2023 Pediatric Health Care Survey Report

Survey Methodology and Response Rate

On November 15, 2023, a web-based survey was fielded to a random sample of 10,000 individuals who identified as being speech language pathologists (SLPs) working in pediatric healthcare. Follow-up email reminders were sent to non-respondents on November 29 and December 6. The survey closed on December 8. Of the 10,000 SLPs, 103 emails bounced and 128 individuals opted out of Survey Monkey-based surveys for a usable population size of 9,769. A total of 1,177 individuals responded to the survey for an overall response rate of 12%. This report was prepared by ASHA's Surveys and Analysis Team.
Note: Some of the questions utilized a skip pattern logic, meaning that participants see or don't see certain questions depending on their answers to previous questions. Questions of this nature will be indicated through the report.

Survey Results

1. What is your primary work setting?

Answer Choices	Responses (*n* = 1,177)	
	%	#
Early intervention program or home health care setting	20.7	243
Hospital	13.7	161
Inpatient rehabilitation	0.9	11
Outpatient clinic/office	54.7	644
N/A; I'm currently unemployed or retired.	1.4	17
Other (Please specify.)	8.6	101

Other responses

- All ages, telehealth
- Both inpatient rehabilitation and outpatient rehabilitation
- Contract 1099 for School Board of Palm Beach County & PRN OP Peds at a Pediatric Hospital W2
- Contracted into school.
- Currently work in an outpatient office. 36 years in early intervention in public schools.
- Early Intervention and Outpatient clinic
- Early Intervention BUT I have worked in all settings listed.
- Educational clinic
- Elementary school (3)
- Full time school based SLP working with ESE PreK, part time work with early intervention in the afternoons after the school day.
- Half early intervention, half private practice clinic

- Half inpatient setting and half outpatient
- Home based private practice.
- Home Health
- Home Health- Adults
- Hospital based outpatient clinic.
- Hospital Outpatient (3)
- I don’t work in pediatric health care.
- I have my own visits, virtual and home visits.
- Independent Contractor
- Inpatient and Outpatient at hospital
- Intensive ABA clinic
- Mental Hospital
- Mobile Pediatric Private Practice
- NICU
- Nursing home and private pediatric clients
- Outpatient clinic
- Outpatient Hospital
- Outpatient in rural hospital
- Outpatient pediatric and adult rehabilitation institute
- Outpatient Rehabilitation Program within Hospital
- Owner of Private Practice
- pediatric day health care facility
- Pediatric home health care
- Pediatric private practice/clinic (4)
- Private clinic (2)
- Private pediatrics seeing patients in their homes or at their preschools.
- Private Practice (15)
- Private practice in-home and on-site
- Private practice within a family wellness center
- Private practice, private schools
- Private school
- Private, non-profit speech and hearing center
- Providing services in daycares/preschools
- Public school
- Public School: Preschool - 5th grade.
- Rehabilitation clinic part of a rural hospital system
- Rural hospital with inpatient and outpatient
- Rural hospital with outpatient clinic
- School (11)
- School and outpatient clinic
- School Contractor
- School district
- School, home, and teletherapy
- School; some outpatient clinic
- Self-employed, private practice
- Skilled nursing
- Solo practice
- Telehealth/Teletherapy (5)

- Telehealth for outpatient
- University
- University supervision of preschoolers at Head Start
- Virtual supervisor and private practice

2. How long have you worked in pediatric health care?

Answer Choices	Responses (*n* = 1,151)	
	%	#
0–4 years	25.6	295
5–9 years	19.3	222
10–15 years	19.7	227
16–20 years	10.3	118
21+ years	23.1	266
N/A; I don't work in pediatric health care.	2.0	23

3. What patient populations do you currently work with? (Select all that apply.)

Answer Choices	Responses (*n* = 1, 124)	
	%	#
Infants	52.7	592
Toddlers	92.6	1041
School-age children	84.6	951
Adolescents	57.2	643
N/A; I provide no clinical services.	0.3	3

4. What diagnoses do you primarily treat in your practice? (Select all that apply.)

Answer Choices	Responses (*n* = 1,117)	
	%	#
Cognitive-communication disorders	48.3	540
Feeding and swallowing disorders	49.2	549
Speech-language disorders	88.5	988
Other (Please specify.)	9.6	107

Other responses

- AAC (4)
- AAC, Apraxia
- AAC, Pragmatic therapy, Apraxia, and Autistic children
- Accent modification, corporate speech
- Airway management (PMSV)
- All of the above (2)
- Apraxia
- Apraxia, ASD, Stuttering

- Apraxia/ Articulation. I don't do language.
- Articulation
- ASD/Autism (21)
- ASD, Developmental
- Aural Habilitation
- Autism and ADHD
- CAS, Stuttering, Cluttering, Pragmatic Language Disorders, etc
- Cleft lip and palate, voice
- Communication disorders related to developmental disabilities.
- Complex communication needs
- Craniofacial disorders
- Developmental Care/NCCU
- Developmental Delays
- Developmental NICU
- Diagnostics
- Dyslexia
- Executive functioning (2)
- Feeding Aversion
- Fluency (4)
- Gender affirming voice and communication.
- Hearing impairment/loss (3)
- Hearing loss related speech-language delays
- Infant development
- Language Learning Disabilities and Reading, Voice Disorders
- Language-based literacy (i.e., dyslexia)
- Learning and literacy disorders
- Literacy (4)
- Literacy, dyslexia, dysgraphia, executive functioning
- Myofunctional Disorders (3)
- NICU
- Nonverbal, AAC
- Oral myofunctional disorders (3)
- Orofacial Myofunctional Disorders (5)
- Pragmatic, executive functioning, Apraxia
- Reading
- Resonance disorders/VPI
- Sensory
- Sensory processing deficits as the underlying cause of a speech/language disorder
- Social Communication
- Social Pragmatics Disorders (2)
- Social skills
- Social-emotional
- Speech disorders only, not language
- Speech sound disorders
- Speech/language delay, oral motor delay/differences
- Stuttering and related disorders
- Stuttering Cluttering Fluency Disorders
- Tongue thrust.

- Traumatic brain injury
- VCD
- Velopharyngeal Dysfunction
- Voice & Resonance (Craniofacial Team)
- Voice and Airway and gender affirming voice care.
- Voice and Upper Airway Disorders (3)
- Voice, resonance
- We see everyone; not bed bound.

5. Did your graduate program have a dedicated course in pediatric medical speech-language pathology and/or pediatric dysphagia?

Answer Choices	Responses (*n* = 1,120)*	
	%	#
Yes	26.8	300
No	73.2	820

*Questions 6 and 7 were answered by participants who answered **'No'** to Question 5.

6. If not, did you feel that your graduate coursework in dysphagia adequately covered pediatrics and that you understood the anatomic and physiologic differences between adult and pediatric populations?

Answer Choices	Responses (*n* = 814)	
	%	#
Yes	15.0	122
No	85.0	692

7. Did you seek out additional learning opportunities relevant to pediatric health care while in graduate school?

Answer Choices	Responses (*n* = 1,110)	
	%	#
Yes	49.1	545
No	50.9	565

*Participants who answered 'No' to this question were skipped to Q9, while those who answered 'Yes' answered Q8.

8. If yes, what were they? (Select all that apply.)

Answer Choices	Responses (*n* = 543)*	
	%	#
Continuing education courses	71.3	387
Engagement in ASHA's Special Interest Groups (SIGs)	12.3	67
Engagement in other professional organizations' special interest groups (local, state, or national)	21.9	119
Mentorship	63.2	343
Research self-study	42.2	229
Other (Please specify.)	10.3	56

Other responses

- Additional 4-week pediatric rehab extends hip in addition to adult hospital externship.
- additional classes in early intervention
- Arranged my own internship at a hospital in 1983.
- Assisted in facility.
- Autism conferences
- Classes on this subject, related internships
- Clinical externship
- Clinical placement
- Clinical practicum in a rehab hospital for children
- Coworker
- Elective for medically complex population
- Electives
- Electives centered on infants and toddlers.
- Externships (3)
- Externship beyond clinical placements
- Externship, student placement, shadowing
- Extra externship at pediatric medical setting
- Feeding/swallowing pediatric internship
- Grant study in AAC
- Hospital volunteer opportunities
- I graduated with my MA in the 1990s. Swallowing in general was new. ALL my training has been hands on and CEU.
- I worked at a Children's Hospital and learned with the SLPs there. However, it was not an official mentorship.
- IDTrain Interdisciplinary program, 2-year concurrent training
- Independent study with professor mentor
- Internship with a board-certified NANT-CCC-SLP
- Internships (2)
- LEND program (2)
- Meeting with early intervention SLPs.
- My college had a preschool program as part of my training. I was awarded a traineeship with infants/toddlers.

- Observation opportunities
- Observation opportunities w/ pediatric dysphagia clients
- Observations and clinical rotations
- Observations with pediatric inpatient therapists
- Optional clinical placements
- Part time work with individuals with special needs in various settings
- Pediatric clinic placements
- preschool classroom placement
- Professional Literature like “Source for Pediatric Dysphagia”
- Requested that my medical placement be at a children's hospital.
- Seeked out clinical rotations and fellowship
- Shadowed Pedi acute care SLP
- Shadowing a pediatric SLP at a hospital
- Shadowing opportunities (3)
- Specialized courses over the years
- Study abroad class
- Undergraduate and Graduate Assistant
- We were offered a J term course in these topics.
- Work as an SLP-A
- Worked with children as a tutor and school shadow.

9. Did you have graduate clinical experience in a pediatric medical setting?

Answer Choices	Responses (*n* = 1,107)	
	%	#
Yes	42.6	472
No	57.4	635

10. If yes, in what setting?

Answer Choices	Responses (*n* = 471)*	
	%	#
Early intervention program or home health care setting	8.9	42
Hospital	34.2	161
Inpatient rehabilitation	5.1	24
Outpatient clinic/office	45.2	213
Other (Please specify.)	6.6	31

*Participants who answered ‘Yes’ to question 9 were directed to this question.

Other responses

- Acute, AIR, outpatient
- All
- Both EI in home and in another setting was through op at hospital, graduate clinic clients as well.
- Both inpatient and outpatient settings
- Cleft palate and Craniofacial

- Clinic, EI
- Early intervention, outpatient, inpatient
- EI/HH and hospital placements
- Health department
- Hospital and outpatient
- Hospital Outpatient/MBSS Clinic
- I was the only person in my graduate program who received pediatric medical experience.
- In hospital, outpatient services, one day observation
- Inpatient and outpatient rehab
- Long term care facility for medically fragile children
- Outpatient and Hospital
- Outpatient clinic/office and hospital (two placements)
- Outpatient Hospital (2)
- Phoenix Children's Hospital- inpatient & outpatient
- PICU
- Prescribed Pediatric Extended Care (PPEC) facility.
- Private pediatric clinic
- School (4)
- School setting dealing with 3 yr. olds.
- School, NICU observations
- Special services school district
- Specialty school for medically complex students

11. If not, why not? (Select all that apply.)

Answer Choices	Responses (*n* = 640)	
	%	#
I wasn't interested in having that experience.	13.3	85
It wasn't an option for me.	79.7	510
Other (Please specify.)	13.3	85

*Participants who answered 'No' to question 9 were directed to this question.

Other responses

- A clinical rotation for pediatric medical was not available in my area.
- Adult medical
- Adult placements were stressed by clinical supervisor.
- At the time I chose the nursing home for my externship and looked forward to an experience in the pediatric medical setting as a CFY/clinician.
- At the time it did not seem relevant
- Challenges due to COVID (3)
- COVID restrictions limited clinical experiences.
- Covid restrictions. Many locations were not accepting graduate students during this time.
- COVID severely limited such opportunities. If a medical placement had been available, it probably would have been with adults.
- Did a school placement instead.
- Did not get placed in those options.
- Didn't think to do so.

- Had medical experience with adults.
- I can't remember if it was an option. At the time I thought I would be working with adults
- I chose to do one placement in a hospital and one placement in a school setting.
- I couldn’t afford housing near where I would have been able to do a rotation in a peds medical setting.
- I did but can't go back.
- I didn't get this placement. There was only one in my grad school option at a children's hospital.
- I don't know if school had any such settings.
- I don't recall asking specifically for ped's. I completed a school internship and a medical rehab internship.
- I got a master's degree in 1964 - we were not even considering feeding and swallowing for any age group as I recall.
- I graduated with my Masters in 1992, and dysphagia was not in the curriculum at that time. The exposure I had in Pediatric was speech and language related only.
- I had it secured but my grad school couldn’t get the contract finalized and cost me the placement.
- I had one client in my outpatient peds setting that was working on feeding/swallowing. All the rest were communication/speech. The clinic does treat PFDs but that was just how it worked out.
- I had other experiences, but it was available to me.
- I had outpatient adult (somewhat) medical experience, and for my second semester 2nd year was in peds home health/ private practice.
- I have been in practice for many years and many of those courses have been offered in the last five years.
- I knew that I was going to be going to into school setting after graduation. I was school based for 10+years prior to moving into clinical setting.
- I needed adult hours for the medical placement.
- I thought I wanted schools or adults at that time.
- I thought I wanted to work with adults.
- I was focused on adult rehabilitation at that time.
- I was focused on school-based services have spent much of my time in the schools.
- I was given a school. They did not give me a pediatric medical placement, only adult.
- I was interested in a school position at that time.
- I was nervous since I had not had much coursework on it.
- I was placed at an OP clinic that saw both peds and adults but was not peds-specific. And, we primarily focused on speech and language disorders, not feeding/swallowing.
- I was placed elsewhere for my externships.
- I was prescribed 1 "healthcare" and 1 school-based; peds healthcare was few and far between and I also wanted to explore adults/acute care so I did not have extra opportunity to do all of the above
- I wasn’t allowed. I was told my pediatric experience had to be in a school.
- I wasn’t selected as there were a limited number of spots.
- If we wanted a medical clinical , it was with adults.
- It was mostly adult medical setting, some pediatrics (though minimal)
- It was not an option for my program at that time.
- It was not part of our internship program.
- Limited availability offered by my graduate program.
- Limited opportunities. My pediatric experience was school based only.
- Limited placements, they put me in a school even though I expressed I never wanted to work in a school.
- Long drive into LA
- Medical experience was in an adult inpatient/outpatient setting.

- My graduate experience was many years ago (in the early 90's). I don't recall it being an option.
- My hospital placement was adults and children.
- My program did not explore other placement opportunities for me.
- My site of exp was chosen for me and I was assigned to an adult hospital setting.
- Needed to have an adult setting to meet hours.
- No sites/Limited sites available (5)
- Not enough internships available in that setting so I was put on the school based SLP track in grad school.
- Only as an observer, briefly
- Options in the area were limited & very competitive.
- Outpatient clinic
- Pediatric language program (similar to a preschool) but not medical
- Pediatric placements were almost exclusively school-based or itinerant EI.
- SNF
- Students are not allowed to do clinical in NICU because it is an advanced area of practice. I had a research assistantship and shadowed frequently when I finished my work but did not perform any hands on with patients.
- The pediatric medical externship applications were due much later than other medical externships and I chose an acute adult inpatient externship.
- There was only one lottery position available and I did not "win."
- There were limited spots with high levels of interest, I was not chosen.
- There were no available placement meeting that description.
- There were no medical pediatric settings that had a contract with my school for clinical placements.
- They let us tour a peds hospital and observe at a private clinic that was medical based, but we only had a couple spots at each and I ended up in a basic private outpatient clinic (not really medical)
- University clinic setting, not medical. Did my internship w adult rehab and shifted to pediatric population 9 years later.
- Very few medical clinical placements and none available for pediatrics
- Very hard to secure.
- Very limited medical setting placements were offered in my program, and not all clinicians had the opportunity.
- Wasn't available; just a general hospital setting with mostly adults.
- Wasn't interested at the time.
- We had lots of peds at our university clinic.
- We had to find our own placements in pediatric medical settings and there was only one position available at CHLA.
- Working school setting before

12. How prepared did you feel to practice in a pediatric health care setting as a Clinical Fellow after graduate school?

Answer Choices	Responses (*n* = 1,089)	
	%	#
Very prepared	11.3	123
Somewhat prepared	51.3	559
Slightly prepared	27.5	299
Not at all prepared	9.9	108

13. How prepared did you feel to independently practice in a pediatric health care setting after your Clinical Fellowship?

Answer Choices	Responses (*n* = 1,081)	
	%	#
Very prepared	27.3	295
Somewhat prepared	46.4	502
Slightly prepared	17.1	185
Not at all prepared	9.2	99

14. Did or does your employer provide you with mentorship outside of what is required for the ASHA Clinical Fellowship?

Answer Choices	Responses (*n* = 1,084)*	
	%	#
Yes	56.6	613
No	43.5	471

*Participants who answered 'No' to this question were guided to answer Qs 15 & 16, the others were skipped to Q17.

15. If not, did or do you seek out mentorship on your own?

Answer Choices	Responses (*n* = 471)	
	%	#
Yes	61.2	288
No	38.9	183

16. If yes, where? (Select all that apply.)

Answer Choices	Responses (*n* = 285)	
	%	#
ASHA	22.5	64
Other related professional organizations (e.g., Feeding Matters or the National Association of Neonatal Therapists)	31.6	90
Professional connections	85.3	243
Social media or online speech-language pathology communities	47.7	136
Other (Please specify.)	8.8	25

<u>Other responses</u>

- CEU classes/conferences
- CEUs
- Cold emailing pediatric hospitals
- Colleagues from grad school who worked with peds.

- Conferences/CEU opportunities
- Constantly seeking out mentorship and asking colleagues their perspectives on tricky cases
- Copious amounts of CEUs
- Full day conferences and workshops
- I did continuing education (and for the private practice side of things I had a business mentor)
- I work as an independent Early Intervention / Preschool contractor. I do not see children with feeding difficulties as I have had no direct training. I do work on some oral sensory issues if I have an OT supporting me.
- Many continuing ed workshops by many more experienced professionals
- Networking with other healthcare providers outside of speech pathology
- Other pediatric therapists
- Podcasts/CEUs
- So many courses
- Social media didn't exist in 1987!!!
- Special workshops and trainings
- Specific feeding courses
- State conferences
- Targeted continuing education courses
- Therapist at the clinic.
- Took additional courses.
- Training at work and pursued courses in Pediatric Feeding Disorders
- Way before social media. Found professionals.
- Within my healthcare system

17. Do you feel that the continuing education resources available to you that are relevant to pediatric health care are adequate to support learning?

Answer Choices	Responses (*n* = 1,066)	
	%	#
Yes	79.5	847
No	20.5	219

18. Where do you prefer to seek out continuing education resources relevant to pediatric health care? (Select all that apply.)

Answer Choices	Responses (*n* = 1,059)	
	%	#
ASHA	52.1	552
Other related professional organizations (e.g., Feeding Matters or the National Association of Neonatal Therapists)	60.2	637
Local hospitals or clinics	18.5	196
Virtual continuing education providers	80.4	851
Other (Please specify.)	10.1	107

Other responses

- Aerodigestive Society, ACPA, SENTAC
- AG Bell Academy, ACIA
- All courses that are available
- All of the above
- Anything free since hospital pays nothing for CEUs.
- Anywhere that is free.
- Assistive Technology professional organizations
- Beckman
- Certifications courses (SOS, Beckman, etc.)
- CEUs my company provides.
- Ciao Seminars
- Coworkers and mentors
- Colleagues (4)
- Colleagues who specialized or accidentally fell into a specific population.
- Conferences
- Content Expert Colleagues - internal trainings
- Continuing ed through my employer (VUMC ped speech clinic)
- Employer, speechpathology.com
- Experienced colleagues
- Facebook groups for speech therapists - I see what they're talking about and then research it
- Fall Voice and Voice Foundation
- Feed the Peds
- For feeding/swallowing, I go to OT colleagues for guidance and teaching.
- Grad programs should require a comprehensive dysphagia course. It's the only aspect of our scope that could be life threatening, yet we are allowed to do swallow evals with little/no experience. Agencies, for example, hired me to do SNF work with no questions asked until I removed myself for patient safety reasons.
- Have consulted university clinicians specializing in stuttering disfluency, Passy Muir, SIGs, colleagues at hospital feeding or cleft palate clinics.
- I look for specific feeding gurus and seek out when they have seminars.
- I present seminars/webinars and lectures at conferences national and international on these topics. I don't think this survey is intended for me.
- I would like hands on mentorship if I chose to pursue this. Which I'm not as I am 65
- In person courses/Continuing ed. Opportunities (2)
- In person observation/classes
- In person opportunities by CEU providers
- In person training (2)
- In person workshops
- Independent trainings: Beckman, Feed the Peds, Can Eat, etc.
- informed SLP
- In-person continuing education courses and workshops
- IPBIS
- It is rare to find helpful CEU coursework.
- It varies and is course dependent.
- Live CE opportunities
- Live, on-site Cont. ed seminar
- Local experts
- Local seminar offerings

- Local university
- Local university's NSSLHA chapter offers continuing education live courses as a find raiser
- looking for training for specific populations, such as speaking valves in infants; feeding aversions for ASD toddlers.
- Mary Massery 3-day workshop
- Medbridge
- MedSLP
- Mentorship
- Mentorship with therapists who currently have pediatric clients.
- My direct mentor during my CFY was Joan Arvedson, SLP
- Myofunctional courses
- NDTA
- Offered at work.
- On site visits to other programs
- On-site CEU courses
- Other continuing education companies
- Other experienced clinicians
- Other professional connections
- Other providers
- Other workshops
- Pediatric Feeding Disorders in-person courses
- Peer reviewed articles
- PESI, EDU Resources
- Podcasts (3)
- Podcasts. Professional courses
- Professional connections
- Programs provided through my employer.
- Reading and videos, robust research; even feeding matters and approved CEUS are often not evidence based at all
- Research articles
- Shadowing/collaborating with other SLPs working with pediatric dysphagia.
- So many courses
- So many over 25+ years. Never from ASHA
- Social media
- SOFFI training
- SOFFI, SOS
- SOS, Soffi, CLC
- Specific Pediatric courses in person
- Speech Therapists
- speechlanguagepathology.com
- Speechpathology.com
- Speechtherapypd pro, Talk Tools, The Breathe Institute, I still refer more severe feeding clients.
- SpeechTherapyPD.com
- Stand-alone pediatric hospitals
- state
- State association
- State conference (3)
- Talk Tools, Beckman, PROMPT

- Talk Tools, The Informed SLP
- Talk Tools; IAOM.
- TeachMeToTalk.com, Laura Mize
- TSHA (2)
- URLEND, Orofacial Myology Training
- Websites of leading professionals
- Within my organization

19. Does your facility or team use competencies to measure speech-language pathology skills?

Answer Choices	Responses (*n* = 1,054)*	
	%	#
Yes	49.3	520
No	50.7	534

*Participants who answered 'Yes' to this question were directed to Q19, all others were skipped to Q21.

20. Where did your facility or team seek out resources for developing competencies? (Select all that apply.)

Answer Choices	Responses (*n* =520)	
	%	#
ASHA	53.5	278
Other facilities or professional connections	38.9	202
Other related professional organizations (e.g., Feeding Matters or the National Association of Neonatal Therapists)	34.0	177
Social media or online speech-language pathology communities	10.8	56
I don't know.	32.3	168
Other (Please specify.)	6.2	32

Other responses

- ASHA; however, I don't feel the current available competency forms are over generalized by my company and not specific to accurately determine competency for our patient population. My company prefers competency to be acquired via mentorship provided via fellow SLP colleagues as opposed to independent study. My preference is first course work and then mentorship. Mentorship is most successful when paired with an independent knowledge base. It can be difficult to keep up with current best practice given trends, but it is so important to provide skilled evidence-based practices.
- BACB
- CEUs
- data based literature for outcomes, etc.
- Dept of Education
- Developed independently based on opinions of older SLPs.
- Employee input related to current high demand need.
- ESDM, DIR, Play Project workshops.
- From courses, textbooks, and experiences

- HR
- I create my own standards.
- I created them with a team of other advanced clinicians.
- I have often been the only SLP who held the role. competencies were established according to ASHA, APTA and AOTA
- I have to write them myself.
- I spent a lot of time and money taking seminars.
- IDDSI
- Internally developed.
- It works with our local university and specialists to determine clinical competency in infant and pediatric dysphagia. Our hospital reimbursement is for state license only, not asha CCC. It does not recognize asha or follow ASHAs guidelines.
- Leadership training
- Literature reviews
- Med bridge
- NANT
- Peer reviewed journals
- Research articles
- Sandra Holtzman Orofacial myology program
- Specialists in the area (i.e., OT for sensory feeding, SLP for swallowing, PT for musculoskeletal) design our competencies using references and their clinical knowledge.
- speechpathology.com; meaningful speech courses
- State Guidelines for EI programs
- Use of department specialists
- We also use the norms from NIH.
- We develop them ourselves.
- We use awareness of appropriate test presentation, documentation, and toy cleaning.

21. Does your facility accept graduate student interns?

Answer Choices	Responses (*n* = 1,050)*	
	%	#
Yes	77.0	808
No	23.1	242

*Participants who answered 'Yes' to this question were guided to Qs 22 & 23, all others were skipped to Q24.

22. Do you feel that your employer supports you and provides the resources you need to successfully mentor a graduate student?

Answer Choices	Responses (*n* = 812)	
	%	#
Yes	67.1	545
No	12.1	98
N/A; I don't mentor graduate students.	20.8	169

23. Does your team or facility have a process for supervising students throughout their clinical rotation?

Answer Choices	Responses (*n* = 802)	
	%	#
Yes	78.9	633
No	21.1	169

24. Does your facility accept Clinical Fellows?

Answer Choices	Responses (*n* = 1,040)*	
	%	#
Yes	75.7	787
No	24.3	253

*Participants who answered 'Yes' to this question were guided to Qs 25 & 26, those who answered 'No' were skipped to Q 27.

25. Do you feel that your employer supports you and provides the resources you need to successfully mentor a Clinical Fellow?

Answer Choices	Responses (*n* = 787)	
	%	#
Yes	59.0	464
No	10.8	85
N/A; I don't mentor Clinical Fellows.	30.2	238

26. Does your team or facility have a process for mentoring Clinical Fellows outside of what is required by ASHA?

Answer Choices	Responses (*n* = 773)	
	%	#
Yes	52.7	407
No	47.4	366

27. Does your team use clinical pathways to standardize care for certain diagnoses or medical conditions (e.g., NICU, trach/vent, cardiac)?

Answer Choices	Responses (*n* = 1,023)	
	%	#
Yes	29.1	298
No	70.9	725

*Participants who answered 'Yes' were guided to answer Q28, those who answered 'No' were skipped to Q29.

28. If yes, what resources did your team use to develop said pathways? (Select all that apply.)

Answer Choices	Responses (*n* = 289)	
	%	#
Interprofessional practice (IPP) team input	80.6	233
Other facilities' protocols	54.3	157
Research/technical reports	67.1	194
Other (Please specify.)	5.9	17

Other responses

- Clinical Specialists in that area helped develop protocols.
- I develop my own protocols.
- I don't know (10)
- I'm not involved in assessment.
- Not as systematic as would be most useful.
- Our hospital's designed protocol
- Understanding of our community's needs
- Unknown- not working IP.

29. Did you receive training in trauma-informed care or counseling at either the graduate school or professional level? (Select all that apply.)

Answer Choices	Responses (*n* = 1,015)*	
	%	#
Yes, at the graduate school level	23.5	238
Yes, at the professional level	40.0	406
No	43.5	441

*Participants who answered 'Yes' to this question were guided to Q30, those who answered 'No' were skipped to Q31.

30. If you received training in trauma-informed care or counseling, do you feel that it was adequate?

Answer Choices	Responses (*n* = 572)	
	%	#
Yes	53.3	305
No	46.7	267

31. What are the biggest barriers to implementing evidence-based practice in your setting? (Select all that apply.)

Answer Choices	Responses (*n* = 1,002)	
	%	#
N/A; there are no barriers.	22.4	224
Administrative policies or guidelines (“red tape”)	19.6	196
General hesitancy to change amongst colleagues	21.6	216
Lack of buy-in from colleagues	11.9	119
Productivity demands and/or lack of time	62.7	628
Research is lacking or slow to develop.	26.1	261
Other (Please specify.)	8.2	82

Other responses

- Access (paywall)
- Access to research
- All other SLPs use ABA or compliance-based treatment.
- Although I make sure to provide EBP
- ASHA not providing free ceus or fee journal access with our yearly dues.
- Budget for new materials
- Buy in from families.
- CEU's are very expensive.
- Cost
- Cultural change is challenging and research is often conflicting.
- Decreased knowledge from colleagues
- Dedicating the time to keep on top of newest evidence
- Differences between clinical practice recommendations and medical team knowledge
- Difficult to find research/ having it readily available without memberships
- difficulty accessing relevant non-ASHA publications
- Doctor pushback
- Expense
- Extremely cost prohibitive to attend CEU courses in pediatric feeding & swallowing. I wish there were more SLPD or university level classes focused in this area because then my employer would pay for it.
- Family and parental involvement needed for implementation.
- Finances/Funding (3)
- Financial barriers and ASHA has also approved cues based on pseudoscience.
- Funding for training in evidence-based practice/or funding for equipment
- General hesitancy to change among ownership.
- I am a new PP owner and solo practitioner. Most continuing education courses/certificates are costly. Previously I have had so many administrative policies limited my continuing education that I am playing catch up now with the freedom of my own PP.
- I am self-employed. I do my best to research EBP practices and implement on my own.
- I conduct home visits- we are limited in EI due to medical vs developmental model
- I just have to take the time to study the areas I am not familiar with and then implement the evidence-based practice.
- I own my own practice so I feel we are able to implement evidenced based practices at my setting
- I work with a very unique population and there is not AS much research/data for them.
- I’m independent I don’t do initial eval

- In regard to trauma informed care (previous question)- I chose to become a trauma-informed professional on my own.
- Inconsistent patient attendance
- Insurance and financial barriers
- Insurance barriers
- insurance limitations to frequency/duration of treatment
- insurance reimbursement
- insurance/financial and/or scheduling difficulties for optimal frequency of sessions
- Lack of access to materials & cont. education
- Lack of buy in from clients/parents unable to provide examples of goal activities that would be functional for them
- Lack of buy in from insurance companies/refusal to reimburse more expensive EBP
- Lack of buy in from other disciplines
- Lack of buy in from other health care providers
- Lack of buy-in from families
- lack of centralized implementation and/or education
- Lack of education/ experience/ buy-in from EI director
- Lack of implementation and take aways
- Lack of knowledge
- Lack of motivation for colleagues to keep up with best practice, lack of best practice guidelines from Asha, evidenced maps aren't enough
- Lack of resources- having to pay out of pocket for materials/CEUs
- Lack of resources, so many of the ASHA has so many of the research articles locked down and you have to pay when I already pay for a membership and access to the practice portal.
- Limited access to actual research articles needed
- Limited buy-in from caregivers and support staff in daycare facilities
- Limited hands on training opportunities
- many variables within and across infants and children
- my current caseload is limited, so CE is sought out when needed.
- No company funded support to access journals
- No opportunities for teaching/learning
- Not adequate access to resources
- Not connected to a clinical learning hub.
- Other professions not buying in
- Other SLP colleagues lack of knowledge and utilization of current best practices.
- parent attitudes/preferences/beliefs
- Paywalls to access research articles
- poor or lack of mentorship, minimal learning opportunities due to overwhelm from failing education and health care systems
- Private Practice
- Quick access to new info
- Restrictions from insurance companies
- Rural health - lack of resources in select areas of practice
- Scope of practice issues with OT, we need ASHA to be advocating for SLPs
- Small private practice and I am the owner
- Some materials are not available. As part of home visitor team, we often have difficulty getting parents to buy in and continue to work on protocols.
- Space and resources
- That's why I'm in private practice. No barriers. Maybe insurance payment.

- The money required to get adequate continuing education in needed areas as they are considered specialty.
- The population that I work with is not easy to standardize and create a "set" of treatment for
- Time is the biggest negative impact in my setting (acute care) I think for us all. That doesn't mean we can't use evidence-based practice. It would be better if there were no time constraints but that is not realistic.
- Time!
- Too much cost for materials and training
- Too much paperwork to prove to insurance whatever they need to know to fund the treatment.
- We are on the road w EI. In homes. No opportunities for interaction w colleagues for discussion of evidence-based practices, networking, peer education etc unless on a monthly staff meeting, via ZOOM w/ many things in agenda. Face-to-face opportunities are missed and were valuable when offered in the past. They were dwindling before the Covid pandemic and almost nonexistent now.

32. Does your administration and colleagues support Interprofessional Practice (IPP)?

Answer Choices	Responses (*n* = 994)	
	%	#
Yes	83.1	826
No	16.9	168

33. What frustrations or barriers do you face relevant to scope overlap or IPP? (Select all that apply.)

Answer Choices	Responses (*n* = 973)	
	%	#
N/A; I don't face any frustrations or barriers.	29.1	283
Lack of role delineation, unclear boundaries	21.3	207
Lack of time to educate interprofessional team members	43.9	427
Personality clashes	11.0	107
SLP's role is disregarded on the IPP team, poor understanding of our role by other members of the IPP team	21.9	213
Reimbursement challenges or limitations	36.7	357
Other (Please specify.)	6.8	66

Other responses

- ABA needs an ethical scope of practice that does not include communication.
- ABA??
- Arizona views all EI therapists are equals as we cotreat.
- Constantly changing providers in educational setting
- Difficult to co-treat.
- Doesn't apply. Only SLP office
- Ego overruling the need for cooperation, especially with BCBAs and others in the ABA field overstepping their scope of practice.
- Encroachment

- High and fluctuating caseload with staffing shortage, and productivity expectations
- Huge caseloads
- I am a small independent practice.
- I am the sole provider and not in a team-based facility.
- I don’t know if they support it.
- I don’t see my colleagues and rarely communicate with them.
- I don't know what IPP is (5)
- I struggle with knowing how best to communicate with doctors outside of my practice.
- I work on my own in private practice and don't experience this.
- I’m newer to this agency and have not heard of experienced this where I work.
- In NJ, children are given Developmental Intervention services when they need SLP. Families are told they are not “ready” for speech due to not having acquired prelinguistic skills. They often don’t get ST til 32-34 months when autism is suspected. I need them sooner, like 14/15 months.
- Insurance companies are unwilling to negotiate with small businesses.
- IPP is supported but limited at this current time being a solo practitioner.
- Lack of collaboration opportunities
- Lack of comprehension of scope of SLP as a science. Gradually improving
- lack of time at work available to communicate with others outside the office.
- Limitation of resources provided by insurance to provide the best collaborative treatment.
- limited availability of IPP professionals
- Limited pediatric staff in organization
- Medicaid will not pay for co-treatment and some children would really benefit from that.
- minimal leadership buy in
- Most colleagues don't consider it, I don't actively promote it
- My practice is private pay only and I don't feel parents would want to "double" pay for a session (and possibly preschool at the same time)
- NICU
- No opportunities to interact with other professionals.
- No trouble with rehab IPP difficulty with doctors and time to meet/round.
- Not applicable to private practice
- Not initiated by admin/supervisory staff
- Occupational therapist taking too large a role in treating swallowing disorders
- Often there was poor understanding of our role in dysphagia.
- our clinic has only SLP's
- our sessions are shorter than colleagues due to reimbursement.
- productivity
- Productivity demands creating scheduling challenges.
- Regionally, OT's have overtaken all feeding/swallowing even in hospital instrumental evaluations of swallowing.
- Scheduling (2)
- Scope of practice issues with OT, we need ASHA to be advocating for SLPs
- Structure of the program, EI, at people's homes, travel, scheduling
- There are frustrations and challenges working with other stakeholders in a patients care outside of the clinic. Typically, this occurs with professionals trained in ABA. This seems to confuse parents especially when there are conflicting techniques and recommendations.
- There are no specific practices in place. I’m a case by case basis, we work as a transdisciplinary team for more complex children.
- These survey questions are not applicable to me as a private provider as I don't have an employer. I don't know what IPP is..

- They work for other companies so we're in different locations.
- Time
- Time to coordinate efforts.
- Unclear boundaries at first, although my clinic is actively working to refine roles.
- Unclear boundaries in reference to ABA and BCBA's/RBTs. They are often working outside of their scope and/or competency.
- We don't have other types of providers in our office, just SLP.
- We don't use this term IPP.
- We need someone other than ourselves to say who we are and our expertise; nobody believes someone who says "I can do this" but they might believe a larger awareness campaign for example.
- We're all independent providers, so collaboration is limited.
- Years ago we were always able to co treat, we are no longer able to do that due to billing.
- You need permission to work together in EI.

34. What resources do you use to support your practice in the day-to-day? (Select all that apply.)

Answer Choices	Responses (*n* = 978)	
	%	#
ASHA SIGs	27.6	270
Other professional organizations' special interest groups (local, state, or national)	53.0	518
Journal articles	63.5	621
Professional memberships	58.1	568
Social media	60.0	587
Other (Please specify.)	8.5	83

Other responses

- AAPPSPA, IAOM. I think ASHA is worthless and does nothing really to help the profession. I have to go to other organizations to learn and get support. Right now RDH want to do feeding and swallowing and trying to get it in their licensure and ASHA is doing nothing about it! Shameful ASHA!
- Advocacy for appropriate insurance reimbursement. Pediatric private practice is being driven out of business by insurance. My rural population can't afford to pay out of pocket. Health care is becoming a privilege available only to those with means. I've had to drop all but 2 insurances, and those have held rates stagnant for 20 years and one just dropped by $7/unit. They refuse to renegotiate.
- Any resource I find using Google that seems reliable and puts into plain language things I read in research articles.
- ASHA Learning Pass (2)
- ASHA website and association resources for inquiry
- Blogs
- Books, experience
- CEU providers (podcasts)
- CEUs
- Classes I have taken online.
- Collaboration with colleagues of other therapies/disciplines
- Collaboration with other SLPs and professionals

- Collaboration among coworkers and sharing of information.
- Collaborations with colleagues (9)
- Colleagues-we each read current articles and share that info with each other on a regular basis.
- Conference with other professionals and referrals to them
- Conferences
- Constantly seeking out con Ed
- Consult with colleagues.
- Continuing ed
- Continuing ed and consultation with colleagues here and elsewhere
- Continuing Ed, books, articles, research articles other professionals, families
- Continuing education
- Courses
- Credible SLP websites on Google search
- EBP
- Feeding Matters, WHO
- I am considered a resource in this entire area of practice in pediatric swallowing and feeding disorders.
- ASHA Wire
- I'm done with ASHA - I learn very little from them. It's a money grabbing organization.
- In house CEUs
- Independent material developers, Teachers Pay Teachers
- Informed SLP (4)
- Interactions with other professionals
- Knowledgeable Coworkers
- Local professionals that are experts in the areas targeted
- Mentorship
- Mentorship of supervisors , collaboration with colleagues
- My hospital provides access to medical journals since ASHA does not.
- My own critical thinking and decision making; knowing my clients and their stated needs. Why isn't this the first option here? Btw, I do not trust ASHA to guide me on ANYTHING. ASHA is a woke joke.
- My peers and online resources
- NANT
- Online learning (2)
- Online CEUs
- Online resources and education opportunities
- Peer to peer
- Peer trainings and large rounds with pediatric feeding interest from several children's hospitals
- Podcasts (3)
- Professional collaboration
- Professional connections
- Professional podcasts
- Researching challenging topics/clients/disorders on my own, contacting peers
- Resource materials
- Resources from continuing education
- Resources from my professional trainings; consulting with colleagues, professional articles in speech and other fields
- Resources/training provided by my company.
- SLP colleagues

- Small groups of peers via online/zoom I highly respect who I can collaborate with
- Specialists within the specialty
- Staff/Specialty committee interactions and meetings
- Subscription services and blog/materials online/pay-for ready-materials.
- Support/ knowledge shared between coworkers.
- Teachers pay teachers, twinkl.
- teachmetotalk podcasts, website, manuals
- Team meetings in the organization I work for
- Textbooks
- Virtual CEUs
- Websites such as Teachers Pay Teachers, Lessonpix, vendor websites such as Tobii, DynaVox, and Assistiveware

35. Is there SLP representation in your management or administration?

Answer Choices	Responses (*n* = 994)	
	%	#
Yes	69.8	694
No	30.2	300

36. If you work in the NICU or on a specialty unit, is your position housed under rehab or under the specialty unit on which you work?

Answer Choices	Responses (*n* = 994)	
	%	#
Rehab	15.6	155
Specialty unit	2.2	22
N/A; I don't work in the NICU or on a specialty unit.	82.2	817

37. Are there staffing shortages in your speech-language pathology program?

Answer Choices	Responses (*n* = 994)*	
	%	#
Yes	62.5	621
No	37.5	373

*Participants who answered 'Yes' to this question were guided to Q38, those who answered 'No' were skipped to Q39.

38. If yes, do you find it difficult to recruit SLPs with the skills needed for your setting?

Answer Choices	Responses (*n* = 619)	
	%	#
Yes	92.3	571
No	7.8	48

39. What can ASHA do to best support you in your clinical practice? Leave the field blank if nothing comes to mind.

Responses

- Access to free or discounted continuing education courses relevant to pediatric speech therapy.
- Actually advocate for higher reimbursement rates. It's basically robbery that ASHA charges so much for a membership and its members receive ZERO tangible benefit. ASHA should be ashamed of themselves for charging such a high fee every year.
- Actually advocate for us and our needs. Do something with the money we send you every year. Or reduce the amount we must give to maintain our CCC's, as I do not feel I receive any support as an SLP from ASHA. I feel I throw away money to you, just to practice in my field.
- Actually advocate for us instead of take all our money and do nothing for us
- Actually use the money we pay every year to advocate for better insurance reimbursement rates so we can get paid better instead of lining the pockets of the board. We need to get paid more period. ASHA also needs to advocate for reduced tuition. I'm so deep in student loan debt for this career I'll never get out of debt and I don't get paid well there is no where I can go to get paid better. I shouldn't have to work two jobs with a masters degree to make ends meet.
- Address policy at the state level. NJ early intervention refuses to allow Slp's to directly address feeding issues in our goal though we test for it and discuss it. Many treat anyway because with the family. It's not good to have services under the radar. Nj advocates have had no success
- Address productivity demands
- Advocacy for Peds dysphagia, Peds medical coursework in grad school. Advocacy regarding productivity expectations
- Advocacy for reimbursement from Medicaid and other payers. The greatest struggle in practice has been that it is impossible to make the business financially feasible in an underserved community where the children desperately need services, but are 99% Medicaid patients.
- Advocacy re reimbursement
- advocate and educate the public/aba clinics/insurance companies/etc regarding the importance of our roles.
- Advocate at the state and national level for increased reimbursement for our services which will in turn lead to better pay/flexibility for lower caseloads. Advocate for development of unions, caseload caps in schools on a national level, and pay for slps to be placed on a related services scale rather than a teacher pay scale.
- Advocate at the state level for higher pay. We do not get paid enough for what we do and we are the only specialty that doesn't. ASHA should support us, not just take $250+ from us every year for very little return
- Advocate better for equal pay.
- Advocate for appropriate compensation, adequate productivity, and better courses in graduate school.
- Advocate for appropriate salary increases so we can pursue continuing education courses and certifications. Advocate for lower productivity requirements to allow to research and professional development.
- Advocate for better insurance and Medicaid reimbursement rates.
- Advocate for better insurance funding so we can get better reimbursement and earn appropriate wages without the burnout factor
- Advocate for better insurance regulation, implement case load caps (especially for schools), and consider residency program development for some specialized areas (feeding/swallowing, craniofacial, voice)
- Advocate for better pay from insurance providers.
- Advocate for better reimbursement from Medicare and Medicaid. Increase research

- Advocate for better reimbursement insurance rates so we can have time to educate others on our profession and provide the necessary coordination of care for our clients.
- Advocate for better reimbursement to improve pay in medical setting
- Advocate for better reimbursement rates for our field, offer more cost effective continuing education, reduce our annual dues or make them biannual
- Advocate for better understanding of our profession. With IPP, there are other professions that try to take our place and we have an uphill battle to explain our relevance and importance. Also advocate for better pay within our field.
- Advocate for better wages.
- Advocate for differentiation between PT/OT and SLPs in productivity expectations as well as advocate for adequate time for documentation and research due to the wide range of disorders that we see and interact with daily.
- Advocate for graduate programs to include education on and clinical opportunities in medical pediatric speech-language pathology.
- Advocate for greater pay, reduce membership fees, and lobby for better licensure laws (e.g. limited licensure is not renewable any more in Michigan which makes it difficult for CF's if they are mot able to finish their fellowship in 1 year).
- Advocate for higher insurance reimbursement rates.
- Advocate for higher insurance reimbursement. We can't increase pay for our employees without rate increases. And it's difficult to hire
- Advocate for higher insurance reimbursement. We faced a DECREASE over the last few years and that means we have to work more to make up for it- less time to do the research, training and outreach that we want to do. Less funds to purchase the materials and courses we need.
- Advocate for higher pay AND advocate for paid time for inter professional collaboration AS WELL AS documentation time. I am 1099 contractor and am only paid for my billed hour with clients. I often feel I am working so much off the clock in order to collaborate and complete documentation. This is inherently lowers my hourly rate and does not feel fair practice. I know this is did tacked by insurance reimbursement, however, I feel even contractors should be offered some form of compensation for hours spent outside of the session.
- Advocate for higher pay and lower productivity requirements to allow for documentation
- Advocate for higher reimbursement from Medicaid and Medicare! Lobby. Reduce waste. Lobby for higher insurance reimbursement. Educate SLPs on how to credential with insurances and submit claims.
- Advocate for higher reimbursement rates for insurance and Medicaid for pediatric clinical services
- Advocate for higher reimbursement rates from government funded programs & insurances + advocate to have billable time with indirect time with patients (I.e., writing reports, contacting/collaborating with other professionals, scheduling phone calls with patients/caregivers to discuss ongoing tx plan, creating homework or home care plan for carryover)
- Advocate for higher reimbursement rates from Medicaid.
- Advocate for higher reimbursement rates so SLPs in smaller clinics can receive fair and competitive pay.
- Advocate for higher reimbursement rates so that employers will compensate competitively.
- advocate for higher reimbursement, work with regional centers to allow CFs to treat and assess in Early Intervention
- Advocate for higher SLP reimbursement rates. Change our certification standard to Doctorate level, as PT did several years ago. Our education and expertise warrants it, and it would help with the healthcare industry recognizing the importance of what we do.
- Advocate for higher wages and reimbursement from insurance
  Encourage more states to join the compact licensure
- Advocate for improved reimbursement from insurance companies. Reimbursement for services is always an issue, especially with Stuttering.

- Advocate for increased diversity among SLPs
  Officially condemn behaviorist treatment of autistic clients
  Require education about natural language acquisition (analytic and GESTALT language development) at the undergraduate and graduate level
  Require more education about neurodiversity (ADHD, autism) as those diagnoses will likely continue to be the majority of most pediatric SLP's caseloads
- Advocate for increased pay, in order to recruit and train younger SLP. Advocate for salary increases for very experienced therapists.
- Advocate for increased reimbursement for Early Intervention. My current pay is $30K less than other areas of SLP practice in MA
- Advocate for increased reimbursement for speech related services
- Advocate for insurance companies to pay more for services so we may be properly compensated
- Advocate for insurance companies to reimburse speech therapy codes adequately.
- Advocate for more peds medical education in graduate school.
- Advocate for our profession to continue to ensure proper compensation for our masters level specific skills.
- Advocate for pay increases for SLPs.
- Advocate for reasonable insurance reimbursement and more publicly for the role of SLPs in the diagnosis and treatment of dyslexia.
- Advocate for reduced productivity requirements and increased education time.
  Advocate for increased requirements for pediatric education in graduate programs
- Advocate for stronger boundaries and penalties for ABA therapists attempting to treat communication disorders
- Advocate for the insurances to increase the reimburse for private practice owners to speech therapy services.
- Advocate for timed codes. Support us as insurance companies make ridiculous demands and deny coverage on a whim. Get us regulations more in line with what other clinical professionals have.
- Advocate for us to have more pay, reduced productivity demands to reduce burnout.
- Advocate for us! We continuously get underpaid, overworked, and unappreciated. I feel fooled to have entered this profession. I wake up sad every day. Do better for people who just want to help people.
- Advocate to increase reimbursement
- Advocate, lobby, encourage development of state unions/national union
- Advocating for increased pay
- Advocating to hire reimbursement rates from insurances to allow for better pay rates for SLPs working in rural areas with excessive amounts of commuting between patients and increased caseloads due to lack of availability to SLPs in rural communities.
  Simple, short, digestible and applicable EBP recommendations related to sensory dysregulation and gestalt language processors/processing.
- Allow for working with patients across state lines, there are so many kids who need intervention but maintaining multiple state licensures makes that very challenging
- As an SLP working in a children's hospital, I find that there is a general lack of information/research as it pertains to pediatric TBIs. I would love for ASHA to provide CEU courses or further information to highlight this topic so that we can better serve this patient population. Additionally, it would be ideal for there to be a push to have a collaborative network of medical SLPs specifically working with the pediatric population. My colleagues and I previously attempted to facilitate multi-site journal club with other children's hospitals in the past without success (due to the lack of time we have to allocate towards these efforts during the work day). Please help our small subset of pediatric medical SLPs have a place or platform to connect.

- ASHA can begin to advocate for speech therapists including fighting insurance companies to increase reimbursement rates so we can actually be paid what we deserve to be paid. ABA programs are being carried out by RBTs that have 40 hours of experience and insurance is covering up to 40 hours per child, yet we fight to get insurance to cover 1-2x/week and speech therapists continue to be paid low rates. I feel that ASHA could step it up and be the voice for us. There also needs to be a clear statement in regards to ABA therapy and its role in creating trauma in autistic individuals.
- ASHA can fight for higher pay for SLPs across the board. ASHA needs to take a hard look at the cost of yearly membership and SIGs.
- ASHA can support me best by getting the fuck out of my way. ASHA can stop stealing my money and holding my licensure and therefore ability to provide for my family, hostage. ASHA can stop speaking for me and my morals and ethics by making political statements that are in direct opposition with my personal and held beliefs. ASHA can stop sending invoices for CE registry that is optional but made to look obligatory. Fuck right off.
- ASHA could lower its yearly fees as it seems they do little to nothing to support SLPs with that money. They use it fill their own pockets
- ASHA could make a much stronger effort to increase billing rates nationally. We are under appreciated and under respected which means we are underpaid and overworked. The reimbursement rates are an embarrassment to ASHA, never mind the individual pathologists. I don't get the impression that ASHA has much pride in taking actionable steps to support its members. Most communication from ASHA is largely irrelevant to the day-to-day workers relying on insurance reimbursement to pay our staff, serve our community, and survive. It is what makes our profession possible.. and it is less and less sustainable by the week!

  It is also insulting that an organization as large as ASHA charges such an intense fee to post job listings. That doesn't seem to be in the heart of our profession. This is not beneficial to our ASHA members looking for jobs, either, because both employers and possible employees are turned off by the cost requirement. Small businesses can't afford $3k for a single job listing and therefore don't use the feature. This means less jobs advertised in one place for those looking for the position of their dreams. ASHA does not bring SLPs together in this way, you pit us against each other through demanding money to connect with each other. Isn't that what our dues are for?
- ASHA has been providing high quality CEUs. If their prices can be lower/more affordable it would be great. Thank you.
- ASHA needs to advocate for better insurance reimbursement for speech language pathology services. Medicaid in Oklahoma is reducing its reimbursement rate for SLP services, yet the cost of living is going up. Many private insurance companies limit the visits for SLPs to provide services. I did not get a raise last year and might not this year because of the insurance issues.
- ASHA needs to advocate for higher insurance reimbursement and overall awareness of our field and skill set.
- ASHA needs to do a better job providing unrestricted content that I can use in clinical practice. I pay more than enough in dues and I hate being nickel and dimed to be able to access content from ASHA.
- ASHA needs to work with graduate schools to expand their programs. CSD at graduate level is very competitive because most programs accept less than 100 students. Compare this to the education field where programs are more robust. There is a SEVERE shortage of SLPs in every are of practice and this will not end until we get more students graduating.
- ASHA should support increase reimbursements to help raise our pay to attract and train qualified therapists. Many slps are provided jobs with no benefits. I absolutely love being an EI SLP, but I could not do it without my husband having the job he has. My position has no benefits or PTO and the pay rate should be raised due to the rise in cost of living. Our jobs should not be accessible due to our marital status. EI is a critical component in supporting development and all therapists involved should have fair compensation.
- ASHA website is difficult manipulate to find info

- Assist with reimbursement negotiation and increases in reimbursement so that we can be competitive for hiring as well as keep up with the high cost of living increases.
- Assistance to streamline documentation/ best practice implementation and work with insurance companies to improve coverage for SLP services.
- Back off and let us do our jobs instead of creating more hoops for us to jump through unnecessarily. No SLP I know thinks ASHA is valuable.
- Be more aggressive in fighting for higher reimbursement rates w/ insurance companies so that our salaries are more competitive and recruiting for small practices more effective. Establish some sort of group health insurance program for small practices to be able to provide health insurance benefit to their employees. Promote an increase in the number of graduate students in our field to reduce shortages. Protect our roles from being compromised byother professionals such as OT and ABA working on articulation, language, and feeding. Allow for private practice development as continuing education credits.
- Be more supportive to applied behavior analysis. Promote EB work rather than opinion. Facilitate collaboration more and in a positive way.
- Because I am a sole provider, I need quick CEUs and short articles to stay up to date on EBP.
- Become true advocates for speech-language pathologists in ALL settings.
- Better advocating to the insurance companies regarding the number of sessions and importance of our work. Most insurance companies we work with only support 30 sessions in a year
- Better professional journals
- Better reimbursement
- Better reimbursement from insurance companies. I live in Illinois and only one insurance company (BCBS) reimburses for speech therapy in the pediatric population. Also RDH (dental hygienists) in my state are lobbying to get their license changed so they can treat infant and toddler feeding disorders. I wish ASHA would step up to help us fight these battles so more families could have access to speech therapy through their insurance and so RDHs won't potentially put infants/babies at risk by performing a service they are not adequately trained to perform
- Better support and regulate graduate programs. Create better guidance for CF mentorship. Stop charging me 100s of dollars a year just to maintain my CCC without offering meaningful support.
- Beyond ASHA and business- related.
- Bring back requirements for clinical externships so they have more than just the specialized experiences (I.e. NICU, cardiac units)
- Challenge insurances like Tricare to allow CF's to see their patients.
- Change billing coding to allow more focus on quality of therapy and not quantity of patients. Changing the time is sessions allows less focus on productivity
- Change our name, SLP does not clearly show what we do at a pediatric hospital level. Improve access to quality CEU's (cost is a huge barrier) and many employers now only reimburse for certifications. Stop making political statements and start focusing on the needs of SLPs
- CHARGE LESS FEES. ITS STUPID TO PAY $225 FOR NOTHING ANNUALLY. ASHA IS ONLY WORTH <$25 a year to me and EVERY SINGLE SLP I KNOW. It is grossly out of touch with how terribly we are paid to price gouge us into an obscene annual fee for no reason that NO other equivalent professional field has to pay. Stop. The. Madness.
- Competencies in specific areas of heightened concern for safety may be established by ASHA as indicated by CEU's and caseload…
- Consider lobbying for better bill rates with insurance companies.
  2. Set a minimum standard bill rate at the state level (specific to setting) for professionals to negotiate salaries.
  2. Due to the demand and need for SLPS in the US. ASHA should advocate for immigration policies for its professionals trained in the US such as considering SLPS to be listed under occupations of national interest as there's always a need for SLPS.

- Continue advocacy for reimbursement of services at a level that is adequate to hire and retain skilled therapists at a commensurate pay.
- Continue advocating for appropriate reimbursement rates to keep pay at a livable wage vs decreasing when compared to inflation
- Continue the ASHA Learning Pass, it is affordable to my employer and helps me stay up to date on latest practices and evidence based practice, strategies and techniques.
- Continue to advocate for adequate staffing and pay
- Continue to lobby for insurance coverage of SGDs
- Continue to offer CEU opportunities. Information sharing in ASHA Now (as you have been doing).
- Continue to offer the nice variety of continuing education courses.
  2. Better lobbying efforts for insurance reimbursement. Payments have not increased in the last 10 years!
- Continue to produce high quality continuing education, as well as continue to produce recommended competencies (such as the FEES competency)
- Continue to provide CEU specific to NICU training
- Continue to provide education in the area of infant/newborn feeding difficulties
- Continue to support challenges in rural and remote locations
- Costs of SIGs and CEU's decreased, more accessible research articles, fight for higher reimbursement rates so that more time can be spent on learning new skills rather than overscheduling caseload
- Decrease cost for clinicians to receive and continue to pay for CCCs. It feels like ASHA is in the money making business and not out to support clinicians.
- Decrease cost of asha dues/provide resources with paying for the dues
- Decrease cost of membership. I do not get any benefit from ASHA and only pay because my employer requires it
- Decrease the amount we pay in dues. It is too expensive and I don't see any benefits. I do not make enough to spend that kind of money at the end of the year.
- Decrease the prices to post job listings
- Do away with Asha dues.
- Educate graduate students in oral motor and feeding skills, sensory skills and positioning.
- Educate the state of New Jersey's early intervention program on the importance of SLP being provided to children who demonstrate delays. DI is not the same as SLP. DIs are not qualified to treat communication disorders. Children are entitled to access to SLP sooner.
- Eliminate productivity requirements. Continued competencies throughout the lifetime of the license
- Encourage graduate schools to increase their class sizes. There is a major shortage of SLPS. My clinic alone has been looking for an SLP for over 6 months are we are located in a populated area.
  ASHA can also do more to incentives SLPs to take students (discounted ASHA dues, etc.). I believe there is a lack of placements for graduate student
- encourage more onsite training; stricter standards for who can provide supervision to students/CF; increase variety of education such as pediatric dysphagia or dysarthria
- Ensure graduate students are receiving education in orofacial myofunctional disorders and how to improve oral motor skills from infancy to adulthood.
- facilitating increased number of graduates.
- Fight against insane, anti-scientific and harmful mask mandates for children.
- Fight for appropriate reimbursement
- fight for better reimbursement of services and valuation of services provided.
- Fight for higher reimbursement from insurance, lower productivity standards to reduce burnout. Paid documentation time
- Fight for higher reimbursement rates

- Fight for reimbursement rates and better pay so that we don't constantly have shortages. With shortages come all the other challenges mentioned in the survey.
- Fight the ABA fraud that's overtaking our scope and harming clients
  Better insurance reimbursements, incentivized pay scales based on acquiring skill, not years in the field
  Generally better working conditions
  Greater understanding from educational, healthcare, local communities of our role, importance, and specialization.
- Find ways to assist with insurance reimbursement standards or advocate for us to balance bill!
- Frankly, I am in a unique "senior" position - this survey appears more relevant to younger/mid-level SLPs.
- Free access to all journal articles and CEUs. Stop supporting ABA and help conduct research regarding autism using input from autistic professionals. Mostly stop supporting ABA and speak out against their encroachment into our field.
- FREE Ceu opportunities, use ASHA's money and membership fees to advocate on behalf of SLPs and make changes in the department reflective of what it's members would like, reduce costs of membership, make earning continuing education more accessible and less expensive to increase opportunities to continue to learn as a professional
- Free CEUs (2)
- Free Ceus. Advocate for productivity limitations.
- FREE CONTINUING ED, EMPHASIZE & ADVOCATE FOR REIMBURSEMENT FOR SPEECH TO INSURANCE, STOP CHARGING US A FORTUNE FOR NOTHING!!
- Free/low cost CEU, better advocacy for reimbursement
- Further research for standardization in initial evaluations, brochures for parent handout, better access for resources for families
- Get higher reimbursement rates and reimbursement for more services such as report writing, parent conferences and phone calls.
- Get insurance payors to pay us what we deserve. Pay for longer assessments.
- Get more people in the field and make education Accessible and Affordable.
- Go to bat for us regarding reimbursement
- Graduate schools should accept more qualified people into their programs rather than limit the number of students that are accepted I also think they need to accept students based on their qualifications (performance as an undergrad,GRE scores, references from clinical supervisors) not based solely on their Sex, gender, race or all the diversity issues that are being pushed by society
- Grants for budgets, our biggest barrier to patient access is space and money. We can't hire more SLPs due to limited space/treatment rooms.
- Hands on training for acute care SLP in peds is absolutely necessary no matter if student, CF, or established SLP
- Have a forum of graduate students to post their resumes for free; or jobs for free.
- Have graduate schools have a specific pediatric feeding course.
- Have graduate students have more on-campus, in-person experience prior to beginning internships, not master clinician type experiences.
  Nor focusing on school-based or medical-based speech pathology, but rather on effects of all disabilities, regardless of practice setting.
  More opportunities for SLPAs in the outpatient setting.
  Insurance reimbursement should be different for the types of therapy we provide.
- Have more *truly* advanced continuing ed, particularly as related to healthcare, including reviews of research being published in non-ASHA journals, physician speakers, more collaboration with other professional organizations/associations/societies
- Have more free CEUs available online.

- Have more research, current research available on line
- Have pediatric Dysphagia course mandatory for graduate education.
- Help get more speech therapy programs into graduate schools
- Help guide educational institutions on the curriculum that would help prepare SLPs work with the field of pediatric dysphagia,
  2. Communicate with OT profession on promoting team vs. sole OTs providing hospital based feeding therapy.
  3. Maybe consider a roster of seasoned SLP volunteers to mentor other SLP interested or starting to practice in pediatric feeding d/o
  4. Decrease cost of CEUs, ASHA sponsored
- Help increase SLP pay - it has decreased markedly over the past couple of decades. I would never have chosen this profession now. There are other related fields where you can make a lot more. This career is for married/partnered woman with a dual income. It is not a good option for the school debt and salary after grad school if you have to support yourself.
- Help provide more support to our organizations to allow much needed time to do research, provide better services to students and CFs, and give ideas on ways to look into research easier. Our organization also only accepts students from the main U of M campus and not to the other smaller campuses, which is frustrating. I went to school at one of the smaller campuses and had a lot less option for learning at pediatric hospitals and wish I would have known that going into grad school to set myself up better for success and learning in areas of interest.
- Help push Rural Coverage and lessen hours needed due to increased travel for our SLPs and CFs
- Help us form a union so that SLPs are able to take time off work to complete CEUs and have CEUs reimbursed without being penalized for missing work for professional development. Mandate that pediatric feeding and swallowing disorders be addressed in graduate programs as an individual course not a day or two taken out an adult- focused course.
- HELP US GET FAIR WAGES. I am humiliated to share what I make with peers in other fields given the amount of time and energy I put into my job. It's sickening. In my view ASHA does absolutely nothing with the hundreds of dollars in dues that I pay them
- Help us increase Medicaid reimbursement rates in WA state. $44.79 per session is NOT sustainable. My health ins premiums increases by 32% and cost of living continues to increase steadily, yet Medicaid rates dropped.
- Help us negotiate productivity requirements and pay
- Help with issues in the workplace. Lobby for better working rights and push for more rotation, set boundaries and expectations that employers have to follow. Provide more free CEUs
- Help with reimbursement challenges
- Higher reimbursement rates, caseload caps
- I am an EI SLP in the home environment. Having classes that support the family at home and are parent friendly.
- I am concerned about ABA encroachment into our profession and ASHA needs to take a stand against what they are doing
- I can no longer afford to hire skilled clinicians given what insurance reimburses. I can hire only new grads at rates exponentially higher than what I paid before Covid. They are worth higher wages, but I can only afford minimal cost of living raises for about 5 years before I'm priced out. Then they go to the schools for a $10k raise/year and 3 months vacation. Private practice is dying and I'm feeling zero support from ASHA. Yes, I'm on the state CPC committee. We're all feeling lost.
- I can't think of anything right now
- I graduated from grad school in 1998. We had ONE class period for pediatric dysphagia as part of our dysphagia course. A guest speaker came into class and presented. That was it on pediatric dysphagia for our entire education. Everything I know about infant/toddler feeding I know from professional development I've done on my own since graduating. I don't know if it can be required, but I feel like

ASHA should at least strongly encourage universities to provide more training on pediatric dysphagia. I worked in a school setting for six years after graduation and did not need it, and have worked in early intervention since that time and have needed it and had to get training on my own but still don't feel fully competent and in severe feeding cases where I feel over my head, I pass the referral on to our feeding expert therapist, who just happens to be that guest speaker from back when I was in grad school. I could never have gone into a hospital setting and known what to do with medically fragile babies with the training I received at the university.

- I just found out that the university I graduated from doesn't have a cleft palate class anymore. I don't know if they cover it in another class, but I just recently referred a child with a cleft lip to the local hospital craniofacial clinic and the SLP there said that she had a 14 year old submucosal cleft child show up on her doorstep after having been treated by at least 3 SLPs who never caught it. I believe that we need more medical training. After graduating, I had no introduction to PT, OT and what they do. I had never seen a child in a wheel chair or even knew how to work one, yet alone a trach patient. I did not feel prepared to work with the severe medical patients and yet I learned as I went along. Knowledge from the PTs and OTs was invaluable. If ASHA can give more classes on medically fragile children, that would be good. Also, counselling classes on how to work along side parents who are overwhelmed and just found out their child's diagnosis. Perhaps also going over how to work with medical professionals in a hospital setting. This is not my work setting now, but I think it is great that I had experience in the past with the craniofacial team and knew where to refer my client.
- I just want to say that my lack of training whether at the undergraduate or graduate levels was because I went to school in the 70s. I barely heard about dysphasia, but we never had any courses in it. We also did not have courses in AAC, autism, or feeding in those days. That came through continuing education.
- I think there are many great resources out there. I wish there was more at the graduate level regarding pediatric health care. We had a school issues class that was mandatory. I think we should have the option to take school issues or a health care issues course. So much of school-based concerns don’t apply at a hospital. Parent coaching needs to be a much stronger focus. Also, there was such an emphasis on theoretical diversity values and not on practical tips and strategies to facilitate communication across settings.
- I think there should be dedicated pediatric dysphagia courses and dysphagia courses in all graduate programs to prepare new grads. It would also be helpful to teach Trauma informed care in grad school.
- I work in a specialized pediatric feeding and swallowing program. It is very difficult for us to find prospective candidates with experience in pediatric feeding, or working with children with medical complexity. I went to school in a different region of the US, at a school that had classes in this area and allowed for a medical focus during clinical rotations. I now live in the DC area, and very few schools in the area seem to address pediatric feeding and swallowing, or have a focus on med SLP. I think schools should either divide tracks: med/core/school SLP, or schools should be required to have courses in pediatric dysphagia.
- I would appreciate expanded access to continuing education opportunities integrated into my membership. The separate charge for the ASHA Learning Pass seems incongruent. While recognizing ASHA's business objectives, I currently perceive limited benefits beyond maintaining membership status.
- I would love a specialty area or pediatric feeding and swallowing
- I would love to better use my SIG membership. Offering more affordable CEUs to getting on top of these people/programs that offer crazy amounts for CEUS would be great too. Most are so unaffortable.
- I would love to have access to continuing education resources that are included with our membership fee. I’m paying $225 annually to ASHA, and additionally paying hundreds to thousands of dollars each year for continuing education/training. This is in conjunction with low pay & low reimbursement rates. As a result I’m investing a significant amount of my personal income for continued education. I would also love to see some education/regulations and advocacy for SLPs and our scope of practice. I’ve worked in many ABA facilities and have seen quite a bit of encroachment and lack of respect and professionalism from BCBAs. I have only had one facility out of the many I have worked with over the

years be respectful of scope and willing to collaborate. The lack of compassion and lack of trauma informed care that I have seen with ABA therapy is highly concerning. Specific examples: non removal of spoon with feeding (after declining to collaborate with feeding therapist-this child-who had a documented medical reason for his limited diet- ended up on a gtube due to severe aversions as a result of these experiences), locking child in a bathroom for “bathroom protocol”, holding child down on a toilet for multiple hours, shutting patient in a closet and not allowing them to come out until they “calm down”, holding a large gym mat (by two grown adults) on a child until they “calm down”). These are just a FEW examples of what I’ve had to see over the years. All while BCBAs refuse to collaborate and refuse to understand there are skills that need to be taught along with compassion and connection in order for regulation and learning to occur. From a “boots on the ground” perspective, this is one of the many frustrating experiences SLPs have to watch on a daily basis. Support for this and advocacy for the children we serve would be so helpful. I’m passionate about the children we serve and I’m just asking that we find some type of solution so all of our children are respected and not harmed through any type of compliance-based therapy (including other disciplines (speech, OT, PT) that practice in this manner).

- I would love to see more ASHA-created videos demonstrating therapy techniques when possible. Sometimes CEs outline a program very well on paper, but it's unclear what this looks like when you put it into practice. Also, I'd love to see more video examples of what to do when clients don't engage or comply (adult and pediatric). Most CEs show how to complete a program with a perfectly compliant client, but don't provide a lot of examples of how to adjust if they aren't compliant.
- I'm in private practice which relies heavily on appropriate insurance reimbursement rates. Currently, in the state I practice and reside in, we are looking at private insurance companies possibly cutting reimbursement rates which will severely affect our ability to hire, train and provide support to CFYs or CCC-SLPs
- Impress upon hospitals and schools that multiple SLPs and SLPAs are a must; that there needs to be built in administrative time for SLPs like teachers have; that to limit school SLPs to at most 2 schools / have weighted caseloads; no meetings after school hours; provide more trainings of actual treatment of specific deficits and not so many courses consisting of majority background/theory and only a little bit of treatment. Instead, walk SLPs through the actual treatment process steps and provide guides to reference after trainings
- Improve the education programs for which you provide accreditation. Some programs a very lacking in providing staff with adequate backgrounds for the material that they teach.
- Incentivize PhD programs for new graduates, standardize dysphagia curricula across accredited programs, mandate more stringent vetting processes for adjunct lecturers who are teaching dysphagia, especially if there is no distinct peds dysphagia course available at the institution…my dysphagia lecturer had NO experience in peds dysphagia and glossed over the topic.
- Include graduate programs that specialize in pediatric medical setting. Include competencies that hold SLPs accountable for their knowledge and expertise in the anatomy and physiology of the oropharyngeal swallowing mechanism.
- Increase coursework required by graduate school
- Increase early intervention specific CEU's; SIG, etc.
- Increase education on cognitive and assessments needed for specific diagnostic evaluation/testing such as ADOS, KBIT, Mullen, Bayley, etc.
- Increase grad school education in pediatric and infant feeding and swallowing
- Increase graduate school openings and make cost of becoming an SLP less costly.
- Increase insurance reimbursement rates
- Increase Medicaid and insurance reimbursement
- Increase Medicaid funding to include payout for education of colleagues.
- Increase reimbursement and approved units for insurance
  - Educate about our scope of practice
  - Advocate for pediatric medical content to be taught in grad school and internships

- Advocate for better access to MBSS/FEES swallow studies rather to prevent poor practice
- Make continuing education free through ASHA with membership.

- Increase requirements for pediatric medical settings. Our local programs focus on educational settings for pediatrics and medical for adults with limited to no pediatric medical externship placements. Students and CFs do not see the complexities of patients we treat on a daily basis.
- Increase training in grad schools, advocate our skill base with other professional disciplines including doctors and dentists.
- Insurance reimbursement
- It would be beneficial if the ASHA Learning Pass was included in our ASHA dues so that I can use this resource to better my education. It is already financially hard enough to afford my dues each year, and I cannot afford to pay for the learning pass as well.
- It would be helpful if ASHA published evidence-based practice guides that could be easily implemented in the hospital setting.
- It would be helpful to have pediatric dysphagia be a required topic to cover in depth during graduate school. I felt underprepared to enter the workforce without sufficient education in this area.
- It's too expensive to keep up with ASHA dues. My organization doesn't cover those fees. That's a lot for just 1 year! OT/PTs make significantly more that SLPs but our fees are as high (PT) or higher (OT).
- Less $ for dues, advocacy for higher pay
- Less expensive resources, greater access to continuing education opportunities, advocating for reimbursement, encouraging graduate programs to address medical peds.
- Literally EVERYTHING. Better pay, less productivity/demands, case-load caps, more education (locally and nationally) about what SLPs do and how important/vital they are. Support us when we tell you we are BURNT OUT AND EXHAUSTED and want to leave this field. We love being SLPs but it is NOT an easy job and ASHA needs to do better in TRULY supporting us, not just taking our money.
- Lobby and fight for increased reimbursement rates for SLPs and respect as part of the therapeutic professional team. SLP reimbursement is lower than that of OT/PT counterparts, which means SLPs are asked to see more patients for shorter periods of time compared to others in our practice. This does not allow for the quality of care our patients deserve. We are equals in the care team and should be reimbursed accordingly.
- Lobby for a Federal license (no more state licenses) to make telehealth more seamless and accessible to all regions!!
- Lobby for better insurance reimbursement rates! Private practices are struggling.
- Lobby for better pay, better insurance reimbursement, and caseload caps for us!
- Lobby for better reimbursement for early intervention
- Lobby for better reimbursement for service provided - absolutely ridiculous that we are still a one time charge when are services touch on a wide range of skills at any given time - it's honestly an insult to our profession and a moral killer as that reflects in our pay across the board - truly truly unacceptable
- Lobby for higher insurance reimbursement rates or decrease cost of yearly membership
- Lobby for higher reimbursement from insurance companies. My company can't accept patients in Network for certain plans because the rate is less than 30$ per session. They will loose money seeing these patients in network. Its terrible that these insurance companies can offer "speech services" but have such a limited network due to their poor reimbursement.
- Lobby for increased insurance reimbursement, which will in turn provide higher pay for SLPs. SLPs are leaving the field because of low wages and poor insurance reimbursement.
- Lobby for increased/consistent reimbursement so that we are not plagued with unreasonable productivity demands in order to earn a livable wage.
- Lobby for insurance companies to be required to increase rates a certain number of years. Or require them to negotiate or pay a standard rate based on a CPT code. In NJ there are instances where insurance companies have not raised rates on some CPT codes since 2010 for small private practices and they will not negotiate rates unless you are a large corporation. The rate is less than 50% of what

Medicare pays. I know of an outpatient clinic that is through a larger hospital system that is being paid 3x the rate i receive for the same service and amount of time. It makes it difficult to have a specialized practice for patients, to hire the right people because you can't compete with pay and to run an office for these clients. ASHA should be lobbying for private therapy offices to be receiving the same rates as larger healthcare corporations, skilled nursing facilities and hospitals. By ignoring these rate disparities many private therapists are only accepting private pay and leaving specialized care to families who can afford to pay out of pocket, this is a travesty for the patients that unable to financially do so and still need the same care.

- lobby for less productivity demands and more time to allot for training, CEU's, supervision
- Lobby for more fair reimbursement from insurance companies. Lobby for more specific codes for reimbursement including paperwork time. Change reimbursement to timed so clinics can't get away with half hour sessions that aren't appropriate.
- Lobby for SLP's to receive reimbursement that matches or exceeds other ancillary services (OT and PT).
- Lobby insurance to increase SLP rates and allow SLPAs to practice in all states.
- Lower annual fees so we can spend that money on CEUs; offer free CEUs
- lower cost continuing education and dues
- Lower dues, make licensing universal across states, create more education/guidelines to ensure those practicing in specialty positions have the appropriate level of training.
- Lower prices of dues
- Lower rates required for renewal dues, subscriptions, etc. Provide free learning pass for continuing education.
- Lower the price for continuing Ed courses .
- Lower your dues.
- Lowering cost of SIGs, providing discounts for CEUs, etc. to encourage professional development.
- Make all journal articles open access. Why do we pay for ASHA membership if we then have to pay to have access to pertinent research/education. It's frustrating to not have easy access to new research to support practice.
- Make continuing education more affordable and time-efficient. Help advocate for funding for speech pathology services in Medicare and Medicaid programs. Educate and emphasize to politicians and policy makers on how important Speech-language pathology is so they support legislation and funding for us. My paycheck is so low. Lower dues and/or free quality continuing education opportunities would really help me. Perhaps advocate to insurance companies and medical businesses to significantly increase the pay rate of the Speech-language pathology teams.
- Make courses free
- Make education free or donation based.
- Make education, certifications, and access to research more accessible - I.e. not at an additional cost to the already expensive fees we incur for membership. Advocate for fair pay for SLPs on a national level.
- Make it free to log ceus. I understand why we have to pay for them, the presenters need to get paid for their work. But please don't charge us yet more money to log the hours
- Make more affordable CEUs available, provide access to current research, advertise research opportunities more clearly in the community, provide more standardized resources such as intakes, family education, etc
- Make online CEUs through pathways more easily accessible and more affordable
- Make pediatric feeding its own class at the university level
- Make peds feeding a part of grad school
- Make sig memberships free, improved national best practice guidelines for pediatric feeding and swallowing, pediatric MBSIMP & improved access to pediatric hands on FEES courses
- Make trainings more affordable. I would have loved to take the pediatric feeding course, but it was too expensive for me to pay for. I've been taking other courses that are less expensive as well as the few SLP

specific trainings my employer has offered. I think trainings through ASHA should be very inexpensive for those who are members and have paid dues for many years. Maybe have a tiered level of cost for CEUs where the longer you've been a member, the less expensive the courses become.

- Make virtual trainings better and less expensive for members. Include more resources with membership and support women's rights. Educate the public better about our role in language and literacy. It feels like we don't get anything for paying dues except the CCC-SLP by our names.
- Making sure that companies understand the importance of not putting productivity in front of quality of service.
- Many universities are recommending new graduates do not peruse home health, and there a large part of the recruitment pool is "off limits" or have been misinformed by their professors.
- Medicaid cuts have negatively impacted individual SLPs and our clinic as a whole. Several SLPs quit and now we are forced to take on more clients to try to make-up for the cuts. This leaves little time for collaboration and continuing education in the workplace. Dosage for treatment is primarily prescribed by productivity expectations. We are encouraged to have 30-minute sessions for all patients, regardless of diagnosis. We can increase the time but are not paid for the additional time. Billing in units could help the situation.
- Medical placements were hard to come by. Pediatric medical is very challenging and it's hard to get your foot in the door without mentorship or some previous experience.
- Mentorship opportunities or hands-on training opportunities (not just online lectures) after clinical fellowship for areas within the profession that I have not had the opportunity to gain experience in (e.g., Dysphagia).
- More advocacy in legislation for reimbursement. More advocacy for caseload/productivity standards. More presence/advocacy in the Western states.
- More CEUs included with our membership fee
- More collaboration with graduate school training and pediatric EI workplaces.
- More continuing education for pediatric health care
- More Early Intervention, Birth-three options at ASHA and the ASHA passport.
- More education in graduate school about early intervention- development in the first 5 years of life, how to evaluate this population, write and choose goals, methods of intervention, and talking to parents/caregivers. In the area I work I have supervised CFs for 4 years and each year they come out of the program with little to no knowledge of the early intervention population.
- More education on early intervention as a whole for graduate students as well as more education of autism, gestalt language processing, and AAC for the early intervention population
- More free access to CEUs that are from leaders in the field
- More free educational opportunities
- More guidance and continued education related to pediatric feeding and swallowing
- More information and support for private practice and telehealth practitioners
- More niche trainings in pediatric feeding
- more options for free CEUs; education and encouragement for insurance companies to increase the allowable limit of visits allowed for speech therapy
- More pediatric dysphagia education and research
- More pediatric feeding continuing education!
- More pediatric feeding training in grad school and beyond
- More pediatric research, EBP, and training would be amazing!
- More pediatric swallowing training
- More podcasts
- More readily available ceus.

- More reasonably priced CEUS or courses, advocating for professional work environments that do not lead to burnout for the majority of its employees. This has been a career wide problem and is considered "normal."
- More research and trainings for early intervention
- More support and advocacy around SLPs roles in diagnosing and treating autism. More guidance with IPP
- More support for Early Intervention
- More support with feeding in the pediatric population.
- More synthesized continuing education based on special interests. For example, a page for NICU protocols, continuing education and latest news about legal or ethics on the same page. The efficiency in finding relevant articles can be tricky as well as well as the frustration of research hidden behind paywalls can be a barrier to implementation of the research. I appreciate the summaries though.
  I appreciate how the continuing education pass has specialized sections for apraxia and TBI. Maybe if general pages were sectioned more as master or landing pages?
- More training and support to work with non-white patients
- More training specific to treating pediatric feeding disorders, not just identifying the problem and its cause
- My facility needs to see representative salaries for our field. The pay they offer is too low to compete, but online salaries are so high above our pay as to seem unrealistic.
- New graduates are expecting far greater independence than they are ready/competent for.
- NICU rehab is done only by OTs. Asha does not offer free ceus or access to journals. It does nothing that impacts my daily work life and my organization doesn't even acknowledge the need for CCC. However my state license does. I don't see an impact that asha has on my life other than making me spend hundreds of dollars a year to the organization. The leaders articles have not been helpful and if I want to read research it's talking about you don't give access. The informed SLP is way more helpful and if you had open access to research reviews I would be a lot more happy with Asha.
- Not charge extra for each SIG - not charge at all!!!
- not make everything so expensive
- Not make everything so expensive.
- Not require SLPs to have CCC!
- Not sure at this time.
- Offer a variety of free CEUs annually for members, even if each member has a limit annually. Help improve education in graduate programs to better prepare entry level SLPs for pediatric feeding and sensory related issues.
- Offer cheaper CEU courses
- Offer continuing education opportunities at the lowest price possible, making continuing education accessible to all members.
- Offer more free CEUs. Early on in your career is the most important time to be taking CEUs, but this is also the time when clinicians are least financially stable. I often find cost to be the barrier preventing me from taking more CEUs.
- Offer more free resources
- Offer more resources for private practice owners
- Offer relevant and progressive continuing education
- Offer stronger continuing education related to healthcare. Re-work graduate education requirements to allow for more flexibility in course content (e.g. do not require that everyone be educated about fluency, if they never plan to treat it, and replace that class with content that'll be applicable to their career path).
- Offer training that is not a graduate level professor's lecture. The ASHA website does not offer in depth training on special issues. i.e. laryngeal cleft. Moving from external to oral feeds

- Oh ASHA. I work with a very international, impoverished, gender creative, neurodivergent, and/or BIPOC community. I just don't see any of my clients represented in ASHA especially when there is overlap (e.g., gender creative, neurodivergent, and BIPOC)
- Organize continuing education within a specific milieu (AAC, Voice, Feeding/Swallowing, etc.) based on a hierarchy that correlates to needs for Board Certification in that area (or needs for upcoming Board Certification in that area if it does not currently have certification).
- Orofacial myofunctional and pediatric feeding training in grad schools (ASHA could push for this)
- Our field doesn't have the backing of PT, OT, and nursing. We are not paid or lobbied for as the other professions are and our benefit to the team goes unrecognized unless SLP's advocate for themselves. We have SLP's coming out of grad school that think that an MBSS or Fees give all information resulting in patients being placed on unsafe diets resulting in aspiration and multiple hospitalizations. Patients aren't getting treatment because without that MBSS some clinicians aren't treating.
- Our field needs more medical based SLP's
- Our reimbursement from insurance is too low to adequately reimburse us for our skills. This is in part because the research is lacking - insurance will only pay for 30 visits per year, so how do we treat apraxia that is recommended for 4x/week? the codes are untimed, so why would our employer give us 60 minutes when it pays the same as 30? If I do voice and swallow eval same day, why can't I bill for both? If a kid with ASD needs to be in the sensory gym working on AAC carry over, I can't do it because OT and SLP can't bill at the same time and same rate despite it requiring our skills the same. Same with feeding therapy. With low rates, we cannot adequately treat. We also can't adequately stay in these positions as the cost of graduate school is not worth what we are making in the field. We need more advocacy and active change on these rates. How does ABA get to see kids 40 hours per week and I get 30 minutes per week? How would I ever affect the same rate of change? It's no wonder they're taking over our field and delivering inappropriate services to our ASD population
- Pay us better.
- Pay us more
- -pediatric dysphagia and feeding courses in grad school
  -evidence based feeding, a lot of clinicians treating feeding with outdated and non evidence based practices like zvibes and oral motor stretches
  -most importantly asha needs to be advocating for our scope of practice, we are highly trained in MBSS and have taken extra courses and extra clinical training to be specialized in pediatric swallowing and our scope is often compromised by OT who does not have any training in MBSS and using none evidence based practices
- Pediatric evidence-based practice with feeding- outpatient is "creative" with oral motor that doesn't have actual evidence to support
  Set clear boundaries to limit OT dx and tx of dysphagia/completing mbss
  Adequate compensation for these higher level skill sets
- Pediatric feeding information for communities in rural settings-can be very difficult for families to access supports in the medical realm as well as educating pediatricians on Pediatric feeding--so many families are told to just feed their child or they will eat when they are hungry. Having nutrition supports and access when working with families with children with various feeding concerns has also been a barrier. I think overall having ASHA support and education in the Pediatric realm would be amazing-something for most of my career has been lacking. There has not been enough information for SLPs in school and out of school that would make most SLPs feel ready to dive into helping with this population-so much more for adult population. There were so families in need of feeding supports in the beginning of my career and nothing that I could refer them too in my rural area, which is what prompted me to do my own research and many continuing Ed opportunities. I feel there is more out there for SLPs to learn at the level they feel confident but definitely cam be improved upon.

- PLEASE ADVOCATE/LOBBY FOR REIMBURSEMENT INCREASES FROM INSURANCE!!! Cuts are happening left and right making it difficult for SLPs to have growth in their careers, maintain their pediatric private practices, and hire quality therapists. It feels like no one has our back.
- Please have more CE about medically complex kids, teaches/vents and PMVs.
- Please provide access to research articles with ASHA membership.
- Position statements, easier to use and better evidenced maps, cracking down and keeping people from sharing none evidenced based practice(people who say tongue ties cause all the problems or stretching lips can change tone, I know there isn't that much research, but they shouldn't be allowed to over promise)
- Private insurances need to be held responsible to reimburse a fair rate for speech services. Many private insurances are refusing to reimburse speech services, or will only reimburse up to a very limited number of sessions.
- Productivity standards recommended or implemented by ASHA for rehab settings and better delineation of skill sets for speech- e.g., clearing up behaviorists trying to treat communication disorders and feeding disorders
  Board certifications for more specialties like voice or AAC that can add more respect for our services
- Promote services in the NICU that would improve professional collaboration
- Promoting what we do as pediatric therapists
  Requiring more in the graduate programs
- Provide actual benefits, assistance, representation for the annual cost of membership. I feel like the membership is kind of meaningless and just one more thing I have to pay for with nothing to show for it.
- provide better reimbursement for overall services and fight for IPP/co-treat outside of hospital setting (e.g., outpatient clinic)
- Provide CEUs for the exorbitant price we pay for dues each year
- Provide CEUs included in the cost of membership
  Advocate to increase reimbursement rates nationwide
- Provide education on quantity of paperwork and how to set professional boundaries
  - Education on medical aspects of pediatric care (e.g., how to read monitors, physiological stability measurements for various ages, medical terminology, etc)
  - Pediatric dysphagia course
- Provide free additional CEU opportunities to therapists in big areas of need (e.g., pediatric feeding, apraxia)
- Provide free/dues-included resources and continuing education courses for the development of clinical knowledge and skills. Utilize dues for more advocacy at the local level
- Provide healthcare options as a practice practitioner.
- Provide information on best practices, standardize procedures such as infant feeding evaluations.
- Provide management with education on appropriate productivity, work with insurance companies to reimburse adequately for SLP services
- Provide more accessible research backed data to families, hospitals, and clinicians. Make the link between research and clinical practice easy to understand. Fight for SLPs performance to be measured on the outcomes of our patients (and not SLP productivity). Promote SLPs in management/ leadership roles at hospitals.
- Provide more classes at the university level addressing the Early Intervention population.
- Provide more information regarding private practice and building a business.
- Provide more learning opportunities at the grad school level for childhood feeding disorders and autism
- Provide more materials and support for private practice treating pediatric feeding disorder medically complex infants and toddlers after discharge.
- provide or encourage mentorships, or clear pathways/flowcharts to assist in expanding one's own competencies when trying to gain new skills.

- Provide resources for “specialty” areas- myofacial, cleft, feeding (sensory based), infant feeding (bottle systems, positioning)
- Provide resources for training graduate clinicians and clinical fellows and young professionals in pediatric feeding disorders and dysphagia. I have such a hard time finding pediatric feeding follow up clinics post nicu discharge. There are not enough therapists trained in feeding. Families should not have to travel great distances to find a competent feeding therapist. They end up having to see an OT for feeding. Why is SLP not training our students or at least offering an elective course in pediatric feeding? I feel that there are MANY children who SLPs serve for speech-language disorders who also have feeding disorders which are NOT addressed. No telling how many children in the schools are being fed by teachers aides who have no idea how to safely feed an individual with dysphagia when there is a licensed SLP in that school who is not addressing that child’s difficulties even though it is in their scope of practice.
- Provide resources that don’t come with additional fees.
- Provide some free CEU options
- Provide state guidance when it comes to areas in speech therapy that are not always discussed. An alternative might be to have a contact when we are not sure to help guide ethical and professional decisions. The local school district in my area refers dyslexia assessments to the clinic where I work. I know that literacy is in our scope but I would rather the psychologist conduct the assessment. When I reached out to the billing coder that person helped me out to state I can conduct the assessment but as language and part under a psychologist. I know that this question could have been handled with a contact at ASHA.
- Providing more ceu opportunities for infant feeding.
- Providing scholarship opportunities to attend the ASHA convention at a lower cost. Making ASHA available via virtual participation. People with small children or financial restrictions are limited in ability to travel to different cities and I feel unable to access the continuing education provided through the ASHA convention due to the exorbitant cost and need for travel away from my family associated with attending. We live in a rural state where ASHA does not hold its conferences and most years are a significant distance from my home. Given the opportunity to attend virtually would assist in the ability of many to attend. Scholarship opportunities could open doors for those of us who don’t have the financial means for more expensive continuing education opportunities.
- Push for higher pay to retain and recruit more SLP’s into the field of EI
- Push for more billable codes such as parent meetings/education, meetings with other disciplines, get more research out on pediatric feeding especially neurodiversity affirming approaches
- Rally for better insurance coverage from private insurance for speech and language services for individuals with developmental delay. For kiddos who have private insurance, our facility is limited to treating for only 30 minutes secondary to the reimbursement rate not even covering overhead. Some families have to pay private rates because insurance will only cover if there was an incident not developmental delay.
- Realize that many rural facilities only have one therapist who has to treat all ages and diagnoses. There is no specializing
- Recognized the experiences that we have from another countries.
- Reduce ASHA fees.
- Reduce cost of annual fee for doing pretty much nothing for me, release helpful articles instead of harmful ones claiming people with autism can lose their diagnosis, place focus and learn from people ACTUALLY practicing instead of academic professors who have no concept of the difficulties SLPs face day to day
- Reduce cost of fees and increase free education resources.
- Reduce licensing fees
- Reduce membership fees
- Reduce or eliminate dues.

- Reduce the insane cost of renewing my dues, so that maybe I could actually afford to join a SIG.
- reduce yearly cost. provide free resources, open up the fast-pass again, advocate for changing of trends in healthcare that support SLPs. Help SLPs feel like they matter in real and practical ways (provide free resources in the mail, etc., based upon listed populations, etc.) Change the cap with Medicare so that SLP and PT no longer have to share Medicare funds, advocate for telepractice to be an option for all who are clinically appropriate and who desire it. Thanks.
- Refresher courses on basic therapy treatments/diagnoses, for therapists who have not treated those cases in a while
- Reimbursement advocacy. Better resources for non-SLP management with regard to measuring "productivity".
- reimbursement for what we do; we need to be paid enough to call doctors and nurses, get orders, schedule and plan video swallows, help collaborate for autism diagnostics, etc which are all currently unpaid and our compensation does not make up for this time (as, say, a doctor's would)
  - other team members understanding our role and education is huge; they all think I'm the exception and am specialized, which is true to some extent, but ALL SLPs could be doing these same things
  - help other SLPs know what is in our scope, how to advocate for families in medical field, and stop acting like we know less than other team members (we are pathologists - we diagnose - we don't have to be the same as OT and PT)
- Reimbursement rate representation for insurance. It's pathetic
- reimbursement rates need to improve to better support finding and keeping staff
- Require gestalt language processing education at the graduate level, include sos approach strategies in pediatric dysphagia courses
- Require graduate programs to offer a course in infant and pediatric dysphagia. Reduce the cost to maintain ASHA membership/CCCs. Track CF feedback on their clinical supervisors because some of the SLPs acting as CF supervisors are horrible, unethical, & we have no easy way to report them. Publish caseload caps for different settings so we don't burn out, stay in the field longer, have time to conduct research, & time to attend continuing education within our work week. Advocate for our terminal degree to be an SLPD instead of a masters level SLP - similar to PTD/OTD so that we are taken more seriously within the rehab/medical community. Encourage more graduate programs to offer pediatric feeding and swallowing specialty tracks or SLPD programs.
- Require higher standards and accountability for clinical fellowship supervisors and facilities who accept CFs
- Require universities to provide more and repeated clinical therapy and diagnostic experience. It feels like they offer less and expect more and more from field supervisors.
  Our students are getting too much credit for practicing on each other and watching videos. They need to be on the floor and getting to know the play and learning joys, needs, and sensitivities in real little people, so they will be more competent beginning clinicians. The students also need to be able to be good communicators with WRITTEN, as well as spoken language.
- Research into the emphasis of productivity in healthcare setting and burnout in SLPs
- research on the effect of covid on children born during the covid so called crisis
- Resources on how to navigate barriers, e.g. insurance/billing, within private practices
  Greater advocacy for quality of education and higher income for SLPs
  Increased incentive for supervision of CFs, e.g. stipends, across all settings
  More research on burnout across different settings for SLPs
- Send more user-friendly content that can be easily read and absorbed on-the-go, reviewing research that is available through membership
- Set and enforce clear boundaries. ABA is overstepping in our field claiming to work on speech and language. Also, in the Orofacial Myology specialty, other fields are undermining our work as SLPs or becoming "orofacial Myologists" without the proper degree or training. It seems like our field is disregarded by other disciplines. It's very discouraging.

- Set productivity standards or guidelines for hospitals/outpatient clinics to follow, including INDIRECT/non billable time (charting, documentation, home programming customization, etc). This allows us to point to our governing body with administrators who are NOT SLPs, who do NOT understand our scope of practice.
- Share free resources to supervision topics
- Short video clips on targeted topics following EBP that are easy to access or sent to my email as a weekly subscription.
- SIG 13
- Speak to employers about productivity. The expectation is set high and SLPs are demanded to continue to work hard in the medical setting.
- Stop allowing Speech Language Assistants without a masters degree see patients and students, they are not qualified.
  2. Provide training in feeding in graduate school.
- Stop being so political and do more advocating. Quit trying to have a political stance on issues that Asha sees as important while marginalizing other groups. Russia has become entirely too political. They say they're helping us, but we are not seeing it at a clinical level. They say they are advocating for us, but we don't see it. when we ask questions of members of Asha, they dodged the questions. We don't feel heard and we don't feel represented.
- STOP CHARGING TO MAINTAIN MY CREDENTIALS.
- Stop mandating we have our CCCs to be employed as an SLP. Our state licensing agency requires CEUs. ASHA does *not* need to keep insisting that our CCCs are necessary to be employed. I would also appreciate lobbying with the $$ I give every year for 1) better reimbursement/higher wages 2) clear delineation of scope of practice between OT, DT, & SLP.
- Stop Registered Dental Hygienists from practicing speech and swallowing therapy under the guise of "myofunctional therapy," for one thing! Why did I go to an accredited school and take out loans when I all I really need to do to practice speech and swallowing therapy is become a registered dental hygienist. This is my biggest concern in private practice. And the fact that new grads are horrible employees. New grads need to understand the workforce better. I think the new grads are the worst I've ever seen. No one wants to hire them and they want starting salaries that exceed their professors. It's a tough time to be an SLP right now and I feel like ASHA is the most worthless organization. it does nothing to help us who are out here trying to make a living and run a business.
- stop requiring the CCC to save me money, stop putting it out that it is required for Medicaid/Medicare reimbursement when it is not for most states. Work more on increasing reimbursement, time based codes, and student loan forgiveness. In social media groups when students post asking about jobs, there are many responses stating not to go into SLP and to look into OT, PT or Physician assistant instead. Sadly, our pay rates and reimbursement are not sufficient to support the level of education required to practice. The amount of money ASHA takes in for dues relative to other professional organizations should be used to support SLPs in increasing pay rates and our reimbursement.
- Stop sitting on your asses and actually advocate for us with insurances- if we don't get paid by insurance, we'll never get more SLPs. The CCC is useless and the dues money goes to god knows what. ASHA could do it's job and actually help the field.
- Stronger CF mentorship standards, more free CEUs through ASHA (based on the membership dues we pay).
- Support caseload caps or other methods to prevent overwork/burnout
- Support continued research related to pediatric dysphagia in the infant and pediatric population with round table discussions about how the research can inform evidenced based care.
  Outline ethical billing practices for infants who need evaluation/treatment sessions on an as needed basis vs. scheduled (weekly/monthly) therapy visits.
- Support graduate studies in peds dysphagia, support EBP, help members distinguish between EBP and marketed programs

- Support in shifting the overbearing caseload sizes and overall pay wages leading to a feeling of burnout
- Support increase in requirement for increase in dysphagia courses in college curriculum
  Increase mentorship on mental health education for therapist as we also deal with Personal trauma and how to manage
- Support increased compensation for SLP's to better compensate for work/case/CE load demands to entice ongoing practice growth.
- Support increases in insurance reimbursement and diversification of ICD-9 codes that are billable for SLPs as well as the practices for billing.
- Support Orofacial Myologist and recognizing that it is a speech language pathology disorder
- Take stands when it comes to legislation that effects the medical field and SLP specifically. Fight for a seat at the table when CDC is changing developmental norms that effect pediatrician referral sources and timelines. We pay a lot of money a year to be a part of this organization that does not give us much in return for that money. If there are any groups or CEUs that are helpful, we often have to pay extra for those.
- The field of Speech Pathology needs to be regarded as essential to the wellbeing of clients. Just as mental health and physical medicine are. Therefore leading to increased insurance reimbursement so that a higher level of care can be provided. Insurance rates have been declining every quarter. Also I find that my professional opinions and recommendations are disregarded by other medical professionals. ENTs in particular
- The productivity demands make for lack of time to prepare, research, create materials, and overall support my patients and team. Productivity standards have skyrocketed since I began treating in 2013, with reimbursement rates from insurance staying relatively the same or even declining (BCBS IL). Would appreciate advocacy for therapists to determine length and duration of treatment sessions, and for insurance reimbursement to reflect our expertise as it does with other health professionals.
- The salary survey results that they keep publishing are damaging to ability to recruit because it is giving graduate students unrealistic expectations for the amount of salaries/ pay rate that they should receive. I do not feel those surveys are helpful at all and seem to cause problems with hiring. Educate graduate students with more realistic expectations for beginning CF position pay rates. Also they need to advocate for more coursework and training for apraxia, autism, and pediatric feeding throughout the graduate programs in the country.
- There is a large gap between graduate student's clinical experience and the skills required to ethically and effectively treat pediatric patients. There is a large gap in pay/caseload expectations and reality for new graduate clinicians. There is are very serious insurance reimbursement issues (e.g. lack of increases spanning years) that limit employers' ability to keep up with the inflated costs of doing business and adequately pay their therapists. I would like to see more presence and involvement by ASHA to improve these issues.
- This survey needs to be better written. I am a pediatric therapist - privately contracted with health department to see children in their home. You need to clarify what groups of SLPs you are targeting. ASHA can support me by being upfront and clear as to what the organization is about. I should not be paying extreme dues to "prove" my competency. I have my CCC's, I have my Masters Degree, and I complete continuing education. Why do you put out the false narrative that me paying $250 or more a year proves my competence. You have "earned" $10,000 plus from me over my entire career. What a scam!!
- Train bilingual SLPs using the bilingual extension program from the Leaders Project as part of graduate school or as an optional track in graduate school.
- Unionize and support better compensation. We get paid very little compared to other medical professionals and companies are encouraging us to work off the clock to document and complete paperwork (notes, evaluations, etc). Please help us show our worth!

- Unsure, but a lot of support is needed for improved training and recruitment, for improving job satisfaction for employee retention and overall improvement of quality of practice with decreased focus on productivity
- Update pediatric feeding and dysphagia competencies to include requirement for independent course work. Provide or increase professional discussions better clarify what constitutes as "evidenced based practice". I would greatly benefit from a better understanding and category system for various intervention practices. For example, is NMES, Oromyofunctional, craniosacral considered "specialized therapy"?
- Use our annual fees to improve health policies and advocate for better reimbursement instead of a magazine every quarter.
- Use the high membership fees to fund development of evidence based trainings in more in depth topics in pediatric acute care and infant feedings settings across disciplines widely accessible.
- Vehemently advocate for SLPs who are assessing and treating oral myofunctional disorders, as this is within our scope of practice. OMDs impact all ages and stages of life and education on this topic is essentially ignored at the graduate level. This needs to change, as airway health and craniofacial development impact every aspect of life. Every client needs to be screened for OMDs.
- We are in desperate need to improve our reimbursement rate from insurance companies. We get paid so little for our quality services from some of these companies. They also need to become to allow visits for children without a medical diagnosis. This is promoting "wait and see" approach. Also, more insurance companies need to allow co-treat with other disciplines to maximize therapy outcome, especially for those children with sensory needs. We can't do our job when they are not regulated. ASHA needs to fight with the better and prove our worth.
- We are in need of higher reimbursement rates for insurance and Medicaid. New grads are coming out of college expecting huge salaries that are more than I make as CEO of two clinics. They have no clue about the reimbursement for different settings and what those settings entail.
- We need ASHA to fight to protect SLP scope of practice (encroachment by registered dental hygienists, for example) and advocate for higher reimbursement rates in order for the SLPs to be able to do our jobs, achieve outcomes for our patients and to earn a living commensurate with the amount of education (at the graduate level and the extreme amount needed in post-grad work because we truly are not prepared for everything we are supposed to know when we graduate).
- We need better compensation from insurance companies so that we are not so full of direct care so that we can spend time learning and developing new skills or teaching others
- We need better dysphagia classes teaching the "book work" - the foundations of anatomy and physiology but also diet, tx techniques, and background medical info- especially some medical background info. This is needed for both adult and peds.
- We need lobbying for better insurance reimbursement rates for private practice. BCBS of Alabama has not increased their reimbursement for speech therapy in years despite the fact that cost of living has increased steadily. We have tried to fight for better pay for ourselves but we NEED the backing of our professional organization. This is a huge issue and is the reason so many private practices have moved to only accepting private pay clients. This is keeping many families from being able to get the services they need because insurance refuses to pay SLPs what they deserve to be paid. PLEASE do something to make us feel supported/heard in this issue!
- We need more medical based training. Clinicians need more swallowing training especially as they seem terrified of it and hate to address it after graduating. I feel that younger clinicians are terrified because they aren't exposed as much. It is the main way that we are liable to risk life their lives so why do we provide hours upon hours of literacy, grammar, language development but not near enough on life expansion through nutrition and safety of it.
- We need more SLPs in general. I sometimes feel that we need to have less educational demand to reduce the expense and increase the output but I KNOW that affects the quality of care.

- We need to get reimbursement increased in the pediatric setting - we are so highly skilled in many areas outside of "traditional" SLP skills (i.e., apraxia vs general artic; non-verbal communication/AAC vs general language), medically based (e.g., swallowing disorders in infants) - but with our reimbursement so low, it is hard to recruit much less maintain staffing - in the end, the kids pay the price with low skilled workers, subpar care, or waiting lists
- Well, first, understand the differences between a hospital-based therapist and a private practice. Very few of these questions related to my situation. I do not work with swallowing or medically intense kiddos. Just sweet little preschool kiddos with speech and language issues. This was not an appropriate survey for my setting. I really love the Evidence Maps...those are terrific! More links to resources would be great :)
- Work for better reimbursement rates and higher wages at schools. I believe without these changes our profession will die because we can't fill the need and those working within the field are burning out
- Work for the government to increase the rates.
- Work to increase reimbursement rates and lobby for a Medicare reassessment re: COL vs rates, and lobby for laws that require other insurances to pay Medicare rates at the minimum for in-network providers.
- Work to increase reimbursement, including timed codes.
  Clear competencies for NICU and pediatric feeding.
- Work with states and insurance companies to provide pay/reimbursement which adjusts according to standard of living increases.