



ASHA
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SLP HEALTH CARE 2025 SURVEY

Survey Methodology, Respondent Demographics, and Glossary

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Executive Summary

The American Speech-Language-Hearing Association (ASHA) conducted a survey of speech-language pathologists (SLPs) in the spring of 2025. We designed the survey to provide information about health care–based service delivery and to update and expand information gathered during previous *SLP Health Care Surveys*. We have presented the results in a series of reports.

We drew data from six types of health care facilities: (a) general medical, Veterans Affairs (VA), military, long-term acute care (LTAC), or university hospitals; (b) home health agencies or clients' homes; (c) outpatient clinics or offices; (d) pediatric hospitals; (e) rehabilitation (rehab) hospitals; and (f) skilled nursing facilities (SNFs).

Highlights

- The survey was fielded in early 2025 via both postal mail and SurveyMonkey (i.e., electronically).
- The combined response rate was 18.6%.
- Two postcards resulted in an estimated 1.4-percentage-point increase in the SurveyMonkey response rate.
- 86% of the respondents were primarily clinical service providers.
- 70% of the respondents were employed full time.
- 45% received primarily an hourly wage.
- The median number of years of experience was 15; the mean was 17.
- 3% of respondents had earned a doctoral degree.
- 39% of respondents worked in the South.
- 43% of respondents worked in city or urban areas.

Survey Methodology

Mixed Mode

We used mixed modes (i.e., postal and electronic) when fielding the *2025 SLP Health Care Survey*. We sent the postal version to Group A on February 27, 2025. Individuals who returned their surveys were removed from second (March 27) and third (April 24) mailings. Group A's surveys had 31 questions in Arial 11-point font on 11 in. × 17 in. white paper, folded to 8.5 in. × 11 in. and printed in a format of two columns per page on four pages. We designed the surveys in Teleform to be scannable.

We personalized cover letters with the sample member's name and address and mailed them under the signature of ASHA's chief executive officer. Each postal mailing consisted of a personalized cover letter, a numbered survey, and a #10 postage-paid business return envelope inserted into a #11 window envelope with an ASHA return address. Metered postage was at the full, first-class rate.

We sent (via email) Group B the SurveyMonkey (SM) version on February 27. Although we typically send email reminders (known as *fieldings*) for SM surveys every week or two, we extended the period between fieldings for this survey to parallel the timing of the postal version. Individuals who completed their surveys were removed from second (March 27), third (April 24), fourth (May 8), and fifth (May 12) fieldings. Data collection for SM ended on May 19. Each SM version of the survey had 36 questions—five more than the postal version.

We emailed both Group A and Group B on February 14 telling them to be on the lookout (BOLO) for the survey in their postal mail or email boxes, respectively. Additionally, Group B received two printed postcards reminding them to check their emails for the surveys (see Table 2).

Stratified Sampling

We drew the sample from ASHA-certified speech-language pathologists (SLPs) who were employed full- or part time in health care facilities in the United States (50 states plus the District of Columbia).

We stratified the sample based on population sizes in each of six employment facility types (see Table 1). Because facilities with few SLPs (e.g., pediatric hospitals) were oversampled and those with many (e.g., SNFs) were undersampled, we used weighting when we analyzed data to restore all groups to their actual proportion in the population of ASHA SLPs.

Table 1: Sampling Design

Facility	Population	Group A: Postal Sample	Group B: SM Sample
General medical, Veterans Affairs (VA), military, long-term acute care (LTAC), or university hospital	11,875	900	1,800
Home health agency or client's home	8,882	740	1,480
Outpatient clinic or office	25,408	1,400	2,800
Pediatric hospital	2,512	500	1,000
Rehabilitation (rehab) hospital	4,529	560	1,120
Skilled nursing facility (SNF)	11,351	900	1,800
Total	64,557	5,000	10,000

Note. SM = SurveyMonkey.

The use of electronic surveys and the use of postal surveys have different pros and cons. Electronic surveys are less expensive than postal surveys when the cost per respondent is calculated. Also, the time between the closing of a survey and the availability of data to be used for analyses is shorter for electronic surveys than for postal surveys—the latter of which require time spent waiting for postal mail to be delivered and time spent scanning the returned surveys. However, the response rates for electronic surveys are lower than for postal surveys.

Research Question

In an effort to increase response rates for the electronic surveys, we mailed two physical postcards to Group B as reminders. We randomly selected 5,000 sample members who had not yet responded to the first fielding, and we mailed the first postcard on March 13 to 4,997 members who had active mailing addresses in the ASHA database. We then randomly selected 2,500 of the 5,000 recipients who still had not yet responded to the survey, and we mailed a second postcard to 2,498 of them on April 10.

Our question of interest was whether the postcards sent to Group B would have a positive effect on their response rate.

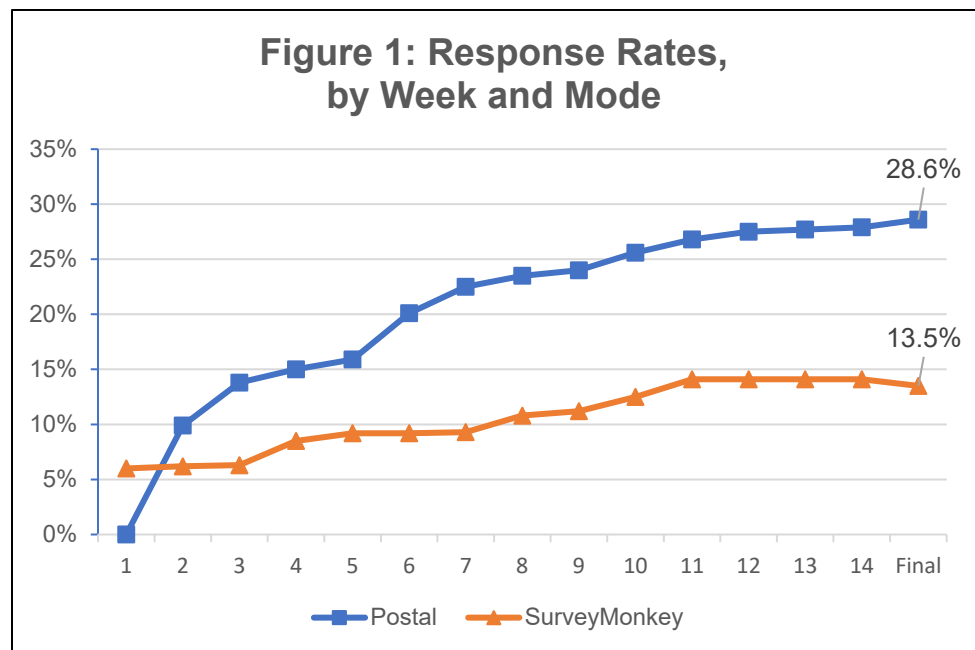
Table 2: Fieldings and Response Rates, by Date				
Date	Group A	%	Group B	%
2/14/25	Sent electronic BOLO to both groups			
2/27/25	First mailing (<i>n</i> = 5,000)		First fielding (<i>n</i> = 10,000)	
3/7/25	Week 1	0.0	Week 1	6.0
3/13/25			First postcard mailed (<i>n</i> = 4,997)	
3/14/25	Week 2	9.9	Week 2	6.2
3/21/25	Week 3	13.8	Week 3	6.3
3/27/25	Second mailing (<i>n</i> = 4,205)		Second fielding (<i>n</i> = 9,071)	
3/28/25	Week 4	15.0	Week 4	8.5
4/4/25	Week 5	15.9	Week 5	9.2
4/10/25			Second postcard mailed (<i>n</i> = 2,498)	
4/11/25	Week 6	20.1	Week 6	9.2
4/18/25	Week 7	22.5	Week 7	9.3
4/24/25	Third mailing (<i>n</i> = 3,733)		Third fielding (<i>n</i> = 8,762)	
4/25/25	Week 8	23.5	Week 8	10.8
5/2/25	Week 9	24.0	Week 9	11.2
5/8/25			Fourth fielding (<i>n</i> = 8,549)	
5/9/25	Week 10	25.6	Week 10	12.5
5/12/25			Fifth fielding (<i>n</i> = 8,401)	
5/16/25	Week 11	26.8	Week 11	14.1
5/19/25			Survey closed	14.1
5/23/25	Week 12	27.5		
5/30/25	Week 13	27.7		
6/6/25	Survey closed	27.9		
	Group A Final Response Rate	28.6	Group B Final Response Rate	13.5

Note. Final percentages are net percentages, with ineligible surveys removed.

Fielding dates and gross weekly response rates (i.e., the count of responses before any data cleaning to delete duplicate responses, ineligible respondents, etc.) for both Groups A and B are in Table 2.

The first noticeable difference between the modes is that Group B's response rates exceeded Group A's only at week 1. The reason is most likely that the electronic survey arrived at their email inboxes within minutes of being sent and could also be returned within minutes of being completed, whereas Group A's survey required waiting for mail to be delivered twice: once on the way *to* the respondent and then again on the way *back* to ASHA.

The second difference that stands out is the final response rates. Group A's response rate is more than double that of Group B's (see Table 2 and Figure 1).



Note. $n = 14,496$.

The research question that we explored was this:

Does the act of physically mailing reminder postcards to samples of the SurveyMonkey group have an effect on their response rates? And if so, how do the response rates differ based on how many (zero, one, or two) reminder postcards were sent?

To examine that question, we first compared the response rates of three groups within the SurveyMonkey mode (Group B; see Table 3):

- the 4,947 SLPs who received no postcard
- the 2,500 SLPs who received one postcard
- the 2,500 SLPs who received two postcards

Table 3: Response Rate, by Experimental Condition	
Condition	Response Rate (%)
No postcard	18.9
One postcard	12.9
Two postcards	6.1
Overall Response Rate	13.5

Group response rates alone do not give us enough information to evaluate the postcards' effectiveness. The reason for this is because the groups who got the postcards were already groups that were harder to reach—because they were nonresponders at multiple stages. In order to evaluate the postcards' effectiveness, instead, we need to look at (a) whether the timing of the group's responses was within close proximity of the date(s) on which the postcards were sent/received and (b) whether the group's response rate was higher than what it would have been had we not sent a postcard.

The remaining experimental analyses were conducted by capstone students in the Joint Program in Survey Methodology, a master's degree partnership program between the University of Michigan (U-M) and the University of Maryland (UMD).

For the group that received **one postcard**, their response rate was an estimated 1.26 percentage points higher than if they had not received the first postcard. For the group that received the second postcard, their response rate was an estimated 0.19 percentage points higher than if they had not received the second postcard. The overall effect of the postcards on response rate (1.44 percentage points) was significant compared with no postcards but was primarily driven by the effect of the first postcard.

Net Response Rates

The U-M/UMD capstone students also examined whether the number of responses was different for the postcard groups within a week of receiving the postcard. They found that although response rates slowly declined, which is typical for survey response rates, the decline was smaller among first-postcard recipients than among nonrecipients, and the second-postcard group showed a modest increase relative to the one-postcard-only group.

In summary, the postcard experiment was moderately effective for increasing response rates among initial nonresponders, but most of this effect was seen with the first postcard. For more specific information about the statistical techniques employed in these analyses, please contact ASHA's Surveys and Analysis Team at surveys@asha.org.

Members of the sample who (a) had undeliverable addresses, (b) were retired, or (c) were not currently employed in a health care facility were deleted from the calculation of the response rate. The net sample size was reduced from 15,000 to 14,496, resulting in the following response rates:

- 18.6% overall
- 28.6% for Group A
- 13.5% for Group B (see Table 4).

Table 4: Net Response Rate, by Mode

Disposition	Total	Group A: Postal Sample	Group B: SM Sample
Original sample size	15,000	5,000	10,000
Undeliverable postal address	48	48	
Undeliverable email address	199		199
Ineligible: opted out of SM	132		132
Ineligible: Retired	7	7	
Ineligible: Other reasons	118	76	42
Net sample size	14,496	4,869	9,627
Number of respondents	2,693	1,394	1,299
Response rate	18.6%	28.6%	13.5%

Note. SM = SurveyMonkey

Data Cleaning

The response rate for the postal surveys exceeded that of the electronic surveys (see Table 2). The difference was statistically significant ($z = 21.9, p < .001$).

We used a scannable form to field the postal survey. Data entry was limited to verifying each response on the scanner and making corrections by hand where the scanner misidentified answers. Additional data cleaning was done on both survey modes by removing conflicting responses (e.g., respondents who said that they received an annual salary but keyed in hourly amounts; respondents who selected three response options when the question asked for a maximum of two). The ASHA staff member with primary responsibility for the survey corrected or deleted erroneous responses.

Demo-graphics

Not only is it typically the case that some individuals who receive a survey do not complete it (*unit nonresponse*), but it is likewise true that some who return their surveys do not answer every question (*item nonresponse*) and, thus, do not qualify for inclusion in portions of a report. The survey originator may exclude these individuals from analyses because they did not answer a question at all or because their answer disqualified them (such as stating that they were employed part time when a particular analysis was limited to full-time employees). For example, among the 2,693 SLPs who responded, only 2,674 (weighted value) were included in reporting on their primary employment facility because they

- ◆ indicated that they were employed full time, part time, or per diem and
- ◆ identified the type of employment facility where they worked.

The closer the match between survey respondents and the population of ASHA health care–based SLPs from which they were drawn, the more validity there is in generalizing from the sample to the population—that is, the more truth there is in saying that the people who answered the survey questions represent the broader group from which they were selected.

Demographic variables that are present in both the membership database and the survey include *primary employment function*, *highest earned degree*, and *region of the country*. Another variable, *primary employment facility*, also appears in both databases but is not included in the comparison because the survey sample was stratified by oversampling and undersampling that variable (see

Respondents Versus Population

Table 1). Table 5 shows the comparison for the three remaining characteristics that were available from both the membership database and the survey. Groups A and B were weighted.

Table 5: Comparison of Respondents With Population				
Characteristic	Health Care Population (%)	All Respondents (%)	Group A (%)	Group B (%)
Clinical service provider	86.2	86.2	87.0	85.4
Doctoral degree	2.8	2.4	2.8	2.3
Region of the U.S.:				
Northeast	17.6	17.9	17.7	17.4
Midwest	21.0	25.0	24.0	25.4
South	43.3	38.3	38.6	39.1
West	18.1	18.8	19.6	18.0

Primary Employment Facility

More respondents worked in outpatient clinics or in offices than in any other type of facility (see Table 6). Because a disproportional random sample was drawn from each facility, this distribution does not reflect the distribution of SLPs within the Association.

Table 6: Primary Employment Facility		
Facility	Unweighted (n = 2,675)	Weighted (n = 2,674)
General medical, VA, military, LTAC, or university hospital	18.3	15.3
Home health agency or client's home	15.0	15.8
Outpatient clinic or office	28.9	39.8
Pediatric hospital	8.3	3.8
Rehabilitation hospital	9.4	6.1
Skilled nursing facility (SNF)	17.3	16.2
Other health care facility	2.8	2.9

Note. VA = Veterans Affairs; LTAC = long-term acute care.

Excluding *Other*

We have included the 78 (weighted value) individuals who reported working in an *other* facility in the *ASHA 2025 Health Care Survey Reports* only as part of the total—not as a separate category of facility—due to the ambiguous nature of this group of individuals.

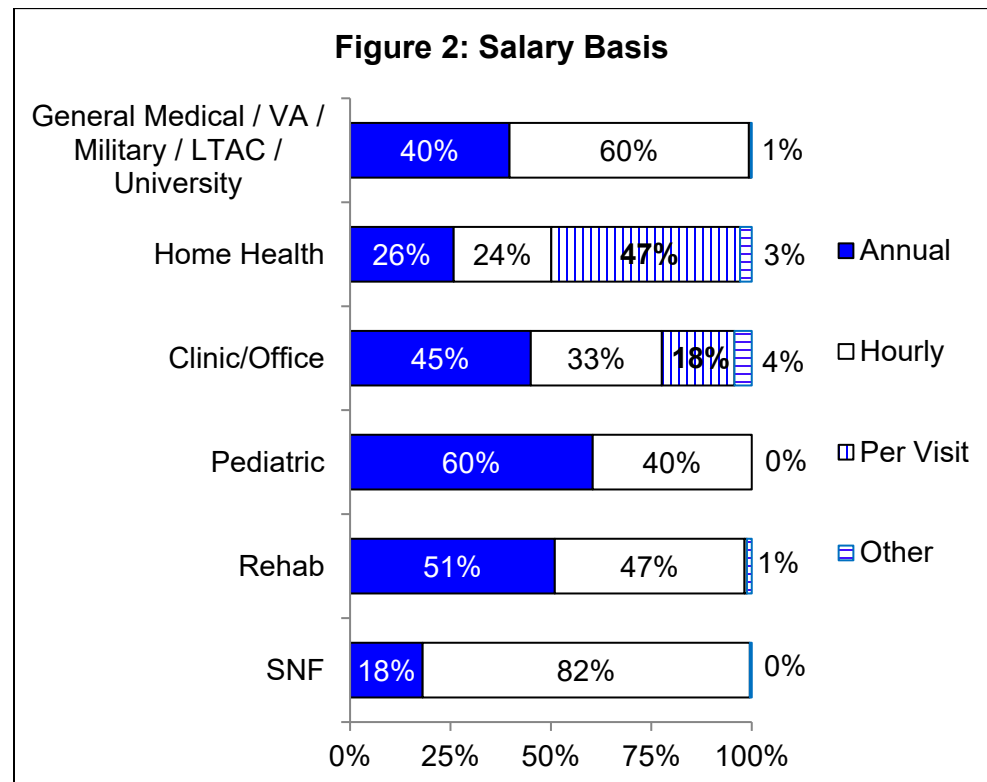
Employment Status

All of the SLPs whose responses were included in the analyses worked *full time* (70%), *part time* (20%), or *per diem / as needed* (11%). SLPs in pediatric hospitals were more likely than SLPs in other types of facilities to work *full time* (79%); SLPs who worked in home health agencies or clients' homes were more likely than those in other types of facilities to work *part time* (28%); and SLPs in (a) general medical, VA, military, LTAC, or university hospitals and (b) rehab hospitals were more likely than SLPs in other types of facilities to work *per diem / as needed* (18%; $p < .001$).

Salary Basis

As a group, 45% of the responding SLPs received primarily an hourly wage; 37%, primarily an annual salary; 15%, primarily a per-visit payment; and 2%, primarily an *other* type of payment.

Individuals in pediatric hospitals were the most likely group to be paid an *annual wage*. More than half of the SLPs in (a) general medical, VA, military, LTAC, or university hospitals, (b) rehab hospitals, and (c) SNFs received an *hourly wage*. Almost half of the SLPs in home health agencies or clients' homes received a per-visit wage ($p < .001$; see Figure 2).



Note. $n = 2,583$. VA = Veterans Affairs; LTAC = long-term acute care.

Years of Experience

The median number of years of experience was 15, and the mean was 17. The median number of years ranged from 13 in rehab hospitals and pediatric hospitals to 18 in home health agencies or clients' homes. The mean number of years ranged from 16 in rehab hospitals, in pediatric hospitals, and in outpatient clinics or offices to 20 years in home health agencies or clients' homes ($p < .001$).

Primary Employment Function

In previous iterations of the *ASHA Health Care Survey*, we asked respondents to identify whether they were (a) clinical service providers or (b) administrators or supervisors. Beginning in 2021, we expanded the categories to three options: (a) primarily clinical service providers, (b) primarily administrators or supervisors who saw some patients, and (c) exclusively administrators or supervisors. Findings from this survey revealed that . . .

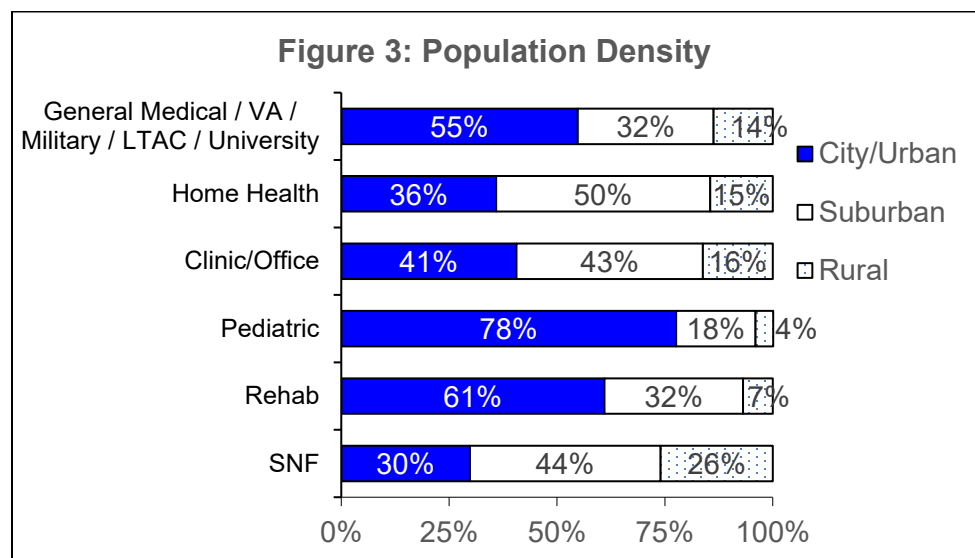
- 86% of SLPs who were employed full time, part time, or per diem were primarily clinical service providers.
- 10% were primarily administrators or supervisors who saw some patients.
- 4% were exclusively administrators or supervisors.

Highest Degree

Only 3% ($n = 66$) of the SLPs reported having received a doctoral degree. There is not enough evidence from the data to say that the responses vary by facility type ($p = .146$).

Population Density

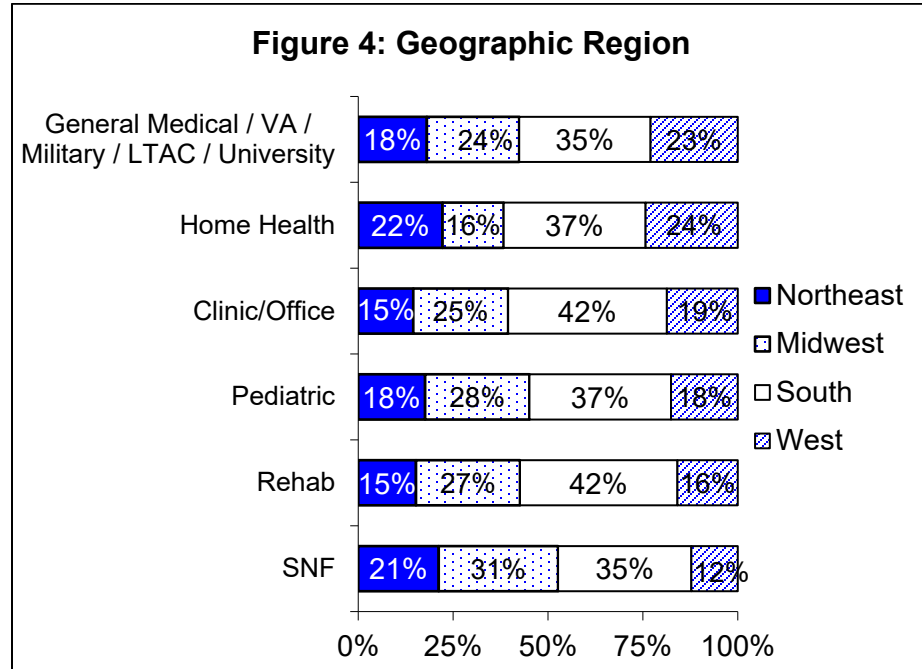
Few SLPs worked in rural areas (16%); most worked in either city or urban areas (43%) or in suburban areas (41%). Facility type was significantly related to population density ($p < .001$; see Figure 3).



Note. $n = 2,493$. VA = Veterans Affairs; LTAC = long-term acute care.

Geographic Region

More than one third (39%) of the SLPs worked in the South. The rest were fairly evenly distributed—with 18% working in the Northeast, 19% in the West, and 25% in the Midwest (not shown in any table). The region where SLPs worked varied by facility type ($p < .001$; see Figure 4). See the state-by-state listings for each geographic region on page 14.



Note. $n = 2,596$. VA = Veterans Affairs; LTAC = long-term acute care.

Glossary

In this section, we include a glossary of terms used in the *ASHA 2025 SLP Health Care Survey Reports*. Respondents self-identified for each of the variables—described below.

Employment Facility

Facility Type:

- General medical, Veterans Affairs (VA), military, long-term acute care (LTAC), or university hospital
- Home health agency or client's home
- Outpatient clinic or office
- Pediatric hospital
- Rehabilitation (rehab) hospital
- Skilled nursing facility (SNF)
- Other

Employment Function	Function: • Primarily clinical services provider (e.g., SLP) • Primarily administrative or supervisory position, but I do see some patients • Exclusively administrative or supervisory
Employment Status	Employment status: • Employed full time • Employed part time • Employed per diem / as needed
Population Density	Population density: • City/urban area • Suburban area • Rural area
Highest Degree	Highest degree: • Master's • Clinical doctorate (e.g., SLPD, CScD) • Research doctorate (i.e., PhD) • Other doctorate, specify
Experience	Number of years employed in the speech-language pathology profession, excluding their clinical fellowship

Regions of the Country**Northeast**

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

South

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

Midwest

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

West

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

Response Rate The response rate was calculated using the following equation:

$$RR = \frac{(C + P)}{S - (Ret + I)}$$

where

RR	=	Response rate
C	=	Number of completed surveys
P	=	Number of partial surveys
S	=	Sample size
Ret	=	Ineligible because of retirement
I	=	Ineligible for other reasons (e.g., does not work in health care, is no longer in the field, is on a leave of absence)

$$RR = \frac{(2,693)}{15,000 - (7 + 568)} = 18.7\%$$

n The number of items in a set

Measures of
Central
Tendency

Mean: Add the total of all values and divide by n .

Median: Arrange the values in order, from lowest to highest. Select the value in the middle position.

Mode: The value that occurs more often than any other.

Example: Sample data set

1, 1, 7, 34, 88

Mean: $(1 + 1 + 7 + 34 + 88) / 5 = 26.2$

Median: 7

Mode: 1

Because medians are more stable and less sensitive to extreme values than are means, we use medians as the most commonly presented statistic in the *ASHA 2025 SLP Health Care Survey Reports*.

Survey Reports

We present results from the *ASHA 2025 SLP Health Care Survey* in a series of reports at www.asha.org:

- *Survey Summary Report: Number and Type of Responses*
- *Caseload Characteristics*
- *Workforce*
- *Practice Issues*
- *Annual Salaries*
- *Hourly and Per-Visit Wages*
- *Survey Methodology, Respondent Demographics, and Glossary*

Suggested Citation

American Speech-Language-Hearing Association. (2026). *ASHA 2025 SLP Health Care Survey: Survey methodology, respondent demographics, and glossary*. www.asha.org.

Resources

Agresti, A., & Finlay, B. (2008). *Statistical methods for the social sciences* (4th ed.). Pearson.

Dillman, D. A., Smyth, J. D., & Christian, L. M. (2009). *Internet, mail, and mixed-mode surveys: The tailored design method* (3rd ed.). Wiley.

Additional Information

For additional information regarding the *ASHA 2025 SLP Health Care Survey*, please contact Brooke Hatfield, senior director, Health Care Services in Speech-Language Pathology, 800-498-2071, ext. 5692, bhatfield@asha.org.

Thank You

ASHA would like to thank the SLPs who completed the *ASHA 2025 SLP Health Care Survey*. Reports like this one are possible only because people like *you* participate.

We would also like to thank the Joint Program in Survey Methodology graduate students at the University of Michigan and at the University of Maryland who assisted with the postcard analyses: Sagnik Chakravarty, Yuchen Ding, Feiran Ge, and Ruisi Ma.

Is this information valuable to you? If so, please accept invitations to participate in other ASHA-sponsored surveys and focus groups. You are the experts, and we rely on you to provide data to share with your fellow members. ASHA surveys benefit *you*.