small group, several individuals from university settings mentioned undergraduate students not having opportunities to go on to graduate school. That has not been our experience. Our undergraduate (Midwest) have multiple options for graduate school. Our program wonders if we are seeing fewer undergraduates in CSD programs in the Midwest overall. Our own enrollment has been steady. Also, we are seeing more adult learners who are interested in changing careers.
- In our small group break out, we discussed how the CF is often misunderstood by professionals outside of SLP/AUD. Oftentimes, employers look for someone who needs little to no supervision, which isn't the case for new graduates. I wish we had some way of standardizing competencies (perhaps in the way of OSCEs). Again, I worry about adding more to the plates of faculty and supervisors who are already stretched thin.
- In the end, we want all of our clinicians to feel prepared to work across the lifespan and across areas of treatment while maintaining awareness and sensitivity to all cultures.
- It seems that drawing from work other allied health fields and other countries have done would make sense.
- It seems that it may be wiser to not adjust too many variables at once, so you can truly determine the impact of the change you are implementing. The education model is not where I would start. By further siloing information into tracks, our students would lose the perspective of see the person as a whole. The shift would be age or disorder-based and NOT person-centered.
- Look at curricula. A course in neuroscience is not a required course at the UG or graduate level and it should be. We focus on the Big 9 without looking at foundation science classes such as a neuroscience class.
- Looking forward to seeing the results of the work!
- Many SLP graduate programs are increasing their student capacity. Clinically-based CBE assignments and assessments are usually more time-consuming than just giving a multiple choice exam. How will programs with large student cohorts implement this type of student assessment?
- More support providing guidance for university on-campus clinics is desperately needed! There are so many regulations that significantly limit training opportunities with individuals in our community who could benefit from what we could offer, while providing students with greater variety of training experiences.
- More time is not always better. Recall when some states allowed undergraduate students to practice prior to enrolling in a master's level program. I was one of these individuals and was very successful. 5 or 6 semester programs can work if we think smarter - less focus on number of credits for courses and more focus on addressing ASHA standards using a spiral curriculum approach as well as periodic webinars, round tables, podcasts to support students with opportunity to enhance their 21st Century skills and habit as a lifelong learner

- Nearly all programs will have some faculty teaching a course or two outside their primary area of expertise. Creating some open educational resources on needed topics would support those faculty.
- Once strategy is to identify a few core competencies to work on first. That might be more workable than trying to move everything to a competency based model at once.
- Perhaps this will be addressed in other discussions, but perhaps the challenge isn't adding more time to the program, but adding time that is taught by skilled clinical educators. Most programs lose at least two semesters with full time placements. I struggle with the idea that students learn more with any supervisor (who now needs a 3-hour class in supervision, but that is it) than time spent with a master educator. Just doing it isn't necessarily learning it, and it isn't necessarily learning it the right way.
- Please make sure the ASHA conversion rate is available for members of NSSLA or NBSLHA.
- Sharing more information and research
- Side note: I know the goal is to not have a facilitator to keep the conversation natural but it's hard when the group veers way off topic to have someone who can bring it back without appearing to be bossy
- SLPD should hold faculty positions and many already do. They bring a skill set that others may not- knowledge of teaching, ability to supervise, strong clinical skills which are research-based.
- Some fields of study have developed open access educational resources. These are modules that can fit into other courses and a possible way of providing supplemental instruction for students needing more time to master knowledge and skills.
- Somewhat interested in the modules but who would teach those modules? How would clinic work with each module? How would an SLP go back to complete a module when working? Is a clinical aspect required?
- Thank you for beginning this process.
- Thank you for the opportunity to have conversation.
- The 30-minute presentation was a good intro/overview. More in-depth information on How to develop and implement CBE, get faculty and clinical buy-in, and what the timeline would be would all be helpful as next steps.
- The topics in this series are great but are so intertwined. I would like to see a session that brings everything together. I also think an emphasis on systemic issues that affect our field (and others) should be discussed (e.g. the absurd costs of higher education in the U.S.; low pay in the "caring" professions; gendered employment, etc.). If some of these issues are addressed country-wide, we would see trickle-down changes in SLP.
- There's so much evidence in adjacent health professions with respect to how to implement and use holistic review for graduate admissions - including recent publications in SIG 10! And AJSLP! Yes, I know I'm saying these things as the person that is leading this discussion within our field about holistic review - but I've been talking to people at ASHA since 2018 about holistic review, and began to make some progress when Mike Skiados was the membership person - but even he encountered resistance at the academic affairs level when staff made comments about "why do we have to change admissions - we get 'plenty of good students'" - what does that mean? We have to focus on that conversation and this topic - it's ALL about gatekeeping (and reducing gatekeeping) and re-imagining what "good students" look like - even TODAY in this webinar, the comment about a student NOT having a 4.0 (which is REALLY DIFFICULT by the way) but "showing clinical potential" through research experiences ... it is classist and reductionist and exclusionary. SO MANY first generation students are just trying to figure out college - or lower SES students are trying to figure out how to pay for college AND the GRE AND their grad school apps while also working ... and so working in a research lab or spending hours in office hours is just not possible. We have to think about admissions - but also accessibility of programs - and also advising that is not about telling students that because they got one B in a class sophomore year - that their chances for graduate school are not good. THIS SHOULD NOT BE THE MESSAGE.
- This info was the most useful presented to date in this series of webinars.

- This is a great beginning of the conversation but much more time needs to be spent discussing the nuances of the situation.
- This topic seemed more ambiguous to our group in comparison to previous.
- To improve availability of externship placements and CFY supervisors, is it possible for ASHA to further incentivize this? Such as, CEU hours offered for taking on a student (a good student-supervisor relationship involves a two-way street of learning)? Or possibly financial stipends (such as a discount on ASHA dues)?
- Understanding the why if content is essential. I frequently get a sense of students looking for an answer versus deep understanding.
- Universities need to hire SENIOR, seasoned professors of practice. Minimum 5-8 years of experience in the field.
- University academia need to be educated and learn about the SLP role in health care. Their lack of knowledge and understanding about the practitioner's role is evident in the work groups.
- Very good attempt at bringing this webinar series to the table for discussions.
- We do not want to make the critical mistakes made by audiology which increased cost, time and limited accessibility. This is having a severe impact on the field. The career flexibility is something that attracts students to SLP. I would hate to lose this by only having certification in a specific area.
- We need to add academia with a university title and background: Professor of Practitioner.
- We need to find a way to stop the deep seated divide in our field of medical versus school SLP and that starts at the university. We also need to work with employers about what to expect about an entry-level SLP
- Where are the individuals representing healthcare SLP in the work groups? The makeup of the work groups seems to be primarily academia -with school based focus.
- You need to provide models of what this would look like. Discuss other programs (fields) that have incorporated this and discuss advantages and disadvantages
- Your work groups consist primarily of academia that have already structured education that is not working. There needs to be healthcare SLPs -practitioners in your work groups in order to obtain an adequate and real understanding of the educational needs and problems.

Appendix B: Future of Learning Webinar Survey Results

Ad Hoc Committee to Plan Next Steps to Redesign Entry-Level Education for Speech-Language Pathologists' Next Steps 2022 Summer Webinar Series

Introduction

On June 7, 2022, a survey was made available as part of the Ad Hoc Committee to Plan Next Steps to Redesign Entry-Level Education for Speech-Language Pathologists' Next Steps 2022 Summer Webinar Series on the Future of Learning. Individuals who participated in the live webinar, as well as those who viewed the recorded session, had the opportunity to complete the survey by August 30. A total of 46 individuals responded to the survey, 45 from the live webinar and one who viewed the recorded session. Responses are presented for all respondents combined.

Results follow. Comments have been lightly edited for spelling and grammar. This report was prepared by ASHA's Surveys and Analysis unit.

Results

1. Which of the following best describes your current ASHA affiliation status? (Check one.)

Response	Percent	Number
ASHA-certified in audiology	4.4	2
ASHA-certified in speech-language pathology	91.3	42
ASHA-certified in both audiology and speech-language pathology	0.0	0
Noncertified member	0.0	0
Clinical Fellow	2.2	1
International affiliate	0.0	0
Speech-language pathology or audiology assistant	0.0	0
Student (undergraduate, graduate or research doctoral)	0.0	0
Other (See below.)	2.2	1

Other responses:

- ASHA SLP Certified Retired

2. How many years have you been employed? (Check 0 if none.)

Response	Percent	Number
0	2.2	1
1-5	0.0	0
6-10	2.2	1
11-15	8.7	4
16-20	17.4	8
21 or more	69.6	32

3. Which of the following best describes your current primary employment setting? (Check one.)

Response	Percent	Number
Early intervention/ pediatric home health	0.0	0
School (preschool, elementary, etc.)	2.2	1
College/university	84.4	38
Hospital (all types, inpatient and outpatient)	8.9	4
Nonresidential health care facility (clinic, physician's office, etc.)	2.2	1
Residential health care facility (skilled nursing facility, etc.)	0.0	0
Adult home health	0.0	0
Private practice	0.0	0
Agency, organization, or research facility	0.0	0
Industry	0.0	0
In audiology externship and/or clinical practicum	0.0	0
Not employed (student, retired, on leave of absence, etc.)	0.0	0
Other (See below.)	2.2	1

Other responses:

- Higher education consulting

4. What is your current primary employment function? (Check all that apply.)

Response	Percent	Number
Clinical service provider (i.e., audiologist or speech-language pathologist)	13.3	6
College/university academic faculty	55.6	25
College/university clinical faculty	26.7	12

Researcher	6.7	3
Consultant	2.2	1
Administrator/executive officer	2.2	1
Chair/department head/manager	17.8	8
Supervisor of clinical activity	6.7	3
Other director/supervisor	6.7	3
Other (See below.)	8.9	4

Other responses:

- Currently a research assistant but will be academic faculty starting in August 2022
- Director of Clinical Education
- Graduate Program Coordinator
- Graduate Program Director in SLP

Note. Only individuals who selected “college/ university academic faculty” or “college/university clinical faculty” moved on to question 5. All other respondents were automatically skipped to question 6.

5. What is your current faculty rank? (Check one.)

Response	Percent	Number
Lecturer	6.7	2
Assistant professor	23.3	7
Associate professor	30.0	9
Full professor	23.3	7
Other (See below.)	16.7	5

Other responses:

- Adjunct
- Associate Instructor
- Director of Clinical Education
- Professional staff (but teach clinical courses). All future hires in this position in various fields are NTT clinical faculty
- Tenured instructor

6. In what state do you reside?

Response	Percent	Number
Alabama	2.2	1
Alaska	0.0	0

Arizona	4.4	2
Arkansas	2.2	1
California	6.7	3

Colorado	4.4	2
Connecticut	2.2	1
Delaware	0.0	0
District of Columbia	0.0	0
Florida	4.4	2
Georgia	0.0	0
Hawaii	0.0	0
Idaho	0.0	0
Illinois	4.4	2
Indiana	2.2	1
Iowa	2.2	1
Kansas	0.0	0
Kentucky	0.0	0
Louisiana	0.0	0
Maine	2.2	1
Maryland	2.2	1
Massachusetts	4.4	2
Michigan	2.2	1
Minnesota	4.4	2
Mississippi	2.2	1
Missouri	4.4	2
Montana	0.0	0
Nebraska	2.2	1
Nevada	0.0	0
New Hampshire	0.0	0
New Jersey	4.4	2
New Mexico	0.0	0
New York	2.2	1
North Carolina	4.4	2
North Dakota	0.0	0
Ohio	2.2	1
Oklahoma	0.0	0
Oregon	2.2	1
Pennsylvania	2.2	1
Rhode Island	0.0	0
South Carolina	2.2	1
South Dakota	2.2	1
Tennessee	0.0	0
Texas	11.1	5
Utah	4.4	2
Vermont	0.0	0
Virginia	2.2	1
Washington	0.0	0

West Virginia	0.0	0
Wisconsin	0.0	0
Wyoming	0.0	0

7. The current educational model to prepare speech-language pathologists to enter practice is a master's degree (approx. 2 yrs.) comprised of academic and clinical educational experiences covering the full scope of practice across the lifespan. How well is the current educational model working to prepare speech-language pathologists to enter practice?

Response	Percent	Number
Not well at all	0.0	0
Not very well	13.0	6
Somewhat well	82.6	38
Very well	4.4	2
No opinion	0.0	0

8. What is working well? List up to three aspects, each on a separate line. Leave blank if none.

- Able to cover scope fairly well in terms of classes / clinic
- Allowing students to try things they don't think they will like
- Application of knowledge in externships
- Application of problem-based learning
- Attracting strong students
- Breadth of clinical experience
- Breadth of content facilitates flexibility in practice settings
- Breadth of knowledge in the big nine
- Broad exposure to different aspects of the field
- Builds relationships between students and supervisor
- Case-based learning
- Clinical experience in schools and medically based setting
- Clinical experience on campus for 3 semesters
- Clinical experiences must be diverse
- Clinical externships
- Clinical Fellowship
- Clinical placements
- Clinical practice
- Clinical simulation
- Clinical training in a broad range of areas
- Clinicals
- Collaboration between academic and clinic faculty
- Combination of clinical and academic experiences.
- Combination of didactic and clinical experiences
- Combining clinical practicum with academic learning
- Consideration of clinical pedagogy
- Core coursework in big nine areas
- Covering everything that we have in the scope of practice
- Critical thinking skills
- Current emphasis on multiculturalism and diversity
- Dedicated faculty to teach across areas
- Dysphagia prep is much stronger than when I went through my Master's program

- Educational setting preparation
- Educational standards for speech-language pathologists are well established in the different areas of practice
- Emphasis on evidence in clinical service
- Enough time for students to participate in coursework across Big 9 areas
- Exposes students to different settings
- Exposes students to diverse students across age span
- Exposure across the big nine
- Firm understanding of all 9 areas of practice
- For us, going back to in-person classes has helped the students bond, support each other and lower anxiety.
- Foundation
- Front loading with simulation
- General coverage of Big 9
- General Praxis prep
- Generalist training allows clinicians to be flexible in their career
- High Praxis scores
- Increased awareness for education of clinical educators
- Increased awareness of need for EBP in education
- Individualized meetings with students for clinical
- Interprofessional education
- Interprofessional practice opportunities are occurring
- Knowledgeable faculty
- Length of time isn't excessive
- Most students gain experiences working with a variety of clinical populations.
- Most university programs have some form of online learning as COVID wended down
- Need for improvement in clinical education has been recognized by increased number of position postings for clinical faculty
- Obtaining knowledge about different conditions/diagnoses
- Opportunities to explore the profession
- Preparing generalists
- Programs have flexibility to design processes, tracks, etc. that support new professional success
- Provides a general academic overview of the field
- Provides a general clinical overview of the field
- Providing book knowledge
- Providing experience in SOME areas of SLP
- Required courses cover the Big 9
- Research opportunities
- School CFYs are very prepared
- Shift to accept simulation
- Simucase
- Some clinical experiences
- Some of the big 9 areas
- Students appreciate widespan of learning.
- Students are able to get clinical experience in a variety of settings and with many different populations
- Students are introduced to various professional work environments
- Students ARE leaving programs able to practice
- Students are prepared academically across the Big 9.

- Students are successful in their first employment settings
- Students begin to learn how to interact with clients as a professional.
- Students begin to learn their professional work responsibilities for some work environments.
- Students demonstrate growth and skills across the program
- Students gain considerable knowledge and skills in the discipline
- Students gain knowledge on the theory behind the assessment and treatment of communication disorders across the lifespan
- Students have hands-on clinical learning experiences
- Students learn theoretical foundations
- Students must meet competencies not linked to course grades
- Students participate in several clinical experiences, become generalists in field, pre-CF ready
- Students pass the praxis and earn employment
- Students prepare/complete the program in a reasonable timeframe
- Students report feeling well-prepared in many areas in post-graduation surveys
- Students show some integration of clinic and classroom learning
- Telepractice
- Telepractice experience
- Theoretical knowledge
- Theories surrounding CSD and audiology are taught very well
- They know how to evaluate
- They know how to treat
- Two years is a competitive length compared to other master's degree programs in and outside of our field
- University faculty are doing the best they can with additional requirements being put on them and all of the constraints that the university puts on them
- Varied clinical experiences
- Varied clinical opportunities with sufficient hours
- We are getting students out to the job force
- Workforce SLPs report excellent student preparedness

9. What is not working well? List up to three aspects, each on a separate line. Leave blank if none.

- 400 hour requirements
- Academia continue to demonstrate limited knowledge about the job responsibilities of working SLPs
- Academic professors need to open their eyes to what is going on in the field of SLP
- Accreditation and certification standards add new requirements without eliminating any
- An opportunity might be to better support students from theory to practice.
- Broad scope of practice to gain knowledge across all
- Cannot cover any one of the Big 9 in depth
- Class sizes becoming too large
- Clinical clock hour model is not a good model for comprehensive clinical skill development
- Clinical education models
- Clinical placements not linked to academic coursework
- Clock hour requirements
- Clock hours are restrictive
- Clock hours do not equate to competency
- Cost

- Coursework and clinic are not always connected
- Covering content areas leaves little room for critical thinking
- Covering skills and knowledge of nine disorders across the life span and addressing personal and professional identity growth including mental health in students.
- Critical thinking
- Demand of 400 hours without any adjustments has been tough
- Demands of higher education hinder relationship-rich education
- Desire to teach beyond entry level
- Development of soft skills needed for success (e.g. critical thinking, etc.)
- Difficult to get external placements
- Disagreement about best practices and established competency among practicing SLPs
- District starting salaries are low
- Dysphagia is minimally addressed in many academic programs though it is the first and primary modality treated in the healthcare setting.
- Ensuring cooperating clinicians understand, utilize and teach best practices
- Ensuring students have depth in knowledge across the Big 9
- Faculty must have PhD
- Faculty need more support!
- Faculty support to teach and serve various roles (chair, director, etc.)
- Finding externships is a challenge
- Focus on 400 clinical hours/difficult finding placements
- Focus on clock hours, less on competencies/skills
- For some students, may take longer to demonstrate competencies
- Fragmented cohesion between academic and clinical learning
- I don't think we faculty demonstrate or teach the balance between life and work.
- I think the student is changing, and we need to understand them better
- I'm a CAA site visitor, I'm in disbelief that almost all programs I've visited over 11 years are not providing clinical experiences and training in a skill set that is as life threatening as swallowing.
- Important experiences such as coaching parents or teachers don't count towards clock hours
- Inadequate confidence or lack of confidence
- Inefficient use of credit hour system - three hours for everything
- Inexperience in ALL areas of SLP
- It is challenging as an educator to incorporate all of the professional issues (such as IPP, counseling, etc.) that need to be addressed in addition to academic content in coursework.
- It is challenging to encourage thinking across courses/integration of knowledge
- It is difficult for students to apply foundational knowledge to clinical settings
- It is impossible to obtain clinical experiences in all of the Big 9 in externships alone.
- Lack of clinical supervision/extern locations
- Lack of early practical experience connecting theory and application
- Lack of general professional skills
- Lack of integrated academics with clinicals
- Lack of overlap in Big 9
- Lack of qualified faculty to meet ASHA desire of over 50%
- Lack of standardization for clinical educator training
- Lack of standardization to "entry level"
- Lack of time
- Lack of time for faculty to serve as IT, administrators, etc. while also responsible for teaching, grading

- Lack of transition from undergrad to grad resulting in students needing a semester to shift approach to learning
- Lack of willingness for medical settings to take students for outplacements
- Large class sizes
- Liberal arts requirements affect earlier introduction of core SLP coursework
- Limited critical thinking
- Many newbies go with contract companies which are more expensive for school districts but pay newbies better
- Many students not demonstrating cultural humility
- More recent students (since COVID especially) are overwhelmed with the amount of learning in the 2-year program.
- Moving EBP from classroom teaching into clinical experiences
- No agreement on what determines readiness to enter the field
- No standard measure of learning from undergraduate pre-requisite courses thus students enter master's program with varying background knowledge
- Not enough access for rural students or those who cannot afford to move to a program - also a financial barrier.
- Not enough advocacy
- Not enough coursework for specialty area
- Not enough depth of knowledge.
- Not enough faculty
- Not enough new resources on combining the academic and clinical skill areas
- Not enough SLP graduate programs
- Not prepared for medical settings
- Not sure if all students are getting similar experiences across programs
- Our 'curriculum' organization is so dated -- our classes are set up in the Big 9 which is how it was taught when I was a student.
- Pressure to obtain, secure clinical placements in the community or in your university to help students demonstrate skills across the Big 9
- Removing silos of education and understanding complex clients
- Requiring PhD to teach masters level
- Salaries are too low to justify a longer educational program
- Siloed within a narrow academic home
- SLP graduate students frequently report feeling highly stressed
- Some students graduate feeling like a jack of all trades, master of none. This can leave them feeling unconfident or incompetent in different areas of practice.
- Standard format lecture class
- Student anxiety is at an all-time high.
- Student readiness is somewhat subjective
- Students are coming to graduate school lacking in writing skills.
- Students are extremely stressed and overwhelmed
- Students are generally not prepared to begin work in healthcare environments, requiring mentoring that employers frequently decline to provide on the understanding that the graduate has a degree and license and it is assumed they are prepared to function independently.
- Students cannot always get training in specialized areas of practice, even if they would like training in those areas
- Students have difficulty when there's not a clear-cut or black and white answer to a clinical case

- Students lack of time and limited flexibility in the program result in poor learning practices (e.g., do it to get it done; memorization; survival!)
- Students learn surface level
- Students not confident in their ability to apply theory to clinical settings
- Students not learning at the same rate as others go on remediation plans
- Students semester credit hours are at the maximum our university allows
- Students so focused on 400 hours rather than becoming competent
- Students sometimes take AP Stats as high school juniors and then are unprepared for stats at the Master's level
- Students struggle to integrate information between the Big 9 because we teach in that way and then students
- Students tendency to look for answers (e.g. internet search) over creating their own plans/ideas
- Students that apply and begin work in my state and local work environments are unable to function as a medical SLP and complete the work responsibilities expected of employers, insurance companies, and physician referrals. One example is the ability to research and apply evidence based practice to their diagnostics and treatments.
- Students worried about grades over competency
- The full time two-year model is financially exclusionary for many people- results in less diversity of backgrounds and experience.
- The scope of practice is a mismatch for a 2-year (typically) degree
- The scope of practice of speech-language pathologists is too broad to learn about in depth in a two-year program, especially if clinical skills are also being emphasized
- The separation between academics and clinicals is not conducive to experiential/ hands on learning that our other allied health professionals receive during lab components in their programs
- The transition from theory to practice is difficult and not always well supported by clinical master's programs
- This is going to be hard to solve with different administrations and communities
- Time
- Too much content
- Too much redundancy across academic courses
- Traditional lecture methods are not effective with all learners.
- Unevenness of clinical supervision and clinical fellowship supervision
- Use of more effective pedagogy

10. How critical is it to reconsider the educational model for preparing speech-language pathologists to enter practice?

Response	Percent	Number
Not at all critical	0.0	0
Not very critical	13.0	6
Somewhat critical	82.6	38
Very critical	4.4	2
Unsure	0.0	0

11. How critical is the need for change in each of the following areas?

All Respondents	Not at all critical		Not very critical		Somewhat critical		Very critical		Unsure	
	%	#	%	#	%	#	%	#	%	#
Clinical experiential learning	0.0	0	6.8	3	25.0	11	68.2	30	0.0	0
Availability of clinical placements and supervisors	0.0	0	2.3	1	18.2	8	79.6	35	0.0	0
Curricular capacity	0.0	0	2.3	1	40.9	18	54.6	24	2.3	1
Faculty capacity	0.0	0	0.0	0	31.8	14	68.2	30	0.0	0
Faculty development	0.0	0	0.0	0	45.5	20	54.6	24	0.0	0
Faculty sufficiency	0.0	0	4.6	2	29.6	13	63.6	28	2.3	1
Faculty diversity	0.0	0	2.3	1	29.6	13	65.9	29	2.3	1
Student diversity	0.0	0	2.3	1	22.7	10	72.7	32	2.3	1
Instituting a competency-based framework	0.0	0	4.6	2	31.8	14	61.4	27	2.3	1
Preparation for the future of work	0.0	0	2.3	1	36.4	16	56.8	25	4.6	2

Other responses [and criticality]:

- Demands of accreditation bodies (e.g., SACS), buy-in from stakeholder (e.g., future employers, payer sources, state licensing variability) [Very critical]
- Examining the purpose and role of the undergraduate degree. Are pre-requisites and a grad model a better match? Should undergrad focus be on advocacy and promoting equity for people with CD?
- Gosh. I was listening to the conversation and the whole time I was thinking about how different my university is compared to the others. Or how different my students are versus what it sounds like theirs are. My administration is different. My rural community is different. I don't know that ASHA can really do a whole lot to fix this because all of us in terms of universities are so different. A lot of what is tying my hands right now is my administration, as in my dean and my provost. The process of changing curriculum. The pressure to admit greater numbers of students for the money. I keep hearing more and more people talking about the solutions and then I'm thinking, my dean won't go for that. We need more than just the faculty at this table. If you want to find solutions, you have to bring in all the stakeholders. [Very critical]
- Hands on experience in an interdisciplinary environment. Move away from simulation, students need work with REAL patients and clients! Even if it incorporates telepractice which is better than Simucase. Simucase is ok for 1st semester students, after students need to go live! [Very critical]
- I would like to see more research done and clearer definitions of competency-based education prior to adopting it in our programs. [Somewhat critical]
- Many of the skills addressed in the webinar are life skills that young people need in general. I would like to see problem solving, team work, inquiry, addressed at the UG level. So that a foundation is there to build discipline specific knowledge on top. [Very critical]
- Our professions already have a competency-based framework, but the way it is implemented may discourage or stigmatize students who take longer to master an area. [Somewhat critical]
- Require different tracks or more education to compete and improve competency in healthcare settings [Very critical]
- We need more faculty so there are more SLPs so caseloads and workloads are manageable. We need more advocacy for better salaries for SLPs who work in schools. [Very critical]

12. Indicate the degree to which you agree/disagree with the following statement. My educational program aligns teaching with the science of learning. [Excludes respondents who are not in a college/ university setting.]

Response	Percent	Number
Strongly disagree	4.7	2
Somewhat disagree	11.6	5
Neither agree nor disagree	14.0	6
Somewhat agree	55.8	24
Strongly agree	14.0	6

13. Indicate the degree to which you agree/disagree with the following statements. My educational program prepares students ... [Excludes respondents who are not in a college/ university setting.]

All Respondents	Strongly disagree		Somewhat disagree		Neither agree nor disagree		Somewhat agree		Strongly agree	
	%	#	%	#	%	#	%	#	%	#
... to work in a diverse society.	0.0	0	2.3	1	11.6	5	62.8	27	23.3	10
... to nurture 21st Century skills.	0.0	0	9.3	4	16.3	7	60.5	26	14.0	6
... to develop technological competency.	0.0	0	14.0	6	16.3	7	53.5	23	16.3	7
... to instill lifelong learning.	0.0	0	2.4	1	11.9	5	42.9	18	42.9	18

14. What innovative approaches has your educational program implemented related to any of the above (i.e., working in a diverse society, nurturing 21st Century skills, developing technological competency, or instilling lifelong learning)? List up to 3, each on a separate line. Leave blank if none or if you are not in a college/university setting.

- 1:1 technology with current treatment apps
- Assigning projects where students can go back to their communities to be role models to younger students considering careers in CMD
- Bridging coursework and clinic and research
- Building information literacy skills explicitly through the undergraduate program (in collaboration with a university librarian), starting with evaluating information on the open web
- Case based instruction
- Clinical experiences in local school districts focused on assessment for underrepresented students
- Commitment to diversity on multiple dimensions
- Courses that utilize problem-based learning
- Covering/teaching DEI topics in coursework/clinical methods courses
- Developed a social justice curriculum throughout the program to begin in full 9/2022.
- Developing critical thinking skills

- Diversity
- Diversity: support groups for underrepresented populations, diversity of staff, dialogs in class and clinic about respecting the culture of colleagues and clients.
- EBP focus that is woven across courses and clinic seminar
- Expanding clinical opportunities to an unrepresented city.
- Expanding the undergraduate student population (number of students).
- Experience with telepractice service provision
- Faculty are all using varied educational experiences in the class
- Flipped classroom model
- Flipped learning classrooms
- Hands on-direct experience with other profess to learn their roles/responsibilities and the SLPs role as a team member.
- Holistic admissions
- Holistic admissions
- Hybrid learning model has been continued post-COVID
- Implementation simulation at the undergraduate level to help map learning to practice
- Implemented professional development series in which students attend with professionals
- Incorporating 21st Century skills into academic and clinical education settings.
- Increased orientations on basic clinic skills and mental health needs
- Increasing diversity in faculty and student cohort is a priority
- Innovative partnerships with campus childcare center
- Instill lifelong learning
- Integration of coursework and clinic - we're doing a curricular revision
- Interprofessional education
- Interprofessional education in multiple deliberate manners
- Interprofessional student experiences
- IPCP educational opportunities
- IPECP
- Jesuit principles dictate lifelong learning
- Labs
- Legitimate, evidence based simulation work for students
- Lock step progression of clinical placements and academic coursework
- Mentor program in clinical placement so students receive training in supervisory skills
- Moving toward more “lab time” within the academic course
- Moving toward more problem based learning approach
- Not sure if this is innovative but specific diversity events/speakers, and it is infused in all classes
- Opportunities to learn about and apply evidence based practice
- Oral finals in clinic to discuss clients
- Our clinic model, although evolving, supports interactive and shared experiences.
- Presentation of complex practice problems that require deeper learning and application of knowledge and principles: ethics and EBP
- Provide case-based learning and clinical rounds, etc. opportunities to students
- Relational connections to students
- Require evidence-based practice assignments in coursework but also tied to clinical practicum
- Role model for lifelong learning (by all faculty members)
- Simulated clinical hours
- Simulated clinical learning
- Simulated patients in courses

- Simulation
- Simulation
- Special clinical preparation programs
- Specialty tracks and certifications, including a multi-language track
- Specific courses in cultural competence and professionalism
- Specifically teaching about the science of learning in undergraduate classes, linking it to the coursework from the particular class
- Specifications grading
- Standards-based grading and simulation activities
- Strengths-based graduate advising, instead of a focus on remediation and weaknesses
- Students have opportunities for experience with telepractice
- Students learning is supported with several hands on simulators, not just computer simulations.
- Students use an electronic EMR system
- Students who get involved with research have opportunities for some technological competencies. But it is not universal.
- Teaching EBP
- Team-based learning with critical thinking and application
- Technological competency: use of EMR system for submitting clinical work
- Telepractice implementation and training
- These questions are challenging to answer, as a program is comprised of a number of faculty and our students. Faculty take vastly different approaches to these goals, some investing more time and effort than others.
- Training on cultural and linguistic diversity, including training on how to use interpreters
- Trauma-informed teaching practices
- Use of simulated training cases during master's coursework
- Using clinical simulation - but we have a long way to go
- Utilize an EMR within our university clinic
- We are based in a diverse city, in a diverse area, with an organically diverse student body
- We offer a bilingual certificate program (working in a diverse society)
- Working with diverse clients

15. What challenges does your educational program face related to any of the above (i.e., working in a diverse society, nurturing 21st Century skills, developing technological competency, or instilling lifelong learning)? List up to 3, each on a separate line. Leave blank if none or if you are not in a college/university setting.

- 21st century skills: productivity and understanding EBP with information literacy
- A few students cannot accept even the most constructive feedback and just spiral downwards
- Addressing mental health and burnout
- Attracting students of diverse backgrounds is a challenge.
- Budget model is analogous to "fee-for-service" not "value-based" care
- Burnout from trying to do so much on a skeleton crew and increased HIED and ASHA/CAA/CFCC demands.
- Can't keep up with technology needs (e.g., LMS)
- Classes are too large for online UG courses. 30 students.
- Clinical site availability
- Creating additional ways to develop tech competency
- Critical thinking
- Difficulty getting experienced faculty to embrace new ideas

- Diversity
- Diversity
- Diversity and navigation of diverse society
- Diversity of faculty and students
- Educational supervisor expertise
- Emphasis on skill learning rather than competency-based learning
- Encouraging students to engage in "lifelong learning" model when stressed to complete program and all of the requirements
- Faculty and students resistant to adopting new technologies or strategies
- Faculty expertise
- Financial resources to free up faculty
- Financial support to build technological competency
- Finding enough clinical placements for different learning models
- Funding for equipment and technology
- Getting all faculty onboard with importance of instill professional education as essential component of lifelong learning
- Helping those students who have low technological skills to catch up their knowledge while launching into their first semester of classes and clinic.
- Hesitancy by leadership to require DEI training
- Implementing practical lab-based practice to prepare students for medical settings
- Incorporating technology when faculty are not engaged
- Increasing numbers of students seeking academic accommodations and unusual requests (scribe for exams, ability to leave lectures at will, etc.)
- Instilling lifelong learning. Students don't want to learn anything new or grow competencies once they graduate.
- Keeping the required credit hours to an affordable and do-able level for 5-6 semesters
- Lack diversity in faculty and students
- Lack of diversity in faculty and student body
- Lifelong learning
- Limited availability of qualified candidates for faculty openings
- Limited budget for technology
- Limited diverse clients/ limited critical thinking students more so since COVID
- More students wants, medical placements than we can provide
- Need at least one more consistent clinical faculty line as opposed to hiring different adjunct each semester
- Non diverse staff
- Not enough clinical and academic faculty to consistently support students' needs.
- Not enough collegial discussion about program adjustments for facilitating student learning
- Not enough faculty
- Not enough faculty
- Not enough faculty
- Not enough support from CAA to support the program with HIED administration
- Not enough time/semester in the program, only 5 not 6
- Nurturing 21st Century skills - difficult
- Obtaining diverse clinical placements
- Offering online learning more broadly to accommodate more diverse learners
- Our department is understaffed because of retirements and pandemic-related budget constraints at our institution

- Our faculty largely consists of white women
- Our students need a lot of life skills taught in addition to content
- Our students report being very busy so faculty feel some pressure to reduce the workload for courses.
- Placing students with clinical supervisors who are also diverse and respect diversity in their work
- Predominantly white faculty and white student body
- Promoting student and faculty wellbeing (there's SO much burnout with the pace we are expected to maintain and the addition of ONE more thing to the ASHA guidelines)
- Recruiting and supporting diverse students (age, background, cultural, linguistic, race)
- Recruitment and retention of diverse students - financial barriers are the biggest concern in my opinion.
- Soft skills
- Some faculty who have not evolved their teaching style
- Students/grad clinicians cling to older methods and targets without thought. I'm not even sure where they hear of them.
- Support staff
- Tackling DEI issues and meeting the students where they are and the placements that are available
- Technological competency - many faculty do not have these skills themselves, so how can they teach them?
- Technology can be a challenge because of the rural nature of the state
- The cost of technology prohibits us from adopting some options
- The pandemic has left our department quite burnt out -- our capacity to add to our already full plates is limited
- The pool of applicants, either faculty or students, is not very diverse
- There is not a practical mechanism in the university for sharing inter professionally
- There is so much to learn, that students take short cuts
- Time to go deep in learning
- Too much content to put into a 5 semesters
- Too much university restructuring and not enough effective leadership too down to facilitate communication.
- Training in learning science and its application in courses at all levels
- We teach cultural sensitivity very well but our community is not that diverse so it's hard for the students to get practical experience

16. What ideas do you have about advancing SLP education? List up to 3, each on a separate line. Leave blank if none.

- Accredit the clinical doctorate and require this degree for work in healthcare settings.
- Active learning classrooms
- Add a new educational title: the professor of practice
- Advocacy
- Allow more clinicians (masters level) to teach clinicians
- Allow students to achieve competencies at their own pace
- Allowing programs to have specialized "tracks" for SLP training for certain environments (e.g., school-based track, medical-based track)
- An undergraduate degree in SLP should provide students with the skills and competencies to work as SLPAs.
- Bolster undergraduate education by accrediting it (like BSW/MSW)
- CAA more prescriptive in some areas possibly?
- CAA support for faculty needs

- CBE is a key
- Change programs to offer separate learning tracks to improve education for work environments
- Collaboration among programs that have gaps
- Comprehension of job sites
- Consider if liberal arts UG is what is needed in 21st Century. Is a technical training model better?
- Consider stacked credentials to specialize beyond generalist but more reachable than specialty certification
- Consider whether clinical doctorate would better prepare entry level - if we want to continue training generalists
- Create separate tracks for educational work and medical SLP
- Creating standard competencies to be used at all SLP programs
- Critical thinking
- Develop fundamental knowledge, professionalism, and writing in undergrad
- Developing teaching methods that are effective for a wide variety of learners
- Development of competencies for successful practice
- Different levels of clinical placements like OT has
- Embrace technology by involving younger, more tech savvy faculty in program design; employ co-teaching if older faculty do not have the skills needed to use high tech tools.
- Encourage students to have work experience in CMD-related or CMD-adjacent settings before beginning graduate school (students who go straight through are often so burned out by the time they start graduate school, that their capacity for the challenges of graduate school is reduced)
- Encourage use of science of learning pedagogy, for example 'flipped classroom' and deliberate opportunities for mistake learning
- Encouraging lifelong learning with a variety of tools - scholarly reading but also scholarly media such as podcasts and webinars and provide student access a low cost.
- Engage other health-related disciplines in competency-based education models
- Explicitly teach cultural humility
- Faculty development that focuses on learning specific, new approaches to pedagogy.
- Families and clients are choosing telehealth despite in-person options. Allow university clinics to increase the number of hours/competencies to conduct intervention and assessments via teletherapy.
- Flipped classrooms
- Focus on foundational skills with certificates for specific areas (like fellowships similar to medical training)
- Future SLPs of America high school clubs
- Guidelines for labs to be added to curriculum (ex. 2-1 faculty model) to support CBE
- Have ASHA set maximum number of students per class size like other similar professions
- Having more opportunities for service- or community-based learning in undergraduate programs (with models, examples, guidance, and resources for faculty to integrate it into their courses relatively easily)
- Highlight the highly successful individuals in our profession how represent the diversity of society.
- How can competency learning allow for streamlining at individual pace?
- I think it is time to reconsider our models for academic and clinical preparation so that we move away from our "silos" and relying heavily on medical models.
- If raise the bar, programs should be more universal and similar to each other.
- Implementation of team-based learning
- Increase explanation rather than correct or incorrect
- Increased clinical opportunities
- Increased emphasis on clinical skills during master's coursework, perhaps with "flipped classroom" approach

- Integration of developing soft skills in all work - academic and clinical
- Journal clubs
- Knowledge and skills check offs
- Liberal arts coursework could be reduced to introduce core SLP coursework sooner.
- Like idea of specialization; badges/microcreditally
- MA for educational setting and clinical doctorate for healthcare settings. PR right had a similar system-BA degree for educational setting (speech therapist) and MA for health care settings (speech language pathologist)
- More discussion in classes
- More incentive for supervisors and medical businesses to accept students (i.e. earn CEUs for supervision, free ad space for companies etc.)
- More practical hands on labs and practical application to encourage clinical reasoning
- More review of clinical pedagogy
- More training for on-site supervisors to give students more ownership for their therapy.
- Much more significant focus on TEACHING AND SCIENCE OF LEARNING to turn that around for many professors who are stuck in old ways
- No need to raise a bar for various reasons
- Paired clinical didactic course to complement experiential learning in clinical settings
- Perhaps we should look at the CF in a new way as a final summarize experience- with more supervision.
- Post grad specialization certificates (where the taker earns CEUs for the courses) for lifelong learning and improving the specialization areas
- Preparation of new faculty for teaching and learning
- Probable eventual shift to doctoral level training
- Problem-based learning
- Provide more supports for faculty. Make SoTL type offerings online and free for universities.
- Provide option to specialize
- Recognize that the best person teaching a course may not be a PhD
- Reimagine curriculum to be one that spirals rather than isolated courses taken out of sequence
- Remove 400 hour requirements
- Require a different learning model and skill set/competencies for medical SLP
- Require clinical department personnel to engage, train, and support external and CF supervisors.
- Restructure or eliminate the undergraduate degree
- Scholarships for high schoolers going into communication disorder fields
- Separate medical and educational tracts
- Soft skills focus in undergrad
- Specialization within the profession
- Start case based instruction/simulation in undergrad
- Start with the UG programs. Students need to enter grad school better prepared so we can start out at grad-level teaching and not basic knowledge
- Steer away from a full-time 2-year model so that more diverse applicants (who cannot stop working for two years) can transition into this career. Part time, asynchronous options should be more available.
- Stricter requirements and increased education to increase use of science-based principles of learning in classrooms
- Stronger connections between clinic and class
- Supervision training should be part of the curriculum to systematically prepare students to become clinical educators
- This is a systemic issue in the U.S. but the cost of this degree is too high when you consider potential income in most settings.

- Training off-site supervisors in effective methods of mentoring student clinicians.
- Universities continue a mentoring model through the student CF year
- We may consider practical SLP courses beginning in undergraduate education, similar to the way our colleagues in nursing do
- We need guidelines and requirements for SLPD programs, they drastically differentiate from each other.
- Week long retreat of incoming graduate students to build relationships and explore 21st century skills and concept of lifelong learning

17. Have we addressed the most critical issues—specific to this webinar topic of the future of learning—from your perspective?

Response	Percent	Number
Yes	90.9	40
No	9.1	4

18. If no, what other issue(s) should be addressed? List up to 3, each on a separate line.

- Being on faculty is hard!
- Dysphagia teaching improvements
- Funding sources drive so much of what we do -- as SLPs and also as university faculty. Underfunded state university systems are at a disadvantage in serving students well and in maintaining reasonable workloads for faculty (that allow for creative re-envisioning of courses and updates in pedagogical methods)
- Higher ed doctorate degree for healthcare settings. Doctorate degrees are emerging in other fields-med science, pharmacy, psychology, occupational therapy.
- IMPROVE swallowing education and training at the university level. Throw out the idea of teaching one class in dysphagia and sending the student to an externship. Improve foundational learning and ON CAMPUS swallowing teaching in the university clinics.
- Improve competency in medical SLP
- In most healthcare settings, typically 80% or more of the caseload is swallowing disorders! Swallow intervention takes priority over all other interventions in our scope of practice because what we do or don't do can take a life!
- SLPD degree

19. Please provide any other comments that you would like to share with the Ad Hoc Committee to Plan Next Steps to Redesign Entry Level Education for SLPs.

- Faculty capacity to create new programs, approaches, and instructional techniques is limited. It was before the pandemic and is even more so now.
- I disagree that this is not related to college degree decisions.
- I feel like we've had some of these conversations before. It seems that the "old guard" within the broader membership stopped discussions of a shift in clinical education models. So - is this really something the membership at large decides? I feel like once the scope of practice is outlined, then CAA, CFCC and the programs themselves should make final determination of the "how to's".
- I think a focus on ungrading / competency-based education is really important

- I think this transition is necessary but very big in scale to achieve
- I was worried this webinar would be focused on the SLP-D as an entry level requirement. I'm glad to know that other options are being considered since requiring a further degree could only compound our current problems.
- I would love to see more student opinions on what worked well and what didn't in their graduate program.
- In my small group, several individuals from university settings mentioned undergraduate students not having opportunities to go on to graduate school. That has not been our experience. Our undergraduate (Midwest) have multiple options for graduate school. Our program wonders if we are seeing fewer undergraduates in CSD programs in the Midwest overall. Our own enrollment has been steady. Also, we are seeing more adult learners who are interested in changing careers.
- In the end, we want all of our clinicians to feel prepared to work across the lifespan and across areas of treatment while maintaining awareness and sensitivity to all cultures.
- More time is not always better. Recall when some states allowed undergraduate students to practice prior to enrolling in a master's level program. I was one of these individuals and was very successful. 5 or 6 semester programs can work if we think smarter - less focus on number of credits for courses and more focus on addressing ASHA standards using a spiral curriculum approach as well as periodic webinars, round tables, podcasts to support students with opportunity to enhance their 21st Century skills and habit as a lifelong learner
- Thank you for beginning this process.
- Thank you for the opportunity to have conversation.
- The topics in this series are great but are so intertwined. I would like to see a session that brings everything together. I also think an emphasis on systemic issues that affect our field (and others) should be discussed (e.g. the absurd costs of higher education in the U.S.; low pay in the "caring" professions; gendered employment, etc.). If some of these issues are addressed country-wide, we would see trickle-down changes in SLP.
- Understanding the why if content is essential. I frequently get a sense of students looking for an answer versus deep understanding.
- University academia need to be educated and learn about the SLP role in health care. Their lack of knowledge and understanding about the practitioner's role is evident in the work groups.
- Very good attempt at bringing this webinar series to the table for discussions.
- We need to add academia with a university title and background: Professor of Practitioner.
- Where are the individuals representing healthcare SLP in the work groups? The makeup of the work groups seems to be primarily academia -with school based focus.
- Your work groups consist primarily of academia that have already structured education that is not working. There needs to be healthcare SLPs -practitioners in your work groups in order to obtain an adequate and real understanding of the educational needs and problems.

Appendix C: Alternative Educational Models Webinar Survey Results

Ad Hoc Committee to Plan Next Steps to Redesign Entry-Level Education for Speech-Language Pathologists' Next Steps 2022 Summer Webinar Series

Introduction

On June 21, 2022, a survey was made available as part of the Ad Hoc Committee to Plan Next Steps to Redesign Entry-Level Education for Speech-Language Pathologists' Next Steps 2022 Summer Webinar Series on Alternative Educational Models. Individuals who participated in the live webinar, as well as those who viewed the recorded session, had the opportunity to complete the survey by August 30. A total of 33 individuals responded to the survey, 31 from the live webinar and two who viewed the recorded session. Responses are presented for all respondents combined.

Results follow. Comments have been lightly edited for spelling and grammar. This report was prepared by ASHA's Surveys and Analysis unit.

Results

1. Which of the following best describes your current ASHA affiliation status? (Check one.)

Response	Percent	Number
ASHA-certified in audiology	6.1	2
ASHA-certified in speech-language pathology	93.9	31
ASHA-certified in both audiology and speech-language pathology	0.0	0
Noncertified member	0.0	0
Clinical Fellow	0.0	0
International affiliate	0.0	0
Speech-language pathology or audiology assistant	0.0	0
Student (undergraduate, graduate or research doctoral)	0.0	0
Other (Specify.)	0.0	0

2. How many years have you been employed? (Check 0 if none.)

Response	Percent	Number
0	0.0	0
1-5	0.0	0
6-10	9.1	3
11-15	15.2	5
16-20	6.1	2
21 or more	69.7	23

3. Which of the following best describes your current primary employment setting? (Check one.)

Response	Percent	Number
Early intervention/ pediatric home health	0.0	0
School (preschool, elementary, etc.)	3.0	1
College/university	84.9	28
Hospital (all types, inpatient and outpatient)	3.0	1
Nonresidential health care facility (clinic, physician's office, etc.)	0.0	0
Residential health care facility (skilled nursing facility, etc.)	0.0	0
Adult home health	0.0	0
Private practice	0.0	0
Agency, organization, or research facility	0.0	0
Industry	3.0	1
In audiology externship and/or clinical practicum	0.0	0
Not employed (student, retired, on leave of absence, etc.)	3.0	1
Other (See below.)	3.0	1

Other responses:

- Pediatric medical center outpatient clinic

4. What is your current primary employment function? (Check all that apply.)

Response	Percent	Number
Clinical service provider (i.e., audiologist or speech-language pathologist)	9.4	3
College/university academic faculty	53.1	17
College/university clinical faculty	34.4	11
Researcher	9.4	3
Consultant	3.1	1
Administrator/executive officer	6.3	2
Chair/department head/manager	12.5	4
Supervisor of clinical activity	18.8	6
Other director/supervisor	12.5	4
Other (See below.)	6.3	2

Other responses:

- Clinical and academic faculty, clinical service provider
- Coordinator - 10% caseload

Note. Only individuals who selected “college/ university academic faculty” or “college/university clinical faculty” moved on to question 5. All other respondents were automatically skipped to question 6.

5. What is your current faculty rank? (Check one.)

Response	Percent	Number
Lecturer	4.4	1
Assistant professor	13.0	3
Associate professor	34.8	8
Full professor	34.8	8
Other (See below.)	13.0	3

Other responses:

- Director of Clinical Education
- Professor Emeritus
- Senior Instructor

6. In what state do you reside?

Response	Percent	Number
Alabama	3.1	1
Alaska	0.0	0
Arizona	3.1	1
Arkansas	0.0	0
California	9.4	3
Colorado	3.1	1
Connecticut	0.0	0
Delaware	0.0	0
District of Columbia	0.0	0
Florida	3.1	1
Georgia	0.0	0
Hawaii	0.0	0
Idaho	0.0	0
Illinois	0.0	0
Indiana	3.1	1

Iowa	9.4	3
Kansas	0.0	0
Kentucky	0.0	0
Louisiana	0.0	0
Maine	0.0	0
Maryland	3.1	1
Massachusetts	0.0	0
Michigan	0.0	0
Minnesota	0.0	0
Mississippi	3.1	1
Missouri	3.1	1
Montana	0.0	0
Nebraska	0.0	0
Nevada	0.0	0
New Hampshire	0.0	0
New Jersey	3.1	1
New Mexico	0.0	0
New York	15.6	5
North Carolina	0.0	0
North Dakota	0.0	0
Ohio	6.3	2
Oklahoma	0.0	0
Oregon	0.0	0
Pennsylvania	6.3	2
Rhode Island	0.0	0
South Carolina	3.1	1
South Dakota	0.0	0
Tennessee	3.1	1
Texas	15.6	5
Utah	0.0	0
Vermont	0.0	0
Virginia	0.0	0
Washington	0.0	0
West Virginia	0.0	0
Wisconsin	3.1	1
Wyoming	0.0	0

7. The current educational model to prepare speech-language pathologists to enter practice is a master's degree (approx. 2 yrs.) comprised of academic and clinical educational experiences covering the full scope of practice across the lifespan. How well is the current educational model working to prepare speech-language pathologists to enter practice?

Response	Percent	Number
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Not well at all	0.0	0
Not very well	15.2	5
Somewhat well	78.8	26
Very well	6.1	2
No opinion	0.0	0

8. What is working well? List up to three aspects, each on a separate line. Leave blank if none.

- Ability to start general and specialize later
- Accepting students with majors other than CSD - majors that may have more focus on writing and critical thinking skills development
- Accreditation processes maintain standards
- All SLPs hypothetically have same core training, easier for employers
- Breadth of clinical experience
- Broad clinical knowledge base
- Broad exposure to depth and breadth of scope of practice
- Certified at end of CFY
- CLD infused across the curriculum
- Clinical preparation
- Clinical supervision training puts out great clinicians
- Cohort models where students feel part of a community
- Competency in knowledge and clinical skills
- Content covered
- Core required knowledge and skills ensure that students are starting from at least a minimum level of competence
- Coursework covers the Big 9
- Coursework covers the lifespan
- Curriculum content
- Employers tell us that our students are well prepared.
- Entry level practice
- Exposure across the lifespan
- Flexibility in definition of "competency"
- Focus on foundational skills
- Full time internships versus doing internships while also doing classes
- Having a broad knowledge of treatment of disorders across the lifespan allows for flexibility in future employment settings.
- High employment rate
- High graduation and certification rates
- High Praxis rate so students are learning the material
- Increased used of hybrid education models and embracing of telehealth practices have increased access for students to participate in degree programs.
- Lifespan approach enables flexibility
- Newer focus on DEI and IPE has been emphasized in many programs
- On campus clinical experience

- On-campus clinics and clinical practicum experiences are the best avenue for students to gain functional skills for immediate application upon entering the workforce.
- Our program clinical supervisor spends more time than ASHA requires with student - as a result they are better prepared
- Pass Praxis
- People are coming out still passionate
- Practicums in both age populations- pediatrics and adult
- Preparation as generalist
- Provides a framework for us to target
- Provides a structure about which we can talk with students
- Students acquire a broad clinical experience, ensuring they have opportunities to learn about what they want to do or not want to do as a clinician
- Students are able to find employment after graduation.
- Students are able to have formative experiences during grad school without having to select a population preference before they have completed any clinical work
- Students are broadly prepared to work in a variety of settings.
- Students are passing the Praxis, indicating some level of basic competency across the nine areas
- Students are prepared across the lifespan; thus, SLPs have at least some background knowledge and skills across areas within the scope of practice.
- Students do get information across all areas
- Students get academic and clinical experiences across disorder areas and across the lifespan
- Students get experience across the Big 9
- Students pass Praxis
- Teaching clinical thought processes
- Teaching foundations of all areas
- The CF provides an additional layer of support and mentorship, which is essential for entry-level clinicians
- The current model “introduces” students to medical SLP
- The current model prepares students to work in the schools.
- The knowledge and skills students acquire in graduate school prepare them for a clinical fellowship and lifelong learning.
- There are some programs that excel
- Transition from in-program clinic to externships to CF provides a good level of support as students become more independent
- Variety in disorders and coursework
- We are recognizing a need for post-education learning
- We focus heavily on clinical education
- We have a full year of internships which allows a student to experience adult and child real world, full time experience
- We have PT, OT, Audiology, Sports, and SLP in our program both inpatient and outpatient. This allows for a big picture look at a pediatric medical placement
- We require students to be at the setting at least 20 hours a week in no more than 3 days to simulate real life work setting

9. What is not working well? List up to three aspects, each on a separate line. Leave blank if none.

- 2-year degrees are very stressful for students
- Academic preparation is widely varied for students.
- Clinical education model
- Clinical educator mentorship varies greatly
- Content continuously added to the curriculum
- Cost of the education
- Deeper knowledge in content areas
- Depth of coverage in all areas
- Development of problem solving
- Difficult to cram material into an academic program
- Difficult to experience all in our broad scope of practice
- Disconnect between academic theory/evidence and clinical application
- Each university has its own clinical evaluation tool versus a standardized, consistent tool for all SLP graduate students.
- Education for employers on what to expect
- Employers are often not willing to hire CFs as they are looking for employees who are better prepared to jump in and work with minimal support
- Faculty
- Focus on quantity of hours rather than quality
- For students who come into the profession knowing what they want to do, they have to spend a lot of time learning about things they are unlikely to need/use
- Full scope of practice is not covered, or is covered insufficiently
- Graduate students report high levels of stress.
- I think UG courses at most universities are not doing their job - students are ill prepared when they enter graduate school so we have to teach everything over again
- Inconsistency in breadth and depth of programs
- Interpretation of entry level competency is broad and largely left up to the university; it's not consistent
- It is a really terrible idea to divide coursework into adult vs children, there are plenty of adults with developmental disorders and plenty of children with acquired impairments - we have created a false dichotomy and any move towards codifying that in practice is a bad idea
- It is nearly impossible to cover the scope of practice across settings and ages in a 2-year program
- Lack of ability to align clinical experiences with academic curriculum
- Lack of ability, resources and opportunities for specialization. This creates a lack of "experts" in our field and also decreases confidence clients and other providers have in an SLPs ability to adequately treat specific disorders. Clinicians should be able to practice "at the top of their license" by providing excellent care in their areas of expertise, however, because we are encouraged/forced to have a basic competency across all of the Big 9 that does not allow for growth or specialization in specific areas.
- Lack of clinical placements
- Lack of consistent preparation across the Big 9 areas
- Lack of education re: science, culture, arts, and humanities
- Lack of oversight in what is taught in some courses at the graduate level
- Limited clinical placements

- Many 'academic' professors haven't practiced clinically in years; huge disconnect between knowledge and clinical practice or skills
- Many students leave graduate school feeling incompetent/underprepared in some service areas.
- Minimal externship placement opportunities are burdensome to university programs scrambling to find appropriate externship experiences for their students. This can result in a sub-par learning experience if students are not learning from clinicians best qualified to teach them in the settings needed to ensure preparation for future employment.
- Not enough time to cover all the content and skills that students will need
- Not enough time to focus on specific disorders
- Opportunities for direct clinical experience in some areas is limited.
- Programs aren't sufficiently teaching students - if we address it in adults, we address it in children (and vice versa) - I have so many say well we don't work on executive function in kids - there are a lot of people out there who pretend that the scope of practice is only for one age group. I also have plenty of people who will not address language-learning abilities in adults.
- Rigor and time commitment in courses impact on student mental health
- Should all the material be at a master's level
- Significant challenge finding clinical placements, particularly in medical areas, that prepare students for entry level acute medical work
- Skill silo
- SLP graduate students have heavy course loads to fit everything into their program of study.
- Some faculty believe students leave graduate school under/unprepared in some service areas.
- Sometimes difficult to find experiences in all nine areas
- Sometimes difficult to get the students to full competency
- Student generalization across Big 9
- Students aren't adequately prepared to work with limited English or no English speaking individuals.
- Students are less prepared for the expanded rigor of the profession- this causes much anxiety
- Students are NOT adequately prepared to work in a medical field. This results in the need for extensive self-study and reliance for ongoing education beyond the degree to obtain the knowledge needed to be an effective clinician in these settings.
- Students are not generalizing skills/knowledge from the Big 9 post-graduation.
- Students are not well prepared for professionalism in a clinical setting.
- Students do not receive the same clinical experiences across universities
- Students in class/clinic all day every day
- Students often come in not knowing which setting or population or age group they want to work with, which is an appeal of our profession; narrowing that in some way may discourage some students from our field
- Students receive different levels of instruction across universities
- The graduate workload is PACKED
- The students are not prepared for the medical model in SLP
- The students don't understand their role and responsibilities among peers in an interdisciplinary setting
- There is a huge amount of content to cover in a small amount of time.
- Too little time to cover everything that is required in standards, by university programs, and desired by students
- Too much emphasis on just our scope of practice/discipline
- Unclear expectations for what entry level is

- Undergraduate preparedness - graduate programs are having to spend 20% of class time covering UG content
- Unrealistic expectations of external supervisors
- Vast differences in clinical externship and CF experiences leading to different levels of preparation
- We have people getting trained but not having confidence to practice.
- We need students to have baseline fundamentals in all areas of Big 9
- Wide range/focus

10. How critical is it to reconsider the educational model for preparing speech-language pathologists to enter practice?

Response	Percent	Number
Not at all critical	0.0	0
Not very critical	6.9	2
Somewhat critical	44.8	13
Very critical	48.3	14
Unsure	0.0	0

11. How critical is the need for change in each of the following areas?

All Respondents	Not at all critical		Not very critical		Somewhat critical		Very critical		Unsure	
	%	#	%	#	%	#	%	#	%	#
Clinical experiential learning	3.6	1	10.7	3	28.6	8	57.1	16	0.0	0
Availability of clinical placements and supervisors	0.0	0	3.6	1	7.1	2	89.3	25	0.0	0
Curricular capacity	0.0	0	7.1	2	32.1	9	57.1	16	3.6	1
Faculty capacity	3.6	1	3.6	1	32.1	9	60.7	17	0.0	0
Faculty development	3.6	1	3.6	1	39.3	11	50.0	14	3.6	1
Faculty sufficiency	3.6	1	7.1	2	28.6	8	53.6	15	7.1	2
Faculty diversity	3.6	1	10.7	3	39.3	11	46.4	13	0.0	0
Student diversity	3.6	1	7.1	2	35.7	10	53.6	15	0.0	0
Instituting a competency-based framework	0.0	0	0.0	0	46.4	13	50.0	14	3.6	1
Preparation for the future of work	0.0	0	0.0	0	32.1	9	67.9	19	0.0	0

Other responses [and criticality]:

- Being viewed as "equals" compared to other rehabilitation professionals and comparative disciplines (e.g., PT, OT, AuD, MD, LSSP, etc.) [Very critical]
- Change in the thinking about the SLPD. Need to move to doctoral level education. [Very critical]
- Faculty competency for clinical training vs. academic training; having a terminal degree does not make you more qualified to teach a course than a highly-competent clinician. [Very critical]
- The discussion in this series targeted alternative education at the graduate level. Any of these discussions need to also address changes to UG experience. The two must be discussed in combination. The one directly impacts the other. [Very critical]

- There needs to be clinical professors who also work in clinical settings to teach PRACTICE and EBP application. [Very critical]
- To some degree, programs are trying to fit competency assessment into their traditional course models. [Somewhat critical]

The next two questions aim to capture your perceptions about the current educational model in speech-language pathology, which consists of a roughly 2-year master’s degree program wherein the curriculum aims to prepare students for entry-level practice across the big nine areas and to work with individuals across the lifespan and practice settings.

12. Indicate the degree to which you agree/disagree with each of the following statements.

13. The current educational model in speech-language pathology is:

All Respondents	Strongly disagree		Somewhat disagree		Somewhat agree		Strongly agree		Unsure	
	%	#	%	#	%	#	%	#	%	#
...successful in preparing students for entry-level practice across the big nine areas and to work with individuals across the lifespan and practice settings.	3.5	1	20.7	6	72.4	21	3.5	1	0.0	0
...sustainable as a means of preparing students for entry-level practice across the big nine areas and to work with individuals across the lifespan and practice settings.	31.0	9	37.9	11	24.1	7	3.5	1	3.5	1

Comments:

- Adequate preparation of students for school settings.
- Although the model has its benefits, I fear that its time is running short. While I would argue that most of my students are competent in a variety of skills, I'm not sure that they are all competent in all skills nor could I "prove" or provide sufficient evidence to support such competency.
- I think this varies wildly program to program - there are some programs doing it well and some that are not. Yes, could my students know more when the graduate - but that is true no matter how long they are in a program, I learn more every day.
- If the current program were successful and sustainable this Ad Hoc committee would not have been deemed necessary. The sheer fact of its existence is telling that there is a problem with the current system.

- Responses to this question require an understanding of or agreement on what constitutes preparedness for entry level practice. I do not think we have reached agreement on this as a field.
- The professions may be asking too much of entry level professionals. This leads to considerable graduate student stress.
- This question completely fits with my earlier comment - these discussions need to involved UG preparedness and not just graduate changes. In addition, the first part of the webinar mentioned different levels of preparedness - where is the CAA in this - that is part of their role in terms of national accreditation of graduate SLP programs. The persons in my group all felt their graduate SLP students were prepared as entry level practitioners. This group has data from survey of graduate programs in terms of preparedness. We need to have data from the persons being graduated, for example, one year out, three years out, five years out. An instructor with years of experience and/or doctoral degree will always want that student to have the knowledge she/he/ze has that took years of continuing professional development and experience.
- Yes, sustainable - but with modification in how it is approached. The lifespan model could work if implemented in more relevant and thoughtful manner, without extended time.

14. The current educational model in speech-language pathology should be maintained...

All Respondents	Strongly disagree		Somewhat disagree		Somewhat agree		Strongly agree		Unsure	
	%	#	%	#	%	#	%	#	%	#
...but the duration of graduate programs should be extended beyond 2-years to enable delivery of the full curriculum and adequate time for students to fully develop the clinical competencies needed for entry into clinical practice.	20.7	6	27.6	8	24.1	7	17.2	5	10.3	3
...but more content should be moved into the undergraduate degree so that undergraduates are able to complete coursework and clinical practica required for the graduate degree and for clinical certification in speech-language pathology.	17.2	5	24.1	7	34.5	10	20.7	6	3.5	1
...and should be left unchanged because students are consistently being prepared for entry-level practice across the big nine areas and to work	34.5	10	27.6	8	27.6	8	3.5	1	6.9	2

with individuals across the lifespan and practice settings.										
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Comments:

- "consistently being prepared" I have no control over this at other programs nor do I think creating longer programs solves this - programs that are doing a poor job will continue to do a poor job. I worry about depending on the undergraduate curriculum changes - students already come ill-prepared and do not have a useful grasp of their content from undergrad, if I expect them to know even more and they don't know it, I have even more to reteach.
- A change needs to take place in educational CONTENT and clinical experiences to address the needs and student preparation in med SLP.
- I appreciate the inclusion of UG in this question. What about the question of teaching pedagogy - that is a question that is pertinent to UG and graduate preparation? I reiterate that the group I was in believe that their students are consistently prepared. The time commitment in a two-year program to get them prepared can negatively impact mental health. We need to know more about who is saying they are unprepared and what that unpreparedness looks like before making such large decisions.
- I'm often perplexed and angered that we are told that this committee is not discussing the entry-level degree, and yet, questions incorporate adding more time into the programs. I encourage the committee to be realistic and think about where education occurs: the university. We are already under pressure to get students finished in a 2-year time frame; yet, this is considering adding more time to a master's degree. THIS IS UNREALISTIC WITHOUT MOVING TO A CLINICAL DOCTORATE. No one wants to spend four years in school and have a master's degree and administration will not support it. If we are not going to advance our profession with increased rigor and therefore a higher degree indicating better qualifications, the current model may not be perfect but it is sufficient. Undergraduate programs, in my opinion, are not always necessary. I do not approve or support making the undergraduate program have more content. Many students cannot handle undergraduate responsibilities.
- It is unclear to me what content can be removed/changed at the undergraduate level to accommodate time and credit hours for more content. This seems like it would require a change in the certification standards. If master's programs are extended beyond two years, is the goal to keep the same certification standards (to address the same knowledge, skills, and clock hour requirements)? If so, it seems like there should be guidance/agreement on the purpose of the extension.
- There are already too many credits for a master's degree that covers the entire scope of practice. Master's degrees in some other disciplines take one year, not two. Any extension of a student's time in graduate school for SLP should result in a degree higher than master's
- You can't extend the length of the program to be almost consistent with a clinical doctorate and expect to have students want to come into this field.
- You did not include the SLPD in this equation. It was discussed for the past two years and now it cannot be discussed?

15. To what degree do you support further consideration of track models for speech-language pathology, wherein graduate students prepare to work with either pediatric or adult populations after completing a common core curriculum?

Response	Percent	Number
Do not support at all	48.3	14
Slightly support	27.6	8
Moderately support	20.7	6
Highly support	3.5	1
Unsure	0.0	0

16. To what degree do you support further consideration of modular models for speech-language pathology, wherein graduate students prepare to work in a subset of clinical areas after completing a core curriculum (with pathways available to acquire additional competencies in other clinical areas throughout one’s career)?

Response	Percent	Number
Do not support at all	24.1	7
Slightly support	20.7	6
Moderately support	51.7	15
Highly support	3.5	1
Unsure	0.0	0

17. Have we addressed the most critical issues—specific to this webinar topic alternative educational models—from your perspective?

Response	Percent	Number
Yes	44.8	13
No	55.2	16

18. If no, what other issue(s) should be addressed? List up to 3, each on a separate line.

- Accessible to all qualified students
- All of your plans seem to be based on a silo approach instead of an integrated approach - you can't really think critical thinking is that important or having skills that will help you continue to be relevant if you have no opportunity for integration. It is also bad for faculty relationships - the programs with the most siloed faculty and staff seem to have the worst interprofessional relationships.
- Already have a significant encroachment from OT in dysphagia, if we make it more confusing this will only get worse. Our 1 dysphagia class is still better than 8 hours of OT dysphagia training.
- By siloing more and more practice areas, you are teaching people that distinct certification is needed, that they need to have hyper-detailed knowledge. I would want a clinician for my mother with aphasia who knows what a noun is and has previously been working with children than someone who has a "certificate" in adult language disorders who can't tell the difference between a neuter noun and an indefinite noun.
- Consider post-graduation, add on certifications

- Consider separate tracks for educational and medical settings with adoption of a doctoral degree for hospital work.
- Cost to student
- Discussion / sharing of more data in terms of what does the unpreparedness look like - is there then benefit from initially a more targeted approach versus tracks and longer in school
- Doctoral education
- From the clinical supervisor/program faculty perspective, the more we specialize or individualize graduate education, the faculty are needed to support student learning. At my university, there is no support for hiring additional personnel. Even if there were, the faculty shortage creates a subsequent barrier.
- From the employer perspective, it seems like it would require SLPs/ASHA to provide a lot of education and advocacy so that employers understand this certification process. Since SLPs who complete track or modular programs may not be trained in particular service areas, employers need to know that up front. From my understanding, if an SLP is hired in the schools, but didn't complete a module in a service area, they would be unable to support students with those needs because they are not certified. This seems like a major barrier.
- How do we account for depth?
- How do we cram more into a packed graduate program in a meaningful way?
- How the marketplace will respond to these changes- who would know what SLP to hire based on their modules
- How to create a model that can enhance the diversity of our field
- How to increase consistency in core
- How to modify a current two-year approach to the lifespan model
- How to recognize our preparatory education in the context of other healthcare professions who serve on our teams
- I don't know if these survey questions make sense of our breakout room discussion
- In looking at tracks- how would you train pediatric medical (voice, dysphagia) and adult SLPs who focus on autism, developmental disorders
- It is a problem that ASHA and the profession keep pushing a dichotomy in our field between acquired/developmental, adult/child - there are more similarities than differences.
- Need much stronger dysphagia education. 80% or more of med SLP caseload is dysphagia.
- Not enough information
- Post-entry education and specialty certification
- Revision of standards to include what isn't being covered adequately in current graduate program models
- Should not focus just on content
- Since SLP practice is considered a medical science, an educational model that incorporates components of medical teaching should be applied.
- Students entering graduate programs less prepared than in years past and ideas to improve that
- Survey of audiology challenges so we do not follow the same path
- Teaching pedagogy at UG and graduate level
- The CF experience
- The pre-entry level educational model
- The track and modular models make sense to me in theory; however, I foresee many barriers from a variety of perspectives (student, clinical supervisor, program faculty, and employers). I could see students

and SLPs become extremely frustrated by the fact that they would need to continue formal education/certification (which I'm sure would add an additional cost for individuals, many of whom have already accumulated student loans in the master's program).

- These don't address the content that needs covered.
- This can't be separated from the clinical piece.
- We need a paradigm shift, not just models.
- What are the best models to allow access for students from diverse backgrounds?

19. Please provide any other comments that you would like to share with the Ad Hoc Committee to Plan Next Steps to Redesign Entry Level Education for SLPs.

- Consider work groups that include academia AND supervisor/lead, seasoned practitioners in the field in EQUAL numbers to obtain better input from group discussions.
- Due to the rigidity of standards and prescriptive nature of program requirements, it is difficult for programs and educators to innovate and try something new. I think it would be beneficial to design and pilot some innovative models and allow selected universities to pilot them and report back. I would be willing to be a pilot program!
- Global skills are more important than highly specific skills. I can teach social communication in general and it applies to those with autism, those with executive function disorders, those with acquired disorders, those with developmental disorders. If I just teach autism it is much harder to have the generalized skills that are truly an SLPs strengths. Siloed classes are not a good idea and long term will leave even larger gaps in care.
- I am fearful for the graduate students of the move towards tracks and modules and person's enjoyment in the field and thus staying in the field. There is quantitative and qualitative data that graduate SLP students change their areas of interest / degree of interest based on the courses they take and their internships. Asking a graduate student to select if they want to be a pediatric or medical SLP is unfair to that graduate student in light of this data. The courses and internships with children and adults is crucial to helping them make that choice. This also reduces the employment opportunities for new graduates. A new graduate that completed a medical track has fewer opportunities for employment and that is a thought they might not be able to fully process / appreciate when being asked to make this decision. For many SLP professionals the ability to move from one setting to another is what keeps us in the field and having a high level of positive satisfaction in the field. What about the SLP who wants to work in a medical setting with children. Does that SLP go the medical route or the school route? Courses that might be in a medical route or a school route - how do you separate those? Is dysphagia medical or school?
- I am very concerned that doctoral level education is not an option. I understand that CAA does not feel that accrediting SLPD programs is not within their scope. That is not a reason to abandon doctoral discussion. I would encourage the development of more doctoral programs and that is the place to include a track model. ASHA should work with doctoral programs on improving curriculum and goals for doctoral learning. Hold workshops and seminars on doctoral issues. I believe without doctoral programs we are doing a disservice to master's graduates who are now competing with doctoral level health care workers (OT, PT, nursing) in healthcare settings. I think we need to think 10-20 years down the line to see the implications. Can you see any of these professions treading on our scope of practice? How will SLPs move up a career ladder to administrative positions if others hold the doctoral degree? What if regulatory agencies reconsider the type of payment we receive based on level of education and training

when compared to other professions? I would gather data on existing SLPD programs to see how these programs affected the graduates. How did their careers improve or not improve? What more did they learn that they hadn't learned at a master's level? I think these stakeholders may be an untapped source of information.

- I believe we need to examine all levels of education -- pre-entry level, entry-level, CF, and post-entry. Different models for the different levels. For example, lifespan for pre-entry and entry levels; track for CF; and modular for post-entry specialty certification (e.g., residency models)
- I hope this doesn't lead us further down a specialization path.
- I think it would behoove the Next Steps Committee to research even more models of education. For example, could we move to more of a medical school model? I know that several individuals are concerned about the student debt and DEI issues associated with a clinical doctorate. That said, in medical education, only certain pre-requisites are required for admission. There are several doctors who only have their MDs; they do not always have bachelor level degrees. This might help enhance the quality of education and the models while also allaying some of the difficulties that might come with an "advanced" degree. Also, has anyone consulted on how audiology has changed their model? So often, I feel we do not speak to our sister profession and there's a lot we can learn from them. Also, what about more of a case-based/grand rounds model? Would a business/MBA type model work? I feel that there were very limited models provided. I am not in support of the track model. This will only cause more divide in the profession. No longer is there really a difference between a school SLP and a medical SLP. Some individuals just have a chip on their shoulder and a superiority complex. I think that tracks might also lead to other professions taking us less seriously. I like the idea of a lifespan model but only if 1) instructors (both clinical and academic) understand the importance of teaching and learning for ENTRY-level proficiency as well as alternative forms of teaching; and 2) we move to a clinical doctorate. I think that the modular model is interesting; however, I would like more details before completely endorsing it. Again, I think that the modular model could be more like a medical school model. That said, I have trouble motivating my students enough as it is. I also think that being certified in ONLY certain areas has some benefits but also may create problems in areas of need (e.g., rural communities, public schools). Ultimately, I am glad that we are having these conversations for the future of our students, patients, and professions.
- It seems that it may be wiser to not adjust too many variables at once, so you can truly determine the impact of the change you are implementing. The education model is not where I would start. By further siloing information into tracks, our students would lose the perspective of see the person as a whole. The shift would be age or disorder-based and NOT person-centered.
- Perhaps this will be addressed in other discussions, but perhaps the challenge isn't adding more time to the program, but adding time that is taught by skilled clinical educators. Most programs lose at least two semesters with full time placements. I struggle with the idea that students learn more with any supervisor (who now needs a 3-hour class in supervision, but that is it) than time spent with a master educator. Just doing it isn't necessarily learning it, and it isn't necessarily learning it the right way.
- Side note: I know the goal is to not have a facilitator to keep the conversation natural but it's hard when the group veers way off topic to have someone who can bring it back without appearing to be bossy
- Some fields of study have developed open access educational resources. These are modules that can fit into other courses and a possible way of providing supplemental instruction for students needing more time to master knowledge and skills.
- Somewhat interested in the modules but who would teach those modules? How would clinic work with each module? How would an SLP go back to complete a module when working? Is a clinical aspect required?

- This info was the most useful presented to date in this series of webinars.
- This is a great beginning of the conversation but much more time needs to be spent discussing the nuances of the situation.
- To improve availability of externship placements and CFY supervisors, is it possible for ASHA to further incentivize this? Such as, CEU hours offered for taking on a student (a good student-supervisor relationship involves a two-way street of learning)? Or possibly financial stipends (such as a discount on ASHA dues)?
- We do not want to make the critical mistakes made by audiology which increased cost, time and limited accessibility. This is having a severe impact on the field. The career flexibility is something that attracts students to SLP. I would hate to lose this by only having certification in a specific area.
- We need to find a way to stop the deep seated divide in our field of medical versus school SLP and that starts at the university. We also need to work with employers about what to expect about an entry-level SLP.

Appendix D: Competency-Based Education Webinar Survey Results

Ad Hoc Committee to Plan Next Steps to Redesign Entry-Level Education for Speech-Language Pathologists' Next Steps 2022 Summer Webinar Series

Introduction

On June 14, 2022, a survey was made available as part of the Ad Hoc Committee to Plan Next Steps to Redesign Entry-Level Education for Speech-Language Pathologists' Next Steps 2022 Summer Webinar Series on Competency-Based Education. Individuals who participated in the live webinar, as well as those who viewed the recorded session, had the opportunity to complete the survey by August 30. A total of 25 individuals responded to the survey, 24 from the live webinar and one who viewed the recorded session. Responses are presented for all respondents combined.

Results follow. Comments have been lightly edited for spelling and grammar. This report was prepared by ASHA's Surveys and Analysis unit.

Results

1. Which of the following best describes your current ASHA affiliation status? (Check one.)

Response	Percent	Number
ASHA-certified in audiology	4.0	1
ASHA-certified in speech-language pathology	96.0	24
ASHA-certified in both audiology and speech-language pathology	0.0	0
Noncertified member	0.0	0
Clinical Fellow	0.0	0
International affiliate	0.0	0
Speech-language pathology or audiology assistant	0.0	0
Student (undergraduate, graduate or research doctoral)	0.0	0
Other (Specify.)	0.0	0

2. How many years have you been employed? (Check 0 if none.)

Response	Percent	Number
0	0.0	0
1-5	0.0	0
6-10	8.0	2
11-15	24.0	6

16-20	8.0	2
21 or more	60.0	15

3. Which of the following best describes your current primary employment setting? (Check one.)

Response	Percent	Number
Early intervention/ pediatric home health	0.0	0
School (preschool, elementary, etc.)	0.0	0
College/university	92.0	23
Hospital (all types, inpatient and outpatient)	0.0	0
Nonresidential health care facility (clinic, physician's office, etc.)	0.0	0
Residential health care facility (skilled nursing facility, etc.)	0.0	0
Adult home health	0.0	0
Private practice	0.0	0
Agency, organization, or research facility	4.0	1
Industry	0.0	0
In audiology externship and/or clinical practicum	0.0	0
Not employed (student, retired, on leave of absence, etc.)	0.0	0
Other (See below.)	4.0	1

Other responses:

- Pediatric outpatient clinic for medical center

4. What is your current primary employment function? (Check all that apply.)

Response	Percent	Number
Clinical service provider (i.e., audiologist or speech-language pathologist)	12.0	3
College/university academic faculty	56.0	14
College/university clinical faculty	32.0	8
Researcher	0.0	0
Consultant	4.0	1
Administrator/executive officer	4.0	1
Chair/department head/manager	16.0	4
Supervisor of clinical activity	16.0	4
Other director/supervisor	20.0	5
Other (See below.)	4.0	1

Other responses:

- Clinical and academic faculty

Note. Only individuals who selected “college/ university academic faculty” or “college/university clinical faculty” moved on to question 5. All other respondents were automatically skipped to question 6.

5. What is your current faculty rank? (Check one.)

Response	Percent	Number
Lecturer	0.0	0
Assistant professor	17.7	3
Associate professor	52.9	9
Full professor	11.8	2
Other (See below.)	17.7	3

Other responses:

- Adjunct
- Professor Emeritus
- Tenured instructor

6. In what state do you reside?

Response	Percent	Number
Alabama	4.0	1
Alaska	0.0	0
Arizona	8.0	2
Arkansas	4.0	1
California	8.0	2
Colorado	4.0	1
Connecticut	8.0	2
Delaware	0.0	0
District of Columbia	0.0	0
Florida	4.0	1
Georgia	0.0	0
Hawaii	0.0	0
Idaho	0.0	0
Illinois	0.0	0
Indiana	4.0	1
Iowa	4.0	1
Kansas	0.0	0
Kentucky	0.0	0
Louisiana	0.0	0
Maine	0.0	0
Maryland	4.0	1
Massachusetts	4.0	1
Michigan	0.0	0
Minnesota	4.0	1
Mississippi	0.0	0
Missouri	4.0	1
Montana	0.0	0

Nebraska	0.0	0
Nevada	0.0	0
New Hampshire	0.0	0
New Jersey	0.0	0
New Mexico	0.0	0
New York	12.0	3
North Carolina	0.0	0
North Dakota	4.0	1
Ohio	0.0	0
Oklahoma	0.0	0
Oregon	0.0	0
Pennsylvania	4.0	1
Rhode Island	0.0	0
South Carolina	4.0	1
South Dakota	0.0	0
Tennessee	4.0	1
Texas	8.0	2
Utah	0.0	0
Vermont	0.0	0
Virginia	0.0	0
Washington	0.0	0
West Virginia	0.0	0
Wisconsin	0.0	0
Wyoming	0.0	0

7. The current educational model to prepare speech-language pathologists to enter practice is a master's degree (approx. 2 yrs.) comprised of academic and clinical educational experiences covering the full scope of practice across the lifespan. How well is the current educational model working to prepare speech-language pathologists to enter practice?

Response	Percent	Number
Not well at all	8.0	2
Not very well	12.0	3
Somewhat well	72.0	18
Very well	8.0	2
No opinion	0.0	0

8. What is working well? List up to three aspects, each on a separate line. Leave blank if none.

- 2-year degree controls student debt
- Academic coverage of 9 main areas
- Academic learning is paired with clinical learning to develop students' ability to apply knowledge
- Accreditation helps keep programs meeting the same standards but allows for flexibility in how that is accomplished.
- Addition of electives
- Availability
- Because students cannot be exposed to EVERY client and EVERY clinical situation, emphasis is on critical thinking and integration
- Breadth of experiences
- Class to clinic connections
- Clinic practice opportunities
- Clinical experience
- Clinical placements
- Clinical supervision
- Collaboration between clinical and academic faculty
- Content knowledge through classes
- Dependent on the university program and student preparation
- Employers report that they are pleased to hire our graduates
- Entry level clinicians are prepared across the scope of practice for choice in work settings.
- Experiences and education across the scope of practice
- Exposure
- Exposure to the types of diagnoses we encounter
- Flexibility
- For our setting, we interview students in advance - that works well for a pediatric medical center and clinics
- Foundational skills
- Generalist degree with experiences across lifespan
- Generally strong clinical preparation
- Generally strong entry-level knowledge base
- High demand for SLPs
- High graduation and certification rates

- Hours are easy to track
- In built clinical experiences
- Knowledge that addresses development and acquired, educational and medical components
- Most students are introduced to ethics, EBP, scope of practice, etc.
- Most students graduate with basic knowledge in the "Big 9"
- Opportunities
- Piques the interest of students
- Praxis
- Problem based learning
- Requirement for variety in clinical placements and lifespan
- Scaffolded and spiraled clinical curriculum
- Sequencing of academic courses
- Streamlined education minimizes faculty advising/variability
- Students are prepared for basic clinical skills
- Students are supported by the CF experience as they continue to learn by practicing
- Students currently get a lot of theoretical knowledge in academic classes.
- Students have broad exposure to the full scope of practice
- Students have opportunities to develop broad knowledge and clinical skills
- Students learn about disorders, assessment, and treatment across the Big 9 areas
- Students pass Praxis
- Students receive a variety of clinical experiences across the two-year program
- Students show readiness for work settings
- The clinical fellowship
- The clinical fellowship provides the support and depth of training for particular work settings rather than focusing on that at the master's level.
- The requirement for the 450 clock hours
- Training in assessment and treatment
- Training in scope of practice
- University run clinics do a nice job of preparing students early on.
- We have a clinical coordinator who connects on a regular basis with the university coordinator.

9. What is not working well? List up to three aspects, each on a separate line. Leave blank if none.

- 5 semester programs, instead of 6, resulting in deletion of important disordered coursework
- A large focus on school-based services still
- Add courses to align to standards
- Any and all training for dysphagia management--we are not preparing our students well to work in any medical settings
- Anyone can supervise based on continuing education rather than experience teaching
- Assigning clients in a university clinic to students who have not yet taken disorder coursework yet
- Broad generalists with limited specialization
- Cannot fit all the information into the program
- Clinical documentation- hard to teach in a way that works across settings
- Clinical proficiency based on clock hours rather than clinical competencies
- Clinicians lacking basic clinical and soft skills upon graduation
- Cost of education for students is increasing and already burdensome
- Critical thinking across disorders
- Dependence on volunteers to provide clinical supervision in clinical placements

- Difficult to prepare students in competency in dysphagia if there is no medical university attached to the academic program
- Difficulty finding clinical placements
- Disconnects between academic theory and clinical practice
- Education not quite meeting shift in practice from memorizing all to knowing how to think critically and problem solve with available digital resources.
- Equitable clinical instruction- some students might need more hours in certain areas than others
- Expectations to cover information on all Big 9 areas in specific depth
- Faculty burnout
- Focus on amount of hours rather than quality of such
- Full scope of practice is not being consistently covered
- Generalizing skills across clients and settings
- Hard to provide enough experiences across the Big 9 areas
- Hesitancy of SLPs to take students
- Impossible to adequately cover scope of practice in appropriate breadth and depth in two years
- Individualized education is limited in lock-step model
- Insufficient preparation in IPE, cultural competence, critical thinking, billing, ethics
- It is difficult for students to develop depth of knowledge in any area.
- Lack of practicum sites
- Learning all aspects of the scope of practice is nearly impossible in a two-year time frame
- Limited diagnostic opportunities
- Medical sites are often unwilling to hire CFs stating that they need people who are ready to jump in with both feet with less mentoring than what they currently need
- Not enough faculty
- Not enough knee to knee experience
- Not enough placements
- Not enough spaces in programs
- Perceptions of entry-level skills upon graduation from other disciplines
- Praxis exam. Almost 100% of our students pass on the first attempt. I know our program is good, but every student in our program isn't that good. We need a higher bar for the national exam.
- Professional communication
- Reliance on clinicians to volunteer time to support students (with little to no reward or recognition for such)
- Reliance on unpaid community supervisors to take students- can be hard for academic programs to find and guarantee placements to students
- Separating expected development from disordered or different development
- Silo approach to 'communication disorders'
- Some programs minimally cover some of the Big 9 areas, i.e., lectures within a class vs. an entire class on the topic.
- Some students do not have professional accountability.
- Students are not academically prepared for the placement.
- Students are not typically very prepared to navigate the billing side of practice or understand advocacy.
- Students can still graduate with no clinical experience in some areas
- Students graduating with poor critical thinking or soft skills
- Students having difficulty applying critical thinking and clinical decision-making
- Students leaving programs unprepared to practice
- Students may have heavy academic requirements alongside of the clinical placements
- Students report considerable stress throughout their graduate studies

- Students understanding the professional demands of various workplaces
- The clinical clock hour is overly prescriptive and the guidelines seem arbitrary at times for "what counts"
- The cost of graduate school is very high, which may limit programs from adding credits for fear of driving people away due to economic concerns
- The great number of new programs and lack of enrollment caps is putting a huge strain on clinical placements in the community. Some programs have nearly 1,000 online students.
- The role of simulation (e.g., online or standardized patients) and the provision of services via telepractice are not well defined or provided to students.
- The scope of practice is far too large to cover adequately in two years
- There are too many knowledge and skill standard to address in each disorder area for a two-year program.
- Time to teach methods
- Too many hours in one domain or one age group or one setting
- Training students to be generalists in a two-year program is not feasible. Having tracks or an entry level SLPD would be better.
- Two years is too short a time to cover all aspects and make students competent
- Variability in student success in graduate school as well as in their future employment
- Working to hour marks

10. How critical is it to reconsider the educational model for preparing speech-language pathologists to enter practice?

Response	Percent	Number
Not at all critical	0.0	0
Not very critical	0.0	0
Somewhat critical	54.2	13
Very critical	45.8	11
Unsure	0.0	0

11. How critical is the need for change in each of the following areas?

All Respondents	Not at all critical		Not very critical		Somewhat critical		Very critical		Unsure	
	%	#	%	#	%	#	%	#	%	#
Clinical experiential learning	0.0	0	4.2	1	37.5	9	58.3	14	0.0	0
Availability of clinical placements and supervisors	0.0	0	4.2	1	4.2	1	91.7	22	0.0	0
Curricular capacity	0.0	0	8.3	2	29.2	7	58.3	14	4.2	1
Faculty capacity	0.0	0	4.2	1	25.0	6	70.8	17	0.0	0
Faculty development	0.0	0	4.2	1	29.2	7	66.7	16	0.0	0
Faculty sufficiency	0.0	0	0.0	0	20.8	5	79.2	19	0.0	0
Faculty diversity	0.0	0	8.7	2	21.7	5	69.6	16	0.0	0
Student diversity	0.0	0	4.2	1	25.0	6	70.8	17	0.0	0
Instituting a competency-based framework	0.0	0	0.0	0	41.7	10	50.0	12	8.3	2
Preparation for the future of work	0.0	0	0.0	0	20.8	5	79.2	19	0.0	0

Other responses [and criticality]:

- I do think that there is a need for blended program of academics and CBE. [Very critical]
- Many programs are trying to implement competency-based approaches but doing so within the traditional academic structure is not easy. [Somewhat critical]

12. What is the most critical thing the Ad Hoc Committee needs to know to implement competency-based education?

- Although I am hesitant to identify just one critical thing, I would say faculty professional development.
- Difficulty incorporating competency -based into semester system
- Faculty knowledge and experience
- Faculty will need a LOT of examples and CEU training to implement this in their classes. Some are already doing it, but many are not (unless passing a mid-term and final exam counts as CBE...which I don't think it does)
- How ASHA will support programs in learning about, implementing, and having the bandwidth to institute any substantive changes
- How do we educate faculty and external supervisors/preceptors on CBE and how to implement it?
- How to measure and how to make it work for a diverse group of students who are very different in their learning
- If we move to this model, guidelines for competency assessment will be KEY. Programs should not be expected to develop all aspects.
- Implementing competencies across the Big 9. It will be very hard to demonstrate competencies for all areas.
- Importance of using culturally-responsive (anti-racist) lens in designing and implementing competency-based education.
- It should not result in "watered-down" education for our future SLPs and AUDs; it should replace an outdated, inefficient method of clinical education. Medical speech-language pathology has seen a large uptick in medically complex patients, especially during and following the pandemic. We need to ensure that our students are prepared for this challenge.
- Provide strong and easily accessible educational programs on competency-based education to get wide-spread support and effective implementation
- Shift to CBE will be new change that will require a gradual roll out to support the learning curve of faculty and students who are not accustomed to this model.
- Significant training for and reimagining the work load of academic, clinical, and preceptor faculty will be key.
- The core competencies addressing both academic and clinical skills to prepare students for entry into the profession as lifelong learners that will continue their more in depth specializations as they learn and grow.
- The current model of education is not entirely broken but it has its limitations. Not every new graduate is competent to work in a school with the diverse population; not every graduate is competent to work in a hospital and perform swallow studies. Not every new graduate is a good voice therapist. If we move towards a competency-based model, it will need to be clearly defined what "entry-level" competency is from both academic as well as work-setting perspectives. A consensus will have to be determined and then, both educational and clinical professionals will have to be mindful of this in order to truly educate students to be competent across or within work settings.
- The discrepancies between data reporting for different boards is maddening for departments, and this takes critical resources away from student education. Streamlining how boards work together and expectations is critical to promoting any change.

- There are many challenges -- cost, limited time, limited faculty bandwidth. Our best bet would be to apply what we can from our allied health colleagues who are already doing this (such as embedding more practical education into undergraduate coursework like in nursing) and to team up with allied health programs already doing competency-based education (which would promote interprofessional education).
- There is inadequate preparation for SLP students in audiology and hearing loss.
- This is going to be a huge change that will require support and advocacy from a national level. Faculty, external supervisors, and all stake holders can't be expected to overhaul their systems without support and resources from ASHA and state organizations. This change will take time, and I worry that it will stretch already scarce resources.
- We should look to other countries that have implemented this successfully.
- We use competencies in our university, but the ratings or definitions of what is a 3 versus a 5, for example, varies from supervisor to supervisor. For the CBE to be effective, I think the ratings of competency need to be as objective as possible.
- What level of skill determines competency and who determines the level?

13. What other information do you want to share with the Ad Hoc Committee about competency-based education? Leave blank if none.

- Cost (human and financial) to transition to CBE curriculum.
- Determining competencies for different practice settings and for specific populations
- I think this is necessary in the field and will help streamline the current standards (from CAA and CFCC).
- If the goal is to graduate more entry level SLPs, this needs to HELP rather than burden academic programs.
- I'm glad that action is being taken to look at this.
- In competency-based system, student moves ahead at their pace. This means that courses need to be available in a just-in-time format.
- In our meeting last night, someone referenced having a "school SLP" designation and a "Med SLP" designation with respect to competency assessments. I don't think that is appropriate. I also think it would be wise to take advantage of undergraduate years to allow students to earn some hours/competencies in order to avoid requiring a clinical doctorate.
- More about the model; examples
- Our discipline needs well defined, measurable competencies as models. We also need to have evidence-based, reliable and valid ways to measure competencies.
- There are going to need to be very clear guidelines, that also take into consideration constraints of graduate programs that confer degrees.
- There are great models to follow in other disciplines and globally so not reinventing the wheel, but buy in will be affected if changes are not accompanied by strong and free access to education and networking.
- Time, money, and people are going to be the most difficult factors to consider if the profession moves to a competency model. Frankly, although I recognize that the purpose of this meeting is not to discuss or address the academic degree, I do not know that the AHC is realistic on moving to a competency based model without considering a doctorate-level degree akin to our fellow rehabilitation professions (PT, OT, and AUD). There is already so little time to address what we need to in the current model. Also, I'm not too sure that we aren't already doing some CBE; as one colleague mentioned, this is "knowledge and skills" in a new dress. Also, the caliber of students is not the same. We already address student anxiety, imposter syndrome, and so on. Making CBE more mandatory may only increase problems as students will feel like they have more "tests" to complete.

- Use the COMPASS model as a guide, do not reinvent the wheel. Which competencies are important and need to be part of the curriculum and who decides? There isn't enough time to teach students to competence in every clinical area or skill. Which competencies must be covered and which are excluded? How competent is competent? Is a satisfactory performance passing or must all students be able to do the skills independently at superior levels? Again, who will decide this?

14. What is your level of readiness to change to a competency-based education model?

Response	Percent	Number
Not at all ready	8.0	2
Not very ready	16.0	4
Somewhat ready	36.0	9
Very ready	36.0	9
Unsure	4.0	1

15. What is your level of interest in moving to a competency-based education model for graduate training in SLP?

Response	Percent	Number
Not at all interested	0.0	0
Not very interested	0.0	0
Somewhat interested	32.0	8
Very interested	64.0	16
Unsure	4.0	1

16. How knowledgeable are you about competency-based education?

Response	Percent	Number
Not at all knowledgeable	8.0	2
Not very knowledgeable	24.0	6
Somewhat knowledgeable	56.0	14
Very knowledgeable	12.0	3
Unsure	0.0	0

17. Have we addressed the most critical issues—specific to this webinar topic of competency-based education—from your perspective?

Response	Percent	Number
Yes	68.0	17
No	32.0	8

18. If no, what other issue(s) should be addressed? List up to 3, each on a separate line.

- A realistic framework for competency across the lifespan and work settings
- Assurance of streamlined management of accreditation process

- Current CFCC and CAA standards are broad and provide programs with a lot of flexibility to meet the standards in many different ways. (In some cases the standards are little too flexible). How can this be implemented in a flexible way that will ensure buy-in from programs?
- Examples of assessment
- How to determine competencies
- How to educate faculty and supervisors and get buy-in
- I don't know that you can address the most critical issues yet since this is early in discussion. This webinar got the conversation going! Raised many questions that would need to be addressed.
- I would have liked more information on what CBE and examples of how competencies could be addressed in a master's program.
- Increases to program length. Most public universities are under strict mandates to limit credit hours in graduate programs.
- Lack of clinical placements in certain practice areas that might be linked to learning specific competencies (i.e., trachs and vents)
- Managing time and resources in education
- Need detailed examples of courses structured with CBE
- Need detailed examples of programs using CBE
- Need to see model/example of students who have participated in CBE programs
- Proposals for discussion/consideration as a place to begin
- What all is involved in planning and implementing CBE

19. Please provide any other comments that you would like to share with the Ad Hoc Committee to Plan Next Steps to Redesign Entry Level Education for SLPs.

- I am sorry to say but I felt the presentation on this topic was rather empty. It would have been nice to have something to work with rather than a flash of resources that were considered...considered in what way, how do you apply these?
- I think that it is important that we have this discussion. I think our profession is great; however, I think we are still in a rut of wanting to be health care but have the flexibility of education. Should we or should we not expect persons entering the profession to be competent? We should; however, our current model does not promote that for any setting or specific skill. I am not arguing that there aren't some benefits from the logistic side of things about our current model. I also am not implying that one setting is better or more difficult than others (e.g., medical versus school). I am, however, suggesting that competencies need to be better defined as well as given some thought about how to assess these for entry-level professionals rather than those with 5 to 10 years' experience.
- In our small group break out, we discussed how the CF is often misunderstood by professionals outside of SLP/AUD. Oftentimes, employers look for someone who needs little to no supervision, which isn't the case for new graduates. I wish we had some way of standardizing competencies (perhaps in the way of OSCEs). Again, I worry about adding more to the plates of faculty and supervisors who are already stretched thin.
- It seems that drawing from work other allied health fields and other countries have done would make sense.
- Many SLP graduate programs are increasing their student capacity. Clinically-based CBE assignments and assessments are usually more time-consuming than just giving a multiple choice exam. How will programs with large student cohorts implement this type of student assessment?
- Once strategy is to identify a few core competencies to work on first. That might be more workable than trying to move everything to a competency based model at once.
- Sharing more information and research

- The 30-minute presentation was a good intro/overview. More in-depth information on How to develop and implement CBE, get faculty and clinical buy-in, and what the timeline would be would all be helpful as next steps.
- You need to provide models of what this would look like. Discuss other programs (fields) that have incorporated this and discuss advantages and disadvantages

Appendix E: Faculty Growth and Sufficiency Webinar Survey Results

Ad Hoc Committee to Plan Next Steps to Redesign Entry-Level Education for Speech-Language Pathologists' Next Steps 2022 Summer Webinar Series

Introduction

On June 28, 2022, a survey was made available as part of the Ad Hoc Committee to Plan Next Steps to Redesign Entry-Level Education for Speech-Language Pathologists' Next Steps 2022 Summer Webinar Series on Faculty Growth and Sufficiency. Individuals who participated in the live webinar, as well as those who viewed the recorded session, had the opportunity to complete the survey by August 30. A total of 14 individuals responded to the survey, 12 from the live webinar and two who viewed the recorded session. Responses are presented for all respondents combined.

Results follow. Comments have been lightly edited for spelling and grammar. This report was prepared by ASHA's Surveys and Analysis unit.

Results

1. Which of the following best describes your current ASHA affiliation status? (Check one.)

Response	Percent	Number
ASHA-certified in audiology	14.3	2
ASHA-certified in speech-language pathology	78.6	11
ASHA-certified in both audiology and speech-language pathology	0.0	0
Noncertified member	0.0	0
Clinical Fellow	7.1	1
International affiliate	0.0	0
Speech-language pathology or audiology assistant	0.0	0
Student (undergraduate, graduate or research doctoral)	0.0	0
Other (Specify.)	0.0	0

2. How many years have you been employed? (Check 0 if none.)

Response	Percent	Number
0	7.1	1
1-5	7.1	1
6-10	7.1	1
11-15	0.0	0
16-20	14.3	2
21 or more	64.3	9

3. Which of the following best describes your current primary employment setting? (Check one.)

Response	Percent	Number
Early intervention/ pediatric home health	0.0	0
School (preschool, elementary, etc.)	0.0	0
College/university	92.3	12
Hospital (all types, inpatient and outpatient)	7.7	1
Nonresidential health care facility (clinic, physician's office, etc.)	0.0	0
Residential health care facility (skilled nursing facility, etc.)	0.0	0
Adult home health	0.0	0
Private practice	0.0	0
Agency, organization, or research facility	0.0	0
Industry	0.0	0
In audiology externship and/or clinical practicum	0.0	0
Not employed (student, retired, on leave of absence, etc.)	0.0	0
Other (Specify.)	0.0	0

4. What is your current primary employment function? (Check all that apply.)

Response	Percent	Number
Clinical service provider (i.e., audiologist or speech-language pathologist)	7.7	1
College/university academic faculty	69.2	9
College/university clinical faculty	30.8	4
Researcher	15.4	2
Consultant	0.0	0
Administrator/executive officer	7.7	1
Chair/department head/manager	30.8	4
Supervisor of clinical activity	15.4	2
Other director/supervisor	7.7	1
Other (Specify.)	0.0	0

Note. Only individuals who selected “college/ university academic faculty” or “college/university clinical faculty” moved on to question 5. All other respondents were automatically skipped to question 6.

5. What is your current faculty rank? (Check one.)

Response	Percent	Number
Lecturer	0.0	0
Assistant professor	22.2	2
Associate professor	22.2	2
Full professor	33.3	3
Other (See below.)	22.2	2

Other responses:

- Professor Emerita
- Senior Instructor

6. In what state do you reside?

Response	Percent	Number
Alabama	7.7	1
Alaska	0.0	0
Arizona	0.0	0
Arkansas	0.0	0
California	7.7	1
Colorado	0.0	0
Connecticut	0.0	0
Delaware	0.0	0
District of Columbia	0.0	0
Florida	7.7	1
Georgia	0.0	0
Hawaii	0.0	0
Idaho	0.0	0
Illinois	0.0	0
Indiana	7.7	1
Iowa	15.4	2
Kansas	0.0	0
Kentucky	0.0	0
Louisiana	0.0	0
Maine	0.0	0
Maryland	7.7	1
Massachusetts	0.0	0
Michigan	0.0	0
Minnesota	0.0	0
Mississippi	0.0	0
Missouri	0.0	0
Montana	0.0	0
Nebraska	0.0	0

Nevada	0.0	0
New Hampshire	0.0	0
New Jersey	7.7	1
New Mexico	0.0	0
New York	7.7	1
North Carolina	0.0	0
North Dakota	0.0	0
Ohio	0.0	0
Oklahoma	0.0	0
Oregon	0.0	0
Pennsylvania	0.0	0
Rhode Island	0.0	0
South Carolina	7.7	1
South Dakota	0.0	0
Tennessee	0.0	0
Texas	7.7	1
Utah	0.0	0
Vermont	0.0	0
Virginia	15.4	2
Washington	0.0	0
West Virginia	0.0	0
Wisconsin	0.0	0
Wyoming	0.0	0

7. The current educational model to prepare speech-language pathologists to enter practice is a master's degree (approx. 2 yrs.) comprised of academic and clinical educational experiences covering the full scope of practice across the lifespan. How well is the current educational model working to prepare speech-language pathologists to enter practice?

Response	Percent	Number
Not well at all	7.7	1
Not very well	15.4	2
Somewhat well	69.2	9
Very well	7.7	1
No opinion	0.0	0

8. What is working well? List up to three aspects, each on a separate line. Leave blank if none.

- Admissions/applicant numbers
- Aphasia introduction
- Breadth of content
- Clinical hands on experience
- Employment rates
- Exposure to primary, fundamental concepts
- Flexibility in actual practicum experiences
- Having two 10- to 12-week full time internships
- Infusing EBP
- Language development
- Master's graduates are broadly prepared
- Nearly all students complete our program
- Numerous professional development opportunities to take a master-level trained person with an interest in a specialty to gain knowledge and experience to then teach graduate course in that area of specialty
- Passionate learners
- Praxis pass rates
- Program is completed within reasonable number of semesters
- Providing students with generalist training that allows students to pursue careers in medical or school settings - many skills do serve as a foundation for both settings and across disorder areas and ages
- Related to faculty sufficiency, several of our recent graduates have completed or are in PhD programs
- The pool for master's level is good
- There is continued interest in the field

9. What is not working well? List up to three aspects, each on a separate line. Leave blank if none.

- Adequately covering all areas of scope of practice
- Applicant pools for faculty positions are very small
- Cannot always hire in specific areas of expertise
- Consider clinical doctorate as doctoral level
- Difficult to get clinical externships
- Diversity of both faculty and students is low
- Dominance of pediatric-based topics
- Faculty numbers
- Increasing diversity of faculty
- Increasing diversity of student body
- Lack of faculty who are BOTH clinically and academically competent
- Need competency based assessment of student skills not just knowledge
- Need for more than 50% doctoral level
- No support from university to grow own PhD faculty
- Not enough faculty
- Outdated curriculum
- Percent of PhD required on staff
- Poor integration of research into clinical practice
- Poor salaries to support extra education
- Poor salary
- Reduced availability of internship / externship sites and supervisors
- Related to faculty growth and sufficiency, the PhD shortage plays a major role in the preparation of future speech-language pathologists. Smaller programs, including those at teaching-focused universities often struggle to recruit and hire PhD-level faculty.
- Should not take longer than 5-6 semesters to obtain master's degree
- Student and faculty diversity
- Student funding
- Too many new graduate SLP programs being accredited

10. How critical is it to reconsider the educational model for preparing speech-language pathologists to enter practice?

Response	Percent	Number
Not at all critical	0.0	0
Not very critical	0.0	0
Somewhat critical	50.0	6
Very critical	41.7	5
Unsure	8.3	1

11. How critical is the need for change in each of the following areas?

All Respondents	Not at all critical		Not very critical		Somewhat critical		Very critical		Unsure	
	%	#	%	#	%	#	%	#	%	#
Clinical experiential learning	0.0	0	9.1	1	54.6	6	36.4	4	0.0	0
Availability of clinical placements and supervisors	0.0	0	9.1	1	18.2	2	72.7	8	0.0	0
Curricular capacity	9.1	1	0.0	0	27.3	3	63.6	7	0.0	0
Faculty capacity	9.1	1	0.0	0	0.0	0	81.8	9	9.1	1
Faculty development	9.1	1	18.2	2	0.0	0	63.6	7	9.1	1
Faculty sufficiency	0.0	0	9.1	1	9.1	1	72.7	8	9.1	1
Faculty diversity	0.0	0	18.2	2	9.1	1	63.6	7	9.1	1
Student diversity	0.0	0	18.2	2	27.3	3	45.5	5	9.1	1
Instituting a competency-based framework	0.0	0	10.0	1	40.0	4	50.0	5	0.0	0
Preparation for the future of work	0.0	0	9.1	1	36.4	4	54.6	6	0.0	0

Other responses [and criticality]:

- I have heard discussions about changes to make (alternative delivery model webinar) to graduate education. I would like this group and ASHA to also consider changes to undergraduate education. The undergraduate degree in communication sciences and disorders is not preparing many students for a graduate program and changes also need to happen there. [Very critical]

12. If you are at a research institution that offers a research doctoral degree, what student-centered practices does your doctoral program implement? (Check all that apply.) Leave blank if you are not at a research institution that offers a research doctoral degree.

Response (<i>n</i> = 3)	Percent	Number
Flexibility (e.g., able to work outside program)	66.7	2
Part-time option	66.7	2
Remote options	66.7	2
Strong mentoring (e.g., recognize individual and professional interests, regular conversations with faculty advisors, development plan)	66.7	2

13. Which of the following approaches does your university/program use to meet master's SLP curricular needs across the full scope of practice? (Check all that apply.) [Excludes respondents who are not in a college/university setting.]

Response	Percent	Number
Shared coursework (through grants, interdepartmental collaborations)	16.7	2
Institutional collaborations or partnerships	33.3	4
Courses taught by off-campus experts (local or remotely based)	66.7	8
Simulations, standardized patients	83.3	10
Other (See below.)	16.7	2

Other responses:

- Employ faculty across multiple areas of the discipline
- Faculty sufficiency is fine where I am at

14. Give us your best solution, real or imagined, to maximize faculty resources for master's SLP education.

- Before the webinar, I was not aware that programs were providing shared coursework and engaging in institutional partnerships. I can see many logistical barriers in developing these opportunities and partnerships, and think it would be extremely helpful to discuss--on a large scale!--where these things are working well so that other faculty and programs can consider how to implement in their contexts. Awareness is the first step, and then learning about successful models would help other programs create similar opportunities.
- Clinical experts
- Collaboration, IPE
- Fewer restrictions on number of faculty who teach
- Have a directory of qualified individuals who are available to teach a course although not employed full time in academic setting
- I think that a "grow your own" model is best. Programs should intentionally assess students who have good clinical potential as well as academic/research potential to then groom and mentor for doctoral-level study. They could offer them jobs that are contingent upon completing a terminal (PhD or EdD) degree. However, I do not think that all terminal degreed faculty are always prepared adequately for clinical instruction or supervision. As such, we cannot negate that the ideal faculty member is a master clinician, an expert at specific areas of research, and is a master teacher. To truly empower and continue to promote the field of SLP, faculty members must be all three. In my experience, however, faculty members often have only one of these attributes (often master clinicians or research experts). I know that a few propose that we should allow clinical doctorate to suffice. There are several benefits to this. It would likely be more appealing and realistic for the majority of persons in the profession who want to have a career in academia. Also, it would emphasize that our main goal is clinical practice. At the same time, I must argue that such a decision would have dire consequences. We have to acknowledge that the clinical doctorate is likely to become the entry-level degree for clinical practice. As such, we will only run into this problem again. Also, the infrastructure of most USA universities insist that a PhD or EdD are the degrees necessary for leadership and administration positions. As such, promoting the clinical doctorate would be limiting our field for possible tenure, promotion, and opportunities. I honestly feel that in terms of faculty resources, we are going to have to find a way to bridge clinicians to academics using training, information, and hybrid programs. Would it be feasible to start a subspecialty in the field regarding educating other SLPs? Nursing has had master-level nurse educators for years now. I also think that more training on how to teach and become an academic is imperative.
- Lower the percentage of academic courses that must be taught by PhD or EdD faculty for accreditation
- Many SLPD programs have a teaching component. Thus you have people who have expertise in clinical areas, knowledge and application of EBP, knowledge base to supervise, and the ability to teach
- Modification of the percentage needed for PhD and MS faculty to allow more flexibility
- Not adding additional degrees
- The group that I was in did not come up with solutions.
- Work with universities to allow practicing clinicians without a PhD to teach graduate level courses

15. Have we addressed the most critical issues—specific to this webinar topic of faculty growth and sufficiency—from your perspective?

Response	Percent	Number
Yes	53.9	7
No	46.2	6

16. If no, what other issue(s) should be addressed? List up to 3, each on a separate line.

- Climate in SLP graduate programs needs to be positive so students want to work in higher education
- I appreciate the focus on flexibility and part-time/remote options and think these are important; however, until we, as a field, recognize and VALUE various types of research and work as important, we will continue to recruit and support "traditional" PhDs. It is, of course, important that PhD programs prepare researchers; however, we also need to be preparing teachers and clinical supervisors of the same caliber. Teaching and supervision are vital to the preparation of future speech-language pathologists. Until our field recognizes SoTL as a valuable research area, we will be missing out on folks who are interested in getting their PhD. These individuals receive messaging (whether explicit or implicit) that becoming high-quality teachers/supervisors/ SoTL researchers "is not what PhD programs are about--they're about research." We need to value teaching/supervision/ SoTL and support individuals who are passionate about this work in PhD programs and in their work as junior faculty.
- Lack of university/college support to increase faculty ratios
- Mentorship programs for practicing clinicians or recent grads to direct them to PhD programs
- Should there be a distinction between clinical and academic faculty?
- You need to bring the issue of SLPD into the discussion

17. Please provide any other comments that you would like to share with the Ad Hoc Committee to Plan Next Steps to Redesign Entry Level Education for SLPs.

- Allow for pediatric/adult or medical/educational tracts
- Exposure to variety of work settings for graduates.
- I suggest that SLP learn from the somewhat failed model of the AuD to better address entry-level education without making it unsustainable for students or programs.
- I think these talks are so interesting and beneficial. Our field has to change. To be frank, I feel that the DEI movement has masked other major concerns about our field. The fact that we are not paid like other rehabilitation specialists, sometimes purely due to the letters behind our names (master's versus doctorate) as well as the old "pumps and pearls" stereotypes that SLP is not a real health care profession but one in which educated women (and a few men) can be the hybrid of a teacher and a health worker but never have the responsibility of either. The problem is that our profession has changed so much in the past 30 years. Per this webinar series, we have done next to nothing to change with the times in almost 60 years. That is a problem. Kudos to this committee and thanks for their hard work. I will argue that SLPs and their organizations are going to have to decide: do we want what is best for our students, our patients, and our profession? I promise you: no one is asking "Oh, we have to worry about student debt," or "Life is so hard for young adults now" in the law schools or medical schools. Why should we be any different? I am all for more of a professional school model (such as medicine, pharmacy, nursing, business) rather than the current one. I also recognize as a minority and first-generation student that there have to be more students supports without compromising integrity and rigor. Not everyone who wants something should achieve it. I'm not saying that these are simple solutions and with every change, different problems arise. I am arguing, however, that as the AHC assesses and analyzes these trends towards the Next Steps, they also advocate for realistic change and rigorous change. This is at the student, faculty, and registration/licensure/credentialing levels. I am sometimes surprised: for our profession to be the experts in communication, have we even reached out to other professions to know what might work for us in the future?

- Nearly all programs will have some faculty teaching a course or two outside their primary area of expertise. Creating some open educational resources on needed topics would support those faculty.
- SLPD should hold faculty positions and many already do. They bring a skill set that others may not- knowledge of teaching, ability to supervise, strong clinical skills which are research-based.

Appendix F: Faculty Development Webinar Survey Results

Ad Hoc Committee to Plan Next Steps to Redesign Entry-Level Education for Speech-Language Pathologists' Next Steps 2022 Summer Webinar Series

Introduction

On July 19, 2022, a survey was made available as part of the Ad Hoc Committee to Plan Next Steps to Redesign Entry-Level Education for Speech-Language Pathologists' Next Steps 2022 Summer Webinar Series on Faculty Development. Individuals who participated in the live webinar, as well as those who viewed the recorded session, had the opportunity to complete the survey by August 30. A total of 10 individuals responded to the survey, all from the live webinar. Responses are presented for all respondents combined.

Results follow. Comments have been lightly edited for spelling and grammar. This report was prepared by ASHA's Surveys and Analysis unit.

Results

1. Which of the following best describes your current ASHA affiliation status? (Check one.)

Response	Percent	Number
ASHA-certified in audiology	0.0	0
ASHA-certified in speech-language pathology	100.0	10
ASHA-certified in both audiology and speech-language pathology	0.0	0
Noncertified member	0.0	0
Clinical Fellow	0.0	0
International affiliate	0.0	0
Speech-language pathology or audiology assistant	0.0	0
Student (undergraduate, graduate or research doctoral)	0.0	0
Other (Specify.)	0.0	0

2. How many years have you been employed? (Check 0 if none.)

Response	Percent	Number
0	0.0	0
1-5	0.0	0
6-10	10.0	1
11-15	10.0	1
16-20	20.0	2
21 or more	60.0	6

3. Which of the following best describes your current primary employment setting? (Check one.)

Response	Percent	Number
Early intervention/ pediatric home health	0.0	0
School (preschool, elementary, etc.)	0.0	0
College/university	77.8	7
Hospital (all types, inpatient and outpatient)	22.2	2
Nonresidential health care facility (clinic, physician’s office, etc.)	0.0	0
Residential health care facility (skilled nursing facility, etc.)	0.0	0
Adult home health	0.0	0
Private practice	0.0	0
Agency, organization, or research facility	0.0	0
Industry	0.0	0
In audiology externship and/or clinical practicum	0.0	0
Not employed (student, retired, on leave of absence, etc.)	0.0	0
Other (Specify.)	0.0	0

4. What is your current primary employment function? (Check all that apply.)

Response	Percent	Number
Clinical service provider (i.e., audiologist or speech-language pathologist)	22.2	2
College/university academic faculty	55.6	5
College/university clinical faculty	22.2	2
Researcher	22.2	2
Consultant	0.0	0
Administrator/executive officer	0.0	0
Chair/department head/manager	44.4	4
Supervisor of clinical activity	11.1	1
Other director/supervisor	0.0	0
Other (Specify.)	0.0	0

Note. Only individuals who selected “college/ university academic faculty” or “college/university clinical faculty” moved on to question 5. All other respondents were automatically skipped to question 6.

5. What is your current faculty rank? (Check one.)

Response	Percent	Number
Lecturer	0.0	0
Assistant professor	20.0	1
Associate professor	60.0	3
Full professor	20.0	1
Other (Specify.)	0.0	0

6. In what state do you reside?

Response	Percent	Number
Alabama	0.0	0
Alaska	0.0	0
Arizona	0.0	0
Arkansas	0.0	0
California	22.2	2
Colorado	0.0	0
Connecticut	0.0	0
Delaware	0.0	0
District of Columbia	0.0	0
Florida	0.0	0
Georgia	0.0	0
Hawaii	0.0	0
Idaho	0.0	0
Illinois	0.0	0
Indiana	0.0	0
Iowa	0.0	0
Kansas	0.0	0
Kentucky	0.0	0
Louisiana	0.0	0
Maine	0.0	0
Maryland	0.0	0
Massachusetts	0.0	0
Michigan	0.0	0
Minnesota	0.0	0
Mississippi	0.0	0
Missouri	0.0	0
Montana	0.0	0
Nebraska	0.0	0

Nevada	0.0	0
New Hampshire	0.0	0
New Jersey	0.0	0
New Mexico	0.0	0
New York	11.1	1
North Carolina	0.0	0
North Dakota	0.0	0
Ohio	11.1	1
Oklahoma	11.1	1
Oregon	0.0	0
Pennsylvania	22.2	2
Rhode Island	0.0	0
South Carolina	0.0	0
South Dakota	0.0	0
Tennessee	0.0	0
Texas	11.1	1
Utah	0.0	0
Vermont	0.0	0
Virginia	11.1	1
Washington	0.0	0
West Virginia	0.0	0
Wisconsin	0.0	0
Wyoming	0.0	0

7. The current educational model to prepare speech-language pathologists to enter practice is a master's degree (approx. 2 yrs.) comprised of academic and clinical educational experiences covering the full scope of practice across the lifespan. How well is the current educational model working to prepare speech-language pathologists to enter practice?

Response	Percent	Number
Not well at all	0.0	0
Not very well	22.2	2
Somewhat well	66.7	6
Very well	11.1	1
No opinion	0.0	0

8. What is working well? List up to three aspects, each on a separate line. Leave blank if none.

- Adapting to telepractice and using virtual platforms
- ASHA acknowledges the need for growth mindsets and infusion of cultural humility
- CAA accreditation
- Can cover basic content
- CFY
- Clinical hours required
- Exposure to depth and breadth of fundamental skills
- Flexibility in means to assess competency
- Focus on functional application of fundamental skills
- Foundational knowledge
- I've answered this question 5-6 times before :)
- SLPS change lives
- Students are receiving preparation for school setting.
- Therapists are graduating with some knowledge.
- Time for clinical training
- Time to graduation and employment
- Use of clinical staff

9. What is not working well? List up to three aspects, each on a separate line. Leave blank if none.

- Balancing programs across the lifespan with diversity
- Equal supervision for easy and hard skills
- Faculty diversity
- Faculty with fixed mindsets and chairs who say, this is how we always done it.
- Hard for students to grasp all content equally well
- Inability to discuss or focus on relevant clinical issues (e.g., billing, writing for reimbursement versus an academic assignment)
- I've answered this question 5-6 times before :)
- Lack of clinical knowledge
- Lack of clinical tracing sites with growing number of programs
- Lack of recognition of integrated content

- Lack of specialization
- Mentoring
- No incentive
- Online education
- Perception that some skills or domains are more important than others
- Poor research support
- Student diversity
- Students are not equipped to document about evidence based practice.
- Students are not prepared for medical settings.
- Students are not prepared to evaluate and treat dysphagia.
- Time to integrate added knowledge requirements into program and courses
- Too little time in each domain/emphasis/work setting

10. How critical is it to reconsider the educational model for preparing speech-language pathologists to enter practice?

Response	Percent	Number
Not at all critical	0.0	0
Not very critical	11.1	1
Somewhat critical	33.3	3
Very critical	55.6	5
Unsure	0.0	0

11. How critical is the need for change in each of the following areas?

All Respondents	Not at all critical		Not very critical		Somewhat critical		Very critical		Unsure	
	%	#	%	#	%	#	%	#	%	#
Clinical experiential learning	0.0	0	0.0	0	28.6	2	71.4	5	0.0	0
Availability of clinical placements and supervisors	0.0	0	0.0	0	0.0	0	100.0	7	0.0	0
Curricular capacity	0.0	0	0.0	0	42.9	3	57.1	4	0.0	0
Faculty capacity	0.0	0	0.0	0	14.3	1	85.7	6	0.0	0
Faculty development	0.0	0	0.0	0	28.6	2	71.4	5	0.0	0
Faculty sufficiency	0.0	0	0.0	0	14.3	1	85.7	6	0.0	0
Faculty diversity	0.0	0	14.3	1	28.6	2	57.1	4	0.0	0
Student diversity	0.0	0	0.0	0	42.9	3	57.1	4	0.0	0
Instituting a competency-based framework	0.0	0	0.0	0	57.1	4	42.9	3	0.0	0
Preparation for the future of work	0.0	0	0.0	0	42.9	3	57.1	4	0.0	0

Other responses [and criticality]:

- Thank you for caring! [Very critical]

12. Describe ways that SoTL is supported and implemented by your department/program.

- ACUE opportunities through the university system. Discussion and sharing of ideas for how to assess/organize/teach courses. Review of outcomes and objectives. Most PhDs have taken some sort of pedagogy course.
- Can have assigned time to engage in SoTL
- General encouragement for improving student teaching and learning.
- Grant funding for SoTL research. Travel funding for CEUs and/or presentation of SoTL.
- Journal clubs, professional development monies
- Learning across disciplines; IPP/IPE
- University colloquium. University learning opportunities and support.
- Updating course(s) as one item toward tenure.

13. Does your institution recognize scholarly contributions in teaching and learning for promotion and tenure decisions?

Response	Percent	Number
Yes	100.0	7
No	0.0	0

14. Describe how scholarly contributions in teaching and learning are recognized by your institution.

- At our institution, we focus on students. Anything that enhances student experiences is considered viable and respectable for the university's mission. We also look at scholarly activity (e.g., presentations, consultation) rather than just publications and traditional research.
- Complete a yearly faculty decision report
- Counts as research if research.
- Counts in area of 'Teaching'.
- More opportunities
- Promotion docs. Merit. Teaching awards
- Service contributions - journal editor, specialty training as it relates to teaching (our university is 60% teaching)
- Teaching weighted most heavily in RPT vs. research, Center for Teaching and Learning, grants to support educational activities, release time for course development/revision

15. Describe any formal faculty mentoring initiatives that exist for your faculty. (Leave blank if none.)

- All faculty have in house mentors.
- New faculty assigned mentor from other department or college.
- There is nothing formal. As a small faculty, we regularly discuss teaching and learning.

16. Have we addressed the most critical issues—specific to this webinar topic of the faculty development—from your perspective?

Response	Percent	Number
Yes	50.0	4
No	50.0	4

17. If no, what other issue(s) should be addressed? List up to 3, each on a separate line.

- CAA and ASHA support for manageable workload for faculty.
- Certification/specialization/ etc. for SoTL
- Clinical educators understanding that they are no longer "supervisors;" students require instruction rather than the ability to walk in and take a job.
- Faculty needs to know and understand current job descriptions and expected roles/responsibilities for SLPS
- Faculty needs to know what is expected of SLPs from third party payors
- How do you fund these efforts? Tons of research money (well, comparatively) but almost nothing for SoTL, teaching quality/training
- Preparing academic educators versus clinical educators
- Teaching is a skill set that not everyone has or can master. Just because you are a great clinician does not make you a "shoe-in" for teaching.
- Varying faculty into SLP programs with other healthcare science degrees

18. Please provide any other comments that you would like to share with the Ad Hoc Committee to Plan Next Steps to Redesign Entry Level Education for SLPs.

- Competency based education and clinicals
- I feel that there needs to be more consensus and agreement about teaching in our disciplines (SLP and AuD). First, we need to acknowledge that clinical instruction is not "clinical supervision." There needs to be more realistic opportunities as well as expectations for clinical educators who take students to teach and train these soon-to-be graduates rather than just "throw them to the wolves" or "sink or swim." We need to provide resources to these individuals. Also, I think that there needs to be more of an understanding that not everyone is supposed to be a teacher or faculty member. Again: it is a separate skill set. I think that PhD programs should incorporate more pedagogy based courses and balance those with research/methods courses. I am not too sure that we shouldn't start "teaching how to teach" to our students in graduate school. Other disciplines (e.g., nursing) have specific sub disciplines that they can specialize in order to train future professionals. Could we do something similar? I think that it is imperative that ASHA strive to inform and educate that teaching and faculty is not "just the next step" in an important clinical career.
- I feel these two comments are critical. 1. SLP is a health science, but the teaching and training is inadequate for a health device major. 2. The "pathology" part of our title indicates we study diseases and disorders. Better faculty and student education and training is needed to maintain such title or it should be officially changed to therapist or tech, otherwise we are misrepresenting ourselves as a profession.
- This topic seemed more ambiguous to our group in comparison to previous.

Appendix G: Student Diversity Webinar Survey Results

Ad Hoc Committee to Plan Next Steps to Redesign Entry-Level Education for Speech-Language Pathologists' Next Steps 2022 Summer Webinar Series

Introduction

On July 26, 2022, a survey was made available as part of the Ad Hoc Committee to Plan Next Steps to Redesign Entry-Level Education for Speech-Language Pathologists' Next Steps 2022 Summer Webinar Series on Student Diversity. Individuals who participated in the live webinar, as well as those who viewed the recorded session, had the opportunity to complete the survey by August 30. A total of 13 individuals responded to the survey, all from the live webinar. Responses are presented for all respondents combined.

Results follow. Comments have been lightly edited for spelling and grammar. This report was prepared by ASHA's Surveys and Analysis unit.

Results

1. Which of the following best describes your current ASHA affiliation status? (Check one.)

Response	Percent	Number
ASHA-certified in audiology	7.7	1
ASHA-certified in speech-language pathology	76.9	10
ASHA-certified in both audiology and speech-language pathology	0.0	0
Noncertified member	7.7	1
Clinical Fellow	7.7	1
International affiliate	0.0	0
Speech-language pathology or audiology assistant	0.0	0
Student (undergraduate, graduate or research doctoral)	0.0	0
Other (Specify.)	0.0	0

2. How many years have you been employed? (Check 0 if none.)

Response	Percent	Number
0	7.7	1
1-5	7.7	1
6-10	7.7	1
11-15	0.0	0
16-20	15.4	2
21 or more	61.5	8

3. Which of the following best describes your current primary employment setting? (Check one.)

Response	Percent	Number
Early intervention/ pediatric home health	0.0	0
School (preschool, elementary, etc.)	0.0	0
College/university	83.3	10
Hospital (all types, inpatient and outpatient)	0.0	0
Nonresidential health care facility (clinic, physician's office, etc.)	0.0	0
Residential health care facility (skilled nursing facility, etc.)	8.3	1
Adult home health	0.0	0
Private practice	0.0	0
Agency, organization, or research facility	0.0	0
Industry	8.3	1
In audiology externship and/or clinical practicum	0.0	0
Not employed (student, retired, on leave of absence, etc.)	0.0	0
Other (Specify.)	0.0	0

4. What is your current primary employment function? (Check all that apply.)

Response	Percent	Number
Clinical service provider (i.e., audiologist or speech-language pathologist)	8.3	1
College/university academic faculty	50.0	6
College/university clinical faculty	25.0	3
Researcher	0.0	0
Consultant	0.0	0
Administrator/executive officer	0.0	0
Chair/department head/manager	25.0	3
Supervisor of clinical activity	16.7	2
Other director/supervisor	0.0	0
Other (See below.)	8.3	1

Other responses:

- Regional sales manager

Note. Only individuals who selected “college/ university academic faculty” or “college/university clinical faculty” moved on to question 5. All other respondents were automatically skipped to question 6.

5. What is your current faculty rank? (Check one.)

Response	Percent	Number
Lecturer	0.0	0
Assistant professor	12.5	1
Associate professor	75.0	6
Full professor	12.5	1
Other (Specify.)	0.0	0

6. In what state do you reside?

Response	Percent	Number
Alabama	7.7	1
Alaska	0.0	0
Arizona	0.0	0
Arkansas	0.0	0
California	7.7	1
Colorado	0.0	0
Connecticut	0.0	0
Delaware	0.0	0
District of Columbia	0.0	0
Florida	7.7	1
Georgia	0.0	0
Hawaii	0.0	0
Idaho	0.0	0
Illinois	0.0	0
Indiana	0.0	0
Iowa	7.7	1
Kansas	0.0	0
Kentucky	0.0	0
Louisiana	0.0	0
Maine	0.0	0
Maryland	0.0	0
Massachusetts	0.0	0
Michigan	0.0	0
Minnesota	0.0	0
Mississippi	0.0	0
Missouri	0.0	0
Montana	0.0	0
Nebraska	0.0	0
Nevada	0.0	0
New Hampshire	0.0	0
New Jersey	0.0	0
New Mexico	0.0	0
New York	15.4	2
North Carolina	7.7	1
North Dakota	0.0	0
Ohio	15.4	2
Oklahoma	0.0	0
Oregon	7.7	1
Pennsylvania	7.7	1
Rhode Island	0.0	0

South Carolina	0.0	0
South Dakota	0.0	0
Tennessee	0.0	0
Texas	0.0	0
Utah	0.0	0
Vermont	7.7	1
Virginia	7.7	1
Washington	0.0	0
West Virginia	0.0	0
Wisconsin	0.0	0
Wyoming	0.0	0

7. The current educational model to prepare speech-language pathologists to enter practice is a master's degree (approx. 2 yrs.) comprised of academic and clinical educational experiences covering the full scope of practice across the lifespan. How well is the current educational model working to prepare speech-language pathologists to enter practice?

Response	Percent	Number
Not well at all	7.7	1
Not very well	15.4	2
Somewhat well	69.2	9
Very well	7.7	1
No opinion	0.0	0

8. What is working well? List up to three aspects, each on a separate line. Leave blank if none.

- Child language development/disorders
- Clinical and didactic courses in curriculum
- Comprehensive examinations
- Engaged and dedicated faculty (clinical and academic)
- Focus on Big 9
- Our past graduates report being well-prepared in most areas to enter clinical practice.
- Praxis
- Recruitment
- Related to this topic, ASHA appears to be making great efforts here
- Strong emphasis on clinical experiences
- Students are finding employment in the settings of their choice.
- Students are receiving broad exposure to many aspects of the discipline.
- Students are required to complete varied clinical experiences
- Students are required to develop competencies
- Students basically don't need an UG degree to enter the masters
- There are many different program options
- There is more information about the profession than ever before

9. What is not working well? List up to three aspects, each on a separate line. Leave blank if none.

- ASHA doesn't hold programs accountable for teaching critical content, so student knowledge is varied
- Clinical education has become more about collecting clock hours than developing competency
- Enrollment
- Faculty diversity
- Faculty recruitment for scope of practice
- Impossible to cover the full scope of practice
- Lack of ability to specialize even by age prevents adequate prep in any area
- Lack of flexibility for students
- Lack of medical placements
- Lack of preparation from undergraduate CSD programs
- Numbers are going up slightly (student data) but not sure if actually certified SLPs is meaningfully moving
- People don't understand what holistic admissions ACTUALLY is ... and how it works

- Recruitment
- Retention
- Scope of practice is too broad to cover in 2 years
- Scope too broad to teach well in a program
- Student diversity
- Students don't have enough time to be ready for entry level practice
- Students in our program report feeling considerable stress because of the workload.
- Terminal degree being masters, where no specialty is able to be developed / honed
- The discipline is becoming increasingly female and in some cohorts we have not males.
- Too much information in too short of a time
- We have some students from diverse backgrounds in our program, but not nearly enough.

10. How critical is it to reconsider the educational model for preparing speech-language pathologists to enter practice?

Response	Percent	Number
Not at all critical	0.0	0
Not very critical	0.0	0
Somewhat critical	30.0	3
Very critical	70.0	7
Unsure	0.0	0

11. How critical is the need for change in each of the following areas?

All Respondents	Not at all critical		Not very critical		Somewhat critical		Very critical		Unsure	
	%	#	%	#	%	#	%	#	%	#
Clinical experiential learning	0.0	0	10.0	1	40.0	4	50.0	5	0.0	0
Availability of clinical placements and supervisors	0.0	0	0.0	0	20.0	2	80.0	8	0.0	0
Curricular capacity	0.0	0	0.0	0	40.0	4	60.0	6	0.0	0
Faculty capacity	0.0	0	10.0	1	40.0	4	50.0	5	0.0	0
Faculty development	0.0	0	10.0	1	30.0	3	60.0	6	0.0	0
Faculty sufficiency	0.0	0	10.0	1	20.0	2	70.0	7	0.0	0
Faculty diversity	0.0	0	0.0	0	0.0	0	100.0	10	0.0	0
Student diversity	0.0	0	0.0	0	0.0	0	100.0	10	0.0	0
Instituting a competency-based framework	0.0	0	10.0	1	50.0	5	40.0	4	0.0	0
Preparation for the future of work	0.0	0	10.0	1	20.0	2	60.0	6	10.0	1

Other responses [and criticality]:

- Address the pressure students are perceiving to improve their mental health and well-being. [Very critical]
- Meaningful and safe mechanisms for student input into programmatic decisions and feedback regarding experiences [Very critical]
- Undergraduate teaching model. undergraduate CSD students should come out with the ability to work in the field. Additionally, the overinflated GPAs coming from the "worthless" undergraduate CSD have

created a false baseline for competency entering the graduate level. A person who may have many more and varied experiences in a more rigorous major is unable to compete financially and academically with someone who is not challenged in the undergraduate CSD coursework. The overemphasis on the CSD undergrad has created a homogenous group of people applying for graduate SLP programs. If this is investigated further, most of the undergrads are predominantly "rich, white women" with the means to be able to focus on school amongst other things, compared to those with other backgrounds. [Very critical]

12. What barriers are programs experiencing in their recruitment efforts of diverse students for their graduate SLP programs? (Check all that apply.)

Response	Percent	Number
Insufficient funding levels to support initiatives	80.0	8
Recruitment efforts not aligned with overarching DEI departmental or institutional strategy	80.0	8
Inconsistent faculty and staff commitment to recruitment efforts	70.0	7
Limited resources to support recruitment efforts	60.0	6
Lack of (insufficient or inconsistent) institutional support	40.0	4
Lack of awareness of appropriate resources	40.0	4
Other (See below.)	60.0	6

Other responses:

- Dismissiveness of other experiences as being integral in their impact on current historically marginalized community members. That is, rich white women telling not rich white women that their experiences either aren't that bad, valid, or there isn't a way to change
- Implicit bias
- Lack of knowledge about appropriate use of holistic admissions framework for graduate admissions processes
- Lack of really effective strategies to improve our recruitment of diverse students. We have funding to offer, our university places a strong emphasis on recruiting students from diverse backgrounds, we take part in many activities such as high school visits, but we still have limited success.
- Some programs have limited leadership support, which completely sinks you
- Views of 'professionalism' and lack of recognition it looks different in different populations

13. What retention strategies are successful for diverse students? (Check all that apply.)

Response	Percent	Number
Access to appropriate financial support	100.0	10
Access to social, cultural networks (build community and engagement)	100.0	10
Ease of access to departmental/institutional programs, systems that support diverse student populations	90.0	9
Peer-mentoring (formal or informal)	90.0	9
Access to qualified, approachable academic advisors	70.0	7
Establish measurable goals	40.0	4

Other (See below.)	30.0	3
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Other responses:

- Access and emphasis on therapy and mental health support
- I think all of the above could be important but we should be asking our students this question.
- Inclusive teaching strategies employed at graduate level to facilitate success of diverse learners (UDL, Transparent Teaching, appropriate accommodations, faculty acceptance and facilitation of accommodations)

14. What do students need to feel included, and graduates prepared to be SLPs, that deliver culturally affirming services? (Check all that apply.)

Response	Percent	Number
Culturally responsive coursework	90.0	9
Mentorship (i.e., faculty, peer)	90.0	9
A variety of experiences with clients from varying backgrounds during clinic rotations	80.0	8
Financial resources	80.0	8
Supportive faculty	80.0	8
Be involved in organization	40.0	4
Other (See below.)	30.0	3

Other responses:

- Clinical supervisors (external in particular) who are supportive/mentoring. This is a HUGE challenge
- Inclusive teaching strategies and faculty members who know how to employ these strategies (and use the evidence based methods that have been shown to work)
- Interpersonal communication coursework/skills

15. What are some outreach strategies that have led to the successful recruitment of diverse students? (Check all that apply.)

Response	Percent	Number
Career days at high schools/community colleges	87.5	7
Health care fairs at high schools/community colleges	87.5	7
Open houses/information sessions for interested students	62.5	5
On-campus summer programs for high school students	50.0	4
Graduate School Fair at the ASHA Convention	37.5	3
Promotion at events for incoming college freshmen/transfer students	37.5	3
Networking at the National Black Association for Speech-Language and Hearing (NBASLH) Convention	25.0	2
Social media blasts about degree programs	25.0	2
Visits to programs at HBCUs/HSIs	12.5	1

Other (See below.)	12.5	1
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Other responses:

- We have done most of the above. Making early contact, at the high school or even middle school level, is important. Having faculty that represent greater diversity also is key and we lack that.

16. What information, resources, or strategies do faculty need to effectively advise students from different cultures? (Check all that apply.)

Response	Percent	Number
Information about advising students from different cultures	90.0	9
Resources about advising students from different cultures	80.0	8
Strategies that yield successful advising of students from different cultures	80.0	8
Other (See below.)	30.0	3

Other responses:

- Collaboration w/ other programs that may have more diversity or more knowledge on pedagogical approaches to diversity. education departments, EdD programs, etc.
- Cultural humility and responsiveness to the different cultures from which students come from (and also a de-emphasis on traditional / metric based criteria that are rooted in white supremacy)
- Not just advising but direct academic and clinical support of students from diverse backgrounds, how to support in external placement

17. Have we addressed the most critical issues—specific to this webinar topic of student diversity—from your perspective?

Response	Percent	Number
Yes	30.0	3
No	70.0	7

18. If no, what other issue(s) should be addressed? List up to 3, each on a separate line.

- Cultural humility
- Cultural humility and privilege are really important concepts. I don't think our discipline fully understands those elements so students who represent diversity still have negative experiences in our programs.
- Culturally humble and responsive advising at the undergrad and graduate level
- Have to address the 'old guard' faculty and faculty with a view of what SLPs should be
- Have to start honoring/respecting/applauding diverse life experiences over 4.0 GPAs and NSSLHA presidents
- HOLISTIC ADMISSIONS - what was said in this webinar wasn't correct (there's no specific "holistic admissions criteria" - that's not how it works)
- Increasing admission rates for BIPOC students

- Knowledge about inclusive teaching strategies - more discussions about this, in order for diverse students to be successful at both undergraduate and graduate levels
- Mostly cost
- Recruitment
- Reducing racist behavior of faculty and students
- Retaining student interest in continuing after undergrad programs
- Retention
- Some students want to return to school and complete our program on a part time basis. They cannot easily do so because financial assistance for part time students is much more limited than for full time students.
- Tangible directions in what to do to be more open and affirming
- The webinar and survey addressed many critical issues, but we also need ways to deliver SLP education in more flexible ways - part time students, students who are place bound, etc.
- Undergraduate education curriculum

19. Please provide any other comments that you would like to share with the Ad Hoc Committee to Plan Next Steps to Redesign Entry Level Education for SLPs.

- Allow student members to vote in ASHA elections.
- Create ASHA-mandated anonymous course feedback forms to track faculty/program performance in areas of DEI
- Looking forward to seeing the results of the work!
- Please make sure the ASHA conversion rate is available for members of NSSLA or NBSLHA.
- There's so much evidence in adjacent health professions with respect to how to implement and use holistic review for graduate admissions - including recent publications in SIG 10! And AJSLP! Yes, I know I'm saying these things as the person that is leading this discussion within our field about holistic review - but I've been talking to people at ASHA since 2018 about holistic review, and began to make some progress but then encountered resistance when people made comments about "why do we have to change admissions - we get 'plenty of good students'" - what does that mean? We have to focus on that conversation and this topic - it's ALL about gatekeeping (and reducing gatekeeping) and re-imagining what "good students" look like - even TODAY in this webinar, the comment about a student NOT having a 4.0 (which is REALLY DIFFICULT by the way) but "showing clinical potential" through research experiences ... it is classist and reductionist and exclusionary. SO MANY first generation students are just trying to figure out college - or lower SES students are trying to figure out how to pay for college AND the GRE AND their grad school apps while also working ... and so working in a research lab or spending hours in office hours is just not possible. We have to think about admissions - but also accessibility of programs - and also advising that is not about telling students that because they got one B in a class sophomore year - that their chances for graduate school are not good. THIS SHOULD NOT BE THE MESSAGE.

Appendix H: Clinical Experiential Learning Webinar Survey Results

Ad Hoc Committee to Plan Next Steps to Redesign Entry-Level Education for Speech-Language Pathologists' Next Steps 2022 Summer Webinar Series

Introduction

On July 12, 2022, a survey was made available as part of the Ad Hoc Committee to Plan Next Steps to Redesign Entry-Level Education for Speech-Language Pathologists' Next Steps 2022 Summer Webinar Series on Clinical Experiential Learning. Individuals who participated in the live webinar, as well as those who viewed the recorded session, had the opportunity to complete the survey by August 30. A total of 10 individuals responded to the survey, all from the live webinar.

Results follow. Comments have been lighted edited for spelling and grammar. This report was prepared by ASHA's Surveys and Analysis unit.

Results

1. Which of the following best describes your current ASHA affiliation status? (Check one.)

Response	Percent	Number
ASHA-certified in audiology	0.0	0
ASHA-certified in speech-language pathology	100.0	10
ASHA-certified in both audiology and speech-language pathology	0.0	0
Noncertified member	0.0	0
Clinical Fellow	0.0	0
International affiliate	0.0	0
Speech-language pathology or audiology assistant	0.0	0
Student (undergraduate, graduate or research doctoral)	0.0	0
Other (Specify.)	0.0	0

2. How many years have you been employed? (Check 0 if none.)

Response	Percent	Number
0	0.0	0
1-5	0.0	0
6-10	20.0	2
11-15	20.0	2
16-20	20.0	2
21 or more	40.0	4

3. Which of the following best describes your current primary employment setting? (Check one.)

Response	Percent	Number
Early intervention/ pediatric home health	0.0	0
School (preschool, elementary, etc.)	0.0	0
College/university	70.0	7
Hospital (all types, inpatient and outpatient)	10.0	1
Nonresidential health care facility (clinic, physician's office, etc.)	0.0	0
Residential health care facility (skilled nursing facility, etc.)	0.0	0
Adult home health	0.0	0
Private practice	0.0	0
Agency, organization, or research facility	0.0	0
Industry	0.0	0
In audiology externship and/or clinical practicum	0.0	0
Not employed (student, retired, on leave of absence, etc.)	0.0	0
Other (See below.)	20.0	2

Other responses:

- Consultant to K-12 public schools; adjunct
- Contract for hospitals and schools

4. What is your current primary employment function? (Check all that apply.)

Response	Percent	Number
Clinical service provider (i.e., audiologist or speech-language pathologist)	30.0	3
College/university academic faculty	50.0	5
College/university clinical faculty	40.0	4
Researcher	0.0	0
Consultant	0.0	0
Administrator/executive officer	0.0	0
Chair/department head/manager	10.0	1
Supervisor of clinical activity	20.0	2

Other director/supervisor	0.0	0
Other (See below.)	10.0	1

Other responses:

- Consultant to public school language therapists

Note. Only individuals who selected “college/ university academic faculty” or “college/university clinical faculty” moved on to question 5. All other respondents were automatically skipped to question 6.

5. What is your current faculty rank? (Check one.)

Response	Percent	Number
Lecturer	20.0	1
Assistant professor	0.0	0
Associate professor	80.0	4
Full professor	0.0	0
Other (Specify.)	0.0	0

6. In what state do you reside?

Response	Percent	Number
Alabama	0.0	0
Alaska	0.0	0
Arizona	0.0	0
Arkansas	0.0	0
California	20.0	2
Colorado	0.0	0
Connecticut	0.0	0
Delaware	0.0	0
District of Columbia	0.0	0
Florida	0.0	0
Georgia	10.0	1
Hawaii	0.0	0
Idaho	0.0	0
Illinois	0.0	0
Indiana	0.0	0
Iowa	10.0	1
Kansas	0.0	0
Kentucky	0.0	0
Louisiana	0.0	0

Maine	0.0	0
Maryland	0.0	0
Massachusetts	0.0	0
Michigan	0.0	0
Minnesota	0.0	0
Mississippi	0.0	0
Missouri	10.0	1
Montana	0.0	0
Nebraska	0.0	0
Nevada	0.0	0
New Hampshire	0.0	0
New Jersey	0.0	0
New Mexico	0.0	0
New York	10.0	1
North Carolina	0.0	0
North Dakota	0.0	0
Ohio	10.0	1
Oklahoma	0.0	0
Oregon	0.0	0
Pennsylvania	10.0	1

Rhode Island	0.0	0
South Carolina	0.0	0
South Dakota	0.0	0
Tennessee	0.0	0
Texas	20.0	2
Utah	0.0	0
Vermont	0.0	0
Virginia	0.0	0
Washington	0.0	0
West Virginia	0.0	0
Wisconsin	0.0	0
Wyoming	0.0	0

7. The current educational model to prepare speech-language pathologists to enter practice is a master's degree (approx. 2 yrs.) comprised of academic and clinical educational experiences covering the full scope of practice across the lifespan. How well is the current educational model working to prepare speech-language pathologists to enter practice?

Response	Percent	Number
Not well at all	10.0	1
Not very well	10.0	1
Somewhat well	80.0	8
Very well	0.0	0
No opinion	0.0	0

8. What is working well? List up to three aspects, each on a separate line. Leave blank if none.

- Academic knowledge acquisition
- Clinical experiences often result in IPE/IPP experiences
- Course then clinic
- Culminating experience
- Diverse opportunities for learning
- Documentation
- Flexibility in skill exposure and acquisition
- Focus on fundamental/foundational knowledge
- Focus on generalist skills
- Hours requirement
- Integrated coursework and clinic
- Interacting with people with communication disorders
- Our students find medical externship placements, although it is difficult sometimes
- Our students find placements in school settings, although it is difficult sometimes
- Running sessions
- Simulations
- Students generally get some opportunity to learn some areas in-depth
- Students get to learn details/nuts and bolts of settings with full-time placements
- Variety of experiences
- We have an on campus clinic, so our students are able to get clock hours before they leave campus
- Wide array of settings

9. What is not working well? List up to three aspects, each on a separate line. Leave blank if none.

- Accumulating hours does not equal ensuring quality experiences- either the educator, diversity, etc.
- Because of the 'hours' requirement, students may miss out on other valuable experiences in settings like team meetings, working with families, etc.
- Clinical instructor/preceptor attitudes
- Coordination of courses with practica
- Depth of experiences
- Different expectations on competent
- Entry level competence in all Big 9 areas
- Experience with low-incidence disorders and diagnostics across all areas
- Faculty diversity
- Focus or emphasis that some areas are “better” than others (e.g., swallowing is more important that speech sounds)
- Getting all students in a program comparable, comprehensive experiences
- It is SO challenging to find places that will accept students, particularly in medical settings.
- Lack of medical clinical placements
- Lack of sufficient supervision training
- Lack of supervisors
- Length of program with expanding scope of practice
- More places to get clock hours or what can count as clock hours
- Not enough time for all 9 areas
- Not enough time to really train skills and competencies
- Number of quality outplacement supervisors especially in medical settings
- Student diversity
- Students and CFs are not adequately prepared to work in medical settings, lacking knowledge in medical practices (vitals, respiration, and SLP practice as it relates to swallow and how we function.
- Students lack knowledge about the physician’s role and documentation for reimbursement.
- Students lack understanding about others’ roles and responsibilities (inter professional practice)
- Too little exposure to all domains/settings

10. How critical is it to reconsider the educational model for preparing speech-language pathologists to enter practice?

Response	Percent	Number
Not at all critical	0.0	0
Not very critical	0.0	0
Somewhat critical	44.4	4
Very critical	55.6	5
Unsure	0.0	0

11. How critical is the need for change in each of the following areas?

All Respondents	Not at all critical		Not very critical		Somewhat critical		Very critical		Unsure	
	%	#	%	#	%	#	%	#	%	#
Clinical experiential learning	0.0	0	0.0	0	33.3	3	66.7	6	0.0	0
Availability of clinical placements and supervisors	0.0	0	0.0	0	11.1	1	88.9	8	0.0	0
Curricular capacity	0.0	0	11.1	1	33.3	3	55.6	5	0.0	0
Faculty capacity	0.0	0	11.1	1	22.2	2	66.7	6	0.0	0
Faculty development	0.0	0	22.2	2	22.2	2	55.6	5	0.0	0
Faculty sufficiency	0.0	0	11.1	1	33.3	3	55.6	5	0.0	0
Faculty diversity	0.0	0	22.2	2	33.3	3	44.4	4	0.0	0
Student diversity	0.0	0	0.0	0	44.4	4	55.6	5	0.0	0
Instituting a competency-based framework	0.0	0	0.0	0	44.4	4	55.6	5	0.0	0
Preparation for the future of work	0.0	0	0.0	0	44.4	4	55.6	5	0.0	0

Other responses [and criticality]:

- Restructure clinical learning- different model and learning opportunities needed. [Very critical]

12. Does your program use any of the following alternative pedagogical methods for clinical experiential learning, in particular, those involving simulation? (Check all that apply.) [Excludes respondents who are not in a college/ university setting.]

Response	Percent	Number
Digitized mannequins	87.5	4
Virtual patients	62.5	3
Immersive reality	50.0	1
Task trainers	37.5	5
Computer-based interactive learning	12.5	7
Standardized patients	12.5	3
None of the above	37.5	0
Other (See below.)	0.0	2

Other responses:

- Sim lab experience in the nursing lab, Simucase

- Skills lab

13. If your program does not use simulation for clinical experiential learning, what prevents you from using these methodologies?

[No responses]

14. In which of the following clinical professional skills are graduating students most lacking competency? (Check all that apply.)

Response	Percent	Number
Counseling	77.8	7
Interprofessional practice (IPP)	77.8	7
Problem solving	77.8	7
Cultural competency and diversity, equity, and inclusion	66.7	6
General knowledge of insurance and billing	66.7	6
Professional communication skills	66.7	6
Professional ethics (cyberbullying, harassment, etc.)	55.6	5

15. Does your program require students to complete both one externship in a pediatric setting and one externship in an adult setting?

Response	Percent	Number
Yes	85.7	6
No	14.3	1

16. How long is each externship? (Leave blank if not applicable.)

Pediatric Setting	Median	Mean	Std Dev	Range	n =
Number of weeks	15.0	14.8	1.6	12-16	5
Number of days at the placement per week	4.0	4.0	1.0	3-5	5
Number of hours on-site at the placement per week	35.0	29.0	14.4	6-40	5
Adult Setting	Median	Mean	Std Dev	Range	n =
Number of weeks	16.0	15.0	1.7	12-16	5
Number of days at the placement per week	4.0	4.0	1.0	3-5	5
Number of hours on-site at the placement per week	40.0	30.0	15.1	6-40	5

17. How many externship experiences beyond on-campus or initial clinical experiences does your program require? (Enter 0 if none.)

Response	Median	Mean	Std Dev	Range	n =
Number	2.0	1.6	0.9	0-2	5

18. What are the current barriers to recruiting more clinical educators and/or securing more clinical placements? (List up to 3 for each area, each on a separate line.)

Barriers to recruiting more clinical educators:

- Academia
- Because the training as a clinical educator is minimal, aren't really prepared to handle challenges and it also prevents them from taking students in the future
- COVID
- Doing it right is more work for the supervisor, there is very little (to no) reward for doing this
- Employer not supportive
- Employer restrictions (administration feels that instructing a student takes away from primary responsibilities)
- Employers view it as taking time away from productivity; discouraged by employers

- Funding
- Lack of compensation
- Lack of compensation/benefits for supervisors
- Lack of incentives
- Location of our university
- Money
- Need for more in depth training/support in supervision
- No tangible reinforcement/incentive
- Productivity requirements
- Program directors
- Qualified CCC-SLP
- Salary
- The university program itself that can't think outside the box to develop opportunities right on campus and with resources they already have.
- Time [3 responses]
- Time to invest in recruitment/retention
- Time/workload
- Workload

Barriers to securing more clinical placements:

- Academia and lack of awareness about what's going on in the daily work of SLPs
- Administrative burden to support/onboard students
- Caseloads
- Caseloads/workloads too high
- CCC-SLP willing to take students
- Competition
- Competition with programs
- COVID
- COVID
- Employer restrictions
- Employer restrictions on student participation
- Employers view it as taking time away from productivity
- Lack of knowledge to use technology.
- Large gap between academic and clinical "thinking."
- Many facilities are not taking students post-COVID
- Number of SLPs
- Size of caseload
- Some areas already have a shortage of SLPs; challenging to ask to do more when they are already covering multiple positions
- Staffing numbers
- Student refusals of COVID-19 vaccination
- Time

19. Have we addressed the most critical issues—specific to this webinar topic of clinical experiential learning—from your perspective?

Response	Percent	Number
Yes	77.8	7
No	22.2	2

20. If no, what other issue(s) should be addressed? List up to 3, each on a separate line.

- Assessment of clinical skills versus academic knowledge
- Basic, functional teaching and training is needed for medical settings. SLP is a medical science!
- Foundational learning about how to assess the patient and monitor the patient before initiating and continuing our diagnostics and interventions.
- Improve the teaching and training involved in the “pathology” part of our title; the study of diseases and disorders
- Models of clinical education
- Skill acquisition

21. Please provide any other comments that you would like to share with the Ad Hoc Committee to Plan Next Steps to Redesign Entry Level Education for SLPs.

- As said in the breakout room for this session, I feel there are multiple levels of disconnect. I feel there are still SLPs in certain settings who could care less about the profession as a whole, but want to pretend that because they work in a certain setting, the majority of new graduates and current clinicians are incompetent. I also feel that clinical sites and universities do not communicate with one another. Universities are going to be restricted by resources and other components of the infrastructure. Hospitals and schools have their restrictions per state laws and reimbursement. I don't think we realize always that we cannot be accountable for everything for everyone. I think we should consider rounds for SLPs, increased simulations, case studies, and more time in the degree plan (yes, meaning a clinical doctorate even though "it's not in the charge) to truly teach students knowledge and skills.
- I personally think there is value in extended, intense time in a placement. I wonder, however, if our traditional 'hours' are the most important metric (vs. competency and/or period of days/weeks, etc.). Also think there should be increased value on quality simulation to get experiences; you can learn and reason through a bedside in simulation with a well-prepared clinical educator than a less prepared, overworked, stressed, and busy externship supervisor. Who do we value teaching these skills more?
- I would propose starting with observations in grad school (and do away with the undergrad degree). Maybe then incorporate rounds then incorporate more individual clinical experiences.

- Look at curricula. A course in neuroscience is not a required course at the UG or graduate level and it should be. We focus on the Big 9 without looking at foundation science classes such as a neuroscience class.
- More support providing guidance for university on-campus clinics is desperately needed! There are so many regulations that significantly limit training opportunities with individuals in our community who could benefit from what we could offer, while providing students with greater variety of training experiences.
- Universities need to hire SENIOR, seasoned professors of practice. Minimum 5-8 years of experience in the field.